CAREGIVING PROCESS OF THAI CAREGIVERS TO ELDERLY STROKE RELATIVES: A GROUNDED THEORY APPROACH

by

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This dissertation has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.
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ABSTRACT

A grounded theory approach was used in this study to generate a substantive theory that explains the process of caregiving based on the perspectives of Thai caregivers of elderly stroke relatives. The study sample consisted of 20 primary caregivers living in five districts of Chachoengsao Province, Thailand. The participants were interviewed in their homes. Observations were made during the interviews and the researcher’s memos were maintained. All interviews were tape-recorded and transcribed verbatim. All data accumulated from the interviews, observations, and notes were analyzed.

The substantive theory that emerged from the data was called “maintaining caregiving at home.” This theory described how and why Thai caregivers cared for their elderly stroke relatives. The process of maintaining caregiving encompassed the following seven aspects which helped caregivers provide care for their relatives: (a) caregiving as an integral part of life; (b) caregiving: an unavoidable task; (c) caregiving with love, sympathy, and attachment; (d) family and kinship support; (e) community support; (f) managing treatment; (g) managing problems and difficulties.

This theory can help nurses and other health care providers gain a better understanding of the caregiving process of Thai caregivers. Major factors identified in this theory can be related to concepts or variables indicated in previous studies and existing models. Problems and difficulties experienced by participants suggest the need for caregiver support services.
Personal beliefs due to religion and culture played major roles throughout the caregiving process. Also, important religious and cultural concepts such as karma, bunk hun, merit, sin, and heaven are needed to understand the theory. Health care providers should integrate scientific, religious, and cultural knowledge into their clinical practice for promoting quality of life of family caregivers and their elderly stroke relatives. Further research is needed to test the theory with larger samples and its value in developing appropriate interventions for Thai caregivers and stroke patients.
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CHAPTER 1

INTRODUCTION

Problem Statement

Stroke is one of the leading causes of disability among Thai elderly. Siriphanich (1982) found that more than 25% of the total disabled persons were elderly. Loss of hearing, stroke, blindness, and loss of limbs were major types of disablement. Choprapawon, Na Songkhla, Chirawatkul, Kachondham, and Chayowan (1997) indicated that 1.7% of the persons aged 50 and over had problems related to stroke. Stroke was the major cause of death among the Thai people in 1995 (Ministry of Public Health, 1996).

In Thailand, family members play a major role in providing care for stroke survivors. Most survivors, left disabled after stroke, remain at home for months or years and are cared for by their families. This may be because people in Thailand or other Asian countries still believe that providing care for older parents is the responsibility of their children. Chuto (1982) reported that 90% of Thai older people live with their children or relatives. A study regarding facts and attitudes among younger Thais toward the care and support to elderly found that most of the younger generation frequently provided care and support to elderly parents for more than 5 years (Siriboon, 1992). Siriboon also found that the majority of the younger generation intended to continue support until their elderly
parents, or they themselves, passed away.

Stroke survivors who are disable can also develop psychosocial problems. Both physical and psychosocial changes cause much stress and often require help and support from family caregivers. Family relationships have been found to help stroke patients adapt and achieve a greater sense of well-being (Sirivarasai, 1993). In the United States, there are numerous studies regarding the effects of caregiving and coping behaviors of caregivers of stroke patients. These studies have shown that caregivers of stroke patients have experienced considerable burden, emotional distress, and fatigue (Brocklehurst, Morris, Andrews, Richard, & Laycock, 1981; Clark & Rakowski, 1983; Elmstahl, Malmberg, & Annerstedt, 1996; Pearlin, Mullan, Semple, & Skaff, 1990; Silliman, Fletcher, Earp, & Wagner, 1986; Zarit, Reever, & Bach-Peterson, 1980). Also, many studies suggest that caregiver support groups reduce stress and burden among caregivers, including reducing the propensity of caregivers to place their care-receivers into nursing homes (Clark & Rakowski, 1983; Green & Monahan, 1987; Mohide, Pringle, Streiner, Gilbert, & Muir, 1990). Therefore, a variety of supportive services aimed at reducing stress and burden among family caregivers have been developed.

In Thailand, there are few research and supportive services focused on family caregivers of stroke or any other chronically ill patients. Most of the prior studies have focused on caring for these patients in hospital settings. Older adults who experience a stroke are taken to the hospital and cared for by hospital staff until their conditions were stable. The family caregivers are then briefly instructed on how to take care of their relatives at home before hospital discharge. These suggestions emphasized only how to deal with the patients' problems. Since 1993, some stroke
survivors have been visited by home health care teams, including physicians, nurses, nutritionists, and social workers every 2 to 3 months. However, these home health care programs mainly focused on caring for stroke patients. No current special supportive programs are known which directly aim at reducing the burden and psychological effects on family caregivers.

Research on the process of caregiving for elderly stroke patients at home is needed in Thailand for the following reasons. First, as previously mentioned, there is a lack of research and intervention focused on caregivers. Second, although there are numerous studies on family caregivers of stroke patients in the United States, few studies have explored caregiving situations from the perspective of caregivers. Thus, there is little information available on the ongoing process of family caregiving to stroke survivors. Finally, stroke is a major health problem among the Thai elderly, with family caregivers playing an important role in caring for their relatives who have suffered from strokes.

In order to enhance the quality of care and to reduce the negative effects of caregiving on caregivers, it is necessary for nursing professionals and other health care providers to develop appropriate interventions. This ultimate goal cannot be achieved without a better understanding of the caregiver process at home. This study can provide a more comprehensive understanding of the caregiving process of Thai caregivers. The results of this research can also be used to support the development of interventions that will benefit Thai families and their caregivers. The findings may contribute to further development of research aimed at changing health policy in Thailand to address caregiving issues and caregiver needs.
Purpose and Research Questions

The overall objective of this research was to generate a substantive theory that describes and explains the process of caregiving based on the perspectives of Thai caregivers of elderly stroke relatives. The research questions were as follows:

1. How do Thai caregivers define their caregiving situations?
2. What do Thai caregivers do as caregivers and why?
3. How does caregiving affect the Thai caregivers’ lives?
4. How do Thai caregivers manage to be able to continue as caregivers?

Assumptions

The following assumptions of this study were derived from the symbolic interactionist framework.

1. Caregiving is a process which involves the interaction among caregivers, care-receivers, and significant others in natural settings.
2. The caregiving process can be observed, described, and explained. It is assumed that caregivers are able to describe and explain their caregiving situations.
3. The caregiving process varies depending on the individuals’ beliefs, spirituality, culture, background, and environment.

Conceptual Framework

Grounded theory is based on the theoretical framework of symbolic interactionism, that is, a framework for understanding human behavior (Becker, 1993; Glaser, 1978).
Three assumptions of symbolic interactionism provided the underlying theoretical foundation for this study. First, reality is a process in which social life is consistent with the way in which situations are defined rather than the way in which they are, in some sense, objectively constituted (Lauer & Handel, 1977). Symbolic interactionism is a perspective that sees humans actively define their situations and act according to their definitions (Charon, 1979). Therefore, in order to understand the caregiving process, it is necessary to determine how caregivers define their situations.

Second, humans live in a symbolic and a physical environment. Symbols that humans use not only exist linguistically but also include nonlinguistic factors such as physical objects and human acts (Charon, 1979). A system of symbols, or a language, “is the means whereby individuals can indicate to one another what their responses to objects will be and, hence, what the meanings of the objects are” (Mead, 1934, p.122). Thus, symbols are important in understanding human behavior and social process.

Finally, humans live in a world of meanings. They respond to events and objects in terms of meanings they have attributed to them. The meanings of events are dynamic and flexible. The world is populated with many cultural groups, each recognizably human and each responding to events in characteristic and unique ways. Even within each culture or subculture, there are individual differences in how people respond to the world (Lauer & Handel, 1977).

**Significance to Nursing**

Caregivers perform a major role in the nursing system and health care arena. They may work in close association with physicians, nurses, and other health care providers.
Orem (1991) pointed out that there are increased needs for dependent-care agents or caregivers with the growth in the aging population and in the number of persons with chronic illnesses, debilitating illnesses, and disabling conditions. Nurses in hospitals and communities are increasingly placed in positions where they must work with families or individuals to identify and select persons psychologically and physically able and willing to function as caregivers for family members or friends.

Family is one aspect of the environment that has been found to influence adaptation after a stroke and to be affected by the member with stroke (Evan & Bishop, 1990).

"Long-term caregiving is a dynamic process" (Elmstahl et al., 1996, p. 177). As home care use increases, the need to understand family caregiving over time is critical. The aim of this study was to explore the caregiving process of caregivers of elderly stroke relatives based on the caregivers' perspectives. The substantive theory derived from this study can allow nurses to better understand the caregiving situations in natural community-based settings. This can enable nurses to develop more comprehensive nursing interventions, plan family-centered care, and formulate health policies that support families and caregivers at home. By supporting caregivers, care-recipients are also more likely to receive better quality care.
CHAPTER 2

LITERATURE REVIEW

The literature in grounded theory studies can provide sensitizing concepts and awareness of the gaps in knowledge. Initially, this chapter covers previous studies regarding caregiving of stroke survivors and the effects on caregivers. The model of caregiver stress developed by Pearlin and colleagues (1990) based on prior research on caregivers is also presented in this chapter.

Effects of Caregiving on the Caregiver

Studies on the effects of caring for a dependent person on the family caregiver have been primarily quantitative. In a review of these studies, caregiving has been shown to affect the family caregiver positively and negatively. Several researchers have reported satisfaction associated with the caregiving role including a sense of fulfillment for the caregiver, increased feelings of closeness between the caregivers and their relatives, and pleasures resulting from day-to-day interaction with the care-recipient (Harper & Lund, 1990; Kinney & Stephens, 1989; Kinney, Stephens, Franks, & Norris, 1995; Lawton, Moss, Kleban, Glickman, & Rovine, 1991; Miller, 1988; Moss, Lawton, Dean, Goodman, & Schneider, 1987; Motenko, 1987; Stephens, Franks, & Townsend, 1994). Kinney and
colleagues (1995) used two stepwise multiple regression procedures to examine caregiver and care-recipient characteristics associated with the appraisals of uplifts among caregivers to older stroke patients. The results of these analyses showed that across the three domains of uplifts (behavior, cognitive, and practical uplifts), younger caregivers reported more uplifts. Caregivers to more physically impaired and younger care-recipients reported more uplifts in activities of daily living (ADL) and practical uplifts. Caregivers to more physically impaired and less socially withdrawn care-recipients reported more uplifts stemming from their relatives' cognitive status.

Regarding the negative effects of caregiving, most caregivers have been shown to experience a considerable burden in providing home care (Brocklehurst et al., 1981; Draper, Poulos, Cole, Poulos, & Ehrlich, 1992; Elmstahl et al., 1996; Silliman et al., 1986; Wade, Legh-Smith, & Hewer, 1986; Zarit et al., 1980). Emotional disorders with symptoms of anxiety, stress, depression, and fatigue have been widely documented (Brocklehurst et al., 1981; Carnwath & Johnson, 1987; George & Gwyther, 1986; Johnson, 1983; Kinney et al., 1995; Pearlin et al., 1990; Shulz, Tompkins, & Rau, 1988; Silliman et al., 1986; Stein, Gordon, Hibbard, & Sliwinski, 1992; Williams, 1994). Factors related to stress, depression, and the burden of family caregivers of stroke patients have been reported in a number of previous studies. Biegel, Sales, and Shulz (1991) indicated that being married to the stroke patient, being female, and experiencing declines in standard of living or confiding relationships were related to higher levels of caregiver depression. Brocklehurst and colleagues (1981) reported that among a sample of 62 caregivers of persons with stroke, the behavior of the stroke person was the most salient problem. They cited irritability, demanding behavior, depression, and confusion in the person with stroke.
as examples of problem behaviors, whereas incontinence and the need for bathing were minor but frequently encountered problems for most caregivers in their sample.

Williams (1994) explored the sources of stress among 29 caregivers to stroke patients. Caregivers identified many additional causes of stress which centered within three domains: (a) stressors which related to the effects of stroke, including behaviors of the person with stroke and the impact of those behaviors on the caregiver; (b) stressors which related to the environment and other aspects of life such as job or children; and (c) stressors which related to caregiver well-being such as physical distress, emotional distress, and fatigue. Causes of stress which related to the effects of the stroke were further divided into four primary categories: (a) dependence of the person with stroke with resulting confinement of the caregivers, (b) irritability, (c) cognitive impairment, and (d) the physical condition of the person with stroke. The most frequently cited stressors related to dependency and irritability of the stroke patient. Stressors related to the living environment were important to 8 of the 29 caregivers and were found to represent four categories: (a) stress in the workplace, (b) financial concerns, (c) concerns about another family member, and (d) stress related to household tasks. Some caregivers also identified their own fatigue and physical or emotional distress as causes of their stress.

Kinney and colleagues (1995) found that the caregivers of stroke patients who exhibited more cognitive confusion and higher levels of social withdrawal reported more of each type of hassle. In addition, caregivers to relatives with more physical limitations reported significantly more ADL hassles.

Elmstahl and colleagues (1996) assessed the burden experienced by caregivers 3 years after a primary stroke by using a 22-item Caregiver Burden (CB) scale. This
measurement showed high reliability (test-retest stability) with kappa values .69 or higher for all indices. Findings showed that a closer relationship was correlated to a higher degree of general strain ($r = -.14$, $p < .05$), isolation ($r = -.23$, $p < .01$), disappointment ($r = -.27$, $p < .0001$), and emotional involvement ($r = -.21$, $p < .01$). The corresponding correlation coefficient between the type of relationship and total burden, including all 22 items, was $r = -.23$, $p < .01$. The patient’s degree of extroversion and quality of life were negatively correlated to caregiver burden ($r = -.46$, $p < .05$ and $r = -.59$, $p < .01$, respectively). Surprisingly, when divided into tertiles, the highest caregiver burden was found among patients showing the greatest improvements of ADL.

In summary, the effects of caregiving on caregivers to stroke persons have been found in a number of previous quantitative studies. Caregivers have been shown to experience considerable burden, anxiety, stress, depression, and fatigue. Despite the widely documented difficulties involved in caregiving, several researchers have also reported satisfaction associated with the caregiving role. Factors related to stress, depression, and burden among family caregivers to stroke persons were widely reported such as type of relationship between caregiver and care-recipient, characteristics of the caregivers (such as age and gender), and characteristics of stroke person (such as age, type of personality, behavior, level of ADL, and quality of life). Taken together, these findings point to the complexity of the caregiving situation, a situation that embodies positive and negative components and consequences.
Qualitative Research on Caregiving to the Stroke Person

Caregiving to stroke persons has been quantitatively studied from a variety of perspectives, including stress, burden, and coping. However, many findings from these studies still lack the broader understanding of the whole caring experience, especially over the life course. Some investigators have attempted to address these gaps by using qualitative methodology to study in-home caregiving from the perspective of the caregivers. These studies are described below.

Periard and Ames (1993) used a multimethod approach to assess the perceptions of lifestyle changes and coping patterns of 20 caregivers of first-time elderly stroke survivors in the poststroke period. An outcome-oriented matrix was employed for qualitative analysis, and findings were expanded by additional quantitative analysis. Three themes emerged: (a) pervasiveness of lifestyle change, (b) cohort difference in the perception of lifestyle change and coping patterns, and (c) primary issues of time and confinement.

Regarding the first theme, with the exception of one caregiver, all experienced at least one lifestyle change. Caregivers reported negative changes in their leisure activities (65%), dietary or nutrition habits (55%), physical activities or exercises (45%), participation in community activities (45%), relationships with their family (40%), relationships with friends (40%), their daily personal care (30%), and their financial status (15%).

The second theme involved the cohort and development or age differences that emerged from the data. The perception of lifestyle change and caregiver strain scores were considerably lower for the older cohort. In terms of coping patterns, Periard and Ames (1993) found that caregivers aged 70 and over appeared to reflect a general attitude of acceptance. This attitude may reflect an emotionally focused coping skill. In contrast,
younger caregivers’ comments reflected specific strategies or more problem-centered coping such as praying, keeping busy, reading, crying, working, watching television, and walking.

The final theme that emerged concerned restricted time and confinement. Many lifestyle changes were perceived as being physically confining or restricting blocks of time to engage in activities such as personal care, leisure, and church or community participation. Findings also suggested that strains relative to caregiving may result from upsetting established patterns of daily life (Periad & Ames, 1993).

Jongbloed (1994) used ethnographic research methods to examine the process of adaptation of a person who experienced a stroke and her spouse over 2 years. A semistructured interview was applied to elicit issues of most importance to participants. The participants were asked to describe their lives since the stroke; the chief problems the stroke had caused; and how the stroke had affected their activities, roles, and relationships. The analysis revealed that a stroke could not be understood as an individual phenomenon because the life course of both the woman and her husband were profoundly affected by it. The man’s roles as family member, caregiver, home maintainer, and hobbyist required change after his wife’s stroke. The woman’s experience of her changed body, dependence, and altered homemaking role were influenced not only by her husband’s attitudes but also by societal values and expectations.

Robinson-Smith and Mahoney (1995) explored the effects of cerebrovascular accidents on 7 older couples. The in-depth interview method was used to identify major themes in the couples’ accounts of their post-stroke experiences. Four major themes emerged: (a) experiencing physical changes, (b) feeling down and worrying about the
future, (c) being restricted and adjusting to limitations, and (d) seeking a new balance in the marriage. Stroke survivors and spouses differed in how they described the impact of the stroke for older couples. All stroke survivors described physical outcomes resulting from the stroke such as feeling pain, not having control over parts of their bodies, feeling changes in sensations, experiencing double vision, and lacking balance. Spouses of stroke patients described having to do more work such as cooking, driving, and sometimes helping the stroke survivor with daily hygiene and walking. Several spouses also mentioned losing weight. In terms of feeling down and worrying about the future, female spouse caregivers expressed frustration in response to the stroke, especially in regard to taking care of their partner. Stroke survivors mentioned feeling sensitive, helpless, frustrated, and worried about getting better.

Being socially restricted and experiencing difficulty in adjusting to the resulting confinement were frequently mentioned by stroke survivors and their spouses. The stroke often limited traveling and vacations, and some caregivers mentioned the effects of the stroke on their jobs. The stroke survivors and their spouses also recognized the limits on activities the stroke had brought and feeling of loneliness. In terms of seeking a new balance in the marriage, for all couples, a new equilibrium was being sought in an attempt to resolve the impact of the stroke. The couples attempted to work out a new balance in their relationship by facing practical and emotional issues.

Holroyd and Mackenzie (1997) used ethnographic methodology to explore the perceptions and moral determinants of caregiving from personal accounts of primary caregivers in 10 Beijing families. Analysis generated themes of labor and routines of caregiving, restricted resources, health, and illness linked by the sentiment of establishing
a connection, family time, personal time, gendered time, and reciprocity. For these Beijing families, caregivers, often in poor health themselves, were actively engaged in rendering complex and often intimate care to family members in their own homes. Special acts such as the preparation of food were a gesture of caring. Certain behaviors in the dependent person such as an altered mental state, as well as physiological changes such as incontinence, tended to confuse the nature of respect and love that previously existed. Caregivers accorded and enacted caregiving based on diffuse sentimental and behavioral, as well as cultural guidelines, drawing on the nature and quality of the relationship, past patterns of reciprocity, and a clear sense of who was most able to provide care and why.

**The Model of Caregiver Stress**

In addition to quantitative and qualitative studies, useful knowledge can be gained from existing theoretical and conceptual models. One such model has been proposed by Pearlin and colleagues (1990). They developed a conceptual model of Alzheimer's caregivers' stress based on previous studies. According to this model, four domains make up the process of caregiver stress, each comprising multiple components: (a) background and context of stress, (b) stressors, (c) mediators of stress, and (d) outcomes or manifestations of stress.

The background of the stress process includes key characteristics of the caregivers, caregiver history (type of relationship and length of time of caregiving), network, and use of resources and programs. The effects of ascribed status such as age, gender, and ethnicity, along with educational, occupational, and economic attainments, are expected to
be threaded throughout the entire stress process. The types and intensities of stressors to which people are exposed, the personal and social resources available to deal with the stressors, and the ways stress is expressed are all subject to the effects of these statuses.

Stressors were divided into primary and secondary. Primary stressors were viewed as driving the process that follows. By and large, they directly result from the needs of the patient and the nature and magnitude of the care demanded by these needs. The labels of primary and secondary in this model were not intended to suggest that one is more important than the other but only to point out that a configuration of interrelated stressors can and often does emerge as individuals are immersed in the long-term care of an impaired relative. Pearlin and colleagues (1990) also indicated that one set of stressors can lead to another. Primary stressors include the following indicators: (a) the cognitive status of the patient, (b) the problematic behavior of the patient, (c) the number of activities for which the impaired person is dependent on the caregiver and the extent of dependency for each activity, (d) the condition of the patient, and (e) the hardships subjectively experienced by caregivers. Secondary stressors are divided into two types. One type, comprising role strains, is found in roles and activities outside the caregiving situation. The second type is made up of a variety of intrapsychic strains. Secondary role strains include family conflict, work conflict due to caregiving, economic problems, and constriction of social life due to caregiving tasks. Secondary intrapsychic strains represent the final but crucial step in an antecedent process. Intrapsychic strains, for the most part, involve dimensions of self-concept and kindred psychological states.

Pearlin and colleagues (1990) suggested that the relentless and progressively expanding demands of caregiving, along with enduring secondary role strains, are
capable of diminishing positive elements of self. This, in turn, leaves people increasingly vulnerable to stress outcomes.

In terms of mediating conditions, coping and social support are generally regarded as the two principal mediators. Mediators may serve to lessen the intensity of stressors and to block their contagion at junctures between the primary and secondary stressors. To the extent that these mediators have positive consequences, they would indirectly be limiting deleterious outcomes. Coping was conceived in response to life problems as having three possible functions: (a) management of the situation giving rise to stress, (b) management of the meaning of the situation such that its threat is reduced, and (c) management of the stress symptoms that result from the situation. Regarding social support, there are two types of social support: (a) instrumental and (b) expressive. Social support can prevent or inhibit the development of secondary stressors. According to Pearlin and colleagues (1990), the effects or outcomes of the stress process include mental health effects (such as depression, anxiety, irascibility, and cognitive disturbance) and physical health effects. They pointed out that elements of emotional distress are likely to surface first, and if they persist, they may eventually adversely impact physical well-being.

Finally, Pearlin and colleagues (1990) suggested that it is useful not to think of caregiver stress as an event or a unitary phenomenon. Instead, caregiver stress is a mix of circumstances, experiences, responses, and resources that vary considerably among caregivers and that, consequently, vary in their impact on the caregivers’ health and behaviors. The mix is not stable; a change in one of its components can result in the change of others. A great deal has been learned in previous research about the
components of the stress process and how they are best measured and evaluated. Obviously, however, much remains to be learned concerning how the various elements enter into and shape the direction of the caregiver's life.

The next chapter presents details of the methodology used in the current research on Thai caregivers to elderly persons who have had strokes.
CHAPTER 3

METHOD

A grounded theory approach was used in this study to examine more closely the personal lives of Thai caregivers. Grounded theory is a method developed by Glaser and Strauss (1967) that allows discovery of both the participants' points of view and the ways they process the situations over time (Glaser, 1992). This method provides structure for conceptualization in describing and exploring a phenomenon and is especially useful in areas where little previous research has been conducted (Corbin & Strauss, 1991; Glaser & Strauss, 1967; Stern, 1980). The purpose of this study was to develop a substantive theory of the caregiving process of Thai caregivers of elderly stroke relatives and to have the theory reflect the perspectives of the caregivers. Thus, grounded theory was particularly appropriate to use in this study.

