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From basic care to beyond: A Q methodology study into the English communication needs among Thai caregivers of foreign older adults

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A R T I C L E I N F O

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A B S T R A C T

A shift toward the aging population worldwide brings about a growing demand of caregivers, who can communicate effectively with their care recipients. Using Q methodology, this study investigates the English communication needs among Thai caregivers of foreign older adults, aiming to profile the specific tasks that necessitate effective intercultural communication. Data were collected through card-sorting task and follow-up interviews. The findings show that caregiver's target tasks can be classified into *hands-on nurturers, emotional supporters*, and *trusted companions*. The hands-on nurturers focused on tasks requiring direct physical care and day-to-day assistance, emphasizing the role of English in activities such as bathing and aiding with hygiene. The emotional supporters recognized the importance of English in providing psychological and emotional comfort. Trusted companions placed value on English for fostering social connections, engaging in leisurely activities, and facilitating casual exchanges. This study highlights Thai caregivers' multifaceted roles, stressing the necessity for comprehensive English training for intercultural communication in caregiving.

1. Introduction

Globally, the proportion of the population aged 65 years or older has grown from 6 % in 1990 to 9 % in 2019, and it is projected to further increase to 16 % by 2050 (United Nations, 2019). This reality has augmented the crucial role of caregivers in society, transforming them into vital support pillars for ageing population. Beyond facilitating daily activities, caregivers contribute to the overall security and safety of older adults (Faes et al., 2010; Mamani et al., 2019), while also providing them with emotional and social support (Adelman et al., 2014). Caregivers fill various roles such as geriatric case managers, medical record keepers, paramedics, and patient advocates, effectively bridging the gaps in an often uncoordinated, fragmented, and bureaucratically frustrating system (Bookman and Harrington, 2007; Asis and Carandang, 2020).

In response to the Thai government's strategic plan to elevate the nation's medical sector as a global 'Medical Hub,' the country's health care and wellness services, along with its extensive medical industry, are being positioned as among the 13 pivotal industries poised to drive the nation's economic growth over the forthcoming decade (Thailand Board of Investment, n.d.). This, along with globalization, has led to a sharp rise in the number of care recipients migrating from mostly Western countries over the past few years (Sunanta, 2020; Bender et al., 2020), demanding more caregivers who are proficient in English to provide effective care while ensuring clear and efficient intercultural communication in increasingly multicultural care environments. For caregivers with limited English proficiency, navigating the complexities of the health care system heightens communication challenges and could lead to stress (Semere et al., 2019).

As part of a broader initiative to understand intercultural communication strategies that consider trust, comfort, and comprehension and offer training for Thai caregivers of foreign older adults (Phanthaphoommee and Siwapathomchai, 2024), this study aims to commence an assessment of their communication needs for further development of English for communication course. This involves identifying key focus areas and developing customized learning solutions to enhance the language skills they require for effectively accomplishing day-to-day tasks. We adopted an innovative approach—Q methodology (hereafter Q)—which has been proven effective in conducting needs assessments (Chinnis et al., 2001). As a self-referential process, Q entails participants analyzing statements and arranging them within a grid to reflect their subjectivities (e.g., attitudes, experiences, beliefs, perspectives, preferences, emotions) (e.g., Stephenson, 1953; Watts and Stenner, 2012; Lundberg et al., 2022; Phanthaphoommee and Thumvichit,

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2024). Q typically gathers data from multiple “reality” sources. It thus helps address methodological concerns about the quality of data collection instruments, such as irrelevance, complexity, ambiguity, and abstractness of questions (Long, 2015; Serafini et al., 2015), as well as the lack of triangulation in research on need analysis for English for Specific Purposes (ESP) and *ad hoc* translation/interpreting.

Our objective is to identify and characterize the caregivers' diverse English communication experiences. Ultimately, the findings from this study will aid in the development of strategies aimed at improving communication between caregivers and their care recipients.

2. Situations and research sites

Thailand is widely known as a favorite retirement destination on a global scale. Its government has advocated vigorously for the growth and promotion of health and medical tourism. Providing care services in Thailand is being seen as part of the phenomenon of long-term tourism and immigration (Kogiso, 2012). Since 1998, the Thai Ministry of Commerce has implemented a program for long-term stays and health care. The Tourism Authority of Thailand also certified a state-sponsored corporation to support foreigners who are financially able to engage in long-term tourism with a special visa scheme for retirees from abroad (Scuzzarello, 2020). More than sixty thousand people entered the country on long-term visas in 2016, and the number of applications from affluent retirees soared by more than thirty percent just three years after that (“Foreign expats' lot”, 2021). Since 2018, when the military government adopted the Thailand 4.0 policy to accelerate economic growth, the ideal of ‘Medical Hub’ has gained appeal as a means of drawing revenue to the country. The long-stay tourism campaign was one of the solutions to this policy because of the country's favourable climate, high-quality medical services, and wide range of facilities, all at a reasonable rate (Sunanta, 2020). In this sense, the country's emphasis on economic growth seems to be a surefire recipe for the aging population, contributing to the local employment and benefiting international retirees alike. However, as Sunanta and Jaisuekun (2022) caution, the government's lack of clear definitions of what constitutes caregiving for foreigners, its plans to train local personnel, and disparities in treatment approaches in various care homes and hospitals for long-term residents make it challenging to secure the many benefits of foreign retiree care in Thailand.

