Exploring the factors associated with depressive symptoms and understanding stigma associated with living in a care home among older adults residing in care homes in Thailand



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Abstract

Background: Thai culture venerates caring for elders, thus care homes are stigmatised as the domain of poor older adults with no family. This impacts negatively on the psychological wellbeing of older residents and the high prevalence of depression reported among them. However, little is understood about the key factors influencing the depressive symptoms and how such stigma is experienced among care home residents. This study explored factors associated with depressive symptoms, internalised stigma, self-esteem, social support and coping strategies among residents from the perspectives of residents and staff.

Methods: Mixed methods research (convergent parallel design) was conducted in two care homes in northeast Thailand using a cross-sectional questionnaire, in-depth interview and non-participant observation. A cross-sectional questionnaire study was conducted with 128 older care home residents (with a response rate of 98.46%) using the 15-Item Thai Geriatric Depression Scale, Internalised Stigma of Living in a Care Home Scale, Thai Version of Rosenberg Self-Esteem Scale, Thai Version of Multidimensional Scale of Perceived Social Support and a Coping Strategies Inventory Short Form. Qualitative interviews were conducted with 30 older residents and 20 care home staff purposively sampled from both care homes. Non-participant observation was conducted in various public spaces of the care homes in both care homes for one month. Quantitative data was analysed using the

Statistical Package for Social Science (SPSS) IBM PASW Version 22.0 for Windows. Thematic analysis was used to analyse the qualitative data.

Results: Depressive symptoms were significantly correlated with internalised stigma, self-esteem and social support (r= 0.563, -0.574, -0.333; p< 0.001), respectively. Perceived internalised stigma of living in a care home was the strongest predictor of care home residents reporting depressive symptoms (odds ratio=9.165). In addition, the qualitative research explained the dynamics of the process of stigma related to three elements: the causes of stigma, the manifestation of stigma and the mitigating factors. Negative beliefs about care homes and people who live in them, coupled with negative attitudes and stereotypes toward older people, are the causes of stigma which are dominated by negative societal attitudes towards care homes. In addition, care home features contributing to stigma and staff issues are negative perceptions and experiences among residents whilst living in care homes. These factors trigger residents exhibiting negative emotions and behaviours (including depressive symptoms). However, the mitigating factors help to diminish or control the manifestation of stigma. These include coping strategies, social support and activities provided in care homes.

Conclusion: Older adults who perceived high internalised stigma of LiCH were over nine times as likely to report experiencing depressive symptoms. This was related to the dynamics of the process of stigma with three elements (the causes, the manifestation and the mitigating factors of stigma). The causes of stigma are the factors creating the

negative emotions and behaviours among residents living in Thai care homes. In addition, the mitigating factors help to diminish the manifestations of stigma. The most compelling need to improve the physical and mental wellbeing of elderly residents of care homes in Thailand is to combat the societal and cultural stigma associated with this population. This may be achieved through media collaboration, educational interventions in the care home setting and organising social activities for residents and their families.

Academic Achievement over the Period of Study

Peer reviewed publications

- Tosangwarn, S., Clissett, P. and Blake, H. 2017. Psychometric properties of the Thai Internalised Stigma Scale (TIS-LCH) for care home residents. ***Clinical Gerontologist*****,** *40*(5), 362-368.
- Tosangwarn, S., Clissett, P. and Blake, H. Predictors of Depressive Symptoms in Older Adults Living in Care Homes in Thailand. ***Archives of Psychiatric Nursing,*** *32*(1), 51-56.
- Tosangwarn, S., Clissett, P. and Blake, H. 2017. Stigma Associated with Living in a Care Home: Perspectives of Older Residents Living in Care Homes in Thailand. **In: Proceeding of WASET: the world academic of sciences, engineering and technology ICMH 2017: 19th International Conference on Mental Health**, 21st-22nd May 2017, Berlin, Germany. p. 2,398.
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- **2016 Best Poster Award at 13th International Conference on Psychiatric-Mental Health Nursing, London, UK** (3rd -4th October 2016)

- **2016 Certificate of Appreciation for a conference moderating at 13th International Conference on Psychiatric-Mental Health Nursing, London, UK** (3rd-4th October 2016).
- **2016 Thai Government Travel Bursary** for attending 5th Thai Student Academic Conference, Alghero, Italy (11th- 14th May 2016).
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Glossary of Terms and Abbreviations

ASSIA	Applied Social Sciences Index and Abstracts
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CASP	Critical Appraisal Skills Programme
CSI-SF	Coping Strategies Inventory Short Form
IS-LCH	Internalised stigma of living in a care home scale
LiCH	Living in a care home
MEDLINE	Medical Literature Analysis and Retrieval System Online
MSPSS	Multidimensional Scale of Perceived Social Support
OK	Olga Klein (the second reviewer for a systematic review)
PICo	Population or Problem, Interest and Context
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PROSPERO	International Prospective Register of Systematic Reviews
PsycINFO	Psychological Information Database
RSES	Rosenberg Self-Esteem Scale
ST	Suhathai Tosangwarn (the researcher)
15-TGDS	The 15-Item Thai Geriatric Depression Scale

Thesis Summary

Living in a care home (LiCH) is a source of stigma which can be associated with the development of depressive symptoms, particularly in conservative countries where family support is promoted. The purpose of this thesis is to explore the factors associated with depressive symptoms and understanding stigma associated with LiCH. The findings of the study present the dynamics of the process of stigma related to the causes of stigma, how it impacts on care home residents and how they cope with their residency experiences.

Chapter one explains the introduction and rationale of the study. It outlines the context of Thailand in terms of its culture and traditions, religion, government and policy regarding older adults and care homes. It presents a review of literature regarding the prevalence and severity of depression among older adults, identifying stigma associated with care homes as an important factor. Consequently, a systematic review regarding stigma associated with care home residency was conducted to provide the evidence base concerning how care home stigma can lead to the development or maintenance of depressive symptoms among this population.

Chapter two presents the systematic review of qualitative research, with meta-synthesis critically evaluating existing studies related to stigma associated with LiCH. The question of the review regards how stigma associated with care home residency influences the development or maintenance of depression among older adults (aged 65 years and older

living in care homes in any countries). The review provided the process of data extraction, quality appraisal of included studies and the data synthesis. The results of the review of existing evidence identified a gap in knowledge regarding stigma associated with care home residency, the factors associated with depressive symptoms in this population remain unclear. Therefore, this study explores the factors of stigma associated with care home residency among older Thai adults.

Chapter three explains the underlying methodology underpinning the research philosophy, and presents the aim of the study, research design, participant recruitment, data collection and data analysis. Mixed method approach was used with quantitative followed by qualitative phases. Ethical considerations regarding the study are discussed at the end of this chapter.

Chapter four presents a pilot study conducted in order to determine the feasibility of the research process and outcome measures used in the study. Furthermore, the psychometric properties of the questionnaires (the Thai versions of IS-LCH and CSI-SF) are developed and presented in this chapter. The Thai version of IS-LCH demonstrated good reliability and validity for measuring internalised stigma associated with LiCH. In addition, the Thai version of CSI-SF showed acceptable level of internal consistency of the scale.

Chapter five presents the findings from quantitative research aimed to explore the factors associated with depressive symptoms. These factors comprised internalised stigma, self-esteem, social support and coping

strategies. The results of study showed that perceived internalised stigma of LiCH was the strongest predictor of care home residents reporting depressive symptoms.

Chapter six presents the findings from qualitative research aiming to understanding stigma associated with a care home. The findings present the dynamics of the process of stigma related to three elements. The first element is the causes of stigma, which demonstrated various causes of stigma from the perspectives of residents and members of staff, including negative beliefs about care homes and people who live in them, the natures of the care home population, attitude and stereotype toward older people, care home features contributing to stigma and staff issues. The second and third elements, the manifestations of stigma and the mitigating factors of stigma, are presented in the next chapter.

Chapter seven continues to explain the process of stigmatisation, presenting the findings from qualitative research from the perspectives of care home residents and members of staff. The second element (the manifestation of stigma) showed how stigma affects residents' emotions and behaviours. The third element (the mitigating factors) illustrated how residents adapt to life in a care home life, including coping strategies, social support and activities.

Chapter eight illuminates the ways in which the identified elements of the stigmatisation process (i.e. causes, manifestations and mitigating factors) are experienced and exhibited by residents by analysing their experiences using five case studies.

Chapter nine presents the discussion and conclusion of this study, highlighting the salient findings that contribute to existing knowledge. The main discussions are the factors associated with depressive symptoms, how stigma associated with LiCH affects residents and how residents can diminish their stigmatisation of LiCH. The strengths of the study are discussed and the limitations identified, with commensurate recommendations for future research. Moreover, implications for practice and policy makers are suggested.

Chapter One: Background and Rationale

1.1 Introduction

The trend of an ageing population is a global phenomenon, as a result of declining fertility rates and longer life expectancy (World Health Organisation, 2017). By the middle of this century, the aging population will outnumber children for the first time in history. According to the United Nations (2015), the number of older adults over 60 years of age is growing at a rate of 3.26 per cent per year. In 2015, the number of this group was reported to be approximately 901 million worldwide, and it is expected to grow to over two billion people by 2050. Approximately 66 per cent of the increase between 2015 and 2050 will occur in Asia (United Nations, 2015).

Thailand is one of the countries in Asia that is experiencing an increasing number and proportion of people over the age of 60 years. Thailand is ranked as the second most aged country (after Singapore) in Southeast Asia (Knodel et al., 2015). The latest survey of the Thai ageing population in 2016 reported that the total number of older adults is approximately 9.9 million, the largest concentration of whom live in Northeast Thailand, numbering approximately 3.1 million (Department of Older Persons, 2017).

Traditionally, older adults are an important group within Thai society and they are respected and honoured by their children. In Thai culture, children (and their spouses) are expected to take care of their parents in older age (Knodel and Chayovan, 2012). This expectation originates in

the Buddhist doctrine of reciprocity, which reflects a positive view of and respect for older people. Gratitude in Buddhism represents the way out of suffering, which means that reciprocated gratitude is the sign of grateful and good people (Choowattanapakorn, 1999; Leelavanichkul et al., 2017). These beliefs and cultural values continue to impact Thai society particularly among Buddhists with strict religiosity. They still have high regard for the value of older adults. Figure 1 shows the location of Thailand.



Figure 1: Thailand in Southeast Asia

(O'Douuell, 2017)

Most Thai people view the concept of letting their ageing parents live in a care home with disapprobation, and some children state that even if

they were poor they would never let their parents move into or live in care homes. Some families believe that a residential care home is a place only for older people who have no family (Choowattanapakorn, 1999; Pornsema et al., 2014). In addition, 93% of elderly parents expect their children to take care of them when they get older (Philips & Chan, 2002); they particularly need to depend on their children when they are sick (Knodel and Chayovan, 2008). Previous research conduct in rural districts of Northeast Thailand supported that the value of familial responsibility for older adults reinforces the expectation of filial care from children (Rittirong et al., 2014).

However, this traditional expectation and way of life is facing serious challenges in the context of increasing migration of working age and younger generation Thais to urban areas, where most paid work is available; as a result, older parents are increasingly left to live alone in rural areas (Chottanapan, 2007). Financial support can be provided by the migrating children to their older parents, but this circumstance is in conflict with the traditional quality of being a grateful child taking care of parents, which was previously paramount among Thai children (Choowattanapakorn, 1999; Knodel and Chayovan, 2008). Furthermore, it has been suggested that the loss of support has harmful psychological effects due to the migration and older adults being “left behind” (Hendricks and Yoon, 2006; Nguyen et al. 2006).

Living alone and lack of support from children among older people can lead to many problems, including physical and psychosocial issues

(Suttajit et al., 2010). The major problems among older adults who live alone include loneliness, social isolation, not having anybody who can take care of them when they get sick, and difficulty sorting out daily activities (Suttajit et al., 2010). This is especially the case among older adults with disabilities and severe or chronic illness who need special care from their children or families because they cannot help themselves with activities. Older adults only rely on kin, friends and neighbours, who are traditionally charged with such care in Thai society, unlike the welfare state culture of Western Europe (Rittirong et al., 2014). Consequently, older adults may feel that they are a burden on their families. In Thailand, older adults may be sent (or voluntarily go) to live in a care home which is aimed primarily at those of low income who are unable to stay with their families or who are without relatives to live with (Wongpakaran and Wongpakaran, 2012a).

The Thai government promotes the value of family care and the traditional values of filial piety (Chuakhamfoo and Pannarunothai, 2014). As a result, the government only supports a very small number of care homes with a few thousand residents (Knodel et al., 2013b). Most older adults are underprivileged, poor, or abandoned (ibid). Currently, all over Thailand (76 provinces in four regions, including North, Northeast, Central and South), there are only 20 care homes (Wibulpolprasert, 2005). There are currently only four care homes which are supported by the government available in the Northeast region of Thailand for serving over three million older people in this region (Department of Older

Persons, 2017). These care homes are located in Nakhon Ratchasima province, Buriram province and Mahasarakham province.

In Northeast Thailand, nearly one-quarter (23%) of older adults living in care homes reported suffering from Major Depressive Disorder (MDD), and a suicide risk was found for one-third of the subjects (Wongpakaran and Wongpakaran, 2012a). In addition, a study conducted in Northern Thailand has shown a slight difference in the prevalent rate of MDD (24%) and suicidal thoughts (27%) among older adults living in care homes (Wongpakaran and Wongpakaran, 2013).

Living in a care home may cause severely depressive emotions among older adults due to elevated social loneliness (Scocco et al., 2006), social withdrawal (Watson et al., 2003), lack of social network (Burroughs et al., 2006) lack of motivation, lack of recreational and occupational opportunities, inadequate social activity and inadequate walking space within care homes (Dobbs et al., 2008; Osgood et al., 1991) and especially, stigma associated with LiCH (Dobbs et al., 2008; Fisher, 1990; Roth et al., 2016). The social construction of the home as a place for poor or abandoned older people effects discrimination against elderly residents and precipitates the development of depressive symptoms (Wongpakaran and Wongpakaran, 2012a).

Stigma is generally identified as negative attributes toward an individual who belongs to one or more groups that are commonly viewed with social disapprobation (Goffman, 1963). Living in a care home has been identified as a source of stigma (Dobbs et al., 2008; Roth et al., 2016). It

is possible that the significantly elevated levels of depression reported among older adults living in care homes are associated with the stigma surrounding the experience of having to live in a care home, although this has not yet been investigated.

Currently lacking is an understanding of stigma associated with LiCH, and important questions remain about the factors associated with depressive symptoms in this population. Consequently, it was of interest to explore and understood this gap in existing knowledge in order to usefully inform and support future psychological intervention or nursing care for prevention of depression and stigma among older adults residing in care homes.

1.2 Literature Review

Depression is one of the most prevalent mental disorders in older adults and it is associated with increased mortality rate, functional disability, health care utilization and medical costs (World Health Organisation, 2017); thus it presents a financial and systemic health burden before one considers the more immediate (ethical) concern of the decreased quality of life of depressed older adults (World Health Organisation, 2017). Although currently there are treatments available for depressive disorder such as antidepressants or psychotherapy, it is still reported as a leading cause of death and disability among older adults (World Health Organisation, 2017). The poor prognosis of depression makes it difficult to monitor and treat. One possible reason which makes depression among this particular group difficult to address has been found to be

particularly linked to stigma (Kim et al., 2011), which arise from the negative influences of status loss (Link and Phelan, 2001), loss of self-esteem and poor treatment (Corrigan and Watson, 2002a).

In order to understand the overview of depression among older adults, the prevalence and severity of depression and the association between stigma and depression, this study critically reviews existing literature to identify gaps in current research and to develop a research plan. The following sections provide the aim of the review, the method of search strategy and the results of the literature review.

1.3 Aim of Literature Review

The aim of this study was to assess prevalence and severity of depressive symptoms among older adults. The specific objectives were the followings:

To identify and synthesise evidence from quantitative and qualitative studies related to prevalence and severity of depressive symptoms among older adults.

To identify and synthesise evidence from quantitative and qualitative studies related to stigma and depression among older adults.

1.4 Search Strategy

Key electronic databases were used to identify studies, including CINAHL, MEDLINE, PsycINFO, ASSIA and Cochrane Library. Furthermore, manual search for reference lists was used to identity included study in this literature review. The databases were searched

from between June and July 2017. The search strategy was limited to studies published in English.

The search terms used to identify relevant studies are shown in the table below. Furthermore, text searching strategies were used to expand or include all forms of the search terms, such as Boolean operators (AND, OR), and truncations (*). Text searching operators which automatically find terms within five words of each other were also used, including NEAR, ADJ5 and N5.

Table 1: Search terms

prevalence	*severity*	*depression*	*stigma*	*older adults*
Preval*, epidemiology, frequen*, rate	sever*, impair*	depress*, mood	Stigma* or discrimination* or Prejudic*	Ag?ing, geriatric, older adult?, older people, elder*, senior*

1.5 Results

1.5.1 Depression prevalence in elder care homes

The literature consistently points towards higher rates of depression among older adults living in care homes (14% to 42%) compared to those living in the community (0.9% to 9.4%) (Djernes, 2006; Polyakova et al., 2014), particularly among older adults living care homes in Asian countries. The findings of the prevalence rates of depression (of general and specific types) among older adults living in care home as discovered by numerous empirical studies are presented in table 2. It can be seen that high prevalence rates of depression were found among older adults residing in care homes in Asian countries including Hong Kong, Taiwan,

Japan and Thailand, and very high rates of depressive symptoms were reported among older residents in Hong Kong (65.4%) and Taiwan (49%) assessed using the Geriatric Depression Scale Short Form (GDS-S) (Tsai et al., 2005a; Tsai et al., 2005b).

In Japan, 50% of residents had depressive symptoms, assessed by the Cornell Scale for Depression in Dementia (CSDD); however, Watanabe et al. (2007) used a small sample size (n = 44) with only a single care home, thus the findings are highly specific to the study context and may not be generalizable for larger populations. However, the salient findings were corroborated by Tsai et al. (2005b), who used a more representative sampling method; they applied random sampling to select two out of 18 public elderly centres, and 200 participants were selected by computerised randomisation, from whom it was found that nearly half of participants residing in care homes had depression.

Table 2: Prevalence of depression among older adults living in care homes

Study	Setting	Sample/ Age (years)	Scale assessed for depressive symptoms	Prevalence %
(Jones et al., 2003) USA	951 Nursing facilities	n=3,710/ ≥65 (81.7±0.26)	MDS*	20.3% (95% CI= 18.9–21.7)
(Watson et al., 2003) USA	193 assisted-living facilities	n= 2,078/ ≥65	CSDD*	13% were depressed
(Tsai et al., 2005b) Taiwan	A public elder care home	n=200/ ≥65	GDS-S*	Prevalence of depressive symptoms were 49%
(Tsai et al., 2005a) Taiwan and Hong Kong	8 Nursing homes in each region	n=150 (Taiwan) n=214 (Hong Kong)/ ≥65	GDS-S	Prevalence of depression in Hong Kong (65.4%) and Taiwan (43.3%)
(Davison et al., 2007) Australia	10 low-level care facilities	n=290 / ≥65 (M=85.38, SD=6.47)	DSM-IV*	16.9% were diagnosed with major depressive disorder
(Mcdougall et al., 2007b) England and Wales	Institutional settings	n=340/ ≥65	GMS and the AGECAT*	The prevalence of depression was 27.1% (95% CI 17.8–36.3)
(Watanabe et al., 2007) Japan	A health care institution	n=44/ ≥65	CSDD	Prevalence of depressive symptoms was 50%
(Wongpakaran and Wongpakaran, 2012a) Thailand	A long term care facility	n=81/ ≥63	GDS-15*	The prevalence of major depressive disorders was 23.5
(Tiong et al., 2013) Singapore	6 elderly nursing homes	n=375/ ≥55	DSM-IV	Point prevalence for depression was 21.1% (95% CI: 17.1%–25.6%)

*MDS = Minimum Data Set (MDS) diagnoses; CSDD = the Cornell Scale for Depression in Dementia; GDS-S = the Chinese version of the short-form of the Geriatric Depression Scale; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; GMS and the AGECAT = the Geriatric Mental State and the Automated Geriatric Examination for Computer-assisted Taxonomy system; CES-D = the Centre for Epidemiologic Studies Depression Scale; GDS-15 = the Geriatric Depression Scale-15

Furthermore, the findings of the studies conducted in Thailand and Singapore support a high prevalence rate of depression in Asian countries, with older Thai residents having 23.5% major depressive disorders, assessed by GDS-15 and CSDD (Wongpakaran and Wongpakaran, 2012a), and Singaporean older residents reported 21.1% depression with point prevalence according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (Tiong et al., 2013).

Elderly residents of care homes who live in the West typically report lower prevalence of depression compared to older adults living in Asian countries. A relatively high prevalence (by Western standards) was approximately 27.1% in England and Wales (McDougall et al., (2007b), based on a high response rate for the screening interview (80%). In Australia the prevalence of depression among elderly care home residents was approximately 16.9% with major depressive disorders. The results of (Davison et al., 2007) showed very interesting data related to depression treatment: it was found that less than half of the older people with major depressive disorders had been detected or treated, reflecting that depression among older adults in care homes is often overlooked and untreated. In addition, older adults residing in residential homes in the US displayed prevalence of depression close to their counterparts in Australia, ranging from 13% (Watson et al., 2003) to 20.3% (Jones et al., 2003).

There is still little empirical evidence to explain why there is greater prevalence of depression among elderly residents in care homes in Asia than in the West, but most studies assume that this is related to socio-cultural factors, such as religions, the value of family support, traditional practices of living in extended kin groups and the perception of stigma LiCH, although such issues are difficult to measure (Tiong et al., 2013; Tsai et al., 2005a; Watanabe et al., 2007; Wongpakaran and Wongpakaran, 2012a). In addition, the differences of health care structure, aged care systems and quality of life among older people residing in care homes are likely to be important factors that influence the prevalence of depression among this group. However further research regarding depression among older adults living in care homes is needed to substantiate such speculations. Specifically, the relationship between depression and stigma is still unclear due to the paucity of evidence examining the relationship between them.

1.5.2 Severity of depression in later life

Depression in later life has poor prognosis and widespread impacts. The most significant impact of depression in later life is its association with disability and chronic illnesses such as stroke, heart disease, Parkinson's disease and pulmonary disease (Roose and Sackeim, 2004). Furthermore, the severity of symptoms is related to role impairment and comorbidities (Gotlib and Hammen, 2009). This section examines and synthesizes the research focused on severity of depression in late life in a narrative summary. These include suicidal ideation; mortality; comorbidity and multi-morbidity; and functional impairment and disability.

1.5.2.1 Depression and suicidal ideation

Attempted suicide is a serious consequence amongst older adults who suffer from depression. Older adults aged 65 years and older have been reported to have the highest suicide rate of any age group (Hoyer et al., 2009). In addition, the research conducted in residential homes in England and Wales found that severity of depression was associated with suicidal ideation, with 21% of older adults suffering from depression reporting that they frequently wished to be dead (Mcdougall et al., 2007b). This study reflects a concerning issue among elderly depressed people in care homes that should be addressed.

There is a high prevalence of suicidal ideation among Thai care home residents, with 27% reporting suicidal thoughts (Wongpakaran and Wongpakaran, 2013). Unfortunately, the reasons for this were not explored by the study, but the finding in itself suggests that care providers should be aware of and detect this problem as soon as possible in order to devise appropriate interventions for vulnerable residents.

Very important questions regarding the factors associated with suicidal ideation have been tentatively explored by some pioneering scholars, including perceived burdensomeness or lack of meaning in life (Jahn et al., 2011; Van Orden et al., 2012), perceived lack of social support (Szanto et al., 2012; Van Orden et al., 2015) and particularly psychological problems, including depression (Van Orden et al., 2015; Wiktorsson et al., 2010). Suicidal ideation has been extensively explored with regard to adolescents in terms of age-related risk factors including

depression, but few studies have specifically focused on elderly people as a distinct group. A major study conducted in Korea (where suicide is the fourth-greatest cause of death) among 1567 men and 3726 women aged over 20 years (in their 50s on average) listed age as the foremost risk factor for suicide attempts among both men and women with suicidal ideation, followed by numerous other factors including depressive disorder:

> *"Among people with suicidal ideation, age, education, cancer, and depressive disorder were selected as risk factors for suicide attempt in men. Age, education, national basic livelihood security, daily activity limitation, depressive disorder, stress, smoking, and regular exercise were selected in women"* (Choi et al., 2017, 579).

The development of suicidal ideation among elderly people, particularly those living in care homes, remains underexplored. From the previous studies, it is clear that depression is a fundamental factor correlated with suicidal ideation, which is in any case inevitably bound with depression. Therefore, in order to address the issue of suicidal ideation among care home residents, the issue of depression among older adults in care homes should be addressed as well.

1.5.2.2 Depression and mortality

During recent decades the influence of depression on mortality has been investigated in numerous studies, which have demonstrated that depression appears to increase the risk of death among older adults

(Geerlings et al., 2002; Kawamura et al., 2007; Scafato et al., 2012; Teng et al., 2013; White et al., 2015).

A longitudinal case control study of older adults with and without depression conducted in Japan over 15 years revealed that depression was correlated with increased risk of mortality, particularly in females, as the results showed a hazard ratio (HR) of 1.55 (95%, CI = 1.16-1.89) for mortality in the depressed group compared to the control group (Kawamura et al., 2007). However, the long period of follow-up (i.e. 15 years) means that other mortality factors such as alcohol consumption, smoking habits or comorbidities could be involved, in addition to depression.

A cohort study conducted among elderly Italians for a 10-year follow-up period highlighted that the transition to a worse severity status leading to increased depression severity is significantly associated with increased mortality in both genders (78% for women and 27% for men) (Scafato et al., 2012). Change in severity of depression is significantly associated with seven-year mortality, with an estimated relative risk reduced by 44% for subjects with remission, and a 46% increased risk for those whose symptoms worsened (ibid). In addition, a UK longitudinal study of ageing reported that depressive symptoms are associated with an increased mortality risk across the full range of severity even at low level of symptoms (White et al., 2015). Consequently, the severity of depression could have negative impacts on older adults in all types of depressive symptoms.

The findings of previous studies suggest the need to improve case finding of later life depression by using a suitable screening process; moreover, factors and processes of change in depressive symptoms over time (e.g. longitudinally) should be developed and the mechanisms underpinning the associations between depressive symptoms and mortality should be illustrated in order to develop appropriate interventions for later life depression.

1.5.2.3 Depression, comorbidity and multi-morbidity

Severity of depression among older patients correlates with comorbidities and multi-morbidities. Research conducted among older adults who live in care homes in Norway reported that most elderly care home residents had problems with physical impairments and were suffering from chronic illnesses such as cerebrovascular disease, congestive heart failure or cardiac disease and diabetes (Drageset et al., 2011a). A study conducted in Canada found that most common problems of older adults in assisted living related to heart disease, and that arthritis and hypertension were common in this population (Bekhet and Zauszniewski, 2014).

Interestingly, it has been reported that chronic health problems are related to level of depressive symptoms (Lee and Brown, 2010; Wong et al., 2008). Older adults who have more chronic diseases and physical impairment have higher levels of depressive symptoms (Lee and Brown, 2010; Schoevers et al., 2003). More chronic diseases are correlated with poorer daily functioning and self-assessed health (Bekhet and Zauszniewski, 2014).

When older adults are suffering from chronic diseases, they need to continue living with such long-term conditions with the optimum quality of life. However, comorbidity and multi-morbidity can cause more financial strain (Gilman et al., 2013), poor daily functioning (Bekhet and Zauszniewski, 2014), low life satisfaction and increased depressive symptoms (Polku et al., 2015). This is a quiet (often undiagnosed) mental illness that could exacerbate the problems faced by elderly resident with chronic diseases. Older adults with clinical symptoms of depression are known to be likely to avoid seeking help for treating depression or their chronic illnesses.

Depressive symptoms are difficult to detect but they are particularly common among patients with comorbidities and multi-morbidities, which may have harmful impacts on both depression and the chronic diseases themselves. Further research is required to explore the role and causality of depression among older adults with comorbidities and multi-morbidities to improve the success of treatment of depression among older adults, particularly older adults living in care homes, who have markedly high prevalence of depression, comorbidities and multi-morbidities.

1.5.2.4 Depression and functional impairment and disability

Depression coexisting with physical illness has been shown to increase levels of functional impairment and disability among older adults (Da Silva et al., 2013). The close relationship between severity of depression and physical impairment was supported by the study of Ganatra et al.

(2008) conducted in Pakistan, which showed that depression was significantly associated with a greater number of health problems. In addition, another study also found that depression was correlated to functional disability among older adults in England and Wales as well (Mcdougall et al., 2007a).

Physical impairments commonly found among older adults include osteoarthritis, digestive system diseases and urinary system diseases, which have been found to predispose them to depressive symptoms, particularly the latter (Ganatra et al., 2008). This problem may be related to the restriction of older adults' social lives, as they are unable to engage in social or public activities due to their perceived ill health (e.g. urinary incontinence); this dearth of social interaction consequently exacerbates or causes depressive symptoms such as loneliness, isolation and low self-worth.

The acute link between physical impairment and depression was underscored by Weyerer et al. (2008), who found that the depression rate among older people with impaired mobility was 17.4%, compared to only 5.4% among those who were mobile. Moreover, the prevalence of depression among care home patients with impaired vision and impaired hearing was significantly higher than among care home patients without such deficits. The findings suggested that preventing or diminishing the effects of functional impairment may reduce the prevalence and impact of depression among older adults.

Functional impairment and disability may be related to self-assisted daily activities. Drageset et al. (2011) found that greater dependence of older people on others to assist them with activities of daily living (e.g. bathing, going to the toilet, dressing, transferring from bed to chair, continence and feeding) was associated with depression. The findings of this study suggest that being dependent for activities of daily living is a cause of social loneliness, leading to depressive symptoms due to lack of social contact (ibid).

Most previous research has confirmed that depressive symptoms among older adults are positively associated with functional impairment and disability. However, it is still not clear whether functional impairment is a trigger of depression or vice-versa. Functional impairment is associated with social isolation, which contributes to depression; thus, even if functional impairment is caused or exacerbated by depression, it itself compounds the depression.

1.5.3 Conclusion

Elevated levels of depression in older adults have been consistently reported in the literature. Depression is among the most commonly reported and debilitating mental disorders among older adults, associated with risk of suicide, mortality, comorbidity and multi-morbidity, functional impairment and disability. It is clear that depression is common and severe among older people, particularly in those residing in care homes. There is a clear need for further research on effective clinical

management of depression in particularly among older adults living in care homes.

1.5.4 Stigma and depression among older adults

1.5.4.1 What is stigma?

The term stigma is widely used in various disciplines, including psychology, sociology, political sciences and anthropology (Corrigan and Watson, 2002a; Link and Phelan, 2001; Rüsch et al., 2005). *Stigma* ultimately derives from the ancient Greek concept of those who were literally branded (e.g. burned or cut) to indicate that they were criminals or slaves (Goffman, 1963). The stigmatised person thus avoids appearing among the community that has ostracised him or her because of their manifestly inferior status and the shame associated with it (ibid).

The most widely used definition of stigma in psychological literature is that of Erving Goffman: “an attribute that is deeply discrediting which reduces the bearer from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p.3). Many subsequent scholars have developed Goffman’s original definition (Corrigan and Watson, 2002a; Gary, 2005; Link and Phelan, 2001; Mason, 2001). For instance, Mason (2001, p.2) defined stigma as the labelling of a person by others that related to the differences of cultural beliefs in society. For example, marrying a 13-year-old could be acceptable in the society of Pakistan, whereas it is unacceptable in Western countries (ibid). In other words, Mason holds that people are stigmatised based on their violation of culturally specific norms, and not universal mores, thus a cause of stigma

in one community could be normal in another. However, in order to have a formal definition that could be applied in various societies and disciplines, Link and Phelan (2001) defined stigma as a co-occurrence of its components (labelling, stereotyping, separation, status loss and discrimination) existing when all these elements happen together.

The identification and labelling of individual differences are based on society's selection of salient human characteristics, depending on groups - such as categories of black or white people - or time and place. This leads to labelled differences which are linked to stereotypes that could create social discrimination – an 'us and them' attitude - due to a set of undesirable characteristics arising from the stereotypes and automatic cognitive efficiency, such as whites being linked to positive words like 'smart' and 'clean' compared to blacks. As a result, an individual who is stereotyped is likely to suffer a reduction of his or her status in the eyes of others, resulting in fewer life opportunities; for example, rejected job applications or having requests to rent houses refused. Based on the definition above, stigma is the labelling of an individual by others, which depends on the culture or beliefs of a particular society.

People with mental illnesses are especially prone to stigmatisation because of the characteristics of such illnesses and the socially constructed fears of those who suffer from them (Corrigan and Watson, 2002a; Rüsch et al., 2005). Stigma in this group refers to "the collection of negative attitudes, beliefs, thoughts, and behaviours that influences the individual, or the general public, to fear, reject, avoid, be prejudiced,

and discriminate against people with mental health disorders" (Gary, 2005, p.980). The general public's negative perception of mentally ill people has been presented in studies by Wolff et al. (1996) and Gureje et al. (2005), the results of which highlighted many negative social perceptions, including feelings of fear, and consequently the ostracism of mentally ill people, authoritarianism (i.e. the lives of people with mental illness being dictated by others owing to their perceived irresponsibility), and benevolence (mentally ill people needing to be cared for by others because of childish behaviour) etc. (ibid). Research into the mentally ill points out the need to understand the stigmatisation of this group. This is introduced in the concept of mental illness stigma in the next section.

1.5.4.2 The conceptualisation of stigma in mental illness

The various definitions of stigma applied in different areas reflect different conceptualisations of stigma (Corrigan and Watson, 2002a; Link and Phelan, 2001; Rüsch et al., 2005). As mentioned previously, the pioneering conceptualisation of stigma was that described by Goffman (1963), related to society, social identity and social status. He argued that stigma is intimately associated with stereotypes, which refer to negative beliefs about a group and the self (Corrigan and Watson, 2002a), and that both are related to the collective unconscious and socially constructed expectations and norms which act as unseen arbiters in all social encounters (ibid). One of the leading conceptualisations of stigma is that developed by Corrigan and Watson (2002a).

Corrigan and Watson (2002) conceptualised stigma with greater emphasis on self-stigmatisation, while acknowledging the role of the society. They defined *public stigma* as negative perceptions held by the general public towards the stigmatised group whilst they also emphasised *self-stigma* as negative attributes ascribed to the stigmatised individual by themselves (Corrigan and Watson, 2002a). Corrigan et al. (2000, 2002) applied a social-cognitive model to identify and distinguish between these terms using three dimensions of public and self-stigma: stereotype, prejudice and discrimination. Stereotyping in public stigma refers to negative beliefs about the group (dangerous, incompetence, or character weakness), whereas in self-stigma it refers to negative beliefs about the self (incompetence or character weakness).

Secondly, prejudice includes two components: attitudes (favour or disfavour) and belief (based on overgeneralisation or erroneous information) in both public stigma and self-stigma refer to agreement with beliefs and/or negative emotional reactions, while both types of stigma show different reactions. The emotions of anger or fear appear most in public people, while low self-efficacy or low self-esteem have been found among mentally ill people with self-stigma. Lastly, discrimination is manifest as behaviour responding to prejudice against mentally ill people (e.g. withholding help, housing opportunities and work in public stigma, or failing to pursue work or housing opportunities and not seeking help in self-stigma) (Corrigan and Watson, 2002b; Rüsch et al., 2005).

The conceptualisations of stigma presented above strongly reflect that stigma is an important issue among people exposed to stigmatisation, especially people with mental health illness. In this group, stigma can lead to negative consequences towards treatment for mental diseases. In addition, the literature review highlighted the important point that the conceptualisation of stigma is influenced by and interacts with variations in the cultural beliefs of each society.

1.5.4.3 Stigma and cultural differences among people with mental illness

Culture is an all-pervading and fundamentally important phenomenon affecting all individuals within a society. Culture comprises socially transmitted ideas (e.g. language or norms), practices (e.g. laws or values or traditions), institutions (e.g. families), or artefacts (e.g. media) which are important factors in the expression of meaning in human action in the present and future (Wong and Tsai, 2007). Cultural belief is a factor which influences stigma among people with mental diseases, because the foundation of this emotion arises from others' negative evaluation or social devaluation, which fuels individuals' feelings of being unattractive or bad in the eyes of others (Gilbert and Miles, 2002).

Western culture is more likely to accept people with mental illness - specifically, depression – than Asian culture, according to a cross-sectional study about depression related to stigma among older adults by Turvey et al. (2012). The results showed that fewer participants in the USA (6%) believe that depression reflects personal weakness compared to older adults in Korea and Russia (78% and 61% respectively). The

attitude of the participants in the USA towards depression might reflect personal characteristics showing greater acceptance of depressed persons than the participants in Korea and Russia. Ascribing negative attributes to mentally ill people has been repeatedly found in Asian cultures. For instance, a study of beliefs about stigma among Chinese-American mentally ill people by Lin (2013) found that in Chinese culture people with mental illness are not commonly accepted, thus they are usually excluded from social opportunities or exposure to Chinese culture and language. Moreover, the findings show that stigma is experienced by Chinese families due to one of their members having a mental illness.

However, attitudes towards mental illness vary among Asian cultures depending on their culture and beliefs in each region. For example, a cross-cultural study in Asia by Kurihara et al. (2000) found that Balinese had significantly lower devaluation or discrimination towards people with mental illness than participants in Tokyo. The more positive attitude of the Balinese towards people with mental illness might correlate with the prevalence of beliefs that mental illness is caused by malevolent spirits or black magic, which can be alleviated by traditional healers. This is a particular example of how culture fundamentally influences the ways in which mental illness is perceived.

1.5.4.4 The relationship between stigma and depression

Stigma has been found to be significantly prevalent among those with mental illnesses, including schizophrenia, psychosis and depression (Corrigan et al., 2000; Corrigan and Watson, 2002b; Pyne et al., 2004).

A cross-sectional study about the relationship between perceived stigma and depression severity by Pyne et al. (2004) found that greater depression severity was associated with higher level of perceived stigma among people in treatment for depression compared to people who never experienced depression. Similarly, Yen et al. (2005) studied the correlation between self-stigma and depressive disorders in out-patients. They found that patients with higher severity of depression had correspondingly higher levels of self-stigma (ibid). These findings highlight the strong relationship between perceived stigma and self-stigma among people with depression. As a result, labelling a person with depression may lead a stigmatised person to feel low self-esteem or devaluation. They may tend to conceal themselves and avoid exposure to the public due to fear of discrimination, which leads to more negative emotion, low self-esteem or escape behaviour, as a result of developing or maintaining depressive symptoms. Stigma is highly correlated among people with depression. However, a limited number of studies have focused on exploring the role of stigma and the development of depressive symptoms, especially among older adults living in care homes.

1.5.5 Conclusion

Stigma is related to concern the 'otherness' of an individual from the prevailing mores and norms of a given society. People with mental illness are particularly susceptible to socially constructed attitudes and behaviours related to stigma, although these vary according to the nature and beliefs of the society in question. The literature review identified a

gap in existing studies concerning the high prevalence of depressive symptoms and stigma associated with older adults residing in care homes. There is still little empirical evidence to explain the key factors associated with the experience of depressive symptoms and very limited knowledge on stigma associated with living in a care home including, the relationship between them, the process of stigma and the potential role of stigma. This is especially how stigma develops or maintains of depressive symptoms and how stigma impacts on life of older adults residing in care homes. Findings from this study could assist in the development of appropriate psychological interventions to address depression and stigma, and provide an appropriate care for older adults residing in care homes. The next chapter of this thesis presents a systematic review of qualitative research. It illustrates how stigma associated with living in a care home influences the development or maintenance of depression among older residents living in care homes.

Chapter Two: Systematic Review on Stigma and Depression Associated with Elder Care Homes

2.1 Introduction

The second chapter of thesis discusses the background and rationale of a systematic review of qualitative studies on the topic of how stigma associated with living in care homes influences the development or maintenance of depression among older adults living in care homes. The study illustrates the method of this systematic review including stage 1: Systematic literature search, stage 2: Data extraction, stage 3: Quality appraisal of included studies, and Stage 4: Data synthesis. The results of the systematic review are explained after the method section. Discussion and conclusion of the review is presented at the end of this chapter.

2.2 Background

Depression is a significant contributor to the universal burden of mental illness across the world (Marcus et al., 2012). In excess of 150 million people experiences depression of some sorts during their life time (The European Commission, 2004). Depression is particularly prevalent among older adults (World Health Organization, 2012) and has been consistently linked to significant physical and mental health problems in this population (Hirsch et al., 2011; Mehta et al., 2002; Päivärinta et al., 1999; Tan and Wong, 2008; Wong et al., 2008). Higher rates of depression ranging between 14 and 42% have been consistently reported among older people living in care homes compared to those

living in the community (Djernes, 2006). Possible reasons underlying the relationship between LiCH and depression include high levels of emotional and social loneliness (Drageset et al., 2012; Scocco et al., 2006), social withdrawal (Watson et al., 2003), lack of warmth of a real home (Harris, 2007; Tavormina, 1999), lack of social network (Burroughs et al., 2006) and stigma associated with LiCH (Buck, 1985; Dobbs et al., 2008; Fisher, 1990).

Stigma is defined as an "*attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one*" (Goffman, 1963, p.3). Generally, stigmatisation arises when an individual is identified as belonging to what is commonly perceived as an unfavourable group that is associated with certain negative attributes. Such groups include asylum seekers, refugees and homeless people (Lamb et al., 2012), and being diagnosed with mental or certain physical illnesses (e.g. HIV/AIDS) (Mittal et al., 2012).

With regard to LiCH, certain negative attributes such as being dependent, frail and incapable of socialisation (Dobbs et al., 2008) or the use of oppressive and restrictive practices by facility staff (Coughlan and Ward, 2007; Dobbs et al., 2008; Shippee, 2009), could be a potential source of stigma among care home residents. Stigma can have detrimental consequences for the stigmatised individual including poor help-seeking behaviour (Barney et al. 2006; Conner et al., 2010b), low self-confidence, poor social relationships, isolation, self-harm and depression (Mason, 2001). It is possible, therefore, that the elevated levels of depression

reported in older adults living in care homes may be associated with the above negative attributes and the stigma surrounding the experience of having to live in a care home.

Based on the above, it is important to investigate *whether* and *how* stigma associated with LiCH is associated with the development and/or maintenance of depression among older adults. To the best of the authors' knowledge there are no systematic reviews examining this topic. Therefore, this systematic review addressed this evidence gap and could inform strategies and intervention to improve the care delivery in residential homes.

2.3 Review Question

How does stigma associated with LiCH influence the development and/or maintenance of depression among older adults?

2.4 Methods

The protocol of this study was registered with the PROSPERO International Prospective Register of Systematic Reviews (ID: CRD42016051126). The data of included studies were synthesised by using the thematic synthesis of qualitative research by Thomas and Harden (2008). The review was conducted in four stages.

2.4.1 Stage 1: Systematic literature search

A search strategy was developed based on the inclusion criteria (type of participants, phenomena of interest, context, and types of studies) and the exclusion criteria. This systematic review included the studies that

have participant's aged 65 years and older living in care homes in any country. The review included qualitative research studies that explore older adults' perceptions and experiences of stigma associated with LiCH and how these perceptions and experiences might influence the development or maintenance of depression among this population.

Included studies were conducted in care homes in any country. A previous Cochrane review by Ward et al. (2003) described the term "care home" as including private institutions and various public facilities dedicated to the care for dependent older adults. Moreover, an environment of residential care is described as an institute that provides the following services: general living services for elderly residents, overnight accommodation for dependent older people and nursing or personal care for residents (Ward et al., 2003).

Types of studies were qualitative studies including those based on an analytical design (e.g. grounded theory, phenomenology, ethnography and action research) as well as studies with qualitative strand of mixed-method designs exploring older adults' perceptions and experiences of stigma associated with LiCH and how these perceptions and experiences might have influenced the development or maintenance of depression in this population. The justification to only focus on qualitative studies was because the nature of qualitative studies tended to gain an understanding of research questions by exploring participants' perceptions and experiences of research phenomena. In addition, quantitative studies tended to quantify the research question by generating numerical data

and this would not provide the understanding of stigma in-depth and cannot fulfil to answer the research question of this study regarding understanding how older people associate stigma with the development or maintenance of depression.

The exclusion criteria were studies involving older adults under the age of 65, not published in English or conducted in a community or hospital setting, or any other setting that is not the permanent residence of subjects, such as post-acute care or intermediate care. Quantitative studies, literature reviews and commentary articles were excluded from the review.

A search of systematic review databases (Cochrane and JBI Database of Systematic Reviews and Implementation Reports) was undertaken prior to commencing the review and no previous systematic reviews were identified related to this topic. Six key electronic databases: MEDLINE, PsycINFO, EMBASE, CINAHL, Scopus were searched along with the thesis database ProQuest Dissertations & Theses A&I. In addition, Google Scholar, ResearchGate and hand searching of articles on reference lists were searched in order to ensure that no relevant study was missed.

Search terms to identify studies included in a systematic review must be calibrated to hone the research focus on stigma, while capturing broader studies such as research related to the lived experiences of care home residents, residents' perception of relocation and care homes, or residents' experience of depression, which could contain nested

information pertinent to stigma that can be extracted for subsequent analysis by the systematic reviewers. Therefore, any study containing the search terms; stigma* or discrimination* or prejudic*, in its title, abstract, index terms, and whole text were included. Furthermore, text searching strategies were used to expand or include all forms of the search terms, such as Boolean operators (AND, OR), and truncations (*). No date restriction was applied. The bibliographies of all identified studies were inspected for further relevant studies. The search strategy was pilot tested by the primary reviewer (ST).

The search was carried out by the researcher (ST). Reference manager (Endnote) software was used to remove duplicate references. The titles and abstracts of the identified studies were evaluated by two independent reviewers (ST & OK) using the inclusion and exclusion criteria. Full texts of identified studies were assessed by two reviewers (ST & OK) using the exclusion and inclusion criteria of this systematic review.

The search from databases identified 1,808 records and additional search 43 records, the total record after the duplication was 1,208 records. All of them were independently screened for title and abstract by the researcher (ST) and the second reviewer (OK). One thousand one hundred and seventy articles were excluded from the study after screening of titles and abstracts. Thirty-eight articles were independently full-text screened by ST and OK. The third and fourth reviewers (HB & PC) were consulted in order to make adjustment on two papers of the 38 articles.

Twenty-three articles were excluded from the review for the following reasons: Did not apply to a key question or research interested (n= 6); did not conduct among older adults living in care homes (n= 7); Literature review (n= 4); Not an original article (n= 2); Quantitative study (n= 3); and Not in English (n= 1). Finally, fifteen articles met the inclusion criteria after screening full-text. The study selection process is reported in the PRISMA 2009 Flow Diagram shown in Figure 2.

2.4.2 State 2: Data extraction

The data extracted included specific details about setting, the phenomena of interest, study methods, sampling strategy, participants, and analytic strategy. When these details had been extracted, findings related to residents' perceptions or experiences of stigma associated with LiCH were focused on. If differences of opinion arose between the two independent reviewers (ST & OK), those issues were discussed and if a consensus was not reached, a third and fourth reviewers (HB & PC) was consulted.

The included studies were extracted by ST and OK using a data extraction table as shown in Table 3.

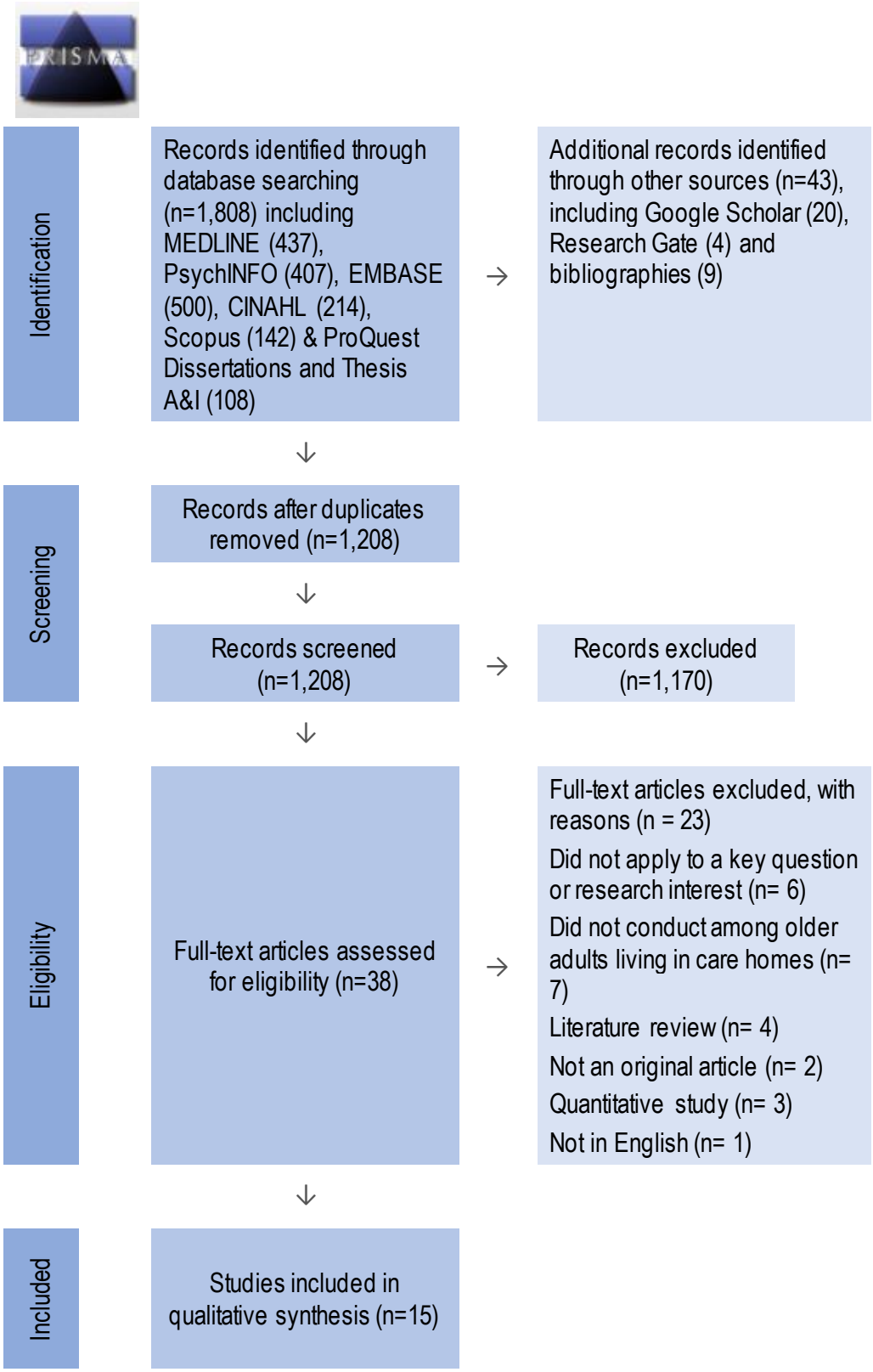


Figure 2: PRISMA 2009 Flow Diagram

Table 3: Data extraction

Study	Country	Sampling strategies/ Participants	Participants Age (years)	Method of analysis	Key themes
(Fisher, 1990)	USA	Unclear/ Over 150 residents	Not available	Unclear	The outsider's view of Rolling Meadows Residents' isolation from outside friends Keeping up appearances: Avoiding the nursing home look Grouping residents as a source of stigmatisation Strained friendships across residency classifications
(Groger, 1995)	USA	Opportunity Sampling/ 20 African American elders (10 nursing home residents and 10 home care clients)	Not available	Thematic analysis	Circumstances of nursing home placement Criteria used for defining "home" Continuity after institutionalisation Home care clients' views of nursing homes
(Fiveash, 1998)	Australia	Purposive sampling/ Eight residents	Not available	N/A*	Against my will Living in the public domain Cultural implications of living with others The impact of nursing home residency
(Bergland and Kirkevold, 2006)	Norway	Purposive sampling/ 26 nursing home residents (20 women and 6 men)	Aged range between 74-103 years (mean= 89.5)	Unclear	Premises for the experience of thriving in nursing homes Aspects contributing to thriving in nursing homes (Core aspects contributing to thriving; Additional aspects contributing to thriving) Differential importance of additional aspects related to residents' mental attitude and to thriving and non-thriving residents

Study	Country	Sampling strategies/ Participants	Participants Age (years)	Method of analysis	Key themes
(Franklin et al., 2006)	Sweden	Purposive sampling/ 12 people (10 women and 2 men)	Aged over 85 years	A hermeneutic approach	The unrecognisable body Dependency and fragility Inner strength and a sense of coherence
(Pope et al., 2006)	USA	Unclear/ 24 older adults participated in the study.	Aged 65 years and above (M= 82.54, SD=5.55)	Grounded theory	Long term care environment Emotional and well-being among participants and influencing event Participants' perceptions of residential emotional well-being and influencing events Resources used to cope during difficulties Enjoy activities Journaling as a coping resource
(Coughlan and Ward, 2007)	Canada	Convenient sampling/ 18 seniors (five men and 13 women).	A mean age of 84.35 years	Grounded theory	Relationships are the foundation of quality care (Relationship with family and friends; Building new bonds with staff) Waiting, activity and grieving loss of personhood (Waiting; Activity; Grieving the loss of personhood)
(Hellstrom and Sarvimaki, 2007)	Sweden	Purposive sampling/ 11 people living in housing facilities for older people (six women and five men).	Aged range were between 73 and 93 years	Manifest and latent qualitative content analysis	Facing a fait accompli (No information; No participation) Pleasing others (No demands; No complains) Being dependent (From self-determination to dependency; Dependent on others; Dependent on directives/ political decisions; Dependent on routines) Feeling of resignation (Feelings of anger, rage; Silence, disappointment; Feeling of being a victim) Feeling of not being valued (Lack of respect; feeling of worthlessness)

Study	Country	Sampling strategies/ Participants	Participants Age (years)	Method of analysis	Key themes
(Choi et al., 2008)	USA	Purposive sampling/ 65 older nursing home residents	Aged range: 65-99 (M=82.45, SD=8.44)	Theme-based content analysis	Self-perceived causes of depressive symptoms and/or negative effects (Loss of independence, freedom, and continuity; Social isolation and loneliness; Roommates and sharing bathrooms ; Institutional regimen and regulations – loss of autonomy; Cognitively impaired residents; Frequent encounters with death and grief; Staff turnover and shortage; State programing and lack of meaningful in house activities) Coping strategies and mechanism (stoicism and religious coping; sense of reality; positive attitude; family support) Acceptance of group and individual therapy
(Dobbs et al., 2008)	USA	Purposive sampling/ 153 residents	Not available	Unclear	Ageism in long term care Stigma as related to disease and illness (cognitive and physical) Sociocultural aspects of stigma Residential care and assisted living as a stigmatising stigma
(Tsai and Tsai, 2008)	Taiwan	Purposive sampling/ 33 older residents (24 females and nine males)	Aged range of 65-97 years (M=75.6, SD=8.9)	Thematic analysis	A temporary home to nurture health Everyday life in the nursing home (highly structure lifestyle; restricted activities; safety concerns; social interactions: family relationships, relationships with other residents and relationship with staff)
(Shippee, 2009)	USA	Purposive sampling/ 35 residents (22 from IL, 7 from AL and 6 from NL)	Aged 79 to 99 years	Thematic analysis	Autonomy (Being told to move; Threats to privacy and personal space; Rules regarding transitions and life in AL/NL) Fatalism (Death; Irreversibility of the move) Social disengagement (Amount of social interaction, Nature of social interaction)

Study	Country	Sampling strategies/ Participants	Participants Age (years)	Method of analysis	Key themes
(Williams and Warren, 2009)	USA	Convenient sampling/ Five women residents	Not available	Constant comparison method	Interpretative frameworks (Personality and decline; Race, class and cohort; Peer group and families: collective interpretation of communication;) Monitoring and compliance (Staff monitoring of residents; Residents' self and other-monitoring; some of them are very nice) Critiques of the Alf (the universal helper: food service and bed and body work; Overwork and turnover; My residents have the right to sleep)
(Wiersma and Dupuis, 2010)	Canada	Purposive sampling/ Three residents (two men and one women)	Not available	Hermeneutic phenomenological approach	The making of institutional bodies (Placing the body; Defining the body; Focusing on the body; managing the body; Relating to the body)
(Nakrem et al., 2011)	Norway	Purposive sampling/ Fifteen residents (nine women and six men)	Aged range between 75 and 96	Unclear	Getting the basics right: quality of care for, and alleviation of medical, physical and psychological needs (General and specialised care; Health promotion and prevention of complications; Too old and sick to be prioritised) Protecting the resident's integrity: the foundation for quality care (Self-determination and dependency; Altered role from homeowner to resident; Fear of indignity and depreciation of social status) Building relationships that enhance psychosocial well-being: a key issue of quality of care (Balancing the need for social contact and to be alone; Preserving the social network)

2.4.3 State 3: Quality appraisal of included studies

Two independent reviewers (ST & OK) assessed the methodological quality of included studies using a quality assessment tool; the Critical Appraisal Skills Programme Tool for qualitative research (CASP Qualitative Checklist). This appraisal tool was used because it is broadly applicable to evaluate different qualitative designs, address descriptive validity and generalisability, it is a popular appraisal instrument ready to use and free of charge (Hannes et al., 2010). The essential criteria for appraising qualitative studies included a clear statement of the aim of the study, methodology, research design, recruitment strategy, data collection, ethical issues, data analysis, finding and transferability. A third reviewer (research supervisor) was consulted in order to make adjustment on critical appraisal of two papers of the included studies. The details of assessment of methodological quality of included studies can be found in Table 4.

Table 4: CASP Qualitative Checklist assessment of methodological quality of included studies

Screening questions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4. Was the recruitment strategy appropriate to the aims of the research?	U	U	U	Y	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y
5. Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6. Has the relationship between researcher and participants been adequately considered?	U	Y	U	Y	Y	U	U	U	U	U	U	Y	U	Y	Y
7. Have ethical issues been taken into consideration?	U	Y	U	Y	Y	U	Y	Y	U	Y	Y	Y	Y	Y	Y
8. Was the data analysis sufficiently rigorous?	U	U	U	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10. How valuable is the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

* Y= Yes and U= Unclear

** 1. Fisher (1990); 2. Groger (1995); 3. Fiveash (1998); 4. Bergland and Kirkevold (2006); 5. Franklin et al. (2006); 6.Pope et al. (2006); 7. Coughlan and Ward (2007); 8. Hellstrom and Sarvimaki (2007); 9. Choi et al. (2008); 10.Dobbs et al. (2008); 11.Tsai and Tsai (2008); 12. Shippee (2009); 13.Williams and Warren (2009); 14.Wiersma and Dupuis (2010); 15. Nakrem et al. (2011)

2.4.4 State 4: Data synthesis

The researcher (ST) identified themes, sub themes and core findings reported in each study. The findings were analysed applying the Thematic Synthesis by Thomas and Harden (2008) (Thomas and Harden, 2008). This method preserves an explicit and transparent link

between the conclusion and the result from a primary study, which had been extended to combinations of studies with a wide range of theoretical perspectives (bid). It had been widely used in a review of health promotion research as well. The analysis phase included the coding of text “line-by-line”, the development of “descriptive themes” and the generation of “analytical themes”.

2.5 Results

This thematic meta-synthesis explored a clear and explicit question on how stigma associated with care home residency influences the development or maintenance of depressive symptoms among older adults living in care homes. We formulated the research question based on PICo for qualitative studies (Population characteristics, Phenomena of interest and Context) (Murdoch University, 2017). Furthermore, we developed a protocol of systematic review of qualitative studies and registered the review in PROSPERO. We conducted a comprehensive search for relevant studies within six electronic databases, including the major bibliographic citation databases MEDLINE and CINAHL, plus other internet platforms such as Google Scholar and ResearchGate, and a hand search of reference lists to ensure relevant papers were not missed. We included 15 studies related to the topic of stigma associated with care home residency for thematic meta-synthesis. This screening process was undertaken by two independent researchers (ST & OK) under the supervision of the two researchers (HB & PC).

Two independent researchers (ST & OK) assessed the methodological quality of included studies using the Critical Appraisal Skills Programme

Tool for qualitative research (CASP Qualitative Checklist). Only two studies – Fisher (1990) and Fiveash (1998) – had unclear reporting on four questions based on CASP regarding recruitment strategies, the relationship between researcher and participants, ethical consideration and data analysis rigour. In addition, four studies – Groger (1995), Pope et al. (2006), Choi et al. (2008), and Williams and Warren (2009) – had unclear reporting on two questions based on CASP (see Table 4). Only one unclear question regarding the relationship between the researcher and participants was found in four studies: Coughlan and Ward (2007), Hellstrom and Sarvimaki (2007), Dobbs et al. (2008) and Tsai and Tsai (2008). All 15 included studies were considered valuable for thematic meta-synthesis.

Consequently, the findings from 15 qualitative studies conducted across the world, including North America, Europe, Asia and Australia related to topic of stigma, perceptions and experiences of older adults living in care home were synthesised using thematic synthesis (Thomas and Harden 2008). Most studies applied purposive sampling strategies to identify participants, but two studies (Fisher 1990; Pope et al. 2006) had unclear reporting on sampling strategies used for selecting participants. Included studies applied various approaches and techniques for data analysis, including thematic analysis, grounded theory, humanistic approach, content analysis and constant comparative method. In addition, five studies had unclear reporting for data analysis methods used (details are explained in Table 4).

Thematic synthesis was performed for stigma associated with depression among older adult care home residents based on 15 studies including 578 participants. The studies were performed in the US (n=7), Canada (n=2), Norway (n=2), Sweden (n=2), Australia (n=1) and Taiwan (n=1). Four main themes were identified from thematic synthesis: *negative beliefs, perceptions and experiences about a care home*; *psychological symptoms of depression*; *negative behavioural responses*; and *mitigating factors*.

2.5.1 Theme 1: Negative beliefs, perceptions and experiences associated with care home residency

This theme illustrated the views of care home residents related to issues about stereotyping regarding ageing and negative experiences of care home communities and staffing issues.

2.5.1.1 Stereotypes about ageing

The negative view about the ageing process, particularly disease and illness such as dementia, hearing loss and speech difficulties, were presented in the synthesis from the findings of the studies. These stereotypes included cognitive disability, dependence, weakness and incompetence.

2.5.1.1.1 Cognitive disability and illness

Older adults with cognitive impairment and disability are seen as a stigmatised group by other residents due to the negative believes about them. For example, some residents considered that severe cognitive decline was a symbol of misfortune:

> *"I was scared when I had to live with an unconscious person. It* [seeing that person] *made me feel that I could be in his situation in the future. I was also afraid that he would pass away in this room. You know it is not good for Chinese people to see someone die in the same room. This would make me feel the soul or ghost is surrounding the room, which is a symbol of misfortune. And maybe I would be the one following him soon"* (Tsai and Tsai 2008, p.1919).

Negative beliefs regarding cognitive decline led older adults to avoid staying close to residents who suffering with cognitive impairment or having social interactions with them. For instance, some residents complained about being placed with others who had dementia.

> *"How dare they put me with a woman with dementia?!"* (Dobbs et al. 2008, p.521).

> *"Most of them here are completely out of it because they just look at you. You can tell when you look at them that they are not taking in anything that you are saying, and they can't answer you and you can't do anything. They just sit in the hall and hang over their wheelchairs and they're out of it, and it's a big group that is that way. And it just seems like people are getting worse and worse"* (Choi et al. 2008, p.541).

> *"Assisted living is best for somebody like me—some of them in here don't belong in here—they belong in a nursing*

home, or whatever you call it, where you have problems with your head—or something like that—I think. Now that's my opinion... a lot of them —I say—don't know what they are saying— don't know what they are talking about—and I just think they should be separate from us" (Dobbs et al. 2008, p.521).

The above quotations illustrate residents with cognitive impairment or having dementia were stigmatised by other residents due to their declining abilities to remember, understand, reason or communication. This may put them at risk of harm and be vulnerable to emotional distress. Some residents grouped residents in other floors as people having special needs and mental incapacity.

"The people on the 4th floor have been put up there who aren't as mentally able. Their minds aren't developed enough for them to think for themselves. Some people don't know who they are (Woman, 88)" (Fisher 1990, p.55).

The quotation illustrates the sense of separation among residents and this may leave the stigmatised group to emotional distress, particularly from depressive symptoms.

2.5.1.1.2 Weakness and incompetence

The process of ageing can be seen as weakness and incompetence in the eyes of other residents who are independent. This is explained by the following quotation:

> *"I don't… play bridge… 'on this side* [ALF]*'… I will play bridge with the independent people because they're, as I put it, playing with a full deck… I'm more comfortable that way… There's more competition and it's much more fun"* (Williams and Warren 2009, p.13).

The perception of weakness and incompetence can lead to emotion distress in some older adults, e.g. a resident commented on her/his declining in health:

> *"I have macular degeneration in my right eye and am technically blind in that eye. I miss driving. It makes me feel diminished"*(Pope et al. 2006, p.161).

The above quotation illustrates degeneration of the resident's health and this may leave him with the feeling of lack of self-worth.

2.5.1.1.3 Dependence

Residents expressed feeling dependent on others. This aging experience can be seen as a violation of a person's dignity due to residents perceiving that they are no longer in control of their lives and basic needs.

> *"I wouldn't want to be here at all, but with old age you don't get to say, because you know that at 82 years you are usually depending on others" (Hellstrom and Sarvimaki 2007, p.418).*

> *"I need help with everything; I can't even go to the bathroom by myself"* (Franklin et al. 2006, p.137).

> *"It's horrible not being able to take care of myself. I can always get help but it's horrible to wake up when you wet your own bed. Everything you do you're dependent on others. For example, when you need to go to the toilet. It doesn't feel good to ask for help going to the toilet, just like babies"* (Franklin et al. 2006, p.138).

Some participants stigmatised older residents with illness or cognitive impairment as a misfortune. The perception of weakness, incompetence and dependence were commonly articulated by residents. This stereotype about aging might be one of the important factors leading residents to become vulnerable to emotional distress especially when they see themselves negatively as weakness, incompetent or dependent.

2.5.1.2 Negative experiences of care home community

Negative experiences associated with care home community residency caused some residents to perceive residency as an essentially unpleasant experience. The specific negative experiences that residents faced included a depressing environment, lack of privacy and lack of freedom, and a lack of autonomy.

2.5.1.2.1 Depressing and isolated environment

Stigmatising public beliefs about care homes influenced residents' own experiences and perceptions. For example, a female resident stated about the perceptions that her friends had regarding the care home.

> *"Some of my friends are afraid of this place. One friend who came to visit me refused to come inside saying all the*

> *people who live here are feeble minded. You can imagine how I felt about that (Woman, SIL, 80)"* (Fisher 1990, p.52).

The quotation illustrates the resident's sense of being stigmatised by her friends and this may have left the resident with a feeling of low self-worth or a depress mood. Residents perceived that LiCH led them to have depression, particularly when they saw other residents with disabilities.

> *"I think that everybody gets it* [depression] *in a nursing home, because you're stuck in a place that you're not used to it. And it's a place that you really don't want to be stuck in"* (Choi et al. 2008, p.539).

In addition to the inherently depressive environment of care homes, many residents perceived that the homes are isolated environments wherein they have less contact with family and friends, partly because of the implicit stigma itself, which makes guests reluctant to visit.

> *"The hardest part about moving here was knowing that you won't be seeing the people you did... your neighbours, your friends, your church (Woman, SIL, 86)…*
>
> *"Coming here changed my outside friendships. They don't come to see me. We don't look so good so people are disappointed when they see you (Man, IC, 86)"* (Fisher 1990, p.51-52).

Residents perceived that care homes are isolated from the outside world. They are also aware of the stigma associated with a care home and this

may leave them to contact their friends less or to lose contact with friends due to the thought that some of their friends may have a fear or feel uncomfortable with the atmosphere of the care homes.

2.5.1.2.2 Lack of freedom and autonomy

Rules and regulations about LiCH have a negative impact on the perceptions of older residents toward residency, causing residents to perceive their circumstances in terms of a lack of freedom and autonomy, compared by some to a militaristic style of garrison living.

> *"Having to conform to their rules, that's not freedom"* (Shippee 2009, p.6).

> *"Living here is like living in the army"* (Tsai and Tsai 2008, p.1918).

Rules and regulations in care homes impact on the residents' perception lack of freedom while LiCH. Some residents felt a lack of autonomy as they need to follow the routine schedule of the care home.

> *"I am a victim. I can't decide anything for myself. I don't have any influence... everything goes according to my contact person's schedule; one week I get to have a shower on a Monday, the next week it will be on a Wednesday"* (Hellstrom and Sarvimaki 2007, p.420).

The resident perceived lack of autonomy is due to having no control over there life. Rules and regulations of a care home impact on the residents. As some residents felt like they were in a prison.

> *"We* [residents] *used to laugh and say we were in prison…I don't feel free any more since I can't get out and go freely. You have to sign out and sign back in within 72 hours. When my mother died in* [a city]*, my sisters drove me there. It took about 8 or 9 hours. I had to turn right around and come back. I did not get to stay and be with my family when we were grieving. I am the oldest of 10 kids, and I should have been the one to take care of the business and stuff"* (Choi et al. 2008, p.541).

Rules and regulations of care homes generate the sense of a lack of freedom or autonomy to many residents. This may be related to when their behaviours were monitored by members of staff.

2.5.1.2.3 Lack of privacy

Participants illustrated that they perceived a lack of privacy while LiCH, particularly related to the circumstances of sharing facilities such as bedrooms and bathrooms. They associated this with a lack of freedom which consequently made them feel that the care homes are not *their homes*. The following quotations illustrate the feeling of a lack of privacy whilst LiCH among residents.

> *"I don't like to complain, but there is nowhere to go that's private. It's like living in a hospital or, worse, like a prison — an inmate. Residents come and touch my possessions, nurses walk in and out. You can't call the place your own;*

there is nowhere to go to not be disturbed (Woman)" (Fiveash 1998, p.169).

"I have no private place of my own" (Fiveash 1998, p.169).