Study Setting

The setting of this study was the Chachoengsao province, eastern region, Thailand. This province was selected because it is large with both urban and rural communities. Statistics also have shown that stroke is the leading cause of death among people living in Chachoengsao (Office of The Prime Minister, 1995). I am familiar with this region and
have existing personal contacts that made the study more feasible.

Chachoengsao province is 100 km east of Bangkok and occupies an area of 5,351 km². The total population of Chachoengsao province is 609,241 (Ministry of Interior, 1996). The major income of this province is derived from industry and agriculture. There are approximately 753 factories in this province because it was designated as an investment promotion area.

Chachoengsao is administratively divided into 10 districts (Amphoes) and one subdistrict (King Amphoe): Muang, Bangkha, Bang Nam Prieo, Bang Pakong, Banpho, Phanom Sarakham, Sanam Chai Khet, Plaeng Yao, Ratchasan, Thata Kiap, and King Amphoe Khongkuan. Additional information about each district and subdistrict such as the number of villages included in each district, area, and the total population of each district is shown in Appendix A.

There is one public general hospital with 300 beds in Muang district. The remaining districts and subdistrict have a community hospital with 30 to 90 beds. The following five hospitals were selected as sources of information and support for this study:

1. Muang Chachoengsao Hospital is a 300-bed public hospital located in a municipal area of Chachoengsao (Muang district).
2. Bang Nam Prieo Community Hospital is a 30-bed public hospital located in Bang Nam Prieo district 19 km north of Muang district.
3. Bang Pakong Community Hospital is a 60-bed public hospital located in Bang Pakong district 24 km south of Muang district.
4. Phanom Sarakham Community Hospital is a 90-bed public hospital located in Phanom Sarakham district 32 km east of Muang district.
5. Sanam Chai Khet Community Hospital is a 60-bed public hospital located in Sanam Chai Khet district 50 km east of Muang district.

Participants

Purposive or theoretical sampling is characteristic of grounded theory research when the goal is to yield a rich description rather than generalizable findings (Lincoln & Guba, 1985). Therefore, a purposive sample of caregivers to elderly stroke relatives living in Chachoengsao province was used in this study. Caregivers were eligible if they (a) lived with their elderly stroke relatives in Chachoengsao province, (b) identified themselves as the principal family member providing day-to-day care to relatives at home, (c) did not suffer from a life-threatening illness that would prevent them from continuing in the caregiving role over the length of the study, (d) were not financially reimbursed for caregiving activities, and (e) had been a caregiver for a minimum of 6 weeks prior to the study. Stroke relatives were individuals who (a) had a medical diagnosis of stroke, (b) were age 60 years or older, (c) did not suffer from a serious concomitant illness likely to result in death during the study period, and (d) were dependent in one or more of the following ADLs: bathing, dressing, toileting, transfer such as getting in or out of a chair, continence, and feeding (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963).

Recruitment Process

The aim of this study was to generate a substantive theory of the caregiving process experienced by Thai caregivers to elderly stroke relatives that accounted for most behavioral variation within a group. In order to accomplish this, a diversity of
perspectives or experiences was necessary (Hutchinson, 1993). Therefore, the study participants included caregivers with variation in age, gender, socioeconomic status, educational level, occupation, relationship to the stroke patient, length of time in the caregiving role, and the level of dependency among stroke relatives. These diverse factors were considered because previous studies indicated that they may influence caring behaviors and perceptions of family caregivers (Barusch & Spaid, 1989; Chaoum, 1994; Draper, Poulos, Poulos, & Ehlich, 1995; Elmstahl et al., 1996; Green & Monahan, 1989; Harper & Lund, 1990; Kinney et al., 1995; Miller, MacFall, & Montgomery, 1991; Pearson, Verma, & Nellet, 1988; Pett, Caserta, Hutton, & Lund, 1988; Saewun, 1994; Suksawat, 1991; Young & Kahana, 1989). In order to obtain the desired diversity among family caregivers, the following recruitment steps were applied.

1. Five hospitals in Chachoengsao province were selected as sources for information regarding elderly stroke patients and their family caregivers. In addition, a nurse and a physician who had responsibility for a home health care program in each hospital were members of the recruitment and assessment team. The five hospitals were selected to represent the various sizes and geographical areas of Chachoengsao province.

2. Letters requesting permission to conduct the research and to obtain information regarding elderly stroke patients who used services of the five hospitals for the last year (names, addresses, and health records) were sent to the provincial chief medical officer and directors of the five hospitals.

3. After receiving permission from the provincial chief medical officer and directors of the five hospitals, I contacted the nurses and physicians who had been assigned
to be members of the recruitment and assessment team representing each hospital.

4. In each hospital, the recruitment and assessment team which included me, nurse, and physician identified elderly stroke patients who met the study criteria based on their health records.

5. The family caregivers of the selected stroke elderly were contacted by telephone or in-person, informed about the research project, and asked to participate in the assessment stage of this study. After receiving permission, the caregivers and their elderly stroke relatives were visited and assessed by the recruitment and assessment team members in their homes. Background data of the family caregivers and their elderly stroke relatives such as age, gender, marital status, financial status, and educational level were collected (see Appendix B). Caregivers who met the criteria were listed in a population frame.

6. The study participants were selected from the population frame based on their background data in order to obtain a study sample with the desired characteristics. The study participants were given an overview of the study, and were asked to establish mutually agreeable times for in-home interviews to occur. Written consent for subject participation was obtained prior to commencement of the interview.

In terms of grounded theory, it is impossible to know how many participants will be involved. The sample size is determined by the data generated and the analysis of those data. The researcher continues to collect data until saturation is achieved (Streubert & Carpenter, 1995). Saturation refers to the completeness of all levels of codes when no new conceptual information is available to indicate new codes or the expansion of existing
ones. The researcher, by repeatedly checking and asking questions of the data, ultimately achieves a sense of closure (Hutchinson, 1986). Therefore, the sample of this study was continuously adjusted until no new information was obtained. The complete sample size was 20.

Data Collection and Data Analyses

Grounded theory requires that the researcher collects, codes, and analyzes data from the beginning of the study. “The method is circular, allowing the researcher to change focus and pursue leads revealed by the ongoing data analysis” (Hutchinson, 1986, p.119). Maxwell and Maxwell’s (1980) five steps to conduct grounded theory guided this study: (a) collection of empirical data, (b) concept formation, (c) concept development, (d) concept modification and integration, and (e) writing the theory (see Figure 1). Each step is described as follows.

Collection of Empirical Data

In order to enhance validity and credibility of this study, multiple methods were used. Data for this study were obtained from semistructured interviews, observations, and my memos. Each participant was interviewed by me at his or her home. I spent 1 1/2 to 2 hr each time with the participants and their families in order to get acquainted and to conduct the interviews. When the research interview began, it included only me and the participant. The participants were asked to describe their caregiving situations, how these situations affected their lives, and how they responded to them.
Figure 1. Outline of Research Procedure

Note. Adapted from Stern and Pyles (1985).
** Memoing can occur during any stage
The interview guide was developed first in English by me based on the aims of this study (see Appendix B). The interview guide was approved by the supervisory committee and the Institutional Review Board (IRB) at the University of Utah to ensure that the questions used were valid and appropriate for the purpose of the study. The approved interview guide was translated into Thai language by me, a Thai committee member, and a Thai faculty member from the department of English at the Burapha University. The translated interview guide was pilot tested by interviewing 5 caregivers with elderly stroke relatives in Chachoengsao province. I discussed and improved the interview guide with the Thai committee member. The final interview guide was translated into English by me, the Thai committee member, and the Thai faculty member from the department of English at the Burapha University. The English interview guide was then reviewed by the supervisory committee in the United States to ensure that it was appropriate.

Each participant was interviewed once. However, two caregivers were interviewed twice in order to clarify some data received from the first interviews. Each interview was tape-recorded after receiving permission from the participant.

Observations were also made while interviewing the participants in their homes. In grounded theory research, observation focuses on the interaction in a situation and analysis focuses on the symbolic meaning transmitted via action. Analysis focuses on interaction, patterns of interaction, and their consequences (Chenitz & Swanson, 1986). Thus, the context of observations included the participant’s actions, appearance, feelings, interaction with the care-recipient, family, and living environment that relate to the caregiving situation. I recorded data derived from observation immediately after interviewing.
Observations provided not only more information that might have been lost if the interviewing was used alone but also rich information that could confirm data derived from other data collection methods. For example, while interviewing a participant who cared for her husband, I observed that there were materials and equipment in her home such as a wooden side rail and rope rings. When I asked her about such materials, this caregiver said that she and her children made them for the patient to hold while walking and getting up from his bed. The data of this observation allowed me to know that developing materials and equipment was a way to manage some problems related to the caregiving. Therefore, the next participants were asked about materials and equipment provided or developed for their patients.

Memos or field notes were maintained during data collection and analysis. Memoing is a regular and critical part of the grounded theory process. The process of memoing helps the researcher “to catch the creative flashes of insight, hunches, abstractions, and emerging hypotheses when they occur” (Stern & Pyles, 1985, p. 18). Memos of all types also leave an audit trail for the research and may provide data for presentations, publications, and additional research (Hutchinson, 1993). For example, I wrote a memo after interviewing and observing the participant as mentioned above: (a) Why did this participant have to make some materials and equipment for her husband? (b) Was it because she did not have enough money to buy them or because she had other reasons? Based on these hypotheses, I paid more attention to observations and asked other participants about the utilization or development of materials and equipment, as well as their reasons for development.
This study required interpersonal interaction between me and the participant, allowing me to be aware of personal perceptions, values, and beliefs. Hutchinson (1993) suggested that only through self-awareness of mind-set can the researcher begin to search out and understand another world. Expressing personal feelings and reflections is often helpful in sustaining this heightened level of awareness. Therefore, I noted my feelings and reflections during the course of data collection. For example, while interviewing a low-income participant who cared for her older husband alone, I felt sympathy and pity. The participant said with teary eyes that she experienced many difficulties related to financial problems and caregiving. After I left the interview, my feelings were recorded as field notes. This record helped me be aware of personal bias during data analysis process.

**Concept Formation**

All interviews were tape-recorded and transcribed verbatim. All the data, including the interviews, observations, and memos, were entered into the computer with the Word Perfect program. A tentative conceptual framework was generated from the collected data at this stage. The process of coding and categorizing was used to formulate a tentative framework. In the coding process, the data were examined sentence by sentence. A key word or words used by participants were coded by me, the Thai committee member, and a nurse instructor experienced in qualitative research. These codes are called “substantive codes” (Glaser & Strauss, 1967).

In the categorizing process, the constant comparative method was used to treat the data (Hutchinson, 1993). The data were coded and compared with other data, as assigned,
to cluster or categorize according to obvious fit (Stern, 1980). Each category was then compared with all other categories to ensure that they were mutually exclusive (Streubert & Carpenter, 1995). Table 1 shows five responses and gives examples of cluster-related codes placed into a category.

Concept Development

Three major steps were used to expand and densify the emerging theory:

(a) reduction, (b) selective sampling of the literature, (c) selective sampling of data (Stern, Allen, & Moxley, 1982). Each step is described below.

Table 1

Substantive Codes and Categories

<table>
<thead>
<tr>
<th>Response</th>
<th>Substantive Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>It's my karma. I have to take it as it is.</td>
<td>karma</td>
<td>Personal beliefs due to religious Instruction.</td>
</tr>
<tr>
<td>It's that I return gratefulness (bunkhun) to her for what she did for me when I was young.</td>
<td>bunkhun</td>
<td></td>
</tr>
<tr>
<td>To abandon or leave him is a sin.</td>
<td>sin</td>
<td></td>
</tr>
<tr>
<td>Taking care of your parents, ... will gain merit.</td>
<td>merit</td>
<td></td>
</tr>
<tr>
<td>Giving good care to our parents or spouses, we will go up to heaven.</td>
<td>heaven</td>
<td></td>
</tr>
</tbody>
</table>
Reduction is a step to reduce the number of categories. The researcher compares the categories with other categories and clustered them under a broader category or "high order category" (Stem, Allen, & Moxley, 1984). For example, in this study, the two categories of caregiving as a daily routine and caregiving as a burden and a duty were related. I reduced these two categories under the broader category of "caregiving as an integral part of life."

The step of selective sampling of the literature was used when theory began to develop. "The existing literature used as data is woven into the matrix consisting of data, category, and conceptualization" (Stem et al., 1984, p. 378). In this study, literature was carefully scrutinized in order to help expand the substantive theory and then relate it to other theories. For example, I selected literature about Buddhist teaching to support and expand the following concepts that emerged from the data: karma, bunkhun, merit, and sin. In order to relate these concepts to other theories, articles about related concepts such as reciprocity, indebtedness, and obligations were also selected.

Selective sampling of data is used to collect additional data in a selective manner for the specific purpose of developing the properties of the main categories (Stem et al., 1982). Therefore, the process of selective sampling of data included inductive and deductive processes. For example, in the inductive process, I questioned under what conditions the variable "trial" occurred. Data were collected with the specific purpose of answering this question. The findings revealed that the participants, relatives, or both (a) received information about treatment, (b) had experiences with treatment, (c) believed in treatment, and (d) hoped that the patients would recover from paralysis.
In the deductive process, the hypotheses generated from the data were tested by collecting additional data. For example, the educational level of the participants was not associated with their beliefs in traditional medicine and alternative therapies. The answer was validated by the selection of participants who had different educational levels.

Saturation of a category was completed when no new information was obtained and no further explanations of a particular view emerged. Data collection then ceased for that particular category.

**Concept Modification and Integration**

Theoretical coding and memoing were the two processes used in this step in order to move the conceptual framework emerging from the data from descriptive to theoretical explanations.

Theoretical codes gave direction to the process of examining data in theoretical rather than descriptive terms (Stern, 1980). Through this process, the grounded theory that emerged from the data could be developed out of a description. "The six C's" that include causes, contexts, contingencies, consequences, covariances, and conditions have been useful to help conceptualize categories related to each other and to enhance the researcher's ability to think more abstractly (Glaser, 1978; Hutchinson, 1986; Stern, 1985).

During concept modification and integration, memoing was used to maintain my ideas pertinent to the emerging theory. Memoing preserved emerging hypotheses, analytical schemes, hunches, and abstractions (Corbin, 1986). Memos were sorted into cluster concepts. Sorting allowed me to tie up loose ends or to cut them off. During writing and sorting memos, inductive and deductive thinking processes were used
alternatively. The inductive process helped me to conceptualize the concept or idea, and the deductive process helped me to assess the concept or idea.

In this study, the categories and themes that emerged from the data were conceptualized and related to each other. The central theme or the core variable, maintaining caregiving at home, was identified from the data. This core variable linked all of the data together because the seven categories, the main concepts, and the covariances derived from the data were the major factors or contexts involved in maintaining the caregiving process. Stern and Pyles (1985) stated that the core variable must be “well-integrated, easy to understand, relevant to the empirical world, and must explain the major variation in the process or phenomenon studied” (p. 15).

Writing the Theory

In order to enhance the credibility, applicability, and dependability of this study, the research report included an extensive description of the findings of the study and how it was conducted. This can allow others to grasp its meaning and to apply it to other persons, situations, and research studies. The trail of records of this research process was kept in order to allow other researchers to examine the records so that they will be able to understand the rationale involved in interpreting the study results. This strategy enhanced the confirmability of this study (Lincoln & Guba, 1985).

In order to achieve accuracy of the translation, the Thai research report was translated into English by me, the Thai committee member, and the Thai faculty member from the Department of English at the Burapha University. After the translation, I discussed the English research report with the supervisory committee to ensure the accuracy of meanings.
Lincoln and Guba (1985) suggested the following four criteria for evaluating the trustworthiness and rigor of qualitative research: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability. These criteria were used for evaluating this study as follows.

**Credibility**

Credibility is the criterion for internal validity or truth value of a qualitative study (Lincoln & Guba, 1985; Sandelowski, 1986). The truth value of a qualitative study resides in the “discovery of human phenomena or experiences as they are lived and perceived by the subjects” (Sandelowski, 1986, p. 30).

Member checks is suggested as a useful technique for establishing credibility. Lincoln and Guba (1985) stated, “the member checks, whereby data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected, is the most crucial technique for establishing credibility” (p. 314). In this study, member checks were conducted by turning the data over to 5 participants for their feedback during data analysis and final conclusion. This process gave the participants an immediate opportunity to correct errors of fact and then to challenge what were perceived to be wrong interpretation (Lincoln & Guba, 1985).

A study is also credible when other researchers or readers can recognize the experience when confronted with it after having only read about it (Psathas, 1973). A Thai researcher and an American researcher who had experiences in qualitative studies
and who were not acquainted with this study read the study findings and determined that
the substantive theory was believable.

In this study, different methods of data collection, including interview, observation,
and memo, were used. Observations provided rich information that could confirm and
complete data derived from interviews.

Independent analysis of data by another researcher can serve to validate findings
(Sandelowski, 1986). In this study, data were coded and categorized by me, the Thai
committee member, and the nurse instructor experienced in qualitative research
independently. Meetings were conducted during data collection and data analysis to
discuss and summarize. This process allowed me to receive multidimensional
perspectives throughout the process of data analysis and to prevent me from bias due
to personal perceptions.

Transferability

Transferability is defined as applicability or fit of the study findings to another
context or situation. A study is transferable when its findings can “fit” into contexts
outside the study situations and when its audience views its findings as meaningful and
applicable in terms of their own experiences (Guba & Lincoln, 1981; Sandelowski, 1986).
The study also meets these criteria when the findings fit the data from which they are
derived (Sandelowski, 1986).

In this study, a detailed description was provided and a detailed “decision trail” was
formulated to help the reader or another researcher make decisions about the fit of the
data. This description and decision trail followed the reasoning involved in developing
and implementing this research project.

**Dependability**

Dependability is the consistency in the findings and the audibility of data and data collection methods. A study and its findings are dependable when another researcher can clearly follow the “decision trail” used by the investigator in the study (Guba & Lincoln, 1981). These criteria also are met when another researcher can arrive at the same or comparable but not contradictory conclusions given the researcher’s data, perspective, and situation (Guba & Lincoln, 1981; Sandelowski, 1986). In this study, the interviews were conducted by me, and the interview guide was developed to enhance the audibility of the data collection method. In addition, a detailed decision trail was formulated to allow other researchers to follow it if they need to conduct research in the same phenomenon.

**Confirmability**

Guba and Lincoln (1981) stated that confirmability is the criterion of neutrality in qualitative research. Neutrality refers to the freedom from bias in the research process and product. Confirmability refers to “the findings themselves, not to the subjective or objective stance of the researcher” (Sandelowski, 1986, p. 34). Confirmability is achieved when audibility, truth value, and applicability are established (Guba & Lincoln, 1981).

Lincoln and Guba (1985) suggested that keeping a residue of records of the research process is important in achieving confirmability. In this study, I kept a residue of records that included raw data, memos or field notes, personal notes, data reduction and analysis products, data reconstruction and synthesis products, process notes, and existing relevant
literature for examining confirmability.

In order to reduce bias due to my feelings, I noted my feelings and reflections during the course of data collection and data analysis. These notes could remind me to be aware of any bias that might occur (Hutchinson, 1993).

**Limitation**

Major limitations of this study included the following.

1. The substantive theory derived from this study could not be generalized to all Thai caregivers of elderly stroke relatives because of the purposive sample used.

2. The study participants were recruited from lists obtained from five hospitals in the Chachoengsao province. Therefore, the theory can only be generalized to Thai caregivers of stroke relatives who used services of the five hospitals and who lived in the Chachoengsao province.

3. The study sample did not include all caregivers of a different culture, religion, education, socioeconomic status, and previous experience with caregiving. Thus, the substantive theory that emerged from the data could not be generalized to caregivers with all of these diverse characteristics.

4. This study focused on the perspective of participants who were primary caregivers of stroke patients. Therefore, the substantive theory was limited by the ability of the participants to communicate how they perceived their caregiving situations and caregiving process.

5. The report of this study was translated from Thai into English. Some Thai words might vary from their true meanings when translated into English.
CHAPTER 4

STUDY FINDINGS

This chapter presents information about the Thai caregiver participants, the stroke patients, and the numerous qualitative findings. The demographic characteristics of the participants are first presented, followed by the demographic characteristics of the stroke patients who were cared for by the participants. The central phenomenon of the caregiving process of Thai caregivers, maintaining caregiving at home, also is described.

Demographic Characteristics of the Participants

As presented in Table 2, of the 20 participants, 13 were women and 7 were men, ranging in age from 28 to 73 years. Fourteen of them were middle-aged (30 to 59 years of age) whereas 1 participant was under the age of 30 and 5 were over the age of 60. Fifteen participants were married and 3 were single. One participant was widowed and 1 was divorced.

The educational level of 13 participants was Prathomsuksa 4 (Grade 4), which in the past, was the compulsory educational level. Six participants had higher level of education (Mathayomsuksa 6 or Grade 10, diploma, and undergraduate) and 1 was illiterate. The majority of the participants were Buddhists (n = 14), 5 were Muslim and 1 was Christian.
### Table 2

**Demographic Characteristics of the Participants (N=20)**

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<tr>
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<th>Number</th>
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<tr>
<td>Male</td>
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<td>Female</td>
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<td><strong>Age</strong></td>
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### Table 2 (Continued)

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<th>Data</th>
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<td><strong>Current occupation</strong></td>
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<tr>
<td>Do not work</td>
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<td>Day laborer</td>
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<td>Overextended</td>
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<tr>
<td>Making ends meet</td>
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<tr>
<td>Comfortable</td>
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<tr>
<td><strong>Family income/month (Bath)</strong></td>
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<tr>
<td>500-5,000</td>
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<td><strong>Living area (district)</strong></td>
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<tr>
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<td>Wife</td>
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<tr>
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</tr>
<tr>
<td>Son</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Daughter-in-law</td>
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Most participants did not work \((n = 12)\), 4 were farmers, 3 were day laborers, and 1 operated a restaurant. Eight participants were financially comfortable, whereas 7 participants described their financial status as "making ends meet." The remaining 5 could not make ends meet. Most participants received monthly family income of 500-5,000 baht \((n = 12)\). Seven participants reported their monthly family income as 7,000-10,000 baht. Three participants received monthly family incomes of 20,000-50,000 baht and 1 participant received a monthly family income of 100,000 baht. Seven participants lived in the Bang Nam Prieo district. Six lived in Muang, 4 lived in Phanom Sarakharm, 2 lived in Bang Pakong, and 1 lived in Sanam Chai Khet.

The 20 participants included 5 wives, 3 husbands, 4 daughters, 3 daughters-in-law, 1 son and 1 son-in-law. The length of time in which the participants aided their relatives ranged from 2 months to 17 years. Most of the participants looked after their stroke relatives for 1 to 4 year(s). Six reported that they were caregivers for less than 1 year, 4 had cared for their family members 5 to 9 years, and 1 participant had aided a relative for 17 years.

Time spent providing care on a daily basis ranged from 3 to 24 hr. Eight participants spent 6 to 12 hr per day caring for their stroke relatives and 7 participants spent 20 to 24 hr a day. The remaining 5 spent 3 to 5 hr on a daily basis as caregivers.

Twelve participants lived in their homes, which included six to nine family members (including themselves and their stroke relatives). Five participants reported three to five family members living in the same household. Three participants lived alone with their stroke spouses. Almost all of the participants \((n = 17)\) reported that there were two to four generations living in their homes, whereas 3 participants who lived alone with their stroke spouses reported only one generation living in their homes.
Demographic Characteristics of the Stroke Patients

According to Table 3, of the 20 stroke patients, 11 were men and 9 were women. They ranged in age from 60 to 87 years. Fourteen of these patients were more than 70 years old. The majority of the stroke patients were married (n = 14). Five were widowed and 1 was divorced. The education level of 17 patients was Prathomsuksa 4 (Grade 4). One patient completed Prathomsuksa 2 (Grade 2), 1 completed Prathomsuksa 3 (Grade 3), and 1 patient reached a higher level of education (Mathayomsuksa 6 or Grade 10). Fifteen patients were Buddhists and 5 were Muslim.

