

A Grounded Theory Study of the Quality Relationships between Family Caregivers and Persons with Head and Neck Cancer

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Abstract: The purpose of this grounded theory study was to explore the meaning and characteristics of the quality of relationships between Thai family caregivers and persons with head and neck cancer. Data was collected via in-depth interviews and the constant comparative method was used to analyse data to generate a theory of quality relationships among family caregivers of persons with head and neck cancer. Participants included 15 family caregivers; 13 spouses and two sons. The core category emerging from data analysis was *quality relationships*, which had four subcategories: *feeling of love*, *sympathy*, *caring* and *connectedness*. Love was defined as the caregiver's desire to return the care-receiver's love. Sympathy was defined as the caregiver's feeling toward their care-receiver's having cancer and suffering from the disease, and feeling sad for their care-receiver. Caring was defined as the caregiver's feeling of concern and worry about their care-receiver. Connectedness was defined as the caregiver's feeling of becoming closer to the care-receiver than before they started caregiving. The quality relationships between caregivers and persons with head and neck cancer is a dynamic process which occurred in three phases; the reason to be a caregiver, quality relationship, and provision of care. The Thai cultural context and religion influenced every phase of quality relationships. Nurses and other providers should integrate scientific, religious, and cultural knowledge into their clinical practice for promoting quality relationships in order to improve quality of care between family caregivers and persons with head and neck cancer.

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Introduction

Quality relationship is a concept that has gained the attention of researchers from a variety of disciplines,¹ particularly in family caregiving research.²⁻⁴ It has two distinct yet related dimensions: positive and negative evaluation of quality relationship. However, its meaning lacks conceptual clarity. For example, mutuality and reciprocity have been used along with a large number of terms, such as satisfaction,

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adjustment, success, happiness, companionship. Some of these terms have been used interchangeably or have become a dimension of another concept. At the same time, the differences or the rationale for the different terms used have not been clearly explained. Thus these terms tend to be used interchangeably and the conceptualizations and operationalizations of quality relationships are inadequate.

Quality relationship between family caregivers and care-receivers is very important because if the caregiver and care-receiver have a good quality relationship, this can contribute positive outcome to both of them. Furthermore, caregiving literature describes that good quality relationships allow caregivers to continue caregiving despite objectively difficult situations⁵, and adds to the relationship between patients and caregivers in chronic illness such as cancer, and in Alzheimer's disease is positively related to better health outcomes.⁶ Particularly, family caregivers of persons with head and neck cancer (HNC) are a very important group because they deal with both the psychological and physical problems of the care-receivers.⁷ They may encounter unique difficulties because of the centrality of this area and the specific roles in social and emotional expression and communication; changes in the care-receiver's anatomy or functioning can have devastating consequences.⁷ In Thailand, head and neck cancer is among the five leading cancers and the most common cancer in men.⁸ However, only a few studies focused on family caregivers of persons with HNC.^{9,10}

Quality relationships between a caregiver and care-receiver may be a key concept in caregiving for persons with HNC because the caregiver must deal with the many problems experienced by the care-receiver during the treatment for cancer. Whether quality relationship between the caregiver and care-receiver is high or low can influence whether the outcome of the interaction is positive or negative for either of them. In the literature reviewed for this study, the majority of concepts and definition of quality relationships were developed and studied within western cultures.

Therefore, studies to examine concepts or meanings from different culture perspectives are crucial. There are few Thai studies that focused on the concept of quality relationships among Thai family caregivers and care-receivers.¹¹⁻¹³ These studies were mostly quantitative and did not explore the quality relationships from the perspective of Thai meaning. Rather, they dealt with the primary caregiver of elders, chronically ill adults with either physical or mental health problem, or children with chronic diseases. In a Thai sense, "quality relationship" is a very sensitive issue since most of Thai people usually avoid expressing and evaluating the relationship between family members. Hence, as a concept, the term quality relationships has been rarely used in a Thai cultural context. Before the similarities and differences between the concept of quality relationships in family caregiving in Western and Thailand can be identified, the concept needs to be explored. Therefore, the purpose of this study was to explore the meaning of quality relationships between family caregivers and persons with HNC.

