"*Katanyu katavedi*" and Caregiving for Frail Elderly Parents: The Perspectives of Thai Families in Metropolitan Bangkok, Thailand

By

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dissertation to my beloved country "Thailand" where I learned and feel so grounded in her.

ABSTRACT

TITLE: KATANYU KATAVEDI AND CAREGIVING FOR FRAIL ELDERLY PARENTS: THE PERSPECTIVES OF THAI FAMILIES IN METROPOLITAN BANGKOK

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This study aimed to explicate and define Thai traditional cultural value of *katanyu katavedi* in relation to caregiving for frail elderly parents from the perspectives of Thai families in Metropolitan Bangkok. A qualitative method, using social setting analysis (Lofland & Lofland, 1995) was used to discover and understand the context and patterns of behavior from people's lifeways in their natural settings and environment. Intensive interviews (30 formal interviews) with 15 adult children who took care of their frail elderly parents were done, including participant observations during the home visiting, totalling 55 visits. The specific purposes of this study were to: a) explore the concept of *katanyu katavidi* in relation to caregiving for frail elderly parents in families of urban Thailand; b) describe the caregiving provided by families to frail elderly parents in Metropolitan Bangkok; c) identify the perspectives of the Thai families regarding the effects of social changes in modern Thailand on *katanyu katavedi* and on caregiving for frail elderly parents; and d) describe the effects of caregiving for frail elderly parents on families and caregivers.

The concept of *katanyu katavedi* in relation to caregiving for elderly parents is structured by three dimensions which

included: a) *bun khun* of parents: total benefits of parents have bestowed upon children; b) *katanyu*: the sense of gratitude towards parents; and c) *katavedi*: the obligatory actions in paying back to parents. These three dimensions are interrelated. The concept of *katanyu katavedi* has been valued by Thai families and helps to maintain the caregiving for elderly parents of Thai families.

Caregiving provided by families in this study was categorized into three dimensions: a) physical caregiving; b) psychological caregiving; and c) spiritual caregiving. Physical caregiving found in this study was caregiving practices in which caregivers: a) maintain parents' daily activities; b) provide nursing care activities; c) modify home and setting environment to promote parental function; d) obtain assistance from health care services when having problems about parents' condition; and e) seek and try alternative methods of treatment. Psychological caregiving was described by the caregivers as: a) talking with parents; b) being there; and c) using humor. The spiritual caregiving was defined as caregiving related to religious beliefs or practices part of caregiving that the caregivers performed for their frail parents, which were a) merit-making for parents and b) praying or vowing for a better condition of their parents.

Cultural and societal-economic contextual factors played crucial roles and influenced caregiving and consequences of caregiving in Thai society. The societal and economic contextual factors were: a) the relationships within the family; b) caregiving support system; c) financial status of the family; and d) the availability of the caregiver. Three cultural contextual

factors which underlie the social practices of family caregiving for the elderly parents in Thailand emerged from the data. These three cultural contextual factors were: 1) hierarchical relationships between parents and child; 2) social value of obligation to parents; and 3) religious teaching. The cultural contextual factors of *katanyu katavedi* was still valued as important cultural value by all caregivers who participated in this study. However, social and economic contextual factors also heavily impact and influenced the caregiving experiences of the Thai families.

Three types of effects of caregiving on families and caregivers were identified: 1) positive consequences; 2) negative consequences; and 3) ambivalence in the caregiving situation. The positive consequences of caregiving situations were: happiness, sense of self-pride, recognition of praise from others, warmth, attaining of merit, and feelings of being lucky. The negative consequences of caregiving situation were: frustration with other family members, burden, deterioration of the caregiver's health, petty conflict with the care receiver, physical strain, stress, feelings of guilt, and social isolation. Ambivalence in the caregiving situation was described by the caregivers as being unsure whether their caregiving was meritorous or demerit.

A conceptual model (as shown in Figure 6) represented and described the relationships between the cultural value contextual factors of *katanyu katavedi* and caregivng, the societal-economic contextual factors, and the consequences of caregiving situations.

This study discussed and suggested the implications of the findings for nursing theory, practice, and research in the future. With the findings which provided empirical knowledge and understanding about family caregiving in Thailand from a holistic perspective, the specific characteristic of Thai culture which influenced caregiving practices for elderly parents in Thailand is wished to be maintained and valued in Thai society.

THAI TERM GLOSSARY

Term	Meaning
bun khun	the total benefits that parents bestow upon their children
bun	merit
bap	demerit
bhalang jakawarn	a kind of supernatural belief of people using magic power as a treatment for disease
katanyu	the sense of gratitude that a child or children have towards parents
katavedi	the obligatory actions done to pay back parents
kah nam nom	price of mother's milk
luk katanyu	a social acceptance of a child who takes good care of parents
matabhitu uppathanang	a Buddhist doctrine teaching about reverence to parents
pra somdej	a kind of Buddha image used as a talisman among Thai people
pubbkari	those who have rendered a favor such as father, mother, elders, and ancestors
sang ka tarn	a kind of merit-making in Buddhist belief by giving a set of food, clothes, and items necessary for living donated to monks
tham bun	merit-making
rom bho rom sai	Thai metaphor of a father and a mother as two kinds of big trees
ru khun	the realization of benefits received from others

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CHAPTER 1

INTRODUCTION

Statement of Problem

Aging has been a priority area for health and social research in developed countries for many years. This has not been the case, however, in less developed parts of the world. The United Nations (UN) reported that the profile of the world population will change dramatically especially during the next four decades and beyond. By the year 2025, people 60 years of age and over will number 1181 million, as compared with 543 million in the year 1995, and comprise 14% of the world population. Over half (52%)of the world's elderly population dwell in Asia. (United Nations, 1996).

In Thailand, the number of people aged 60 years and over has been increasing steadily from about 1.2 million in 1960 to 2.4 million in 1980. Currently, there are about 5.1 million persons over the age of 60 in Thailand or 8% of the population (National Statistical Office, 1997). Between 1991 and 2020 Thailand's total population will increase by about one-third. One of the important trends is the rapidly growing number of elderly persons in Metropolitan Bangkok, the capital city of Thailand. Bangkok's lower mortality rates, as well as the aging of its sizable young adult population, contribute to this statistical projection (Francese & Kinsella, 1992).

More than any other institution, the family has provided the central focus of social life for older people in Thailand. Thai culture and norms set the expectation that the family will

take full responsibility for the care of its elderly members. Within the family, responsibility is usually shared among members according to their age and abilities (Limanonda, 1995). Care and support provided by adult children for elderly parents is based on a strong sense of moral obligation (Knodel, Saengteinchai, & Sititrai, 1992).

Underlying the moral obligation of children to repay parents is the concept of *katanyu katavedi*. This concept is firmly ingrained in Thai culture and has no English equivalent (Podhisita, 1985). "*Katanyu*" refers to a sense of awareness and gratitude toward someone who has done something that benefits, while "*katavedi*" refers to doing something in return for those benefits (Royal Thai Scholars Association, 1982). The concept of *katanyu katavedi* usually refers specifically to parent-child relationships. Since giving life to and raising a child instills a sense of gratitude and debt, it leads to the sense of obligation that the adult child has to provide support and care to his/ her parents in return (Knodel, Saengtienchai, & Sittitrai, 1992).

Despite the general practice and cultural norms of family care for elderly parents in Thai families, there are still limited numbers of studies about caregiving for Thai elderly by family, especially in times of rapid social change. Some studies were done in the fields of Sociology and Population Studies (Knodel, Chayovan, & Siriboon, 1991; Knodel & Debavalya,1992, Wongsith, Siriboon, & Entz, 1996) which looked at living arrangements, material supports, and social supports for Thai elderly. However, these studies did not provide information about caregiving

practices in family settings. Anthropological nursing studies by Caffrey (1992a & 1992b) provided information about caregiving practices in Thai culture, identifying the meaning of caregiving, levels of caregiving, and impacts of modernization. However, these studies focused on caregiving for the elderly in Northeastern Thailand which is a rural area. Samanawan's (1994) study of the family caring for demented elderly in Bangkok reported negative caregiving outcomes to caregivers, such as emotional distress and physical illness. Nonetheless, the essense of current caregiving and understanding of the traditional value of *katanyu katavedi* which is the main factor in responsibilty for caregiving, are not explicitly known as they affect metropolitan families who give care to elderly relations with all sorts of health problems.

Presently, Thailand is rapidly undergoing modernization. Trends and changes in Thai society such as industrialization, migration, and declining fertility are expected to affect the traditional practices of family obligation in caregiving for elderly parents in several ways (Caffrey, 1992a, Knodel, Chayovan, & Saengtienchai, 1994, Limanonda, 1995). Bangkok, which is the most urbanized and populated area of Thailand, is directly affected by the pressures of rapid social, economic, and cultural changes (Office of the Prime Minister, 1991). Exploration of the Thai cultural value of *katanyu katavedi* and caregiving phenomena and practices in families of Metropolitan Bangkok, Thailand during these rapid changes is essential to give valuable information for policy makers and health care providers in determining impacts of these changes on caregiving systems and families.

Significance to Nursing

The purpose of this study was to explicate and define the traditional cultural value of *katanyu katavedi* in relation to caregiving for the frail elderly from the perspectives of Thai families. The exploration of family caregiving in the Thai cultural perspective is expected to help understanding and providing empirical knowledge that is useful for nurses who work with families in communities. A qualitative method, using social setting analysis (Lofland & Lofland, 1995) was used to discover and understand the context and patterns of behavior from people's lifeways in their natural settings and environment. The researcher used participant observation and intensive interviewing to obtain caregivers' descriptions of (a) the essence of the concept *katanyu katavedi*, (b) caregiving practices for frail elderly in Thai families, (c) the families' perspectives of the effects of social changes on their caregiving situation, and (d) effects of caregiving for frail elderly parents on families and caregivers.

The specific purposes of this study were to:

1. Explore the concept of *katanyu katavedi* in relation to caregiving for frail elderly parents in families of urban Thailand;

2. Describe the caregiving provided by families to frail elderly parents in Metropolitan Bangkok;

3. Identify the perspectives of the Thai families regarding the effects of social changes in modern Thailand on *katanyu katavedi* and on caregiving for frail elderly parents;

4. Describe the effects of caregiving for frail elderly parents on families and caregivers.

Sociocultural Background

Information about Thailand

Thailand is a tropical country in the Indo-Chinese peninsula of Southeast Asia with an estimated 1997 population of approximately 63 million (National Statistic Office, 1996). Covering an area of some 513,115 square kilometers, Thailand displays considerable geographic and climatic variety in its four major regions.

The North, with 19% of the nation's population, is mountainous with lush valleys watered by numerous of rivers and streams. The Northeast is an area containing 35% of the population living mainly on a semiarid plateau with relatively infertile soil. The narrow Southern peninsula, has 13% of the population. It's long coastlines between the Gulf of Thailand and the Indian Ocean allow this region to be influenced by the monsoons for several months. The South is devoted largely to the cultivation of rubber, coconut, and fruit; though tin mining is another important activity. The Central plains region, including the Metropolitan Bangkok, area contains 33% of the national population (Office of the Prime Minister, 1991). The main river of the country, Chao Phraya River, flows through the central region which is one of the most fertile rice-growing areas in the world. Its fertile alluvial plains, combined with the presence of Bangkok as the center of governmental and economic activity, make it the most developed and most densely settled region.

Because of the geographic differences between each region of the country, people in each part have their own regional, cultural identities such as dialects, foods, costumes, and regional festivals. Although this regional ethnic self-identification is taken into account by people from the different regions, most Thais consider themselves as being of Thai nationality. Recent census figures from the National Statistical Data (1996) show that nearly 99% of the populace are citizens of Thailand, 97% of them speak Thai, and the majority (95%) of them adhere to Buddhism.

Bangkok: Urbanization and Socio-economic Change

Bangkok is the capital city and the main center of all economic activities of Thailand. It is also densely populated and the area that is most vital and a source of great socioeconomic activity in the country. With an area of 1,569 square kilometers and 6.1 million population (Office for Central Civil-Registration, 1997), Bangkok has been dramatically impacted by urbanization, industrialization, and socio-economic change during the past two decades. Uncontrolled growth of Bangkok has led to physical deterioration of the environment such as air pollution, traffic congestion, noise and water pollution. Some authors say the consequences of urbanization impact not only the physical environment of Bangkok, but also the social structure, family life, family relationships and even Thai values and aspects of culture (Ross and Poungsomlee, 1995). Family and community cohesion deteriorated as a result of the long hours of people spend away from home because of the traffic conditions (Ross and

Poungsomlee, 1995). Family relationships have also been affected by environmental and financial stresses suffered by members. The urban lifestyle of modern Bangkok raises questions of how the social and economic changes impact Thai families and the traditional cultural value of caregiving to elderly parents.

Thai Family Structure

The Thai word for family, *krob krua*, is a kin group consisting of those who are related mainly, but not exclusively, through blood ties. Family members live in the same house and share many aspects of day-to-day activities (Limanonda, Podhisita, & Wongsith, 1991). In the Thai family, the father is regarded as the head of the household to whom the wife and children show due respect. Within the family, chores are interchangeably performed by men and women, and the division of labor between the two sexes is generally flexible (Smith, 1973). However heavy physical labor is done by men, while cleaning, cooking and child rearing are done by women. The elderly reportedly have a very high status (Office of Prime Minister, 1991). Young people respect and support the elders who serve as the cornerstone of the family. Their elders' presence contributes to the effective functioning of the family unit both through taking over household duties and through the role of family consultant on important matters. When elders die, it is the duty of the young to hold traditional ceremonies of merit-making for the deceased.

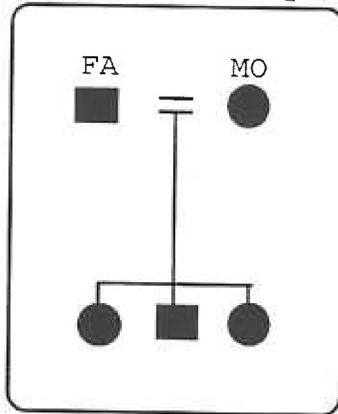
From Atal's (1992) and Limanonda's (1995) explanation of the Thai family life cycle, the pattern of this cycle could be summarized into three stages of family formation. In the first

stage, the family begins as a nuclear type consisting of a father, a mother, and young unmarried children. The second stage occurs when young newly married children form a sub-unit in the parental household. Therefore the household becomes a joint family. The married adult children might live in the family until they have their own child or children. As a joint or extended family, sometimes three or more generations live together with both vertical and lateral extensions. The last stage develops when the next daughter or son gets married, or when the other couple moves out to set up their own household. With this cyclical development, stage three of the family life cycle is a breakdown of the joint family into nuclear and stem families. Therefore, the stem family is a family of procreation with one married child living with the parents. The developments in family structure, however, are consistent with changes in the ages of heads of households. For instance, stem families are very rare for households headed by younger persons, but constitute the majority of those headed by someone 60 years or older (Knodel, Chamratrithirong, & Debavalaya, 1987).

Viewing families as represented in these different stages, the following configurations can be identified:

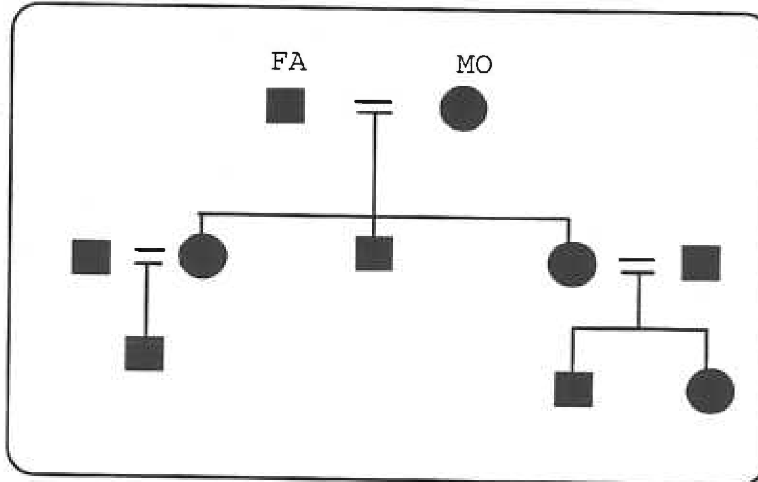
Nuclear Family

Stage I

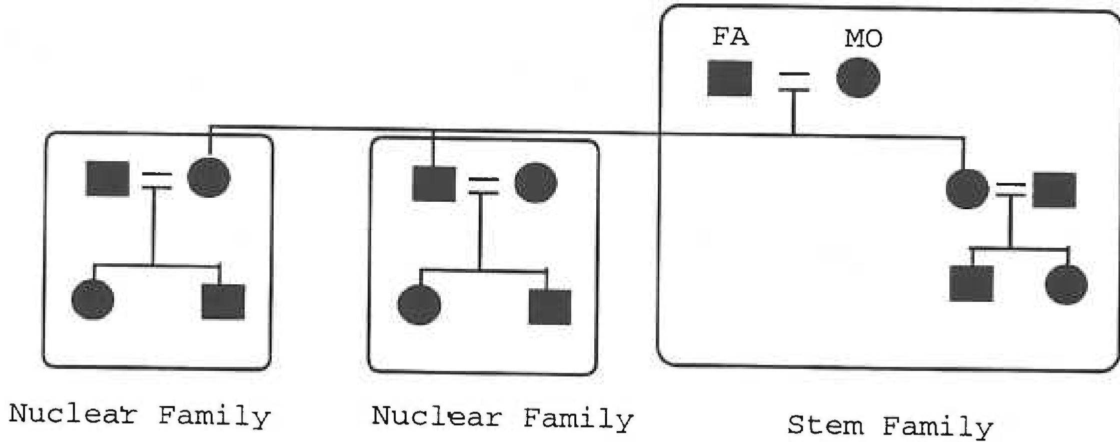


■	male
●	female
FA	father
MA	mother

Stage II Joint Family/ Extended Family



Stage III Breakdown of Joint Family



From the latest Labor Force Survey in 1989, Phananiramai (1991) found that 60.8% of the households in Thailand are nuclear, 23.3% are vertically extended (stem family), 9.0% are extended (joint) in which parents and some of their children and grandchildren and other kin live together in the same household. Only 6.1% are one person households, and 0.8% are primary individual households. Although a majority of Thai families' structures are nuclear in structure, it has also been demonstrated that one child stays with the parents in the stem family when the parents become old. This is still a norm and practice in Thailand. In the 1990 Thai Census (Knodel, Chayovan, & Saengtienchai, 1994), the majority (77%) of Thai women aged 60 and over reported having at least one of their children co-residing with them. The level of co-residence shown by the 1990 census is quite consistent with the results of the survey that was done a decade earlier. The percentages of elderly women living with at least one child in 1980 was 76%.

Thai family structure is fundamentally a bilateral kinship structure, other terms that are used to describe the bilateral kinship of the families in Thailand are "cognatic" or "nonunilineal." The kinship structures are not based on a principle of descent that stresses either the male or female side (Keyes, 1995). Neolocal residence, or system in which a couple establishes an independent household after marriage, is the most prevalent situation in urban areas while it is less prevalent in the rural areas. Among couples who do not establish their own residence after marriage, living with the husband's parents or

patrilocal residence is found to be most prevalent in the urban South, the Central region, and Bangkok. This reflects a relatively large proportion of Chinese in these areas. On the other hand, living with the wife's mother or matrilocal residence is more common in the rural Northern and Northeastern regions (Limanonda, 1979).

Chamratrithirong (1984) found that in modern Thai society there is also a preference to live with the parents who have the most resources. The couple almost always lives in a joint family or shared household and chooses among the options of living with the husband's parents, bride's parents, husband's relatives, or bride's relatives. The choice is governed by the strategic resources. Thus, flexibility has been identified as one of the characteristics of the modern Thai household pattern. Flexibility also extends to the length of time the couple spends living with either the husband's or bride's parents or relatives. The length of stay is determined by the circumstances and resources of both the newly married couple and the older persons.

In summary, the major form of Thai families is nuclear family; however, it is typical that the elderly parents will be taken care in the family or have living arrangements with one of their children. The decision about with which adult child to stay with differs by geographical areas and ethnic group.

Thai World View of Life Related to Family

Podhisita (1985), a Thai sociologist, summarized the Thai world view of life which specifically represents Thai characteristics. In this section, the review of Thai world view of

life related to family will be based on Podhisita's (1985) article "Buddhism and Thai world view".

Generally, world view is manifested in various forms of behavior and attitudes which can be observed when the individual finds himself in various situations. It can be seen as a collective characteristic of the people enculturated in the same cultural setting (Podhisita, 1985). World view, in its simplest sense, may be understood as the sum of ideas and conceptualizations which individuals in the cultural system have towards their environment and universe.

Podhisita (1985) described the Thai world view in terms of the forms of behavior and attitudes that are characterized as "Thai" because they are unique and identify Thai people in general. Underlying this Thai world view are the Buddhist teachings and beliefs that guide Thais' behaviors and attitudes. Some parts of the Thai world view are related to family values. These family components of the Thai world view are described below.

The World View of *Bun Khun*

Bun khun is sometimes referred to as "*phra khun*" There is no English equivalent for this term but it may be described as any good thing, help or favors done by someone which result in gratitude and obligation on the part of the beneficiary.

The *bun khun* system of obligation and the network that develops from it is based on the provision of benefits or favors of any kind by one party to another and the special relationship thus established between the two parties. The relationship is

unequal due to the fact that the grantor party places the grantee in his debt by his favor while the grantee, by accepting the benefit, contracts the obligation to show gratitude and return the favor at an appropriate time (Podhisita, 1985).

Bun khun obligation is very important in Thai social life. Indeed, it is related to kinship in importance as a basis for social relationships in Thai society. Those who recognize the *bun khun* of others and do not fail to return the favor are always praised. Those who neglect this obligation are disliked. This *bun khun* obligatory relationship is especially strong within the family and kin circle where the younger generations are very much obligated by the *bun khun* rendered by the older generations. Phillips (1965) described this as a contractual relationship between parents and children. The *bun khun* relationship is also strong outside of the kinship circle.

The *bun khun* relationship in Thai society may be seen as validated by the Buddhist teaching concerning "rare persons" which is familiar to most Thai people. It is expounded in temples as well as in schools. According to this doctrine, rare persons are:

1.1) those who have rendered a favor (*pubbkari*) and are persons such as father, mother, elders, and ancestors.

1.2) those who show gratitude and repay the favor done to them.

In the Thai context, *katanyu katavedi* refers directly to the obligation to repay parents and is a value firmly ingrained in the culture (Podhisita, 1985). Thai peasants consider one's own father and mother as the most revered of relatives. Father and

mother give life and take good care of their children. They therefore deserve to receive gratitude in return and be taken care of by their children, especially when they become old. A prominent feature of the Thai concept of family and making-merit for their deceased parents is also viewed as a part of exhibiting filial piety to their parents. Buddhism regards persons who have *katanyu katavedi* as exemplary individuals whose actions bring harmony and happiness to themselves and society.

In contrast, those who do not take good care of their aged parents are considered ungrateful children and are normally condemned by their other kin and neighbors. They are viewed as the worst of all bad children. To provide a context for comparison, the other bad qualities are, for example, laziness, gambling, drunkenness, frequently engaging in fighting and other crimes.

The World View of Hierarchy

Hierarchy also plays an important role in Thai social life. A significant part of child socialization is oriented toward making the young learn appropriate behavior to deal with hierarchy. Society, as seen by Thai people, is made up of positions which are hierarchically related. It would be very difficult for Thais to perceive how social relations could be organized without recognition of some sort of hierarchy. In the Thai world view, individuals are seen as either higher or lower, younger or older, weaker or stronger, subordinate or superior, senior or junior, richer or poorer, and rarely equal, in relation to one another. This view is expressed both in verbal and non-verbal behavior. Because of this concern about hierarchy, Thais

are quite sensitive to age and seniority in their everyday social interactions so that they use not only proper terms in their conversation, but also appropriate behavior (Podhisita, 1985).

The acceptance of Buddhist teachings on the principle of hierarchical order is well reflected in the predominance of the vertical social relationship among persons that has long been practiced and has become an important characteristic of Thai society. The vertical social relationship is characterized by a formalized superordinate-subordinate relationship. The family is viewed as the basic training ground for its members to learn about the superior-inferior or respect patterns and to behave and to speak appropriately with parents, elders, relatives, teachers, monks, government officials, and others.

The World View of Merit and Demerit

The world view of merit and demerit is related to the main concept of Buddhism, "the law of *kamma*." Buddhists believe that every volitional action, good or bad, has a result which follows the actors as a shadow follows an object, awaiting the appropriate time to manifest itself. That time may be immediately after the action, long after, or even in subsequent lives.

Two concepts, (a) merit, "*bun*", and (b) demerit, "*bap*", play important roles in providing explanations for situations and events affecting individuals' daily lives. *Kamma* and its related concepts of *bun* and *bap* are an important part in Thai thinking and reasoning. As Kirsch (1977 cited by Podhisita, 1985) observes:

> Individuals frequently account for events and experiences in their lives in terms of their relative store of merit;

> all status, situations, and events can - potentially, at least - be interpreted and explained in term of merit. In doctrinal terms, the individual might be thought of as the culmination of *kamma* garnered through past lives as well as the present one. In simple terms, an individual might be viewed as being a balance of cumulated merits and demerits (1977, p 246).

The significance of *kamma*, *bun* and *bap* in Thai cognition may also be seen in rituals and ceremonies. Among Thai Buddhists, almost all important rituals and ceremonies involve some sort of merit-making (*tham bun*) whether those ceremonies are for individuals, households, or communities as a whole. In the people's understanding at least, religious activities are dominated by merit making. Besides, doing good of any kind may also be seen by the Thai as merit-making. Thus, giving food and gifts to monks, praying, supporting the temple, observing the precepts, listening to sermons, and practicing meditation, etc., are all religious activities that result in merit for those who perform them. Similarly, digging communal wells, building roads, taking care of aged parents, helping the poor, and other activities of this sort are also considered by Thai Buddhists as merit-making. Merit-making activity is important because it increases one's store of merit, and merit is important because it is believed to bring a better life in the future.

The above summary highlights some of the common practices and norms about world view of life related to the Thai family. The world views of *bun khun*, hierarchy, and merit and demerit which is

part of Buddhist beliefs play an important role in forming and guiding the attitudes and behaviors of Thais within their families.

CHAPTER II

REVIEW OF LITERATURE

Aging and Caregiving Situation in Thailand

The number of persons aged 60 years and over in Thailand has been increasing steadily since 1960. Life expectancy in Thailand is 66.4 years for a Thai male and 71.8 years for a female (Institute of Geriatric Medicine, 1993). At the same time that the elderly population is growing in numbers, life expectancy is also increasing. Thus the prediction is for increased numbers of elderly and an older old group. One study also reported that the dependency status of the Thai elderly progressively increased with age, with around four-fifths of those aged over 80 considered dependent (Jitapunkul, Bunnag, & Ebrahim, 1993).

Estimates from the Sex and Age Distribution of the World Populations by the United Nations, the number of persons aged 60 years and over will double in the next 20 years. The percentage of Thai elderly populations is predicted to be 16.3 and 24.8% of the total population in the years 2025 and 2050, respectively (Conception, 1996). Such increasing numbers lead to growing concern about the many problems associated with aging, such as provision of medical care, living arrangements, family care, social security, and welfare.

The most common causes of death of Thai elderly people are malignancy, heart failure, pulmonary tuberculosis, intracranial hemorrhage, pneumonia, and intestinal infection (Jitapunkul, Bunnag, & Ebrahim, 1993). The major health problems in the elderly population, surveyed by Institute of Geriatric Medicine (1993),

are divided into two categories: physical health and mental health problems. The physical health problems are muscular pain, high blood pressure, cardiovascular diseases, and cancer. The major mental health problems are anxiety, insomnia, changes in mood, changes in thought, and changes in behavior. All these may require long-term family caregiving. The care for frail elderly is assumed to be a family responsibility that is usually shared among family members according to their age and abilities. In Thailand, it is uncommon for a family to place elderly parents into institutions such as nursing homes or residential homes. The private nursing homes, mostly located in urban areas, are still expensive and could be afforded only by wealthy families. In general, the family is still seen as the fundamental unit in Thailand to provide support and care to frail elderly in their homes.

Presently there are a variety of changes taking place in Thailand which will impact the elderly. For example, the employment situation is changing so that there are increased opportunities for the young to have a formal occupation as compared with the family and village-based employment of the past. This has resulted in a trend towards migration of younger generation members to urban areas. At the same time, changes in education and technology may lead this younger generation to work outside the home instead of at home or in the fields as in former times. In Caffrey's (1992b) study of family care for elderly in Northeast Thailand, she reported that the more land a household owned, the more likely the traditional pattern of elder care was to be maintained. When land was limited, children left home to

find employment elsewhere and sent money to help parents as they were able. Poverty played a major role in the perceived quality of life of the elderly in that study (Caffrey, 1992b). Thus, the relocation of family members, as well as increasing numbers of frail elderly, will likely place strains on the operation and continuation of the current family obligation system.

Caffrey (1992a) further identified four levels of family caregiving phenomena related to developmental and illness transitions in older Thais. Level I is the phase when elderly parents retired from work and turned over the role of being head of household to their children. However, the elders still continued to contribute in helpful household chores or childcare and were also more involved in religious activities. Level II started when the elders became older, ceased their assistance with household activities, and withdrew from religious activities. Level III occurred when the elders became ill and needed closer care and more supervision. During this stage, the family caregiver had to take full responsibility in caring for ill elders. This level usually started when the elderly person was aged 75 or older. However, this stage might occur at any age depending on the elderly person's health status. The sickness may be only temporary, with a return to one of the previous levels of caregiving if the elder recovered; or Level III may be continued until the elder's death. The last stage is Level IV which is identified by religious practices such as arranging an appropriate funeral and making merit to the deceased elders. The study found that the impact of modernization had not resulted in major changes

in caregiving roles since most of the caregivers were living in rural areas involved in farming.

Samanawan, (1994) a Thai nurse, studied the stress, burden, and socioeconomic problems in family caring for demented elderly at home by interviewing 29 caregivers who lived in communities served by the Public Health Center zone 3, Bangkok. Almost all of the caregivers reported emotional distress and physical illness from the burden of caring which caused changes and affected their daily life. Communication problems and incontinence were the major burdens in their caregiving. Samanawan's study focused in the negative problems associated with family care for demented elderly. The essence of current caregiving practices and understanding of the traditional value of *katanyu katavedi,* which might be a factor in responsibility of caregiving, have not been studied. It is reasonable to expect that the changing social, occupational, and economic patterns of urban life, over time, may also change traditional values and thereby caregiving practices also.

Concepts Related to the Study

The relationship between parents and children is a lifelong relationship. Some theorists have identified concepts to explain the adult and child relationships which are related to caregiving behaviors for elderly parents in later life. Such concepts are "filial responsibility expectations" (Seelbach & Sauer, 1977, Seelbach, 1980, Seelbach, 1981), "filial obligation and attachment" (Cicirelli, 1983, Cicirelli, 1993), "family solidarity or intergenerational solidarity" (Bengston, Olander, & Hadda,

1976, Bengston & Roberts, 1988), and "filial piety" (mainly studied in Eastern culture; Hsu, 1971, Sung, 1990, Kim, Kim, & Hurh, 1991). These concepts are used mainly to describe relationships between a parent and a child such as filial relationships, especially when the parent becomes old and needs some kind of care.

From Webster's New Universal Unabridged Dictionary, second edition (1983), "filial" is defined as "bearing on the relationship of a child or issuing from, as offspring" (p.85). Filiality is the relationship or attitude of a child toward a parent. When combining this term with other words to get the new words or new terminologies, the definitions of the new terms vary by the conceptual frameworks or the specific meanings given by the theorists or researchers. In the following section, the research that has been done using these concepts will be summarized.

Filial Responsibility Expectations

The concepts of filial responsibility expectations, sometimes referred to as filial responsibility or filial expectations, have been studied since the 1960's. Schorr (1960 cited by Seelbach & Sauer, 1977) defined the concept as the adults' obligations to meet their parents' basic needs. Seelbach and his team conducted a series of studies about filial responsibility expectations of older parents (Seelbach & Sauer, 1977, Seelbach, 1980, Seelbach, 1981). They investigated the extent to which parents expected their children to assist them in times of need. They also looked at the relationship of filial responsibility expectation to the types and amounts of assistance

that adult children provided. Seelbach (1980) examined the following areas of filial responsibility expectations which identified that children should: live near their parents, take care of their parents when they are sick, give financial help, have frequent contact by visiting or writing to their parent at least once a week, and feel responsible for their parents. These studies revealed no significant differences in filial responsibility expectations or types of assistance between blacks and whites in the U.S. However, there were gender differences. Female elderly parents were more likely than male parents to endorse living with their children. Moreover, Seelbach found that the elderly parents' filial responsibility expectations were inversely associated with their morale.

Blieszner and Mancini (1987) studied the filial expectations of older parents for more abstract demonstrations of filial responsibility such as affection, thoughtfulness, and open communication. Older parent participants expected their children to discuss specific issues such as care in the future in case of medical emergency, long term care preferences, funeral arrangements, and disposition of their property after death. Two major motivations for parent care have been identified from this literature: obligation and attachment.

Filial Obligation

Cicirelli (1993) defined filial obligation as the norm of socially responsible behavior toward aging parents. It is the duty of the adult child to help elderly parents. He specified filial obligation as the feeling of obligation to perform certain

specific tasks for an aging parent. The Obligation Scale (Cicirelli, 1991) was developed to measure feelings of obligation by asking children to respond on a 5-point scale to global statements about reasons for helping parents. It was found that obligation had a direct effect on the amount of help and feeling of burden in daughters who took care of their elderly mothers. In addition, the interaction between level of parent's dependency and obligation had a significant effect on burden. For example, when the mother's dependency was great, the effect of obligation on subjective burden was greater.

Filial Attachment

"Life-Span Attachment Theory" (Cicirelli, 1983) is a theory that was proposed to explain the lifelong nature of the parent-child relationships. Cicirelli (1983) defined attachment as the emotional or affectional bond between two people; essentially it is being identified with, in love with, and having the desire to be with another person. Attachment is an internal feeling that parents and children feel for one another. This feeling can lead to attachment behaviors that follow us throughout our lives. Cicirelli (1983) maintained that feelings of closeness toward elderly parents are manifestations of attachment. Residential proximity, frequent visits, letter writing, and caregiving are all behaviors associated with attachment in adulthood. Moreover, it was found that feelings of attachment by adult children led directly to caregiving behavior. Cicirelli (1993) found that high levels of both attachment and obligation in daughters did not lead to high levels of care. Moreover, he found that attachment was

associated with lower levels of burden, and obligation was associated with higher levels of burden.

Intergenerational Solidarity

Solidarity means the combination or agreement of all elements or individuals or as a group in the opinion, purpose, interest, feeling, etc. (Webster's New Universal Unabridged Dictionary, 1983). Bengston, Olander, and Haddad (1976) proposed a model of intergenerational solidarity based primarily upon sociological work. In their concept, the intergenerational solidarity is defined as the adult child's relationship with their parents which was measured in terms of relationship factors. They described three key factors that compose intergenerational solidarity between elderly parents and adult children. The first factor is "association." The more the elderly parent is associated with the adult child, the more solidarity exists within the relationship. The second factor is "affection." The crucial element of this factor is the feeling of giving help to parents, having a sense of obligation or duty to help their parents. The third factor, "consensus," related to family solidarity is the ability of adult children and elderly parents to reach agreement on values, beliefs, and opinions. The intergenerational solidarity theory proposes that the elderly parent and adult child relationship will remain strong as long as association, affection, and consensus remain strong.

The model of intergenerational solidarity of Bengtson and his team (Bengtson & Roberts, 1991) was revised by combining three elements to support the empirical tests of parent and child

solidarity. Those three elements were: a) functional solidarity (or patterns of instrumental support or resource sharing); b) normative solidarity, which is norms or expectations of individual obligations to the family; and c) structural solidarity or structure for intergenerational relationships. It is assumed by researchers that this revised model of intergenerational solidarity will help in better and more comprehensive understanding of family solidarity.

Filial Piety

Piety means loyalty and devotion to parents and family, especially in Chinese ethics, where reverence for one's parents is considered the prime virtue and the basis of all right human relations (Webster's New Universal Unabridged Dictionary, 1983).

Filial piety, "*Hsiao*", is a major virtue in Chinese culture and a central pillar of Confucianism. It originally meant piety or reverence towards the spirits of the dead, including one's dead parents, but it has come to be applied to the duties towards one's living parents. Obligations towards parents involve not only obedience to them but also caring for and supporting them in their old age, providing a proper funeral for them, and offering proper sacrifices to them after death (Morris, 1994). Filial piety is not seen as an exclusive virtue. It also plays a central role in Confucian ethics, and is understood as the primary and fundamental unit of mutual connection between two or more persons. Kim, Kim, and Hurh (1991) concluded that the meaning of filial piety from the cultural norms of Chinese, Korean, Japanese and other Asian societies influenced by Confucian culture was "traditionally

expected, obliging a married son and his wife to serve the husband's parents unselfishly in a wide range of his parents' need or wishes" (p 236). Aspects of filial piety include: a) physical care; b) social-psychological comfort; c) obedience, respect, and consultation with parents concerning important family and personal matters; d) honoring and glorifying parents through the son's outstanding achievement; e) faithful observance of important ceremonial occasions (e.g., ancestor worship, parents' wedding anniversary or birthdays); and f) continuing the family line (Kim, Kim, & Hurh, 1991; Tsai, 1997).

Filial Motivation

Motivation for parental care is considered to be central in the determination of filial behavior. It is the motivation that is reflected in the adult children's willingness to care for their aging parents (Sung, 1994). This willingness in turn reflects the values prevailing in a society. Sung (1994) studied filial motivations for parental care among American and Korean primary caregivers. The three most frequently mentioned motivational responses by American respondents were obligation, affection, and reciprocity. For Korean caregivers, the most frequently mentioned motivations for parent care were love, repayment, respect, filial responsibility, family harmony, and filial sacrifice. It is significant that both American and Korean caregivers have indicated affection/love, repayment/reciprocity, and obligation/responsibility as the primary motivations for parental care. This shows salient degrees of similarity between the two cross-cultural groups in the major and universal filial

motivations. Nonetheless, the culturally specific characteristics of filial motivations that emerged from Korean families (filial respect, family harmony, and filial sacrifice) reflect a good example of filial relationships as perceived in the cultural context of a collectivistic society.

Reciprocity

Reciprocity is a state of being reciprocal; reciprocal relationship; mutual dependence, co-operation, etc. (Webster's New Universal Unabridged Dictionary, 1983). The concepts of reciprocity and mutuality have drawn the attention of family caregiving researchers as positive views of the parent-child relationship that can lead to positive outcomes of caregiving (Archbold, Stewart, Greenlick, & Harvath, 1992). The concepts of reciprocity and mutuality usually were explained and analyzed by social exchange theory. Reciprocity is the norm of relationships that members of a relationship should expect to experience equitable levels of profit and loss (George, 1986). Reciprocity in these exchange relationships has come to be seen as important for understanding relationship quality (Mancini & Blieszner, 1989). It is known that older parents continue to provide support of various kinds to their adult children and are not the only recipients of support.