Length of time since patients were diagnosed with a stroke ranged from less than 1 year to 17 years. Most patients had been diagnosed with stroke within the least 1 to 4 years. Five patients were diagnosed less than 1 year previously, 4 patients had suffered from strokes 5 to 10 years, and 2 stroke patients had suffered for 13 to 17 years.

According to the participants, 8 stroke patients were dependent in all ADL areas, whereas the remaining 12 required assistance with at least two to five ADLS.

Maintaining Caregiving at Home

The purpose of this study was to identify substantive theory that would help to explain the caregiving process of Thai caregivers of elderly stroke relatives. Four questions guiding this study were the following: (a) How do Thai caregivers define their caregiving situations? (b) What do Thai caregivers do as caregivers and why? (c) How does caregiving affect the Thai caregivers' lives? (d) How do Thai caregivers manage to be able to continue as caregivers?
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A basic social process (BSP), called maintaining caregiving at home, was identified from the data as the central phenomenon of the caregiving process of Thai caregivers for elderly stroke relatives. This theory described and explained how and why Thai caregivers maintained caregiving to their elderly stroke relatives at home.

Maintaining caregiving at home is the process in which Thai caregivers maintain treatment and care of their elderly stroke relatives in their homes. This process encompassed the contexts of (a) routine caregiving tasks; (b) personal beliefs due to society, culture, and religion; (c) family and kinship support; (d) community support; (e) a variety of feelings; and (f) the management of treatment and caregiving-related problems.

Seven categories emerged from the data that define the core variable “maintaining caregiving at home”: (a) caregiving as an integral part of life; (b) caregiving: an unavoidable task; (c) caregiving with love, sympathy, and attachment; (d) family and kinship support; (e) community support; (f) managing treatment; and (g) managing problems and difficulties. These seven categories were the major contexts (factors) that helped Thai caregivers continue caregiving to their elderly stroke relatives at home. Figure 2 shows the core variable and seven related categories. Each of these seven categories is described in detail.

**Caregiving as an Integral Part of Life**

All 20 participants explained their caregiving activities that consist of assisting patients in their daily activities, personal hygiene, treatment, and rehabilitation. Their stories were told with no sense of resentment even though caregiving was a routine
Carcgiving as an Integral Part of Life
- Daily Routine
- Duty & Burden

Family & Kin
- Family Responsibility
- Help & Support

Managing Treatment
- Information
- Hope
- Experience
- Belief
- Trial
- Outcome

Caregiving: An Unavoidable Task
- Religious Instruction
- Role
- Social Expectation
- Personal Readiness
- Need

Caregiving with Love, Sympathy, & Attachment

Managing Problems & Difficulties
- Acceptance & Patience
- Release of Temper
- Learning
- Time Spending or Letting Go
- Creativity
- Rest or Relaxation
- Self Treatment
- Seeking or Receiving Help
- Time Management
- Using Materials or Equipment

Community
- Help & Support
- Praise & Compliments

Central Theme: Maintaining Caregiving at Home

Figure 2. The Central Theme and Seven Related Categories
fully integrated into their lives and that it had become both a burden and a duty which they would continue as long as possible. Therefore, this category consists of two main concepts: (a) caregiving as a routine and (b) caregiving as a burden and a duty.

Caregiving as a Routine

All participants explained their activities at home as their daily work. They assisted patients in activities they could not manage by themselves such as treatment, care, and rehabilitation as seen in the following example.

A 73-year-old participant who took care of his wife for 17 years stated that caregiving was his routine work; therefore, he never neglected it and never was annoyed. “It’s a routine work. We know our duty. When it’s time, we know what to do. It’s a routine and we never forget.” This participant also explained his activities in the following manner.

Everything, . . . starting from getting out of bed and brushing her teeth, giving her a shower, getting her dressed, and serving her chicken soup. At 7:30 a.m., she has breakfast. If she cannot take the food by herself, I will help her. I always change the menu to what she prefers. If she likes to have Thai noodles, I will have to cut them for her to make them easier to eat. Then I serve her with a spoon. . . . Whatever she does, I help her, whether it is taking a nap, exercising, going out. I always take her along with me.

A 35-year-old son who took care of his mother for 1 year stated that he accepted caregiving as his routine work from dawn to dusk. He said,

It’s a routine work. After she wakes up, I put her in the wheelchair, brush her teeth, comb her hair, and help her to gargle. She stays in the wheelchair. When breakfast time comes, my wife brings her food and medicine. After breakfast, my wife and I do the housework until it is time to feed her again in the late morning. Then, we give her time to watch television until she feels sleepy. I carry her to her bed, and that completes the first half of the day. When she wakes up, my wife will feed her in bed by adjusting the bed level. After that, she sits to digest her food, but mostly she prefers lying to sitting. She again
goes to sleep until 4:00 to 5:00 p.m. When she wakes up, we put her in the wheelchair to take a bath. After bathing, she sits in her chair until it is time for dinner. After dinner, we take her outside the house in the wheelchair, or she just sits there until almost dark. I bring her inside the house to watch television. She sometimes watches, . . . sometimes falls asleep.

A 44-year-old participant who cared for her father-in-law also considered caregiving as part of her regular routine work. “I feel that it is something that I have to do for her every day. . . . Keep on doing, doing, and doing.”

A 48-year-old participant who took care of her father mentioned that caregiving was routine work and could not be postponed. “It was chaos at the beginning. But when you are used to it, it is just like your daily work. You finish and that’s it. If you don’t do it thoroughly, it will never finish. You have to do it again and again. You cannot say no.”

In conclusion, all participants explained their caregiving activities as routine work, which had become part of their lives and was something that they could not forget, postpone, or leave. Because the nature of caregiving was perceived by the participants as their daily routine, they were able to maintain it at home.

Caregiving as a Burden and a Duty

Some participants explained that caregiving was their burden and duty. A 63-year-old husband mentioned that since his wife’s stroke, he had less time to be with his friends. However, he accepted the burden of caring for his wife. He said, “I felt nothing. It seems like I knew that I have a burden.”

A 33-year-old son who took care of his mother said, “It’s nothing. Now I have a burden. Another thing, I realize that this is something that I have to do. I have to adjust myself. I cannot go out and meet with my friends as before.”
A 44-year-old participant who cared for her father-in-law stated, “I feel attached to him. I am concerned for him. Wherever I go, I always think of him and worry about him.” This caregiver mentioned caregiving as a burden and a duty yet showed no sign of resentment. Indeed, she accepted her duty as a concern to which she must attend.

A 28-year-old son who looked after his elderly mother explained that caregiving was his duty because he had more time than others. “Yes, now she has no one. So it’s just like a duty.” However, this caregiver intended to carry on his duty and believed he could do it better than others. He said,

I feel that it’s my duty. No one is free to take care of her, so I have to do it. If I get a job or become more stable than this, I might hire someone to take care of her. I am 28 years old now. . . . I need to go to work. . . . I feel that it’s my duty to look after her so I do it. In my opinion, no one can do it better than me.

This caregiver was positive in his position. “It’s nice. It’s like my duty. When I take care of her, she feels happy. It’s different when somebody else does it.” This caregiver also believed that caregiving was a moral obligation. Sons and daughters have to take care of their parents. “Yes, we need to have morals. It’s duty that we must do.”

A 33-year-old son who took care of his mother explained that he cared for her bodily functions because he believed that it was his duty to look after his parents. He said, “At the beginning, I hesitated to clean the stool of my mom. But I thought that my mom did everything for me when I was young. Now she cannot help herself, so it’s my turn to help her. . . . It’s my duty.”

In conclusion, some caregivers accepted the fact that their duty was to care for their ill relatives. Admitting that it was a burden helped them accept their situations and taught them to be responsible, concerned, and attached. They also were willing to take care
of their elderly ill relatives.

Caregiving: An Unavoidable Task

All participants indicated that they were the primary caregivers of their elderly relatives due to one or more reasons such as religious beliefs, personal relationships, social expectations, personal readiness, and the need of patients or relatives. This category, therefore, consists of five main concepts: personal beliefs due to religious instruction, role, social expectation, personal readiness, and need. The following sections provide more detail for each of these concepts.

Personal Beliefs due to Religious Instruction

Data indicated that religious beliefs were strong influences on the caregivers. The beliefs based on Buddhist teaching focus on the law of karma, the bunkhun system, merit, and sin. Beliefs in heaven, as mentioned by three Islamic participants, were based on Islamic instruction. These beliefs or concepts are explained in the following section.

The law of karma. According to the teaching of Buddha, karma was defined as "action based on intention" or "deed willfully done" (Payutto, 1993, p. 6). Actions or karma are what individuals intentionally do physically, as they speak and with their minds (Khantipalo, 1994). Under the law of karma, present life is determined by the cumulative merit of previous existences, whereas deeds in this life will be reflected in the next life. Karma, which operates across the boundary of past, present, and future, account for many of the personal events influencing one's life. In fact, results vary as to the interval between the commission of the karma and the appearance (Payutto, 1993). Thai people believe
karma refers to past actions and deeds as well as to present consequences.

The belief in the law of karma influenced caregivers to maintain the caregiving at home. They believed that the past karma (actions or deeds) of the patients and themselves from previous lives caused the patients to become ill and caused them to become their caregivers. Therefore, they accepted the law of karma and would continue providing care to these patients until the previous actions or deeds were repaid or until both of them passed away. Some examples of these views are presented below.

A 61-year-old participant who cared for her older husband for more than 3 years believed it was necessary to care for him in this life because of the karma she had committed in the past. Accepting the law of karma helped her accept the caregiving situation. She felt pity for the patient and intended to take care of him forever. She wanted to repay the karma she earlier committed. She also believed it was a sin to leave the patient. “I tried to accept it. What to do? It’s my karma. I have to take it as it is. . . . I try not to think too much. If I think too much, I might become nervous and no one will take care of him. I try to think that it’s my karma.” To her, karma meant:

I think that maybe I did something bad in the previous life. So, I have to be a caregiver in this life. There is no point in thinking too much. I just think that it’s my karma. Whatever will be, will be. . . . I will still be here. . . . It’s my karma. . . . I have karma. . . . I returned to earth to pay back my karma. When my karma is over, just let it be.

This caregiver stated that the religious principles regarding the law of karma helped her accept her situation. She said,

It can help. . . . I accept it. I don’t think too much about it. I have the karma, so that is why my life turned out like this. I feel sympathy for the patient and also, I feel pity for him. Some people might leave him because he had a stroke in 1994. . . . How many years? I don’t think of leaving him. I never give up. I think that it’s my karma. If I leave him, I would be sinful.
A 61-year-old husband who took care of his wife for 2 years believed that it was their karma which made them become like this. “I think mostly it is her karma. . . . Also, it is my karma. . . . She suffered from a stroke. . . . Because of my karma, I have to take care of her.”

A 41-year-old daughter believed that it was the karma in her previous life that caused her to care for her mother in this life. “In my previous life, I must have done something so that I have to look after my mother in this life. I always think that because of my karma, I have to look after her.”

Although the law of karma is one of the concepts in Buddhist religion, 1 Islamic participant stated that it was her karma that caused her to endlessly care for the patient. This 70-year-old participant took care of her husband for more than 5 years. She said in her good tempered way, “It is karma that has trapped me like this. I cannot go anywhere. Well, I don’t know when the karma will be over [laughed]. I cannot think any other way. . . . I have to think like this. . . . What is my karma that has trapped me like this?”

This woman explained that even though she believed in the Islamic religion, she lived in Thailand for a long time. So she also believed in Buddhism like most Thai people. “Well, I live in their country, so I believe like them. . . . Buddhism teaches about karma in the previous life.”

In summary, the belief in the law of karma helped some participants accept their caregiving situations. Indeed, these individuals intended to maintain their work until their karma was over or the patients or themselves passed away.

**Bunkhun system.** “Bunkhun,” according to the Thai, refers to good things, favors or help which is meritorious (Podhisita, 1998). Bunkhun system is a long-term obligation
based on a favors of benefits rendered, either among equals or between those of differing status. Those who benefit are obligated to do a good deed in return or repay meritorious debt (Klausner, 1993). The bunkhun relationship in Thai society is validated by the familiar Buddhist teaching concerning “rare persons.” According to this doctrine, rare persons are those who rendered a favor (pubbkari) or those who showed gratitude and repayed the favors done for them (katanyu katavedi). Buddhism regards such persons as exemplary individuals whose actions bring harmony and happiness to society (Podhisita, 1998). The belief in gratefulness (bunkhun) or meritorious debt is a basic tenet of Thai behavior. This major factor helped family members maintain the care of their elderly stroke relatives. Most participants explained caregiving as a way of returning gratefulness to their elderly relatives.

A 41-year-old daughter who took care of her mother for 9 years, described her reason for providing care by saying, “I just thought that she had looked after me since I was a baby. When she can’t help herself, I have to help her. Whatever she wants to eat, I have to fetch it for her.” This caregiver also stated,

It’s that I return gratefulness [bunkhun] to her for what she did for me when I was young. If I kept on thinking that I could not do it, it would be difficult. If I let somebody else take care of her, it would not be the same as if I did it. Also, she would never accept anybody else. I just look after her as I can afford.

A 31-year-old daughter discussed her inner conflict and reasons for returning to care of her mother after she previously ran away for a short while because she could not accept the situation. She said,

I could not take it... I was so tired... Thought, why do I have to encounter this kind of situation?... Although I have seen something like this in the movies such as “Wanlee.”... Oh!... Why do I have to be like this? But
come to think of it, she brought me up. Why can’t I be good to my mother who raised me? When I thought like this, I decided to go back to her.

One of the most appropriate and acceptable forms of “repaying one’s debt” to one’s parents is for a son to become a monk. All grateful male children are obligated to do so, thereby giving merit to their parents. Females are not allowed to become monks; therefore, caregiving of the parents is one way for women to show their gratefulness.

A 48-year-old daughter discussed the benefit of caring for her father. “It’s good for me. I have a chance to return gratefulness to him. I cannot do anything for him. I am a woman, so I cannot become a monk. If I were a man, I could.”

A 31-year-old female participant stated that one reason for caring for her father-in-law was to return gratefulness to him. The patient had donated his blood to her when she had an accident during her pregnancy. She said,

This was before his stroke. When he heard that I had a car accident, he was shocked. The doctor let us choose between mother or baby. He was so worried. When he knew that I needed blood, he wanted to go to the hospital to donate his blood, and he scolded my husband for not visiting me that day.

This caregiver intended to look after her in-law and his family because she wanted to share her gratefulness with everyone who had been good to her. She stated,

No matter what, I will stay in this house until I die because everyone has done good things for me. After the car accident, he [the patient] had a stroke; I thought it was because of me. . . . When I came back from the hospital, I could not do anything. . . . I could not move. . . . My back was still not normal because I was thrown out of the car. My mother-in-law boiled the water and massaged me. My husband’s sister also looked after me. . . . I could not go anywhere. I have to return their gratefulness [bunkhun] because they were so good to me.

A 61-year-old husband who looked after his wife mentioned that as a caregiver, he had a chance to return the goodness which she had shown to him while he was sick.
“It was good that both of us had gotten through difficulties together. Well, when we first got married, I suffered from cholera. She even cleaned up my stool with no resentment. I never forgot her goodness. Now she is suffering, so I have to do the same.”

A 58-year-old wife who cared for her elderly husband talked about his goodness, “When he had money, he gave it to my relatives. He took very good care of me.” This caregiver showed her intention to return her husband’s goodness until death parted them. “Before he suffered a stroke, he was so good to me. I will never leave him, never, never, ... until one of us passes away; who will be the first, I don’t know.”

To conclude, the above mentioned participants believed that caregiving was the way to return goodness to the patients who had been good to them such as bringing them up, looking after them, or being good to them in various ways. These caregivers intended to maintain care to the patients as long as possible.

Merit, sin, and heaven. Merit and sin are related to the concept of karma. Among Thai Buddhists, not only religious activities, but also doing good of any type may be seen as merit making such as caring for aged parents or helping the poor. For sin or demerit, Buddhism refers to bad karma or doing bad of any kind (Podhisita, 1998). As a result, some participants believed that caregiving was a way to gain merit and that leaving their patients or improperly looking after them was a sin. This belief motivated them to continue taking care of their elderly relatives. See the following examples.

A 61-year-old wife believed in merit and sin and planned on looking after her husband as long as possible. She said,

To abandon or leave him [the patient] is a sin. If I am unfaithful to him, or think that it is too difficult to stay here or if I should run away, or leave him to his relatives who might not take care of him, I will commit sin.
But if I help him, I will gain merit. Because when he suffers, I help him. Although he will not be normal, it’s better, . . . I think.

This caregiver also believed that improperly caring for the patient is a sin. “I cook everything for him. If I let him starve, of course, he will suffer, and I will commit sin because I am his caregiver.”

A 28-year-old son said that before his father passed away, his last word was to tell him to look after his mother because it’s a spiritual act of merit. “Before my father passed away, he said, ‘let’s do it my son, taking care of your parents, will gain merit.’ ”

Three Islamic participants believed that those who cared for their parents or spouses would go to heaven or experience only good things in their life which was considered the same as going to heaven. A 50-year-old wife who took care of her husband explained that Islamic teaching played a significant part in helping her to care for her husband. “If we do good things, . . . continue doing them, then, we will go to heaven. By giving good care to our father or husband, we will go up to heaven.”

A 33-year-old son who looked after his mother said, “It is told that if we are close to our mother, our life will be as good as living near heaven.”

A 48-year-old daughter, caregiver of her father, said that religious instruction had helped her gain hope of going to heaven. “It has helped me mentally, . . . to stop me from hating my father, . . . to stop scolding. The outcome of caregiving will help me go to heaven. By taking care of my parents well. I hope.”

In conclusion, the Buddhist religion which teaches about merit and sin, and the Islamic religion which teaches about heaven, helped these participants believe that if they do good, they will receive merit or will go to heaven. However, if they do not take good
care of the patients or leave them, it is sinful. Such beliefs were influential in that participants continued giving care to their patients at home. In accordance with their religious beliefs, these participants hoped for something good in return for their good deeds.

Role

Role refers to the status or position of participants which is based on their relationship to their patients such as being a wife, husband, son, daughter, or in-laws. Data indicated that one reason for caregiving was because of the role that participants had in relationship to their patients. Role is another part of the category of caregiving being an unavoidable task.

A 58-year-old participant who cared for her husband gave her reason for caregiving, “It’s because I am his wife, I have to take care of him. His relatives pay very little attention to him.”

A 50-year-old wife who took care of her husband mentioned one reason for caregiving, “Nothing much... It’s because I am his wife.”

As for the husband who had taken care of his wife, he did not directly say that he had to take care of his wife because he was her husband; rather, he said that the patient was his wife with whom he had shared joys and sorrows, so he wanted to take care of her.

A 63-year-old husband, whose wife suffered a stroke said, “Wife or kids, ... If I do not take care of them, what do I do? ... I have to take care of her. We have shared joys and sorrows... I cannot leave her... We will die together.”
A 48-year-old daughter believed that because the patient was her father, she had to take care of him. “I don’t think anything. . . . How can I let other people take care of him? He is my father. I have to take care of him myself.”

A 28-year-old son said that whatever happened or wherever he went, he would return to care for his mother. “I have to come back. I just can’t leave. She’s my mother.”

A 44-year-old participant who cared for her father-in-law stated that because she was his daughter-in-law and lived in the same house, she had to take care of him. “Because he lives with us and I am an in-law, I have to take care of him.”

In summary, the relationship with patients in various roles such as being a wife, husband, son, daughter, or in-law gave some participants reasons to care for their elderly stroke relatives, particularly in circumstances where no other family member was available.

Social Expectation

Social expectation influenced participants to give proper care in order to avoid blame from their relatives, friends, and neighbors. This also helps explain the category of caregiving as an unavoidable task. Society expected caregivers to provide good care to their patients. For the most part, women were expected to assume the role of a caregiver.

A 31-year-old daughter said that the reason she looked after her mother was to stop being blamed by others. She stated,

It’s got to be done because we still live in the society. When people come by, my brother will feel ashamed if we do not take care of our mother well. Why did our mother look after us before? In rural area like this, it will be something like. . . . Our family has been well known for a long time. . . . For my brother, if his guests come over and see something wrong. . . . Oh! No. . . . We have to take care of her well.
A 41-year-old participant said she had to clean her mother up thoroughly after she urinated or had a bowel movement; otherwise the neighbors would know and blame her for not looking after her mother. “Even if I cannot handle it, I still have to do it because it’s our home. When people walk by, they can smell urine and feces. We have to do this; otherwise she will smell and people will blame us.”

A 63-year-old husband said that he never left his wife because of potential social criticism. “If I leave her while she is not capable of helping herself, people will not respect me. I will have no friends. Society will see that I am a bad guy. No one will want to talk to me. So, I don’t want my friends to think of me in that way.”

A 31-year-old daughter said that she was her mother’s caregiver because she was her daughter and jobless. “Surely, I must do this because I am the only daughter and have nothing to do.” Her relatives and neighbors expected her to take care of her mother because she was the only daughter. “My brother could not do it. I didn’t have to think about it because even my relatives and neighbors said that my mother was fortunate to have a daughter to look after her. They insisted that I do it.” This participant believed part of the reason she was happy to take care of her mother was because of society. “It’s only because of society. I am her daughter, so I have to do it. This is a small community. People know each other well. They know that I am the only daughter. If I don’t do it, others will curse me.”

The sons who took care of their parents believed that society praised them and looked upon them as good sons who were able to take care of their parents just as well as their sisters would. However, some people still believed that it was strange for sons to take care of their parents. For example, a 33-year-old participant who cared for his mother
said, "Well!... No one blamed me. They all praised me. I always heard them say, 'It's very good. Although he is a man, he can take care of his mother just as a woman would.'
... So, I teased them back, 'What can I do?... We are all men. Where can I get a woman?'"

In summary, the social networks around these participants such as relatives, friends, neighbors, or other persons expected the patients to be well taken care of by a caregiver at home and that the caregiver should be a female relative. Social expectations played an important role in motivating family members to provide caregiving at home.

**Personal Readiness**

Most participants (18 out of 20) said that because of their personal readiness, they were the caregivers of their elderly relatives. Personal readiness was categorized according to situation, time, and ability. These are parts of the unavoidable task of being a caregiver. The participants who had situational and time readiness were those who stayed home with their patients more than others could, did not work outside of the home, or were able to leave their jobs more easily than other relatives. Participants with ability readiness were able to provide some care which could not be handled by others, or they had special knowledge and patience to take care of their elderly relatives.

Most participants who took care of their spouses said caregiving was possible because all their children had gone to work. A 58-year-old wife of a stroke patient said, "There is no one at home. Our kids go to work or have their own families. One is still here, he never has time."
A 63-year-old husband whose wife had suffered a stroke spoke in the same fashion, “Our kids don’t live with us. It’s only the two of us. If I don’t do it, who will?”

A 48-year-old daughter whose elderly father suffered a stroke said that she cared for her father because other family members had gone out to work. “No one can take care of him. They all have gone out to work, even my younger brother.” This participant also said that she looked after the patient because her younger brother did not want to help her. “I have to do it no matter what. It’s unavoidable. . . . I told my brother to take him but he did not want to.”

A 33-year-old son spoke of his mother, “I am at home and single, so I have to take care of my mother. The others have their families, so they moved out and have their own lives. They have no time for their parents.”

