Family Strength in Caring for a Stroke Survivor at Home

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Abstract : This hermeneutic phenomenological study explored the meaning of family strength when caring for a stroke member at home. Family strength is considered to be the competency of a family when faced with a stressful life event that can be viewed through a continuous man-environmental interaction process. Six family units were purposively recruited and screened using the Family Hardiness Index (four with high-level of hardiness, and two with moderate-level of hardiness). Data were collected through in-depth interviews, field observations and field notes, and analyzed using Braun and Clarke's thematic analysis method.

Findings revealed families with high-hardiness continuously strove to overcome caregiving hardships and had hope for the stroke member's long existence, while families with moderate-hardiness demonstrated less effort to overcome caregiving hardships and held no hope for the stroke member's long existence. Primary caregivers among families with high-hardiness revealed more self-development in carer role than did those of families with moderate-hardiness. Families with high-hardiness shared caregiving and family task responsibilities, while families with moderate-hardiness lacked collaboration regarding caregiving and family tasks. In addition, family strength emerged from families overcoming caregiving hardships through: hope for the stroke member's long existence; development, accumulated experiences of "can do" family members; and, establishment of shared caregiving and family task responsibilities.

Consideration of views and abilities of the family unit to provide homecare for a stroke member can enhance nurses' understanding of different developmental experiences of home caregiving families. In addition, such knowledge can facilitate adoption of meaningful nursing interventions to support the families.

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Background and Significance

Informal home care for family members who have had a stroke (stroke members) is a common practice in Thailand. More than 80% of Thai stroke survivors are discharged from the hospital to home, although 99% of them continue to need care provided by family members.[1] Prior research has found families of stroke members experience difficulties when providing

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home care, including: feeling unappreciated regarding household routines;[2] changes in family relationships;[3] and, financial strain.[4] It is not unusual for such families to have to deal with family burden,[5] dysfunction,[6] role strain and conflict,[7,8]and, changes in family life,[9] due to having to rearrange family roles and functions, as well as attempts to maintain family patterns based on individual ability.[10]

The ability of a family unit (two or more family members) to work together is relevant to the strength of the family. The family's strength often is referred to as "family strength" or "family hardiness,"[11] and has been conceptualized as an internal resource of the family unit.[12] Family strength has been viewed as being constructed from sharing of capabilities,[13] including cognitive, attitudinal and behavioral characteristics of each family member.[14] In addition, family strength has been shown to be positively linked to families overcoming stressful life events,[15,16] when they have access to social support, an ability to cope and good family functioning[17-19] that facilitates the family's adaptation[16, 20] and well-being.[18,21,22] Thus, family strength may be perceived as a beneficial factor for family units providing home care for a stroke member.

Limited information regarding effects of family strength on family units could be located in English and Thai literature. No studies could be found, which focused on how Thai families view and/or feel when they are providing home care for a stroke member.

Families, according to Parse's theory of human becoming,[23,24] are comprised of open, intentional beings who freely choose meaning in a given situation, construct their own ways of being with the situation and move with their own choices whether opportunities or limitations are present. Three principles of Parse's theory (see **Table 1**), meaning, rhythmicity and cotranscendence, provide a lens through which to interpret family members' lived experiences when providing home care, based on their own ability, for a stroke member.

Table 1 Principles of Parse's Theory of Human Becoming[23,24]

Principles	
Principle 1	"Structuring meaning multidimensionally" is cocreating reality through the languaging of valuing and imaging.
Principle 2	"Cocreating rhythmical patterns of relating" is living the paradoxical unity of revealing-concealing and enabling-limiting, while connecting-separating.
Principle 3	"Cotranscending with the possibles" is powering unique ways of orientating in the process of transforming.

The first principle, meaning, implies families think, move with and interpret situations through their words, body language and actions or inactions as they create their own realities. Thus, a theoretical explanation of this phenomenon may be helpful in developing nursing practices to support families providing home care for stroke survivors. Therefore, this study sought to answer the question: "What is the meaning of family strength when providing home care for a stroke member?"

Method

Design: The qualitative approach of hermeneutic phenomenology[25] was used to investigate the research question.

Participants: Since this study focused on the family as a unit, at least two or more family members, per family, were purposively recruited as potential participants. One family member was identified, by each family unit, as the primary care provider (PCP), while the secondary caregivers, in each family unit, were identified by the PCP.