Stoller (1985) examined the influence of reciprocity on the well-being in aging parents. About one-third of the parents in the study reported reciprocity in exchanges with their children. It was found that the parents' receipt of help from the children was negatively related to depression-like syndromes in parents, but

the provision of help to children was more strongly related to well-being of parents.

Mutuality

Mutuality is also a concept that has been used to look at the quality of relationships between care receivers and caregivers including parents and children. Archbold, Stewart, Greenlick and Harvath (1992) defined mutuality as the positive quality of the relationship between a family caregiver and a care receiver. Their measure of mutuality has four subscales: love and affection, shared pleasurable activities, shared values, and reciprocity. Thus, reciprocity is reviewed as a part of mutuality. However, reciprocity is more focused on the activities of interactional exchange behaviors, while mutuality includes the feelings, relationships, and mutual exchange perspectives.

Family Caregiving

Family caregiving has been conceptualized as occurring when one or more family members give aid or assistance to other family members beyond that required as part of normal everyday life (Walker, Pratt, & Eddy, 1995). Family caregiving for the elderly usually begins when aging family members require some kind of assistance according to their disability, chronic conditions or diseases, or when they are otherwise frail or demented leading to prolonged impairment.

Family caregiving of the elderly has grasped the attention of researchers and theorists in the different fields of psychology, sociology, behavioral science, family studies, and nursing. During the past two decades, there have been multiple

studies on caregiving for the frail elderly. The conceptual approaches of family caregiving have included stress and coping (adaptation) theory (e.g., Pearlin, Mullin, Semple, & Skaff, 1990), role theory (e.g., Archbold, Stewart, Greenlick, & Harvath, 1990), social exchange theory (e.g., Walker, Martin, & Jones, 1992), and feminist theory (e.g., Abel & Nelson, 1990).

There are also some studies of family caregiving which have identified and focused on caregiving tasks and activity types (Archbold, Stewart, Harvath, & Lucas, 1986; Bowers, 1987; Horowitz, 1987). Archbold et al. (1986) defined the nature of the caregiving role by looking at amount and type of direct and managed caregiving tasks which are: personal care; housekeeping; protection; transportation; handling behavior problems; financial, legal, and health decisions; medically related; little extras; and managed care. Bowers (1987) identified five categories of caregiving activities including: anticipatory caregiving; preventive caregiving; supervisory caregiving; instrumental care; and protective caregiving. Horowitz (1985) defined family caregiving in terms of activities or the extent to which help is provided to a family member and categorized them into three levels: (a) tasks that require intermittent help (e.g., shopping, transportation, financial management); (b) in-home assistance that requires regular time commitment (e.g., meal preparation, household keeping); and (c) the most intensive and intimate caregiving (e.g., personal and health care) (Horowitz, 1985). The summarized review of concepts related to the study is presented in Appendix A.

Cultural Perspectives on Caregiving

Caregiving for the elderly or dependent ill parent is a social norm for people in every country. However, the practice and norm might differ depending on the specific culture, as Phillips et al.(1996) maintained that caregiving in family is a cultural environment. The dynamic of caregiving depends upon race and culture. Before developing relevant views or measures of caregiving in different cultures, it is necessary to understand the ways that a specific culture influences caregiving (Phillips et al., 1996).

Individualism and collectivism are described as the cultural variability that emphasizes the differences in norms, values and practices of each culture. These concepts are discussed and examined in many contexts of social sciences, such as community, society and family structures and relationships. There have been several studies across disciplines, such as cross-cultural psychology (Triandis, McCusker, & Hui, 1990; Triandis, 1995), communication (Gudykunst & Ting-Toomey, 1988), and family caregiving (Pyke & Bengston, 1996; Luna, Torres de Ardon, Lim, Cromwell, Phillips, & Russell, 1996) that discuss the cultural context of individualism and collectivism in different societies.

Triandis's (1995) analysis of individualism and collectivism labels these concepts as "cultural syndrome." He maintained that in agricultural cultures there is more collectivism and conformity because it is more functional to conform to authorities for performing public work (e.g., building of irrigation canals, harvesting farms). On the other hand, in

cultures where people make a living by gathering food, hunting or fishing, self-reliance tends to be more functional than dependence on authorities or in-groups. In such cultures, child rearing practices emphasize self-reliance, creativity, the child's autonomy, and independence from the family. In contrast, obedience, duty, and sacrifice for the in-groups are emphasized in collectivist cultures.

Hofdtede (1980) described national cultures by studying the individualism of people from different countries. He found that Western countries, which are more industrialized with related cultural complexity as indexed by such variables as the number of distinct occupations, level of political organization, and population density, tended to be more individualistic than Eastern countries or simple, culturally homogeneous countries. For example, the U.S.A., Australia, the U.K., Canada, New Zealand, Netherlands, Denmark are countries with very high scores on individualism. Examples of countries that are more collectivistic, with very low score in individualism, are Korea, Taiwan, Thailand, Mexico, and Panama. Most of the countries in Asia and South America have collectivistic cultures. His findings are congruent with Triandis's (1995) conclusion that individualism is found mostly in Europe and North America, while collectivism is found in most of the rest of the world.

Studies that intensely focus and explain the specific characteristic of family caregiving by using the cultural dimensions, such as individualistic and collectivistic systems, to describe the contexts of differences in culture, are rare. Only

one study that looked at individualistic and collectivist systems of family eldercare was found (Pyke & Bengtson, 1996). It was more likely for the individualistic families to be reluctant and less involved in caregiving. Although individualists tended to feel obligated toward aging parents, they did not believe that responsibility for care giving should fall on them alone. They also used and more heavily relied on formal supports or formal institutions. In contrast, in collectivist families, caregiving was not provided through formal institutions but assumed by family members. Caregiving was shared usually among two or three family members or groups: siblings, spouses, and children. The high level of commitment to family elder care among collectivists coincided with positive accounts about their elderly relatives. Collectivistic families were more likely to glorify and honor their elderly with very complimentary descriptions. From this study, it was suggested that the policy makers should examine and consider the diversity and cultural differences of families in society before setting up systems or services that would be beneficial in helping families give care to the elderly.

Because the majority of the concepts of family relationships and caregiving were developed and have been studied in the Western culture, studies to examine concepts or meanings from different cultural perspectives are still crucial. Leininger (1991) states that there are more differences than similarities in care phenomena between Western and non-Western cultures. Therefore, before the similarities and differences between family care in Western and non-Western can be identified, the local care

of non-Western setting, phenomena or conceptual frameworks need to be explored. Pelto and Pelto (1978) suggested using emic and etic approaches congruently for the benefit of cross cultural studies and analysis. The emic and etic approaches are the set of conceptual tools that are used to distinguish methods in approaching culture in social sciences research (Headland, Pike, & Harris, 1990). Etic is a term used to describe a concept that is common across cultures, while emic refers to a culture-specific concept that is found in specific group but not other societies (Brislin, 1993). It is expected that the review of concepts and studies from Western cultures (etic approach) will provide an understanding of general concepts which are universal. However, combining the etic approach with the emic approach when doing field research will help apprehend the culturally specific meaning of caregiving for the elderly and the traditional cultural concept of *katanyu katavedi* in Thai culture.

Summary

Thailand is a country in Southeastern Asia which is considered to be homogenous in its culture and characteristics. Family structure is mainly nuclear but most of the elderly people live with at least one of their children in a stem family. Care and support provided by children for elderly parents is based on a strong sense of moral obligation which is known by Thai persons as *katanyu katavedi*. This represents the traditional caregiving system of Thai families in relation to collectivistic cultures which focus on respect, family harmony, repayment, responsibility to sacrifice one's personal needs, and adherence to norms of

society. The effects of urbanization on families and their living situations is likely to have affected how families care for elders during this decade in Thailand. The potential deleterious effects of change upon the well-being of the elderly family members make it a critical issue for the traditional family care system of the aging Thai population. Thus, it is necessary to explore the beliefs and realities of the caregiving situation in modern urban Thailand.

CHAPTER III

METHODS

Overview of Methods

The qualitative exploratory design was used in this study. The methodology for data collection is a combination of intensive interviewing as described by Lofland and Lofland (1995) and participant observation (Jorgensen, 1989). Intensive interviewing consists of face-to-face interviews with participants. The investigator, through intensive interviews, seeks to discover the informant's experience of a particular topic or situation (Lofland & Lofland, 1995). Lofland and Lofland (1995) also emphasized the mutuality of participation and intensive interviewing as central techniques of naturalistic investigation.

Lofland and Lofland (1995) defined the observation of natural settings using the techniques of participant observation or intensive interviewing or both, as social setting analysis. It is sometimes labeled as qualitative field study. The key elements of this method are: collecting the richest possible data; achieving intimate familiarity with the setting; and engaging in face-to-face interaction so as to participate in the thinking of the settings' participants. As family is considered to be one type of social setting, the qualitative method of social setting analysis is expected to enhance the development of new empirical knowledge about Thai family caregiving and reveal the importance of some elements that might be useful and extended to new generic propositional forms of the social structure, processes and nursing knowledge.

Intensive interviewing is consistent with the desired purposes of this study, two of which are to identify the meaning of the concept *katanyu katavedi* and to describe the caregiving for frail elderly parents in Thai families from perceptions of family members. In addition, intensive interviewing permits development of concepts grounded in the perceptions of the people experiencing the phenomenon.

Participant observations helped the investigator establish and sustain a many sided and relatively long-term relationship with family participants; this relationship brings a developing scientific understanding of the daily life and culture of that group (Jorgensen, 1989). Participant observations were recorded using a data log for fieldnotes. The fieldnotes added richness to data by providing a record of the setting, caregiving activities and analytical ideas. The fieldnotes also help in reminding the researcher of the situation during the interview.

In naturalistic inquiry, human beings need to be understood from the totality of their lifeways, bearing in mind the dynamic interplay of these lifeways with social, economic, political, religious, and cultural values. Discovering holistic patterns and themes of a social setting will become a way to understand people and their lives. By combining participant observation with intensive interviews, mutual involvement in personal lives and prolonged engagement in the settings, this study attempted to discover and understand the family caregiving within the natural setting.

Setting

The study took place in Metropolitan Bangkok, Thailand, which is the capital, the biggest, and the most developed city in Thailand with its population of over six million in 1997 (Office for Central Civil-Registration, 1997). As part of the Bangkok Metropolitan Administrative structuring, the Health Department is responsible for provision of public health, family hygiene, and medical services for people residing in Metropolitan areas. Presently, there are 64 Health Centers all over various Bangkok areas under the supervision of Health Department of Metropolitan Bangkok (Bangkok Metropolitan Administration, 1997). These Health Centers are responsible in providing health care services and home visiting for people in communities especially in their geographical areas. The public health nurses from Health Centers usually do the home visiting in the morning and give the in-clinic services at Health Centers in the afternoon. In usual situations, visited cases are maternity and child, chronic illness, pre-school children, and the elderly.

Three Health Centers (Health Centers 15, 25, and 52) were selected as three areas of community setting in which families were recruited to the study. Health Center 15 (Lad Prao, Soi Paowana) is a Health Center which is close to a main street, Lad Prao Street. This area is a community combined with business buildings, homes and living areas. Health Center 25 (Huai Kwang) is located in areas where there are lots of private homes and town houses. Health Center 52 (Samsaen Nauk, Din Daeng) is located near a big market, several communal public flats, and town houses.

These three Health Centers were chosen because: a) the variety of families in terms of ethnic background (Thai, Thai-Chinese) and socio-economic status; b) the high density of population in these areas; and c) feasibility of transportation to the settings.

All participants in this study were families that received home visits or other services from public health nurses from one of these three Health Centers. The interviews with family members and observations took place in the home settings.

Data Collection Methods

Sample

Purposeful sampling was used in this study since the intent of sampling selection was to interview the informants who were in the real situation and could articulate enough to be the experts or informants.

Criteria for Inclusion of Families

Families included in this study were (a) families in stem, joint or extended family structures; (b) families residing in Metropolitan Bangkok; (c) families in which one or more children shared a household with their frail elderly parent/s and provided care for them; and (d) families in which the elderly parents were aged 60 or older. Frail elderly parents were identified as parents who were dependent or needed assistance in at least one activity of daily living (ADL, e.g., bathing, dressing, feeding), or two or more instrumental activities of daily living (IADL, e.g., houseworks, preparing meals, performing religious activities). These criteria were adapted from the meaning of "frail" by the U.S. National Center for Health Statistics (1990) and from the

modification of ADL and IADL Assessment Tool from Ebersole and Hess (1994). The IADL was evaluated by asking about usual activities that the elders could perform by themselves in the past and their needed assistances at present. The ADL and IADL Asessment Tool of this study was shown in Appendix B.

Family members selected as key informants for the in-depth interviews were obtained through public health nurses who had visited or were visiting the families and had information about the families. The family members eligible to be key informants: (a) were at least 18 years or older; (b) were adult children who took responsibility in caregiving activities or defined themselves as primary caregivers for frail older parents; (c) consented to participate the study; and (d) were able to articulate their experiences and perspectives about *katanyu katavedi* and caregiving in the families.

Other family members who took part in caregiving or helped in care activities and were observed by the investigator were also included as informal informants. The interviews with these informants were done as informal interviews, during group discussions and during the observational experiences.

Sample Access Procedures

The investigator contacted the Director of the Health Department of Metropolitan Bangkok to inform her about the study and criteria for sample selection. With the director's approval, the investigator met and described the study to the head nurses of Health Centers 15, 25, and 52. The head nurses and the investigator then discussed the criteria of case selection with

public health nurses in the Health Centers. Public health nurses provided lists of eligible families (total 22 families: 2 families from Health Center 15; 5 families from Health Center 25; and 15 families from Health Center 52) and identified the elderly parents' health status and locations in which they resided.

The public health nurses contacted each potential family and asked their permission for the investigator to visit to explain the study. The investigator visited all potential families with the public health nurses to assess and determine the families that met the criteria regarding sample selection. Out of 22 families, seven were eliminated after the assessment for the following reasons. Three families declined to join the study because of time constraints. Two families were excluded because the investigator was concerned about her own safety (one family resided in a slum area with a high rate of drug trading, and the other family had only male family members present (i.e. frail father, two sons, and a nephew). In one family, the mother (care receiver) was dead. The last family had relocated to a different place.

After identifying 15 families who meet the eligibility criteria for the study and obtaining agreement from key informants to participate in the study, the investigator informed and obtained the verbal permission from heads of the family or elders. The investigator asked about a convenient time for the family to be visited and made appointments for the first interviews. Information about the participant families, such as maps to the houses, names of key informants, and telephone numbers, were

noted. In the first interview with each key informant, verbal consent was obtained and tape-recorded.

Description of Sample

Of the fifteen families in the sample, 5 were nuclear, 4 joint, and 6 stem families. Summary descriptions of the families, the configuration of family structure, and the blueprint of home setting are shown in Appendix C: Description of Participatory Families.

The caregivers (n = 15) who defined themselves as an adult-child and primary caregiver ranged in age from 30 to 67 years. The mean age of these fifteen caregivers was 46.3 years (SD = 9.7). Two of the caregivers were sons, and thirteen were daughters. Characteristics of the caregivers are shown in Table 1.

The care receivers (n = 15) who were frail elderly parents ranged in age from 60 to 90 years with mean age of 75 years (SD = 9.4). Four of the care receiver were fathers, and eleven were mothers. Characteristics of the care receivers are shown in Table 2.

A summary of families is displayed in Table 3.

Table 1

Characteristics of Adult Children (Family Caregivers)

Characteristics	Family caregivers (N =15) n
Age	
Mean = 46.3 yrs (SD = 9.7)	
Range = 30 - 67 yrs	
Gender and Role of Care receiver	
Son	2
Daughter	13
Educational level	
None	2
Primary Education (Grade 1-6)	8
Secondary Education (Grade 7-10)	3
High School Graduate	1
College Graduate	1
Marital Status	
Single	7
Married	4
Divorced	3
Widowed	1
Employment Status	
Homemaker	10
Food vendor	2
Employee	3
Religion	
Buddhism	14
Islam	1
Family Ancestery	
Thai	13
Thai-Chinese	2
Birth Order	
Only child	1
First-born	5
Middle	6
Last-born	3
Years has been caregiver	
1-4 years	11
5 years or more	4

Table 2

Characteristics of Frail Parents (Care Receivers)

Characteristics	Care Receivers (N =15) n
Age	
Mean = 75 yrs. (SD = 9.4)	
Range = 60-90 yrs.	
Gender and Role of Care Receiver	
Father	4
Mother	11
Educational Level	
None	7
Primary Education (Grade 1-6)	6
Secondary Education (Grade7-10)	2
Marital Status	
Married	5
Divorced	1
Widowed	9
Functional Status (ADL Scale)	
Totally dependent	7
Assistance with at least 1 activity	4
Totally independent	4
Functional Status (IADL Scale)	
Totally dependent	10
Assistance with at least 2 activities	5
Totally independent	-
Causes of frailty or illness	
Old-old	2
Stroke	6
Dementia	1
Brain injury	1
Cerebral infarction/atrophy	2
Cerebral meningitis	1
Osteoarthritis	1
Parkinson disease	1

Table 3
Summary of Families in This Study

Family ID	**Caregiver**	**CG's age**	**Care receiver**	**CR's age**	**Type of family**	**CG's marital status**	**CG's occupation**	**Level of CR's dependency**	**Support system**
ID # 1	daughther	42 yrs	father	74 yrs	Nuclear family	single	homemaker	Totally dependent both ADL & IADL	-caregiving activity support +financial support
ID # 2	daughter	57 yrs	mother	87 yrs	Stem family	married	homemaker	Partial need for assistance in ADL, totally dependent in IADL	+caregiving activity support
ID # 3	daughter	30 yrs	father	63 yrs	nuclear family	single	homemaker	Totally dependent both ADL & IADL	+caregiving activity support
ID # 4	daughter	37 yrs	mother	60 yrs	nuclear family	single	homemaker	Partial need for assistance in ADL, totally dependent in IADL	+financial support +caregiving activity support
ID # 5	daughter	50 yrs	mother	80 yrs	stem family	single	homemaker	Totally dependent both ADL & IADL	+caregiving activity support -financial support
ID # 6	daughter	48 yrs	mother	68 yrs	nuclear family	married	homemaker	Partial need for assistance in ADL, totally dependent in IADL	-caregiving activity support +financial support

Table 3 (continued)

Family ID	Caregiver	CG's age	Care receiver	CR's age	Type of family	CG's marital status	CG's occupation	Level of CR's dependency	Support system
ID # 7	son	38 yrs	mother	63 yrs	nuclear family	single	employee	Partial need for assistance in ADL, totally dependent in IADL	+caregiving activity support +financial support
ID # 8	daughter	51 yrs	father	77 yrs	joint family	single	homemaker	Totally dependent both ADL & IADL	+caregiving activity support +financial support
ID # 9	daughter	43 yrs	mother	74 yrs	joint family	married	food vendor	Assistance at least 2 activities in IADL	+caregiving activity support +financial support
ID # 10	daughter	67 yrs	mother	85 yrs	stem family	married	homemaker	Partial need for assistance in ADL, totally dependent in IADL	+caregiving activity support +financial support
ID # 11	daughter	39 yrs	mother	81 yrs	joint family	divorced	homemaker	Totally dependent both ADL & IADL	+caregiving activity support +financial support
ID # 12	daughter	34 yrs	mother	63 yrs	stem family	divorced	employee	Totally dependent both ADL & IADL	-caregiving activity support -financial support

Table 3 (continued)

Family ID	**Caregiver**	**CG's age**	**Care receiver**	**CR's age**	**Type of family**	**CG's marital status**	**CG's occupation**	**Level of CR's dependency**	**Support system**
ID # 13	daughter	50 yrs	mother	80 yrs	Joint family	single	food vendor	Totally dependent in IADL	-caregiving activity support -financial support
ID # 14	daughter	52 yrs	mother	83 yrs	stem family	widow	homemaker	Totally dependent both ADL & IADL	+caregiving activity support +financial support
ID # 15	son	57 yrs	father	90 yrs	stem family	divorced	employee	Totally dependent in IADL	+caregiving activity support -financial support

Procedures

Data Collection Tools

Prior to the study, the Initial Inventory of Keywords (Appendix D) and Initial Observational Guide (Appendix E) were developed by the investigator to use as guidelines for the observations. The Initial Inventory of Keywords is the description of meaning and observed symbolic actions from both English and Thai keywords. The investigator reviewed the Initial Inventory of Keywords and thought about the equivalence of some Thai words that had close or related meanings to the keywords in English. Some English keywords are very similar in the context to describing the caregiving and the relationships between parents and children; examples are filial responsibilty, filial obligation, and filial piety. The investigator, thus, decided to focus and use the Thai keyword of *katanyu katavedi* as the term to discuss with informants. However, the inventory of English keywords was still used and reviewed by the investigator to give ideas and outline some issues that might be relevant to Thai keywords. These English keywords from other studies were helpful to compare and contrast the findings of this study with others.

Because the interviews were done in Thai, and the concept of *katanyu katavedi* and some Thai keywords are related to religious teachings and cultural contexts, the researcher discussed the definitions and meanings of Thai keywords related to the study (e.g., *katanyu katavedi, bun khun*) with three Thai scholars in different disciplines. Names and titles of these Thai scholars are described belowed:

1) Phra Dhammapitaka (P.A. Payutto), a venerable Buddhist abbot, Yansakawan Temple, Nakorn Prathom;

2) Prof. Saksri Yamnadda, a professor in Thai Linguistics and Culture at Faculty of Art, Chulalongkorn University;

3) Prof. Julatat Prayakaranon, an emeritus professor in Thai Studies, Thai Studies Institute, Chulalongkorn University.

The meanings, explanation, and information obtained from these scholars were employed as frameworks in interviewing the informants and for the discussion part of this dissertation.

The Initial Observational Guide was also prepared to use as a guideline for observation of caregiving dimensions, such as physical settings, caregiving activities, family roles, interactions between family members, materials or objects that are related to the family and caregiving interaction, and episodes of caregiving behaviors or connections.

Interviews

The investigator's first visit to each family was made with the public health nurse. The investigator introduced herself, explained the purposes and methods of the study, and scheduled a time convenient for the caregivers to be visited and interviewed. Demographic data about the family, individual members and observational data (such as physical settings) were obtained at the beginning of the home visit, formal interviews, or sometimes during the informal visits. In total, the investigator made 55 visits which included informal and formal visits to these 15 families. Two in-depth-interviews were done with each key informant during these 55 visits, resulting in 30 formal

interviews with 15 caregivers and 25 observational visits. All formal interviews were audiotaped and transcribed verbatim (in Thai). The length of interviews ranged from 30-75 minutes. All key informants gave verbal consents which were tape-recorded before the first interview was conducted. These key informants chose to be interviewed in their home settings. Almost all of the interviews were done in an environment of privacy with only the key informant and the investigator presence. However, during the first interview with case ID #13, one of the informant's friends visited unexpectedly and joined the interview. The investigator found that her comments were meaningful and enriched the interview data. So, the investigator kept her part as additional information to confirm the data. Verbal consent was also obtained from this person. There were three cases (ID #6, 7, and 13) for which the frail elderly parents occasionally came in and listened to part of the interviews for a short period of time.

The Initial Interview Guide (Appendix F) was translated into Thai (the Thai Interview Guide see Appendix G).

To make caregivers feel comfortable and relaxed, simple questions such as information about the informant or the family in general were asked first, then questions about caregiving. The caregiving was started with the grand tour or general questions such as "Can you tell me about your day and life during this time of taking care of your parents?". Then, mini-tour questions were asked to gain more details and led the conversation to caregiving and experiences. Several probes were also used to clarify the caregiver's understanding and experiences of providing care to

elderly parents (e.g., "what is *katanyu katavedi* in your opinion?", "Give me examples of things that you said that it's the *katanyu katavedi* that a child or children do to parents").

In the first interview with case ID #2, the interview guide (Thai version) was followed closely from item to item. Despite the script and the structure of the interview guide which started with mini-tour questions, the investigator noted that the caregiver could not elaborate, and answered questions in a very brief and uninformative way. Therefore, after finishing the first interview using the structured interview guide, the investigator discussed the caregiver's (ID #2) feelings and responses to the interview with her. She said that the interview was too formal and she sometimes felt uncertain about her answers. The investigator noticed that when the conversation was informal without the using of the interview guide, the case ID #2 informant was more relaxed and could express herself more fully and in greater detail. Thus, the modification of the interviews by using the semi-structured approach without the presence of the written script was implemented to help the investigator succeed in gaining full information about the experiences from the caregivers.

The modification in the interviews was done by the investigator using a small notebook which listed some issues, keywords, topics, and questions needing to be discussed or asked during the interview instead of using the Interview Guide. The interviews then were more flexible and started with varied topics or issues depending on the circumstance or situation of each individual case. However, the investigator kept track of concerns

recorded with descriptive details jotted down in the fieldnotes immediately after the home visit. Observations of the physical setting of the home especially the care environment and parent's unit arrangement were more focused and recorded by the investigator in the fieldnotes. The sketched blueprint of the home setting and space arrangement for the frail elderly parent were also drawn to describe the environment of the home (Appendix C). The investigator also observed and sometimes participated in caregiving practices such as wound dressing, gavage feeding, assisting in ambulation, food preparation, and bathing. Observations were also focused on the interactions and relationships within the family.

The investigator took photographs of family settings, activities or interactions during caregiving in order to illustrate Thai family care settings. Photographs of home settings, care receivers' units, and caregiving activities were taken after the investigator obtained permission and consent from participants. Copies of the photographs were given to all families whose pictures were taken.

Protection of Human Subjects

The study was conducted in Thailand which has different norms and practices regarding ethics and human values from the U.S. Thus, it was crucial for the investigator to understand and consider the ethical issues and practices related to the protection of human subjects in a way that was sensitive to these cultural differences.

Bankowski (1996) maintained that "ethics is grounded in sociocultural, philosophical, or religious convictions. These convictions are a society's yardsticks for right and wrong, good and evil. They are often both incommensurable in themselves and untransferable from one culture to another" (p.147). Western medicine has been dominated by the Hippocratic culture, which has provided it with a core of beliefs and values for more than 2000 years. In general, it places an emphasis on individual rights and self-determination that can often be at odds with the dominant ethos of the medical profession and also with many other traditions. However, in traditional Eastern culture, the system of medical ethics usually emphasizes a principle of humaneness or beneficence which largely articulates the responsibility and loyalty of physicians to the profession and commitment to the craft (Christakis, 1992). In the context of human subjects' research, the principle of beneficence to protect research subjects from harm or to minimize possible harm and to maximize possible benefits is also well accepted and practiced as it is in a Western standard which concerns human's rights and benefits of the subjects. However, since there are cross cultural differences in the definition of personhood, considerations of beneficent practice of research subjects may be modified by specific practical and social concerns. For example, the practice of using informed consent might vary by the different standards of different societies. In Western societies, the individual's rights, autonomy, self-determination, and privacy are emphasized as the individualistic nature of humans. Thus, the consent is

directly and necessarily expected from the subject him/herself. In contrast, the Eastern societies stress the embedment of the individual within society and define a person by means of his/her relations to others in that society (Christakis, 1992). Therefore, the focus of the consent process may shift from the individual to the family or to the community. Balancing and justifying between the practices of medical ethics in a culturally sensitive way is crucial for studies in different cultures.

The following protections of human subjects were utilized to prevent ethical problems in doing this study. The proposed study was reviewed and approved by the Institutional Review Board of the Oregon Health Sciences University (Appendix H1) and the Office of the National Research Council of Thailand (Appendix H2) concerning the protection of human subjects, especially sample recruitment and study protocols. The consent form was written in both English and Thai (Appendix I1 and I2: Consent Form English Version and Thai Version). The Office of the National Research Council of Thailand reviewed and approved the equivalence of both English and Thai versions of the consent form. The informed consent in Thai was explained with full information about the research purposes and methods and the rights of participants in the study. Oral informtion about the study was also given to individual members in the family to show respect and awareness of others in the setting. Participants were identified in the transcripts with assigned ID numbers. All information obtained from subjects remained confidential.

The anticipated risks to participants included psychological discomfort or distress related to disclosure of feelings of frustration or difficulty in caregiving situation. These were also of concern to the investigator. During the interviews, four of the caregivers became emotionally upset while talking about the deterioration of health status of their parents. They expressed the feelings of pity and distress about watching their parents' health become worse and more frail. Psychological discomfort was minimized during the interview by the investigator's attention to the participants' reactions. However, most of the participants were satisfied and willing to be interviewed and studied because the investigator also provided them knowledge and answered questions about caregiving during participation in caregiving activities. All the participants gained indirect benefits from the study by gaining an appreciation of their own caregiving situation.

Analysis of Data

Lofland and Lofland's Approach to Analysis of Data

According to Lofland and Lofland (1995), analysis of data is the product of an inductive and emergent process in which the analyst is the central agent. The analysis process should be open-ended and creative in the way that the investigator selects, adapts, and combines different approaches to achieve a comprehensive analysis.

Lofland and Lofland (1995) also gave their six types of strategies in developing an analysis but emphasized that the investigator might devise his/her own strategies of analysis. Data

analysis based on Lofland and Lofland's (1995) six strategies for developing an analysis are; framing, contrasting, coding, memoing, diagraming, and thinking flexibly. These strategies and other analytic tools were used.

Framing

According to Lofland and Lofland (1995), propositional framing or focusing is the way of collecting and ordering data by formulating generic propositions to sum up and organize major portions of data by formulating generic propositions.

Lofland and Lofland (1995) suggest using eight forms of propositions which are type, frequencies, magnitudes, structures, processes, causes, consequences, and agency as tools in organizing and summarizing data. For example, one generic proposition might be "*katavedi* is the obligatory action in paying back to parents regarding *katanyu* that a child/children has/have toward them." Using the eight forms of propositions helped the investigator to look and think thoroughly about this proposition.

Type. Lofland and Lofland (1995) described type as units or aspects which exist or occur in a social setting. Units is a set of tendencies one can see in a fieldwork report. (The units of social setting might be defined as forms of practices, episodes, encounters, roles, relationships, groups, organizations, settlements, social worlds, and lifestyles.)

For example, *Katavedi*, the obligatory action in paying back parents, occurs or exists in Thai family setting (social setting). From the interviews of fifteen caregivers, all of them talked about parent repayment as an obligation (role) when children are

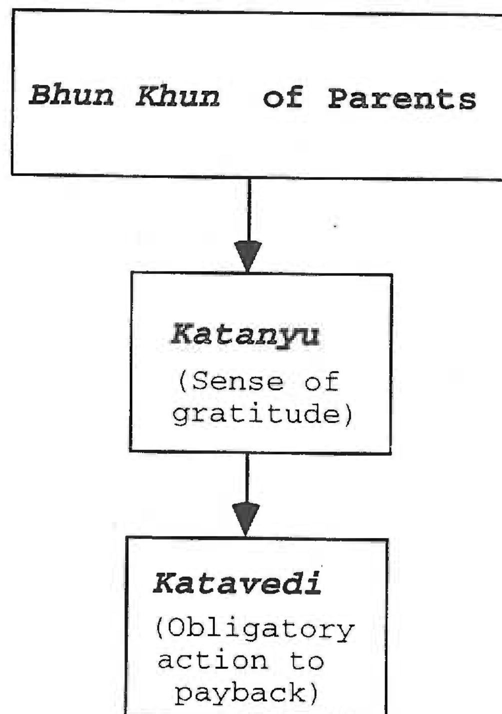
old enough to do something in return for parents. The caregivers mentioned their feeling of gratitude (*katanyu*) that parents have *bun khun* meanings for them such as giving life, rearing them, and taking care of them when they were young.

Frequencies. Frequencies are referred to the number of times that the type occurs during a period of time. For example, the obligatory action in paying back occurs in the family when parents become old, frail, or over periods of time through the parent-child relationship. There are more than 60 data bits that all the caregivers in this study mentioned about their obligatory action to pay back parents as their responsibility. While the actual frequency of caregiving which is viewed as a part of enactment of *katavedi* may begin as an infrequent occurrence if the parents are still healthy and active, overtime it becomes more frequent or often mentioned when parents become frail or aging.

Magnitudes. Magnitudes are defined as the strength, intensity, or size of instances of an occurrence. The example of obligation in paying back is percieved by all key informants to be very important and pervasive as a cultural value in Thai society. Since the world view of hierarchy plays an important role in Thai social structure, parents are considered as the most important and respected persons in child's live. The obligation in paying back parents has been taught in religious teaching (both Buddhism and Islam) and is seen as a characteristic of a good person in Thai society. The *katavedi* is accepted and enculturated as a symbol of a decent person.

Structures. Lofland and Lofland (1995) defined structures as the details or constructural compositions of the occurrence of types. The obligatory action in paying back is structured in terms that the children devote their times and lives to parents, give parents first priority, and do the best or whatever that they can do for the parents. Some caregivers described the details of obligatory action as providing care to parents, looking after them when they become aged, giving them money, and making merit in the name of a deceased when their parents pass away.

Processes. Processes are referred to the activities or developments that occur over a period of time which usually appears in a regularly recurring cycle of change or as the structuring process. For example, the obligatory action of paying back exhibits a process of:



Causes. Causes are referred to as the circumstances or the conditions which facilitate the occurrence of the types. The obligatory action of paying back is caused by factors which are the feeling of gratitude (*katanyu*) toward *bun khun* of parents, the relationships within the family such as relationship between the caregiver and parents or other family members, adequacy of support system, and adequacy of financial status of the family.

Consequences. The consequences are referred to as the dependent variable or outcomes of the types. The analysis may lead to concern about the consequences that maintain a social arrangement or bring change to the setting. For example, the obligatory action in paying back parents has both positive and negative consequences in caregiving situations. The positive consequences help maintain and reinforce the caregivers to provide care to their frail elderly parents. If the *katavedi*, the obligatory action in paying back to parents in Thai culture, was changed or absent from Thai society, then the family caregiving practice and value in Thai society might be affected.

Agency. Agencies or human agencies is defined by Lofland and Lofland (1995) as human viewpoints and and their use of strategies when being in the situations they are facing. In the obligatory action of paying back, the key informants use strategies and tactics by doing the best in their caregiving, devoting themselves to parents, and giving parents priority.

Contrasting

Lofland and Lofland (1995) suggested the use of contrasting framed propositions with other writings, reports or other studies

to expand and broaden previous social science value and the preconceived framing to different framings of practices. An example is comparing the "the obligatory action to pay back" in Thai culture with other cultures. What is the difference between "paying back" and "filial piety" in Chinese culture or filial responsibility in Western literatures? Are the consequences of the obligatory action in paying back to parents the same?

Coding

Coding processes are described by Lofland and Lofland (1995) as categorizing and sorting the data thoroughly and repeatedly from reviewing fieldnotes, memos, and transcripts. Analysis included the coding process of initial coding and focused coding. Lofland and Lofland (1995) describe the "initial coding" as a stage when the researcher looks for what can be defined and discovered in the data. Then, as a corpus of initial coding accumulates, it becomes more focused with some portions being more outstanding than others. This process is called "focused coding", which focuses on a set of codes, that is then applied to an increasing array of data. Categories within the selected codes are elaborated. These focused categories become emergent themes that account for the variation and incidents that can be explained under these categories.

Memoing

Memoing is the process of focusing on explanation and elaboration of the coding categories by using three kinds of memos (elemental/small piece, sorting, and integrating) to distinguish major issues (emerging contexts) from each other.

Diagraming

Diagraming is a visual presentation of the relationships among parts of concepts. It helps to visualize and format the present information in a systematic way. Methods of diagraming are typologizing, matrix making, concept charting, and charting (Lofland & Lofland, 1995).

Thinking flexibly

Thinking flexibly can be accomplished by rephrasing, changing the diagrams, constantly comparing, withholding judgment, thinking extremely and oppositely, talking with fellow analysts, listening to others, and drawing back for a more wholistic look. Lofland and Lofland (1995) also use a matrix of socially oriented cells to assist in describing social settings. These cells are: (a) practices; (b) episodes; (c) encounters; (d) roles; (e) relationships; (f) groups; (g) organizations; (h) settlements; (i) social worlds; and (j) lifestyles. These were used and adapted according to the needs of the analysis.

Actual Analysis of Data

Because this study was conducted in Thai culture, the differences between English and Thai languages had to be considered. The investigator adapted and combined several approaches such as Lofland & Lofland's (1995) strategies of coding, memoing, diagraming; storage and retrieval system by using the Ethnograph 4.0, Thai version (Seidel, 1995) computer software, and content analysis to achieve analytic thoroughness. The investigator has described a detailed scheme for the analysis

process of this study in logical order so that reviewers could follow the analytic pathway.

Transcription and Translation

Taped data were transcribed in Thai by the investigator and trained research assistants, and were verified by the investigator while listening to the tape. The interviews of selected caregivers (case ID #1 and ID #13) were translated into English by the investigator and verified for linguistic equivalency by a professor from the Linguistics Institute of Chulalongkorn University, Thailand.

Analytic Method

After each interview and episode of participant observation, the transcript and fieldnotes from that case were read immediately to gain a sense of a whole and to generate some analytic thoughts and ideas about the findings. In the initial part of the analysis, the coding (Thai) of the transcripts was done by hand on the margins of the transcripts. Analysis in Thai helped preserve culturally relevant themes. As the initial coding statements emerged from data, a focused set of codes was applied and categorized to form an interrelated set of coding categories.

To compare these coding categories and dimensions within the group of the informants, a table of content clustered by categories and ID was set up to quantify and to represent the frequencies of the existing aspects and categories.

In addition to coding by hand, Ethnograph was used to help organize and retrieve coded categories from all data in a way that was more organized and included rapid code searching.

Coding and data analysis in Thai (of two informative cases) were confirmed by two doctorally prepared Thai scholars, one in Anthropology (Associate Professor Dr. Chai Podhisita, Institutute of Population and Social Studies, Mahidol University) and one in Public Health Nursing (Associate Professor Dr.Prabha Limprasutra, St.Louis College of Nursing). A chart summarizing preliminary findings and thoughts about emerging content from data collection and the ongoing analysis of data (in Thai) was developed by the investigator. The summary of preliminary findings and thoughts from the two cases was discussed and confirmed by these two Thai experts. In addition, to confirm the credibility of the analysis, the expert in Public Health Nursing also did open coding on selected Thai transcripts (ID #1 and ID #13). The investigator discussed with her any differences and agreements in coding categories.

To confirm the credibility of the coding method and analysis of data in Thai, peer input was sought. Sharing, verifying, and confirming the analysis was done with a group of three Thai doctoral students at the School of Nursing, Oregon Health Sciences University. These Thai doctoral students were currently studying in the United States, but all were culturally and natively born and reared in Thailand. All of them are well grounded in Thai culture and language, yet have experiences and advanced education in a different culture. All the coding categories in the Thai analysis part were coded by using both Thai terminologies and English equivalents. The Thai peer group helped

validate the coding categories and confirmed the categories as the real contexts and meanings in Thai.