A 35-year-old son said that he left his job to take care of his mother because it was more convenient for him than for other family members to do it. He stated, Actually, everybody wants to work at the job that they have studied. But it’s impossible for me because no one else could do this kind of task [caregiving]. Most of them [his brothers and sisters] are government officers. They have their obligations. They have their goals. For me, I worked in a private company. It was more convenient for me to leave the job, so, I did.

A 34-year-old participant who took care of her mother-in-law gave the following reason for caregiving.

There is no one to take care of my mother-in-law. They [her husband’s relatives] all have jobs. They don’t want to take care of their mother. My husband said that if no one would take care of her, he would work for our family income alone and would let me look after his mother and our child. Others [her husband’s relatives] also said that the one who did not go to work should take care of their mother. So, I have to take responsibility by myself.
In summary, the explanations of the above participants showed that situational and time readiness factors played important roles in their commitment to look after their elderly relatives.

Some participants stated that they were involved in caregiving tasks because they had physical and mental abilities. A 31-year-old daughter who cared for her mother said that although one of her elder brothers was able to take care of their mother, another elder brother, who was the head of the family, trusted her more because she had more patience and a higher education. She also did not have a job. Therefore, she was expected to be the caregiver. “It’s not convenient. I have an education but, I have no job. . . . Also, about the cleanliness, I have more patience. He [her elder brother] knew that I could do better.”

A 41-year-old participant said that her elder brother and younger sister could not lift their mother, but she could. So, she had to do it. She stated,

They cannot do it. They cannot lift her. . . . When she passes bowel, we have to lift her to clean her up. My sister said that she could not lift her, could not do it. . . . I can lift her. I have to grab both of her legs, holding her arm with one of my arms, and holding of her legs with the other arm. My brother cannot lift my mom either. None of them can do it. . . . Sometimes I cannot handle it, but I still have to do it.

A 34-year-old daughter-in-law said that her relatives could not handle the bodily functions of her mother-in-law. She was not disgusted by it, so she did it. She said,

No, they don’t do it. . . . I don’t know. . . . I don’t understand them. If they come over, they stay just for a short while. They never clean up the stool or urine that their mother has passed. So, I have to be the only one who does it. I don’t know. . . . I don’t understand them. . . . No one does it. . . . I have to do it. I do not feel disgusted. No one does it. . . . I can do it.

A 31-year-old participant stated that she could take care of her father-in-law, whereas another in-law could not handle some caregiving tasks such as cleaning up the bodily
functions. “Mom [her mother-in-law] told my husband’s elder sister that she [another daughter-in-law] could not wash any clothes because she could not stand the smell and felt dizzy.” This caregiver also was able to care for her father-in-law without any experience because she was a patient and calm person. “Maybe, because I am calm. I don’t know. . . . I hardly get angry with him.”

In summary, it appears that personal readiness regarding situation, time, and ability played an important role in assuming the role of caregiver.

Need

Need is another concept which emerged from the data related to the category of caregiving as an unavoidable task. Eight out of 20 participants explained that they became caregivers because their significant others, the patients, or both needed them. A 41-year-old daughter who cared for her mother said that both her elder and younger brothers requested her to do it and they were willing to pay all expenses. She said,

My elder brother said, “Take care of mom. I will give you 500 baht a month.” Then my younger brother was asked if he would give me money. He said, “Take care of her. If you need money, I will give you some.” So I stopped making rice noodles and became a full-time caregiver. Also, I have to look after my kids and do laundry service.

A 44-year-old participant had cared for her older father-in-law because her husband asked her to leave her job to take care of his father. She recalled,

At that time, we didn’t have much money and I wondered how I could stay here without money. My husband was so good. He told me not to do anything, . . . just stay home, . . . take care of his father. He said that he would go to work. So, now I just stay home, look after the housework, and take care of my father-in-law.
A 41-year-old daughter said that her mother did not want other people to look after her except for herself or her elder brother. “My mother does not want others to look after her except for my brother or myself. She said that others were not the same as me because they were not kind and they liked to scold her.”

A 34-year-old participant said that her mother-in-law needed her more than others. “She needs me. She never calls anyone else. She said that it hurts when others touch her.” This caregiver did not want to leave her mother-in-law. She said, “I don’t want to leave her. Sometimes, when I leave her to talk to my friends, she calls me back to sit with her, . . . just in case she might faint.”

In conclusion, the needs of close relatives, spouses, or the patients themselves also were factors that motivated these individuals to become primary caregivers.

Caregiving With Love, Sympathy, and Attachment

Nineteen out of 20 participants’ explanations indicated love and attachment between them and their elderly stroke relatives before and during their caregiving experiences. Love and attachment engendered sympathy and pity for the helpless patients. Therefore, the participants had looked after their relatives and would never abandon them.

A 59-year-old daughter explained her feeling of love and attachment towards her father, Since I was a teenager, all my heart has been with my parents. . . , wherever I will go. . . Kind of, . . . my husband wanted to take me away from my parents but I just didn’t want to. . . I was too far from my parents. He would take me to live in another area. . . . He is a northeastern man. . . . He would go to live in that area. Oh! no, . . . I could not leave my parents. I am always concerned about them.
This participant said that she lived with her parents much longer than her siblings. "Yes, for a long time, since I was a teenager. I lived with them until I got married when I was over 30." Besides the attachment to her parents, this caregiver said her parents also love and are concerned about her. "For both of them, if I left them for a few days, they could not sleep. . . . Even after I got married, when I went to Bangkok to stay with my husband, my parents could not sleep. Even if I visited the doctor for 1 day, they started asking whether I would come back or not." She stated that she was very attached to her parents both before and after looking after her father. The feeling of love and pity grew stronger when her father became helpless. "Now, I feel both love and pity for him because he will never be like he was before." Love and pity made her so concerned that she could not leave him. "I have to look after him. I have to be concerned about him more than anything. I cannot go out to work. . . . I mean, I cannot go anywhere because of my father. For others, . . . my kids, . . . I can leave them. But I cannot leave my parents."

A 31-year-old daughter said that although she had never been close to her mother before she took care of her, she knew that her mother loved her a lot. "We were so distant because I did not live with her for almost 11 years. I lived in Bangkok. . . . I only visited her for a short while and asked for money. . . . Anyway, she loves me. I know that she loves me. Whatever I wanted, she would never say no." After she had a chance to take care of her mother, she felt more love and pity for her. "More love, more concern, and more pity." Moreover, this caregiver clearly stated that caregiving not only was a duty but it was an attachment. "Caregiving is a duty to be responsible for, but now it's an attachment." She explained, "I could not go to Bangkok anymore. I feel like, . . . who will do this like I do? . . . Whether they will do it or not, . . . something like
that. I’m afraid that after all I have done, if I left for 1 day, the wound might get an infection. ... What would I do then? ... I’ve become so attached.”

A 48-year-old daughter talked about her love towards her father before she started caregiving by saying, “He was so good. He loved his kids. He never spanked us. ... Love, ... I love my father.” She felt more pity when her father could not help himself as before. “I feel pity for him because he cannot walk.” This participant showed her intention to look after her father. “I will carry on looking after him. ... Anyone who experiences a situation like this has to keep going on. ... What do I do? ... He’s not just anyone. If he were, I wouldn’t look after him. ... But he’s my father.”

A 28-year-old son who took care of his mother talked about his closeness to her in the past. “It seems that my mother and I are very close because I am the youngest one. When she was healthy, she always took me with her during school holidays, weekends, or after school in the evening. Among her four kids, I am the closest one.” This participant said that he loved his mother very much. “I love mom so much. I feel that this should not happen to her. I always want her to recover.” The love and attachment made him look after his mother without feeling awkward. “I can do it. Neither she nor I feel awkward with each other. I never completely bathe her. ... Only help her to wash. Anyway, I don’t feel awkward. Perhaps, it is because of love, ... because there is no one to do it for her. It’s love and attachment.” In addition to love and attachment, this caregiver also felt pity for his mother because he was sad that she could not walk. He said, “I want her to walk by herself and go outside. To take a walk, to go to the market, looking at birds or trees, can refresh one’s life. Living like this is not joyful. It’s made me feel pity for her. Because my dad is not around. ... She doesn’t have a
friend to talk to."

From the explanations of sons and daughters who were the caregivers, it appears evident that children love and are attached to their parents (i.e., blood, closeness, upbringing, living together for a long time). Meanwhile, parents also feel love, attachment, and concern towards their children. Love and attachment, together with pity, sympathy, and concern which grew from caregiving, helped these individuals continue to give care without leaving.

According to the spouses of stroke patients, love and attachment were often based on time spent together. Appreciation of each other’s goodness formed the feeling of pity and sympathy for the ill spouse.

A 61-year-old husband stated that he could not abandon his wife because he felt pity for her. He said,

A sense of pity is very important. . . . The reason which makes me feel pity is that I think of the times we have shared hardship and happiness together, . . . up and down together. We have lived together for a long time. So, when she suffers like this, I cannot just leave her. It’s in my mind. Although we starved, we were together. . . . In the past time, we moved from place to place together.

The sense of pity grew more when he saw his wife suffering from a stroke. "Pity, . . . absolutely, more pity, . . . when she got sick, I felt more pity." The pity stopped him from feeling angry or annoyed with his wife. "Annoyed! . . . never, . . . not ever angry. Well, I felt pity for her. We have lived together, . . . starving, . . . suffering, . . . still manage it together." This participant intended to give his wife the best care. He said,

"I will never let her starve. Whatever she wants, I will find for her. I will do the best."

A 63-year-old husband of a stroke patient said that the reason why he took care of his wife all along was because they had shared hardship and happiness together.
He compared the patient to a cripple who could not help herself, so he had to help her.

He stated,

In my feeling, when she was healthy, we lived together, also, shared hardship and happiness together. When she became sick, I had to take on her burden. Because I'm still healthy, but she is not healthy, ... crippled, ... I have to help her. This is an important reason that helps me to do everything for her. When she became sick, there was only me. I have to do it because our children don't live with us. We live by ourselves.

This participant said that the reason why he could adjust physically and mentally in order to look after his wife was because he felt sympathy and pity. “It’s a principle. I can do this because I feel sympathy and pity.” He also said that everything that he had done for the patient was because of love and pity. “Everything that I have done for her is to show my love and pity.”

A 58-year-old participant who took care of her husband said that she could accept her husband’s behavior and give proper care because of her love towards him. “In the past, I couldn’t accept him until I went to see this doctor [a psychiatrist in a public hospital in Bangkok]. I have to give him many thanks. He gave me good advice. He told me that if I love my husband, I had to do it. Okay! I love him and I must do it. Since then, I help him whenever he needs something, ... everything.” In addition, this participant felt proud in taking care of her beloved husband. She said,

I feel proud and pleased that I have taken good care of my husband, my beloved one. I want him to live and to give moral support to his children, his nieces and nephews, and especially, because he’s the head of the family. Even though he can’t do anything, I feel warm and safe, just like we have the perfect family.

A 61-year-old wife of a stroke patient stated that in the past she frequently had quarreled with her husband. However, when he became paralyzed and helpless, her
feelings changed. “In the past, I never felt pity for him, not like now. I had to run away
twice to become a nun because of the conflicts between us.” The reason why she felt
more pity for the patient was because he could not help himself. “Because he cannot
walk, eat, or whatever. It’s so pitiful. He can do nothing, . . . can go nowhere. . . .
So I felt pity for him.” Pity is one reason that made this caregiver stay with the patient.
“Nothing changes. I only feel more pity, just keep looking after him until this life ends.”

In conclusion, the love and attachment between husbands and wives were based on
the goodness which they shared with each other, as well as the closeness and the time
spent together. Love and attachment encouraged sympathy for the patients, helped to
accept their behavior and stay with them. Pity grew from the caregivers’ knowledge that
their spouses could not help themselves as before. Pity also led to the caregivers’
involvement in maintenance.

Participants who were not blood relatives explained that love and attachment between
the patients and themselves grew out of closeness and goodness shared between them.
A 44-year-old participant discussed the attachment between his mother-in-law and
himself. He helped her take care of her property and belongings. She loved him for his
help and did not want to live with her children. He recalled, “I think she might love me,
so she doesn’t want to live with others. It’s a reflection. I have more goodness. The fact
is that I am not a drunkard or a bad guy. I always take care of her property, the loan, the
funeral fee.” This participant stated that pity made him help the patient even though he
knew she could do some activities by herself. “If she can move by herself, I should not
help her. But I feel pity for her. So I have helped her so far.”
A 44-year-old female caregiver for her father-in-law said she felt love and attachment to him because she used to live and work with him. “We used to work together. . . . In the past, he set up a big tent, . . . kind of, . . . for a wedding ceremony, . . . something like that. . . . I went to work with him. . . .” The love and attachment also developed because the patient was her husband’s father. “I love my husband, so I have to love my father-in-law. My parents taught me that if you love your husband, you must love his parents and relatives too.” She also felt pity and sympathy for the patient. “I feel pity for him. When I saw him cry, I cried too. He used to go out on his own but now he cannot go anywhere. I think to myself, if I was like this, what would I feel? I might feel hurt, . . . like him.” This participant stated that she intended to give good care to the patient because of love. “I take care of him because I love him. . . . I take care of him in order to make him happy for the rest of his life. Sooner or later, he will pass away. I have to take good care of him while he’s still alive. How long will he be with us?”

A 34-year-old participant who cared for her mother-in-law said that being close was one of the reasons that made her become a caregiver. “I wondered if it was because of the closeness between us. I am closer to her than others. Also, I take care of everything.” This caregiver felt so close to the patient as if she was her own mother. “She always calls me. I am so close to her. I feel like she is my own mother.” The feeling of closeness made this caregiver decide to take care of the patient in every way. “Before I took care of her, I thought that she was my own mother, not like my mother-in-law. I had lived with her for a long time, so I decided that I had to do everything.”

The explanations of the in-laws mentioned above indicated that love and attachment between daughters- or sons-in-laws and mothers or fathers-in-law were based on the
closeness which resulted from living together for a long time and helping each other. In addition, the love a person felt for a spouse often extended to include that spouse’s parents.

**Family and Kinship Support**

All participants explained that their family members and relatives helped and supported them in various ways such as assisting in caregiving tasks or domestic work, providing financial aid, providing materials and equipment, and giving mental support. The participants required help and support from their family members more than from outsiders. They perceived that caregiving was the family’s responsibility because they were considerate of others and did not trust anyone else to care for their elderly relatives. Therefore, family and kinship support is an important category that emerged from the data. This category consists of two main concepts: (a) sense of family responsibility and (b) help and support.

**Sense of Family Responsibility**

Participants believed that caring for their patients at home was a family and kinship responsibility. Most participants explained that they did not request assistance from outsiders if possible because they had thoughtful consideration for the feelings of others (krengjai, in Thai). They also believed that others could not take care of their elderly patients as well as they or their relatives could, as shown in the following examples.

A 63-year-old husband discussed his and his wife’s consideration for their neighbors’.

“It’s just that we never unload our troubles on others. We have thoughtful consideration
for our neighbors. They all have to work. We cannot disturb them. We are not supposed to.”

A 33-year-old son who took care of his mother refused to hire an assistant to help him with his caregiving tasks because he was afraid that the assistant might not provide good care. “No, I would never think of it because it’s hard for someone else to do the same as the children do for their parents. How can others do as good as ones’ own children? . . . When I think like this, I don’t want to take any risk.”

In conclusion, these participants believed that caring for their elderly patients was a primary responsibility of all family members, close relatives, or both because of the belief that others could not provide the same quality of care as they themselves, as well as their thoughtful consideration for other persons.

Help and Support

The help and support which participants received from their family members or relatives consisted of caregiving tasks, domestic work, treatment, money, materials or equipment, lodging, and emotional support. The following details are the two subconcepts: (a) family members and (b) relatives.

Family members. Family members mentioned herein are relatives of participants or patients who had lived in the same house. Sixteen out of 20 participants lived with their family in the same house. They received various support from their family members. A 50-year-old wife who took care of her husband described the assistance she received from her son.
My son helps me. . . . We take turns. When I’m out, he will do it. . . . Like, clothing. . . . mostly, my son does it. . . . washing out urine stain, . . . when he [the patient] has to pee. . . . If we didn’t use pampers, he would pass urine through his clothes. . . . no problem with his stool. When doing an enema, my son does everything. If it doesn’t work, he will evacuate with his finger. . . . He does everything. For me, I can’t. I feel like throwing up.

A 35-year-old son who cared for his mother discussed his wife’s assistance. “She helps a lot. Usually, if feeding is not too difficult, she will do it alone. I don’t feed her [the patient]. In the morning, I lift her [the patient] into the wheelchair. Then, I do other work. When it’s time to carry her back to bed, I return to do it.”

In addition to helping in daily caregiving tasks, family members also looked after the patients when the participants attend to business or social matters. A 50-year-old wife who looked after her husband said she never was worried when she went out because her children could also look after him quite well. “It’s not difficult because the children are still around. My son can do everything.”

A 28-year-old son who took care of his mother talked about the help he received from his brother and sister-in-law. “When I have to go out for an exam, I will ask my sister-in-law or brother to take care of her . . . one to two times a month.”

Family members also helped with housework. For example, a 50-year-old caregiver of her husband described her children’s assistance in doing domestic work. “I asked them to do daily chores at home. Help me. . . . Like, when I want something to drink or whatever, they will bring it for me.”

Regarding help in treatment, some family members helped take patients to doctor appointments, provided first aid, or researched information regarding healing techniques. A 50-year-old wife who cared for her husband said, “My son took him [her husband]
A 33-year-old son discussed how his younger brother helped the first day that their mother suffered the stroke.

I just came back from my wiring job. I saw her fall down and sit with both legs bent. I helped her to stand, but she fell down again... this time all the way to the floor. She could not help herself. I called my brother for help. Both of us lifted her up, applied an ammonia inhaler, gave her the herb powder because we thought that she had just fainted, but she did not recover at all. So, we took her to the hospital to be examined. She was so exhausted then.

A 28-year-old participant talked about his elder brother who researched healing techniques for his mother. “My elder brother learned that the Buddhist monk here was good, so we took our mother for a massage. She felt lighter then.”

Family members also played an important role in providing emotional support to the participants by being consultants, giving consolation, and taking them out for pleasure. A 31-year-old daughter-in-law consulted her husband when there was a problem. “If I have some problems, I will talk to my husband, ... to consult him. ... We talk to each other, ... something like that ... because I want to know. ... His father was like this. ... I would tell him.” This participant also mentioned the consolation which she received from her husband and family members. “My husband admires me for what I am doing. My family members never say anything to hurt me. They love me.”

A 70-year-old wife who took care of her husband talked about how her children took her out for social activities. “I didn’t go by myself. My children took me to make merit, ... to contribute. ...”

In summary, family members such as spouses, children, grandchildren, parents, fathers- or mothers-in-law, and brothers or sisters all were sources of help and support for
the caregivers. This assistance included help in caregiving tasks, daily chores, treatment, and emotional support.

**Relatives.** Relatives mentioned here refer to relatives of the caregivers or patients who did not live in the same house. Data indicated that the patients' relatives who had moved out and lived far away or near played important roles in providing various types of help and support to the participants such as visiting, giving financial support, providing materials or equipment, taking the patient out for treatment, providing advice or information, researching for good medicine, occasionally caring for the patients, providing a place to stay, providing food, giving emotional support, and helping with domestic work.

All participants described the visits of relatives who lived elsewhere. A 58-year-old wife talked about the visits of her husband's relatives. "It's good that he had a visit from his relatives. They are his nieces and nephews, the children of his elder sister. They are teachers and quite well off. . . . It's good."

A 70-year-old wife said that even though she hardly visited her and her husband's relatives, she did not have any problems because they visited her and her husband at home. "There is no problem. We don't visit them, but they visit us."

In addition to the visiting, relatives also helped and supported the caregivers in such ways as taking the patient for treatment, collecting the prescribe medicines, and suggesting the place and medicine for healing. A 35-year-old son described the help of his brother when his mother's symptoms became worse.

After 3 months, she suffered again, but this time she didn't want to open her eyes, didn't want to eat, didn't want to do anything at all. She just stayed still. I asked a masseuse to massage and compress her with a ball of herbs. For the first 3 months, it was better, but lately she started to feel exhausted again. When the masseuse came, she didn't want to walk. Her legs had no
strength to walk. Two to 3 days later, she didn’t want to eat... not eat... What could I do? I ran to call my elder brother to drive her to the hospital.

A 58-year-old wife said that her son who had moved away from home was the one who accompanied her husband to the doctor. “Each visit, my son and my assistant will take him, I hardly ever go with him.”

A 70-year-old wife said that relatives who lived far apart brought the masseuse to massage her husband. She recalled, “His relatives knew a masseuse so they brought her here. My son was the one who picked her up and took her home.”

A 33-year-old son, who looked after his mother said that relatives searched for medicine and gave it to the patient to try. “Relatives who live apart bought some medicine for her. They wanted her to try to see whether it’s good or not.”

Seven out of 20 caregivers acknowledged that they received help and support from relatives who took turns or replaced them when they had to go out. For example, a 35-year-old son, who took care of his mother, said that his elder sister and brother-in-law, who lived in the another district, drove to his home and helped look after his mother. He described, “My sister is a teacher. She came to help. She drove from [stated the name of her home district]. She lives in a government home. She comes every Wednesday, Friday, and on weekends. On Monday she goes back to teach her class.”

The relatives also gave money, food, materials or equipment, and a place to live for the caregivers and patients. A 63-year-old husband talked about the financial support received from their children who lived in other districts. “Our children come and stay with us once a month. They bring us some money and go back. They check whether we have enough food or not.”
A 58-year-old wife said that she experienced difficulty in taking care of her husband where they used to live, since it was far from town and the hospital, so her sister and brother asked her to stay with them. She stated,

My younger brothers and younger sisters allowed us to live here. By living here, we can help one another during the hard times because we are near the doctor and near the hospital. We can help carry him into the car. Living in my old house, no one helped me to carry him since there were only two of us. . . . I had to call our neighbors for help.

In conclusion, relatives of the participants or patients, even though they lived away, nevertheless provided help and support to the caregivers and the patients. The types of assistance included visiting, giving financial support, providing food, providing materials or equipment, giving advice and information, taking the patients for treatment, searching for medicine and healing techniques, helping in the caregiving tasks on some occasions, and providing a place to live. The help and support that the caregivers received from their relatives was appreciated and enabled them to maintain the caregiving at home.

**Community Support**

Most participants received various types of help and support including, praise and compliments from their community members. This category, therefore, consists of two main concepts: (a) help and support and (b) praise or compliments.

**Help and Support**

Groups of people in the community from whom the participants received help and support while giving care to the patients at home were neighbors, friends, and health care providers.
Neighbors. All participants noted that they received considerable help from their neighbors by request and without request. This support consisted of visits, advice or information, temporary care of patient, domestic work, materials or equipment, and money or food.

A 50-year-old participant said that when her neighbors learned that her husband was sick, they visited without asking. "They come to visit and observe. If the symptoms become worse, only one person need know, and in a short while, everybody will know and they will come. . . . No need to ask."

A 58-year-old participant who took care of her husband said that even though they had moved to her younger sister's, her neighbors still visited. "I don't feel distant. They always come and visit me because I cannot go anywhere. They have to visit me and the patient."

A 63-year-old caregiver to his wife admitted that the neighbors provided emotional support by visiting. "Yes, sometimes they came and gave me emotional support. They came for chit-chat and to looking after us. At the beginning, a lot of them came to support me."

This participant also said that a neighbor suggested alternative therapy. "It was a neighbor who advised me to take the patient to be treated by this doctor. . . . Perhaps it might work. . . . Just try."

