

A Grounded Theory Study of Thai Family Caregiving Process for Relatives with First Episode Psychosis

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Abstract: This grounded theory study explored the family caregiving process for relatives with first-episode psychosis related to schizophrenia spectrum disorders. The study was conducted during May 2013-March 2014 in lower northeastern region of Thailand using semi-structured interviews and observations, and involved 31 participants from 18 Thai families. The data were analyzed by using Strauss and Corbin's constant comparative method until theoretical saturation was achieved.

The core category emerging from the data was *Balancing family life*, which consisted of three phases: 1) *Communicating to gain support and understanding*, 2) *Capturing solution*, and 3) *Engaging in the family caregiving role*. To keep balance in their family life, family members needed to encourage and support each other and gain understanding toward the illness on Phase 1. They also consulted one another; got suggestions from older or senior person; or depended on the primary caregiver's decision for capturing solutions for care for their relatives in Phase 2. Finally, in Phase 3 they developed their sense of caring; shared care responsibility; provided essential care and controlling illness symptoms once they engage in the family caregiving role. These rich findings provide insight into caregiving in the Thai family context, especially in how they interacted and helped each other in order to provide care for relatives with first episode psychosis. Understanding of this process can assist with the development of interventions to enhance family members' abilities to take on the caregiver role and to provide effective care for their relatives with first-episode psychosis.

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Introduction

Families are important in providing care for family members with first-episode psychosis (FMFEP) related to schizophrenia spectrum disorders. Previous studies have found that caregivers face mainly psychological distress,¹ embarrassment² and stigma³ and feelings of being overwhelmed with services⁴ when entering their new role. They also experience emotional distress in providing care for their ill

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family members.^{2,5} The consequences this include difficulties in family relationships⁵ and sibling conflicts.^{2,6}

In addition to facing stress during a critical period, caregivers generally have inadequate information about caring for relatives with first-episode psychosis (FEP) related to schizophrenia spectrum disorders because they had never had such an experience before.⁵ This may lead to improper care of their ill family members and increased recurrence of symptoms. Although interventions that include patients and caregivers⁷ and community program integration⁸ have reported good outcomes of patients' conditions, the caregivers presented with depression, emotional distress, anxiety, and burden after taking care of persons post-diagnosis with FEP.⁹ In addition, little is known about family interactions while caregivers also managed care of FMFEP following the onset of psychosis.¹⁰⁻¹¹ In the case of factors influencing family caregiving, previous studies have found that family contexts including family role, cultural background, relationship and economic status influence caregiving and vice versa.¹²⁻¹³ In the Thai context, it was found that additional assistance is shared among the family members and other relatives once an illness occurred.¹⁴ Particularly in Thailand and other Asian countries, many family members normally live with or nearby their extended family.¹⁵ In addition, previous studies in Thailand addressed only the primary caregiver's skill development while caring for relatives with schizophrenia at home³⁰ but not specifically for family caregiving of relatives with FEP. Therefore, it was deemed important to investigate family caregiving in Thailand to gain understanding about family interactions and the engagement into the caregiving role of FMFEP, and especially where the family structure and background are culturally bound and quite different from western cultures. Thus in this grounded theory (GT) study, the insider views of family members were considered as the best source to begin with the planning of interventions to help meet the particular needs of FMFEP.

Literature Review

The impact of post-psychotic diagnosis includes the risk for suicide attempts,¹⁶ substance abuse¹⁷ and lower quality of life,¹⁸ all of which lead people with FEP related to schizophrenia spectrum disorders to encounter stressful events. These impacts affect both patients and their first-time caregivers. The impacts of family caregiving were mainly negative effects such as burdensome feelings,¹⁹ emotional distress¹ and depression²⁰ leaving them to experience stress during the acute phase of the illness. This indicates that both relatives with FEP and primary caregivers are in a troubled situation, dealing with emotional distress and difficulties in daily-living.

Regarding tasks that primary caregivers deliver to FMFEP, these consist of a wide array of activities such as daily-living self-care, providing social activity, symptoms and illness management.⁵ In addition, the stance of caregiving experiences involves several aspects based upon primary caregivers' perspectives. First, caregiving can be an unpredictable experience.⁵ Second, entering the new role of caregiving requires dealing with emotional distress²¹, adjusted expectations² and fostering hope for caregivers and ill family members as they somehow maintain the view that taking on the caregiving role is the responsibility of parents.⁵ Throughout this period, caregivers may adjust coping strategies using religious resources and spiritual faith²² and modified daily-activities.² While these previous studies have provided the angle of caregiving based on that of primary caregivers who cared for people with FEP, they did not mention the perspectives of other family members. This raises questions about the caregiving meaning and role engagement of other family members and helped to provide justification for this study.