Literature review

Caregiving is a complex process and there are many factors that may influence how a caregiver adapts to the caregiving role.¹⁴ In particular, caring for persons with HNC is a very difficult task for family members because they have to undertake new and demanding responsibilities associated with the caregiving role. Furthermore, caregiving responsibilities also cause a disruption in caregivers' routines¹⁵ and their ability to participate in valued activities is restricted, such as caring for a family member who is having difficulty eating and drinking or is dependent on tube feedings. Therefore, the cancer caregiving role requires the individual to respond flexibly to a wide range of needs as they arise. The caregiver's motivation and the caregiving context can be influenced by the kin-relationship of the caregiver to the care-receiver and also by cultural norms.

Thai culture is very important to both individuals and groups because it affects their patterns of living. Thailand is a country in Southeast Asia with a traditional view of the hierarchy of social and family obligations.¹⁶ Most of Thai people believe in and practice the “gratitude system”, which obligates them to show gratitude to their parents¹⁷ or other people who have helped them. The reason for this Thai hierarchy can be described by the religious context and indebtedness of relationships in Thai society and family. It is a major key to understanding Thai behavior. Particularly, Buddhist beliefs are important influences that guide the behavior of individual caregivers and influence the roles they play within their family and for their care-receivers. Therefore, a caregiver’s motivation to provide care can impact on the establishment of the caregiving relationship, and the connection between the motivation behind caregiving and quality relationships between the caregiver and care-receiver may influence both of their well-being and the quality of care. Quality relationship is an important concept since it not only connects to the caregiver’s motivation but also affects whether the outcome of caregiving is positive or negative.

From the literature reviewed, the first term used to define and measure quality relationship is intimacy, as an essential concept of many interpersonal relationships. Its definitions were built on various psychological and sociological perspectives. The components of intimacy identified by most theorists involve four aspects, love and affection, personal validation in term of acceptance or individual’s feeling free to open up, trust, and self-disclosure.^{18,19}

The second term, mutuality, is used to define and measure quality relationships, as a way of being in respectful relation to another.²⁰ Mutuality has been operationalized in various ways, but most theorists agree that the components of mutuality involve four aspects, love and affection, shared pleasurable activities, shared values, and reciprocity.^{6,21,22} The third term for quality relationships is reciprocity. Studies carried

out by psychologists and economists, and literature in sociology, ethnology and anthropology emphasize the omnipresence of reciprocal behavior.²³ Reciprocity refers to the normative obligation of the recipients of help to assist the person who help them. Despite differing opinions on the definition of reciprocity, many theorists agree that its components involve the process of giving and receiving. The last term usually discussed as a domain of quality relationships, in addition to intimacy, mutuality, and reciprocity, is love. A type of love can be experienced for a variety of others, including all of humankind. Features or element of compassionate love included: altruism, helpfulness, care and concern, empathy, sympathy, tenderness, and so on.²⁴

The literature reviewed suggested that quality relationships also affect several outcomes such as greater caregiver’s satisfaction²¹; burden and satisfaction²³; and caregiver and care-receiver well-being.²⁵ Furthermore, one study found that caregivers generally did not perceive the care they provide as a burden. Rather, this was considered a relational commitment that showed their love and support for the patient.²⁶ However, this differs from one study of family caregivers’ experience in taking care of their relatives with terminal cancer in Hong Kong, suggesting that caregivers experienced major types of difficulties connected with their relationship with that person, their own emotional reactions to caring, the physical demands placed on them, and the social restrictions caregiving created.²⁷

In brief, quality relationship between caregiver and care-receiver is an important issue due to the fact that it not only motivates the family to take on the caregiving role but also impacts on all of the caregiving processes. In Thai literature, we know certain components of quality relationships such as love and reciprocity that motivate a family to take care of their family.^{10,13,28,29} However, none of the studies explored the meaning of quality relationships in Thai culture. Therefore, a qualitative study that

employed grounded theory methodology was most appropriate for exploring the meaning of quality relationships within Thai context. In order to develop a theoretical understanding of the meaning of quality relationships between family caregivers and persons with HNC based on the individual caregiver's view point, it is most appropriate to study the phenomenon through the lens of grounded theory (GT).

Method

Study design

This study used GT based on Strauss and Corbin's methods and procedures.³⁰ The theoretical framework for GT has its roots in symbolic interactionism, focusing on the processes of interaction between people exploring human behavior and social roles.³¹ Through the use of GT techniques, including a constant comparison of data, theoretical sampling and the use of a coding paradigm to assure conceptual development and density, substantive theory can emerge.