Moreover, the investigator at the same time consulted and worked closely with an American nurse who is fluent in Thai language and accustomed to Thai culture because of her experiences of living in Thailand for nine years. She helped to confirm the translation of data bits and also validated the coding categories by comparing the equivalency between Thai and English.

Moving to the next level of the developing analysis, the investigator formulated concepts or propositions which summed up and provided for major portions of coding categories. These generic propositions were presented in a schematic overview related to topics needed to answer the questions of this study. Several diagrams were developed to display the relationships among these concepts or propositions.

The analysis in English was done using the same group of transcriptions selected for Thai confirmation of coding. These selected, translated English transcripts were coded by the investigator and the dissertation committee. Comparison of the Thai analysis to the English analysis of the same cases were done to review the congruence of the analysis in different languages.

After major conceptual categories and their propositions were developed into a conceptual model, each family's data were reviewed and used to identify the concepts and propositions that were present in their data. Then a matrix was developed using the different families on one axis and the concepts and propositions along the other axis. The frequencies of support for each concept

and proposition were filled in for each family's data. This allowed the investigator to compare across families, looking for similarities and differences in family data being present to support various concepts and propositions. From this matrix, it was noted that families who were similar by having few data bits supportive of certain concepts were also similar in their frequencies of data on certain outcome concepts. For example, the caregiver ID # 12 who had less data on positive relationships with other family members (high frequency in negative relationships with other family members and parents) also had more frequency in negative consequences especially stress, physical strain, frustration, and conflict with other family members.

Reliability and Validity

The criteria that were considered to support trustworthiness of this study are (1) credibility of the research, (2) its applicability or transferability, (3) consistency or dependability, and (4) confirmabilty (Lincoln & Guba, 1985) (see Appendix J). Trustworthiness is a key element in giving a naturalistic study reasonable claim to methodological soundness. Trustworthiness is established by the use of techniques that provide truth value (Lofland & Lofland, 1995 uses the term "trueness") through credibility, applicability through transferability, consistency through dependability, and neutrality through confirmability (Erlandson, Harris, Skipper, & Allen, 1993).

In this study, three strategies that were incorporated into the design to insure the trustworthiness included:

1. To accomplish the credibilty of this study, long-term contact by 2 to 6 visits to each case over 5 months of the study, were done to identify salient characteristics in the situations and to gain richness of observation. Multiple sources of data (interviews, informal discussions, observations) and different times for visits were used to support completeness and convergence of data. These multiple sources of data collected over time were considered to provide triangulation of data as well as demonstrate consistencies of findings.

The total home visits to all 15 families were 55 which included formal and informal visitings. The investigator did not focus on only the key informant, but also spent time in informal discussion with other family members, neighbors, or friends who were present as well. This also confirms the credibility of this study which represents the degree of confidence about the truth and the context existing in the setting being studied. In addition, cordial relationships between the investigator and the key informants developed, and the investigator was present as a friend or consultant, not an inspector. This helped the informants to feel relaxed, trusting, and have a positive attitude toward the investigator.

2. Peer debriefing through ongoing discussions with dissertation committee members by e-mail and with two Thai consultants in Bangkok was done. Copies of the narrative transcripts of two families and coding in Thai were shared with two Thai experts, previously mentioned, to confirm the adequacy of analysis processes within the Thai language and meaning. Selected

transcripts in Thai were coded by both the investigator and the Public Health Nursing expert, previously mentioned, to evaluate the consistency and agreement in coding. This reflected a concern for dependability of this study which refered to a study consistency, stability, or accuracy. The Thai analysis part was also validated and confirmed for the coding categories and the concept framing by the previously mentioned group of Thai doctoral nursing students at Oregon Health Sciences University. Translation of the transcripts of two selected key informants were completed and verified by the investigator and the linguistics professor. Confirmation of the translation of data bits were done by an American consultant who is fluent in both English and Thai. These peer debriefing and member checking also assure the credibilty and dependability of the study.

3. Thick descriptions were obtained through detailed and systematic fieldnotes. All the thoughts and reflections were jotted down in a separate journal for each case. This journal started with the first day of approaching a family and included a record of all contacts through the last day with that family's case. Repeated interviews plus systematic fieldnotes of repeated observations provided thick description for confirmation of findings. The thick descriptions helped to accomplish the transferabilty of the study.

CHAPTER IV

RESULTS AND DISCUSSION

The results of this study are organized by the purposes of the study. These purposes were:

1) Purpose #1: to explore the concept of *katanyu katavedi* in relation to caregiving for frail elderly parents of urban Thailand;

2) Purpose #2: to describe the caregiving provided by families to frail elderly parents in Metropolitan Bangkok;

3) Purpose #3: to identify the perspectives of the Thai families regarding the effects of social changes in modern Thailand on *katanyu katavedi* and on caregiving for frail elderly parents;

4) Purpose #4: to describe the effects of caregiving for frail elderly parents on the families and caregivers.

Results related to each purpose will be discussed in different sections (Section I to Section IV). The last section, Section V, is the summary of the conceptual model developed from this study.

Analysis of the data led to identification of dimensions, categories, and sub-categories that emerged from the findings related to each purpose and are displayed in each section. In addition, the tables of category and sub-category definitions and supportive data exemplars are included. Literature reviews from other studies are incorporated to compare, support and reinforce the findings of this study. The summary and discussion of the

findings under each purpose are presented at the end of each section.

Section I

Purpose # 1: Explore the Concept of *Katanyu Katavedi* in Relation to Caregiving for Frail Elderly Parents in Families of Urban Thailand

The concept of *katanyu katavedi* comprises two separate words: *katanyu* and *katavedi*. *Katanyu* is a sense of awareness and gratitude toward someone who has done something that has benefited to you. *Katavedi* is doing something in return for those benefits (Royal Thai Scholars Dictionary, 1982). These two words are usually used together in the general context of the Thai language and colloquy. The term *katanyu katavedi* is understood as the obligation to repay benefactors who have been helpful or rendered a favor. This concept of *katanyu katavedi* is especially strong within the family and kin circle of Thai people where the children are very much obliged to pay back and do their best to reciprocate the benefits they received from their parents.

Figure 1 depicts a diagram of relationships among the dimensions and categories that emerged from the findings related to Purpose #1. The figure summarizes aspects of the concept *katanyu katavedi* in relation to caregiving for frail elderly parents. It illustrates the relationship between the *bun khun* of parents (total benefits of parents) that makes the children have *katanyu* feeling (gratitude towards parents), then, children have *katavedi* (obligatory actions to pay back) by some kinds of actions.

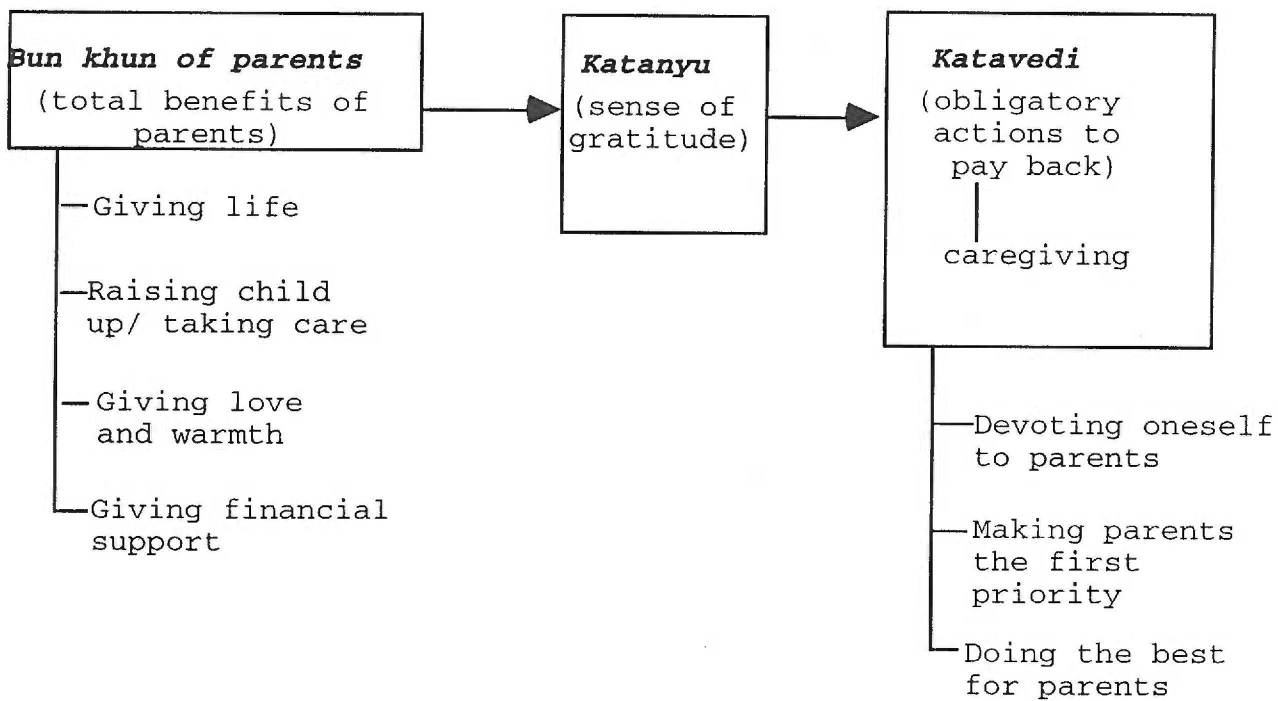


Figure 1. **Concept of *Katanyu katavedi* and Caregiving for Elderly Parents**

In this study, three dimensions emerged from the data helping to refine the definition (meaning) of the concept of *katanyu katavedi* in relation to caregiving to frail elderly parents. These three dimensions are: a) *bun khun* of parents; b) *katanyu*: the sense of gratitude towards parents; and c) *katavedi*: the obligatory actions in paying back to parents.

<u>*Bun khun* of Parents</u>

Bun khun is defined as the total benefits that parents have bestowed upon their children. Because of the *bun khun* of parents, children feel first gratitude (*katanyu*) and then a sense of obligation to pay back or do something in return to their parents' *bun khun*. All 15 caregivers talked about the *bun khun* of their parents as the most important reason for them to become the caregivers (54 data bits from all 15 cases).

The benefits given them by their parents or *bun khun* of parents were described as: 1) giving life; 2) rearing child; 3) giving love and warmth; and 4) giving financial support. Each is defined in Table 4 with relevant supportive data examples.

<u>Giving life.</u> Giving life is defined as parents being creators of a child's life. The caregivers said that parents gave lives to them and they would not have been born if they did not have parents.

In Buddhist teachings, parents are designated as being deserving of four kinds of reverence: a) "Brahma", the God of giving in children's lives; b) "the first devas", the God of children's life; c) "the first teachers"; and d) "those worthy of offerings and gifts from their children" (Bullit, 1998). Parents must be revered by their children because they are held in high respect as a god of

children's life. Parents do much for their children, bringing them up, taking care of them, and introducing them to the world (Saddhatissa, 1997).

Rearing child. Rearing child is defined as parental caring and nurturing of child when the child was young and dependent. The caregivers talked about their parents' devotion in taking care of several children amid difficulty and poverty. For example, case ID #14 reminisced about her mother's devotion in taking care of children when they were young. She remembered the time that her mother caught fish to cook as food so that her children could survive. Some caregivers appreciated their parents nurturing and taking care of them; they realized that raising a child is not an easy task.

Giving love and warmth. Giving love and warmth is defined as parents' taking care of their children from their good will, sincerity and from the heart. The caregivers (ID #11, ID #13, and ID #14) who described the feelings of love and warmth received from their parents mostly were close and had data illustrating strong positive relationships with their parents.

Giving financial support. Giving financial support is defined as parents' contribution of money, assets, or resources to children. Caregivers who reported adequacy of their family financial status, such as case ID # 1 and 8, talked about their appreciation for support and help from their parents. Parents are influential supporters to children since they were young or even when they are grown up.

Table 4

Category, Definition, and Data Exemplars of *Bun khun* of Parents

Category & Definition	**Data Exemplar**
Giving life is defined as parents being creators of a child's life.	Parents gave life to me. Paying them back by doing this, it's still not enough. (ID #13, L 214-215) If we didn't have her (the mother) to give birth to us, we wouldn't be born. (ID #8, L 481-482)
Rearing child is defined as parental caring and nurturing of child when he/she was young and dependent.	I always think about the difficulties during my childhood. I remember when I was young, my mother worked very hard in raising us up. She even went out by herself and caught fish to cook as food for us since our family didn't have money to buy food. (ID #14, L 433-444) Parents took and nurtured us when we were young. (ID #15, L182) He raised us up. I realized that he has 10 children and that's not easy. He took great effort to bring us up. (ID #1, L 331-332) When I was young, my mother always bought me good foods or goodies. Or when I wanted to eat something she would buy it for me. (ID #11, L 465-467)
Giving love and warmth is defined as the parents' taking care of their children from their good will, sincerity and from their heart.	...because I know she (the mother) loves me from her heart. She never refused if I asked her for what I wanted. (ID #11, L 466-467) Parents are always good and sincere to children. (ID #13, L 1019) My father raised me up and is very close to me. If we have our own children, we must nurture them. Our parents love us as we love our children. (ID #1, L 324-328)
Giving financial support is defined as the parents' contribution in money or assets to children.	We are quite happy now because our parents have their inheritance. For example, the land near this house could be sold around 7-8 million baht. Now someone rents it for 18,000 baht per month. He's rented it for 5-6 months. The money that I use for myself is from the amount I got from my mother. (ID #1, L 660-665) I always tell myself that I will never forget or desert my parents if I have more money or be in a better status. Nowadays, I sometimes still have to ask for help or support from them if I had trouble. (ID #8, L 318-321)

Katanyu: Sense of Gratitude to Parents

Katanyu is defined as the sense of gratitude that a child or children have towards the *bun khun* of their parents. It is the awareness of children that their parents have done something that benefits them. Sometimes, the term *katanyu* is combined with the term *ru khun* (the realization of benefits received from others) to emphasize and add more richness to the meaning of *katanyu*. Likewise, *katanyu ru khun* to parents means having a sense of gratitude and appreciation for *bun khun* of parents.

From the interviews with the caregivers, the sense of gratitude (*katanyu*) and *bun khun* of parents were usually related and referred to each other all the time. For example, one caregiver talked about her gratitude to her parents as:

> We grow up to be adults because of our parents. We should not haggle in caring for our parents. Everybody should have gratitude to parents since they raised us up. (ID # 1, L 1160-1164)

Some key informants talked about the sense of gratitude towards parents as a social value, for example:

> In our society, it's important that children take care of their parents especially when they become old. Children should feel gratitude to *bun khun* of their parents. (ID #2, L 354-358)

Katavedi: Obligatory Actions to Pay Back Parents

Katavedi is defined as the obligatory actions done to pay back parents based on the *katanyu* that a child/ children has/ have towards *bun khun* of the parents. Three categories of *katavedi* were

identified in the study: 1) devoting oneself to his or her parents; 2) making parents the first priority; and 3) doing the best (doing as well as can be done) for parents. Table 5 provides definitions and excerpts from the data as exemplars of these three categories of *katavedi*.

Devoting oneself to parents. Devoting oneself to the parents is defined as the caregivers' giving most of their time and energy or sacrificing themselves in caregiving to their frail elderly parents.

Some caregivers talked about devoting themselves by spending all their time and efforts taking care of their frail parents closely, especially when the parents' health condition became worse. The caregivers' devotion might include putting less attention on themselves and spending most of their time and concern on parents. For example, one caregiver (case ID #13) cut her time of sleep to give care when her father was seriously ill. Eight caregivers told about their time of being by the side of their parents when they were admitted to the hospitals, or visiting them everyday. The devotion to parents may also include staying single as case ID #1 talked about her decision to remain single to take care of her frail parent.

Making parents the first priority. Making parents the first priority is defined as the caregivers rating their parents' needs as more important than other things. The caregivers cut their social life or activities to make time for caregiving to parents. Caregiving to parents is considered an important duty and priority.

Doing the best for parents. Doing the best for parents is defined as the caregiver's efforts to provide good care to their parents willingly and with love (with their ability and attempt). Some caregivers (ID #12 and case ID #13) who felt they had difficulties in the caregiving because of other responsibilities such as their jobs or families, described their efforts to do the caregiving for their parents as well as it could be done.

Table 5

Category, Definition, and Data Exemplars of *Katavedi*

Category & Definition	Data Exemplar
Devoting oneself to parents is defined as the caregivers' giving most time and energy or sacrificing themselves in caregiving to the frail elderly parents.	When I came back from my work, I did all those caring things. Caring with no time off, when I prepared stuff to be sold, I also kept my eye on him. I had to look after him closely day and night. (ID #13, l 160-163) I watched him all night. During the time that my father was in serious condition, I could hardly sleep. When he moved I also sprang up to see him. I give everything to my parents. I don't care for myself, I give all to them. (ID #13, L 413-418)
Making parents the first priority is defined as the caregivers rating their parent's needs as more important than other things.	She puts her father and mother as her first priority. She does everything for them, doing everything. All the money she earns is spent for her parents. (a friend of ID #13, L 242-244) I think my parents come first. My parents are my first priority. Husband is not the same as parents. When you divorce or separate from him, he will be someone else and does not care for you anymore. But parents are always our parents. (ID #1, L 1012-1017)
Doing the best for parents is defined as the caregiver's efforts to provide good care for their parents willingly and with love.	When I took care of him (the father) I had to do my best. (ID #13, 179-180) I do my best for her. I don't have anything to pay back for her so I take care of her. (ID #4, L 601-603) It's necessary to do my best in caring for him. At least I can do something for him in return especially taking care of him during this time because we will never have this chance again. (ID #8, L 360-364) I was very careful in giving care to them (parents). I tried to give care to them carefully and tenderly. I didn't want them to get hurt. (ID #13, L 1154-1156)

Summary and Discussion

The concept of *katanyu katavedi* is structured by three dimensions which included: a) *bun khun* of parents; b) *katanyu*: the

sense of gratitude towards parents; and c) *katavedi*: the obligatory actions in paying back to parents.

These three dimensions are interrelated and usually have relationships to each other. The more the children realized or perceived *bun khun* that their parents had done something good for them such as devoted themselves to children when they were young, the more the children felt gratitude and expressed their obligation to pay back their parents. For example, the caregiver ID # 13, a daughter taking care of her unconscious father, stated that:

> I think since parents brought us up (*bun khun of parents*), we should take care of them when they become old and can't help themselves (*katavedi*). We must serve them (*katavedi*). This idea always comes to my mind....Parents raised us up amid happiness until we're grown up (*bun khun of parents and katanyu*). Now it's time to pay back by doing good thing for them, give them good care (*katavedi*) so they can live with us as long as possible. (ID #1, L 833-845)

However, in one case which a daughter mentioned about her relationship with mother (care receiver) during her childhood which her mother did not take care of her because her mother got divorced from her father. The informant had moved around from one relative's house to other's. Although the mother's *bun khun* in taking care of her while the caregiver was young was not very strong, the caregiver informant mentioned the *bun khun* of her mother in giving life to her. Her personal feeling of *bun khun* of her mother might not be very strong, but for the social and

religious beliefs of *bun khun* of her mother in giving life, that was the part that made her became a caregiver to her frail mother.

Children's obligation to their parents is described as a part of the virtue of human being in Buddhist teachings. Payutto (1998) explained the life standard of the Buddhist in maintaining one's relations to parents. As a son or daughter, one should perform the duties in the following ways: 1) look after one's parent in reciprocity; 2) help one's parents in their business or work; 3) continue the family line; 4) conduct oneself as is proper for an heir; and 5) after their death, perform meritorious acts and dedicate merits to them (P.A.Payutto, 1998, p.57). From Buddhist ethics (Saddhatissa, 1997), a part of the layman's duties to his associates described as *Mata Bhitu Uppathanang* or duty of children to their parents are described in five ways. These five ways are: 1) support parents since they at one time supported children; 2) take upon him/ herself the duties incumbent on parents; 3) establish a succession; 4) follow the method of inheritance; and 5) make merits in due course to the dead.

From the interviews with all fifteen caregivers, the children mostly identified their obligation to their parents as taking care and supporting them. This may be because these informants were selected because they were caregivers who were currently providing care to their frail parents. However, when asked about whether these five ways of obligation were duties of children, they agreed that all are duties children should do for their parents.

Performing meritorious acts and dedicating the merits to the deceased parents were also viewed as a part of the obligatory action (*katavedi*) that a child should perform for his/her parents. Making merit in the name of a deceased person is one way of showing appreciation for the benefactors which in this case were parents. In Thai society, it is common to see that children still take their goodness to heart and express their appreciation with an annual act of almsgiving and dedication of any merits arising from the occasion in their parents' memory (Payutto ,1998).

Buddhist doctrine also emphasizes the children's obligation towards parents. A son who becomes a monk is also a way to pay back to his parents for their efforts in child rearing. Buddhists believe that the ordination of a son will make a better place in the next lives of parents. It is expected that after parents' death, they would be lifted into heaven on the yellow robe of their son. Because a daughter could not be ordained as a monk for her parents, she otherwise can pay back parents by caring for them when they are old and sick.

Bun khun of parents especially mother in feeding her baby by her breast milk is also strongly valued by Thai people. "Mother's milk" or *kha nam nom* is symbolically meant *bun khun* of mother. The mother's milk is used as the metaphor to emphasize the relationships between a mother and her children. It makes the children feel gratitude and indebted to their mother in caring for them (Van Esterick, 1996). However, in this study, none of the key informants talked about *kha nam nom* which is more a symbolic term about *bun khun* of parents.

The concept of *katanyu katavedi* plays an important role in family caregiving in Thai society. *Katanyu katavedi* in relation to caregiving for frail elderly parents is defined as a social cultural value in Thai society. It is a cultural value which is viewed as a propriety of societal norms of Thai families. It is accepted as a characteristic or quality of a noble (good) person. Society still values and expects that children should have this quality and fulfill their obligation to parents.

Katanyu katavedi is both reinforcement and pressure for Thai people in giving care to elderly parents. It is viewed as moral and meritorious acts that children would like to achieve and accomplish this social cultural value. But, at the same time it is also a pressure that children may feel that they are pushed by society to fulfill this social cultural value of *katanyu katavedi*.

There are no recent studies in Thailand which explore or analyze the concept of *katanyu katavedi*. Some social studies described the existence of familial support for Thai elderly people (Chayovan & Knodel, 1997, Knodel, Chayovan, & Siriboon, 1992, Limanonda, Wongboonsin, Vibulsresth, & Ruffolo, 1995) and family caregiving in Thailand (Caffrey, 1992a, b, Enz & Rungsophakul, 1998) but did not provide much information about the concept of *katanyu katavedi* in relation to family caregiving. These researchers in these studies described the strength of children's obligation to parents that influenced the familial system of support and care for the elderly population in Thailand. The findings of Caffrey (1992a) and Limanonda, Wongboonsin, Vibulsresth, and Rufflo (1995) pointed out the importance of a

strong value of filial piety or obligation of children to care for aged parents in Thai families. The feeling of filial piety or obligation of children in caring for aged parents (both physically and emotionally) so as to pay a debt of gratitude was found to be valued and adhered to among respondents both in rural and urban areas. The response obtained reflected the fact that the social cultural value of *katanyu katavedi* of children towards parents was still strong and had not changed much. This confirmed the finding of the present which will be discussed further in section III.

The concept *katanyu katavedi* and caregiving for elderly parents in Thai culture is different from filial obligation or filial piety in other Asian countries. Filial piety from the cultural norms of Chinese, Korean, and Japanese which are influenced by Confucian culture is traditionally expected, obliging a married son and his wife to serve the husband's parents (Kim, Kim, & Hurh, 1991, Yamamoto & Wallhagen, 1997). The social value of obligation to parents and hierarchical relationships between parents and child in these countries are also strong and considered the familial care and support for the elderly parents as the prime virtue that needs to be fulfilled by the children. However, the differences in the religious background and social practices make family caregiving for the elderly in Thailand dissimilar to other countries.

In Thailand, religion based on Buddhism plays a more important role on daily life than in other Asian cultures. These other Asian cultures, based in Confucian religious teachings, have social values such as obligation to parents that are stronger than

the religious values. In Thailand, the religious values ground the social values and the way that persons think, making the social and religious almost inseparable.

Section II

Purpose # 2: To describe the Caregiving Provided by Families to Frail Elderly Parents in Metropolitan Bangkok

The caregiving provided by families to frail elderly parents in this study can be categorized into three dimensions. These dimensions are: 1) physical caregiving; 2) psychological caregiving; and 3) spiritual caregiving. Figure 2 depicts a diagram of these three dimensions, categories, and sub-categories emerging from the findings related to Purpose #2. They are discussed in this section.

Physical Caregiving

Physical caregiving is defined as caregiving actions taken to meet the parents' physical needs. The level of physical caregiving performed by family caregivers was based upon parents' health and the degree of their frailty. In this study, nearly half of the parents (7 out of 15 care receivers: ID #1, ID #3, ID #5, ID #8, ID #11, ID #12, and ID #14)) were very frail and totally dependent for their activities of daily living. The remaining 8 elderly parents needed assistance with at least two instrumental activities of daily living. Physical caregiving was found as the major caregiving activity (more than 200 data bits) provided by families to their elderly parents.

Five categories of physical caregiving emerged from data: 1) maintaining parents' daily activities; 2) nursing care activities; 3) environmental modifications to promote parental function; 4) obtaining assistance; and 5) seeking alternative methods of treatment.

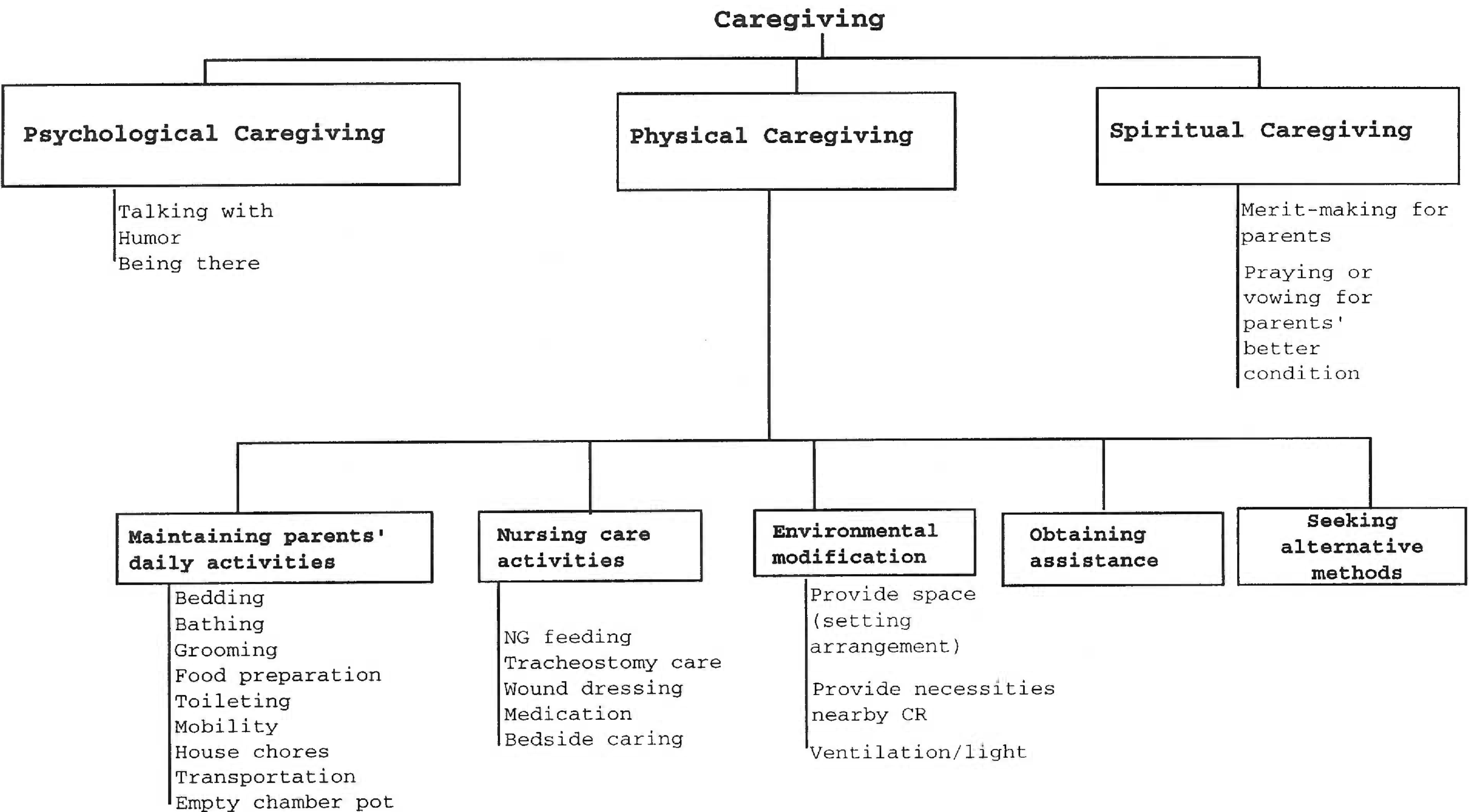


Figure 2. **Caregiving Provided by Families**

Maintaining parents' daily activities. Caregiving to maintain parents' daily living activities is defined as the caregiving performed by children to facilitate their parents in daily activities including assistance with ADL and IADL. Caregiving practices to maintain the parents' daily activities were: bathing, bedding, grooming and cleaning, toileting, food preparation, hand feeding, mobility and transportation, and house chores.

Bathing activity included giving a complete bed bath when parents are in a dependent condition, or preparing a chair or apparatus for parents who could take a shower by themselves. Bedding is preparing beds and apparatus for bedding such as mattress, blankets, and mosquito nets for parents. Grooming and cleaning are taking care of personal hygiene and changing clothes or cleaning when parents were wet or in a soiled condition. Toileting is helping parents get to the toilet, or the chamber pot, and emptying the chamber pot. Food preparation is preparing and cooking food, included blendarized diet, or buying food or supplements for the diet. Moving and transportation are helping parents who have problems in mobility such as parents who were hemiplegic or paralyzed to move or transfer from one place to another place. House chores are activities of housekeeping (e.g., laundry, dish washing, home cleaning) performed by the caregivers because parents were too old or frail to continue household chores by themselves.

Nursing care activities. Nursing care activities is defined as the caregiving practices to meet the nursing and medical needs

of parents. These physical care practices required more technical knowledge, skill and expertise on the part of the caregiver. The nursing care activities that caregivers in this study gave to parents were: giving medications, gavage tube feeding, bedside care when parents' condition became worse, wound dressing, and care of the tracheostomy tube.

In this study, there were seven families in which the parents were very frail and had a high level of need for assistance in nursing care activities. Each of these 7 caregivers told about their care that required nursing care skills and expertise. These caregivers were taught how to take care of their parents by nurses or health care personnel before discharge when their parents were in the hospital.

Environmental modification to promote parental function. It is defined as changes made in the care environment to accomodate parents' physical status and condition.

In this study, most of the families set a space or setting to be used as the parents' unit (see the blueprints of home setting for each case in the Summary of Case Studies 1-15). Settings were selected that provided adequate ventilation and light or sunlight for the parents. In thirteen of fifteen families, the frail parents lived on the first floor because that made moving or transfering more convenient. In addition, in Thai homes, family members usually gather together or have their living activities together at the first floor of the house. So, it is easier for family members to access or look after the frail parents if they live on the first floor.

The elderly parents who were able to perform some activities of daily living for themselves (ID #2, ID # 4, ID #6, ID #7, ID # 9, ID #10, ID #13, and ID #15), were provided necessities by their caregivers who placed the parents' personal belongings nearby the parents' settings for easy access. Some families also established a space outdoors where the elderly parents could spend time outside their rooms during the daytime, such as a small bench under a tree (ID #13), a big wooden bed on the living floor (ID #2), or an outdoor space in front of the house (ID #6 and ID #15).

Obtaining assistance. Obtaining assistance refers to help the caregivers receives by consulting or referring parents to health care professionals when having problems in caregiving. All caregivers in this study refered their parents to health care services such as clinics or hospitals when the parent's condition worsened. Some caregivers called or asked for suggestions from health care personel when having problems in caregiving to parents. For example, case ID #1 called a doctor or nurse who used to take care of her father when the father's condition changed. Case ID #8 and case #14 consulted the public health nurses who visited their families about wound dressing. During the time that the investigator was in the settings, several caregivers (ID #1, 8, 10, and 12) also consulted with her and asked for suggestions about caregiving such as wound dressing and diets for their parents.

Seeking alternative methods of treatments. It is defined as the caregiver's combined other alternative medicine as parts of

caring regimens for their parents. Several caregivers (ID #2, ID #7, ID #14) tried medicinal herbs (e.g., ID #7 used Chinese celery to reduce his mother's high blood pressure) or traditional medicines (e.g., ID #14 gave her mother a concoction she got from a traditional doctor that she believed might help mother from the paralysis) as à part of the care regimens for their parents. These traditional medicines used as supplementary methods are Chinese traditional medicines or Thai traditional medicines which were prepared by traditional doctors or monks. Some caregivers tried other alternative methods to help their parents. For example, caregiver ID # 14 used holy waters mixed with water to feed her mother. Caregiver ID #8 practiced and tried a magic power called "*bhalang jakawan* or Universal Power" to make her father's condition better. This method was done by persons who have practices in using their spiritual concentration and transfering their powers to heal people who are sick. In this case, the caregiver brought her father to receive the curing power from a person who was well-known for his magical power in using this *bhalang jakawan* to cure sickness. She believed this method helped her father to have less coughing and become better.

These alternative methods are commonly believed and practiced as additinal treatments and care especially when patients are in a chronic condition. These alternative methods usually are considered when the modern health care might not be able to treat the ailments such as the patients with cancer, AIDS, or paralysis. Table 6 showed these five categories of physical

caregiving, their definitions and relevant supportive data examples.

Table 6

Category, Definition, and Data Exemplars of Physical Caregiving

Category & Definition	**Data Exemplar**
Maintaining the parent's daily activities is defined as caregiving to facilitate their parent's daily activities, including ADL and IADL. The care provided included bathing, personal hygiene care, feeding, bedding, toileting, food preparation, house chores.	Everything that she could not do by herself, I help her in those things such as preparing food and bathing. It's not too difficult. I can help her. It's not very complicated. (ID #10, L 130-133) My mother gets on the chamber pot by herself. She slowly moves down from her bed and then after she is finished I help move her back to bed. (ID #10, L 141-143) Starting from the morning, I hand feed my mother then give her a bed bath. Again, I feed her for lunch at noon and sometimes milk and desert after lunch. (ID #12, L 217-221) I do everything for my mother. I never let her do anything. I will do it for her, for example, when she gets diarrhea I wash all her clothes. I did the same for my father too. I nver let him do anything. (ID #13, L 131-134) I had to do all house work such as: preparing food for both father and mother, and cleaning all kinds of things. (ID #13, L 563-566)
Nursing care activities is defined as caregiving practices taken to meet the nursing and medical needs of the parents.	...7 am is the feeding time. After feeding the blendarized diet, another step is to give medicines. I wrote down the list of things to do on a piece of paper and put it on the wall. At 10 am it's time to turn father to the other side. Around noon, it's the feeding time again, followed with two kinds of medicines. If father coughs a lot or becomes restless then there are two medicines for him. I jotted down all the routine to do at 2 pm and 4 pm. She has to feed him again at 4 pm with the same kinds of medicines. (ID #1 talked about the caregiving to the father that she described to her elderly sisters, L 278-295)

Table 6 (continued)

Category & Definition	**Data Exemplar**
	After that I fed (gavage feeding) milk for her. Then I hurried to prepare blendarized diet for her, boiling vegetables, rice, eggs and meat then blenderized all the ingredients together to prepare for the next feeding. (ID #14, L 514-521)
	The wounds (pressure sores) at her coccyx and buttocks are shallow now. I do the wound dressing for her twice a day. I use this medicine (betadine solution) to clean the wounds followed by normal saline as the public health nurses recommended. (ID #12, L 226-231)
Environmental modification to promote parental function is defined as the changes made in the care environment setting to accomodate parents' physical status and condition.	All the things that she uses or her belongings, I put them near her bed. Everything is put in a way that's convenient for her. Her mattress and blankets are all set and ready to use. (ID #10, L 334-338)
	At first, my mother's bed was there (the CG pointed to a space close to her room) because I want to hear when she wanted something or when something happened to her. If she stayed nearby the window at that time, it would be difficult for me to listen to her because her voice was so small and she had no energy to shout. Now, she is much better so I moved her bed to be here to get more ventilation. (ID #6, L 800-809)
Obtaining assistance refers to help the caregivers receives by consulting or referring parents to health care professionals when having problems in caregiving.	I take her (the mother) to a private clinic when she becomes sick. I bring her to a clinic which the treatment there is good for her. The doctor will give her the right medicines, IV fluids, and she will get better quickly. (ID #13, L 310-316)
	She (the mother) could not void so I broght her to Rajavithi Hospital. (ID #6, L 91-92)
	Sometimes he has a fever and he coughs, so I ask his doctor or a nurse at the hospital about the medicines that will make him better. (ID #1, L 990-995)

Table 6 (continued)

Category & Definition	Data Exemplar
Seeking alternative methods of treatments is defined as the caregivers combined other methods of alternative medicine as parts of caring regimens for the parents.	Now I give my mother this herbal medicine. (note: it's a liquid elixir prepared by a monk) Someone recommended me that it might help my mother. So I bought it from a temple, 100 baht per bottle. I give this medicine to my mother twice a day, a tablespoon each time. (ID #14, L 780-788) I try all methods that might help my father. When I've heard that there are somethings that might benefit or help my father, I do not hesitate to try. When I brought my father to get the treatment from this magic power (*Bhalang jakawan*), it was not easy to bring him to get the treatment. We (the caregiver and her sister) had to carry him in and out of the car. We brought him there twice a week. The person who practiced this magic power touched and transferred the power to heal specific part of my father's body 5 minutes for each part. (ID #8, L 291-299)

Psychological Caregiving

Psychological caregiving is defined as caregiving activities taken to make the parents feel connected, cared for, and relaxed. In this study, eleven caregivers described caregiving pratices that represented psychological caregiving.

Three categories of psychological caregiving that emerged from the data are: 1) talking with; 2) being there; and 3) using humor.

Talking with. Talking with is defined as the informal conversations children have with their parents to keep the connection between them and parents. Some caregivers talked with or informed their parents about all the activities happening in the house, or all the caregiving given by them. For example, the caregiver (ID #8) informed her father about the visit of the investigator although her father was in a semiconscious condition and could not respond. While the caregivers (ID #11 and ID #14)

fed their parents or dressed a wound, they chatted with or teased their semiconscious parents. The purpose of the conversation is to improve the parents' knowledge that the child is there with them, but some caregivers expressed their own good feelings as a result.