"Think of anything worse than to spend the rest of my life in a room with a stranger" (Shippee 2009, p.5).

"I was frightened. I awoke one night and this man was standing at the end of my bed, looking at me. He had scars and sores on his face, a bandage over his ear. I'd never seen him before. I don't like to complain, but it's very frightening (woman)" (Fiveash 1998, p.170).

"Mealtime is the most depressing hour of the day. I do it because I'm required to. No one says anything, nobody talks... I think: My God, is this what I have to do, eat with these people every day?" (Shippee 2009, p.6).

Residents perceived that the care home environment and community influenced their negative perceptions of LiCH. Some participants perceived care homes to be depressive and isolated environments, while sharing facilities traditionally considered private in normal homes resulted in a lack of privacy. Moreover, rules and regulations in care homes enforced an atmosphere of oppression (i.e. a lack of personal freedom and autonomy), associated with prison-like monitoring of their behaviour by care home authorities.

2.5.1.3 Negative experiences of care home staff

Participants had negative experiences regarding staff workload and a lack of training that undermines the quality of care provided.

2.5.1.3.1 Staff are too busy to provide quality care

Building relationships with staff is very important in adapting to care home life among residents. However, workload and understaffing are barriers that prevent staff from providing quality care for residents.

> *"P: The only thing - problem I have is that they have too much for the girls to do with all the people who are here (7, 431–432)"* (Coughlan and Ward 2007, p.52).
>
> *"I am definitely bored to death. I've got no one to talk to — none of them* [residents] *can talk properly here, and the nurses don't have time (woman)"* (Fiveash 1998, p.171).
>
> *"P: Well… I don't know, they just seem to sit around and go to bed at night. I don't know, they don't… They don't care for talking at all.*
>
> *I: The staff don't want to talk?*
>
> *P: Ya… Don't have time (1, 432–443)"* (Coughlan and Ward 2007, p.51).
>
> *I: Will the staff… the nurses talk?*
>
> *P: No, they're busy; they've cut back on the staff there are only two that circulates in the dining room. They're busy*

going getting the food (6, 359–361) (Coughlan and Ward 2007, p.52).

"Never have time to talk to you" (Williams and Warren 2009, p.14).

The above quotations indicate that residents perceived lack of support from care home staff. This may be related to the workload issues or the care home being understaff and this may leave some residents experience negatively regarding LiCH.

2.5.1.3.2 Staff not well trained

Participants complained about staff not being well trained, particularly in geriatric care, and many were worried about personal hygiene issues.

"I don't think they are trained to be as understanding as they should be… I don't think the staff is properly trained to deal with geriatrics, geriatric people as well as they could be" (Williams and Warren 2009, p.16).

"They need to be trained. They're not trained at all… these gals that work with you go down and do stuff in the kitchen and they serve you… I think that's a very poor combination" (Williams and Warren 2009, p.16).

"They have their finger in the ice cream… they'll walk by and pick up a nut when they're serving food, stick it in their mouth. You know, that's not right" (Williams and Warren 2009, p.16).

Residents also illustrated staff errors related to their safety, including medication administration errors. For example, a male resident complained about a medicine misunderstanding and a female resident was concerned about her safety.

> *"There are repeated staff errors with my medication, even though I myself administer all my medications but one. It's easy for me to spot the errors, but what about all the residents who have no idea what they are taking? (2007: 84)"* (Williams and Warren 2009, p.9).

> *"Some of them (staff) are brand new and they don't have anywhere to gain experience, and consequently, I have been dropped (from the bed) twice"* (Choi et al. 2008, p.542).

Some residents stated that they had negative experiences toward care home staff related to staff not providing quality care, mainly due to a lack of expert training in geriatric care.

2.5.2 Theme 2: Psychological symptoms of depression

The review illustrated that negative beliefs, perceptions and experiences about a care home influence emotional distress among residents. Participants in the included studies expressed their experience of psychological symptoms of depression during LiCH, manifest in symptoms of clinical depression including hopelessness and helplessness, irritability and intolerance of others, lack of motivation or

interest in things, feeling low and sad, loneliness, fear (related to stigma consciousness) and emotional withdrawal.

2.5.2.1 Hopelessness and helplessness

Participants illustrated their feelings of being hopeless and helpless due to LiCH due to their dependence on others, limited responsibilities, and lack of control.

> *"No, no, I don't have any value here. I don't know why but it doesn't make any difference what we think or want because we are worthless. I'm just a number... I feel myself worthless here"* (Hellstrom and Sarvimaki 2007, p.421).

> *"My life is over as far as I'm concerned. I just feel it's time to say goodbye. I really feel it's time for me to go"* (Shippee 2009, p.6).

> *"I don't have control, and I am in the care of others. I don't feel significant. I'm just another resident. I am on someone else's agenda"* (Pope et al. 2006, p.160).

> *"I have no control over anything. I don't ever feel significant—not here"* (Pope et al. 2006, p.160).

> *"My sons don't want to care for me, so they sent me to this place. I can't do anything. All I can do is eat;* [I am a] *useless person. I hope to pass away as soon as possible"* (Tsai and Tsai 2008, p.1918).

The residents showed some signs of psychological of depressive symptoms as they felt hopelessness and helplessness whilst LiCH, Negative experiences regarding care home life may impact on them and this may leave them with feeling of hopelessness and helplessness.

2.5.2.2 No motivation or interest in things

Living in a care home is perceived as being imbued with a malaise with a lack of motivation to undertake activities and a dearth of interest in life, associated with the limited activities available and the lack of autonomy in decision making for residents.

> *"It's hard to find meaning in daily life when you can't do anything on your own"* (Franklin et al. 2006, p.140).
>
> *"Slow, boring" (7, 44) (Coughlan and Ward 2007, p.53).*
>
> *"P: I used to have a very busy life and sometimes it gets boring, you know. So what can you do, not very much… well ah I don't know if you call them typical or not ah sometimes they get rather boring… that's all I ever seem to do is nap (3, 43, & 149–150)"* (Coughlan and Ward 2007, p.53).

Residents feel a lack of motivation with their life in the care home. This Care home atmosphere might be caused when residents have limited option with their activities or routine and have no responsibilities in care homes.

2.5.2.3 Loneliness

Participants explained the feeling of loneliness when they are LiCH, noting that most residents felt this due to a lack of visitors.

> *"It's a lonesome place. Lots of lonely souls here. There are many people whose children don't even show up. Some people never come out of their rooms"* (Choi et al. 2008, p.539).

> *"I can't say I feel happy, but I can't say I feel sad either. So I don't know what to say there. I've felt lonely… No, I don't enjoy my life at all.*
>
> *KW: Really?*
>
> *AJ: Yes"* (Williams and Warren 2009, p.8).

> *"I wish my son would visit me... but I suppose he is busy and has other things to do. You see, his wife is... I don't really know but they never come here. I wish I had someone to talk to. They never have time for us here, not even to say a word; it's like we are nothing"* (Franklin et al. 2006, p.139).

> *"I stay in contact with friends and family but less and less often. When you come here, it seems like there isn't more. It wasn't like that when I was home (R14)"* (Nakrem et al. 2011, p.1362).

Some residents perceived feeling loneliness because of the isolated environment of the care home isolated them from the outside world and some residents feel abandoned by their families. Other reasons are related to the lack of activity in a care home available for them, with some noting that staff members had no time to offer support.

> *"I am definitely bored to death. I've got no one to talk to — none of them* [residents] *can talk properly here, and the nurses don't have time (Woman)"* (Fiveash 1998, p.171).

> *"I come out on the veranda after showering and having a shave and all, then I am isolated and I have nowhere to go. There is no one to see ... nothing to do. (Woman)"* (Fiveash 1998, p.171).

> *"There is nothing else I can do but come in here and wait to die (Man)"* (Fiveash 1998, p.171).

The above quotations show life in care homes has limited activities and no responsibility for residents. This may leave them with low motivation and feeling of being bored or lonely.

2.5.2.4 Emotional withdrawal

The review shows that some residents expressed their emotional withdrawal due to LiCH, which prevented them from expressing their emotions and developing relationships with other residents and care home staff.

> *"Sometimes, I feel like I would like to talk to somebody about whatever I am worried about, but I don't know how to approach it because it's just within, and I can't get my thoughts out like I would like to"* (Choi et al. 2008, p.544).

> *"I feel sad, but I keep my feelings to myself"* (Choi et al. 2008, p.544).

> *"Express emotions? I don't"* (Pope et al. 2006, p.163).

Emotional withdrawal making it difficult for residents to engage or interact with other people around them and this may lead to them feeling vulnerable to emotional distress.

2.5.2.5 Fear (stigma consciousness)

Some residents felt fearful of their stage of physical and cognitive decline, particularly in terms of feeling ashamed and stigmatized, including due to physical impairments such as requiring a wheelchair.

> *"When we see those people up there* [ICI] *and we see them all confused, we see ourselves or what our future could be. It's a sad part of old age. We don't want to end up like that (Man, 87)"* (Fisher 1990, p.57).

> *"I'm scared I'll fall and end up like her* [wheelchair bound]*"* (Fiveash 1998, p.170).

> *"I hope I don't get like them* [confused]*"* (Fiveash 1998, p.170).

> *"Yeah, but now she's the one in the wheelchair. And guess what? Now she doesn't want to go to the dining room, 'cause then people will think that she doesn't belong. I have to cook for her quite a bit in the apartment"* (Shippee 2009, p.7).

The above quotations illustrate that some residents felt distressed and worried about themselves when they saw other residents with cognitive impairment or disability. This make some residents avoiding to contact with them.

2.5.2.6 Low mood, sadness and depression

Participants expressed the feeling of sadness or depression while LiCH and this has been observed by either their peers or themselves.

> *"I have been depressed this past week. I have been real depressed"* (Pope et al. 2006, p.160).

> *"They sit and stare into space and have sad expressions on their face. Some of them have tears in their eyes"* (Pope et al. 2006, p.162).

> *"It is from the expressions and tones of their voice—whimpering or half crying"* (Pope et al. 2006, p.162).

One reason for such sentiments is the frequent loss of their peers (i.e. the deaths of other residents), as revealed in the following quotations.

> *"It is most depressing to make friends and then they die. We had two of them die yesterday. See across the hall, this woman had no one, and then she died. It's just awful. And then see them hauled out. I don't like that. That is terrible. Having to see them going down, down, down – that is depressing"* (Choi et al. 2008, p.542).

> *"It is depressing to see so many people just leaving us all of a sudden. They die overnight. You make friends with people, and then one day, they're here and the next day, they're gone"* (Choi et al. 2008, p.542).

> *"We lost a lot of people over the winter, which is upsetting for everyone because it is such a small place"* (Pope et al. 2006, p.162).

Various reasons seem to underline negative emotions particularly sad or depressed moods among the elderly residents. However, negative perceptions or experiences such as losing a peer seem to be an factor related to depressed mood of some of the residents, particularly those they have had a close relationship with or in the small care home where residents knew each other very well.

The review showed that some participants experienced negative emotions while LiCH. This included feelings of hopelessness and helplessness, a lack of motivation or interest in things, feeling low and sad (with some describing this in the clinical context of depression), associated with loneliness, emotional withdrawal and fear (stigma

consciousness). These negative emotions are diagnostic psychological symptoms of clinical depression.

2.5.3 Theme 3: Negative behavioural responses

The review demonstrates that participants had negative behavioural responses such as isolation and social exclusion. In addition, residents related perceiving negative behaviour by other residents, such as avoidance or separation by other residents, and care home staff being neglectful or disrespectful toward them.

2.5.3.1 Negative behavioural self-responses

2.5.3.1.1 Isolation and social exclusion

Some participants who perceived stigma associated with care home residency stated their social isolation and social exclusion while LiCH.

> *"No, I don't see any of them. I think they say, 'The heck with them living there* [in NL]*!' And you don't make new friends here. You think you would, but you don't"* (Shippee 2009, p.7).

> *"I don't really relate to the people here… I sorta stick by myself. I have my computer and TV"* (Williams and Warren 2009, p.17).

> *"It's affected my friendships with people I knew on the 5th floor there's a dividing line there a distance between us. When I came here it seemed to me that all my rights and privileges were taken from me. I think that makes a*

difference too. It's an isolation (Woman, 93)" (Fisher 1990, p.56).

The above quotations illustrate that the care home environment and features seem to be an additional factor underlining the stigma. For example, where residents will be placed or the grouping. This impacts on residents' behaviour when they felt like others are not in the same conditions as them, they then decide to isolate themselves from others due to their stigma consciousness.

2.5.3.2 Negative behavioural responses among residents

2.5.3.2.1 Avoidance or separation by other residents

Some participants avoiding contact with other residents who are ill because they wished to avoid similar conditions.

> *"The people on the 4th floor have been put up there who aren't as mentally able. Their minds aren't developed enough for them to think for themselves. Some people don't know who they are (Woman, 88)"* (Fisher 1990, p.55).

> *"I was downstairs in the lobby. I heard a woman say, 'There's Mary Rumfoord. She doesn't belong here.' How would you like it? You're cut right down. There's a stigma. They think I don't belong among them* [SIL residents] *anymore (Woman, 93)"* (Fisher 1990, p.56).

> *"If you see other people who have gone on further than you, you don't want to admit that you are the same way, so you stay away from them"* (Shippee 2009, p.7).

This subtheme explains the impact of stigma consciousness among residents when they feared that they would have poor conditions like they perceived others who lived in the care home. Therefore, some older adults tended to stay away or separate from other. These would leave stigmatised older adults to have negative feeling about themselves.

2.5.3.3 Negative behavioural responses by care home staff

Residents perceived negative behavioural responses from care home staff, which made them feel neglected and disrespected.

2.5.3.3.1 Being neglected by staff

Some participants complained about being neglected by care home staff when they needed help.

> *"Rachel: … The only complaint I do have is you phone in the night for a bed pan, and they tell you off…They said they'd be here in a few minutes and they never come at all* (Wiersma and Dupuis 2010, p.285).

> *"It doesn't work like it should. It takes too long. Once I watched and it took over an hour before someone came. So they* [other residents] *lie there and holler instead. You're supposed to use the alarm but they've found out that it works if they holler (R7)"* (Nakrem et al. 2011, p.1361).

"One thing that's not great is when you need help, and you put your call light on, and it takes them forever to come. Sometimes you need help in the bathroom because you get stuck in the bathroom for 40 minutes, and nobody comes to get you out" (Choi et al. 2008, p.542).

The quotations illustrate the issues of inadequate care from a member of staff perceived by a resident. These may leave them to have a negative experience of LiCH and lead to emotional distress.

2.5.3.3.2 Not being respected by staff

One of the issues repeatedly expressed by residents in numerous contexts was the feeling of being disrespected by staff members, particularly in terms of being treated like children due to the perceived weakness and frailty of the elderly.

"Not getting the help I need means I am not respected, and that is the most difficult problem here; it makes you so sad" (Hellstrom and Sarvimaki 2007, p.421).

"P: … they're talking back and forth… about where they went on holidays… they pour mine and reach over and get the other two or pour theirs and reach over and get mine (8, 581–582)" (Coughlan and Ward 2007, p.53).

"P: We are supposed to be sleeping, it's very noisy. They (the staff) are banging the door when they go… they never think to hold the door. In out in out in out and then

somebody else would come to the door. And they talk loudly—people that are on at night (8, 631–651)" (Coughlan and Ward 2007, p.53).

"It's like they think we're children… at least they give the attitude. So I think they should recognize people here are elderly but they aren't stupid and they aren't three years old" (Williams and Warren 2009, p.14).

"treat you like you're three years old… And I think they should be told, you know, that's not the right way to treat [elderly] *people"* (Williams and Warren 2009, p.14).

Infantilisation language or loud noise are perceived as not being respected in the eyes of some residents. These actions of care home staff may leave some residents to feel disrespected with LiCH and can become an additional cause of stigma perceived by residents.

2.5.4 Theme 4: Mitigating factors

The review demonstrated that older adults applied various strategies to cope with the negative feelings they experienced due to LiCH or more particular stressors. These strategies comprised individual perspectives to cope with their stressful situation, care home activities, social support and religion.

2.5.4.1 Individual perspective

Participants expressed their individual perspectives that helped them cope with their emotional distress, which were conducive to acceptance and positive thinking.

2.5.4.1.1 Acceptance

Residents found it easier to adapt to life in a care home by trying to adopt an accepting attitude as reported in the following quotations.

> *"Your attitude is the main thing. You have to come to an agreement with yourself that you are going to stay here… I am content… You have to make up your mind to be content"* (Bergland and Kirkevold 2006, p.687).

> *"Just accept it" (Choi et al. 2008, p.543).*

> *"I have accepted it. There is no point in me beating against the wall, I'm not going to move* [out]*, I can't get rid of my disease, it is irretrievable. Not to accept it would be just asking for torment"* (Shippee 2009, p.6).

These quotations illustrate that residents have made up their mind to settle into care home life. This would help them adapt to live life in care homes more easily.

2.5.4.1.2 Positive thinking

Participants described using positive thinking to help them adapt and be happy when LiCH. The following quotations demonstrated how they adapted positive thinking in their lives.

"I try to see something positive in each day; i.e. look at a beautiful flower outside my window…" (Franklin et al. 2006, p.137).

"I am probably not perfect, but I can be thankful when I see other people here" (Williams and Warren 2009, p.13).

"Fortunately, I have good eyes and ears" (Nakrem et al. 2011, p.1363).

"At least I haven't had a stroke" (Nakrem et al. 2011, p.1363).

"I learned from different friends that being sorry for yourself is not good. I've never allowed myself to have that much time on hand to feel sorry for myself. I just don't experience that [depression]*"* (Choi et al. 2008, p.539).

2.5.4.2 Activities

The review found that participants illustrated how they used activities to cope with the problems of care home residency, including exercise, reading and participating in social activities held in the homes. In addition, a few of them stated that watching TV and playing games such as bingo and canasta helped them to pass the time pleasantly.

2.5.4.2.1 Exercise

Exercise helps some residents maintain their physical and mental wellbeing. There were different forms of exercises, some residents enjoyed exercising by walking or joining an exercise class.

> *"I try to take part in whatever activity they have… I try to walk every day"* (Williams and Warren 2009, p.13).

> *"I know to… eat well and do my exercises… You gotta get with it. Not sit around and feel sorry for yourself… I do what they ask me to do. I've never had to go over there* [nursing home] *yet"* (Williams and Warren 2009, p.13).

> *"When the weather is bad, I walk the stairs and halls of the building. I also exercise three mornings a week with others. The physical therapist conducts the classes"* (Pope et al. 2006, p.163).

Some residents were concerned with their health and tried to maintain their physical and mental wellbeing by exercise as much as they could. However, there was barrier to exercises such as the weather.

2.5.4.2.2 Social activities

Social activities help residents to get together and build a good relationship among them. Some residents expressed the thought that these created the sense of self-worth to be part of the care home community.

> *"I feel part of this community. I was put on the social committee and my husband was put on the board—so it makes us feel very significant"* (Pope et al. 2006, p.160).

> *"I like people and enjoy sharing happy times with them"* (Pope et al. 2006, p.161).

> *"I enjoy 'bull sessions' with the guys"* (Pope et al. 2006, p.164).

Participants stated that they enjoyed being part of social activities in the care home. This shows that social activities in the care home help to generate good social interaction among residents.

2.5.4.2.3 Barriers of exercises and social activities

Participants also illustrated the barriers that limited their daily activities. Most of them were fearful of being injured due to exercise or activities, while those with known disabilities and illness were even more averse to (as they perceived it) exacerbating their conditions by engaging in activities.

> *"I can't do anything. Since they amputated my legs I just wheel around in my wheelchair"* (Franklin et al. 2006, p.137).

> *"I have fallen a couple of times here and I didn't get hurt. I feel sorry for those whose hips give way"* (Williams and Warren 2009, p.13).

> *"They* [staff] *encourage me here because they don't realise how difficult it can be for me… the stress of trying to do beyond my sight"* (Williams and Warren 2009, p.13).

> *"I couldn't get out of that bed. My legs were getting so weak that things that I took for granted were coming to the fore*

now (Brian, Feedback Interview)" (Wiersma and Dupuis 2010, p.286).

2.5.4.2.4 Reading

Participants stated that reading helped them to enjoy life when they are LiCH including reading books, newspapers and the Bible.

> *"I live through the books I read. They fill up my days"* (Bergland and Kirkevold 2006, p.688).

> *"Reading is very enjoyable to me. I read the paper daily and drink my coffee. I like that private time"* (Pope et al. 2006, p.163).

> *"Activities I enjoy doing—reading my Bible alone and with others"* (Pope et al. 2006, p.163).

It seems that reading could help some residents fulfil their day and it also creates a sense of privacy in some residents.

2.5.4.2.5 Helping others

The review found that participants felt more self-worth when helping others. They feel more value when they contribute to the care home community.

> *"After I read the morning paper I'll ask somebody, 'Anything you want me to do?' I'll ask the girls that's working, 'You got something you want me to fold? Bring me your washcloths or something to fold up,' and I'll fold them up and put them*

on their cart nicely. I always make them find me something to do. I don't enjoy sitting around looking. I love to be active. And I'm at a place where I can be and love to be (Woman)" (Groger 1995, p.149).

"I feel significant when I make a worthy contribution the other occupants could appreciate and enjoy" (Pope et al. 2006, p.160).

"I feel significant when I can help someone else" (Pope et al. 2006, p.160).

It seems that helping others by doing activities help some residents maintain their physical wellbeing and help them to generate self-worth as well.

2.5.4.3 Social support

Social support was an important resource utilised by older adults LiCH, derived from their families, peers and care home staff.

2.5.4.3.1 Support from family

Family was a pervasive dimension of residents' experience, and visitation was a major issue for them, with family visits being perceived to be an index of being cared for and general wellbeing.

"Talking with members of the family was a big help" (Pope et al. 2006, p.163).

> *"P: His wife comes in twice a day… for dinner and supper… She's a wonderful woman. Comes every day—never misses… Ya… got a good woman, comes to see him and stays hours with him (4, 375–383)"* (Coughlan and Ward 2007, p.51).

> *"My son is a very filial child. He comes to visit me every day. He also brings food for me such as fruit or cookies. He says, 'Mom, all you have to do here is to nurture your health. You don't have to think too much'"* (Tsai and Tsai 2008, p.1919).

It seems like family visits are a main factor in preventing residents from the feeling of isolation and loneliness when LiCH.

2.5.4.3.2 Support from peers

Another form of support apart from the residents' families is from their friends or peers. Support from peers was very helpful in enabling daily activities.

> *"P: I was over there 20 months, there was a man, I was in bed here and he was in bed beside me—we got to be good friends, I was down to see him the other day. He's down stairs. He's a goody. Good guy (weak voice, very sad) (4, 179–181)"* (Coughlan and Ward 2007, p.52).

> *"I: Mmm, what about extra stuff you need, like soap and tooth paste have they got somewhere in here that you can buy that kinda stuff? P: Oh I guess so, my friend gets it for*

me… I met her over at the (seniors centre name), and we became close and we are still close today. She's a true friend (6, 389–401)" (Coughlan and Ward 2007, p.51).

"One resident described a current friendship that had developed P: So, most of the time we'll watch TV together after dinner, you know and things like that, you know (3, 208–209)" (Coughlan and Ward 2007, p.52).

It seems like support from peers or friends help residents to adapt into care home life. Moreover, they were the key people who looked after them when LiCH.

2.5.4.3.3 Support from staff

Participants suggested that care home staff are a very important group of people who help them with physical and mental needs, particularly in relation to emotional support.

"The staff makes us feel welcome and loved and for that we are thankful" (Pope et al. 2006, p.159).

"Well yes, you see – they do the best they can for you. They work hard all day long. They help you right away… if you need it (R11)" (Nakrem et al. 2011, p.1361).

"Don't come in and visit with me. I don't expect them to… this lady came and picked up. But she's the cleaning lady. A very nice gal" (Williams and Warren 2009, p.14).

> *"He makes us laugh. And I think that's very good for us"* (Williams and Warren 2009, p.15).

> *"I am so glad when she is here!* [Referring to her favourite caregiver]*. We know each other so well. It is so important who comes into my room in the morning. We do not have to talk so much, because she knows exactly how I want to be helped. I am so glad I do not have to explain"* (Bergland and Kirkevold 2006, p.687).

It seems like residents develop some relationship with their carers and that carers seems to be a key important person influence on residents' mood and emotion whilst LiCH.

2.5.4.4 Religion

Some residents experienced improved wellbeing from religious perspectives or activities, including praying or acknowledgment of their God.

> *"I am not a person who talks about my inner feelings. Praying is my salvation as well as being with loved ones"* (Pope et al. 2006, p.163).

> *"I don't go around thinking about if I'm happy or not happy. I don't say, "I don't have this or don't have that". I'm just grateful for what I've got. The Lord's been good to me – I mean, to someone that was born in* [a poor mountain state] *during the Great Depression and with no more education*

than I had. I just... I just use what God gave me" (Choi et al. 2008, p.543).

Various factors help residents adapt and cope with their life in a care home. Some residents tried to adapt their thoughts toward acceptance and positive thinking about LiCH. Some tried to participate activities provided in the home, such as social activities or exercise. Some fostered individual interests such as reading or helping other. Social support played a very important role toward older residents. They got support from various sources, including staff members, family and peers. Residents also used religious activities to cope when they were stressed. Table 5 summarises the thematic structure and papers endorsing each theme and sub-theme presented in the findings.

Table 5: Thematic structure and paper endorsing each theme and sub-theme presenting in the findings

Themes	Subthemes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Negative beliefs, perceptions and experiences associated with care home residency	Stereotype of aging (physical and cognitive impairment)	X				X	X		X	X	X	X		X		
	Negative experiences of care home community	X		X					X	X		X	X			
	Negative experiences of care home staff			X				X		X				X		
Psychological symptoms of depression	Hopelessness and helplessness						X		X			X	X			
	No motivation or interest in things					X		X								
	Loneliness			X		X				X				X		X
	Emotional withdrawal						X			X						
	Fear (stigma consciousness)	X		X									X			
	Low mood, sadness and depression						X			X						
Discrimination: negative behavioural responses	Negative behavioural responses toward themselves	X											X	X		
	Negative behavioural responses among residents	X											X			
	Negative behavioural responses by care home staff							X	X	X				X	X	X
Mitigating factors	Individual perspectives				X	X				X			X	X		X
	Activities		X		X	X	X							X	X	
	Social support				X		X	X				X		X		X
	Religion						X			X						

1. Fisher (1990); 2. Groger (1995); 3. Fiveash (1998); 4. Bergland and Kirkevold (2006); 5. Franklin et al. (2006); 6. Pope et al. (2006); 7. Coughlan and Ward (2007); 8. Hellstrom and Sarvimaki (2007); 9. Choi et al. (2008); 10. Dobbs et al. (2008); 11. Tsai and Tsai (2008); 12. Shippee (2009); 13. Williams and Warren (2009); 14. Wiersma and Dupuis (2010); 15. Nakrem et al. (2011)

2.6 Discussion

The synthesis revealed four themes related to how stigma associated with care home residency influences the development or maintenance of depression: negative beliefs, perceptions and experiences about care home residency; psychological symptoms of depression; negative behavioural responses; and mitigating factors. Participants reported having negative beliefs, perceptions and experiences of LiCH related to stereotypes about aging (particularly physical and cognitive impairment), negative experiences of care home staff and having a negative experience of care home community.

The systematic review highlights stereotypes associated with care home residency created by consequences of the biological ageing process, with included studies noting the cultural and social associations of physical and cognitive impairment and their effect on residents, who were also active agents in reaffirming such perceptions among themselves. Consequently, when they relied on others (e.g. other residents or care home staff) to assist them in routine activities they experienced emotional distress, including depressive symptoms. The research suggested that this may be because they perceive themselves to be intrinsically lacking in worth or value due to the lack of control they can exert over their own bodies (Franklin et al., 2006). The review reveals that many residents fear acquiring a stigmatising condition, particularly the group of residents with cognitive decline, dementia or disability (Choi et al., 2008; Dobbs et al., 2008; Tsai and Tsai, 2008; Williams and Warren, 2009). This causes

some residents to discriminate against such stigmatised groups by avoiding contact with them.

Negative experiences of care home communities are revealed as a source of stigma associated with LiCH among the residents in this review. Some participants illustrated that care homes are depressive and isolated environments due to the fact that they lack contact from their families and friends outside (Choi et al., 2008; Fisher, 1990; Fiveash, 1998; Shippee, 2009). Many residents in this review also complained about the rules and regulations to which they were subjected due to LiCH, with their perceptions of reduced personal freedom, autonomy and privacy, compounded by an atmosphere of suspicion, reporting and monitoring by staff members, causing them to compare the homes with prisons or military institutions. These may leave residents with a feeling of disengagement or disempowerment (Shippee, 2009). Sharing facilities such as bedrooms and bathrooms was very challenging for some residents, and most of them would have preferred more privacy and personal areas to feel like they were at home; the sense of belonging can create the feeling of a home environment. It is suggested that this issue can contributed to a low quality of life among residents (Choi et al., 2008).

Staffing issues are found in this review to contribute to stigma associated with LiCH. Many residents complained about negative experiences from contact with care home staff, that professionals are not suitably trained (particularly for geriatric care) and that they do not have time to provide quality care (Choi et al., 2008; Coughlan and Ward, 2007; Fiveash, 1998;

Williams and Warren, 2009). They also reflected that being seen as elderly, weak and incompetent caused others to see them as being of low value, including care home professionals, compounding the problems of high workload and understaffing revealed in the review, which were ironically attributed by residents to the high responsibilities of caring for older residents, causing burnout. It is suggested that negative staff experiences could influence residents' quality of life while living in care homes (Choi et al., 2008).

The review highlights that many residents experienced negative emotions, particularly depressive symptoms whilst LiCH (Choi et al., 2008; Pope et al., 2006). Psychological symptoms of depression were illustrated by participants' experiences of hopelessness and helplessness, lack of motivation or interest in things, low mood, sadness and depression, loneliness, emotional withdrawal and fear (stigma consciousness). These distressful emotions are collectively symptoms of clinical depression and these may have manifested negative perceptions and experiences of care home life which has been suggested is the main source of stigma among older adults residing in care homes.

This review shows that many residents experience negative behaviours whist LiCH (Fisher, 1990; Hellström and Sarvimäki, 2007; Shippee, 2009; Williams and Warren, 2009). The negative behavioural responses include isolation and social exclusion among residents, particularly the ostracism of residents with cognitive impairment (dementia), disabilities and terminal illness as describe previously. They were stereotyped by

some residents who wanted them to be separated from the general group due to negative beliefs about the aging process or illness, such as misfortune or fear (Dobbs et al., 2008; Fisher, 1990). Furthermore, negative behavioural responses were perceived from care home staff. Residents perceived that care home staff behaved disrespectfully toward them and that they displayed a lack of concern. This may be related to residents' appearance might be perceived by other people as weakness and incompetent (Fisher, 1990; Franklin et al., 2006).

This review highlights the mitigating factors that participants applied in order to adapt into life in care homes. The factors that helped them cope when there were feeling stressful, including their own individual perspectives such as acceptance or positive thinking (Shippee, 2009; Wiersma and Dupuis, 2010) , the activities provided in a care home (Franklin et al., 2006; Pope et al., 2006), social support from their own families, peer and care home staff (Nakrem et al., 2011; Tsai and Tsai, 2008) and religious activities (Choi et al., 2008; Pope et al., 2006). Helping others or doing some volunteering appealed to residents and generated self-worth and self-esteem. Moreover, the responsibility helped residents keep more active, as they had an aspirational goal around which to structure their daily lives. The key mitigating factors found in this review are to control or diminish the impacts of stigma toward elder residents.

2.7 Limitations

A small number of the included studies had unclear reporting on their methods and methodology, including recruitment strategies, ethical consideration and data analysis (according to quality appraisal by CASP), therefore the reader should note this when considering the findings of those papers. However, overall appraisal indicates that the results of these papers display clear findings and contribute to existing knowledge on the topic of stigma, particularly in the context of the synthesis undertaken. While some may argue that the results from synthesis of qualitative studies may not be widely applicable due to the de-contextualisation of the findings of each component study. The concept that is identified in each setting may not be used for other settings (Thomas and Harden 2008). However, the synthesis was careful checking that each transfer was valid and not misleading from the original paper. Furthermore, details of each study (including setting, participants, methods and the main results) were provided to make sure that the readers for this thematic synthesis can judge on their own the findings of the review and whether they are transferable or not.

There are very small number of studies focussed on the topic of stigma associated with care home residency. We found only two studies that mentioned “stigma” in their titles. In addition, other included studies did not explore stigma associated with care home residency even implicitly, although they nevertheless revealed very important data regarding participants’ beliefs, perceptions and experiences of stigma associated with care home residency. This highlighted the fact that researchers and

other professionals who work to provide care for older adults living in care homes constantly face the issue of stigma and attempt to reduce it.

2.8 Conclusion

The review aimed to understand how stigma associated with LiCH causes or exacerbates depressive symptoms among older adults living in care homes across the world, based on 15 qualitative studies related to the topic of stigma included in the review and assessed by quality appraisal. Meta-synthesis identified four main themes related to the influence of stigma associated with care home residency on depression: negative beliefs about a care home; psychological symptoms of depression; negative behavioural responses; and mitigating factors. The review showed that stigma is created (i.e. manifest) due to wider societal and cultural beliefs actualised by the interactions, experiences and perceptions among residents themselves and care home staff members. Providing information regarding related issues may help to reduce the stigma associated with care home residency. Further research must explore a more comprehensive understanding of stigma itself, including its causation and the emotional and behavioural responses of residents and professionals. Research on how residents cope with their situation would be helpful to investigate factors that help reduce stigma associated with care home residency. This review showed the gap of knowledge in the research area of stigma associated with care home residency, as there were very few studies aiming to understand stigma *per se*, despite it being ubiquitously acknowledged as a fundamental feature of geriatric care. Therefore, there is an urgent need for more research to explore this

area. The next chapter of the thesis illustrates the methodology and methods used in this study. The study applied mixed method research in order to address the research questions regarding factors associated with depressive symptoms and understand stigma associated with living in a care home.

Chapter Three: Methodology and Methods

3.1 Introduction

Chapter three presents methodology and procedure that were used in the study in order to explore the factors associated with depressive symptoms and understanding stigma associated with LiCH among older residents residing in care homes in Thailand.

This chapter begins by outlining a philosophical underpinning of the research that leaded to research design of the study; mixed method (convergent parallel design). The overall aim of the study is presented in the next section along with the details of the research design and the study settings. The details of cross-sectional questionnaire study and case study are presented separately in the next section in order to clarify the justification of applying different research approaches. However, the procedure of data collection including recruitment and ethical considerations is presented together due to the process of data collection starting in the same period of time.

3.2 Philosophical Underpinning

The previous sciences e.g. positivism or post-positivism offers a very limited view of understanding the world and a limited view to explore or enhance new knowledge (Clark, 1998; Noor, 2008). This kind of scientific method is unable to examine a complex context that need more in-depth explanation and causation. The study adopted Critical Realism (CR) as a philosophical underpinning. CR is generally used as a philosophy

underpinning a wide range of research, including quantitative research, case study, action research methodologies and mixed-method (Walsh and Evans, 2014). CR is a specific version of realism in philosophical science. It is commonly associated with the British philosopher and sociologist Roy Bhaskar (Roberts, 2014; Walsh and Evans, 2014). Bhaskar (1989) suggests that the purpose of science includes the discovery of the unobservable; it should not be confined to knowledge that can be studied or explored empirically. Critical realists believe that our knowledge is never complete or infallible; it is always partial and subject to revision. As a psychiatric nurse who has applied research regarding social sciences to help explain and understand the health issues of patients, I believe that CR can be used as a guide to explore the new knowledge in a complex world, particularly in the area of depression and stigma associated with a care home community which involve various group of people in the society. My rationales of applying CR in this study includes that the stratified ontology of CR exposes differentials and explains change at the empirical level (Archer, 1998), providing values of autonomy, freedom and equality (Mcevoy and Richards, 2003), and it provides a basis for a holistic and integrated knowledge platform (Walsh and Evans, 2014).

Bhaskar critiqued ontology on three levels: the empirical, the actual and the real (Archer et al., 1998). The first layer is the most superficial, as it can be experienced and observed (Walsh and Evans, 2014). The actual could be known but not always observed. This layer is compared to a tree trunk hidden by a wall. The real or “deep or metaphoric” level (Fleetwood,

2014) cannot be observed, comparable to the roots of the tree (Walsh and Evans, 2014). This layer includes structures and mechanisms and is concerned with the knowledge of social science. The ontological layers of CR could be applied as a guide to explore, understand and enhance the knowledge of depression and stigma associated with a care home. Figure 3 shows the tree diagram of three ontology levels.

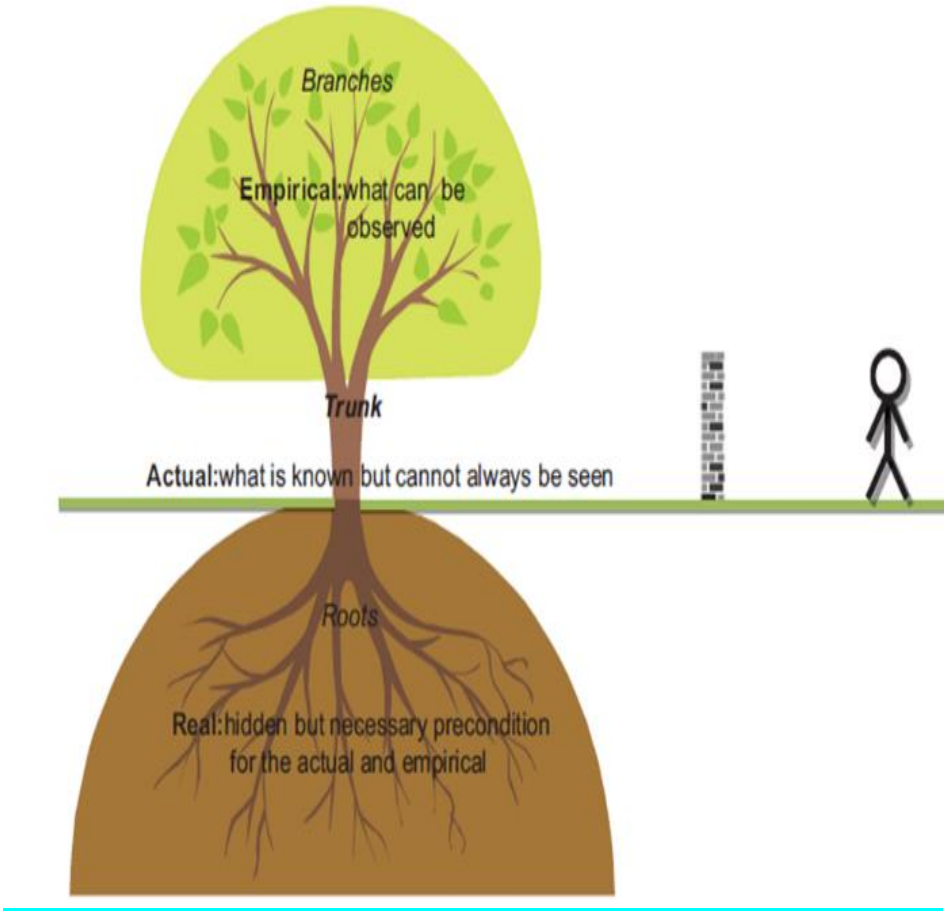


Figure 3: Tree diagram of three ontology levels

Adapted from Archer et al. (1998), Dyson and Brown (2005) and Walsh and Evans (2014)

According to McEvoy and Richards (2003), CR provides a deep understanding of effective intervention in the context of clinical practice

by encouraging researchers to search for a generative mechanism to explain how things relate and work that may not be experienced or observed using the formula Context + Mechanism = Outcome (Mcevoy and Richards, 2003). This concept of understanding the world can identify causal mechanisms on a deeper level (Wikgren, (2005). I argue that applying CR as a philosophical underpinning of research asserted the value of a study, specifically in terms of autonomy, freedom and equality (Walsh and Evans, 2014), because CR encourages searching for mechanical causation of events.

CR encouraged me to search for mechanisms in a complex situation and a specific context; particularly in a setting of a care home, which influenced the development or maintenance of depressive symptoms among older adults rather than focusing on general factors which could be observed or experienced, such as the effectiveness of medication or some interventions. As a result, other factors related to occurrences of depression or depressive symptoms which may possibly not be observed or experienced; especially, stigma associated with a care home, which has found related to depression among this population were considered as a mechanism underlining high prevalent rate of depression among older people residing in Thai care homes.

3.3 Aim

The aim of this study was to explore the factors associated with depressive symptoms and to understand stigma associated with a care home among older residents living in care homes in Thailand.

3.4 Research Design

In order to achieve the aim of this study, a mixed-method approach draws from the strengths of both quantitative and qualitative approaches to achieve a more comprehensive overview. Mixed-method research (called integrated, multi-method, or triangulation design) is a combination of both quantitative and qualitative techniques or methods for collecting or analysing data which compensates for the weaknesses associate with using a single method and generates a more comprehensive understanding of the research phenomena (Boswell and Cannon, 2014; Doyle et al., 2009).

Qualitative approaches typically gain an in-depth view of participants' perspectives and experiences, whereas quantitative methods generate numerical data to test hypotheses of the study (O'cathain et al., 2007). Moreover, the roles of the different methods within a mixed-method approach could provide an understanding in the different aspects of the phenomenon when the data of both methods are combined (Doyle et al. 2009). A quantitative study confirms or interprets statistical relationships whereas a qualitative study helps to explain factors underlying the relationship in a quantitative study (ibid). A mixed method was applied in this study, combining the findings of a cross-sectional questionnaire study and case study. The quantitative strand explored the factors associated with depressive symptoms and the qualitative strand explored stigma associated with a care home from the view point of older residents and care home staff.

Mixed method can be divided into three basic designs (Convergent design, Explanatory sequential design and Exploratory sequential design) and three advanced design (Intervention design, Social justice design and Multistage evaluation design) (Creswell, 2015). Convergent parallel design was applied in the study in order to provide different insight of the problem of high prevalent rate of depression among Thai care home residents from multiple angles and multiple perspectives (residents and care home staff). Convergent parallel design comprises the separation of data collection and analysis from quantitative strand and qualitative strand and intends to merge the findings from both analysis (ibid). Quantitative findings provides trends and relationships of variables, while qualitative results provides in-depth details on experiences and perceptions of residents and care home staff regarding living in care homes. Both these data are very useful for complete understanding of the problem of depression in Thai care homes. Another rationale for selecting this typology was on the timing of the quantitative and qualitative stands (Doyle et al., 2009) which were conducted in the concurrent time. The data from both strands are very useful to gain multiple pictures of the problem from several angles.

Furthermore, another reason for choosing this typology was that both research designs (a cross-sectional questionnaire study and case study) were equally prioritised to explore depressive symptoms and understand stigma associated with a care home respectively. The last decision related to the merging of quantitative and qualitative findings. This was done by using the findings from quantitative study (internalised stigma

scores and depressive symptoms scores) to confirm with qualitative findings regarding the dynamics of the process of stigma and describe stigma associated with a care home by using case studies who having variation scores of internalised stigma and depressive symptoms. The convergent parallel design of this study was illustrated in Figure 4.

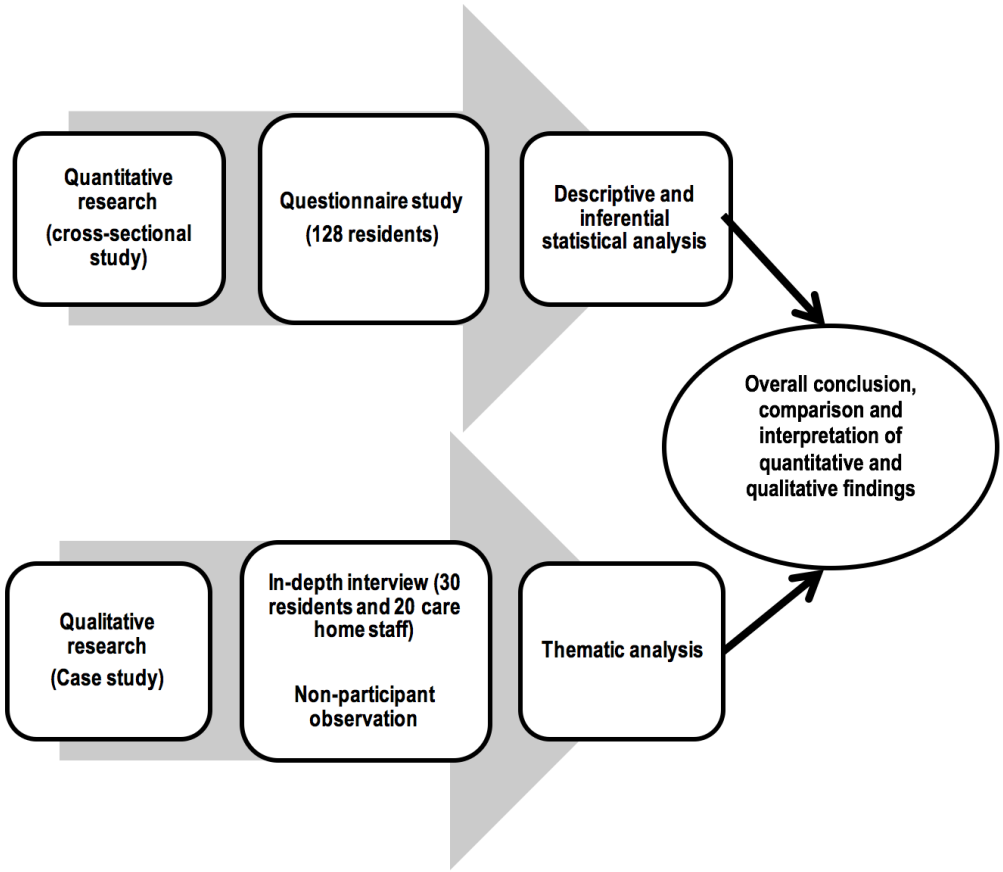


Figure 4: Typology of mixed-method designs (convergent parallel design)

Adapted from Creswell and Clark (2011)

3.5 Setting

3.5.1 Overview about Thailand

Thailand is a middle-income country. It is located in the South-East Asian peninsula and borders Myanmar (Burma), Lao People's Democratic Republic, Cambodia and Malaysia (United Nations Thailand, 2018). It is generally classified into four geographical regions comprising the central region, the northern region, the north-eastern region and the southern region for economic, social and ecological reasons. The estimate population in Thailand is 64 million people. The official language is Thai. Approximately 95% of the Thai population is Buddhist (the Theravada or Hinayana Buddhism).



Figure 5: Geographic location of Thailand

3.5.2 Study setting

This study was conducted in two care homes: *Care home A* which provided care for only female older adults, in the Northeast part (Isan) of Thailand and *Care home B* which was a setting providing care for both male and female older adults. Previous studies suggested gender differences in depression prevalence, with higher rates among women (Chonody and Siebert, 2008; Kuehner, 2003). Higher depression among women is generally related to socio-economic inequalities, which affect the way in which depressive moods are experienced (Chonody and Siebert, 2008). Related to such inequalities, there is a high correlation between depression and perceived stigma (Pyne et al., 2004). Therefore, female residents may have perceived internalised stigma differently compared to their male counterparts. Consequently this study aimed to identify the differences in relation to depressive symptoms and internalised stigma between older adults who lived in single sex (female) and mixed sex care homes. However, the results of the cross-sectional study revealed no significant differences in depressive symptoms and internalised stigma among older adults who lived in the single sex and mixed sex care homes.

Isan is the largest part of Thailand with the largest population, but it is also the poorest part of Thailand. This region has the highest rates of migration among the younger generation (De Jong et al., 1996; Zimmer and Knodel, 2010). It includes 19 provinces bordering on Cambodia and Laos. Isan region has a variety of ethnic identifications including Lao (the majority), Khmer, Suay, Phu Tai and Vietnamese (Mccargo and

Hongladarom, 2004). Although Isan has the largest population, including older adults, there are only four care homes funded by the government available to support poor or dependent older adults. Two care homes locate in Nakhon Ratchasima province, one is in Mahasarakham province and the other one is in Buriram province.

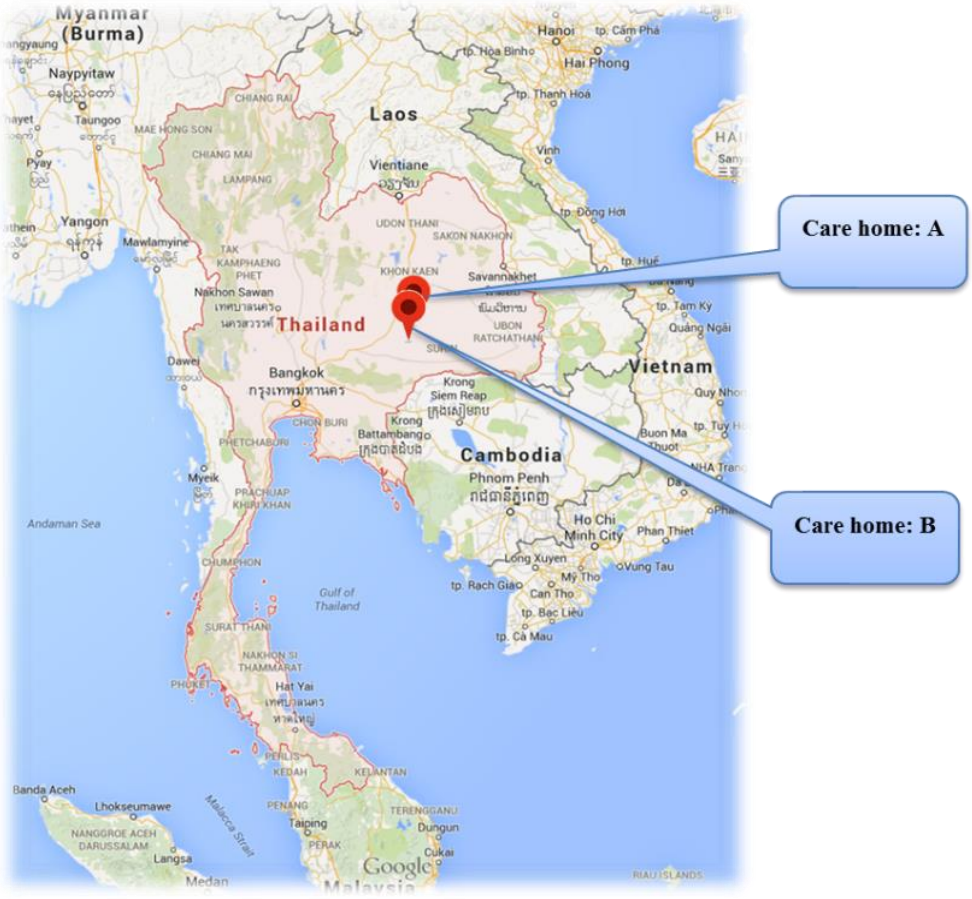


Figure 6: The study settings

The care homes offer free services providing general living services, overnight accommodation, food (three meals per day) and personal care for dependent older adults. The criteria for older adults who would like to enter to care homes are as the following (Wibulpolprasert, 2005):

- Older adults with Thai nationality aged 60 years and over.

- Willing to move into the care home (i.e. voluntarily).
- Not having committed a criminal offense or being under official investigation or subject to criminal proceedings.
- No severe chronic disease or risk of communicating disease.
- No disabilities or mental infirmity.
- Must be able to conduct routine daily activities themselves.
- Experiencing hardship due to poverty or lack of caregiver, and being unable to stay with their families.

3.6 Quantitative Research: Factors Associated with Depressive Symptoms among Older Adults Living in Care Homes

3.6.1 Research Objectives

The purposes of the cross-sectional questionnaire study were the following:

- To describe the characteristics of older adults residing in care homes in Thailand regarding age, gender, marital status, religion, qualification, time of LiCH, have own child or adopted child, an average of visitors, and health problems
- To compare sample characteristics and other variables comprising depressive symptoms, internalised stigma of LiCH, self-esteem, perceived social support and coping strategies between older adults who live in both care homes

- To examine the relationships between depressive symptoms, internalised stigma of LiCH, self-esteem, perceived social support and coping strategies among older adults residing in care homes
- To explore the factors predicting depressive symptoms among older adults residing in care homes

3.6.2 Research Design

A cross-sectional questionnaire study was used in order to achieve the aim of this study regarding exploring the factors associated with depressive symptoms among older residents (Polit and Beck, 2012). It is the method of determining the prevalence of disease or other health related event in a population at a point in time or a short period (Mckenna et al., 2006). A prevalence study is a valuable method of obtaining information of older adults residing in care homes. Therefore, the findings from this cross-sectional questionnaire study could provide a good picture of health care needs of this target population.

3.6.3 Population and Sample

At the study time, there were only 20 care homes where were supported by the Thai government (Wibulpolprasert, 2005). This study was carried out in two care homes situated in Northeast Thailand. There were only 174 residents living in both care homes during the period of data collection. Since the number of older adults living in care homes was relatively low, it was intended to recruit every eligible older resident in both care homes in order to adequately describe the characteristics of this population, and examine the factors associated with depressive

symptoms. Older adults who could participate in this study were selected according to the following eligibility criteria:

- Thai older adults aged 60 and above
- Fluency in Thai language
- Absence of severe cognitive impairment which would prevent comprehension of the participant information sheet and completion of the questionnaire (this was determined by care home staff)
- Absence of severe psychological disturbance preventing comprehension of the participant information sheet and completion of the questionnaire (this was determined by care home staff)

Older adults who were having current psychiatric disorders involving psychosis, hallucinations, hearing voices, or a lack of awareness of their surroundings were considered incapable of giving information or communication due to conditions associated with their illness, such as delusions or disorders, including disconnection of speech content and lack of insight and cognitive ability (Aleman et al., 2006; Amador et al., 1993; Fusar-Poli et al., 2007).

3.6.4 Research Measurements

The questionnaire that was used to collect data in this study consists of six parts, as described below.

3.6.4.1 Personal demographic characteristics

The demographic characteristics questionnaire included setting, age, gender, marital status, religion, qualification, time of LiCH, having own child or adopted child, an average of visitors and physical health issues.

3.6.4.2 15-Item Thai Geriatric Depression Scale (15-TGDS) (Wongpakaran et al., 2013)

Depressive symptoms were measured by the 15-item Thai Geriatric Depression Scale (15-TGDS). The Geriatric Depression Scale (GDS) was first created by Yesavage et al. (1983), and it has been tested and used extensively among elderly populations worldwide. A Short-Form GDS consisting of 15 questions was developed in 1986 (Yesavage and Sheikh, 1986), which has been determined to be easier to use for this population, especially older adults with physical illness and mild to moderate cognitive impairment (i.e. short attention spans or easily feeling fatigued). It takes about five to seven minutes to complete, and has been extensively used in community, acute and long-term care settings.

The validity and reliability of the GDS was reported with a high correlation ($r = .84$, $p < .001$) (Yesavage and Sheikh, 1986). The Thai version has been tested for its reliability and validity on 130 older adults, and it was found to show good internal consistency (Cronbach's alpha = 0.85) (Wongpakaran et al., 2013). Of the 15 items, 10 indicate the presence of depression when answered positively, while the others (question numbers 1, 5, 7, 11 and 13) indicate depression when answered negatively. The interpretation score of depressive symptoms are as the

following: 0 - 4 scores (normal range), 5 - 8 scores (mild depressive symptoms), 9 - 11 scores (moderate depressive symptoms) and 12 – 15 scares (severe depressive symptoms).

3.6.4.3 Thai Internalised Stigma of Living in a Care Home Scale (ISLCH) (Wong-Anuchit et al., 2016)

Perceiving internalised stigma among older residents was assessed by ISLCH Scale, which was adapted from the Internalised Stigma of Mental Illness Scale (ISMI) (Boyd Ritsher et al., 2003). The original scale (ISMI) was designed to measure the subjective experience of stigma focussing on assessing alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance (Boyd Ritsher et al., 2003). The ISMI has been widely used in the 55 versions in many different countries, including versions for depression, schizophrenia, leprosy, smoking, parents or care givers of people with mental illness and ethnicity (Boyd et al., 2014). The various versions show validity and reliability across a wide range of languages, cultures and writing systems (ibid). The 29-items ISMI reported excellent internal consistency, with a Cronbach's alpha of 0.90 demonstrated through reliability testing with 127 outpatients of the mental health service (Boyd Ritsher et al., 2003).

The ISMI consists of 29 items answerable on a four-point Likert scale (1 = strongly disagree, 4 = strongly agree). Higher scores indicate more internalised stigma. Lysaker et al. (2007) suggest that internalised stigma scores can be divided into four categories: 1.00 to 2.00 (minimal to no internalised stigma), 2.01 to 2.50 (mild internalised stigma), 2.51 to 3.00

(moderate internalised stigma) and 3.01 to 4.00 (severe internalised stigma). In addition, it is suggested that perceiving internalised stigma also can interpret into two categories: 1.00 to 2.50 (does not report high internalised stigma) and 2.51 to 4.00 (reports high internalised stigma) (Boyd & Phelan, 2004). The details of the development psychometric properties of Thai version of ISLCH Scale are provided in chapter four (see section 4.3).

3.6.4.4 Thai Rosenberg Self-Esteem Scale (RSES) (Wongpakaran and Wongpakaran, 2012b)

Self-esteem was measured by the Thai Version of the Rosenberg Self-Esteem Scale (Thai-RSES) (Wongpakaran and Wongpakaran, 2012b). The RSES (1965) is identified as one of the global self-esteem measurements. It has been used in various populations and has received more psychometric analysis and empirical validation than any other self-esteem measure (Robins et al., 2001). This measurement provides good indications of general rather than specific views of the self (e.g. 'on the whole, I am satisfied with myself') (Ciarrochi et al., 2007).

The Thai- RSES has been tested for its reliability and validity among 479 adult participants (Wongpakaran and Wongpakaran, 2012b), showing good internal consistency (Cronbach's alpha = 0.87) (ibid). The Thai-RSES is a 10-item questionnaire with a four-point Likert scale ranging from "strongly agree" to "strongly disagree". It takes about five minutes to complete this questionnaire. Higher scores are associated with higher levels of self-esteem. It has been suggested that the score between 15

and 25 are considered average level of self-esteem. The scores lower than 15 are interpreted low level of self-esteem and the scores more than 25 are considered high level of self-esteem (Cabrillo College, 2018).

3.6.4.5 Thai Multidimensional Scale of Perceived Social Support (MSPSS) (Wongpakaran et al., 2011)

The Thai version of Multidimensional Scale of Perceived Social Support (Thai-MSPSS) was used to assess perceived social support among older adults residing in care homes (Wongpakaran et al., 2011). The MSPSS was first developed by Zimet et al. (1988). The aim of this measurement is to assess perceptions of social support adequacy from three specific source including family, friends and significant other (ibid). It has proven to be psychometrically sound with diverse samples and to have good internal reliability and test-retest reliability, and robust factorial validity (ibid). This measurement has been used to assess perceived social support among 1,041 people aged between 18 and 77, and has been found to have good internal consistency (Cronbach's alpha = 0.88) (Prezza and Pacilli, 2002).

The validity and reliability of the Thai-MSPSS has been tested for its reliability and validity with 462 adult participants (310 medical students and 152 psychiatric patients) and found to show good internal consistency (Cronbach's alpha = 0.91 in student group and Cronbach's alpha = 0.87 in patient group) (Wongpakaran et al., 2011). The MSPSS is a brief, easy to administer self-reported questionnaire, which contains twelve items rated on a seven-point Likert scale. Each item is intended

to measure the extent to which an individual perceives social support from different sources as the following: Significant Others (SO) (items 1, 2, 5, and 10), Family (FA) (items 3, 4, 8, and 11) and Friends (FR) (items 6, 7, 9, and 12). The scores of the MSPSS are ranging from 'very strongly disagree' (1) to 'very strongly agree' (7). A higher score on the MSPSS is associated with a greater perceived of social support. Any mean scale score ranging from 1 to 2.9 is considered low support; a score of 3 to 5 is considered moderate support; a score from 5.1 to 7 is considered high support (Zimet et al. 1988).

3.6.4.6 A Coping Strategies Inventory Short Form (CSI-SF) (Addison et al., 2007)

Coping strategy was assessed by the a Coping Strategies Inventory Short-Form (CSI-SF) (Addison et al., 2007). The original CSI was constructed as a 78-item questionnaire (Tobin et al., 1989), shortened to a 16-item version for use in the Jackson Heart Study of patients with coronary disease and caregivers of Alzheimer's patients (Addison et al., 2007). This measurement is developed to categorise coping response based on coping target and directionality of response.

The CSI-SF includes a 16-item survey answerable on a five-point Likert scale (1= never, 2= seldom, 3= sometime, 4=often and 5= almost always). However, it has been suggested that the item 16 should be discarded due to its poor performance, with reported factor loadings of 0.13 (Addison et al., 2007). The CSI-SF has been tested for its reliability and validity on 5,302 African-Americans between the ages of 35 to 84

(Addison et al., 2007). It has shown acceptable levels of reliability (with Cronbach's alpha values between 0.58 and 0.72). Higher scores indicate greater coping skills. The details of development psychometric properties of Thai version of CSI-SF are provided in chapter four (see section 4.4).

3.6.5 Data Analysis

The data was analysed using the Statistical Package for Social Science (SPSS) IBM PASW Version 22.0 for Windows. The researcher started by logging in forms and reviewing data for completeness and legibility in order to retrieve pieces of missing information. The data was cleaned before entering and recording data by checking for outliers and wide codes (Freeman and Walters, 2006). Furthermore, 10% of the computerised data files was randomly selected to proof against the original file in order to ensure the accuracy of the data file (Tabachnick and Fidell, 2001). All data was backed-up (Boynton, 2004) and password-protected. Frequency distributions and scatter plots were tested for observing an erroneous of the distribution of values, shapes of distributions such as skewness or peakedness, kurtosis and homogeneity of variance (Moore, 2010).

Descriptive statistics (means, standard deviations and frequency distributions) (Polit and Beck, 2012) were used to describe the characteristics of participants, their level of depressive symptoms, internalised stigma associated with LiCH, self-esteem, perceived social support and coping skills of the residents. Inferential statistical analysis was applied to answer hypothesises. A significance level of 0.05 was

established *a priori* for all the statistical levels due to the fact that nothing too risky could happen in this study (Greene and D'oliveira, 2005). The justification for selecting each statistical test is explained below.

- Chi-squared test was used in order to explore the differences in demographic data (age group, gender, marital status, religion, highest qualification, time of LiCH, have own child and adopted child, and average of visitor) between residents who lived in care home A and B. Moreover, Chi-squared test also was used to analyse the differences in health characteristics (diagnosed with one or more diseases, Diabetic mellitus, Hypertension, Hypercholesterolemia, Heart disease, have one or more health problems, difficulties of hearing, difficulties of seeing, difficulties to walk, and pain) between older adults who lived in two care homes. The rationale for exploring the differences between the two care homes was the differences in their fundamental features, such as the number of residents, gender (single sex and mixed sex care homes), number of staff and location.
- Unrelated t-test was used (Kanji et al., 2006) to test for a difference in internalised stigma associated with LiCH, and this was treated as interval level data among an unrelated group between residents who lived in care home A and B. Parametric assumptions were met, including a normal distribution, interval level data and homogeneity of variance (Coolican, 1997).
- Mann Whitney U test (Kanji et al., 2006) was used to test for differences in depressive symptoms and residents in different care

home settings, which was treated as ordinal level data among an unrelated group between residents who lived in both care homes.

- The Pearson's product moment correlation (Freeman and Walters, 2006) was used in order to investigate the relationships among depressive symptoms, internalised stigma of LiCH, self-esteem, perceived social support and coping strategy. These variables were measured on a Likert scale, yielding continuous data (Bennison and Wicks, 2013). Although they could be categorised as an ordinal level of measurement, they were treated as continuous data or interval measurements (Jamieson, 2004). In addition, parametric assumptions were met: a normally distributed population, interval level and homogeneity of variance (Coolican 1997).
- Logistic regression (Polit and Beck, 2012) was used to analyse the prediction of independent variables (gender, age, diagnosed with one or more diseases, level of internalised stigma, and perceived social support) and the categorical dependent variable (depressive symptoms; non-depressed and depressed group).
- Multiple regressions was used to predict depressive symptoms and also confirmed the best predictor of depressive symptoms between internalised stigma of LiCH and perceived social support.

3.7 Qualitative Research: Understanding Stigma associated with living in a Care Home in Thailand

3.7.1 Research purposes

The aim of qualitative research was to understand stigma associated with living in a care home and how stigma influenced the perspectives on beliefs and behaviours of older residents living in care homes in Thailand.

3.7.2 Research questions

- What was stigma associated with living in a care home, from the perspectives of older residents and care home staff?
- How did stigma associated with living in a care home influence the perspectives on the beliefs and behaviours of older residents living in care homes in Thailand?

3.7.3 Research Design

A case study approach (Baxter and Jack, 2008) was applied in the study, based on the research purposes and questions; understanding stigma associated with living in a care home. A case study is rooted in various disciplines, including psychology, law, political sciences and medicine (Maxwell, 2012). A case study is defined as an empirical inquiry that investigates a contemporary phenomenon in depth and within its real world context, especially when the boundaries between phenomenon and context may not be clearly evident (Yin, 2014, p. 16). As shown in chapter two, a systematic review on qualitative research, the study on stigma associated with living in a care home is still under researched and it is unknown how this phenomenon is relevant to high prevalence of

depression among older adults residing in care homes in Thailand. Therefore, a case study could provide the best answer for an in-depth understanding of the phenomenon (Creswell, 2012). Furthermore, a case study is a good approach when the inquiry has clearly identifiable cases with boundaries and seeks to provide an in-depth understanding of the case or comparison of several cases.

Further rationales of using case study research as a design of the study was the research questions of this study. It focused on understanding stigma associated with a care home and how stigma associated with a care home influenced on the perspectives on belief and behaviour of older residents living in care homes in Thailand. This justification was supported by Yin (2014), who suggested that the nature of the research question of case study seeks to answer the questions related to how or why inquiry. Furthermore, the study sought to examine contemporary phenomena within a real-life context (especially the boundaries between stigma phenomenon and the context of a care home), which were not clearly evident. These were the strengths of case study approach and was applied in this study (Yin, 2014, Lauckner et al., 2012).

A case study enables the researcher to explore complex situations and to allow the gathering of multiple perspectives from a range of sources (Lauckner et al., 2012). In order to understand stigma associated with a care home and how stigma influenced the relevant stakeholders, the researcher collected data from multiple perspectives (residents and care home staff) in order to see numerous viewpoints of stigma associated

with care home residency. Furthermore, the researcher applied various methods e.g. in-depth interview and non-participant observation (see section 3.7.7) and also maintained field notes to answer the research questions throughout the data collection period.

Finally, case study research helps us to understand an in-depth description and analysis of a case or multiple cases by focusing on an issue or a problem (Creswell, 2012). By apply this approach the researcher explored in depth regarding stigma associated with a care home within the different contexts in both care homes.

3.7.4 Determining the case and units of analysis

The case is defined as a phenomenon of some sort occurring in a bounded context (Miles et al., 2014). Stake (2000) suggests that researchers should choose cases from which they feel they can learn the most. It has been suggested that the classic case studies generally focus on an individual person as the case. However, the case also can be defined as specific events, programs, small groups, communities or organisations (Yin, 2014, p. 31). A case study is a good approach when the cases with boundaries has been clearly identified and seeks to provide an in-depth understanding of the cases (ibid). For this study, the case was defined as “a care home community” which involved a group of older residents and care home staff (units of analysis). The multiple or collective case study was applied in this study. It helped to analyse the phenomenon of interested (stigma associated with LiCH) in each setting and across settings (Baxter and Jack, 2008). Furthermore, it could help

to predict similar results or predict contrasting results but for predictable reasons (Yin, 2014).

Two of the care homes in Northeast of Thailand were selected as a specific context of a case to capture a breadth of understanding of stigma associated with living in a care home. Although both were in the same province and supported by same organisation, there were still some differences in the key features of the characteristics of residents and the care home context. The comparison of key features of both care homes was explained in Table 6.

Table 6: The differences in the key features of both care homes

Feature	Care home A	Care home B
Residents' characteristics		
Gender	Female	Male and female
Number of residents	77	97
Staff' characteristics		
Number of staff	32	26
Number of different professions	Nurse (1) Social worker (1) Nursing assistant (2) Care assistant (8)	Nurse (1) Social worker (1) Nursing assistant (4) Care assistant (8)
Location	Near a temple, a fresh market and a bus station (1.21 acres)	Nearby a city municipal and an office building (1.42 acres)
Building	There were the four buildings separated for older adults who can take care of themselves and who need special care from the staff, such as older adults with dementia or frail older adults. All buildings were connected to each other and share a cafeteria at the centre of the building.	There were separate buildings between male and female residents, care home staff and the cafeteria of the care home. Older adults who needed special care, such as cancer, frail older adults or dementia patients were separated in the extension of the building of male and female older adults.

It has been suggested that the case is in effect the unit of analysis (Miles et al., 2014). In this study, a care home community related to with several units of analysis which were identified as the key stakeholders (groups) associated with a care home, including older residents and care home staff.