When family members respond to giving care, they consider this a family responsibility²³ and of necessity they obtain knowledge from the experiences of others.²⁴ In addition, family members require

support from one another while adjusting to taking care of ill family members. For example, family members' support, especially emotional support, is a significant factor influencing family caregiving.²⁵ Family members necessarily mobilized themselves in taking care of ill or frail persons²⁶⁻²⁷ and supported one another. Furthermore, previous studies have found that family contexts, including family role, cultural background, relationship and economic status, influence caregiving and vice versa.¹²⁻¹³

In the Thai context, previous studies exploring caregivers' adaptation, perception, skills in caring for relatives with chronic mental illness have been based upon primary caregivers' perspectives. Family caregiving for relatives with mental illness presents a unique experience underpinned by Buddhist beliefs.²⁸⁻²⁹ It is essential that caregivers develop skills for delivering care³⁰ as well as adjusting themselves to the caregiving role. One study suggested that psychiatric nurses could engage in family participation by establishing trust, strengthening connections, promoting creativeness in care, and supporting families.³¹ In addition, it was found that additional assistance is shared among family members and other relatives during hospitalization¹⁴ and assistance can be affected by changes in the family structure when family first encountered the illness of their relative.¹⁵

Aim

This study explored the family caregiving based on the perspectives of Thai family members who were living with or caring for relatives with first-episode psychosis related to schizophrenia spectrum disorders.

Methods

Design

This qualitative study was conducted from May 2013–March 2014 and employed the GT methodologies of Strauss and Corbin.³⁵

Sample and Setting

Two types of sampling were used: 1) purposive sampling and 2) theoretical sampling.

Purposive sampling: Initial recruitment took place after staff at the hospital referred people who met the inclusion criteria. Potential participants, who came for follow-up appointments with their relative with FEP, were asked permission to engage in this study when they visited the out-patient department of a psychiatric hospital in lower northeastern region of Thailand.

Theoretical sampling was also applied. For example, it was found during analysis that family caregiving might be influenced by family relationships under different family structures. In others words, participants from different family structures may provide and engage in care differently. In this case the researcher then selected participants who lived in a different family structure from the previous informant to test how this impacted the caregiving. Family structures included extended, nuclear, and special family (where family members lived separately or where ill family members were being cared by other relatives). This sampling enabled comparison of interactions among family members while living with or caring of relatives with FEP from different family structure.

Inclusion and exclusion criteria

Participants were included if they were a father, mother, sibling, son, daughter, or other family member caring for an ill relative aged 18–25 years, who was diagnosed with a schizophrenia spectrum disorder at first episode under DSM-IV-TR or ICD-10, and had no previous treatment; either living with or taking care of relatives with FEP from the beginning of the episode over two years; aged over 18 years; and spoke Thai. However, potential participants were excluded from the study if they had been diagnosed with an organic brain syndrome, severe mental or physical illness, and/or could not communicate with others.

Ethical Considerations

Study approval was obtained from the Institutional Review Board of Chiang Mai University and the hospital where the study was conducted (No.005/2013). The researcher informed the participants about their rights, including the right of privacy and confidentiality, their ability to withdraw from the study at any time, and to be referred for specialist care in case of perceived emotional harm while being interviewed.

Data Collection and Analysis

Data collection and data analysis occurred concurrently throughout this GT study, with two forms of data collection: semi-structured, in-depth interviews and observations following guides. Interviews were conducted during participants' convenient times, took place either at the hospital or their home, were digitally recorded, and lasted approximately 20–90 minutes. Observations of 2–3 hours in length were performed with different caregivers in seven families including parents (four families), a husband (one family), a sibling (one family), and an aunt (one family). This involved observing the ways that family members talked and acted toward the ill relative members and each other.

Interview questions probed about participants' lives when the illness occurred, and what and when they did as caregivers taking care of the ill member, for example a main question was: 'What do you feel about your family when you have member with psychosis?' or more specifically, 'You're the father. What do you provide care of your son or to help your wife for taking care of your son?'

