




## Family members' perspective of depression in old people in Vietnam

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### ABSTRACT

#### Article History

Received: 26 April 2023

Revised: 4 July 2023

Accepted: 7 August 2023

Published: 6 September 2023

#### Keywords

Depressive symptom

Family member

Geriatric depression

The elderly.

The most prevalent disorders that lead to emotional distress in older people are depression and its disorders. Older people's sadness is usually misinterpreted and misdiagnosed in this demographic. The effectiveness of the illness' treatment will certainly be impacted by family members who frequently care for depressed older people. The purpose of this research is to analyze the perspectives and experiences of family members with regard to older people's depression. In this study, a total of 804 caregivers of senior patient with depression in the province of Quang Ngai received a questionnaire that contained a total of 26 items. The questionnaire was distributed in Quang Ngai province, Vietnam. The most important finding was that the majority of family members who provide care for elderly patients exhibiting depressive symptoms were aware of the factors that contribute to the development of depression in older people and used their own coping mechanisms in order to provide care for them.

**Contribution/Originality:** The findings of this study have made a contribution to the theoretical foundation of perspectives held by family members on depression in adults in the province of Quang Ngai in Vietnam.

## 1. INTRODUCTION

The percentage of old people is rising worldwide especially in developing countries. Vietnam's population is expected to reach 100 million people by 2024 with old people making up 13.0% of the total. By 2050, the average life expectancy of Vietnamese people will be 80 years. Adults have to face unique physical and mental health challenges. The capability to adapt to the environment, physical and mental health, resistance and immunity decline in old age creating favorable conditions for diseases. Their illness takes a long time to recover, responds slowly to treatment and requires help in daily activities.

Cardiovascular disease, stroke, diabetes, chronic obstructive pulmonary disease, osteoarthritis, decreased vision and mental problems are the common diseases observed in the elderly leading to a decline in health. Major depression disorders are the most common affective disorders causing emotional suffering in old people (Blazer, 2003; Hidalgo et al., 2009). According to prevalence rates, 10% to 26.5% of older people have depressive symptoms or other forms of depression (Beekman et al., 1995; Gabryelewicz et al., 2004).

Every year, nearly 3,000 people commit suicide due to depression worldwide. Depression is diagnosable and treatable in primary care. This disorder ranked second after cardiovascular disease in terms of affecting people's daily lives and will be the leading cause of disease burden worldwide by 2030 (Dwyer et al., 2020). In a study with

539 elderly home care patients from a certified home health agency in New York City, Bruce (2002) reported that 73 participants had been diagnosed with and suffered from major depressive disorders while 52 patients were experiencing the initial phase of depression. He also revealed that only a small percentage of depressed patients receive treatment in mental health care. According to the study of Gureje, Kola, and Afolabi (2007) on the epidemiology of major depressive disorder in 65 year old people or above, the authors reported that women living in urban areas who are widowed, divorced, single or have a high socioeconomic status are more depressed than others in Nigeria. Several scientific studies found that cerebrovascular disease, coronary heart disease, cardiac catheterization, diabetes, obesity or body mass index may be associated with geriatric depression (Blazer, Moody-Ayers, Craft-Morgan, & Burchett, 2002; Carney & Freedland, 2003; Sachs-Ericsson et al., 2007). According to Cole and Dendukuri (2003), new medical illness and low health status are also risk factors for geriatric depression. In addition, psychological factors such as personality traits, social support and life stressors may play a significant role in elucidating the causes of depression in old people. A significant predictor of geriatric depression is a low level of mastery, self-efficacy (Steunenberg, Beekman, Deeg, & Kerkhof, 2006), uneasy attachment style, loneliness, bereavement, lower income and poor social adaptation (Paradiso, Naridze, & Holm-Brown, 2012; Tiikkainen & Heikkinen, 2005; Blazer, 2005; Tiikkainen & Heikkinen, 2005). The chronicity and perceived uncontrollability of daily hassles, ongoing difficulties, functional decline, lack of social contacts and disability have been regarded as stressful conditions that may lead to feelings of worthlessness or hopelessness, thereby increasing the risk of depression in older people (Bruce, 2001; Bruce, 2002; Kraaij, Arensman, & Spinhoven, 2002). The detrimental effects of major depression on older people are well documented and studied. Several scientific researchers showed the negative impacts of depressive symptoms on suicide mortality (Conwell, Van Orden, & Caine, 2011; Djernes, Gulmann, Foldager, Olesen, & Munk-Jørgensen, 2011), earlier life roles such as educational attainment, parental function and diminished financial success (Kessler, 2012) and quality of life because of work force exits (Sobocki, Lekander, Borgström, Ström, & Runeson, 2007). Additionally, depression in old people is associated with daily functional decline from impairment in essential daily activities, coexisting medical illness (Bruce, 2002; Taylor, 2014) and a greater risk of prevalent dementia (Steenland et al., 2012). Financial burden is also a significant problem for old people with depression or their relatives due to medical services or increasing health care expenditures for assessment, diagnosis and effective treatment (Crystal, Sambamoorthi, Walkup, & Akincigil, 2003).