Our study sites for data collection comprised three different types of facilities in Chiang Mai—one of the highest concentrations of care providers in Thailand, with many international visitors choosing to reside there each year. Facility A was established in 2014 to serve foreign seniors with dementia and those with special needs (see Fig. 1). It offers both long-term and short-term visitors a vacation destination with bungalows built in a tranquil setting of nearby hills and paddy fields. It has a zone for care recipients' family members to stay as hotel guests, a swimming pool and recreation area, a restaurant, and a patisserie, for the long-stay care recipients to not feel as though they are in an isolated care facility. Typically, the caregivers accompany their care recipient during daily activities within the facility and, as necessary, outside. The educational requirement for employment as a caregiver in this facility is a two-year associate degree in basic nursing.

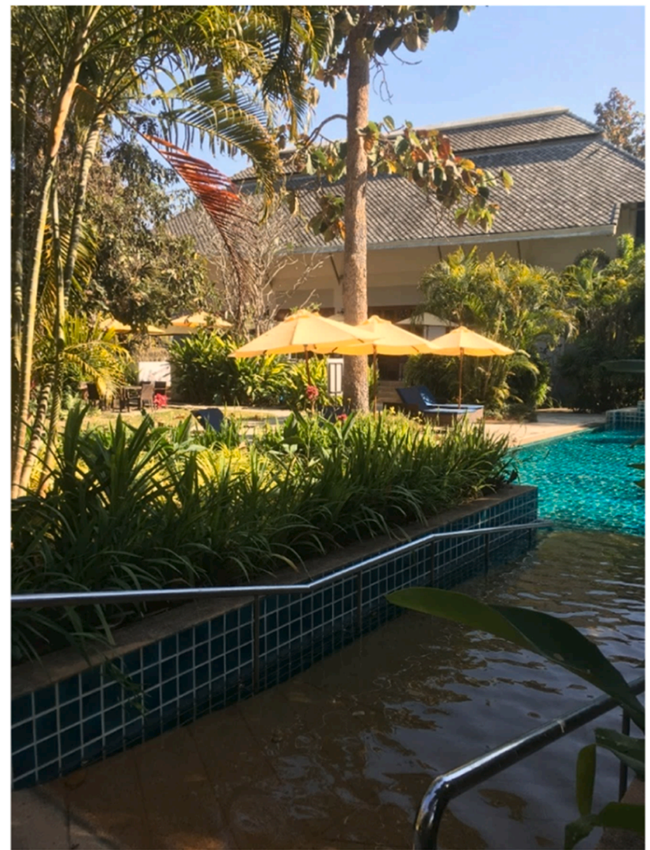

Fig. 1. Pool area at Facility A (Photo: the authors' own work).

Fig. 2. A common area at Facility B (Photo: the authors' own work).

Facility B is a hospital with several services for inward aging patients and a private area for care recipients (both foreigners and Thais). This location once served as a leprosy rehabilitation center in 1907, with its location on a large island in the province's main river isolated it from the downtown or other villages. Since then, it has been transformed into a facility for senior care and retirement. The hospital includes a semi-independent unit and a 24-hour nursing unit. The care community has an open dining hall, a common area (Fig. 2), and several gardens. As of May 2023, there are fewer than 15 caregivers due to a decrease in international visitors as a result of the COVID-19 pandemic. Most caregivers have over four years of experience. The staff received internal training in English as a requirement for passing probation, but their command of English is limited to basic communication, making it challenging to engage in long conversation. Only the chief nurse and administrative staff serve as translators and interpreters during critical incidents. Most care recipients are from the UK and Scandinavia, with a few from Japan.

Located in the Doi Saket District of Chiang Mai, almost 100 km from the city center, Facility C has ten houses (Fig. 3), all of which are wheelchair accessible. A typical house has one floor, a kitchenette, a bathroom, and a linking living and bedroom room. Every guest has at least two caregivers in rotation to watch for 24 h, depending on the request. The owner, a professional nurse, typically visits each guest in

Fig. 3. Houses at Facility C (Photo: the authors' own work).

the morning and evening rounds for medication and a hypertension check-up. During the researchers' site visit, most care recipients were permanent residents. In most cases, their relatives live in their home countries (only some in the city center) and visit them occasionally. All the caregivers here have at least one year's experience in caring for frail people, but urgently need training in English communication skills.

3. Methodology

The aim of this study was to explore communication needs among Thai caregivers of foreign retirees. That is, we sought to link caregivers' experience of using English for communication to the tasks they perform in their daily work routine. In this study, we hypothesize that English communication needs are subjective among the caregivers. This means that we attempted to divide them into subgroups based on shared views of different stakeholders, resulting in the identification of unique profiles of English communication needs. We proceeded with the following sequential steps: Q sample, P sample, Q sort, and data analysis and post-sort interviews.

3.1. Q sample

The Q sample (also known as Q set) is a set of statements drawn from the *concourse*—a population of remarks that reflect the widest range of views concerning the topic of interest (Brown, 1980). The concourse in this study centered on the potential target tasks performed by caregivers. It is important to note that the term *target tasks* used here referred to caregivers' specific duties that require English language communication. The concourse identification was guided by the question, 'What are the target tasks performed by Thai caregivers of foreign retirees?' To answer this question, a naturalistic approach was adopted (McKeown and Thomas, 2013). That is, we first consulted relevant documents, (e.g., job descriptions, reports, brochures, care schedules, and field notes). This was followed by informal conversations with caregivers themselves, doctors, and nurses. At this stage, our goal was to generate as many statements as possible. The initial collection of statements then underwent several screenings by the research team, yielding a list of 60 statements.