To perform data analysis, the GT approach of Strauss and Corbin³⁵ was used. Three coding types were addressed in detail along with combination of the constant comparative method³⁵, and memos and diagrams as follows:

1. Open coding: The transcripts were read and reread until understanding emerged, and then the data was broken down line-by-line and labeled using in vivo coding and then conceptual coding used which was more abstract. To illustrate, when participants

expressed, "We only talked as husband–wife and comforted each other. We didn't fight or blame each other. If we had, who would help us?", the researcher coded 'talked as husband–wife'. At the end of this stage the researcher ended up with conceptual coding.

2. Axial coding: At this level, the conceptual coding was read and grouped based on their property as into conditions, actions/interactions, consequences, or contexts of a formulated category. For example, 'accepting care as their fate, 'learning from others' experiences', and 'sharing information with one another' were the interactions/actions in which all of them are shared the common meaning or property, for this example, that is how they developed a sense of care before they engaged to it. Therefore, the category namely 'developing a sense of care' was formed. The formulated categories were examined as to whether all coding were relevant to each other, or formed a category or sub-category, by using conditional relational matrix.³⁵

3. Selective coding: The core category was elaborated by using family mapping diagrams and a story line to describe how family members responded to the caregiving of FMFEP. The emerging categories were examined as to whether they were antecedent or consequences, then the diagram and story were drawn to link all those categories, and then the written phrases were pursued to explain all categories. Finally, the proper phrase was selected to explain the whole process of family members' actions to care of the ill relatives; it became the core category of this study.

Rigor and Trustworthiness

Strauss and Corbin,³⁵ suggested two criteria for assessment of a GT study: 1) judging of the adequacy of research process and 2) assessing the empirical grounding of findings. In the former, participants were selected because of their deep experience to caregiving for FMFEP. In addition, the participants carefully were recruited into research project based

upon theoretical sampling. The indicators that influenced caregiving such as the family relationships were systematically probed throughout the study. To verify the relevancy among categories and to formulate concepts, the conditional relation matrix³⁵ was applied to assess the empirical grounding of findings, which formulated category is more density in terms of property and dimension. The constant comparative method³⁵ was used to compare among participants' descriptions, and to verify the consistency of emerged concepts. This helped the researcher to reexamine discrepancies that arose from the set of descriptions in order to gain credibility of the study.

Findings

In this study using GT helped to reveal how family members interacted with one another when they engaged in caregiving role for their loved ones within a specific context. In addition, GT was able to explore family interactions and behaviors affecting one another. This also generated a substantive theory of Thai family caregiving process of FMFEP. Of the 31 participants from 18 families, the age range was in two groups, 36–45 years (16 participants) and over 46 years (15 participants). Most were educated in elementary school (25 participants) and the majority were farmers (16 participants). The participants lived in different family structures including 6 extended families – where the family included parents, children, grandfather/mother; 6 nuclear families which consisted

of parents and their children; and 6 special families where members separately lived for reasons including economic status, widow, or where the ill family member was raised by relatives. The average size of the families was four persons. Most participants lived in rural areas but two families lived in urban areas. The participants' family status was father, mother, sibling, aunt or grandmother and the majority were parents or mothers. The families' homes in rural areas were located approximately 100–150 kilometers from the psychiatric hospital and approximately 50 kilometers from general hospitals. A district health promotion hospital was sited near all the families' homes.

Balancing family life

The core category was balancing family life consisting of three phases: communicating to gain support and understanding, capturing solutions, and engaging in the family caregiving role. This process explained the family members' actions to handled unexpected situation, that is, first episode psychosis of relatives until they able to provide care and live their lives as balanced as possible. This model also demonstrated substantive theory of Thai family caregiving of FMFEP, especially as the participants described about how family members were involved in what was identified as three phases of caregiving. An outline model of series actions that families acted to each other in order to balance their life and sub-categories of each phase is described in Figure 1.