Sample and setting

Purposive selection involved both criterion-based and theoretical sampling. Criterion-based sampling involved seeking caregivers who had experience taking care and lived with their care-receivers. They were >18 years of age, serving as the primary caregiver and providing day-to-day care to a care-receiver at home, were not suffering from a life-threatening illness, were not financially reimbursed for caregiving activities, and had been a caregiver for a minimum of 6 weeks.

Ethical considerations

This study was approved by the Human Research Ethical Committee of Ramathibodi hospital in Bangkok and Lopburi Cancer Hospital in Lopburi Province, Thailand. All participants were informed about the purpose; nature of the study, including that participant was voluntary. The protection of confidentiality and anonymity of participants and data, was assured. The participants' names were replaced with a numerical

code number. Other identifiers such as the participants' address or location of the interview were removed from the transcripts.

Data collection

The primary data collection techniques included in-depth interviews and observations. Each participant was interviewed one or twice depending on the information obtained on the first interview. Observation was undertaken while interviewing the participants and focused on the interaction in a situation such as participant's action, appearance, body language, and interaction with the care-receiver that relate to the caregiving situation.

Data Analysis

Data analysis was composed of open coding, axial coding, and selective coding. In the open coding process, the researcher used the data from the in-depth interviews and observations. After the interviews were transcribed, data were examined line-by-line and conceptual labels were placed on each discrete incident, idea, and event. To portray this process, an example of one female participant in the preliminary work is given here. The words of the caregiver were: *I come by myself and my feeling with my husband is sharing both suffering and happiness because we spent time together for long time ago, my responsibility as wife's role, and feeling sympathy.* This statement clearly indicated a reason to be a caregiver.

The next stage, axial coding, was employed by linking subcategories to a category. This process proceeded together with the open coding process, as the interview data were coded and clustered into categories in open coding and then compared and examined for linkages in axial coding. Categories and their properties and dimensions were developed at the

same time that the relationship was sorted out. Subcategories were linked to a category in several relationships such as causal condition, action/reaction strategies, and consequence. From the previous example, “reason to be a caregiver” and “giving meanings of quality relationship” led to the category of “provision of care” as a consequence of quality relationship.

The final coding procedure was selective coding. This is the process of validating the relationship between a core category and other categories. The tentative core category was “reason to be a caregiver, quality relationship and provision of care.” In this step, the researcher wrote a general descriptive overview, and verified it with the participants. The researcher began using theoretical sampling on the basis of the concept that had proven theoretical relevance to the evolving theory in order to refine the concept.

Theoretical sampling continued until theoretical saturation of each category was reached. In this study, the researcher interviewed the next participant after adapting the interview guide and then comparing and analyzing the coding to the last participant. The researcher used the interview results from the previous participant to plan for interviewing the next participant, and this was done repeatedly for all of the 15 participants. As a result, saturation was obtained. Rigor in this study was required to prevent error of either a constant or intermittent nature. The establishment of trustworthiness includes credibility, transferability, dependability, and conformability.³¹ Credibility was achieved by methodological techniques which included using constant comparative methods; prolonged involvement; triangulation; and peer debriefing in order to enhance the credibility of the data collection and analysis. Transferability was ensured by explaining the quality of relationships and how they change or do not change during a caregiving situation and also how this affects the individuals involved. The dependability of the interpretation process was increased by having nine samples of interview transcriptions analyzed by the researcher and a team

of researchers with experience with both qualitative methods and caregiving research. The concepts and categories were compared and discussed until agreement was reached.

Findings

The majority of participants were spouses (12 wives and one husband) while two were sons. Most of them were Buddhists (n=14). Before taking on the caregiving role, the mean time that the caregiver and care receiver had been together was 23 years, ranged between 3 years to 42 years. Their mean caregiving experience was 6 months, ranged between 2 months to 1 year and 8 months. All of the caregivers (n=15) reported their caregiving activities including providing assistance with activities of daily living (ADLs), and most of them reported special care activities including wound care (n=12), such as for a jejunostomy wound and a tracheostomy. All of the cases required feeding tube, and five cases had a tracheostomy tube. All caregivers had to prepare food for tube feeding and feed their relatives. Among the care-receivers diagnosed with HNC, there are 13 spouses (12 husbands, one wife), and two fathers. The types of cancer treatment varied: two cases were receiving radiotherapy only, the rest were receiving a combination of other treatments such as chemotherapy (n=9), surgery (n=1), surgery and brachytherapy (n=1), and surgery and chemotherapy (n=2). Most of the care-receivers in this study (n=10) were diagnosed with HNC stage 4.