Common manifestations of depression in older people are often underestimated and underdiagnosed. The effects of physical health issues are frequently linked to somatic symptoms such as insomnia, loss of energy, decreased concentration and psychological symptoms such as depressed mood, loss of interest or pleasure in activities, low self-esteem ideas, feeling worthless or excessive or inappropriate guilt (Cohen-Cole & Stoudemire, 1987; Hasin & Link, 1988). The diagnosis of depression in old people is very challenging since its symptoms might be misdiagnosed as physical health causes, other diseases, drug side effects or cognitive problems (Voyer & Martin, 2003). Antidepressant medications and psychotherapies including cognitive-behavioral therapy (CBT), problem-solving therapy (PST) and interpersonal therapy (IPT) have the strongest evidence base for treating major depressive disorder in old people (Kiosses, Leon, & Areán, 2011; Thompson, Coon, Gallagher-Thompson, Sommer, & Koin, 2001). Based on the following principles, melancholy is treated (Benazzi, 1999; Stern et al., 1999).

- Early and accurate detection of depression, manifestations of depression and the physical symptoms of many other specialized diseases.
- It is necessary to determine the level of depression.
- It must be clearly determined whether the cause is endogenous depression, reactive depression or another type.
- It is important to select the right antidepressants, understand how to use them and get a timely prescription for them. It must be determined whether depression is associated with other psychotic disorders.

- Know how to prescribe a combination of antipsychotic medications when necessary.
- Along with drug treatment, psychotherapy must also be used.
- When treatment for depression is effective, it should be continued for at least 6 months, sometimes annually to prevent recurrence.

According to Thomas, Hazif-Thomas, & Clement, 2003, older people's responses to depression may be slower than other populations and predicted by depression history, severity of depression, comorbid physical illness and disability (Bosworth, McQuoid, George, & Steffens, 2002; Geerlings, Beekman, Deeg, Twisk, & Van Tilburg, 2002; Hays, Steffens, Flint, Bosworth, & George, 2001). Family is also a contributing factor that may affect how old patients with depression are treated. Family relationships such as the relationship between grandparents and their offspring have a great effect on the feelings and mood of the elderly during treatment.

An average of more than twenty-four hours a week is spent by family members who are caregivers. Their responsibilities as caregivers for their family members feel burdened. Depressive symptoms could be a significant factor causing distress and burden for the elderly's caring relatives (Sczufca, Menezes, & Almeida, 2002). Sczufca et al. (2002) conducted a study with 82 patients with depression and their relatives to investigate the levels and factors associated with burden reported by caregivers of older patients with depression. The authors demonstrated that caregivers who were women, the offspring of patients or experiencing more physical health problems and distress suffered more burden. Older people who had more severe depression for a longer period of time placed a heavier burden on caregivers. Primary caregivers of depressed people experienced greater severity of psychological distress (Rosenvinge, Jones, Judge, & Martin, 1998). The caretaker's workload would increase as a result of depression among the medically ill population (Langa, Valenstein, Fendrick, Kabeto, & Vijan, 2004; Sewitch, McCusker, Dendukuri, & Yaffe, 2004). The depressive symptoms of the old people need to be treated effectively to reduce the burden on caregivers.

Various studies in Vietnam focused on the causes, manifestations and treatment of depression while a few examined the perceptions of depression among primary caregivers of the old people. Family members who often take care of the old people with depression always influence the effectiveness of depression's treatment. This study investigates family members' perceptions of the causes of depression in older people, the caring of family members and the knowledge and participation of adults with depressive symptoms in depression screening and intervention activities. The research starts with reviewing the literature on depression's prevalence, causes, treatment and caregivers of old people with depression. In the second section, a basic analytical framework is described including the research methodology, results and discussion respectively. Finally, the conclusion is in the last section.

## 2. METHODS

### 2.1. Participants

In Vietnam's Quang Ngai province, 804 family caregivers of depressed old people were surveyed for the study. After explaining the purpose of the study to each participant, the researchers obtained informed consent. The survey questionnaire was distributed and explained to family members of old people, none of whom were eliminated after the questionnaires were returned and verified.

