Hopeful Endless Caring to Maintain Normal Life: A Grounded Theory of Thai Mothers' Caring for Adult Children with Schizophrenia

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Abstract: Owing to multiple roles, including caregiving provision, mothers of children with schizophrenia experience a high level of stress. How these mothers adapt themselves to this caregiving, in addition to their other roles in the family, requires understanding before the development of an intervention. This study explored the process of adaptation among 20 Northeastern Thai mothers caring for children with schizophrenia who had provided such care for more than one year. They were interviewed in-depth, and Strauss and Corbin's grounded theory approach was used for collecting and analyzing.

Hopeful endless caring to maintain normal life emerged as the core category, and consisted of three phases. Phase 1, Dealing with immediate care demands, involved mothers responding to their situation with supernatural rituals, combining treatment, finding medical treatment, and taking advice. Phase 2, Adjusting ourselves, involved mothers trying to adjust the caring and strategies, living situation, and their mental state. In Phase 3, Restoring self-balance, they adjusted their mind, tried to heal body and mind, reframed thoughts, and tried to get back to normal.

The findings provide a deep understanding of mothers' adaptation process toward their caregiving over time, based on their perspectives. In developing a robust program to improve adaptation competency, mental health care providers, including nurses, need to understand what could be involved in the lives of caregivers, and take steps to realize each person's uniqueness, and that adapting to caregiving is a process. Heath professionals thus need to adjust interventions to be most appropriate for the different phases experienced by mothers.

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Introduction

As impairments caused by schizophrenia may limit the ability of the sufferers to remain independent in various domains of psychosocial functioning, they

usually require long-term support and care.[1-2] This is especially so when there is a child with schizophrenia in the family, and mothers are their primary caregiver,[3-4] for they are also usually the significant caregivers for all the family. They need to provide not only caregiving activities related to the impact of the illness but also to try to seek and maintain both psychosocial and personal daily living support for their adult children with schizophrenia.[3-6] Many studies report that mothers are confronted with caregiving demands and the time needed to be spent on these.[3,4,6] Mothers as caregivers often confront troublesome, multiple tasks that contribute to their difficulty of sustaining a normal life. And mothers of ill adult children with schizophrenia experience more distress due to the severity and chronicity of psychotic symptoms and the illness's long-term duration.[3,5,7] These problems are indicators of maladaptation, the adverse outcome of the adaptation process.[8,9] Regarding the link between health or illness and adaptation, the term illness is the state in which the person cannot adapt or shows maladaptive behaviors.[8-9] Consequently, they may contribute to having an illness, and caregivers need help to better adapt to their circumstances to maintain their own health and to provide adequate care. A systematic review indicated that adaption time for caregivers is essential while taking care of people with schizophrenia, and the integration of this role into their lives is required to enhance their normal life. [10]

In Thai studies, most caregivers of people with schizophrenia are mothers,[11-12] and they experience the need to adapt their emotional responses to the illness of their son or daughter, and caregiving. They also needed to adjust their sense of role mastery, developing expertise, and accepting caregiving as an integral part of life.[10] Owing to the difference of relations between the sufferer with schizophrenia and the female caregiver as a mother, sibling, daughter, or wives, the perspective of each female caregiver is also different.[4-5,13-14] The sense of love, feeling of responsibility, and kind of relationship may or may not be similar among female family caregivers when being a primary caregiver for those with schizophrenia.[3,5,13-14] This is especially true when the caregivers are mothers,[3-5] and the mother-child bonding and feeling of responsibility is different from other family members.

Thai culture values the nurturing role of women taking care of children or ill people in the family. Mothers are expected by society to be primary caregivers. They are also expected to do household chores and take care of their husbands or relatives, whereas a father is expected to work outside the household to earn money.[4,15] As a result, individual family caregivers identify what family caregiving means to them, based on the relationship to the person with schizophrenia and how they interact with their ill relatives in the family.[16] Regarding the mother-child relationship, they tend to give more attentive care to their loved one whenever caring for their child with schizophrenia, than other family members.[3-5] Especially in the context of northeastern Thailand, black magic or supernatural beliefs may influence the perception of, and responses to, a person with schizophrenia, quite different from other cultures.[6,15] Thus, mothers' adaptation is constructed based on the meaning between children with schizophrenia, and caregiving situation under their circumstances.[16,17] However, this might be different from mother-to-mother owing to the situated meaning that mothers create based on their feelings and interaction with their adult child and the dynamic process of caregiving itself.

