

PROMOTING THE STRESS-COPING ABILITY OF INFORMAL CAREGIVERS FOR OLDER ADULTS THROUGH A COMMUNITY-BASED CLUB MODEL

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Abstract

Objective. Informal caregivers in Vietnam often face many pressures in their care work for older people, resulting in stress-related challenges. The study aims to enhance the capacity of informal caregivers to cope more effectively with stress through a pilot community-based club model.

Material and methods. This study employed both quantitative and qualitative research methods in two phases. In the first phase, we assessed the stress levels of 166 informal caregivers of older people in rural areas, using the Depression, Anxiety, and Stress Scale – 21 Items. In the second phase, a community-based club was established and implemented, involving 23 informal caregivers selected from the phase-one participants.

Results. The results reveal that 43.4% of the surveyed informal caregivers experienced mild to severe stress levels, with the factors contributing to stress including a lack of both knowledge and skills related to caregiving, inadequate family and community support, poor financial conditions, and the inability to balance caregiving responsibilities with personal work. The study also suggests that club participation can enhance the members' confidence and improve their mental well-being, regardless of whether they are under or over 60 years old.

Conclusions. The results demonstrate the effectiveness of community-based support models in enhancing the stress-coping capacity of informal caregivers of the elderly. This approach enhances stress-coping for informal caregivers of older adults and may improve caregiving quality within Vietnam's limited formal care system.

Keywords: community-based club, informal caregivers, stress-coping, the elderly.

Suggested citation (APA)

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Introduction

The world population is experiencing rapid ageing. Reports from the United Nations (2019, 2024) indicate that the number of people aged 65 and over doubled between 1990 and 2019, and is expected to account for about 16% of the global population by 2025, reaching 2.2 billion and surpassing the number of children (under age 18) by the late 2070s. In the context of

population ageing, older people require more care; however, in many countries, there are still not enough appropriate social support services from the government's social welfare system, especially in developing countries, which are considered to have a faster ageing rate than developed countries. Vietnam is a developing country in Southeast Asia but reached the status of an ageing society in 2011 and will transform into an aged society by 2036 (United Nations Fund Population in Vietnam, 2011). In 2038, people aged 60 and over will make up 20 percent of the total population (General Statistics Office of Vietnam, 2021). Demographic changes toward an ageing population, while the economy is developing and social welfare is limited, has led to challenges in ensuring the lives of older people in this country. Data on Vietnam's ageing population indicate that just over 25.5 percent of older people receive pensions or social benefits, while, 70 percent have no material savings, 2.3 percent face difficulties and deprivation, and 18 percent live in poor households. Notably, the number of older adults living with and depending on their children and grandchildren accounts for 72.3 percent, most of whom live in rural areas (United Nations Fund Population in Vietnam, 2011). This situation indicates that the formal social welfare system is insufficient in meeting the needs of older people, leading them to rely increasingly more on support from informal networks, including family and communities.

In Vietnam, there are two models of care for older people: care in social protection facilities and care in the family and community (Bùi, 2015). Older people who live in social protection facilities will receive care from formal caregivers, including social workers and nurses. In contrast, those living in the community mostly rely on the support of informal caregivers like family members, volunteers, and community members. These care models are similar to those in other countries in the world. Informal and formal caregivers engage in all facets of elder caregiving work, including physical, intellectual, and emotional care, but they do it at varying levels and for different reasons (Ward-Griffin, 2002). Specifically, formal caregivers are considered professionals who work in organizations such as hospitals or care centers and have a labor (Diniz et al., 2018). Informal caregivers, on the other hand, are typically family members or close relatives of older adults who take care of them usually without pay (Carmichael et al., 2010).