Being there. Being there is defined as the caregivers' staying close or being with their parents in order to observe parents' symptoms or problems, to look after parents and make parents feel good by having children be close. Seven caregivers (ID #1, ID #6, ID #8, ID #11, ID #12, ID #13, and ID #14) in this study described staying close to their parents all the time, such as being with parents at home or staying by the bedside when parents were in the hospitals.

Using humor. Using humor is defined as using a playful attitude to lighten a tough situation in caregiving. Humor was also used to lessen the conflict or negative feelings that could occur during the caregiving process. Some caregivers (ID # 6, ID #7, ID #11, ID #13, and ID #14) said that humor reduced the stress in caregiving and reduced emotional conflict between them and their parents. The finding of humor in this study is consistent with Stanhope and Lancaster (1992)'s concept about humor and illness. They described humor as a playful attitude that can assist persons and families in coping with illness and adversities.

These three categories of psychological caregiving, their definitions and relevant supportive data examples are presented in Table 7.

Table 7

Category, Definition, and Data Exemplars of Psychological Caregiving

Category & Definition	Data Exemplar
Talking with is defined as informal conversations that children have with their parents to keep the connection between them and their parents.	When she (the mother) hears my voice she opens her eyes. She remembers my voice. If she didn't hear me then she would sleep. (ID #14, L 352-354) I talk with her, sometimes sing for her. I don't know whether she can understand or not,.... (ID #14, L 569-572) Do anything to make parents feel encouraged such as giving time, talking with them so they will feel that they are not left alone. (ID #4, L 559-564) It's like...when I was with him. I could sit down and talk with him. It's really joyful. (ID #8, L 372)
Being there is defined as staying close or being with the parents in order to observe parents' symptoms or problems, to look after them and/ or make parents feel good because the children are close.	Every night. I sleep in this room near him. Around 10 pm after I give him the last feeding, I turn him to the other side then I go to sleep. After sleeping for 2 or 3 hours, around 1 am or 2 am, I have to wake up to see him because he may cough. (ID #1, L 405-410) Even though she was admitted in the hospital, still I had to be with her (the mother). For example, when she was thirsty, nobody paid attention to her. During the time that she was admitted at a hospital, I visited her every other day and spent half a day with her. (ID #12, 447-450) We've stayed together all along. Some people wondered why I brought her to Bangkok to face hardship. Though we face hardship, we are still together. If we were apart, I couldn't take care of her, especially when she became sick. If she lived far away, it's too far. If we are together I can help her. (ID #13, 50-56) When she was admitted to the hospital--in a private room, I was in the hospital with her every day and night. (ID #14, L 754-757)

Table 7 (continued)

Category & Definition	Data Exemplar
Using humor is defined as using a playful attitude to lighten the tough situation and help reduce conflict or negative feelings that could occur during the caregiving process.	Sometimes when I feel like being humorous, I tease her or talk fun with her (the mother). (ID #13, L 377-378) When my mother becomes upset or angry, I tease her or talk about something funny. Then, she will feel better. I let her complain about me and never argue with her. Then I will ask her if she feels better or "tired yet?". I tease her until she feels better. (ID #13, L 1059-1064) She (the mother) got angry with me so I told her I would call my younger sister to argue with her. Then, I asked her whether she wanted me to help take a bath. If she wanted, she should sit still. So she laughed and understood that I want to do good for her. Actually I like to play and tease with her. (ID #2, 281-285) Sometimes when I was drinking (in the house) I teased her (the mother) and she teased me back. We like to banter with each other. It helps reduce our stress. (ID # 7, L 289-291)

Spiritual Caregiving

Spiritual caregiving is defined as caregiving related to religious beliefs or practices that are part of the cultural rituals of Thai people. Spirituality and Thai way of life are very connected, especially the faith of belief in religion or higher power. In this study, there are 7 caregivers (ID #1, ID #2, ID #5, ID #8, ID #11, ID #13, and ID #14) who mentioned spiritual caregiving practices for their parents. Two categories of spiritual caregiving emerged from the data of this study: 1) meri-making for parents, and 2) praying or vowing for a better condition for the parents.

Merit-making for parents. It is defined as the caregiver's performing meritorious acts and dedicating the associated merits to their parents who could not perform the acts by themselves. All

caregivers who mentioned merit-making for their parents were Buddhist and believed that merit-making is a way to bring better conditions to their parents. In Buddhist beliefs. merit-making is a method to accumulate merits for the present and future lives of the parents.

Praying or vowing for the parent's condition to improve. It is defined as spiritual or religious communication with Lord Buddha or an object of worship in hopes that it will help obtain better conditions for the parents. The caregivers believed that their worship to religion or spirits is a way to make their parents become better and live longer, or protect parents from bad things (spirits or danger). It is common for Thai people to pray to a diety for receiving good things and avoiding bad things.

The caregiver ID #13 is a good exemplar case of praying for better conditions of her parent as a spiritual caregiving. She told about her strong beliefs and faith in "*Guan Im*" Goddess in helping her family and taking care of her parents. When her mother was seriously ill with a diarrhea, the caregiver prayed and vowed (made a promise to trade for the help or achievement of what she prayed for) for help from this Goddess. The key informant said that she performed the repetitive chant of the holy words for nearly five hours for help from the Goddess without moving. She vowed that if her mother recovered from the sickness she would practice vegetarianism for 50 days. After the mother was better, this caregiver did as she promised to the Goddess.

Some key informants prayed or chanted for help from Lord Buddha, Buddhist monks of high reputation, or even the King (King

Rama V or recent King Rama IX). Thais believe that these images of their respect may have supernatural power to help them accomplish what they pray for or vow to do in return for an asked favor.

Table 8

Category, Definition, and Data Exemplars of Spiritual Caregiving

Category & Definition	Data Exemplar
Merit-making for parents is defined as performing meritorious acts and dedicating the associated merits to parents.	In July of last year, I donated money to build a main Buddha statue for a temple at Choomporn province in the Southern part of Thailand. I put my father's and mother's names, my name, and my friends' altogether at this Buddha statue. I think this donation for building a Buddha statue might help my father to get better. I want him to get merit. (ID # 1, L 223-229) I offer food to monks on all Buddhist holy days. I wish the merit goes to my parents. Although my mother is still alive I also wish the merit goes to her. When I offer food to monks, my mother-she cannot go with me. So I ask her to make a wish before I go to offer the food to the monks for her.(ID #13, L 947-955) I bought her (the mother) a set of *sang ka tarn* a couple days ago and invited a monk to chant for her at home. (Note: *sang ka tarn* is a set of food, clothes, and neccesary items for living donated to monks as merit-making in Buddhism) (ID #2, L 559-560)
Praying or vowing for better condition of parents is defined as spiritual or religious communication with Lord Buddha or an object of worship focused in hopes that it will help obtain better conditions for the parents.	I believe in *Gaun Im* Goddess. I really believe in her. I think she helps me a lot. (*Gaun Im* Goddess is a Chinese Buddhist goddess of kindness. A lot of people in Thailand respect and believe in this goddess). I think she also takes good care of my parents. My mother can survive because of this goddess's power. My father also gets better from the convulsion because of her. I light the incense sticks and pray for her help. Nowadays, I still pray every morning. (ID #13, L 1194-1201) I always pray for my father and wish him to live longer..... When I pray I say this out loud and wish the Lord Buddha and the monks that I respect and want to protect my father from bad things. (ID #1, L 438-451) When I gave food as alms to monks in the morning I wish the merit goes to her. I pouring the water and make the wish, the merit to the spirits that might influence mother's life as well. (ID #11, L 420-421)

Summary and Discussion

Families in this study provided three types of caregiving pratices for their frail elderly parents: physical caregiving; psychological caregiving; and spiritual caregiving. Because the care receivers in this study were frail elderly parents and nearly half of them (7 care receivers) were in a dependent condition (totally dependent in the assistance for their ADL), the caregiving performed by the caregivers was heavy on the physical caregiving. There were several cases (7 families) in which the caregivers provided nursing care activities at home. The caregiverss who cared for the frailest parents, with high levels of need for assistance in ADL and IADL, talked about their lives as a rountine of caring. They spent a lot of time in the physical caregiving activities that had to be completed on a time schedule.

Findings from this study will be compared to those of other studies of caregiving for the elderly people in Thailand (Caffrey, 1992a; Enz & Rungsophasakul, 1998; Knodel, Amornsirisomboon, & Khiewyoo, 1997). Caffrey (1992a) found that the caregiving activities for elderly people in a rural area of Thailand included common household activities such as cooking, doing the laundry, giving money, cleaning, changing bed clothes, and emptying the chamber pot. In her study, the elders included in the sample mostly could perform activities of daily living by themselves. There were only two elders who needed intensive personal care such as bathing, dressing, assistance with eating, and constant observation and monitoring to prevent the elder from wandering off. No psychological caregiving was described in this study;

however, a type of spiritual caregiving (the Buddhist healing ritual in the Northestern part of Thailand called "*sutra khwan luang* "), a ritual for calling the spirit essense of the person who is ill, was described as a family care activity during the episode of illness.

Enz and Rungsophagul (1998) studied the role of caregivers for elders in Thai health care, and identified that meal preparation is the major activity that caregivers provide for the elderly. Providing medicines and assisting with daily living activities were also activities that caregivers performed for the elderly people in their families. The caregiving activities in this study mainly focused on physical activities and tasks. These findings are consistent with the findings of the present study which found the focus of caregiving practices is mainly placed on physical caregiving. However, one different was that the psychological and spiritual caregiving found in the present study were not described in the Enz and Rungsophagul study.

Knodel, Amornsirisomboon, and Khiewyoo's (1997) study that used the 1994 national survey of elderly in Thailand, found that the disability status of elders was related to the support that the elders received. In this survey, elders who were more disabled received more support than elders who were less disabled. Types of supports received by disabled elders from their families were financial support, food preparation, house work assistance, and nursing care. Nonetheless, in that study there was no detail about what nusing care was done or how the families gave care to the frail elderly.

To date, the investigator has not found other studies of family caregiving for the elderly people in Thailand that discussed or identified the psychological caregiving. However, there are some studies which were done in the U.S. or western countries that discussed psychological and spiritual caregiving.

Section III

Purpose # 3: To Identify the Perspectives of the Thai Families Regarding the Effects of Social Changes in Modern Thailand on *Katanyu Katavedi* and on Caregiving for Frail Elderly Parents

The original purpose was to understand the perspectives of Thai families regarding the effects of social and economic changes on *katanyu katavedi* and the caregiving for frail elderly parents. However, the effects of social and economic changes in Thai society take a period of time before their effects can be observed. In order to track long term outcomes of social and economic changes on *katanyu katavedi* and caregiving, a longitudinal study might provide more informative and comprehensive data to serve this Purpose #3.

Nonetheless, the findings of this study yielded identified contextual factors which influenced caregiving in Thai society. Thus, the third purpose of this study was modified to represent the contextual factors emerged from the data. Contextual factors influencing the caregiving in Thai families found in this study can be separated into two dimensions: a) cultural contextual factors and b) societal and economic contextual factors. The investigator found that the cultural contextual factors directly influenced the caregiving for elderly parents in Thai families. Societal and economic contextual factors, however, influenced the consequences of caregiving situation. These relationships will be discussed in Section V. Figure 3 depicts a diagram of these two dimensions, categories and sub-categories that emerged from the findings related to Purpose #3.

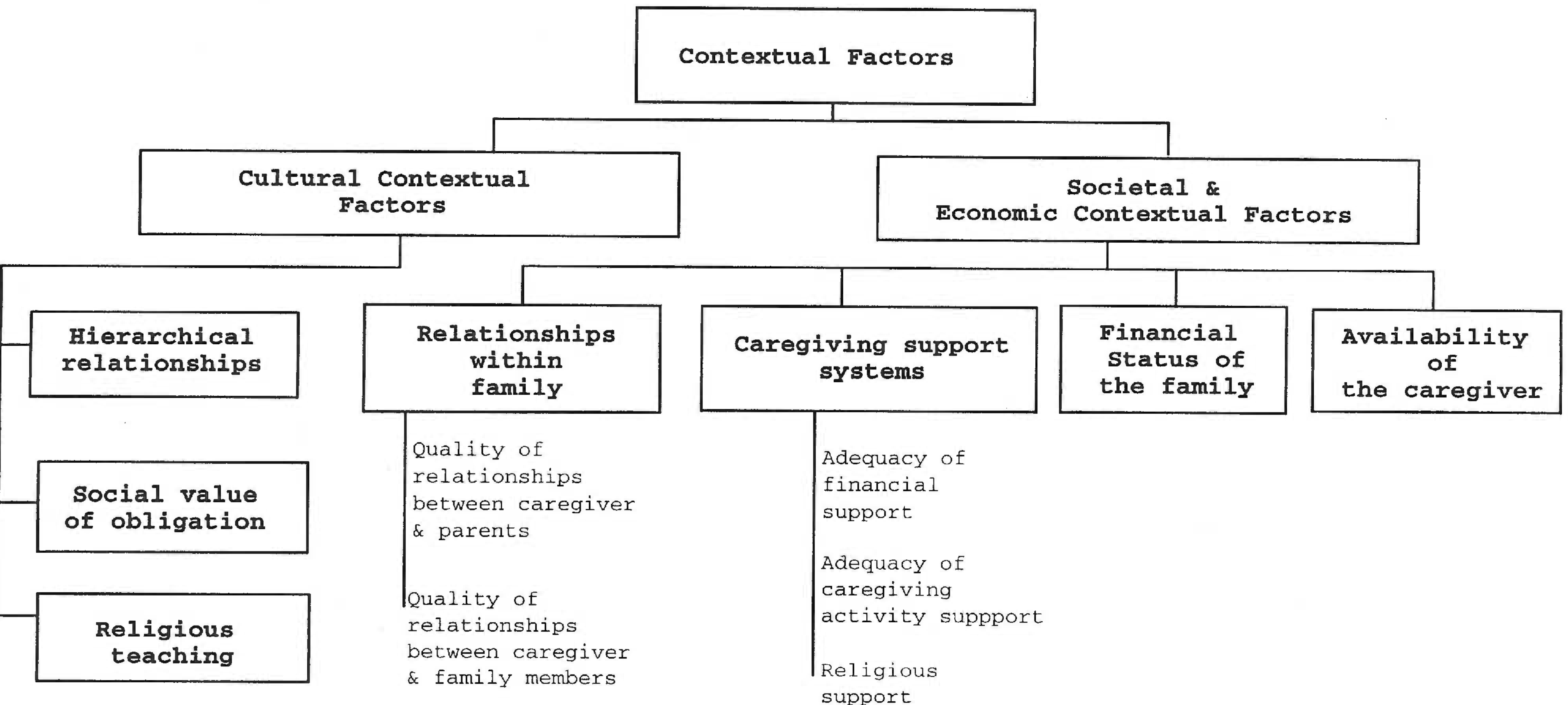


Figure 3. **Contextual Factors Influencing Caregiving**

Cultural Contextual Factors

As described in section I, *katanyu katavedi* is an important social cultural value that is deeply rooted in Thai society. Three categories emerged from the data of this study. These three cultural contextual factors were found to influence to the concept *katanyu katavedi*: 1) hierarchical relationships between parents and child (in Thai society); 2) social value of obligation to parents; and 3) religious teaching. These three factors explained why the concept of *katanyu katavedi* is such a firm foundation for family relationships in Thai society.

Hierarchical of relationships between parents and child. In Thai society, this is defined as a social norm that parents have a higher status and should be respected and obeyed by children. As a son or a daughter, one should honor one's parents as having highest status in the family.

In this study most of the parents were frail or semiconscious, and could no longer give counsel or provide help to their children. Yet, the caregivers still placed (and held) their parents in the highest position or valued the parents as a revered person. The relationship between parent and children is based on not only the hierarchical relation of the elders to the youngers but also the superior status of parents over children. One result of this hierarchical relationships is that the caregivers give the best of what ever they have for benefit of their parents.

Podhisita (1985) explained that Thai society organizes and views social and human relations in a hierarchical way. The hierarchical relationship plays an important role in human

relations especially in family life. Elders are placed in a higher status than younger, and should be respected by the younger. The aged are considered to be people with many experiences in life who could provide advice, consultation on family matters and life in general (Limanonda, 1995). Children are taught in early life to understand hierarchical rank in the family. They have been ingrained in hierarchical relations since they were young. Parents are viewed as super ordinate while children are placed as subordinate. Results from a recent study by Ingersoll-Dayton and Sengtienchai (1997) about the respect for elderly in four Asian countries (Singapore, Taiwan, Thailand, and Phillipines) show a trend of change in traditional expressions of respect for the elderly because of changes in family structure and function, education, income, and modernization. These results do not mean, however, that elderly status is no longer revered in Asian culture because respect to elders is not equated to absolutely obedience. Being polite, asking for advice from elders, and informing elders of their decisions are still valued as ways to show respect to the elders. In addition, financial support and personal care to the elderly people remained values as well.

Social value of obligation to parents. The social value of obligation to parents is defined as the strong value and expectation in Thai society that children should have a sense of gratitude toward parents. Children are obligated to take care of their parents when they become old or frail. In Thai culture, the obligation to parents is defined as an attribute and a commendable quality of a good person or a good child. It is believed that a

good child will receive good things as a reaction of good karma (of doing good to parents) in return in some way some day.

Thai society is a collectivistic culture because of the cultural homogeneity of its people (Triandis, 1995). In collectivistic societies, people in the community believe strongly in the same values. A person in the community who follows and achieves the social values is usually praised and glorified. On the contrary, people who do not follow a social value or norm might be condemned as unacceptable in the community. When talking about their reasons for giving care to their parents, these caregivers used words like "ought", "should", or "must" to express caregiving to parents as an obligation, duty, and responsibility that people in Thai society are expected carry out.

Children who take good care of their parents or devote themselves to their parents are usually admired and praised by the community, or even in public ways like newspapers or television. For example, a story of "Wallee" a daughter who took care and devoted herself in taking care of her frail mother. Her story was published in newspapers and was raised as an example of a "*katanyu* child" or "*luk katanyu*" praised by people all over Thailand. She took care of her mother (who was paralyzed) by running back and forth from school to home several miles every noon to feed her mother who could not help herself at that time. She took all the responsibility in taking care of her family while her mother was ill. From the interviews with one participant (ID #13), a caregiver mentioned the time that her friends called her "*Wallee*, a *katanyu* child" because her friends saw her devotion in giving

care to her frail father. This represents the social value in Thai society that honors and recognizes one who follows the social value of obligation to parents. Seven out of fifteen key informants in this study talked about how their caregiving to parents was being recognized and praised by their friends or people in the community which led to positive consequences in the caregiving situation. This will be discussed in Section IV.

Religious teaching. Religious teaching is defined as the teaching and beliefs developed from religious doctrine about the gratitude and obligation of children toward their parents. The caring of parents is valued as a virtue, and desertion of parents is condemned a sin. This belief includes the caring for elderly parents, its value and virtue in connection with religious teachings in Buddhism, which is the dominant religion in Thailand. While Buddhism teaches obligation to one's parents, it is not the only religion with this belief. In this study one of the caregivers was an Islamic, caregiver ID #9, who said that Islam also teaches and values children's obligation in taking care of parents.

Based on the beliefs from the Buddhist concept of *karma* which relates to the law of action and reaction, being a good child by taking care of parents is considered to be a way of making good *karma*. It is also believed that respect and obedience to mother and father is meritorious and honorable.

These three contexts are foundations which make the concept *katanyu katavedi* rooted and grounded deeply in Thai culture, and influence directly the rationale for caregiving to

parents of Thai families. Data exemplars for the three contextual factors influencing *katanyu katavedi* appear in Table 9.

Table 9

Definition, and Data Exemplars of Cultural Contextual Factor Influencing *Katanyu Katavedi*

Cultural Contextual Factor & Definition	Data Exemplar
The hierarchical relationship between parents and child is defined as the social norm that parents have a higher status and should be respected and obeyed by children.	For parents, we place them in a high status, and should not make them feel sorry or upset. If we make them upset, we will have sinned (ID #13, L 1340-1342) I put them in a highest position. This belief is in my head all the time.... We can buy anything by using money, but we could not find anything to substitute for parents. (ID #8, L 329-330)
Social value of obligation to parents is defined as strong value and expectation in Thai society that children should have a sense of gratitude toward their parents.	The world will denounce you if you don't take care of your parents! It means our society will blame me about not taking care of my own father! We live in a community of our society. This is the main issue. The society will blame and abhor the person who doesn't take care of his/ her parents because he/ she doesn't care for anybody even his/ her own parents. (ID #15, L 368-376) Thai people, especially the elders love to have their children or grandchildren around. In our culture, parents should be taken care by their children or family. We won't accept the way that letting the elderly living alone. That's not proper. (ID #5, L 368-373)
Religious teaching is defined as the teaching and beliefs developed from religious doctrine about gratitude and obligation of children toward their parents.	The old writings said that taking care of parents is meritorious. (ID #10, L 658-659) In our teaching (Islamic teaching) about parent repayment, it's very sinful if a child deserts or does not take care of his/ her own parents. (ID #9, L 132-134) We are Buddhist, we never desert our parents. (ID #5, L 438) Taking care of parents is the greatest merit of all. Although we do other kinds of merit, taking care of parents is greater. Building a temple or something similar does not make us have as much merit as taking good care of parents (ID #13, L 889-895)

All fifteen caregivers in this study said that they still valued *katanyu katavedi*. They believed it is crucial for the family to continue caregiving to their parents when they become old and frail. The social cultural contextual factors have not eroded although there have been dramatic changes in social and economic situations in Thailand. From this study, it confirms the strong foundation of religious support for the social cultural value of *katanyu katavedi* in Thai culture which maintains the familial system to support and care for frail elderly parents. The finding of this study confirms the results in several recent studies such as Limanonda, Wongboonsin, Vibulsresth, and Ruffolo (1995), Knodel and Chayovan (1997) which found the relationships between parents and children is still relatively strong. Family caregiving and supports for Thai elderly people are still mostly provided by their own offspring. The number of the elderly parents co-residing with their children has been not much changed.

Societal and Economic Contextual Factors

Societal and economic contextual factors are defined as the factors related to social and financial structure of the family such as relationships within family or financial status that influence the caregiving situation. In these societal and economic contexts, four categories emerged from the data of this study. These four categories are: 1) relationships within the family; 2) caregiving support system; 3) financial status of the family; and 4) availability of the caregiver.

Relationships within the family. This category is defined as the caregiver's perception of their current relationships with

parents and other family members, especially their brothers and/or sisters. The relationships within the family can be grouped into two sub-categories: a) the quality of relationships between the caregivers and their parents; and b) the quality of relationships between the caregivers and other family members especially other children.

a) The quality of relationships between the caregivers and their parents. This was described by the caregivers as their feelings of how well they get along with their parents and the quality of their relationships. There were twelve caregivers (ID #1, ID #2, ID #3, ID #4, ID #5, ID #7, ID #8, ID #9, ID #11, ID #13, ID #14, and ID #15) who expressed positive more often than negative relationships with their parents. The positive relationships with parents is defined as the caregivers' feelings of having good relations with parents by being close, being together, and feelings of love that they have towards their parents.

Three caregivers (ID #6, ID #10, and ID # 12) showed more negative relationships with their parents. They felt that the caregiving situation induced the emotional conflict or disagreement between them and their parents. These three caregivers felt that their parents did not listen to them and made their caregiving activities more difficult. However, these caregivers said that the emotional conflict was a minor disagreement or hot temper from both sides.

b) The quality of relationships between the caregivers and other family members. This was described by the caregivers from

their feelings of how well they got along with other family members especially their brothers and/or sisters and the quality of their relationships. This relationship was also strongly related to the caregiver's perception of a support system they received from other family members.

There were seven caregivers (ID # 3, ID #4, ID # 5, ID #8, ID #9, ID #11, and ID #14) who said they had more positive relationships with other family members. The positive relationships with other family members from these caregivers' views was defined as the feelings of getting along well with other family members (sisters, brothers, or relatives) in the caregiving situation. They stated that they received adequate support or help from other family members and had good relations with them. Negative relationships with other family members is defined by eight caregivers in this study (ID #1, ID #2, ID # 6, ID #7, ID #10, ID #12, ID #13, and ID #15) as bad relations and a negative attitude towards their family members especially their brothers and/or sisters. These negative relationships caused the caregivers' feelings of frustration, resentment and anger with other family members. The caregivers felt that other children did not provide enough assistance or support in caregiving, or sometimes paid less attention to parents and left the caregiving to the caregivers alone. The sub-category, definition, and data exemplar of the relationships within the family are shown in Table 10.

Table 10

Sub-category, Definition, and Data Exemplars of Relationships within the Family

Sub-category & Definition	Data Exemplar
Positive relationships with parents is defined as the caregiver's feelings of having good relations with parents by being close, being together, and feelings of love that they have towards their parents.	We have been together for a long time. Don't ask me about love! I do love her. (ID #13, L 123-126) I think my mother wants to stay close to me because she will feel warm when I'm being around. (ID #13, L 296-297) It's the bonding of parents and child. When I was young...I remember we (my mother and I) together lived through the hard time. (ID #14, L 539-541) I am close to her. We are together like this for long time. I've lived and grown up with her, do house chores together, learn to read and write with her. She taught me since I was young. (ID #4, L 300-304) I give care for him (the father) with love. I care for him with the feeling of love and the feeling of bonding...never feel reluctant in giving care to him. (ID #8, L 497-499)
Negative relationships with parents is defined as the caregiver's feelings of emotional conflict or disagreement between them and their parents during the caregiving situation.	We quarrel sometimes. I got angry and could not control my temper. She (the mother) also got mad at me even though she looks like she is very quiet (now). (ID #10, L 428-431) Sometimes I get angry at her because she never listens to me like I told her not to scratch her elbow. Actually it did not have any sore, but she scratches until the skin breaks. At the hip area, she scratched until the wound became worse. (ID #12, L 965-969)
Positive relationships with other family members is defined as the caregiver's feelings of having good relations or getting along well with other family members in the caregiving situation.	My family, we love each other (sister and brothers). We love our parents." (ID #4, L 508-509) We always talk to each other. There is no problem when I want to go out for a while and leave him (the father) with others. There are several children in this family. And we help each other. Like my younger sister, she helps me taking care of the father during the night time. (ID #8, L 275-280)

Table 10 (continued)

Category & Definition	Data Exemplar
	No, we don't have problem or argument about the caring of mother. If I want something for my mother like the air-conditioner for this room (mother's room), my elder sister paid for it. When I want caring supplies or medicines, I just tell them and they will have no problem paying for all that stuffs. (ID #14, L 195-199)
Negative relationships with other family members is defined as the caregiver's feelings of having bad relations, attitude towards their family members especially their brothers and/or sisters.	I don't want to talk about my sister. If I said it would be like I blame her. She never takes care of mother. I don't understand about her heart. (ID #10, L 1039-1042) Sometimes I get angry with my sister that left my mother to be my responsibility. (ID #12, L 250-252) My sister rarely come to see mother. She just walked past this house. I don't want to get (into a) quarrel with her. So I just do what I can do. (ID #2, 516-520)

Caregiving support system. Caregiving support system is defined as assistance that caregivers receive from other family members (i.e. mother, sisters, brothers, relatives, or friends). The supports found in this study were identified as three sub-categories: a) adequacy of financial support; b) adequacy of caregiving activity support; and c) religious support.

a) Adequacy of financial support. This is defined as the caregiver's perception of adequacy of money or assets that were given by others (sisters, brothers, or relatives) to help in caregiving activities such as buying medicines or caregiving supplies or helping with the caregiver's living and household expense.

However, there are some caregivers who felt that the financial support they received was inadequate for caregiving

expenses. These were especially likely to be the families that already had problems in financial status such as ID # 12, and ID #13.

<u>b) Adequacy of caregiving activity support.</u> This is defined as the caregiver's perception of adequacy about amount and quality of assistance in caregiving activities from other family members (i.e. sisters, brothers, grandchildren, or other relatives). Some caregivers in this study used their own judgment to evaluate quality of caregiving support from others. When they felt the quality of care from others did not meet their expectation, they felt the caregiving activity support from others was not adequate. There were two caregivers (ID #1 and ID #12) in this study who strongly expressed these kind of feelings and felt they had no one help in their caregiving activities. On the other hand, the caregivers (ID #2, ID #5, ID #8, ID #10, ID #11, and ID #14) who stated that they received adequate support in caregiving activities, mostly were satisfied with the quality of care from others and judged the caregiving provided by others as enough. These differences suggested that quality as well as amount of caregiving activity support are both important but may interact with each other.

<u>c) Religious support</u> is defined as the type of support related to emotional well-being of the caregivers in this study from religious and spiritual beliefs and practices. There were six caregivers (ID #1, ID #6, ID #8, ID #11, ID #13, and ID #14) who told about their religious or spiritual beliefs and practices when faced with difficulties in caregiving or in their own lives. The

strategies they used included praying (making a wish), prayer chanting (repetitive holy chants), meditation, merit-making, or making a vow to religious or holy images. The caregivers practiced their religious and spiritual ceremonies for the expectation of better conditions and/or merits for their parents as described earlier, as well as the sense of peace in their own mind. Thus, this religious support is closely related to the spiritual caregiving to parents.

From this study, sharing the feelings or talking with other family members or friends is found less practice among these caregivers. There is only one caregiver (ID #13) in this study that talked with her friend when she had problems in the caregiving situation. The remaining caregivers said that they rarely talked or shared their emotions or feelings about caregiving responsibility with other people. The sub-category, definition, and data exemplars of the caregiving support system are shown in Table 11.

Table 11

Sub-category, Definition, and Data Exemplars of Caregiving Support System

Category & Definition	Data Exemplar
Adequacy of financial support is defined as the caregiver's perception of adequacy of money or assets that were given by other family members to help in caregiving activities or to help the caregiver's living and household expense.	My mother gave me money two years ago when she sold the land. At that time I got 100,000 baht and I kept that amount of the money for my living expenses. (ID # 1, L 575-582) My elder sister gave 5000 baht. The younger sister and a younger brother altogether gave 5000 baht. Me and another elder sister added 5000 baht. The other sister gave 3000 baht. So we got totally 18,000 baht to buy this new airbed for our mother. (ID 14, L 168-171) My younger sister and my nephews, who already have their own jobs, give me sometimes 3,000 or 4,000 baht. If I want something extra for father, everybody will help without problem. (ID #8, L 475-478) My two younger brothers help for all the expenses of mother's medicine and health care services. He (one of the brothers) can get the health care benefit for her from his work--also the admission to a hospital. (ID #14, L 382-384)
Financial support (inadequate)	None of us can get the welfare from the government. We are all poor. When my father was ill, there was no one to help. That's really my tough time. (ID #13, L 548-550) I know that my elder sister who lives at Din Daeng also has problems in her financial status. I rarely ask for help from her. When she visited the mother sometimes she gave me 500 or 1000 baht helping for the expense of care for mother. Actually, that is not enough for the real expense for the care of mother. (ID #12, L 26-30)
Adequacy of caregiving activity support is defined as the caregiver's perception of adequacy about amount and quality of received assistance in caregiving activities from other family members	We always talk to each other. There is no problem when I want to go out for a while and leave him (the father) with others. There are several children in this family. And we help each other. Like my younger sister, she helps me take care of the father during the night time. (ID #8, L 275-280) My youngest daughter (caregiver's daughter) can give care to my mother as well as I do. She can do everything. May be better than me! She helped to evacuate my mother's feces before I could. (ID #14, L 299-303)

Table 11 (continued)

Sub-category & Definition	Data Exemplar
	There are several people in this house that help in taking care of my mother. I have two nieces who can take care of my mother. If someone is not home, there will be the others who take care instead. They are very good. They never feel dislike or unwillingness to help. (ID #5, L 541-548)
Caregiving activity support (inadequate)	Even if there is someone who can take care of my father instead of me , it's not the same as when I do it myself. For example, when I leave him with others for about 2-3 hours while I was going out, I find that he is wet all over after I come back....I used to let my niece look after him for a while. She only fed him and then left him alone. She did not pay attention to him. (ID #13, L 188-195)
	During the time that I was sick, my elder sister took the mother to stay with her. I don't know how she takes care of her. Only about a month, my mother had the pressure sores and got the sepsis. (ID #6, 288-291)
Religious support is defined as type of support related to emotional well-being of the caregivers from religious and spiritual beliefs and practices.	Everyday around 10 AM I must offer water to King Chulalongkorn (Rama V) statue and fruits to *Som dej Puthajarn To*. In the evening, I pray at the spirit house (a ritual Thai traditional model of house that is usually located in front of the house. It's believed to be a place in which the spirits that protect one's house live). (ID #1, L 1561-1567)
	I offer foods to monks every Buddhist holy days. I become a temporary vegetarian on Buddhist days. I also do the prayer chanting (repetitive holy chants) every night. (ID #13, 945-948)

Financial status of the family. It refers to the socio-economic status of the family which is an important factor influenced the caregiving for frail elderly parents. Two families (ID #12 and ID #13) had total incomes less than 5500 baht (~ 150 US dollars) per month compared to the average income of Thai people which is 6651 baht (~ 180 US dollars) per month (Bangkok Post, 1998). Moreover, these two caregivers were the main sources

of income for their families. Both caregivers talked about their difficult financial situation and this in turn affected their perceived negative consequences from the caregiving situations, especially feelings of stress, burden, and physical strain. In contrast, two families (ID #1 and ID #8) that had more security in financial status and expressed less in feelings of burden and stress. However, it was found that the finances in these two cases mainly came from the parents' assets or properties.

Availability of the caregivers. It is defined as a factor that caregivers explained or gave as the rationale for their assumption of the caregiver's role. Reasons for becoming a primary caregiver are complex and usually differed in each case. Availability to be the caregiver from the participants in this study can be identified as: a) being single; b) homemaking (rather than having a career); and c) woman's role.

a) Being single. It refers to the reason that some caregivers in this study remain single in order to take care of their parents. In this study, there were seven caregivers (ID #1, ID #3, ID #4, ID #5, ID #7, ID #8, ID #11, and ID #13) who were single. Some of these caregivers (ID #1, ID #8, ID #13) said they took responsibility to take care of their parents because they were single while the other children were married and had their own families. Their single status made them available to be the caregivers. One caregiver chose to remain single (rather than marry when asked) so that she could continue to be her parent's caregiver.

b) Homemaking. It refers to the caregiver's being at home so he/she is able to provide caregiving for his/her frail elderly parents. This is another reason that the caregivers in this study gave for their availability to be caregivers was their homemaking work. There were 10 caregivers in this study who defined themselves as homemakers. So, they assumed care of people at home while other family members worked outside. These caregivers said that it would be more difficult to take care of parents if they did not work at home.

c) Woman's role. It refers to a customary expectation and usually a general practice in Thai families which caregiving is commonly provided by women. Nearly half of the participants (six caregivers) in this study said that caregiving responsibility tended to be the daughter's duty. They thought the daughters could provide better care to parents because of their caring nature and tenderness. However, nine participants (including two adult son caregivers) said that there was no difference between the son and daughter in giving care to parents. They believed that the caregiving responsibility depends on the children's willingness and availability.

Summary and Discussions

Two factors, the cultural contextual factors and the societal and economic contextual factors, play important roles in caregiving practices in Thai society.

The cultural contextual factors found in this study are: 1) hierarchical relationships between parents and child (in Thai society); 2) social value of obligation to parents; and 3)

religious teaching. Cultural contextual factors directly influence *katanyu katavedi* which is deeply rooted and strongly adhered by Thai people. These three contextual factors are Thai social bases underpinning the norms and practices of family caregiving for elderly parents in Thai society. It is considered a virtue and moral duty for children to care for their parents. Such care provides merit (*bun*) or good *karma* back to the children who take good care and revere their parents.

Four societal and economic contextual factors were found in this study: 1) relationships within the family; 2) caregiving support system; 3) financial status of the family; and 4) availability of the caregiver.

The quality of relationships within the family may differ from family to family and can influence the consequences of a caregiving situation. The caregiving support systems especially the adequacy of caregiving activity support and financial support are very important and influence the consequences of caregiving situation. The societal trend towards reduced family size means there are fewer possible resources from siblings. The caregivers in this study stated that children must agree about how the care will get done or have one sibling devoted to being a primary caregiver. Support from health care services or groups like self help groups is still rare and not viewed as important as support from family.

The financial status of family is a critical issue. It was found in this study that the more problems in financial status or financial aspects of caregiving support system, the higher the

report of negative consequences (discussed in section IV). Caregivers in this study reported that the cost of caring was paid mostly by the family because there is no social welfare or social security. Therefore, it was found that the families which already had difficulty in their financial status faced more problems about the expenses of caring for their frail parents.

The availability of the caregiver is also an important factor. The use of traditional criteria for choosing the caregiver may be inconsistent with social and economic changes. The smaller family size with most family members working outside the home influences this. More and more women who used to take the role as homemakers and caretakers of children and elderly at home are now participating in the labor force (Pongsapich, 1992). This raises a questions about who will be the one that is available to be a caregiver. It was found that societal and economic contextual factors also heavily impact and influence the caregiving experiences of the Thai families.

All fifteen caregivers in this study stated that the family is still the center of caregiving. To them, it is socially unacceptable for children to institutionalize parents or place elderly relatives into residential homes. Such children are negatively judged by friends, neighbors and the greater community. The other option for the new generation is to hire a housemaid to live in and take care of their parents while the sons or daughters go out to work. This is seen and practiced in some families which have enough money. But, all of the caregivers interviewed said that quality of hired caregiving is not the same as they give

themselves. Hired caregiving does not substitute or meet the quality of caregiving that comes from children or family.

Section IV

Purpose # 4: Describe the Effects of Caregiving for Frail Elderly Parents on Families and Caregivers

The effects of caregiving for frail elderly parents on families and caregivers from the findings of this study were grouped into three dimensions. These dimensions are: 1) positive consequences of the caregiving situation; 2) negative consequences of the caregiving situation; and 3) ambivalence in the caregiving situation.

It was found that all fifteen caregivers in this study had both positive and negative consequences of the caregiving arena. From the interviews with these caregivers, they expressed feeling good or positive feelings in being a caregiver and at the same time talked about the negative parts such as stress and strain in their caregiving responsibility.

Positive Consequences of Caregiving Situation

The positive consequences of the caregiving situation are defined as the family caregiver's experiences of having feelings of pleasure in the role of being a caregiver. There were six categories of positive consequences of the caregiving situation that emerged from the data of this study. These six categories are structured in terms of: 1) happiness; 2) sense of self-pride; 3) recognition of the praise from others; 4) attaining merit; 5) warmth; and 6) the feeling of being lucky. The diagram of categories related to positive consequences in the caregiving situation is shown in Figure 4. Each of these categories is described below with their data exemplars.