As Serafini et al. (2015) suggested, for task validation, it is essential to consult domain experts (in our context, experienced caregivers) to obtain insider knowledge of what constitutes successful performance within a specific job or professional role. As such, five experienced caregivers were invited to review the statements, focusing on relevance and repetition. After the review and several rounds of screening, some statements were removed, while some others were revised based on the experts' feedback. The final Q sample comprises 36 statements, each reflecting a potential target task (see Appendix).

3.2. P sample

The P sample (also known as the P set) denotes a group of individuals whose viewpoints are of interest. The main aim of Q is to investigate individual subjectivity by revealing diverse viewpoints on a particular topic within the target demographic (Stainton Rogers, 1995; Watts and Stenner, 2012). Due to the lack of a universal consensus on 'subjectivity', it is recommended that Q researchers construct their own understanding of this concept (Lundberg et al., 2022). Considering the concept of ESP needs analysis (Brown, 2006), we consider subjectivity as a unique and complex outcome, derived from the interaction between the individuals and their environment.

We obtained formal approval for P sample recruitment from the Institutional Review Board, Institute for Population and Social Research, Mahidol University (IPSR-IRB-2022–224), in compliance with international guidelines in human research protection. We also obtained consent from participants who expressed interest in participating in the project.

The P sample is not a random sample; rather, "it is a structured sample of respondents who are theoretically relevant to the problem under consideration" (van Exel and de Graaf, 2005: 6). The purposive sampling technique used in this study was intended to secure the heterogeneity rather than the representativeness of the population. The sampling process began with the question, 'Who can tell us about the communication needs of caregivers?' At first, care recipients were considered as having firsthand experience with their caregivers. However, involving them in the study was ruled out due to ethical reasons, possibly to protect their privacy and to avoid potential discomfort. The participants were selected based on their roles within the caregiving environment and their direct experiences with care recipients. As such, the sample included individuals from various roles including nurses (who were direct supervisors to caregivers), facility administrators, and caregiver themselves. While caregivers were selected because they directly interact with care recipients, nurses and facility administrators were also recruited as they oversee caregivers' work and are responsible for the overall management within the facilities.

A formal invitation was sent to all potential participants based at the three research sites (as described in Section 3). A total of 42 participants were recruited, including 27 caregivers, nine nurses, four administrators, and two managers (see Table 1). While the sample size may raise concerns in traditional quantitative research, Q prioritizes the nature of the participants over the number. In Q research, the number of participants is far less important than who they are (Brown, 1978). A P sample size ranging between 40 and 60 participants is deemed appropriate for Q research. (Brown, 1980; Stainton Rogers, 1995). Participants are designated as P1 through P42.

3.3. Q sorting

Data collection in this study involved a card-ordering procedure known as 'Q sorting'. Participants were given the statement cards printed in Thai and asked to rank them on an 11-column reverse pyramid-shaped grid, ranging from –5 (most unlikely) to +5 (most likely), with 0 indicating neutral attitudes (see Fig. 4). Participants were then instructed to sort the cards into the grid independently, adhering to the following condition of instruction: *Please specify the degree to which caregivers' sufficient command of English is necessary in performing each task*.

We conducted a pilot test with five caregivers, encouraging them to give feedback on Q sorting, particularly highlighting any challenges they faced when completing the sorting grid. After the pilot test and some minor adjustments, the package (the statement cards and the grid) was handed out to each participant. They were given as much time as

Table 1
Participants' demographics.

No.	Sex	Job title	Age	Experience (year)
1	Female	Caregiver	29	8
2	Female	Caregiver	23	1
3	Female	Caregiver	48	8
4	Male	Caregiver	42	2
5	Female	Caregiver	28	7
6	Female	Caregiver	32	8
7	Female	Administrator	45	13
8	Female	Nurse	48	25
9	Female	Nurse	44	20
10	Male	Caregiver	39	20
11	Female	Caregiver	54	24
12	Female	Nurse	42	18
13	Female	Caregiver	56	15
14	Male	Caregiver	30	18
15	Female	Caregiver	30	21
16	Female	Nurse	41	17
17	Female	Caregiver	55	14
18	Female	Caregiver	29	9
19	Female	Caregiver	22	4
20	Female	Caregiver	26	5
21	Female	Nurse	44	11
22	Female	Administrator	43	6
23	Female	Nurse	44	11
24	Female	Administrator	43	6
25	Female	Caregiver	28	6
26	Female	Caregiver	22	1
27	Female	Caregiver	47	10
28	Female	Caregiver	29	1
29	Female	Manager	37	8
30	Female	Caregiver	29	2
31	Female	Manager	39	12
32	Female	Nurse	33	10
33	Female	Nurse	30	8
34	Female	Nurse	29	6
35	Female	Caregiver	20	2
36	Female	Caregiver	20	1
37	Female	Caregiver	21	1
38	Female	Caregiver	21	1
39	Female	Caregiver	22	2
40	Female	Caregiver	20	1
41	Female	Caregiver	68	27
42	Female	Administrator	32	5