Figure 7 demonstrates the component of the unit of analysis in each case study (residents and care home staff). In this study, a typical case consisted of the following:

- 30 older residents (15 people from each care home)
- 20 care home staff (10 people from each care home)

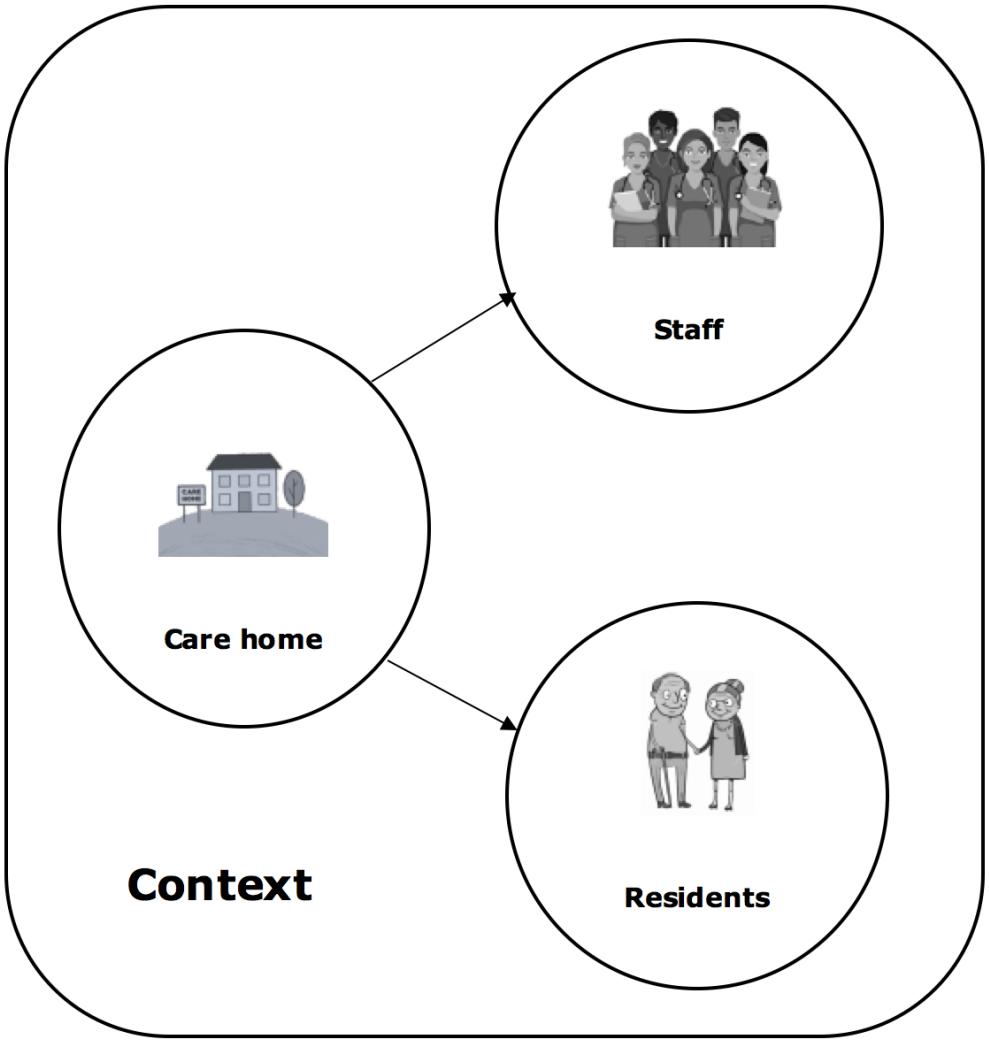


Figure 7: The design of the case study

3.7.5 Sampling and selection of the cases

The main unit of analysis (Gray, 2009) was defined as a care home community in this study. In addition, the unit of analysis was defined as a group of people who were involved in a care home, which included older residents and care home staff. In order to achieve a complete view of the topic being explored, person (data) triangulation was used to select the participants from multiple perspectives (residents and care home staff) (Adami and Kiger, 2005; Thurmond, 2001). In-depth interview and

non-participant observation were used to collect data from residents and care home staff (see section 3.7.7).

In qualitative research, there are three broad approached to select a sample: convenience sample, judgement sample (purposeful sample) and theoretical sample (Marshall, 1996). A purposive sampling strategy was used to select eligible residents and care home staff from each care home that met the objectives of the study and had experiences with the phenomena of interest. This sampling technique provided a rich source of data in order to generate a more comprehensive understanding of the research phenomena (Creswell, 2012; Procter and Allan, 2006; Sandelowski, 1995).

The following inclusion criteria were applied in order to identify eligible older residents who could participate in an in-depth interview:

1. Thai residents aged 60 and above
2. Ability to communicate in Thai language
3. Have been resident in the care home for at least three months
4. Absence of severe cognitive impairment which would prevent comprehension of the participant information sheet (this was determined by care home staff)
5. Absence of severe psychological disturbance preventing comprehension of the participant information sheet (this was determined by care home staff)

In addition, care home staff who could participate in an in-depth interview was selected according to the following eligibility criteria:

1. Fluency in Thai language
2. Working experiences in a care home for at least three months
3. Working closely with residents including a nurse, a nursing assistant, a care assistant, a social worker and a head of a care home

In qualitative research, there are no definitive parameters for the appropriate sample size; the selection of sample and size should be appropriate to answer the research question (Procter and Allan, 2006). However, it has been suggested that in qualitative research, a sample size of ten might be judged adequate for certain kinds of homogeneous or critical case sampling (Sandelowski, 1995). In addition, the researcher must decide which of the varieties of data concerning the case to sample to explicate its atypicality, especially evident in cases involving aggregates of one, such as family and organisation (ibid).

Therefore, the number of participants for an in-depth interview of ten to fifteen participants were applied for purposively selected a group of people (residents and care home staff) involved with a care home in order to have an adequate sample for certain kinds of homogeneous. For the diversity of participants, residents were purposively selected according to gender, experience of LiCH and physical functioning. In addition, care home staff were purposively selected according to their professions e.g. a nurse, a social worker, a nursing assistant or a care assistant and their experience of working in the care homes. The number of staff who were selected according to their professions was comparable in both care

homes. The number of the participants consists of fifteen older residents and ten care home staff from each care home (50 people in total from both care homes). However, the interview was stopped when data saturation was reached; the point at which no new information or themes emerge from the data (Guest et al., 2006).

3.7.6 Participant recruitment for the cross-sectional questionnaire study and the case study

The recruitment process for the cross-sectional study and the case study were happening at the same period of time. Eligible participants for the cross-sectional questionnaire study were recruited from the population of older adults who lived in two care home settings.

Two weeks before collecting data, the researcher contacted the heads of the care homes and members of staff in order to explain the purpose and the procedure of the study and asked them to assist with screening for eligible residents and care home staff. All eligible residents for the cross-sectional questionnaire study and care home staff were approached face to face by the researcher who explained all information of the study including the purpose and the procedure. They were given time for at least three days to decide whether they would like to participate in this study or not and then the researcher visited their care home setting after around three days in order to identify willing participants. They could also express their interest by directly contacting care home staff or the researcher via email or mobile phone.

A high response rate is anticipated since previous research was conducted in a care home in Northern Thailand (Wongpakaran and Wongpakaran, 2012a) achieved a 71% response rate. It has been suggested that a good response rate increases the representativeness of a sample, while a low response rate can have a significant impact in undermining the usefulness of the findings (Murphy-Black, 2006).

Therefore, a range of following strategies were applied to approach older residents and care home staff in order to get the number of response rate and reached to an at least estimate value for a cross-sectional questionnaire study: an advertisement were put out during care home meal times; the researcher made a contact with interested participants when visiting the care homes (Davies and Nolan, 2006); the researcher made follow-up contacts with eligible residents and care home staff (Murphy-Black, 2006); and incentive raffle tickets were offered (the prize for which was 300 Bath) for three winners from a prize draw for eligible residents and one winner from a prize draw for care home staff who participated in this study from each care home in order to promote participation and rapport (Edwards et al., 2002).

Older residents and care home staff who provided their consent to take part in this study were asked to arrange a face-to-face structured questionnaire interview for resident and a face-to-face in-depth interview for care homes staff at a time and a place convenient to them, and then the researcher visited them at a place of their preference in order to describe and discuss any queries that they had about the study in detail

and to ensure that they thoroughly understood the nature of the research and their potential participation. In addition, older residents also were asked about their willingness to take part in an additional in-depth qualitative interview on similar issues at the beginning before taking their inform consent.

Participants could withdraw from the study either at their own request or at the discretion of the researcher. The participants were made aware that this would not affect their future care for residents and future work in the care homes for care home staff. Before the interview, they were informed again about the information related to the research project using the information sheet for an interview. The recruitment process was explained in Figure 8.

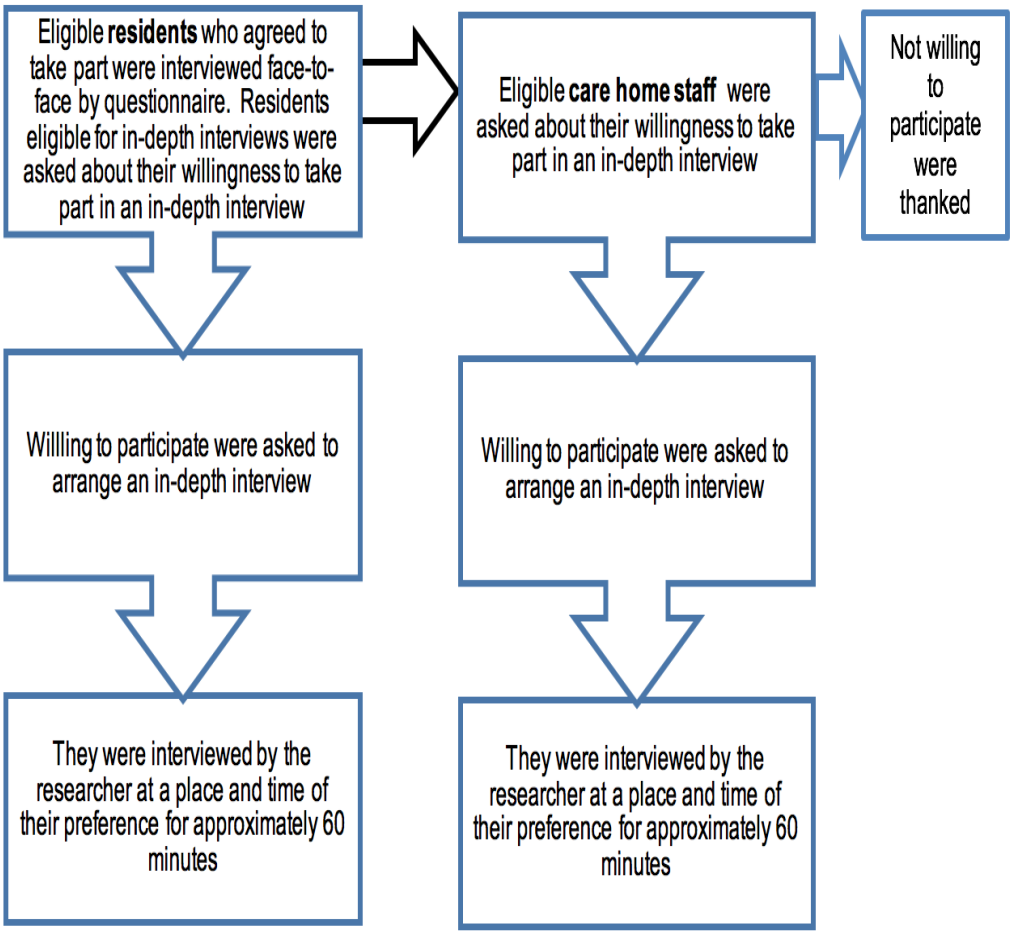


Figure 8: Recruitment process flowchart

3.7.7 Methods of data collection

3.7.7.1 A structured questionnaire interview

After receiving the informed consent, older residents were interviewed face-to-face by the researcher using the questionnaire comprising six sections: personal demographic characteristics, the 15-Item Thai Geriatric Depression Scale (15-TGDS), Internalised Stigma of Living in a Care Home Scale (Thai version of IS-LCH Scale), Thai version of Rosenberg Self-Esteem Scale (Thai version of RSES), Thai version of Multidimensional Scale of Perceived Social Support (Thai version of MSPSS) and Coping Strategies Inventory Short Form (Thai version of

CSI-SF). The whole stage of the structure questionnaire interview for older residents took around one hour to one and half hour per person.

3.7.7.2 An in-depth interview

The interview aim was to encourage participants including older residents and care home staff to talk freely about the topic of stigma associated with a care home in their own words (Polit and Beck, 2012). This study used semi-structured interviews, which had predetermined topics and open-end questions laid down in an interview schedule (Tod, 2006) (see appendix 10). This type of interview retains the flexibility necessary to follow issues raised by participants that had not been anticipated (ibid).

The interview took approximately 30 to 60 minutes. The conversation was audiotaped, with due regard for confidentially. After each interview with resident or care home staff, the field note was written immediately in order to write briefly the researcher's observations, informal or spontaneous interview and participant's non-verbal cues following the word-processing of field notes (Yin, 2014). This allowed the researcher to stay focused on what was really happening and facilitated coding without distraction.

3.7.7.3 Non-participant observation

The strengths of observational research are used to collect data from real events and real life (Moule and Goodman, 2009). As previous research using observational methods in real situations has found a care home is considered to be a stigmatising setting (Dobbs et al., 2008). It is reported that a care home is an oppressive environment, with dehumanised staff

(ibid). Therefore, in order to understand stigma associated with living in a care home and gain a direct understanding of a phenomenon in its natural context, non-participant observation (overt) was applied in this study.

In this technique, the researcher assumes the role of complete observer and endeavours to have no influence on the phenomenon under observation (Watson and Whyte, 2006a). The observation was conducted to follow the activities of daily routine of the care home's schedules (selecting events to observe) including meal times, recreation activities, and praying or meditation in various public spaces of the care homes, including the dining room, corridors, lounges and activities areas (Hubbard et al., 2003) for approximately one to two hours per day at different times; morning and afternoon including weekdays and weekend in both care homes for one month in order to gain a better understanding of social interactions and behaviours, interactions of residents, staff interactions and activities with residents, residents' everyday lives and how residents used and spend their time. Moreover, semi-structured observation was used in this study (see appendix 10). After each observation period, the semi-structured observation was word-processed (Yin, 2014), which was written immediately after each observation in order to record descriptive and reflective notes of observed events.

Conducting non-participant observation can raise some ethical challenges including consent and privacy issues. Therefore, in order to protect the participants in the investigation, the researcher sought

permission for conducting non-participant observation from the head of each care home. They were contacted and informed in advance by the researcher in order to seek their permission for conducting non-participant observation and to allow them to inform care home staff and residents about the non-participant observation.

In addition, care home staff and residents who were observed were verbally asked for their consent and informed again about observation before each period of non-participant observation. Moreover, the researcher provided participants with the opportunity to discuss and to ask questions related to non-participant observation before starting an observation. Furthermore, participants were informed that participation was voluntary and that refused to participate or subsequent withdrawal from the study would not result in any loss of service or benefit to which the participant was entitled while residing in a care home. As the researcher was aware of the importance of protecting the consent, privacy and confidentiality of those who were observed, if they said that they were unwilling to be observed, the researcher would stop an observation. However, the information that had been already collected cannot be erased and that this information was still used in the project analysis by maintain anonymity.

There were some changes in non-participant observation from focusing on overall participants to more narrow attention to individuals who were interviewed in depth. The change of the target of observation was applied during the initial phase of observation after discussion with the

supervisory team. The rationale for this was to enable data triangulation with other data collection methods, including in-depth interviews and cross-sectional study for each individual. Therefore, it was worth focusing on the individual behaviours and interactions rather than the general participants

3.7.8 Data analysis for the case study

All data resources related to the single case was reviewed and recorded in one folder to facilitate the accessibility of the individual cases separately from other cases. This was prevent cases from being mixed with other cases and protect the contextual unique characteristics of each case (Stake, 2000). The researcher transcribed all data gathered from interviews and observations. These data was saved in a computer with password protection accessible only to the researcher.

In order to organise and describe the data in rich detail, the researcher applied thematic analysis method to identify, analyse and report the data thematically (Braun and Clarke, 2006). All interviews in this study were conducted in Thai language. The audio recordings of interviews transcribed verbatim, and then translated into English after the analysis in order to preserve cultural nuances in the data (Chen and Boore, 2010). However, the transcripts of the 10% of all interviews (3 residents and 2 care home staff) were translated from Thai to English for academic purposes in order to get feedback from the supervisors. In order to ensure the quality of the translating process, two bilingual independent reviewers were consulted to compare the transcripts and translations. As Cruz et

al. (2000) suggest, using an independent bilingual translator helps to enhance the quality of translation and has the potential to recognise inconsistencies that may need clarification. Six phases of thematic analysis were undertaken serially in order to develop thematic analysis in this study (Braun and Clarke, 2006). The details of how the researcher approached them are provided in Table 7.

Table 7: The six phases of thematic analysis, adapted from Braun and Clarke (2006)

Phases	Processes
Phase 1	Familiarisation with the data It was very important to familiarize myself with the data, in order to understand the research phenomena at the macro level. I read and reread the transcripts and listened to the audio recordings several times to achieve data immersion and to identify significant phrases or sentences (Polit and Beck, 2012, Braun and Clarke, 2006) directly related to the experiences and perceptions of perceived stigma associated with a care home.
Phase 2	Generate initial codes Having become deeply familiarized with the data, the preliminary generation of ideas and identification of items of interest within the data. Organise data into groups to form codes.
Phase 3	Search for themes Codes were ascribed to data items and codes were grouped together to precipitate the emergence of themes.
Phase 4	Review potential themes Having collected all relevant codes within potential themes, the latter were checked in relation to the coded extracts and the dataset.
Phase 5	Define and name themes I reviewed names and definitions for each theme in order to ensure whether these themes generate clear names and definitions.
Phase 6	Final analysis and producing the report Finally, producing the report, I reviewed the production of themes with reference to examples of selected extracts of data. The results were used to describe experiences and perceptions of stigma associated with LiCH in the perspectives of residents and care home staff.

3.7.9 Trustworthiness in qualitative research

Trustworthiness in qualitative research is equivalent to the quality criteria used to assess the quality of quantitative research comprising internal and external validity, reliability and objectivity. In qualitative research, trustworthiness is determined by research credibility, transferability, dependability and confirmability (Krefting, 1991). The study applied various strategies in order to demonstrate rigour in these parameters, as described below.

3.7.9.1 Credibility

Credibility involves establishing that study findings are credible and believable, and how well the research represents the actual phenomenon under consideration (Morse, 2015). It focuses more on the richness of information rather than the quantity of data. Credibility has been related to the concept of internal validity in quantitative research (Morse, 2015; Rolfe, 2006). It has been suggested that various strategies can increase credibility of qualitative research, including prolonged and varied field experience, time sampling, triangulation, member checking, peer examination and intervention technique (Krefting, 1991). This study applied many strategies to increase the credibility of the research, including prolonged engagement with participants and persistent observation, peer review or debriefing and triangulation.

Prolonged engagement with participants and persistent observation can help to increase rapport between the researcher and participants (Hadi and Closs, 2016). This could help the researcher gain more in-depth data

and ensure that the research phenomena are explored comprehensively (Hadi and Closs, 2016). In this research, the researcher spent time and regularly visited participants, including residents and care home staff, in the study settings (care homes) over two months before beginning the data collection. Furthermore, the researcher participated in social activities in the care home during the data collection period. This was to ensure that the researcher gained participants trust and established rapport toward the researcher.

Peer review or debriefing helps to prevent bias during the development of the study, particularly for new investigators (Morse, 2015). The peer review could help synthesise and see the pattern of the data. The process of peer review was manifested in supervision meetings held regularly nearly every month during data collection, in person and by Skype, emails and WhatsApp messages. The complete transcripts of five participants were read by the supervisors and were discussed throughout the process of data collection and data analysis.

Triangulation can cover a number of dimensions including the investigator, data, theory and methods, but it is usually refers to using two or more sets of data or methods to answer one research question (Morse, 2015). There are a number of types of triangulation, including triangulation of data methods, triangulation of data sources, theoretical triangulation and triangulation of investigators (Krefting, 1991). This study applied triangulation of data methods, including in-depth interviews and non-participant observations, and triangulation of data sources from

residents and care home staff, in order to enhance the quality of the research. The data from different methods and different sources were cross-checked during the data analysis and data interpretation.

3.7.9.2 Transferability

Transferability refers to the degree in which the research can be transferred to other contexts (Morse, 2015). Transferability is related to external validity or generalisability in quantitative research (Morse, 2015; Rolfe, 2006). It has been suggested that transferability is relevant to thick description. It is very important in transferring the original findings to other individuals, populations or contexts (Morse, 2015). The strategy that helps to achieve thick and rich description is a purposive sampling strategy. This could help to achieve in-depth information on the group of people who experienced the phenomenon of interest. As the study adopted a purposive sampling strategy to select residents who had at least six months' experience of LiCH and care home staff who had at least three months experience of working in a care home.

3.7.9.3 Dependability

Dependability is related to ensuring that the research findings would be the same when conducting another study in a similar context; it is analogous to reliability in quantitative research (Morse, 2015; Rolfe, 2006), being concerned with the consistency of the findings (Krefting, 1991). Various strategies can be used to demonstrate dependability, including dependability audit, dense description of research methods, stepwise replication, triangulation, peer examination or code-recode

procedure (ibid). This study used peer examination by supervision meetings and triangulation to assess the dependability of the study. The findings from two methods (in depth-interview and non-participant observation) and two perspectives (residents and care home staff) were compared during the data analysis to make sure both methods and sources give the same results.

3.7.9.4 Confirmability

Confirmability is related to how the study findings are supported by the data collected (Morse, 2015). Confirmability is similar to objectivity in quantitative research (Morse, 2015; Rolfe, 2006). There are a number of strategies that can be used to establish confirmability of qualitative research, including confirmability audit, triangulation, reflexivity or external review (Krefting, 1991). This study used open coding rather than pre-determined coding or categories. The findings of the study also showed multiple quotations from many interviews to illustrate each category. External review was also used during data collection and data analysis by supervision meetings.

In conclusion, the trustworthiness of qualitative research can be assessed by credibility, transferability, dependability and confirmability. A summary of interventions with which establish of trustworthiness of a study is shown in Table 8.

Table 8: Summary of interventions to establish trustworthiness

Criteria of Trustworthiness	Interventions
Credibility	Prolonged engagement with participants and persistent observation Peer review or debriefing Triangulation
Transferability	Purposive sampling Tick description
Dependability	Peer examination Triangulation
Confirmability	External review during the development of the data

3.7.9.5 Rapport and reflexivity

Reflexivity refers to an awareness of the influence that the researcher has on the research process and outcomes, in terms of their actions, feelings and perceptions (Darawsheh, 2014). In addition, rapport refers to a range of positive psychological features of an interaction such as a sense of connection, comfort, willingness to disclose or share sensitive information, motivation and empathy (Garbarski et al., 2016). I was consciously aware of the issues of rapport and reflexivity that could arise in this study as a nurse and a researcher working among older adults residing in care homes. Residents tended to perceive me as a health care professional rather than a researcher due to my visits to the care homes prior to data collection, which could inhibit their participation in the study or which could make them reticent to voice critical experiences they feel may be disparaging to professionals or institutions. They also may perceive that negative information during their participation may affect the care they receive. However, by prolonged contact and regular visits to care homes nearly two months before data collection began I was able

to build rapport and residents were familiarised with me. Moreover, I also explained the details of the research and data collection to all participants and made sure that they understood that they could withdraw from the study at any time without giving any reasons, and participations, non-participation or withdrawal would not affect the service and care provided by care home staff.

Other issues surrounding building rapport and subsequent 'exiting' from the field of the study were entering the lives of others, developing attachment, feeling guilty and exhaustion. I appreciated all participants who took part in this study. They allowed me to enter to their personal stories which were often very confidential and difficult for them to tell anyone. Some participants emotionally expressed their unhappy experiences when I interviewed them. I was consciously aware of this issue. Therefore, I expressed my respect to them by active listening, offering to pause or stop if they did not want to continue and making sure that they knew that they could withdraw from the study at any time by reiterating such rights. Furthermore, prolonging my relationship with participants led to developing genuine emotional attachments. I often felt overwhelmed by listening to the unhappy stories of individual participants. I tried hard to separate myself from distressing information but discussing this issue with my supervisors during supervision meetings was very helpful and helped me to manage my emotional distress. I also prepared to exit from the fieldwork two months before the due time to ease the emotional rupture for myself and participants. I regularly informed the participants face-to-face and also attended the

social activities of the care homes to formally inform all participants before leaving the sites.

3.8 Ethical Considerations

The ethical dimension is of fundamental importance when conducting research on humans, particularly the vulnerable groups typically studied in nursing research (Polit and Beck, 2012). Vulnerable groups are people at risk of psychological and physical harm, such as children, prisoners and pregnant women etc. (Polit and Beck, 2012). People with mental illness and learning difficulties, the terminally ill and frail older adults can also be considered as vulnerable (Gerrish and Lacey, 2006).

Thus, the researcher was consciously avoiding any risk of harm to participants including residents and care home staff during data collection of this research. Hence, in order to avoid the negative consequences all of the important points of the ethical considerations were taken in to account including the ethical approval process, informed consent, data protection and confidentiality and management for emotional distress. The ethical consideration processes are described below.

3.8.1 Ethical approval

Ethical approval was obtained from a University Institutional Review Board in the UK (Ref: OVSa16042015 SoHS) and Hospital Institutional Review Board in Thailand (Ref: 053/2015). Moreover, the Nakhonratchasima Provincial Administrative Organization was contacted to solicit permission to conduct research in the aforementioned

institutions in Nakhonratchasima Province, Thailand. Upon receiving permission to conduct the study, the researcher contacted head of TPWDCOP and TWWDCOP for ethical approval. No data was collected without permission from the Research Ethics Committees.

3.8.2 Informed consent

Full details about the aim of the study, the data collection process, likely benefits and ethical protocols, including anonymity and the right of participants to freely withdraw their voluntary participation at any time without stating a reason (and without affecting their care) were explained in full details in the participant information sheet distributed to all participants, and verbally reiterated prior to conducting the interviews. Moreover, the researcher provided participants with opportunities to discuss and to ask questions related to the study before starting the interview. Consent to participate in the research was taken by the researcher using a consent form. The major potential benefits of participating in this study were declared to participants, such as that they were able to discuss their perceptions regarding a care home and the satisfaction that their information was useful for older adults who living in care homes.

3.8.3 Data protection and confidentiality

Confidentiality and voluntary participation were emphasised by maintaining anonymity throughout the study. The identifiable information including the consent form and personal demographic data sheet were maintained separately. Participants' names were not included in the

study; a unique code in quantitative data and an alias name in qualitative data were applied for participants' identities instead of using their names. Thus the identity of participants was not disclosed at any time during the research process. All electronic data in softcopy was stored in password-protected computers and files and all information collected during the data collection was stored in a secure and locked office. The researcher was the only one who had access to all participants' personal information. The data was used only for academic purposes, including discussion during supervision, informal meetings or conferences when the findings are presented.

However, there was the exception of information that was revealed during a structured questionnaire interview, or during an in-depth qualitative interview, which was of concern and needed reporting i.e. potential risks to participants such as psychological distress (the residents who were reported with moderate or severe depressive symptoms). This information was reported to a member of staff (a nurse) in each care home by the researcher in order to provide an appropriate care and solution. The number of residents who reported with moderate was reported in five residents and severe depressive symptom was reported in eight residents in both care homes.

All research data will be kept securely for 7 years. After this time the data will disposed of securely. During this time all precautions will be taken by all those involved to maintain confidentiality, only members of the research team have access to personal data.

3.8.4 Confidentiality, consent and privacy regarding non-participant observation

Although the goals of the research included obtaining information from participants, or an area which was observed, the value attached to individual privacy should be consciously considered. It has been suggested the researcher should be consciously concerned that participants' privacy and confidentiality are maintained continuously (Polit and Beck, 2012). The researcher should be consciously aware of the impact on individual participant's privacy and confidentiality during an observation. Therefore, as non - participant observation was taking place mainly in public spaces of the care homes, the observation was not started until after gaining the permission of the heads of both care homes. The researcher sought permission to conduct non-participant observation and formally informed the heads of care homes of the details of the observation two weeks before an observation. Observations took place mainly in public spaces, including the dining room, corridors, lounges and activities areas in different times of day.

During observation the researcher was consciously aware of the impact of the research on the ethical challenges, including consent, confidentiality and privacy of residents and care home staff, even when the observation was taking place in a public area. Before beginning the interview, care home staff and residents who were staying in the area which was to be observed were verbally asked for their consent and informed about the observation before each period of observation in order to protect their privacy, dignity and confidentiality. Participants had

the right to refuse to be observed or to participate in the research (Yin, 2014). The researcher provided participants with the opportunity to discuss and to ask questions related to non-participant observation before starting an observation.

As the researcher was aware of the importance of protecting the privacy, consent and confidentiality of those who were observed, if they said that they were unwilling to be observed, the researcher would stop observation. However, the information that had been already collected could not be erased and that this information was still used in the project analysis by maintain anonymity. Moreover, the researcher would ensure any emotional and physical harm to participants was avoided. The researcher would simply observe the process of each activity and wrote an observation record at the end of each observation immediately, using semi-structured observation guideline (see appendix 10) in order to record descriptive and reflective notes of observed events.

3.8.5 Emotional distress

It has been suggested that when carrying out research involving vulnerable groups such as older adults or children, every effort should be made to secure their safety and protecting them from harm (Silverman, 2014, p. 144). Therefore, during the data collection process, the major potential risks which might influence the participants were considered, including psychological or emotional distress during an interview. Participants were encouraged to pause or stop if they found it very

stressful and they were informed that they could withdraw from the study at any time without providing the reason.

In addition, it was important to consider the issues of confidentiality and safeguarding among participants who became upset. Especially, if it was the complicated issues such as the situations where participants had been the subject of abuse, or might be in some kind of danger or might be potential risk. The results of their participations in the study, they will not be put in any undesirable position (Yin, 2014, p.78). Therefore, the researcher clarified with the participants at the beginning of the interview process when obtaining consent that, as a registered nurse, there was a responsibility to pass on such information to an appropriate professional who was involved in the organisation of the care arrangements i.e. potential risks to participants such as having moderate or severe depressive symptoms which was reported by the researcher to an administrator or staff of the care homes in order to provide an appropriate care.

In addition, if poor practice was revealed or reported during the interviews then the researcher must breach confidentiality in order to protect the older adults/participants. The researcher was report such incidences to the Nakhonratchasima Provincial Administrative Organization; the government office that was responsible for care homes in Nakhon Ratchasima Province. Furthermore, the negative consequences after interviewing, such as feeling depressed or experiencing emotional distress, were observed in older people who lived in both care homes.

The researcher collaborated with an administrator or staff member in both care homes to observe the consequences during and after the data collection processes in order to provide appropriate care. The next chapter of the thesis presents a pilot study and development of psychometric properties of the questionnaire regarding Thai Version of Internalised Stigma of Living in a Care Home Scale (IS-LCH) and Thai Version of Coping Strategies Inventory Short Form (CSI-SF).

Chapter Four: Pilot Study and Psychometric Properties of Thai IS-LCH and CSI-SF Questionnaires

4.1 Introduction

A pilot study is defined as a small study carried before the actual research is conducted in order to confirm that the research tools are calibrated to assess the intended phenomena (Thabane et al., 2010). It is one of the most important stages in a research project and it can identify deficiencies in the research instrument and test the feasibility of the study protocol (Zailinawati et al., 2006). The general aim of the pilot study in this project was to develop the psychometric properties of the questionnaires, the Thai Version of Internalised Stigma of Living in a Care Home (IS-LCH) Scale and the Thai Version of a Coping Strategies Inventory Short-Form (CSI-SF), and to test the feasibility of the study protocol.

This chapter will discuss the aim of pilot study, setting and population, sample size, procedure of development psychometric properties of the questionnaires, instruments, measure outcome, data analysis, ethical consideration, results and discussion.

4.2 Objectives of the Pilot Study

The overall aim of this pilot study was to test and finalise the research procedure and to test the quality of IS-LCH Scale and the translated Thai Version of CSI-SF. This pilot study had the following two objectives:

1. To validate and cross-culturally adapt the Thai version of IS-LCH Scale and Thai version of CSI-SF
2. To determine the feasibility of the research processes and outcomes measures used in this study.

4.3 Thai Internalised Stigma of Living in a Care Home Scale (Wong-Anuchit et al., 2016)

Internalised stigma of LiCH among older residents was assessed using the Thai version of IS-LCH Scale, adapted from the Thai version of Internalised Stigma of Mental Illness (ISMI) Scale (Wong-Anuchit et al., 2016). The original scale of ISMI was designed to measure the subjective experience of stigma among people living with mental illness by focussing on the assessment of alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance (Boyd Ritsher et al., 2003).

The ISMI Scale has been widely used in 55 versions in many different countries, including versions for depression, schizophrenia, leprosy, smoking, parents or care givers of people with mental illness and ethnicity (Boyd et al., 2014). The various versions show validity and reliability across a wide range of languages, cultures and writing systems (ibid). The ISMI Scale consists of 29 items answerable on a four-point Likert scale (1 = strongly disagree, 4 = strongly agree). Higher scores indicate more internalised stigma.

Lysaker et al. (2007) suggest that internalised stigma scores can be divided into four categories: 1.00 to 2.00 (minimal to no internalised

stigma), 2.01 to 2.50 (mild internalised stigma), 2.51 to 3.00 (moderate internalised stigma) and 3.01 to 4.00 (severe internalised stigma). In addition, it is suggested that perceiving internalised stigma can also be divided into two categories: 1.00 to 2.50 (does not report high internalised stigma) and 2.51 to 4.00 (reports high internalised stigma) (Boyd & Phelan, 2004).

Three phases for the development and validation of the Thai version of ISLCH Scale were applied in this study: [Phase 1] obtaining copyright permission for using the scale in the study from Dr Jennifer Boyd Ritsher (the creator of the original version of ISMI); [Phase 2] obtaining permission for adapting Thai version of ISMI Scale to Thai version of ISLCH scale from Dr Choochart Wong-Anuchit (who created the Thai version); [Phase 3] selection of an expert panel and reliability testing of the developed scale (Thai version of ISLCH Scale).

4.3.1 Phase 1: Obtaining copyright permission

To begin with, the researcher contacted Dr Jennifer Boyd Ritsher and Dr Choochart Wong-Anuchit in order to request copyright permission to use the instrument for the original and Thai versions (see appendix 12), during which the purpose of revising the items to refer to stigma associated of LiCH instead of mental illness was discussed and explained.

4.3.2 Phase 2: Content validity

The researcher contacted the panel of experts, which included three professional experts and three lay experts in order to assess whether the

developed scale is well constructed and suitable for testing. At least three experts (professionals and lay experts) were recommended by McGartland et al. (2004) in order to conduct a content validity study. Professional experts were selected according to the number of publications and their work experience in the area of geriatric psychology, due to the fact their knowledge can be helpful in determining whether the scale is well-constructed and suitable for psychometric testing (Rubio, et. al., 2003). All of the professional experts in the study were in academia, had doctoral degrees and were engaged in research on mental health. The professional experts comprised a physician in geriatric psychology, Professor Nahathai Wongpakaran; an expert on psychogeriatric screening tests, Dr Choochart Wong-Anuchit; and a psychiatric nurse, Dr Sukjai Charoensuk. These three professionals formed the panel to check the cultural appropriateness and content validity of this scale.

In addition, the lay experts were three volunteer residents LiCH in north-eastern Thailand. They helped to address the issues about phrasing and any unclear terms, and made other recommendations regarding the measurements. The lay experts were selected according to being Thai citizens aged 60 and above, fluent in Thai language (speaking, reading and writing skills), with the absence of severe cognitive impairment and psychological disturbance (as determined by care home staff), and expressed interested in acting as lay experts in the study.

Professional experts were contacted by email, and sent a cover letter, a copy of the revised scale, and the response form (descriptive feedback

and rating for Content Validity Index of the revised scale) in order to assess whether the revised scale is well-constructed and suitable for testing among older adults residing in a care home. The feedback from the three experts was compared and synthesised to produce the new version of the revised scale, which was then reviewed by the lay experts in order to address the issues about phrasing or unclear terms. Finally, the final revised scale was produced for testing the reliability of the scale in the pilot study.

4.3.3 Phase 3: Testing reliability

The developed scale was tested for internal consistency and test-retest reliability (between 7 to 14 days) using Cronbach's alpha and Intraclass Correlation Coefficient (ICC) respectively with 15 older adults residing in a care home. Grammatical errors, misspellings and other minor discrepancies were addressed and were corrected before field-testing. Figure 9 illustrates the process of development psychometric properties of the Thai version of the ISLCH Scale.

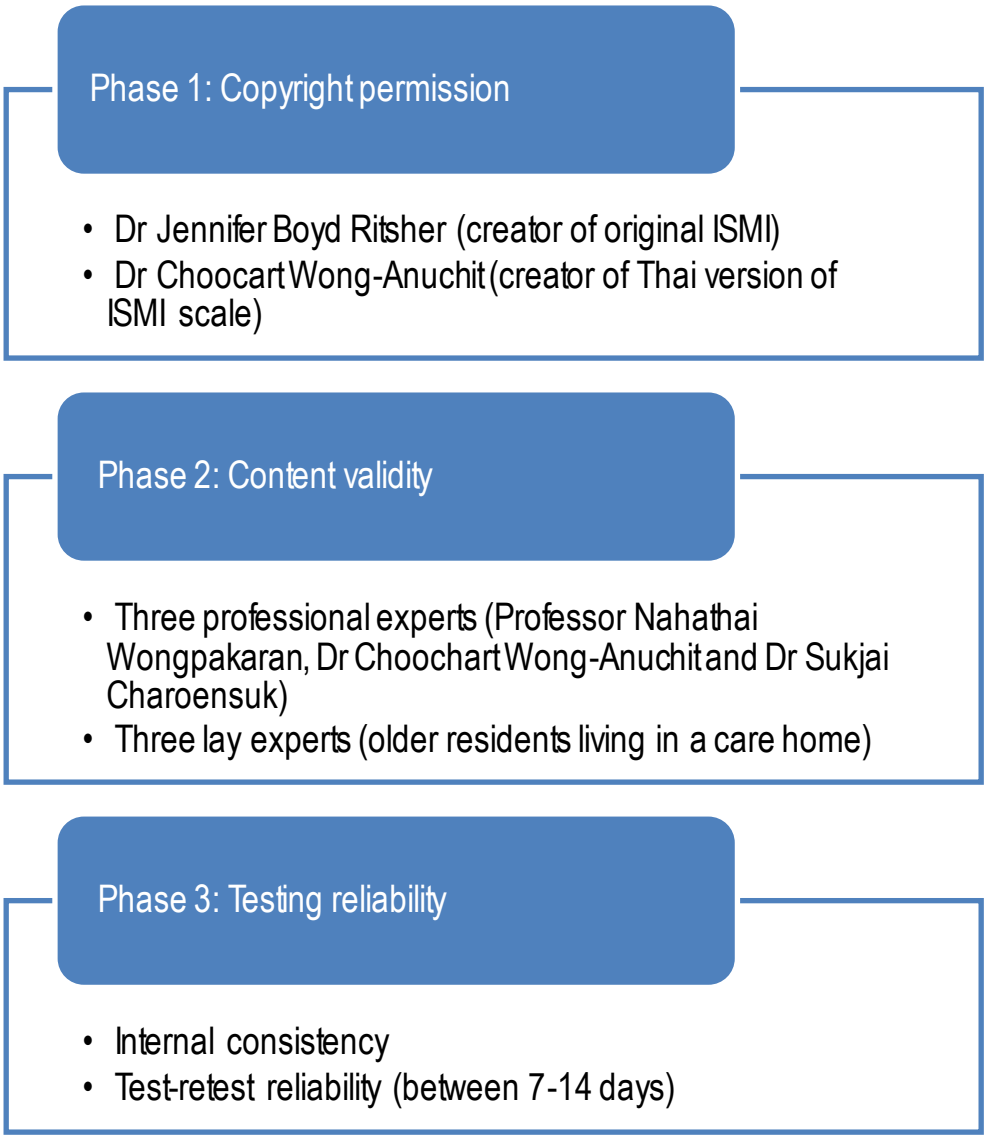


Figure 9: Development psychometric properties of the Thai version of IS-LCH Scale

4.4 Thai Coping Strategies Inventory Short Form (CSI-SF)

Coping strategies were assessed by Thai version of CSI-SF. The original CSI was constructed as a 72-item questionnaire designed to assess the coping thoughts and behaviours in responding to stressed situation (Tobin et al., 1989). It includes fourteen subscales: eight primary scales (Problem Solving, Cognitive Restructuring, Social Support, Express

Avoidance, Wishful Thinking and Social Withdrawal), four secondary scales (Problem Focused Engagement, Emotion Focused Engagement, Problem Focused Disengagement and Emotion Focused Disengagement) and two tertiary scales (Engagement and Disengagement). The original CSI asks participants to respond indicating how often they cope with stress in certain ways with a five-point Likert format response (none, a little, some, much and very much). The original CSI has alpha coefficients ranging from 0.71 to 0.94 (m=0.83).

The shortened version of CSI is a 16-item version used in the Jackson Heart Study of patients with coronary disease and caregivers of Alzheimer's patients (Addison et al., 2007). This measurement was developed to examine coping skills among 5,302 African-American men and women aged 35-84 in the Jackson Heart Study cohort after a validation study was conducted among headache sufferers, patients with coronary heart disease, and caregivers of Alzheimer's patients. The CSI-SF includes a 16-item survey answerable on a five-point Likert scale (1= never, 2= seldom, 3= sometime, 4=often and 5= almost always). However, it has been suggested that the item 16 should be discarded due to its poor performance, with reported factor loadings of 0.13 (Addison et al., 2007). Higher scores indicated greater coping skills. The CSI-SF (a 16-item version) has been tested for its reliability and validity and it has shown acceptable levels of reliability (with Cronbach's alpha values between 0.58 and 0.72).

4.4.1 The Process of Cross-Cultural Adaptation of CSI-SF

In order to develop the Thai version of a CSI-SF, three phases were involved: [1] copyright permission, [2] translation process, and [3] validation of reliability of the translation scale. The researcher started by contacting Dr Clifton C. Addison in order to obtain copyright permission for using the scale in the study and also for translating it into Thai language (see appendix 13). After getting this permission and discussing the translation of the questionnaire with Dr Clifton C. Addison, the translation process was started. The guideline for the process of Cross-Cultural Adaptation by Beaton et al. (2000) was used as a guideline to translate the scale into Thai language due to the fact that the guideline aims to minimise the issues of translation and also cultural adaptation of the scale (ibid).

The process of cross-cultural adaptation adapted from Beaton et al. (2000) comprised five stages of the translation, including initial translation, synthesis of the translations, back translation, expert committee and testing reliability of the Thai version CSI-SF.

4.4.1.1 Stage 1: Forward translation

It is suggested that the forward translation stage from the original language (English) to the target language (Thai), should include at least two bilingual translators whose mother tongue is the target language (Thai), and they also should have different academic backgrounds (Beaton et al., 2000). Forward translation involved two independent bilingual translators (1 and 2), one of whom is aware of the concepts of

the Coping Strategies scale (Dr Sukjai Charoensuk) and the other of whom is a professional expert in English and Linguistics (Associate Professor Payung Cedar). They both worked independently in order to translate the scale from English to Thai language. The first forward translation (T1) and the second forward translation (T2) were produced.

4.4.1.2 Stage 2: Synthesis of the translation

The two Thai forward translations (T1 and T2) were then compared by the researcher. If there was any discrepancy, a third translator was consulted, Miss Panitsara Leekuan, a bilingual translator. After the synthesis, the T-12 version (Thai language) of the scale was produced.

4.4.1.3 Stage 3: Back translation

The back translation was focused on working with the T-12 version of the scale while blinded to the original version. It is suggested that the back translation should include at least two bilingual translators whose mother tongue is the original language (English), and they also should have different backgrounds. The back translation in this study was undertaken by Professor John Hartmann, whose mother tongue is English and who specialises in Thai culture and linguistics, and Miss Kodchakorn Watthanawinitchai, whose mother tongue is Thai and who specialises in the area of mental health. Both translators have no knowledge of the wording on the CSI-SF from the original English version. They both worked independently in order to back translate the scale from Thai to English. The first back translation (BT1) and the second back translation (BT2) were consequently produced.

4.4.1.4 Stage 4: Expert committee

The expert committee included four bilingual translators who are health professionals and language professionals, Dr Clifton Addison and the researcher. The roles of the committee were to review the translation of the scale and reach a consensus on any discrepancy. All translations were compared item by item, and were revised through consensus by the bilingual translators, Dr Clifton Addison and the researcher. The final Thai version of CSI-SF was produced for pretesting of reliability of the scale.

4.4.1.5 Step 5: Pretesting

The final Thai version of CSI-SF was tested for internal consistency and test-retest reliability (between 7 to 14 days) using Cronbach's alpha and Intraclass Correlation Coefficient (ICC) respectively with 15 older adults residing in a care home. Grammatical errors, misspellings and other minor discrepancies were addressed and corrected before field-testing.

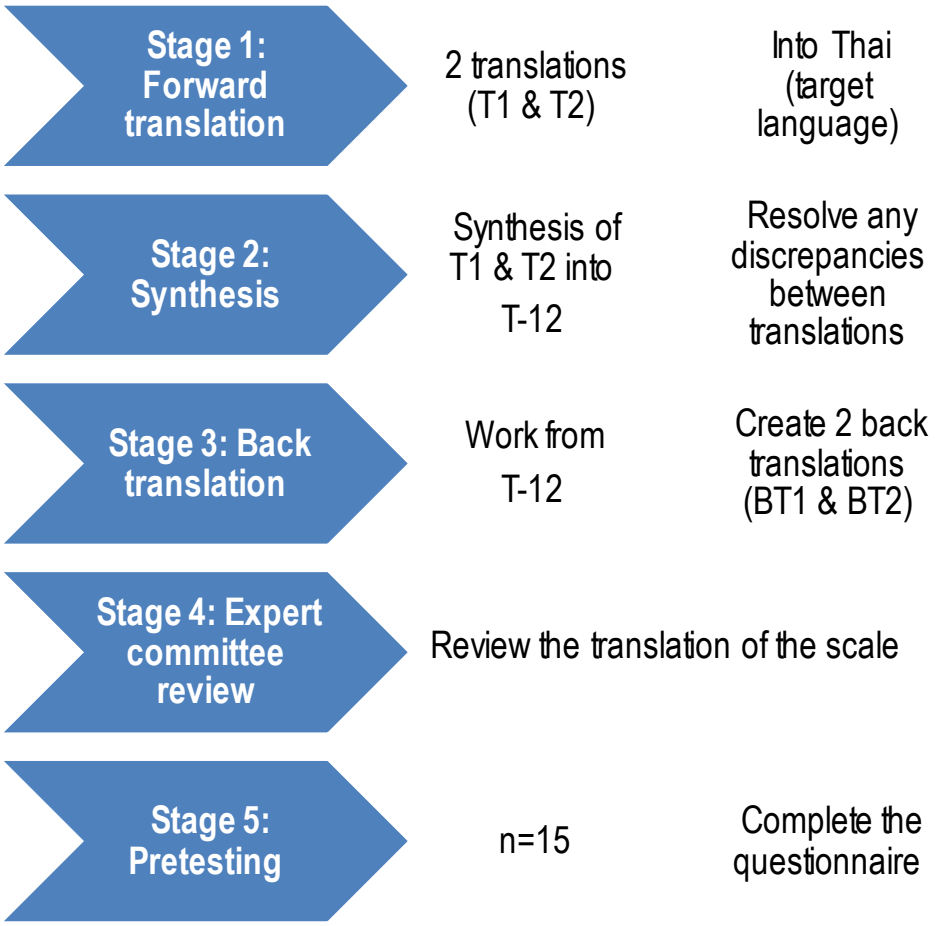


Figure 10: Flowchart of the process of cross-cultural adaptation of Thai version of CSI-SF

4.5 Methods

4.5.1 Setting and population

The pilot study was conducted in one care home, more details on which are provided in chapter three. This care home is a setting providing care for female older adults in the north-eastern Thailand. The pilot study was conducted over approximately one month between 11th July 2015 and 11th August 2015, before starting the actual data collection.

During the pilot study, there were 77 female residents living in the care home when the data were collected. This relatively small number of residents reflects the fact that the care home was being refurbished during the period of the pilot study. During the refurbishment, 30 care home residents who could assist themselves in daily routine activities were transferred to stay temporarily (for approximately four months, from July to October 2015) in a single, large room of a temple nearby the care home. In addition, the remainder of them stayed in a single open area close to a staff office room in the care home.

The inclusion criteria of older adults who can participate in the pilot study were based on the inclusion criteria used in the main study (as described under inclusion criteria in chapter three). Seventeen residents were excluded from the pilot study due to severe cognitive impairment as determined by care home staff (n=14), being younger than 60 years (n=1), dying during the recruitment for the pilot study (n=1) and being illiterate and mute (n=1). Finally, 60 older residents were eligible to participate in the pilot study.

It is suggested that a rule of thumb of the number of participants who participated in the pilot study should be large enough to provide useful information about the aspect being assessed (Thabane et al., 2010). Lancaster et al. (2004) stated that the sample in a pilot study is dependent on the parameters used. In this pilot study, there were 15 older residents participating in order to test internal consistency of the scales (the Thai versions of the ISLCH Scale and CSI-SF). The results

of pilot study would be embedded within the overall sample in the quantitative part if the measures were not changed after testing reliability.

4.5.2 Data collection

Two weeks before the beginning of the pilot data collection (the week beginning on the 29th of June 2015), the researcher contacted the head of care home and care home staff in order to inform them about the purpose of the pilot study, the research procedure and the eligibility criteria of the participants in the pilot study and the main study, the time period for conducting pilot study and the main study, and request support with identifying potentially eligible participants from care homes staff.

Furthermore, a range of the following strategies were applied to approach older residents, including verbal announcement during a meal time or an activity time of the care home, and an incentive prize (300 Baht) was offered for three winning residents (randomly selected by a resident) who participated in the pilot study or the main study, and follow-up contact was made with eligible residents. Fifteen eligible residents, who first expressed their interest in participating in the pilot study to a staff member or the researcher were approached by the latter in order to explain all information related to this pilot study, including its purpose and procedures. They were also informed that they could refuse to participate in this study at any time without giving a reason.

The researcher then asked them to sign a consent form to show their willingness to participate. After receiving informed consent, the participants were interviewed (face-to-face) by the researcher for

approximately 60 minutes using the 15-Item Thai Geriatric Depression Scale (15-TGDS), the Thai version of Internalised Stigma of Living in a Care Home Scale (T-ISLCH), the Thai Version of Rosenberg Self-Esteem Scale (T-RSES), the Thai Version of Multidimensional Scale of Perceived Social Support (T-MSPSS) and the Thai version of Coping Strategies Inventory Short Form (T-CSI-SF). Participants of the pilot study were deemed eligible to be included in the main study only if there were no revisions required to the T-ISLCH and T-CSI-SF measures.

4.6 Ethical Considerations

4.6.1 Ethical approval

The research protocol, including the pilot study and relevant documents, was submitted to the Medical School Ethics Committee at the University of Nottingham in March 2015 (Ref: OVSa16042015 SoHS) and Maharat Nakhon Ratchsima Hospital Institutional Review Board in April 2015 (Ref: 053/ 2015). After getting the ethical approval from the Ethics Committee, this document was submitted again to the Nakhonratchasima Provincial Administrative Organization in order to solicit permission to conduct research in the aforementioned institutions in Nakhonratchasima Province, Thailand. After securing approval from the Nakhonratchasima Provincial Administrative Organization, the researcher contacted the head of the care home in order to get permission for recruitment for the pilot study. No data collection was conducted before getting this permission.

4.6.2 Informed consent

Eligible participants were invited to participate on a voluntary basis. They were encouraged to ask or discuss any queries with the researcher if they were concerned. Informed consent to participate in this study was taken by the researcher using a consent form. The participants were informed of their right to withdraw from this study at any time without giving a reason and without it affecting their statutory rights or affecting the regular service and care they received.

4.6.3 Data protection and confidentiality

Confidentiality and anonymity were assured. All questionnaire tests were stored safely in a locked filing cabinet or in password-protected computers and files accessible only to the researcher and the study team. In accordance with the provisions of the UK Data Protection Act (1998), the data from the pilot study and the main study will be kept securely for a period of seven years on servers at the University of Nottingham after which it will be disposed of securely. During this time all precautions will be taken by all those involved to maintain confidentiality.

4.6.4 Emotional distress

The major potential risks which might influence the participants during the interview were considered, including psychological or emotional distress. Participants were encouraged to pause or stop if they found the experience very stressful, and they were informed that they could withdraw from the study at any time without providing the reason. Furthermore, the researcher collaborated with an administrator or staff

member in the care home in order to observe any consequence during and after the data collection processes.

4.7 Measure Outcome

4.7.1 Internal consistency

Reliability can be explained as the ability of a measurement to consistently and accurately measure the concept under study (Coughlan et al., 2007). This pilot study assessed the reliability of the Thai version of ISLCH Scale and the Thai version of CSI-SF by evaluating internal consistency in order to determine the extent to which related items of a questionnaire measure the same concept using the Cronbach's alpha coefficients. Coefficient alpha can be interpreted to the normal range between .00 to +1.00, with higher values reflecting higher internal consistency (Polit and Beck, 2012). An alpha coefficient value above 0.7 is indicative of good internal consistency in a questionnaire and an item-total correlation cut-off of less than 0.3 was considered to indicate that it did not add to the explanation power of the questionnaire (Rattray and Jones, 2007).

4.7.2 Test-retest reliability

Test-retest reliability is one of the tests frequently used apart from internal consistency in order to assess the reliability of a scale. It is assessed by calculating the correlation between the two scores obtained by the same person on different occasions (Pallant, 2013). A high test-retest score indicates a more reliable scale (ibid). The test-retest reliability of this pilot

study was conducted between seven to fourteen days after the first structure questionnaire interview with participants in the pilot study.

4.8 Data Analysis

The data of the pilot study was analysed using SPSS PASW Version 22.0 for Windows. Descriptive statistics were used to summarise the demographic data from the pilot study (percentage, mean, medium and standard deviation). The internal consistency reliability was determined by calculation of the Cronbach's alpha coefficient. This statistic was used to determine whether constituent items are measuring the same domain (Rattray and Jones, 2007). Test retest reliability was assessed by calculation of the intraclass correlation coefficient (Weir, 2005).

4.9 Results

4.9.1 Demographic data

Characteristics of participants in the pilot study are shown in Table 9. All of the participants were female (100%) with age ranged from 61-94 years (mean 74.67, SD 9.522). Over half of them (53.3%) were widowed. All residents in the pilot study were Buddhist. One-fifth of them had no qualifications. Older residents have been living in the care home for between six months and sixteen years. Approximately 27% of residents had received no visitors at the care home since they became residents.

Table 9: Personal demographic characteristics of the participants in the pilot study

Characteristics of Participants	Care Home (n=15)	
	N	%
Age (Mean, SD)	74.67	9.522
Age group		
60-70 years old	6	40.0
71-75 years old	2	13.3
76 years old and over	7	46.7
Gender		
Female	15	100.0
Marital status		
Single	5	33.3
Separated/divorced	2	13.3
Widowed	8	53.3
Religion		
Buddhism	15	100.0
Highest qualification		
No qualifications	3	20.0
Primary school	7	46.7
Secondary school and higher	5	33.3
Time of LiCH		
≥ 1 year	3	20.0
< 1 to 5 years	5	33.3
< 5 to 10 years	5	33.3
< 10 years	2	13.3
Have own child or adopted child		
None	6	40.0
Yes	9	60.0
An average of visitors		
None	4	26.7
≥ 1 month	5	33.3
>1 to 6 months	5	33.3
>6 months to a year	1	6.7

4.9.2 Health characteristics

Table 10 shows the health characteristics of participants in the pilot study. The majority of residents (80.0%) reported being diagnosed with one or more diseases. Most of them (80.0%) self-reported hypertension, and one-third (33.3%) self-reported hypercholesterolemia. The vast majority of residents (93.3%) self-reported having one or more health problems. Over half of them (53.3%) experienced difficulties in walking.

Table 10: Health characteristics of the study participants in the pilot study

Characteristics of Participants	Care Home (n=15)	
	N	%
Diagnosed with one or more diseases (self-reported)	12	80.0
Diabetes mellitus	2	13.3
Hypertension	12	80.0
Hypercholesterolemia	5	33.3
Heart diseases	3	20.0
Stroke	1	6.7
Have one or more health problems (self-reported)	14	93.3
Difficulties of hearing	2	13.3
Difficulties of seeing	6	40.0
Difficulties to walk	8	53.3
Pain	1	6.7

4.9.3 Reliability of the scales

4.9.3.1 Thai Version of Internalised Stigma of Living in a Care Home (IS-LCH) Scale

The results of the pilot test showed that the internal consistencies of the entire scale of Thai Version of IS-LCH were good, with a Cronbach's

alpha of 0.86. Acceptable levels of internal consistency were found in most subscales, with Cronbach's alpha values of 0.85, 0.64, 0.35, 0.62 and 0.52 for alienation, stereotype endorsement, discrimination experience, social withdrawal and stigma resistance, respectively.

Furthermore, the results of testing for reliability of the scale showed a split-half coefficient of 0.87 and ICC of 0.90. They demonstrated very good internal consistency of the entire scale. Preferable levels and acceptable levels of internal consistency were found also in most subscales by test-retest reliability (after seven to fourteen days) with reported Cronbach's alphas of 0.83, 0.73, 0.80, 0.84 and 0.67 for alienation, stereotype endorsement, discrimination experience, social withdrawal and stigma resistance, respectively. The details of reliability of the scale are provided in Table 11.

Table 11: Reliability of Internalised Stigma of Living in a Care Home Scale

Reliability of sub-scale	Internal consistency (Cronbach's alpha)	Internal consistency (split-half coefficient)	Test-retest reliability (ICC)
The entire scale	0.86	0.87	0.90
Alienation	0.85	-	0.83
Stereotype endorsement	0.64	-	0.73
Discrimination experience	0.35	-	0.80
Social withdrawal	0.62	-	0.84
Stigma resistance	0.52	-	0.67

Table 12 shows the details of correlated item to total correlation and Cronbach's coefficient alpha if the item is deleted from the Thai version

of IS-LCH Scale. The correlated item to total correlation is used to indicate the degree to which an item correlates with the total score. A score lower score than 0.3 indicates that the item is measuring something different from the scale as a whole (Pallant, 2013). In addition, Alpha If Item Deleted must be considered in terms of the impact of removing each item from the scale by comparing these values with the final alpha value obtained. If any of the values in the column are higher than the final alpha value, the item might be considered for removal from the scale in order to increase the general alpha value of the scale.

According to the results of alpha for subscales of the Thai IS-LCH Scale, some subscales were reported to have low alpha values of 0.35 and 0.52 for discrimination experience and stigma resistance, respectively. In each subscale, the value of the correlated item to the total correlation of the three items of the discrimination subscale "item 3: People discriminate against me because I live in a care home" demonstrated a low score (-.277) on the correlated item to total correlation. If this item was thus removed from the subscale, increasing the value of the overall subscale to .741, which indicates an acceptable level of internal consistency.

The value of the correlated item to the total correlation of the three items in the stigma resistance subscale scored lower on the correlated item to total correlations: item 7: Older adults who live in a care home make important contributions to society (.211); item 24: Living in a care home has made me a tough survivor (.105); and item 26: In general, I am able to live life the way I want to (.149). In addition, if item 24 was removed

from the subscale, the value of alpha in the overall subscale increased to .571. However, the result would still indicate low internal consistency.

Table 12: Correlated item to total correlation and Cronbach's coefficient alpha if item deleted of Thai version of IS-LCH Scale

Items	Correlated item to total correlations	Alpha if item deleted
Subscale: Alienation (6 items), Cronbach's alpha = 0.85		
1. I feel out of place in the world because I live in a care home	.816	.776
5. I am embarrassed or ashamed that I live in a care home	.649	.815
8. I feel inferior to others who don't live in a care home	.811	.783
16. I am disappointed in myself for LiCH	.749	.793
17. Living in a care home has spoiled my life	.769	.791
21. People who live outside a care home could not possibly understand me	-.141	.905
Subscale: Stereotype endorsement (6 items), Cronbach's alpha = 0.64		
2. Older adults who live in a care home tend to be abandoned	.039	.722
10. Older adults who live in a care home cannot live a good, rewarding life	.721	.422
18. People can tell that I live in a care home by the way I look	.344	.613
19. Because I live in a care home, I need others to make most decisions for me	-.055	.710
23. I can't contribute anything to society because I live in a care home	.766	.419
29. Stereotypes about LiCH apply to me	.504	.561
Subscale: Discrimination experience (4 items), Cronbach's alpha = 0.35		
3. People discriminate against me because I live in a care home	-.277	.741
15. People often patronize me, or treat me like a child, just because I live in a care home	.438	-.034[a]
22. People ignore me or take me less seriously just because I live in a care home	.501	-.125[a]
28. Others think that I can't achieve much in life because I live in a care home	.308	.141

Table 12 cont.

Items	Correlated item to total correlactions	Alpha if item deleted
Subscale: Social withdrawal (5 items), Cronbach's alpha = 0.62		
4. I avoid getting close to people who don't live in a care home to avoid rejection	.425	.543
9. I don't socialize as much as I used to because of LiCH	.597	.429
11. I don't talk about myself much because I don't want to burden others	.113	.656
12. Negative stereotypes about LiCH keep me isolated from the 'normal' World	.582	.475
13. Being around people who don't live in a care home makes me feel out of place or inadequate	.204	.652
Subscale: Stigma resistance (5 items), Cronbach's alpha = 0.52		
7. Older adults who live in a care home make important contributions to society	.211	.511
14. I feel comfortable being seen in public with older adults who live in a care home	.487	.303
24. Living in a care home has made me a tough survivor	.105	.571
26. In general, I am able to live life the way I want to	.149	.532
27. I can have a good, fulfilling life, despite living in care home	.517	.299

4.9.3.2 Thai Version of a Coping Strategies Inventory Short-Form (CSI-SF)

The Thai version of CSI-SF was reported to have an acceptable level of internal consistency with an overall Cronbach's alpha of 0.66. Acceptable levels of internal consistency were evident in most sub-scales, with Cronbach's alpha values of 0.86, 0.74, 0.52 and 0.15 for problem focused engagement, problem focused disengagement, emotional focused engagement and emotional focused disengagement.

In addition, the internal consistencies and test-retest reliability (after seven to fourteen days) of the entire scale of the Thai Version of CSI-SF

revealed acceptable levels of internal consistency with reporting a split-half coefficient of 0.73 and ICC of 0.77. Acceptable levels of internal consistency were found in most subscales, with reporting ICC of 0.81, 0.57, 0.85 and 0.41 for problem focused engagement, problem focused disengagement, emotional focused engagement and emotional focused disengagement. The results of reliability testing for the scale are shown in Table 13.

Table 13: Reliability of Coping Strategies Inventory Short Form

Reliability of sub-scale	Internal consistency (Cronbach's alpha)	Internal consistency (split-half coefficient)	Test-retest reliability (ICC)
The entire scale	0.66	0.73	0.77
Problem focused engagement	0.86	-	0.81
Problem focused disengagement	0.74	-	0.57
Emotional focused engagement	0.52	-	0.85
Emotional focused disengagement	0.15	-	0.41

Table 14 shows the results of correlated item to total correlation and Cronbach's coefficient alpha with the deletion of items from the translated scale (CSI-SF). Two subscales were reported with low internal consistency, comprising Emotional focused engagement and Emotional focused disengagement, with Cronbach's alpha coefficients of 0.52 and 0.15.

In Emotional focused engagement, two items reported low values on the correlated item to total correlation comprising item 6: I try to talk about it with a friend or family (-.044) and item 13: I ask a close friend or relative that I respect for help or advice (.025). The alpha value if item 6 was deleted increased to .678, indicating an acceptable level of internal consistency.

Emotional focused disengagement subscale showed very low internal consistency. There were three items of the subscale reporting with low value of correlated item to total correlation comprising item 3: I try to spend time alone (-.159), item 15: I tend to criticize myself (.229) and item 16: I keep my thoughts and feelings to myself (-.025). If item 3 of the subscale was removed, the highest possible alpha value for the subscale would be achieved (.384), but this would still indicate a low level of internal consistency.

Table 14: Correlated item to total correlation and Cronbach's coefficient alpha of item deleted from Thai CSI-SF

Items	Correlated item to total correlations	Alpha if item deleted
Problem focused engagement, Cronbach's alpha = 0.86		
1. I make a plan of action and follow it	.797	.787
2. I look for the silver lining or try to look on the bright side of things	.665	.841
8. I tackle the problem head on	.737	.816
9. I step back from the situation and try to put things into perspective	.667	.844
Emotional focused engagement, Cronbach's alpha = 0.52		
5. I try to let my emotions out	.731	-.033[a]
6. I try to talk about it with a friend or family	-.044	.678
11. I let my feelings out to reduce the stress	.667	-.017[a]
13. I ask a close friend or relative that I respect for help or advice	.025	.624
Problem focused disengagement, Cronbach's alpha = 0.74		
4. I hope the problem will take care of itself	.661	.632
7. I try to put the problem out of my mind	.584	.652
12. I hope for a miracle	.401	.756
14. I try not to think about the problem	.545	.681
Emotional focused disengagement, Cronbach's alpha = 0.15		
3. I try to spend time alone	-.159	.384
10. I tend to blame myself	.303	-.228[a]
15. I tend to criticize myself	.229	-.161[a]
16. I keep my thoughts and feelings to myself	-.025	.269

4.10 Discussion

4.10.1 Thai version of IS-LCH

The Thai version of ISMI was adapted into a Thai version of IS-LCH and then tested for the psychometric properties of the scale. The findings indicated that the Thai version of IS-LCH had good internal consistency, with a Cronbach's alpha of 0.86 for the entire scale. This finding of internal consistency of the scale was similar to that found for the Thai version of ISMI, which had a Cronbach's alpha of 0.88 for the entire scale after testing reliability of the scale among 390 psychiatric clinic patients in Thailand (Wong-Anuchit et al., 2016). In addition, the original scale of the 29-items ISMI reported excellent internal consistency, with a Cronbach's alpha of 0.90, identified by testing reliability with 127 outpatients of the mental health service (Boyd Ritsher et al., 2003).

The result of test-retest reliability coefficient of Thai version of ISLCH was excellent for the entire scale (ICC= .90). In addition, the subscale of Thai version of IS-LCH demonstrated the result of test-retest reliability with acceptable to good for Alienation (ICC= 0.83), Stereotype endorsement (ICC= 0.73), Discrimination experience (ICC= 0.80), Social withdrawal (ICC= 0.84) and Stigma resistance (ICC=0.67). These findings of test-retest reliability are comparable with the results of test-retest reliability of the study of the Thai version of ISMI, which was found to be good to excellent for all subscales. The total score testing with twenty sample participants comprised: total Thai version of ISMI (ICC= .81), Alienation (ICC= 0.93), Stereotype endorsement (ICC= 0.79), Discrimination

experience (ICC= 0.79), Social withdrawal (ICC= 0.89) and Stigma resistance (ICC=0.85) (Wong-Anuchit et al., 2016).

Overall, the Thai version of IS-LCH demonstrated excellent internal consistency for the entire scale and acceptable to excellent internal consistency for all of five subscales. The stigma resistance subscale of Thai version of IS-LCH had weaker Cronbach's alpha and ICC than the other four subscales. This subscale was also reported as having weaker psychometric properties in the original study on the 29-items ISMI (Boyd Ritsher et al., 2003). This subscale is tested again relative to the findings from the main study.

4.10.2 Thai version of CSI-SF

The Coping Strategies Inventory Short Form (CSI-SF) was blind back translated into Thai language by four bilingual translators and then tested for its psychometric properties. The findings showed that the Thai version of CSI-SF had acceptable internal consistency for the entire scale, with a reported Cronbach's alpha of 0.66. All subscales were analysed for internal consistency reliability. The results revealed reliability between 0.15 and 0.86. However, the results of test-retest reliability after seven to fourteen days demonstrated a higher value of internal consistency, with reported ICC of 0.41 to 0.85. An acceptable level of reliability was also reported in the original study of psychometric evaluation of a CSI-SF, with Cronbach's alpha values of 0.58 to 0.72 for all of the subscales (Addison et al., 2007). The original scale of CSI-SF was used to test the reliability of the scale among 5,302 African-American men and women aged 35-84

(ibid). Emotional focused disengagement subscale of this pilot study had weaker psychometric properties than the other three subscales. It showed poor internal consistency with a Cronbach's alpha value of 0.15 and test-retest reliability reporting ICC of 0.41. This subscale showed weaker psychometric properties than other three subscales in the original study of CSI-SF (Addison et al., 2007). It had internal consistency reliability of 0.58 in the original scale (ibid). They suggested removing the item 16 (I keep my thoughts and feelings to myself) in this subscale due to poor factor loading (0.13). In addition, the Thai version of CSI-SF also showed a low value for Correlated item to total correlations (-.025). However, if this item was removed from the subscale, it would increase the Cronbach's alpha to only .269, which still indicates poor internal consistency.

Overall, the Thai version of CSI-SF was found to have an acceptable level of internal consistency and test-retest reliability. These results of reliability were comparable with the original study of CSI-SF. One of the subscales (Emotional focused disengagement) reported notably poor internal consistency reliability in both the Thai and original versions.

Some of the limitations in this pilot study need to be taken into account. First, the small number of participants in the pilot study, comprising only fifteen older residents in order to test reliability of the questionnaires within a limited time. Clearly this limits the representativeness of the findings. Lancaster et al. (2004) suggested as a general rule of thumb that a sample size for a pilot study should involve 30 participants to

adequately estimate parameters. Therefore, testing for reliability and factor analysis was recommended in confirming psychometric properties. Secondly, the study was conducted in a single region of Thailand. This may limit the representativeness of the findings. Further, reliability testing of both questionnaires should be conducted with a sample of Thai older adults in different regions of Thailand or Thai older adults living in other countries with similar cultural contexts. Finally, establishing validity for the low internal consistency reliability of some subscales of the Thai version of ISLCH and CSI-SF should be applied in order to assess how each item groups into a particular theme.

4.11 Conclusion

The Thai version of IS-LCH demonstrated good reliability and validity for measuring internalised stigma of LiCH among older adults residing in a care home. In addition, the translation of CSI-SF showed an acceptable level of internal consistency of the scale, comparable to the original version. Both scales were appropriate to apply in order to access internalised stigma of LiCH and coping strategies among older adults residing in a care home in the main study. The results of the questionnaire study are presented in the next chapter. These findings show the factors associated with depressive symptoms among Thai older adults residing in care homes.