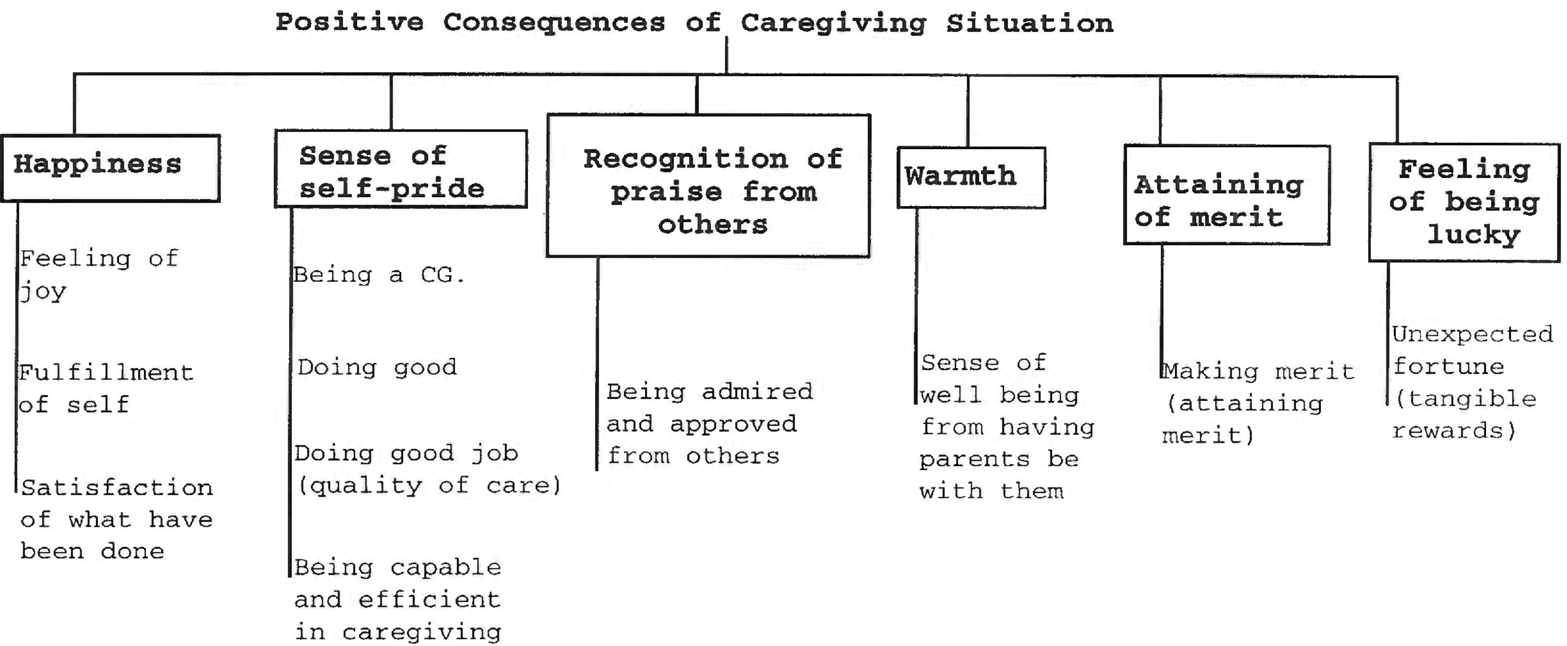


Figure 4. Positive Consequences of Caregiving Situation

Happiness. Happiness is defined as feelings of joy, the fulfillment of self, and the satisfaction that caregivers receive. This happiness comes from the knowledge that they have performed their caregiving responsibilities willingly and to the best of their ability.

Feelings of joy occurred when the caregivers saw improvement in their parents' condition. They also expressed the feeling of joy in being able to enjoy time with their parents. The caregivers expressed feelings of fulfillment in their ability to achieve their caregiving responsibility. Their satisfaction is based on their sense of being able to provide care and that their care is quality care. These three sub-categories of happiness and supportive data examples are presented in Table 12.

Table 12

Sub-category, Definition, and Data Exemplars of Happiness

Sub-category & Definition	Data Exemplar
Feelings of joy is defined as the caregiver feels good from improved condition of parents or have good time with parents.	When I saw that my mother could walk and was becoming healthier, I felt good. (ID #6, L 456-458) Since now she can void by herself, I feel very good. (ID #6, L 463) Yeah, I feel happy. It's like when I was with him, I could sit down and talk with him. That's really joyful. (ID #8, L 371-372)
Fulfillment of self is defined as the caregiver's feelings of fulfillment in his/ her own ability to achieve the caregiving duty from their own will (intention).	I do what I think is right. I think that when I do this (taking care of the mother) I feel happy.... I feel like my heart wants me to do this. Really willing to do it from my heart. (ID #13, L 866-872) It's very difficult to express the feeling that I have. It's my delight and very fulfilling to take care of father. (ID #1, L 1478-1479)
Satisfaction about what has been done is defined as the caregiver's feelings of satisfaction about the quality of caregiving provided to his/ her frail parents.	I feel satisfied in what I've done for her. (ID #2, L 326-327) I am satisfied that at the very least I could do something as this in return for what my parents have done for me. In all my efforts, I try to do the very best that I can for them (ID #13, L 286-289) When we all had learned how to care for him, we saw his condition improve. We all felt happy with his condition and satisfied with our care. We realized that his condition was no longer critical. (ID #8, 279-281)

Sense of self-pride. The sense of self-pride is defined as the caregiver's feeling of being proud of themselves in their caregiving role. The sense of sense-pride may be different depending on the particular circumstance. The participants in this study expressed their sense of self-pride as:

a) pride of being a caregiver. This is defined as the caregiver's feeling of pride in having the opportunity to care for their parents.

b) pride of doing good. This is defined as the caregiver's feeling of pride in doing the right thing on a personal level as well as doing what is considered right by societal values.

c) pride of the quality of care. This is defined as the caregiver's feeling of pride in his/ her ability to provide good care to parent (quality of care) with a positive outcome;

d) pride of being capable and efficient in caregiving. This is defined as the caregiver's feeling of pride in being able to perform the caregiving tasks efficiently while becoming better in controlling the caregiving situation.

The caregivers' feelings of self-pride were also found and indicated in several studies. Lawton, Kleban, Moss, Rovine, and Glicksman (1989) using the term "caregiving mastery" to define caregivers' positive views of their own ability and ongoing behavior in the caregiving process. Haley, Levine, Brown, and Bartolucci (1987) called the caregivers' confidence in their caregiving proficiency self-efficacy. However, in this study, the investigator decided to use the term "sense of self-pride" because the caregiving role led the caregivers to a sense of personal goodness and self-pride. Four sub-categories of sense of self-pride and supportive data examples are presented in Table 13.

Table 13

Sub-category, Definition, and Data Exemplars of Sense of Self-pride

Sub-category & Definition	Data Exemplar
Pride of being a caregiver is defined as the caregiver 's feeling proud of having an opportunity to take care parents	People usually praise me for being a good daughter and taking care of my parents. It doesn't mean that I want others to admire or praise me. They just see what I do for my father. (ID # 1, L 1311-1314)
	Taking care of father gives me joy and is very fulfilling. I'm also proud of myself. (ID #1, L 1479-1480)
	I used to be a very hot tempered person and very impatient. It surprises me that I can take care of my father and remain so calm. I feel that I am now more tranquil and mellow. (ID #8, L 235-239)
Pride of doing good is defined as the caregiver's feeling proud of self in doing a right and good thing accepted in society	Yes, people around here know what I am doing for my parents (taking care of parents). I sometimes hear what they say about me. That makes me feel proud of myself and I know that I am doing the right thing. (ID #4, L 779-781)
	They pointed at me and said that I'm a "*katanyu* daughter". By them saying this I know that they recognize and understand what I am doing for my father. (ID #1, L 1465-1466)
Pride of quality of care is defined as the caregiver's feeling pride in his/ her ability in providing good care to parents which bring good outcome to parent's condition.	I think that I do a good job in taking good care of my mother. In the three years that I have cared for her she has never had a pressure sore. (ID #12, L 271-273)
	My father has not had to go to the hospital for 2-3 years. I think I've learned to take care of most of my father's health problems so that he has not needed to go to the hospital as often as he had to go in the past. (ID #1, 1017-1021)
	My mother's friends came to visit her and they said that she (the mother) looked much better and happier than she had in the past. Her face was bright and she was smiling. Everyone notices the difference. I don't have to say anything. People know that she is happy because her face shows it. (ID #4, L 787-795)

Table 13 (continued)

Sub-category & Definition	Data Exemplar
Pride of being capable and efficient in caregiving is defined as the caregiver's feeling of being capable, efficient and becoming an expert and in control of caregiving situation.	When my father was discharged from the hospital, his care became my responsibility. So, I reviewed how the nurses had done it. First I put on gloves and a mask then I gave him an enema. I tried to do it just as the nurses had done. I then had to use my hand to evacuate his feces. I have learned how to do it because I have to do it frequently. Now it's an easy task for me and it only takes me five or ten minutes to complete. It's easy for me now. (ID #1, L 492-503) Last night my sister stopped by to see my mother. She asked me why I scrub the wound (the pressure sore) so hard. I told her that it's necessary to do because it will help the wound to heal faster. I scrubbed all the dead tissue out. Now the tissue is much pinker and that's a good sign. (ID #14, L642-648)

Recognition of praise from others. Recognition of praise from others is defined as the caregiver's perception of being admired or approved by others because of their caregiving role. This role encompasses the care they provide to their parents and the quality of that care. Seven participants in this study talked about the recognition and approval they received from friends, neighbors, and relatives because of their caregiving role. Such approval and recognition is a positive consequence and is viewed as an important factor in reinforcing to the caregivers their value and the admiration by the community and society as a whole.

Warmth. Warmth is defined as the caregiver's feelings of inner peace and the sense of emotional well being from having their parents with them. There were eight participants who mentioned their feelings of warmth about having their parents living with them. Some participants used the term "*rom bho rom sai*" to describe how having parents with them can provide a sense

of emotional security. This term is generally used in Thai metaphor to infer the existence of parents as two kinds of big trees, *bho* and *sai*, which are shady and secure for animals to live safely and peacefully under their branches.

The finding of this sub-category of warmth is strongly related to the positive feelings between parent and children. The caregivers who said that they had the feelings of warmth mostly were daughters who were close to their parents. Thorbek's. (1987) study "Voice from the City: Woman of Bangkok", also found that daughters expressed their love for their mothers strongly. Some young woman said that they want to live near their mother; if they could not, they would miss them very much. The strongly expressed love for the mother might be more or less strongly felt; but it was the expression of an expected form of behavior.

<u>Attaining merit.</u> Attaining merit is defined as the caregiver's feeling of doing something good or worthwhile by taking care of their parents. This related to Thai religious beliefs as being a form of merit-making. In Buddhist teaching, merit-making is believed to bring someone a better life in the future. Twelve caregivers of this study talked about their belief that caring for their parents was a way of attaining merit for themselves. Of the caregivers who now have their own children (ID #2, ID #10, and ID #14) all of them said that they would not expect their children to take care of them when they became old. At the same time, these caregivers also said that the merit they attained from now being caregivers may have positive results such

as receiving caregiving from their own children when they grow old.

Feeling of being lucky. The feeling of being lucky is defined as the caregiver's feeling of having the potential to receive unexpected fortune. This fortune could be a tangible reward such as money or another precious thing. This category emerged from interviews with four caregivers (ID #1, ID #7, ID #13, and ID #14). In Thai culture and beliefs about the attainment of merit through caregiving, having good luck is an encouraging factor to the caregivers. Because these caregivers are Buddhist they have been taught and have adhered to the law of *karma*. They strongly believed that their vocational action of doing good to parents through caregiving is a way of merit-making and may lead them to desirable outcomes such as future happiness or wealth in their own lives (Podhisita, 1985). The definitions and data exemplars of Recognition of praise from others, Warmth, Attaining merit, and Feeling of being lucky are shown in Table 14.

Table 14

Category, Definition, and Data Exemplars of Recognition of Praise from Others, Warmth, Attaining Merit, and Feeling of Being Lucky

Category & Definition	Data Exemplar
Recognition of praise from others is defined as the caregiver's realization that other people, friends or neighbors admire and approve about their caregiving to parents.	People usually praise me for being a good daughter and taking care of parents. (ID #1, L 1310-1312) People admire me. I know. Sometimes my neighbors walked past my house, they liked to talk and are very friendly and kind to me. They did not praise me directly, but I can feel from their friendliness.(ID #3, L 560-563) She's really good to her parents. She puts her father and mother as her first priority. She does everything for them, doing everything. All the money she earned is spent for her parents. Her father even died in her arms. It's difficult to find people who are good such as this. (a friend of ID #13, L 242-246)
Warmth is defined as the caregiver's feelings of inner peace and the sense of emotional well being from having their parents with them.	Even during the time that I had my own family I still feel very attached to her. (ID #11, L 301-302) I have stayed with her all the time. When she was admitted to the hospital, I missed her very much. I visited her everyday. I felt as if I would die if I didn't see her. (ID #11, L 304-305) Some people suggested that I should come to Bangkok without bringing my elderly parents because it would be easier for me to earn a living. They said I should leave my parents to live in the rural area. But, I could not do that, I feel that we should be together. Even though we might face difficulties, being together gives me a sense of warmth and happiness. (ID #13, L 769-774) Hopefully making my parents happy and giving them good care, they will live a long and full life with us. They can be our beloved parents as well as giving us a sense of well-being. (ID #1, L 850-853)
Attaining merit is defined as the caregiver's feelings of taking care of parents as a form of merit making.	Taking care of one's parents is very important. It's also the greatest avenue of attaining merit. Although we do other kinds of merit, nothing else can compare to the merit obtained through taking care of one's parents. Even building a temple or something else of that magnitude will not give us as much merit as we receive by taking good care of our parents. (ID #1, 1128-1132)

Table 14 (continued)

Category & Definition	Data Exemplar
Attaining of merit (continued)	May be in the future my life might be better or I might be luckier in life if the merit I attain is genuine. (ID #12, L 763-766) High merit. It's the highest form of merit. I now feel that many good things have happened to me. For example, my sister and others who used to think that I was a bad person, now realize and accept that I'm a good person. They know that I'm the only one who takes care of our mother. (ID #6, L 561-567)
Feeling of being lucky is defined as the caregiver's feeling of being lucky or having the potential to receive unexpected fortune which is a tangible reward.	Since my father has passed away I have won the lottery twice. I made merit for him on the 100th day after his death. It seems like he gave me some good luck at that time. There were other people who unexpectedly joined me and brought food to make merit. I told them at the merit making ceremony to buy the lottery number XXX which I knew to be lucky, but no one bought one because they did not believe me. Just as I thought the number XXX came out as a winner. (ID #13, L 1098-1104) One time when my mother could still move, she raised her hand. I observed her fingers. She made her finger sign. I like to play unofficial lottery. So when my mother raised her hand and made a finger sign, I interpreted that to number to be XX and I bought that lottery number. It was right! The number came out XX. I won that number. My relatives wondered why I often win the lottery when I don't do anything special. I said to them "well! I win because I am the one who take care of mother." (ID #14, L 384-391) I unexpectedly received the amulet of *Pra Somdej Watrakang* (a small religious Buddha image made by the highest priest during the reign of King Rama V) from someone. That person said "you're a good person who takes good care of your parents so you should have this valuable gift". It's priceless. I had never asked or even thought of getting one. Even if I had tried to buy one I don't think I could have found one. I believe luck (good fortune due to good deeds) helped me to possess this precious Buddha image (ID #1, L 346-353)

Negative Consequences of Caregiving Situation

The dimension of negative consequences of caregiving is defined as the caregiver's experience of having problems, difficulties or unpleasantness in their caregiving situation. Eight categories emerged from this dimension. They are 1) the frustration of having conflict with other family members; 2) burdens of caregiving; 3) the deterioration of the caregiver's own health; 4) petty conflicts with their parents; 5) physical strain; 6) stress; 7) feelings of guilt; and 8) social isolation.

The diagram of these categories related to the negative consequences in caregiving situations are shown in Figure 5. Each of these categories is described along with data exemplars.

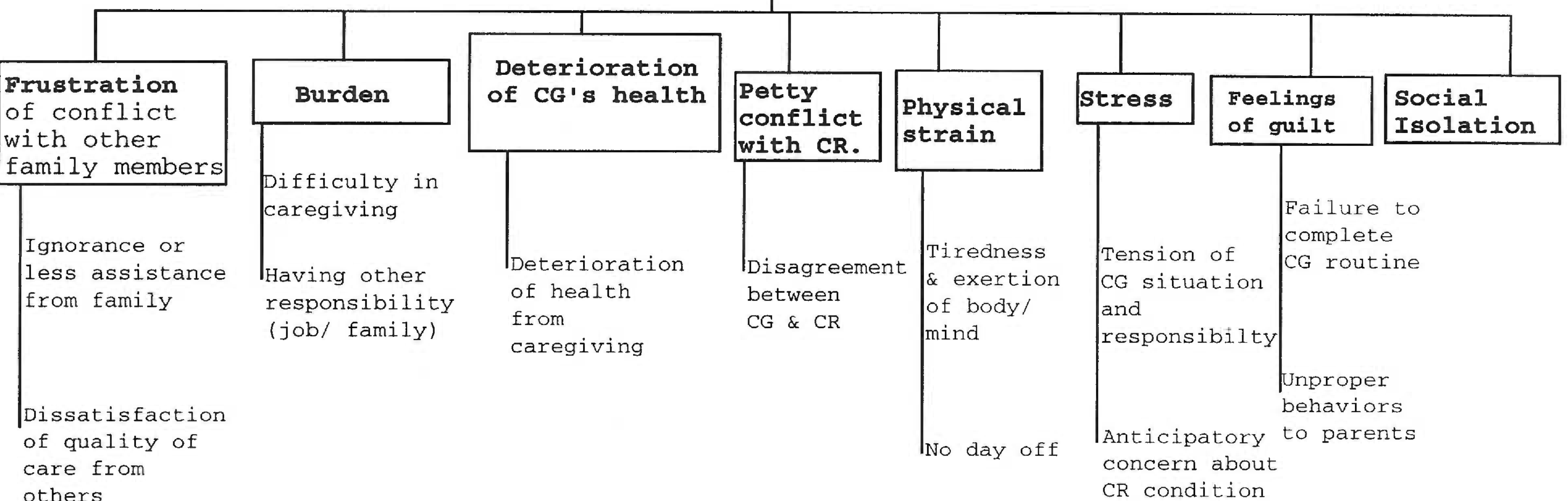


Figure 5. Negative Consequences of Caregiving Situation

The frustration of having conflict with other family members. This is defined as the caregiver's feelings of anger that come from disagreements and/or dissatisfaction with other family members. The caregivers told of events and situations that made them feel frustrated. These included the caregiver's feeling that other family members ignored the parent and gave no assistance in caring for the parent. Another frustration came when other family members did participate in caregiving but did not provide the same quality of care to their parents as the primary caregiver did. For example, caregiver ID #1 talked about her frustration and unhappiness when she left her father for a couple hours to be cared for by her niece. She felt that the niece did not provide the same quality of care and the care was neither as good nor adequate.

The frustration of caregivers from conflict with other family members about caregiving responsibility is an important category. The frustration they feel can also be linked and influenced by the adequacy of their support system in caregiving. Sub-categories and supportive data examples of frustration of having conflict with other family members are presented in Table 15.

Table 15

Sub-category, Definition, and Data Exemplars of Frustrations of Having Conflict with Other Family Members

Category & Definition	Data Exemplar
Ignorance or less assistance from others is defined as the caregiver's perception that other children did not provide enough help, caregiving support to them.	Before leaving for Choomporn province, I told my elder sister to look after our father while I was not here. But my sister said that she wanted to hire a nurse instead. I got angry with her because I don't understand why she could not take care of him by herself. This would make her busy for only two days. I, myself, have been looking after him for 7 years. (ID #1, L 238-244)
	I don't want to talk about my sister. If I said it would be like I blame her. She never takes care of mother. I don't understand about her heart. (ID #10, L 1039-1042)
	Sometimes I get angry with my sister that left my mother to be my responsibility. (ID #12, L 250-252)
	My sister rarely comes to see mother. She just walked past this house. I don't want to quarrel with her. So I just do what I can do. Not pay attention to her. (ID #2, 516-520)
Dissatisfaction of quality of care from others is defined as the caregiver's feeling that caregiving by the other is not right or as good as caregiving by him/ herself.	I sometimes complained about this behavior of my sister, she did not pay attention to father like did not spread mosquito net, letting mosquitoes bite father. (ID #13, L 693-695)
	During the time that I was sick, my elder sister took mother to stay with her. I don't know how she takes care of her. Only about a month (later) my mother had pressure sores and got sepsis. (ID #6, 288-291)
	Even if there is someone who can take care of my father instead of me, it's not the same as I do myself. Nobody can take as good care of him as me. For example, when I leave him with other people for about 2-3 hours while I was going out. I find that he is wet all over. That's really annoying. No one pays attention to giving care to father. (ID #1, L 188-193)

Burden. Burden is defined as the caregiver's feelings of having difficulty in caregiving when having other responsibilities such as job or family.

The difficulty in caregiving is described by the caregivers of activities that are complicated or not easy tasks for them especially at the beginning phase of care. The caregivers also felt they had other responsibilities such as their job and family which caused them to feel overloaded from all the responsibility. Aneshensal et al (1995) described role overload as the caregiver's internal experience of being overwhelmed by care related tasks and responsibilities. However, from the findings of this study the participants said their feelings of burden occurred because they felt overloaded with caregiving duty and other responsibilities, not only those related to care activities. Sub-categories and data exemplars of burden are presented in Table 16.

Table 16

Sub-category, Definition, Data Exemplars of Burden

Sub-category & Definition	Data Exemplar
Difficulty in caregiving is defined as the caregiving activities or practices which are complicated or not easy tasks for the caregiver which usually occurred during the beginning phase of being a caregiver.	At the beginning of being a caregiver, I did not have much experience and didn't know how to take care of my father. So it's quite hard for me. I was not good in caring at that time. (ID # 1, L 1326-1329) When my mother was discharged from the hospital back to this house, sometimes I was still up at 3 or 4 am to take care of her. She sometimes felt thirsty or hungry and I had to hand feed her but actually she could eat only five spoons. I thought that was a really difficult time for me. She woke up very often. I slept by her but my ears were still listening to her. My body is sleeping but my mind still wakes up. I was in that situation for several months. I took care of her like my baby. When she passed urine or feces, it's all my duty. (ID # 10, L 188-199)
Having other responsibilities is defined as the caregivers' having responsibility in other things more than the caregiving such as their job, family, etc.	During the time that I was sick, I felt I had nobody. Moreover, I had to look after my own son and a nephew. I didn't know how I can take care of my mother so I called my elder sister to pick her up to live with her. (ID # 12, L 378-382) I am the main person in taking care of them. Having enough, or not enough money, I am the person who has to work for their living. If they are sick and we don't have money, I try to do everything to get money for the treatment. If I stop working, then we won't have enough money to pay for the treatment. (ID #13, L 766-771)

Deterioration of health. Deterioration of caregiver's health is defined as the worsening of health status caused by being a caregiver. One caregiver (ID # 10) who is an aging daughter (67 year-old) told about her own health problems of diabetes and arthritis that made it difficult for her to take care of her mother sometimes.

The worsening of caregivers' health status caused by being caregivers emerged from the interviews with some caregivers (ID #2, ID #6, ID #10, ID #13). Mostly deterioration of health

concerned minor health problems such as pain in bones and muscles after giving care. One caregiver (ID #13) told about her story of physical overexertion she experienced in taking care of her critical ill father. Ultimately she nearly collapsed. Nonetheless, there was no caregiver who was so seriously ill or had such serious health problems that they had to be admitted to a hospital or get treatments.

Petty conflict with care receiver. The petty conflict with the care receiver is defined as the disagreement and/ or argument with parents that caused upset, unhappy, or disappointed feelings to caregivers. The caregivers (ID #2, ID #6, ID #10 and ID #13) who told about petty conflict with their parents mostly attributed it to their being the closest persons and being with their parents all the time. Thus, sometime they had disagreements or arguments.

Physical strain. Physical strain is defined as the caregiver's feeling of tiredness and excessive exertion of body and mind from being a caregiver combined with the feelings that they did not have time for a break from the caregiving duties. Ten caregivers in this study told about their feelings of physical strain in their caregiving lives. This physical strain usually related to the health status and condition of parents. However, the most influential factor affecting physical strain found in this study was the caregivers' support system. As the investigator discussed in section III, the negative consequences of the caregiving situation was strongly related to the support system that the caregivers perceived

The feeling of not having enough time to get a break from caregiving is another sub-category that the participants talked

about. These caregivers felt that caregiving to parents needs close attention and is a 24 hour duty. Nearly all of the participants in this study (13 participants) said that they were the main person in caregiving responsibility and never left their parents with others for days. Definition and supportive data examples of Deterioration of health, Petty conflict with care receiver, and Physical strain are presented in Table 17

Table 17

Category, Definition, and Data Exemplars of Deterioration of Health, Petty Conflict with Care Receiver, and Physical Strain

Category & Definition	Data Exemplar
Deterioration of health is defined as the worsening of caregiver's health status caused by being a caregiver.	Nowadays, I still have the feeling of pain. The doctor said that I have the problem of my bones. I think it might be that I carried my mother. (ID #10, L 916-919) My arms were hurt because I carried my mother by myself. I am now also old so the arms were hurt. I had to put on analgesic cream and took the medicine for pain. (ID #2, L 485-489) At that time she was very sick. I carried her up and down from her bed until I got the back pain. (ID #5, L 609-611)
Petty conflict with care receivers is defined as the disagreement or minor argument between the caregiver and parents.	We quarrel sometimes. I got angry and could not control my temper. She (the mother) also got mad at me even though she looks very quiet (now). (ID #10, L 428-431) My mother said something showed her sensitive feelings. That also made me upset. So I sometimes could not control my emotion and spoke out. I also felt hurt so I said to her "please stop complaining! I did everything for you. I know that sometimes it's not exactly right as she wants. Actually I'm not her favorite. She loves her sons most but never ask them to do anything. If anybody talked about sons in a bad way, she would protect them. Other people try to compromise by telling her not to scold me because I am the one who does everything for her! But she said that she did not scold, just complain. (ID #2 L 267-278)

Table 17 (continued)

Category & Definition	Data Exemplar
Physical strain (from tiredness and exertion of body and mind) is defined as the feeling of physical and mental exhaustion from the caregiving responsibility.	When my father was sick, I had to carry him on my back to see the doctor. I was so tired and very exhausted. I was nearly faint! It may be because I could not eat and not enough rest. (ID #13, L 446-452) I was irritable because I was so tired and exhausted. I sometimes feel very tired in the evening. I had no energy to do anything. I felt like I didn't have even energy to eat. I just want to lie down and sleep. If I lied down I would easily fall asleep because of the tiredness. (ID #12, L 540-541) The biggest problem that I faced is the feeling of tiredness. I am now aging and doing all these caregiving made me very exhausted. I felt I could do nothing. I just sit and cry. I cried a lot during the first stage of being like this. (ID #6, L 376-379)
Physical strain (from no day off) is defined as the feeling of not having enough time to get a break from caregiving	I never have a day off. Sometimes I want to relax at the seaside or go out to make merit with friends. That would be great. It might be once in a year. That's enough for me. (ID #1, L 602-607) I have been by her side every day! Never go anywhere or leave her (the mother) alone for nearly 6 months! (ID #14, L 389-391) I haven't been out of town for nearly 10 years. When I took the vacation I still be here, being at home with him (the father). I told my children or others to enjoy the trip and just supported them with some pocket money. I'm afraid that when something happened to him (my father) like he fell down, who is gonna take care of him if I were not home. That's why I decided not to go anywhere. (ID #15, L 415-423)

Stress. Stress is defined as the feelings of tension in the caregiving situation and responsibility and caregivers' anticipatory concern about parents' condition. Tension in the caregiving situation and responsibility refers to the caregivers' feeling of tenseness and pressure in their lives from their caregiving situation and responsibility. The caregivers (ID # 6 and ID #12) who told about their high level of tension in caregiving and responsibility usually stated they had no one with who to share their feelings or sources of emotional supports.

Anticipatory concern about the parent's condition refers to the caregivers' expression of their worry and concern about their parent's condition especially if they left their parents to be cared for by others. The caregivers who showed high level of stress related to anticipatory concern about parents' condition were cases ID # 1 and ID #13. Sub-categories and data exemplars of stress found in this study are presented in Table 18.

Table 18

Sub-categories, Definition, and Data Exemplars of Stress

Sub-category & Definition	Data Exemplar
Tension from caregiving situation and responsibility is defined as the caregivers' feelings of having tension and pressure in their lives from their caregiving situation and responsibilities.	I felt like everything in my life was so stressful. I even thought that I might break down some days because of this responsibility (caregiving). When the feeling of stress was nearly peaked I thought I was gonna be crazy. However, I could get through that tough time. That period of time is the most critical in my life. I was very tense and very discouraged. (ID #6, L758-765)
	Taking care of my mother and looking after my own family....all are my responsibility. It's very heavy. I don't have someone to talk to. No one to consult with. My sisters also have their own family and responsibility. She has several children of her own so she could not help me. Now it's nearly the beginning of the school term for my son and I still don't know how to get money to pay for his school. Everything is tense for me. (ID #12, L 864-890)
Anticipatory concern about parent's condition is defined as the caregivers' expression of their worry and concern about their parents' condition if the caregiver cannot be there.	I feel stress sometimes, when I have an important errand and no one can temporarily assume my responsibility while I am away. When getting out, again I often worry about my father that something wrong may occur to my father, or he might be wet. It's really stressful. It also makes me nervous and can't enjoy eating out. I will keep on watching my watch and keep telling myself that it's time to go back. That causes my stress. (ID #1, L 1349-1356)
	I'm worried about who is gonna take care of her if I were not here with her. She (the mother) needs someone to be with her and take care of her all the time. So, I decided not to be away from her because she is in need of help. (ID #10, L 967-971)
	I was not happy and very worried while I was out. I knew that he (my father) was in a serious condition....My thought and my mind were always occupied with my worry about him and his condition. (ID #13, L 578-584)

Feelings of guilt. Feelings of guilt is defined as the caregiver's feelings of own fault because of failing to give caregiving completely or behaving in an improper manner toward their parents. Caregivers told how they sometimes forgot or were remiss in some caregiving activities. The guilt about improper behaviors toward parents came from practices such as lying to parents, not giving a certain kind of care sometimes, or incompleteness of the care.

Social isolation. Social isolation is defined as the caregiver's expression of their feelings of disconnected or lack of social activities with their friends or group because caregiving responsibility consumed most of their time. Because the participants put parents as their priority, they cut other activities which were not important compared to caregiving the parent. Aneshensel et al (1995) used the term "role captivity" to describe when a person feels trapped or compelled to be and do one thing, while preferring something else. Role captivity from this viewpoint describes the caregiving role as an unwanted role. Caregivers feel they are obliged to assume this unwanted role. However, the caregivers in this study did not say that they were forced to take care of their parents. Some caregivers did mentioned that they had an obligation to repay their parents but viewed caregiving to parents as a way to fulfill their duty to the parents. So, generally, caregiving to parents in Thai culture is not an unwanted role for the children. But, they sometimes find it difficult to fulfill this role because of the limitations of their own resources, capability, support, and availability to assume the role. The two categories of Feelings of guilt and Social isolation and data exemplars are presented in Table 19.

Table 19

Category, Definition, and Data Exemplars of Feelings of Guilt and Social Isolation

Category & Definition	Data Exemplar
Feelings of guilt (from failure to give care completely) is defined as caregiver's expression of feelings of guilt because they did not provide some caregiving to parents.	I realized that sometimes I also fell asleep and was remiss about changing his clothes. This does not occur very often. I realized that I must change his clothes and look after him more closely because I know he still perceives everything. (ID #1, L 1108-1112) For the chest tapping, I accept that I do not do it to him very often. Nurses had taught me how to do it. This is my fault. I accept. The tapping is rarely done, I skip it. (ID #1, L 1446-1449)
Feelings of guilt (from improper behaviors to parents) is defined as caregiver's expression of realization that they sometimes behave in an improper way to their parents.	Like when I was so tired and feel that nobody helps or shares this caregiving responsibility, I said to my mother that I don't want to take this responsibility anymore. I will send her to live with my elder sister and won't pay attention to her. I said this to mother because I get angry that she did not listen to me. She called names of other people all day and I felt irritable. But, I would never do that to her. I just scold her because I want her to be quiet. (ID #12, L 700-706) I used a trick to take her back here. She still complains about this. I lied to her that she would be here for just a short period of time to get better treatment. (ID #13, L 224-229)
Social isolation is defined as the caregiver's feelings of being disconnected or lack of social activities with their friends or group because caregiving responsibility consumed most of their time.	I can not go anywhere. When my friends ask me to go out, I have to refuse them because no one will take care of my father. (ID #1, 215-218) My friend also asked why I did not find a job that can earn more than just washing and ironing clothes. She asked me to get out with her. But I couldn't do that. I told her that I couldn't leave my mother alone. Who will take care of her if I was not home? I have no time to go out. When I have to buy blue Chux pads or stuff for her I went for 2 or 3 hours and hurriedly come back home. That's the only time that I left her alone. (ID #12, L 1000-1010) Even though people asked me to go out to make merit, I still could not do so. Thus, forget about going out for fun or travel. I could not go anywhere. (ID #13, L 596-601)

Ambivalence in Caregiving Situation

The ambivalence in the caregiving situation is defined as the caregiver's feelings of uncertainty in their caregiving role. The caregivers were not sure about whether the caregiving for their parents was a merit or demerit. The caregivers stated that they sometimes feel proud and realized that they attained merit (*bun*) in taking care of their parents. On the other hand, they also had the feelings that they did the improper behaviors or their caregiving provided to the parents was not totally free of their emotional distress. This led to the feelings that they might attain demerit (*bap*) at the same time. Supportive data examples of Ambivalence in caregiving situation are shown in Table 20.

Table 20

Category, Definition, and Data Exemplars of Ambivalence in Caregiving Situation

Category & Definition	Data Exemplar
Merit or demerit is defined as the caregivers' feelings of unsureness about their caregiving to parents as merit or demerit.	I was very tense and very discouraged. I know I talked badly to her (the mother) because I felt angry that why it's me to take this responsibility. I blamed her a lot that my mother put this burden to me. It might be my sin in doing that. But, actually while I complained I never ignore or desert her. I always pay attention and am concerned about her. While I was sleeping, I would listen to her if she called me or wanted something. (ID #6. 765-772) I don't know it's the merit (*bun)* or demerit (*bap*) in doing this. Sometimes I heard she (the mother) complained she was unsatisfied with me. I realized that if I just did not pay attention or ignored her words, that would be a merit in giving care to her. But, it's difficult for me to control my emotion or be calm with that. I argued with her, which I know it might be my sin. (ID # 10, L 238-244) In giving care to my father, I realized that I may have sin/demerit (*bap*). Sometimes I know that my neighbors are so generous to my father. So they gave some sweets or confectionery to him everyday. Well, then the result of eating lot of sugar caused the problem to my father which I had to take responsibility. So, I decided to cut out the problem by hiding those sweets or pretend that I forgot to serve them to him. (ID #15, L 87-95)

Summary and Discussion

The effects of caregiving for frail elderly parents on families and caregivers emerged into three dimensions: 1) positive consequences of caregiving situation; 2) negative consequences of caregiving situation; and 3) ambivalence in caregiving situation.

The positive consequences were categorized as the caregiver's having happiness, sense of self-pride, recognition of praise from others, attainment of merit, feelings of being lucky, and warmth in their caregiving situation. The caregivers in this

study talked about the negative consequences of caregiving situation as frustration from conflict with other family members, burden, deterioration of their own health, emotional conflict with care receivers, physical strain, stress, feelings of guilt, and social isolation. Some key informants also expressed their feelings of ambivalence about their caregiving where they were not sure whether it was a merit or demerit. All of the caregivers in this study experienced the effects of caregiving for frail elderly parents in both positive and negative ways.

Numerous studies about family caregiving have been focused on the effects or outcomes of caregiving processes. Although voluminous research studies of research (Pearlin, Mullan, Semple, & Skaff, 1990, Young & Kahana, 1989) had focused on the negative consequences of caregiving situations, recently, there are increasing numbers of research studies about the positive aspects or gains in family caregiving (Archbold et al, 1990, Cartwright, Archbold, Stewart, & Limandri, 1994, Beach, 1997, Harris, 1998, Motenko, 1989).

Archbold et al (1990) described the quality caregiving as the enrichment processes which enhances meaning and satisfaction in caregiving to both caregivers and care receivers.

Harris (1998) studied sons' caregiving experiences and identified the positive outcomes of caregiving process. These positive outcomes of caregiving experiences are : 1) a chance to pay back their parents for their care; 2) a sense of purpose and personal growth; and 3) the importance of being a role model for their children. Cartwright, Archbold, Stewart, and Limandri (1994)

defined the positive aspects in family caregiving to frail elders as the enrichment.

The findings of this study are somehow different from the studies being done in Western culture. In the West, the positive aspects of caregiving are usually described as the caregivers' experiences in terms of positive outcomes for the self or personal views like self satisfaction, gratification, mutuality, increased self esteem. However, there are fewer positive outcomes that focus on social views which are more valued in a collectivistic society where people perceive themselves as parts of a social community or unit. In this study the participants expressed the positive consequences which occurred in their own self such as happiness, sense of self-pride, and warmth. In addition, there are positive consequences that were found in this study, but not mentioned in other studies. The recognition of praise from others, attainment of merit, and being lucky are the consequences that are influenced by societal values that suggest the dominant characteristics of collectivistic society.

Section V

A Conceptual Model of the Study

A conceptual diagram was developed to help visualize and chart the concepts and the relationships among them that were identified through the analysis. Concept charting is a display of elements or concepts that uses line drawings or other physical space or distance to denote relationships (Lofland & Lofland, 1995).

Figure 6 illustrates relationships among concepts as well as depicting different forms of network display related to the purposes of the study.