Studies indicate that bidirectional intergenerational support among family members – both from parents and grandparents to children and grandchildren, and vice versa – contributes to strengthening the sense of personal usefulness and fostering a positive outlook on life. However, families can become overwhelmed when caring for an elderly person with serious health issues (Rada, 2018). In some Asian countries like China, Japan, South Korea, and Vietnam, informal caregivers play a more and more crucial role because of changes in family, economy, and social structure (Capistrant, 2016). The provision of care for older adults is rooted in filial piety, which is a core value in traditional cultures regarding the treatment of the elderly (Nguyen, 2023). This tradition makes young generations think that sending parents to social protection facilities (including nursing homes) is viewed as filial piety, an abdication of responsibility. Therefore, the responsibility of caring for the elderly will fall on the shoulders of informal caregivers such as daughters, daughters-in-law, or older adults' wives (Capistrant, 2016). That is one of the reasons why informal caregivers remain the primary source of care for older people in Vietnam.

Although playing a crucial role in caring for the elderly, informal caregivers have faced many challenges. A study on family caregivers for older people at home in Vietnam showed that they frequently experience negative emotions such as exhaustion, anxiety, frustration, loneliness, and a sense of absence. These feelings led to burnout and loss of their living energy (Lê et al., 2024). Reports by international organizations also indicated that family caregivers struggle with a lack of knowledge and skills in elderly care, as well as insufficient financial resources for long-term care. They seldom receive any financial support for their work, as it is considered a family and community responsibility rooted in filial piety toward older people. Furthermore, they also seldom join any training courses for stress coping in caring for the elderly. The lack of knowledge

and skills to care for the elderly made them struggle to balance caregiving responsibilities and personal work. In addition, the physical and mental pressures of long-term caregiving can lead to stress, fatigue, and even depression among informal caregivers (United Nations Population Fund in Vietnam, 2011; World Bank, 2021; World Health Organization, 2015). Facing many challenges in caring for the elderly, informal caregivers need to receive more attention and support from family, community, and society to enhance their ability to cope with the pressures of caring (Sörensen et al., 2002).

Many countries with ageing populations in Asia have introduced strategies to support caregivers for older people, including developing community-based services, long-term care, and social support for family caregivers (Ansah et al., 2016; Mulati et al., 2024; Xu & Chow, 2011). Vietnam's government has also been trying to support the elderly and caregivers through policies and national programs. However, given the limited resources of the national social protection system, which do not fully meet the needs of older people, support activities from family and communities are encouraged to develop in order to strengthen care for both older adults and informal caregivers (Truong & Huynh, 2021). Based on this government strategy, we designed a community-based club model that includes members who are informal caregivers for older adults in the community in a rural area of Vietnam. Through the activities of the club model, we expect to create support for informal caregivers based on internal resources in the community. Therefore, this article aims to describe in detail the stress-related challenges of informal caregivers for older people in rural communities and promote their stress-coping ability. Simultaneously, we want to provide insights and recommendations to support better informal caregivers who play a key role in caring for older adults, thereby enhancing the development of appropriate support policies and programs in the context of population ageing in Vietnam nowadays.

Material and methods

Research site and sample selection

This study was implemented from January 2023 to March 2024 at Quang Phu Commune, Quang Dien District in Thua Thien Hue Province, Vietnam (since July 1, 2025, this area has been part of Dan Dien Commune, Hue City). This is a large rural commune located in central Vietnam where about 1200 older adults live at home with their children and grandchildren. There are nine villages in Quang Phu Commune, and we collected 20 respondents from each village using a designed questionnaire. We used the convenience sampling technique to choose samples from the informal caregivers' lists provided by the village head. The sample was selected from households with older adults requiring regular care. We only chose one sample per household, specifically the primary caregiver in the elderly's family, who has lived in the research site for at least twelve months.

We collected data using interviewer-administered questionnaires. Interviewers approached each research participant and recorded their answers directly on the questionnaire. The data collector visited each household and conducted face-to-face interviews with caregivers identified from the available list. If any person on the list was absent or could not answer the questions at the time of the survey, we tried to replace them with another person from the same village, using the same sampling criteria to ensure a sufficient sample size. Five interviewers conducted the study over a two-week period. After the survey, 172 people participated in the interview. The questionnaires were checked and cleaned, and some were excluded due to missing information. Finally, only 166 responses were eligible for data processing.