In Western countries, there have been studies of the adaptation of caregiving mothers, for example, they need to create some balance in their own lives, to be able to cope with caregiving demands.[18] In Thailand, some researchers have described a little about the adjustment of parents, for example that they had to adjust their lives to deal with unpredictable psychotic symptoms and daily problems over time and to try to restore their lives.[4,6] However, the process of how mothers adapt themselves to take care of adult children with schizophrenia needs to be deeply understood within

the context of northeastern Thailand and the maternal role. Hopefully, this knowledge will increase understanding of mothers' adaptation, or maladaptation processes when they provide long-term caregiving in the Thai context.

The adaptation process refers to a continuous series of actions or steps among an individual's efforts to stay balanced when facing a threatening situation in their life.[11] Maintaining multiple roles with the family, especially enormous caregiving demands, can be a major threatening situation that impacts mothers' adaptation process,[3-5,12] and may contribute to their ill-health. Research of caregivers of those with schizophrenia reveals that mothers have negative caregiving experiences,[3-5,7,11] leading to psychological distress for these mothers, including the burden of stress or sorrow.[7,11,19] This reflects an outcome of maladaptation. Thus, mothers need to adjust themselves harder to maintain their life equilibrium,[4,10,19] and caregivers have altered perceptions and caregiving provision. To illustrate, wives or mothers may perceive the meaning and relationship with their husband or son differently. However, social values also play a significant role in shaping caregiving provision; for example, in a qualitative study of 17 caregiving wives of husbands with schizophrenia, they struggled in trying to sustain their lives. They adjusted their marital relationship into a sibling relationship instead and took over responsibility as a leader for the family. However, they expressed that they had to live with and care for their husbands with schizophrenia until they died because of their social values.[14] This is similar to mothers who sacrifice their lives to take care of their ill son or daughter until death.[3-4,17] As a cultural value, Thai mothers' perceive that caregiving of their son or daughter is their direct responsibility.[4,6,17,19] They put much effort into caring for their children, despite the serious nature of the illness. And they began to change their point of view to accept the illness for what it was and provide caregiving as much as they could to continue their life.[4, 6,12,17,19]

How mothers perceive their caregiving role in addition to other household roles, and how they might adapt to these multiple roles, is important to explore and understand to identify any help they need through various stages or phases of caregiving. Symbolic interactionism (SI) was used to guide this study to enhance understanding of the mother's adaptation processes in caring for children with schizophrenia. A person acts based on the meaning they derive from symbolic interactions through an interpretive process.[20] They can create meaning and shape their future by interpreting the use of symbols (verbal or non-verbal behavior) when interacting within their particular context.[21] Mothers too ascribe meaning, based upon their particular social context, towards symbols/the meaning of their care-recipient, which alter within a particular context and impacts on their adaptation process.[20-21] Therefore, to explore mothers adaptation process in caring for children with schizophrenia, grounded theory was considered a useful qualitative method for understanding the processes involved within a social structure.[22]

Aim

To explore northeastern Thai mothers' adaptation process in taking care of adult children with schizophrenia.

Method

Design: Grounded theory methodology, based on symbolic interaction to explore social processes within a social structure.[22-24]

Participants and Setting: Participants were mothers who received service at the outpatient clinic department of a provincial hospital in Thailand's northeastern region. The inclusion criteria were: mothers aged ≥18; full-time primary caregivers of an adult child aged ≥18 who had been diagnosed with schizophrenia, using the DSM -IV-TR, DSM-V or ICD-10 criteria, and living in the same household; had provided care for at least one year; and able to communicate in Thai. Mothers who had co-morbid disorders were excluded.

Participants were first sampled purposively, then selected based on theoretical sampling[24] guided by theoretical sensitivity. To illustrate, in data analysis categories emerged of how the mothers adapted to caregiving, the husbands were found to be their substitutes in managing household tasks and making a living, as the participants need to provide care for their ill child. Consequently, these mothers felt pleasure and perceived lower stress in maintaining caregiving tasks. So then, the different types of family support were considered and that needed to be explored further as to whether they would contribute to the participants' adaptation process. In this case, the principal researcher (PI) sought out single mothers who had no support from their husbands or partners to make comparisons in adaptation experiences in the caregiving. In this case, sampling was continued until theoretical saturation of the categories was achieved.[22]

Ethical Considerations:

This study was approved by the committees of the Institutional Review Board of the Faculty of Nursing, Chiang Mai University (IRB approval number 151/2017) and the hospital where the study took place (IRB approval 17984/8). Protection of confidentiality and anonymity were explained to participants and they could ask any questions regarding the study and had the right to refuse be involved at any time. If they agreed to participate, a signed informed consent form was obtained. Code numbers were used to identify individual transcriptions.