This study provides an evolving theory entitled the meaning of quality relationships from the perspective of family caregivers and quality relationships process of Thai caregivers for persons with HNC. The quality relationships process had three overlapping phases consisting of reason to be a caregiver, quality relationship, and provision of care. Quality relationship was a dynamic process because caregiving experience was not stable. Caregivers' thought and feeling can

change depending on many factors such as changes of caregiving situation, perception of caregiving role, or care-receiver's reaction. While the feeling or reason to be caregiver changes, it effects the caregiver's perception or sense of declined or increased quality relationship. Once this feeling of quality relationship with care-receiver changes, it effects the provision of care. In this study, the resulting quality relationship from the caregiver's perspective was therefore the provision of care that can be variable over time.

The reasons to be a caregiver were the causal conditions in the process of quality relationship. It involved love, sympathy, commitment to care and obligation. The second phase of quality relationship, as core category was the central explanatory concept pertaining to the phenomena under study. The

subcategories also highlighted the quality relationships included love (*ruck*), sympathy (*songsarn*), caring (*huangyai*), and connectedness (*pookpun*) with the relatives HNC. Notably, the terms of love and sympathy in the first phase still remain in this second phase but the level of love and sympathy might be fluctuate based on the caregiving situation.

The third phase considered the caregiver's perception about their provision of care. It comprised the positive and less positive ways that the relationship was experienced. In addition, it was important to note that the Thai cultural context influenced every process of quality relationship. This involved concerns about the Buddhist doctrine, social expectations, and a caregiver's attitude toward cancer as a disease. The evolving theory in this study is summarized in **Figure 1**.

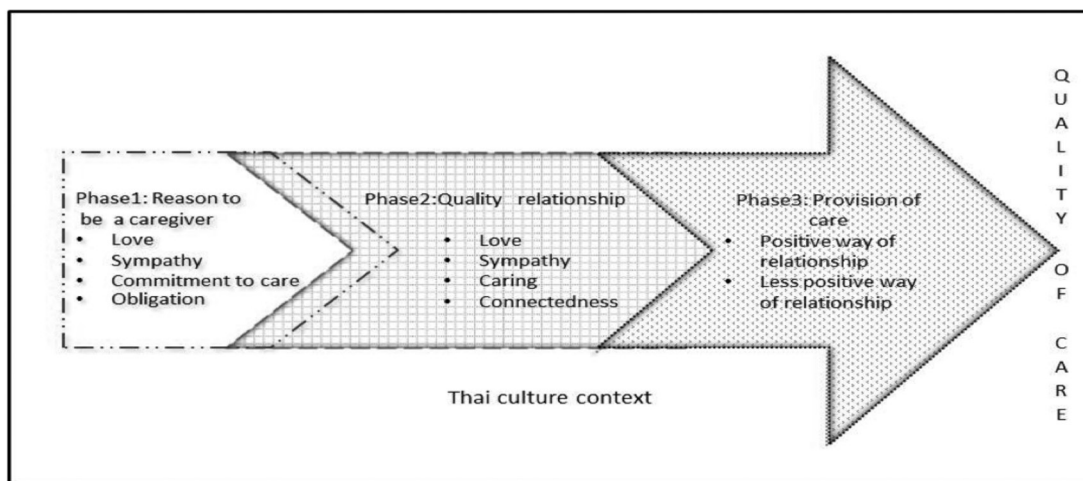


Figure 1: A diagram illustrating an evolving theory of quality relationships process of being a Thai family caregiver of a person with HNC