The central factor of the interest in the figure is the cultural value of *katanyu* and *katavedi*. This part of the figure illustrates the conceptual finding of Purpose #1 of this study. *Katanyu* and *katavedi* are cultural value factors that have direct effects on family caregiving in Thai families. From the figure, the two-way arrows show that *katanyu*, a sense of gratitude towards parents, and *bun khun* and denote how these two concepts are related and interact with to each other. For example, we can say that children have *katanyu* towards *bun khun of* parents. Likewise, we can say that because of the *bun khun* of parents, children feel gratitude to them. *Katavedi* denotes the obligatory actions done to pay back parents because of the *katanyu* that children have towards *bun khun* of parents. These three concepts are key factors suggesting that caregiving to parents in Thai families is still intact as a cultural value. In this study, the investigator found that there are three cultural contextual factors that influence

Societal-economic Factors

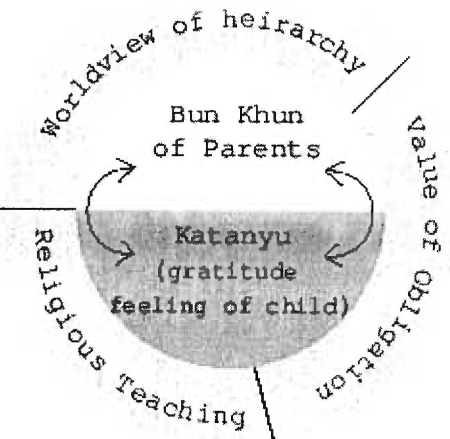
Relationships in Family
Quality of Relationships
Caregiver & Parents
Caregiver & Family members

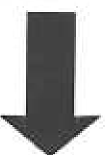
Caregiving Support System
•Caregiving Activity Support
•Financial Support
•Religious Support

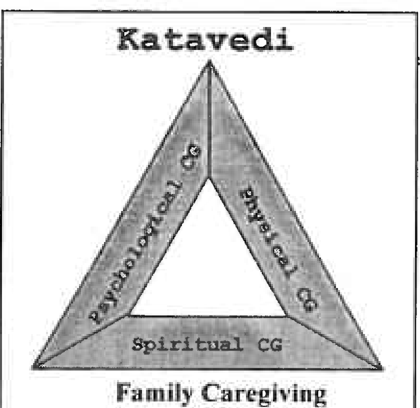
Financial Status of Family

Availability of Caregiver
-Single
-Homemaking
-Women's role

Cultural Value Factors







Consequences of Caregiving Situations

Positive Consequences
-Happiness
-Sense of self-pride
-Recognition of praise of others
-Warmth
-Attaining merit
-Feeling of being lucky

Ambivalence

Negative Consequences
-Frustration
-Burden
-Deterioration of CG's health
-Petty conflict with CR
-Physical strain
-Stress
-Feelings of guilt
-Social isolation

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Figure 6. Conceptual Model of Caregiving of Thai Families

how the concepts of *katanyu katavedi* still exist and strongly influences Thai society. These three factors are a) the hierarchical relationships in Thai society; b) the social value of obligation to parents; and c) religious teaching.

Family caregiving is found as a part of *katavedi* in paying back to parents. As depicted in the Figure 6 with the triangular structure, the family caregiving found in this study is categorized into physical caregiving, psychological caregiving, and spiritual caregiving. This part of the figure is the conceptual display related to Purpose #2 of the study.

Societal and economic contextual factors were depicted in the figure to conceptualize and describe the findings related to the Purpose #3 of this study. These include relationships within family: relationships between the caregiver and the parents and the relationships between the caregiver and other family members. Adequacy of the support system and financial status of the family are also important factors influencing the outcomes of caregiving situations.

Consequences of the caregiving situation found in this study consists of three dimensions: the positive consequences; the negative consequence; and ambivalence in caregiving situations. The positive consequences are categorized as: a) happiness; b) sense of self-pride; c) recognition of praise from others; d) attaining merit; e) warmth (of having their parents with them); and f) the feeling of being lucky. The negative consequences consist of a) frustration from conflict with other family members; b) burden; c) deterioration of the care giver's health;

d) petty conflict with care receivers; e) physical strain; f) stress; g) feelings of guilt; and h) social isolation.

The arrows between the relationships within family and consequences of caregiving situations indicate that the quality of relationships affects the consequences in the caregiving situation. It was found that the caregivers who expressed more positive relationships between themselves and their parents also expressed more positive consequences in their caregiving situations. For example, ID #1, ID #4, ID #11, and ID #13 talked more about their closeness, affection, and being together with their parents. The investigator found that the positive consequences in this group of caregivers were identified more often when they were compared to the caregivers who had less positive relationships with their parents. And, the caregivers (ID #6 and ID #10) who talked about negative relationships such as petty conflicts with their parents during the caregiving situations seemed to have more negative consequences during the caregiving episodes.

The relationship between the caregivers and other family members especially with other children is also an important factor that affected the caregiving consequences. This factor is closely related to the adequacy of support system perceived by the caregivers (as seen by the arrow linked in the figure). The caregivers who felt that they had good relationships with their sisters or brothers usually described the supports they received from their relatives as satisfying. Some caregivers in this study (ID #4, ID #8, ID # 11, and ID #14) were good exemplar cases of

having good relationships and having adequate support from other children. This resulted in reducing the negatives consequences in the caregiving situation, especially frustration from conflicts with other family members and feelings of burden.

Adequacy of caregiving support system and the financial status of the family directly influenced the consequences of the caregiving situation. The caregivers who felt that they got less support (caregiving and/or financial support) from other family members, expressed more negative consequences. When compared, the caregivers who had the same level of financial status and level of care demand but differences in perception of adequacy in support system (ID #1 and ID #8) differed in consequences. Caregiver (ID #1) who felt she got less support in caregiving activities had a higher frequency of negative consequences. In particular, the feelings of frustration from conflict with other family members, burden, and stress emerged as negatives for this caregiver. However, because of the small number of cases, conclusions from this need to be made cautiously. Religious support also plays an important role in influencing the consequences of the caregiving situation. In this study, it was found that half of the caregivers (ID #1, ID #4, ID #7, ID #8, ID #11, ID #13, and ID #14) had practiced some kind of religious practices or spiritual rituals as their support system. These caregivers who had support from their religious beliefs usually expressed more positive consequences. The religious support system acted like an outlet or buffer to reduce the negative feelings.

The financial status of the family also affected the consequences of caregiving. The caregivers in families (ID #12, and ID #13) that had financial problems showed high negative consequences in caregiving, especially stress.

The last aspect of societal and economic contextual factors found in this study is the availability of the caregivers. This factor includes the caregiver's being a homemaker, being single, and woman's role. The availability of the caregivers in assuming the caregiver's role is most often mentioned as the reason that the participants became the primary caregiver to their parents. Ten of the participants in this study were homemakers. They said that because they did not work outside their homes they were available to give care to their parents. Seven participants were not married and said that being single made them free from having responsibility for their own families. Nearly half of the participants (six caregivers) in this study said that caregiving responsibility tended to be the daughter's duty. They thought the daughters could provide better care to parents because of their caring nature and the woman's role.

CHAPTER V

IMPLICATIONS AND CONCLUSION

This chapter includes discussion of the following: 1) implications for nursing theory; 2) implications for nursing practice; 3) implications for nursing research; 4) strengths and limitations of the study; and 5) conclusion.

Implications for Nursing Theory

This study produces findings that provide empirical knowledge and understanding about family caregiving in Thailand. This information is useful for nurses and health care professional who work with Thai families in urban communities during the time of social and economic change. The findings also expand the knowledge of family caregiving in Thailand, while most previous studies have concentrated more upon nursing care or upon the social contexts of family caregiving. For example, the family caregiving studies done within the field of nursing (Kaewraya, 1997, Samanawan, 1994, Tepsiri, 1997) focused on the stress and burden of caregiving. Studies of caregiving outcome measurements were conducted using tools developed or modified from Western culture. The studies done in the field of sociology and population studies (Knodel, Chayovan, & Siriboon, 1991; Knodel & Debavalya, 1992; Knodel & Chayovan, 1997, Wongsith, Siriboon, & Entz, 1996) focused on broader views of socio-economic issues related to the support of the Thai elderly, such as living arrangements, material support, and social support. There are only two studies (Caffrey, 1992a, b) done by a nurse anthropologist that explored family caregiving from both the nursing and social perspectives. These two studies provided a

comprehensive picture of family caregiving systems in rural Thailand. None of these studies has yet described or developed the concept of family caregiving as a holistic process from the perspective of Thai families within their own culture.

Family caregiving process generally exists in every culture. This process has been studied and conceptualized as family caregiving theory by several researchers in western countries. Aneshensel, Pearlin, Mullan, Zarit, and Whitlatch (1995) viewed and approached family caregiving by focusing on the stress and the coping (adaptation) theory. Archbold, Stewart, Greenlick, and Harvath (1990) developed a conceptual model of caregiving which included: antecedent factors (characteristics of the caregiver, the care receiver, family, and caregiving environment); nature of the caregiving role; and outcomes of caregiving (for the caregiver, the care receiver, and the family. There are some similarities of caregiving that are universal concepts such as strain and burden in caregiving. Strain and burden have been found to be universal concepts in caregiving while other concepts of caregiving differ widely based on varied cultural practices and social values.

The findings of this study are unique to the Thai culture and the value it places on caregiving for one's parents. Because family caregiving is such an embedded long-term cultural assumption, Thai people may have taken the concept of family caregiving for granted. Making the cultural value of family caregiving explicit as an aspect of conceptual modeling is crucial for true understanding of caregiving in Thai culture. Often caregiving is assessed from social, physical, and/or psychological

perspectives but rarely from the perspective of cultural values and the impact and importance that they play in the caregiving role. The exploration of the cultural value of *katanyu katavedi* in relation to caregiving of Thai elderly parents is a new approach and is an example of looking at caregiving from a cultural perspective. This perspective adds an in-depth understanding and specific distinctions of caregiving in Thai culture, while identifying its differences from other cultures.

One important finding related to theories of family caregiving in Thai culture includes the concept of caregiving being an opportunity for the caregiver to become lucky and also as a way that one attains merit. This finding had not emerged in prior caregiving studies. This study also shows what a significant role and influence religion has within the Thai caregiving system. This includes spiritual caregiving which caregivers performed in the religious practices of merit-making, or sometimes praying and vowing for their elderly parents. There are some caregiving studies that discuss the spiritual care (Chang, Noonan, & Tennstedt, 1998, Neel & Kenny, 1998), however the examination of spiritual care in these two studies focused on the spiritual care of the caregivers. This type of spiritual caregiving is not the same concept as the spiritual caregiving described in this study which is the spiritual care for parents. There is one study (Li, 1996) that found family caregivers in the U.S. to be performing religious activities for the care receivers. Li found some caregivers in her study engaged in religious or spiritual

activities such as praying, reading the Bible or other religious writings to the care receivers.

Implications for Nursing Practice

Nursing Practice in Thailand

This study is also useful for public health nurses who visit families in their community settings of Thailand. It suggests that it is imperative for nurses to assess the family as a whole system, rather than focusing on only the nursing or physical care needs. It is crucial for public health nurses to effectively assess families or family caregivers which have problems or difficulties in their caregiving situations. Family caregiving is a complex system which includes several aspects and contextual factors. Nurses might want to help encourage caregivers to have a sense of self-pride in being a caregiver and doing well in their job, as part of positive consequences of the caregiving situation. This might make caregivers feel good about themselves. Nurses can be a support system to caregivers by being a consultant or a resource of knowledge about the care of the elderly. Nurses also play a role in helping find resources and solutions for families that face difficulties with societal factors and economic challenges, such as inadequacy of financial status or lack of support system. These factors appear to directly influence the consequences and outcomes of caregiving. Nurses may refer cases to social workers at local Health Centers. In Thailand, the government now attempts to help and provide health care benefits to low-income families by making available social welfare services within all public hospitals or health care services. Although, this might not solve the difficulty

in financial status of the families, it can help in reducing the families' expenses of direct health services or care supplies.

Public health nurses can also help the caregiver by being a facilitator for the caregiving support group. From this study it was identified that caregivers may need someone to share their feelings and caregiving experiences with. Up until this time there has not been a support group of family caregivers in urban Bangkok, Thailand. A support group would allow these caregivers to have chance to meet other people who are in their same situation. The public health nurses can facilitate a meeting for these caregivers and provide meeting locations such as the local Health Center. For the caregivers who have difficulty leaving their parents to join the support group, public health nurses should visit and closely assess the families in order to find strategies which appropriate to the families.

International Nursing Practice

This study is expected to be helpful for persons or health care professionals working with family caregiving in the US. and other multicultural western nations which need awareness of varied contextual caregiving concepts so to promote high quality care for pluralistic populations. The assumption that the dominant culture's values can be overlaid on populations that do not embrace them can be problematic. This information may help nurses understand caregiving practices with in the Thai immigrant populations as well as for non-Thai Buddhist Southeast Asian immigrant people such as Laotian.

Policy for Practice

The policy implications from this study are very important. The Thai government has publicly tried to promote family caregiving, however, there is no concrete governmental strategic planning to assist these families caring for their elderly parents. Although the Thai government has tried to help poor families by providing free health services for low-income patients in public hospitals, all the expenses of care such as medicines, medical supplies still have to be paid by the families. This is becoming even more of a concern as the Thai population ages which is happening at a rapid rate. Moreover, the economic crisis in Thailand has made financial difficulties for millions of Thai families, affected by job-cuts, lay-offs, and shrinking incomes. This will directly influence the families by increasing the negative consequences of caregiving if the families have frail elderly parents to be cared for. All fifteen caregivers in this study said that they can cut other costs or expenses to preserve money to spend for caregiving for their parents, nonetheless, economy was still a critical issue in some cases. It is vivid that the social cultural value of *katanyu katavedi* to elderly parents strongly supports the principle of family caregiving in Thai families. From this study's findings, the supports that the caregivers received came from their own families and sometimes the community. This study also provides information about caregiving practices, factors that influence caregiving, and the family consequences of the caregiving situation. This information is expected to help policy makers identify others support system to help caregivers such as home health care services by the

governmental agencies. Any kinds of services or programs which might promote or support societal-economic contextual factors such as projects to encourage positive relationships within family or to advocate caregiving support sytem for caregiving in family might be considered and implemented.

Interviews with caregivers revealed that public health nurses from the Health Centers had visited and helped these families in their communities, but the interventions offered by public health nurses were not perceived as particularly useful or supportive by the 15 families interviewed. In order for the public health interventions to be more useful and supportive, assessments should be made considering the family caregiving situation as a whole. This would mean using the inductively derived factors deemed important in caregiving and thus determining the positive or negative consequences. Some of the factors influencing the positive or negative consequences are not open to change or adaptation (such as relationships in family), however, many of them (such as support system--emotional support, caregiving support, or the social cultural value factors) could be influenced. For example, a public relations campaign that promoted and supported the social cultural value of *katanyu katavedi* and family caregiving would be very positive. This would help to reinforce and sustain the value of *katanyu katavedi* and caregiving to the elderly within the society. Recently, the public media of television and newspapers have taken occasional opportunity to publicize and honor children who have devoted themselves in taking good care of their parents. The government could strengthen the importance of the social cultural

value of *katanyu katavedi* and caregiving to the elderly by awarding a prize for a child or children who take good care of their elderly parents. (Currently in Thailand, a similar event takes place every National Mother's Day (August 12th), when there is a ceremony to award and honor mothers selected from all over the country who are deserving of the recognition as an "ideal mother" or the "honorable mother"). Government might also consider decreasing the taxes or providing some kind of social benefits or incentive such as receiving free health care services for children who care for their elderly parents.

Some other Asian countries are also trying to promote and maintain caregiving for their elderly population through the venue of family caregiving. In Korea, a "Filial Piety Prize" is awarded to individuals whose long standing service represents their outstanding respect and care to the elderly parents (Sung 1990). The Singaporian government also uses the media to emphasize filial duty to parents. They also use legislative initiatives to persuade and promote three generation families to live together by offering such families more desirable housing units (Mukerjee, 1982 cited by Ingersoll-Dayton & Saengtienchai, 1997).

Implications for Nursing Research

Much of the previous research of family caregiving has come from Western nations. Yet now there is a growing body of research that explores caregiving in non Western contexts and internationally. This qualitative, inductive study is based on the Thai context and helps to explicate family caregiving in Thailand so that it may be understood by the international caregiving

research community. This study will also be useful for researchers and scholars interested in caregiving issues in Thailand. The typical findings of this study (such as being lucky, attaining merit, sense of self-pride, spiritual caregiving, and cultural contextual factors of religious teaching that are so grounded in Thai way of life) may be useful for researchers who would like to do studies about Thai family caregiving but cannot find the concept developed from a Thai perspective. The conceptual model of this study might be useful or gives idea for these researchers.

To strengthen and confirm the research in completing the model of Thai family caregiving, there is still a need for further research about caregiving for the Thai elderly people by studying more specific areas. Quantitative or measurement studies might be designed to examine the relationships of support systems and/or relationships within family to the consequences of the caregiving situation. For example, using measures and multiple regression, a researcher may explain how and why support systems (caregiving support, emotional support, and financial support) have effects (the mediator effects) on the consequences of caregiving situation. (Or do the study to specify the certain effects (moderator effects) of the financial status of the family on the consequences of the caregiving.

Studies of Thai family caregiving need to include a wider range of caregiving families, a more inclusive sample or different settings such as the family caregiving in rural area of Thailand are also needed to be further explored. Caffrey's (1992a, b)

studies were done to explore the family caregiving in rural areas of Thailand, however, the studies had been done a decade ago.

Comparative studies to see the similarity and differences of the concept of family caregiving for the elderly parents in different Asian cultures such as Thai, Japanese, Chinese, Korean, Vietnamese would also be an interesting issues to be studied. This group of cultures used to be viewed as the Asian culture/collectivistic cultures, however some similarities and dissimilarities among these cultures could be identified.

The collaborative research with interdisciplinary team is another option for future research that would expect to yield comprehensive understanding of the caregiving phenomena in Thailand. The family caregiving for the elderly people is a complex issue and combines with several aspects (e.g., sociology, nursing, psychology). The research with multidisciplinary team would make the findings both in-depth and inclusive.

Further development of nursing intervention, such as a study or a research and development (R & D) project to add support systems for caregivers, may be considered as an action research in the future. Through collaboration with Health Centers of Metropolitan Bangkok, this project might be initiated by co-ordinating with 4-5 Health Centers, recruiting the caregivers from the communities that are under supervision of these Health Centers, and organizing meetings at one Health Center. The researcher jointed with the public health nurses may collaborate and develop the program of doing focus groups, support groups, educational

refresher course, and follow up home-visiting by the team of investigators

Strengths and Limitations

Because this study used qualitative methods, it allowed the investigator to come to an understanding of the Thai context of caregiving from the inside out. Data were gathered from the voices of people involved, and from within the family caregiving setting. This allowed for new notion definition of caregiving to emerge from the families themselves rather than validating an already existing framework. For example, when examining consequences of the caregiving situation, "being lucky" and "attaining of merit" are non-Western notions, information about these would not have been found using a quantitative study developed from a western conceptual model.

Another strength has to do with the principal investigator's U.S.educational experience and consequent sensitization to Western society's emphasis on the individual's rights and differences. These experiences caused the investigator to look at and be aware of her own Eastern cultural values and practices from an "outsider's" perspective, encouraged exploration and comparison/contrasts of those values with those of a more individualistic culture. Hence, values specific to Thailand stood out in sharper contrast and were more apparent than being taken for granted and secondary.

By using the qualitative methods of interviews and observations, achieving prolonged engagement, and building trust between the investigator and the caregivers, the researcher was

able to get the in-depth information which was had not been found in other studies. A thick description of data in this study was also achieved based on in-depth interviews and participant observations. Triangulation was achieved by using multiple data collection strategies such as different methods of formal/informal interviews and observation, different visiting times to see family interactions. Multiple sources of data and additional materials were also applied in this study such as interviews with three Thai scholars of Buddhism, Thai linguistics, and Thai studies; photographs of the families; informal interviews with friends or neighbors of the caregivers.

The adequacy of data obtained is another strength of this study. The purposive sampling to recruit the adult children who take the role as primary caregiver was successfully done with help from the public health nurses of the Health Centers. These 15 families were very informative and represented diverse in aspects and characteristics of their caregiving situation and experience. These aspects represented differences in family financial status, caregiving support systems, family structure, and individual characteristics of caregivers and care receivers. This helped to achieve variability of cases and is useful for the comparisons among cases. Consultations with two Thai experts in Anthropology and Public Health Nursing, as well as the additional interviews with three Thai scholars (in Buddhism, Thai linguistics, and Thai studies) helped to confirm the rigor of this study.

The thoroughness of data focusing and analysis was achieved by peer debriefing (by two Thai consultants and three Thai graduate

nursing students), investigator's field notes, memos, and audit trail. The development of preliminary findings and thoughts, diagrams of coding categories and sub-categories, and the developed conceptual models were done and shared to confirm and get feedback from the dissertation committee throughout the analysis.

This study is considered to be a study which is extremely timely for the contribution of the aging population in Thailand. The findings may conduce information useful for the governmental policy regarding Thai elderly caregiving in the future.

There are some limitations found in this study which will be discussed. First, this study took place in central Bangkok which is the most urbanized area of Thailand and is heavily influenced by social and economic changes. Thus, the caregiving for elderly parents in rural area is likely be somewhat different. The study of family caregiving for the elderly in rural Thailand by Caffrey (1992a, b) showed some differences from this study. Caffrey found health status of the elderly parents in her study were mostly good or excellent. Almost all of these elderly parents did not require intensive care from their family members. She also noticed that poverty, difficulties in accessing to the health care services, and limitation of medical care resources are some problems that found in her study (R. A. Caffrey, personal communication, April 9, 1999). This may account for the difference of the severity of care receiver's condition between the rural and the urban Thailand environment. Caffrey (1992a) concluded that the elderly people in rural areas who are relatively healthy can survive. When these elderly become frail or ill and totally dependent, they usually

live to be cared for by their families for short period of time, then die.

The second limitation of this study was the generalization of the findings of this study to family caregiving in diverse settings. Like most qualitative research, the purpose of this study was to explore, describe, and present a detailed view of the topic of interest in a particular setting rather than to produce and to generalize the outcomes.

Another limitation of this study was the validation of the hypothesis developed from the findings. For example, the hypothesis that the investigator developed from her analysis "improved caregiving support systems will produce less negative consequences in the caregiving situation" still needs to be validated. The validation of hypothesis, instrument development, and eventual measurement of this will need to occur. This study allowed for conceptual exploration and for a "big picture" analysis of caregiving context for a limited number of Thai families living in Bangkok, but support for the hypothesis will require further studies.

Conclusion

Social cultural value of *katanyu katavedi* is the core of maintaining caregiving for Thai elderly parents. The cultural contextual factors of <u>hierarchical relationships between parents and child</u>, <u>social value of obligation</u>, and <u>religious teaching</u> are very deeply grounded in Thai culture. These cultural contextual factors play important roles in guiding Thai children to take care of their aging parents. It was found in this study that all

caregivers still valued *katanyu katavedi* as an important social cultural value that they adhere to.

Caregiving provided by children for their frail elderly parents are physical caregiving, psychological caregiving, and spiritual caregiving. Because this study focused on frail elderly parents, it was found that the majority of caregiving is focused around physical caregiving.

Relationships within family; caregiving support systems such as financial support, caregiving activity support, and emotional support; availability of the caregiver and financial status of the families are also important as societal-economic contextual factors that influence caregiving. These societal-economic contextual factors directly affect the consequences of caregiving situations. The consequences of caregiving situation found in this study are positive consequences, negative consequences, and ambivalence in caregiving. It was found in this study that the tension from financial status increase negative consequences on caregiving. Less supports or resources increase negative consequences among the caregivers. The caregivers might feel more negative consequences although the positive consequences (sense of self-pride, attaining of merit, being lucky, recognition of praise from others) help to balance the consequence findings, but these may be not enough if the caregiving support systems or financial status is inadequate.

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Concept name	Study by, year/ (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial responsibility expectations (FRE)	Seelbach, 1980 (Sociology) 595 elder's data was selected from data of the larger Aged Services Project/ a descriptive correlational study using data from interview and scale questionnaire	Filial responsibility refers to adult offspring's obligations to meet the various needs of their aging parents. Filial responsibility expectations are level of expectancies which the older parent has regarding the duties or obligations of their offsprings which include: -live near -take care when parents are sick -give financial help -frequency contact (visiting, writing)	•no significant differences in FRE among elderly Black and White •female elderly more likely than male prefer to live with their children •FRE in aging parents inverse associate with morale (morale ↑ -> FRE ↓ morale ↓ -> FRE ↑)	U.S.A.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial responsibility expectations	Blieszner & Mancini, 1987 (Family studies) 25 parents of adult children / an exploratory descriptive study using focus group method	FRE include more abstract meanings of affection, thoughtfulness, and opened communications between parents and children	•parents's expectation of children centered on affection, assistance, respect, responsibility, and open communication. •desired relationships with adult children were characterized by warmth, sharing, affection, and avoidance of direct interference in each other's lives. •opened communication includes discussion about future in case of medical emergency, long term care preference, funeral arrangement	U.S.A.

Concept name	Study by, year/ (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial responsibility expectations	Lee, Netzer, & Coward, 1994 (Sociology) 387 elderly parents/ descriptive correlational study using telephone survey method	FRE are the extent to which adult children are believed to be obligated to support their aging parents Filial responsibility expectations is measures by 6-item scale which are: -shared activity -live nearby / visit -live close so be able to help each other (exchange/ reciprocity) -sacrifice and support aging parents -parents are entitled to some return of their sacrifice to their children	Based on the intergenerational solidarity concept (Bengtson & Roberts, 1991) •parents' resources (education, income, and health) are negatively related to FRE but positively related to aid given to children •parent's FRE do not effect help received from children •FRE are positively related to aid given to children	U.S.A.

Concept name	Study by, year/ (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial responsibility	Novero Blust, & Scheidt, 1988 (Family Studies) 40 dyads of elderly widows and their primary caregivers in urban and rural areas of Philippine/ descriptive comparative study using structured interviews	Filial responsibility means the responsibility for parents exercised by children. This includes expectations for care and support of parents. Actual filial behaviors in this study are: -financial and material aid -personal care (sick care, grooming, dressing, bathing) -service provision (laundry, food preparation, shopping, house cleaning, escorting) -respect (consulting and listening) -warmth and affection (gift giving, visiting, touching, hugging)	The pattern of filial expectations of widow mothers and daughters are similar. •respect is expected more than other types of support •warm and affection ranked second follows by instrumental types of support •daughters' filial expectations of providing financial and material aid, personal care, services, and warmth & affection are higher than their mothers expected from them •for the actual behaviors, daughters report providing more personal care than their mothers report receiving	Philipp-ine

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Shared filial responsibility	Matthews & Rosner, 1988 (Sociology) 50 pairs of sisters who take care of their old parent (aged over 75 yr.)/ exploratory descriptive study using face-to-face interviews and telephone interviews	Filial responsibility is the shared and organized of providing adequate care among adult siblings to meet the needs of elderly parents. It is not specific responsibility of caring to parents by one family member	•styles of filial activity partici-pations of family members vary from -routine (regular assistance) -backup (provide support or services when were asked) -circumscribed (participation in specific assistance that is highly predictable but carefully bounded) -sporadic (provide services at their own convenience) -dissociation (could not count on any assistance) •factors affected style of participation in filial responsibility are: family structure; family history, and extra familial ties	U.S.A.

Concept name	Study by, year (discipline)	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial obligation	Albert, 1990 (Anthropology) 70 caregivers who take care of the impaired parents/ exploratory descriptive study using semi-structured interviews	Caregiving is identified as the repayment of a debt to the parent or to caring someone who is considered a part of oneself. Obligation in caregiving to the elderly parents is influenced by the combination of caregivers'view of parents'dependency and their commitment to care Caregiving system is described as -caregiving as a return to one's parent -caregiving as caring for a part of oneself -the impaired parent as an ill person -the impaired parent as a child	•two main groups show specific characters of caregiving culture: •caregivers who see their caregiving as a repayment are more likely to see parents as ill or declining •caregivers who view their obligation as caring for part of oneself or as a connection of physical bonding are more likely to see parental dependency as caring for a child (role reversal)	U.S.A.

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial obligation	Cicirelli, 1993 (Psychological Sciences) 78 caregiving daughters (who provided care at least 10 hr to their elderly mothers)/ descriptive correlational study using interviews-questionnaire	Filial obligation is based on socialization to a cultural standard or expected socially responsible behaviors in response to elderly parents' dependency . Filial obligation in Cicirelli's concept is assessed by the feeling reflects global statement of general cultural norms about obligation to help.	•filial obligation and attachment are motives related to caregiving behavior in children to their parents. •high level of attachment and high level of obligation does not directly affects on high level of caregiving •degree of parent's dependency is more accounted for portion of help •filial obligation has a significant effect on burden (the more feeling of obligation, the more feeling of burden)	U.S.A.

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial attachment	Cicirelli, 1983 (Psychological Sciences) 148 adult children with living elderly mothers/ descriptive correlational study using interview-questionnaire	Filial attachment is an internal feeling that parents and children feel for one another. It is the propensity or tendency for psychological closeness and contact. This feeling leads to attachment behaviors which include residential proximity, frequent visits, letter writing and caregiving. Four basic aspects of attachment are: feelings of love, feelings of security or comfort, distress on separation, and joy on reunion.	•filial attachment directly affects adult's child commitment to provide helps to elderly parent •filial attachment has an indirect effect on burden (high level of attachment decrease the feeling of burden) •affection is an indicator for attachment but is not the same concept nor a direct measure of attachment •attachment behaviors of adult's child to the parent are influenced by parental dependency	U.S.A.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Intergenerational solidarity	Bengtson & Robert, 1991 (Sociology) 363 pairs of elderly parents and middle-aged adult children/ descriptive correlational study using interview-questionnaire	Intergenerational solidarity is a concept to explain and characterize relations between elderly parents and adult children which derived from social theory. The intergenerational solidarity has six components of solidarity which are: -associational -consensual -affectional -functional -normative -structural	•five components of intergenerational solidarity reflect behavioral, affectual, and cognitive orienta-tions of family members relations. These five components are: association or contact, -affection or emotional attachment -consensus or agreement -function or patterns of instrumental support or resource sharing -norms or familism or expectations of obligations to the family •the sixth component, structural solidarity reflect structure of family such as number of family members, proximity	U.S.A.

Concept name	Study by, year (discipline)	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial Piety	Kim, Kim, & Hurh, 1991 (Sociology & Anthropology) 617 Korean adult immigrants in Chicago/ exploratory descriptive study using questionnaire	Filial piety is a virtue of cultural norms in Confucian for child (especially a married son and his wife) to deeply commit or follow traditional expectations in providing the normative obligation to parents by: -physical care -social-psychological comfort -respect and consult -honoring and glorifying parents -faithful observance of important ceremonies	•changing of socio-economic conditions faced by Korean immigrants caused strain especially among elderly parents and child relationships •traditional expectation of filial piety are suggested to be modified by -more flexible -not only responsibilities of one son (should be shared by all siblings) -mutual understanding and join decision between parents and children	Korean immigrant in the U.S.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial piety	Tsai, 1997 (Nursing) 6 immigrant Chinese young adult children/ exploratory descriptive study using ethnographic interviews	Filial piety means duties or expectations of children to oblige to parents by: -support parents either financially or morally -continue the family line -obey and respect -self-sacrifice -attend parents all the time especially when parents are old or sick -honor parents and ancestors	•parents and children are interdependent. Children depend on their parents in childhood; they rely on their children in old age •parents and children have particular obligations for their roles; parents are obligated to raise their children once they are born. Children are expected to obey, respect, support, and make parents proud. •parents who fail to fulfill their obligations lose their privileges in receiving the obligation from children. The privilege can transferred to others who take over the defined parent roles.	Chinese immigrant in the U.S.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Filial motivation	Sung, 1994 (Social Work) American data of 203 primary caregivers caring for their older relative Korean data of 226 primary caregivers caring for their elderly parents/ descriptive comparative study using interview method	Filial motivation means the motivation reflects the adult children's willingness to care for their aged parents. The willingness reflects the values prevailing in society. Korean's filial motivation are categorized as: -respect to parent -filial responsibility -care with sacrifice -filial sympathy -harmonization of family -compensation for unaccomplished family matters -desire to repay -religious belief -love of parent	•American respondents identify the three major motivations of filial behavior are obligation, affection, and reciprocity; Korean respondents identify repayment, respect, responsibility, family harmony, and sacrifice. •filial motivation in Korean culture reflects the moral ideal of reciprocity toward parent and child through out the life long relationships	Korean families & American families

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Reciprocity	Stoller, 1985 (Family studies) 753 elderly persons/ exploratory descriptive study using in-depth interviews)	Reciprocity is defined as the exchange of assistance between elderly and informal helpers (children relative, friends, and neighbors)	•the elderly report reciprocity in exchange with their children is the most frequent (about one-third) followed by relatives and friends and neighbors •elders who provide help are more likely to be women with less problems of activity limitation •failure to provide help according to physical limitation has a negative effect on elders' morale	U.S.A.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Mutuality	Hirschfeld, 1983 (Nursing) 30 demented elderly and family caregiver dyads/ exploratory descriptive study using grounded theory method	Mutuality in caregiver is the caregiver's ability to find gratification in the relationship with impaired person and could perceive reciprocal between self and the dement.	•mutuality, rather than sociodemographic or impairment variables, influenced the decision to institutionalize. •management ability, morale, and tension correlated strongly with mutuality, and also contributed to the decision to institutionalize. •caregivers who reported high levels of mutuality could tolerate caregiving for a demented longer than caregivers who had low level of mutuality	U.S.A.

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Mutuality	Archbold, Stewart, Greenlick,& Harvath, 1990 (Nursing) 78 dyads (care receiver and primary caregivers)/ descriptive correlational study using interview method	Mutuality is the positive quality of the relationship between a family caregiver and a care receiver. Mutuality comprised with four dimensions: -love and affection -shared pleasurable activities -shared values -reciprocity	•higher level of mutuality and preparedness in caregiving are associated with lower level of caregiver role strain (in aspects of strain from direct care, increased tension and global strain) •mutuality does not reduce strain from economic burden or lack of resources and also does not ameliorate strain from worry	U.S.A.

Concept name	Study by, year (discipline) method/ sample	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Reciprocity	Carruth, 1996 (Nursing) 303 adult children who provides care to their elderly parents/ methodological study to test and develop Care Reciprocity Scale using interviews and tool test-retest	Reciprocity is an intergenerational exchanges of assistance and support between an adult child and parent. Four constructs of reciprocity scale are developed which are: -warmth and regards (expression of esteem, gratitude between caregiver and care recipient) -intrinsic rewards of giving (reflect caregiver experience rewards by performing the act itself) -love and affection (reflect feeling of love and appreciation) -balance within family caregiving (reflect balance between caregiver and family member)	•demographic data does not influence the differences in level of reciprocity but in-law relationship might affect (significantly higher reciprocity score of caregivers of parents than in-law mother)	U.S.A.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Intergeneration Caregiving	Bowers, 1987 (Nursing) 27 parents and 33 offsprings/ exploratory descriptive study using grounded theory method	Caregiving activities is distinguished by the purpose or meaning attributes to behaviors rather than by the nature or demands of the behavior itself.	•five categories of caregiving are defined as: -anticipatory caregiving (behaviors or decisions based on anticipated or possi-ble needs of a parent) -preventive caregiving (prevention the parent from illness, injury, complications) -supervisory caregiving (observation the situation where identifiable care might be given to a parent) -instrumental caregiving (hands-on caregiving such as doing for, assisting, providing, giving) -protective caregiving (protection parent from consequences that could not be prevented)	U.S.A.

Concept name	Study by, year/ (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Caregiving involvement	Horowitz, 1985 (Family Studies) 131 adult children identified as primary caregivers for frail elderly parents/ descriptive compparative study using structured interview method	Caregiving involvement was defined as the objective level of time and task (assistance) providing to the older parent. Caregiving type of assistance are defined as: -escort/ transportation -household chores -meal preparation -errands/ shopping -personal care -health care -financial management -linkage -financial support -emotional support	•çaregiving is primarily the role of daughters and daughters-in-law; sons tend to take on the role as primary caregiver when the female sibling is unavailable •daughters are significantly more likely to help parents in "hands-on" assistance, such as transportation, household shores, meal preparation, and personal care •sons tended more involving in financial management, financial assistance,and dealing with bureaucratic organizations	U.S.A.

Concept name	Study by, year (discipline) sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Family caregiving	Hasselkus, 1988 (Occupational therapy) 15 family caregivers/ exploratory descriptive study using ethnographic interview method	The meaning of family caregiving from perspectives of caregivers are defined as: -sense of self -sense of managing -sense of future -sense of fear and risk -sense of change in role and responsibility -tensions	•five themes of the meaning of caregiving of this study reflect the invisible works from caregiver's framework. -sense of self shows caregiver's concerning of self, personal capabilities and feeling of personal causation -sense of managing means the caregiver's feeling of get every-thing done or undercontrol -sense of future is the feeling of caregiver's uncertainty for the future of caregiving situation -sense of fear and risk refers a fear of change or anything which might cause a change	U.S.A.

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Family caregiving (cont.)	Hasselkus		-sense of change in role and responsibility shows the feeling of distancing and uncertainty in role and relationships between caregivers (CG) and care receivers (CR) -tension shows the tensions among the CG and CR caused by the caregiving situations -relationships between CG and health professionals are described in two different meanings: sense of caregiver's managing to modify the health professionals' instruction; adjusting between the cost of certain recommendations and values to the concept of wastefulness and CG's modification	

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Family caregiving systems	Keith, 1995 (Sociology) 31 families which have sons or daughters providing care to their cognitively impaired mother/ exploratory descriptive study using grounded theory method	Caregiving systems are defined in three types: -primary caregiver which one family member carrying all or most of the caregiving responsibility -partnership is the caregiving system when two offspring contribute relatively equitably to the CG work (both are equal in authority, responsi-bility and making, implementing decisions) -team is not very specific how tasks are apportioned among the offspring. Offspring perceived themselves to be organized in a planned and inte-grated manner in CG	•size of the family and its gender composition, and values characteristic of the family contribute to development of its CG system. •factors such as employment status and geographical location also explain the caregiving arrangements •almost all of the samples are primary system, only one family exhibited a team system •values hold by the family are also factors contributing CG systems. These values are: -justice refers to allocation of tasks and authority on basis of criteria such as gender, geographical	

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Family caregiving systems (cont.)	Keith, 1995		proximity, and weight of competing responsibilities -affiliation is defined as a motivating value which is particular powerful in explain allocation of the primary CGrole -equity is the prominent theme from partnership CG system which is committed to equitable contributions, sharing participation among partners -emotional protection is the predominant motive in the team system. This value is defined as each sibling do his/ her part in order to prevent any sibling's excessive exposure to mother's demands or criticisms	

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Caregiving role	Archbold, Stewart, Harvath, & Lucas, 1986 (Nursing) 50 spouse caregivers/ exploratory descriptive study using structured interviews	Nature of caregiving role is defined by the amount and type of direct and managed care performed by the caregiver to the care receiver Amount of direct care are: -personal care -house keeping -protection -transportation -behavior problems -financial, legal & health decisions -medically related -little extra -managed care	•viewing caregiving as a role which described in relation to which tasks or caregiving activities done by caregivers •personal care activities e.g., feed, assist bathing, clean incontinence, brush teeth, assist dressing, help during nights, check skin, help toilet, assist hair care •house keeping activities e.g., prepare meal, change linens, do housekeeping •protection activities e.g., assist walking, keep one eye on, protect falls	U.S.A.