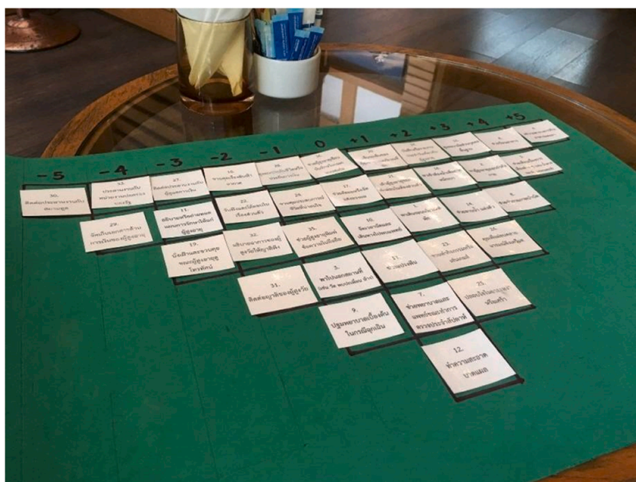

Fig. 4. A sample of Q sort distribution at Facility A (Photo: the authors' own work).

they needed to complete the sorting grid. Once completed, we took photographs of each completed grid for data computation.

3.4. Data analysis and post-sort interviews

In Q research, the sorts are subjected to 'inverted' factor analysis (also known as by-person factor analysis), rather than R factor analysis in conventional quantitative research. Inverted factor analysis is a variation of traditional factor analysis where the focus is on identifying patterns in the data by examining how individuals are grouped based on their responses to a set of variables. Unlike standard factor analysis, which looks for correlations between variables, inverted factor analysis looks for similarities and differences among participants, allowing researchers to uncover distinct profiles or clusters within the sample.

For this study, we used the Ken-Q Analysis Desktop Edition (KADE) application (version 1.2.1) to plot and analyze all 42 Q sorts (Banasick, 2019). The data was entered into an Excel spreadsheet, which was then imported into the application. The baseline criteria for factor extraction included: an eigenvalue exceeding 1.00 (McKeown and Thomas, 2013) and a minimum of two Q sorts loading significantly on a single factor (Watts and Stenner, 2012). We explored multiple factor solutions, extraction methods, and rotation strategies before finalizing our decisions. The most robust results were derived from a principal component analysis with varimax rotation. The first three factors were retained for further analysis. These factors explained 66 % of the variance, suggesting a satisfactory solution (> 35 %) (Watts and Stenner, 2012) (see Table 2). Flagging at $p < 0.01$ indicated that 38 Q sorts (90 %) loaded significantly on at least one factor. The correlation between factors is presented in Table 3. The factor loadings in Table 4 demonstrate the extent to which each Q sort correlates with each factor.

Twelve of the participants, who had highest factor loading values in each factor, were invited for the follow-up interviews (Albright et al., 2019). The aim was to capture their reflective thoughts, and this was facilitated using probing questions, such as, "I notice you've rated this statement as '+5'; could you tell me why?" All interviews were audio-recorded and transcribed verbatim, which was used to support interpretation. We adopted a narrative style for interpretation due to its effectiveness in preserving a holistic view (Watts and Stenner, 2012; Thumvichit, 2023). The interpretation was largely guided by factor arrays (see Appendix), focusing on the statements sorted at both ends of the grid (*characterizing statements*) and the statements that differentiated the factors (*distinguishing statements*).

4. Results

From the analysis, three distinct factors surfaced, each corresponding to a specific group of caregivers. The combined Q sort of each factor, known as the factor array, can be found in Appendix. This section delves into the profiles of these three factors, which are supported by quotes from interviews. The position of each statement is provided in parentheses, where the statement number is represented with "#" and its value is indicated by its placement on the sorting grid (ranging from –5 to +5).

4.1. Group A: caregivers as hands-on nurturers

Group A had an eigenvalue of 21.92 and explained 52 % of the variance. It was significantly loaded with 28 sorters, including 26

Table 2
Factor characteristics.

	Factor A	Factor B	Factor C
Eigenvalues	21.92	3.01	2.74
Explained variance (%)	52	7	7
Cumulative explained variance (%)	52	59	66

Table 3
Factor correlation scores.

	Factor A	Factor B	Factor C
Factor A	1	0.4	0.4676
Factor B	0.4	1	0.1964
Factor C	0.4676	0.1964	1

Table 4
Factor loadings.