Some participants noted that their neighbors helped them to look after patients on some occasions. For example, a 61-year-old wife said that neighbors helped her to apply first aid when her husband had a convulsion at home. "If something serious happened such as when the patient had a convulsion, I would tell my neighbors and they would
come to stay the night. When he recovered, they would return home. They also work for a living because they are poor.” This caregiver added that a neighbor helped look after her husband when she went to the temple. She recalled, “Since my husband got sick, I have only been to the temple once. I asked my neighbor to look after him. He said he could do everything even when he [the patient] moved his bowels, ... passed urine. So I went to do merit once, ... during the Buddhist lent.” In addition to the caregiving tasks, the neighbors also offered help with daily chores. “Sometimes, I don’t have enough time to wash clothes or prepare food. They always help me.”

In case the participants could not attend some social activities or parties such as weddings, Buddhist ordinations, and funerals, they would ask their neighbors to take gifts or donations to the host of such activities or parties. A 58-year-old wife who was her husband’s caregiver said, “Any occasions in the evening, ... I wouldn’t know when I would come back. ... Having dinner. ... it might be late. ... So how could I leave him. I couldn’t leave him alone. On occasions like parties, weddings, Buddhist ordinations, I can’t go. I always ask someone to take the donation or gift on my behalf.”

Regarding financial support, a 61-year-old female participant who took care of her husband alone said that her neighbors felt pity on her so they gave her money. “Sometimes they gave, sometimes they didn’t. When they would see us, they would feel pity so they gave us money.” Besides the financial support, one of her neighbors also paid for the bus fare to take the patient for treatment. “There was a man who came from that area and worked on a farm near my home. He said a monk used to heal other patients. He wanted my husband to recover. He helped by taking us and he didn’t ask for bus fare. When I tried to pay back, he refused.” This participant also received food from the neighbors.
“They share their food with us. Whatever they cook, they always share some with us.”

Moreover, a neighbor helped her to make a wooden walker for the patient. “The boy next door helped me without charging any money.”

The above explanations indicated that the neighbors assumed a major role in helping the caregivers and the patients, especially when the caregivers and the patients lived by themselves or received low incomes.

Friends. Some participants described that they received help and support from friends who lived near by and far away. These friends provided emotional support, advice, and medical equipment.

A 70-year-old participant who took care of her husband stated that talking with friends helped her feel comfortable. “We would talk about many topics. When they [her friends] got sick, I would go to look after them. It sort of consoled me.”

A 28-year-old son who cared for his mother said that talking to friends helped him relax. “Here at the market, a short ride by motorcycle. I talk to my friends about other topics, then, I come back home, feeling relaxed.”

Friends also played an important role in providing advice regarding treatment. For example, a 33-year-old son who took care of his mother said that friends advised him about traditional medicine. “Most advice came from my friends and I would ask them if it was good. I also asked for the patient’s opinion.” This participant also said that a friend gave him an air bed. “My friend bought the air bed for his friend. Perhaps his friend had recovered or something, so he gave it to me.”

Health care providers. Thai participants always used the word “Mor” when referring to health care providers such as doctors, nurses, and practical nurses. However, most
caregivers usually used the term "Mor" when referring to individuals who examined and prescribed medication for them. Some participants, especially older caregivers, could not identify differences among health care providers whether they were doctors, nurses, or others in the medical field.

Most participants stated that while caring for the patients, they received help and support from health care providers. This help and support consisted of giving advice, providing physical examinations and treatment, solving caregiving-related problems, and providing emotional support.

Five out of 20 participants said that they were told the diagnosis of the illness from doctors at the hospital. For example, a 44-year-old caregiver to her father-in-law said, "He was taken for a check up. The doctor said he would never recover because he had a brain infarction. He said we should encourage the patient to help himself, ... to walk, ... to do things. So I try to do everything for him."

Ten out of 20 participants said they learned some caregiving techniques from health care providers. A 58-year-old wife described how she received advice about her husband's symptoms from the doctor. She stated,

The psychiatrist at a hospital in Bangkok suggested that my husband needed special care. Giving him some medicine is one type of treatment, but the relatives should give him full support: Firstly, don’t desert him; secondly, treat him as an important person in the family; thirdly, give him whatever he wants.

A 58-year-old wife who took care of her husband received advice about wound dressing and feeding from the health care providers who visited their home. She recalled, "They advised me to take care of the wound and said, 'You did it! Aunty (the caregiver) did very well. The feeding was correct. Make sure that the wound is clean.' They
taught me many things. I follow their instructions.”

A 35-year-old son said that before he took his mother home, the health care providers at the hospital advised him regarding medicine and physiotherapy. “They advised that the medicine be taken constantly. The physiotherapy must be practiced by lifting the patient’s arms and legs. Try to help the patient to move. That’s all. . . . We have to practice at home.”

A 59-year-old daughter who took care of her father said that before they brought him home, health care providers at the hospital advised her about the significant symptoms to watch for in the patient. “They advised that whatever happens, coughing or feeling tired. I have to take the patient back to the hospital.” Moreover, this participant also said that the health care provider was a good source to consult when she encountered a caregiving-related problem such as feeding through the plastic tube. She stated,

I consulted a doctor at the community hospital or the local health center. At first, the health care providers in the community didn’t come, so I called to consult the health care providers at a public hospital in Bangkok. They said that if the patient vomited after feeding, I had to reduce the quantity. If he got worse, I must bring him to the hospital. I didn’t do anything without consulting.

A 44-year-old female caregiver of her father-in-law said that health care providers at the hospital advised her about exercise and equipment preparation. “The doctor asked me to lift the patient’s backside, to massage him, and many things. The health care providers at the hospital advised me to buy it certain equipment.”

The above explanations indicate that health care providers assumed the role of consultants regarding the illness, the caregiving techniques, and preparation of medical equipment. These participants appreciated the advice and wanted the health care providers
to offer more advice. For example, a 58-year-old wife, caregiver of her husband said, “The doctor at the hospital is a role model for me. I will never forget him.” This participant also wanted the health care providers to give more advice to the patients’ relatives. “I want the government officers to realize more about this issue because common patients and relatives don’t understand how to deal with caregiving. Some have money but lack knowledge and understanding.”

Besides giving advice, health care providers also examined and treated both the patients and the caregivers. A 61-year-old wife, caregiver of her husband, discussed the help she received from health care providers who visited her home, “I used to ask for the medicine from health care providers at the local health center or those who visited us at home. I asked them to check the blood pressure of the patient.” The health care providers also treated this participant. “Yes, they checked my blood pressure too, because it is pretty high. Also, I asked for some vitamins.”

A 59-year-old daughter took care of her father said that health care providers helped her do a complicated technique that she could not do by herself. “I couldn’t change the urine tube. I am scared. I have to ask the health care provider to do it for me. We have no equipment. . . . I don’t want to take any risk so I have to ask them to do it for me.”

Some participants said that health care providers not only helped in examining the patient but also emotionally helped support them. For example, a 44-year-old caregiver for her father said, “Those health care providers from the community hospital have paid us visits quite often. It’s good. It can support the patient’s emotion. When he saw them, he would smile.”
Home visits were important health services for some participants. For example, a 41-year-old daughter who took care of her mother said that she wanted more visits from health care providers because it was difficult for her to bring the patient to the hospital. She said,

I want them to come . . . If she gets sick and can be cured by some medicines, I want her to received such medicines. It's difficult now for us to take her to visit the doctor. I have to carry her. It makes me so tired. If she is admitted to the hospital, she is afraid. So, I just want them [health care providers] to come, to check on what kind of disease she has, then prescribe her the medicine.

From these observations, it would appear that health care providers played a major role in providing support to the caregivers and the patients by offering advice, providing examinations and treatment, helping solve problems related to the caregiving, and giving emotional support. This assistance gave the participants a feeling of satisfaction, especially when they received advice and home visits.

Praise and Compliments

Thirteen out of 20 participants stated that caring for the patients at home was the accepted practice in their society. Praise and compliments from their neighbors, friends, and health care providers made them feel proud and motivated them to maintain home caregiving as long as possible.

A 73-year-old husband who took care of his wife for 17 years said, “I have done something good. Everybody admires me. Wherever I go, I always receive compliments. People said, ‘Some people might have found a mistress and not look after their wife like this, . . . not give any treatment, . . . just let the patient die.’” This participant felt proud of himself because people had complimented him as a role model. “Oh! A lot, as a role
model. I didn’t honor myself. You can ask people at the market. Everyone there will say that you would never find such a husband, not one in 100 or even 1,000.”

A 58-year-old wife who cared for her husband described that she was complimented by many people including health care providers that she could save her husband’s life and she could look after him very well. “The good point is that many people even nurses or doctors in the hospital, said that it was unbelievable that my husband will get well. Many people thought that he would die.”

A 31-year-old daughter who took care of her mother said that her friend and her friend’s mother praised her for returning home to look after her mother. “My close friend told me to go back home and her mother also praised me. She said it’s hard to find a person who will look after their mother.”

Although it was unexpected that a son would be the primary caregiver, they also received compliments. A 28-year-old caregiver of his mother said that no one teased or reprimanded him. All his friends praised him. “Mostly they admire me. When I come back home, my friends know that I will have to prepare dinner for my mother. If I have something to do or if I want to go out, it has to be after 7:00 p.m.”

A 44-year-old caregiver for his mother-in-law said, “For the most part, it’s good. People praised me [he laughed]. They asked if there was anyone else like this around here. They meant a son-in-law who looks after his mother-in-law.”

Praise and compliments received from society made the caregivers feel proud of themselves and gave them motivation to continue caring for the patients. A 63-year-old husband who has taken care of his wife said, “I feel so proud that they praise me, compliment me.” A 44-year-old caregiver of her father-in-law discussed how she felt
when receiving compliments from others. “Wow! I felt so high. I love being admired. When they said what I did was good, I would do it with all my heart.”

The above descriptions show that no matter what the social expectations are regarding the role of primary caregivers, they all received praise and compliments for their caregiving activities. Praise and compliments helped them feel proud of themselves and motivated them to continue caring for their elderly relatives at home.

Managing Treatment

Managing treatment for the patients was an important caregiving activity. All participants described the various treatments they tried during the caregiving process, such as modern medicine, traditional medicine, and alternative therapies. The decision to try or not to try a treatment depended on the caregivers, the influence they received from others, or both. The important factors which influenced their decisions included treatment information, hope for recovering, beliefs in treatment, experiences with treatment, and outcomes of treatment. The styles of treatment included using one treatment at a time, as well as many types of treatment simultaneously. The decision to stop or continue treatment was influenced by the treatment outcome. If the outcome indicated positive results, treatment would continue. If the outcome remain status quo, the treatment might be continued or terminated. However, if the outcome indicated negative results, the treatment would be discontinued. If there were barriers such as affordability, difficulty in traveling, and lack of patient need, the treatment would not be provided for the patients or would not be continued.
The main concepts in this category, therefore, consist of information, hope, experience, belief, trial, and outcome as described below.

**Information**

Information about treatment or healing methods played an important role in the decision to try a treatment. The caregivers stated that they received treatment information from various sources such as family members, relatives, neighbors, friends, patients who previously experienced the treatment, treatment providers or healers, health care providers, and the patients. In addition, some caregivers said that they searched for information on their own.

A 48-year-old daughter who took care of her father said that she decided to take him to see a doctor in Bangkok after speaking to her relatives. “He’s a specialist in neurology, so we went there. We went to his clinic regularly. Our relatives knew that he was great.”

A 50-year-old caregiver to her husband stated that her son brought the traditional medicine to the patient. “People said this medicine is good. Some stroke patients tried it and they recovered. So my son brought it for him [the patient] to try.”

A 34-year-old female caregiver to her mother-in-law said that the patient’s sons and grandchildren heard about traditional massage, so they took the patient to try it. “Her sons and grandchildren suggested that she go. I never go with them. They learned that some patients had been healed, so they brought their mother for trial.” This participant admitted that the treatment information evolved into the decision to take the patient for treatment. “Her sons got the information, then they had a discussion, and took their mother for treatment.”
A 33-year-old son who took care of his mother stated that some people suggested traditional medicine, so he let his mother try. He said, “They showed the traditional medicine to me and let the patient try it. Perhaps it might work.”

A 44-year-old care caregiver for his mother-in-law said that he was going to use modern medicine. He stated, “We will try a new medicine. Some people told us to get it from a public hospital. If it is good, I will bring it to her to try.”

A 73-year-old husband who took care of his wife said that he took her to have alternative therapy many times because some patients told him that they had recovered as a result of this treatment. “We went to try this treatment because I asked some people who were treated by this method and they said that they had recovered. So I took the patient to try it many times. Maybe, my wife had a more severe condition than others, so it might take time.”

A 44-year-old female who cared for her father-in-law said that health care providers from the community hospital advised her to take the medicine from the community hospital. She stated,

The doctor visited us at home. He asked, “What kind of medicine that the patient took? What kind of illness? Where did the patient have the treatment?” I told him that he had been treated at a private hospital in Bangkok. I showed him the medicine. The doctor said that the community hospital also had this medicine. Oh! What a relief! We don’t have to go so far. We don’t have to spend any money. We can just take him there. So we take him there.

Health care providers also gave the participants information about traditional medicine. For example, a 58-year-old wife said that she bought a herb medicine for curing constipation from a medical doctor’s clinic. She stated, “I would give my husband a herbal medicine, called “Ma-kham khak.” I would give him four tablets
every 2 days. I bought them from the clinic.”

A 73-year-old husband said that he let his wife try acupuncture because the acupuncturer paid a visit to the home and offered to treat the patient without charge. He stated,

The acupuncturer came from China and treated stroke patients by using the acupuncture method. He came to visit my neighbors next door. When he saw my wife, he asked if he could be of any help. He would treat the patient without any charge. He had studied in this field and had practiced in a hospital in China. I asked him about the acupuncture method. He said that it was not dangerous and that the patient would be better.

A 61-year-old caregiver to his wife said that many venders came to his home to sell traditional medicine. “Some venders brought traditional medicine to sell us at home. They knew the stroke patients in our community. They said that they used it to treat some stroke patients and those patients recovered. I believed them, so I bought it from them. It was kind of pot medicines.”

A 28-year-old son said that his mother received the information from the conversations of others and from the radio. “Sometimes she listened to what we [caregivers and relatives] said. Sometimes, she listened to the radio. The radio would say this temple is good, that temple is good for this illness treatment. My mother knew a lot about treatment.”

A 61-year-old wife said that she asked the masseuse to massage her husband because she previously knew her. She stated, “No one introduced her to me. I knew her by myself. She [the masseuse] said that my husband had a problem regarding his blood vessels or tendons. So she rubbed and pressed them.”
In conclusion, the information about treatments played an important role in decision to try or not to try any treatment. This information either was provided or sought by family members, relatives, community members, other patients who previously experienced the treatments, health care providers, healers, venders, patients, and caregivers themselves.

**Hope**

Hope in seeing patients recover was an important factor which influenced the decision to try a treatment. All participants hoped that the patients would recover or could help themselves like before. Therefore, they searched for various kinds of treatment.

A 50-year-old wife admitted that she took her husband to have many treatments because she hoped to see him recover. To her, the meaning of “recover” meant, “His condition is improved. It’s doesn’t matter if he can’t walk. I just want him to be able to talk because he will tell me whenever he’s hungry. Now, I don’t know when he wants to eat.”

A 35-year-old son described the reason why he took a masseuse to massage his mother, “If there is any chance to help her recover, I have to take that chance. I have to let her try everything.” The meaning of recover defined by this caregiver was interpreted as following. “I want her to be able to do something by herself such as holding the spoon, eating, walking, sitting, telling me when she wants to pass the bowel or urinate. Well, she doesn’t have to walk. It’s impossible. Just be able to eat.”

A 34-year-old participant took her mother-in-law to many places for treatment. “Because I want her to recover, to be able to walk, to do everything by herself.”
Experience

Experience in using any kind of medicine played an important role in deciding whether or not to try it. Six out of 20 participants stated that they decided to use a medicine or treatment for the patients because either they, the patients, or the relatives tried it and received effective outcomes.

A 48-year-old daughter who took care of her father said that he asked her to buy a traditional constipation medicine because he remembers it as being effective. “Sometimes my father asked me to buy a traditional medicine called ‘Radompol’ from the store for him. It worked. He had a bowel movement. He never took the medicine from the hospital. He said that this traditional medicine was more effective.”

A 31-year-old daughter said that she gave a traditional medicine called “Ya Knom Med Tra Bai Hor” for constipation to her mother because all of her family members usually used this medicine. “We have used this medicine for a long time. If the children do not have a regular bowel movement, they will use this medicine.”

A 59-year-old daughter said that because she had experience with an effective antibiotic, she gave it to her father. “If his bed sore wound becomes infected, I give him two tabs. I used it twice after giving birth to my two sons. I got this antibiotic and the wound was healed very well.”

Belief

Belief concerning treatments or medicines were involved some participants’ decision to provide the medicine for their patients. A 33-year-old son said that he never believed in witchcraft treatment, so he did not let his mother try it. “Someone had recommended
but I didn’t let her try it. For this situation, it’s unreasonable to believe it that way. As we all know, this illness takes time to recover. So, I didn’t let her try.”

Some participants believed that traditional medicine had no side effects on the patient even when using it with modern medicine. For example, even though some herbal medicines have side effects, a 35-year-old son said that he gave both herbal medicine and modern medicine to his mother because he believed that the herbal medicine had no side effects. “I took a herbal medicine from Lampang province because I thought that this medicine had no side effects. It mostly contained of pepper. It’s a herb. It might not have any effect on the modern medicine which she had.”

A 31-year-old daughter said that she provided both modern and herbal medicine to her mother because she believed that herbal medicine caused no harm. “Oh! I give it to her as usual because someone said that it was okay. It doesn’t destroy anything. Everybody said that it was good to try the herb. It has no poison.” This participant also stated that sometimes she stopped giving her mother the modern medicine because she thought that it had side effects. “Sometimes, when I saw her refreshing as normal people, although doctor gave her medicine, I didn’t let her take it. I judged it by myself. If she gets more medicine, she will get worse. It will accumulate in her body.”

Trial

During the trial period, patients tried various kinds of treatment to cure or heal their symptoms related to stroke. The decision to have a trial was made either by the caregiver, relative, or the patient individually or together. Factors that influenced the decision process included treatment information, hope for recovery, personal belief about treatment,
treatment experience, and treatment outcome. After deciding to try a treatment, they would wait to see the outcome. If the treatment showed positive results, they generally continued trying it. If the treatment showed negative or neutral outcomes, most patients stopped trying it and would seek other treatments to try. Some participants let their patients try many treatments at the same time and then would stop using treatments which gave neutral or negative outcomes. Other factors involved in the decision-making process were cost, affordability, distance between home and treatment place, and patient need. Treatments used by the patients consisted of modern medicine, traditional medicine, and alternative therapies.

**Modern medicine.** All participants but one stated that their elderly relatives received modern medicine or treatment which was based on modern medical sciences. Types of health care providers and facilities used by participants included hospitals, health centers, private medical clinics, injection doctors, drugs stores, and traditional doctors.

Most of the participants (13 out of 20) took their elderly relatives to hospitals when they first had a stroke. Only a few patients tried other treatments such as Thai traditional massage; however, it was not effective. Therefore, these patients were then taken to the hospitals. For example, a 61-year-old wife took her husband to a masseuse. Since he did not improve, she took him to the community hospital. "She pressed and massaged him. He got worse, so I took him to the hospital."

During caregiving at home, most patients were taken to the hospitals in order to have examinations, treatments, or physiotherapy according to the medical appointments. In some cases where patients could not go to the hospital, the participants or their relatives would go in order to update the physicians about the patients and to obtain medication.
For example, a 35-year-old son talked about taking his mother to the hospital,

> Usually, the doctor makes an appointment about twice a month. In the beginning, the doctor wanted to examine her. The orthopedist had examined her knees, arms, and legs. After the examination, my mother would have physiotherapy. The doctor would check as to whether she was healthier. I always take her to the hospital whenever she has the appointment.

Some participants took the patients to the hospital when they had any health problems, such as fever or refusing food. For example, a 58-year-old wife said, “If my husband was not well, sort of having a fever or other symptoms, he would be taken to the hospital. If nothing was serious, I would give him medicine. But if it was necessary to be in the hospital, he would stay there for many days.”

Since 1993, the Ministry of Public Health observed a policy regarding home health care. Therefore, the public hospitals must provide health care services for patients at home. Nine out of 20 participants stated that the health care providers from the community hospitals and the local health care centers had visited them at home. For example, a 48-year-old caregiver to her father said, “The health care providers came here. At first, they came here once a month. It was good that they visited us. They gave us the medicine and vitamins. They also taught me many things.”

Five out of 20 participants described that they took their elderly patients to private medical clinics both near to and far from their homes when the patients had first attack or after they had tried other types of treatment.

A 35-year-old son said that he and his relatives took his mother to a private medical clinic when she had a stroke. He stated,

> It was not a hospital. We went to the clinic. When coming back home, she still could walk but she was not strong as before. After coming back from the clinic, she rested all night and she looked good the next morning. But later she
didn’t want to walk. She could sit but couldn’t walk. She took medicine for a few days. Then, my relatives came for visit. We had a discussion and decided to take her to the hospital. The doctor admitted her to the hospital.

A 50-year-old wife stated that she and her relatives took her husband to a private medical clinic after trying other kinds of treatments. “We tried many places for treatment but he didn’t recover. After going to the hospital, we took her to the clinic at a distant district. There was a doctor. Someone said that he was great, so we went there.”

In addition to hospitals and private medical clinics, 3 out of 20 participants said that their elderly relatives received treatment from the injection doctor. The injection doctor mentioned here refers to a subdistrict doctor or a local doctor who did not graduate from a modern medical school. One patient was taken to the injection doctor after trying many kinds of treatments. The remaining 2 patients were treated by the injection doctor when they first had a stroke. Yet, they did not recover. For example, a 50-year-old caregiver to her husband said, “His mouth was full of his tongue. I listened to his voice. It seemed like his mouth was full of his tongue. I took him to the injection doctor but nothing changed. So I took him to other doctors.”

Drugs stores also provided some medicines for patients and their families in communities. Two participants stated that they bought the modern medicine for their patients from the drug stores. A 59-year-old caregiver to her father said, “When the bed sore didn’t heal, the problem was how to heal it. So, I bought him the antibiotic. It costs 4 baht a tablet. He took it twice a day, morning and evening. If the wound got better, I would give him only one tablet. I bought it from a drug stores.” A 28-year-old caregiver of his mother said, “It’s a laxative called ‘Bisolax.’ I bought it from the market. It’s good.”
Modern medicine not only was used by health care providers but it also used by traditional doctors. A 44-year-old participant stated that when her father-in-law was suffered a stroke, her husband’s relatives took him to a traditional doctor who gave him a modern medicine. “He was a traditional doctor, but he gave him the western medicine. It didn’t make him recover... Nothing changed.”

**Traditional medicine and alternative therapy.** In addition to modern medicine, all participants stated that the patients tried various kinds of traditional and alternative treatments in order to cure paralysis and lessen symptoms related to their strokes. These treatments consisted of traditional or herbal medicine, traditional massage, and various types of alternative treatment. Patients received them from masseuses, local doctors, vendors, traditional doctors, Buddhist monks, drug stores, modern medical doctors, and neighbors. Most patients tried traditional medicine or alternative therapy after they had tried other types of treatment. Some patients used different treatments simultaneously.

All 20 patients used medicines which were made from medicinal plants and herbs. These medicines included pot medicine, herbal laxative, and small balls of compressed medicine. The most popular medicine was the pot medicine made from various medicinal plants. This kind of medicine was provided by masseuses, local doctors, vendors, traditional doctors, drug stores, and Buddhist monks. Most of the caregivers said that the pot medicine did not make the patients recover.