In the quality relationship process, caregivers considered whether or not to take on the caregiving role by using various reasons based on their prior relationship with the care-receivers. The participants described their reasons for caregiving as comprising of love, sympathy, commitment to care, and obligation. Love was the causal condition that led to the caregiver's decision to take care of the person. Most participants

stated that their love for their relative involved taking care of them, and the care-receivers had an intention to return this love. Sympathy for their relative becoming ill with cancer was also reported by most of the caregivers as a reason to take on the caregiving role in addition to the fact there might be no one else to take on this role. The caregivers' commitment to the role of caregiver was also influenced by their

shared past experience with the care-receiver, and the fact that they were relieved on for care. Most of them felt that for people who lived and enjoyed together, if any of their family members suffered, they should be there to take care of one another. The last reason to be a caregiver was obligation. This refers to the caregiver's feeling that this caregiving role was unavoidable. Whether they were willing to care or not, they have to do it. Some believed that it was their responsibility and obligation to take care because of their relationship, for example, as spouse or son. They reported that this obligation was due to their social role and societal norms in the family and society. All women were supposed to take care of their husband. Feeling obliged in caregiving was the condition that forced the caregivers' responsibility for caring the care-receiver.

In the second phase, quality relationship was a core category of this study. Four subcategories were identified as feeling of love, sympathy, caring, and connectedness.

Love (ruck): Love is called "ruck" in Thai language. The meaning of love in this study can be described in various ways. For example, the caregivers who were spouses mostly expressed their feelings about their husband or wife in a way of returning the feelings of love received from their spouse, noting how their spouse gave them love and took good care of them. They had lived together for a long time prior to the caregivers' taking on the caregiving role. During the caregiving period, most caregivers showed this feeling toward their care-receiver as they thought they would perhaps not live long. One of the caregivers expressed that now she loves her husband even more. This is because when they were healthy they did not take much care of each other but just hanging out and eating out together.

It's because everything I've done came from our love for each other. Everything I've done was my willingness. Sometimes I had to cook for him even if it was eight pm when I was usually in bed but I was willing to do so.

Sympathy (songsarn): This feeling arose after their relatives were diagnosed with HNC and the caregivers experienced their relatives' suffering from cancer. Most caregivers had lived with the care-receivers for a long time and felt sympathy toward the one they love who was suffering from eating and breathing difficulties and in severe pain due to cancer. This feeling of sympathy may be influenced by their belief about cancer and the care-receiver's pain. The majority of them expressed their sympathy as:

I felt sorry for him being like this. His life shouldn't be this way with the disease. Previously I thought about his car driving, I was afraid he might be hit or have a car crash, I'd focused only on it but never thought of this severe disease.

Caring (huangyai): Caring was defined as the caregiver's feeling of concern and worry toward their care-receivers just like how they felt and if they were in pain or happy or sad. Caring became more distinct than before when they were healthy and living their lives together. Some of the caregivers shared that they now feel more concern as:

When he was not ill he could do anything, he took care of himself, and so did I. Each of us took care of ourselves on our own as we all have burdens and I had to take care of my grandchildren too. Now I am much concerned about him. Whatever he did, he became exhausted, I helped him with everything.

Connectedness (pookpun): This was defined as the caregiver's feeling of becoming closer to the care-receivers than before the diagnosed cancer. Since the caregivers had to stay with the care receivers almost 24 hours a day helping with activities of daily living and special care activities such as wound care and feeding, they started to feel closer to their relatives, for example:

Very close. Previously I thought he was alright, so we each lived our own life. Sometimes he stayed out at the farm for one or two weeks then came back home. When he was in good health, he stayed at the farm to make a living. Here I stay with my daughter, just the two of us. My daughter went to school, I went to work and came back for her. Every one or two weeks that I could see my husband. Now that he falls ill, during this time we are closer and never are apart.

While the quality relationship process was in progress, there were factors that affected the quality relationship between caregiver and care-receiver. This involved Thai cultural context on the concern about Buddhist doctrine, social expectation and caregiver's attitude toward cancer disease.

Concern about Buddhist doctrine influenced the caregiver's feelings on caring for the care-receivers and their willingness to continue their caregiver role. The influence of Buddhist doctrine included such as the *law of karma* as a determinant of the caregiver's taking care of the care-receiver and a sense of being redeemed for what they had done to the care-receiver. They also viewed cancer being faced by the care-receivers as something that can occur to anyone, and their death will occur for sure as for every human being. One caregiver talked about her experience of being obliged as caregiver, noting that Buddhism provided her the mental anchor and spiritual support needed for her to take care of her husband.