Chapter Five: Predictors of Depressive Symptoms in Older Adults Living in Care Homes in Thailand

5.1 Introduction

The chapter five presents an overview of the findings from a cross-sectional questionnaire study aimed to exploring the factors associated with depressive symptoms among older adults residing in care homes in Thailand. This chapter begins with the results of recruitment for research participants. Then the next section follows by the discussion of representativeness of the study participants. Furthermore, the results of checking normal distribution, the outliers and the homogeneity of variance are presented in this chapter. The next part of the chapter presents demographic characteristics of participants, statistical comparison of measurements, factors associated with depressive symptoms. Finally factors predicting depressive symptoms are presented in the end of the chapter.

5.2 Recruitment

The participants consisted of older adults recruited from the two care homes. The recruitment was undertaken between 29th June 2015 and 13th November 2015. There were 174 residents across both care homes at the time of the study. The number of residents eligible to participate in the study was 130 people. There were 44 residents not eligible to participate. Reasons for non-eligibility included severe cognitive impairment as determined by care home staff (n=31), severe psychological disturbance including auditory hallucination and visual

hallucination as determined by care home staff (n= 5), being younger than 60 years (n=3), died during the recruitment period (n=3), illiterate and mute (n=1), left a care home during the recruitment process (n= 1).

In total, 128 care home residents agreed to take part in the study. One of these care home residents refused to participate in the study without giving a reason and the other one was absent and uncontactable during the study period. The response rate of the study was 98.46%.

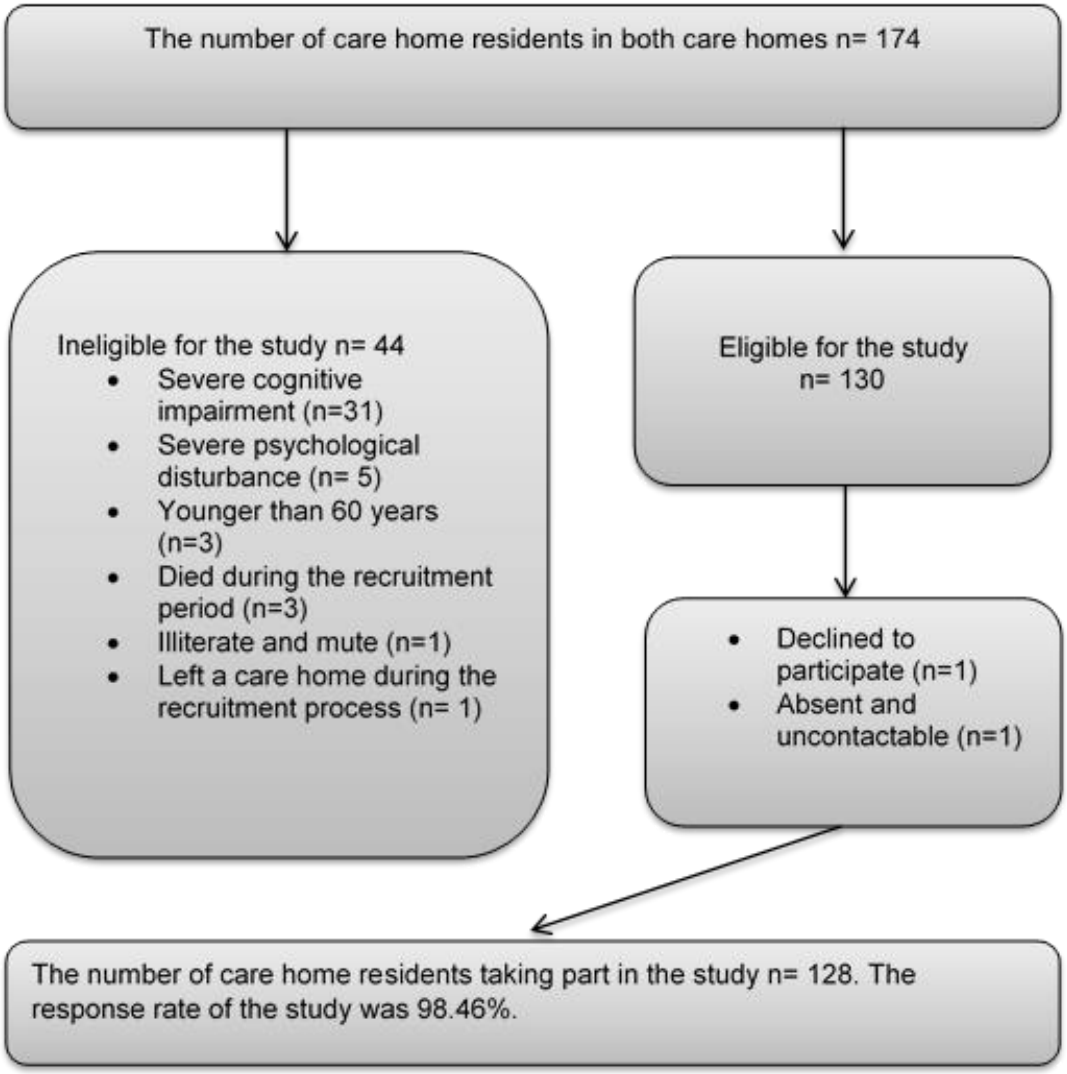


Figure 11: Flow chart of recruitment participants through the study

5.3 Representativeness of Study Participants

The representativeness of the study was assessed within the population of care home residents. The demographic data were available and were assessed comprising age, gender and marital status. The results demonstrated that there were no significant differences in demographic characteristics (age and gender) between the study participants and the population group. However, there was a significant difference in the marital status among older adults in the study and the population group. There were older adults who were separated or divorced in the study more than the population group. The findings are illustrated in Table 15.

Table 15: Comparison of the study participants and population of care home residents in Thailand

	Study participants (n= 128)	*Care home residents in the previous study (n= 81)a*	*P value*
Mean age in years	76.86 ±(7.78)	76.96 ±(7.10)	0.93 b
Gender			
Male n (%)	48 (37.5)	36 (44.4)	0.32 c
Female n (%)	80 (62.5)	45 (55.6)	
Marital status			0.003 c
Single	27 (21.1)	16 (19.8)	
Separated/divorced	34 (26.6)	6 (7.4)	
Widow	62 (48.4)	52 (64.2)	

a: From the study on prevalence of major depression disorders and suicide in long-term care facilities: a report from northern Thailand (Wongpakaran and Wongpakaran, 2012a)

b: Independent t-test

c: Chi-squared test

5.4 The Results of Checking Normal Distribution and Outliers

Normal distribution of variables were assessed by checking for visual methods and statistical tests for normality. These included continuous variables of the study: depressive symptoms, internalised stigma of LiCH, self-esteem, perceived social support and coping strategies. The frequency distribution (histogram) was used for checking normality visually. This method provides a visual judgment about whether the distribution is bell shaped and about gaps in the data and outliers outlying values (Ghasemi and Zahediasl, 2012). It is suggested that normal distribution is described as a bell-shaped curve, which has the greatest frequency of score in the middle with smaller frequencies towards the extremes (Pallant 2013, p.61). In addition, if variables are not normally distributed, scores will be skewed to the left or right. The following histograms (Figures 12-16) provide information about the distribution of scores on the continuous variables of the study; depressive symptom scores, internalised stigma scores, self-esteem scores, social support scores and coping strategies scores respectively.

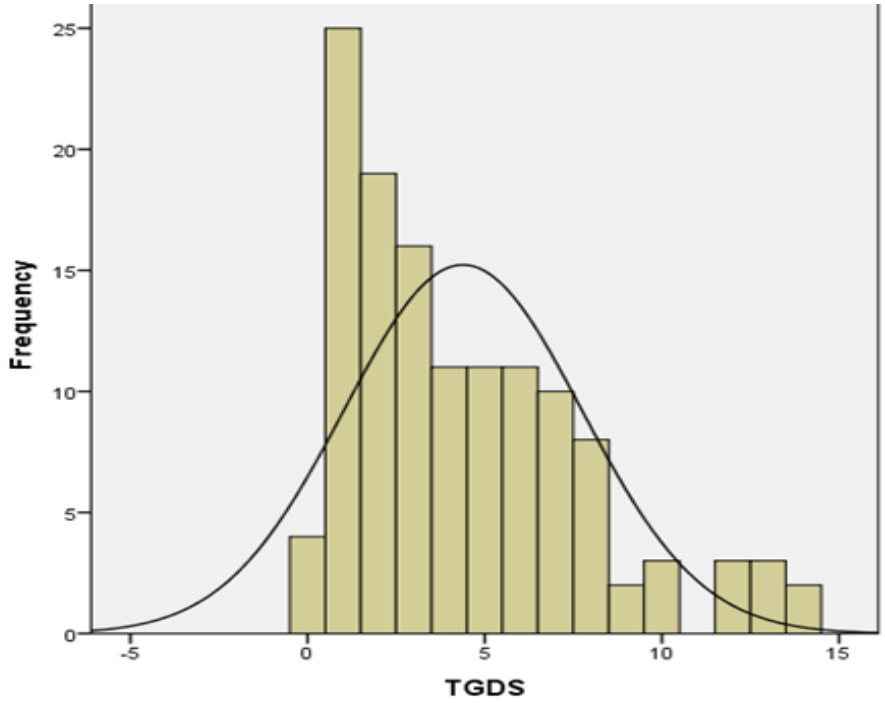


Figure 12: Geriatric depression scores

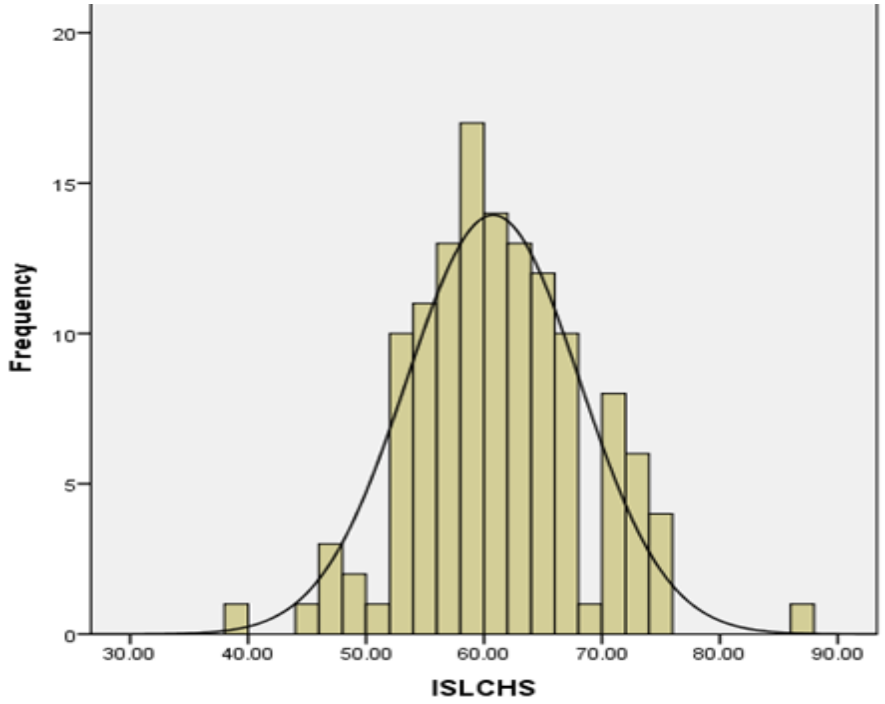


Figure 13: Internalised stigma scores

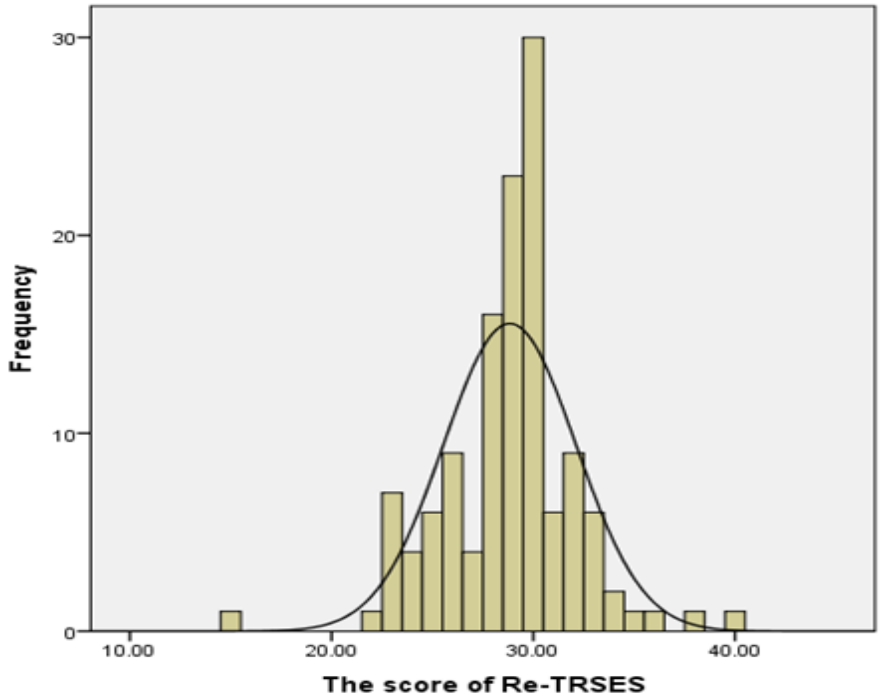


Figure 14: Self-esteem scores

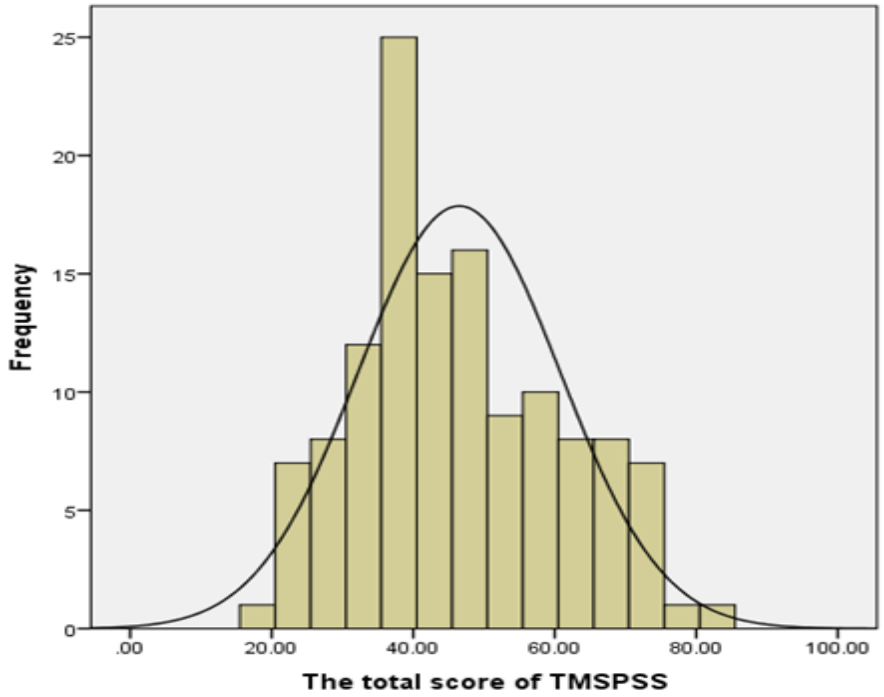


Figure 15: Social support scores

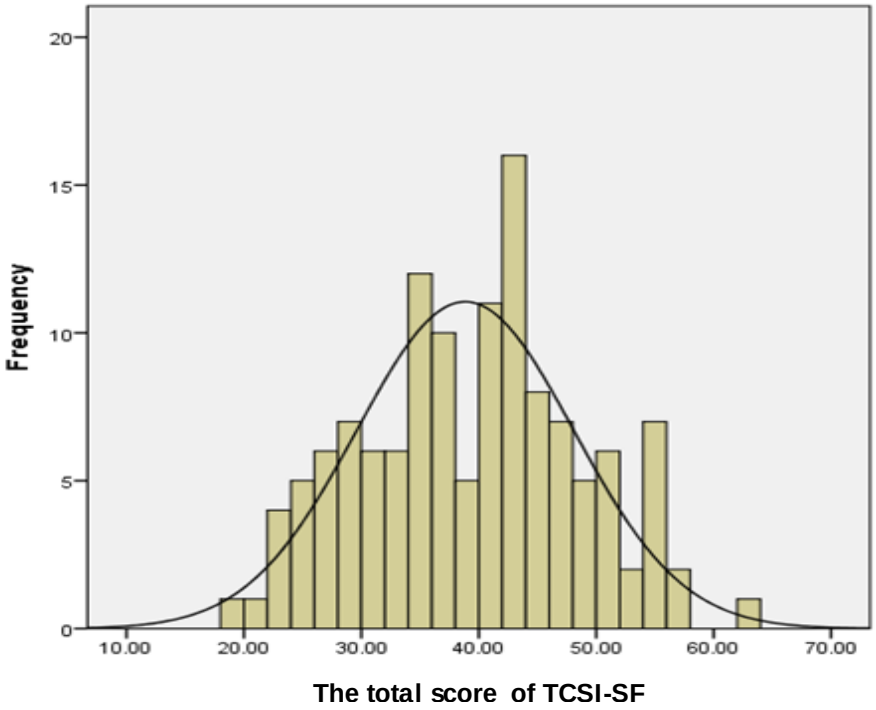


Figure 16: Coping strategies scores

For the statistical test, the Kolmogorov-Smirnov (K-S) and Shapiro-Wilk were used to test the assumption that the sample data was drawn from a normally-distributed population. The results of this statistical test are showed in Table 16.

Table 16: SPSS output for Kolmogorov-Smirnov and Shapiro-Wilk tests of normality

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	P value	Statistic	df	P value
The scores of TGDS	.160	128	.000	.898	128	.000
The scores of ISLCHS	.072	128	.175	.985	128	.182
The scores of TRSES	.150	128	.000	.942	128	.000
The scores of TMSPSS	.093	128	.009	.971	128	.008
The scores of TCSI-SF	.069	128	.200	.986	128	.227

TGDS: Thai Geriatric Depression Scale; T-ISLCH: Internalised Stigma of Living in a Care Home Scale; T-RSES: Thai Version of Rosenberg Self-Esteem Scale; T-MSPSS: Thai Version of Multidimensional Scale of Perceived Social Support; T-CSI-SF: Thai version of a Coping Strategies Inventory Short Form.

The results of checking for normal distribution of variables show all variables including depression, internalised stigma, self-esteem, social support and coping strategies reasonably normally distributed as histograms showed that most variable scores occurred in the centre with tapering out towards the extremes. Even though depression scores show slightly negative skewness (left skew) (Rose et al. 2014).

The results of the Kolmogorov-Smirnov and the Shapiro-Wilk tests for internalised stigma and coping strategies scores showed a non-significant results (the p-value is greater than 0.05). These indicate that both data come from a normally-distributed population. In addition, the significant results showed in the depression scores, self-esteem scores and social support scores. These indicated violation of the assumption of normality. However, it is suggested that this could be found commonly in large samples (Pallant, 2016, p.63).

The outliers of variables were assessed by checking the histograms (the tails of the distribution), comparing means with the 5% Trimmed Mean, checking at the Extreme Values and observing the box plot. The numbers of outliers were found between one and two for internalised stigma and self-esteem variables but these outlines had no significant effect on the results of the analysis tests. As comparing the trimmed mean and mean values of these two variables were not different. Therefore, these extreme values were included in the results.

5.5 The Results of Checking the Homogeneity of Variance

One of the assumption of using parametric techniques is that samples are obtained from populations of equal variances (Pallant 2013, p.214). This indicates that the variability of scores for each of the group is similar. Levene's test was used to assess the equality of variances. The test revealed that Sig. values for Levene's test were larger than .05 in all variables which mean that the group of residents in care home A and B had equal variance. Therefore, t-test for equal variance was used in all variables. The results of Levene's test are showed in Table 17.

Table 17: Levene's test results for homogeneity of variances for primary and secondary outcomes.

Variables	Care home A (SD)	Care home B (SD)	F	P value
The scores of TGDS	2.92	3.68	3.391	.068
The scores of ISLCHS	7.41	7.16	.205	.651
The scores of TRSES	3.23	3.29	.341	.560
The scores of TMSPSS	13.57	14.98	1.863	.175
The scores of TCSI-SF	9.74	8.83	.720	.398

TGDS: Thai Geriatric Depression Scale; T-ISLCH: Internalised Stigma of Living in a Care Home Scale; T-RSES: Thai Version of Rosenberg Self-Esteem Scale; T-MSPSS: Thai Version of Multidimensional Scale of Perceived Social Support; T-CSI-SF: Thai version of a Coping Strategies Inventory Short Form.

5.6 Sample Characteristics

5.6.1 Demographic data

Characteristics of participants within both care homes are shown in Table 18. Two settings were compared and p values were calculated to indicate whether there was a significant difference between the two care homes. The details of statistic that used to analyse the data were provided in the chapter four. Sample characteristics of participants in care homes were compared using Chi-squared tests.

There were no statistically significant differences in most of the demographic characteristics between care home residents who lived in care home A and B. The age groups were comparable between care home A and B: 60-70 years old (25.4% and 21.7%), 71-75 years old (20.3% and 20.3%) and 76 years old and over (54.2% and 58.0%), respectively. The majority of residents in both care homes were widowed (Care home A= 57.6% and Care home B= 40.6%). Buddhism was the only one religion that the majority of the study participants respected in

the both care homes (Care home A= 96.6% and Care home B= 100%). The majority of the study participants in both care homes graduated at elementary educational level (Care home A= 54.2 and Care home B= 62.3%), respectively. Interestingly, over 15% of the study participants in each care home had no qualification (Care home A= 22% and Care home B= 15.9%). At the time of data collection, one third (33.9%) of the residents in care home A, and nearly half (46.4%) of residents in care home B had been living in the care home for between one and five years. Furthermore, the results illustrated that two thirds of residents in both care home had their own child or adopted child (Care home A= 69.5% and Care home B= 66.7%). However, the findings showed that many residents in the both care homes (Care home A= 32.2% and Care home B=34.8%) had no visitor who visit them since they started living in the care homes.

However, there was a significant difference in gender between the care homes. The majority of participants overall were female (62.5%). However, all of residents in care home A, who participated in the study were female (100%). There were male (69.6%) and female (30.4%) in care home B participating in the study. The details of personal demographic data comparison by both care homes are provided in Table 18.

Table 18: Differences in background demographic of the study participants between two care homes (n=128)

Characteristics of participants	Care home A (n=59)	Care home B (n=69)	P value a
Age group			0.877
60-70 years old	15 (25.4)	15 (21.7)	
71-75 years old	12 (20.3)	14 (20.3)	
76 years old and over	32 (54.2)	40 (58.0)	
Gender			0.001
Male	0 (0)	48 (69.6)	
Female	59 (100)	21 (30.4)	
Marital status			0.050
Single	13 (22.0)	14 (20.3)	
Partnership	0 (0)	5 (7.2)	
Separated/divorced	12 (20.3)	22 (31.9)	
Widowed	34 (57.6)	28 (40.6)	
Religion			0.211
Buddhism	57 (96.6)	69 (100)	
None (Atheist)	2 (3.4)	0 (0)	
Highest qualification			0.595
No qualifications	13 (22.0)	11 (15.9)	
Primary school	32 (54.2)	43 (62.3)	
Secondary school and higher	14 (23.7)	15 (21.7)	
Time of LiCH			0.479
≥ 1 year	12 (20.3)	14 (20.3)	
< 1 to 5 years	20 (33.9)	32 (46.4)	
< 5 to 10 years	14 (23.7)	12 (17.4)	
< 10 years	13 (22.0)	11 (15.9)	
Have own child or adopted child			0.880
None	18 (30.5)	23 (33.3)	
Yes	41 (69.5)	46 (66.7)	
Average visitors			0.919
None	19 (32.2)	24 (34.8)	
≥ 1 month	12 (20.3)	10 (14.5)	
>1 to 6 months	10 (16.9)	11 (15.9)	
>6 months to a year	14 (23.7)	18 (26.1)	
More than a year	4 (6.8)	6 (8.7)	

Values are number and percentages in parenthesis. a: Chi-squared test

5.6.2 Health characteristics

Table 19 presents demographic information of study participants in care home A and B. The two care homes were compared and p values were calculated to show whether there was a significant difference between the care homes. More details of the data analysis are provided in the chapter three (see section 3.6.5).

The results illustrated that the majority of older residents in both care homes (Care home A= 74.6 and Care home B= 66.7) self-reported with one or more diseases. The number of resident who self-reported with diabetic mellitus and heart disease were comparable between care home A and B. Surprisingly, there were significant differences in residents who self-reported with hypertension and hypercholesterolemia in both care homes. A greater proportion of residents who lived in care home A, self-reported hypertension and hypercholesterolemia than residents who lived in care home B: (61.0% vs. 36.2% and 15.3% vs. 2.9%, respectively).

Regarding self-reported health issues, the results demonstrated that there were no significant differences in health problems in the two groups. Overall, the majority of residents (87.5%) self-reported having one or more following problems: difficulties in hearing (16.4%), difficulties in seeing (52.3%), difficult to walk (43.8%), and pain (16.4%). The details of the health characteristics of study participants were shown in Table 19.

Table 19: Health characteristics of the study participants between care home A and B (n=128)

Characteristics of participants	Care home A (n=59)	Care home B (n=69)	P value a
Diagnosed with one or more diseases (self-reported)	44 (74.6)	46 (66.7)	0.434
Diabetes mellitus	10 (16.9)	13 (18.8)	0.963
Hypertension	36 (61.0)	25 (36.2)	0.009
Hypercholesterolemia	9 (15.3)	2 (2.9)	0.030
Heart diseases	7 (11.9)	3 (4.3)	0.212
Have one or more health problems (self-reported)	53 (89.8)	59 (85.5)	0.639
Difficulties of hearing	12 (20.3)	9 (13.0)	0.383
Difficulties of seeing	29 (49.2)	38 (55.1)	0.623
Difficulties to walk	27 (45.8)	29 (42.0)	0.806
Pain	9 (15.3)	12 (17.4)	0.931

Values are number and percentages in parenthesis. a: Chi-squared test

5.7 Statistical comparison of measurements between both care homes

Table 20 displays the descriptive statistics (mean and standard deviation) of the measurements that were used in the study between care home A and B. The p values were calculated in order to indicate whether there was a significant difference in the two groups. The details of the analysis were provided in the chapter four.

The results illustrated that there were no significant differences in depressive symptoms, internalised stigma, self-esteem, perceived social support and coping strategies between the two care homes. The details of statistical comparison of the measurements were reported in Table 20.

Table 20: Statistic comparison of measurements between both care homes

The questionnaire scale	Care home A (n=59)		Care home B (n=69)		Statistic	P value
	M	SD	M	SD	t-test	
The 15-TGDS	4.02	2.921	4.70	3.675	-1.143	0.255
T-ISLCH	59.63	7.407	61.75	7.165	-1.648	0.102
T-RSES	19.36	3.226	18.38	3.290	1.693	0.093
T-MSPSS	46.24	13.570	46.71	14.976	-0.186	0.853
T-CSI-SF	39.36	9.745	38.41	8.830	0.578	0.564

Note. The 15-TGDS: the 15-Item Thai Geriatric Depression Scale; T-ISLCH: Internalised Stigma of Living in a Care Home Scale; T-RSES: Thai Version of Rosenberg Self-Esteem Scale, T-MSPSS: Thai Version of Multidimensional Scale of Perceived Social Support; T-CSI-SF: Thai version of a Coping Strategies Inventory Short Form.

5.8 Depressive Symptoms and Other Factors That Related to Depressive Symptoms

5.8.1 Depressive symptoms

5.8.1.1 Residents in both care homes

Overall, 41.5% of care home residents were experiencing some level of depressive symptoms as measured by the 15 TGDS. For most of these participants, symptoms were mild although one tenth of the sample was classified as having moderate (3.9%) or severe depressive symptoms (6.3%) (see the cut-points in section 3.6.4.2).

Figure 17 shows the differences in levels of depressive symptoms of older residents between care home A and B. There was no significant differences in the levels of depressive symptoms of the both groups (p= 0.648). The details of the levels of depressive symptoms among older adults were described in Figure 17.

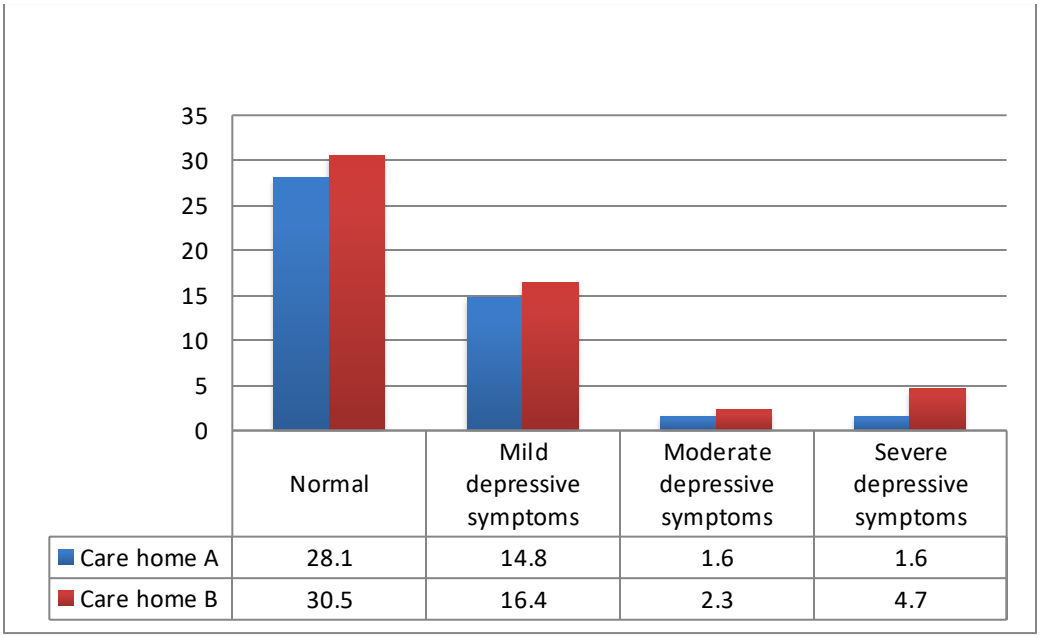


Figure 17: Levels of depressive symptoms of the care home residents between two care homes

5.8.1.2 Demographic characteristics between non-depressed and depressed group

Table 21 compares the personal demographic data of care home residents who are depressed and non-depressed. The results showed that there were no statistically significant differences in demographic characteristics between the non-depressed and depressed groups.

Table 21: Demographic data of non-depressed and depressed groups

Characteristics of participants	Non-depressed group (n=75)	Depressed group (n=53)	P value (Chi square)
Setting			0.738
Care home A	36 (28.1)	23 (18.0)	
Care home B	39 (30.5)	30 (23.4)	
Age group			0.906
60-70 years old	18 (14.1)	12 (9.4)	
71-75 years old	16 (12.5)	10 (7.8)	
76 years older and over	41 (32.0)	31 (24.2)	
Gender			0.211
Male	32 (25.0)	16 (12.5)	
Female	43 (33.6)	37 (28.9)	
Marital status			0.657
Single	17 (13.3)	10 (7.8)	
Partnership	4 (3.1)	1 (0.8)	
Separated/divorced	18 (14.1)	16 (12.5)	
Widowed	36 (28.1)	26 (20.3)	
Religion			0.170
Buddhism	75 (58.6)	51 (39.8)	
None (Atheist)	0 (0.0)	2 (1.6)	
Highest qualification			0.235
No qualifications	11 (8.6)	13 (10.2)	
Primary school	44 (34.4)	31 (24.2)	
Secondary school and higher	20 (15.6)	9 (7.0)	
Time of LiCH			0.721
≥ 1 year	16 (12.5)	10 (7.8)	
< 1 to 5 years	30 (23.4)	22 (17.2)	
< 5 to 10 years	17 (13.3)	9 (7.0)	
< 10 years	12 (9.4)	12 (9.4)	
Have own child or adopted child			1.000
None	24 (18.8)	17 (13.3)	
Yes	51 (39.8)	36 (28.1)	
An average of visitors			0.892
None	24 (18.8)	19 (14.8)	
≥ 1 month	13 (10.2)	9 (7.0)	
>1 to 6 months	12 (9.4)	9 (7.0)	
>6 months to a year	21 (16.4)	11 (8.6)	
More than a year	5 (3.9)	5 (3.9)	

Values are number and percentages in parenthesis.

a: Chi-squared test

5.8.1.3 Health characteristics between non-depressed and depressed group

Table 22 demonstrates the health characteristics of non-depressed and depressed residents. The findings revealed that there were no statistically significant differences in the health characteristics between the non-depressed and depressed groups. The details of the statistic comparison were provided in Table 22.

Table 22: Health characteristics between non-depressed and depressed group

Characteristics of participants	Non-depressed group (n=75)	Depressed group (n=53)	P value a
Diagnosed with one or more diseases			0.380
No	25 (19.5)	13 (10.2)	
Yes	50 (39.1)	40 (31.3)	
Diabetes mellitus			0.648
No	63 (49.2)	42 (32.8)	
Yes	12 (9.4)	11 (8.6)	
Hypertension			0.931
No	40 (31.3)	27 (21.1)	
Yes	35 (27.3)	26 (20.3)	
Hypercholesterolemia			0.361
No	67 (52.3)	50 (39.1)	
Yes	8 (6.3)	3 (2.3)	
Heart diseases			1.000
No	69 (53.9)	49 (38.3)	
Yes	6 (4.7)	4 (3.1)	
Have one or more health problems			0.946
No	10 (7.8)	6 (4.7)	
Yes	65 (50.8)	47 (36.7)	
Difficulties of hearing			0.562
No	61 (47.7)	46 (35.9)	
Yes	14 (10.9)	7 (5.5)	
Difficulties of seeing			0.785
No	37 (28.9)	24 (18.8)	
Yes	38 (29.7)	29 (22.7)	
Difficulties to walk			0.231
No	46 (35.9)	26 (20.3)	
Yes	29 (22.7)	27 (21.1)	
Pain			0.065
No	67 (52.3)	40 (31.3)	
Yes	8 (6.3)	13 (10.2)	

Values are number and percentages in parenthesis.

a: Chi-squared test

5.8.2 Internalised stigma of LiCH

5.8.2.1 Internalised stigma among residents in both homes

Overall, the vast majority of the sample perceived some level of internalised stigma from LiCH (92.3%). For one quarter of those residents who reported some level of internalised stigma (25.4%), this feeling of internalised stigma reached moderate or severe.

Figure 18 showed the differences in levels of internalised stigma from LiCH among older residents between care home A and B. There was no significant differences in the levels of internalised stigma from LiCH of the both groups (p= 0.119). The details of the levels of internalised stigma from LiCH among older residents were described in Figure 18.

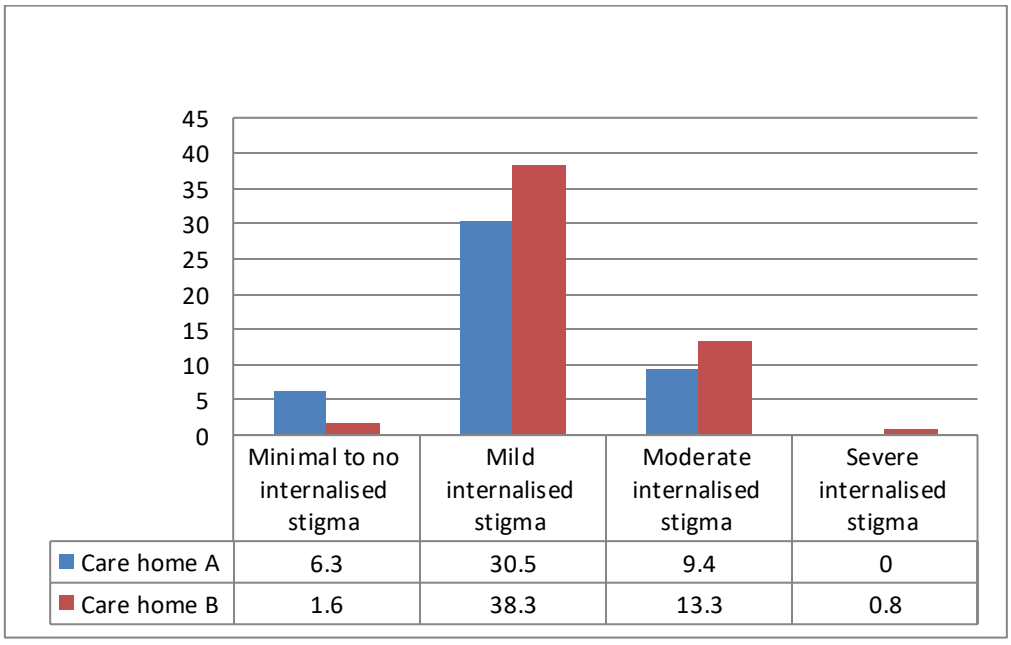


Figure 18: Internalised stigma of LiCH in both care homes

5.8.2.2 Demographic characteristics between a group of residents who perceived low internalised stigma and high internalised stigma of LiCH

Table 23 compares the personal demographic data of residents who perceived low internalised stigma with those who have high internalised stigma of LiCH. The results showed that there were no statistically significant differences in demographic characteristics in the two groups.

5.8.2.3 Health characteristics between residents perceiving low and high internalised stigma of LiCH

Table 24 compares the health characteristics between a group of residents who perceived low internalised stigma and those with high internalised stigma. The results showed that there were no statistically significant differences in the health characteristics in the two groups.

Table 23: Personal demographic data between a group of residents who perceived low and high Internalised stigma

Characteristics of participants	Low internalised stigma (n=98)	High internalised stigma (n=30)	P value a
Setting			0.578
Care home A	47 (36.7)	12 (9.4)	
Care home B	51 (39.8)	18 (14.1)	
Age group			0.411
60-70 years old	25 (19.5)	5 (3.9)	
71-75 years old	21 (16.4)	5 (3.9)	
76 years older and over	52 (40.6)	20 (15.6)	
Gender			0.914
Male	36 (28.1)	12 (9.4)	
Female	62 (48.4)	18 (14.1)	
Marital status			0.777
Single	22 (17.2)	5 (3.9)	
Partnership	4 (3.1)	1 (0.8)	
Separated/divorced	27 (21.1)	7 (5.5)	
Widowed	45 (35.2)	17 (13.3)	
Religion			1.000
Buddhism	96 (75.0)	30 (23.4)	
None (Atheist)	2 (1.6)	0 (0.0)	
Highest qualification			0.373
No qualifications	18 (14.1)	6 (4.7)	
Primary school	55 (43.0)	20 (15.6)	
Secondary school and higher	25 (19.5)	4 (3.1)	
Time of LiCH			0.748
≥ 1 year	22 (17.2)	4 (3.1)	
< 1 to 5 years	39 (30.5)	13 (10.2)	
< 5 to 10 years	19 (14.8)	7 (5.5)	
< 10 years	18 (14.1)	6 (4.7)	
Have own child or adopted child			0.961
None	32 (25.0)	9 (7.0)	
Yes	66 (51.6)	21 (16.4)	
Average visitors			0.374
None	33 (25.8)	10 (7.8)	
≥ 1 month	19 (14.8)	3 (2.3)	
>1 to 6 months	14 (10.9)	7 (5.5)	
>6 months to a year	26 (20.3)	6 (4.7)	
More than a year	6 (4.7)	4 (3.1)	

Values are number and percentages in parenthesis and a: Chi-squared test

Table 24: Health characteristics between a group of residents who perceived low and high Internalised stigma

Health characteristics	Low internalised stigma (n=98)	High internalised stigma (n=30)	P value a
Diagnosed with one or more diseases			0.521
No	31 (24.2)	7 (5.5)	
Yes	67 (52.3)	23 (18.0)	
Diabetes mellitus			0.252
No	83 (64.8)	22 (17.2)	
Yes	15 (11.7)	8 (6.3)	
Hypertension			0.739
No	50 (39.1)	17 (13.3)	
Yes	48 (37.5)	13 (10.2)	
Hypercholesterolemia			0.719
No	90 (70.3)	27 (21.1)	
Yes	8 (6.3)	3 (2.3)	
Heart diseases			0.243
No	92 (71.9)	26 (20.3)	
Yes	6 (4.7)	4 (3.1)	
Have one or more health problems			0.762
No	13 (10.2)	3 (2.3)	
Yes	85 (66.4)	27 (21.1)	
Difficulties of hearing			0.781
No	81 (63.3)	26 (20.3)	
Yes	17 (13.3)	4 (3.1)	
Difficulties of seeing			0.453
No	49 (38.3)	12 (9.4)	
Yes	49 (38.3)	18 14.1	
Difficulties to walk			0.563
No	57 (44.5)	15 11.7	
Yes	41 (32.0)	15 11.7	
Pain			0.557
No	83 (64.8)	24 18.8	
Yes	15 (11.7)	6 4.7	

Values are number and percentages in parenthesis and a: Chi-squared test

5.8.3 Self-esteem

Figure 19 shows the differences in levels of self-esteem among older residents between care home A and B. There was no significant differences in the levels of self-esteem in the both groups (p= 0.148). However, low self-esteem was only evident in the minority of the residents in both care homes (10.2%).

In addition, the majority of the sample (89.8%) was reported having normal and high self-esteem.

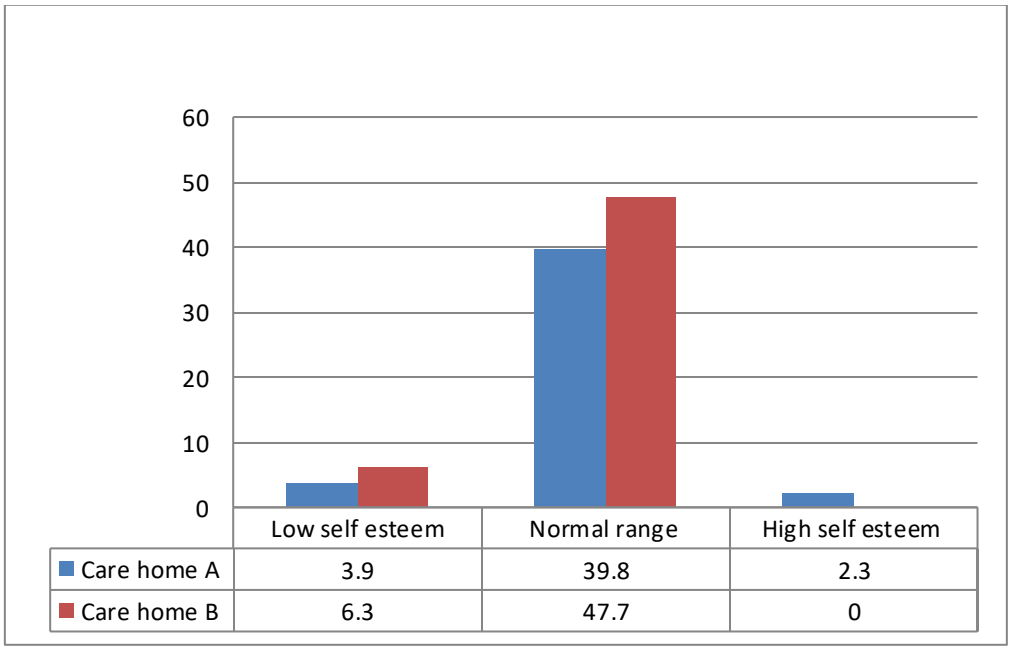


Figure 19: Self-esteem of older residents in both care homes

5.8.4 Perceived social support among older residents

5.8.4.1 Perceived social support among older residents in both care homes

The majority of residents in both care homes perceived that they had low or moderate levels of social support (80.5%). Interestingly, over one fifth

of them perceived low social support (21.9%). Figure 20 illustrates the number and percentages of older residents in both care homes perceiving social support. However, p values were calculated and the result showed that there was no significant differences in the levels of social support in both groups (p= 0.412).

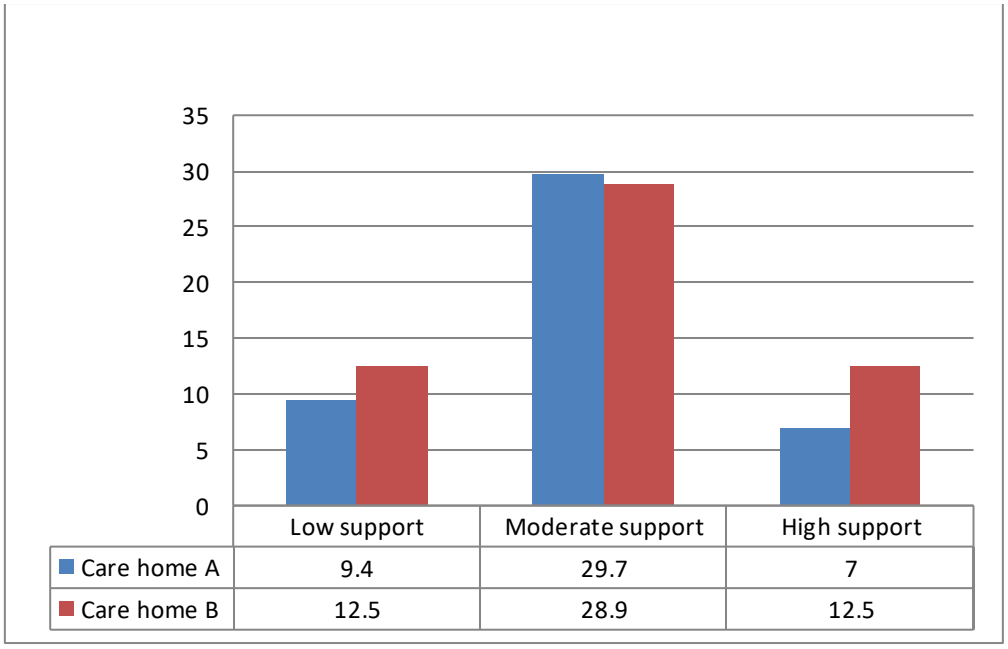


Figure 20: Older residents in both care homes perceived social support

5.8.4.2 Perceived social support from family

Forty-three per cent of older residents in both care homes perceived low levels of social support from their families (42.9%). Only one quarter of residents reported high level of support from families (25.7%). However, there was no significant differences in perceived social support from their families among older residents in both care homes (p= 0.531). The details of the number and percentages of older residents who perceived social support in both care homes were illustrated in Figure 21.

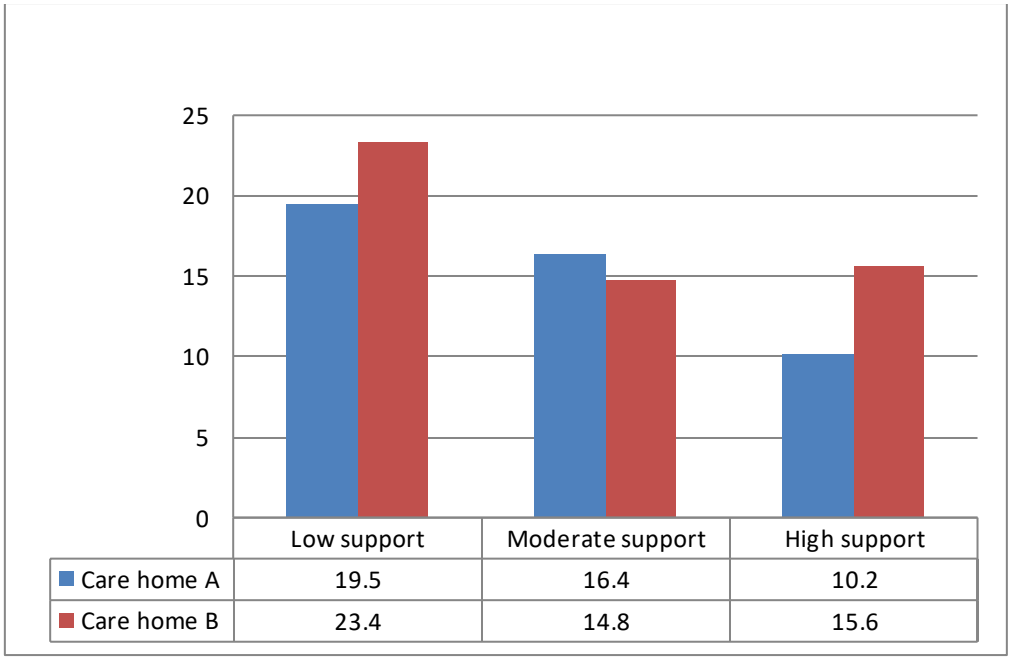


Figure 21: Older residents in both care homes perceived social support from family

5.8.4.3 Perceived social support from friends

Figure 22 illustrates the numbers and the percentages of older residents perceiving social support from their friends. Overall, just under two-thirds of older residents in both care homes perceived low and moderate levels of social support from their friends (62.6%). High level of support from their friends was reported equally by residents only for 18.8% in each care home.

The p value was calculated and the result showed that there was no statistically significant differences in perceived social support from friends among the two groups (p= 0.590).

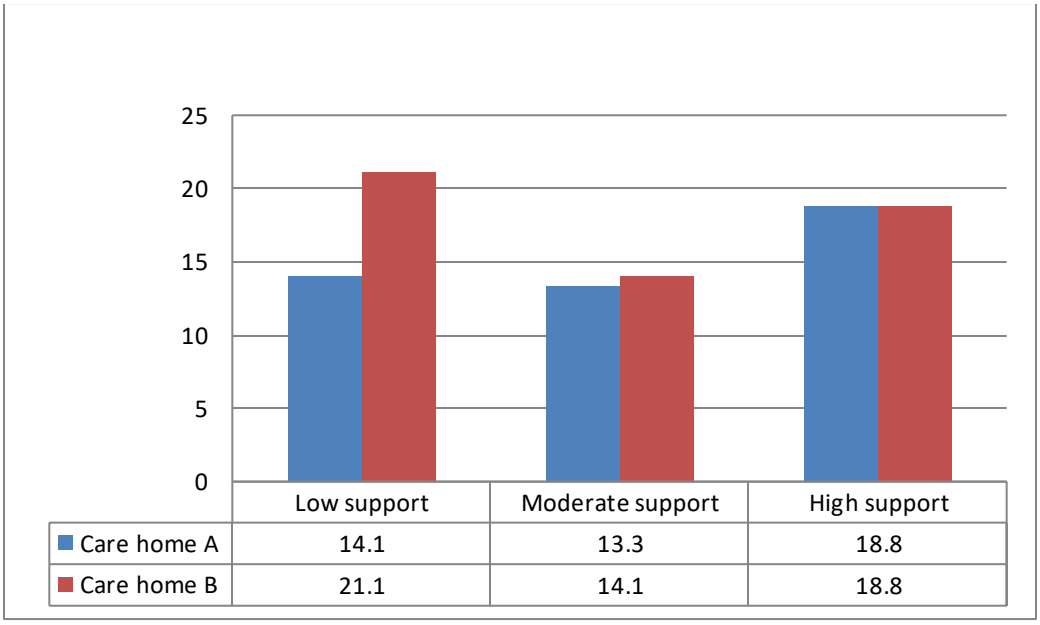


Figure 22: Older residents in both care homes perceived social support from friends

5.8.4.4 Perceived social support from significant others

Figure 23 demonstrates the numbers and the percentages of older residents who perceived social support from their significant others. In generally, almost three-quarters of older residents perceived low and moderated levels of support from significant others (72.7%). Older residents who lived in care home A, perceived lower support from significant others than the residents who lived in care home B (14.1% vs. 16.4%).

In addition, nearly twice proportion of residents who lived in care home B perceived high support from significant others than older residents who lived in care home A (18% vs. 9.4%). However, there was no significant difference in perceived social support between the both care homes (p= 0.223).

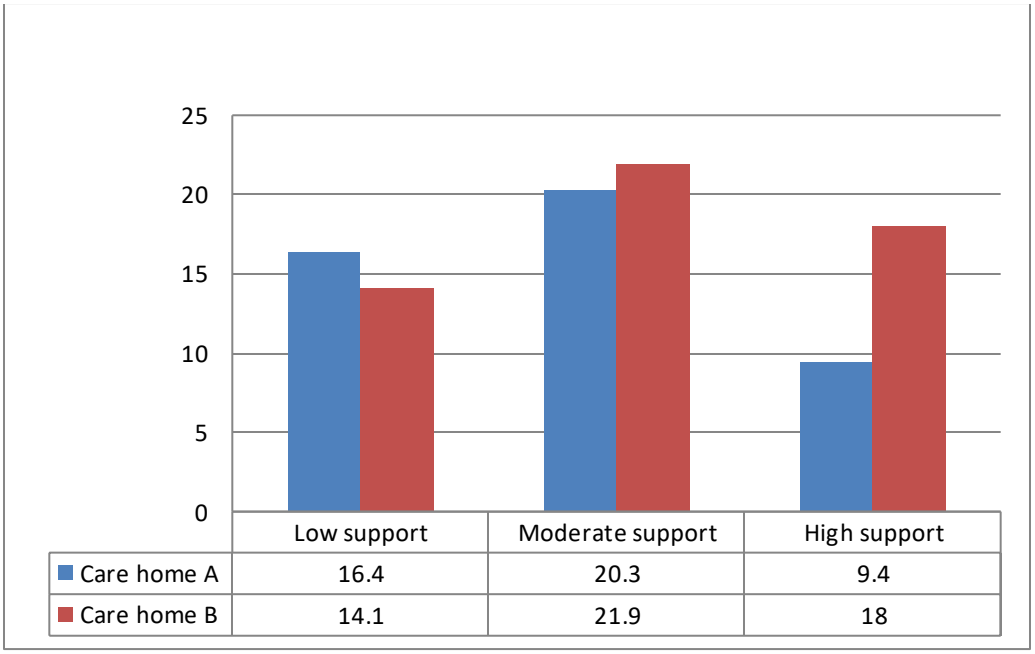


Figure 23: Older residents in both care homes perceived social support from significant others

5.8.4.5 Demographic characteristics and perceived social support among older residents in both care homes

Table 25 illustrates the personal demographic data of care home residents who perceived differences in levels of social support. The results showed that there were no statistically significant differences in demographic characteristic among those groups.

Table 25: Differences in perceived social support and demographic characteristics

Characteristics of participants	Low support (n= 28)	Moderate support (n= 75)	High support (n= 25)	P value a
Setting				0.412
Care home A	12 (9.4)	38 (29.7)	9 (7.0)	
Care home B	16 (12.5)	37 (28.9)	16 (12.5)	
Age group				0.552
60-70 years old	4 (3.1)	19 (14.8)	7 (5.5)	
71-75 years old	6 (4.7)	17 (13.3)	3 (2.3)	
76 years older and over	18 (14.1)	39 (30.5)	15 (11.7)	
Gender				0.451
Male	9 (7.0)	27 (21.1)	12 (9.4)	
Female	19 (14.8)	48 (37.5)	13 (10.2)	
Religion				0.561
Buddhism	27 (21.1)	74 (57.8)	25 (19.5)	
None (Atheist)	1 (0.8)	1(0.8)	0 (0.0)	
Highest qualification				0.107
No qualifications	9 (7.0)	12 (9.4)	3 (2.3)	
Primary school	16 (12.5)	46 (35.9)	13 (10.2)	
Secondary school and higher	3 (2.3)	17 (13.3)	9 (7.0)	
Time of LiCH				0.324
≥ 1 year	5 (3.9)	16 (12.5)	5 (3.9)	
< 1 to 5 years	14 (10.9)	26 (20.3)	12 (9.4)	
< 5 to 10 years	2 (1.6)	18 (14.1)	6 (4.7)	
< 10 years	7 (5.5)	15 (11.7)	2 (1.6)	
Have own child or adopted child				0.249
None	8 (6.3)	28 (21.9)	5 (3.9)	
Yes	20 (15.6)	47 (36.7)	20 (15.6)	
An average of visitors				0.239
None	12 (9.4)	26 (20.3)	5 (3.9)	
≥ 1 month	4 (3.1)	10 (7.8)	8 (6.3)	
>1 to 6 months	2 (1.6)	16 (12.5)	3 (2.3)	
>6 months to a year	7 (5.5)	17 (13.3)	8 (6.3)	
More than a year	3 (2.3)	6 (4.7)	1 (0.8)	

Values are number and percentages in parenthesis.

a: Chi-squared test

5.8.4.6 Health characteristics and perceived social support among older residents in both care homes

Table 26 illustrates the health characteristics of care home residents who perceived differences in level of social support. The results showed that there were no statistically significant differences in the health characteristic among those groups.

Table 26: Differences in perceived social support and health characteristic

Characteristics of participants	Low support (n= 28)	Moderate support (n= 75)	High support (n= 25)	P value a
Diagnosed with one or more diseases				0.169
No	12 (9.4)	18 (14.1)	8 (6.3)	
Yes	16 (12.5)	57 (44.5)	17 (13.3)	
Diabetes mellitus				0.256
No	25 (19.5)	58 (45.3)	22 (17.2)	
Yes	3 (2.3)	17 (13.3)	3 (2.3)	
Hypertension				0.160
No	18 (14.1)	34 (26.6)	15 (11.7)	
Yes	10 (7.8)	41 (32.0)	10 (7.8)	
Hypercholesterolemia				0.067
No	27 (21.1)	65 (50.8)	25 (19.5)	
Yes	1 (0.8)	10 (7.8)	0 (0.0)	
Heart diseases				0.792
No	25 (19.5)	70 (54.7)	23 (18.0)	
Yes	3 (2.3)	5(3.9)	2 (1.6)	
Have one or more health problems				0.827
No	3 (2.3)	9 (7.0)	4 (3.1)	
Yes	25 (19.5)	66 (51.6)	21 (16.4)	
Difficulties of hearing				0.520
No	24 (18.8)	64 (50.0)	19 (14.8)	
Yes	4 (3.1)	11 (8.6)	6(4.7)	
Difficulties of seeing				0.611
No	15 (11.7)	33 (25.8)	13 (10.2)	
Yes	13 (10.2)	42 (32.8)	12 (9.4)	
Difficulties to walk				0.893
No	15 (11.7)	42 (32.8)	15 (11.7)	
Yes	13 (10.2)	33(25.8)	10 (7.8)	
Pain				0.711
No	22 (17.2)	64 (50.0)	21 (16.4)	
Yes	6(4.7)	11 (8.6)	4 (3.1)	

Values are number and percentages in parenthesis.

a: Chi-squared test

5.8.5 Coping strategies among older residents

Table 27 presents descriptive statistics of coping strategies that older adults typically used to cope with their stresses. This shows that older residents more commonly used emotion-focused disengagement coping strategies (11.13, SD=3.37) to cope with unpleasant or stressful situations. In addition, emotion-focused engagement (8.73, SD=3.19) was less commonly used by older residents comparing with the other coping skills. The details of descriptive statistics of coping strategies were provided in Table 27.

Table 27: Descriptive statistics of coping strategies among older residents

Scale	Mean	SD	Median	Range
1st Tier Subscale				
Total Engagement (E)	17.91	5.838	17.00	8-31
Total Disengagement (D)	20.94	5.284	21.00	9-35
2nd Tier Subscale				
Problem-focused engagement (PFE)	9.18	3.43	9.00	4-19
Problem-focused disengagement (PFD)	9.81	3.17	10.00	4-17
Emotion-focused engagement (EFE)	8.73	3.19	8.00	4-16
Emotion-focused disengagement (EFD)	11.13	3.37	11.00	4-20

5.9 The Relationship between Depressive Symptoms and Other Variables

Table 28 illustrates the correlations between depressive symptoms and other variables including internalised stigma, self-esteem, perceived social support and coping strategies. The findings reveal that there were

significant correlations between depressive symptoms and other variables including internalised stigma, self-esteem and social support.

Self-esteem and perceived social support were found to have a significant negative correlation with depressive symptoms ($r=-0.574$) ($p< 0.001$) and ($r=-0.333$) ($p< 0.001$). In that, participants with a higher level of self-esteem and social support reported lower level of depressive symptoms. In addition, internalised stigma of LiCH was significantly positively correlated with depressive symptoms ($r=0.563$) ($p< 0.001$). This means that participants with a higher level of internalised stigma of LiCH also reported a higher level of depressive symptoms.

Furthermore, there was a significant negative correlation between internalised stigma of LiCH and other variables comprising self-esteem and social support ($r=-0.721$) ($p< 0.001$) and ($r=-0.333$) ($p< 0.001$), respectively. These results suggested that participants with higher levels of self-esteem and social support reported lower levels of internalised stigma.

In addition, self-esteem was found to have a significant positive correlation with perceived social support ($r=0.331$) ($p< 0.001$) which means participants with high self-esteem reported high perceive social support as well. Moreover, there was a significant positive correlation between perceived social support and coping strategies ($r=0.288$) ($p< 0.001$), it was indicated that participants with high perceived social support reported also high scores of coping strategies.

Table 28: Correlations between depressive symptoms and other variables

Questionnaire scale	The 15-TGDS	T-ISLCH	T-RSES	T-MSPSS	T-CSI-SF	Mean±SD
The 15-TGDS	1.00					4.38±3.35
T-ISLCH	r=0.563 (0.001)*	1.00				2.34±0.28
T-RSES	r=-0.574 (0.001)*	r=-0.721 (0.001)*	1.00			18.83±3.28
T-MSPSS	r=-0.333 (0.001)*	r=-0.333 (0.001)*	r=0.331 (0.001)*	1.00		3.87±1.19
T-CSI-SF	r=0.48 (0.589)	r=0.091 (0.307)	r=0.090 (0.311)	r=0.288 (0.001)*	1.00	2.43±0.56

*: significant difference when p< 0.001. The 15-TGDS: The 15-Item Thai Geriatric Depression Scale; T-ISLCH: Internalised Stigma of Living in a Care Home Scale; T-RSES: Thai Version of Rosenberg Self-Esteem Scale; T-MSPSS: Thai Version of Multidimensional Scale of Perceived Social Support; T-CSI-SF: Thai version of a Coping Strategies Inventory Short Form.

5.10 Logistic Regression Predicting Likelihood of Reporting Experiencing Some Levels of Depressive Symptoms

Table 29 presents the results of logistic regression. Direct logistic regression was performed to assess the impact of a number of factors on the probability that respondents would report that they experienced some levels of depressive symptoms. The model contained five independent variables (gender, age, diagnosed with one or more diseases, the scores of internalised stigma of LiCH, and the score of perceived social support). In addition, Self-esteem variable was omitted from the model due to these two independent variables (internalised stigma and self-esteem) reporting high correlation than 0.7. If self-esteem was included in the model, it would violated the assumptions of using Logistic regression.

The full model containing all predictors was statistically significant, Chi-square (5, N= 128) = 33.618, p< 0.001, indicating that the model was able to distinguish between respondents who reported and did not report depressive symptoms. The model as a whole explained between 23.1% (Cox and Snell R square) and 31.1% (Nagelkerke R Square) of the variance in experiencing some level of depressive symptoms, and correctly classified 75% of cases.

As shown in Table 29, only two independent variables (perceived internalised stigma of LiCH and perceived social support) made a unique statistically significant contribution to the model. Perceived internalised stigma of LiCH is the strongest predictor of reporting experiencing some level of depressive symptoms, recoding an odds ratio of 9.165. This indicates that respondents who had high internalised stigma of LiCH were nine times more likely to report experiencing some levels of depressive symptoms than those who did not report high internalised stigma of LiCH, controlling for all other factors in the model.

Furthermore, the odds ratio of 0.969 for score of perceived social support was less than one, indicating that for every additional score of perceived social support, they were 0.969 time less likely to report having experiencing some level of depressive symptoms, controlling for other factors in the model. This shows that social support is a protective factor that decreases the chances of depressive symptoms among older adults living in Thai care homes.

Table 29: Logistic regression predicting experiencing some levels of depressive symptoms

	B	S.E.	Wald	df	p	Odds Ratio	95% C.I. for Odds Ratio	
							Lower	Upper
Gender	.682	.449	2.306	1	.129	1.977	.820	4.766
Age	-.034	.027	1.577	1	.209	.967	.917	1.019
Diagnosed with one or more diseases	.229	.473	.233	1	.629	1.257	.497	3.180
Level of Internalised stigma	2.215	.540	16.850	1	.000	9.165	3.182	26.396
Perceived social support	-.032	.016	4.057	1	.044	.969	.939	.999
Constant	2.600	2.289	1.291	1	.256	13.464		

Note. CI= confidence interval for odds ratio (OR)

5.11 Multiple Regression Predicting Depressive Symptoms

5.11.1 Standard multiple regression

Question 1: How well do the two measures of control (internalised stigma; T-ISLCH and perceived social support; T-MSPSS) predict depressive symptoms; the 15-TGDS?

Question 2: Which is the best predictor of depressive symptoms: internalised stigma of LiCH or perceived social support?

Standard multiple regression was used to answer the two questions above. Table 30 provides the details of mean, standard deviations and intercorrelations for depressive symptoms and predictor variables. The results presented that both of the scales (internalised stigma of LiCH and perceived social support) correlate with depressive symptoms (0.56 and

-0.33 respectively). The correlation between independent variables or predictor variables was -0.33, which is less than 0.7.

Table 30: Mean, Standard deviations, and Intercorrelations for depressive symptoms and predictor variables

Variable	M	SD	1	2
Depressive symptoms	4.38	3.35	0.56*	-0.33*
Predictor variable				
Internalised stigma of LiCH	2.34	0.28	-	-0.33*
Perceived social support	3.87	1.19	-	-

*P< 0.001

Figure 24 presents Normal P-P Plot of Regression Standardized Residual. The Plot demonstrates that the points lie in a reasonably straight diagonal line from the bottom left to top right, although there were some points showing slightly curved at the middle. This suggested that no major deviations from normality.

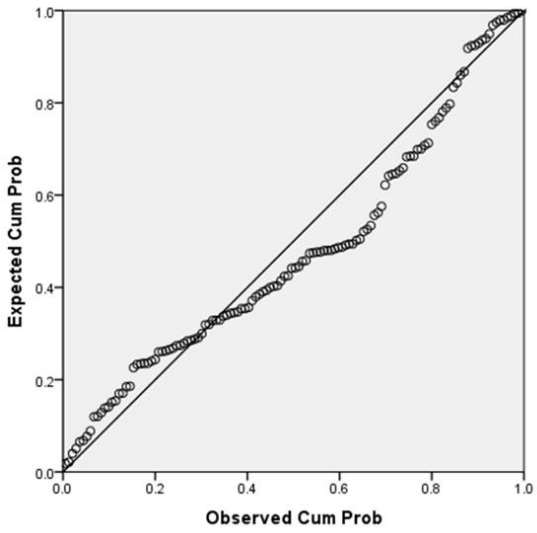


Figure 24: Normal P-P Plot of Regression Standardized Residual

Figure 25 presents the scatterplot for dependents variables; depressive symptoms. The scatterplot showed that the residuals were roughly rectangularly distributed, with most scores concentrated in the centre (along with the zero point) and with only one outlying residual more than 3.3.

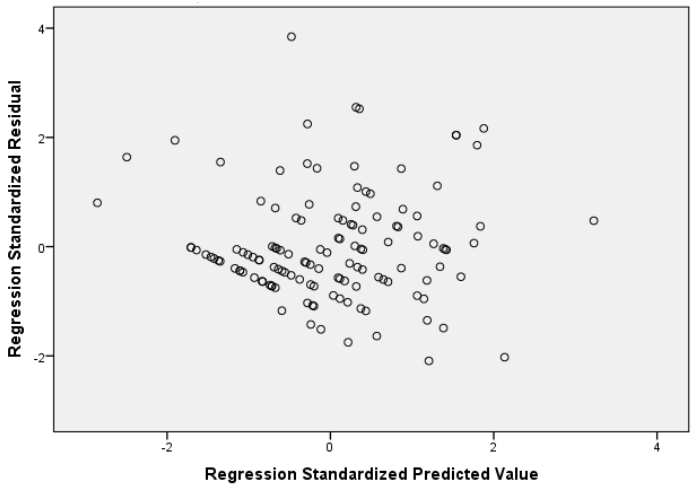


Figure 25: Scatterplot for dependent variable TGDS score

To summarise, the model, which included control of internalised stigma of LiCH and control of perceived social support, explains 34.1 per cent of the variance of having depressive symptoms (question 1). Of these two variables, internalised stigma of LiCH made the largest unique contribution (beta= 0.51), in addition, perceived social support also made a statistically significant contribution (beta= -0.16) (question 2). The details of standard regression analysis are provided in Table 31.

Table 31: Regression analysis summary for variables predicting depressive symptoms

Variable	B	SE B	95% CI	β	t	p
Internalised stigma of LiCH	6.05	0.92	[4.24, 7.87]	0.51	6.60	0.001
Perceived social support	-0.46	0.22	[-0.89, -0.03]	-0.16	-2.12	0.036

Note. $R^2 = 0.34$ (N= 128, $p < 0.001$). CI= confidence interval for B

5.11.2 Hierarchical multiple regression

Question 3: If the possible effect of age, gender and diagnosed with one or more additional diseases was controlled, is the set of variables (internalised stigma of LiCH and perceived social support) still able to predict a significant amount of the variance in having depressive symptoms?

Hierarchical multiple regression was used to assess the ability of two control measures (T-ISLCH and T-MSPSS) to predict depressive symptoms (the 15-TGDS), after controlling for the influence of gender, age and diagnosed with one or more diseases. Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity, and homoscedasticity.

Gender, age and diagnosed with one or more additional diseases were entered at step 1, explaining 3.5 per cent of the variance in having depressive symptoms. After entry of internalised stigma; the T-ISLCH and perceived social support; the T-MSPSS at step 2, the total variance explained by the model as a whole was 36.6 per cent, $F (5, 122) = 14.10$, $p<0.001$.

The two control measures explained an additional 33.1 per cent of the variance in having depressive symptoms, after controlling for gender, age and diagnosed with one or more additional diseases responding. R squared change = 0.33, F change (2, 122) = 31.87, p< 0.001. In the final model, only the two control measures were statistically significant, recording a higher beta value (beta= 0.51, p< 0.001) than (beta = -0.16, p< 0.05). The details of hierarchical regression analysis were presented in Table 32.