A 41-year-old daughter said, “I bought the pot medicine from a masseuse who came here to massage my mother. I had bought many pots of medicine. She had tried them once or twice. She didn’t want to take it any more. She said that there was no improvement.”
A 63-year-old husband stated that he bought the pot medicine, a laxative, from a vender. It was not effective, so he stopped giving it to his wife. “The pot medicine was a laxative made from the plants’ root. I boiled it for her to drink, but she didn’t pass her bowel. She still passed her bowel every two to three days, so I stopped giving it to her.”

Besides the pot medicine, laxatives made from herbs also were mentioned as a commonly used. The sources which provided the herbal laxative were drug stores and private medical clinics. According to the caregivers’ perception, all patients who used this kind of medicine received good results. Some participants stated that they gave the small ball of compressed medicine (i.e., a pill) to the patients in order to cure paralysis. They received these medicines from traditional doctors, Buddhist monks, drug stores, venders, and local doctors. The results, as perceived by the participants, were effective in some cases, but not in all cases.

A 50-year-old caregiver to her husband stated that she and her relatives took the patient to a traditional doctor who gave the patient a pill to cure paralysis. She said, “We also went to see a traditional doctor. People said that he was good. He was a doctor who provided Chinese medicine, not western medicine. He gave a small ball of compressed medicine to the patient. The patient took six to seven tablets at the same time morning and evening. There was no improvement.”

A 48-year-old daughter said that she bought the pill from a Buddhist monk for her father. This medicine made the patient recover from twitching. “I bought it from the temple. After he took it, he stopped twitching. He felt better.”

Other herbal medicines tried by a few patients included herbal wound ointment, herbal vitamins, and other herbal medicines in various forms.
A 31-year-old daughter said that the Buddhist monk had used herbal medicine to heal her mother’s bed sore wound. “This monk had the medical equipment. He was very efficient. His treatment was very good. Oh! The wound was very deep. Even an orange could be put inside. He cleaned the wound and then applied the herbal medicine which was very effective.”

A 34-year-old participant said that she gave the instant herb tablet extracted from garlic to her mother-in-law in order to make her healthier. “It was called garlic medicine. I asked my mother-in-law about the result but she said that she didn’t know. Anyway, I noticed that after she took this medicine, she had more appetite.”

A 59-year-old daughter said that her younger brother gave her father the traditional medicine in the form of powder for painting his lips and mouth in order to make him talk. Yet, it was not effective. “My younger brother got a traditional medicine. Someone said that it could make the patient talk. My father tried it but it didn’t work.”

Sixteen out of 20 participants stated that their elderly relatives experienced traditional massage in order to reduce symptoms related to stroke such as muscle pain, weak arms, and weak legs. These individuals who provided traditional massage were masseuses, Buddhist monks, and caregivers. In some cases, results indicated no improvement, yet in other cases, there was improvement.

A 73-year-old husband said that he hired two masseuses to massage his wife at home. “They were the traditional masseuses living in our village. They came to visit my wife. Someone recommended that they were good. They had the herbal compresses. They boiled the compresses and used them to scrub the patient’s muscle.”
A 63-year-old participant stated that the masseuse had massaged his wife but nothing improved. Therefore, he used the herbal compress to compress her by himself and it was effective. “I took the herbs from around my home. Someone recommended that I try it. So I compressed her. She gradually improved. At first, she could not walk. I made her be able to walk, . . . a little bit.”

A 34-year-old caregiver to her mother-in-law said that the patient’s relatives took her to a temple for having massage. “Her relatives learned that many patients had recovered by applying the powder and massage. So they took the patient to try it. The Buddhist monk applied the powder around her hands and legs and then he stepped on them.” This participant said that the patient did not recover, so she was taken back home after a few days.

Other treatments or healing methods which some patients experienced included witchcraft or black magic, spiritual power, universe power, alcohol and drugs, and acupuncture. These treatments were provided by local doctors, Buddhist monks, neighbors, and caregivers.

Seven out of 20 participants stated that their elderly relatives tried the witchcraft or black magic treatments provided by local doctors and Buddhist monks, with the results indicating no improvement. For example, a 59-year-old daughter stated that her younger brother took the holy water from a Buddhist monk for her father. They hoped that after drinking this water, the patient would be able to talk; but he still could not talk. “My younger brother took the holy water from Bangkok. Even though the patient drank it every day, he still could not talk.”
A 61-year-old husband was the only participant who stated that his wife received a treatment called “Yo-Rae,” which based on spiritual power. His neighbor provided it for the patient at home. “He came here last year. His home is over there. He often comes. He gives her the treatment without any charge, but her condition did not change.”

A 58-year-old wife was the only participant who gave her husband a treatment based on the universe power. She stated,

Later, I had some kind of inspiration to learn what is called “the universe power,” so I used this power to help him too. It was obvious that from having no hair at all, after I treated him with “the universe power” for 21 days, his hair grew again. Also, it is said that this treatment could heal some kinds of symptoms like a choking problem. When he first got stroke, he choked so many times that the doctor was afraid that he might develop pneumonia. Until I treated him with “the universe power,” his choking has gone unnoticeably. His depressed feeling has gone too.

Alcohol and drugs were used by a participant to reduce symptoms related to stroke. A 31-year-old caregiver gave her mother the Chinese wine to increase her appetite. “It was the Chinese wine. Someone told me that it could cure everything. . . . Good! . . . It was good. I did agree with them. My mother looked healthier after having it. She also ate more and talked more.” This caregiver also gave her mother opium to relieve muscle pain. However, this made her be worse. She stated,

We occasionally gave opium to her in order to relieve pain and to make her sleep. Because sometimes I have tension and my elder brother is very busy, we cannot look after her all the times. So we give her the opium. Once, we gave her the opium and she slept then. But she had a very deep sleep and did not move at all. Also, she had a fever. So I called the nurse from the community hospital to come for examination. She was sick. Maybe she got allergic.

Regarding acupuncture, a 73-year-old husband was the only participant who stated that he believed in acupuncture, so he let her wife tried this treatment many times. He said,
A healer, . . . I didn’t know where he came from, stayed in a temple. He had a very high skill in acupuncture. He didn’t have a practicing license, so he couldn’t treat patients openly. Sort of, . . . giving the treatment for charity. Everyone could go to the temple. He didn’t mind if patients would give him money or not. I took my wife there for about 10 times because I had confidence in acupuncture.

Outcome

Three different outcomes were found during the trial period: (a) positive, (b) neutral, and (c) positive. The treatment outcome played an important role in deciding whether or not to continue treatment. When patients experienced negative outcomes, they usually stopped trying the treatment. If the treatment offered positive results, they continued trying it. If the treatment resulted in a neutral outcome, some continue and some stopped. However, other factors also involved in the decision-making process included cost, affordability, distance between home and treatment place, and patient’s need. The decision-makers included caregivers, relatives, and the patients individually or together.

Positive outcome. All participants hoped to see the patients recover when trying any treatment. They expected the treatment to cure paralysis and some symptoms related to stroke. If any treatment provided expected or positive outcomes, it would be continued. Treatments which indicated good results to all or most of the patients who applied them included herbal laxatives, herbal wound ointment, universe power, and acupuncture.

Regarding modern medicine, 6 out of 10 participants who reported the outcomes complained that modern medicine did not help patients recover. However, 3 participants stated that health care providers at the hospitals effectively treated and rehabilitated
the patients. The remaining participant said that the antibiotic which she bought from the
drug store healed the bed sore.

Neutral outcome. According to the caregivers' observations, the results of most
treatments were "the same" or there were "no changes" in the patients' conditions,
especially when some kinds of traditional medicine and alternative treatments (i.e., pot
medicine, traditional massage, witchcraft or black magic) were used. For the modern
medicine, although some participants admitted that the health care providers could save
the patients' lives during an emergency period, some participants also stated that modern
medicine could not cure or heal paralysis and symptoms related to stroke during the
convalescent time. If any treatment showed neutral outcomes, caregivers or their
relatives either stopped the treatment or let the patients continue treatment for a short
period of time.

A 61-year-old husband stated that he used modern medicine provided by the hospital
for his wife. However, her condition remained the same, so he stopped giving it to her
and used the pot medicine instead. "She was the same, so I decided to let her try the pot
medicine."

A 34-year-old participant said that her husband bought pot medicine from the local
doctor for her mother-in-law. However nothing changed. So she stopped giving it to her.
"It was a Chinese medicine which was made from mixing leaves and boiling them
together. . . . Very good smell! . . . Now, she stopped taking it. . . . She had taken three
pots of it for 3 months. It didn't work, so we stopped trying it."

Negative outcome. Treatments which caused negative outcomes or worsened the
patients' conditions were reported by 2 participants. These treatments included treatment
provided by the local doctor and using opium to reduce pain. Both caregivers decided to stop treatments. For example, a 48-year-old daughter stated that her father grew worse after receiving treatment from the local doctor, so she took him home. “Someone recommended us to go there for treatment. They said that the local doctor was great. So I took him and let him stay there. When I went to visit him, I hurriedly told my younger brother to drive him back home right away... Oh! He was very thin. His tongue was full up his mouth.”

Managing Problems and Difficulties

Problems and difficulties refer to the negative effects resulting from caregiving experiences. Data indicated that the participants reported both positive and negative effects related to caring for their dependent relatives. The positive effects included such factors as a sense of fulfillment for the caregivers, returning gratitude and virtue to the patients, doing other activities, saving the patients’ lives, gaining merit, feeling close to the patients, and being comfortable.

All participants experienced various kinds of difficulties such as physical, mental, economic, and social problems. Physical symptoms commonly experienced by the caregivers included tiredness, not enough sleep, faintness and dizziness, chest pain, and wrist pain. The causes of these symptoms as perceived by the caregivers included economic problems, caregiving activities, emotional distress, patient behavior, and work overload. Emotional or mental symptoms frequently reported by the participants included stress, anger, short-temper, hurt feeling, discouragement, uncomfortableness, and boredom. Patient behaviors, lack of support, economic problems, work overload,
and insufficient sleep were perceived by the participants as the major causes of emotional and mental health problems.

Patient behaviors related to the effects of stroke, which were the major causes of health problems both physically and mentally, were constipation, trouble speaking, trouble eating or drinking, difficulty taking medicine, incontinence, being helplessness, diarrhea, pain, choking, convulsion, high sexual need, crying, depression, anger; short-temper, constant calling for help, immature behaviors, and confusion.

Regarding the economic problems, this study found that 9 out of 20 participants quit their jobs in order to become full-time caregivers at home. As a result, 7 caregivers received no income and had to accept financial support from their children or relatives. This led to health problems and family conflicts.

For social effects, although most caregivers admitted that they had less chance to meet their peers and participate in social activities, they did not have any problem. This was because they could manage their time and receive help or support from the family and community.

Other problems experienced by some participants included lack of materials and equipment, difficulty in lifting patients, and emergency situations. This study also found that problems and difficulties varied for participants depending on their gender, financial status, the patients’ behavior or condition, and assistance received from their social networks.

In order to maintain caregiving at home, participants used many strategies in managing problems and difficulties. The ones most frequently used were acceptance and patience, rest or relaxation, release of temper, self-treatment, seeking or receiving help,
learning, time management, time spending or letting go, using materials and equipment, and creativity. Participants stated that these strategies helped them reduce or solve their difficulties throughout the caregiving process.

Acceptance and Patience

Most participants managed problems and difficulties by accepting their situations and being patient. This strategy helped them alleviate physical and mental symptoms and reduced some conflicts related to caregiving as noted below.

A 50-year-old wife stated that at first, her husband always was angry with her. However, she did not respond to him because she could accept his behavior. "I could accept his behavior [she laughed]. . . . I don’t know why. . . . I just thought that he behaves like this because of his illness."

A 34-year-old caregiver of her mother-in-law stated that sometimes she felt hurt because the other daughter-in-law had not helped her take care of the patient. Consequently, she learned to be patient and accept her situation. "Because I had no job, I needed to take care of her and my kid. This is the reason. . . . I have to be patient. . . . I can accept that. . . ."

A 48-year-old daughter stated that she had to negate the disgusting feeling toward her father’s stool by accepting it. "It smelled all over, . . . very bad smell. I felt like vomiting. Then, I tried to accept it. I thought that when I was young, he did everything for me. Also, I was a woman so I couldn’t enter a monk hood to return gratitude for him. Thus, I had to take care of him. I accepted it."
A 35-year-old son stated that he had stress because his mother did not open her mouth to eat. "I had to be patient. We also took turns among my sister, my wife, and myself. We all had to be patient."

A 63-year-old husband stated that he had financial problem because he quit his job to care for his wife. However, he tried to accept his situation. "I need to accept my situation. My income is reduced. I cannot go out because I have to take care of her."

A 20-year-old son who took care of his mother stated that he could not go out with his friends as much as before. However, he accepted his situation, so he had no problem. "No problem about going out. I could accept my situation. So there is no problem."

A 61-year-old wife stated that she had to be patient because after looking after her husband, she never joined any merit-making ceremony. "I can neither go out to the merit-making ceremony nor go out to other places. So I have to be patient. If I want to earn a merit, I will practice meditation at home instead."

Rest or Relaxation

Rest or relaxation was a strategy used by the caregivers in order to reduce physical and psychological symptoms related to the effects of caregiving. The methods of rest and relaxation frequently reported by the participants are as follows: sleeping; taking a break; and pursuing other activities such as reading, listening to music, watching television, sports, going out, and doing housework.

A 58-year-old wife who cared for her husband said, "When getting tired, I rest, then continue my work [caregiving]. When tired again, I usually lie down while looking after him, then continue my work again."
A 48-year-old daughter stated that sometimes she felt hurt because no one helped her look after her father. So she had to relax by taking a break and sitting for a while. “I just sat, sat for a while until I felt more relaxed. I have no one to talk to.”

A 31-year-old caregiver of her father-in-law stated that when she was bothered by the patient’s behavior, she would stay away and rest or relaxation by sitting, reading, and listening to music. “If I don’t like his behavior, I will keep my feelings. I will stay away, . . . not respond to him, . . . just stay away, . . . listen to music, reading, and then take a nap. I usually buy books every week for reading.”

A 28-year-old son who took care of his mother stated, “Sometimes, when I have stress, I will go out in the evening and play soccer with my friends.”

Release of Temper

When experiencing emotional stress resulting from caregiving, some participants released their tempers by talking to others or crying. Few caregivers aggressively responded to the patients.

A 48-year-old daughter who cared for her father stated that she sometimes had stress because of the financial problems and the caregiving role. Consequently, she released tension by talking to her neighbor. “Sometimes, I talk to my neighbor to release tension.”

A 34-year-old female caregiver of her mother-in-law talked to her husband and cried when she had stress. “I talked to him. I also cried. It helped. . . . I felt better, . . . at least just for a while.”

A 41-year-old daughter said that sometimes she scolded her mother because she kept calling her all the time. “Sometimes, I scold her. However, I have a reason to do that.”
Sort of, . . . I sometimes told her not to bother me at night because I was so tired.”

A 31-year-old daughter who cared for her mother was the only participant who released tension by throwing things because at first she could not accept both the patient’s behavior and her caregiving situation. “Sometimes, when I was angry with her, I threw away things around me. At first, I could not accept her behavior and my situation.” However, this participant did not have any aggressive response when her mother improved and she could accept the caregiver role.

Self-Treatment

Some participants treated themselves when they had physical and psychological problems by taking various types of medicines such as pain relieving drugs, sleeping pills, tranquilizers, and herbal medicines. The major sources of these medicines were drug stores and hospitals. In addition, a few participants used the patients’ medicines to treat themselves.

A 73-year-old husband taking care of his wife stated, “Well, I had many kinds of medicine. If I can’t sleep, I sometimes take sleeping pills. If I can’t sleep until midnight, I will get out of bed to take the sleeping pills. This is because I have to get up at 5 a.m. So if I can’t sleep, I have to take medicine.”

A 44-year-old caregiver to her father-in-law stated that she took her medicines and the patient’s medicines when she had a headache and stress. She said,

I took the pain relieving drugs from the hospital. The dosage was two tablets per time but I took only one tablet. I felt better. Any way, I hardly take it now. I also got the tranquilizer when I had stress. It was my father’s medicine, but I myself took it [she laughed]. It helped me feel better and sleep.
Seeking or Receiving Help

All participants stated that they received help and support both by request and without request from their social networks which included family members, close relatives, neighbors, friends, and health care providers. The types of help and support were assistance in caregiving tasks, occasionally taking care of the patient, assistance in housework, providing food, providing materials or equipment, providing living space, financial support, and giving treatment (as already described in the past two categories: [a] family and kinship support and [b] community support). The help and support received from the family and the community helped caregivers reduce their workload, solve problems and alleviate physical and mental symptoms which resulted from caregiving effects. Therefore, they were able to handle problems and difficulties and to continue caregiving at home.

Learning

Learning was a method which the participants used to gain information and knowledge about illness, treatment, and caring. Sources of this knowledge consisted of health care providers, traditional doctors, relatives, friends, older persons, caregivers’ previous experiences, and mass media.

A 28-year-old son who took care of his mother stated that the doctor at the hospital told his father about the diagnosis. “The doctor said that her smallest brain vessel was broken [cerebral hemorrhage]. If it [the brain vessel] was the big one, the patient might have passed away.”
A 44-year-old caregiver learned about his mother-in-law's illness from a traditional doctor. "The traditional doctor said that she got paralysis. She also warned me to prevent the patient from falling down; otherwise it would be hard to help her recover."

A 31-year-old daughter said that she learned how to take care of her mother from the nurses at the hospital. She stated,

I asked the nurses to teach me. At first, I could not do anything, but after they taught me, I could. I early asked them to train me. Since I had some basic knowledge, it was quite easy to understand when I just observed what they did. They taught me how to turn my mother over, how to practice physiotherapy, and how to manage when she urinated.

A 35-year-old son stated that he learned how to take care of his mother by observing the nurses and attendants both at the hospital and at home. He said,

I had learned about caregiving from the nurses and attendants because at first I could not take care of the patient with this illness. When I stayed with her in the hospital, I observed how the nurses and the attendants did. Also, when we came back home, I kept observing them. So I am able to take care of her by myself and I don't hire them anymore.

This participant also admitted that his own knowledge and experience could be applied to the caregiving. He said,

Usually, I have some basic knowledge because I learned about health and hygiene at school. Also, I have worked as a village health volunteer for many years. This could help. Sort of, I have some basic knowledge, so when I have to be her caregiver, I can recall it, or maybe I just want to learn a little bit more.

A 73-year-old husband stated that he learned how to take care of his wife from his friends and the elderly. "My friends and the older persons told me that if the patients with paralysis lay down for a long time, their backs would get an infection. The important point is that if we don't keep on turning her over, her back will get worse. Then, it will be hard to treat her."
Time Management

Most participants stated that caregiving had no negative effect on their social activities or other aspects of their lives because they managed their time in order to help them have time to rest, meet other people, join social activities, go out for business, and do other work.

A 59-year-old daughter who took care of her father stated that she had to adjust the feeding time to help her have more time to rest. She said,

I don't feed him at midnight. It doesn't mean that I don't want him to have food but because I need enough time to sleep. If I get some health problems, my father will be in trouble. I feed him at 8 p.m. Then I watch the television waiting for feeding him again at 10 p.m. I don't need to feed him at midnight, so I have enough time to sleep.

A 58-year-old wife who took care of her husband stated that she had no problem about participating in social activities because she could manage her time. “No problem. I can manage my time because right now I join social activities alone. In the past, my husband helped me participate in some community activities or ceremony. Anyway, now I still am able to attend those activities.”

A 34-year-old daughter-in-law stated that she managed her time to take care of her mother-in-law and to do housework. “Before doing the housework, I have to complete taking care of her, such as taking a bath, because no one can help me. I have to finish taking care of her before 3:00 a.m. During 4:00 to 5:00 p.m., I can do other housework.”

A 33-year-old son who took care of his mother stated that caregiving had no effect on his job because he could manage his time. “No problem. Sort of, I have to manage my time. If I have to go out for work, I go after 4:00 p.m. because my younger brother can take care of her in the late afternoon. If it's necessary to go out all day, I will ask
my younger brother to take care of her. Sometimes we have to take turns.”

**Time Spending or Letting Go**

Some participants stated that they were able to do some caregiving activities and to accept the patients' behaviors because over time they had gained a sense of familiarity as well as skill and experience in caregiving. These participants found that as time passed, conditions improved.

A 59-year-old daughter stated that she gained more skill over time by using the nasogastric tube to feed her father. “At first, it was so hard for me to feed him. Now, I have more skill to do that.”

A 48-year-old daughter stated that at first her father did not allow her to clean his body because he was shy. However, later on, he became more comfortable, so he let her do that. “At first, he was so shy. He always pulled his clothes up. Even when I asked him to let me clean him, he still resisted. Later on, he started getting used to it, so he allowed me to clean him up.” The sense of familiarity helped this participant manage the stool and urine of the patient. “At first, I threw up. When time passed, I got used to it.” This participant also admitted that over time she gained more skill in communicating with the patient who had difficulty speaking. “I tried to interpret his body language. At first, it was very difficult to understand his language.”

A 44-year-old caregiver to her father-in-law stated that she had no lifting problem because she knew how to do it. “No pain at all. Some people wondered why I could lift such a big guy like him. For me, it’s no problem because I get used to it.” The sense of familiarity also helped her reduce the stress related to the caregiving. “Oh! At first,
I had very high stress. I couldn't handle anything. Now, I get used to it. I have taken care of him for a long time, so I can adjust myself to deal with the caregiving.” This participant always let time pass in order to make things better when she had conflicts with the neighbors in relation to the caregiving. “I didn’t respond to them. Just let them blame me. This made me feel better and all things were going well.”

Using Materials and Equipment

Some caregivers used various types of materials and equipment to provide care for the patients. Equipment and materials commonly used included bed pans, walker aids, wheelchairs, special beds and mattresses, exercise and physiotherapy equipment, wound dressing equipment, personal care equipment. Most participants who used this equipment admitted that they were a convenient help. However, the decision to use any equipment and materials was dependent on one or more of the following factors: affordability, perceived benefit, information, convenience of use, and patient needs.

A 73-year-old husband stated that he had no financial problem, so he could buy useful medical equipment for his wife. “It helped her a lot. This walker aid is used for helping her to walk around here. If she wants to go farther, I will take her in the wheelchair. I bought a special bed for her too.”

A 48-year-old daughter stated that she wanted to buy the wheelchair for her father, but she had a financial problem. “I have not enough money to buy it. My neighbor had lent us one but it was broken. It didn’t work.”

A 63-year-old husband stated that he did not buy the wheelchair for his wife because he was afraid that she would have no physical activity if she used it. “If I took her in the
wheelchair, she would not have a chance to exercise. But if I helped her to walk, she will have some physical activity. Walking is better than sitting in the wheelchair, so I didn’t buy it for her.”

A 31-year-old daughter who took care of her mother stated that she did not use the wheelchair because it was not convenient. “When I took her in the wheelchair, she complained that she got pain. Also, the road in front of my home is so terrible.”

A 44-year-old caregiver said that his mother-in-law did not want to use pampers, so he did not provide them for her. “I let her urinate through her clothes. She doesn’t like to use pampers, so I didn’t buy them for her even though I can afford it.”

Creativity

Some participants created or developed materials, equipment, healing methods, and caring methods for the patients. Various types of equipment included wooden rails, rope rings, chairs for inserting bed pans, plastic bed pans, wooden wheelchairs, and wooden posts for restraining the patient’s wrist. Participants who developed the equipment stated that it helped them provided effective care in a convenient and economical manner.