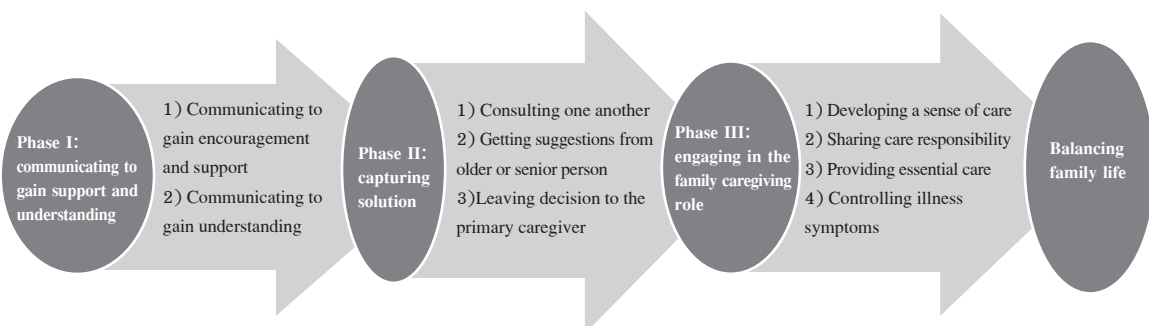


Figure 1: Balancing family life as core category of family caregiving process

Phase I: Communicating to gain support and understanding. This phase emerged when family members began to recognize their ill relatives presenting with ‘weird’ behaviors. They had limited information as they had never experienced others with psychosis. They wondered what happened to their relative, and were overwhelmed with shock, despair and pity. They tried to support each other and sought information related to the cause of the illness. This phase consisted of two sub-categories:

Sub-category I: Communicating to gain support. This referred to the family members expressed encouragement and support both intra- and inter-family. As one mother, Dee, said:

At the time, we only talked together and comforted each other as husband and wife. We didn't fight or blame each other... we needed to encourage and take care of each other.

Others received encouragement from elsewhere:

We got encouragement from our relatives and neighbors. They kept on asking whether or not our son had gone to hospital for follow-up yet. Those who were nearby always expressed their concern in asking like this (Si, father).

Family members communicated with one another openly in what they felt to be a chaotic situation. They could not only express emotions among members within the family but also other relatives and neighbors outside the family and received encouragement.

Sub-category II: Communicating to gain understanding. Family members also communicated to provide explanations regarding the cause of illness. Interestingly the family members conveyed messages to other members in explaining the cause of the illness without blaming one another. Instead, they conveyed the possibly reasons including child trauma from accidents, using certain drugs, or governing by superstition. They provided possible causes for the illness based upon their limited information beforehand, for example:

My husband and I keep saying that the sickness might have been caused by a head injury when he was a child, or substance or amphetamine abuse that caused him to get sick. We don't really know what caused it (La, mother).

Some family members were informed by shamans about the cause of the illness saying that the ill relative's spirit was governed by superstitious things:

In the beginning, his grandfather thought someone had done black magic on him. Once we went to the shaman, he mentioned that my son had fallen victim to black magic ...then we did things to resolve that issue (Dee, mother).

These explanations had the purpose of decreasing guilt and conflict among family member regarding the cause of the illness.

Phase 2: Capturing solutions. In Phase 1 the family members began seeking traditional methods based on the belief that the illness came from the superstitious power. These included splashing and bathing with holy water and dispelling bad luck. However, when these methods could not relieve the illness, they started thinking of taking their ill relatives to psychiatric hospital. Phase 2 reflected the actions of how family tried to find a solution by consulting one another, getting suggestions from older or senior person, and relying on primary caregivers' opinions.

Sub-category I, Consulting one another. The families consulted and compromised about ideas among members in selecting treatment for their ill relatives.

"When my daughter was really seriously ill, we gathered here and consulted within our family about how we should do the best for my daughter," (Ree, mother).

Sub-category II: Getting suggestions from older or senior person.

Some families lived with two or three generations consisting of grandfathers, grandmothers, mothers-in-law, or fathers-in-law. Therefore, they relied on older or senior persons' recommendation in selecting treatment.

My mom and dad, and some older persons who lived nearby told me, 'Why don't you take your son to a psychiatric hospital? There the doctors can cure patients well' (Jai, mother).

Noticeably, they relied on the older persons who lived with or outside family. In this case, Thai culture requires that younger persons paid respect to elder persons and placed them high in hierarchy with power for decision-making.

Sub-category III, Leaving decision to the primary caregiver. Some families accessed treatment based upon the past experience of primary caregiver. This was because they believed in their subtle information regarding the illness, which had been gathered over time when they served as primary caregivers.