Six families (16 family members) who were providing care for a stroke member were recruited via a multiple recruitment process (see **Figure 1**). Inclusion criteria included families who: provided home care, in Songkhla Province, Thailand, for at least 1 year, for a family member who had experienced a moderate-severe stroke; scored 0 -11 on the Modified Barthel Activity of Daily Living Index (MBAI);[26] scored 21 - 60 on the Family Hardiness Index (FHI);[11] and, had at least two family members who could be considered key informants. Four families had high FHI scores (41, 47, 48.5, 51), while two had moderate FHI scores (37.7, 38). The stroke member of each family included 4 men and 2 women, who ranged in age from 53 to 91 years, and had an ischemic stroke score of 0 - 7 on the BMAI.

Step 1	Obtaining names of families	Provided 75 families who cared for a stroke member at home for at least 1 year.
Step 2	MBAI*	Provided 37 families who scored 0 - 11 on the MBAI and care for a stroke member at home for at least1 year.
Step 3	FHI**	Provided 12 families who scored 21- 40 on the FHI, and 25 families who scored 41-60 on the FHI.
Step 4	Selection matrix	Placed 25 families into a high degree of hardiness group and 12 families into a moderate degree of hardiness group.
Step 5	Purposive sampling	From the two groupings of families, selected 6 families (4 with a high degree of hardiness and 2 with a moderate degree of hardiness). From these 6 families, 16 participants, as sub-units of the analysis, were recruited. Of the 6 families, 3 had 2 participants, two had 3 participants and one had 4 participants.

* MBAI = Modified Barthel Activity of Daily Living Index
**FHI = Family Hardiness Index

Figure 1 The Multiple Step Recruitment Process

The 16 family members [11 women (68.75%)] and 5 men (31.25%)], who served as key informants, were stroke members' wives, daughters, sons, and son-in-laws. They ranged in age from 24 to 67 years, predominantly (n=13; 81.25%) were married and resided nearby or within the same household as the stroke member. Three (18.75%) wives, and three (18.75%) daughters, had been providing home care for their respective stroke member for 13 to 168 months, and were identified as each respective family's primary caregiver.

Data collection: Prior to data collection, ethical approval of the study was granted by the primary researcher's (PI) institution and the provincial public health office where data were gathered. Health volunteers, at the distinct public health organization: identified 75 families who were providing home care for a stroke member; took the PI to each respective home; and, introduced her to the families.

Since this research focused on the family, as a unit, at least two or more family members per family were recruited as potential study participants, in accordance with Rosenblatt and Fischer's recommendations.[27] Thus, potential participants recruited consisted of each family's PCP and at least one other family member, identified by the respective PCP as assisting in the care of the ill family member.

In determining family unit eligibility for inclusion in the study, the PI, utilizing the MBAI, asked each of the 75 families' PCP who else in the family had provided home care and support, through both direct and indirect actions, for the stroke member. The identified PCP also was asked to confirm if he/she was indeed the PCP. This process eliminated 38 of the potential family units.

Then the FHI was used to determine which of the remaining 37 family units might have differences in their strength behaviors or activities when caring for their stroke member. Twelve family units were identified has having a moderate degree of hardiness (FHI = 21-40) and 25 family units had a high degree of hardiness (FHI = 41-60). Using purposive sample selection, 4 family units with a high degree of hardiness (FHI = 41; 47; 48.5; 51) and 2 family units with a moderate degree of hardiness (FHI = 35.5; 37) were selected to participate in the study.

In regards to recruitment of potential participants (subunits of analysis), PCPs initially were recruited and informed about the study's process, their right to withdraw at anytime without repercussions, and that their anonymity and confidentially would be maintained prior to being asked to sign a consent form to participate. After the PCPs consented to participate and identified the secondary care providers (SCPs), those who assisted with the family's stroke member, the SCPs were approached and told: about the study; their anonymity and confidentiality would be maintained; and, they could withdraw at anytime without repercussions.

Prior to interviewing each participant, he/she was provided an opportunity to reconsider participation in the study, and asked to verbally consent for his/her interviews to be tape-recorded. Family members who could not be contacted or chose not to participate were considered to be non-respondents and, subsequently, excluded from the study. Thus, 2 - 4 members per family participated in the study (see **Figure I**). Each was interviewed 2 - 3 times, by the PI, providing a total of 34 interviews. Twelve interviews were obtained from the two moderate-hardiness families (6 members), and 22 interviews were conducted with the four high-hardiness families (10 members).

The tape-recorded interviews lasted 1 - 3 hours in each respective family's home. Each interview began with the request: "Please speak about what life is like for you providing home care for your family member who has experienced a stroke." In an effort to gain increased information, focused and probing questions and requests were made: "Please share something you, as a family unit, are concerned about regarding providing home care for your stroke member;" "Why do you provide home care for your stroke member, if it means more burden for you?" and, "Is there anything else, given the circumstances, that would have made the home care you provide your stroke member better (worse)?" In addition, the PI noted respondents' body language and voice tones. All observations of family activities and interactions were recorded in field notes, along with the researcher's self-reflections. Each recorded interview was transcribed verbatim for analysis.