A 58-year-old wife stated that she manage the lifting problem by developing the method to lift her husband. “Well, I can manage it. I have him wear a wrap, then slowly hold him up and pull him over. Holding and pulling, I put the wrap around and under both sides of the armpits. Then I hold it high and pull it over to avoid backside bumping.”

A 63-year-old husband said that he made the herbal compress to massage and compress his wife. “I massage and compress her by myself. I made the compress from various kinds of herb. I made it by myself.”
A 61-year-old husband said that he made the wooden side rail and the rope ring for his wife to hold. "I made it by myself. She cannot get up by herself, so I had to make it for her to hold." This participant also made the bed pan from a plastic bucket. He said, "Sometimes, when my wife passed the urine, it spilled because the bucket was too light. Anyway, it helps a lot."

In summary, this chapter presented the demographic characteristics of participants and their stroke patients. The central theme called "maintaining caregiving at home" and the related seven categories were also identified and described. Next chapter presents summary and discussion of the research results including recommendations for nursing practice, national policies, and further research.
CHAPTER 5

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

This chapter presents the summary and discussion of the study results. Recommendations for nursing practice, national health policies, and research are also presented.

Summary

The grounded theory methodology was used in this study to explore the process of caregiving based on the perspective of Thai caregivers of elderly stroke relatives. The study sample consisted of 20 primary caregivers living in five districts of Chachoengsao Province, Thailand.

The majority of participants were women (n = 13). Five participants were wives of the stroke patients, 3 were husbands, 4 were daughters, 4 were sons, 3 were daughters-in-law, and 1 was a son-in-law. Their ages ranged from 28 to 73 years, with most of them being middle aged (30-59 years). Fifteen participants were married, 3 were single, 1 was widowed, and 1 was divorced. The educational level of most participants was Prathomsuksa 4 (Grade 4). Fourteen participants were Buddhists, 5 were Muslim, and 1 was Christian. Most of the participants were not employed.
Eight participants considered their financial status comfortable. Seven were able to barely make ends meet, and 5 were financially overextended. Caregiving hours ranged from 3 per day to a full 24 hr a day. Most participants lived in their own homes with three to nine additional family members. Three participants lived alone with their ill spouses.

The majority of stroke patients were men (n = 11), who ranged in age from 60 to 87 years. Fifteen patients were married, 5 were widowed, and 1 was divorced. Most of them completed Prathomsuksa 4 (Grade 4). Fifteen patients were Buddhists and 5 were Muslim. The length of time since they were diagnosed with stroke ranged from less than 1 year to 17 years. Eight patients were dependent in all ADL areas, and the remaining 12 required assistance with two to five ADLs.

The participants were interviewed in their homes. Observations were made during the interview and my memos were maintained. All interviews were tape-recorded and transcribed verbatim. All data accumulated from the interviews, observations, and notes were analyzed, using the five steps of Maxwell and Maxwell (1980) as follows: (a) collection of empirical data, (b) concept formation, (c) concept development, (d) concept modification and integration, and (e) writing the theory.

The substantive theory emerged from the data was “maintaining caregiving at home.” This theory described how and why Thai caregivers cared for their elderly stroke relatives at home. The process of maintaining caregiving encompassed the following seven aspects which helped caregivers provide care for their elderly relatives: (a) caregiving as an integral part of life; (b) caregiving: an unavoidable task; (c) caregiving with love, sympathy, and attachment; (d) family and kinship support; (e) community
support; (f) managing treatment; and (g) managing problems and difficulties.

Caregiving as an integral part of life explained the nature of caregiving as perceived by the caregivers. Caregiving was considered daily routine work, as well as a burden and duty, which became part of caregivers' lives. In this manner, the caregivers accepted and sustained the responsibility of providing care to their elderly relatives.

Caregiving as an unavoidable task described the factors which motivated them to become caregivers and continue the care at home. These factors included beliefs due to their religious instruction, social expectation, their relationships with their patients, personal needs, and personal readiness.

Caregiving with love, sympathy, and attachment indicated the connection between love, sympathy, and attachment to involvement in the tasks at hand. These feelings developed throughout the caregiving process because they were based on relationship, closeness, and the reciprocity between the caregivers and the patients. Feelings of love, sympathy, and attachment played major roles in their caring for elderly relatives.

Family and kinship support explained the multiple types of support providing by the family and close relatives of the caregivers and the patients. Assistance among family members and relatives was based on strong family tie and responsibility of Thai families. Family and kinship reduced physical and psychological causes and effects of the caregiving, thereby enabling caregivers to aid their patients at home.

Community support identified the help and support including praise and compliments from neighbors, friends, and health care providers. Community support helped the caregivers eliminate and reduce problems and difficulties related to caregiving. In this manner, they continued providing care for their elderly relatives.
Managing treatment described the process of maintaining treatment including the major factors of the process. In order to maintain treatment, caregivers allowed patients to try various types of treatments such as modern medicine, traditional medicine, and alternative therapy. The important factors which influenced their decision included hope for recovery, information regarding treatment, experience in using the treatment, belief in the treatment, and the treatment outcome. The following variables such as treatment cost, affordability, distance between home and the treatment place, and patient need also were a part of the decision process.

Managing problems and difficulties identified strategies used by caregivers to reduce or eliminate the causes and consequences of the problems in order to maintain caregiving at home. These strategies included acceptance and patience, rest or relaxation, release of temper, self-treatment, seeking or receiving help, learning, time management, spending time or letting go, using materials and equipment, and creativity. However, the caregivers experienced different problems depending on gender and financial status of the caregivers, patient behavior or condition, and support received from the social network.

Discussion

Maintaining caregiving at home, the substantive theory derived from this study, expands knowledge and helps health care providers gain a better understanding of the caregiving process of Thai caregivers. The major factors identified in this theory can be related to concepts or variables indicated in previous studies and existing models. Each category of this theory is discussed below.
Caregiving as an Integral Part of Life

Participants viewed caregiving as daily routine work which was part of their daily life. This finding was consistent with Holroyd and Mackenzie (1997) who determined that primary caregivers in 10 Beijing families described caregiving as laborious and routine work, yet the descriptions were offered without resentment. They were described as a part of life.

Some participants perceived caregiving as a burden and a duty. This perception, together with the feeling of attachment and a personal moral beliefs resulted in their immediate involvement in assuming caregiving tasks. This finding was consistent with previous studies (Lewis & Meredith, 1988; Ungerson, 1987) which indicated that the reason for taking care of the elderly at home was a combination of (a) love and duty and (b) affection and obligation. The results of this research also were congruent with prior qualitative research (Boland & Sims, 1996) which found that responsibility was one of the core concepts that emerged from the data. The core category of responsibility was linked somewhat with burden related to caring. The commitment to care, expressed as personal responsibility, appeared to moderate burden.

Caregiving: An Unavoidable Task

Participants described that they cared for their elderly relatives because of personal beliefs due to their religious instruction, social expectation, the relationship between the patients and themselves, personal readiness, and personal need. A particularly striking result was that their religious teaching played a major role in their commitment to providing care to their elderly patients. Buddhist participants followed the law of karma,
the bunkhun system, merit, and sin, whereas the Muslims focused on heaven.

Because the principle of karma and its result states, “Good actions bring good results, bad actions bring bad results” (Payutto, 1993, p. 2), some participants believed that the sickness of their elderly relatives and their becoming a caregiver was the result of previous bad deeds in the past. Therefore, it was necessary for them to repay their past deeds by caring for the patients as long as possible (until the patients or themselves passed away).

In Thai society, the bunkhun obligation relationship not only is strong within the family and kin but it also is strong outside the kinship circle (Podhisita, 1998). Those who show gratitude and repay favors done for them always are praised, whereas those who neglect these obligations are disliked. This study found that all the participants, whether or not they enjoyed a blood relationship with the patients, firmly believed that bunkhun must be repayed through good care.

The concept of bunkhun found in this study was related to other concepts which explained why people helped or provided care for others such as reciprocity, indebtedness, and obligation. According to sociological studies, reciprocity is the social norm which enjoins people to pay back what others give to them (Biegel et al., 1991). A theoretical basis for indebtedness as a motive for helping was developed by Greenberg (1980) who noted that feeling indebtedness created motivational properties, such that the greater its magnitude, the greater the resultant arousal and discomfort, and hence, the stronger the ensuring attempts to deal with or reduce it. Regarding the obligation, Finch (1989) stated that help between parents and children was a duty and obligation. Parents, especially mothers, always retained a special bond with the children they have borne; therefore children owe a permanent debt of gratitude to the parents who reared them.
Bunkhun, however, is based on social norms and Buddhist teachings. This terminology possesses more meanings than duty or obligation because it is described as any good thing, help or favor provided by individuals, thereby entailing gratitude and obligation on the part of the beneficiary. The obligated individuals have meritorious debts that must be repayed. The debt of bunkhun, unlike other debts never is completely repaid (Podhisita, 1998). The favors may be returned after a short period or after many years, depending on individuals' abilities to return the favors in kind. Their favors may be returned on a continuing basis over an indefinite period where no one act would be commensurate with the original benefit bestowed. Being constantly aware of the favors others have bestowed is a highly valued character trait in Thai society (Klausner, 1993).

Besides the Buddhist teaching about the law of karma and the bunkhun system, concepts regarding merit and sin also were important in caring for elder relatives. Some participants believed that helping the patients was merit-making, whereas leaving them was a sin. Therefore, it was imperative that they cared for their relatives in order to earn merits that would be consequential in their future or next life. This belief about merit (doing good of any kind) and sin or demerit (doing bad of any kind) based on the Buddhist law of karma according to which every volitional action (good or bad) has a result which follows the actors as the shadow that follows the object, awaiting the appropriate time to manifest itself (Podhisita, 1998).

In terms of Islamic instruction, the concept of heaven becomes a motive for providing care to elderly relatives. Most Muslim participants believed that caring for their parents or spouses would help them in their entrance to heaven because Islamic teachings imply that persons who do good things to their parents will live in the heaven (Arab Universities
This study also determined that social expectation partially influenced decision making in becoming the primary caregiver. Thai culture expects elderly patients to receive quality care from their family members, with women more often than men being the caregivers. This finding was supported by prior research (Pramualratana, 1992) which found that most Thai elderly believed their daughters were best suited in providing care to the old. Some mentioned that spouses were second best, followed by daughters-in-law, then sons. Pramualratana (1992) suggested that such differences between daughters and sons in this role probably were the result of early socialization. Daughters were taught to take care of a household, whereas sons were encouraged to socialize and expand their circle of obligatory friends. This research finding also was consistent with additional literature conducted in western countries (Brody, 1981; Brody, 1985; Cantor, 1983; Finch, 1989; Finch & Groves, 1983; Horowitz, 1985; Johnson & Catalano, 1983; Shanas, 1979; Stephen & Christianson, 1986; Stone, Cafferata, & Sangl, 1987; Troll, 1971). Finch and Groves (1983) stated that men and women responded differently to demands of the caregiving role due to different life experiences and socialization patterns experienced by men and women. Women in western country, especially the current generation of caregivers, grew up during a time when females were trained to be family-oriented and nurturers, whereas men were socialized into the external world outside the home. As a result, these women viewed caregiving as a continuation of earlier responsibilities, though men viewed the same caregiving demands as a foreign experience.
The relationship between caregivers and patients in different roles such as wife, husband, son, and daughter was one reason for providing care. This result was consistent with the study of Holroyd and Mackenzie (1997) which reported that claims to kinship or marriage were cited as a reason for caregiving by Beijing caregivers. This finding also supported the four principles which determine who were considered the most able caregivers in British populations (Finch, 1989). These principles stated that (a) the marriage relationship is primary, so that spouses become the first source of support for married people; (b) the parent-child relationship indicated that children were major sources of support for their elderly parents and that parents were the principal supporters of adult handicapped children; (c) individuals who are members of the same household also are major providers of support; and (d) women rather than men are more likely to be caregivers of elderly relatives.

Personal readiness was a reason for being a primary caregiver. Some participants stated that they engaged in this role because they had more time, ability, and patience to care for their elderly relatives than other family members. This observation was consistent with Holroyd and Mackenzie (1997) who reported that Beijing caregivers became involved in the care of elderly family members directly as a result of their age as well as their stage of family life (i.e., retirement, children leaving home). This finding also supported previous study in the United States which reported that being a caregiver required diverse skills, patience, dedication, sacrifice, perseverance, good physical and mental health to cope with the many challenges (Lund, 1993).
Caregiving With Love, Sympathy, and Attachment

Most participants stated that love, sympathy, and attachment formed the basis for them to become the caregivers for their elderly relatives. These findings were consistent with other studies indicating that affection, mutuality, or attachment were important factors in becoming caregivers (Adams, 1968; Callahan, 1985; Cicirelli, 1983, 1993; Finley, Roberts, & Banahan, 1988; Hirschfeld, 1983; Holroyd & Mackenzie, 1997; Leigh, 1982; Levin, Sinclair, & Gorbach, 1983; Marshall, Rosenthal, & Synge, 1983; Robinson & Thurner, 1979; Tompson & Walker, 1984; Walker, Pratt, Shin, & Jones, 1990).

This study indicated that being a caregiver helped them develop more love and attachment toward the patients. This factor was consistent with previous findings (Cantor, 1983; Horowitz & Shindelman, 1983; Silliman, 1984). In addition, most participants who were daughters and sons of the patients stated that love and attachment between them and their parents developed during their life because their parents gave birth to them and raised them. This finding supported prior research (Ainsworth, 1989; Frank, Avery, & Laman, 1988; Hartup & Lempers, 1973; Rossi, 1989; Troll & Smith, 1976; Whitbeck, Simons, & Conger, 1991) and Cicirelli's (1981, 1983, 1991) adult attachment model of helping based on Bowlby's (1969, 1973, 1979, 1980) life span attachment theory indicating that the children's primary attachment to their mothers or initial caregivers continued throughout adulthood.

This study also found that among the participants who were not blood related to the elderly patients, love and attachment between the two groups were based on the closeness and the reciprocity resulting from living together for a long time. This result was consistent with literature that noted the major connecting tie between generations is that
of loyalty based on the integrity of reciprocal indebtedness (Boszomenyi-Nagy & Spak, 1973).

Family and Kinship Support

This study indicated that the primary and major sources of support for the participants were their family members and close relatives. This finding was consistent with prior research (Khenchaiwong, 1996) which found that sources of social support for Thai caregivers of stroke patients were children, spouses, significant others, parents, neighbors, and coworkers, respectively. However, this finding differed from previous studies in the United States which indicated that caregivers rarely received assistance from their family members or children (Barusch & Spaid, 1989; Beach, 1993).

This study also determined that a strong sense of family responsibility and thoughtful consideration were the significant factors which led to the participants’ reticence in seeking help from those outside their families or kin circles. Most participants believed that caring for their aging relatives was the responsibility of family members and close relatives. In addition, these participants did not ask for help from others because they were being considerate of them. This factor reflected the Thai traditional behavior and the strong kinship tie in Thai society. Of the various relationships, kinship is the most emphasized by Thai people. Relatives are expected to help each other in times of need. Indeed, it is believed that kinship could not be destroyed (Bandhumedha, 1998).

Thoughtful consideration is a traditional Thai behavior. Thai people use the word “Krengjai” which means being reluctant to impose upon or to have consideration for. Krengjai is observed in individuals’ reticence in seeking help or asking for something from
a superior or those of equal status unless it is absolutely necessary (Klausner, 1993).

Therefore, some participants did not request assistance from others, including their
children or relatives, even though they really needed their help. However, they expected
their family members and close relatives to support them more than others.

Community Support

Community members also played important roles in providing various forms of help
and support to the caregivers, especially those who were childless, lived alone with their
elderly patients, or had a substandard income. This finding supported previous studies in
Thailand which indicated that family members, especially children, were the primary and
major sources of help and support for their elderly relatives. However, in instances in
which the elderly were childless or lived in poverty, they sometimes depended upon help
from their community members (Siriboon, 1996; Wongsith, 1996).

Mutual help and support among people living in the same community possibly were
due to the traditional way of life and belief of community members which resulted from
the Buddhist religion. Thai elderly were treated with respect and considered valuable
assets to society. Moreover, it is a traditional belief that helping the elderly is a part of
earning merit, thereby resulting in a better lifestyle for the elderly and for those who
organized the activities (Siriboon, 1996). Receiving help as well as providing help is
common in Thai society. Interdependency among kin, friends, and neighbors, and even
among coworkers in modern organization is a major cultural pattern of Thai society.
To be popular and respected by others, individuals must give their own property to poor
relatives, friends, and others less fortunate occasionally (Smuckarn, 1998). In addition,
Thai people regard those who provide care to their aging parents or relatives to be good people and exemplary individuals. Not surprisingly, most participants in this study reported that not only did they receive assistance, but also they received praise and compliments from their community members.

**Managing Treatment**

Data indicated that all participants managed treatment for their elder patients through various types of treatments such as modern medicine, traditional medicine, and alternative therapy. This finding was consistent with previous qualitative research regarding self-care process among Thai adults with diabetes which found that during the trial and error period, participants sought cures from modern, traditional, and alternative therapies that were available in their own cultural health care system (Sritanyarat, 1996). This possibly was because traditional medicine was integrated in Thai daily life for a long time.

Traditional medicine has been used to treat patients since the 12th century or before and was developed to combine with modern medicine over a long period of time (Subcharoen, 1995). For the past decade, a number of research and programs regarding Thai traditional medicine were developed. A new division was established under the jurisdiction of the Ministry of Public Health. This division was known as the “Medicinal Plants and Traditional Medicine Section” and was directly responsible for the promotional and supporting activities relating to the use of medicinal plants and traditional Thai medicine (Saralamp, Chuakul, Temsiririrkkul, & Clayton, 1996). According to the Seven National Development Plan (1992 to 1996), traditional Thai medicine, herbal drugs as well as other forms of indigenous health related technologies, such as traditional massage,
were to be revived, promoted, and integrated into the existing health care system. Not surprisingly, this study found that traditional doctors and modern medical doctors combined traditional and modern medicine to treat their patients.

Buddhist monks also played a major role in providing treatment to the patients by using various types of healing methods, especially traditional medicine and witchcraft or black magic treatment. According to Subcharoen (1995), this may be the result of a relationship between Thai traditional medicine and Buddhist philosophy.

Historical evidence pointed towards an integrated system of medicine incorporating the Buddhist Philosophy, the four of Mahaputa (four elements) and other folk medicine of India and the Chinese systems amalgamated with a deep rooted belief in the supernatural, mystique and astrology. The principle philosophy of Thai medicine leans toward the Buddha teaching which is the attainment of an equilibrium among the four basic elements, namely earth, water, wind and fire, the very essence of life. To command respect from their patients, traditional doctors or healers must possess honesty and goodness in all their deeds. (p.15)

In the case of witchcraft or black magic treatment, it was of interest that participants with different backgrounds allowed their elderly relatives to try many types of witchcraft or black magic treatments. This finding supported prior research (Komin, 1998; Komin & Smuckam, 1979; Smuckam, 1998) which indicated that magical acts and beliefs in various forms of traditional medicines were still prevalent both in rural and urban areas of Thailand. In addition, education and occupation were not associated with supernatural-related behavior. Smuckam (1998) suggested that sources of knowledge about nature and supernature were Buddhism, Hinduism, and Animism or the belief in spirits in general which was widespread in Thailand. Although Thailand is a Buddhist country, the influence of Hinduism is noticeable and surprisingly strong. Hindu Gods are well-known divinities in Thailand. The supernatural aspects of Hinduism provide
a colorful interpretation of life after death and serve as a counter point to the dryness of Buddhism which emphasizes philosophical tenets. In addition, Hinduism parallels animism in a harmonious fashion. Thai people, therefore, believe in spirits, Gods, and good and bad acts (karma).

This study noted that public health services facilities provided the sources of help and support other than relatives for most participants and their elderly patients. Some participants and their patients received treatment and support from health care providers at home and at the hospitals. This possibly is because health care services in Thailand are mostly provided by the government. The Ministry of Public Health (MOPH) using the health services facilities, distributed health care services throughout the country. These facilities include regional or provincial hospitals, district hospitals, health centers, and midwifery centers, which were located in the provinces, districts, subdistricts, and villages (Tantinimitkul & Tips, 1986).

Besides using public hospitals, some patients received modern medicine from private hospitals, private medical clinics, local doctors, and drug stores. This may be because Thailand's health care delivery system included the MOPH network, as well as a number of other public and private networks which served both general and specialized needs. In addition, many unlicensed physicians practiced extensively in the rural areas and numerous commercial pharmacies provided information and prescriptions to patients in their areas (Tantinimitkul & Tips, 1986).

Regarding decision-making processes, this research found that important factors which influenced the decisions for trying a treatment included treatment information, hope for recovery, experience with the treatment, and belief in the treatment. Barriers
also involved in the decision-making process included high cost of treatment, lack of affordability, difficulty in traveling, and lack of patient need. These findings partially supported the Health Belief Model (HBM) (Rosenstock, Strecher, & Becker, 1988) and the theory of reasoned action (TRA) (Fishein & Azjen, 1975). Perceived benefits, information, and barriers were suggested as influential factors in the HBM. These factors also played a major role in the determining whether or not to use any treatment by the participants in this study. According to the TRA, behavioral change ultimately was the result of changes in beliefs, noting that people perform certain behavior patterns if they believe it is expected of them. This study found that beliefs in treatment and outcomes of treatments partially influenced decisions as to trying any treatment.

Hope for recovery was found as a major factor in influencing the decisions to try different types of treatments for patients. Data indicated that most participants hoped their stroke relatives would recover; therefore they provided various types of treatment for them. This factor was supported by literature indicating that hope was a motivating force and was action oriented (McGee, 1984). In addition, hope generated energy that enabled individuals to cope with numerous problems, overcome obstacles in life, and continue functioning during chronic illness (Travelbee, 1971).

Managing Problems and Difficulties

Participants in this study reported positive and negative effects as a result of caring for their elderly relatives. Positive effects found in this study also were noted in other studies (Harper & Lund, 1990; Kinney & Stephens, 1989; Kinney et al., 1995; Lawton et al., 1991; Miller, 1988; Moss et al., 1987; Stephens, Franks, & Towsend, 1994; Silliman, 1984).
These positive outcomes included a sense of fulfillment for the caregivers, feeling of closeness with the patient, feeling comfortable, having opportunities to do other activities, and saving the patients’ lives. In addition, because of their Buddhist beliefs, some participants stated that engaging in caregiving tasks helped them return gratitude and virtue to the patients, thereby having the opportunity to earn a merit.

Negative effects reported by the caregivers included physical problems (i.e., being tired, lack of not sleep, faintness, dizziness); emotional problems (i.e., stress, anger, short-temper); financial problems; and family conflict. These findings were consistent with numerous previous studies (Boland & Sims, 1996; Brocklehurst et al., 1981; Carnwath & Johnson, 1987; Cohen, 1988; Evans, Noonan, Bishop, & Hendericks, 1989; George & Gwyther, 1986; Harper & Lund, 1990; Holbrook, 1982; Holroyd & Mackenzie, 1997; Johnson, 1983; Kinney et al., 1995; Pearlin et al., 1990; Shulz et al., 1988; Siliman et al., 1986; Stein et al., 1992; Williams, 1994).

Social restriction resulting from caregiving were indicated in prior research (Boland & Sims, 1996; Kessler & Mcleod, 1984; Miller, 1990; Periard & Ames, 1993; Robinson-Smith & Mahoney, 1995; Siliman, 1984). These results differ from the finding of this current study. Although some Thai participants stated that they had less time for social activities, they did not consider time limitation a problem because they accepted their caregiving situations and managed their time. These participants also received help and support from other family and community members.