I noticed that I did everything following local customs, but my daughter was still in bad condition. I thought to myself, 'If I leave her like this too long, she is definitely going to get worse.' So, I took her to a psychiatric hospital ...because I had experience with someone else who had received treatment there (Fa, mother).

In this phase the family members obtained solutions in selecting treatment for ill relatives based upon suggestions from others or primary caregivers' decisions. They significantly used suggestions from older or senior persons and primary caregiver to make decisions for subsequent actions

Phase 3: Engaging in the family caregiving role.

This phase occurred immediately after the ill relatives received psychiatric treatment and when participants engaged in caregiving role and took responsibility taking care of their ill relatives. This drove them to develop a sense of caregiving involving several methods and shared caregiving tasks based upon their relationship. Finally, they provided essential care through daily-activity care and controlling illness symptoms. This phase represented a family dynamic in which the family members adjusted themselves into caregiving. Three sub-categories happened under this phase:

Sub-category I, Developing a sense of care.

The family members gained an understanding about the characteristics of caregiving and its tasks by accepting care as their fate, learning from others' experiences, and sharing information with one another.

"People's fates are different. I've been thinking like this when taking care of my son. When it happens to us, we should accept our fate. This helps me feel relieved (Dee, mother).

Discussion with others who had the same experiences assisted family members in understanding what caregiving involved, for example:

We have relatives who lived in the province with a son who was sick with the same kind of sickness. And then we would ask about their experiences in taking care of their ill son and analyze those experiences (Maw, mother).

At the same time, the primary caregivers of each family shared information in taking care of ill relatives with other family members. For example:

My husband and I always tell our daughters, 'Let your younger brother (the family member with FEP) do whatever he wants. Speak with him nicely. If he is aggressive, be careful of yourselves. You may not be able to resist him (Raui, mother).

Sub-category II, Sharing care responsibility.

Once family members accepted the role of caregiver, they then shared their responsibility of taking care of the ill relative within the family. This was done on the basis of the family relationship and using several actions including exercising authority, providing companionship, taking turns with duties, and remote monitoring.

The family members who represented authority figures and were able to control their ill relative took responsible for stopping violent behaviors. For example, one mother explained:

If my son is going to lose control of himself, my husband is the one who can control him. He hugs our ill son until he stops aggressive

behavior, when our son is going to be aggressive. After his father hugs him or says to stop, my ill son will calm down (Si, mother).

Some siblings provided companionship for their ill brothers or sisters, for example:

My daughter is always sitting and talking with her ill cousin. She invites him to snacks together. They have lived together in such good company for so long. That's why my daughter didn't refuse him, even though he was sick (Fa, aunt).

In cases where the primary caregivers left their duties for a while, other family members would take turn on duty. For example:

My husband also helps me provide medicine for our son when I go out for social activity. I told my husband what medicine should be given to him. When I come home, I'll check on whether my son has taken his medicine or not (Raui, mother).

When family members lived a long distance apart, they would telephone the primary caregiver or the ill relative to ask about the illness progression. For example:

When she was sick, all people were worried about her, even my younger brother (the patient's uncle) also called so often. He always called and talked among us (Mak, mother).

Sub-category III, Providing essential care. This involved family members delivering daily care to assist them to maintain their lifestyles, and responded to their needs as much as possible. Daily care included helping them with hygiene and grooming, preparing food, buying some new clothes for them, and trying to relax them when they got stressed:

In the beginning, we needed to take him to bathe and brush his teeth because my son couldn't help himself. My husband and I did that for him; we did everything for a month. (Nong, mother)

My ill son asked me to buy new clothes. I did that for him. I please him with everything he wants. I want him to be happy. (Ma, mother)

I sometimes wash his clothes or his elder sisters do that for him. We don't refuse to do that. (Sa, mother)

I don't take much care of my son... just preparing him food or meals; after that he'll take care of himself. (Sang, mother)

Sometimes, a mother also needed to promote mental relaxation to ease the tension of her daughter for example:

I use kidding with my daughter to relieve her tension. If I notice that she is stressful, I kid with her or make jokes, so she laughs with me. I'm afraid she might get stressed (Mak, mother).