Data Collection and Analysis:

Data collection and analysis were undertaken concurrently from November 2017 to August 2018. All participants were interviewed using semi-structured. Interviews were conducted 1-2 times at home, based on participant convenience, approximately 30-90 minutes each time. Four participants were interviewed twice, and 16 were interviewed once. The questions included *"Tell me about your experiences of taking care of your (son) (daughter) with schizophrenia?"* and *"How have you adapted yourself to the caregiving situation of someone with schizophrenia?"* Probes were used as necessary, such as *Please explain what you mean*; *Please tell me about 'Tamjai';* and *How do you take action when (he) (she) needs money?* Field notes were written at the end of each interview included the interview's tone, the researcher's feelings and observances about the situation, and the participants' actions.

Data analysis employed the GT approach of Strauss and Corbin.[23-24] Firstly transcripts were read line-by-line until better understood and analysis started with open coding when the PI labeled the text with preliminary codes; some coding used was based on the verbatim expressions of what the participants said, known as *in-vivo* coding. Second, conceptual coding occurred where the open codes were read repeatedly, and some ideas were marked with more abstract coding. This process led to the generation of conceptual coding. For example, when participants addressed the topic of receiving help from husbands or other family members, the conceptual coded was generated as "social support." The next step was axial coding. Larger categories were established by making connections and identifying patterns and relationships among the categories and sub-categories. To illustrate, sub-categories of "self-adjusting the caring," "adjusting living situation," and "adjusting mental state" were linked under the category of "adjusting themselves with care demands." The next step was selective coding. The core category was refined using mothers' adaptation mapping diagrams and storylines, which was drawn to link all those categories to explain how mothers adapted when they provided caregiving under their context. Finally, the basic social processes of mothers' adaptation to care for ill children emerged when describing and reflecting the whole process of adaptation.

Trustworthiness

According to Lincoln and Guba (1985),[25] study trustworthiness comprises four criteria: credibility, transferability, dependability, and confirmability. In

this study, peer debriefing, and member checking were used to enhancing credibility. Peer debriefing initially performed when the first three interviews were coded and confirmed with co-authors. The second round of peer debriefing occurred when the conceptualizations were discussed among grounded theory experts and co-authors. Furthermore, the preliminary findings were presented to five participants for member checking. Direct quotes from participants were used to name the categories and findings, to enhance confirmability. The detail of the research process, participants, setting, and findings were presented in order for the readers to determine the applicability or transferability of the finding. To enhance dependability, an audit trail was achieved by tracking the memos, field notes, and transcribed interviews that the PI produced across the research process. Interviewing stopped when saturation of data was achieved, and no new ideas were being heard.[23-24]

Findings

Participant characteristics

There were 20 participants who were older adults ranging from 50-80 years old (mean age 65.95 years). All lived in rural areas with either their husband or other sons or daughters. Family members living in the same household varied from 2-7 people, including the person with schizophrenia. Six participants were widowed. Their main occupation was agriculture, so this meant they could take care of their son or daughter when they were at home or sometimes take them to the field. All participants had completed primary education and had inadequate incomes. Incomes ranged from 700 to 10,000 Thai baht per month, around 22 to 317 USD. The participants provided care for ill children from 2 to 41 years old (mean =19.74).

Of the adult children with schizophrenia in total care of mothers, 16 (80%) were males, and four (20%) were females. Their ages ranged between 22-57 years (mean = 36.63). The duration of being diagnosed with schizophrenia ranged between 2-41 years (mean =19.74). Fifteen were unemployed, four (20%) worked as laborers, and one (5%) was a farmer.

Core category: *Hopeful endless caring to maintain normal life*

This emerged as the process by which participants strived to fight and endure with hope in lifelong caregiving for their son or daughter with schizophrenia. They strove to maintain strength to living with normalcy throughout their lives. This adaptation process consisted of three phases, displayed as a model in **Figure I,** and described below:

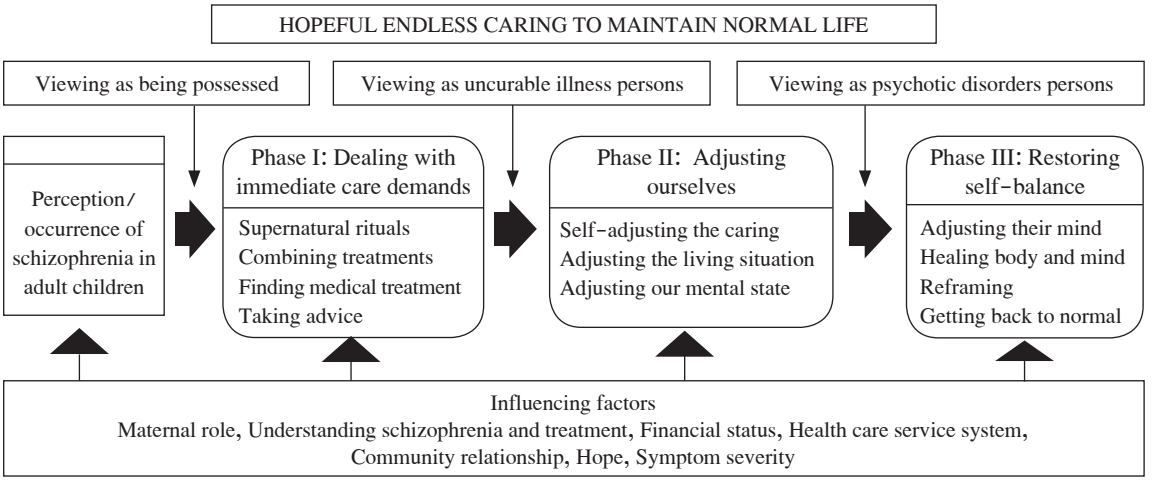

Figure 1. Hopeful Endless Caring to Maintain Normal Life: A Grounded Theory of Thai Mothers' Caring for Adult Children with Schizophrenia

Phase I – Dealing with immediate care demands: This phase defined the strategy mothers used in responding to the initial caregiving situation, based on their experiences and local beliefs they interacted with, and created meaning for their son or daughter. They had strong hope that their child would return to normal life and used every means to get them cured. Phase 1 was characterized by four sub-categories: *Supernatural rituals*, *Combining treatments*, *Finding medical treatment*, and *Taking advice*.

1. ***Supernatural rituals.*** When mothers initially faced the weird or aggressive symptoms in their ill son or daughter, they thought they looked like a stranger, like a person controlled by a supernatural power, a ghost, or black magic. Mothers thought they were possessed, and the caregiving of most of them involved the use of the supernatural belief rituals to aid healing, for example:

> *He had been like this for several days, so I brought the shaman, a superstition doctor, to see him, but it did not work. So I took him to the doctor. ... I was afraid that he might be cursed or something.* (M2)

2. ***Combining treatments.*** As this was their first experience of caregiving for someone with schizophrenia, they did not know how to take care of their ill child whom they wanted to get better as soon as possible. Therefore, they dealt with the caregiving situation by trying out both conventional care and black magic rituals that they believed might cure their ill children, as in the following example.

> *I want to know that it is real or not or can be cured. I have been to all four directions, north, south, west, and east. Nevertheless, it is not; it is not that disease. Then I quit it. I ended up at Hospital A (the tertiary and specialty care of psychiatric hospital of the northeastern region of Thailand) back to Hospital B (general hospital in patients' hometown). It is in the networking Hospital A or another specialty hospital). He was cured at* ***Hospital B.*** (M8)

3. ***Finding medical treatment.*** As the mothers combined treatments, they also learned that modern treatments could improve their children's symptoms. Consequently, 11 mothers searched for modern medicine with the hope of curing their children as quickly as possible. They changed hospitals if a treatment failed to improve symptoms, until their son or daughter's symptoms eventually improved. For example:

> *At that time (my son) was admitted in the big hospital (Hospital B) we (mothers) were not satisfied with that since if one is having the psychotic symptoms, they must have to go to (a certain) psychiatric hospital to get to know exactly for what it was and to get cured as soon as possible. (M7)*

4. ***Taking advice.*** The mothers also took advice as another strategy to help them during the early stages of care. Most ordinary people took the advice of people the mothers respected, such as neighbors or relatives who generally recommended supernatural rituals. For example,

> *They advise... the villagers advised trying with wisdom or local healing performed by the local shaman or whatsoever. So, we have tried, but it was not cured. It was cured in ... (hospital B).* (M7)