Data analysis: Data analysis simultaneously occurred with data collection through use of a thematic analysis method[28] with a human becoming perspective.[23,24] The PI began the analysis process through immersion into each data set so as to gather the core ideas of each participant. Then, analysis of the data sets, within the same family, was accomplished so as to capture commonalities across participants, including comparison of significant statements. All textual data were read, while giving full and equal attention to line-by-line raw data, and manually marked with initial codes so codes could be reanalyzed and combined as potential abstract themes. A thematic map was used to link codes, sub-themes and themes until they fit together.

Trustworthiness of the research was assured through credibility, dependability, confirmability and transferability.[29] Prolonged engagement with each family's caregiving experiences was accomplished via prolonged home visits and participation in family activities. All dialogues were translated into English through parallel efforts of a native English language teacher and a southern Thai-English bilingual teacher, born in the research setting area and able to comprehend the local dialect. Both contacted the primary researcher when clarification regarding the study's context was needed.

Participants were asked to review the accuracy of interpretations of the findings regarding their experiences, views and feelings. For interpretations considered inaccurate, corresponding data were reanalyzed and revised interpretations were presented to participants for review.

An audit trail was conducted, with the assistance of four qualitative inquiry experts (one nurse educator and 3 hermeneutic phenomenologic and ethnographic research advisors), wherein discussion and summarization of interpretations and conclusions drawn from the data were accomplished. In addition, transferability was illustrated through use of specified families used as informants.

Results

Three main themes emerged from the data as the meaning of family strength in providing home care for a stroke member. They included: "Overcoming the hardship with hope for the stroke member's long existence;" "Building up a 'can do' person through accumulated experiences;" and, "Establishing co-responsibility in handling caregiving and family tasks."

Overcoming the hardship with hope for the stroke family member's long existence

The first theme refers to the families' continuous effort in facing suffering and difficulties of providing home care for their respective stroke member, along with hope for the stroke members' long existence. This theme was derived from three components of the families' experiences: suffering and difficulties of living with and caring for the stroke member; putting effort into overcoming hardships; and, valuing the long existence of the stroke member.

Having to face suffering and difficulties living with the stroke member began for families when the family member suddenly and unpredictably, without any alarms, signs or symptoms, had a stroke at home: *"One day at night time she (stroke member) fell down. I didn't know what she hit...She tried to get up, but she couldn't."* Later, family members realized their loved ones' stroke would involve a prolonged process and could not be cured: *"I knew in my heart that he (stroke member) would not get better because he had an illness with severe symptoms."* Participants then observed the continual health changes the stroke member experienced: *"In fact, he (stroke member) could use a cane, but now he cannot...he could raise his arm, but now, he cannot...I don't know what happened."* Since they felt unprepared to deal with the changes, each change in health of their loved one brought new difficulties for family members because the changes required them to acquire new knowledge and skills.

Informants stated being stressed because of not knowing how to provide appropriate care for the stroke member: *"I was so stressed because I'd never seen anything like this before...I didn't know what to do."* Providing care for the stroke member was an added task that changed routine family activities, making it difficult for them to meet the stroke member's needs, as well as to accomplish other family tasks. Within the family, the person who expressed feeling most overwhelmed and experienced the greatest turmoil was the PCP: *"The first year my father was sick...he could not get better. I thought it was so bad because I had even more responsibilities."* Sometimes the PCPs sought help to deal with their responsibilities, but said they still had feelings of helplessness and being overwhelmed:

> *"It's difficult to ask for other's help. Sometimes my neighbors help us to take him (stroke member) there (hospital). But we are hesitant to ask them because they have helped us many times already."*

Although family members felt overwhelmed in dealing with the stroke member's condition, they recognized the necessity to provide continuous home care for their loved one. They knew it was the family's responsibility to provide home care, even though doing so was tiresome and hard to face:

> *"Tired...But I'm not discouraged... I'm not afraid of hardship or being tired... Some people take care of the patients and they wonder when they will die. But for me, I don't think like that. Even though it's hard for me, I must take care of her."*

Regarding putting effort into overcoming their hardships, families with high-hardiness expressed being troubled due to the amount of time, energy and money they spent providing care for the stroke member. However, they made an effort to overcome their hardships and kept track of treatments that produced good outcomes and preserved the stroke member's life:

> *"We rented a car and carried her (stroke member) by 2 or 3 persons. It's so terrible and so hard to take her there (hospital). It took a long time to carry her to see the doctor. If I don't carry her to take medicine, I don't know what would happen to her... May be she would have died for a long time already."*