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Caregiving role	Archbold, Stewart, Harvath, & Lucas, 1986 (Cont.)		•transportation activities e.g., do shopping, accompany shopping, take to medical appointments, take to other places •behavior problems handle e.g. handle crying, paranoid, aggression, wandering; listen repetitive question, remind who & where •medically related activities e.g., assist in medication, handle pain •little extra activities e.g., sit spend time, participate leisure time, hold hands •managed care activities e.g., find out services, get services, managed services	

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Caregiving in rural Thailand	Caffrey, 1992 (Anthropological Nursing) 39 female caregivers in rural area of Thailand/ exploratory descriptive study using interview method	Caregiving is a cultural phenomenon occurring within the context of shared norms, values and belief. Filial obligation focusing on the concept of "parent repayment" which is the part of Buddhist teaching plays an important role for caregiving in Thai culture Motivations for CG were identified as: a) fulfilling the expected cultural norm of filial obligation b) love or affection to the elders c) a desire to reciprocate for past services and to build up future merit for themselves.	•levels of caregiving are described in 4 levels: -Level I-the elder retired from works, role of head of household bust still help family in household activities -Level II-the elder stopped assisting household activities -Level III-the elder became ill or frail and need more caring assistance from family members -Level IV-the death of the elder, family arranged appropriate funeral •caregiving activities included common household activities e.g., cooking, doing laundry, financial support, cleaning, bedding, and emptying	Thailand

Concept name	Study by, year discipline sample/ method	Definition of concept	Findings/ important issues	Cultures/ national groups in which the concept has been applied
Caregiving in rural Thailand (cont.)	Caffrey, 1992		chamber pot •only two elders of this study needed intensive Level III care which included bathing, dressing, assisting with eating, careful monitoring •the CG activities if the elders became ill are: -obtaining medicalcare -buying medicines and administering them to the elder regularly -providing personal care e.g., bathing, staying up at night to take care or sleep nearby, cooking special foods, dressing, bedding, emptying chamber pot, giving special medical treatments such as dressing wound -arranging appropriate Buddhist healing ritual	

APPENDIX B

ADL and IADL Assessment Tool

ADL and IADL Assessment Tool

Activities of Daily Living (ADL) **Family CaseID#______**

Activities	Independent	Dependent	
Bathing			•Initiation of bath •Type of bathing (shower, bedbath) •Bath preparation •Ability to wash self •Hair washing
Dressing			•Clothing selection •Puttng on garments •Fasten bottons,etc. •Approriateness of attire •Undressing •Laundry
Transfer			•From bed to chair •From chair to standing
Toileting			•Able to find bathroom •Able to use toilet appropreiately •Hygiene
Bowel/Uninary continence			•Frequency and control •Constipation •Incontinence
Feeding			

Intrumental Usual Activities of Daily Living (IADL)

Activities	Alone	Assist	Never	No longer	
Telephone					•Look up number •Dial
Medication					•Preparation •Taking
Outside of home					•Organization •Getting lost
Driving					
Houseworks					•Organization •Doing (list what able to do)
Food preparation					•Planning •Shoppping •Preparing
Finances					•Banking •Paying bills
Shopping					

Note: Modified from Ebersole, P. & Hess, P. (1994). Toward healthy aging: Human needs and nursing response. St.Louis, MO: Mosby.

APPENDIX C

Description of Participatory Families

Family ID # 1

Information:

Family ID # 1: is a Thai Buddhist nuclear family whose members are a frail elderly father age 74 and a 72 year old mother who is considered to be the head of the family since her husband is in a frail state. This couple has ten adult children which includes six sons and four daughters. Currently, the couple lives in their own home with their unmarried sons and a daughter (the informant) who is also single. Three daughters in the family are married and live elsewhere with their own families as well as the two oldest sons. The mother continues to provide the living expenses of the household.

Family caregiver (the key informant): is the unmarried daughter who lives at with her parents. She is their fourth child and is 42 years old. She is college educated and has a higher certificate in education. For the past seven years she has taken the role of primary caregiver of her father. She has no other job, however she occasionally is given some money from her mother when her mother has sold some of the family property.

Care receiver (the father): A frail 74 years old man who is unconscious due to the head injury that occured seven years ago after falling off a ladder. He also had to have a brain surgery at that time. He now has a tracheostomy tube, gstrostomy tube for gavage feedings. His right leg was amputated below the knee and he has stiffness in the left knee. Cachexia ia also present. He is completely dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly father. She takes all the responsibilities in caregiving activities for ADL such as feeding, bathing, toileting, position changing. Her mother helps in the preparation of blendarized diet for feeding however she is not involved in other caregiving activities.

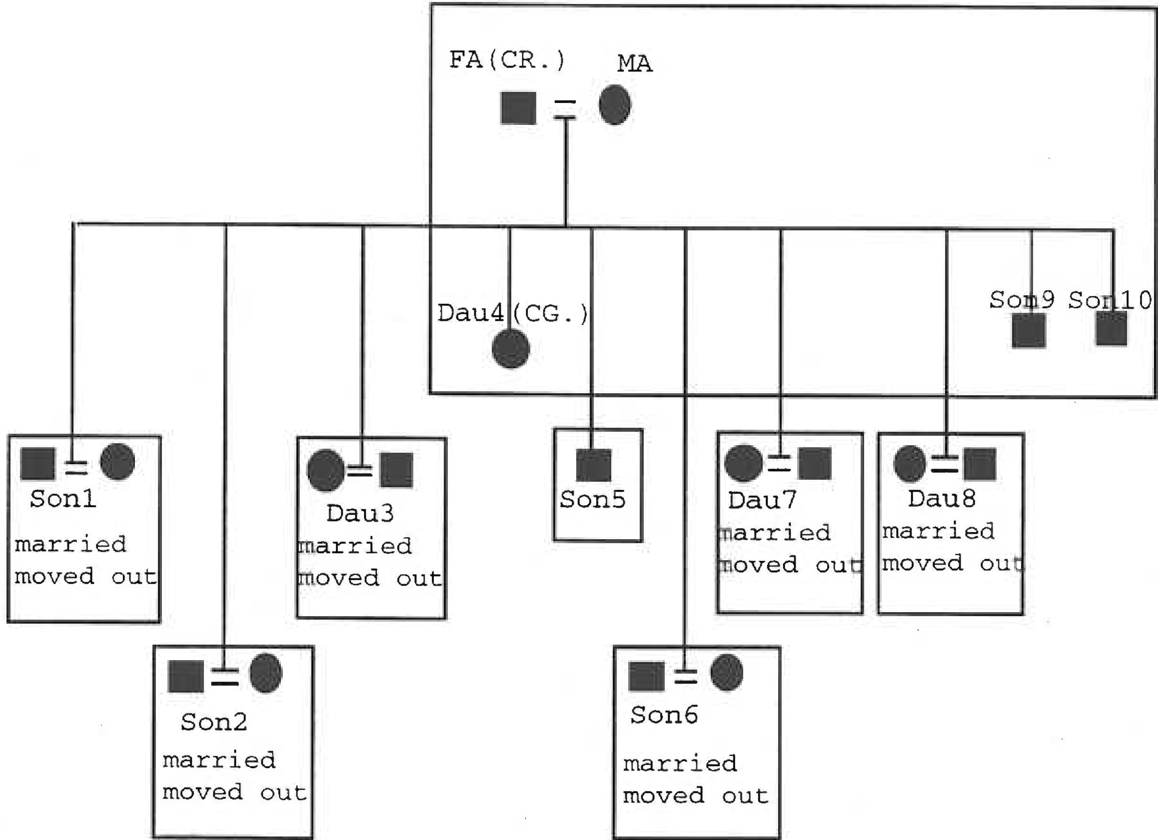
The eldest daughter is the person who financially provides for her father's care needs, including all health services, medications and any care supplies. The other two married daughters do contribute

financially at times as they are mindful of the fact that they are not able to give physical care for their father.

Setting: The family home was built a year ago and is of traditional Thai style. The home is two story and is made of rare teak wood. The first floor includes a living room, a dining area and two bed rooms. The second floor has an open space which is used for the family religious practice, where there are many Buddha statues and pictures of the King and respected Buddhist monks. On the second floor there is also a bedroom where the father stays and another bedroom which belongs to mother.

The father's (care receiver) room is the only room that has air conditioning and is approximatedly 16 square meters in size. There are several windows in the room and the informant states that she usually opens these windows every morning (around 5 AM) for ventilatation and to allow the morning sun to brighten the room. The care receiver's bed is in the middle of the room. The medical equipment, such as the electric suction machine and other pieces of care supplies are easily accessible. A bedside table is also next to the bed. On the wall above the bed, there are pictures of Lord Buddha and King Rama V (King Chulalongkorn) which are considered holy images. In one corner of the room, there are shelves holding care supplies such as normal saline solution 0.9% for wound dressing, betadine solution, blue chux pads, cotton and his clothing. In the adjoining bedroom whch belonging to the mother, there is a shelf of medication supplies, feeding equipment and supplies.

NUCLEAR FAMILY



<u>Note</u>

■ male

● female

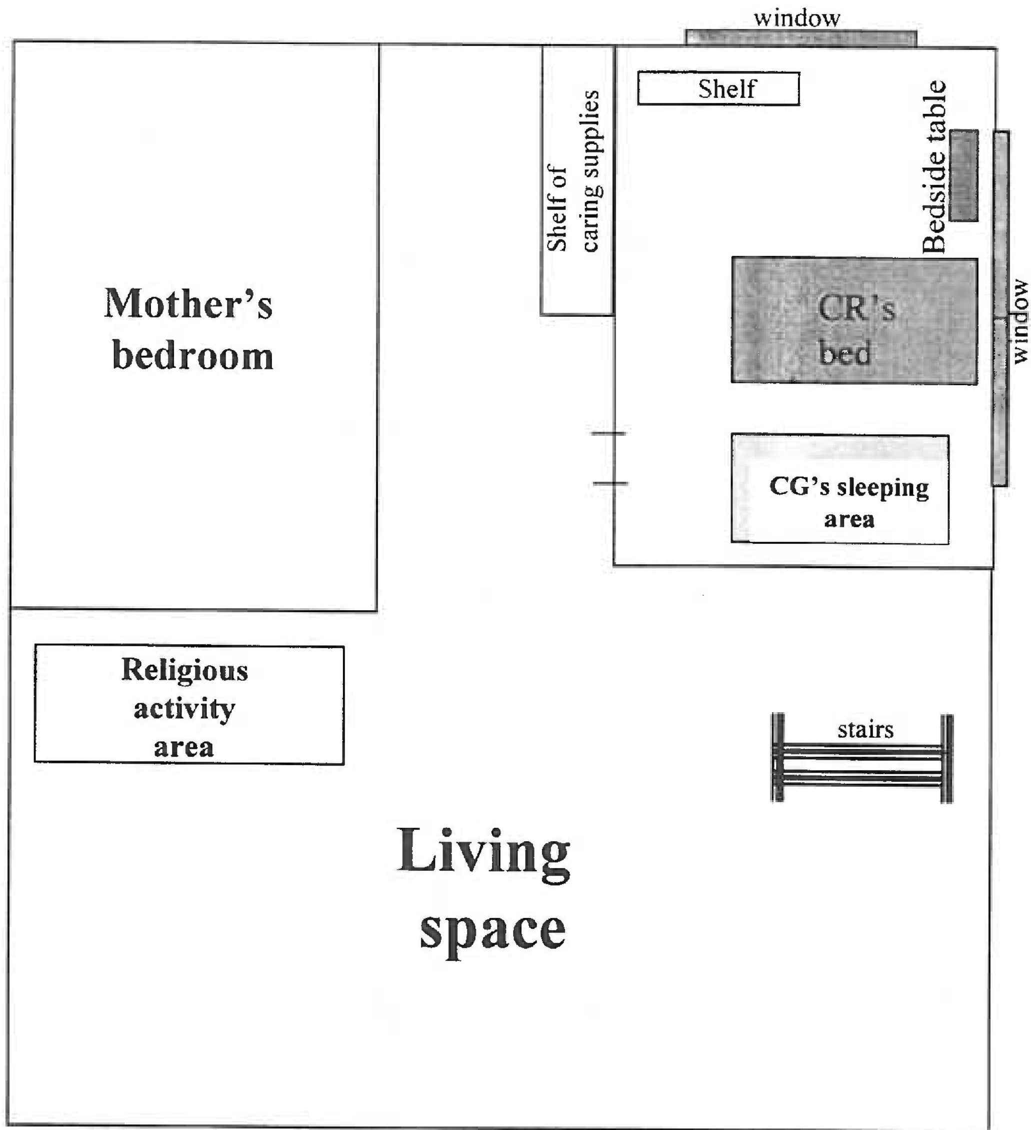
FA father

MA mother

Dau daughter

CG caregiver

CR care receiver



Home Setting of ID #1

Family ID # 2

Information:

Family ID # 2: is a Thai Buddhist stem family whose members are a frail 87 year old mother (care receiver), her adult daughter (caregiver) and the daughter's family The father died nearly five years ago. Currently, the mother and the daughter (caregiver) lives in the parent's home.

The mother has seven adult children which includes three sons and four daughters. However, one son and one daughter died several years ago. The remained (five) children are all married. Four of them live elsewhere with their own families. The daughter (the key informant) is the third child in the family. Her family (her husband and three daughters) also live in this house. One of her daughters (the middle) is married but still lives in the same household. The living expenses of the household comes from the informant's husband and her daughters.

Family caregiver (the key informant): is a 57 year-old, third child, married, housemaker who lives with her mother. She is secondary level (grade 10) educated. The informant has taken the role of primary caregivers for her mother for about a year.

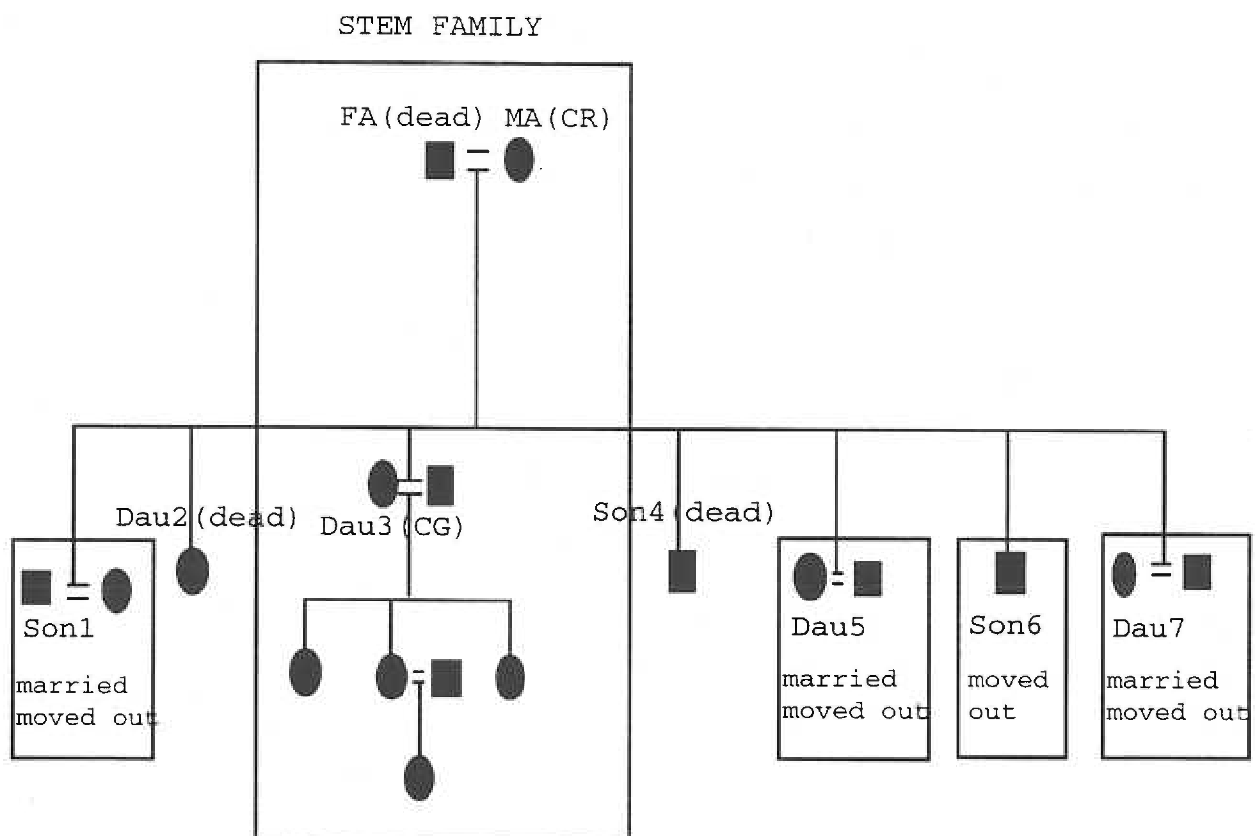
Care receiver (the mother): is a frail 87 year old woman whose right side is hemiplegic due to a stroke a year ago. She now is conscious and has no problem with communication or intellectual functions. However, she needs help to some degree with her activities of daily living (ADL) such as bathing, transfering, and toileting. For the instrumental activities of daily living (IADL), the care receiver cannot perform IADL independently, the caregiver is the main person who provides the assistance with the tasks such as meal preparation, housekeeping, medications.

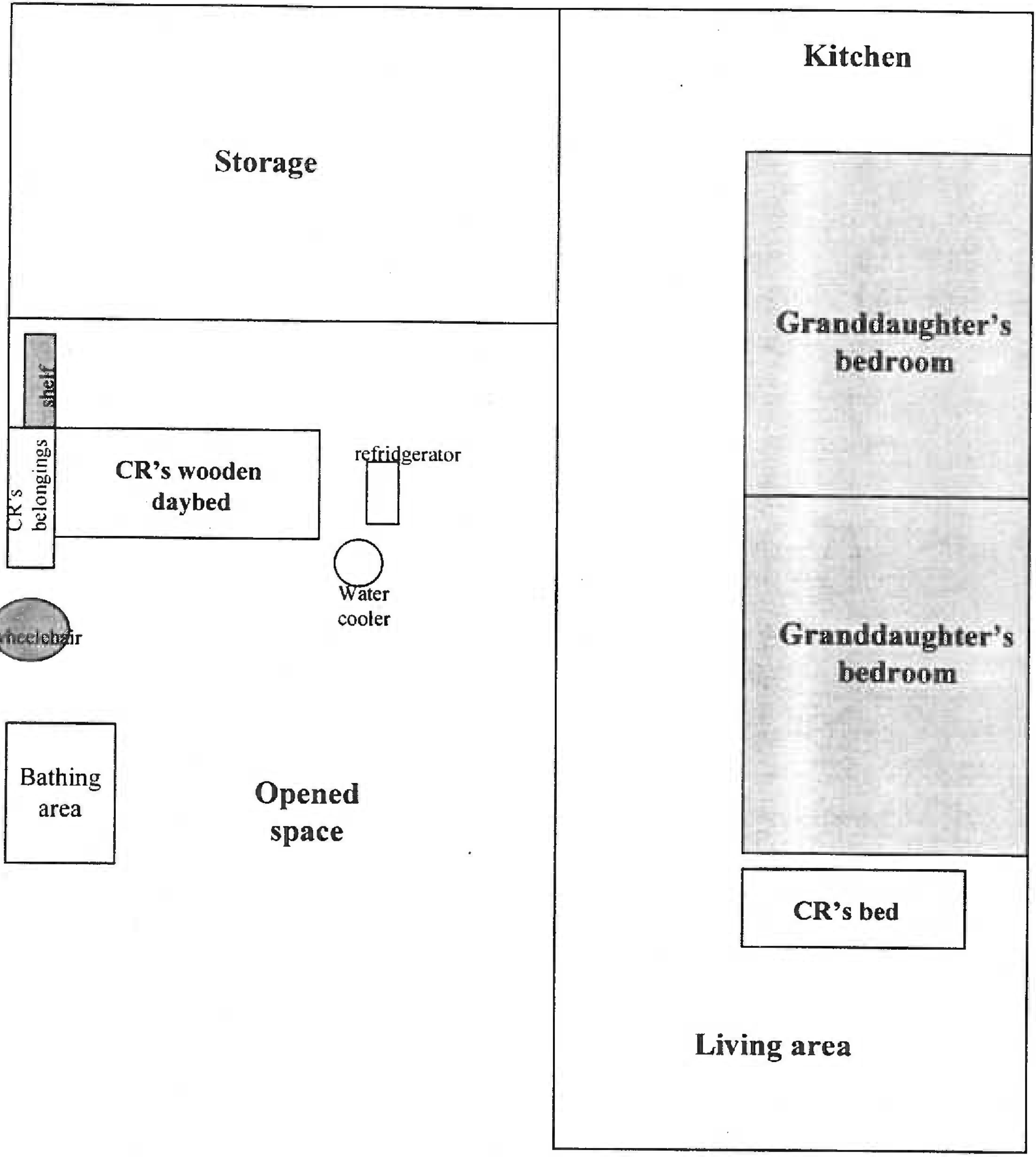
Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly mother. She helps in caregiving activities for ADL which the care receiver could not perform herself. The caregiver's daughters (the grand-daughters of the care receiver) usually assist in caregiving for the frail elderly mother. There is no support from other children (brothers and sisters) in

caregiving task; however, some of them visit or give money to the mother from time to time.

Setting: The family home is a Thai style, two-story wooden house located in a small street which is quiet. Some trees and opened spaces still remain around the house. The house floor is lifted up from the ground leaving an opened space between the ground and the first floor. This space is used as a living place for the frail mother during daytime. There is a big wooden bed in the living space on the ground floor that is the mother's bed during the night. The informant will set up the bed (blankets, mosquito net) and prepare the setting for her mother to sleep in this place every night. The informant herself sleeps on the upper floor above the mother's bed area so she can hear or listen to her mother's calls or any movements.

The living place that the frail mother stays during daytime is an open space with a wooden raised-up seat. Some appliances and her personal belongings that are used for her daily living such as electric fan, cooler for water, fruits, basket containing betel leaves and areca nuts for consumption are set in areas around the mother.


STEM FAMILY
FA(dead) MA(CR)
Dau2(dead)
Dau3(CG)
Son4(dead)
Son1
married
moved out
Dau5
married
moved out
Son6
moved
out
Dau7
married
moved out



Home Setting of ID #2

Family ID # 3

Information:

Family ID # 3: is a Thai Buddhist nuclear family whose members are a frail 63 year old father(care receiver),the mother (a 57 year old working woman), and a daughter (the key informant). The mother works as a pharmacist assistance in a public hospital in Bangkok. She is considered to be head of the family since her husband has been sick.

The couple has only one child which is the key informant. They all live together in a house owned by parents, located in a small and quiet community in Bangkok. The living expenses of the household come from the mother's salary and the father's pension.

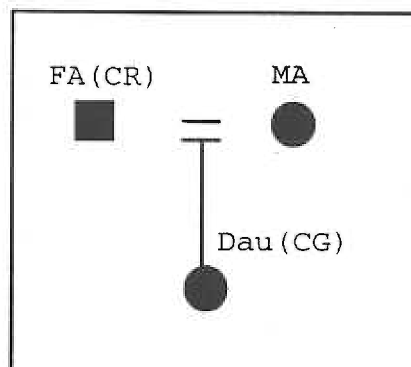
Family caregiver (the key informant): is the unmarried daughter who lives at with her parents. She is 30 year old, high school educated. She said that she was unsuccessful in her study (could not finish the college study) and could not find a job so her mother asked her to look after the father and gives her a monthly allowance to her 3,000 baht (90 US dollars) every month. She has taken the role of primary caregiver of her father for the past four years.

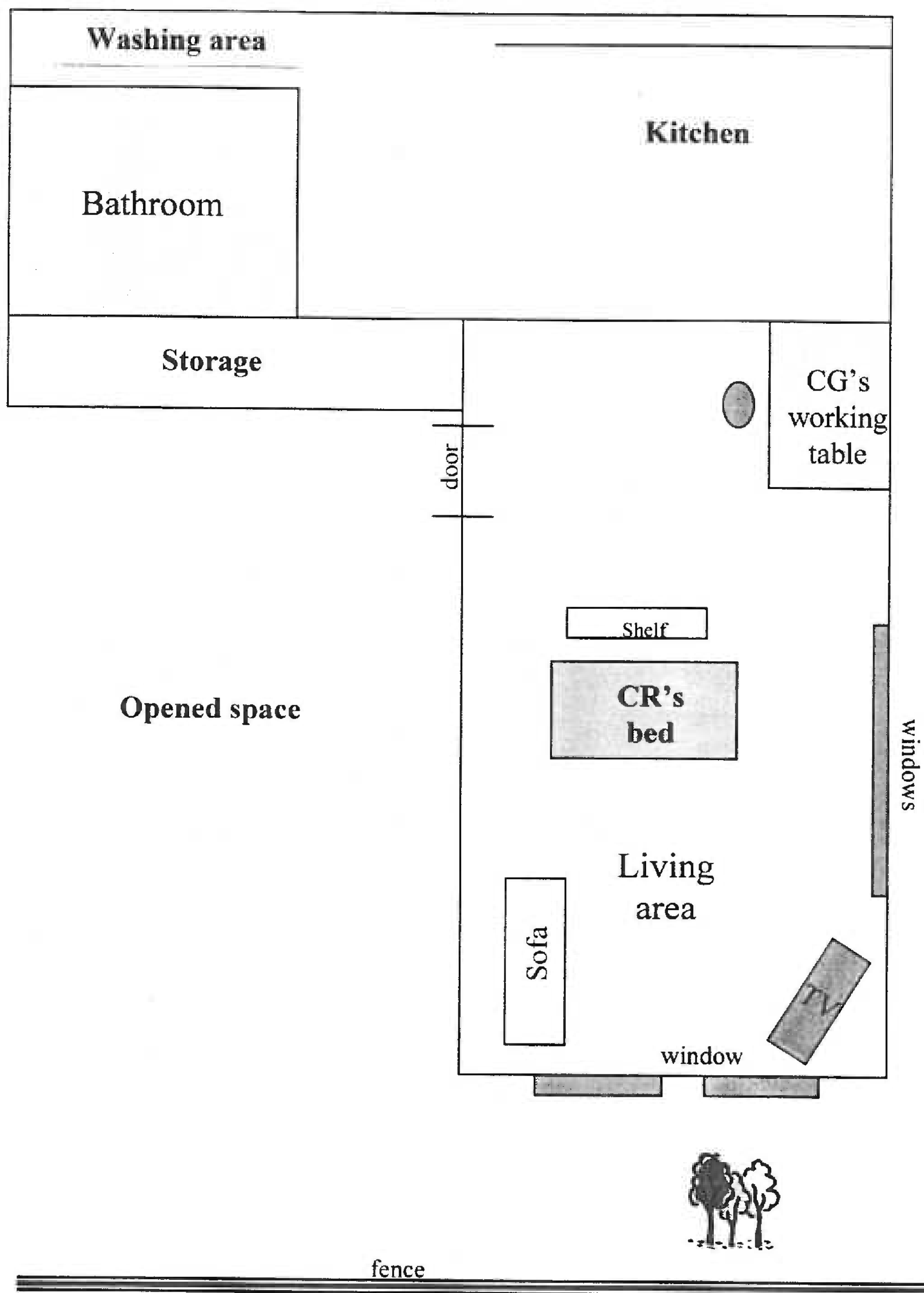
Care receiver (the father): is a frail 63 year old man who has been retired from his work (an officer at the Tax Revenue Department) five years ago due to his illness (a stroke). He now is conscious, hemiplegic on the left side, aphasia, and still has problems with chewing and swallowing. He is totally dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system. The mother used to be a primary caregiver during the first three months of her husband's illness. After that she hired a maid to help in taking care of him for a year. However, now the daughter takes the role as his primary caregiver especially during the time that the mother goes to work (6 AM until 4 PM.). The key informant takes all the responsibilities in caregiving activities for ADL such as feeding, toileting, position changing during the daytime. However,

in the evening or during the weekend, the mother will take care of the father herself.

Setting: The house is a two story, wooden house with a small garden in front of it. There are several windows in the house which help in making good ventilation and reduce the temperature inside. The father lives on the first floor which is a living space that is close to the bathroom, kitchen, and dining area. His bed is set in the middle of the living space with a small bedside table and a shelf to keep the caring supplies such as his clothing, urinal, medicines, and blue chux pads. The father mostly stays in this bed all day and night. The mother sleeps by his side every night, but the informant sleeps in her bedroom on the second floor.





Home Setting of ID #3

Family ID # 4

Information:

Family ID # 4: is a Thai Buddhist nuclear family whose members are a frail 60 year old woman (care receiver), her husband and their children. The husband, 63 years old, is a retired officer who is considered to be the head of the family. This couple has three adult children which includes two sons and a daughter. None of them are married. The daughter (the key informant) is the eldest child in this family. The middle child is a son who works in a private company in Bangkok. The youngest son works in the Public Railway Department and lives in another province. The daughter and the middle son reside with their parents. They live in a two- bedroom apartment owned by parents.

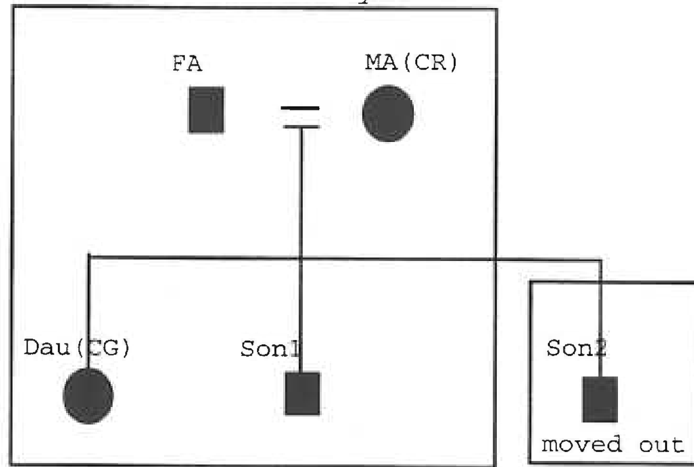
The living expenses of the household come from the father's pension, the sons' financial support from their salaries, and the daughter's earning sometimes.

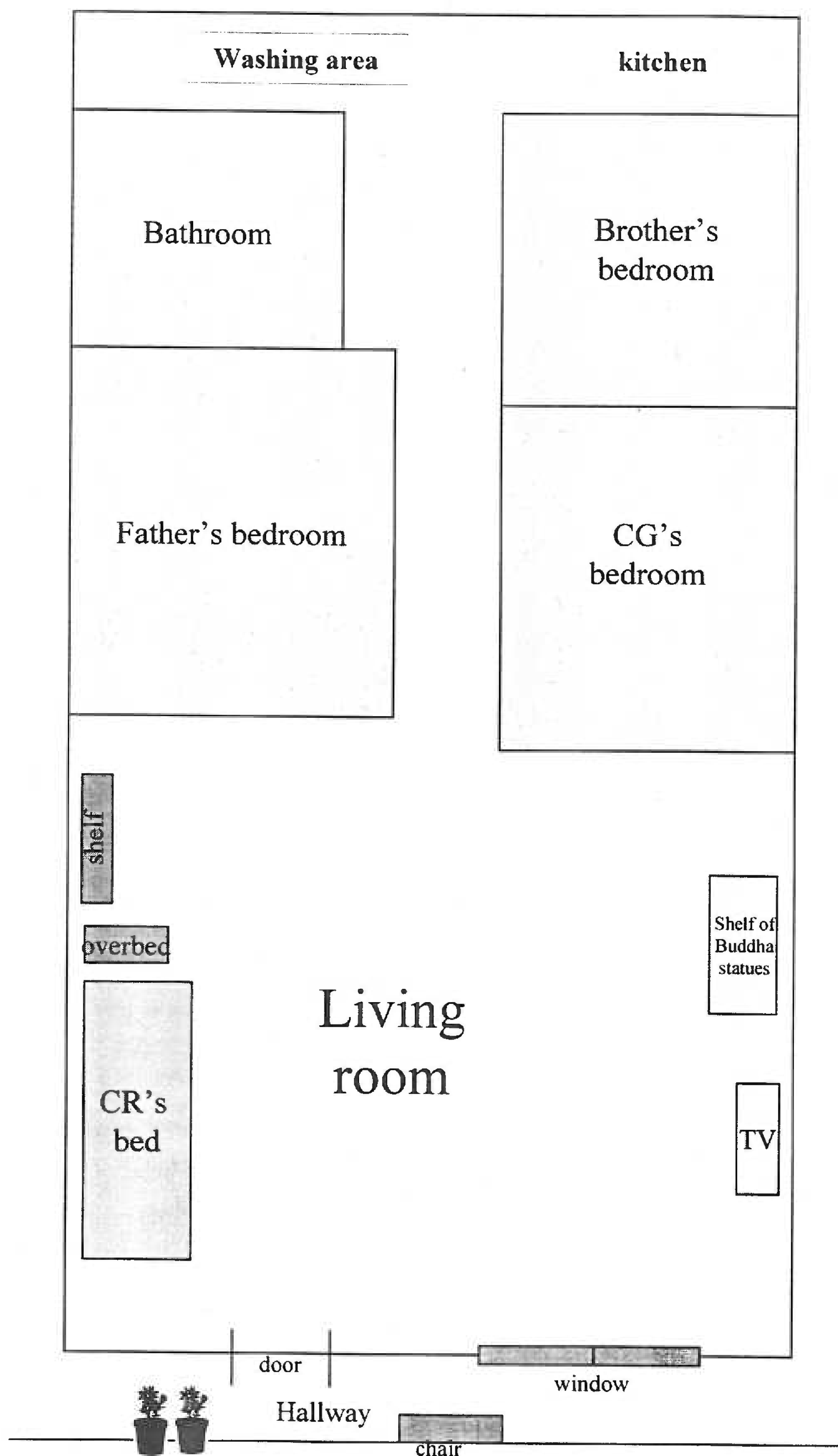
Family caregiver (the key informant): is 37 years old, unmarried, eldest child of the family. She has a polio handicap with both legs atrophied since she was young. She never went to school because of her disability. However, she was taught to read and write by her mother when she was young. The informant has taken the role of primary caregiver of her mother for the past two years. Now, she defines herself as a housemaker who stays and looks after both of her parents (mainly the mother). She sometimes works as a baby sitter for her neighbors to earn some money for herself.

Care reciever (the mother): is a 60 year old woman with the right side hemiplegia from a stroke two years ago. She now is conscious and alert, but still has a problem with communication. However, she needs help to some degree with her activities of daily living (ADL) such as assistance in bathing and toileting. For the instrumental activities of daily living (IADl), the care receiver cannot perform IADL independently. The caregiver is the main person who provides the assistance with the tasks such as meal preparation, housekeeping, medications.

Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly mother. She helps in caregiving activities for ADL which the care receiver could not performed herself. During the time when her mother was first discharged from the hospital which the care receiver's condition and was completely dependent, her two brothers also helped her in the caregiving activities such as bathing, toileting, feeding. Now they help in providing financial support and all health services for the mother's needs.

Setting: The apartment is on the third floor of Din Daeng Apartment, which is one of several apartments organized by the governmental housing services. The apartment is a two bedroom unit with a living room, small kitchen, and a bathroom. The mother's bed is a Fowler's bed placed at one side of the living room, close to the front door. There is enough light and ventilation flow through the mother's unit. Some appliances such as an overbed table, a walker, an electric fan are easily accessible. A bedside table with some care receiver personal belonging items such as books, a glass, eyeglasses is next to the bed. There is a set of Buddha statues placed on the shelves at the other side of the living room. The caregiver sleeps in a bedroom that is close to the mother's bed.


Nuclear Family
FA
MA(CR)
Dau(CG)
Son1
Son2
moved out



Home Setting of ID #4

Family ID # 5

Information:

Family ID # 5: is a Thai Buddhist stem family whose members are a demented mother aged 80 (care receiver), a daughter (caregiver), a sister-in-law and her children (two nieces and two nephews). The father died several years ago. The parents had three adult children which included two daughters and a son. However, the informant is the only remaining child in her family because her elder brother and an elder sister died a couple of years ago. They live in the house owned by her late brother.

The living expenses of the household come from the caregiver's saving, nieces and nephews's financial support, and their earnings from receiving a packaging job to work at home sometimes.

Family caregiver (the key informant): is a 50 years old single, youngest daughter who has the level of education of primary school level. The informant used to work as a housemaid for several years. Then, she quit her job and has taken the role of primary caregivers for her mother for three years because her mother became very frail and lost ability to take care of herself. The informant is now a homemake who mainly looks after her mother.

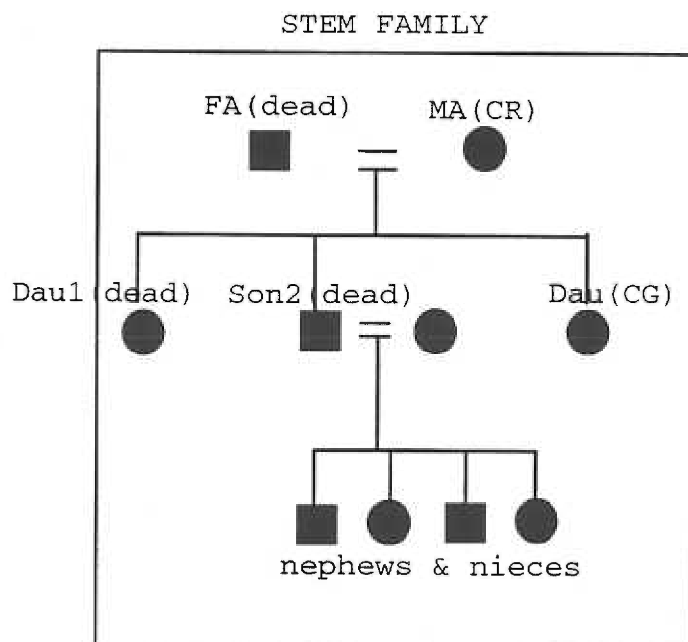
Care reciever (the mother): is a frail 80 years old woman who is completely dependent due to the severe degree of her impairment in cognitive functions (loss of all verbal and psychomotor abilities). She needs total assistance in all care needs based on the functional assessment of ADL and IADL.