### 2.2. Measurement

The survey questionnaire for family members of older people with depression includes 12 items about the causes of depressive symptoms, 6 items about the caring of family members for adults with depressive symptoms and 8 items about knowledge and participation in depression screening and intervention activities for adults with depressive symptoms. An informed consent process was used to ensure participation. The contribution was made on a completely voluntary basis.

Table 1. Family members' perceptions of the causes of depression in old people

The causes of depression	N	M	SD
Illness and disease	804	1.23	0.980
Lack of exercise	804	0.59	0.758
Unfit to work	804	0.94	0.899
A decrease in income	804	0.83	0.957
Lack of money for personal living expenses	804	0.87	0.953
Disappointed and unhappy after retirement	804	0.31	0.714
No job after retirement	804	0.31	0.719
The disruption of social relationships after retirement	804	0.31	0.708
Lack of friends to communicate	804	1.16	0.794
Lack of caring from family members	804	1.70	0.910
A sense of being unable to fulfill their vital role in the family	804	1.51	0.904
Family relationships are not good	804	1.46	0.953

Note: N: Sample size; M: Mean; SD: Standard deviation.

### 3. RESULTS

The mean scores of items about family members' perceptions of the causes of depression in older people are shown in Table 1. Among twelve items about causes of depression, the top five indicators which are listed from the highest to the lowest average points are as below: *Lack of caring from family members* ( $M = 1.70$ ,  $SD = 0.910$ ), a sense of being unable to fulfill their vital role in the family ( $M = 1.51$ ,  $SD = 0.904$ ), *family relationships are not good* ( $M = 1.46$ ,  $SD = 0.953$ ), *Illness and disease* ( $M = 1.23$ ,  $SD = 0.980$ ) and lack of friends to communicate ( $M = 1.16$ ,  $SD = 0.794$ ). The top three indicators that have the same and lowest score are disappointment and being unhappy after retirement ( $M = 0.31$ ,  $SD = 0.714$ ), no job after retirement ( $M = 0.31$ ,  $SD = 0.719$ ) and disruption of social relationships after retirement ( $M = 0.31$ ,  $SD = 0.708$ ).

Table 2. The care of family members for old adults with depressive symptoms.

The care of family members	N	%
They don't care because they think it's a common disease among old people	39	2.7
Buy medicine and self-medicate	50	3.4
See a doctor for examination, diagnosis and treatment	662	45.2
See a psychologist for advice	423	28.9
Discuss with a social worker for support	173	11.8
Send old people to a mental hospital	116	7.9
Total	1463	100

Note: N: Sample size; %: Percentage.

According to Table 2, the highest score indicator is "to see a doctor for examination, diagnosis and treatment (45.2%)" just over a quarter of family members (28.9%) decided to see a psychologist for advice, a small family member (11.8%) decided to discuss with a social worker for support and just an insignificant minority of family members decided to buy medicine and self-medicate (3.4%) and not really care because they think it's a common disease of old people (2.7%) when their adults had depressive symptoms.

Males ( $M=0.87$ ,  $SD=1.050$ ) received a higher score than females ( $M=0.71$ ,  $SD=0.954$ ) for the survey item "old people have essential information about mental health services" (Table 3). The scores for the item "old people actively participated in health screening at home and health facilities" varied between males ( $M=0.41$ ,  $SD=0.891$ ) and females ( $M=0.71$ ,  $SD=0.638$ ) based on gender. Males ( $M=0.49$ ,  $SD=0.883$ ) scored higher than females ( $M=0.43$ ,  $SD=0.787$ ) on the statement "old people received counseling and mental health care." The evaluation of the item "old people were screened with depression assessment techniques by psychiatrists and psychologists" differed between males ( $M=0.20$ ,  $SD=0.557$ ) and females ( $M=0.14$ ,  $SD=0.450$ ). Males ( $M=0.26$ ,  $SD=0.655$ ) received a higher score than females ( $M=0.18$ ,  $SD=0.515$ ) for the survey item "old people with depression were treated with drugs at health facilities." The mean score of males ( $M=0.40$ ,  $SD=0.858$ ) was slightly higher than the mean score of females ( $M=0.38$ ,  $SD=0.827$ ) when evaluating the statement "local authorities organized programs to raise depression awareness among old people." Males and females evaluated the statement "the elderly received

relaxation therapy" differently ( $M=0.24$ ,  $SD=0.610$ ). Only one item, "older adults have opportunities to participate in activities aimed at reducing the risk of depression," received identical ratings from males ( $M=0.50$ ,  $SD=0.905$ ) and females ( $M=0.50$ ,  $SD=0.817$ ).