Phase II – Adjusting Ourselves: To maintain their positive feelings to move forward in this phase participants adopted various strategies to cope with demands of care, for instance, daily living activities, medication taking, and dealing with unpredictable, complicated and troublesome behaviors, which resulted from psychotic symptoms. After adapting to the caregiving demands in Phase 1, the mothers had gained direct experience together with an advanced understanding of the nature of schizophrenia and its treatment. Consequently, their original views changed from believing their children were possessed by

superstitious things, to believing they had a mental illness. They still hoped that their children would get better with the best treatment regimen from the hospital they had chosen, integrated with the very best caregiving they could provide. This hope pushed forward their adaptation in the caregiving process, and in this Phase II emerged three sub-categories: *Self-adjusting the caring*, *Adjusting the living situation,* and *Adjusting their mental state.*

1. ***Self-Adjusting the Caring*** is defined as the action of mothers responding toward the caregiving situation, trying to keep a balance between high demands of care and their own everyday life to try to overcome problems and psychotic symptoms. For example, a mother deliberated how she tried to find the best care for her son:

> *Well, I think very hard and cannot get to sleep the same as my child. I think about how to make him recover so that when I am old, he can take care of me. I think aimlessly. I want to find a way to cure him. I don't care if I have to lose all of my land (to get money to cure him). I just want him to recover. This is what is going on in my mind.* (M8)

2. ***Adjusting the living situation***. This refers to how mothers adjusted their lifestyle, roles, and communication to try to live with balance, while facing the responsibility of taking care of their ill son or daughter. For example, they had to change their communication styles whenever speaking to them:

> *I speak nicely. The family understands one another, so I speak to him. If I speak well, then all is well. If I speak well, he is well and will not argue. I cannot handle it if he becomes loud. When they get loud (people with psychiatric symptoms), you cannot hold them back.* (M3)

3. ***Adjusting their mental state.*** This was a way for the mothers to empower themselves as they managed negative emotions and overcame problems arising from caregiving situations. It can be categorized into two forms: self-encouraging and dealing with negative emotion, as described below:

Self-encouraging. Fighting and enduring facilitate mental energy to drive the self toward overcoming difficulties and challenges faced by caregiving mothers when trying to improve their son or daughter's conditions, for example:

> *I have fought. It has been so long now, and I don't know how I survived. I fought. I only knew then that I had to fight. Fighting was the only solution. I tried my best to fight, so my child would recover.* (M8)

> *...I constantly remind myself and warn myself, telling myself that I have to be strong, that I have to fight. No matter what, I have to fight to help my child recover.* (M8)

Mothers had to endure repeated treatments and continually engage in caregiving, aiming to get their son or daughter better:

> *I bear it. I bear it. I know it immediately when he acts up.* (M7)

> *...I endure it as much as I can (laughter). I do not know where to run or escape. I have to endure and care for my child. When he is hospitalized, I get a bit of comfort for a while...it is just temporary, but when he gets exacerbation, here you go again, I need to endure it.* (M7)

Dealing with their own negative emotions. The participants used positive and negative techniques to try to maintain a state of positive emotions when caring for children with schizophrenia. Positive techniques included using distraction, not overthinking, ignoring, seeking health care, applying Buddhist beliefs, and *dharma* practices, which occur by praying, wishing, making offerings, and devoting merit to persons with past deeds from another life. In the context of

Buddhism in Thailand, *karma* is viewed as caused by self, for doing good *karma* (gaining merit or doing good things) or bad *karma* (meaning having done bad things or sinned in the past to which people need to confess. It was more comforting this way, as shown in the following examples:

I do not think too much. I just think that it is my karma, something I did in the past.

> *Somewhere said, there are actual merit and sin, having fate which I need to build up. So, I just keep on trying.* (M9)

Negative techniques participants used to deal with their mental state included verbal or physical abuse, and drinking alcohol, for example:

> *Well, it gets out of hand. It is not just saying it once or twice. It's many times. He gets all tardy, I get angry. Sometimes I say nice things. Sometimes I say bad things. It's annoying. I can't make a living. 'I make a living just to look after you.' I say these things, like 'Don't you have the mind or wit to help yourself? You do whatever you want.' I yell at him.* (M9)

Mothers assisted their ill children as much as possible to find a cure, making efforts to provide care and dealing with the difficulty of caregiving demands of Phases I and II. They finally got to the point of acceptance that a cure was unobtainable, and was then that their adaptation moved onto Phase III.