Q sort	Factor A	Factor B	Factor C
P15	0.8417*	0.1518	0.2932
P35	0.8407*	–0.1052	0.2054
P37	0.8377*	0.1645	0.2492
P14	0.8359*	0.2109	0.3553
P40	0.8203*	–0.0193	0.3219
P17	0.8196*	0.2245	0.2318
P36	0.8154*	–0.1626	0.2402
P16	0.7979*	0.1394	0.2484
P27	0.7964*	0.1388	0.1946
P38	0.7913*	0.2095	0.2869
P39	0.7834*	0.1762	0.3543
P8	0.7774*	0.2554	0.3035
P31	0.7768*	0.1717	0.2469
P34	0.7688*	–0.0725	0.1677
P28	0.7668*	0.1826	0.2137
P13	0.7457*	0.4195	0.2785
P6	0.741*	0.2912	0.1034
P26	0.6965*	–0.0585	–0.005
P5	0.6888*	0.2771	–0.1115
P3	0.6769*	0.1629	0.369
P12	0.6747*	0.5653	0.242
P42	0.6621*	0.2651	0.479
P30	0.6549*	0.1693	0.2846
P29	0.6378*	0.1409	0.3073
P32	0.6188*	0.2224	0.2283
P2	0.5862*	0.2991	0.26
P11	0.5775	0.5534	0.2842
P4	0.5334*	0.2221	0.331
P1	–0.0738	0.7561*	–0.0558
P10	0.4114	0.7183*	0.2034
P9	0.3858	0.7007*	0.1403
P22	0.2345	0.4948*	0.2334
P24	–0.248	0.4392*	–0.1366
P18	0.1053	0.0536	0.9359*
P19	0.1239	0.082	0.9308*
P20	0.1451	0.1762	0.8876*
P21	0.4192	0.0766	0.6145*
P7	0.4722	0.1714	0.6129*
P41	0.4956	0.2422	0.4443
P41	0.4956	0.2422	0.4443
P25	–0.4905	0.2608	–0.4728
P33	–0.4292	0.1929	–0.4854

Note. *Factor values indicate statistical significance ($p < 0.01$).

women and 2 men. The majority served in caregiving roles ($n = 21$), with the remainder distributed among nursing ($n = 4$), managerial ($n = 2$), and administrative roles ($n = 1$). The group's average age stood at 33.92 years, while their professional experience averaged 8.6 years.

Group A is a cluster of those who portrayed caregivers as *hands-on nurturers*, emphasizing the integral connection between fundamental care responsibilities and effective communication. Central to this group was the priority given to target tasks that ensure physical care. They indicated that assisting with bathing and dressing (#14, +5) as well as helping with bathroom use (#16, +3) are foundational to both caregiving and the use of English. That is, effective communication was primarily required for addressing concerns, understanding preferences, or ensuring safety during such intimate routines. Sufficient command of English was also essential in feeding (#6, +4) and ensuring basic personal hygiene (#15, +4). At first glance, these tasks did not seem to demand much verbal communication, but they were laden with personal preferences. Apart from physical interaction, feeding encompasses addressing dietary needs, discussing potential allergic reactions, and understanding feedback on food preferences. P15 and P37 provided the context as follows:

> P15: When they need help with personal cleanliness, like showering or using the restroom, I'm usually the one who steps in. It's a tough job that often requires English to communicate. I've got to make sure both I and my co-worker, who might not speak English well, are polite, gentle, and careful.
> P37: We need to know some basic English, even if the guests might not get us right away. Most of our conversations are about serving food, helping them eat, and cleaning up. All these things need patience because many times they may not understand us right away.

In addition, the responsibility that came with communication was related to situations where caregivers help their care recipients move around the care facility. The findings suggest that tasks that needed English also revolved around helping care recipients with exercise (#2, +3). P14 illustrated:

> P14: Some of them have trouble moving. I have to talk to them when I help them keep their balance going to the toilet or stepping outside their room.

This implies that for caregivers in this group, enhancing the comfort and sanitation of care recipients outweighs other tasks, and highlights the importance of a sufficient command of English. It also indicates that these services, despite varying levels of English required for specific care tasks, are primarily about interpersonal communication for personal care.

Beyond the practicalities, effective communication likewise served in building trust between caregivers and care recipients. When individuals are cared for by someone who can converse and address their concerns well, it can provide reassurance of the caregiver's competency and attentiveness. P35 explained:

> P35: People need to be treated with kindness. I'm expected to help them with our heart. Once they trust me, I can communicate with ease to tell them how to do many activities properly.

On the flip side, some tasks were identified as less reliant on English communication. Coordinating with the embassy (#30, –5) and interfacing with governmental administrative units (#33, –4) were tasks those participants perceived to be less intertwined with their core caregiving responsibilities. These roles were often seen as administrative, where their L1 or dedicated professionals play a more prominent role. P14 added:

> P14: We aren't likely to share care recipients' information with outsiders. Although English isn't required for these tasks, they're uncommon and usually done by nurses or managers.

In a similar vein, managing financial documents (#29, –4) was reported to be less dependent on English communication. The practical nature of such tasks, coupled with the availability of native language forms, offers a reprieve from the consistent need for English. The presence of these alternative resources reduces the constant pressure on caregivers to use English when dealing with financial paperwork.

4.2. *Group B: caregivers as emotional supporters*

Group B showed an eigenvalue of 3.01, accounting for 7 % of the variance. Comprising five sorters, this group are made up of two caregivers, two administrators, and a nurse (four women and one man). Their average age and professional experience were 39.6 and 12 years, respectively.

This group, aptly named *emotional supporters*, is a cluster of those who reported the deep emotional connection that caregivers cultivate with those under their care and the importance of English in fortifying this bond. Listening to stories about the retiree's home abroad or past experiences and, at the right moment, responding in English (#22, +4) and consoling (#25, +3) were particularly salient in this context. P1 explained:

> P1: Everyone who works as a caregiver at our facility is willing to talk to others [often in basic English] about their time on duty. I think that being mindful of these tasks helps keep us accountable and ensure our commitment to helping our care recipients stays consistent throughout their stay with us.