**Table 3.** Family members' evaluation of knowledge and participation in depression screening and intervention activities for adults with depressive symptoms.

The statement	Male		Female	
	M	SD	M	SD
The old people have essential information about mental health services	0.87	1.050	0.71	0.954
The old people got counseling and mental health care	0.49	0.883	0.43	0.787
The old people actively participated in health screening at home and in health facilities	0.41	0.891	0.31	0.678
The old people were screened with depression assessment techniques by psychiatrists and psychologists	0.20	0.557	0.14	0.450
The old people with depression were treated with drugs at health facilities	0.26	0.655	0.18	0.515
The old people were treated with relaxation therapy	0.24	0.610	0.17	0.515
The old people raised depression awareness with programs organized by local authorities	0.40	0.858	0.38	0.827
The old people have opportunities to participate in activities aiming to reduce the risk of depression	0.50	0.905	0.50	0.871

Note: M: Mean; SD: Standard deviation.

#### 4. DISCUSSION

The study's two major goals are interrelated. First, it investigates family members' perceptions of the causes of depression in old people and the caring of family members for adults with depressive symptoms. Secondly, it evaluates the participation in depression screening and intervention activities of adults with depressive symptoms. The results of the study revealed that most family members who are caregivers of old people with depression had information about the causes of depression and also cared for them with their own strategies.

The first finding of the study showed that caregivers of older people with depression had knowledge about the causes of depression. Family members spent time searching for and gaining information about their loved one's symptoms. They knew that illness and disease, the lack of friends to communicate with, the lack of caring from family members, the feeling that they could not continue to play their vital role in the family well and family relationships were contributing factors that could lead to negative emotions in old people. This finding was also supported by previous studies that indicated that medical illness, specific medical conditions such as cerebrovascular disease, coronary heart disease, diabetes, obesity functional decline, lack of social contacts and loneliness could increase the risk for geriatric depression (Blazer et al., 2002; Carney & Freedland, 2003; Cole & Dendukuri, 2003; Sachs-Ericsson et al., 2007; Bruce, 2001; Bruce, 2002; Kraaij et al., 2002).

Most caregivers participating in the study reported that when old people had depressive symptoms, they would take them to a doctor for examination, diagnosis and treatment or to a psychologist for appropriate advice. Participants in this study were aware of the serious threat of depressive symptoms and recognized the important role of depression treatment. Therefore, early and accurate detection of depression is extremely essential. Besides, antidepressants must be prescribed in a timely manner; patients must know how to choose the drugs, dosages, and ways to use them. Along with drug treatment, psychotherapy must also be used (Benazzi, 1999; Stern et al., 1999). Our study also reported that an insignificant minority of family members or caregivers did not really care about depressive symptoms in old people because they thought they were manifestations of a common disease. Depression in old people is difficult to identify since its symptoms can be mistaken for physical health issues, other diseases, medicine side effects or cognitive issues (Voyer & Martin, 2003).

Finally, the achieved finding revealed that Vietnamese old people with depressive symptoms did not have essential information about mental health services to get counseling and mental health care. Therefore, few depressed old people were screened with depression assessment techniques by psychiatrists and psychologists or treated with drugs at health facilities. Older people also did not actively participate in health screening at home or

in health facilities. They need more opportunities to participate in activities aimed at gaining information about depressive symptoms and how to reduce the risk of depression.

## 5. CONCLUSION

This study provided important evidence about the family members' perception of the causes of depression in old people, the caring of family members and knowledge and participation in depression screening and intervention activities of adults with depressive symptoms in Vietnam. The findings showed that caregivers of adults with depression had knowledge about the causes of depression. Additionally, family members can recognize depression's symptoms in the elderly and then take them to a doctor for examination, diagnosis and treatment or to a psychologist for appropriate advice. The authors suggest that there is a need to communicate information and educate people about depressive symptoms to improve their understanding and protect their mental health.

**Funding:** This research is supported by Department of Science and Technology, Quang Ngai Province, Vietnam (Grant number: 01/2019/HĐ-ĐTKHCN).

**Institutional Review Board Statement:** The Ethical Committee of the Department of Science and Technology, Quang Ngai Province, Vietnam has granted approval for this study on 12 April 2019 (Ref. No. 01/2019/HĐ-ĐTKHCN).

**Transparency:** The authors state that the manuscript is honest, truthful, and transparent, that no key aspects of the investigation have been omitted, and that any differences from the study as planned have been clarified. This study followed all writing ethics.

**Competing Interests:** The authors declare that they have no competing interests.

**Authors' Contributions:** All authors contributed equally to the conception and design of the study. All authors have read and agreed to the published version of the manuscript.

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