In addition, families with high-hardiness continued seeking the best treatment for the stroke member, including alternative medicine, hoping it would heal the stroke member:

> *"I try to get him (stroke member) healed... if I know new doctors, I'll take him to see them. In 14 years I've spent about 100,000 baht in doctor's bills...If someone tells me this is good medicine, I just buy it. I don't think about myself. I wanted him to be completely healed."*

In relating what was important to them when faced with hardships, families stated most valuing the "stroke member staying alive." Eight informants stated their stroke member's long existence would make the family complete, especially since all of the family lived together and interacted with one another:

> *"I still want him (stroke member) to stay alive...if everyone in my family can live together forever, we'll feel warm... It is better if we can see each other face to face rather than sitting and talking to a picture...We can discuss things together."*

Since they were Buddhist and believed in "Karma," six family members felt the long existence of the stroke member would allow him/her an opportunity to repay wrongs from the past. They felt the stroke was due to past deeds. Thus, being alive would allow the stroke member time to payback his/her *"chai-kaam"* [paying back the past deed]. They said:

> *"This is his (stroke member) karma. (whispered) The neighbors say that this is his karma, and he must pay it off completely. I thought that."*

In addition, four informants stated the stroke member's long existence would provide an opportunity for carers to repay him/her, since during their past lives they may have done something bad to him/her. Thus, they felt it would be good to *"chai-wein-chai-kaam"* [repay all of the bad deeds in this life]. They remarked:

> *"This karma causes him (stroke member) to have trouble and causes others around him to have trouble also. It makes us take care of him. We did this karma together, and now we must pay it off together."*

Effort to overcome hardships in providing home care for the stroke member also was made by moderate-hardiness families. However, their efforts were limited due to lack of family support and feelings of hopelessness:

> *"I don't have the ability to do many things at one time. Sometimes I don't know if I should take care of my dad (stroke member) first, or my kids first, or take care of myself, or take care of my house, or take care of my staff in the office. It's too much for me! I cannot do it all!"*

> *"I don't hope for anything. Nobody helps me...I want him (stroke member) to die first because if he dies after me, he will be in trouble because my kids won't take care of him."*

Building up as a 'can do' person through accumulated experiences

The second theme refers to families' efforts in learning caregiving skills and how to provide effective home care for the stroke member. The PCPs recognized they developed personal competencies via their accumulated experiences: *"I must learn step by step and practice by myself...I have learned so far that I can do."* They also spoke of self-knowing as 'can do' persons: *"I have the ability. If I didn't have the ability to do it, I could not take care of her now."* The building up of each of them as a 'can do' person was revealed in their reflections.

The high-hardiness families primary caregivers did not hesitate to ask physicians questions related to the stroke member's illness and caregiving needs. In addition, they felt they had the right to ask questions:

> *"I like to ask, and I want to know... Most other people are afraid of the doctor. Actually, if the patient asks the doctor, the doctor will answer...But the patients are usually afraid to ask the doctor...If someone is sick like this, we must ask the doctor."*

They also sought information regarding 'how to care' from books, the internet and friends: *"When we fix the problem, we must find information. Mostly we find information from the books. Sometimes we search on the internet. If it's not clear, I will call my friend because she is a nurse."* In addition, other experienced caregivers served as sources of caregiving information for them:

> *"I've seen when the patient wears pampers... and then the caregivers leave the patient at home. The pampers aren't changed often...When they check, the patient has wounds on his/her buttocks...I don't use pampers; I use soap to clean her body and then wipe her (stroke member) dry. I think it's safer for her."*

However, moderate-hardiness PCPs demonstrated less information seeking:

> *"I don't know the right questions to ask... I didn't talk much because when... I asked the doctor some questions, the doctor didn't explain much. If I didn't ask, the doctor wouldn't have said anything."*

High-hardiness PCPs spoke about lessons they learned from their direct and indirect care experiences. They stated they did not always believe everything they were told, but were willing to try what was recommended. If what was recommended proved to be effective, they then would continue it.

> *"The doctor recommended that he (stroke member) eat egg whites so that his wounds will heal quickly...When I heard that, I didn't believe him 100%...But I tried to do it and he got better. His wounds disappeared...Every time he has wounds; I let him eat egg whites."*

The PCPs sometimes used metaphors to describe how they gradually performed the caregiving tasks:

> *"I taught her (stroke member) like I taught children...If the people who take care of the kids don't talk, the kids won't know how to talk...I speak to her every day and she can understand me. I force her brain to work."*

In addition, PCPs said they had to learn how to *"kid-eang-tham-eang,"* meaning they initiated and implemented some caregiving tasks on their own. Two PCPs remarked:

> *"I must learn and practice by myself... Nobody teaches me...I teach myself by common sense...For example, when I give her (stroke member) a shower, I must use two towels. The first towel I use to clean her buttocks to her feet. The second towel I use to clean from her waist to her shoulders. I use two buckets too...I think if I use only one bucket maybe she will have germs in her eyes."*

> *"I thought by myself that it's better for him (stroke member) to lie on a bamboo bed than a mattress because the air can pass through it easily. The patient cannot sit up by himself so he lies down 24 hours a day. I don't have time to help him to move his body...It's better that he lies down on a bamboo bed to get a massage. This idea we call the knowledge from the common people."*

Because of the amount of time spent with the stroke member, PCPs were able to determine whether others provided acceptable care, as well as to adjust their skills in accord with the stroke members' needs. One noted:

> *"I observe him (stroke member) every day so I know... When he is so tired, his eyes are red, he looks confused and gets hungry often. Sometimes he eats, sleeps, eats, and sleeps...then I told my brother to just take him to see the doctor... I think his blood sugar is too high. I take him to the hospital to get his blood sugar checked. And his blood sugar actually is high."*

The most distinctive characteristic of high-hardiness PCPs was their perception of themselves as a 'can do person' regarding positive outcomes. They remarked: *"Now, we don't have stress because we have passed the serious time already."* This perception appears to reflect PCPs feelings of being competent, while living with and providing home care for the stroke member. As they noted, this perception extended to the entire family: *"We live together. We can do it by ourselves."*

However, among moderate-hardiness PCPs, the perception of being a 'can do person' was not clearly evident. The PCPs stated: *"We cannot do it... There is nobody to take care of him (stroke member). I don't know what to tell you."*

Establishing co-responsibility in handling caregiving and family tasks

Within the third theme, co-responsibility was seen as the families' collaborative efforts to provide home care for the stroke member in conjunction with family functions. This was evident in that co-responsibility was expressed in terms of *"mai-mee-khai-geang"* [nobody refuse to do] and *"khai-tum-khon-nun-tum"* [whoever is there does the tasks].

Among high-hardiness families, 'a sense of the family unit' also was noted: *"We have eighty percent unity in our family. Everyone wants to help and we each help with different things."* Thus, the caregivers' assignments and how they assured continuity of care for the stroke member reflected how families took responsibility for caregiving tasks.

Caregiver assignments, with respect to who was assigned, as well as how they were to accomplish tasks, were determined by consensus after families discussed and assessed who could assume the caregiver role: *"We discuss things together about our mom (stroke member)... Other people in our family told me it was up to me".* When asked to differentiate roles, the PCP was seen as the one in charge of care 24 hours a day. All other family members were seen as helpers who could be assigned to perform certain tasks:

> *"The first person (younger sister) is responsible for taking care of our dad (stroke member) for 24 hours a day. She doses everything such as his health, his food and everything else. Other people are helpers. She is in charge of taking care of him. If she (primary caregiver) asks for help; for example, she wants to take him (stroke member) to the hospital... I drive them there all the time.*
>
> *I buy everything else... I cannot take care of her (stroke member). I only pay the money...Just let me know."*

Although caregiving was performed by the PCP, certain time consuming tasks were assigned to others since they often required more than one person to be completed. Other family members also provided care when the PCP needed to attend to personal matters and/or do things outside the home. Thus, family members assisted each other to ensure adequate and continuous care was provided.

> *"When it is time for his (stroke member) shower, my kids will help me to take off his clothes and carry him to the bathroom. And then I will give him a shower... Sometimes my kids or my daughter-in-law does it for me.*
>
> *"When I go to the temple to make merit, (her husband's name) stays at home to take care of her (stroke member)."*

Besides providing care, PCPs had to do tasks related to their family roles and functions. These tasks included daily household tasks, financial matters, social activities and providing care for one another:

> *"At 5 AM I do my job like a housewife... after I've cooked for my husband, I'll prepare her (stroke member) meals. Then, I sweep and mop the floor...I also feed the pigs that I am raising for sale."*

Caring for others was obvious among members of high-hardiness families. They tended to sympathize with PCPs whom they recognized as bearing hardship in providing care for the stroke member: *"If there is something else that I can do, I'll do it. She's so tired;"* or, *"Doing like this everyday...I pity her so I give her help."* They also expressed willingness to give emotional support to the PCPs.