This means that beyond the rudimentary procedure of care, when caregivers took the time to listen to the personal stories of their care recipients, having a good grasp of English was paramount, enabling caregivers to truly engage with the depths of the experiences, emotions, and histories shared by the care recipients. In turn, they could respond with genuine empathy, building a bond of trust.

In line with Group A, apart from the emotional-support tasks, discussing personal hygiene preferences necessitated effective communication to uphold the health of care recipients (#15, +5). This group also highlighted caregivers' interpersonal communicative experiences by recognizing the usefulness of English skills in specific situations, such as contacting care recipients' relatives (#31, +4), small talking to soothe their stress (#26, +3), and consoling in times of loneliness or sadness (#25, +3). P10 explained that:

> P10: Although we don't speak English well, it is important to pay attention to the person we are helping and those who are involved too. It would help a lot if we listened carefully. Experience can teach us how to use it properly.

When interacting with care recipients' relatives, caregivers sometimes needed to communicate effectively to relay information, address concerns, or facilitate meaningful interactions between the care recipient and their family. Such communication ensured that both care recipients' and their families' needs were fulfilled. In some cases, as in P9—a nurse who was responsible for overseeing the caregivers' routine—communicating with relatives might call for effective written correspondence.

> P9: Every caregiver under my supervision has been responsible for sending information of daily or weekly medical checkups along to our care recipients' respective family members via SMS or WhatsApp. Normally, I train them in this straightforward task so they can use basic, understandable English words in their messages.

According to P22, however, a tendency to take a more active role in contacting the care recipient's relatives via e-mail or other mobile apps for messaging might be occasionally observed among certain caregivers. This was especially true for those whose workload increased during the COVID-19 pandemic due to a shortage of caregivers at the facility.

On the other end, the process of handling financial documents seemed to take a backseat in terms of requiring a good command of English (#29, –5). Like those in Group A, participants in this group viewed this task as largely transactional, where the essence of their role was not heavily intertwined with the language of the documents. The details, numbers, and figures of financial documents, often supplemented with symbols and standard formatting, might have reduced the need for profound English understanding. P9 illustrated that:

> P9: The person in charge of these tasks is mainly our manager who is reliable and skilled. Caregivers here do not have access to these documents, so they are unlikely to discuss [in English] these financial matters with our senior guests despite their daily interaction and close contact with them.

The underuse of English to fulfill these tasks (e.g., drafting reports for relatives abroad, helping with texting, filling out forms) largely stemmed from the caregivers' limited command of English. However, oral communication skills can often be more easily acquired later in life, explaining why many caregivers reported more verbal exchanges with their care recipients.

4.3. Group C: caregivers as trusted companions

Group C explained 7 % of the total variance with an eigenvalue of 2.74. This group comprised five participants (four women and one men). Three of them are caregivers, while the remainders include a nurse and an administrator. Their average age and experience were 33.2 and 8.4 years, respectively.

This group represents participants who viewed caregivers' roles as not just providers of basic care, but also as companions who form meaningful bonds with their care recipients. For these participants, establishing a trusting, genuine connection is of paramount importance, and effective communication is a bridge to that connection. A notable profile of such caregiving focused on engaging in casual conversations about topics, such as the weather (#18, +4), while watching TV (#19, +3). Based on this group, caregivers fostered familiarity and a sense of normality, breaking down barriers and making care recipients feel more personal. English communication proved essential in the scenario where they attempted to relax and ease tension of their care recipients (#26, +4), indicating that caregivers might be adept at using conversation as a tool for comfort, with effective communication acting as a crucial facilitator. P18 and P19 stated:

> P18: I think I need to be more than just a caregiver. I need to be a trusted friend. Our care recipients want someone to talk to and share their thoughts with. It can be very hard for them because they are far from the home
> P19: I think that our care recipients are more likely to lose their memory or even have a stroke. Once, our Korean-American care recipient had a stroke, and I had to be the one to talk to him when he got back from the hospital to make him feel less lonely and improve his general health.

Moreover, assisting nurses and doctors during weekly check-ups was noted to require a sufficient command of English (#7, +5). This suggests that participants fully recognized that caregivers were vital in being present, informed, and involved in the health care process.

The role of these caregivers also involves being attuned to the physical needs of the care recipients, meaning that tasks such as feeding (#6, +3), cleaning minor wounds (#12, +3), and assisting in physical therapy (#8, +2) highlight these caregivers' hands-on approach. This ultimately helps them become good companions, such as spending time with care recipients to help relieve their anxiety (#26, +4). P20 illustrated:

> P20: Most likely, just being there for them is the best thing we can do for their health—both physically and mentally. I can get to know them very well by doing things like talking about general topics or simply sitting beside them.

This response highlights how crucial it is for caregivers to have an attentive mindset when carrying out their duties. In some instances, this attention to detail may extend to more complex tasks, such as administering medications, managing health records, or communicating with external parties. However, similar to the other groups, coordinating with the embassy (#30, –5), managing financial documents (#29, –4), and reviewing insurance plans (#28, –4) were least focused.