Sub-category IV, Controlling illness symptoms. This occurred when family members took actions in order to prevent relapse of the illness, such as continuing drug adherence and inhibiting dangerous behavior. This helped the ill relatives returned to normality as much as possible. For example, the family members actively participated in adherence to medication regimens using several methods. One mother said:

I give him medicine myself. I'm afraid he'll make mistakes if he does it himself. I put the medicine on his palm and bring water for him, too. If I don't do it like this, I am not sure whether he will take the medicine or not (Raui, mother).

Other family members took actions to prevent risk behaviours such as self-harm, drinking and smoking or violence by close observation, hiding weapons, giving advice and reasoning and communication tactics. Examples include:

We keep close watch on her. I closely observe her all day. I'll do housework when my daughter falls asleep. I always stay near her and my husband does the same as me. I heard that the persons with psychosis often do self-harm (Raay, mother).

In addition, there was a belief that the occurrence of symptoms was associated with a blaming atmosphere so the family members nicely spoke with their love one to inhibit dangerous behavior:

I keep on monitoring his emotions. If he cries out, I have to speak nicely. We shouldn't fight with him when he is like that. We should go along with him. I always speak with him nicely (Raay, mother).

Discussion

The findings revealed family processes where members interacted from the start of the illness of their relative until they engaged in caregiving role. This study shed light on how the family members involved in caregiving in the Thai context, especially when relatives and older persons contributed their help to families. It was clear that in each phase the senior or older persons in the family needed to be involved, especially at the stage of when the family needed to make a decision about where to get treatment, what to do first, and how to properly care for their ill relatives. Also this process represented the family dynamic where family members adjusted themselves into the current situation in which they were able to deal with the chaotic situation and strove to meet the family balance afterwards. This is consistent with a previous study reporting that the family would be subject to impacts from the occurrence of illness as a ripple effect.³⁴

In Thai culture, when the family members are hospitalized, the family generally receives assistance from other family members, especially regarding health-related issues and assistance.¹⁴ This was also

found in this study in Phase I; the family members received emotional and informational support from others which provided them understanding of the illness and they felt encouraged. The assistance was received not only from their relatives but also from neighbors and shamans. In Phase 2, to help with family decision making, they sought suggestions from the older persons until they accessed treatment. This is typical in Thai culture in that older people hold power regarding decision-making. Likewise a previous study³⁶ found that the experience of the older family member was valuable for their descendants, especially regarding suggestions. They are considered a respectful person in Thai family. In Phase 3, family members shared the caregiving based upon their relationship for helping the ill relatives to meet the needs; this differed from other study⁶ in a western country that solely emphasized sibling involvement of care.

Thai mental health services have been reported as being not accessible for persons with psychosis, particularly in rural areas.³² In the current study the homes of the participants were in rural areas located approximately 50 kilometers from general hospitals or district health promotion hospitals. Families were prepared to take their ill relatives to a psychiatric hospital which provided specialized care even those this located further away. This reflects the non-availability of mental health services in outreach areas to meet peoples' needs and it could be a barrier for families who not be able to access to specific and immediate treatment

In the cognitive model of caregiving, it has been proposed that caregivers' appraisal of patients' behavior, illness and caregiver-patient relationships influences the actions of caregivers³³ and they adjust themselves into a new role as caregiver.⁵ These studies focus on the caregivers' perspectives in terms of the caregiving performance and taking on a new role. However, this study extended knowledge about family members communications to each other for

gaining support and understanding toward the illness and they made decisions through family consultation or based upon the advice of older persons. They also engaged in care of the ill relatives within the family by developing a sense of care and sharing care responsibility among its members. This study thus revealed a shift from primary caregiver to family members' perspectives in taking on the caregiving role.

Limitations

This study was conducted in rural north-eastern Thailand where the most of participants and the perspectives of these participants may be very different to those of city dwellers or those from other Thai regions. Therefore further studies are needed to assist with gaining understanding about caregivers elsewhere.