> *"(We) take care of the feelings of the caregivers too. If (younger sister's name) is all alone, she'll be bored, right? We come in and let her vent for a bit...For example, she might tell us, "Today dad (stroke member) didn't take a shower, he didn't eat a lot." We tell her, "Just try to treat him, later he'll eat a little bit"... We try to reassure her...encourage her, too."*

If the PCP needed to attend social activities, other family members took over required care or provided what was needed:

> *"We give some money to the care-giver because she doesn't work. Sometimes she has to go to a party, a wedding, a funeral or the ceremony for someone becoming a monk. She wants to spend money too. I just give money to her because she sacrifices to take care of our mom."*

Concern for the PCP and other family members not only was expressed in doing care tasks together, but also in looking after each others' health. Thus, they took on one another's tasks whenever appropriate and did what was needed:

> *"There was one time I came here and slept here for two or three nights because my mom (primary caregiver) got sick. I wiped her body all night for three nights.*
>
> *"I help with anything I can. Sometimes I cook, cut beef, cut vegetables, and cook rice or curry. I can do anything about food because my wife (primary caregiver) is busy."*

While caregiver assignments were similar, the number of assistant caregivers was less among moderate-hardiness families than among high-hardiness families:

> *"Only I provide daily care because my kids never help me to take care of my husband...My kids think that they have their mom to take care of their dad, and they aren't interested."*

Moderate-hardiness PCPs said fewer activities were performed by other family members to ensure continuity of care. Thus, the majority of caregiving tasks were accomplished by PCPs:

> *"I don't take care of him (stroke member) because when I get up, he isn't awake yet. I must go to work... Only my mom takes care of him."*

However, moderate-hardiness family members did what was needed to assure family tasks were accomplished:

> *"I must go to work ...If our family has some trouble with finances, other members give some money to me so that I have time available to take care of him (stroke member)...After I get up in the morning, I can take my turn to do family tasks."*

Discussion

In regards to the first theme, "Overcoming hardship with hope for the stroke family member's long existence," findings suggest, within high-hardiness families, providing care for stroke members was done with hope and continuous effort, even in the midst of hardships. Families experienced numerous stressful situations and sometimes felt helplessness, especially at first, when responding to the numerous changes and continuous care required by the stroke member. However, the families were committed to providing care due to viewing the long existence of the stroke member as an opportunity to be a complete family and to repay past bad deeds.

When integrated with Parse's Theory of Human Becoming,[23, 24] overcoming hardship with hope is a force that is connected to the ways families affirm-not affirm, while moving with possibilities and restrictions. In this study, overcoming hardship with hope can be linked to the continuous efforts of high-hardiness families who confirmed themselves to doing care activities within their home. These families pushed their efforts to the surface of their 'way of being,' while caring for the stroke member, when they sought and obtained help as needed. Help from others, such as health professionals, neighbors and the other family members, was one available source of support.

By contrast, moderate-hardiness families lacked help and support, especially from immediate family members. Due to lack of help and support, moderate-hardiness primary caregivers were constrained in their efforts to provide sufficient care for the stroke member.

The theme, "Overcoming hardship with hope for the stroke member's long existence," can be conceptually integrated with powering, a concept in Parse's Theory of Human Becoming[23, 24] (see **Table 2**). Powering is viewed as the force of human existence and involving all-at-once living with what is not yet known "in the process of incarnating one's intentions and actions in moving toward possibilities."[24, p. 47] In this study, hope for the stroke members' long existence shed light on powering as a force that drives and gives direction to families for getting over barriers and persisting with stroke victims caring activities, as well as something families have to do in their lives. Valuing the stroke members' long existence was a priority for high-hardiness families compared to moderate-hardiness families. Continual caring seemed to be a choice for high-hardiness families as they envisioned, as a way of life, the long existence of the stroke member.

Table 2 Progressive Abstraction of Themes of Family Strength when providing Home Care for a Family Member who has experienced a Stroke

Themes	Structural Transposition	Conceptual Integration
Overcoming hardship with hope for the stroke family member's long existence	Pushing-resisting with hardship	Powering
Building up as a 'can do' person through accumulated experiences	Inventing possibles	Originating
Establishing co-responsibility in handling caregiving and family tasks	Inventing possibles Harmonious togetherness	Originating Connecting-separating

Core themes: a) Overcoming the hardship with hope for the stroke family member's long existence; b) building up as a 'can do' person through accumulated experiences; and, c) establishing co-responsibility in handling caregiving and family tasks

Structure: Family strength in caring for a stroke member at home is overcoming the hardship with hope for the stroke member's long existence arising with building up a "can do" person through accumulated experiences and establishing co-responsibility in handling caregiving and family tasks

Structural transposition: Family strength in caring for a stroke family member, at home, is harmonious togetherness arising while inventing possibles amid pushing-resisting with hardship.

Conceptual Integration: Family strength in caring for a stroke member at home is connecting-separating in the originating of powering.