Another influencing factor was a concern about social expectation in Thai culture since it is expected that family takes care of ill family members. This social expectation influenced the family caregivers' decision making process regarding whether or not to stay with their relative once it was discovered that they had cancer and needed care. A Thai social expectation is that when a family member is faced with difficulties or illness the family have to help and care for each other, for example an adult child must to look after parents in illness. Traditionally, the value

of filial piety in Thai society is taught from childhood so that when turning into adulthood it becomes one's obligation to take care of parents in return for the care given by them. If children are not responsible for caring their parents in old age or in illness and with self-care inability, they will not be accepted by the society. Other than children's role in caring for parents as expected by Thai society, husband and wife in intimate relationships are also supposed to care for one another when each was sick. In particular, it is expected that females should take care of household chores and food and should also provide comfort to family members. All of the caregivers in this study automatically understood that their role was to take care of their husband during his illness.

A caregiver's attitude towards cancer was also an important influence that motivated the participants to take on the caregiving role. Intense fear of cancer was pervasive among all of the caregivers in this study. Strong fear was associated with many aspects of the disease, including death, pain, and the destruction or mutilation of the patient's body. Most of them expressed their fear about the suffering and pain that the cancer victims must endure and consistently described that "cancer disease is suffering" and the person who was diagnosed with cancer will not live long. Most of them thought about the care-receiver's dying if diagnosed with cancer, and believed that "cancer is comparable to death."

The outcome of the quality relationship process was the caregiver's perception about their provision of care. Subcategories under the provision of care included positive perceptions such as "willing to care" or "doing my best"; and less positive perceptions expressed as "doing as normal life" and "doing good but not reaching expectations".

"Willing to care" and "Doing my best" were the outcomes of a perceived good quality relationship with the care-receiver, i.e. the feelings of love, sympathy, caring and connectedness. However, the phases were not mutually exclusive but rather interactive. When the caregivers had the feelings of love and

sympathy towards their care-receivers, the feelings of care and connectedness may follow. This was also influenced by the extended time they spent together as mentioned previously. Further, the enhanced quality relationship experience may occur when the caregivers decided to take care of the care-receivers because of their greater sense of love, sympathy, caring, and connectedness than in the past. Although the caregivers reported their taking on caregiving role was initially due to their feeling obliged as wife or son, after spending some time with the care-receiver, most of them felt closer and more concerned for the care-receiver than in the past. When asking about their feelings about the caregiver role, they said they themselves preferred and were willing to do so since they believed they understood the care-receivers who wanted to be cared by them.

Some of the caregivers, however, expressed less positive perceptions of their care. Rather, they reported having a difficult time with the care-receiver and perceived their role as a result of feeling obliged, e.g., as wife supposed to take care of husband or concern with Thai culture such as in Buddhist doctrine. As Thai culture influenced those with a more positive perception, their perceptions and feelings also evolved during the caregiving process, whereas those with a less positive perception remained influenced mostly by the sense of obligation. For the latter, the quality of their relationship with the caregiver at entering the caregiving experience was less positive and their feelings of love, sympathy, caring and connectedness did not increase in their first step into caregiver role. They viewed provision of care as “doing as normal life” or “doing good but not reaching expectations”

Discussion

An evolving theory in this study is the meaning and process of quality relationship in Thai family caregiver of persons with HNC. The reason to be a caregiver is the causal condition in quality relationship

process. It is composed of love, sympathy, commitment to care, and obligation. The decision to take on the role of caregiver is based on various reasons and influences. In Thai caregiving context, love is a pivotal component that impacts on the caregiver’s continuing to care for their care-receiver.²⁷ Love was also found to be pivotal in this study, and the power of love motivated family members to take care of their patients.^{7,8,28} According to Thai culture context, it can be explained that all of the reasons to be a caregiver are influenced by Buddhist doctrine, concern about social expectation and caregiver’s attitude toward cancer disease. Most Buddhists believe in the *law of karma* that includes physical, verbal, and mental actions. It is believed to result from accumulated past *karma* in the form of *boon* (merit) and *barp* (demerit). Therefore, for Thai caregivers Buddhism holds that as a consequence of one’s action, the power of *karma* is endlessly present to manifest itself in the life of the individuals. Moreover, the essential doctrine of Buddhism is merit-making that is the central part of the religious experience of the Thai Buddhism. The important acts of making merit that can be motivated the most of family caregiver taking the caregiving role is the provision of support for one’s parents, elders and charitable causes. Furthermore, social expectation in Thai culture as a set expectation that the family will take full responsibility for the care of family members who need special care. This social expectation influences the caregiver’s decision making process regarding whether or not to stay with their care-receivers. Most of caregivers reported their obligation is due to their social role and social expectation in the family and society. This condition can force caregivers to take responsibility for care of their care-receivers. The last Thai culture context that influence caregiver’s reason to be a caregiver is caregiver’s attitude toward cancer disease. Intense fear of cancer was pervasive among all of the caregivers in this study. Most of caregivers in this study described cancer disease is suffering and the person who was diagnosed with cancer will not live long.