Phase III: Restoring Self-Balance. This phase marked a steady point where mothers could reframe personal thinking toward their son or daughter, and begin to take care of themselves in a more balanced manner. They had hope to keep a balance, and this seemed to be the new start of their new normal life. *Restoring Self-Balance* encompassed four sub-categories described below:

1. ***Adjusting their minds.*** Once the mothers had provided care for an extensive period, they realized that the illness that their child struggled could not be cured. They realized that symptoms could only be maintained and stabilized, and that care had to be provided constantly for the rest of their son or daughter's life. To restore balance in their lives as they cared for their children, they focused on balancing their mental state while living with schizophrenia in life-long caregiving. *Adjusting their minds* in the Thai cultural context involved: using *tamjai* (reconciliation to a situation or letting something be) and acceptance. Through the use of these important mechanisms the mothers could find balance in themselves, to reconcile or *tamjai* themselves to the need to become life-long carers. They focused on the Buddhist concept meaning "Whatever happens, happens" or what is known as resignation.

> *I have to come to terms with it, too. It is not that I can have him just recover. I wanted him to recover. But now, I just let it progress gradually... I reconcile myself (tamjai) to the situation and let it go. I have to let it go and let whatever is going to happen, happen. He has already been born, so I let it go.... I let it go. Whatever will happen, will happen.* (M9)

Once a mother realized that her son or daughter had an incurable mental illness, then she was responsible for the child's care, accept the fact that a cure is not possible, and she has to continue living with them. It may result from reconciliation or *tamjai*. All the mothers were able to accept this because the patients were their children. They felt they had to accept. They understood that their child had mental illness and that they had to accept to always care for them, for example:

> *I have to accept it. When it happens, it has to be accepted. I accept it. I cannot abandon him. Because of that, I have to accept it. ...It has already happened, so I have to care for him and try to fix it...* (M9)

2. ***Healing the body and mind.*** After achieving a state of acceptance through the adjustment period,

mothers started to deliberate think of how to take care of their body and mind to be able to carry on with their life in the role of the endless caregiver.

The following two methods were involved in this healing, Applying Buddhism beliefs and dharma practices and Keeping healthy. For example, the Thai mothers took care of their mental health, using Buddhism beliefs and dharma practices. They used meditation, praying, and wishing to provide ways to bring peace, contentment, and relaxation to the mind:

> *When my child is recovering, I go to Wat Dhammakaya. I also go to other temples. I practice dharma with them. They adhere to the Five Buddhist Precepts. I go to every temple. When they make merit and or go to temples, I go with them. After I accepted it, I became peaceful. Once I was at peace, (my) asthma recovered.* (M12)

Keeping and staying healthy was important self-care for the mothers. They had to stay healthy because they always had to care for their children:

> *Exercise improves our health. When I am healthy, I have energy to do gardening. Then, whatever it is I am over-thinking becomes less troubling.* (M8)

3. ***Reframing.*** This was a way for participants to change the existing way of thinking about their child with schizophrenia, the caregiving situation, and to care for themselves in a balanced manner. They used re-considering and lowering expectations to gain greater comfort in caregiving, and this lead to a normalized coexistence

Re-considering involved mothers deliberately re-considering situations, mobilizing positive thinking about the self or thinking about their child's positive attributes and trying to see others who had even greater difficulty in caring for their children, to make themselves feel better. For example,

> *I am at peace these days. Just look at what we have and what other people's children have. Some people can still clumsily get by. Our child does not have any serious symptoms. With that thought, I make peace with it.* (M12)

Lowering expectations was another mechanism for reframing thinking. This involved lowering expectations for the child to match the actual situation more appropriately, and this form of reframing of thinking helped the mothers to live a regular life:

> *He stays at home. He does not have outbursts. Nothing bad is happening, so I am glad about that. ... He used to have outbursts in the past, so I was not as comfortable as I am now. But now, he is quiet and does not do anything harm so that I can be proud of that.* (M4)

4. ***Getting back to normal.*** This was the point when mothers in this study viewed that no matter what happened, they had to stay together with their ill children and take care of each other for the rest of their lives. With this thought, they tried to live with the situation, make a living and continue to care for the child and family.

> *In the past, I did not want to see his face. I wanted to go away to visit my relatives here and there. But when time passed by, I gained an understanding. After living for so long, I understood, and we can live together based on understanding.* (M3)

In each phase, many factors influenced the adaptation of mothers caring for an adult child with schizophrenia, and these emerged in three phases, such as multiple roles, understanding schizophrenia and treatment, financial status, health care service systems, community relationships, hope, symptom severity, and support from family or healthcare professionals. These factors were narratively described and served to provoke explication of the conditioning

factors to caregivers' responses across the adaptation process.