Research procedure

This study was implemented in two phases.

In the first phase (between 2023 and 2024), the goal was to answer the following: What are the stress-related challenges of informal caregivers? We used the Depression, Anxiety, and Stress Scale – 21 Items (DASS-21) to assess the stress status of informal caregivers of the elderly. The DASS-21 scale instrument measures the three related negative emotional states of depression, anxiety, and stress. Each of the three DASS-21 scales contains 7 questions, in which stress is measured by questions related to difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable /over-reactive, and impatient (Lovibond & Lovibond, 1995).

The DASS-21 has been translated into Vietnamese by the National Institute of Mental Health of Vietnam and is determined to be highly reliable and valid in many public health research studies (Lê, 2024; Pham et al., 2024). This scale was used simultaneously with the self-designed questionnaire in the collection of information. The self-designed questionnaire consisted of two sections. The first section collected socio-demographic information, including name, age, gender, education level, occupation, and relationship with older people. The second section focused on caregiving-related variables, such as caregiving time, trouble caring, the reasons, the need for support, and the level of social support received from resources available in the community.

Although we used the DASS-21 scale to assess the mental health of informal caregivers of older adults, only stress levels were analyzed in this article, while depression and anxiety were excluded.

In the second phase, we designed and implemented a pilot club model in the community. To select participants, we collaborated with the local Women's Union to invite caregivers who met the following three criteria: (1) participated in the survey of the first phase, (2) lived within two km of the community house (club location), and (3) were willing and committed to fully participating in club activities. We initially planned to limit the number of participants to twenty to ensure better interaction among members. However, during the registration process, three additional caregivers who met the criteria requested to join the club. Thus, the pilot club model commenced with twenty-three members.

The pilot club model aims to promote members' ability to cope with eldercare stress through social interaction activities organized within the club. It was established with the support of the local government and the local Women's Union. The establishment process of the club model is illustrated in Figure 1.

The club's board of leaders, consisting of three members, was responsible for planning activities, discussing monthly plans with the researchers, and organizing activities for the club. Under the coordination of club leaders, members met every two weeks at the community house in Village 2. The club's activities focused on three main components:

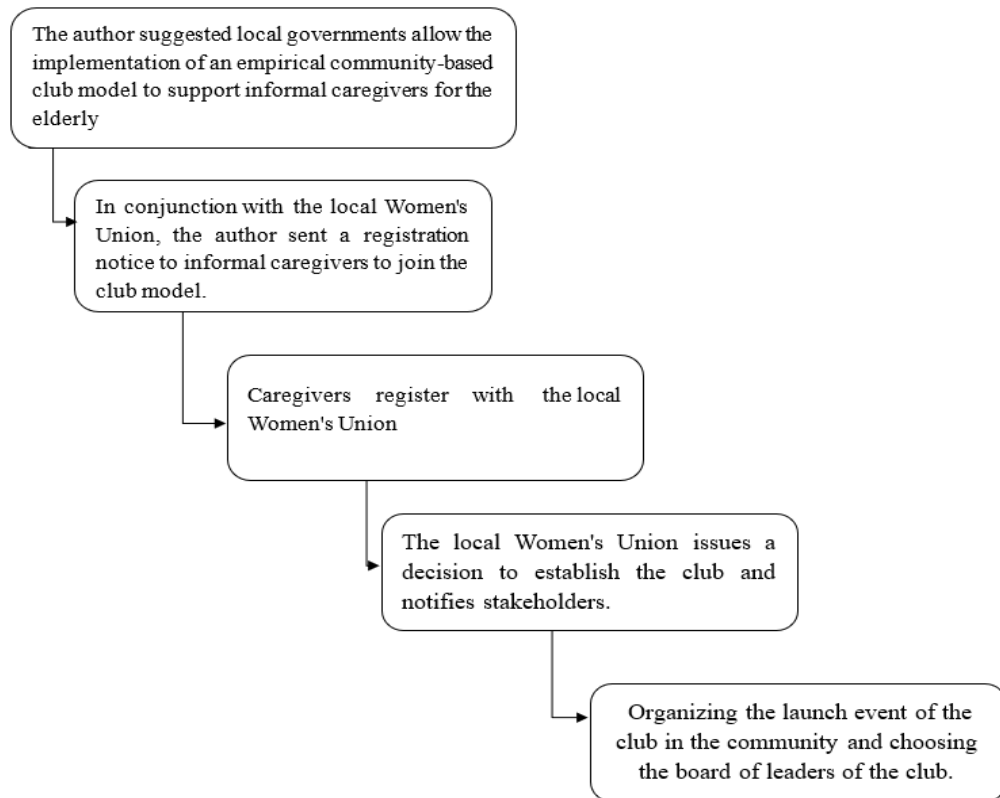
(1) Providing knowledge and skills in elder caregiving for club members: This content was aimed at providing practical knowledge for elder caregiving. Activities included training in nutrition knowledge for the elderly, basic first aid skills to assist older adults in unexpected injury situations at home, skills of managing personal emotions for caregivers, and talks related to health with local doctors and nurses.

