Perceived Role Perception and Role Performance of Family Member-Directly Observed Treatment (FM-DOT) Observers

Nanthiya Phromrak, Urai Hatthakit, Sang-arun Isaramalai

Abstract: This study aimed to describe the perceived role perception and role performance of Family Member-Directly Observed Treatment (FM-DOT) observers. Purposive sampling was used to recruit 65 subjects who had been assigned to be FM-DOT observers for a family member with pulmonary tuberculosis who attended the outpatient tuberculosis clinic at six hospitals in the lower southern part of Thailand. Three questionnaires were used in this study: Demographic Data Questionnaire, Role Perception of FM-DOT Observer Questionnaire (RPC-FMQ), and Role Performance of FM-DOT Observer Questionnaire (RPF-FMQ). The content validity of the questionnaires was tested by a panel of three experts in the field. Cronbach's alpha of the RPC-FMQ, and RPF-FMQ were found to be 0.71 and 0.74, respectively. The data were analyzed using descriptive statistics and Pearson's correlation coefficient. The findings revealed that the FM-DOT observers total and subtotal role perception scores were at a moderate level. The total score of role performance and the subtotal score of treatment regimen support were at a fair level; the subtotal score of psychosocial support was at a moderate level, while the subtotal scores for financial support and case finding were at a poor level. Moreover, no significant relationships were found among role perception and the various aspects of role performance.

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Thailand is one of 22 countries worldwide with the highest number of estimated cases of tuberculosis.[1] A joint 1995 World Heath Organization (WHO) and Thailand government review of the National Tuberculosis Control Program (NTP) of Thailand revealed that cure rates, for smear-positive tuberculosis patients in various parts of the country, were only 17%-68% and that there continued to be high default rates.[2] Following review of the NTP, in 1996, the government of Thailand adopted the WHO recommended strategy, known as Directly Observed Treatment Short Course (DOTS), for controlling tuberculosis.[3] Directly Observed Treatment

***Nanthiya Phromrak**, MNS, RN. Hat Yai Hospital, Hat Yai, Songkhla Province, Thailand.*
***Correspondence to Urai Hatthakit**, PhD, RN. Assistant Professor, Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkhla Province, Thailand. E-mail: urai.h@psu.ac.th, uraihster@gmail.com*
***Sang-arun Isaramalai**, PhD, RN. Assistant Professor, Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkhla Province, Thailand.*

(DOT), which is one element of the DOTS strategy, is defined as observation of the patient by a health care provider or other responsible person as the patient ingests anti-tuberculosis medications.[4] The person conducting DOT needs to be someone who is accessible to the patient, accountable to the health service and acceptable to the patient.[5] There are three main types of DOT observers used in Thailand: health personnel, community members and family members.[6] In Thailand, the majority of DOT observers are assigned family members[7,8] who have demonstrated the feasibility of using DOT.[7,9,10]

In 1999, in the lower southern part of Thailand, 74.8% of family members of patients with pulmonary tuberculosis (PTB) were assigned as DOT observers.[11] However, between 2003 and 2005, the incidence of PTB in Southern Thailand remained high, with 4,327 cases still demonstrating positive sputum. The cure rate at that time was 77%,[12] which did not reach the WHO global target of 85%.

Although FM-DOT observers have shown effective treatment outcomes,[7, 13] research has revealed that they have the highest likelihood of not practicing DOT when compared to health personnel and community members.[10] The main reason for failure to comply with DOT protocols was because DOT observers simply did not carry out their responsibilities.[14] This could be a result of lack of information and their perception of their role as FM-DOT observers. To ensure delivery of the most effective care by FM-DOT observers, there is a need to understand the role perception and role performance of FM-DOT observers. Therefore, this study aimed to: (a) describe the perceived role perception and role performance of FM-DOT observers, and (b) examine the relationships among various aspects of both perceived role perception and role performance of FM-DOT observers.