Discussion

This study's core category was the process of Hopeful Endless Caring to Maintain Normal Life which reflected fighting and endurance characteristics so prominent in this group of mothers. This was different from another study when the caregiver was a wife or had another relationship with the person they cared for, as participants mentioned about leaving the ill person, once they got to a specific point of adaptation.[4,14] The adaptation of mothers to the caregiving process was universal in this study, and no negative cases could be found in the data. From analysis, three phases of adaptation clearly emerged. The use of grounded theory and symbolic interactionism to uncover the experiences and meanings of caregiving for our participants was, in hindsight, a valuable decision. Rich data emerged throughout the study as described above.

In Phase I, similarities in the Asian context can be found in a China study where mothers who take care of their children with schizophrenia sought healing and relied on traditional healers' opinions.[6,15,26] After trying various types of supernatural rituals that yielded unsuccessful outcomes, the trial and error method was the behavioral action used to respond to caregiving demands. This finding is consistent with previous studies on caregivers of children with early schizophrenia in which trial and error were noted as part of the adaptation to providing care for them at the earlier stage of the caregiving process.[6] The mothers then sought assistance from health care services in both psychiatric and general hospitals to get the best care for their children. This finding is similar to the findings[3] where Chinese mothers attempted to seek a good hospital to cure ill children.

In Phase II, findings were similar to previous studies, in that mothers tried to survive by using the method of walking away, avoidance, and remote observation due to the severity of the psychotic symptoms of their children with schizophrenia.[4,6,19] Adjusting their mental state, also involved self-encouragement and dealing with negative personal emotions. Self-encouragement, fighting, and enduring were used for empowerment to increase mental strength for living with schizophrenia throughout the lifespan. A sense of high tolerance was found to be the character of rural Isan women[27] in northeastern Thailand, a matter that we as researchers also came to realize in this study.

After attempting to do everything possible for their ill children, the mothers recognized that the schizophrenia not necessarily improve or be cured. The adaptation of mothers as caregivers moved on to Phase III, restoring self-balance, adjusting their minds, tamjai, and acceptance, all were similar to the findings of previous studies.[4,19] On the ability to continue caring for persons with schizophrenia while carrying on with a normal life, the participants became reconciled (tamjai) to their circumstances and accepted the need to adjust personal thought processes.[4,12,28] In our experiences in Thai culture, mothers are concerned with their maternal role's social expectations and obligations in caring for a child. Children can stay home with parents for the rest of their lives, especially ill children, which might differ from Western values. They used tamjai to reconcile their mind for unconditional acceptance of their situations. Tamjai may be understood within a religious or spiritual context of Thai culture.[28] In some cultures, caring children with schizophrenia, may make parents powerless or even want their child to die before them.[29]

After the participants were able to accept the reality of living with ill children and having to be caregivers, many healed their body and mind by staying healthy and applying Buddhist beliefs. The use of Dharma practice was consistent in the studies of Napa et al.[6] and Tungpunkom,[17] who described that Thai mothers used this to make them feel better.

Reframing, by re-considering and lowering one's expectations, was also found to be similar to previous studies, for example in Taiwanese caregivers were found to selectively focus on existing positive aspects[30] or in Thai caregivers compared themselves with other people who had no better lives than their own.[4] Therefore, the conditional context always played a vital role in interpreting the phenomenon of study, however, the influencing conditions are interrelated. It was also found that the maternal role or maternal bonding, is the leading force for the mother to take care of their children unconditionally.[4,18,31,32]

Limitations

The low socio-economic status that all 20 mothers in this study had might make their adaptation process different from those who come from a different economic status. Therefore, further studies with a mix of socio-economic backgrounds of participants might be needed to confirm this emergent theory of the adaptation process. Also, as previously discussed, the relationship between care-recipient and caregiver played a major role in illuminating both the caregiving and adaption processes. Therefore, these research findings can represent only the mothers as caregivers, while references to other caregiver positions might not be appropriate. Another possible limitation of this study is the lack of participant observation, which was not possible in this study, but would make for richer findings in future studies. Therefore, the data was extracted from only one source, in-depth interviews.

Conclusion

This study used grounded theory methodology. The basic social process that conceptually explained how Thai mothers adapt to taking care of children with schizophrenia was entitled "Hopeful Endless Caring to Maintain Normal Life." This reflected the strategies mothers used to adjust themselves to the caregiving situation and women's characteristics from the northeast of Thailand. These findings serve as an initial first step and theory to develop a tailor-made intervention and test its effectiveness before moving to recommendation for practice to assist those mothers of each stage of caregiving process to enhance the positive outcome of adaptation. Further research is clearly needed before such interventions are developed and implemented.