(2) Psychosocial support and promoting the capacity of self-help and mutual support among members: This component focused on creating a supportive peer environment. During the meetings, members were encouraged to engage in mutual support activities, such as home visits providing care when a member fell ill, sharing caregiving experiences, and even sharing food and assistive devices. In addition, the club organized cultural and artistic events to promote social interaction among members on national occasions such as Vietnamese Family Day, Women's Day, and the Day for the Elderly.

(3) Fundraising activities: The club built a small savings fund where members can contribute money. Fundraising activities were organized on an ongoing basis, such as collecting and selling recyclable waste to raise funds, receiving contributions from members' children and grandchildren, as well as from charitable individuals or local government support programs. The funds were used for home visits to sick members and to assist members during emergencies or hardship.

Figure 1

The steps establish a community-based club model



We assessed changes in members' after they had participated in the club model for six months. Based on the phase 1 survey data, the 23 members had a mean baseline stress score (DASS-21) of 25.56 (SD = 4.78), with scores ranging from 18.00 to 34.00. These results indicate that most members experienced a significant level of stress. In this evaluation step, we aimed to explore the members' awareness of the pilot club model and any perceived changes in their well-being. Therefore, we used the focus group discussion method with all participants. We did not use the DASS-21 scale again in this evaluation step because the primary goal of this pilot phase was not to measure the stress level of members, but to understand in-depth insights into the model's feasibility and the members' experiences. We wanted to know how the pilot club model impacted caregivers and what specific activities were most beneficial.

The 23 club members were divided into two groups: one group had 12 members, and the other had 11. The participants were interviewed using the following form of a designed questionnaire under the coordination of the researcher. Each focus group discussion took about one hour and was audio-recorded with the participants' permission.

Data analysis

The data collected in the first phase were entered and processed by SPSS 25.0 software. The authors used descriptive statistics for categorical variables to describe the prevalence of stress among informal caregivers and the factors contributing to it.

The recording data in the second phase was entered into the Memobot software to convert audio files to text. The transcripts were then analyzed using Thematic Analysis. First, the researcher read the transcripts multiple times. Then, we generated initial codes for important data to summarize ideas. These codes were then collated and organized into potential themes. Finally, we reviewed and defined these themes to ensure the essence of the participants' experiences in the pilot club, including theme (i) Ability to provide a supportive environment to manage stress; theme (ii) Ability to boost supportive relationships among club members, and theme (iii) Ability to promote participation in community activities of members.

Results

Socio-demographic characteristics of participants

The participants' sociodemographic information includes gender, age, education, occupation, and the relationship with the elderly. The characteristics of the sample are shown in more detail in Table 1.