Conceptual Framework

The conceptual framework of the study was based on DOT observers' roles outlined in "The Practice Guidelines for DOT Observers" purposed by the Tuberculosis Division, Ministry of Health, Thailand. "The Practice Guideline for DOT Observers" consisted of four dimensions: treatment regimen support, psychosocial support, financial support, and case finding.[15] Role is the pattern of behavior associated with expected and actual behaviors a person should perform to maintain a specific position or situation.[16] Role performance refers to an individual's capacity to function in accord with social expectations of a particular role[17] and is influenced by role perception that is an individual's belief about what constitutes his/her role.[16] Therefore, if the FM-DOT observers perceive and understand their roles according to "The Practice Guidelines for DOT Observers" purposed by the Tuberculosis Division, Ministry of Health, Thailand, they will be able to carry out their roles in a suitable and effective manner.

Method

Sample

A descriptive correlational design, using purposive sampling, was employed. The sample consisted of 65 family member-DOT observers who had been assigned to provide care for people with PTB. Since there was no previous research reporting the relationship of the study variables, the estimated number of subjects needed was determined by using power analysis at a power of .80, significance level of .05 and medium effect size of .50.[18] Subjects were recruited from six hospital outpatient TB clinics located in the southern part of Thailand: one regional hospital, one general hospital and four community hospitals. Criteria for inclusion included: assignment to be a DOT observer for 2 to 5 months; documentation, by the TB clinic, that the individual

was a DOT observer; ability to verbally communicate; orientation to time, place and person; and willingness to participate in the study.

As reflected in **Table 1**, most subjects were females between the ages of 15 and 30 years, with a mean age of 37.9. Most were married, Muslim and had an educational background at the primary school level. The primary occupations were agriculturists and employees. One-third reported an inadequate family income with almost 50% reporting earnings of 3,000-9,000 Baht per month (average = 8,138 Baht).The largest percentage of subjects had no underlying diseases; were wives or daughters of the patient with PTB; lived with the patient in the same household; had no past experience in providing TB care; had either 2 or 5 months experience in providing care; had 5-7 people in the family structure; assessed the patient's TB severity to be moderate; had a high ability for following instructions; received TB information from the clinic staff; and indicated that the health care staff made no home visits to the patient with TB.

Table 1 Demographic characteristics of subjects (n = 65)

Characteristics	*Frequency (n)*	*Percentage (%)*
Gender		
Female	54	83.1
Male	11	16.9
Age (years)		
15-30	27	41.5
31-45	17	26.2
46-60	16	24.6
> 60	5	7.7
Marital status		
Single	15	23.1
Married	45	69.2
Widowed	4	6.2
Divorced/Separated	1	1.5
Religion		
Buddhist	25	38.5
Islam	40	61.5
Educational level		
No formal education	3	4.6
Primary school	35	53.8
Secondary school	20	30.8
Diploma	6	9.2
Bachelor's degree	1	1.5
Occupation		
Unemployed	13	20
Employee	18	27.7

Table 1 (continued)

Characteristics	*Frequency (n)*	*Percentage (%)*
Agricultural	19	29.2
Trade/ Business person	11	16.9
Others (Student)	4	6.2
Adequacy of family income		
Adequate	43	66.2
Inadequate	22	33.8
Averaged family income (Baht per month)		
3,000-6,000	27	41.5
6,001-9,000	20	30.8
9,001-12,000	7	10.8
12,001-15,000	10	15.4
> 15,000	1	1.5
Presence of underlying disease		
Yes	13	20
No	52	80
Type of underlying disease		
Hypertension	3	23.1
Diabetes mellitus	2	15.4
Hypertension + Diabetes mellitus	2	15.4
Allergy	2	15.4
Arthritis	4	30.7
Number of family members (persons)		
2- 4	28	43.1
5-7	30	46.1
8-10	5	7.7
11-13	2	3.1
Relationship with patient		
Mother	7	10.8
Husband	4	6.1
Wife	20	30.8
Sibling	5	7.7
Son	1	1.5
Daughter	23	35.4
Others (Grandmother, Niece, Daughter-in Law, and Uncle)	5	7.7
Living in same household with patient		
Yes	60	92.3
No	5	7.7