The aim of this study was to explore the meaning and characteristic of the quality relationship in the perspective of Thai family caregiver of persons with HNC. It was revealed within Thai context as love (*ruk*), sympathy (*songsarn*), caring (*houngyai*) and connectedness (*poogpun*). These characteristics emphasize strong Thai culture and family kinships, and Buddhist beliefs influences the quality relationships between caregivers and their care-receivers. The meaning in this study has unique characteristics that differ from the other studies in caregiving.

The meaning of quality relationships and the characteristics of that relationship differ from the concept of intimacy although most of the participants in this study were spouses. They mentioned that the meaning of quality relationships was composed of the feelings of love, sympathy, caring and connectedness. Only the characteristics of feeling of closeness and connectedness from the concept of intimacy concept are similar to the findings in the current study. When compared with the concept of mutuality, only the feeling of love is similar to the findings of the current study. The majority of caregivers did not define quality relationships in the characteristics of shared pleasurable, shared values and reciprocity; rather they described it as the feeling of love, caring, sympathy and connectedness. Most did not explain about the feeling of sharing but in the process of quality relationship, the caregiver's feeling of caring and connectedness occurred when they spent time together, sharing both happiness and suffering. Quality relationships from the caregiver's perspective in this study might be different from the concept of mutuality in terms of expressing feelings toward other people. In particular, the component of reciprocity may be different in terms of expressing feelings. This was confirmed by researchers who used a mutuality scale and had to adapt some items or change some words to help the caregivers understand the meaning. The word "warmth" was changed to "*auarthon*" in Thai as being very close to the feeling of caring reported

by the caregivers.¹¹ Similarly, Monkong suggested that some items of mutuality may not represent the precise meaning of mutuality, especially, in the dimension of reciprocity from her study with caregiver elders.³¹

In Thai caregiving research, reciprocity is viewed as a key factor affecting a family member's decision to become primary caregiver. The meaning and characteristic of quality relationship in this present study differ from the meaning of reciprocity concept. Caregivers reported their feeling of love, sympathy, caring, and connectedness. They did not explain their feeling about reciprocity. The components of reciprocity include warmth and regards, intrinsic rewards of giving, love and affection, and balance within family caregiving.³² Only one component, the feeling of love, as explained by caregivers regarding their feeling about the meaning of quality relationships, differed in the meaning of love.

Love is not a common topic to discuss in Thai culture and family. Love is manifested in various forms and at various levels. The meaning of love in this study differs from those described in other studies. It is different from the meaning of compassionate love but defined as a type of sharing that is selfless, helpfulness, care and concern, empathy, sympathy, and tenderness.³³

Limitations

This study has some limitations. The data focuses only on caregivers, and thus the perception of quality relationships from the perspective of persons with head and neck cancer has not been assessed. Moreover, the sample mainly consisted of spouses who were female and under Buddhists religious. Therefore, these limitations may reduce the applicability of the study finding to other Thai caregivers.

Conclusion and Implications for Nursing practice

The finding from this study revealed that the meaning and characteristics of the quality relationships in the perspective of Thai family caregivers of persons

with HNC refers to the feeling of love, sympathy, caring and connectedness. Each of the characteristics of quality relationships can occur any time during the caregiving and some of them are comparable to some reasons to become caregiver such as love and sympathy. In addition, each of characteristic of quality relationship interacts with one another. However, most caregivers could not describe what first feeling they had, but they knew that a quality relationship must contain the feelings of love, sympathy, caring and connectedness.