Table 1

Socio-Demographic characteristics

	Variables	Amount (n)	Percentage (%)
Gender	Male	31	(18.7)
	Female	135	(81.3)
Age	Under Age 60	127	(76.5)
	Age 60 and above	39	(23.5)
	Mean age	48.5 years	
Education	Illiterate	06	(3.6)
	Primary	58	(34.9)
	Secondary	97	(58.5)
	College/ University	5	(3.0)
Occupation	Farmer	78	(47.0)
	Fisher	36	(21.7)
	Worker	25	(15.1)
	Civil servant	9	(5.4)
	Others	18	(10.8)
Relationship with the elderly	Spouse	31	(18.7)
	Son	12	(7.2)
	Daughter	39	(23.5)

Variables	Amount (n)	Percentage (%)
Daughter-in-law	73	(44.0)
Relatives	7	(4.2)
Others	4	(2.4)

Table 1 shows some key characteristics of study participants: Women were the primary caregivers for older people, accounting for 81.3 percent of the total sample. Notably, the majority of them were daughters-in-law (44.0 percent), daughters (23.5 percent), and wives (18.7 percent) of older persons. Most caregivers were middle-aged, with an average age of 48.5 years. On the other hand, their education levels were uneven and relatively low. In particular, they had only attained primary or secondary education (mainly up to middle school). More notably, 3.6 percent of participants were illiterate.

The stress-related challenges experienced by informal caregivers for older adults

Nearly half of the informal caregivers surveyed (43.4%) experienced stress while caring for older adults at home. Stress levels range from mild to extremely severe, with mild and moderate levels being the most common. This is illustrated more clearly in Table 2.

Table 2

The stress level using the DASS-21 scale

Level	Stress	Amount (n)	Percentage (%)
Normal	0-14	94	(56.6)
Mild	15-18	28	(16.9)
Moderate	19-25	35	(21.1)
Severe	26-33	07	(4.2)
Extremely Severe	≥ 34	02	(1.2)
Total		N (166)	100 %

Factors contributing to the stress of informal caregivers for the elderly

The survey results show that the majority of the informal caregivers surveyed agreed that the most potent stress factor was the lack of professional training, which made caregiving at home complex and put pressure on them. However, respondents expressed neutral views regarding other factors such as financial conditions, family and community members' support, the psychological state of the older adults and the balance between caregiving responsibilities and personal work. More specific results are presented in Table 3.

Table 3

Several causes of stress in informal caregivers were analyzed by mean values

Variables	Minimum	Maximum	Mean	SD
Deficiency in caregiving knowledge and skills	1	5	4.36	1.004

Variables	Minimum	Maximum	Mean	SD
The financial pressures associated with caregiving	1	5	3.34	1.287
The absence of support from family and community members	1	5	3.30	.869
Managing the balance between elder caregiving and personal work responsibilities	1	5	2.69	1.245
The emotional instability in the elderly	1	5	2.62	.925

Note: N = 166.

1 = Completely disagree (Mean: 1.00 – 1.80)

2 = Disagree (Mean: 1.81- 2.60)

3 = Neutral (Mean: 2.61 – 3.40)

4 = Agree (Mean: 3.41 – 4.20)

5 = Extremely agree (Mean: 4.21 – 5.00)

Table 3 illustrates that the factor of "deficiency in caregiving knowledge and skills" had the strongest impact on the stress status of research participants, with an average score of 4.36 on a 5-point Likert scale. Compared to other factors, such as the emotional changes in older adults, the caregiver's ability to manage emotions, the availability of support from others, and financial pressure, scores between 2.62 and 3.34 suggest a neutral to substantial influence on informal caregivers in the study.

The impact of the community-based club model on the stress-coping capacity of informal caregivers

The community-based club model included activities that provided knowledge and skills in elder care, supported members to communicate and mutually aid each other, and organized fundraising activities in the community, which positively impacted informal caregivers' stress-coping ability.