In Parse's Human Becoming Theory, powering is viewed as a paradox rhythm of pushing-resisting.[24] Thus, overcoming hardships with hope, while caring for a stroke member, sheds light on the concept of powering. Hope can push families toward providing day-to- day care, while the presence of hardships, related to provision of care, can serve as resistance in the ability to perform care activities.

High-hardiness families were enabled to provide care that involved continuous efforts, while simultaneously living with opportunities in terms of receiving help and support from others. By contrast, moderate-hardiness families were unable to provide continuous care because of often lacking sufficient help and support from others. Thus, overcoming hardship with hope involved the rhythmic paradox of enabling-limiting, while simultaneously living with opportunities that assisted in overcoming hardships related to the provision of care. Therefore, since family strength is dependent upon what is considered of value to the family, one can conclude it may not be fixed, but rather fluctuates while caring for a stroke member. Information regarding overcoming hardship with hope could not be found in the literature, and little literature, specifically addressing the phenomenon of family strength in home caring of a stroke member, is available. However, research has been conducted regarding exploring a sense of hope in PCPs[30] and stroke survivors.[31] A Thai study revealed one's belief in the law of Karma influences caregivers' acceptance and maintenance of care for those who have experienced a stroke.[32]

With the second theme, "Building up as a 'can do' person through accumulated experiences," it became apparent that high-hardiness PCPs gained ability to care for the stroke member through: seeking and asking for information; observing the actions of others; and, practicing caring tasks. The increasing self-confidence of the PCPs led to the emergence of each of them as a 'can do' person.

"Building up as a 'can do' person, through accumulated experiences," was noted among high-hardiness PCPs and, as a theme, can be conceptually integrated with Parse's concept, 'originating' (see **Table 2**). "Building up as a 'can do' person, through accumulated experiences," was one 'possible' that families selected as part of their way of living with and caring for the stroke member. According to Parse, 'originating' "is inventing new ways of conforming-not conforming in the certainty-uncertainty of living."[24, p. 49] Therefore, building up a 'can do' person may be seen as "distinguishing personal uniqueness,"[24, p. 49] by which primary caregivers provided care to stroke members. By contrast, moderate-hardiness families had to move themselves, the best way possible, with restrictions that inhibited their ability to live with and care for the stroke member.

Prior research on the process of self-development suggests stroke members' caregivers learn caregiving activities through experience and personal efforts, as well as by way of asking questions, observing, listening and reading.[33] Therefore, "building up as a 'can do' person" appears to be the manner in which primary caregivers, in this study, confirmed themselves in their caregiving role.

The third theme, "Establishing co-responsibility in handling caregiving and family tasks," was well established, by high-hardiness families, as a way of managing day-to-day care of the stroke member, as well as the family tasks (see **Table 2**). By comparison, co-responsibility in providing caring for the stroke member and in handling family tasks was lessened among moderate-hardiness families.

From the perspective of the "Human Becoming Theory," co-responsibility is the "all-at-once engaging-distancing while living with others,"[24, p. 45] and can be conceptually integrated with the concept, 'connecting-separating', which involves the paradox rhythm of "being with and apart from others, ideas, objects and situations all-at-once."[24, p. 45] The findings indicated that members of high-hardiness families connected with respect and care by staying together, and talking to and helping each other. By comparison, moderate-hardiness families demonstrated separateness by taking attention away from caregiving tasks and not providing caregiving assistance.

Co-responsibility also can be conceptually integrated with the Human Becoming Theory concept, 'originating', and be considered a way for families to successfully live together, while providing home care for a stroke member (see **Table 2**). By inventing possibilities for dealing with the demands of caregiving, as well as carrying out family tasks, high-hardiness families, in this study, were able to function at a higher level compared to moderate-hardiness families. Prior studies have shown that 'helping each other' serves as a mediator that can influence caregivers' well-being,[34] as well as increase family problem-solving skills.[35] This suggests the better the level of family togetherness, the greater the level of adaptability of the family.[36] However, if togetherness is not present, and there is an unequal distribution of caregiving responsibilities, conflict can occur among family members, with primary caregivers becoming overwhelmed by caregiving tasks. Previous research also has shown an unequal distribution of caregiving responsibilities, among family members, can lead to frustration and anger,[37] as well as distress and overburden[38] among those actively involved in providing caregiving activities.

Limitations and Future Research

This study has two major limitations which need to be taken into consideration when interpreting and applying the findings. First, all members of each family were not involved, thus a total view of each family's functioning ability was not available. In addition, meaning obtained from the data was from the unique perspective of the informants and may not reflect that of other families within other contexts. Therefore, future research involving all members of a family who are providing home care to a stroke member needs to be accomplished.