Contextual or situational variables which contributed to negative outcomes as perceived by the caregivers in this study included economic problems, lack of social support, patients’ behavior, work overload, and caregiving activities. This finding was
consistent with the results of many previous studies (Brocklehurst et al., 1981; Brooks & McKinley, 1983; Cripp & George, 1990; Draper et al., 1995; Goldstein, Regnery, & Wellin, 1981; Holroyd & Mackenzie, 1997; O’ Conner, Pollitt, Roth, & Brook, 1990; Poulshock & Deimling, 1984; Sanford, 1975; Williams, 1993; Williams, 1994; Zarit et al., 1980). In addition, this finding supports existing models of caregiving which considered these variables to be the stressors. These models included a conceptual model of Alzheimer’s caregivers’ stress (Pearlin et al., 1990) and the caregiving stress and coping model (Biegel, Sales, & Schulz, 1991).

Patients’ behaviors identified by the caregivers in this study as the major source of physical and psychological problems also were indicated in other studies (Brocklehurst et al., 1981; Brooks & McKinley, 1983; Draper et al., 1995; O’ Conner et al., 1990; Williams, 1993; Williams, 1994). These behaviors included trouble speaking, trouble eating and drinking, incontinence, helplessness, depression, anger, short-temper, restlessness, and annoyance, constantly calling, immature behavior, and cognitive impairment. However, this study also found symptoms and behaviors which rarely were reported in prior research such as constipation, diarrhea, pain, body fatigue, choking, convulsions, and high sexual need. Interestingly, a female spouse stated that after her husband suffered a stroke, he was demanding in his sexual needs, thereby resulting in a conflict between them. This factor was supported by a minimum amount of research which indicated that sexual issues affected couples after stroke (Holbrook, 1982; Robinson-Smith & Mahoney, 1995).

In handling problems, most participants used various strategies to minimize or eliminate causes and consequences of stress or other problems they confronted.
throughout the caregiving process. The management strategies frequently reported by the participants were as follows: acceptance or patience, rest or relaxation, release of temper, self-treatment, seeking or receiving help, learning, time spending or letting go, using materials or equipment, and creativity. These results supported coping strategies indicated by Lazarus and Folkman (1984) and Moos and Billings (1984).

Use of different management strategies varied according to the problems. Some participants employed more than one strategy to deal with specific problems. For example, a female caregiver used acceptance and seeking help to reduce her emotional stress. This finding was consistent with previous studies which indicated that caregivers who effectively coped with stress usually combined many coping strategies to lessen their stress levels (Almberg, Grafstrom, & Winblad, 1997; Siegler & George, 1983).

Prior studies pointed out that gender played a significant role in caregivers' patterns of coping (Barush & Spaid, 1989; DeVries & Hamilton, 1997; Lutzky & Knight, 1994; Park & Pilusk, 1991; Prucho & Resch, 1989; Quayhagen & Quayhagen, 1988). However, this study did not find a difference in the way men and women used management strategies. On the other hand, factors involved in decisions to use materials or equipment for providing care to their patients included financial status, perceived benefits, patient needs, and convenience.

Besides methods of strategy use, results of this research indicated that the use of management strategies exerted a positive impact. Some participants employed these strategies to reduce or eliminate stressors or sources of problems. In addition, management strategies were used to lessen the severity of problems or negative outcomes after the stress or problems were experienced. These findings supported the Caregiver
Stress and Coping Model developed by Biegel and colleagues (1991) and a conceptual model of Alzheimer's caregivers' stress developed by Pearlin and colleagues (1990). These models regarded coping and social support as the two principal mediators which could reduce stressors and buffer their outcomes.

**Recommendations**

Maintaining caregiving at home, the substantive theory emerging from data, explains the major contexts or variables which helped Thai caregivers become involved in and continue caring for their elderly stroke relatives. Therefore, these results grounded in the data suggest useful implications for practice, national health policies in Thailand, and research development.

**Recommendations for Practice**

Family was the major and primary source of help and support for caregivers who needed many types of help from their children and relatives (i.e., financial aid, assistance in caregiving tasks, assistance in house work). Most importantly, they needed love, attention, and understanding from them. Lack of these types of assistance resulted in physical and psychological symptoms such as tiredness, headaches, stress, feeling of neglect. Therefore, it is important to prepare family members and close relatives so that they assume roles of effective supporters to family caregivers and stroke patients. Nurses and other health care providers in hospitals and communities should develop programs aimed at helping caregivers' families understand the nature of caregiving, the caregiver role, effects of caregiving on caregivers' lives, and how to provide quality support for
caregivers and their care-recipients.

Besides family members and relatives, this study showed that community members were important in providing help and support to the caregivers, especially those who were childless, lived alone with their elderly patients, or lived in poverty. Although most caregivers did not want to ask for help outside their families, they were satisfied with assistance, visits, and compliments received from their neighbors and friends. Thus, interventions or services aimed at supporting family caregivers should include groups of community members in order to enhance their knowledge, abilities, and attitudes regarding help and support for caregivers of stroke patients. Community nurses and other health care providers should cooperate with community leaders, village health volunteers, peer groups, and related agencies in providing various types of assistance to caregivers and their elderly care-recipients.

Trial-and-error was found to be the main process in managing treatment for stroke patients. Data showed that patients accepted various types of treatments which included modern medicine, traditional medicine, and alternative therapy. According to caregivers’ perspectives, most traditional and alternative therapies provided neutral or negative outcomes, especially treatments offered by unlicensed local healers and vendors. Factors which influenced decisions to try new treatments included hope for recovery, information about treatment, belief in treatment, experience in treatment, and outcome. Some caregivers lacked accurate knowledge about their patients’ illness as well as the methods of treatment, rehabilitation, and care. As a result, these caregivers believed that their patients would recover from their disabilities by using other treatments because modern medicine could not cure paralysis.
In order to help caregivers effectively manage treatment for their patients, health care providers should encourage caregivers to share their personal knowledge, beliefs, experiences, and hope about illness, treatment, and care. Long-term-care plans for stroke patients need to be developed by teams of health care providers, patients, and caregivers before hospital discharge. Community nurses and other health care providers should continue to help caregivers and their families provide effective treatment and care for their elder patients at home.

In order to reduce risks of self-experiment, health care providers should enhance their own abilities by learning about traditional medicine and alternative therapies and how to combine them for improving the quality of life of stroke patients. Institutions or agencies that conduct research regarding traditional medicine and alternative therapies should provide information regarding effective medicines or treatments (i.e., scientific procedures, safety precaution, sources) for health care providers, caregivers, patients, and families. Training programs should be developed for traditional doctors, local healers, Buddhist monks, masseurs, and masseuseuses in order to increase their knowledge, attitudes, and abilities to heal stroke patients. Moreover, health care providers should cooperate with community leaders, community groups, families, and village health volunteers in order to prevent caregivers and patients from using harmful treatments.

Findings suggested that home caregiving created problems and difficulties resulting from patient behavior, work overload, financial problems, lack of support, and caregiving activities. Physical and psychological symptoms such as headaches, stress, insufficient sleep, and hurt feelings, frequently were reported. Some caregivers experienced difficulty in managing caregiving-related problems, particularly during the early stage. Thus,
hospitals should develop caregiving training programs in order to prepare caregivers for their diverse caregiving tasks at home. Nurses in hospitals should educate caregivers so they understand the illness, symptoms, treatments, and common behavior of stroke patients. Caregivers need to learn how to deal with problems related to caregiving and how to perform specific procedures (i.e., feeding, wound dressing) according to their patients’ conditions. After hospital discharge, nurses and health care providers in communities should help caregivers handle problems and difficulties by serving as consultants and supporters. In addition, caregiver support programs and self-help groups should be conducted by community health nurses and other health care providers in order to provide assistance for caregivers and encourage them to share management strategies and caregiving experiences.

This study indicated that home health care services were needed by caregivers, especially those with low incomes, those who lived far from hospitals, and those who experienced travel difficulties. Thus, home health care programs need to be expanded. Moreover, these services should include caregiver support programs aimed at helping caregivers solve their problems and reducing their physical and psychological symptoms.

Self-treatment is an important issue in this study. When experiencing physical or psychological symptoms, some caregivers treated themselves by using medicines without consulting health care providers. In order to minimize the risk of self-treatment, health education programs, caregiver support groups, and home health care services should provide accurate instruction to caregivers regarding drug use and self-care techniques.

Lack of help in emergency situations was an issue raised by some caregivers. Therefore, development of services aimed at helping caregivers and patients in case of emergency (i.e., mobile services, hot line services, 24-hr help centers) should be
considered. Community health care providers should train caregivers and families to manage emergency situations and provide information regarding sources of help.

Low-income caregivers indicated lack of materials and medical equipment as a major problem. Some caregivers creatively developed materials and equipment for their patients. Community health care providers, especially physiotherapists, should instruct caregivers about materials and equipment which are useful for patients and also direct application of them. For low-income patients who are in need, health care providers should cooperate with agencies and community members in seeking donated resources. In addition, various types of effective and economic equipment developed by some caregivers should be introduced to others.

Health care providers also can use these findings as a basis for improving or developing interventions and services for Asian caregivers living in the United States or other western countries. Beliefs and behaviors of caregivers and their families, due to culture, traditions, and religions, should be considered when developing health care services for these populations.

Recommendations for National Health Policies in Thailand

Personal beliefs due to religious teachings and social values were the important factors which motivated individuals to care for their elder relatives. Therefore, existing public policy aimed at strengthening and maintaining the traditional and cultural values of respect and care for the elderly should be expanded.

Findings suggested that family caregivers needed multiple types of assistance because home care for elderly patients resulted in physical, psychological, financial, and social
problems. Thus, caregiver support policies need to be developed in order to help the caregivers reduce burdens and problems related to the effects of caregiving. Based on these results, caregivers support policies should focus on the following factors:

1. Develop services and programs that emphasize preparation, training, and support that caregivers can use when caring for their elder relatives at home (i.e., caregiver training programs, health education programs, home health care services, self-help groups, counseling services, home visits).

2. Promote services and interventions aimed at enhancing knowledge, attitudes, and abilities of families and community members in providing help and support to family caregivers and their elderly patients.

3. Strengthen and expand existing services and programs which serve the needs of family caregivers (i.e., home health care services, free-of-charge health care for low-income elderly).

4. Encourage and promote participation of public organizations, private agencies, communities, families, and volunteer groups in developing supportive services such as emergency aid, financial support, material and equipment support, respite care, spiritual and emotional support.

5. Develop special services and programs that help caregivers who are poverty-stricken (i.e., mobile services, home visits, home-health-care services, free-of-charge health care for caregivers and their elderly relatives, income-generating programs, medical supplies and equipment support, tax deduction or exemption program).
6. Establish strategies to protect elderly patients from ineffective or harmful treatments as follows: (a) enhancing accurate knowledge of caregivers and their families concerning illness and treatment, (b) increasing abilities of health care providers in helping caregivers effectively manage treatments for their elder patients, (c) promoting and supporting research regarding actions, outcomes, and side effects of herbal medicines and alternative methods, (d) providing information regarding traditional and alternative therapies which are effective to caregivers and their families, (e) enhancing knowledge and quality of local healers in providing healing for the patients, (f) eliminating unqualified healers from health care systems.

7. Develop information-support systems at the national and local levels in order to provide useful information for caregivers and their families (i.e., sources of services and assistance, knowledge regarding treatment and caregiving, caregiver networks).

Recommendations for Further Research

The substantive theory derived from this study cannot be generalized to all Thai caregivers because of the purposive sample used. Future research regarding caregiving processes should include caregivers more diversity in backgrounds in order to represent a larger population of Thai caregivers.

This study only focused on the perspective of caregivers. Thus, the substantive theory which emerged from the data was limited by the ability of the caregivers in describing their caregiving experiences. In order to develop and validate this theory,
further research should explore the caregiving process from the perspectives of family members, health care providers, and patients.

The results of this study, and especially the theory "maintaining caregiving at home," identified several concepts and contextual situations which should serve as a basis for future research.

1. Interesting concepts not reported in other caregiving studies are related to religious teachings such as karma, bunkhun, merit, sin, and heaven. These concepts were found to be motives for caregivers to provide caregiving tasks. Further research should clarify the meaning and explore the relationship of these concepts with other related concepts in order to conceptualize and expand the field of knowledge.

2. Major concepts or factors were identified which involved the decision of caregivers to allow their elderly patients to use a treatment during a trial period. These concepts need to be conceptualized and studied in depth, particularly the concepts which directly related to cultural and traditional beliefs (i.e., experience and belief in treatment). The intensity of association between these factors and the decision making of caregivers should be explored in greater depth. Research aimed at developing interventions for enhancing accurate knowledge, attitudes, and abilities of caregivers regarding illness and treatment by using these findings as a basis should be encouraged.

3. This study identified and described the effects of caregiving on caregivers' lives, the sources of problems related to caregiving, and the strategies used by caregivers to manage problems. These results are useful for developing instruments and research regarding stress and coping among Thai caregivers. In addition, future
research should use these findings as a basis for developing interventions aimed at reducing burden and stress among caregivers.

4. Families and communities were found to be the major sources of help and support for caregivers. Multiple types of assistance provided by these sources were reported in this study. These findings can serve as a basis for developing instruments and research regarding social networks and social support among Thai caregivers. Moreover, future research may use these results as a framework for developing interventions which focus on the roles of families and communities in supporting caregivers.

The results of this study also indicated some issues that need to be studied further:

1. Some caregivers in this study self-medicated themselves by using medicines without consulting health care providers. Therefore, future research should examine the self-care process of Thai caregivers and the factors involved in this process in order to gain more knowledge and understanding of their self-care behavior and to improve the quality of self-care.

2. Various types of traditional medicines were used by stroke patients in this study. Research on the effectiveness of these medicines should be conducted in order to help patients find traditional medicines that are helpful and safe for them to use.

3. Financial status was found to be an important factor in the caregiving process. Low-income caregivers in this study were more likely to experience problems such as physical and psychological problems related to finances, lack of medical materials and equipment, and lack of affordability for treatment. Therefore, research on problems and needs of caregivers who live in poverty should be
conducted. In addition, future research should study the cost and effectiveness of family caregiving in order to provide basic information for developing caregiving support policies.

4. Personal knowledge and beliefs of some caregivers in this study differed from those of health care providers. Ethnographic studies should be used to further explore the cultural meaning of illness (stroke) and the treatment by lay persons and professionals in order to reconstruct the appropriate concepts to be applied in practices.

5. A female spouse discussed her difficulty in dealing with her husband who experienced a high sexual desire after having a stroke. Little research has been conducted regarding sexual issues of stroke patients. Future research should examine sexual issues that affect couples after stroke.

Last, in order to enhance the generalizability and applicability of these results, researchers should use the findings as a basis or framework for future research on family caregiving of Thai or other Asian caregivers living in the United States or other western countries.
Figure 3. The Map of Chachoengsao Province
### Table 4

#### The Information Regarding Each District and Subdistrict of Chachoengsao Province

<table>
<thead>
<tr>
<th>District</th>
<th>Number of Village</th>
<th>Area (km²)</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Muang</td>
<td>184</td>
<td>378.663</td>
<td>136,885</td>
</tr>
<tr>
<td>Bangkha</td>
<td>56</td>
<td>227.890</td>
<td>45,569</td>
</tr>
<tr>
<td>*Bang Nam Prieo</td>
<td>146</td>
<td>498.659</td>
<td>75,797</td>
</tr>
<tr>
<td>*Bang Pakong</td>
<td>107</td>
<td>257.893</td>
<td>75,843</td>
</tr>
<tr>
<td>Banpho</td>
<td>73</td>
<td>217.593</td>
<td>45,209</td>
</tr>
<tr>
<td>*Phanom Sarakham</td>
<td>84</td>
<td>550.000</td>
<td>74,148</td>
</tr>
<tr>
<td>*Sanam Chai Khet</td>
<td>56</td>
<td>1,666.000</td>
<td>62,149</td>
</tr>
<tr>
<td>Plaeng Yao</td>
<td>47</td>
<td>237.230</td>
<td>33,309</td>
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<tr>
<td>Ratchasan</td>
<td>31</td>
<td>134.900</td>
<td>12,348</td>
</tr>
<tr>
<td>Thatakiap</td>
<td>30</td>
<td>1,054.772</td>
<td>34,369</td>
</tr>
<tr>
<td>Khong Kuan</td>
<td>30</td>
<td>127.400</td>
<td>13,570</td>
</tr>
</tbody>
</table>

(sub district)

*Note.* From Ministry of Interior, 1997, p.6

* The study area
Caregiver’s Background Data

1. Gender
   ( ) male   ( ) Female

2. Age .................. years old

3. Educational level
   ( ) No education
   ( ) Specify the highest grade he or she completed ........................................

4. His or her present marital status
   ( ) Single   ( ) Married
   ( ) Widowed   ( ) Divorced, separated

5. Religion
   ( ) Buddhism   ( ) Islam
   ( ) Christianity   ( ) Other, specify .........................

6. His or her occupation
   ( ) Do not work   ( ) Work, specify ..........................

7. His or her family income per month ......................... baths

8. Relationship to the care-recipient
   ( ) Son   ( ) Daughter
   ( ) Son-in-law   ( ) Daughter-in-law
   ( ) Wife   ( ) Husband
   ( ) Other, specify .................................................

9. Length of time being the caregiver .................. months

10. Times spending for taking care of the care-recipient ........ hr/day
11. Number of other persons living in the same household .......... persons

/specify gender, age, and relationship with caregiver/

<table>
<thead>
<tr>
<th>Order</th>
<th>Gender</th>
<th>Age</th>
<th>Relationship with caregiver</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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<td>................................</td>
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</table>

Care-Recipient’s Background Data

1. Gender

( ) Male    ( ) Female

2. Age .......... years old

3. Educational level

( ) No education

( ) Specify the highest grade he or she completed .........................
4. His or her present marital status

( ) Single      ( ) Married
( ) Widowed     ( ) Divorced, separated

5. Religion

( ) Buddhism    ( ) Islam
( ) Christianity ( ) Other, specify ......................

6. Length of time (since he or she was diagnosed as stroke) ........... months

( ) Bathing     ( ) Dressing
( ) Toileting   ( ) Transfer such as getting in or out of chair
( ) Eating      ( ) Continence
Interview Questions

1. Tell me about your life with your stroke relative?

2. What do you mean when you said you have (taken care of/helped/supported) your stroke relative?

3. How did you become a caregiver to your stroke relative?

4. What have you done over time as a caregiver?

5. How do you feel about what you have done and are currently doing?

6. Do you have someone to help you take care of your stroke relative? If yes, what do they do? If no, why not?

7. Does caregiving affect your daily life? If yes, how and why?

8. Does caregiving affect your physical and mental health? If yes, how and why?

9. Does caregiving affect your job? If yes, how and why?

10. Tell me about your relationship before the stroke? Has it changed over time?

11. Does caregiving affect your relationships with others (such as husband, wife, other family members, relatives, friends, neighbors, significant others)? If yes, how and why?

12. Does caregiving affect your involvement in community? If yes, how and why?

13. Does caregiving affect any other aspect of your life? If yes, how and why?

14. What are some of the good things about being a caregiver?

15. What are some of the most difficult experiences you have had as a caregiver?

16. How did you deal with these experiences or situations? Did it help or make things more difficult?
17. Did you seek help from others? If yes, how and why?

18. What kind of help do you need most?

19. What advice would you give to other stroke caregivers?

20. Do you have any advice for how nurses or other health professionals could be more helpful?
APPENDIX C

INFORMED CONSENT
Information

Background

I am Rarcharneeporn Subgranon, a doctoral student at the University of Utah College of Nursing. I am conducting a study to learn about your experiences as a caregiver of your elderly stroke relative from your perspective. I would like you to tell me what caregiving means to you. What do you do as caregiver and why? How does caregiving affect your life? I also am interested in talking with you about how do you adapt/manage/cope to be able to continue as a caregiver. Findings of this study can help nurses and other health care providers better understanding about the caregiving process of Thai caregivers. The results of this research can also be used to support the development of interventions and policies that will benefit Thai elderly and their caregivers.

Study Procedure

If you agree to be a participant in this study, the following will happen:

1. You will be interviewed one time by the researcher in your home. You will be asked to tell the researcher about your caregiving situation as described above.

2. If clarification is needed from the first interview, you will be asked to participate in a second interview.

3. Each interview will be tape-recorded and transcribed verbatim by the researcher for further analysis.

4. You will be asked to provide background data about yourself and your elderly stroke relative, such as age, educational level, marital status, religion, occupation, family income, relationship to the stroke patient, length of time
being the caregiver, etc.

Risks

1. Some of the questions may make you feel uncomfortable or upset, but you are free to decline to answer any question you don’t wish to or to stop the interview at any time.

2. The interview will take approximately 1 1/2 to 2 hr. However, time schedules for the interviews will be set at mutually convenient times by you and the researcher.

3. In addition to your time and my intrusion into your privacy, there are virtually no risks associated with this research.

Benefits

You may learn about your own caregiving process and may value your contribution to the development of knowledge regarding family caregiving. You also may feel a sense of comfort in having been able to share your experiences as a caregiver.

There will be no cost to you as a result of taking part in this study. Also, you will not be reimbursed for participating.

Alternatives Procedure

You are free to choose not to participate in this study, or to withdraw from it at any point. You also are free to decline to answer any question you do not wish to, or to stop the interview at any time.
Confidentiality

Study records will be kept as confidential as possible. No individual identities will be used in any report or publication resulting from this study. You will be assigned a code number and the study information will be coded using this number. Information will be kept in a locked file at all times. Only the researcher will have access to the file.

Person to Contact

This research project was approved by the Institutional Review Board, University of Utah, which is concerned with protection of participants in this study. If you have further questions about the study, you may contact me (Rarchaneepon Subgranon) at (038) 390462 or (038) 390288. If you have comments or questions about participating in this study, you should first talk with the researcher. If for some reason, you do not wish to do this, you may contact my supervisory committee member, Dr. Puangrat Boonyanurak, by calling (038) 745900 extend to 3609, or by writing Faculty of Nursing, Burapha University, Bangsaen, Chonburi 20131.

Institutional Review Board

If you have questions regarding your rights as a research subject or if problems arise which you do not feel you can discuss with the investigator or the supervisory committee member, please contact the Institutional Review Board Office by calling 0011(801) 5813655, or by writing the Institutional Review Board Office, University of Utah Health Science Center, School of Medicine, Room 1C-426, Salt Lake city, Utah 84112, the United States of America.
Medical Treatment or Compensation for Injury

In the event you sustain injury resulting from your participation in the research project, the University of Utah can provide to you, without charge, emergency and temporary medical treatment not otherwise covered by your own insurance. If you believe that you have sustained an injury as a result of your participation in this research program, please contact the Office of the Vice President for Research, telephone number 0011(801) 5817236. By signing this document you are not giving up your right to pursue legal action against any and all parties involved with this research, in accordance with the Utah Governmental Immunity Act, Section 63-30-1: 63-30-34 Utah Code Ann. 1953 (as amended).

Right of Investigator to Withdraw Subjects

The investigator reserves the right to withdraw you from the study if your caregiving situation changes or the researcher determines you are otherwise ineligible to participate.

Unforeseeable Risks

As with any research, there may be unforeseeable risks that arise as a result of the research.

New Information

Any findings that develop during the course of the research which may relate to your willingness to continue participation in the study will be provided to you.
Number of Subject

Approximately 30 caregivers will participate in the study.

Consent

I have read the foregoing and my questions have been answered. I desire to participate in this study and accept the benefits and risks. A copy of the consent document has been given to me.

______________________________  _____________
Signature of Research Participation  Date

______________________________  _____________
Witness  Date
REFERENCES