Table 1 (continued)

Characteristics	*Frequency (n)*	*Percentage (%)*
Duration of being FM-DOT observer		
2 months	24	36.9
3 months	16	24.6
4 months	23	35.4
5 months	2	3.1
Past experience of taking care of patient		
Yes	5	7.7
No	60	92.3
Severity of illness as perceived by observers		
Severe	23	35.4
Moderate	31	47.7
Mild	11	16.9
Level of following instructions		
High	52	80
Moderate	12	18.5
Low	1	1.5
FM-DOT observer received information regarding TB /caring for TB patients		
Yes	58	89.2
No	7	10.8
Source of information (select more than one)		
Leaflet	11	16.9
Radio, television	2	3.1
Physician, nurse	23	35.4
TB clinic staff	51	78.5
Health center staff	13	20
Magazines, newspaper	2	3.1
Others (Zonal tuberculosis center 12 staff, classes at school, talking with TB patient, and people in neighborhood)	14	21.5
Health center staff visit patient's home		
Yes	21	32.3
No	44	67.7
Number of time home visited		
Once	2	9.5
Twice	9	42.8
Three times	7	33.3
Five times	1	4.8
Eight times	2	9.5

Instruments

The instruments used consisted of 3 researcher developed questionnaires: Demographic Data Questionnaire, Role Perception of FM-DOT Observer Questionnaire (RPC-FMQ), and Role Performance of FM-DOT Observer Questionnaire (RPF-FMQ). The demographic component of the instrument was constructed to obtain data related to the subjects': gender, age, marital status, religion, educational background, occupation, perceived adequacy of family income, average family income, number of family members, relationship to the person with TB, duration of care-giving, presence and type of underlying personal diseases, experience in providing care for a person with PTB, presence in the home of the patient with TB, perceived assessment of the severity of the patient's TB, ability to follow instructions, receipt and source of information on caring for a patient with TB, and identification of the number of home visits made to the patient with TB by a member of the health care staff.

The RPC-FMQ component was developed based on the practice guidelines for DOT observer roles proposed by the Thai Tuberculosis Division.[15] It consisted of 20 items within four dimensions: treatment regimen support (8 items), psychosocial support (5 items), financial support (4 items), and case finding (3 items). Each item was scored on a 4-point Likert-type scale with 1 = strongly disagree, 2 = somewhat disagree, 3 = somewhat agree, and 4 = strongly agree. There were 17 positively stated items and 3 negatively stated items. The scores of the negative items were reversed before analysis. The possible total score ranged from 20 to 80. The total and subtotal of the role perception scores were divided into 3 levels using the mean and standard deviation as the cut-off points: low (< mean - S.D), moderate (= mean ± S.D), and high (> mean + S.D). The range of scores for the three levels for the subtotal and total scores were as follows: (a) treatment regimen support (low: < 24.25; moderate: = 24.25-31.53; high: >31.53); (b) psychosocial support (low: <16.21; moderate: =16.21-19.83; high: >19.83); (c) financial support (low: <11.81; moderate: =11.81-15.45; high: >15.45); (d) case finding (low: <8.23; moderate: =8.23-10.85; high: >10.85) and total score (low: <63.99; moderate: =63.99-74.17; high: >74.17). The instrument's content validity was determined by three professional experts in the field. The instrument alpha coefficient was found to be 0.71. The obtained scores were independently rated by the principle investigator and two research assistants with an inter-rater reliability or 98%.