5. Discussion

5.1. The interplay between the roles and communication needs among caregivers

Our data separated participants into three distinct groups, each emphasizing different sets of target tasks in caregivers' day-to-day work routine. Although most participants loaded onto the first group, the presence of the other groups suggests that communication needs among caregivers are beyond homogenous, confirming the stated hypothesis. In this study, caregivers are categorized into hands-on nurturers, emotional supporters, and trusted companions, in accordance with their subjective target tasks. For all these groups, English was used not merely as a functional tool for cross-cultural communication, but as a critical element for understanding and meeting the complex, individual needs of their care recipients. Hands-on nurturers emphatically focused on the link between basic care tasks and the need for effective communication. Notably, they emphasized the importance of communication in activities such as assisting with bathing and dressing, as well as aiding in bathroom use. As participants indicated, English was used beyond just the mechanics of physical care. These seemingly straightforward tasks ('physical') were, in fact, filled with subtleties that could not be adequately addressed without a sufficient command of English. These responsibilities tie into the concept of *action facilitating supporting* (Cutrona and Russell, 1990), which entails messages or behaviors that aid an individual in completing a specific task (e.g., providing information, offering tangible assistance). Managing the sound completion of these tasks (basic activities of daily living) can become problematic due to communication difficulties (Wilson et al., 2013), leading to a deteriorating relationship between caregivers and care recipients (Orange, 1998; Savundranayagam et al., 2005; Williamson and Schulz, 1993).

As for emotional supporters, one of the standout observations is that emotional support is not ancillary to the job; it is the job—or at least a significant part of it. Emotionally connecting with the care recipients emerges as a key component of effective caregiving. The idea that emotional connection is not merely a 'nice-to-have' but is foundational reveals a holistic view of human health that acknowledges emotional well-being as equally important to physical well-being (Stewart-Brown, 1998), as both constituting 'health' (World Health Organization, 1947). The role of caregivers as providers of emotional support is not new; emotional support has long been recognized as a crucial element in the caregiving process (Adelman et al., 2014). For instance, the simple act of listening to an older adult's past experiences or homesickness can be a profound moment of connection that adds qualitative value to their life, perhaps lifting their spirits, reducing feelings of isolation. Communicating effectively across cultural lines allows caregivers to pick up on the subtleties that may be important in emotional exchanges. That is, being able to use specific expressions that hint at a care recipient's feelings, or using idiomatic language to offer comfort, improves sensitivity in managing emotional situations.

Trusted companions, like emotional supporters, are those who encapsulate more than just clinical care; it brings in the facets of friendship and cross-cultural interaction. Caregivers can become a trusted companion who is involved in establishing a relationship with care recipients by having a certain level of language competence beside technical competence. This means that both sides have some common topics of interest (e.g., the weather or television shows) as avenues for building rapport. Social support is not a by-product of their role but rather a central part of it. Through such 'small talk' or 'soothing talk', caregivers help dismantle both social and language barriers, fostering a sense of comfort and normality for those under their care. This is in line with previous studies on *ad hoc* interpreters (Jansson & Wadensjö, 2016; Plejet et al., 2014). In the context of caregiving, social support can be more specifically defined as "verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one's life experience" (Albrecht and Adelman, 1987: 19). Under Cutrona and Russell's (1990) notion, this form of support, along with the previously mentioned emotional support, falls under the umbrella of *nurturant support*, including both verbal affirmations and emotional reinforcement (e.g., kind words or gestures that boost their self-worth).

5.2. The status difference between the giver and the recipient vis-à-vis the local mindset

Identified tasks in Groups 2 and 3 have led to the assumption that social support and companionship are phenomena relatively unique to the Thai culture, which is arguably undergirded by Thailand's flourishing hospitality business, especially through the country's medical tourism policy. As informed by the interviews, many participants clearly used the term *khaek* 'guest' instead of 'care recipient' or simply 'foreigner'. Such use of the term indicates that the role of being a 'host' and providing care to the international 'guest' is of great significance, making our case study stand apart from care businesses in other countries (cf. Mamani et al., 2019; Silva et al., 2013).

It is common that when seeking care in a tourist destination like Thailand, foreign older adults are often regarded as visitors to the care facilities rather than only as patients or retirees receiving medical treatment. Their positionality is predestined to be that of a 'guest' with some qualities of a 'quasi-tourist'. Hence, it can be argued that the concept of care for foreigners in Thai culture encompasses more activities and tasks that demonstrate empathy and are indicative of nurturing virtues for both physical and mental well-being. This aligns with the findings of recent research by Scuzzarello (2020) on elderly foreign immigrants to Thailand and their higher socioeconomic lifestyle and privileges than the locals. Such an imbalance means that the caregivers must keep their 'guest' satisfied and come to terms with the retirees' far better economic status in exchange for financial benefits largely derived from the global hierarchies. This seemingly places an additional burden on the Thai caregivers because, apart from providing physical care, they are forced to assume the role of a good host who needs to harbor the mindset of being good companions and, undoubtedly, have a certain level of English language skills to do their job.

In fact, this mindset also seems to disclose another inherent issue in Thai education, particularly concerning fundamental English teaching. In most caregiving schools, the training programs are usually designed with only elementary English courses that lack a link to the specific skills or tasks required for caregiving. While care students are required to complete a 420-hour training course, there is a limit to how much time prospective caregivers can dedicate to studying English (for caregiving purposes). Consequently, their timely acquisition of the language is inevitably inadequate (Department of Health Service Support, n.d.). This is supported by the testimony of many participants who claimed that they did not engage in intensive English study during their training period or even during their school years—a general trend that is reflective of Thailand's contemporary vocational education (see also Chalamwong and Suebnusorn, 2018).