Implications for Nursing Practice and Research

Understanding the manner in which families go about creating strength as they proceed with caregiving activities associated with meeting needs of a stroke member can enhance nurses' ability to provide appropriate assistance. Realization that families who provide caregiving activities with great endurance, amid hardship, require focus be placed upon what is important to them within the contexts of their abilities so that continuation of care can occur.

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ความเข้มแข็งของครอบครัวในการดูแลสมาชิกที่ป่วยด้วยโรคหลอดเลือดสมองที่บ้าน

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บทคัดย่อ : การศึกษาปรากฏการณ์นิยมเฮอร์เมนนิวติกนี้ เพื่อศึกษาความหมายความเข้มแข็งของครอบครัวในการดูแลสมาชิกที่ป่วยด้วยโรคหลอดเลือดสมองที่บ้าน ความเข้มแข็งของครอบครัวเป็นศักยภาพของครอบครัวในการเผชิญกับเหตุการณ์ชีวิตที่ก่อให้เกิดความเครียดภายใต้มุมมองของกระบวนการปฏิสัมพันธ์ซึ่งกันและกันอย่างต่อเนื่องระหว่างมนุษย์กับสิ่งแวดล้อม โดยศึกษาจาก 6 ครอบครัว (สมาชิกในครอบครัวจำนวน 16 ราย) โดยคัดเลือกแบบเฉพาะเจาะจงและคัดกรองด้วยแบบสอบถามความเข้มแข็งของครอบครัว ซึ่งเป็นครอบครัวที่มีระดับความเข้มแข็งของครอบครัวสูง จำนวน 4 ครอบครัว และครอบครัวที่มีระดับความเข้มแข็งของครอบครัวปานกลาง จำนวน 2 ครอบครัว ข้อมูลได้จากการสัมภาษณ์เจาะลึก ร่วมกับการสังเกตและการจดบันทึกนำมาวิเคราะห์โดยใช้วิธีการวิเคราะห์เนื้อหาแบบธีมาทิคของบรานและคลาร์ก

ผลการวิจัยพบว่า ครอบครัวที่มีระดับความเข้มแข็งสูงแสดงถึงความพยายามของครอบครัวอย่างต่อเนื่องเพื่อผ่านพ้นความยากลำบากจากการให้การดูแลด้วยความหวังเพื่อสมาชิกที่ป่วยด้วยโรคหลอดเลือดสมองมีชีวิตอยู่ได้นาน ส่วนครอบครัวที่มีระดับความเข้มแข็งปานกลางแสดงถึงความพยายามของครอบครัวที่จะผ่านพ้นความยากลำบากในระดับน้อยด้วยไม่มีหวังเพื่อสมาชิกที่ป่วยด้วยโรคหลอดเลือดสมองมีชีวิตอยู่ได้นาน นอกจากนี้ยังพบว่าสมาชิกผู้ดูแลหลักของครอบครัวที่มีระดับความเข้มแข็งสูงมีการพัฒนาบทบาทการดูแลของตนเองมากกว่าสมาชิกผู้ดูแลหลักของครอบครัวที่มีระดับความเข้มแข็งปานกลาง ครอบครัวที่มีระดับความเข้มแข็งสูงยังมีความรับผิดชอบร่วมกันในการดูแลและการงานของครอบครัว ขณะที่ครอบครัวที่มีระดับความเข้มแข็งของครอบครัวปานกลางขาดความร่วมมือกันทั้งภาระในการดูแลและการงานของครอบครัวอย่างชัดเจน ดังนั้น ความเข้มแข็งของครอบครัว เป็นปรากฏการณ์ที่เกิดขึ้นจากการผ่านพ้นความยากลำบากด้วยความหวังเพื่อให้สมาชิกที่ป่วยด้วยโรคหลอดเลือดสมองมีชีวิตอยู่ได้นาน การพัฒนาความสามารถของสมาชิกครอบครัวจากการสะสมประสบการณ์และการกำหนดความรับผิดชอบร่วมกันในการดูแลและการงานของครอบครัว

การคำนึงถึงมุมมองและความสามารถของครอบครัวในการดูแลสมาชิกที่ป่วยด้วยโรคหลอดเลือดสมองที่บ้านช่วยสร้างเสริมความเข้าใจของพยาบาลต่อประสบการณ์ครอบครัวที่มีวิวัฒนาการในการดูแลที่บ้านแตกต่างกัน นอกจากนี้ ความรู้นี้สามารถนำมาใช้ในปรับการปฏิบัติทางการพยาบาลเพื่อช่วยเหลือสนับสนุนครอบครัวต่อไป

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คำสำคัญ: การดูแล ความเข้มแข็งของครอบครัว ปรากฏการณ์นิยมเฮอร์เมนนิวติก การปรับเปลี่ยนของมนุษย์

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