Table 32: Hierarchical regression analysis summary for variables predicting depressive symptoms (N= 128)

Step and predictor variable	R^2	ΔR^2	sr	β
Step 1	.035	.012		
Gender			.102	.102
Age			-.074	-.074
Diagnosed with one or more diseases			.111	.112
Step 2	.366**	.340		
Internalised stigma of LiCH			.508	.508**
Perceived social support			-.181	-.157*

Note. sr= semipartial correlation coefficient. *p<0.05 and ** p<0.001

The next chapter of the thesis presents the findings from qualitative research. This chapter shows the dynamics of the process of stigma associated with living in a care home. It begins with the information regarding the participant characteristics and shows the causes of stigma such as negative beliefs about care homes and people who live in them, the nature of the care home population, attitudes and stereotypes toward older people, care home features contributing to stigma and staffing inadequacies.

Chapter Six: The Process of Stigmatisation (Causes of Stigma)

6.1 Introduction

The previous chapter in the thesis found that internalised stigma associated with living in a care home (LiCH) was positively correlated with depressive symptoms, and stigma also was the strongest factor predicting depressive symptoms among residents. This chapter focuses on the qualitative data, giving details about the characteristics of the people who participated in this aspect of the study and outlining the findings that illustrate a process of stigma which appears to occur due to the interaction of three elements: the causes of stigma, manifestation of stigma and the mitigating factors.

6.2 Participant characteristics

Qualitative interviews were conducted with fifty participants from the two care homes in Northeast Thailand, comprising 30 residents (15 residents from each care home) and 20 care home staff (10 staff from each home). Over half of resident participants were female (19/30). The mean age of the residents was 74.17 years (SD = 6.99, range 61-86 years) and the mean length of time being in a care home was 4.94 years (SD = 4.58, range 0.25-21.25 years). Over one-third of residents were widowed (11/30). The marital status of the remaining residents were separated (8/30), single (7/30), divorced (3/30) and one in partnerships. In terms of their highest level of education, half of residents had graduated from a primary school (17/30) and nearly a quarter from a secondary school

(7/30). Over one tenth of residents did not have any qualifications (4/30). In addition, one resident held a bachelor's degree and another one a master's degree.

Almost all care home staff participants were female (18/20). The mean age of staff was 44.60 years (SD = 8.51, range 31-58 years) and the mean length of time working in a care home was 11.25 years (SD = 8.64, range 1-33 years). The majority of staff were married (13/20), while others were single (6/20) and divorced (1/20), respectively. 40% of staff participants were care assistants (general caregivers without certificated nursing assistant) (8/20), and a quarter of all staff were certificated nursing assistants (5/20). A nursing assistant provides a high level of skill of care to residents compared to a care assistant such as preparing and administering oral tablets and liquid medications, wound care or taking vital signs. However, these activities are supervised by a registered nurse. The remaining staff were nurses (2/20) social workers (2/20), heads of the care homes (2/20), and a physiotherapy assistant (1/20). The highest educational attainment of staff members were primary school (1/20), for a care assistant; secondary school (4/20), for two care assistants and two nursing assistants; diploma (6/20), for three care assistants, two nursing assistants and one physiotherapy assistant; bachelor's degree (5/20) for one nursing assistant, two care assistants and two nurses; and master's degree (4/20) for two social workers and two heads of care homes.

The summary of the descriptive information regarding all participants is presented in Table 33 for residents and Table 34 for care home staff from both homes. All the names used in the thesis are pseudonyms.

Table 33: Summary of resident characteristics

Resident ID: Name	Gender	Age	Marital status	Highest qualification
R01: Gam	F	84	Widowed	No qualification
R02: Chatchai	M	83	Separated	Primary school (*Y4)
R03: Naree	F	76	Divorced	Primary school (*Y4)
R04: Thanawat	M	66	Divorced	Secondary school (*Y3)
R05: Therapat	M	75	Separated	Primary school (*Y4)
R06: Werawat	M	71	Widowed	Primary school (*Y4)
R07: Sutinan	M	72	Separated	Secondary school (*Y3)
R08: Pim	F	68	Separated	Primary school (*Y4)
R09: Apisit	M	74	Separated	Secondary school (*Y3)
R10: Therasak	M	77	Widowed	Primary school (*Y4)
R11: Boonrit	M	73	Separated	Primary school (*Y4)
R12: Tangkwa	F	78	Single	Primary school (*Y4)
R13: Thanasorn	M	83	Partnership	Secondary school
R14: Phadet	M	84	Separated	Secondary school (*Y3)
R15: Somchai	M	68	Widowed	Primary school (*Y2)
R16: Kanta	F	84	Single	Bachelor degree
R17: Pang	F	81	Widowed	No qualification
R18: Mookda	F	61	Single	Primary school (*Y4)
R19: Kannika	F	72	Widowed	No qualification
R20: Jinda	F	69	Divorced	Primary school (*Y4)
R21: Aum	F	84	Widowed	Primary school (*Y4)
R22: Kwan	F	75	Single	Primary school (*Y4)
R23: Sirada	F	66	Widowed	Primary school (*Y4)
R24: Fang	F	65	Separated	No qualification
R25: Nam	F	68	Widowed	Diploma/Secondary school
R26: Ploy	F	66	Single	Secondary school
R27: Fon	F	76	Single	Primary school (*Y4)
R28: Arisa	F	71	Single	Master degree
R29: Khim	F	69	Widowed	Primary school (*Y4)
R30: Sai	F	86	Widowed	Primary school (*Y4)
N = 30	M = 11 F = 19	Mean = 74.17 years (SD = 6.99)	Single = 7 Separated = 8 Divorced = 3 Widowed = 11 Partnership = 1	No qualification = 4 Primary school = 17 Secondary school = 7 Bachelor degree = 1 Master degree = 1

* The year they left school. Primary school (*Prathom*) and secondary school (*Matthayom*) were for six years each, but it was not compulsory before 2009 (Unicef, 2017).

Table 34: Summary of staff characteristics

Staff ID: Name	Gender	Age (yrs)	Marital status	Highest qualification
S01: Warunya	F	54	Married	Primary school (*Y4)
S02: Chanchira	F	52	Married	Diploma
S03: Metha	M	36	Single	Diploma
S04: Wanna	F	34	Single	Diploma
S05: Kittiya	F	32	Married	Bachelor degree
S06: Wipada	F	51	Married	Master degree
S07: Nittaya	F	31	Married	Secondary school
S08: Komkorn	M	37	Married	Diploma
S09: Aroon	F	37	Married	Bachelor degree
S10: Apasara	F	51	Divorce	Master degree
S11: Areeya	F	48	Single	Master degree
S12: Kalaya	F	58	Married	Master degree
S13: Jai	F	52	Single	Secondary school (*Y3)
S14: Chompoo	F	48	Single	Diploma
S15: Dokrak	F	54	Single	Bachelor degree
S16: Buppha	F	53	Married	Bachelor degree
S17: Kai	F	44	Married	Secondary school (*Y2)
S18: Urai	F	36	Married	Diploma
S19: Sasithon	F	43	Married	Bachelor degree
S20: Darunee	F	41	Married	Secondary school
N = 20	M = 2 F = 18	Mean = 44.60 (SD = 8.51)	Single = 6 Married = 13 Divorce = 1	Primary school = 1 Secondary school = 4 Diploma = 6 Bachelor degree = 5 Master degree = 4

* The year they left school. Primary school (*Prathom*) and secondary school (*Matthayom*) were for six years each, but it was not compulsory before 2009 (Unicef, 2017).

6.3 A process of stigma with three elements: the causes of stigma, manifestation of stigma and the mitigating factors of stigma

The aim of the qualitative study was to understand stigma associated with a care home, how it influences residents and how residents cope

with stigma associated with LiCH. Three elements of a process of stigma emerged from the data, with each element having several codes. This process of stigma is presented in Table 35.

Table 35: Stigmatisation process with three elements

Aspects	Codes
Causes of stigma	
Negative beliefs about care homes and people who live in them	The concept of "*Song Kroh*", being poor and abandoned, being in a jail, poor accommodation
The nature of the care home population	People who feel abandoned, people with psychosis, people with cognitive impairment, people with alcoholism
Attitude and stereotype toward older people	Dependence on others, demanding to caregivers, dirty and smelly and dealing with germs
Care home features contributing to stigma	The culture and environment of the care home (communal living, lack of privacy, lack of freedom), Perception and judgment from other residents (peer pressure and gossip, monitoring, ring leaders and cliques, differences in social class) and Unequal power relations between residents and care home staff (rules and regulations, punishment, no authority, obey the rules, power imbalance)
Inadequacies regarding staffing	Uncaring, negative job attitude and low motivation, lack of knowledge and training skills, lack of teamwork and communication among staff, understaffed care home, high workload burnout and stress
Manifestations of stigma	
Negative emotional reactions	Shame and embarrassment, hopeless and sense of worthlessness, failure and disappointment, low self-esteem, fear, aggression, frustration, depression and suicidal ideation
Negative behavioural responses	Isolation and social exclusion, conflict, violence and crime, committed suicide, hiding
Mitigating factors of stigma	
Coping strategies	Buddhist approach, stoicism, comparing with others, positive thinking
Social support	Friends, peers, family, care home staff, ordinary people
Activities in a care home	Handicraft, travelling, having a role and responsibility, meditation

Element 1: The Causes of Stigma

Where residents experienced stigma as a result of LiCH, this seemed to occur as a result of the combination of numerous factors. The process appeared to start before the person moved into the care home with their own beliefs about what the care home would be like and would be exacerbated by the fact that many people who were at risk of being admitted could be described as being vulnerable. This tended to be compounded by negative attitudes towards older people that seemed to be held by both residents and members of staff, many of whom were working in difficult circumstances and were not adequately prepared for their roles.

6.4 Negative beliefs about care homes and residents

A number of negative beliefs were held by people as they moved into the care homes. These included the belief that care homes offer a poor quality of accommodation, that care homes are for people who are poor or abandoned, that LiCH is like imprisonment and that people living in care homes are inferior to other people. In addition, participants associated LiCH with the concept of “Song Kroh”, which was viewed very negatively. Ultimately, participants seemed to suggest that they viewed a move into the care home as the option of the last resort.

6.4.1 Care homes offer a poor quality of accommodation

Negative perceptions about care homes were held by participants in this study, particularly concerning poor accommodation. Kanta, a female resident, told the researcher how she felt about a care home before LiCH.

"At first, I thought it would be like a typical place for older people. I thought the accommodation would be in poor condition with residents not following rules and regulations, just sitting around not doing anything much (R16).

This quotation illustrates a negative impression of care homes that exists among the general public, including residents before they come to live in such facilities. Such negative stereotypes affect the attitudes of current and potential residents. Kwan, a female resident, reflected her perception of a care home before moving into one:

"I thought that a care home would be in poor condition, full of overgrown trees, damp and with dirty toilets. I thought it would be full of depressed older people who were waiting to die. That's why I delayed my decision to register to live in a care home" (R22).

The quotation illustrates the influence of negative impressions on Kwan's behaviour, causing her to delay the decision to move into a care home.

6.4.2 Care homes are for people who are poor or abandoned

Another negative public perception of care homes identified in this study was that they are places for poor or abandoned older adults. For instance, Therapat, a male resident, expressed his view on people LiCH before he himself became a resident:

"I thought that most of old people who lived in a care home were underprivileged. It meant they were unable to work,

they had no relatives, or they couldn't get on with their family. That was my perception of people living in a care home" (R05).

The quotation illustrates a negative impression toward older adults residing in care homes and it seems likely that this would leave some residents feeling a lack of self-worth. Pang, another female resident who had resided in a care home for five years, expressed a similar view, mainly relating to the social perception that older adults who LiCH have been abandoned:

"They (the public) must have thought that older people who live in a care home have been abandoned by their children. People brought their parents to a care home and abandoned them" (R17).

It seems likely that the negative public perception of most residents as being poor and abandoned influenced some residents themselves to believe these characterisations. For example, Thanawat, a male resident, spoke of his view that care homes were specifically provided for people who were destitute rather than the affluent or those with their own homes:

"Rich people or people who have their own homes should not come to live in care homes. The care homes [Song Kroh] *are a place for underprivileged people" (R04).*

With this quotation Thanawat manifested the negative belief that care homes were for desperate people requiring government assistance only. The implication of this is that it is viewed as antisocial (i.e. a negative behaviour) for wealthy people to avail themselves of care home services because they can afford to live independently in their own homes. This could be a barrier to care home residency for homeowners.

6.4.3 Living in a care home is very regimented

The findings of this study show that older adults perceived LiCH to be very regimented, mainly related to rules and regulations, as noted by Thanawat:

> *"Other residents used to live comfortably in their homes. They used to wake up late and eat or do whatever they wanted. However when they moved to the care home, they could not do whatever they wanted. They had to participate in care home activities, such as praying. They have to follow the rules and regulations of the care home" (R04).*

Rules and regulations and routine activities of care homes seem to affect on older adults' perception of LiCH. Many participants compared LiCH to being imprisoned. As Kalaya, an experienced staff member who had worked in a care home for over 30 years, mentioned this:

> *"People who have never come to live in the care home would say they wouldn't come to live here. They feel they have dignity. Living here would be like being in jail" (S12).*

Kalaya explained that some older adults feel that they lose their dignity when they LiCH. They also have to follow the rules and regulations of a care home, which some may find restrictive, thus they would prefer to live in their own homes. This might suggest that people living in care homes are inferior to other people.

Negative public beliefs about LiCH were pervasive and internalised by care home residents. For instance, Phadet, a male resident, expressed his experience of being looked down upon when his friends who lived outside home discovered that he was LICH:

> *"They said to me like 'You were wealthy in the past. These days your children don't take care of you anymore. You have to come to live in a care home'. It felt like they thought I deserved it" (R14).*

This resident perceived that other people devalued him due to LiCH, which would predispose him to feel low self-esteem in his current situation. The sense of being looked down by others was more common among male residents compared to female ones due to the association of maleness with being independent and a breadwinner, as affirmed by Kalaya's statement:

> *"Some people may think that these older adults who don't live with their families have no dignity. Especially for the male older adults, some people may think that men should not ask for support from the government. They should work and support themselves" (S12).*

The above quotation illustrates that the public view of LiCH (i.e. stigma) has a more keenly felt influence on male residents.

6.4.4 The concept of "*Song Kroh*"

The concept of "*Song Kroh*" was commonly articulated throughout the study. It refers to a government service or institution for helping or assisting vulnerable and underprivileged people (i.e. the destitute, disabled or homeless) in Thai society who are dependent for financial assistance and who are desperate for a place to live. This word carries negative connotations that are transposed to care homes when the latter are understood in this vein. The word also influences the public view toward care homes and their residents. As Thanawat explained:

> *"The public may perceive that older adults who live in Song Kroh are penniless or destitute. The words 'Song Kroh' are scary" (R04).*

This resident's view encapsulated the negative public view of Song Kroh as being a place for destitute paupers, which caused fear among those interviewed. Kwan, a female resident, also agreed about the negative impact of "*Song Kroh*":

> *"Nobody feels positive with the word 'Song Kroh'. They think it carries a negative connotation" (R22).*

The quotation directly alludes to the stigmatising impact of this label. Apasara, a member of staff, also noted that this word entrenches public stigmatisation of LiCH:

"The word 'Song Kroh' puts people off coming to live in a care home, because it sounds like destitution" (S10).

Indeed, staff themselves were affected by this linguistic conception, particularly in deciding to apply for work in care homes. Komkorn, a male staff member, explained:

"Before I applied for the job here, I thought for many days whether I should work here or not because the word of 'Song Kroh' made me think a lot. Wow, taking care of older people? I didn't think I could do the job" (S08).

The widespread negative associations of *Song Kroh* thus influence the career choice of care professionals as well as care home residents.

6.4.5 Care homes are an option of the last resort

The findings suggest that these negative beliefs became self-fulfilling prophecies for many elderly people: they considered care homes to be undesirable places for marginalised people, places to be avoided. For example, Pim, a female resident who did not have her own family and who was rejected by her relatives, expressed her experience of knowing that she would be sent to live in a home.

"I didn't know that there was a care home here. I had never been here before. I cried when I was at home because my friend told me that her sister lives near a care home. She saw residents working in the care home. So, they also pitied me (people in her community) because they didn't want me

to come to live and work in a care home. They also cried for me" (R08).

Some people would tolerate extremely difficult living conditions if the only alternative was moving into a care home. For instance Kalaya, an experienced staff member, recalled the reaction of an older adult abandoned by her children and living alone in a poor shed without any electricity. She was invited to move to live in the care home, but she refused such offers:

"When we went to pick her up to live in the care home. She told us that if she had to live in the care home, she would commit suicide. We had to send her back to her home" (S12).

The quotation indicates that the negative associations of LiCH were so acute for this resident that she originally threated to kill herself rather than face the perceived indignity of care home residency. This shows that the public stigma profoundly affects older adults' decision to move into care homes and causes great distress.

In summary, negative beliefs about care homes and people who live in them is one cause of stigma and is entrenched by the negative public view toward care homes, particularly older adults residing in them. The process of stigma is already evolving before older adults move to live in care homes due to the public view (i.e. stigmatisation) of LiCH. These beliefs render care homes the last-resort options for Thai older adults and could leave them with emotional distress when they are confronted with

the decision to move into care homes. This impact is illustrated by some older adults who needed government support preferring to remain in unsafe and potentially squalid conditions in their own homes rather than moving into a care home.

6.5 The nature of the care home population

The resident participants were essentially a vulnerable population, highly likely to have experienced emotional distress before coming to live in the home due to experiences such as being abandoned or abused by their families. They came in with conditions such as cognitive impairment, psychosis or alcohol addiction. These conditions left them vulnerable to being stigmatised by others as well.

6.5.1 Abandonment and abuse

Interviews with residents and members of staff illustrate a vulnerability to experience emotional distress of some older adults who had been abandoned or abused, particularly by their own families. For example, Fang, a female resident, described her experiences of being abused by her own family (her husband and sons) when she was at home with them.

> *"My house was full of alcoholics. They fought with each other when they were drunk. I could not live with them. When they were sober, they were OK. When they were drunk, I could not stay near them. They scolded me. I could not live with them. That's why I had to come to live in a care home" (R24).*

The quotation illustrates a lack of support experienced by Fang and the abuse she suffered from her family when she was at home. This female resident needed to leave her home in a village to go to a city to find a job to raise money to pay for her living costs. Luckily she met someone who brought her to live in a care home. Buppha, a member of staff, explained about the vulnerability of some people who were admitted to a care home.

> *"It seems like older adults who live in a care home were abandoned by their children. They were lonely when they lived at home or they were physically or mentally abused by their families" (S16).*

While this is a general observation, it is supported by Kai, a care assistant, who described some experiences encountered while working with residents:

> *"Some residents were physically abused by their children because older adults didn't have money to give to their children to buy alcohol. So, they were physically abused by their children" (S17).*

The study also found that older adults with mental illness sometimes were admitted to a care home due to the fact that they were abandoned or rejected by their families because of stigma associated with mental illness. Nittaya, a nursing assistant, explained one reason why older adults with mental illness were moved to live in a care home:

"Some residents were patients in the psychiatric hospital. When the hospital did not have enough beds, they tried to remove the patients by looking for their relatives but their relatives just left them in the hospital. A social worker had to contact us in order to refer them to our care home" (S07).

The above quotation illustrates many residents were abandoned or abused by their families. This will leave them more vulnerable to experiencing emotional distress whilst LiCH, and indeed before moving in to care homes, which can exacerbate stigma.

6.5.2 People with cognitive impairment and psychosis

There seemed to be a significant proportion of people LiCH who had some form of cognitive impairment and psychosis. Sometimes older adults with cognitive impairment were left alone at home or were homeless and were brought to live in a care home by their community or other government organisations.

"When an old person was homeless, we had to allow them to stay in the care home, particularly when the case was referred by another organisation… Sometimes, they might continue talking aimlessly and didn't make much sense. At the point, we would allow them to live in the care home. We hoped that one day they could recollect something about their lives. Then, we could go and find out more information such as their real names or whether they had any relatives" (S12).

The quotation illustrates circumstances of mental illness perceived by Kalaya and this could impact on residents' experience of the home in a number of ways. It could create difficulties in adapting to care home life compared to other older adults due mainly to memory loss, general confusion and disorientation. Areeya, a member of staff, explained the problem of a resident with cognitive impairment when moving into a care home.

> *"When the resident who was physically abused by her son, who was currently in jail, first moved to our care home, she tried to run away. She wanted to go back to her home but she didn't have a home anymore. Her son was in jail. The house she used to live in was a rental property and it was let to a new tenant. She still wanted to go back to her home. One day she carried a bag to the gate of the care home when the staff were busy with other residents. She was healthy but she started to have memory impairment. We needed to put her in the dementia residents' unit because she tried to escape from the care home." (S11).*

This resident had difficulty adapting to care home life due to her condition, which needed attention from care home staff. Another staff member, Chompoo, expressed her perception of taking care of older adults with cognitive impairment, noting their heavy reliance on care home staff:

> *"We provide routine services to older people with cognitive impairment. …. In the care home, we feed them three times*

a day. We wash them and dress them. However, we have to go back home at night. Sometimes, an older resident leaves the care home or has a fall. For example, in the case of the resident who stayed in the room number one, when the room was being fixed, she opened the door by herself, walked out and was hit by a car. Therefore, we need to limit their space. Their children could provide a one-to-one care. Here, sometimes we have four people who have cognitive impairment in each room. We have to put them together. Sometimes, one resident is playing with their urine while another is playing with their faeces. We cannot clean it immediately at night. We have to clean it later in the morning" (S14).

The quotation illustrates the vulnerability of people with cognitive impairment. Physical and cognitive impairment seem to have a negative impact on older adults particularly when they have multiple health problems and also sometimes when they have cognitive impairment. They need to rely on other people. This may have a negative impact on their self-esteem and self-worth.

Once settled in the home, the effects of having a cognitive impairment can impact on the way some older adults relate with their peers. Komkon, a care assistant who had been working in a care home for over 10 years, illustrated a problem of misplacing belongings of residents with cognitive impairment:

"They usually have a problem with a person who is in the next bed regarding their belongings because old people tend to forget where they place things. Sometimes, they mistakenly use someone else's belongings. Then, they have an argument with each other. This is a main problem" (S08).

In addition, when a resident with mental illness moved to live in a care home they more likely to be discriminated against and be victim of prejudice from other residents. For example, Therapat, a male resident, complained about the problem of residents that he perceived had psychosis:

"What I don't like is the fact that there are many types of people who came to live here. They are from different backgrounds. Some have brain disorders… the place can sometimes be dirty and I have to live with people with psychosis. If I lived outside, I could choose. In here, I cannot choose. That is the role of the staff. That's what I think. But if I don't like it, I will avoid it. If I don't like them, I will not talk to them. I will avoid a person with psychosis" (R05).

The above quotation shows that other residents tended to avoid contact with residents who have mental illness which might lead to increased feelings of isolation for both parties. Another example from Wanna, a

member of staff illustrated the problems between residents with mental illness and their peers.

> *"She has a sign of mental illness but she doesn't want to take any medicines or see a doctor. She is bad-tempered. She likes to threaten to kill her peers but when we asked her about this she refused (treatment) and told us that her peers tried to accuse her. Her roommates could not sleep because she threaten them" (S04).*

This resident refused to be treated for having a sign of mental illness, which may be because she didn't want others to perceive her as someone who has mental illness, which would result in being stigmatised by other residents (public stigma of mental illness). These findings suggest that where residents have cognitive impairment or psychosis, their limited understanding can cause emotional distress and can lead to conflict with their peers while LICH.

6.5.3 People with alcoholism

Older adults who are addicted to alcohol seemed to have a difficulty to adapt to care home life, particularly with their peers. Phadet showed his view on another resident who drank large quantities of alcohol:

> *"One of our residents is drunk all the time. You may have met him today. He is the one who has scruffy beard and very dirty hair. The staff sent him to Ban Matta (It is a residential institution providing temporary accommodation for homeless people) many times but he has not changed.*

When people come to give a donation of 20, 50 or 100 Baht, he will spend the money to buy alcohol" (R14).

The above quotation illustrates that the behaviour of the individual with alcoholism influences the perceptions of other residents. Moreover, Apasara, a member of staff expressed the belief that members of this group of residents have difficulties in adapting to care home life, particularly with rules and regulations of a care home:

"Elderly residents who are physically independent, smokers or alcoholics find it difficult to adapt to a care home life. They tend to create problems and negotiate to get what they want" (S10).

This quotation highlights the issue that people with alcoholism who reside in care homes when they adapt to life in a care home and they are perceived as being problematic by members of staff.

In summary, the nature of the care home population is one of the aspects creating causes of stigma associated with LiCH. Many residents of care homes were vulnerable and more prone to emotional distress and mental illness before being moved or being sent to live in care homes. Moreover, their conditions such as alcoholism, cognitive impairment or psychosis are already stigmatised among the general public, in addition to care home residency. These factors could exacerbate the impact of stigma among this population.

6.6 Attitudes and stereotypes toward older people

Both care home staff and residents themselves expressed negative attitudes and beliefs about older people. These included the belief that older people had high levels of dependence on others that they placed demands on caregivers, they were dirty and smelly and, for care workers, dealing with germs were an inevitable part of working with older people.

6.6.1 Older adults are demanding

Physical and cognitive impairment occurring in old age were associated with greater reliance on others, particularly for residents with health problems. Mookda, a female resident, stated that some of her peers could not autonomously meet their basic needs and they relied completely on care home staff:

> *"The lady behind us cannot get up by herself. She needs help with a shower. She needs someone to pull her up. She is not getting any better since she came four years ago" (R18).*

This example shows that older adults with significant health issues are dependent on others to meet their basic needs. Kittiya, a staff member, also supported the opinion that some older adults are fully reliant on care home staff due to their health conditions:

> *"Some bedridden residents need to be turned every two hours… also changing their diapers every two hours. These could help to protect bedsores. A care assistant would help*

them with everything, such as turning them, hygiene care and feeding them every meal" (S05).

This quotation illustrates that working with some older adults is particularly demanding and needs careful attention, due to functional impairment that makes it difficult for them to maintain their independence, making them vulnerable to accidents. For instance, Urai explained an accident that commonly happened among residents:

"Some older adults cannot go to a toilet by themselves. They need to be assisted by staff, otherwise, they may fall over and may injure their heads" (S18).

Residents with physical and cognitive impairment need to rely on other people for their basic needs, such as hygiene care or having a meal. Some of them with severe health issues need more attention from care home staff, and may even require assistance twenty four hours a day. Sasithon, a care assistant who had worked in a care home for over 10 years illustrated the demands of working for older residents:

"For example, I work in a building of female residents. Some residents urinate or defecate by accident or some residents with cognitive impairment may pull their nappies down. I have to keep an eye on them all the time. It seems like I have to work all day and all night. The job is complex. Some people may not be able to cope with it" (S09).

The above quotation shows that some older residents could not help themselves with their routine lives, as a result of which care home staff had to help them with routine activities and also monitor their behaviours of particularly residents with cognitive impairment. The quotation also points out that the staff member seemed to have a negative perception of this demanding work and this seems to have a negative impact on the staff member. Another staff member who had worked in a care home for over 13 years also mentioned his never ending work when taking care of older residents:

> *"If a resident is wet or soiled, I will give him another shower. I also have to clean the room again" (S08).*

Demands on caregivers were described by care home staff as a never-ending task, or working "24-7", which clearly reflected the issue of the burden placed on caregivers, which undermines QoC (Quality of Care) and which could cause emotional distress among residents themselves.

6.6.2 Dirty work

This study found that some staff perceived that taking care of older adults was a dirty and smelly job. This perception was mainly related to having to deal with older adults' urine and stools. Some older adults had urinary incontinence and they faced the problem of urine leaking. For example, Aroon, a nursing assistant, perceived her work as dirty and smelly.

> *"This work does not sound nice because we have to work with urine and faeces. They are very smelly. The urine from an adult nappy, for example, is really stinky" (S09).*

The above quotation illustrated that the member of staff harbour negative feelings about her work and they clearly resented caring for older adults in terms of dealing with urine and faeces. Some staff found this work difficult and challenging but they made a determined effort to be patient. Kai, a care assistant who had been working in a care home for six years, expressed her negative perception of dealing with urine and faeces even when she was eating food, but she had to be patient about it:

> *"At the beginning I didn't know whether I could cope with the job in a care home having to work with urine and faeces. I was having a lunch break when a resident came in, urinated and passed faeces by accident. At first, I didn't know whether I could cope, but these days I'm used to it. The residents' urine and faeces do not bother me anymore" (S17).*

The above quotation indicates that member of staff have to deal with resident's toilet behaviour. This could make her work with older adults more distasteful. Taking care of older adults entails dealing with hygiene care as a matter of course, including urine and faeces, and some staff expressed the concerns that arise from dealing with germs. For example, Komkon illustrated about his work.

> *"For a lot of people, it is a difficult job. You need to take care of older people. Some may say it's a job which you have to deal with germs. They cannot put up with it. Some started working in the morning and quit in the evening" (S08).*

Staff members themselves perceived caring for older adults to be stigmatised by the public. Some staff also mentioned that working with the urine and faeces of older residents impacted on their physical and mental well-being. For instance, Aroon explained about her job.

> *"It seems like I breathe germs all day collecting them in my body. It has reduced my physical health and well-being every day" (S09).*

The above quotation illustrates that some care home staff find their work very challenging when they have to deal with urine and faeces of residents. They perceived that this can create the issues with their physical and mental health problems.

In summary, caring for older adults is demanding due to the physical and cognitive impairment associated with old age. This affects their independence as they need to rely on others to assist them with routine activities, which is likely to cause experiences of emotional distress whist LiCH. Furthermore, the nature of caring for older adults is stigmatised by the public and particularly among many care home staff in this study, because this type of work requires dealing with residents' toilet behaviours (i.e. dirty and smelly and unclean jobs). This belief may exacerbate the issue of stigma. The dynamics of the process of stigmatisation of LiCH are rooted in public perceptions whereby care homes are generally regarded as undesirable places to live; indeed, as the last resorts of the utterly destitute and abandoned. The dynamic is accelerated by vulnerable populations who are already stigmatised

groups in society and the nature of work perceived as dirty by the general public and many care home staff.

6.7 Care home features contributing to stigma

The study found that care homes offer an environment that is perceived by some residents as being oppressive which may contribute to stigma. This subtheme illustrates that residents shared their negative experiences of LICH relating to the culture and environment of the home, perception and judgment from other residents; and unequal power relations between residents and care home staff.

6.7.1 Culture and environment in a care home

This study found that a care home setting is a closed environment involving two major groups of people: staff and residents. Residents from different backgrounds were admitted to a care home and need to share rooms and common areas with other residents. The majority of residents expressed their perception of a lack of privacy because of communal living and a lack of freedom due to rules and regulations and the features of a care home.

6.7.1.1 Communal living

Nam, a female resident, complained about her roommates' behaviour during the night when she needed to sleep.

> *"For example, at night some residents break wind loudly. Some make loud noises trying to find their medication in a carrier bag. Some cough all night but refuse to take*

medication. Some talk in their sleep. Some take a shower at 2 am. Some try to find their stuff" (R25).

Such erratic behaviour on the part of roommates could clearly impair sleep, and thus result in numerous negative psychological and physical outcomes for residents. Another resident, Mookda, also told the researcher that she had to be patient with other residents' behaviour because she knew that a care home is not her own home.

"Some people may walk loudly or make noises but I don't mind because it is not my home. I have only a bed. I cannot be self-centred" (R18).

The resident had the sense of not belonging here in a care home because of communal living, and there was no sense of ownership of the 'home' among residents. Some residents expressed their experience of frustration and aggression while LiCH, particularly with their peers (e.g. a situation in which some residents with faecal and urinary incontinence did not clean a floor when there was occasional leakage of stool or urine). For example, Kannika, a female resident, told of her feelings of aggression with her peer who did not take responsibility for cleaning.

"I always clean other residents' faeces. When I am tired or unwell, I will ask them why they don't clean their own faeces. I will tell them if they don't wipe their faeces, they will have to lick them off. It is not my duty to clean up. I want to grab their heads and use them to wipe the faeces off the floor" (R19).

The above quotation illustrated issues among residents when sharing the common areas. The irresponsible behaviours of some residents may be because they felt shy and wanted to conceal their problems (faecal and urinary incontinence) from other residents as well as staff members. Consequently, some residents may refuse to take responsible or to clean up after this situation, which is perceived by others as being irresponsible and disrespectful and which was a common trigger for conflict. For instance, Kanta, a female resident, illustrated her experience of seeing other residents having an argument.

> *"Some people are angry and some are also outspoken. They can be impulsive. They don't think before they act. Some cannot control their anger. If someone says anything to upset them, it can end up in a big argument" (R16).*

The quotation illustrates that some residents cannot control their emotions when they are angry, which then increases the likelihood that they will have conflicts or arguments with other residents. The communal life of residents can be an additional cause of stigma which is likely to trigger severe impacts of stigma in general among residents, which can lead to conflict or violence in care homes.

6.7.1.2 Lack of privacy

Lack of privacy seems to be one of the reasons why residents feel stigmatised by LiCH. As the observation data showed that residents needed to share their bedrooms and other facilities with other residents. Some of the residents expressed their feeling of lack of privacy and less

security while LICH. For example, Pang, a female resident, told the researcher that she was scared of another resident who wanted to harm her.

> *"She wanted to injure me but she was moved to another building due to her leg fractures (by accident). I can breathe now. I am more comfortable because I don't need to worry that she will attack me when I am sleeping" (R17).*

The above quotation shows the impact of the lack of privacy when LiCH. Sharing a bathroom and toilet with other residents can cause a problem or conflict among the residents because of the lack of privacy. For instance, Kanta complained about her friends who didn't clean the toilet after she used it.

> *"Cleaning is very important when sharing the facility but they don't know how to clean. E.g. someone used the toilet but they didn't flush after using" (R16).*

The quotation illustrates the problem of cleaning when sharing facilities among residents. This may leave residents feeling stressed and emotionally drained. Another resident, Mookda, cited her perceived lack of privacy when she needed to take a shower. She also explained that older adults who need help from care home staff have to take off their clothes before taking a shower.

> *"I feel embarrassed being naked in front of others. When I take a shower, I have to be naked in the dark. I have to wait*

until its dark. I don't want others to see me naked… If you need help with a shower, you have to take off all your clothes. I feel embarrassed" (R18).

The quotation illustrates the issue of lack of privacy among residents. This can create negative perception of LiCH and may be emotional distress in some older adults.

6.7.1.3 Lack of freedom

The restriction or the rules and regulations of a care home influence how residents perceive their lives. Some residents feel like they do not belong to the home because of the sense of lacking fundamental freedom. For example, Thanawat illustrated how he perceived life outside the care home.

"The life outside a care home has more freedom. I can go out in the night. I can eat whatever I want. If I want to come to visit my friend, I can go. If I want to eat something or go somewhere I can. It is freedom" (R04).

The above quotation illustrates the perception of this resident that life outside the care home is free, which may have caused him to experience LiCH as relatively restrictive. This perception may be related to rules and regulations of care homes, as Somchai, a male resident, stated:

"I am too old, I can live here. If someone doesn't think a lot, they can live here. If someone thinks a lot, they may go crazy… We cannot go outside without inform anyone. If we

want to go out we have to sign our name… we have to inform a member of staff and we have to tell them what time we will be back. Otherwise, they will not let us go. Some people who live here for long time seem to be crazy. Some of them escape from a care home by climbing over the fence" (R15).

The quotation illustrates that this resident felt a lack of freedom when LiCH, which left him feeling emotionally distressed, and he narrated experiences of people literally escaping and absconding from homes. It is likely that the general policies intended to protect residents are experienced by them as being restrictive, and they perceive their lives as being determined by them, without their own decisions or freedom. Some care home staff were also aware of the issue of residents feeling their lives are strictly controlled in the care home. For instance, Kittiya, a staff member, illustrated residents' feelings of LiCH.

"Actually, older adults don't want to come to live in a care home because they have to live with a lot of people and also they have to follow the rules and regulations. They don't have freedom like when they are outside the care home. The care home also has very limited space. Older adults don't have a lot of freedom like when they are in their own community before coming to live in the care home" (S05).

The above quotation shows that the residents' perception of reduced freedom during LiCH is a manifest reality also acknowledged by staff members.

Culture and environment in a care home exacerbate the dynamics of the process of stigma as it grounded by communal living where people need to share facilities with others, in the context of rules and regulations which were instrumental in creating the issues around the lack of privacy and lack of freedom expressed by many residents. These may leave a sense of not belonging among many residents that affect them negatively.

6.7.2 Peer pressure to conform

One possible cause of stigma associated LiCH is the pressure to fit in with other residents. The pressures are the impact of group and ringleader, gossip and monitoring from peer. Participants report that some residents tend to monitor others and make judgements about them. In particular, judgements appear to be made about their faecal or urinary incontinence, their background and the differences in social class, which caused outright conflict between residents and rendered some residents vulnerable to emotional distress, including feelings of shame and embarrassment.

6.7.2.1 Group and ringleader

The study found that because older adults from different backgrounds entered the care home, they tended to gather into cliques of residents with whom they felt rapport. In addition, others who were not included in

these groups made friends with care home staff. There were ringleaders among residents who were more respected, as Kalaya explained:

> *"A ringleader, in this case, is someone who feels that others must listen to her. She is not a bully. Other residents respect her and would like to make sure that she is first to be serviced. The ringleader is always nominated to give a thank-you speech. When she is sick and I need to find someone else to give a thank-you speech to the visitors, other people will be reluctant to fill the role as they feel that it's disrespectful to her" (S12).*

The above quotation shows that a ringleader has influence on how other residents' behaviour when LiCH. Ringleaders by definition influence how residents in cliques behave. For instance, Boonrit told a story when he joined a group of some residents when he just moved to the care home:

> *"When I moved in to the care home, I didn't know about life in the care homes… I liked to follow other residents, I stayed with a group but it was not helpful… When I saw other residents having a quarrel and then they ended up drinking alcohol. Some of them were sent away from the care home. I thought that it is not helpful to have a group" (R11).*

The quotation illustrates some negative behaviours from some members of his group that seemed to influence his emotions. Kalaya, a member of

staff, also stated that a ringleader could have a negative impact on a new resident who just moved to a care home.

> *"Sometimes, when a new resident moved into the care home, the person who acted as a ringleader of the group would boss the new resident around. It made the new resident feel uncomfortable" (S12).*

Group and ring leaders have an effect on the adaptation of new residents when they move into the care homes. It's been suggested as one of the causes of stigma as the behaviour and perceived judgement from other residences could causes negative emotions and behaviours.

6.7.2.2 Monitoring and gossip

Some residents monitored other residents' behaviour and reported what they deemed inappropriate or gossiped with others. This behaviour made some residents uncomfortable and caused them emotional distress. For example, Kanta narrated a story of her peers gossiping about problems of faecal and urinary incontinence:

> *"Some older adults have a problem of faecal incontinence and sometimes it causes them to have a leakage of some urine and stool. Some residents would speak sarcastically to let other residents understand that this person is dirty or nasty… Sometimes they may talk about this story for month and month. It causes that person to be very upset" (R16).*

The quotation illustrates that pressure from peers by monitoring and gossip can cause some residents to feel emotional distress. Such issues were also reported by another female resident, Kannika, who complained about her peers gossiping and about some residents broadcasting details of their urinary and faecal incontinence.

> *"If someone defecates, she will announce it. When X defecated, she told me about it. I don't know why she doesn't make an announcement when she defecates... If someone has a problem, she will keep talking about it all day. She will tell the nursing students and doctors who visit the care home. I told the visitors not to listen to her because she is not mentally stable. She thinks she is good while the rest of us are bad. She always discredits others" (R19).*

The quotations illustrate that the behaviour of gossiping among residents can lead to conflict among them. There was no clear reasons for these negative behaviours, but Kalaya felt that it was due to jealousy of potential favouritism among residents:

> *"When a resident offers to help the staff, other residents may sneer at them because they are afraid that the care home staff will love this resident more than them. They may say it is the care home staff's responsibility and it is not the resident's responsibility. The staff must do the work for them" (S12).*

The quotation illustrates that behaviour of gossiping and monitoring among residents may be related to power relations between staff and residents, whereby residents would like to be favourites among staff, for their own material advantages while LiCH. Negative judgments from peers may exacerbate causes of stigma. For example, Chatchai, a male resident aged 83 years old, felt like other residents looked down on him and his children.

> *"It seems like the residents who live in the care home tend to look down on others. For example, they may say, 'You have a lot of children. Why did they let you come to live in a care home?' I think I am fine here, I don't think like them. That's why I told my children that 'You don't need to come to visit me, I don't want you to feel embarrassed'" (R02).*

This resident had a negative perception toward his peers due to being subjected to their judgments relating to LiCH, and their negative views toward his children, which also caused him to ask his children not to visit, reflecting as well as manifesting the stigma of LiCH related to traditional family expectations in Thai society. This monitoring and peer pressure leads to some residents discouraging visits from family members because they want to protect them from embarrassment due to the social scrutiny of other residents. This then results in residents being isolated from their families, and thus vulnerable to further secondary problems (e.g. social withdrawal and depression).

6.7.2.3 Differences in social class

Residents who live in a care home come from different socio-demographic backgrounds in terms of socio-economic class and regional origins. Therasak, a male resident, illustrated that older adults who live in a care home came from the different areas in Thailand:

> *"Oh, they are from the north-east, the south, the central part and the north – from everywhere. They came from the different places" (R10).*

Another male resident, Therapat, mentioned he used to know one of the residents who was a beggar before moving in a care home.

> *"There is someone. I asked him where he used to sleep before living here. He said he slept at the train station. I asked him where he got the money from. He said he begged. He managed to put himself into the care home because he got all the documents required" (R05).*

The quotation illustrates some older adults were homeless with poor backgrounds before moving to live in care homes. This may be one cause that make residents have difficulty to adapt to each other. Older adults who come from different backgrounds having an issue about adaptation to a care home life with other residents. Therapat also complained about not liking to live with people from different backgrounds:

"What I don't like is the fact that there are many types of people who came to live here. They are from different backgrounds" (R05).

The reasons why residents did not get along together was because of some of their behaviours. For example, Thanason, a male resident, stated that:

"They are too old to change. Their habit when they were home, followed them to the care home. They wanted to do whatever they do when they were at home. Some people (male residents) don't wear a top when they are with their friends. I never act like them. I always wore a top when I was at home. Except when I went to take a bath. There are a lot of issues because we are from different city, districts and villages" (R13).

The above quotation reflects on the differences between the social classes of the residents. People living in a rural area who are uneducated and underprivileged would be topless when they are at home. Kannika, who is Thai Chinese, also explained about her experience of being looked down by other resident because she could not speak Thai properly when she first moved to live in a care home.

Resident: When I first came to live in the care home? I could not speak Thai properly

Interviewer: What do you mean?

Resident: My friend told me that I am a dotty.

Interview: I see

Resident: When I said things, they didn't understand. They told me that I am a retard (R19).

The educational differences among residents are a barrier between peers to adaptation to care home life. Arisa, a female resident who had graduated with a master's degree from abroad, stated that she did not have a close friend in a care home because of different views and behaviour:

"I don't get along with other residents because we have different interest. My thought is different from them" (R28).

Arisa also complained about some residents' behaviours who were not well educated or poor as they did not have any toilet facilities when they were at their home.

"I was so annoyed when I saw some older people who suddenly stand and walk to pee outside near the small garden. They went outside to the small garden, then they sit down and pee. I was so annoyed" (R28).

Furthermore, Komkon, a member of staff, also mentioned that some older adults who came from a higher social status also have a difficulty to adapt to a care home life.

"She did not communicate well with other people. She was a bit aggressive. She said something like her son was rich and in a high position. She didn't want to talk to other people in the care home" (S08).

The above quotation illustrates the differences in social class among the residents. This causes them to have difficulty in adapting into the care home community.

6.7.2.4 Conflict among residents

Residents often have arguments among themselves. Phadet stated that he had fought with another resident who he did not get along with:

"I had a fight with another resident in front of the bathroom when I had been here for a couple of years. I had a problem with a resident who was addicted to smoking and alcohol. We fought in front of the bathroom" (R14).

The quotation illustrates that arguments among residents can lead to physical harm, which may lead them to have some emotional distress and feel insecure whist LiCH. Kalaya illustrated residents' conflict because of their behaviour.

"Some residents want to have their own space. Some like telling people to do things. They act like a staff member. Their peers will not like this kind of person. We wouldn't want our colleagues to interfere with our own business either. We wouldn't want our colleagues to criticise us.

Older adults are the same as us. They also don't like to be criticised. For example, someone might ask why they did not rinse the clothes after being washed. This can lead to a disagreement. It may start with voice raising, followed by physical contact. The staff will have to go and stop them" (S12).

The above quotation illustrates the staff members' view that bossy behaviours or criticising other residents precipitated conflict among them.

In summary, peer pressure to confirm is one of the causes of the stigma of LiCH. Residents tried to adapt their lives to fit in with others, but the impact of group and ringleader social dynamics or monitoring and gossip among residents caused emotional distress or conflict. Judgment from other residents, particularly relating to differences in social class, background and the problem of incontinence, were notably important issues contributing to stigma within homes.

6.7.3 Unequal power relations between staff and residents

This study shows that within a care home, there were only two groups of people - staff and residents - seeing each other on a daily basis. This category shows how unequal power relationships among them are created and how these influence them. These included rules and regulations and power imbalance within care homes.

6.7.3.1 Rules and regulations

Some residents believe that high conflict among residents who live in a care home necessitates rigorous administration to set rules and regulations. Therapat explained the rules and regulations for residents:

> *"There are more than 10 rules for residents in the care home. They are on a display board at the entrance of the canteen… The main ones are no quarrelling, no drinking, and no stealing. Don't lend money to the staff. The care home property must be well taken care of. Don't use the resources wastefully. Smoking is not allowed in a building or in a bedroom. These are the important rules, but there are more than 10" (R05).*

The quotation illustrates the main important rules of the care home that resonate with the conflict triggers emerging from incidents discussed previously. According to the rules and regulations, if some residents break any rules, they have to be punished in numerous ways, as illustrated by Therepat:

> *"If it was not serious, the care home would give them a warning. If it happened again, it would be a final warning. If it happened again for the third time, that person would be sent for rehabilitation at the Social Services' sheltered accommodation. It is different from the care home. It is for underprivileged people. They will be sent there for a month.*

If they refuse to join the rehabilitation programme, they will be evicted from the care home. It's a rule" (R05).

This quotation illustrates that punishments are applied for residents breaking care home rules and regulations. This seems to be a factor creating power imbalance between residents and staff, as residents are essentially a group of people whose behaviour is monitored by staff, and if negative behaviours are detected, punishments are applied to them.

6.7.3.2 Power imbalance

The study found that the rules and regulations and the punishment created power imbalance between staff and residents. Residents consciously know that their behaviour is monitored by care home staff. For example, Sutinan, a male resident, explained his perception of care home staff.

"Care home staff are our boss. They are our boss. They take care of us. If someone does something wrong, they will write a report of our inappropriate behaviour and inform the head of the care home. They are our boss" (R07).

This resident felt that care home staff have more authority than residents due to their roles regarding caring and monitoring, indicating both positive and negative perceptions. Another resident, Therapat, mentioned his peer's experienced of lending money to staff.

"There was an incident involving a staff member who kept borrowing money from a resident. The resident felt he

couldn't say no, and he lent some money to that staff member. When the resident was short of money and asked for the money back, the staff member refused to pay his debt" (R05).

Therapat explained that the resident could not refuse to give money to staff because he was afraid that he would not get a good care in the future:

"If he didn't let the staff borrow money, he was afraid that he wouldn't receive a good service from the staff. I'm talking about a junior staff member here" (R05).

Clearly this amounts to extortion. Residents are aware they are obliged to obey the rules of a care home. For example, Kalaya requests residents to come to participate in social activities when visitors come.

"I also told the residents that when we have visitors, the residents must come in the canteen to meet the visitors. They have to talk nicely with the visitors to make them feel welcome and want to come back again" (S12).

The quotation illustrates that residents have to obey rules and regulations of the care home, including compulsory participation in care home activities such as public visits by potential donors. As a result, residents may perceive that they should not suggest anything or voice their opinions whist LiCH. An example of this was evident when the researcher asked Pang that how she would improve the home, and she replied:

"It depends on the staff. I cannot express any opinion. I have to follow their rules. It depends on them" (R17).

The quotation presents her perception that as a resident she had no power to suggest any improvements for her own life in the care home: her task was simply to obey the rules and regulations.

In summary, the rules and regulations of care homes were instituted to protect residents and staff members and developed in response to negative previous incidents (e.g. quarrelling and fighting, stealing or gambling). This suggests that care homes are latently prone to conflict, which is understandable given the nature of the institutions (e.g. many generally unwilling and stigmatised individuals dwelling in common facilities within close proximity), which is affected by the dynamics of the process of stigma rooted in general social attitudes, such as negative beliefs about care homes and the nature of care home populations. In addition, there are many features of life in care homes that exacerbate the impact of stigma among residents. Stringent rules and regulations are perceived by many residents to be an additional causes of stigma, mainly experienced in terms of a disempowering power imbalance between themselves and care home staff. Residents learned to calibrate their voice regarding life in a care home according to this imbalance.

6.8 Staffing inadequacies

Staff issues were expressed by staff and residents relating to stigma in terms of understaffing; high workload, burnout and stress; negative job

attitude and low motivation; lack of knowledge and training skills; lack of teamwork and communication among staff; and elder abuse and neglect.

6.8.1 Understaffing and high workload

Care home staff expressed the problems of understaffing at the care home, which obviously increased their workload and led to burnout and stress, particularly among care assistants. For instance, Komkon who had been working in a care home for over 13 years told the researcher about an issue of understaffing:

> *"Care assistants told the head of care home that they could not cope with the workload because they didn't have enough staff members to take care of an increasing number of residents. Many care assistants have resigned" (S08).*

Working in a care home is intrinsically demanding, which is compounded by understaffing, causing stress and burnout, particularly due to demanding shifts such as early starting times. Komkon illustrated this:

> *"If I work in the male patient room, I need to start working at 4 or 4:30 am. I turn on the hot water and need to wait for 30 minutes for the water to be ready. Then I give the patients a shower. There are three care assistants at the moment. Each care assistant looks after five patients. If a care assistant is absent, we will have only two staff members" (S08).*

Komkon also mentioned that he had to look after a high number of older adults:

> *"In here, we don't look after only one person. Each staff member looks after 10 residents" (S08).*

The quotation illustrates the understaffing issue in care homes as perceived by members of staff, which may cause of burnout and stress. For instance, Chanchira, a member of staff who worked in the care home nearly 30 years, explained a feeling of discouragement whist working in care homes.

> *"Sometimes, I am bored. My work has to deal with many people… I am bored in general. I am bored of the atmosphere… In the past, I wanted to resign from the work but I didn't know what I was going to do. That's why I continue working in the care home" (PS002).*

The quotation illustrates that Chanchira perceived discouragement in her career working in a care home. Her issues may be related to the problem of understaffing, high workload and boredom.

6.8.2 Negative job attitude and low motivation

Some members of staff felt a negative job attitude and low motivation to work in care homes. For instance, Komkon stated his low motivation of working for residents:

> *"I think they* [the general population] *look down on care assistants. They look down on people who work in a care*

home. They think we work with germs… It makes me feel discouraged" (S08).

This quotation illustrates a lack of motivation among staff due to the low status accorded them in Thai society. The nature of work whereby staff need to deal residents' toilets behaviours may be related to negative attitudes about the work. For example, Aroon, a nursing assistant, found her job very challenging and she felt stigmatised.

"Working in care homes is hard work. Oho, the job is not delightful and nobody wants to do this job. Only a small number of people are working for this job. Many people resigned from this work. They could not be patient about the work" (S09).

The quotation illustrates working in care homes is perceived to be very distasteful by staff themselves, and the participant alluded to high staff turnover, which is often an indicator of lower QoC. Another staff member, Wipada, illustrated why she had low motivation in her current job when the researcher asked her about how she felt about her work situation.

Interviewer: What were your expectations when you started working in a care home?

Staff: When I first came to work in the care home. I would like to use my knowledge in counselling to help the residents to solve their problems, particularly their psychological issues and their adaptation to a care home

life. However, after I have been working here, I found the job is far too challenging for me. It made me feel like I have failed. I am not happy with the job. Actually, I want to resign from my work every day (S06).

The quotation illustrates that various issues in care homes affect the personal attitudes of staff members, leading to higher intention to leave the profession. Furthermore, Wipada told the researcher that if some staff members have no motivation about working, this will obviously have negative impacts on the QoC they subsequently provide to older adults.

"When staff members are not motivated, they do not care about their job. Their lack of motivation affects the residents directly. The residents are not well taken care of" (S06).

The quotation indicates the impact of lack of motivation on staff members' job performance, which directly affects older adults receiving care from them.

6.8.3 Lack of knowledge and training skills

Lack of knowledge and training skills among care home staff can be a risk to the physical and mental well-being of older residents. For instance, Kanta complained about the lack of knowledge and training in skills among care home staff with an example:

"I want the staff to have more psychological knowledge. When a resident is unwell or not being able to stand or balance herself, the staff must not demand that she do an

activity or walk. If a resident is unwell, the staff should not let her walk. I am afraid that a resident may fall over when she walks. The staff should know how to assess the resident's wellbeing" (R16).

The quotation illustrates poor training of health assessment among staff, which might affect the physical and emotional wellbeing of residents. The problem of lack of knowledge and training skills among staff was also expressed by staff themselves; Wanna, a nursing assistant, expressed her stress because of lacking knowledge and skill:

"When a resident is unwell, the staff will ask me, a nursing assistant, to examine the resident's health. I am not a qualified nurse. I don't have knowledge of nursing. Sometimes, I feel that the resident is fine, but I end up going home worrying if her condition gets serious, and she may be dead in the morning because I didn't take her to the hospital. I would feel so guilty if it happened" (S04).

The quotation presents a lack of training skills of health assessment of the nursing assistant, which caused her to feel anxious due to unforeseen circumstances that may happen after her work.

6.8.4 Lack of teamwork and communication among staff

One of the staff issues is lack of teamwork and communication among staff. Warunya, a care assistant explained about this issue:

"The staff members in the care home do not care about others. They don't have empathy. They don't work as a team. They never share. They are selfish. I cannot trust them" (S01).

The social communities of the care homes in this study seemed not to be conducive to professional rapport and mutual support. Another care assistant, Choopoo, gave an example of how she felt working in a care home:

"After I worked here for two years, I wanted to resign. I knew some of the staff before I started working here, but after I started working here, they ignored me, pretending they didn't know me. They never take care of me. The work culture in the care home is different from other workplaces. Everything is so different here" (S14).

The quotation illustrates poor relationships among care home staff perceived by the individual, and this negative attitude of working was linked to a lack of inspiration of working in care homes, which may be detrimental to QoC.

6.8.5 Inadequate care

The study suggested that the staff issues, particularly the underlying problem of understaffing; high workload, burnout and stress; negative job attitude and low motivation; lack of knowledge and training skills; and lack of teamwork and communication among staff have negative impacts on

older residents. For instance, Warunya illustrated the negative care receive by older residents:

> *"Some care assistants don't give a refreshment or water to the residents in the patient room because it makes the residents urinate or defecate more often. Some care assistants give them only rice (main course)" (S01).*

The quotation indicates that residents received poor care from some of members of staff, which may be related to the previously discussed issues of high workload and understaffing. Furthermore, Warunya also explained how residents have been treated by some irresponsible staff.

> *"They are not willing to work for older residents. For example, when the residents are having a meal, some staff collect the plates and clear the tables even before the residents finish the meal. They don't pay attention to how the residents have a meal, whether a spoon is provided, or to help removing the bones from the fish fillet. Some older adults cannot feed themselves very well and they may need some assistance when eating. Some staff only want to collect the plates and clean the room. They never care whether the residents have had enough food" (S01).*

The quotation presents how a negative attitude toward working effected poor QoC provided by some members of staff, who should be more sensitive while working with a vulnerable group of people who need more attention and compassion from professional caregivers.

In summary, various issues regarding staff have been found to be additional causes of stigma associated with LiCH. The dynamics of stigma appear to manifest due to the negative public view of care homes, older adults residing in care homes and old age. These beliefs were internalised by some older adults who moved into care home facilities. Their stigmatised beliefs and perceptions were exacerbated by the features of care home life, such as culture and environment, peer pressure to conform, power imbalance of residents and care home staff, and the issues of inadequacies regarding staffing. They all have the potential to impact on the negative emotions and behaviours of the residents who perceived stigma of LiCH.

The next chapter of the thesis continues with the other aspects of a process of stigma: the manifestations and the mitigating factors of stigma. Moreover, this chapter also seeks to illustrate the dynamics of the process of stigma by using case studies of residences who experienced a varying degree of internalised stigma associated with living in a care home.

Chapter Seven: The Process of Stigmatisation (Manifestations and Mitigating Factors)

Element 2: Manifestations of Stigma

The participants in this study seemed to suggest that stigma associated with LiCH manifested itself in numerous ways. In particular, it had an influence on residents' emotions and behaviour.

7.1 Negative emotional reactions

The study found that residents experienced negative emotions while LiCH, including feelings of abandonment and lack of worth; failure and disappointment; loneliness; self-blame; shame and embarrassment; low self-esteem; hopeless and helpless; and depression and suicidal ideation.

7.1.1 Feelings of abandonment and lack of worth

Some residents expressed their feelings of having a lack of worth with regard to their families. For example, Therapat described how he felt about being placed by his off-spring:

> *"The fact that my child put me in here has an impact on me. There is no love and warmth here. I feel unworthy because my child can look after me, but she chose to put me here" (R05).*

These feelings might have been reinforced by the perceptions of members of staff. For instance, Darunee, a care assistant, illustrated her feeling of working in a care home toward older residents.

> *"Sometimes, when I see the residents' relatives coming to visit them in the care home, I wonder why they do not come to pick their parents up and look after them" (S20).*

The above quotation illustrates that some care home staff themselves also believe that taking care of older adults should be a role carried out by their children. Komkon told his experience of seeing residents who were literally abandoned by their children.

> *"When I first started working here, I saw somebody abandon his mum. He left his mum in the care home. He drove a Mercedes Benz car. His mum was running after his car like a child. We had to stop her. Three staff members tried to hold her. She wanted to follow her son" (S08).*

The above quotation illustrated how some older adults in this study expected that their children should take care of them, not leaving them in a care home. This could lead to the expression of negative emotions. For instance, Chachira, a nursing assistant, explained why some residents who felt abandoned expressed such emotion.

> *"They are hurt because their children did not take care of them. Some residents who were dying cried because their*

children didn't come to look after them. They saw only staff who looked after them" (S02).

The above quotation shows that many members of staff perceived that many residents have been abandoned by their families and relatives. Kalaya described that LiCH can be viewed as source of feelings of lack of worth in the eyes of the public.

"Some people may think that these older adults who don't live with their families have no dignity" (S12).

Where family members did not visit the resident, members of staff perceived that the residents had been abandoned by their families and relatives. For example, Nittaya stated her perception toward residents' children.

"They may be afraid that we will have a negative view of them and wonder why they don't take care of their own parents" (S07).

In addition, another staff member, Aroon, described a situation where relatives pretended not to be related to the resident to avoid feeling judged by members of staff:

Staff: Some residents didn't want to live in a care home but their families brought them here. When we asked about their relationship with the resident, they didn't tell us that they were the resident's children. They told us that they were neighbours.

Interviewer: Why did they not tell you that they were the resident's children?

Staff: I thought they might be ashamed of themselves having to let their parents live in a care home. However, they looked so similar to the resident. They could be relatives, children or cousins. They looked very similar but they told us that they were not related. We had to listen to them (S09).

The study shows that stigma pervades the whole context of residency, for professionals and family members as well as residents themselves, with numerous negative emotional influences, particularly the feeling of abandonment and lack of worth.

7.1.2 Loneliness

Some older residents' experience of loneliness while LiCH, as noted by Tangkwa, a female resident (who subsequently passed away three months after the interview):

"Sometimes, I felt lonely and isolated" (R12).

Isolated environments stimulate feelings of loneliness. For instance, another female resident, Sai, illustrated her experience of her roommate who felt loneliness because of missing her family.

"She cannot sleep because she misses her children. She talks about her children most of the time" (R30).

The quotation illustrates loneliness leading to the negative impact on residents' health and wellbeing. Jinda, a female resident, supported the idea that older residents felt loneliness because of not having visitors during LiCH.

> *"There are a lot of people who don't have any visitors. They feel lonely. They may wonder why they don't have any visitors. Throughout my time here, I witnessed about 20-30 residents who never had any visitors until the day they died" (R20).*

The above quotation suggested that many residents had no visitors at all during their whole LiCH experience. This may be related to stigma by association where residents' families or friends feel shame to visit the care home as they may be seen as irresponsible people by other people, particularly members of staff. Care home staff perceived that residents feeling of loneliness was directly related to missing their families as well, as Dokruk, a nursing assistant stated.

> *"They miss their families, don't they? They must have thought about their grandchildren" (S15).*

Residents' relationships with their own families seemed to play a very important role in their emotional wellbeing. Kai, a care assistant, supported this.

> *"They spend most of their time looking at the entrance of the care home. They look forward to seeing their children walking up that road. They are lonely" (S17).*

The above quotation suggests the personal opinion of a care assistant regarding residents' children. Living separately from their families seems to stimulate residents' emotional distress. Another staff member, Warunya, emphasised that LiCH makes residents feel very isolated from their families, and some of them would like to have end of life care with their families in their own homes.

> *"They want to go back home. They want to see their children's faces. They want to die at their own homes" (S01).*

Interestingly, another staff member, Apasara, suggested that there were reasons for optimism and enjoyment about LiCH, but their depressive symptoms led to feeling loneliness:

> *"Older adults who don't have their own homes should be happy about living in a care home. However, when they moved into a care home, some of them felt lifeless. They seemed so lonely" (S10).*

Many residents seemed to experience loneliness during living in the care homes, related to being isolated from their families and rarely (or in many cases never) receiving any visitors, which is related to the manifestation of stigma by association (as discussed previously).

7.1.3 Failure and disappointment

Some residents expressed their feeling of failure and disappointment about themselves in the eyes of others who live outside, particularly their families, friends and communities. For example, Jinda told the researcher how her relatives reacted when they knew that she was LiCH.

> *"They look down on me. They think that I don't have anywhere to live because I cannot work anymore" (R20).*

This dimension of LiCH as a manifestation of material poverty (and thus of disgrace) was particularly acute among male residents. Another male resident, Therasak, explained his perception of LiCH.

> *"I cannot work like others. I cannot earn money like others. I have my own house but I don't have anybody who can take care of me. These are my shortcomings. I cannot work anymore" (R10).*

This resident compared himself with others in a better position than him in some aspects, which may leave him vulnerable to emotional distress. The feeling of failure and disappointment caused resident to feel unhappy while LiCH. For example, Therasak complained about feeling deprived.

> *"I am not really happy because I feel I'm deprived of so many things" (R10).*

Negative beliefs about the implications of care home residency had a major negative influence on the emotions of residents.

7.1.4 Self-blame

Another negative emotion that related to failure and disappointment associated with emotional abuse, particularly self-blame. Some residents expressed the feeling of self-blame of LiCH e.g. Nam, a female resident, expressed her self-blame.

> *"I should not have been extravagant in the past. If I had not been extravagant, I would have had a house. My father worked as a government officer. If I had not been extravagant or gambled, I would have had some savings. I should not have behaved like that. I would have had a house. I had a high salary. I could afford to buy a house but I didn't buy one. I had to ask for help living in a care home in the end. I should not have behaved like that. I am disappointed with myself. I would have had a house. I would have been happy. I am disappointed with myself and my life in the past" (R25).*

This resident blamed her behaviours in the past for leading her to LiCH. This perception about herself may leave her with a feeling of a lack of self-worth, failure and disappointment. Pang also stated her feeling of blaming herself related to LiCH.

> *"Some people said that if the residents had been good to their families, their families would not have let them LiCH. It was mentioned that a nice person would be able to live with their family and would not have to end up here. It has*

been generalised that a good person will not end up in a care home" (R17).

This resident pointed out that poor relationships between residents and their families may be related to residents' negative behaviours, which consequently cause them to be unable to live with their families and thus they are sent to care homes.

7.1.5 Shame and embarrassment

Many residents felt shame and embarrassment about LiCH. For example, Boonrit, a male resident, stated that

"The reason why it was difficult for me to decide to live in a care home because I felt ashamed of living in a care home. My understanding about a care home is that it is a place for people who cannot work anymore. That's why I feel ashamed of living in a care home" (R11).

Negative beliefs about care homes cause such feelings of shame and embarrassment among residents. Another male resident, Therasak, illustrated that he also does not want anybody in his community to know that he is LiCH.

"Hmm, No, I don't tell anyone. When X [name of a resident] *went back home, I told him not to tell anybody that I am living here. I repeated not to tell anyone. When I came here I didn't tell anybody. I also told my daughter not to tell anybody that I am living here" (R10).*

The feeling of shame and embarrassment of LiCH led older residents try to hide and separate themselves from society. Care home staff are aware of the feeling of shame of some residents and they attempted to accommodate this social anxiety. For example, in situations where residents may be exposed to the public, such as through television or newspaper reports, some residents would avoid talking to journalists and tried to avoid encounters with visitors and residents during such events. As an experienced member of staff, Kalaya, illustrated:

> *"When we take the residents on a trip, she will wear different clothes from the others. They can wear whatever they want. She will stay away from other residents. I was told that she said she didn't want to appear on TV. She didn't want to talk to the journalists. She didn't want her children to see her. She refused to meet her children when they came for a visit. What is obvious to me is the way she dressed. Most of the residents will wear a sarong with a nice blouse. She will wear trousers. We let her wear whatever she wants… She may think that if she meets someone who knows her and realises that she lives in a care home, she will not feel comfortable. She doesn't want to be seen as a person who depends on social services" (S12).*

The quotation illustrates feeling of shame and embarrassment toward the outside world felt by many residents. It is likely that

some residents feeling shame of LiCH would act differently from the generality of residents when they feel they are under public scrutiny, even in terms of trying to disguise their identity as care home residents by dressing differently. Furthermore, they generally avoided appearing to the public.

7.1.6 Low self-esteem

The findings show that stigma associated with a care home influences feelings of low self-esteem among residents. For instance, Thanawat stated how the negative, stigmatising view of "other people" influenced him and persuaded him he was "useless."

> *"Other people's view influences how I feel. I have low self-esteem. I feel I am useless to end up living in a care home" (R04).*

This quotation illustrates that public stigma associated with LiCH affects the resident's view himself. This causes him to have low perceived self-esteem and a lack of self-worth, which is associated with the psychological symptoms of depression. Thanawat also stated that:

> *"Older residents feel disappointed that other people look down on them. They may feel they are useless because they live in a care home. That's how they feel" (R04).*

The above quotations suggest that some residents feel low self-esteem of LiCH making them feeling useless. Evidently many older adults had internalised negative beliefs and perceptions of LiCH to the extent that it

made them highly vulnerable to emotional distress, depressive symptoms and poor mental health (which are generally associated with impaired physical health as well).

7.1.7 Hopeless and helpless

The study demonstrated that older adults perceived their condition of LiCH to be hopeless and helpless, as expressed by Tangkwa:

Interviewer: What do you often think about?

Resident: I only think one thing.

Interviewer: What is it?

Resident: Dying.

Interviewer: How do you think about dying?

Resident: I think when my time comes, I will have to go.

Interviewer: Do you have anything else on your mind?

Resident: No (R12).

The above quotation shows that some older adults do not have any hopes or aspirations and are simply waiting to die. When the researcher asked residents about hoping for something, most residents replied they did not have any wishes for their futures. Therasak expressed such sentiments.

"I don't wish for anything because I am too old to wish for anything. If I leave the care home, what am I going to do?

How can I earn money? I cannot work. I wouldn't even get a job doing the washing up" (R10).

Another female resident, Mookda, supported this position:

"I don't have any wish. I don't think about anything. I just live from day to day" (R18).

Therapat, a male resident, explained the reasons of residents' feeling of hopeless and helpless from his experience of his peer:

Resident: There was one (resident) who was a retired colonel. He had children but when he was sick nobody came to visit him. He was not sick [i.e. not seriously ill]*. He had a herniated disc.*

Interviewer: I see.

Resident: He could not walk. He had a massage but he still could not walk. Then he was moved to the patient room and he passed away soon after. He died from grief.

Interviewer: Hmm?

Resident: He looked healthy but I think he died from grief.

Interviewer: What sort of behaviour did he show?

Resident: Clearly, he was depressed. When the staff brought him outside from a patient room to get some sunshine,

Interviewer: Hmm?

Resident: He was gloomy and he didn't eat. That's my observation.

Interviewer: Ok.

Resident: He was so sad. If I were in that situation, I would be the same as him…because it was not a severe disease. It was just a herniated disc (R05).

Therapat illustrated that some older adults were depressed because of feeling isolated or being abandoned by their own families. He also indicated that symptoms of clinical depression tend to exacerbate the severity of physical illness.

7.1.8 Depression and suicidal ideation

Many participants had experiences of depressive symptoms and suicidal ideation, related to the way in which they perceived care homes as depressive and isolated environments, separated from their families and loved ones. Nittaya, a nursing assistant who worked in a care home for over 15 years, explained that:

"Some residents don't talk about their families. They started developing depression after having lived here for some time. They are depressed because their children have left them here and rarely come to visit or never visit them at all" (S07).

The quotation presents that experiencing depressive symptoms seems to be associated with a group of residents feeling abandoned by their children. Urai affirmed that depression among residents is related to the perception of being abandoned by their children:

> *"Residents with depression are absent-minded. If they think of many things, they will sometimes forget things. I asked them 'How are you?'. They replied that they missed their families. They also were more depressed when they saw other families visiting other residents… they must think about why they didn't have any visitors. I asked them and they told me that they miss their children when they saw other people visiting other residents" (S18).*

The quotation supports that some residents feel depressed because of feeling of abandoned and isolated from their families. Some residents are also aware that some residents have signs of depression. For example, Therapat explained his observation of his peers who passed away due to having depressive symptoms.