The RPF-FMQ component was developed based on the practice guidelines for DOT observer roles proposed by the Thai Tuberculosis Division.[15] Some items of the measure were modified from the roles of "Family Members in Caring for Tuberculosis Patients' Questionnaire."[9] The RPF-FMQ was composed of 42 items with four dimensions: treatment regimen support (19 items), psychosocial support (14 items), financial support (6 items), and case finding (3 items). Each item was scored on a 5-point Likert-type scale: 0 = not applicable, 1 = never practice, 2 = sometimes practice, 3 = often practice and 4 = always practice. There were 36 positively stated items and 7 negatively stated items. The scores of the negative items were reversed. Total scores could range from 0 to 168. The actual scores were calculated to show the percentage of total and subtotal role performance scores. The percentage of total and subtotal role performance scores were classified into 5 levels: poor (less than 59%), fair (60-69%), moderate (70-79%), good (80-89%), and excellent (90-100%).[9] Cronbach's alpha for this instrument was 0.74. The obtained scores were independently rated by the principle investigator and two research assistants, with an inter-rater reliability of 95%.

Data Collection and Analysis

The primary investigator and research assistants provided potential subjects who met the inclusion criteria information about the study, informed them their participation was voluntary and that they had the right to withdraw at any time without negative repercussions. Confidentiality and anonymity were ensured by using code numbers on completed questionnaires, and all questionnaires were viewed only by the researchers and research assistants. Completed questionnaires, of subjects consenting to take part in the study, were secured in a locked file cabinet. Data were collected by either the primary investigator or one of the two research assistants, who all were registered nurses and trained in data collection using the study instruments. All three questionnaires were read to each subject and his/her response, to each item, was immediately recorded on the respective questionnaire.

To assess the demographic data, role perception scores and role performance scores, frequencies, percentages, means, standard deviations and score ranges were calculated. Pearson's correlation coefficient was used to determine the relationship between the role perception scores (subtotal and total) and the role performance scores (total and subtotal) of the FM-DOT observers.

Results

With regard to the role perception of FM-DOT observers (See **Table 2**), all subtotal scores (treatment regimen support, psychosocial support, financial support and case finding) and the total score were found to be at moderate levels. Results of the role performance perception (See **Table 3**) suggested poor financial support and case finding, fair treatment regimen support, and moderate psychosocial support. The overall ranking of role performance was found to be fair. No significant relationships were found between any of the subtotal or total scores for both role perception and role performance (See **Table 4**).

Table 2 Possible range of scores, actual range of scores, means, standard deviations, and level of role perception of FM-DOT observers (n= 65)

Variable	**Range of Scores**		*Mean*	*S.D.*	*Level*
	Possible range of scores	*Actual range of scores*			
Treatment regimen support	8-32	18-32	27.89	3.64	Moderate
Psychosocial support	5-20	14-20	18.02	1.81	Moderate
Financial support	4-16	8-16	13.63	1.82	Moderate
Case finding	3-12	6-12	9.54	1.31	Moderate
Total	20-80	51-77	69.08	5.09	Moderate

Table 3 Actual range of scores, percentage range of scores, means, standard deviations, and levels of role performance among FM-DOT observers (n = 65)

Variable	Range of Scores		*Mean*	*S.D.*	*Level*
	Possible range of scores	*Actual range of scores*			
Treatment regimen support	28-65	41-88	66.23	11.93	Fair
Psychosocial support	32-51	57-91	74.78	7.37	Moderate
Financial support	4-17	25-71	52.34	11.71	Poor
Case finding	1-10	25-100	38.40	17.75	Poor
Total	78-122	53-78	66.00	6.13	Fair

Table 4 Pearson's correlation coefficients between role perception scores and role performance scores (n = 65)

Role performance	Role perception
	Correlation coefficients (r)*
Treatment regimen support	.13
Psychosocial support	.11
Financial support	-.00
Case finding	-.06
Total	.13

* All $p > .05$ (ns)

Discussion

With respect to perceived role perception in this study, results suggested all the scores (subtotal and total) were at a moderate level. This may be because of the inadequacy of the information regarding TB provided to the subjects and care of patients with TB. Slightly over ten percent of the subjects never received information, even though they had been assigned to be a FM-DOT observer. In addition, the source of information received was mainly from TB clinic staff (78.5%), who usually had limited amounts of time due to numerous routine duties and a heavy patient case overload. As a result, TB clinic staff members may not have been able to provide a standard educational program for the DOT observers.