Participating in club activities allowed caregivers to share experiences, exchange strategies, and receive emotional support, contributing to their mental resilience and ability to handle stress more effectively. Through regular social interaction with club activities in the community, this model enhanced caregivers' problem-solving abilities, emotional regulation, and overall coping mechanisms, enabling them to maintain their well-being while providing care. More details in Table 4

Table 4

Some impacts of the community-based club model on the stress-coping capacity of individuals after participation for six months

Theme	Example quote
Ability to provide a supportive environment to manage stress	"I cared for my mother-in-law at home before, and when she was angry with me, I felt I was using a lot of nervous energy to think about it. However, when I participated in the club, I learned how to control my thinking and no longer overthink. I can also share my emotions and thoughts with others in our club. That is so good for my mental health" (N2, 31 years old)

Theme	Example quote
	"When I participated in this club, I was trained in nutrition knowledge and the way to cook for older adults. Therefore, I no longer worry about how to cook for my mom to eat every day. I also recognize that the lack of nutrition knowledge for the elderly is why I have been stressed for a long time. Therefore, I think that club helps me better care for older parents, helps me avoid the pressure, and helps me feel comfortable caregiving" (N10, 43 years old)
Ability to boost supportive relationships among club members	"My health is not good because I am also an older adult, but I must spend more time taking care of my husband, who had a stroke. My finances are also not good. Taking care of him for a long time led to my health declining seriously; I felt exhausted and easily touchy with anyone. But that was my status half a year before. Since I joined this club, I have received much support from the members. They help me look after my husband when I am ill, share with me some exercises to relax, and even give me some money to buy food for him. The mutual support among the members made me feel shared and loved, that is the reason why I feel happy each day" (N9, 62 years old)
Ability to promote participation in community activities of members	"The club organizes activities such as fundraising by encouraging members to collect scraps in the village. We sell them to get money and use the money to support some poor elderly people in our village. This activity made us feel valuable and bonded" (N14, 65 years old) "I feel that joining monthly club activities is a part of my life. It is fun here; we share many stories in our personal lives and even sing and dance together. This atmosphere makes me comfortable and motivates me to participate in community activities" (N19, 58 years old)

Discussion

Although both men and women serve as the informal caregivers for older adults in Vietnam, women still make up the majority. This study shows that they include the daughters, daughters-in-law, and wives of the elderly. This finding is consistent with previous studies showing that the responsibility of caring for older adults in Asian families often falls on women (Carmichael et al., 2010). There is evidence that, compared with male caregivers, female caregivers experience higher levels of behavioral problems, greater caregiving burden, and more mental health issues, mainly because women are exposed to more stressors when providing care (Pinquart & Sörensen, 2006).

The mean age of participants in this study was 48.5 years, indicating that most informal caregivers are middle-aged. Other studies in the world also show that informal caregivers are often family members and middle-aged. At this age, they usually have to take on multiple roles and face diverse pressures from personal work, caring for parents, children, and managing their family (Bernal-Alonso et al., 2024; Lüdecke et al., 2012; Tatomirescu et al., 2025, Turcu et al., 2025). They not only take the burden of their family but also have a significantly low level of education. The results of this study reveal that most caregivers' education ended at the primary or middle school level. In some cases, informal caregivers had never attended school and were unable to read or write. This finding reflects their vulnerable status, particularly those living in rural areas with limited educational opportunities compared to their urban counterparts in Vietnam. Therefore,

designing support strategies to improve the knowledge of informal caregivers living in rural areas is important because it may contribute to reducing the vulnerability of these individuals.

Caring for older adults at home puts informal caregivers under chronic stress (Schulz et al., 2020). Nearly half of the informal caregivers surveyed in this study experienced stress ranging from mild to extremely severe - a notable proportion that reflects the significant pressures and challenges faced by informal caregivers in their work. Although caring for the elderly in the family is based on emotional responsibility or is governed by the tradition of filial piety in Vietnamese culture (Cao, 2018; Nguyễn, 2012), informal caregivers, especially women, still face pressures from their families or expectations from the community and society, or simply a decline in their health due to the effects of long-term care for the elderly (Lê et al., 2024).