> *"He died from grief. He looked healthy but I think he died from grief… Clearly, he was depressed. When the staff brought him outside from a patient room to get some sunshine, he was gloomy and he didn't eat. That's my observation. He was so sad" (R05).*

Physical and psychological symptoms of depression were found developing among some residents. For example, Sai, a female resident,

explained that her roommate had insomnia due to thinking about her children.

> *"She couldn't sleep at night. She told me every day that she is thinking about her children… She sometimes is anxious. She told me her troubles. I said to her that 'you should get to sleep and shouldn't think of any things'" (R30).*

This resident showed some signs of depression such as feeling anxious in association with sleep disturbance. Sleeping difficulty was found to be common among residents with signs of depression. For example, Gam, a female resident, expressed her physical symptoms of depression related to finding it difficult to fall asleep at night.

> *"It's because I think of many things. My mind is wandering off. If I don't think about anything, I will be fine but when I think, I will feel very dizzy and feel like my head is very heavy. When I walk, I feel like I will fall over" (R01).*

This resident showed some symptoms of clinical depression that disturb her daily life. Gam also mentioned how her mood changed and she disclosed that she had suicidal thoughts:

> *"This morning I was worried too. I wanted to commit suicide…I don't have a lot of money. I cannot visit my children and grandchildren. I want them to come to pick me up from the care home" (R01).*

The quotation illustrates suicidal ideation of the individual that it is likely to present with her depressed mood and isolated life from her family. Depressive symptoms seem to be prevalent among residents living in care home, which was found to be linked to the issue of isolation or being abandoned by their families.

In summary, the findings illustrated negative emotional reactions among residents, influenced by stigma associated with LiCH. This illustrates the dynamics of the process of stigmatisation when it is manifested. These could be measured and observed by participants, including care home staff and residents. The sense of abandonment and lack of worth, failure and disappointment seem to suggest that residents continue to reiterate the internalised, stigmatising perceptions about LiCH that they held prior to coming to live in the homes. Some residents developed psychological symptoms of depression such as frustration and aggression; low self-esteem; hopelessness and helplessness; depression and suicidal ideation. In addition, perceived stigma, such as shame and embarrassment of LiCH, exacerbated the condition of depressive symptoms.

7.2 Negative behavioural responses

Another observable aspect of manifestations of stigma presented by the findings was negative behavioural responses. Residents and staff described residents' experiences of negative behaviour associated with LiCH, including avoiding contact; isolation and social exclusion; conflict, violence and crime; and suicide.

7.2.1 Avoiding contact

Some residents in the study tried to keep away from others whilst LiCH. For example, Aum, a female resident, stated her perception of other residents as being belligerent:

> *"All older residents tend to brawl a lot. As you can see, I don't talk to anyone much. Even when they ask me to join them for lunch, I don't like it. I like to have a meal on my own" (R21).*

The quotation illustrates negative attitudes toward other residents experienced by the individual that caused her to withdraw and separate from others. Another male resident, Apisit, told the researcher about how the negative behaviour of his peers made him avoid their company:

> *"They say whatever they like. That man, for example, is very direct. You cannot believe what he says. You don't know whether it's true. That's why I don't want to talk to anyone or be close to anyone" (R09).*

The behaviour of avoiding contacting with other residents was systematic among members of the care home community. Sirada, a female resident, stated how she adapted to live in the care home community by not interfering with others.

> *"I know the system. I know what older people are like here. I try not to interfere with anyone's business" (R23).*

Many residents tried to keep away from others. This behaviour may be because they try to avoid conflict with others who could cause some punishments to be applied to them when it is happening, and this also may lead them having some emotional distress. Fang, a female resident, explained that she liked to stay away from others.

> *"I like to sit alone. I don't want to listen when they have argument. I will walk away. I try to not be closed to some residents who had a quarrel problem" (R24).*

The quotation illustrates the avoiding behaviour of the individual and it is likely that she didn't want any issues caused by conflict with other residents. This was supported by Therapat when he explained how he tried to prevent conflict with others.

> *"I try to avoid causing a problem. I don't talk much. I don't hang out with a lot of people. I talk only about certain things. I try to avoid a conflict. I will not talk much with others" (R05).*

Avoiding contact with others seems to be a common tactic used to prevent conflicts and other issues in care homes. Another resident, Sutinan, explained how he behaved when he tried to avoid conflict with other residents.

> *"I would walk away from them. If I don't do like this, we will end up having an argument. I may be the person who is at fault and be punished. I let them loud. I will stay quiet. I*

accept to be a loser. I let them shout at me. I am old. I don't want to flight with anyone" (R07).

This resident avoided having any conflicts with others that could have negative consequences for him, even if this would leave him feeling some emotional distress. Being in a care home is a good position for some residents who had hardships in their life prior to LiCH. For example, Pang illustrated how she avoided contact with others.

"My life was laborious. I can tolerate living in a care home. If I see some bad things, I will stay away from it. It will keep me safe. If someone speaks poorly, I will walk away from them" (R17).

This resident was concerned about security issues whist LiCH. Therefore, she stayed away from others to avoid conflicts with them. Avoiding contact appeared to be a cultural behaviour some participants adopted within the care home in order to avoid becoming embroiled in conflicts with other residents. This may be related to the hierarchy of the population who LiCH and the institutional rules and regulations, whereby many residents tried to avoid involvement with any conflicts due to punishments that may be applied to them. This negative behaviour could be an additional cause of stigma exacerbating the negative culture of stigmatisation in care home communities.

7.2.2 Isolation and social exclusion from the outside world

The study found that older residents illustrated their feeling of isolation or social exclusion from the outside world while LiCH. Some choose to be

isolated from the outside world because of conflict and shame with their own families, such as Therasak feeling isolated himself from his family and community.

> *"I don't want anyone to know. I don't want them to know about my life. I don't want my siblings to visit me. I don't want to have anything to do with anyone. I've made up my mind. I am not related to anybody. I ignore it" (R10).*

The quotation illustrates isolated behaviour from the outside world experience by the individual. Another example was Fon, a female resident who decided to move into the care home to be away from her family.

> *"Since I moved in to the care home, I have never contacted my family. I don't want them to know where I live" (R27).*

The above quotation illustrates the active, self-initiated social exclusion of the resident. It is likely that she would like to exclude herself from the family. This may be related to the issue of conflict within the family, causing her to separate herself from the outside society. Isolation behaviour and social exclusion were observed by Wipada, a member of staff who was obviously aware of this issue:

> *"Sometimes, they don't talk with anyone. They will isolate themselves. They stay quiet" (S06).*

Another member of staff, Kalaya, remarked upon such isolation behaviour among some residents despite the presence of numerous social activities in care homes.

> *"If there is an activity, she will ask to leave the group. She once said she felt dizzy. But I knew that she didn't want to participate in the activity. If I told her to take part, she would just come and sit. I don't want to bother her much. If she wants to go out, I will allow her to do so. I understand how she feels. Some people don't want the society to know that they live here. It is their right. I don't want to force them. I want them to be happy here" (S12).*

The above quotation reflected that staff members were aware of some residents trying to separate themselves from others and to live in isolation, which has obvious negative implications for psycho-social health. However, they did not feel justified in interfering in such behaviours and viewed them as the prerogative of residents. This behaviour was observed by their peers such as Thanawat, who are aware of their negative behaviours:

> *"They don't want to join any activities e.g. singing or dancing. They will sit with an unhappy face and prefer not to participate in any activities. They may place their hand on their forehead. Sometimes, they sit in the corner. They want to leave this place. That is how they behave" (R04).*

The quotation illustrates isolation and social exclusion of some residents. This shows some residents would like to separate themselves from the outside world, which may be relevant to the impact of stigma, as stigmatised people evince negative behaviours such as excluding themselves from the outside world.

7.2.3 Conflict, violence and crime

The study found that living in an isolated environment like in a care home can lead to conflict among residents. Wanna illustrated one resident who was moved into the care home because of her conflict with other residents.

> *"She used to live in X care home. She is bad-tempered. She bit off another resident's ear. That's why she was moved to this care home. It was hoped that she would improve. After she had been here for a while, she started to act like a ringleader, e.g. she doesn't allow anybody to use a toilet that she claims as her personal one. She claims she is the only person who can use it. She says if someone else uses it, it will be dirty" (S04).*

Conflict among residents can create violence among them. For instance, Areeya, a staff member, illustrated a case of violence between a general resident with a resident with cognitive impairment.

> *"A staff member saw that this resident* [X] *hit another resident with a handheld fan because that resident shook the door and she said it was noisy. A staff member warned*

her about her behaviour. The staff told her not to hit another resident. Then she stopped doing it for a while. Then she hit that resident again at around 2 to 3 am. Other residents woke up and heard the noise. Some who were at the visitors' areas saw that she used a broom to hit that resident (with cognitive impairment)" (S11).

Such episodes of physical violence are essentially criminal actions, for which the care home itself (as well as perpetrators) may be liable. One particularly case involved one resident, an ex-convict, assaulting another one, a retired police officer, in a frenzied knife attack:

"They had a fight outside the building and it was not enough. They continued the fight in the building. The ex-prisoner stabbed the retired police officer with a knife at the stairs of the male accommodation. He fell off the stairs" (S08).

The quotation illustrates an incident of violence that happened in the care home due to conflict among residents, presenting the severe impact of stigma exacerbated by various factors of culture and the environment of care homes, such as communal living or different social classes (one of the parties to the conflict was an ex-prisoner and the other was a retired police officer).

7.2.4 Suicide

There was evidence of some older adults committing suicide while LiCH, as in the following narration from a member of staff, Metha:

"He came from Ban Metta. He normally sat by himself and was not interested in anybody. Sometimes, he talked to himself. One day he tried to hang himself in a bathroom but it was not successful. He died from a drug overdose. I am not sure when he died because at that time I resigned from the job here. When I returned to work again, he was gone. A lot of the residents here suffer from depression" (S03).

The motivations of suicides are complex and multifaceted, but the allusion to loneliness and social withdrawal associated with depression rings true for a large proportion of care home residents, and for suicide in general. Therefore, social exclusion behaviour could increase the risk of suicidal thoughts.

In summary, the qualitative findings suggest that stigma associated with LiCH is a process which involved the causes of stigma, manifestations of stigma and mitigating factors of stigma. Residents who perceived a stigma of LiCH demonstrate their negative emotional reactions e.g. feeling of abandonment and lack of worth, loneliness, failure and disappointment, self-blame, shame and embarrassment, low self-esteem, hopeless and helpless and depression and suicidal ideation. Moreover, the manifestations of stigma could be observed by their negative behavioural responses e.g. avoiding contact among residents and others; isolation and social exclusion; conflict, violence and crime and in the worst cases, suicide. These manifestations of stigma can also become an additional cause of stigma whereby it exacerbates the

impacts of stigma toward the stigmatised group e.g. people isolate themselves or become violent and be perceived as a problem who everyone else avoids. These manifestations of negative behaviours of these residents can become causes of stigma.

Element 3: The Mitigating Factors of Stigma

Although residents expressed their negative emotions and behaviour during LiCH, various factors helped them cope with their negative perceptions of their status, including social support, coping strategies and activities.

7.3 Social support

The main factor that helped residents cope with stigma during LiCH is social support. The source of support included from family; friends and peers; care home staff; and ordinary people.

7.3.1 Family

The source of support that most of resident received from their families was money (financial assistance), which helped them to live their daily lives. Pang mentioned that her children financially support her.

> *"My children are good. They send me 1,000 baht every month. My grandchild also gives me 500 Baht. I donate the money to make merit (in charity)" (R17).*

The quotation illustrates that financial support from children causes the resident not to feel abandoned by her children, even when they only visited her a few times a year. Therapat did not have any visitors since he moved into the care home over five years previously, but he did not feel abandoned because he received financial support from his daughter.

"I understood what she meant because she is busy with her job, and she also lives in Lampang, which is far from here. If she comes to visit me, it will take her a day and a night to travel and she will need to take time off work. That's why I think she does not abandon me because if she had abandoned me, she wouldn't have sent some money to me every month" (R05).

However, Kalaya suggested that to prevent depression among residents they should spend more time with their families, and indeed it was overtly stated that they would be in better condition if they lived with them.

"Actually, it is best for older adults to be with their families. Thailand is a country which observes the tradition of paying respect to older people and looking after older people. Therefore, I think older adults should be with their families" (S12).

The members of staff seem to believe that family support is the key factor to prevent older adults from showing depressive symptoms. This shows how filial piety and Thai cultural influence on Thai people views of caring for older people. However, family support is not an option for some participants who felt abandoned by their own families. Therefore, this mitigating factor may not apply to them.

7.3.2 Friends and peers

The study found that most residents received support from their peers who also lived in a care home, particularly emotional and informational

support, e.g. Nam stated about receiving support from her peer who LiCH.

> *"She was older than me. She liked to teach me. I love her and respect her as my mother" (R25).*

The quotation illustrates feelings of emotional attachment among some residents. It is likely that peer support could prevent residents from feeling of isolation and loneliness. Another male resident, Thenawat, illustrated how his roommate supported him while LiCH.

> *"For example, we console each other and it makes us realise that this is the best place for our life compared to the life outside" (R04).*

The above quotations show how residents emotionally supported each other during LiCH. Their peers in the care home influenced their feeling about LiCH, particularly when some of their peers passed away. For instance, Somchai, a male resident, explained to the researcher how he felt when his best friend passed away.

> *"I was so sad because he was my best friend. We were always together even though we were not siblings. We shared a room. We helped each other. When he was in pain, I was the person who helped him. I gave him medication, a blanket, and water. I really loved him. I'm sad that he passed away" (R15).*

While many residents perceived support from their friends who live inside a care home, some preferred to get in touch and get support from their friends who live outside. For instance, Kanta explained about her friends who live outside a care home.

> *"They are friends from outside the care home. I met my friends when I went to the temple. They also have many friends. Sometimes, they bring me things. One of them knows what I like. She is very observant. When she has something delicious, she will bring it for me" (R16).*

Kanta also mentioned that support from friends outside a care home helped her to overcoming her loneliness, despite not having any visitors over three years from moving into a care home.

> *"I am happy. I don't know why. Sometimes I ring them. I don't feel lonely" (R16).*

Staff members promoted peer support to help residents adapt to care home life. For instance, one care assistant referred to a buddy scheme for new residents that the staff members apparently undertook autonomously.

> *"Most of them can adapt to the life here quite easily. They are not very depressed. It takes them about a week to adapt and find new friends. We pair them with other residents and arrange their beds near each other" (S08).*

The support that residents perceived from friends and peers is the main factor helping residents cope with their stress and adapt into a care home life.

7.3.3 Care home staff

Most care home residents perceived that they were supported by care home staff, including emotional and informational support. For example, Pim illustrated the emotional support she perceived from staff.

> *"All care home staff are good. When I have a problem, I can go and talk to them. They will make me laugh" (R08).*

The quotation illustrates how emotional support from staff was experienced by the resident, indicating how emotional support skills are very crucial for working with residents, who are a vulnerable group likely to experience some emotional distress. Another resident, Therasak illustrated the support he received from care home staff.

> *"The care assistants are very helpful here. If the clothes are smelly, they will wash them for me. I'm grateful for what they do. I sometimes give them money. They don't force me to do so. I just want to show my appreciation" (R10).*

The quotation illustrates the feeling of support from staff experienced by the individual. The resident showed his appreciation by giving the staff some money, although this broke the rules and regulations of the care home (residents cannot give money to staff due to previous issues of staff borrowing money and refusing to pay it back in the past, as mentioned

previously). Some residents volunteered to give some money to their favourite staff member, which may have negative consequences on them and the staff in question if the situation is reported to the management. Supportive care from staff inspires emotional attachments among residents, as described by Kanta:

> *"Care home staff have an obligation toward us. They take care of us. They also sacrifice their time for us. Sometimes, they have to leave their personal interest behind because they need to take care of us" (R16).*

The above quotation shows that residents appreciated help from members of staff. Another female resident, Kwan, explained her appreciation toward care home staff:

> *"Sometimes, when staff are having lunch, a resident with cognitive impairment may defecate. The staff have to clean them. When they finish the cleaning and wash their hands, they can continue having their lunch. They can do it even though the residents are not their own parents" (R22).*

Care home staff felt pity toward older residents, which was one of the mitigating factors against stigma, because this feeling helped them to be concerned for residents and more attentive to their needs. Many members of staff expressed that these feelings developed while working with elderly and vulnerable people. For example, Komkon, a care assistant, stated:

"When I started working and I saw old people who could not look after themselves, I felt sorry for them. I decided to continue working. The longer I worked with them, the more sympathy for them I developed" (S08).

This developing empathy reflects an emotional attachment formed among care home staff. Most staff perceived working with residents in terms of working with their own relatives or families. For instance, Dokrak illustrated her feeling toward residents.

"I feel like the residents are my relatives. I love them all. I have sympathy for them. I know what they like and what they don't like. I know what kind of person they are" (S15).

The member of staff showed emotional attachment to residents. The quotation also indicates that the member of staff had got to know the residents deeply, which is indicative of high QoC and compassionate care.

7.3.4 Visits and financial support from members of the public

The main income of residents is from public donations, and most residents received financial support from ordinary people. The donations have a positive impact on older residents, helping them to have more lifestyle options. Mookda illustrated how donations have a positive impact on her life:

"People come and give donations. They are enough to live on. The meals are also provided. I am fine living here. It is

better than when I received 500 Baht allowance. It wasn't enough to live on. In here, people come to give us money or things. If you are a simple person, you don't need a lot in life. You can get 1000 Baht from the donation. You can have a better lifestyle than receiving the allowance from the municipality office" (R18).

Another male resident, Thanason, noted that public donations enabled him to have some spending money each month.

"I don't need to do anything. I eat and sleep, then sleep and eat. Visitors come to give a donation. When I started living in a care home, sometimes I got 100 Baht, 200 Baht, 50 Baht or 20 Baht. People from outside come to visit older people and give a donation. That's why I have money to spend while living here" (R13).

Donations are the primary source of material sustenance and income for residents LiCH. Areeya explained that public feeling pity toward residents, which inspires them to donate:

"I had a chat with the visitors. They come to the care home because they pity the older residents. That's why they would like to make a donation. They feel the residents are lonely, troubled, and poor. So, they come to donate food and other items" (S11).

Kalaya supported the perception of public sympathy toward older residents in care homes.

> *"People sympathise with the older adults who don't have children to take care of them. That's why they need to live in the care home. Therefore, they want to support the care home" (S12).*

Social support is a main resource for older residents LiCH. The various resources including emotion support, information support, financially support, and physical support came from the different sources. These include family, friends and peers, care home staff members and public generosity.

7.4 Coping strategies

Residents in the study used various coping techniques to cope with their stresses during LiCH, including Buddhist approaches, acceptance, positive thinking and comparing with others.

7.4.1 Buddhist approaches

Buddhism played very important role to help residents adapt into a care home life. Some residents applied Buddhist strategies, such as their fatalistic belief in karma, staying calm (Stoicism) and religious devotions for coping with their stress.

7.4.1.1 Karma

The study determined that older residents generally experienced feelings of helplessness and hopelessness, and those who were most successful

in coping with this applied Buddhist strategies associated with the belief in fatalistic karma *[the belief that all the good and bad things that you do in the life affect how good or bad your future life will be]*. For example, Chatchai expressed how he felt of LiCH.

> *"Karma is real. It follows me. I thought about the fact that I left my father alone and did not take care of him in the past. That's why karma is following me. I was separated from my family and have to be in a care home. I have bad karma" (R02).*

The above quotation showed that the older resident understood his feeling of helplessness and hopelessness in terms of a karmic punishment for his own behaviour toward his elders when he was younger, which helped him to accept the situation. Therapat stated he tried to use this coping strategy for similar feelings, with more emphasis on fatalism rather than punishment.

> *"I don't feeling lonely nor discouraged because there is nothing to tire me out. Sometimes, I feel fate is not on my side. I sometimes think that I have a child and my brother also has a child. Why can't I live with my child? My brother can live with his wife and his child. They are such a warm family. I try to convince myself that it's karma" (R05).*

Another male resident, Somchai, stated that he accepted his situation of being in a care home because of he believed that it was because of karma, and he could not change anything in the past.

"I think it is Karma. I have accepted it. I let it be. I used to have a family and my parents. When I was younger, I never looked after my parents. I took care of only my own family. I wanted my own family to be fine. I treated my parents like strangers outside my own family" (R15).

The quotation illustrates the coping mechanism of the resident involving karma, which helped him to accept the situation where he was in the care home. Karma helps many residents accept their situation of LiCH, according to Buddhist metaphysical beliefs.

7.4.1.2 Staying calm (Stoic behaviour)

This study shows that older residents using the Buddhist approach of staying calm to cope with their stresses, analogous to the Stoic tradition in Western philosophy. For example, Therasak illustrated how he can cope with stress whilst LiCH.

"The Buddha taught about equanimity. If we know anything, we must not talk about it. We must not gossip. If you know anything, you should ignore it. Relax your mind. It doesn't matter whether you have money or not. In here, you have something to eat. I'm contented. The Buddha said we should stay calm. I pray every day" (R10).

The above quotation shows some residents practice Buddhist philosophy to cope with LiCH.

7.4.1.3 Religious devotions

Buddhist religious rituals helped some residents to live and adapt to care home life. Pang stated that she prayed every day to help her secure her mind.

> *"I wake up at about 3 am or 4 am. Then, I will drink a coffee. After that, I will come to sit here... I pray 'Phuttho, Phuttho, Phuttho'* [Lord Buddha]*. I pray for myself. I ask the Lord Buddha to protect me. I want to stay healthy. When I die, I want it to be quick and easy. I pray 'Phuttho, Phuttho, Phuttho'. You also can pray 'Phuttho', it's good for you. A monk told me to say 'Phuttho, Phuttho' wherever I go and when I think about my children and my grandchildren" (R17).*

Another female resident, Kannika, used praying to live life in a care home.

> *"I can adapt into a care home life. I pray a lot. Praying is very good. I don't need to think of anything else" (R19).*

Religious devotions evidently helped some residents adapt to live in a care home and put their lives in a more positive perspective.

7.4.2 Cognitive acceptance

Residents applied emotional coping to increase their acceptance of coping with their stresses during LiCH. Therasak stated that his acceptance of LiCH helped to adapt to LiCH.

"No, no one. I don't think of anyone. I can't live here if I have that feeling. I accept it with equanimity" (R10).

Apasara, a member of staff, also pointed out that some residents accepted their fate and cut off everything in their mind before moving in.

"Some residents decided to leave everything behind before moving to a care home. They don't want anything. In the care home, everything is provided by the state. There are staff to look after them as well" (S10).

The members of staff are aware that LiCH could have a negative impact on the residents' emotions. Therefore, cognitive acceptance helps some residents cope with LiCH.

7.4.3 Positive thinking

The study determined that older residents applied positive thinking as an attitude to adapt to life in a care home. One example is Pang illustrated how she adapted.

"We have to be positive. If we are positive, it will be good for us. Some people are good to us while some people are indifferent. So, I can adapt into a care home life" (R17).

Positive thinking was used to adapt into a care home life to see thing in a positive way. For example, Somchai stated about LiCH.

"I let go of everything. I don't think about anything. I am grateful to live here. The staff look after me and there is a place for me to sleep. I'm lucky to be here" (R15).

Some residents suggested that positive thinking techniques help them to cope with a stressful situation.

7.4.4 Comparing with others

The study found that residents used coping strategies by comparing themselves with other people who have a worse condition than them, which enabled them to cope with their stresses. Mookda told the researcher how she copes with stress by comparing herself with others who are in a worse condition than her.

"People who are in worse conditions than me can still survive. So I don't think about anything. There are people who are worse than me. They still survive" (R18).

Therasak compared himself with others who live in a care home, with an attitude of *if they can do it, so can I*:

"I thought if other people could live here, I could live here too. If they couldn't live here, they didn't have to stay. That was the only thing that I thought about" (R10).

The above quotation illustrated how residents adapt into a care home life by comparing themselves with others.

7.5 Activities in a care home

Various activities in a care home help residents maintain their physical and mental health. In addition to remunerated activities, the care homes in this study provided social activities and individual interest for residents.

7.5.1 Remunerated activities

The study shows that participating in handicrafts in a care home helped some residents to become more independent and enabled them to earn money while LiCH. Kalaya illustrated the handicraft activities.

> *"We have training for handicraft skills here, such as making funeral flowers or making door mats. The items made by the residents will be sold and they can earn some money" (S12).*

Kwan stated that handicraft skills helped her to earn money to spend on her daily life needs.

> *"I am the only one who can make funeral flowers. The staff will buy the materials for making funeral flowers for me and sell them for me. Then they will give me a dividend after that. I got money" (R22).*

Although handicraft skill training is one of the options residents use to maintain their well-being, there is a barrier for some residents to participate in handicraft skills as well, particularly if they do not have handicraft skills or interest in such activities, as Naree, a female resident, mentioned:

"I don't have any craft skills. I was a day labourer. I have never done any handicraft. My hobby in the care home is to fold clothes in the morning. They taught me how to make a hat but I was not interested in making a hat" (R03).

Handicraft seems to be a useful activity for some of the residents. However, some residents are not interested in taking part with handicraft activities due to a perceived lack of skills.

7.5.2 Social activities

The study shows that social activities in a care home help residents to maintain their independence, including music and singing and travelling.

7.5.2.1 Music and singing

A care home organised music and singing activities for residents once a week. The activities helped residents to be happy and to earn some money. For instance, Ploy, a female resident, illustrated how social activities were enjoyable for her.

"I like entertaining. I like dancing. Friday afternoons are so fun. People who don't like it [dancing themselves] *can just sit and watch" (R26).*

One of the benefits of music and dance for residents is getting money from visitors. As Kwan illustrated, she received some money from music activities when visitors come to visit residents in a care home.

"I like listening to music and singing. There is a karaoke activity on Fridays. I usually sit at this table. Once a staff

member asked me to sing, so I sang a song. The staff selected the residents who can sing well. Different people may have different voice types to suit different types of songs, such as Lukrung [Thai urban music] *or Luktung* [Thai folk music]*. The staff find the right songs for us. When visitors come to the care home, the residents will be invited to sing for the visitors. The singers will be rewarded with some money. I was given a lot of money" (R22).*

Various social activities have been provided for the residents. Music and singing activities seem to be the most popular activities for many of the residents.

7.5.2.2 Travelling

The care home organised significant travelling excursions for healthy residents approximately once per year, which helped residents exercise more independence. Kalaya stated how she tried to promote travelling to help residents maintain their well-being, including more frequent small-scale visits.

"Once a year, but we go to other districts many times a month. Sometimes, if we are understaffed, we have to reduce the number of the activities...I don't want the residents to feel lonely and I want them to have social activities" (S12).

However, only healthy residents who can help themselves can join these activities. As Nittaya explained in the quotation below.

"A social worker sometimes takes the residents out on a trip, such as going to the temple or going to the beach. However, we can allow only a small number of healthy residents on a trip. We can only take the residents who can travel by bus" (S07).

Travelling activities help residents maintain their well-being. However, this activity is limited to only healthy residents who don't need any assistant from the staff members.

7.5.3 Individual interest activities

Residents use their individual interests to create activities while LiCH that help them avoid loneliness. For instance, Kanta stated that reading helped her relax while LiCH:

"Sometimes, I read books. I loved reading since I was a child. I never stop reading" (R16).

Another female resident, Naree, supported that she also used reading to help her prevent loneliness.

"I bought books to read while living here. It helps me not feeling lonely" (R03).

Activities in a care home play a very important role for residents in terms of helping them to maintain their well-being and independence. These activities included handicraft, social activities and individual interested activities.

In summary, the mitigating factors against stigma including coping strategies, social support and activities in a care home, illustrated the important factors older residents used to cope with the stigma they experienced, which can be used to prevent or reduce such perceptions among older adults. More mitigating factors could help to reduce negative impacts of stigma.

However, some of the mitigating factors are the inverse of some of the causes of stigma. This means if the individual has experienced the relevant cause of stigma, the associated mitigating factor is not available to them. For example, support from residents' families or friends is not an option for some participants because they feel abandoned by their families or friends whilst LiCH. In addition, stigma by association exacerbates this dimension, causing residents and their families to wish to avoid social censure arising from confronting the reality of the situation, thus visitation was mutually avoided in many cases by residents and their family members due to the fear of shame.

The following chapter presents case studies of residents who experienced varying degrees of internalised stigma of LiCH relating to each of the three elements of stigmatisation discussed. These cases illustrate the dynamics of the process of stigma and how each element of stigma interacts in a dynamic process. It suggests that stigma has causes and its impact is limited by the mitigating factors. However, it is visible by the manifestations which, when present, become additional causes of stigma.

Chapter Eight: Case Studies of Residents' Internalised Stigma

The dynamics of the process of stigma associated with LiCH involved three interrelated elements: causes, manifestation and mitigating factors of stigma. Various causes of stigma are rooted in negative public views of care homes, such as poor accommodation or poorer older adults. These factors natural occur before older adults move to live in care homes. In addition, care home features also contribute to stigma, including the culture and environment in care homes (e.g. communal living or lack of privacy and freedom), peer pressure to conform (e.g. group and ringleader or monitoring and gossip) and unequal power relations between staff and residents (e.g. rules and regulations and power imbalance). These additional factors of LiCH trigger and exacerbate the impact of stigma among residents. As a result, some residents manifested their negative emotional reactions or behavioural response, which can also be additional cause of stigma in itself.

However, the mitigating factors could minimise the impact of stigma among residents, including coping strategies, social support and activities in care homes. The following section demonstrates how the dynamics of the process of stigma interact in each stage (causes, manifestation and mitigating factors of stigma) by using case studies who experienced varying degree of internalised stigma, based on the quantitative research. These case studies illustrate that residents who perceived high internalised stigma and low mitigating factors were more

likely to manifest their negative emotional reactions and behavioural responses. However, some residents who perceived high internalised stigma may not be affected by causes of stigma if they have more mitigating factors. Therefore, they showed a normal range of depressive symptoms.

8.1 Resident A: Phadet's story

Using the Internalised Stigma of Living in a Care Home Scale (TIS-LCH scale), Phadet showed signs of moderate internalised stigma of LiCH. However, he had a normal range of depressive symptoms assessed by Geriatric Depression Scale (GDS).

8.1.1 Element: The causes of stigma

Several causes of stigma were identified in relation to Phadet: a sense of abandonment, communal living and conflict with other residents.

There seemed to be several aspects of Phadet's life that could have led him to have a sense of abandonment: He had a conflict with his wife and separated from her before she passed away.

> *"My home life had fallen apart. My wife had died and my three children didn't look after me. I had to find somewhere to live."*

He went to live with his sister's family for a while but had a problem with his sister's family so had to leave there. He had problems in the first care home that he moved to so had to transfer to this one. In addition, since

moving into this care home, his son and daughter have only visited him on a couple of occasions.

> *"My sons and my daughter have only come to visit me a few time in the nine years I have lived in a care home. Apart from them, I haven't had any visitors including my friends and relatives."*

Phadet appears to have struggled with communal living and has had more than one episode of conflict with other residents:

> *"I lived in that care home for around three years. I had a flight with another resident. Staff in the care home tried to get us to be civil with each other. However, I decided to leave that care home and asked the head of the care home to write a letter to support me to live in this care home."*

After moving to another home, Phadet had another problem with a resident and ended up fighting again:

> *"I had a problem with a resident and we ended up fighting in front of a toilet. He is addicted to alcohol and smoking…A social worker told us to go back home for a month and then we can come back to live in the care home."*

8.1.2 Element: Manifestation of stigma

Phadet experienced negative emotions and behaviour living in the care home e.g. abandonment, shame and isolation. He felt shame when he

needed to move in with his son for a month due to the fight with the other resident in the care home.

> *"I carried my bag and begged my son to live with him for a month. I felt a lot of shame."*

Phadet also mentioned that his relationship with his friends and relatives had changed since moving into the care home. He perceived that his peers or relatives may look down on him.

> *"It seems like they looked down on me. They may think that I deserved to be in the care home…they may think that I was fine and had a convenient life in the past but now my children didn't look after me. They must think that I deserved it."*

Phadet didn't have any close friends in the care home as he usually liked to isolate himself from everybody and spend time on his own.

> *"We live separate lives, I never feel close to anybody. I usually go out by myself."*

Phadet was moved to live alone in a separated building with other residents after he had a fight with another resident. The building used to be a temporary accommodation for care home staff. This made him feel like he had more privacy but also meant that he was isolating himself from other residents.

8.1.3 Element: The mitigating factors of stigma

The mitigating factors that helped diminish feelings of stigma for Phadet included a greater sense of privacy, reading and praying and help from the general public.

Phadet felt happier when he lives alone in his room with a private toilet. He has the sense that it belonged to him as he live in the room for a couple year.

> *"I am happy living alone. I don't need to share a bath room or a toilet with other residents. I have my own private toilet in my room. I usually clean them by myself because I live alone."*

He likes to spend time on his own as he mentioned in this following quotation.

> *"Sometime I will stay in my room and read a newspaper and fall asleep …I go out for praying when there is a praying activity."*

Reading and praying help him cope with life in the care home. He also mentioned donations received from the public helped him live his life while living in the care home.

> *"Some people are so kind. You may not believe me e.g. a couple drove a car to the care home and gave us 300 Baht for each person. We gave them a wish, then they left the care home."*

Donations from the public, leisure activities and privacy of living in the care home seem to be a main factors helping Phadet cope with his life in the care home. By improving privacy and reduce sharing facility this would help to reduce the issues with communal LiCH.

8.1.4 Summary

Phadet had moderate stigma associated with LiCH and a normal range of depressive symptoms (not depressed).

When considering the process of experiencing stigma associated with LiCH, Phadet experienced significant and longstanding factors that might be considered causes of stigma. In addition, the manifestations of stigma that he exhibited would be likely to exacerbate this experience. However, he had some mitigating factors that might have the effect of diminishing this stigma.

8.2 Resident B: Naree's story

Using TIS-LCH, Naree showed signs of moderate internalised stigma of LiCH. She also reported moderate depressive symptoms as assessed by TGDS.

8.2.1 Element: Causes of stigma

The causes of stigma for Naree related to communal living, lack of privacy, perception and judgment from other residents, and unequal power relation between care home staff and residents. As an orphan Naree had been vulnerable since her youth, and she explained her inferiority complex in this regard.

"I never met my parents since I was born. My grandma and grandad looked after me. When they passed away I became like a homeless person".

Naree spent most of her life working in Bangkok. She did not have her own house or any relatives. When she was sick because of hyperthyroidism and could not work, she went to live in the care home at her employer's suggestion, and she has since lived there for 21 years. However, she still struggled with communal living and her peers in the care home.

"If I did something wrong, other residents would tell me off. They are self-centred. For example, someone wanted to watch this TV program, another one wanted to watch another TV program, so this would make them estranged. Another example, some residents like a cat and other don't like a cat. This causes them to quarrel".

In addition to the rigours of communal living, she was also aware of being monitored by care home staff.

"Staff leave us to it but they still monitor us. We cannot see them from the outside but they can see us from this mirrored wall".

She felt like power imbalance between care home staff and residents. Therefore, she had to obey the rules and regulations of the care home.

"I don't do anything wrong. That's why I don't mind if they observe me. If some residents had a fight and created a loud noise. Staff would come and tell us off".

She also felt like her peers monitored her and reported her behaviour to care home staff. This caused her to feel a lack of privacy and increased pressure.

"I choose to be quiet. I don't want to make any argument or explain to them. Before too long, they will forget about it. But sometimes if I don't do any wrong, I will speak out. Staff have some spies among us. They will report a story to staff. I don't bother, if I did anything seriously wrong they would send me away from the care home".

Some behaviours of care home staff had negative impacts on Naree, which could create barriers with staff members, as she related with regard to some loud personnel.

"I choose to be quiet. If I argue with them, it will become a long story. Some care assistants are very loud. You may notice about this. I should do not pay attention to them".

8.2.2 Element: Manifestations of stigma

Naree experienced negative emotions e.g. depression, lack of worth and self-blame. She mentioned that she sometimes had a depressed mood.

"I don't have any relatives. Sometimes, I feel depressed because I think why I have to be in the care home. It is

because I don't have any siblings or relatives. I cannot work anymore. I need to get help from the government".

Naree did not have any close friends and she perceived a lack of support from her peers.

"I don't have any close friends in the care home. I know them just superficially. I cannot consult any problems with them… They don't listen to me. When they told me their problems, I was listening to them but when I told them my issues, they were never listening to me".

Furthermore, she blamed herself in the past for living in the care home.

"I used to think why I don't have my own home. When I worked and had some money. I should have bought a house. Why couldn't I think like that at that time? I was a single and went for a night out every day".

8.2.3 Element: Mitigating factors of stigma

Naree appeared to have a couple of mitigating factors helping her cope with her life in the care home. These were activities in the care home, including traveling and individual interest activities. Naree told that she was happy when she was on tour.

"They brought us to travel. We travel once a year, for example going to a beach".

Naree liked to watch films and listen to the radio alone.

"I like to stay alone. I like to watch a film and listen to a radio or sleep on my own".

8.2.4 Summary

Naree had moderate internalised stigma of LiCH and had moderate depressive symptoms.

Considering the process of stigma, she has been LiCH for over twenty years and she experienced many factors that can be considered as causes of stigma, mainly related to the aspect of care home features contributing to stigma. This might lead her to manifest negative emotional reactions, particularly depressive symptoms, as she mentioned earlier. However, she had some mitigating factors helping her to cope with a care home life, but they were very limited and they were also solitary activities that might increase her sense of isolation.

8.3 Resident C: Jinda's story

Using TIS-LCH, Jinda showed signs of moderate internalised stigma of LiCH. She had mild depressive symptoms assessed by TGDS.

8.3.1 Element: Causes of stigma

The causes of stigma identified from Jinda's story mainly related to perception and judgment from other residents and being financially abused by her children. She told her story regarding being financially abused by her children when she was at home.

"If I didn't have any savings, I could have starved to death when I was with my children. They always asked me for

money. I could not stay with them. That's why I moved to live in the care home. I thought if I continue lived with them for a month I would die".

However, she continued to be financially abused even after moving to the care home. From the observational data, she complained that she could not sleep because of thinking about her children who visit her at the care home and ask her for money.

"My life is so sad. My children are not good. They always ask me for some money. I need to use money for my living costs when I would like to buy something. They may think that I am so thin. I may not eat anything. They may think I don't need any money and I may die soon".

Jinda had recently moved in to the care home, about two months previously. She was struggling with the adaptation due to the grouping of residents, and perceptions and judgments from others.

"They live separate lives but they have their own groups. If someone does something wrong, they will gather together and tell that person off. They like to aggravate people. So, I don't want to make any friends... all residents in the care home are loose-tongued and gossipy".

8.3.2 Element: Manifestations of stigma

Jinda appeared to show her negative emotions and behaviours while living in the care home, such as feeling abandonment and lack of worth, and a depressed mood. She felt abandoned by her children.

> *"My son was busy with his work. My daughter was busy with her husband and kids. I was lonely. I had to look after myself. So, I decided to move in to the care home".*

She also showed some signs of depression, such as feeling tearful and sadness when she told the researcher her story of when she lived with her children.

> *"I don't want to talk about my children. I don't want anybody to look down on them. When I was with my daughter, she was busy with her husband and kids. Even though I was ill for a few days, I needed to look after myself, cooking on my own. I was so sad and upset. So, I decided by my own to move to the care home. I was so thin at that time. If I lived with them for some days, I would die. I don't want to tell anybody about this, I don't want anybody look down on my children. I am so sad that they will not look after me. They had only one mother* [crying]*".*

Jinda seemed to avoid contact with other residents since she moved in the care home.

"Older adults who are not patient, they cannot live in the care home because all residents are loose-tongued and loud. You may notice that I avoid talking to other residents. Even though they were having lunch together and they asked me to join them I didn't like to do so. I like to have a lunch alone".

8.3.3 Element: Mitigating factors of stigma

The mitigating factors that helped to diminish feelings of stigma of LiCH for Jinda included a greater sense of social support from her peers and the public. Jinda felt happier when she got along with one of the residents in the care home.

"If they are good with me, I will be good to them. X [mentioned the name of a resident] *sits for lunch at the same table with me. She likes to help other residents. Sometimes, she helps to carry a container of food for me. She is very good to me".*

She perceived support from the public when they visited the care home and gave donations to residents.

"They gave us money quite often. Sometimes, they gave us some food, milk and fruit every day. But currently it is difficult to find money. They gave us small money, sometimes 20 Baht, sometimes 10 Baht for each person".

Religious devotions help Naree to cope with her life in the care home.

"I get used to the life in the care home. I don't think a lot. If they go to do a religious duty, I will go with them. If they observe religions precepts, I will do it with them".

8.3.4 Summary

Jinda had moderate stigma associated with LiCH and had mild depressive symptoms.

When considering the process of stigma associated with LiCH, Jinda's story showed the nature of care home inhabitants who were abandoned and financially abused before moving in. She had evidently experienced emotional distress before moving in to the care home. She also experienced being judged by other residents related to grouping among residents and the grouping of residents. As a result, she manifested negative emotions and behaviours. However, the mitigating factors that might diminish the perception of stigma in her case include social support from her peers and the public, and religious devotions, which help her to cope with the stigma of LiCH.

8.4 Resident D: Mookda's story

Using the Internalised Stigma of Living in a Care Home Scale (TIS-LCH scale), Mookda showed signs of moderate internalised stigma of LiCH. She had mild depressive symptoms assessed by Geriatric Depression Scale (GDS).

8.4.1 Element: The causes of stigma

Several causes of stigma of LiCH were identified in relation to Mookda: being abandoned by her sister's family the only relatives she had, dependence on others and perception and judgment from other residents.

There were several aspects of Mookda's life that could have led her to have a sense of low self-esteem, hopeless and helpless.

> *"My nephews told me that when I came to live with my sister's family, she allowed me to live with her but she said that she felt embarrassed because I was disabled. I was very upset".*

Moreover, she had been abandoned by her sister's family when she had an accident and was admitted to a hospital. This may leave her feeling a sense of abandonment:

> *"They were afraid that I couldn't walk again so they decided to say that I was not her relative. They said I was just a lodger and that they would not let me stay with them any longer".*

Being abandoned by her sister's family and becoming homeless made her feel depressed and she wanted to commit suicide.

> *"I was thinking to commit suicide by jumping into a pond. I really thought so. I thought that I would spend 500 Baht for a taxi to go to the pond nearby and jump into the pond".*

She sought help from the Social Service Department and was transferred to live in the care home when she was just 55 years old. She was younger than other residents when she admitted to the care home. This was an issue that was criticised by another resident. Mookda mentioned this in the below quotation:

> *"She looked down on others. She said people who were not very old shouldn't be allowed to live here. She was talking to someone in front of me that I was under 70 years old and I should not have been allowed to live here. I was very upset. It made me feel that the residents who lived upstairs were gossipy".*

The perception and judgment from other residents made Mookda feel distress. Mookda also felt uncomfortable with communal living as she had to share a shower room with other residents.

> *"I have to wait until its dark. I feel embarrassed to be naked even among other women".*

Several causes of stigma associated with a care home could impact on Mookda's life. The effect of stigma made it visible to observe Mookda negative emotions and behaviours.

8.4.2 Element: The manifestations of stigma

Mookda experienced negative emotions and behaviours when living in the care home e.g. feelings of abandonment and lack of self-worth and avoiding contact with other residents and care home staff. She perceived

a sense of abandonment by her sister's family as stated in the following quotation.

> *"I felt very hurt by what my sister did. I didn't want to go to that province again. I also didn't want to hear the name of that province".*

She didn't want to depend on others or ask for help as stated in the following quotation:

> *"The first three days of living here, I couldn't sleep because I didn't know how to go up a slope. I was afraid to ask for help from a care assistant. The care assistant helped me but I didn't want to bother them. On the fourth day, with a few more attempts I managed to push the wheelchair up a slope".*

She avoided contact with other people and ended up siting in her wheel chair for most of the day.

> *"Mostly, I only sit on a wheel chair all day. I wake up at about 3 or 4 am to have a shower. Then I just sit around. I can sit around for 10 hours".*

8.4.3 Element: The mitigating factors of stigma

The mitigating factors that helped diminish her feelings of stigma included a greater sense of independence, cognitive acceptance, comparing herself with other residents and social support.

Mookda had experienced hardship, this made her be able to cope with living in the care home.

> *"When I was in Udon Thani, life was so difficult. My sister didn't allow me to turn on a fan because she wanted to save money on electricity. She also didn't allow me to open the window because the house was next to a cement factory. I had to sleep with the window closed and use a handheld fan. It's tormenting me".*

Mookda used coping strategy by comparing herself to other residents who had worse condition than her. This enabled her to cope with the stressful situation.

> *"I used to think that I was disabled and disgusting… In here, I live with other people with similar conditions to me. I feel more comfortable".*

She mentioned how she coped with living in the care home.

> *"People who are in worse conditions than me can still survive. So I don't think about anything. There are people who are worse than me. They still survive".*

Although, she is disabled she had a greater sense of independence. She completed her routine activities on her own without asking for help from other residents or care home staff.

"I use a wheel chair. I can take a shower by myself. When I defecate, I can clean up and put dirty pants in the bin by myself. If I have incontinence, I use disposable pads and I clean up by myself. I don't need to ask a care assistant to help me. I can do it by myself".

Mookda was happy to live in the care home because she got donations from the public which meant she had money to spend when she needed it.

"People come and give donations. They are enough to live on. The meals are also provided. I am fine living here".

Coping strategies, a greater sense of being independent and donations seem to be the main factors in helping Mookda cope with her life in the care home.

8.4.4 Summary

Mookda had moderate stigma associated with LiCH and had mild depressive symptoms.

When considering the process of stigma associated with LiCH, Mookda experienced some significant causes of stigma that might effect on her life in the care home. It seems like she manifested some signs of negative emotions and behaviours. However, these were diminished by the mitigating factors that Mookda used to cope with stigma associated with LiCH.

8.5 Resident E: Kanta's story

Using TIS-LCH, Kanta indicated minimal to no internalised stigma of LiCH. She also showed a normal range of depressive symptoms assessed by TGDS.

8.5.1 Element: Causes of stigma

Several causes of stigma associated with a care home affected Kanta, including the aspect of negative beliefs about care homes and people who live in them and perceptions and judgments from other residents. Before moving in to the care home, she perceived that care homes offer poor quality accommodation.

> *"Before I moved to the care home, I thought care homes in a big city would have normal old people. They would have a poor quality of accommodation, no organisation. They may need to sit or sleep roughly".*

Kanta had been living in the care home for over three years. She explained her experiences of seeing conflicts among other residents related to communal living and residents having to share things together. She gave an example of one female resident who felt a chair belonged to her.

> *"'This chair belongs to me. Nobody cannot sit on this chair. This belongs to me'. They like to show that they are the owner of it, even though it is for everyone. If somebody touches it, they may have a fight, a real fight".*

Kanta explained issues of conflicts among residents regarding some residents being unable to control their emotions.

> *"Somebody may be resentful but others may be loud. They would have a fight. It is because somebody cannot control their emotions. Someone may say something that causes a fight".*

Kanta experienced that she was bullied by other residents when she was offered to be a leader of residents and she was responsible to look after other residents during the care home refurbishment.

> *"My shoes were disappearing, I tried to find them but I could not find them… I heard that someone had thrown my shoes away in a rubbish bin. My shoes were in a bin but they were laughing".*

Some causes of stigma clearly affect Kanta's life in the care home. However she appeared to have no to minimal internalised stigma.

8.5.2 Element: Manifestations of stigma

For her interview and observation data, Kanta appeared not to have any negative emotional reactions or behavioural responses. This is related to the quantitative data showing that she reported minimal to no internalised stigma of LiCH and had no depression.

8.5.3 Element: Mitigating factors of stigma

Kanta's story appeared to have many mitigating factors helping her to diminish the feeling of stigma of LiCH. These included coping strategies,

social support and activities in the care home. Kanta showed her cognitive acceptance of her peers and her life in the care home.

> *"Residents in the care home come from different regions but I do not pay attention on them. I will let my negative thoughts go, I don't think of anything. I think everyone has their own life".*

Buddhist doctrine played very important role in Kanta's life and influenced her beliefs, as she followed religious devotions every day.

> *"I pray each morning and evening, since I was a kid. When I am here I will pray four times per day. Sometimes, after helping the staff in the kitchen, if I still have time, I will pray. I choose a prayer from a very important section of the Tripitaka* [the Buddhist scriptures]*. I have completed reading all of the Tripitaka, 45 books".*

Furthermore, she explained her passion about making a merit each year, as she set a goal to achieve it every year.

> *"This year, I intend to do Thot Kathin* [the ceremonial presentation of new robes and gifts to Buddhist monks in Thailand] *in nine temples. If someone comes to ask for a donation for a temple, I will give them some donations until I have donated for nine temples".*

In addition to personal religious observances, Kanta was very actively engaged in communal religious affairs, particularly in her patronage and

support of temple constructions, according to the foundation of spiritual development in Buddhism. She mentioned that she intended to make a donation to a temple.

> *"When I do a good deed, I will think about what I have already donated, for example a prayer book, a pavilion and a monk's cell. I will record what I have already donated, such as a table or a chair, if I have a chance I will give them a donation".*

Kanta demonstrated that she likes to be a giver more than being a receiver, and she spent most of the money she received from public donations on charitable donations to the care home. Kanta had a lot of friends living outside the care home, with whom she visited temples.

> *"I have a lot of friends from outside the care home sometimes, they bring something for me when they visit. I have one friend who knows what I like. When she has something delicious, she will bring it for me".*

Kanta was happy with her life in the care home and she did not feel lonely when living in the care home.

> *"I am happy, I don't feel lonely because I have friends and sometimes I talk to them via the phone".*

Kanta told the researcher that she liked to help other residents who cannot help themselves.

"I like to help other people, for example if someone cannot move or they are ill, I will go to help them, such as giving them food or getting them their cutlery".

She offered some help to care home staff too, which may help her generate feelings of self-worth.

"I go for exercise at around 8 am. Then I will go to help a chef in the kitchen. Nobody asked me to help but I just go and offer some helps. I like to volunteer to help, such as preparing sweet basil leaves or cutting the pork. It depends on what they assign me".

She was offered by the head of the care home to be a leader of the residents, to look after residents' affairs during the care home refurbishment.

"The head of the care home asked me to be leader of the residents. This was to look after them during the care home refurbishment. If someone would like to go outside of the accommodation, they have to tell me. This is because we tried to avoid accidents that may happen to residents".

Kanta was chosen to represent other residents giving a speech when there were visitors to the care home.

"The head of care home asked me to welcome the visitors in English. They were a team from another province. The leader of the team is the President of the Bank for

Agriculture and Agricultural Cooperatives… When it had finished I also gave a speech to thank them for their visit. He made obeisance [wai, a Thai greeting to show respect] *to me and other people followed".*

In addition to being conducive to self-worth, holding an official role as a representative of the care induced respect from her peers. Kanta explained her individual interest activities when she has some free time in the care home. She liked to listen to the radio and read books.

"I have a radio as my friend. If I don't have something to do, I will go and sit under the mango tree. I will bring a radio or a book with me. I loved to read books since I was young. I have never abandoned a book".

Moreover, writing a diary also helped Kanta spending her free time in the care home.

"I've loved to read and write since I was young. I love to write a diary with what I do in a day".

Many mitigating factors helped to diminish causes of stigma that may affect Kanta's life in the care home, such as cognitive acceptance, Buddhist approaches, social support from peers and the public, and activities in the care home.

8.5.4 Summary

Kanta indicated no signs of internalised stigma and depressive symptoms.

Although, some latent causes of stigma pervade Kanta's life in the care home, she perceived minimal internalised stigma and displayed no signs of depressive symptoms. Many mitigating factors appeared to diminish the impacts of stigma, including coping strategies such as Buddhist activities, social support and activities in the care home.

8.6 Conclusion

The findings of the study illustrate a process of stigma with three elements: the causes of stigma, manifestation of stigma and the mitigating factors of stigma. The causes of stigma capture the reasons why stigma was created in Thai care home environment. There are various reasons and factors contributing to the stigma, including negative beliefs about care homes and people who live in them. These beliefs essentially arise from the public due to strong influences of filial piety and family support in Thai culture. Furthermore, the findings identify the nature of care home population, attitudes and stereotypes toward older people, and care home features as contributing to stigma and staff issues, making Thai care homes more stigmatising. As a result, some residents manifest negative emotional reactions, including depressive symptoms and behavioural responses, particularly social withdrawal behaviours related to the stigma of LiCH. However, the mitigating factors could limit the impacts of the causes of stigma and help residents cope with stressful situations. These include coping strategies (particularly spiritual practices), social support and activities provided in the care homes.

The final chapter of the thesis is the discussion and conclusion. This chapter summarises, synthesises and discusses the findings from the quantitative and qualitative research. This chapter also includes the strengths and limitations of the study. It makes recommendations and implications to confront stigma.

Chapter Nine: Discussion and Conclusion

9.1 Introduction

The aim of this thesis was to explore the factors associated with depressive symptoms and to understand more about stigma associated with Living in a Care Home (LiCH). Thematic synthesis of a systematic review for qualitative studies regarding stigma associated with a care home identified that on the whole, stigma is under-investigated, with very few studies considering stigma specifically in the context of care homes. A mixed method approach was applied to explore research questions related to stigma associated with LiCH and the factors associated with depressive symptoms that are known to be closely associated with stigma. This chapter summarises, synthesises and discusses the findings from quantitative and qualitative data regarding the factors associated with depressive symptoms and the dynamics of the process of stigma comprising three inter-related dynamic elements: causes, manifestations and mitigating factors of stigma.

9.2 Key findings

This is the first programme of work aiming to understand stigma associated with LiCH and how it affects residents living in care homes in Thailand. A very high response rate of 98.46% was achieved for the cross-sectional study. One of the salient findings of this study was the high prevalence of depressive symptoms among residents (41.5%), which was not related to participants' demographic and health characteristics; rather the severity of depressive symptoms was found to

be associated with a high level of internalised stigma of LiCH. The cross-sectional study showed that the vast majority of care home residents perceived some level of internalised stigma of LiCH (92.3%), which has not been investigated previously. The severity of depressive symptoms in this sample was associated with low perceived self-esteem and social support. Importantly, residents who perceived high internalised stigma of LiCH were over nine times as likely to report experiencing depressive symptoms.

Interviews with residents and care home staff revealed the dynamics of the process of stigma related to depressive symptoms when residents perceived high stigma associated with LiCH, and manifested negative emotional reactions which could be observed by others and sometimes by themselves. The process of stigma shows a process involving causes, manifestations and mitigating factors as well as interactions between these elements. The causes of stigma originate from the negative public views of care homes, including negative beliefs about care homes and people who live in them, stereotyping attitudes toward older people and the nature of the care home population. In addition, negative life experience of residents inside care homes also create (and exacerbate) the causes of stigma, including care home features contributing to stigma and staffing inadequacies.

These causes of stigma affect older adults who perceived stigma of LiCH manifesting negative emotional reactions and negative behavioural responses. In particular, some of them experienced symptoms of clinical

depression, which is highly correlated with high internalised stigma in quantitative findings, as highlighted previously. The interviews illustrated that older adults coped with their perception of stress and stigma associated with LiCH in different ways. Mitigating factors include specific coping strategies, social support and activities provided in care homes. The following sections discuss the issues of high prevalence of depressive symptoms and the major factors related to depression among older adults residing in Thai care homes.

9.3 Prevalence of depressive symptoms

Previous research showed that Thai cultural traditions regarding care for older adults and expected relationships and duties of family members highly influence how people in the society engage with geriatric care issues (Knodel et al., 2015). Thai older people are an important group in Thai society, respected and honoured by their children and families and venerated in the normative national culture (Knodel and Chayovan, 2012). Thai society expects that families, especially adult children, will play the leading role and undertake the duty to care for elderly family members when they require support (Rittirong et al., 2014). In traditional Thai society, it was the natural life course that children would be nurtured by their parents, get married, have children, care for their parents and in due course be cared for by their own children; however, this timeless idyll is now disrupted by the challenges of economic growth and the migration of working-aged generations to cities, leaving Thai older parents alone at home. When these people can no longer manage to live unassisted, for various reasons, they may come to reside in a care home; this is usually

a last resort and not a preferred choice, particularly during the initial stage of coming to live in such facilities (Knodel et al., 2013a).

The findings of the questionnaire study highlight that depressive symptoms were prevalent in this sample (41.5% reported mild, moderate or severe depressive symptoms). Although previous studies providing rates of depressive symptoms used different measures and therefore may not be directly comparable, the rate observed here was higher than prevalence rates found previously in Thai care home contexts (38.4%) (Wongpakaran et al., 2012a), and higher than those found in other cultural settings such as England and Wales (27.1%) (McDougall et al., 2007b) or the US (13%) (Watson et al., 2003). However, the prevalence of depression in this sample was lower than in previous research conducted in care home populations in Taiwan (43.3%) and Hong Kong (65.4%) (Tsai et al., 2005a). Nevertheless, a generally high prevalence of depression can be seen in Asian countries, which is likely related to traditional cultures wherein extended family support and the concept of filial piety are particularly important.

In the questionnaire study, depressive symptoms were not related to care home residents' socio-demographic characteristics or perceived health characteristics, despite the universally acknowledged link between these factors and depression. The evidence suggests that older adults residing in a care home are more prone to suffer from depressive symptoms than older adults living in the community (i.e. of comparable socio-economic and health status), with prevalence of around 22% (e.g. Abas et al.,

2013). This may relate to the preferences and expectations of older people that they will be cared for by their families, which is highly influenced by social norms and in this case the Thai cultural value of family responsibility (Rittirong et al., 2014). This study reveals that participants reported that they felt *compelled* to live in a care home (i.e. it was not their ideal choice) due to health issues, family conflict, poverty, no family, loneliness and being abandoned by their families. These issues may themselves evoke negative self-perceptions and make residents more prone to having depressive symptoms.

9.4 Prevalence of internalised stigma of living in a care home

To our knowledge, this is the first study to assess internalised stigma among Thai older residents LiCH. The findings show that perceived internalised stigma which has not been researched before was evident among almost all of the care home residents (92.3%). A quarter of residents reported moderate and severe levels of internalised stigma (25.4%). This salient information extended the new knowledge on other key factors associated with depressive symptoms (internalised stigma) among older adults residing in Thai care homes which needs to be addressed due to a wider perception of the public stigma toward LiCH in Thai society.

Previous studies affirm that people are stigmatised due to cultural norms and beliefs, which vary between societies (Mason, 2001). In Thai culture, the virtue of respect for elder parents is a very strong influence on family

and individual life (Thanakwang, 2015). Older Thai parents have improved psychological well-being if treated attentively and supported by their families, particularly their children (Thanakwang, 2015). As a result, it has been found in this study that LiCH can create the perception of internalised stigma among older parents due to the implicit reality that they are not living with their children according to the traditional archetypal paradigm of Thai social life.

Interesting information from this study reveals that perceived internalised stigma associated with LiCH may rise when residents perceive themselves to be lower in social hierarchies than others in society. As a previous study found, residing in care home could be seen as equivalent to being bereft of money, a job (i.e. economic and professional worth), health and family relationships (Yang et al., 2007). Such perceptions could feed into self-prejudice and self-discrimination on the intra-personal level, which is a manifestation of and causative factor in depression (Cox et al., 2012). What is unique about this aspect of the study is the discovery that internalised stigma relates to numerous other factors, such as self-esteem and social support which, in turn, were found to be correlated with depressive symptoms in this sample.

9.5 The relationship between depressive symptoms and other variables

The relationship between self-esteem and social support among residents in this study was found to be negatively significantly associated with depressive symptoms among the sample of residents. This finding

supports previous studies regarding older residents with lower self-esteem and lower perceived social support reporting greater depressive symptoms, as demonstrated previously (Sun et al., 2017). Furthermore, the results suggested that there were no significant difference in self-esteem and perceived social support between the two care homes. It is suggested that self-esteem is an overall attitude people hold toward themselves including positive or negative aspects (Branscombe and Baron, 2017). Older residents of this sample with lower self-esteem reported higher levels of depressive symptoms, affirming the negative correlation between self-esteem and depressive symptoms previously noted in China (Sun et al., 2017). The findings of the study suggest that residents with low self-esteem generally have low self-worth, seeing themselves as being of low value or low worth as people. It is likely that older adults moving to a care home are more dependent, suffering from physical and mental illness and lacking of support from their families (Thammapakorn Phoklang Welfare Development Centre for Older Persons, 2015). These reasons may affect their reporting of low self-esteem.

This study showed that participants reporting low social support reported a high level of depressive symptoms. Previous studies reported similar results of depressive symptoms and social support in older adults elsewhere (Lee et al., 2012). This is a particularly important factor for care home residents, most of whom report experiencing loneliness (Drageset et al., 2011b). Many residents in this study report low social support, this may increase their risk of depression, due to the known link

between these two variables: depression and low social support (Camargo De Oliveira et al., 2014; Sun et al., 2017). Therefore, promoting social support from different resources such as family, friends, members of staff or members of the public may help to improve the perception of support and decrease or prevent depressive symptoms among this population.

Our findings align with the Biopsychosocial Model (Figure 8.1), which proposes that in order to understand illness we need to understand how people interrelate with the social systems of their worlds (Engel, 1980; 1989; Sarafino and Smith, 2014). The findings of the study demonstrate that depressive symptoms among Thai care home residents correlate with psychological factors (low self-esteem), social factors (low social support) and (in particular) perceived high internalised stigma of LiCH, which is still under investigated. Depressive symptoms have also been found to be associated with other multiple biopsychosocial factors among residents of aged care facilities, including environmental mastery, purpose in life and autonomy (Davison et al., 2012), which interrelate in a broader matrix in which depressive symptoms among residents LiCH occurs, related to various biological, psychological and socio-cultural factors.

The Biopsychosocial Model incorporates a philosophy of care and a practical guide by which to understand how diseases or illness affects patients in the multiple levels (from the societal to the molecular) (Borrell-Carrió et al., 2004). Depressive symptoms affect the personal level of

patients such as being a cause of disability, functional decline or cognitive impairment (Davison et al., 2012); this study found that depressive symptoms also have impacts on residents at the societal level, associated with isolation and limited contact with others due to the intrinsic features of depressive symptoms in parallel with stigmatisation, embedding emotional withdrawal. Notably, residents with low social support have greater depressive symptoms.

Furthermore, the Biopsychosocial Model (Figure 26) also helps us to understand patients' subjective experiences at the practical level, contributing to accurate diagnosis, health outcomes and human care (Borrell-Carrió et al., 2004). Therefore, interventions to prevent or decrease depressive symptoms in this population should take a holistic approach. This means care home staff need to consider non-biological dimensions that influence depression, promoting social support and self-esteem and minimising social stigmatisation among the care home population. A holistic approach could prevent or reduce depressive symptoms and bring more empathy and compassion into care for depressed residents.

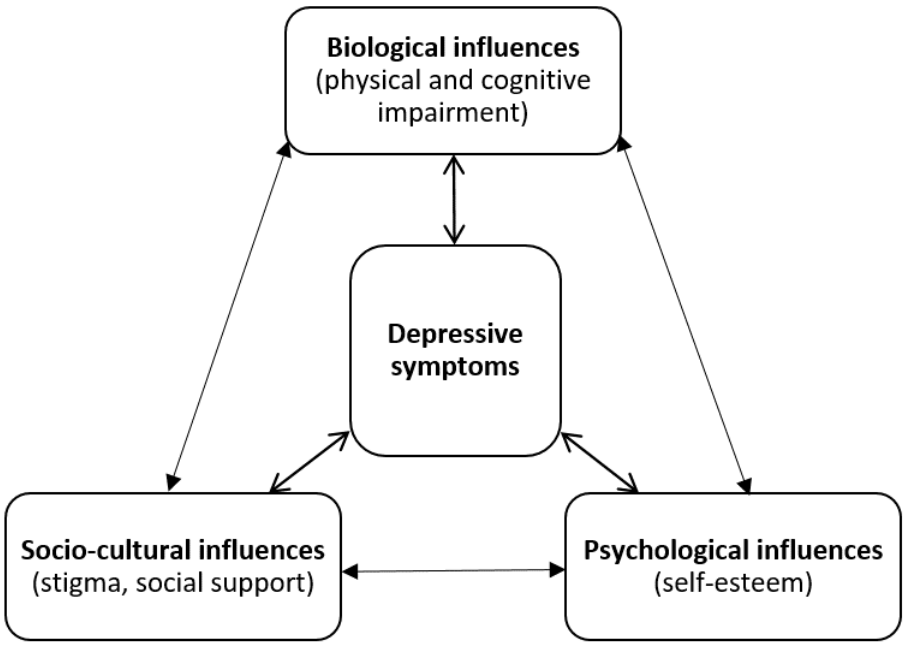


Figure 26: Biopsychosocial model of depressive symptoms

(Garcia-Toro and Aguirre, 2007)

9.6 The process of stigma associated with living in a care home

The study identified crucial knowledge regarding the dynamics of the process of stigma associated with LiCH (Figure 27). Various causes combine to create internalised stigma and other negative emotional reactions and behavioural responses among residents, particularly negative beliefs about LiCH held by the public and negative perceptions and experiences of LiCH held by residents themselves. However, the study also revealed that mitigating factors, including coping strategies, social support and activities provided in a care home, help residents to cope with their stress and perception of stigma. Figure 27 summarises three elements of a process of stigma from the perspectives of residents and care home staff.

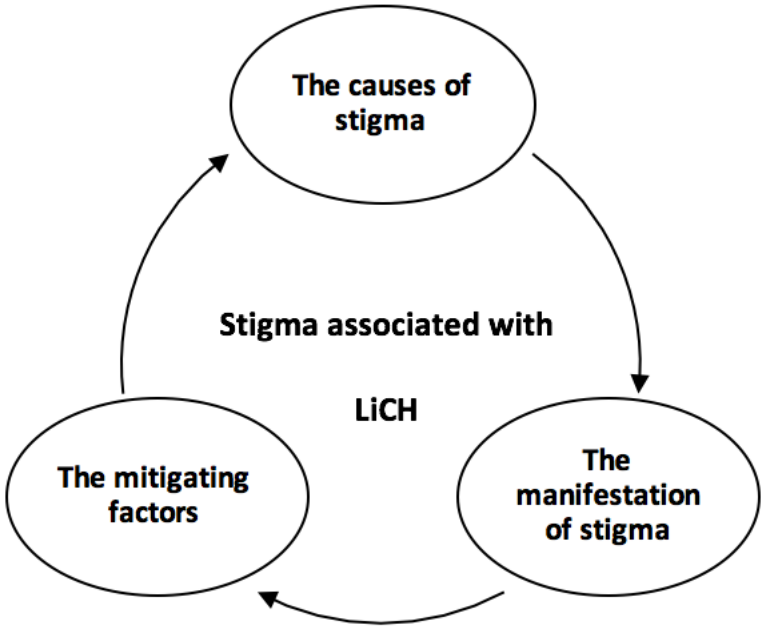


Figure 27: The process of stigma associated with a care home from the perspectives of residents and care home staff

Interviews with residents and care home staff showed their perceptions that a care home is seen by the public as a stigmatising place to live for Thai older adults; previous research conducted in Thailand indicates that over 90% of participants disagree that older parents should ordinarily live in care homes (Knodel et al., 2013a). Sending parents to live in a care home is negatively seen in Thai society, including by children themselves, and this was revealed by some participants in this study who did not wish their children to visit them in the home, to avoid them being identified as shameful children due to the expectation of filial piety toward parents. Furthermore, it has been revealed that many factors influence the process of how stigma associated with LiCH is created. The following sections discuss the process of stigma in more detail.

9.7 The cause of stigma

The results of the qualitative study reveal the causes of stigma related to various factors involving the public, older residents, care home staff and the care home environment. Some causes of stigma are generated by negative public conceptualisation of care homes and old age. These include negative beliefs about care homes and people who live in them, the nature of the care home population, and attitudes and stereotypes toward older people. In addition, some care home features (e.g. policies and inadequate staffing) in tandem with latent perceptions of such facilities contribute to cause stigma and escalate negative perceptions and experiences of LiCH. Figure 28 illustrates the causes of stigma associated with LiCH.

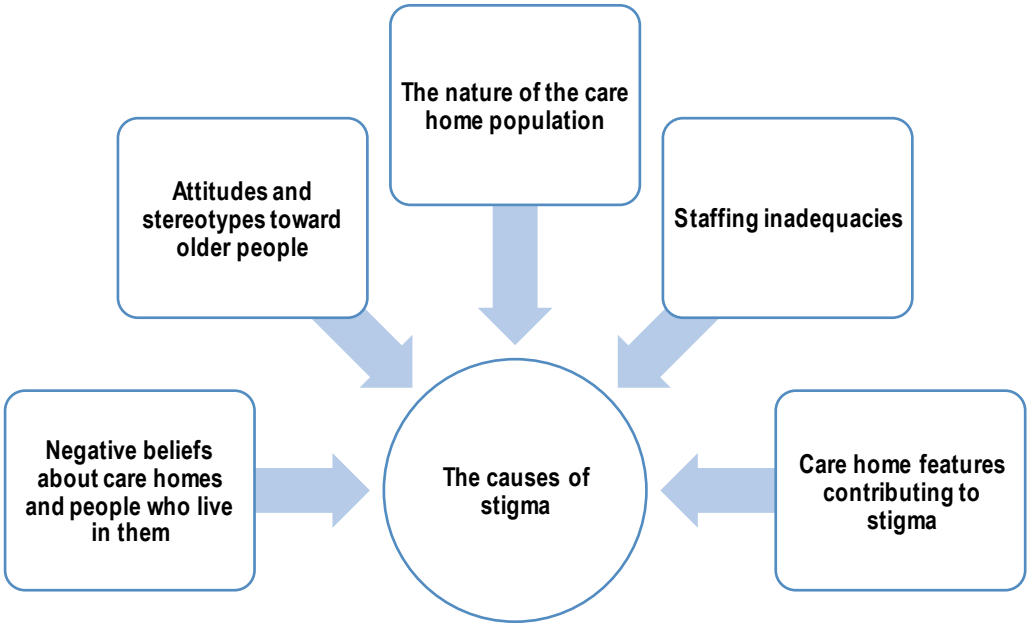


Figure 28: The causes of stigma associated with LiCH

9.7.1 Negative beliefs about care homes and residents

Important findings of the study reveal negative beliefs about Thai care homes and people who live in them. According to qualitative data, this study suggests that this may be related to how care homes have been promoted or shown in the Thai media such as television, radio and newspapers. Care homes in Thailand are seen by the public as places for the accommodation of poor or abandoned older adults, because older adults are customarily expected to be cared for at home by their children (Knodel et al., 2013a; Pornsema et al., 2014). This study highlights that negative beliefs about care homes and older adults who residing in them result in a bad reputation for care homes. For example, the public believe that care homes provide inherently poor accommodation and QoC for residents. As a result of negative beliefs, older adults created feelings of fear and worry about their QoL while LiCH.