The overall role performance of FM-DOT observers was found to be at a fair level. This may be have been related to the fact that FM-DOT observers could not apply what they had learned to real life situations nor synthesize knowledge to manage their care performance. Secondly, even though the FM-DOT observers might have perceived what their role was and knew how to perform it, they did not want to do it because they may have perceived the TB patients as being independent and capable of performing activities of daily living by themselves. As a result, the FM-DOT observers tended to leave their allocated tasks to the TB patients and helped

them with only some required activities. When the FM-DOT observers were asked about the perceived severity of the TB clients' illness, the majority (47.7%) indicated the illness was moderate. This suggests they were aware, that although pulmonary tuberculosis is an infectious disease and can easily spread to others, the disease was not having much effect on the patients' ability to perform activities of daily living. In regards to people with PTB, some of them may have perceived they did not need support and assistance from FM-DOT observers, as they could perform many activities by themselves. Some patients may not have trusted their observers, while a few of them may have been annoyed when the FM-DOT observer directly observed them or reminded them to take the drugs.

Heath care personnel play significant roles in influencing the performance of FM-DOT observers. However, during data collection, it was noted that due to high personnel turnover rates a number of TB clinic staff had never been trained in the DOTS training course. Thus, many did not have specific knowledge and skills in the DOTS practice guidelines, regarding the role of DOT observers, and had minimal experience in practicing DOT activities.

Another problem was the ineffective and inadequate supervision of FM-DOT observers by health center staff. Most of the subjects (67.7%) had never been visited and provided supervision by the health center staff at home. According to the practice guidelines for DOTS of TB patients, even though FM-DOT observers have to manage treatment, the health center staff still is responsible for visiting, at least once a week during the first two months of treatment, the patients and their FM-DOT observers. The purpose of the visit is to monitor drug administration at home, give consultation and advice, and provide health education to FM-DOT observers. The importance of the visit is confirmed by prior research, which found that trained and supervised DOT workers can successfully provide DOT.[4]

The selection process for the FM-DOT observers, in this study, may have been inadequate. Some observers could not stay, at all times in the same household, with the patient with PTB due to having to work or study in another district or province. As a result, they could not adequately carry out their responsibilities all of the time. Additionally, some of the FM-DOT observers may have been too old or never received formal education that might have affected their ability to learn and perform their FM-DOT tasks.

Policy and practice guidelines were other factors that may have influenced role perception and role performance of FM-DOT observers. The DOTS strategy has been implemented in Thailand since 1997, but has been applied only since 2001 in the districts in the southern region.[11] Some of the policies and practice guidelines remain unclear. Although, there are practice guidelines, which were developed by the Tuberculosis Division, MOH Thailand and distributed to hospitals and TB clinics, many health care staff may not pay attention to the material or follow the DOT observer practice guidelines. On the other hand, the practice guidelines which have been developed for all types of DOT observers (health personnel, community members, and family members) may require modifications so that they more accurately reflect the needs of each type of observers. It is possible that the responsibilities and duties of the FM-DOT observers are not accurately reflected in the guidelines, which in turn, could affect the assessment of performance.

The results revealed that role performance of FM-DOT observers on treatment regimen support was at a fair level. One explanation may be that most of the families, in this study, consisted of multiple family members who could share responsibilities in household chores and assistance in caring for those with PTB. This may have allowed the assigned FM-DOT observers to partially abdicate their role regarding such tasks as observing drug intake or

going with the patient for follow up appointments. Thus, even though the score of role performance for the FM-DOT observer was not high, the caring activities for the family members with PTB may have been carried out by someone other than the assigned FM-DOT observers.