Another reason local caregivers require specialized English and intercultural communication training for care (pertaining to the unique tasks in Groups 2 and 3) is the current absence of care schools focused on caregiving foreigners. Only a few training schools specialize in preparing caregivers for work in Japan (Duangkaew, 2022), while other institutions offering care training primarily focus on general care for the local older adults (Supromin and Choonhakhlai, 2019). Our findings, combined with the shortage of schools that offer English training for care-related purposes, thus suggest the urgent need for policymakers to redouble their efforts in meeting the increasing demand for caregivers who can effectively communicate by having the perceived mindset mentioned above. We concur with Mashland et al. (2011) in asserting that care institutions should offer their staff appropriate bilingual training to genuinely connect with care recipients from diverse linguistic

backgrounds. By revealing communication needs for diverse care tasks within Thai culture, as our findings inform, all stakeholders can further design appropriate intercultural communication and English training sessions on extra care-related responsibilities such as mental care (cf. Raj et al., 2021; Adelman et al., 2014) to pursue the quest for the country's thriving hospitality industry.

5.3. Limitations and strengths

There are some limitations of this study that must be acknowledged. First, care recipients, who could offer valuable insights into the communication needs of caregivers, were not recruited for this study due to ethical reasons and business confidentiality. However, including their viewpoints in future research (such as care home management, mental well-being during their stay, specific translation/interpreting for care recipients) could provide a holistic understanding of caregivers' communication needs. Second, due to the cross-sectional nature of this study, data was captured at a single point in time. This means that any evolving shifts in caregivers' communication needs over time remain unobserved.

Despite these limitations, the study has some strengths. First, it provides a detailed examination of the communication needs of caregivers, incorporating diverse perspectives from caregivers, nurses, and administrators, leading to a broader range of perspectives and distinctive experiences. Second, the use of Q led to the discovery of unique profiles of communication needs among caregivers. These combinations offer insights into the specific requirements for specific roles of caregivers (hands-on nurturers, emotional supporters, and trusted companions).

6. Conclusion

This study identified the diverse communication needs of caregivers of foreign older adults in Thailand, emphasizing the critical role of English proficiency across different caregiving roles. Caregivers were categorized as hands-on nurturers, emotional supporters, and trusted companions, each group demonstrating unique communication requirements to fulfill their duties effectively. Their communication needs have much to do not only with their caregiving tasks but also the cultural context of Thai hospitality. As such, they are expected to deliver not only physical care but also emotional support and companionship.

Ethics statement

In compliance with international guidelines for human research protection, formal approval was obtained from Institutional Review Board, Institute for Population and Social Research, Mahidol University (IPSR-IRB) (COA. No. 2022/12-224).

CRediT authorship contribution statement

Athip Thumvichit: Writing – review & editing, Writing – original draft, Visualization, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Narongdej Phanthaphoommee:** Writing – review & editing, Writing – original draft, Validation, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

No potential conflict of interest was reported by the authors.

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Appendix: Factor arrays

No.	Statement	Factor A	Factor B	Factor C
10	Schedule appointments to see doctors.	−1	−1	0
29	Manage financial documents	−4	−4	−4
9	Provide basic first aid in emergencies.	+1	0	0
36	Help with notetaking or fill out forms.	−2	−2	0
4	Explain the schedule of meals and medication.	+1	0	0
25	Console in times of loneliness or sadness.	+2	+3	+1
27	Coordinate with financial caretakers.	−3	−3	−3
1	Walk around the living area.	0	+2	+1
8	Provide or assist with physical therapy.	+1	0	+2
5	Remind about certain avoidance (e.g., sugar, alcohol).	−1	+2	0
30	Coordinate with the embassy.	−5	−3	−5
35	Help with typing messages on mobile phones.	−2	+1	−1
34	Keep daily records or reports	0	0	+2
16	Assist with using the bathroom	+3	+1	0
32	Explain the symptoms to relatives.	−2	0	−1
3	Take out to places (e.g., temple, meet friends, malls).	−1	0	−3
21	Watch over while in private rooms.	0	−1	+2
24	Engage in conversations about interesting life experiences.	+2	+2	−1
26	Talk to relax and ease tension.	+1	+3	+4
28	Review life insurance or financial insurance plans.	−3	−5	−4
17	Help with hair cutting or styling.	+2	−2	+1
12	Clean minor wounds.	+2	−1	+3
11	Explain or convey the treatment plan.	−2	+1	−3
6	Feed	+4	+1	+3
23	Assist in doing activities or playing games.	+1	+2	−2
33	Coordinate with governmental administrative units.	−4	−1	−2
22	Listen to stories.	0	+4	+1
19	Sit and engage in conversation while watching TV.	−1	+1	+3
2	Assist in physical exercise.	+3	−2	−1
13	Help with brushing teeth.	+3	−2	+2

(*continued on next page*)

(*continued*)

No.	Statement	Factor A	Factor B	Factor C
20	Push the wheelchair around the living area.	0	–4	+1
14	Assist with bathing and dressing.	+5	+3	–2
31	Contact relatives.	–3	+4	–1
7	Assist nurses and doctors during weekly check-ups.	–1	–1	+5
18	Engage in casual conversations about the weather.	0	–3	+4
15	Take care of basic personal hygiene.	+4	+5	–2

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