Conclusions and Implications for Nursing Practice

The findings demonstrate that the family members as participants moved through three phases to get their balance as caregivers, starting from the beginning when they had no information and understanding of the illness until when they recognized the psychosis and became involved with the caregiving tasks to meet the ill relatives' needs. In addition, this study added information of Thai family caregiving process that shifted from primary caregivers to others family members' perspectives and involvement. This could be the starting point to emphasize the family as a unit of analysis which lead to the intervention for the whole family. Therefore, nurses should emphasize on the family level in addition to the individual affected by implementing culturally appropriate interventions. Moreover, key persons in the community should not be overlooked to be empowered as necessary resources for mental health. As revealed by this study, the families received emotional and tangible supports from other relatives and neighbors, especially from

shamans at their convenience and of the limited information they had. This might allow the family to get the wrong information about the cause of the illness and delay proper treatment for their ill relatives. Also, the implications of interventions should be emphasized more on the available information related to the psychosis and caregiving for those family members in order to recognize and understand the psychosis. Trial and error in caregiving should not be the case if they are knowledgeable beforehand. In addition, the campaign of providing information about mental illness and how to take care of sufferers need to be further disseminated, especially in the rural area. This recommendation also extends to the training provision for those key persons in the community such as shamans, monks, or neighbors to prepare them for informed help. Furthermore, the mental health services in primary settings, in the rural area, is scares as previously mentioned. As a result, the family members might need to rent a car to take their ill relatives to hospital, which increases the family expenses and resulted in burden of care. Therefore, the last recommendation is to integrate more mental health services into primary settings. This will provide family the choice to access to the special care at their local clinic or hospital, leading to a decrease in the household expense.

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การศึกษาทฤษฎีฐานรากของกระบวนการดูแลในครอบครัวไทยสำหรับญาติที่เจ็บป่วยทางจิตครั้งแรก

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บทคัดย่อ: งานวิจัยนี้ใช้ทฤษฎีฐานรากศึกษากระบวนการดูแลในครอบครัวไทยสำหรับญาติที่เจ็บป่วยทางจิตครั้งแรกในกลุ่มโรคจิตเภท ตั้งแต่เดือนพฤษภาคม พ.ศ. 2556 ถึงมีนาคม พ.ศ. 2557 ในภาคตะวันออกเฉียงเหนือตอนล่างของประเทศไทย เก็บข้อมูลโดยใช้การสัมภาษณ์กึ่งโครงสร้างและการสังเกตในอาสาสมัคร 31 คนจาก 18 ครอบครัว วิเคราะห์ข้อมูลโดยใช้กระบวนการวิเคราะห์เปรียบเทียบของเสตราทีละคอร์บินจนกระทั่งข้อมูลอิ่มตัว ผลการศึกษาพบว่า “การรักษาสมดุลของชีวิตครอบครัว” เป็นสิ่งสำคัญของกระบวนการดูแลที่ประกอบไปด้วย 1) การสื่อสารเพื่อสนับสนุนและเข้าใจ 2) การได้มาซึ่งทางออก และ 3) การเข้าสู่บทบาทครอบครัวผู้ดูแล ในระยะแรกของการเจ็บป่วยสมาชิกแต่ละคนจำเป็นต้องให้กำลังใจและสนับสนุนซึ่งกันและกันเพื่อทำความเข้าใจการเจ็บป่วยและรักษาสมดุลของครอบครัว เมื่อเข้าสู่ระยะที่สองของการได้มาซึ่งทางออกนั้นครอบครัวมีการปรึกษาหารือระหว่างสมาชิก การได้รับคำแนะนำจากผู้สูงอายุหรืออาวุโสในครอบครัว หรือฟังการตัดสินใจจากผู้ดูแลหลัก และในระยะที่สามซึ่งเป็นระยะสุดท้ายของกระบวนการดูแลสมาชิกต้องทำความเข้าใจในบทบาทของผู้ดูแล การแบ่งความรับผิดชอบระหว่างสมาชิก พร้อมทั้งให้การดูแลที่จำเป็นและควบคุมอาการทางจิตสำหรับญาติที่ป่วย จากผลการศึกษาครั้งนี้เป็นแหล่งข้อมูลที่ทำให้เกิดความเข้าใจการดูแลในบริบทของครอบครัวไทยโดยเฉพาะอย่างยิ่งการมีปฏิสัมพันธ์ระหว่างสมาชิกและการช่วยเหลือซึ่งกันและกันเพื่อที่จะดูแลญาติที่ป่วย การเข้าใจในกระบวนการดังกล่าวช่วยให้มีแนวทางในการพัฒนาการดูแลเพื่อส่งเสริมให้สมาชิกครอบครัวเข้าสู่บทบาทของผู้ดูแลและให้การดูแลญาติอย่างมีประสิทธิภาพ

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