In role performance related to psychosocial support, the FM-DOT observers had a moderate level of performance. The findings showed the majority of subjects regularly or often provided sympathy, warmth, attention, leisure activities and other types of relief activities to those with PTB. However, almost half had never encouraged the patients to participate in family recreational, social and community activities. This might be because FM-DOT observers wanted to protect their sick family members from being shunned by others. The primary researcher and research assistants heard FM-DOT observers saying they did not tell other individuals about their family members' TB because they wanted to ensure a normal life for themselves and their loved ones, and did not want to be rejected due to the fear of possibly contributing to the spread of the disease.

According to the role performance financial support scores of FM-DOT observers, the results revealed the majority had poor performance. The average monthly income per household in the Southern region is 11,407 Baht.[19] The present study found that only 16.9% of the subjects had an average family income of more than 12,000 Baht per month, and almost half reported their family income to be 3,000-6,000 Baht per month. Therefore, their economic status was very low. In addition, almost one-quarter of the subjects were unemployed.

The FM-DOT observers had poor performance in case finding activities and the majority never had practiced advising and motivating neighbors or others who were suspected of having TB. The reason for a poor performance may have been that the FM-DOT observers may not have perceived case finding activities as an important part of their role. This also may reflect the Thai culture regarding interaction with others. In the Thai society, people are hesitant to interfere with others' privacy and personal matters. Since many of the patients looked healthy, were able to work and did not outwardly demonstrate symptoms of a TB infection, it is likely that the FM-DOT observers did not feel it necessary to intervene and engage in case finding.

No significant correlations were found between any of the subtotal or total scores of role performance and role perception. One possible explanation may be related to motivation and knowledge. Motivation refers to extrinsic conditions that stimulate certain behaviors and intrinsic responses in addressing needs, wants and drives.[20] Motivation is a fundamental component of learner readiness.[17] When individuals, in this case the FM-DOT observers, manifested low motivation, it was not surprising their readiness and willingness to seek and gain knowledge was affected. This, in turn, may have influenced their perception of role performance. Moreover, positive or desired behaviors should be rewarded or reinforced.[20] Reinforcement motivates and speeds up performance and gives reasons to continue learning.[17] However, those variables were not explored in this study, so this argument could not be strongly confirmed. However, this argument was supported by Roy and Robert's[16] conceptualization of the role function system, which proposes that many factors relate to role performance, not just role perception. Another reason why the study may have failed to find significant relationships, among the variables of role perception and role performance, was because of the small sample size, which lessened the sensitivity in detecting the relationships.

Implications for Nursing Practice

Information obtained from this study can be used to increase nurses' and other health care providers' understanding related to the performance of FM-DOT observers. Inadequate knowledge about the role of FM-DOT observers possibly was the main reason for a low level of role perception of the FM-DOT observers. This suggests that a systemic way is needed to promote the use of DOT strategies. Nurses should provide standardized health education regarding the DOT program. Assignment of the right person in the family to be a FM-DOT observer, based on a set of selection criteria, also is crucial.

Recommendations

Further research is needed to explore the problems and/or obstacles in performing the DOT observer role. Inclusions of variables such as motivation and knowledge also may prove helpful, as would a larger sample size. In addition, in an attempt to expand the understanding of role perceptions and role performance of DOT observers, it would be advisable to examine similarities and differences among the various types of DOT observers (health personnel, community member and family member). This may prove helpful in identifying which type of DOT observer is most effective for each type of patient.