Previous studies have identified stressors for informal caregivers, including caregivers' financial status, changes in the elderly's physiology and psychology, lack of support from other family members, or lack of self-care when spending too much time and energy caring for the elderly (Chiao et al., 2015; Lindt et al., 2020; Yates et al., 1999). However, these factors were not our study's most vital stressors for informal caregivers. The survey results showed that informal caregivers who live in rural areas lack the knowledge and professional skills to provide medical support for the elderly, making them more susceptible to stress than formal caregivers. The informal caregivers living in rural areas have limited qualifications and require better access to information. Many of them, when asked, emphasized that they did not know how to handle an older adult with an urgent health problem, or did not know how to effectively support the elderly mentally and physically. Lack of knowledge and skills forced them to learn on their own. However, with limited access to information, as well as not having any social groups in the community to support them, they fell into a state of stress and exhaustion when they had to fend for themselves to find the best way to care for their older parents.

Several studies aimed at increasing informal caregivers' ability to cope with stress have highlighted community-based interventions, such as establishing groups to help participants develop coping strategies, such as mindfulness, or enhancing social support through community involvement in educational programs designed to improve informal caregivers' knowledge and skills (Lopez-Hartmann et al., 2012; Ye et al., 2023). The empirical results derived from the model of the community-based clubs showed that an effective response to group support measures can help improve participants' ability to cope with stress. This can be considered an effective solution to enhance the stress-coping capacity of informal caregivers for the elderly who live in the community. Through the club activities, participants found support to manage personal emotional stress and benefited from mutual aid in caregiving. This approach has also created support activities for the elderly in the community space where they lived, which is entirely consistent with the trend of supporting the elderly in the family and community that other countries are implementing to achieve active aging and aging in place (World Health Organization, 2015), as well as creating a sharing of responsibility between the state and other external partners, namely family, community, and society.

Conclusion and Implications

Our study shows the prevalence of stress among informal caregivers for the elderly living at home, with levels ranging from mild to extremely severe, with mild and moderate levels being most common. The main factor contributing to the stress of informal caregivers in rural Vietnam was the deficiency in caregiving knowledge and skills.

The result of the empirical community-based club model also illustrates the capacity to improve the stress-coping ability of informal caregivers by developing a support environment among participants and promoting mutual aid to manage the of caregiving.

At the time of the survey, the model was still operating effectively under the coordination of community organizations such as the local Women's Union and the Elderly Association. However, for the club to be sustainable and replicated in other areas, it is necessary to ensure the following factors: (1) Promote initiative and the capacity for self-help and mutual support among club members. (2) Mobilize support resources in the community: human resources, facilities, and means. For the model to be maintained and developed, funding for activities is also vital, in addition to increasing the number of members. Therefore, mobilizing available community resources or contributions from community members should be encouraged to facilitate the development and replication of the model. (3) It is necessary to create a network of connections between stakeholders, in which the main focal point is a community organization (possibly the local Women's Union) to coordinate and gradually replicate the model in other villages throughout the commune. In the context of rapid population ageing in Vietnam, the development and replication of community-based club models becomes an essential strategy. It will contribute to sustaining caregiver well-being and ensuring a sustainable long-term care system for older adults living in the community.

Limits and future directions

The small sample size and the focus on only one locality in Central Vietnam may be a limitation of this study, as it may not represent other rural areas in the North and South of Vietnam. In future research, we plan to include more study sites and to consider regional cultural differences in order to draw more representative and in-depth conclusions regarding potential solutions to enhance the capacity of informal caregivers for the elderly in Vietnam.

Competing interests

The authors declare no competing interests.

Ethics Committee Approval

The research was approved by the Japan Society for the Promotion of Science (JSPS) (no. 31/08.02.2019)

Consent to participate

Informed written consent was obtained from each participant at the time of recruitment. The subjects were informed that they could withdraw from the study at any stage, and they were assured of confidentiality.

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