Implications for Nursing Practice

Based on the findings, nurses' understanding of the characteristics of adaptation of north-eastern Thai women in each phase is essential. Each nurse comes to caring with a unique set of understandings tempered by different backgrounds, culture and living conditions and so forth, and the same can be said for the women in this study in their caregiving roles for adult children with schizophrenia. Understanding the process of adaptation, or maladaptation is vital for nurses so that they can tailor specific caring interventions for mothers, and for the sufferers of schizophrenia. Such caring needs to be holistic and tailor to the individual perspectives and reactions of primary caregivers. In Thailand, mental health nursing care needs to promote Buddhist and dharma practices, positive reframing, promoting using positive strategies to deal with negative emotions, and engaging in physical exercise for mothers to improve and maintain maternal health. In other countries where Buddhists practice, our findings might also be relevant. Further study should investigate how Thai fathers or males who are primary caregivers of children with schizophrenia view and adapt to caregiving. Nevertheless, developing an intervention program to suit each stage of the adaptation process is challenging for psychiatric nurses who work with these maternal caregivers. Further, a randomized controlled trial should be employed as a rigorous method to test whether a developed intervention is effective.

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การดูแลด้วยความหวังอย่างไม่มีที่สิ้นสุดเพื่อธำรงไว้ซึ่งชีวิตที่เป็นปกติ: ทฤษฎีฐานรากของมารดาไทยในการดูแลบุตรที่เป็นโรคจิตเภท

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บทคัดย่อ: การทำบทบาทผู้ดูแลและบทบาทอื่นในครอบครัวส่งผลให้มารดาผู้ที่เป็นโรคจิตเภทมีความเครียดสูง กระบวนการปรับตัวต่อการดูแลของมารดาจึงเป็นประเด็นที่ต้องทำความเข้าใจอย่างลึกซึ้ง เพื่อนำไปพัฒนาการช่วยเหลือให้กับมารดากลุ่มนี้ต่อไป การศึกษานี้ใช้วิธีการวิจัยแบบทฤษฎีฐานราก เพื่ออธิบายกระบวนการปรับตัวของมารดาไทยในอีสานในการดูแลผู้ที่เป็นโรคจิตเภท โดยการสัมภาษณ์เชิงลึกในมารดาของผู้ที่เป็นโรคจิตเภทซึ่งทำหน้าที่หลักในการดูแลมาเป็นระยะเวลาหนึ่งปีขึ้นไป จำนวน 20 คน วิเคราะห์ข้อมูลโดยใช้การวิเคราะห์ตามระเบียบวิธีวิจัยของทฤษฎีฐานรากของสเตราส์และคอร์บิน

"การดูแลด้วยความหวังอย่างไม่มีที่สิ้นสุดเพื่อธำรงไว้ซึ่งชีวิตที่เป็นปกติ" เป็นประเด็นหลักในการปรับตัวของมารดากลุ่มนี้ โดย ประกอบด้วยการปรับตัวสามระยะ ได้แก่ ระยะที่ 1) การจัดการกับความต้องการการดูแลที่เกิดขึ้น ณ ขณะนั้น โดยมารดาให้การดูแลบุตรโดยการใช้พิธีกรรมทางไสยศาสตร์ การลองผิดลองถูก การค้นหาการรักษาแผนปัจจุบันและการทำตามคำแนะนำ ระยะที่ 2) การปรับตัวเพื่อตอบสนองต่อความต้องการการดูแล โดยมารดาได้ปรับกลยุทธ์ในการดูแล ปรับวิถีชีวิตตนเอง และปรับสภาพจิตใจ และระยะที่ 3) การฟื้นคืนสู่ความสมดุลในตนเอง ด้วยการปรับใจ การเยียวยากายใจ การปรับมุมมอง และการกลับสู่ชีวิตที่เป็นปกติ

ผลการศึกษาครั้งนี้ช่วยให้เกิดความเข้าใจอย่างลึกซึ้งถึงการปรับตัวของมารดาไทยในการดูแลบุตรที่เป็นโรคจิตเภทจากมุมมองของมารดาในแต่ละระยะที่มีความแตกต่างกันขึ้นอยู่กับการรับรู้และเงื่อนไขที่มีอิทธิพลซึ่งมีความเฉพาะในแต่ละราย ดังนั้น ในการพัฒนาโปรแกรมที่มีความเหมาะสมในการเสริมสร้างศักยภาพการปรับตัวนั้น บุคลากรทางสุขภาพจิตควรตระหนักถึงบริบทของแต่ละบุคคล และปรับวิธีการช่วยเหลือให้สอดคล้องกับการปรับตัวในแต่ละระยะของมารดาในแต่ละรายต่อไป

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