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การรับรู้บทบาทและการปฏิบัติตามบทบาทของผู้กำกับดูแลผู้ป่วยวัณโรคที่เป็นสมาชิกครอบครัว*

นันทิยา พรหมรักษ์, อุไร หัถกิจ, แสงอรุณ อิสระมาลัย

บทคัดย่อ: การวิจัยครั้งนี้ต้องการศึกษาการรับรู้บทบาท และการปฏิบัติตามบทบาทของผู้กำกับดูแลผู้ป่วยวัณโรคปอดที่เป็นสมาชิกครอบครัว กลุ่มตัวอย่างคือ ผู้กำกับดูแลผู้ป่วยวัณโรคปอดที่เป็นสมาชิกครอบครัว จำนวน 65 ราย คัดเลือกอย่างเฉพาะเจาะจงจากผู้กำกับดูแลของผู้ป่วยวัณโรคปอดที่มารับการตรวจรักษาที่คลินิกวัณโรค แผนกผู้ป่วยนอกของโรงพยาบาล 6 แห่ง ในภาคใต้ตอนล่างของประเทศไทย เก็บข้อมูลโดยใช้แบบสอบถาม 3 ชุด คือ แบบบันทึกข้อมูลส่วนบุคคลของผู้กำกับดูแลที่เป็นสมาชิกครอบครัว แบบสอบถามการรับรู้บทบาทของผู้กำกับดูแลที่เป็นสมาชิกครอบครัว และแบบสอบถามการปฏิบัติบทบาทของผู้กำกับดูแลที่เป็นสมาชิกครอบครัวตามการรับรู้ของผู้กำกับดูแลที่เป็นสมาชิกครอบครัว แบบสอบถามได้รับการตรวจความตรงด้านเนื้อหาโดยผู้ทรงคุณวุฒิ 3 ท่าน และหาค่าสัมประสิทธิ์ความเชื่อมั่นของเครื่องมือได้ 0.71 สำหรับแบบสอบถามการรับรู้บทบาทของผู้กำกับดูแลที่เป็นสมาชิกครอบครัว และ 0.74 สำหรับแบบสอบถามการปฏิบัติบทบาทของผู้กำกับดูแลที่เป็นสมาชิกครอบครัวตามการรับรู้ของผู้กำกับดูแลที่เป็นสมาชิกครอบครัว วิเคราะห์ข้อมูลโดยใช้สถิติบรรยาย และค่าสัมประสิทธิ์สหสัมพันธ์แบบเพียร์สัน ผลการศึกษาพบว่า ผู้กำกับดูแลที่เป็นสมาชิกครอบครัวมีการรับรู้บทบาทของตนเองทั้งโดยรวมและรายด้านอยู่ในระดับปานกลาง มีการรับรู้การปฏิบัติตามบทบาทของตนเองโดยรวม และการปฏิบัติตามบทบาทด้านการรักษาพยาบาลอยู่ในระดับพอใช้ การรับรู้การปฏิบัติตามบทบาทด้านจิตสังคมอยู่ในระดับปานกลาง ส่วนการรับรู้การปฏิบัติตามบทบาทด้านการเงินและการค้นหารายป่วยอยู่ในระดับต้องปรับปรุง นอกจากนั้นยังไม่พบความสัมพันธ์อย่างมีนัยสำคัญทางสถิติระหว่างการรับรู้บทบาท และการปฏิบัติตามบทบาทของผู้กำกับดูแลในแต่ละด้าน

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***นันทิยา พรหมรักษ์**, MNS, RN. โรงพยาบาลหาดใหญ่ อำเภอหาดใหญ่ จังหวัดสงขลา ประเทศไทย.*
*ติดต่อที่ **อุไร หัถกิจ**, PhD, RN. ผู้ช่วยศาสตราจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ อำเภอหาดใหญ่ จังหวัดสงขลา ประเทศไทย. อีเมล์: urai.h@psu.ac.th, uraihster@gmail.com*
***แสงอรุณ อิสระมาลัย**, PhD, RN. ผู้ช่วยศาสตราจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ อำเภอหาดใหญ่ จังหวัดสงขลา ประเทศไทย.*