The negative impacts of such beliefs for both residents and care home staff were illustrated by participants interviewed in this study. They explained how negative emotions occur to them when they knew that they were going to live in a care home. Care home staff were also concerned about working in a care home. Older adults were concerned about being looked down upon by others and their children acquiring bad reputations if people in their community knew that they were LiCH. This finding is supported by another study conducted in Thailand, which identified the impacts of care home residency of an older person on their families, such as being gossiped about and viewed negatively in the community (Knodel et al., 2013a; Pornsema et al., 2014). Consequently,

some residents in the qualitative study felt they needed to hide from their communities due to their status of LiCH, in order to protect their children from disparaging impressions among others. Also, some experienced being 'looked down upon' by others, and some even perceived LiCH to be equivalent to a jail sentence.

An important finding of this study reveals that stigma associated with LiCH is related to the concept of *Song Kroh*, a government service or institution for helping or assisting vulnerable and underprivileged people (i.e. the destitute or disabled) in Thai society (National Statistical Office, 2017), which carries negative connotations that are transposed to care homes when the latter are understood in this vein. In terms of stigmatisation, Song Kroh is analogous to the concept of the nineteenth-century workhouse (or 'Poor House') in Britain, where the destitute could eke out a bare subsistence living as despised paupers on the fringes of society (Bartlett, 1998; Higginbotham, 2017; Pennington, 2017).

In Thailand there were previously 20 care homes for older adults operating throughout the country under the Song Kroh system, supervised by the Department of Social Development and Welfare, Ministry of Social Development and Human Security; in 2004, twelve of these were transferred to local organisations to operate and supervise, with the remaining eight homes providing care for approximately 3,000 people; most homes subsequently removed "Song Kroh" from their names after the transfer in an apparently unsuccessful attempt to escape the associated stigma (Jitapunkul and Wivatvanit, 2008).

9.7.2 The nature of the care home population

This study highlights new information concerning negative public views toward the care home population as an underlying issue of stigmatisation. Some resident participants in this study were from vulnerable groups with experience of emotional distress before moving to live in a care home; they were susceptible to mental illness, particularly depression, which was most acute among those who had been (or who perceived themselves to have been) abandoned or abused by their families. Furthermore, some of the participants had issues regarding cognitive impairment, psychosis or alcohol dependence.

Earlier research reported high prevalence of elder abuse in Thailand, of up to 14.6% (Chompunud et al., 2010; Dong, 2015); for comparative purposes, the UK has negligible rates of older adults being neglected (1.1%) and financially abused (0.6%), largely due to the extensive health and social welfare provision that exists there and which is accessed by elderly people (Biggs et al., 2009; Dong, 2015). This study discovered that some older adults were abandoned or abused by their families before moving to care homes, and some of them were still targeted for financial abuse by their children even after going to live in the homes. This may leave them vulnerable to emotional distress, especially depressive symptoms (Dong, 2015) which could continue in the care home.

This study highlights that residents with cognitive impairment, are at greater risk of elder abuse due to the inherent nature of their condition and the greater difficulty of observing and caring for such residents. This

supports the findings by Dong (2015). This study found that some older adults with severe cognitive impairment have been discovered abandoned and sent to live in care homes by other government organisations. This study found that the majority of older adults with cognitive impairment are dependent, and they need more attention from care home staff. However, the problem of understaffing found in this study could influence their QoC, which could lead to other issues such as vulnerability to mental illness. As reported in a previous study, elder care home residents in Thailand who were dependent felt alienation from society due to the additional cause of frustration and shyness about their conditions (Pornsema et al., 2014).

When considering psychosis, a previous study conducted in Thailand suggested that people with mental illness are stigmatised by the public due to the stereotype that they are dangerous or unpredictable (Burnard et al., 2006). They are normally abandoned in psychiatric hospitals by their families, which arises from and reinforces the stigmatisation of mental illness. As a result, some older adults with psychosis do not have anywhere to stay or recover after their illness, thus they are referred upon discharge from hospitals to live in care homes, as found in this study. This causes them to have more difficulty in adapting to care home life especially with their peers. They also become a target for stigma concerning mental illness from other residents when they avoid contact with them. This increases feeling of isolation from both sides (residents with psychosis and their peers).

People with chronic alcohol-related problems (i.e. alcohol dependence or abuse) have tended to be sent to live in care homes by other organisations. It has been suggested that alcohol use disorders are one of the common psychiatric disorders found among older adults in long-term care homes (Seitz et al., 2010). Interviews with residents and staff indicate that residents with alcohol abuse found it particularly difficult to adapt to care home life and they were frequently involved in conflicts with other residents.

New knowledge on the nature of the care home population presented in this study clearly illustrates that causes of stigma reinforce the negative public view toward care home residents who are prone to psychiatric disorders. Evidently there are many particular attributes such as experiences of being abandoned or abused, have cognitive impairment, psychosis or alcoholism that can exacerbate the general vulnerability of elderly care home residents and render them more prone to emotional distress, particularly depressive symptoms before and after moving to live in care homes.

9.7.3 Attitudes and stereotypes toward older adults

This study highlights that attitudes and stereotypes toward older adults are one of the key drivers for negative perceptions of older adults living in Thai care homes. Ageism underpinned many of the triggers of the stigmatisation of LiCH in an ethnographic study conducted in the US by Dobbs et al. (2008). They revealed the problem of stigma and ageism in residential care and gave examples of how some residents were treated

with ageism by care home staff, such as using infantilisation elder speak when communicating to residents. A later study found the infantilisation of older people by staff to be a common communication issue in care homes (Williams and Warren, 2009). However, this creates a negative perception towards older adults as they feel a lack of respect and being looked down by members of staff (ibid). This study didn't find evidence of infantilisation toward the residents. This may be because of the respect for older adults in Thai culture. In addition, this study reports that many staff members perceived older adults to be too demanding, and that working with them was dirty work. Such perceptions naturally pervade the working environment of staff – and thus the living environment of residents – exacerbating the emotional distress of the latter during their daily residency.

Previous research found that ageism and other forms of prejudice can be reiterated among elderly residents themselves, such as some residents trying to avoid contact with others with cognitive impairments due to their stigmatised consciousness (Dobbs et al., 2008). This study found that physical and cognitive impairment among residents can be seen as a weakness and incompetence not only in the eyes of other residents but also in the eyes of other people including care home staff, leading to the loss of respect from them. These factors may be related to emotional distress whereby residents perceived internalised stigma and felt depressive symptoms, which have been found to be of very high prevalence in this population.

The findings of this study suggest that many care home staff and also many residents perceived that working with older people is demanding. This might be because older people with high levels of physical or cognitive impairment need to rely on other people, especially care home staff. It has been suggested that increasing dependency among residents was associated with cognitive and physical impairment that progressively reduced the control residents could exert over their own lives, leading to negative perceptions and feelings characterised by fear, worry and reduced autonomy and self-efficacy (Franklin et al., 2006). The findings of this research support previous studies in revealing some participants' perceptions of negative emotions about themselves, such as feeling unworthy or helpless due to no longer being in control of their lives and needing to rely on care home staff for their daily routines.

Care home staff participating in this study also expressed feelings of stress and burnout while working with older residents due to the demands placed on caregivers and the nursing shortage (i.e. high workload due to understaffing). Care home staff interviewed here viewed their work as highly demanding and prolific, with some residents requiring 24/7 assistance, especially those with severe cognitive impairments. Recent research found that emotional exhaustion and staff distress were found to be associated with QoC for older residents (Vandrevala et al., 2017). It is revealed in this qualitative study that some residents experienced inadequate care from some members of staff. For example, some staff were not willing to work, not assisting residents when they having meal or not providing any refreshment to bedridden residents.

Findings from this research reveal that ageism may be caused by the nature of work in relation to personal hygiene and health care aids for older residents. Early research conducted with a group of nurses suggested that most people had negative attitudes towards old age e.g. dependent, physical and mental frailty or loss of dignity or identity (Bernard, 1998). In addition, this study found that some members of staff perceived that their work is dirty and smelly, dealing with germs and contamination due to tasks involving residents' urine and faeces. Working with older adults is often perceived as "dirty work" as noted by research studies (Bjerregaard et al., 2017; Stacey, 2005), which sometimes found it affected care home staff ability to perform their jobs adequately due to increased risk arising from the exertions of physical and emotional strain (Stacey, 2005). In this study, some members of staff expressed that working with older adults caused them to experience negative health outcomes themselves, such as allergy or hypertension etc. Additionally, negative attitudes and stereotypes toward older adults by some members of staff influenced their behaviour which had a negative impacts on the residents. In addition, if residents believe the stereotypes about themselves, this will reinforce self-stigma.

9.7.4 Care home features contributing to stigma

9.7.4.1 Culture and environment in care homes

Several previous studies revealed negative experiences of communal living, lack of privacy and lack of freedom as the main negative aspects of care home residency according to residents (Choi et al., 2008; Dobbs et al., 2008; Fisher, 1990). This study extends the knowledge of these

negative perceptions and experiences of the features and the environment in a care home that can contribute to stigma, as explained in the dynamics of the process of stigma. This lived reality exacerbates the impacts of stigma for residents by reinforcing and adding to the negative public views of care homes.

Early research revealed that residents commonly perceived that care homes are depressing and isolated environments, which exacerbates depressed moods (Choi et al., 2008; Fisher, 1990). Negative experiences of LiCH have been revealed in previous studies related to communal living, lack of privacy and freedom, but these results had not demonstrated the affects of these dimension on the stigmatisation of LiCH (Choi et al., 2008; Tsai and Tsai, 2008). However, this study illustrates that these negative perceptions and experiences exacerbate serious impacts of stigma toward residents, which was evidenced using case studies. The participants in the study complained about lacking privacy in the care home due to their need to share their bedroom, bathroom and other facilities with other residents. Moreover, residents need to follow the rules and regulations of care homes, which makes them feel regimented and lacking in freedom and autonomy, thus many participants likened their residency to being in jail, which further increases the antipathy of older people to live in care homes.

9.7.4.2 Perception and judgment from other residents

This study found new information regarding the culture of Thai care homes that makes it difficult for new residents to adapt to care home life

because of the housing of older adults in different stages of care, including independent, dependent and terminally ill residents. The dependent residents (mostly those with cognitive impairments) are commonly separated in special areas of care homes. This raises questions both for those who end up there and those who fear this outcome. In addition, a general heterogeneity of resident conditions was noted in general care home settings. It is suggested that, in mixed company, people tend to normally socialise with people similar to themselves, which is inherently conducive to stigmatisation (Roth et al., 2016); this was confirmed by the findings of this study, which found that residents of different socio-economic backgrounds and conditions creating stigmatised attitudes among themselves.

It was found that residents were prone to compare themselves with other residents, which led to judgments related to social class and group power dynamics, associated with monitoring, gossip, peer pressure and conflict among residents. For example, educated residents do not socialise with uneducated ones due to different interests or preferable activities. Similar results were found in a study of communication in assisted living (Williams and Warren, 2009). Interviews with residents and care home staff in this study revealed that residents like to monitor their own and others' behaviours for comparative purposes, in parallel to professional and institutionalised grouping (e.g. residents with disabilities and cognitive impairments being grouped by their appearance and by the routine work of care home staff), all of which has been found to contribute to stigmatisation (Fisher, 1990). Residents were aware of being

stigmatised by other residents, resulting in manifestations of negative emotions and behaviours as reported in this study. Perception and judgment from other residents, exacerbate negative beliefs and create negative emotions e.g. loneliness or depressed mood or creating negative behaviours e.g. avoiding contact or social exclusion.

9.7.4.3 Unequal power between staff and residents

Another cause of stigma found in this study is unequal power relations between residents and members of staff due to rules and regulations, and punishment applied to residents breaking such policies. It is suggested that relationships and interactions among residents and care home staff were identified as being of two types: social and relational exchanges (Cook and Brown-Wilson, 2010). Social exchanges are explained as focusing on task of caregivers. In addition, relational exchanges are identified as personal or experience sharing. This study found that residents are attached to the development of personal responsive relationship with staff; for instance, some of them expressed that they see care home staff as members of their own families. However, the study also revealed that there is an issue of unequal power relations between staff and residents leading to negative experiences of LiCH and comprising an additional cause of stigma.

According to Foucault, "power is both relational and productive relational", which pertains to the way in which power represents human relationships, including within institutions (Scales et al., 2017, p. 229). A group of staff hold power over a group of residents because of their

responsibility for residents' safely and standard care (e.g. close observation or making a decision or evaluation). Consequently, this study found that residents generally experienced powerlessness. Some older adults perceived that they have no authority due to the authoritarian and restrictive perception of institutional rules and regulations, and monitoring by staff (and other residents), which makes them feel more vulnerable.

Indeed, there were historical issues of some cases in which staff members were reported to have abused this power imbalance to take advantage of residents, such as borrowing money from them and even refusing to repay such personal loans, as well as a general culture of preferentially dealing with cooperative residents and correspondingly 'punishing' residents who complain or who otherwise do not cooperate with staff. This highlights the issue of power imbalance between residents and care home staff does exist in Thailand, which calls for attention by policy makers to change attitudes towards older people in general and to introduce safeguarding education, training and the encouragement of organisational whistle-blowing in care homes.

The issue of power imbalance between staff and residents in this study was associated with the rules and regulations of the care homes. Residents' behaviours were monitored by members of staff, which caused them to feel their lives were regimented and that they lacked privacy, associated with disempowerment and low self-worth. Furthermore, there was evidence that some residents experienced emotional distress because of the unequal power balance and even

mistreatment by some members of staff. Therefore, power imbalance had a negative impact on residents' lives in the care homes.

9.7.5 Staff issues

This study found that staff issues were directly associated with negative perceptions and experiences of LiCH among residents and one of cause of stigma associated with LiCH. The study found various issues related to staff e.g. understaffing and high workload, leading to staff burnout and stress during and after working hours, which can be a reason underlying stigmatisation of LiCH in the eyes of the public, consequently creating fear and worry about the QoC in government care homes among older adults and their families.

These staffing issues can also create a negative job attitude and low motivation among care home staff, particularly among a group of care assistants dealing directly with older adults in their basic daily routine. A recent study found that working with older adults was seen by the public as dirty and undesirable work (Bjerregaard et al., 2017). This stereotype has a direct impact on staff attitudes and motivation to work in care homes.

Furthermore, staffing issues can become an additional cause of stigma among residents whist LiCH. This may impact on QoC for residents and can lead to older adults being abused and neglected in care homes. It was reported in this study that some residents and members of staff perceived that some residents received inadequate care from members of staff due to work-related burnout or stress, which impaired the ability

of care professionals to provide required assistance and services. This could leave residents with the feeling of emotional distress and depression. This affirms the finding of previous research that poor relationships with staff can cause residents to feel sad or depressed (Iden et al., 2015).

9.8 The manifestation of stigma

The terms stereotyping (negative thoughts or beliefs), prejudice (negative feelings or emotions), and discrimination (negative behaviours) can be used interchangeably in the context of the manifestation of stigma, but they are in fact subtly different. Stereotypes are considered cognitive components such as beliefs or perceptions involved in the causes of stigma; prejudice is considered as affective component and discrimination is considered as behavioural component (Branscombe and Baron, 2017 p.207). They are illustrated in the second element of a process of stigma (the manifestation of stigma). The study revealed that residents experience affective and behavioural components of stigma associated with LiCH. Figure 29 shows examples of negative emotional reactions (prejudice) and negative behavioural responses (discrimination) among residents.

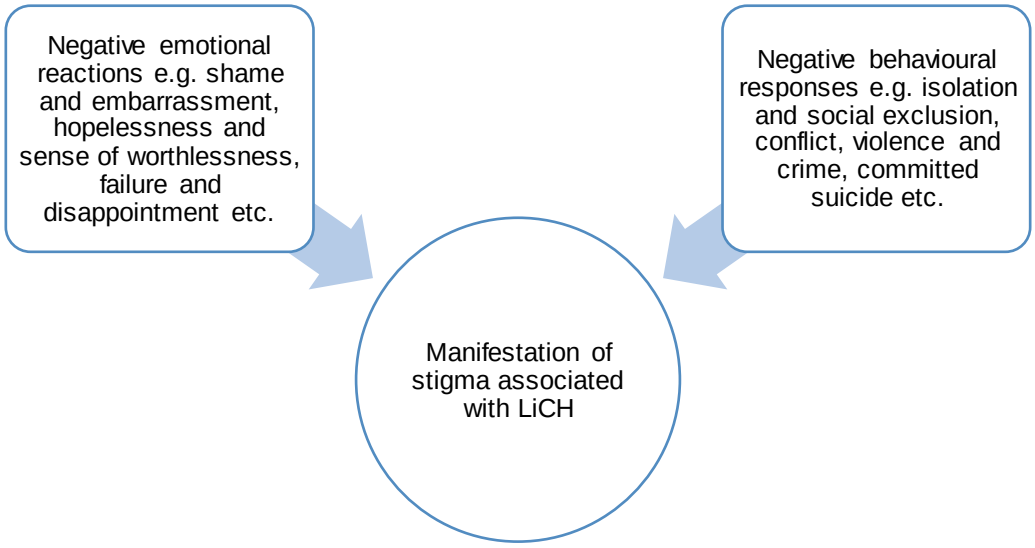


Figure 29: The manifestation of stigma

9.8.1 Negative emotional reactions

Participants reported having negative emotions such as perceptions of being abandoned and unworthy, failure and disappointment, loneliness, self-blame, frustration and aggression, shame and embarrassment, low self-esteem, feeling hopeless and helpless, and depression and suicidal ideation. These emotional reactions are related to symptoms of clinical depression, particularly suicidal ideation, which was found among participants.

9.8.1.1 Abandoned and unworthy

Participants in this study illustrated that residents were compelled to live in care homes due to being abandoned by their families, suffering from an illnesses or having a dependency expressed the feeling of being abandoned and unworthy: LiCH was not their ideal choice, and prior to admission they were part of the public who stigmatise care home

residency. As mentioned previously, and noted by previous study conducted in Thailand, many residents are mentally fragile due to being abandoned or having no families, which could render them more vulnerable and depressive (Pornsema et al., 2014).

Stigma manifestations, such as stigma by association (as discussed previously) inhibiting visitation, caused residents to feel abandoned and unworthy, becoming additional causes of stigma. Stigma tends to play an important role in residents' relationships with their families. This might be because the public may perceive their families to be irresponsible for sending elders into care homes, which makes the families feel ashamed of being present in care homes with their love ones, causing dissimulation by both residents and families to hide their collective shame (Knodel et al., 2013a). As data from this qualitative study shows, the majority of residents did not receive any visitors; this stigma-related factor compounds the general isolation of residents and the stigma itself, exacerbating personal feeling of loneliness.

9.8.1.2 Loneliness, hopelessness and helplessness

Previous studies have observed that loneliness is a critical problem among older adults residing in residential homes worldwide, related to negative psychological problems, particularly clinical depression (Theurer et al., 2015). Loneliness can manifest psychological symptoms of depression such as low mood, sadness or emotional withdrawal. Early research pointed out that loneliness among residents has been found to be related to the isolated environment of care homes (Fiveash, 1998).

This study shows that feelings of loneliness among residents may be linked to the sense of abandonment from their families. This is related to the impact of stigma by association toward the residents' families which may prevent them from visiting the care homes due to feelings of shame about letting their love one LiCH. Many residents also felt hopeless and helpless about the nature of their living situation, stating that they lived on a day-by-day basis. It is suggested that dependence on routines can lead to feelings of not being valued (Hellström and Sarvimäki, 2007). Some residents in the study expressed that they were merely waiting to die. However, some residents observed that these feelings were more prominent among those suffering from depression, and who had fewer or no visitors.

9.8.1.3 Failure, disappointment and self-blame

Failure and disappointment were widespread among residents in this study, particularly male residents of a relatively young age. These participants stated their perception of being failures and disappointments when moving to live in care homes, related to a lack of autonomy, as found in a previous study (Hellström and Sarvimäki, 2007). Additionally, such male residents were clearly influenced by cultural beliefs that they should be breadwinners and supporters of their extended families rather than dependents. Moving to live in care homes thus had a huge negative impact on them, evoking feelings of being looked down by people in their communities. Consequently, some residents participating in this study revealed that they wished to conceal their residency from their communities.

Self-blame was another negative emotional reaction found in this sample. Some residents blamed themselves for ending up living in a care home. This may be the impact of the public stigma toward the care homes and people who live in them. It is suggested that LiCH is seen as being a symbol of residents' inferior status compared to other people in society (Pornsema et al., 2014). The results of this qualitative study also highlight that many residents were unhappy to live in care homes, and some of them blamed their status on their past behaviours. Such beliefs were particularly common among residents who were wealthier and well educated. LiCH made them feel like a failure and they blame themselves, which had negative impacts on their health and well-being.

9.8.1.4 Frustration and aggression

This study points out that communal living life among residents caused feelings of frustration and aggression due to negative perceptions and experiences of LiCH and this shows the impact of stigma that can lead to other forms of negative emotions (frustration and aggression). Interviews with residents illustrated the challenges of LiCH, such as lack of privacy due to sharing facilities with others. Numerous previous studies also identified that such factors serve as triggers for conflict among residents (Choi, 2008; Rosen, 2008b; Williams, 2009), but the phenomena of resident-to-resident aggression remain under-researched; indeed, such events are likely to be under-reported due to the negative publicity such cases bring to care homes and professionals. However, previous research identified this as a very serious topic linked to conflict, violence and crime in care home communities, with impacts on residents' physical

and mental wellbeing (Choi et al., 2008; Rosen et al., 2008a). During observations it was commonly observed that care home staff normally find solutions and mediate between residents who have a problem on an *ad hoc* basis.

9.8.1.5 Shame and embarrassment

As discussed previously, the most pervasive emotional reaction found in this study to care home residency was shame and embarrassment. Many residents stated that the public perceived care homes to be places for people unable to work and support themselves, making them feel ashamed because they were characterised as useless or helpless. A previous investigation revealed that most of older adults living in Thai care homes have in fact been abandoned or rejected by their local communities, as a result of which they are stigmatised, feeling ashamed and embarrassed (Wongpakaran and Wongpakaran, 2012a). It was evident that public stigma towards people LiCH resulted in creating shame and embarrassment among residents, especially those from rural areas, where family support is a more natural and expected phenomenon, increasing their propensity to hide their residency from their communities.

9.8.1.6 Low self-esteem

The findings of this qualitative study reveal that the negative views of LiCH held by the public influenced on how residents see themselves, as discussed previously (e.g. feeling useless). Therefore, it is possible that perceived high internalised stigma of LiCH could result in reducing self-

esteem and increasing depressive symptoms among older residents who live in care homes. As the findings from this quantitative study point out that internalised stigma was reported to have a highly significant correlation with depressive symptoms. It is revealed that this factor also was reported high significant correlation with self-esteem.

Previous research found that low self-esteem is a risk factor for poor QoL (Sun et al., 2017). It has been suggested that LiCH reduces the self-esteem of residents due to the perception that care home residents are of poorer socio-economic status and have poorer resources of family support (Sun et al., 2017). Therefore, this research highlights that the manifestation of stigma caused by negative beliefs about LiCH is likely to render residents prone to depressive symptoms.

9.8.1.7 Depression and suicidal ideation

Participants in this study commonly referred to the most egregious outcomes of stigmatisation: depression and suicidal ideation. As discussed previously, this research and previous studies found a very high prevalence of depressive symptoms among residents in Thai care homes (Pornsema et al., 2014; Wongpakaran and Wongpakaran, 2012a; Wongpakaran et al., 2013) but previous researchers did not link this to the stigma associated with LiCH. This study is the first to spotlight the crucial issue of stigma factors correlated with depressive symptoms in Thai care home settings. As evident from the results of the questionnaire study, the majority of residents experienced some level of internalised stigma.

Interviews and observations with residents and care home staff confirmed that some residents experience depressive symptoms and suicidal ideation. Furthermore, negative emotional reactions toward stigma could be additional cases leading residents to suffer from depressive symptoms, as explained previously, including feelings of abandonment, feeling unworthy, loneliness, hopelessness, helplessness, failure, disappointment, self-blame, frustration, aggregation, shame and low self-esteem. Moreover, some residents illustrated that isolation in care homes and lack of support from their own families are the main factors making them develop depressive symptoms and suicidal ideation.

Earlier research on stigma found high level of perceived of stigma correlated with greater of depressive symptoms among older adults with depression (Conner et al., 2010a), and some studies found that the severity of depressive symptoms is high correlated with suicidal ideations (Mcdougall et al., 2007b; Tan and Wong, 2008; Wongpakaran and Wongpakaran, 2013). Therefore, there is a possibility that stigma is an additional trigger catalysing the negative impact of depressive symptoms more severely among the stigmatised group among older adults residing in Thai care homes in the current research.

9.8.2 Negative behavioural responses

Negative behaviours found among residents were related to avoiding contact, isolation and social exclusion, violence and crime and suicide, all of which were related in numerous ways to stigma associated with

LiCH. They tried to avoid contact from their relatives and friends while LiCH. Some of residents isolated themselves from other residents and also from people outside the care homes.

9.8.2.1 Avoiding contact (isolation and social exclusion)

Previous studies found that avoiding contact was a common discriminatory behaviour involved in targeting stigmatised groups, such as people with mental illness (Corrigan et al., 2014). An interesting contribution of this study was to reveal that stigma affects residents by the internalisation of this trend in terms of social withdrawal and other manifestations of negative behaviour isolating residents from the outside world, including their families or communities; moreover, they also avoided contact with other residents living in the same locale. These behaviours exacerbated feelings of isolation and social exclusion, and prevented residents getting help from others because of barriers associated with social disengagement among these residents. The reason why some residents avoided contact were not all attributable to stigma as suggested previously (Wongpakaran and Wongpakaran, 2012a). However, this happened in some cases related to conflicts between them and their families or between them and other residents. By avoiding contact, social withdrawal may help to minimise conflict, violence and crime in care homes, although it has generally negative effects.

9.8.2.2 Conflict, violence and suicidal ideation

The current study suggests that conflict among those LiCH may also be related to social communities in care homes, where people in this community come from different backgrounds, such as in terms of differences in education or regional background. It is suggested that stigmatised individuals can sometime react in extremes of aggression or intense shame (Goffman, 1963, p.29). Conflict, violence and crime are potential negative behaviours that can arise from emotions of frustration and aggression among residents. It has been suggested that this behaviour is under-researched due to the potential negative publicity it would cause to homes, and implications for the power-relationship between residents and staff (Rosen et al., 2008b). However, it causes severe consequences such as physical injury (e.g. one resident was stabbed by his peer). In addition, the findings of the study do not demonstrate a direct link between stigma associated with LiCH and suicide, but the associated emotional and behavioural reactions were certainly related to suicidal ideation and potential for suicidal behaviour.

9.9 The mitigating factors of stigma

The study identified mitigating factors that can reduce negative emotions and behaviours associated with LiCH: social support, coping strategies and activities in care homes. Figure 30 summarises the mitigating factors of stigma among residents.

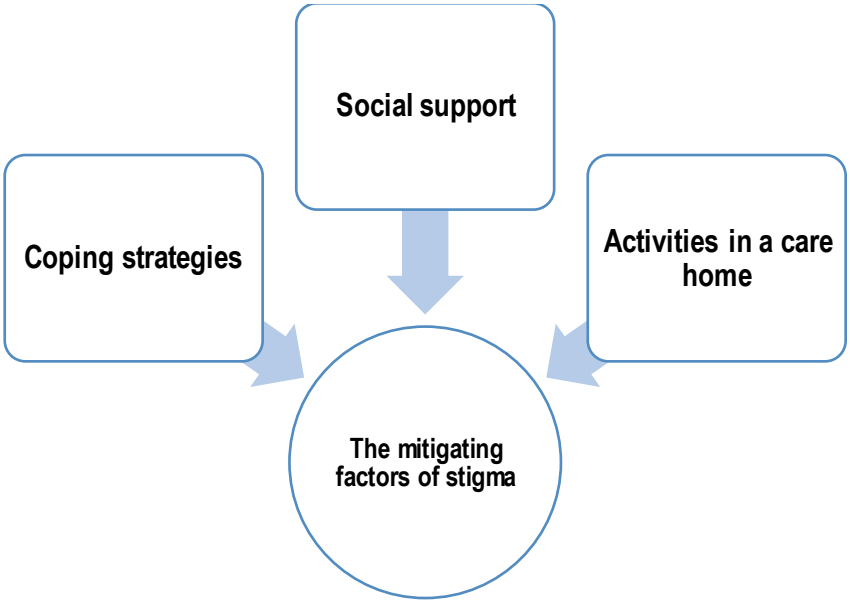


Figure 30: The mitigating factors of ECHRS

9.9.1 Social support

Recent research advocates the benefits of social support from numerous sources (including family, friends or peers, care home staff and ordinary people) as a major mitigating factor of stressful or stigmatising situations, but residents participating in this study perceived low social support, which is common among older adults who have limited contact with families and friends (Pornsema et al., 2014). The current study found that some residents received financial support from their children, which alleviated feelings of abandonment, but without much interpersonal support (in some cases parents received money from children they rarely saw, due to shame and other factors). However, the majority of residents did not receive family support, and they were sustained by charitable support from individuals, organisations or corporate donors of food, clothes, groceries and money. Sometimes volunteers come to care homes for social activities with residents, such as dancing or singing. As

mentioned earlier, the public perceive residents with pity and feel sorry for them, which is generally negative in terms of providing a precursor for stigmatisation, but such feelings also inspire positive behaviours among those motivated to become involved with residents.

The majority of residents do not have any pensions, having in most cases worked as agricultural labourers or small farmers, thus they are often wholly dependent on donations, and most residents face financial difficultly. Only three groups of Thai older persons are eligible for income security programmes: government officers, employees from private firms and those who were self-employed (Sasat and Bowers, 2013). However, in 2002, the Ministry of Social Development and Human Security supported poor older adults with a monthly "Cash Allowance for Older Persons" of 300 Bath (£7), later increased to 500 Bath (£11) (Sasat and Bowers, 2013). Currently, the government has introduced a graded income support system, whereby the allowance increases with age up to 1,000 Bath (£23) for people aged 90 and older.

However, residents LiCH are not eligible to receive any state pension as they receive free services from government care homes such as food, accommodation and health care in lieu of cash. Therefore, the only income that they receive is from public donations. Only a very small number of residents are financially supported by their families or their children.

In terms of emotional support, residents indicated that they had been supported by care home staff. Furthermore, their peers, including their

roommates and friends outside care homes, also support them. Care home staff demonstrated awareness of the positive role of peer support, leading them to promote it, particularly for new residents. In such cases they suggested or introduced “buddies” to help with orientation and adaptation into care home life.

9.9.2 Coping strategies

Numerous coping strategies were used by residents to cope with their stressful situations, as explained below.

9.9.2.1 Spiritual self-efficacy

Buddhism is the official religion of Thailand and the religion of most Thais (Leelavanichkul et al., 2017), and 99% of participants in this questionnaire study identified themselves as Buddhists. Consequently, spiritual self-efficacy was used by many patients, expressed in Buddhist beliefs and practice. These include karma (believing that adversity results from one’s karmic retribution of previous action), mindfulness (presence and engagement in the moment) and religious devotions (e.g. daily meditation, invocations and almsgiving). Religiosity and religious practices have been demonstrated to be socially valuable and to be associated with positive attitudes among older Thai Buddhists (Leelavanichkul et al., 2017).

In this study, residents applied the karma approach to get to the stage of acceptance of their situation more quickly when they needed to live in care homes, rather than focusing on their negative emotions. In addition, mindfulness and religious devotions help them to stay in the moment and

focus on coping strategies rather than remaining preoccupied with their negative mood. This was supported by previous research which found that Buddhist coping strategies help to promote emotional wellbeing among older adults (Choi et al., 2008; Phillips III et al., 2009; Wu and Liu, 2014).

9.9.2.2 Cognitive acceptance, positive thinking and comparison with others

Similar to the karmic approach, this study indicates that cognitive acceptance helped some residents accept their situation more quickly, facilitating their adaptation into care home communities. This is key to helping care home residents minimise stress while LiCH. The acceptance may be part of coping strategies being used among Thai Buddhists, for example the concept of *Plong* and *Anitjang* (the Buddhist teaching that one should accept what has happened and that all things are impermanent). This concept was found to enable coping with depression among elderly Thai Buddhist immigrants in the US (Soonthornchaiya and Dancy, 2006).

Participants in the study illustrated that an attitude of positive thinking is very important to reduce their stress when LiCH. Older residents explained that positive thinking enabled them to adapt to care home communities and their friends. Positive thinking helped to minimise negative emotions and behaviours among residents, which is pertinent as most individuals experienced various causes and degrees of internalised stigma. Previous studies also found that older adults used

positive thinking approaches to adapt with LiCH, such as seeing something positive in each day (Choi et al., 2008; Franklin et al., 2006; Williams and Warren, 2009). The extent to which the personality of the older adult was optimistic played the biggest role in buffering the stressors of care home life, and those with positive attitudes are better adjusted to their lives in care homes (Choi et al., 2008).

Participants used comparison with others to cope with stressful situations, which had the potential for both positive and negative impacts. Some residents used this strategy to compare themselves with others less fortunate than themselves, and thus they felt less worried or more encouraged to be independent compared to people with more serious health problems, for example those who required 24-hour care or who had severe cognitive impairment. Previous studies showed that older residents also used comparison approach to reduce their worry and stresses (Nakrem et al., 2011; Williams and Warren, 2009). This approach helped them to maintain their well-being whilst LiCH.

9.9.3 Activities in care homes

Activities in care homes were found in this study to be mitigating factors of stigma. It was observed that various activities were provided for residents, such as occupational therapy, social activities (e.g. music and singing or travelling), and also individual interest activities (e.g. reading or writing). However, there were barriers preventing residents from engaging in such activities, particularly their physical impairment and illnesses. Some participants in the qualitative research feared failure if

they participated in activities such as exercises. It has been found that residents' health status, environmental condition and organisation can be barriers to physical activity (Benjamin et al., 2014). The general positive effects of exercise for physical and psychological health and wellbeing are universally acknowledged, but physical activity levels are generally far too low among elderly people, and there is insufficient awareness and emphasis on this in geriatric care in clinical settings (Benjamin et al., 2014).

Therefore, the problem can be expected to be much worse in care homes where many factors contribute to residents being less proactive. This includes the physical environment (the layout of buildings or accessibility) and caregiver-related factors (the number of caregivers or their available time) (Douma et al., 2017). Residents with functional disabilities and cognitive impairment are particularly likely to be abandoned by staff and excluded from physical and social activities due to the limited of their cognitive and bodily functions (Benjamin et al., 2014). On the other hand, these groups are especially vulnerable and would particularly benefit from steps to improve their physical and emotional well-being (ibid).

In summary, the process of stigma involves creation from different sources and factors among different groups of people in a socio-cultural societal framework, including residents, their families, care home staff and the public. Residents carried negative perception regarding LiCH and the people who live in them before they moved to live in the homes. Care home life itself exacerbates the impact of stigma, especially when

some residents believed and agreed with the stereotype, in which case the impact of stigma toward them is exacerbated. Thus, they manifested some negative emotions or behaviours which become additional causes of stigma. Nevertheless, the manifestations of stigma were limited by the mitigating factors, as discussed previously. Figure 31 shows the process involved in internalised stigma and mitigating factors. The findings of the study suggest that effective mitigating factors should be used to minimise residents' internalised stigma of LiCH.

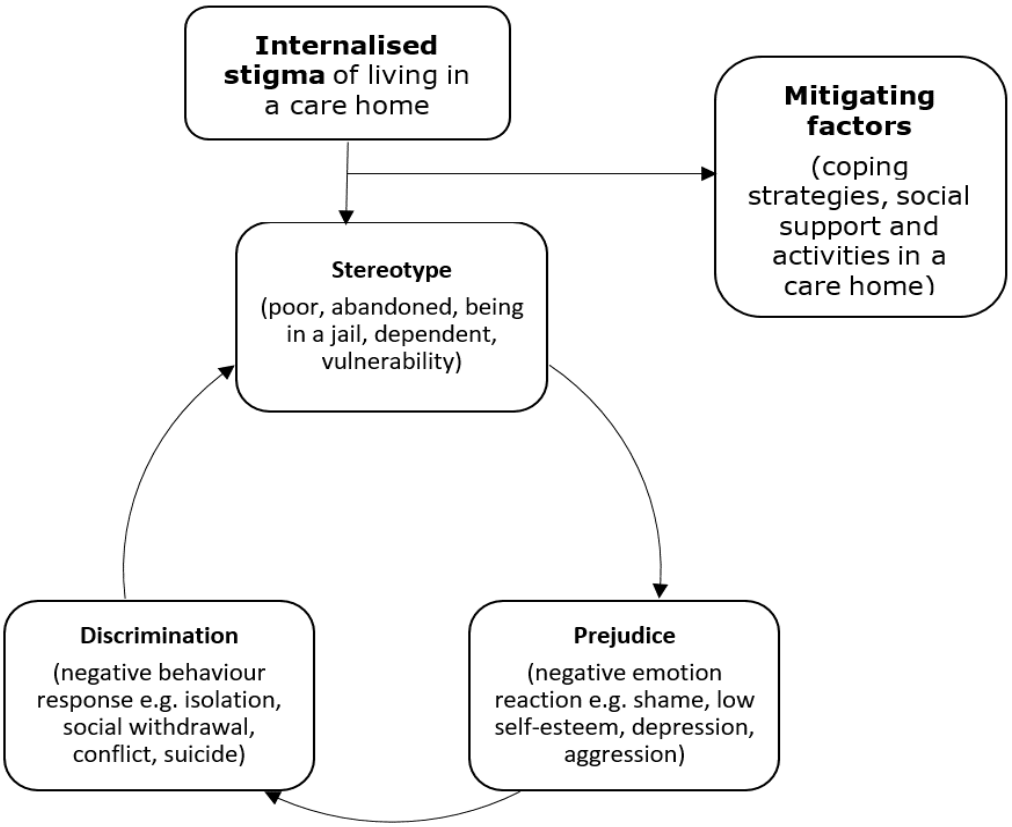


Figure 31: The process involving internalised stigma associated with living in care homes

Adapted from Corrigan and Watson (2002a)

Previous research around HIV-related stigma suggested that stigma manifests in four different dimensions of social life: public stigma, self-stigma or internalised stigma, stigma by association and structural stigma (Pryor and Reeder, 2011). The current study extends knowledge of how stigma manifests itself in these four different dimensions and how this affect residents. It also applies knowledge of stigma to the context of care homes, where stigma is under-studied. Different dimensions of stigma associated with LiCH are shown in

Figure 32 relative to different groups of people who have an impact on residents (including residents themselves).

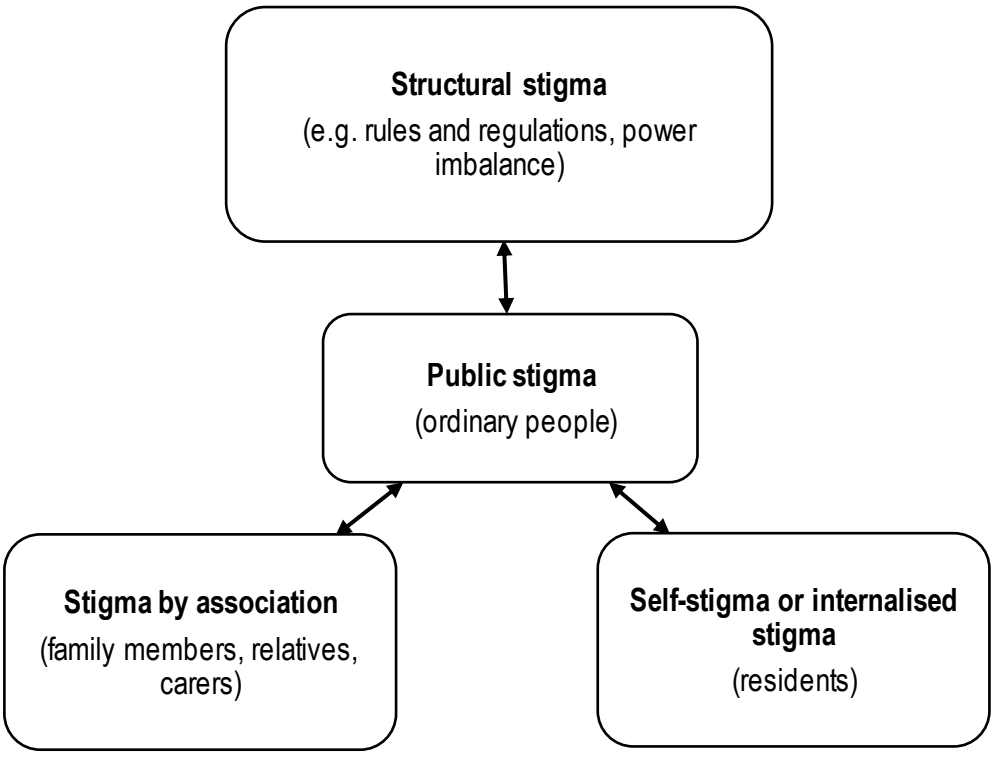


Figure 32: Four dimensions of stigma associated with living in care homes

Adapted from Pryor and Reeder (2011)

9.10 Public stigma

This study clearly illustrates that people who LiCH are stigmatised by the public due to the primordial cultural assumptions of filial piety and extended family support in Thailand. These assumptions are reiterated by social norms and traditional concepts of family support in Thai society, rooted in the public affirmation of the ideal that children should not leave their older parents LiCH (Knodel et al., 2016). It has been suggested that the stigmatised condition in general can trigger negative emotions and behavioural reactions such as onset controllability (e.g. triggering a smoker to get lung cancer), perceived severity of condition (disabled people), perceived danger (people with mental illness) and perception of norm violation (people with HIV) (Bos et al., 2013). This study has found the public perceived the residents, with pity or sorrow. However, this evoked internalised stigma among the residents and had an impact on them. As a results, they manifested their negative emotion reactions or behavioural responses whilst LiCH.

In addition, this study found that some people perceived failure and disappointment toward older adults residing in care homes. This apparently created a negative picture of residents who live in care homes, due to public preconceptions that residents are poor, abandoned and/or abused by their families (Pornsema et al., 2014). This could have negative direct impacts on residents (e.g. feelings of shame, embarrassment or depressed mood), and discourage older adults living in the community who might otherwise benefit from care home facilities and staff, condemning them to a poorer standard of living at home. The

study also identified some positive aspects of the public stigma toward LiCH in term of donations, as the general public is keen to contribute to improve the lives of care home residents, including in terms of donations of money, food, groceries and participating in some social activities. However, the study found negative reactions from some residents about the donations. For example, some residents expressed their feeling of shame by receiving donations from people who younger than them or some residents felt inferior than other people in society when they were perceived as pitiable or poor people in public perceptions.

9.11 Self-stigma or internalised stigma

Another dimension of stigma is self-stigma or internalised stigma. Self-stigma or internalised stigma is when people with a stigmatised condition are aware of the public stigma toward them, which consequently affects how they perceive themselves (particularly in negative ways) (Bos et al., 2013). The findings of the quantitative research show that the vast majority of residents experience some levels of internalised stigma. In addition, the results of this qualitative research illustrate that many residents experience negative emotional reactions and behavioural responses. Psychological stress symptoms were found in many residents, including low self-worth, shame and depressive symptoms. These negative emotions have been found in the research on HIV-related to stigma as well (Pryor and Reeder, 2011) but have not been investigated in relation to care homes. These negative impacts on residents may be related to how residents see themselves when moving to live in care homes (e.g. feeling that they are being abandoned, having

low status in society) as well as how they behave (e.g. by hiding from and avoiding contact with people outside the care home) to avoid being looked down on by others.

9.12 Stigma by association

This study extends the very limited existent knowledge of stigma by association (Pryor and Reeder, 2011). It has been suggested that stigma can affect other people who have connections with stigmatised people (Bos et al., 2013). A study of HIV-related stigma provided an example of how stigma can impact on people belonging to a stigmatised group, suggesting that families and carers of people living with HIV can experience stigma by association (Pryor and Reeder, 2011); however, there is little research on stigma associated with LiCH, and impacts of stigma by association have only been mentioned in very limited details generally. The findings of this study present new knowledge of stigma by association in the context of care home settings, identifying that people associated with care home residents also experience stigma by association particularly the case for Thailand, for instance people who have a personal relationship with a stigmatised target, including family members or relatives. Other people, including care home staff, can perceive negative impacts of stigma as well. Negative judgments from others toward residents pertain to families and relatives who let their older parents reside in care homes. As a result of such beliefs, families often attempt to conceal or hide their relationship with residents.

Some families feel ashamed to let their parents live in care homes. It was obvious during the observation that most residents' families did not come to visit them, which may be due to the perception of shameful or perceived irresponsibility among residents' relatives, due to the stigmatised context. Care home staff themselves in some cases entrenched the negative impact of stigma associated with LiCH, manifesting negative perceptions such as ageism, which was related to their overwhelming and dirty work, which view was shared by the public. However, the findings of this study indicate that due to the arduous nature of this work, the public have a positive perception and appreciation of care home staff and gratitude for their work with the vulnerable minority of care home residents in Thai society.

9.13 Structural stigma

Previous study highlighted that structural stigma refers to the way in which social institutions and ideological systems exacerbate stigmatised status (Bos et al., 2013). Interviews with residents reveal important information that rules and regulations applied to them in care homes include provision for the punishment of rule-breakers, which led to a culture of suspicion among residents and which caused them to feel a lack of freedom and authority commonly compared to being in a prison. This study spotlights new knowledge on structural stigma associated with LiCH that the social dynamics and institutional systems in care homes thus create two groups: the powerful group (care home staff) and the stigmatised, powerless group (general residents). It is suggested that this is called the function of exploitation and domination (keeping people

down) in social psychology (Bos et al., 2013). Consequently, some residents felt that their behaviours was being monitored by members of staff. In addition, some residents seeking to curry favour among staff. Residents were also acutely aware of monitoring from their peers. This social institution is manifest and triggers stigma to get worse.

In summary, the results of the qualitative study explained the dynamics of the process of stigma in relation to three elements, including the causes, manifestation and mitigating factors of stigma. Stigma has a number of potential causes but that its impact can be limited by mitigating factors. The presence of stigma tends to result in emotional and behavioural responses which, when present, can become additional causes of stigma in themselves. This new knowledge on stigma associated with LiCH could encourage and help researchers and practitioners in finding a solution or an intervention to minimise negative impacts of stigma in further research. Further, the findings of the study could help develop strategies to combat stigma, as presented in more detail in section 8.18. The next sections discuss the study strengths, limitations and recommendations.

9.14 Study strengths

The systematic review (conducted in June 2017 with no limit to publication date) presents the findings of primary qualitative research. Thematic synthesis on the topic of how stigma associated with LiCH develops or maintains depressive symptoms helped us to understand the existing gap of knowledge and research. This research topic has been

under-researched for a long period of time, despite stigma being flagged as a pertinent healthcare concern by Erving Goffman over half a century ago (Bos et al., 2013). The results indicate that only a few studies mentioned that they aimed to research the topic of stigma associated with LiCH, and only 15 studies worldwide related to the experiences of older adults residing in care homes; this shows very limited knowledge and understanding on the research topic.

One methodological strength of this study is that a new scale (Thai version of IS-LCH Scale) with good psychometric properties was developed and deployed in the fieldwork; it is anticipated that this will be a highly useful tool for future research in this field. The dearth of research on this important area of geriatric care motivated the adaptation and development of a questionnaire to assess internalised stigma of LiCH, which was found to have good to excellent internal consistency and reliability. This can be used in future research to assess internalised stigma among residents living in similar contexts. Furthermore, the scale can be used to detect older adults who are likely to have depressive symptoms, as depression was found to be correlated with internalised stigma in this sample. Older adults with high internalised stigma were likely to report greater levels of depressive symptoms.

A further strength of the study was the use of standardised, validated measures in the quantitative study. All measurements used in the study (GDS, IS-LCH, RSES, MSPSS and CSI-SF) showed good validity and reliability. Reliability refers to how consistent response are to the

questions and validity refers to how well a questionnaire can measure what it is intend to measure (Coughlan et al., 2007). The measurements (GDS, RSES and MSPSS) have been used previously among Thai older adults living care homes (Wongpakaran and Wongpakaran, 2011; Wongpakaran and Wongpakaran, 2012b; Wongpakaran et al., 2013). The pilot study was undertaken in order to validate the two scales (IS-LCH and CSI-SF) before the actual data collection. Therefore, the results of the study comprise accurate information, helping to achieve the aim of the study.

The next major strength of this study was the exceptionally high response rate from the older residents in the questionnaire study (98.46%) which is higher than the research previously conducted in Thai care home (71.68%) (Wongpakaran and Wongpakaran, 2012a). Therefore, the findings of the study may be generalised to similar populations, particularly in similar cultural contexts (e.g. Asian countries with strongly embedded notions of family support and filial piety). It is suggested that a survey study should be aimed to reach response rate at least 60% (Fincham, 2008). Lack of response rate could reflect nonresponse bias and result in the study not being representative of the population of interest.

An additional strength was that it was possible to generate a rich and contextualised understanding of stigma from various perspectives and a diversity of residents and care home staff. This was based on the experiences and perceptions of stigma associated with LiCH from

numerous viewpoints, including residents who experienced LiCH for at least three months, and care home staff with experience of working in care homes for at least three months. Furthermore, participants were selected from diverse groups in terms of gender, age, education, duration of residency or occupation in care homes, and the working position and education of care home staff. These characteristics provide a broader understanding of the experiences of residents and staff concerning living or working in care homes, and provide a rich and contextualised understanding of stigma associated with LiCH among a broad and representative cross-section of care home residents.

Permission to assess or analyse this research data for academic purposes was obtained from all participants before they participated in this study. Therefore, there is an opportunity for further analyses from datasets, including 128 residents of the questionnaire study, 30 residents and 20 care home staff of in-depth interviews and one month of non-participant observations. This primary research data could be used for further analysis in other areas of research (e.g. geriatric care, depression, stigma or care homes). Furthermore, the datasets could be used to compare with other studies aiming to explore the factors associated with depression among older adults LiCH. The dataset of the study could also be used to run simple analyses for other academic purposes. Using the dataset for secondary analysis would reduce the cost of conducting another research and save time in conducting fieldwork for relevant research questions.

The study also made significant efforts to minimise bias. Bias refers to any tendency which prevents unprejudiced consideration of a question in research; it can occur in any phases of research such as research design, data collection or data analysis (Pannucci and Wilkins, 2010). Bias affects the validity and reliability of quantitative research, and can lead to misinterpretation of findings, which can ultimately have a detrimental impact on EBP (Evidence- Based Practice) (Smith and Noble, 2014). In addition, bias may effect on trustworthiness of qualitative research in terms of credibility, transferability, dependability and confirmability (Clissett, 2008). More details of trustworthiness of this study are provided in chapter 3 (3.7.9 trustworthiness). Therefore, efforts were made to address potential biases throughout this study. We identified very clear research questions to be a guide of design the study, and employed a mixed method approach compiling different types of data (quantitative questionnaire, in-depth qualitative interview and non-participant observations), whose triangulation contributes to the veracity of the findings. Feedback from peers and experts regarding the research design was addressed as part of the process of confirmation review, and ethical permission from the ethic committees of University of Nottingham and the local sites (Morse, 2015).

To reduce risk of selection bias, we applied purposive sampling in qualitative research to select participants to take part in the study. This method could reduce participant bias due to the sample being refined to meet the study aims (Smith and Noble, 2014). In addition, we applied various strategies to recruit participants in the questionnaire study. As a

result, we received a very high response rate from participants. To address data collection bias, we applied all standardised and validated measures in the questionnaire study (Smith and Noble, 2014). In addition, the researcher used semi-structured interviews as a guide during the initial phase of data collection. Furthermore, reflection and field notes were recorded after each interviews and observations. For analysis bias, we used external review during data analysis by the process of supervision meetings, to ensure that the researcher did not overlook data inconsistencies due to personal interests or beliefs (Morse, 2015). In summary, extensive efforts were made to minimise bias in all study phases, and the limitations of the study are freely acknowledged.

9.15 Limitations and recommendations for further research

Although there are many strengths of the study, there are some limitations. Firstly, the limitation of using a cross-sectional study only provides a snapshot of the outcome and characteristics at a specific point in time (Levin, 2006). Therefore, it is difficult to use the findings of the study to make a casual inference of depressive symptoms identified issues are manifest over a longer time period.

A longitudinal study is recommended to explore causal inferences related to depressive symptoms among older adults LiCH at different points in time. Furthermore, a longitudinal study is recommended for future research, particularly prospective cohort study, to follow up residents' depressive symptoms and perceptions of internalised stigma when they

first move into care homes in order to investigate the development of depressive symptoms and internalised stigma and the correlation between these two variables over time, as affected by duration of residency. This will illustrate important information on how internalised stigma or depressive symptoms develop in each point in time. This information is also useful to indicate causes of stigma from the negative public views or care home life features that most affect residents and which can detect residents' depressive symptoms and internalised stigma in order to help residents preventing from severe conditions.

The sample was highly homogeneous, being composed exclusively of Thais who overwhelmingly identified as Buddhists, which makes the findings highly pertinent to general elderly care home residents in Thailand but which significantly limits generalisation for other contexts regarding the prevalence of internalised stigma of LiCH, especially where different social norms and family support concepts and practices are prevalent. However, this study may be generalised to most neighbouring Asian countries with similar religious and cultural heritage, such as Myanmar, Cambodia, Sri Lanka, China, Korea and Japan, where a virtue of respect for one's parents or older adults is encouraged (Xing, 2016). This may be a light to other future research to explore or investigate stigma associated with LiCH among their elder resident populations. Furthermore, this new knowledge on stigma may be transferred to apply quality care to prevent the impacts of stigma or promote mitigating factors in care home environments to reduce and mitigate the high prevalence of depressive symptoms.

While cognitive impairment emerged as a significant issue affecting participants, this research did not assess cognitive function among residents, making it impossible to identify whether cognitive impairment is associated with depressive symptoms in itself. It is recommended that future research investigate or evaluate residents' cognitive impairment in order to identify their relationship with depressive symptoms and perhaps with internalised stigma of LiCH, which was found to be positively correlated with depressive symptoms in this population.

We did not study residents' families or relatives due to the limited time available for fieldwork and limited opportunities to meet residents' families. Indeed, as discussed with regard to the findings, very few people seemed to visit residents in the care homes and some residents had no family. A previous study conducted in north-eastern Thailand found that older adults commonly live with their own families and be looked after by their children and that older adults residing in care homes commonly have no family or are abandoned by their children (Pornsema et al., 2014); this study also offered more penetrating qualitative insights into the phenomena of the families of care home residents, exposing how in many cases residents themselves seek to hide from their former acquaintances, and discourage their children from visiting the homes to avoid negative judgments of them by other residents, staff and society in general.

Further research on this group (residents' families or relatives) would be particularly useful to understand broader social stigma and how this

affects the family life of care home residents, which is highly related to their psycho-social wellbeing, as well as understanding the stigma by association they themselves experience. Indeed, policy makers must consider ways in which the stigma-related barriers to care home visitation can be overcome, to enable residents and their friends and families to finding appropriate strategies to achieve meaningful social and care engagements to improve the QoL among residents and in society in general. Collecting data with residents' families or relatives would help to understand more about their experiences or perceptions concerning their relatives LiCH. In addition, the questions on how they can contribute to continue to support care home residents is very important. However, it may be difficult to assess this information or recruit this group to participate in research studies due to the majority of them not visiting care homes frequently, as explained previously, thus other methods of contacting residents' families of relatives by using technology may be helpful, such as phone calls or Skype interviews, in order to reach this target population.

In terms of qualitative research, the credibility of the study is affected by the fact that participants could have perceived the interviewer, who is a nursing professional, as a representative of health care professionals (and an institutional representative of care homes). Therefore, they may have felt reluctant to criticise the QoC they received, particularly relating to the conduct of care home staff. Previous research suggested that prolonged engagement with participants and persistent observation can help increase rapport between the researcher and participants (Hadi and

Closs, 2016). Therefore, the researcher addressed this issue by spending time and regularly visiting participants (including both residents and care home staff) for over two months before beginning the data collection. Furthermore, the researcher clearly introduced and illustrated her role as a researcher, and the procedures for conducting research (including confidentiality or anonymity to protect their personal data for all participants). These issues were discussed in the section of credibility how this influences the interpretation of the study (see section 3.7.9.1). Therefore, an audience can make their own interpretation about the findings of the study.

9.16 Implications to confront stigma for care home staff

9.16.1 Promoting education and emotional support skills

The findings of this study suggest that stigma is very strongly correlated with depressive symptoms and has a negative impact on residents' emotions (feeling of abandonment, lack of worth and low self-esteem) and behaviours (avoiding contact, isolation and social exclusion). Furthermore, stigma has a negative impact on people associated with residents (the primary target of stigma), such as families, relatives or care home staff (stigma by association). The manifestations of stigma among these groups are still under researched. However, the study revealed some negative impacts toward residents' families or relatives, such as feelings of shame or hiding. In addition, stresses and burnout were found to be negative impacts of stigma among care home staff in this study. This highlights that stigma associated with a care home is an important issue that needs to be urgently addressed.

Therefore, health care professionals who work in geriatric care, particularly in care homes, should pay attention to addressing issues of stigma associated with LiCH, by promoting education among care home staff. Earlier research highlighted that education has been found to be the most expedient approach to reduce stigma (Casados, 2017; Corrigan and Kosyluk, 2013). Education for care home staff should be cover the topic of a process of stigma including three elements of stigma: causes, manifestations and mitigating factors. The results of this study confirmed that the majority of residents perceived some level of internalised stigma. Understanding the dynamics of the process of stigma could help staff understand the factors underlining causes of stigma generated from negative public views of care homes and older adults who reside within them, increasing staff awareness of the public stigma that some older adults may carry with them into the homes and they responding behaviours. This could also help members of staff be aware of the culture and features of care homes that cause stigma in order to avoid or prevent these situations. Understanding the manifestations of stigma can alert staff to the impact of stigma toward residents, accordingly helping them to alleviate the more severe impacts of stigma toward residents and to promote mitigating factors.

Emotional support training skills need to be promoted among care home staff. The findings of this study suggest that negative emotions seem to be a common manifestation of stigma for care home residents in this study. However, there are still very limited sources of support available, as a result of which some residents have experienced psychological

symptoms, e.g. low mood, sadness or depressed mood etc. Training courses regarding support such as communication skills, listening skills, and signposting to formal and profession resources of support should be promoted for care home staff. Educational approaches promoting the topic of stigma and emotional support training skills would help to minimise or prevent stigma issues related to LiCH.

9.16.2 Promoting a compassionate environment with multi-disciplinary teamwork

The results show that one of the causes of stigma was related to staff issues, particularly the conflict among them. It has been suggested that reducing conflict among care home staff is very important in order to promote effective QoC among team members (Cesetti et al., 2017). This may involve training for leadership and teamwork among staff or giving an award for an outstanding and compassionate care for professionals. The nomination may come from residents and their co-workers. This will help to promote positive QoC and relationships between staff and residents. Furthermore, a structured group supervision is recommended for care home staff in order to promote personnel understanding of their own roles (Juthberg et al., 2010). This could help care home staff process their work effectively.

Enthusiastic relationships between care home staff and residents would create a compassionate environment in care homes. Care home staff are very important for residents and their families, as the previous study found that the positive relationship between members of staff, residents

and residents' families could contribute to the empowerment of residents while LiCH (Eldh et al., 2016). The research findings point out that residents are very concerned about their relationships with staff. Therefore, care homes should focus on creating courses to foster supportive and trusting relationships between professionals and residents, based on empathy and confidentiality (Tsai and Tsai, 2008). This could also reduce the feeling of being in prison-like settings wherein staff monitor and police residents, as reported by some participants.

Another recommendation is the promotion of multiple disciplinary team working in care homes. Multi-disciplinary teams need to be deployed in care homes contexts due to the complex needs of older adults that require specialist staff to address their physical and mental health needs. It is suggested that multidisciplinary teams help residences to become more independent and help to develop strategies to provide appropriated care for older adults (Randstrom et al., 2014). However, the situation in care homes in Thailand is quite critical and severe due to the problems of understaffing and the lack of specialist personnel (Pornsema et al., 2014). The data from the research shows that only one nurse and one social worker were working in each care home, responsible for nearly a hundred people in different conditions, including dependent and independent residents. The issue of understaffing was highlighted in prior research conducted in Thai care homes, particularly in terms of the difficulties of caring for residents who are immobile or who have severe illness (Pornsema et al., 2014). Therefore, future research should

investigate and explore staffing issues and the QoC provided to older adults residing in care homes.

9.17 Implications to confront stigma for residents

9.17.1 Observing stigma and promoting mitigating factors

The findings illustrate causes of stigma associated with a care home from various factors e.g. negative beliefs about care homes, attitude and stereotype toward older people and the nature of care home population. These latent causes of stigma are endemic, and are difficult to prevent among older adults admitted to care homes. However, case studies of residents with varying degrees of internalised stigma illustrated that manifestations of stigma by negative emotions and behaviours can be visible and observed, and they can be diminished by the mitigating factors, e.g. coping strategies, social support and activities in care homes. This means residents with experiences of various causes of stigma can experience mitigation, resulting in less negative emotional and behavioural experiences whilst LiCH.

Therefore, residents and care home staff can be alert to manifestations of stigma, including negative emotions (e.g. depressed mood) and behaviours (isolate or social exclusion), which could reduce the prevalence and severity of the most acute psychological symptoms of depression. In addition, care homes should aim to maximise the impacts of mitigating factors. This can be done by promoting activities for residents in care homes such as exercises, traveling or social activities.

Another important mitigating factor among this sample is spiritual self-efficacy. Many participants used Buddhist coping strategies relating to karma and religious devolutions to cope with their stressful situations whilst LiCH. Therefore, care homes should assess residents' spiritual needs, liaising with Buddhist institutions or support residents to practice religious devotions for those who desire such resources. This can also tap the willing ancillary support for the elderly offered by Buddhist institutions, such as monasteries and nunneries, offering material, spiritual and social resources and facilitation to improve the QoL of residents. Indeed, social support should be promoted from all available resources, including care home staff, their peers, the public and particularly their families.

According to the findings, older adults perceived very low support from their families. Some older adults did not have any visitors at all from the time they moved in to care homes. This may be caused by stigma whereby residents' families or relatives felt ashamed to appear in care homes due to the implicit societal understanding that they were irresponsible for allowing their relative to reside in a care home. Therefore, family support for residents should be fostered and maintained as much as possible by care home staff. A previous study showed that residents emphasised the importance of when they felt that their families and friends are welcome in their care homes, such as when care home staff offer their guests for a seat or a cup of tea (Nakrem et al., 2011). Such staff behaviours are of negligible expense but could make a massive difference to the QoL of care home residents.

Moreover, family involvement and cooperation in the care home environment can facilitate the care of residents, and is particularly expedient in enabling social activities throughout the year, such as Songkran Festival, National Day for Older People, Mother's Day and Father's Day. However, in some cases it is very challenging to enhance interactions between residents and their families due to various barriers such as travelling. However, using communication technology such as e-mail, telephone and other sound-based and video-based communication (e.g. Skype, WhatsApp and LINE) to minimise the barriers between residents and their families is an expedient way to engage families (and their supporting resources) with residents. This could be done frequently and regularly (e.g. weekly), with appropriate technical support and help.

9.17.2 Promoting an enthusiastic and empathetic environment

Care homes should promote an enthusiastic and empathetic environment among residents. According to the results of the study, care homes were seen as distressed and isolated environments by many residents. This may be related to the issues of communal living, lack of privacy or perception and judgment from other residents while LiCH. Consequently, these issues could create conflict among them and could lead to negative emotional reactions or behavioural responses such as depression, violence or crime. Hence, promoting an enthusiastic and empathetic environment among residents may help to diminish the negative consequences of stigma and create a more optimistic and supportive ambience in care homes.

Therefore, care homes should consider reviewing their scheduled routines to find changes that could be made to improve the care home environment by cooperating in brain storming sessions with residents in care homes. In addition, applying a peer support approach may help to promote empathy and an enthusiastic environment among residents. The core of peer support refers to people who have similar experiences who can better relate to people with similar conditions and offer more authentic empathy (Repper and Carter, 2011). Peer support approaches have been used in other areas of research, especially in mental health services such as depressive disorder, mood disorder or bipolar disorder (Lloyd-Evans et al., 2014). It has been suggested that peer support is a successful strategy because it shows many positive outcomes, including reducing anti-psychotic prescriptions, fostering positive attitudes, empowerment, empathy and acceptance or reducing stigma (Repper and Carter, 2011). Therefore, peer support in care homes could be benefit to all residents, creating positive attitudes for residents who live in them. This can begin by inviting residents reporting many mitigating factors (which help to diminish the manifestation of stigma) to take part in support groups and potential mentoring and orientation for new residents.

9.18 Implications to confront stigma for policy makers

9.18.1 Targeting stigma reduction by promoting public education and positive attitudes toward care homes through the media

The government should target to reduce stigma associated with LiCH by promoting education and positive attitudes regarding care homes and the ageing population among the public. Depression is highly prevalent

among Thai care home residents, who also have experiences of negative emotions and behaviours, including symptoms of clinical depression that could lead to more severe mental health illness in future, and even suicidal ideation. The majority of residents studied were vulnerable and experienced psychological problems before moving to live in care homes. This showed that the strategies deployed by conventional Mental Health Service under-serve this vulnerable target population. Hence, more attention is needed to reduce stigma (which is highly correlated with depression) in the context of care homes and in older adults in general with the major impacts of endemic stigma, not just curing and treatment. This could be done by promoting education and positive images of care home and the value of family support for older parents thought the media.

Media portrayals are highly instrumental in shaping public attitudes (Nawka et al., 2013). Sentimental idealisations of traditional ways of life are not conducive to help elderly care home residents and their families cope and adjust to changing socio-economic realities and lifestyles. Indeed, the continual reiteration of archetypal cultural tropes (e.g. the dutiful son, the shame of 'abandoning' elders) increase depression among elderly care home residents and entrench the lack of support exhibited by families to ashamed to visit their loved ones. The government should encourage the media to promote positive attitudes regarding care homes by using news, television, videos and social media. This could be done by cooperating with the media or other organisations working related to older people to publish positive stories and images of care homes, such as explaining how care homes contribute to society,

on the Thai National Day for Older People or other important occasions. Furthermore, an understanding of the impact of the negative beliefs of care homes toward older adults, care home staff and residents' families should be disseminated and advice for the public should be issued.

Another recommendation is to promote positive attitudes toward ageing and older adults. Caring for older adults is highly influenced by social norms and Thai cultural values regarding families' responsibilities for older parents (Rittirong et al., 2014). Currently, Thailand implements the Second National Plan for Older Adults in numerous programmes and activities, including promoting a positive attitude to a whole nation, as expressed in the annual fair on the National Day of Older Persons alongside Thai New Year's Day (Jitapunkul and Wivatvanit, 2008). However, it may achieve a more lasting outcome if such efforts are undertaken in collaboration with educational institutions such as schools or universities, promoting factual knowledge of ageing and fostering positive social attitudes toward this population. Furthermore, the competency or ability of elder residents should be displayed to the public, which can be achieved by the exhibition of products and handicrafts produced by care home residents, with awards for outstanding residents in various categories. These activities may help encourage a sense of self-pride among residents.

9.18.2 Promoting security life for older adults

One material recommendation that could greatly improve the QoL of older adults generally in addition to care home residents in particular

would be to allot them a cash allowance, which would greatly improve the economic security of Thai older adults who do not have pensions. Previously studies suggested that most older adults face financial problems when they stop working, as the majority of them work as agricultural labourers without any pensions. Consequently they need to rely on their children, especially for financial support for their daily life needs (Pornsema et al., 2014). Albeit clearly advisable for the QoL of older people, this is a bold recommendation for a healthcare study to make but policymakers must necessarily consider the general needs of socioeconomic development and the needs of older adults – families should not be left alone to support older adults.

Furthermore, the study found that family support is important to promote physical and mental wellbeing and prevent Thai older adults from developing depressive symptoms. In addition, older adults LiCH reported low support from their families, which was found to be related to the inhibition of visiting elderly residents due to perceived shame from staff and society in general due to leaving elders in such facilities. Consequently, stigmatisation exacerbated the depressive symptoms of residents by severing their contact with other people, including in many cases their own children and families. In 2002, the Ministry of Social Development and Human Security established a scheme to support poor older adults who were not eligible for the conventional income security program (Sasat and Bowers, 2013). Currently, the state pension is now available for Thai older adults for the whole nation. Resident participants suggested that the pension really helps some older adults with their living

costs and prevents them from feeling like a burden to their families, particularly in rural areas where general living costs are relatively low. A pension allowance could help older adults stay with their families in many cases and obviate the need for them to live in care homes. Although, this may not address the issue of stigma associated with LiCH, it could promote family support and prevent older adults from experiencing depressive symptoms.