The quality relationship between caregivers and care-receivers is very important and has unique characteristics that were found in this study. In nursing practice in Thailand, we still have no strategy or guideline for supporting and providing the caregivers and their care-receivers to maintain their quality relationships. The meaning and process of quality relationships of family caregivers of persons with HNC provides nurses and other health care providers a comprehensive and culturally sensitive basis for understanding perspectives, beliefs, and caregiving behavior of Thai family. The present study result can be used to inform the design nursing care strategies to help support family caregivers continue providing good care for their care-receivers. Therefore, nurses and other providers should integrate scientific, religious, and culturally knowledge into their clinical practice for promoting quality relationship family caregivers and persons with HNC. Health care professionals who are responsible for cancer care should focus on quality relationships between caregivers and care-receivers from the very beginning of one's reason to be a caregiver, continue to provide care during treatment, and maintain caregiving in the long run.

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การศึกษาสัมพันธภาพที่มีคุณภาพระหว่างญาติผู้ดูแลและผู้ป่วยมะเร็ง ศีรษะและลำคอโดยใช้การวิจัยเชิงทฤษฎีพื้นฐาน

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บทคัดย่อ: การศึกษานี้มีวัตถุประสงค์เพื่อศึกษาความหมายและลักษณะของสัมพันธภาพที่มีคุณภาพระหว่างญาติผู้ดูแลและผู้ป่วยมะเร็งศีรษะและลำคอในประเทศไทย โดยใช้วิธีการวิจัยเชิงทฤษฎีพื้นฐานที่ได้จากการสัมภาษณ์เชิงลึกและวิเคราะห์เปรียบเทียบข้อมูล ของสัมพันธภาพที่มีคุณภาพของญาติผู้ดูแลผู้ป่วยมะเร็งศีรษะและลำคอ จำนวน 15 รายซึ่งประกอบด้วยคู่สมรส 13 ราย โดย 12 รายเป็นภรรยาและอีก 1 รายเป็นสามี ที่เหลืออีก 2 รายเป็นบุตรชาย

ผลการศึกษาพบว่าสัมพันธภาพที่มีคุณภาพหมายถึง ความรัก สงสาร ห่วงใย และผูกพัน โดยญาติผู้ดูแลได้ให้ความหมายความรัก คือ ความรู้สึกที่ญาติผู้ดูแลมีต่อผู้ป่วยเพื่อตอบสนองความรักของผู้ป่วยที่มีมาให้ตน ความสงสารเป็นความรู้สึกที่ญาติผู้ดูแลมีต่อผู้ป่วยจากการเจ็บป่วยและทุกข์ทรมานจากโรคมะเร็งและรู้สึกเศร้าต่อผู้ป่วย ความห่วงใย คือ ความรู้สึกเป็นห่วงและกังวลที่มีต่อผู้ป่วย และความผูกพัน เป็นความรู้สึกใกล้ชิด ผูกพันที่ญาติผู้ดูแลรู้สึกต่อผู้ป่วย สัมพันธภาพที่มีคุณภาพเป็นกระบวนการที่เป็นพลวัตสามารถเปลี่ยนแปลงกลับไปมาได้ทั้งนี้สามารถแบ่งได้เป็นสามระยะ ได้แก่ เหตุผลหรือแรงจูงใจในการก้าวเข้าสู่การเป็นญาติผู้ดูแล นำไปสู่สัมพันธภาพที่มีคุณภาพ และส่งผลต่อ ความตั้งใจที่จะดูแล ซึ่งตลอดกระบวนการนั้นปัจจัยที่มีความเกี่ยวข้องในทุกขั้นตอนคือความเชื่อและอิทธิพลของสังคมและวัฒนธรรมของไทย พยาบาลและบุคลากรทางทีมสุขภาพควรผสมผสานองค์ความรู้ทางด้านวิทยาศาสตร์ ความเชื่อทางศาสนาและวัฒนธรรม นำไปประยุกต์ใช้ในการปฏิบัติการพยาบาลเพื่อส่งเสริมความสัมพันธ์ที่มีคุณภาพระหว่างญาติผู้ดูแลและผู้ป่วยมะเร็งศีรษะและลำคอ

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คำสำคัญ: ความสัมพันธ์ที่มีคุณภาพ ญาติผู้ดูแล มะเร็งศีรษะและลำคอ

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