Another recommendation is to promote health and security among disabled older adults. Informal care support for older adults with disabilities needs to be incorporated in care planning by health professionals in order to enable and benefit from the informal resources offered to the care process. The number of older Thai adults with disabilities is increasing, yet there is no formal care system to help this burgeoning cohort of the population (Kespichayawattana and Jitapunkul, 2008). Currently, disabled people who are registered with a local administration receive some financial assistance from the government (i.e. a monthly allowance of 800 Bath (£18)), but care home residents are specifically invalidated from receiving such forms of remuneration because they are in receipt of care home facilities. The study also found that care homes lack appropriate equipment to serve disabled residents. Therefore, investment in such equipment may help to maintain good QoL among residents. This could potentially be raised from public donations. Although it was beyond the scope of this study, future researchers might seek to investigate the issues related to older adults with disability residing in Thai care homes and their QoL.

Another recommendation is to develop day care centres for the elderly in local communities, as combating social stigma associated with care homes may need a long-term action plan in order to effect positive attitudes toward care homes. Increased exposure to modern care homes with amenable facilities may increase acceptance of residency among elderly people (and the community in general) and thus gradually efface the stigma associated with LiCH. The structural socio-economic and demographic factors that cause the existence of elderly care homes are continuing and increasing, and the number of older adults requiring support services will increase (Knodel and Chayovan, 2012). Thai people are generally living longer and potentially healthier lives. Many older adults who do not need full-time residency would nevertheless benefit from some kind of community support – which could save public resources in the long term. Currently, some older adults receive informal care in communities (Kespichayawattana and Jitapunkul, 2008). Day care centres for older adults in each village or community will facilitate care for older adults and improve their QoL.

Quality accreditation and registration should be implemented for care homes. It is evident that living in “Song Kroh” is stigmatised place in Thai society. It is resulting in preventing older adults who need supported from care homes seeking help and living with their poor conditions at home. However, there is an increasing number of private care homes for moderate and high income families which could be another option for them to transfer to live in private care homes, but their workings and policies are beyond the conventional administration of the Thai health

system (Kespichayawattana and Jitapunkul, 2008). This may cause problems in future because of a lack of accreditation or a responsible organisation responsible to control QoC in these organisations. These may cause serious issues for QoC in the future. Furthermore, the government should try to collaborate with the private sector, which will be a growing and important economic sector in the future, requiring appropriate planning and developing of policies to support older adults.

Table 36 summarises the recommendations to confront stigma associated with LiCH, including interventions for care home staff, residents and policy makers.

Table 36: Summary of recommendations to confront stigma associated with LiCH

Recommendations to confront stigma	Interventions
Interventions for care home staff	Promoting education and emotional support skills to confront stigma Promoting compassionate environment of work and multiple disciplinary teamwork
Interventions for care home residents	Observing manifestations and promoting mitigating factors of stigma among residents
	Promoting enthusiastic and empathy environment of care homes among residents
Implications for policy makers	Targeting stigma reduction by promoting education and positive public attitudes toward care homes (e.g. media awareness) Promoting security and sustainable life for older adults

9.19 Conclusion

High prevalence of depression was found among Thai older residents and this were not related to their socio-demographic characteristics. Their depressive symptoms were found to be strong positively correlated with perceived internalised stigma, which is particularly very crucial factor

since most residents experienced some levels of internalised stigma. Perceived internalised stigma among residents was related to negative public beliefs about LiCH due to social norms, culture and Buddhist religious ethics, including filial piety and family support, which are promoted in this culture. Thai older parents conventionally expected their children to look after them when they got old rather being left behind in care homes, and they perceive the breakdown of this archetypal model to be a negative reflection on themselves and their families.

The study illustrated three elements related to a process of stigma. Care homes are stigmatised places because of negative beliefs linked to the negative connotations of Song Kroh, associated with destitution, poor accommodation and low-status people in society. Other factors can be cause of stigma, such as older adults who move into care homes being more vulnerable to mental health problems, which is also tied in with greater likelihood to be abused or abandoned by their families, particularly in cases with cognitive impairment, psychoses, or alcohol addiction, although the number of such cases was negligible and statistically unimportant.

Culture and care home features can be one of the main causes related to stigma, as there is limited privacy in care homes and many residents feel stifled by restrictive rules and regulations in a culture of monitoring (by staff and peers). Residents need to share care home facilities with other residents, including their bedrooms. The rules and regulations create unequal power relationships between care home staff and

residents, and also influence residents' feeling of powerlessness due to their lack of authority and autonomy.

Perceived stigma created negative emotional reactions and behavioural responses, including depressive symptoms. However, residents using specific coping strategies to cope with their stress. Social support is a key mitigating factor to support residents, particularly from the public. Donations from the public are the main source of income among residents, which helps to maintain their satisfaction of LiCH. Activities provided in care homes also help to maintain physical and emotional well-being among residents.

There was an exceptionally high response rate to the questionnaire study, and the results could be generalised to similar contexts. Furthermore, findings from qualitative research provide a broader understanding about stigma associated with LiCH from diverse groups of residents and staff, providing deeper knowledge of this topic of stigma, and could be transferred to apply in similar contexts. However, there are some limitations of the study, such as the findings from the survey not making a casual inference of depression or identified issues manifest over a long period of time. Therefore, a longitudinal study is recommended in order to understand the development of depressive symptoms and understand relationship between depressive symptoms and internalised stigma among residents over a period of time.

The most compelling need to improve the physical and mental wellbeing of elderly residents of care homes in Thailand is to combat the societal

and cultural stigma associated with this population. This could be done by promoting education on the topic of stigma to the public and those working in care homes. Promoting an enthusiastic and compassionate environment of work among care home staff would help to enhance positive attitudes and improve QoC for residents LiCH. Increasing social support from their own families in order to increase the feeling of worth and connection between families and residents would also alleviate the loneliness, isolation and uselessness experienced by residents. Such connections could reduce the perceived shame of their residents and their families, and could be achieved expediently using information and communication technology to connect residents and their families.

A further recommendation for policy makers is to continue promoting positive attitudes toward ageing and older adults and family support in Thai society. Furthermore, the health and security of older adults, particularly those with disabilities, could be improved by allocating appropriate cash allowances for living costs. In addition, the government should collaborate with the media sectors to promote positive images and attitudes toward care homes and to educate the public, including the specific issue of how stigma can have negative impacts on residents, care home staff and their families.

Moreover, mental health services should target the issue of stigma among elderly care home residents. Quality accreditation should be applied to control and evaluate the QoC in each care home institution. Moreover, to promote families' support in the community and reduce the

number of older adults who need long-term care, day care centres should be developed in local communities to serve the demand of care from older adults who do not want or need to live in care homes but who would benefit from some measure of care (and interaction with peers from similar age groups), while maintaining their independence in their normal communities and family environments.

In summary, stigma has been found to be at the root of the high prevalence of depression among older adults living in Thai care homes, with negative direct impacts including negative emotional reactions and behavioural responses. Stigma also affects residents' families and care home staff, which feeds back to intensify the stigmatisation of residents. The most compelling need to improve the wellbeing of elderly residents of care homes in Thailand is to combat the societal and cultural stigma associated with this population. This could be achieved through media collaboration, promoting positive attitudes, educational interventions in care home settings and organising social activities for residents and their families in order to create an enthusiastic and compassionate environment in Thai care homes and society in general.

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Appendix 1: Systematic Review Protocol

UNIVERSITY of York
Centre for Reviews and Dissemination

NHS
National Institute for Health Research

PROSPERO International prospective register of systematic reviews

How does stigma associated with living in a care home influence the development or maintenance of depression among older adults? Protocol for a systematic review of qualitative studies

Suhathai Tosangwarn, Olga Klein, Philip Clissett, Holly Blake

Citation

Suhathai Tosangwarn, Olga Klein, Philip Clissett, Holly Blake. How does stigma associated with living in a care home influence the development or maintenance of depression among older adults? Protocol for a systematic review of qualitative studies. PROSPERO 2016:CRD42016051126 Available from http://www.crd.york.ac.uk/PROSPERO_REBRANDING/display_record.asp?ID=CRD42016051126

Review question(s)

How does stigma associated with living in a care home influence the development and/or maintenance of depression among older adults?

Searches

Six key electronic databases: MEDLINE, PsycINFO, EBSCO, CINAHL, Scopus will be searched along with the thesis database ProQuest Dissertations & Theses A&I. In addition, Google Scholar and ResearchGate will be searched in order to ensure that no relevant study will be missed.

Search terms to identify studies included in a systematic review must be calibrated to hone the research focus on stigma, while capturing broader studies such as research related to the lived experiences of care home residents, residents' perception of relocation and care homes, or residents' experience of depression, which could contain nested information pertinent to stigma that can be extracted for subsequent analysis by the systematic reviewers. Therefore, any study containing the search terms; stigma* or discrimination* or prejudic*, in its title, abstract, index terms, and whole text will be included. Furthermore, text searching strategies will be used to expand or include all forms of the search terms, such as Boolean operators (AND, OR), and truncations (*). No date restriction will be applied. The bibliographies of all identified studies will be inspected for further relevant studies.

The search strategy has been pilot tested by the primary reviewer (ST). The search strategy will be carried out by one member of the review team (ST). Reference manager (Endnote) software will be used by the reviewer (ST) to remove duplicate references. The titles and abstracts of the identified studies will be evaluated by two independent reviewers (ST& OK) using the inclusion and exclusion criteria. Full texts of identified studies will be assessed by two reviewers (ST& OK) using the exclusion and inclusion criteria of this systematic review.

Types of study to be included

Types of studies: Qualitative studies including those based on an analytical design (e.g. grounded theory, phenomenology, ethnography and action research) as well as studies with qualitative strand of mixed-method designs exploring older adults' perceptions and experiences of stigma associated with living in a care home and how these perceptions and experiences might have influenced the development or maintenance of depression in this population.

Condition or domain being studied

Qualitative research studies that explore older adults' perceptions and experiences of stigma associated with living in a care home and how these perceptions and experiences might influence the development or maintenance of depression among this population.

Participants/ population

Types of participants: Aged 65 years and older living in care homes in any country.

Intervention(s), exposure(s)

Qualitative research studies that explore older adults' perceptions and experiences of stigma associated with living in a care home and how these perceptions and experiences might influence the development or maintenance of depression among this population.

Studies involving older adults under the age of 65, not published in English or conducted in a community or hospital setting, or any other setting that is not the permanent residence of subjects, such as post-acute care or intermediate care. Moreover, quantitative studies, literature reviews and commentary articles will be excluded.

Comparator(s)/ control
None.

Context
Studies conducted in care homes in any country. A previous Cochrane review by Ward et al. described the term "care home" as including private institutions and various public facilities dedicated to the care for dependent older adults. Moreover, an environment of residential care is described as an institute that provides the following services: general living services for elderly residents, overnight accommodation for dependent older people and nursing or personal care for residents.

Outcome(s)
Primary outcomes
Older adults' perceptions and experiences of stigma associated with living in a care home and how these perceptions and experiences might influence the development or maintenance of depression among this population.

Secondary outcomes
None

Data extraction, (selection and coding)
The data extracted will include specific details about setting, the phenomena of interest, study methods, sampling strategy, participants, and analytic strategy. When these details have been extracted, findings related to residents' perceptions or experiences of stigma associated with living in a care home will be focused on. If differences of opinion arise between the two independent reviewers (ST& OK), those issues will be discussed and if consensus cannot reach, a third and fourth reviewer (HB& PC) will be consulted.

Risk of bias (quality) assessment
Two independent reviewers (ST& OK) will assess the methodological quality of included studies using a quality assessment tool; the Critical Appraisal Skills Programme Tool for qualitative research (CASP Qualitative Checklist). The essential criteria for appraising qualitative studies includes a clear statement of the aim of the study, methodology, research design, recruitment strategy, data collection, ethical issues, data analysis, finding and transferability.

Strategy for data synthesis
The included studies will be carefully read and findings related to residents' perceptions or experiences of stigma associated with living in a care home will be identified by the first author who will search for data in the form of themes, sub themes and core findings reported in each study. The findings will be analysed applying the Thematic Synthesis by Thomas and Harden (2008) (28). This method preserves an explicit and transparent link between the conclusion and the result from a primary study, which has been extended to combinations of studies with a wide range of theoretical perspectives (bid). It has been wildly used in a review of health promotion research as well. The analysis phase include the coding of text "line-by-line", the development of "descriptive themes" and the generation of "analytical themes".

Analysis of subgroups or subsets
None planned

Dissemination plans
Findings from this review will be submitted to a leading journal in this field.

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Conflicts of interest
None known

Language
English

Country
England

Subject index terms status
Subject indexing assigned by CRD

Subject index terms
Adult; Depression; Depressive Disorder; Humans; Life; Qualitative Research; Social Stigma

Stage of review
Ongoing

Date of registration in PROSPERO
10 November 2016

Date of publication of this revision
10 November 2016

Stage of review at time of this submission	Started	Completed
Preliminary searches	No	No

Piloting of the study selection process	No	No
Formal screening of search results against eligibility criteria	No	No
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No

PROSPERO

International prospective register of systematic reviews

The information in this record has been provided by the named contact for this review. CRD has accepted this information in good faith and registered the review in PROSPERO. CRD bears no responsibility or liability for the content of this registration record, any associated files or external websites.

Appendix 2: Ethical Approval from University of Nottingham for Original and Amended Versions

The University of Nottingham

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NG7 2UH

Dear Suhathai

Ethics Reference No: OVSa16042015 SoHS PhD – please always quote
Study Title: Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand.
Chief Researcher/Academic Supervisor: Dr Holly Blake, Associate Professor of Behavioural Science, Dr Philip Clissett, Lecturer, School of Health Sciences.
Short Title: Stigma associated with a care home
Lead Researcher/Student: Suhathai Tosangwarn, PhD Student, Nursing Studies, School of Health Sciences
Duration of Study: 1/5/2015-31/10/2016 18mths **No of Subjects:** 200 (+60 yrs)

Thank you for submitting the above application which has been reviewed by the Committee and the following documents were received:

Stigma associated with a care home:

- FMHS Research Ethics Application form version 1.0, Date: 30/03/2015.
- Protocol Final Version 1.0, date 30/03/2015
- Resident's Information Sheet, Final Version 1.0: 30/-03/15
- Consent Form (RESIDENTS) Final Version 1.0: 30/03/15
- Information Sheet of Care Home Staff, Final Version 1.0: 30/03/15
- Consent Form (CARE HOME STAFF) Final version 1.0: 30/03/15
- Questionnaire Front Sheet and questionnaire sections 1-6
- Interview guide for residents (English Version) final version 1.0: 30/03/15
- Interview guide for care home staff (English Version) Final version 1.0: 30/03/15

These have been reviewed and are satisfactory and the study is approved.

On both information sheets, for making formal complaints it might be more practical for the volunteers if you gave the details of one of the local organisations rather than University of Nottingham given the issue of distance and language. This is just something you might want to think about and is for advice only.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

The University of Nottingham

1. A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.

2. Please submit copies of letters of approval from: the Maharat Nakhon Ratchasima Hospital Institutional Review Board (MNRHIRB); the Nakhonratchasima Provincial Administrative Organisation; TPWDCOP and TWWDCOP when these are available for our records.

3. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

4. You must notify the Chair of any serious or unexpected event.

5. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

6. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Clodagh Dugdale

Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

The University of Nottingham

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

14th September 2015

Suhathai Tosangwarn
PhD in Nursing Studies
c/o Dr Holly Blake
Associate Professor of Behavioural Sciences
B33, School of Health Sciences
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

Dear Suhathai

Ethics Reference No: OVSa16042015 SoHS PhD – please always quote
Study Title: Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand.
Chief Researcher/Academic Supervisor: Dr Holly Blake, Associate Professor of Behavioural Science, Dr Philip Clissett, Lecturer, School of Health Sciences.
Short Title: Stigma associated with a care home
Lead Researcher/Student: Suhathai Tosangwarn, PhD Student, Nursing Studies, School of Health Sciences
Duration of Study: 1/5/2015-31/10/2016 18mths **No of Subjects:** 200 (+60 yrs)

Thank you for notifying the Committee of amendment no 1 27th August 2015 as follows:

- Addition of Non-participant observations (Overt) to be conducted to follow the activities of daily routine of the care home's schedules (selecting events to observe) such as having meals, recreation activities, physiotherapy etc for 16 hours per week at different times of day including weekdays and weekends for one month in each care home. This is in order to gain a better understanding of social interactions and activities with residents, residents' everyday lives and how residents use and spend their time (as described in more detail in the Notice of Amendment)

- Addition of Documentary analysis i.e. administrative documents, health record histories, brochures or sign posts etc to yield rich descriptions of the phenomenon that is being studied. (as described in more detail in the Notice of Amendment)

and the following documents were received:

Stigma associated with a care home:

- FMHS Notice of Amendment no 1: 27th August 2015
- The Study Protocol Final Version 2.0 – 27/08/2015
- Observational Template- Appendix 1
- Document Record guideline – Appendix 2

These have been reviewed and are satisfactory and the study amendment no 1: 27th August 2015 has been approved.

The University of Nottingham

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved. That these are in place before data collection for the additional studies is started.

2. Please submit copies of letters of approval for these amendments from: the Maharat Nakhon Ratchasima Hospital Institutional Review Board (MNRHIRB); the Nakhonratchasima Provincial Administrative Organisation; TPWDCOP and TWWDCOP when these are available for our records.

3. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

4. You must notify the Chair of any serious or unexpected event.

5. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

6. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp Lawrence

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 3: Ethical Approval from Maharat Nakhon Ratchasima Hospital Institute Review Board (MNRH IRB) for Original and Amended Versions

คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน โรงพยาบาลมหาราชนครราชสีมา
สำนักงานสนับสนุนการศึกษาวิจัยทางคลินิก: ศูนย์แพทยศาสตรศึกษาชั้นคลินิก โรงพยาบาลมหาราชนครราชสีมา 49 ถ.ช้างเผือก ต.ในเมือง อ.เมือง จ.นครราชสีมา 30000
Maharat Nakhon Ratchasima Hospital Institutional Review Board (MNRH IRB)
Clinical Research Support Office: Medical Education Center. Maharat Nakhon Ratchasima Hospital, 49 Chang Phueak Rd,. Mueang District, Nakhon Ratchasima Province, 30000, THAILAND. Tel. & Fax. + 66 44 295614-5 E-mail irb@mnrh.in.th

Number 053/2015

Certificate of Approval

Protocol title : Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults living in care homes in Thailand

Protocol no. : -

Document of approval/acceptance:

1. MNRH IRB Submission From
2. Research Proposal Thai version
3. In-Depth Interview guideline Final version 1.0 : 04/05/2015
4. Factor associated with depressive symptoms among older adults living in care homes Thailand Final (Thai version 1.0: 04/05/2015 and English version 1.0: 30/03/15)
5. Interview guide for care home staff (English version) Final version 1.0: 30/03/15
6. Participation Information Sheet
7. Inform consent from
8. Investigator's Curriculum Vitae
9. Budget

Principal investigator: Miss Suhathai Tosangwarn

Research site: Maharat Nakhon Ratchasima Hospital

Date of meeting: 16 July 2015

Date of approval: 7 July 2015

This is to certify that Institutional Review Board. Maharat Nakhon Ratchasima Hospital Ethics Committee is in full compliance with Declaration of Helsinki and the International Conference on Harmonization in Good Clinical Practice (ICH-GCP), and approved the study above.

Expired date: 6 July 2016

(If available)

Signature: Nipat Sim.

(Nipat Simakachorn, MD)

Chairman of Institutional Review Board

Signature: S. Tangjaroen

(Somard Tangjaroen, MD)

Director of Maharat Nakhon Ratchasima Hospital

บันทึกข้อความ

ส่วนราชการ ศูนย์แพทยศาสตรศึกษาขั้นคลินิก (จ๐๑) โรงพยาบาลมหาราชนครราชสีมา โทร. ๕๒๒๒-๓

ที่ นม๐๐๓๒.๑๒๔/๒๑๙๙ **วันที่** ๒ ตุลาคม ๒๕๕๘

เรื่อง รับทราบการเสนอชี้แจงแก้ไขโครงการวิจัย

เรียน นางสาวสุหทัย โตสังวาลย์

ตามที่ท่านได้เสนอเอกสารชี้แจงแก้ไขโครงการวิจัยเรื่อง "ปัจจัยที่เกี่ยวข้องกับภาวะซึมเศร้าและการรับรู้เกี่ยวกับตราบาปของการพักอาศัยอยู่ในสถานสงเคราะห์คนชรา ของผู้สูงอายุที่พักอาศัยอยู่ในสถานสงเคราะห์คนชราในประเทศไทย" ดังรายละเอียดในบันทึกข้อความที่ ลงวันที่ ๑๗ กันยายน ๒๕๕๘ และด้วยเหตุผลที่ผู้วิจัยมีความจำเป็นต้องเดินทางกลับไปศึกษาต่อ ณ ต่างประเทศ ในเดือนพฤศจิกายนนี้ ต้องดำเนินการเรื่องเอกสารงานวิจัยต่างๆ ให้แล้วเสร็จภายในระยะเวลาดังกล่าว ดังนั้นผู้วิจัยจึงต้องยื่นเอกสารชี้แจงแก้ไขโครงการวิจัยต่อคณะกรรมการเพื่อเข้ารับการพิจารณาก่อนวันประชุมคณะกรรมประจำเดือน

คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน โรงพยาบาลมหาราชนครราชสีมาได้พิจารณาเมื่อวันที่ ๑ ตุลาคม ๒๕๕๘ แล้วมีมติรับทราบและอนุมัติการแก้ไขโครงการวิจัย และจะนำผลการพิจารณาเข้าแจ้งที่ประชุมในวันพฤหัสบดีที่ ๒๒ ตุลาคม ๒๕๕๘ พร้อมทั้งให้การรับรองเอกสารเพิ่มเติม ดังนี้

- โครงร่างการวิจัย (ฉบับแก้ไข-โดยการเพิ่มเติมการสังเกตแบบไม่มีส่วนร่วมและการศึกษาจากแหล่งข้อมูลข่าวสาร)
- แบบบันทึกการสังเกตแบบไม่มีส่วนร่วม
- แนวทางในการศึกษาจากแหล่งข้อมูลเอกสาร
- เอกสารรับรองจริยธรรมงานวิจัยเกี่ยวกับการเก็บรวบรวมข้อมูลวิจัย โดยการสังเกตแบบไม่มีส่วนร่วมและการศึกษาจากแหล่งข้อมูลเอกสาร จากมหาวิทยาลัยนอทติ้งแฮม (The University of Nottingham) ประเทศอังกฤษ

จึงเรียนมาเพื่อทราบ

(นายนิพัทธ์ สีมาขจร)
ประธานคณะกรรมการพิจารณาจริยธรรมการวิจัยในคน

Appendix 4: Ethical Approval from Nakhonratchasima Provincial Administration Organisation for the Original and Amended Versions

Documentary Proof of Ethical Clearance

The Nakhonratchasima Provincial Administrative Organisation, Thailand

Study Title:	Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand
Chief Researcher/Academic Supervisor:	Dr Holly Blake, Associate Professor of Behavioural Science, University of Nottingham, UK Dr Philip Clissett, Lecturer, School of Health Sciences, University Of Nottingham, UK
Lead Researcher/Student:	Suhathai Tosangwarn, PhD Student, Nursing Studies, School of Health Sciences, University of Nottingham, UK

The study has been reviewed and is satisfactory and the study is approved by the Nakhonratchasima Provincial Administrative Organisation.

Siganture of Head of the Nakhonratchasima Provincial Administrative Organization

(Mr.Anuwat Kanachan)
Deputy Chief of the PAO
Acting on behalf of Chief Excutive of Nakhon Ratchasima
Provincial Administrative Organization

Date of approval...10...../...July.../..2015....

The Nakhon Ratchasima Provincial Administrative Organisation, Thailand

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Study Title:	Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand
Chief Researcher/Academic Supervisor:	Dr Holly Blake, Associate Professor of Behavioural Science, University of Nottingham, UK Dr Philip Clisett, Lecturer, School of Health Sciences, University of Nottingham, UK
Lead Researcher/Student:	Suhathai Tosangwarn, PhD Student, Nursing Studies, School of Health Sciences, University of Nottingham, UK

The study amendment has been reviewed and is satisfactory and Miss Suhathai Tosangwarn has been given permission to collect data using non-participant observation and documentation.

Signature of Head of the Nakhon Ratchasima Provincial Administrative Organisation

(Mr.Anawat Kanachan)
Deputy Chief of the PAO
Acting on behalf of Chief Excutive of Nakhon Ratchasima
Provincial Administrative Organization

Date of approval...2...../..October..../...2015

Appendix 5: Ethical Approval from the Head of Care Home A for Original and Amended Versions

Thammapakorn Watmoung Welfare Development Centre for Older Persons (TWWDCOP)
38 Suranaree Road, Mueang District,
Nakhon Ratchasima Province, 30000
Thailand

10th July 2015

To Whom It May Concern,

Miss Suhathai Tosangwarn; a PhD student at the University of Nottingham, the United Kingdom, has submitted the study; Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults living in care homes in Thailand, to Thammapakorn Watmoung Welfare Development Centre for Older Persons (TWWDCOP).

The study has been reviewed and is satisfactory and Miss Suhathai Tosangwarn has been given permission to collect data using structured questionnaire interview and in-depth interview.

Sincerely,

Natcha

(Mrs. Natcha Semontatamgul)
Head of Thammapakorn Watmoung Welfare Development Centre for Older Persons

Thammapakorn Watmoung Welfare Development Centre for Older Persons (TWWDCOP)
38 Suranaree Road, Mueang District,
Nakhon Ratchasima Province, 30000
Thailand

5th October 2015

To Whom It May Concern,

Miss Suhathai Tosangwarn; a PhD student at the University of Nottingham, the United Kingdom, has submitted the study amendment to Thammapakorn Watmoung Welfare Development Centre for Older Persons (TWWDCOP).

The study amendment has been reviewed and is satisfactory and Miss Suhathai Tosangwarn has been given permission to collect data using non-participant observation and documentation.

Sincerely,

Natcha

(Mrs. Natcha Semontatamgul)
Head of Thammapakorn Watmoung Welfare Development Centre for Older Persons

Appendix 6: Ethical Approval from the Head of Care Home B for Original and Amended Versions

Thammapakorn Phoklang Welfare Development Centre for Older Persons (TPWDCOP)
583 Phoklang Road, Mueang District,
Nakhon Ratchasima Province, 30000
Thailand

10th July 2015

To Whom It May Concern,

Miss Suhathai Tosangwarn; a PhD student at the University of Nottingham, the United Kingdom, has submitted the study; Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults living in care homes in Thailand, to Thammapakorn Phoklang Welfare Development Centre for Older Persons (TPWDCOP).

The study has been reviewed and is satisfactory and Miss Suhathai Tosangwarn has been given permission to collect data using structured questionnaire interview and in-depth interview.

Sincerely,

.....

(Mrs. Potchanee Noknork)

Head of Thammapakorn Phoklang Welfare Development Centre for Older Persons

Thammapakorn Phoklang Welfare Development Centre for Older Persons (TPWDCOP)
583 Phoklang Road, Mueang District,
Nakhon Ratchasima Province, 30000
Thailand

5th October 2015

To Whom It May Concern,

Miss Suhathai Tosangwarn; a PhD student at the University of Nottingham, the United Kingdom, has submitted the study amendment to Thammapakorn Phoklang Welfare Development Centre for Older Persons (TPWDCOP).

The study amendment has been reviewed and is satisfactory and Miss Suhathai Tosangwarn has been given permission to collect data using non-participant observation and documentation.

Sincerely,



.....

(Mrs. Potchanee Noknark)

Head of Thammapakorn Phoklang Welfare Development Centre for Older Persons

Appendix 7: Consent Form

The University of Nottingham

CONSENT FORM (RESIDENTS)
Final version 1.0: 30/03/15

Title of Study: Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand

REC ref:

Name of Researcher: Suhathai Tosangwarn, Dr Holly Blake and Dr Philip Clissett

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number .....dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded using an audio recorder and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself such as psychological distress or being abused. ☐
6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐
7. I agree to take part in the questionnaire section of the study ☐
8. I agree to take part in the interview section of the study (Only eligible residents for an in-depth interview) ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

The University of Nottingham

CONSENT FORM (CARE HOME STAFF)

Final version 1.0: 30/03/15

Title of Study: Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand

REC ref:
Name of Researcher: Suhathai Tosangwarn, Dr Holly Blake and Dr Philip Clissett

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number .....dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded using an audio recorder and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself. ☐
6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐
7. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Appendix 8: Information Sheets

The University of Nottingham

Shool of Health Sciences

Residents' Information Sheet
(Final version 1.0: 30/03/15)

Title of Study: Exploring the factors associated with depressive symptoms and understanding stigma associated with a care home among older adults residing in care homes in Thailand

Study ID .....

Name of Researcher(s): Suhathai Tosangwarn, Dr Holly Blake and Dr Philip Clissett

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

Background
Older adults residing in a care home have been reported to have a high prevalence of depression. Possible reasons for this include the impact of physical and psychological illness, social isolation and stigma specifically associated with living in care homes. Stigma is generally identified as negative attributes toward an individual who belongs to one or more groups that are commonly viewed as unfavourable group. Living in a care home has been identified as a source of stigma. It is possible that the significantly elevated levels of depression reported in older adults living in care homes are associated with the stigma surrounding the experience of having to live in a care home.

What is the purpose of the study?

This research tends to explore the factors associated with depressive symptoms and understanding stigma associated with living in a care home among older adults residing in care homes Thailand.

Why have I been invited?

You are being invited to take part because you are a resident who lives in a care home in Thailand and age 60 year and over. We are inviting 200 participants like you to take part in the questionnaire section of the study and 30 residents who have lived in the care home for at least months to take part in an in-depth interview section of the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This will not affect any service or care which are provided by your staff.

What will happen to me if I take part?

If you accept taking part in this study, you can express your interest by contacting the researcher or a staff in your care home. Within one week, the researcher will contact you

in order to arrange face-to-face interview at a time or a place convenient to you within the care home. On the interviewed date, you will be asked to complete a consent form for a structured questionnaire. In addition, eligible residents for an in-depth interview will be asked about the willingness to take part in the future in an in-depth qualitative interviewed on the similar issues. After signing the consent form, you will be interviewed by the researcher using the questionnaires comprising of six sections: your personal details, depressive symptoms, stigma associated with living in a care home, self-esteem, perceived social support and coping strategy. The whole structured interview is estimated to take around 35 minutes. You also could complete the questionnaires by yourself, if you wish too, and return it to the researcher. For an in-depth interview, it will be taken approximately 60 minutes and be audio-recorded by the researcher using an audio recorder.

Expenses and inconvenience allowance

Participants will not be paid to participate in the study. However, and incentive raffle tickets are offered (e.g. a gift basket or a food hamper) for three winner residents who participate in this study which will be randomly selected by the head of the care home.

What are the possible disadvantages and risks of taking part?

The interview may induce your past memories or experiences that may stimulate sadness feeling. You will be encouraged to pause or stop if you find it very stressful and you will be informed that you can withdraw from the study at any time without providing a reason.

What are the possible benefits of taking part?

The information we get from your participation in this study will provide an understanding of the factors that most predict depressive symptoms among older adults residing in care home and understand how older adults and care home staff perceive stigma associated with a care home. This could inform strategies and interventions to address depressive symptom of residents and improve the care in residential homes.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the study team who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you should then contact the Research Ethics Committee Administrator, c/o The University of Nottingham, School of Medicine Education Centre, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: louise.sabir@nottingham.ac.uk.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being

carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

However, the exception of information being revealed during a structured questionnaire interview or an in-depth qualitative interview which is of concern and may need reporting i.e. potential risks to another person or to yourself such as psychological distress or being abused. This will be reported in order to provide an appropriate solution.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason. However the information collected so far cannot be erased and may still be used in the project analysis. This is because once the data has been entered onto the secure computer system because it has been made anonymous and the data analyses draws together information provided by all participants it becomes impractical to extract and remove individual data from the system.

What will happen to the results of the research study?

The results of the study will be disseminated through thesis of the researcher (Suhathai Tosangwarn), presentations at conferences and though publications. The result of the study will also be available in your care home in order to provide the result to the study sites. If you would like to have a summary of the report, you could express your interest by giving your name and your detail address to the primary researcher (Suhathai Tosangwarn).

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by Praboromarajchanok Institute for Health Workforce Development, the Ministry of Public Health, Thailand.

Who has reviewed the study?

All research in the University of Nottingham is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Medical School Ethics Committee.

Further information and contact details

The University of Nottingham

Shool of Health Sciences

Please do not hesitate to contact Suhathai Tosangwarn (PhD student) for any further information or queries about the study:
Email: ntxst8@nottingham.ac.uk
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Alternatively, you may contact her supervisors:
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Tel: +44(0)115 82 31049

Dr Philip Clissett (Co-supervisor)
Email: philip.clissett@nottingham.ac.uk
Tel: +44(0)115 82 30954

Thank you for reading this information sheet and taking part.

The University of Nottingham

Shool of Health Sciences

Information Sheet of Care home Staff

(Final version 1.0: 30/03/15)

Title of Study: Exploring the factors associated with depressive symptoms and understanding stigma associated with living in a care home among older adults residing in care homes in Thailand

Study ID.....

Name of Researcher(s): Suhathai Tosangwarn, Dr Holly Blake and Dr Philip Clissett

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

Background

Older adults residing in a care home have been reported to have a high prevalence of depression. Possible reasons for this include the impact of physical and psychological illness, social isolation and stigma specifically associated with living in care homes. Stigma is generally identified as negative attributes toward an individual who belongs to one or more groups that are commonly viewed as unfavourable group. Living in a care home has been identified as a source of stigma. It is possible that the significantly elevated levels of depression reported in older adults living in care homes are associated with the stigma surrounding the experience of having to live in a care home.

What is the purpose of the study?

This research tends to explore the factors associated with depressive symptoms and understanding stigma associated with living in a care home among older adults residing in care homes Thailand.

Why have I been invited?

You are being invited to take part because you are a care home staff who has an experiences of working closely with residents for at least three months. We are also inviting 20 participants like you to take part in an in-depth interview section of the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

If you accept taking part in this study, you can express your interest by contacting the researcher. Within one week, the researcher will contact you in order to arrange face-to-face interview at a time or a place convenient to you.

On the interviewed date, you will be asked to complete a consent form and be interviewed by the researcher approximately 60 minutes duration of the interview. The interviewed will be audio-recorded using an audio recorder.

Expenses and inconvenience allowance

Participants will not be paid to participate in the study. However, and incentive raffle tickets are offered (e.g. a gift basket or a food hamper) for one winner care home staff who participate in this study which will be randomly selected by the head of the care home.

What are the possible disadvantages and risks of taking part?

Any disadvantages or risk related to taking part in this study is extremely unlikely.

What are the possible benefits of taking part?

The information we get from your participation in this study will provide an understanding of the factors that most predict depressive symptoms among older adult residing in care home and understand how older adults and care home staff perceive stigma associated with a care home. This could inform strategies and interventions to address depressive symptom of residents and improve the care in residential homes.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you should then contact the Research Ethics Committee Administrator, c/o The University of Nottingham, School of Medicine Education Centre, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: louise.sabir@nottingham.ac.uk.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

However, the exception of information being revealed during a structured questionnaire interview or an in-depth qualitative interview which is of concern and may need reporting i.e. potential risks to another person or to yourself such as psychological distress or being abused. This will be reported in order to provide an appropriate solution.

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason. However the information collected so far cannot be erased and may still be used in the project analysis. This is because once the data has been entered onto the secure computer system because it has been made anonymous and the data analyses draws together information provided by all participants it becomes impractical to extract and remove individual data from the system.

What will happen to the results of the research study?

The results of the study will be disseminated through thesis of the researcher (Suhathai Tosangwarn), presentations at conferences and though publications. The result of the study will also be available in your care home in order to provide the result to the study sites. If you would like to have a summary of the report, you could express your interest by giving your name and your detail address to the primary researcher (Suhathai Tosangwarn).

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by Praboromarajchanok Institute for Health Workforce Development, the Ministry of Public Health, Thailand.

Who has reviewed the study?

All research in the University of Nottingham is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Medical School Ethics Committee.

Further information and contact details

Dr Philip Clissett (Co-supervisor)
Email: philip.clissett@nottingham.ac.uk
Tel: +44(0)115 82 30954
Thank you for reading this information sheet and taking part.

Appendix 9: Questionnaires

Factors associated with depressive symptoms among older adults living in care homes Thailand

Final version 1.0: 30/03/15

Dear participants,

Thank you very much for your participation in completing these questionnaires. This study aim to explore the factors associated with depressive symptoms and understand stigma associated with a care home among older adults residing in care homes Thailand. The questionnaire is broken down into six sections asking you about your personal details, depressive symptoms, stigma associated with living in a care home, self-esteem, perceived social support and coping strategy. The whole structured interview is estimated to take around 35 minutes.

If you have any questions you would like to ask prior to completing the questionnaires, please feel free to contact the researcher. Thank you very much once again for taking the time to complete these questionnaires.

Kind regards,

Suhathai Tosangwarn

Researcher

Participant code.....

Section 1: Personal demographic characteristics

Instructions: Please answer all the questions. This section asks for information about your personal data.

1. Settings

1. TWWDCOP Care homes ( ) 2. TPWDCOP Care homes ( )

2. The length of time that you have been in a care home

.....year .....month

3. Date of birth

...../...../.....

4. Gender

1. Male ( ) 2. Female ( )

5. Religions

1. Buddhism ( ) 2. Christian ( )

3. Muslim ( ) 4. Others ( ) please specify.....

6. The highest qualification

1. No qualifications ( ) 2. Primary school ( ) 3. Secondary school ( )

4. Diploma ( ) 5. Bachelor degree ( ) 6. Master degree ( )

7. Higher than master degree ( ) 8. Others ( ) please specify.....

7. Marital status

1. Single ( ) 2. Married ( ) 3. Partnership ( ) 4. Separated ( )

5. Divorced ( ) 6. Widowed ( ) 7. Others ( ) please specify.....

8. Do you have your own child or adopted child?

1. No ( ) 2. Yes ( ), if you answer is yes please answering the item 8a.

8a. How many your own child or adopted child do you have?

1. Your own child..... 2. Adopted child.....

9. In an average week, how many might visitor you have?

.....people, if you have a visitor please answering the item 9a

9a. the relationship between your and your visitor, Please choose all applicable to you.

1. Family member ( ) 2. Friend ( ) 3. Relative ( ) 4. Neighbour ( )

5. Others ( ) please specify if you can .....

10. Have your doctor already told you that you have any disease?

1. No ( ) 2. Yes ( ), if you answer is yes please answering the item 10a

10a. what is the disease that you have been diagnosed? Please choose all applicable to you.

1. Diabetes mellitus ( ) 2. Hypertension ( ) 3. Chronic airway Obstruction ( )

4. Hypercholesterolemia ( ) 5. Osteoarthritis ( ) 6. Heart diseases ( )

7. Stroke ( ) 8. Paralysis ( ) 9. Cancer ( )

10. Others ( ) please specify.....

11. Do you have any of these issues? Please choose all applicable to you.

1. Difficulties of hearing ( ) 2. Difficulties of seeing ( ) 3. Difficulties to walk ( )

4. pain ( ) 5. Fatigue ( )

6. Others ( ) please specify.....

Section 2: The 15-Item Thai Geriatric Depression Scale (The 15-TGDS) (Yesavage and Sheikh, 1986, Wongpakaran et al., 2013)

Instructions: Please choose the best answer for how you have felt over the past week:

No	Items	Yes	No
1	Are you basically satisfied with your life?		
2	Have you dropped many of your activities and interests?		
3	Do you feel that your life is empty?		
4	Do you often get bored?		
5	Are you in good spirits most of the time?		
6	Are you afraid that something bad is going to happen to you?		
7	Do you feel happy most of the time?		
8	Do you often feel helpless?		
9	Do you prefer to stay at home, rather than going out and doing new things?		
10	Do you feel you have more problems with memory than most?		
11	Do you think it is wonderful to be alive now?		
12	Do you feel pretty worthless the way you are now?		
13	Do you feel full of energy?		
14	Do you feel that your situation is hopeless?		
15	Do you think that most people are better off than you are?		

Section 3: Internalised stigma associated with living in a care home (Adapted from Internalised stigma of mental illness (ISMI) (Boyd Ritsher et al., 2003)).

Instructions: For each question, please mark whether you find is best accordance with you opinion.

No	Items	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
1.	**Alienation** I feel out of place in the world because I live in a care home				
2.	Living in a care home has spoiled my life				
3.	People live outside a care home could not possibly understand me				
4.	I am embarrassed or ashamed that I live in a care home				
5.	I am disappointed in myself for living in a care home				
6.	I feel inferior to others who don't live in a care home				
7.	**Stereotype Endorsement** Stereotypes about living in a care home apply to me				
8.	People can tell that I live in a care home by the way I look				
9.	People residing in a care home tend to be abandoned				
10.	Because I live in a care home, I need others to make most decisions for me				
11.	People living in a care home cannot live a good, rewarding life				
12.	people live in a care home shouldn't get married				
13.	I can't contribute anything to society because I live in a care home				
	Discrimination Experience				

No	Items	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
14.	People discriminate against me because I live in a care home				
15.	Others think that I can't achieve much in life because I live in a care home				
16.	People ignore me or take me less seriously just because I live in a care home				
17.	People often patronize me, or treat me like a child, just because I live in a care home				
18.	Nobody would be interested in getting close to me because I live in a care home				
19.	**Social Withdrawal** I don't talk about myself much because I don't want to burden others				
20.	I don't socialize as much as I used to because living in a care home might make me look or behave 'weird'				
21.	Negative stereotypes about living in a care home keep me isolated from the 'normal' World				
22.	I stay away from social situations in order to protect my family or friends from embarrassment				
23.	Being around people who don't live in a care home makes me feel out of place or inadequate				
24.	I avoid getting close to people who don't live in a care home to avoid rejection				
25.	**Stigma Resistance** I feel comfortable being seen in public				
26.	In general, I am able to live life the way I want to				

No	Items	strongly disagree (1)	disagree (2)	agree (3)	strongly agree (4)
27.	I can have a good, fulfilling life, despite living in care home				
28.	People living in a care home make important contributions to society				
29.	Living in a care home has made me a tough survivor				

Section 4: Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965, Wongpakaran and Wongpakaran, 2010)

Instructions: Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

No	Items	Strongly disagree (1)	Disagree (2)	Agree (3)	Strongly agree (4)
1	On the whole, I am satisfied with myself.				
2	At times, I think I am no good at all.				
3	I feel that I have a number of good qualities.				
4	I am able to do things as well as most other people.				
5	I feel I do not have much to be proud of.				
6	I certainly feel useless at times.				
7	I feel that I'm a person of worth, at least on an equal plane with others.				
8	I wish I could have more respect for myself.				
9	All in all, I am inclined to feel that I am a failure.				
10	I take a positive attitude toward myself.				

Section 5: Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988, Wongpakaran et al., 2011, Wongpakaran and Wongpakarn 2012)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Mark the "1" if you **Very Strongly Disagree**
Mark the "2" if you **Strongly Disagree**
Mark the "3" if you **Mildly Disagree**
Mark the "4" if you **are Neutral**
Mark the "5" if you **Mildly Agree**
Mark the "6" if you **Strongly Agree**
Mark the "7" if you **Very Strongly Agree**

No	Items	1	2	3	4	5	6	7
1	There is a special person who is around when I am in need.							
2	There is a special person with whom I can share my joys and sorrows.							
3	My family really tries to help me.							
4	I get the emotional help and support I need from my family.							
5	I have a special person who is a real source of comfort to me.							
6	My friends really try to help me.							
7	I can count on my friends when things go wrong.							
8	I can talk about my problems with my family.							
9	I have friends with whom I can share my joys and sorrows.							
10	There is a special person in my life who cares about my feelings.							
11	My family is willing to help me make decisions.							
12	I can talk about my problems with my friends.							

Section 6: A Coping Strategies Inventory Short Form (CSISF) (Addison et al., 2007, Tobin et al., 1989)

Instructions: Please read each item below and determine the extent to which you used it in handing your chosen even.

No	Items	Not at all (1)	A little (2)	Some what (3)	Much (4)	Very much (5)
1	I make a plan of action and follow it					
2	I look for the silver lining or try to look on the bright side of things					
3	I try to spend time alone					
4	I hope the problem will take care of itself					
5	I try to let my emotions out					
6	I try to talk about it with a friend or family					
7	I try to put the problem out of my mind					
8	I tackle the problem head on					
9	I step back from the situation and try to put things into perspective					
10	I tend to blame myself					
11	I let my feelings out to reduce the stress					
12	I hope for a miracle					
13	I ask a close friend or relative that I respect for help or advice					
14	I try not to think about the problem					
15	I tend to criticize myself					

Appendix 10: Interview Guides

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Interview guides

Interview guide for residents (English version)
Final version 1.0: 30/03/15

The questions will not necessarily be asked in an order presented and that participants will be invited to discuss issues in greater depth or to clarify things as appropriate.

- How long have you been in the care home?
- Could you tell me what happened that led to you needing to move into a care home?
- Before you thought about moving into the care home, did you know anybody who lived in one? What were your thoughts about this?
- What feelings came to your mind when you knew that you were going to live in a care home? How did you feel about yourself?
- How did you feel about a care home?
- How did people in your community thought about yourself when you moved to live in the care home? How did their thinking effect on you?
- How did other people behave with you? Could you give me an example of their behaviour that you were unhappy with?
- What was it like when you got here?
- To what extent do you feel that you have settled in?
- Was there anything that helped you settle in here?
- How do you get along with the care staff? Is there anyone in particular that you get along well with? Is there anything in particular that they do that is different to other members of staff?
- How do members of care home staff behave with you? Could you give me an example where you think you have been treated well or been unhappy with their behaviours?
- How do you get along with the other residents? Could you tell me more about it?
- Could you tell me about your experiences living in the care home? What are the good things about being here and what don't you like about being here?
- Is there anything that you miss about your own home? Could you give me an example?
- Have your relationships with friends and family changed since moving in to the home? If so, how?
- How does your family or relative behave with you? Could you give me an example?
- Do you ever feel lonely? If so, is there anything that helps?
- Do you get many visitors? If so, what sorts of things do you do with your visitors?
- Do you get to go out at all? What sort of things do you do?
- When you go out, do you think that people realise that you are from this

home? Why?

- How do you feel about yourself when you tell somebody that you live in a care home? What are the feelings come to your mind if somebody knows that you live in a care home?
- How do other people behave when they know that you live in a care home? Could you give me an example?

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Interview guide for care home staff (English version)

Final version 1.0: 30/03/15

The questions will not necessarily be asked in an order presented and that participants will be invited to discuss issues in greater depth or to clarify things as appropriate.

- How long have you been working in the care home?
- What kind of work are you responsible for in the care home?
- What feelings came to your mind when you knew that you were going to work in a care home? How did you feel about a care home?
- What was it like when you started working here? Could you tell me about it?
- What are the good things about working here and what don't you like about working here? Could you give me an example?
- What do you consider to be the main aspects of your role in the home? Could you tell me about your thought?
- How do you feel about working in this role or this position in the care home? Could you tell me about this?
- Are there any particular kinds of older people that move into the care home?
- What are the specific criteria that use to consider about older adults who could move into the care home? Do you agree with the criteria? Why?
- What are the main factors that lead older adults needing to move into the care home?
- How does our belief on taking care of older adults and family support impact on the feeling of residents in the care home? Have you had some opportunities talking with some residents? Could you tell me about it? What is your thought?
- What kind of issues that usually happen with new residents? How does the care home manage to solve the problem? As your role how do you involve with this process? Could you tell me about it?
- How do you feel about residents in general? What does it make you think about this? Why?
- Are there any residents that you get on particularly well with? Could you tell me about them?
- What kind of issue that usually happen with residents who live in the care home for a period of time? How does the care home manage to help this group of residents? How do you involve with this process?
- How do you feel about residents' family members? Why?
- Have you had some opportunities talking with them (family members)? If so, what have you been discussed? Could you tell me about it? If not, what would you like to tell or discuss with them if you have an opportunity? Why?
- What the care home will be like in the future? Could you tell me about your thought?
- If you have an opportunity to make some changes in the care home, what would you like to improve and why would you like to improve?

Appendix 11: Semi-Structured Observation Form

Semi-structured observation form

Date: ..... Time: .....

The setting: .....

The area of observation:.....

The activity being observed: .....

Topics	Details	Comments
The physical setting (i.e. the context, the key features of the setting) **The details of activity** (i.e. purpose, time, process) **The participants** (i.e. number of people or characteristics of the people) **Organization** (i.e. the norms or rules, the event or interaction) **Residents activities and interactions with other residents, care home staff or others** (i.e. activity, interaction, behaviours, facial expressions or types of emotion)		

Adapted from (Polit and Beck, 2012).

Appendix 12: The details of observations

Observational Records

Date	Time	Duration (minutes)	Location	Group observed	What was observed
07.10.15	11:00-11:50	50	Dining room	Residents and staff	The physical setting, the details of activity, the participants and organization Residents activities and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion
14.10.15	11:00-11:30	30	Dining room	Residents and staff Kannika	The physical setting, the details of activity, the participants and organization Residents' activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
22.10.15	15:30-16:15	45	Reception hall	Mookda	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
23.10.15	11:00-12:10	70	Dining room	Gam	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
24.10.15	11:50-12:20	30	Hallway	Naree	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
25.10.15	9:40-10:40	60	Outside patient's room	Residents and staff	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)

Date	Time	Duration (minutes)	Location	Group observed	What was observed
25.10.15	15:35-16:30	55	Hallway	Tangkwa	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
27.10.15	10:50-11:50	60	Reception hall	Mookda	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
01.11.15	15:50-16:35	45	Exercise room	Noppadon	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
03.11.15	10:50-11:30	40	Dining room	Phadet	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
04.11.15	10:45-11:40	55	Dining room	Gam	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
05.11.15	10:50-12:00	70	Dining room	Kannika	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
09.11.15	10:30-11:45	75	Corridor	Kannika	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
10.11.15	10:45-11:15	30	Nursing room	Residents and staff	Residents and staff interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)
10.11.15	11:00-11:40	40	Dining room	Phadet	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)

Date	Time	Duration (minutes)	Location	Group observed	What was observed
12.11.15	10:30-12:30	120	Dining room	Aum	Residents' appearance, activity and interactions with other residents, care home staff or others (i.e. activity, interaction, behaviours, facial expressions or types of emotion)

*The names used in the thesis are pseudonyms.

Appendix 13: Example of non-participant observation, field notes and analysis

Date: 14th October, 2015 Time: 11:00 am to 11:30 am (Duration 30 mins)

Location: Dining room

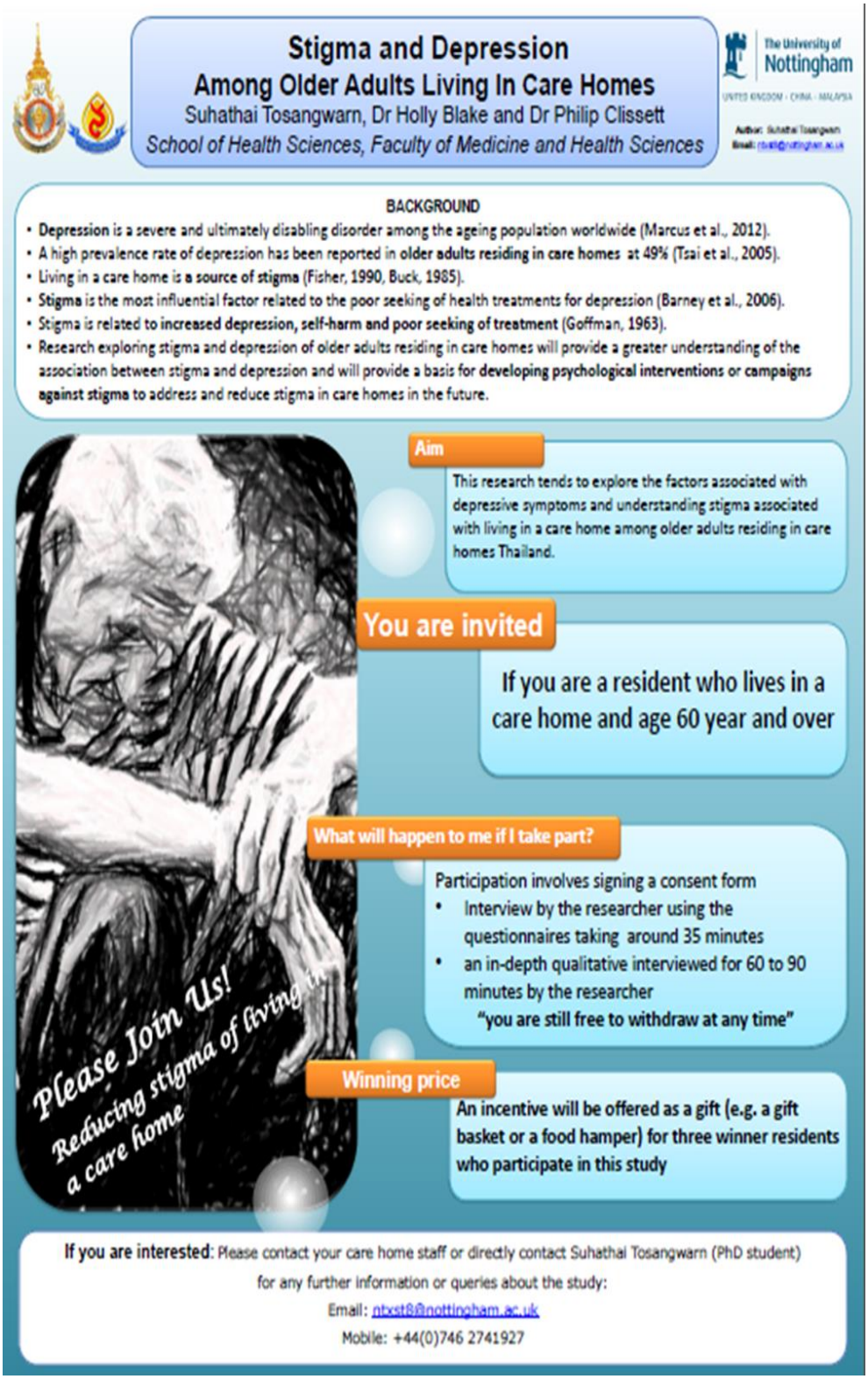
Topics	Details	Analysis (Codes/ Aspects/ Elements)
The physical setting (i.e. the context, the key features of the setting) **The details of activity** (i.e. purpose, time, process) **The participants** (i.e. number of people or characteristics of the people) **Organization** (i.e. the norms or rules, the event or interaction) **Residents activities and interactions with other residents, care home staff or others** (i.e. activity, interaction, behaviours, facial expressions or types of emotion)	There were five round tables in the dining room, each with five residents sitting at it. There were 24 residents in total. Residents would sit in the same place as they had always sat and with the same people. All residents were independent. They could eat independently and perform other daily activities. There were three staff members assisting residents having lunch. The food and the containers were brought to this area by truck because residents who could help themselves were currently required to stay outside the care home due to a refurbishment until the end of the month. As a result, some of residents had to stay in the temple close to the care home as temporary accommodation. All of them needed to share one big bedroom and also other facilities e.g. the dining room, bathroom and toilets. When staff came to the dining room, they carried the food and the containers with them. First they transferred the food into the serving containers until there was enough food in the containers for the residents, then they called all of the residents to walk to collect the food from them. The residents walked to pick up the container with food and then walked back to their own chair. Before starting to have lunch, they would wait until everybody was sitting down at their own table	Communal living/ Care home features contributing to stigma/ Causes of stigma Group/ Culture and environment in a care home/ Causes of stigma Communal living/ Care home features contributing to stigma/ Causes of stigma Care home staff/ Social support/ Mitigating factors Rules and regulations/ Culture and environment in a care

Topics	Details	Analysis (Codes/ Aspects/ Elements)
	and then they would pray together. The benediction for eating has the following meaning in English: "Rice is very valuable. Don't let anything remain. A farmer has to work very hard to grow rice. Sympathies for poor people. In this world there is still poverty and hardship for people. Don't let anything remain, follow your heart and care about others who don't have anything to eat. Thank you for Lord Buddha, Buddha's teaching, monks, farmers, care home staff, and benevolent people, thank you… thank you to everybody whose kindness brought the food to us. We don't have anything to give back to you. Therefore, we intend to do good to others" After praying, the residents started to have their own meal. Some residents put the food on their own plates while some did not eat at that time, so they put the food on their own plates to eat it later when they felt hungry. After 10 minutes, the residents returned the empty containers to the care home staff, who carried them to the truck, and everything was taken back to the care home. In addition, some residents went to sit outside the dining room and some residents still sat at the same table where they had lunch. Most of them had their own area where they normally sat every day.	home/ Care home features contributing to stigma Buddhist approach/ Coping strategies/ Mitigating factors Power imbalance/ Unequal power relations between staff and residents/ Causes of stigma
Internalised stigma of living in a care home based on Internalised Stigma of Mental Illness (Ritsher et al., 2003), which suggested five categories of internalised stigma (1) Alienation (i.e. the subjective experience of being less than a full member of society or having a spoiled identity) (2) Stereotype endorsement (i.e. the degree to	**Kannika:** She came to sit on her table when she saw a truck coming to the eating area. Residents who sit at the same table as her also came to sit at the table. Today there were only four people having a meal at this table because one of the residents who used to sit here had left the care home. Nobody at this table talked to each other while waiting for the care home staff to carry the food and the containers into the eating area. All of them at this table waited for the care home staff to transfer the food into containers or trays. When the care home staff called older adults to pick up	Avoiding contact/ Negative behavioural responses/ Manifestation of stigma

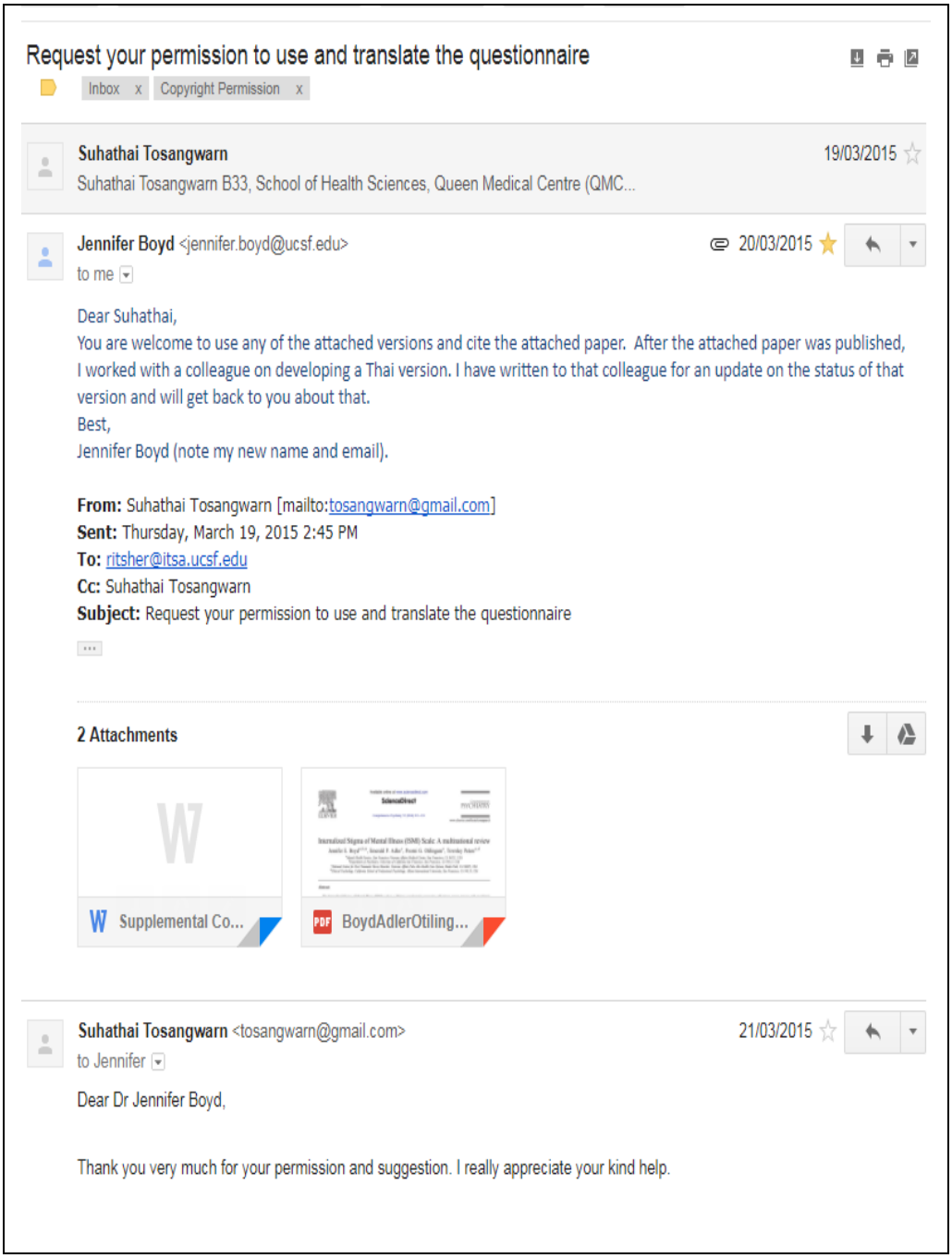
Topics	Details	Analysis (Codes/ Aspects/ Elements)
which respondents agree with common stereotypes about living in a care home, such as being poor or being abandoned) (3) Discrimination experience (i.e. respondents' perception of the way that they currently tend to be treated by others, such as people ignoring them or taking them less seriously) (4) Social withdrawal (i.e. avoiding getting close to others) (5) Stigma resistance (i.e. the experience of resisting or being unaffected by internalised stigma)	the containers, everybody stood up and walked to pick up the containers of food and carried them to their tables. She waited until most of the older adults had picked up the food before she walked to pick up her food in a container and carried it back to her table. She started having lunch after finishing praying. She didn't talk with the people at her table while having lunch. After 10 minutes, when she saw some residents finishing their lunch, she started to put her meal into her own plate, and she carried the empty container to the care home staff. Then, she came back to sit at the same place and continued to have lunch from her own plate, until she finished her meal. She then went to clean her plate and her spoon in the sink near the eating area. All of the other residents also walked away from the table after finishing the meal.	Power imbalance/ Unequal power relations between staff and residents/ Causes of stigma Avoiding contact/ Negative behavioural responses/ Manifestation of stigma Power imbalance/ Unequal power relations between staff and residents/ Causes of stigma
Field notes After informing residents and care home staff about the observation, I was sitting in the corner of the dining room to observe residents and staff activities. This was because I didn't want to participate in participants' activities. However, one resident walked directly to me to invite me for lunch with her. However, I had to refuse due to the fact I was conducting an observation and I also felt it was inappropriate for me to join her for a lunch as a researcher. I was thinking that I should not interfere any activities during the observation as I didn't want to change residents' behaviour and the research phenomena. However, I was concerned that my behaviour was rude in the context, particularly as both of us share the Thai cultural assumptions whereby invitations from elders are an honour that should not be refused. However, I continued doing my observation and I tried to move myself as far as possible from the participants in this context. After around 10 minutes, another resident walked to me and she also invited me to join her for lunch. Again I had to refuse her and I felt more guilty. The social pressure I experienced was more acute as all of the residents were familiar with me and trusted me, and they came to talk to me as a matter of course during my frequent visits over the preceding four months, thus my refusal to join them was counterintuitive and egregious. This made me realise that I need to prepare myself before leaving the field as I had developed strong relationships with the participants thus I could anticipate some emotional distress when I needed to leave the care homes.		

Adapted from (Polit and Beck, 2012, Watson and Whyte, 2006, Ritsher et al., 2003)

Appendix 14: Poster Advertising Study Participation



Appendix 15: Permission to Adapt ISMI to IS-LCH (Email)



Request your permission to use and translate the questionnaire

Inbox x Copyright Permission x

Suhathai Tosangwarn 19/03/2015
Suhathai Tosangwarn B33, School of Health Sciences, Queen Medical Centre (QMC...

Jennifer Boyd <jennifer.boyd@ucsf.edu> 20/03/2015
to me

Dear Suhathai,
You are welcome to use any of the attached versions and cite the attached paper. After the attached paper was published, I worked with a colleague on developing a Thai version. I have written to that colleague for an update on the status of that version and will get back to you about that.
Best,
Jennifer Boyd (note my new name and email).

From: Suhathai Tosangwarn [mailto:tosangwarn@gmail.com]
Sent: Thursday, March 19, 2015 2:45 PM
To: ritsher@itsa.ucsf.edu
Cc: Suhathai Tosangwarn
Subject: Request your permission to use and translate the questionnaire

2 Attachments

Supplemental Co...

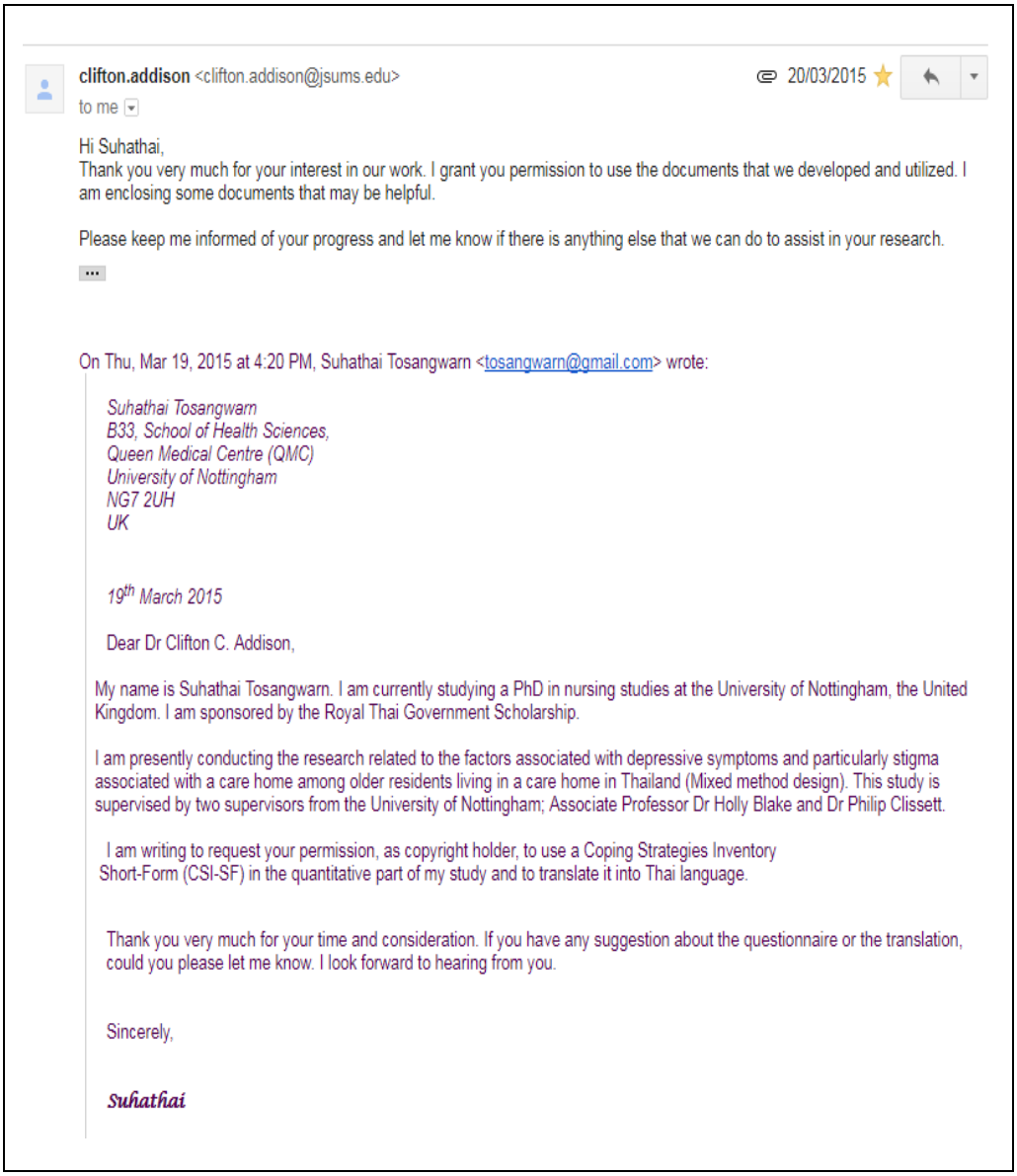
BoydAdlerOtiling...

Suhathai Tosangwarn <tosangwarn@gmail.com> 21/03/2015
to Jennifer

Dear Dr Jennifer Boyd,

Thank you very much for your permission and suggestion. I really appreciate your kind help.

Appendix 16: Permission to Translate CSIT-SF into Thai (Email)



clifton.addison <clifton.addison@jsums.edu> 20/03/2015

to me

Hi Suhathai,
Thank you very much for your interest in our work. I grant you permission to use the documents that we developed and utilized. I am enclosing some documents that may be helpful.

Please keep me informed of your progress and let me know if there is anything else that we can do to assist in your research.

...

On Thu, Mar 19, 2015 at 4:20 PM, Suhathai Tosangwarn <tosangwarn@gmail.com> wrote:

Suhathai Tosangwarn
B33, School of Health Sciences,
Queen Medical Centre (QMC)
University of Nottingham
NG7 2UH
UK

19th March 2015

Dear Dr Clifton C. Addison,

My name is Suhathai Tosangwarn. I am currently studying a PhD in nursing studies at the University of Nottingham, the United Kingdom. I am sponsored by the Royal Thai Government Scholarship.

I am presently conducting the research related to the factors associated with depressive symptoms and particularly stigma associated with a care home among older residents living in a care home in Thailand (Mixed method design). This study is supervised by two supervisors from the University of Nottingham; Associate Professor Dr Holly Blake and Dr Philip Clissett.

I am writing to request your permission, as copyright holder, to use a Coping Strategies Inventory Short-Form (CSI-SF) in the quantitative part of my study and to translate it into Thai language.

Thank you very much for your time and consideration. If you have any suggestion about the questionnaire or the translation, could you please let me know. I look forward to hearing from you.

Sincerely,

Suhathai