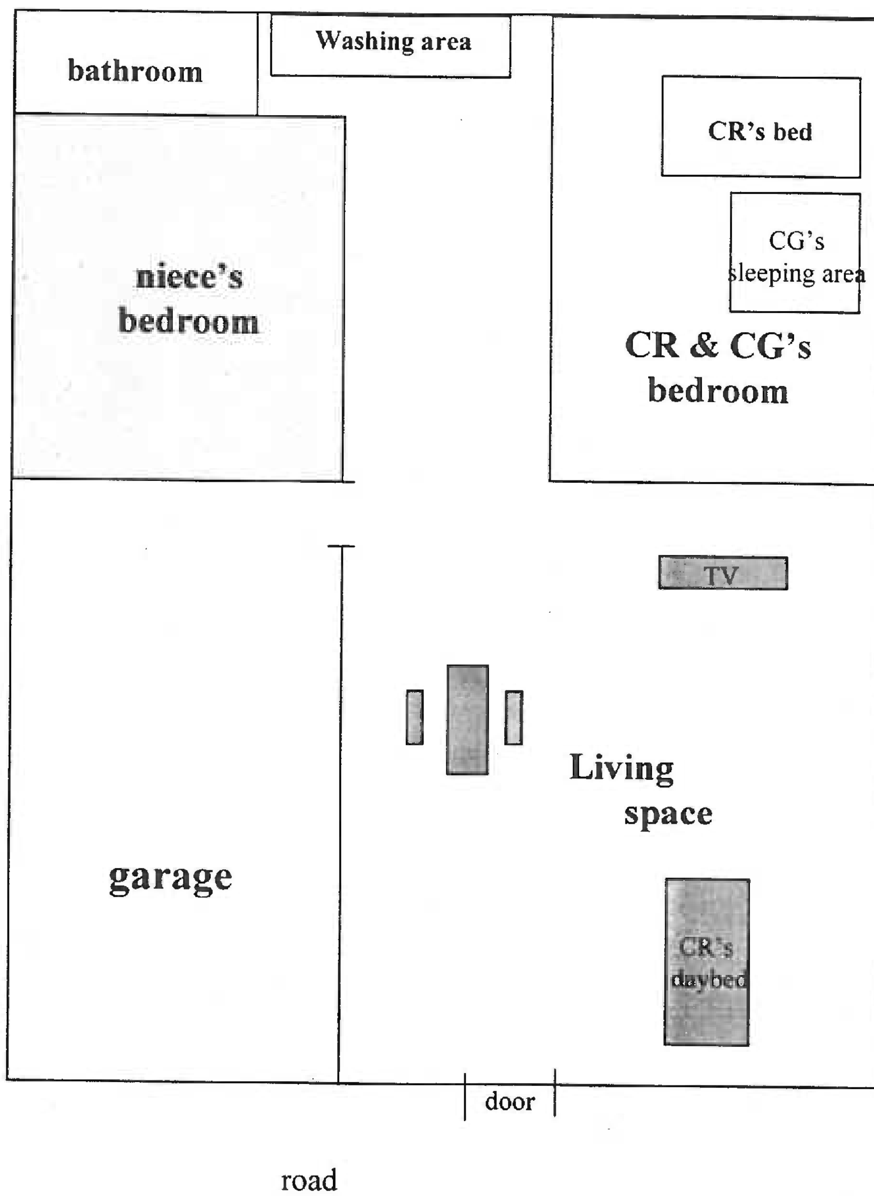
Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly mother. She takes all the responsibilities in caregiving activities for ADL such as feeding, bathing, toileting, position changing. The sister-in-law and nieces help in caregiving activities sometimes.

Setting: The house is two story, half-wooden and half-brick house. The first floor includes a living room, a dining area, and two bedrooms. The care receiver and the informant sleep in the same bedroom on this floor. During the day time, the mother

is brought to stay in the living room where a mattress is placed near the entrance of the room for the purpose of getting ventilation and sun light from outside. There is a shelf nearby holding care supplies such as clothings, medicines, blue Chux pads, a plastic basin and wash cloth. The caregiver spends most of her time being around with the care receiver all day and night.

STEM FAMILY





Home Setting of ID #5

Family ID # 6

Information:

Family ID # 6: is a Thai Buddhist nuclear family whose family members are a frail mother aged 68 years (care receiver), a adult daughter (caregiver) and her husband. The mother (care receiver) has three children with her ex-husband which includes two daughters and one son. She married once again but has no child with the new husband. Now they are separated. The daughter (the key informant) is the eldest child in the family. The middle child is a daughter who was adopted by an other family since she was young. Now she is married and and lives elsewhere. The youngest son is also married and lives with his own family.

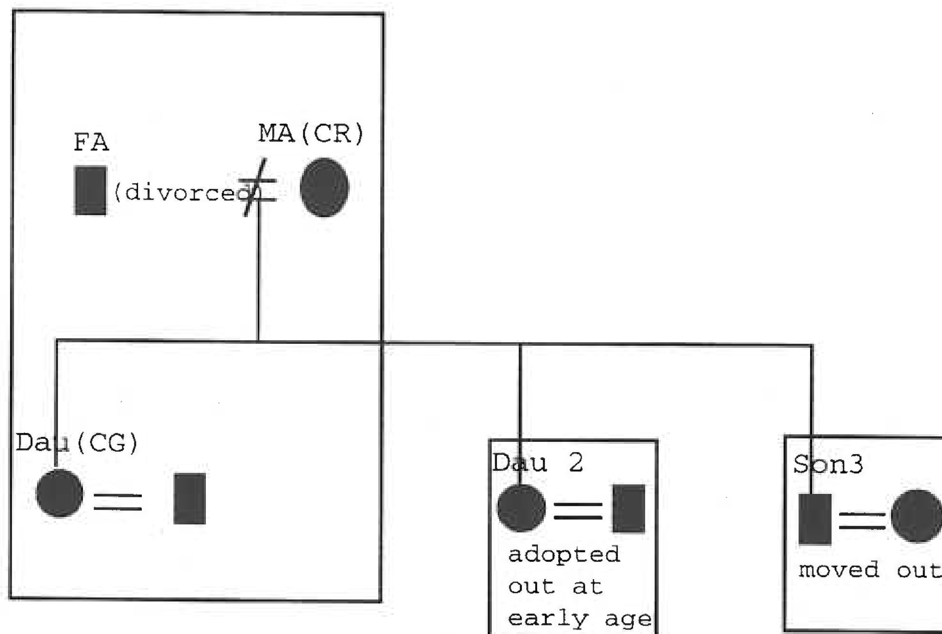
Currently, the family live in a two-bedroom apartment owned by a brother of the care receiver. The living expenses of the household come from the key informant's husband, an uncle's contribution, and the informant's saving.

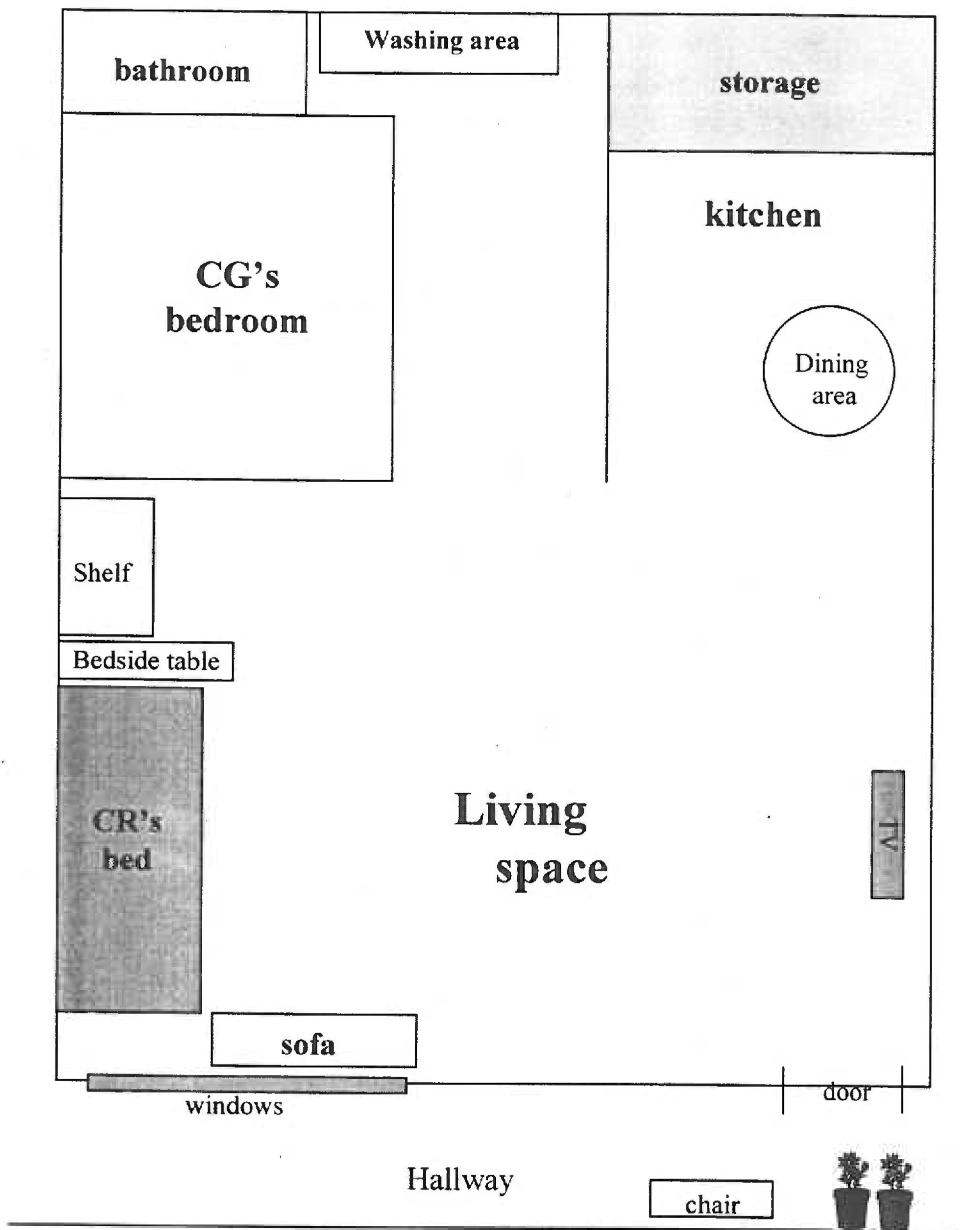
Family caregiver (the key informant): is a married, eldest child. She is 48 years old with compulsory level (grade 6) education. The informant has taken the role of primary caregiver of her mother for the past two years since the mother has been diagnosed with Parkinson's disease. The mother has moved to live with her for about six years. Before being sick, she could do all daily activities by herself. The informant used to work in a private company but she quit her job nearly two years ago. Now, she defines herself as a homemaker who stays and looks after her mother and takes responsibilty of all household chores.

Care receiever (the mother): is a frail 68 years old woman who has been sickend by Parkinson's disease for 2 years. She now is conscious but still has problems in controlling body movement. Based on the functional assessment of ADL, she needs some assistance in toileting, bowel continence, and tranfering. For the instrumental activities of daily living (IADl), the care receiver cannot perform IADL independently. The informant is the person who provides the assistance with the tasks such as; meal preparation, housekeeping, medications.

<u>Caregiving practice and supportive system:</u> The key informant is a primary caregiver to the frail elderly mother. She helps in caregiving activities for ADL which the care receiver could not performed herself such as helping in transfering from place to place (if the distance is far), shampooing, fleet enema or bowel evacuation every three days. The informant's husband sometimes helps in transportation of the mother to get health care services at the clinics or the hospitals. The younger sister does contribute financially sometimes but not very often. The younger brother has not routinely contribute financially or physically to the care needs of the mother.

<u>Setting:</u> The apartment is on the third floor of Din Daeng Apartments, which is one of several apartments organized by the governmental housing services. The apartment is a two bedroom unit with a living room, small kitchen, and a bathroom. The mother's bed is a full-sized wooden bed placed at one side of the living room near the front door and the windows. There is enough light and ventilation through her unit. Some appliances and supplies such as a small bedside table, a walker, an electric fan, and a shelf holding the care receiver's personal belongings (clothing, medicines, bottles of water, books) are set in the areas around the care receiver's bed.


NUCLEAR FAMILY
FA
MA(CR)
(divorced)
Dau(CG)
Dau 2
adopted out at early age
Son3
moved out



Home Setting of ID #6

Family ID # 7

Information:

Family ID # 7: is a Thai-Chinese, Buddhist nuclear family whose family members are a 63 year old frail mother (care receiver), a son (the key informant), and the youngest daughter. The father died nearly fifteen years ago. The parents had four children which includes two sons and two daughters. However, the eldest daughter died when she was young. The key informant is the eldest son in the family. The middle child is a son who was adopted by a related family when he was young. (The care receiver said that her second son was seriously ill when he was young, so she gave him to be a son of her cousin as a traditional belief that it would help the child to survive.) Now, the middle son is married and lives elsewhere with his own family. The youngest daughter is not married and still lives in with the family.

The family lives in a two-bedroom apartment owned by the mother. The living expenses of the household comes from the key informant and the youngest daughter's salary.

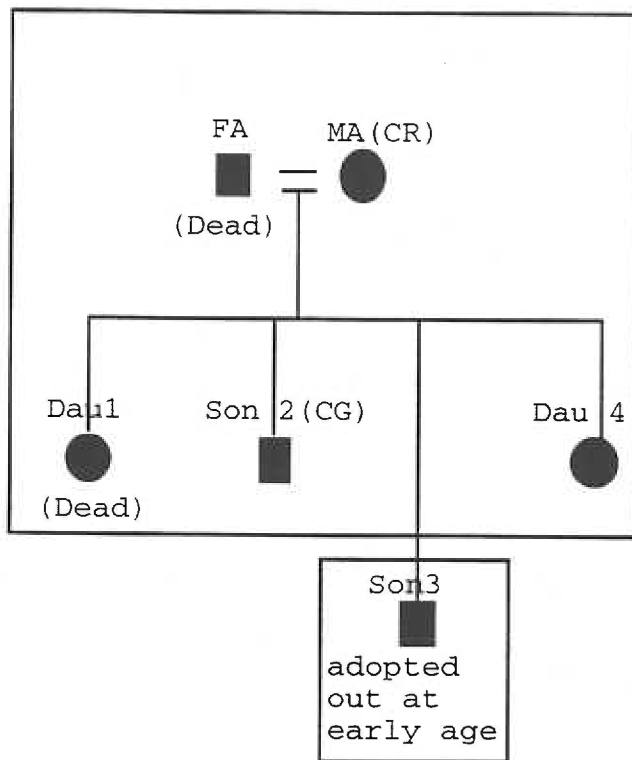
Family caregiver (the key informant): is 38 years old, single, eldest son who has completed grade 10 education. The informant has taken the role of caregiver of his mother for the past four years since she had a stroke. Currently, the informant works as a security guard at the Ministry of Transportation in Bangkok.

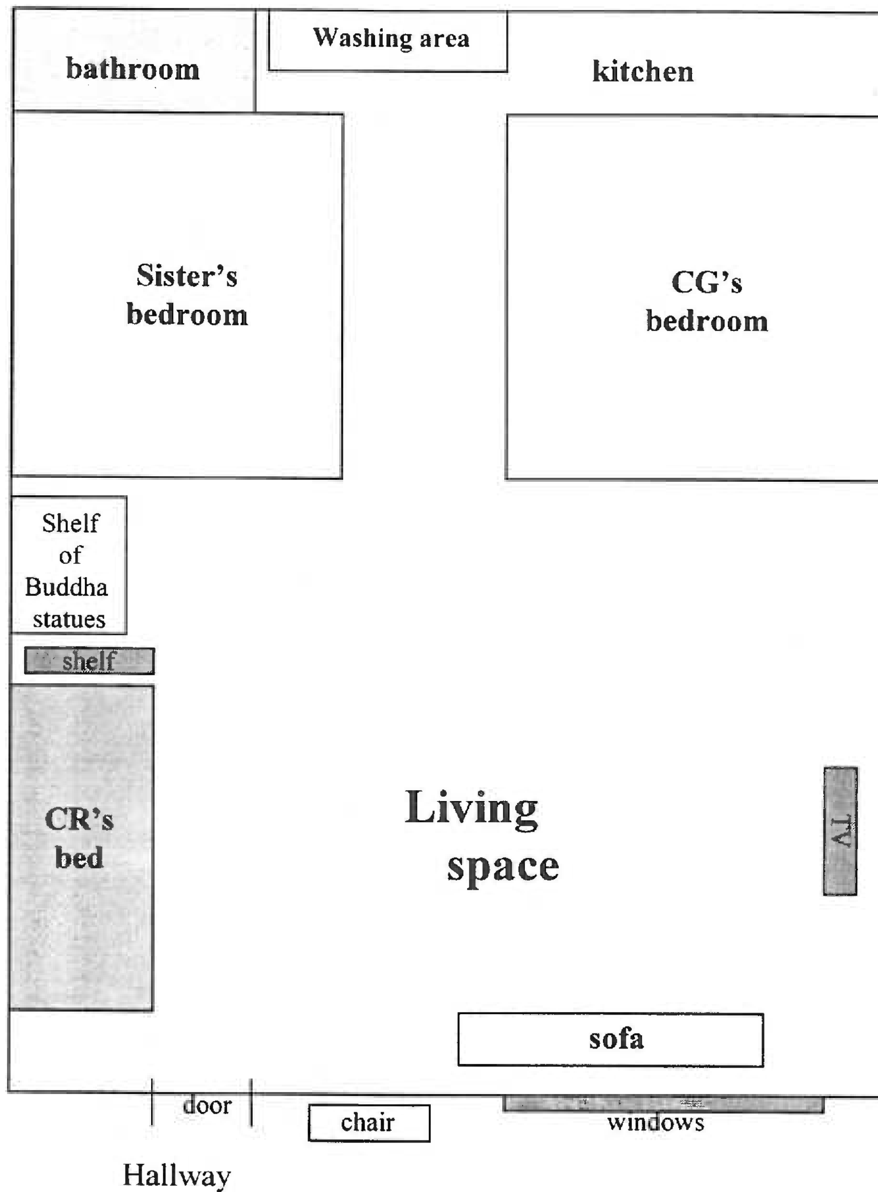
Care receiver (the mother): is a frail 63 year old woman who has the left side hemiplegia from a stroke four years ago. She is conscious and can perform all the functions assessed by the ADl by herself. However,she still need assistance in activities of the instrumental activities of daily living (IADL) such as; meal preparation, housekeeping, transportation, and medications.

Caregiving practice and supportive system: The key informant defined himself as a primary caregiver to the elderly mother. He helps in caregiving activities for IADL which the care receiver could not perform herself such as meal preparation, housekeeping, and transportation. Since he said that now the care receiver is in a much better condition than the time that she was

first had the stroke. At that time he and his younger sister provided all the cargivings to their mother including the ADL assistance. His work is a rotating schedule so he could provide care to his mother during the daytime. During the night, his sister who works in a private company, takes turn in caring responsibility. The younger brother does not provide any financial or cargiving activity support to the mother.

Setting: The apartment is on the second floor of Din Daeng Apartments, which is one of several apartments organized by the governmental housing services. The apartment is a two bedroom unit with a living room, small kitchen, and a bathroom. The mother's bed is a twin-sized bed placed at one side of the living room closed to the front door and the windows. There is a big set of small tables where several Buddha statues, pictures, and spiritual objects are placed. The room is quite dim but the air ventilation of the mother's unit is fine. Some appliances and supplies such as; a small bedside table, a walker, an electric fan and a telephone. A shelf holding the care receiver's personal belongings (medicines, bottles of water, telephone address book) are set in areas around the CR's bed.


NUCLEAR FAMILY
FA
MA(CR)
(Dead)
Dau1
Son 2(CG)
Dau 4
(Dead)
Son3
adopted out at early age



Home Setting of ID #7

Family ID # 8

Information:

Family ID # 8: is a Thai-Chinese, Buddhist joint family whose members are a frail 72 year old father (care receiver), a daughter (care giver), her younger sister, and three nephews (sons of the elder brother). The mother is a 77 year old woman who is still healthy and lives in a home at Pracheenburi province. She stays in this house from time to time. Before the father became sick, they (the parents) lived together in this rural province most of their time. The house in which the key informant and the frail father are now living is also the parent's house. They bought this house nearly twenty years and let children who were not married live in this house.

The couple has eight adult children which includes three sons and five daughters. Three out of five daughters are married and live elsewhere with their own families. The other two daughters, who are not married, are the eldest and the youngest daughter. Two sons died several years ago. Three nephews (sons of the third child) currently live in this house. One daughter (daughter 7) and one son (son 6) are married and immigrated to the United States nearly twenty years ago.

The living expenses of the household come from the informant's saving, the youngest daughter's salary, and assets of their parents.

Family caregiver (the key informant): is a 51 year old, the eldest, unmarried woman who is grade 4 educated. She has taken the role of primary caregivers of her father for about a year since he has been sick. The father was moved from Pracheenburi province, where he lived with his wife, to get medical treatment in Bangkok. The key informant used to have her own business of making and altering garments (women's dresses), however she closed her business several years ago. Now she considers herself as a homemaker who looks after the house, takes care of her father and the nephews.

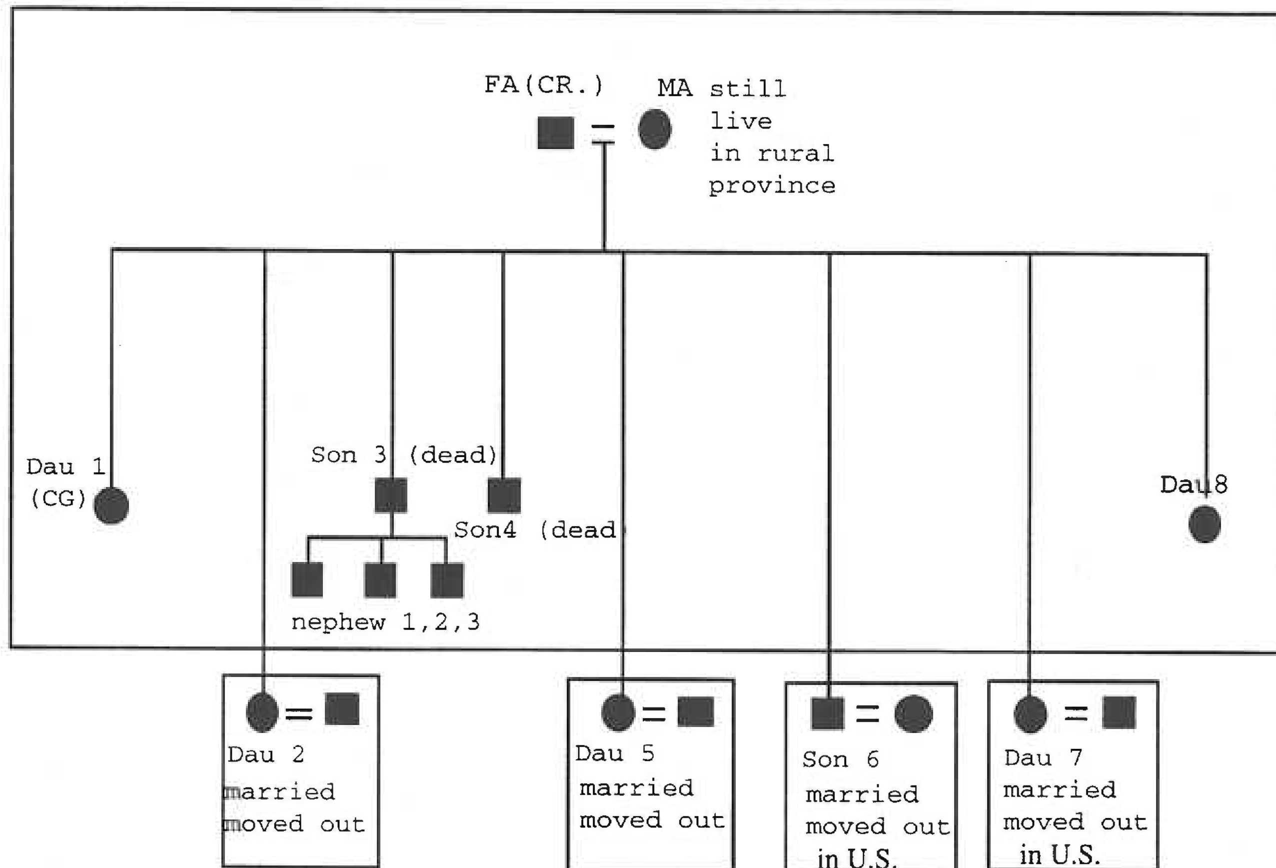
Care reciever (the father): is a frail 77 years old man who is semiconscious due to viral meningitis about a year ago. He was admitted to a hospital in Bangkok for nearly two months and was discharged after the family decided to take care of him at home. He now

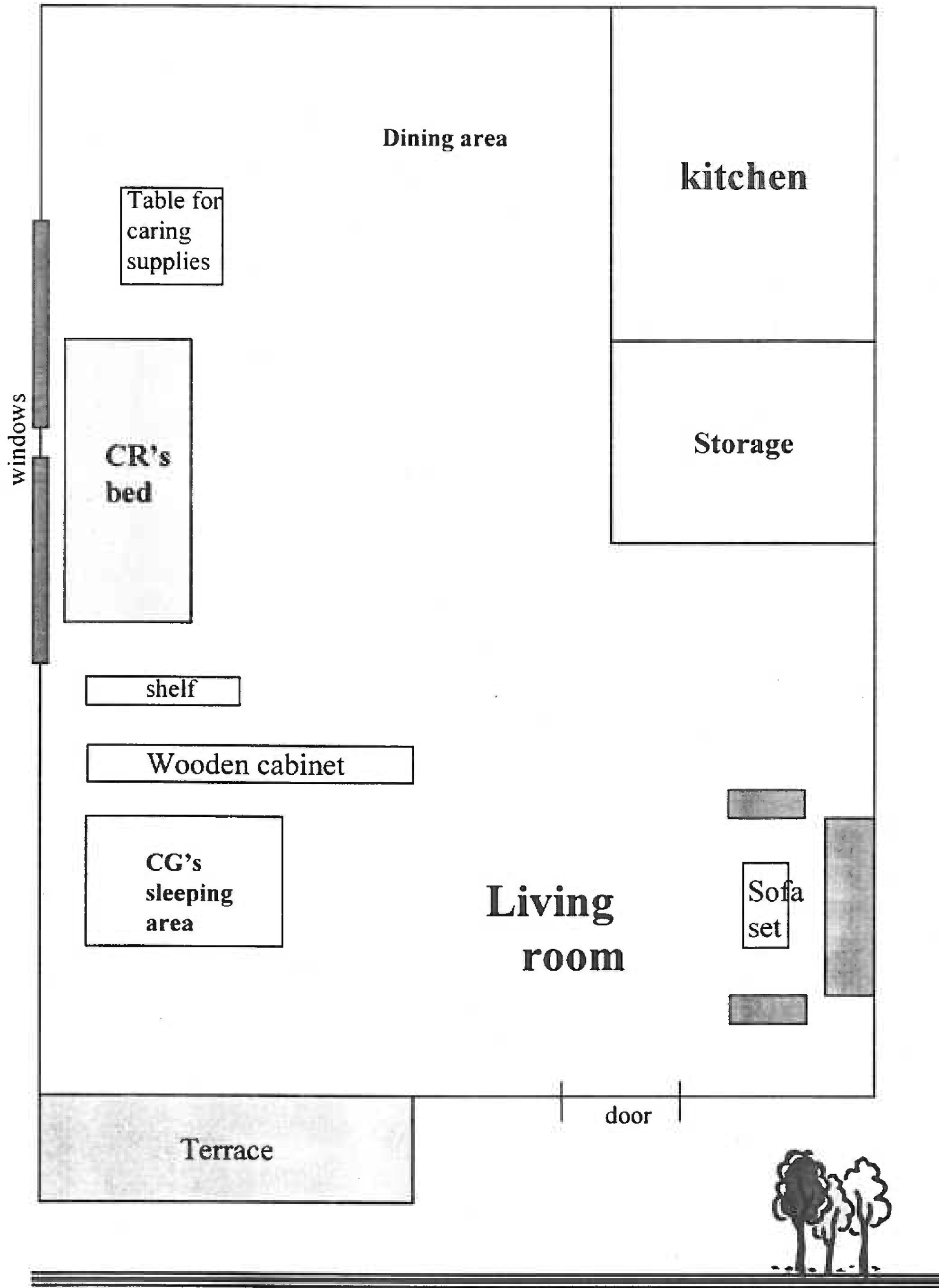
has a tracheostomy tube and nasogastric tube for gavage feedings. Cachexia is also present. He is completely dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The key informant defined herself as a primary caregiver to her father. At the same time, she also gets assistance in caregiving from her youngest sister and a live-in house maid. The youngest sister works fulltime during the daytime so she helps in caregiving during the night. Other sisters and brothers do contribute financially for caregiving supplies or health services as they are mindful of the fact they are not able to physically care of their father.

Setting: The house is a two-story, contemporary style. The first floor includes a living room, dining area, a kitchen, garage, and two bedrooms.

The father's unit is set in a corner between the living space and the dining area. The bed is a Fowler's bed that was put close to the windows for ventilation and sunlight from the outside. The medical equipments such as the electric suction and blood pressure monitor are easily accessible. There is a shelf holding stocks of medical and care supplies such as normal saline solution 0.9% for wound dressing, alcohol, blue Chux pads, cotton, clothing, medicines, feeding equipment, packs of birdnest beverage and pasteurized milk.


JOINT FAMILY
FA(CR.)
MA still live in rural province
Dau 1 (CG)
Son 3 (dead)
Son4 (dead)
nephew 1,2,3
Dau8
Dau 2 married moved out
Dau 5 married moved out
Son 6 married moved out in U.S.
Dau 7 married moved out in U.S.



Home Setting of ID #8

Family ID # 9

Information:

Family ID # 9: is a Thai Muslim, joint family with a 74 year old frail mother (care receiver), her 75 year old husband, a second child daughter and her family, the youngest son, and the youngest daughter (the caregiver) and her family. The father is still healthy. The parents lives in their own home.

This couple has seven adult children which includes three sons and four daughters. Six of them are married and four of the married children live elsewhere with their own families. The living expenses of the household come from the parents' saving and incomes of the daughters who share the house.

Family caregiver (the key informant): is a 43 year old, married, the youngest child of the family. She is primary school (grade 4) educated. She took the role of primary caregiver of her mother about two years ago. The key informant married seven years ago and has only one daughter who is 5 years old. She and her elder sister (the second daughter) run their own business by opening a small food parlor near their home to sell cooked foods.

Care receiver (the mother): is a 74 years old woman who has health problems of arthritis and diabetes mellitus (DM). Three years ago she was diagnosed with osteoporosis and having the difficulty in walking or standing from time to time. She still can perform all the ADL aby herself, but needs assistance in IADL such as food preparation, transportation, houseworks.

Caregiving practice and supportive system: The key informant defined herself as a primary caregiver to her mother because she is the youngest daughter who lives in with parents. Her elder sister also takes turn in taking care of the mother. Other married children live with their own families but not far away from their parents' house. So, they sometimes come to visit and help the key informant to look after parents and provide financial support.

Setting: The house is a two-story, wooden house. The first floor includes a living space, dining area, a kitchen, and

three bedrooms. The parent's room is in the first floor since the mother could not climb up stairs. The informant also live on the first floor so she can help her parents in case if they need assistance.

JOINT FAMILY

FA

MA(CR)

Dau 2

Son 6

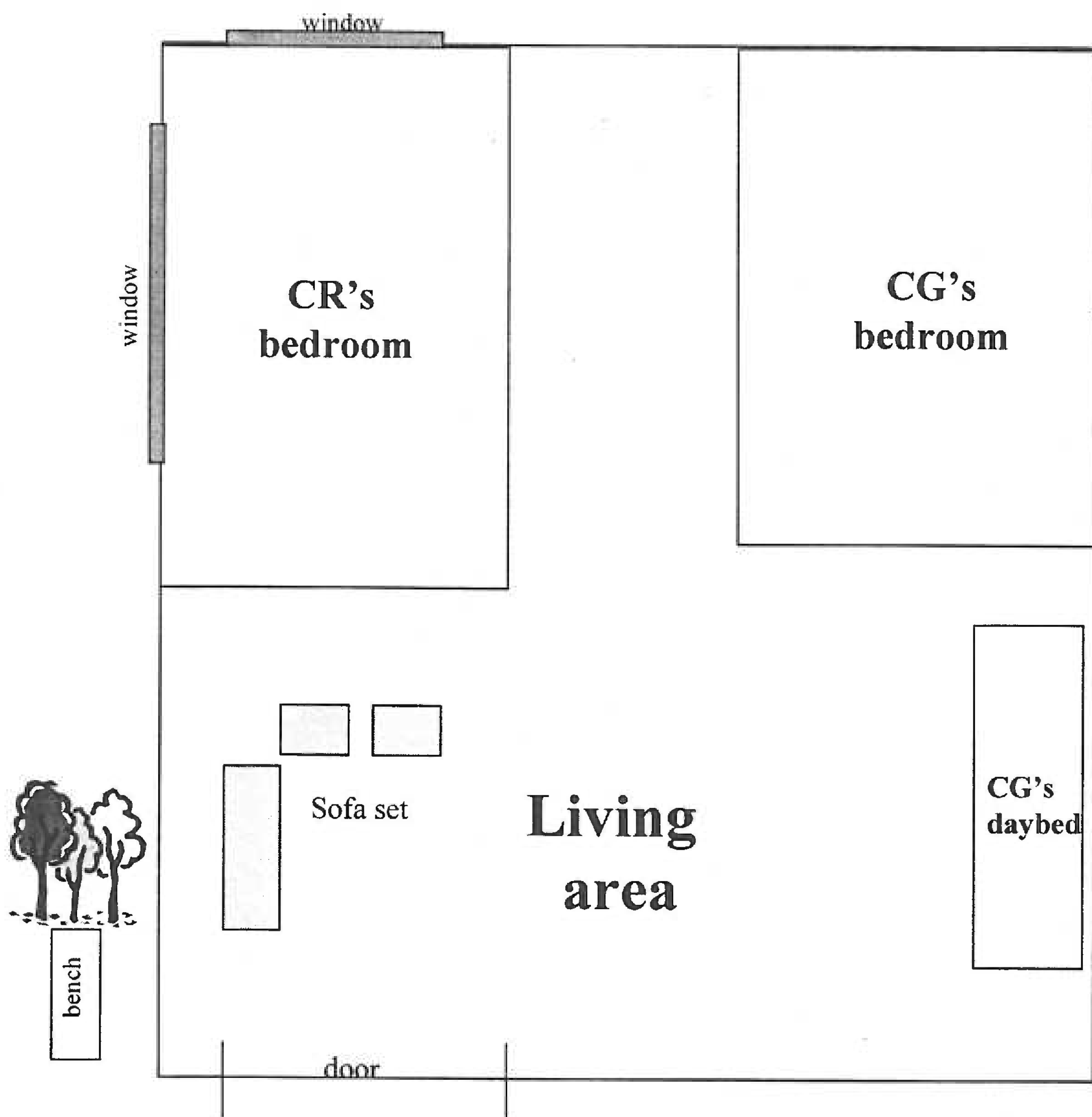
Dau 7
(CG)

Son 1
married
moved out

Dau 3
married
moved out

Son 4
married
moved out

Dau 5
married
moved out



Home Setting of ID #9

Family ID # 10

Information:

Family ID # 10: is a Thai Buddhist stem family whose members are a frail elderly mother aged 85 (care receiver), her adult daughter (caregiver) and her family. The father died nearly seven years ago. Currently, the mother and the daughter (caregiver) lives in a house owned by the caregiver and her husband.

The mother has four adult children which includes three daughters and one son. However, one daughter died when she was young. The key informant is the eldest child in the family. Her youngest sister married and lives elsewhere with her own family. The parents' only son has been ordained as a monk in another province.

The key informant has eight adult children, and six of them who are not married still reside in the same house which is owned by the informant and her husband. The unmarried children of the caregiver are 3 daughters and 3 sons, all of whom live in the house. The husband of the informant is a retired officer. The living expenses of the household comes from the pension of the informant's husband, their savings, and their children's contribution for them every month.

Family caregiver (the key informant): is a 67 year old, the eldest child, married, homemaker who lives with her own family and her mother. She is primary level (grade 4) educated. The informant has taken the role of primary caregivers for her mother for the past five years.

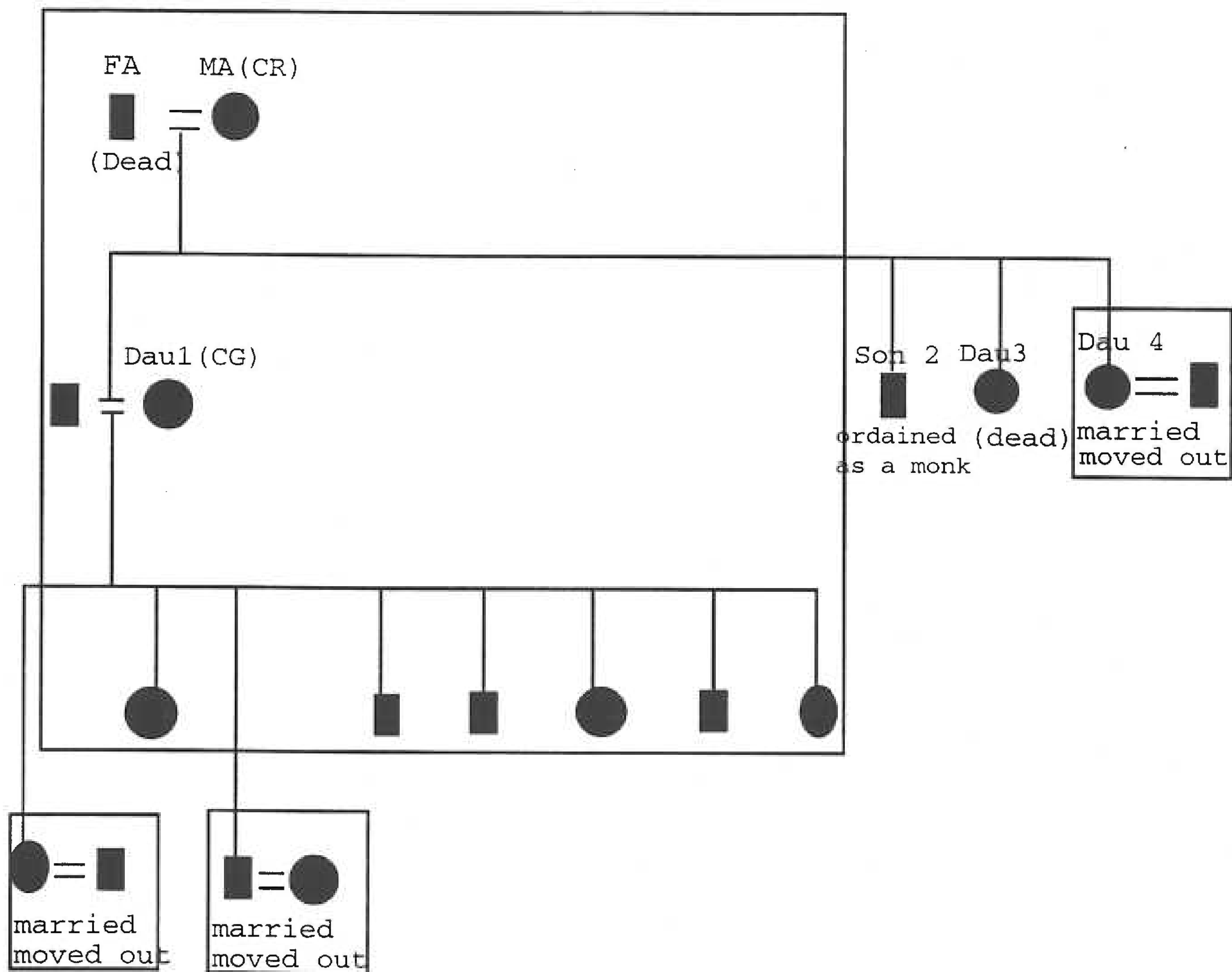
Care reciever (the mother): is a frail 85 year old woman whose left side is hemiplegic due to a stroke five years ago. She also has cataracts in both eyes, but still has memory intact and is without any problems of communication or intellectual functions. However, she needs help to some degree with activities of daily living (ADL) such as assistance in bathing, transfering, and toileting. The care receiver cannot perform IADL independently; the caregiver is the main person who provides the

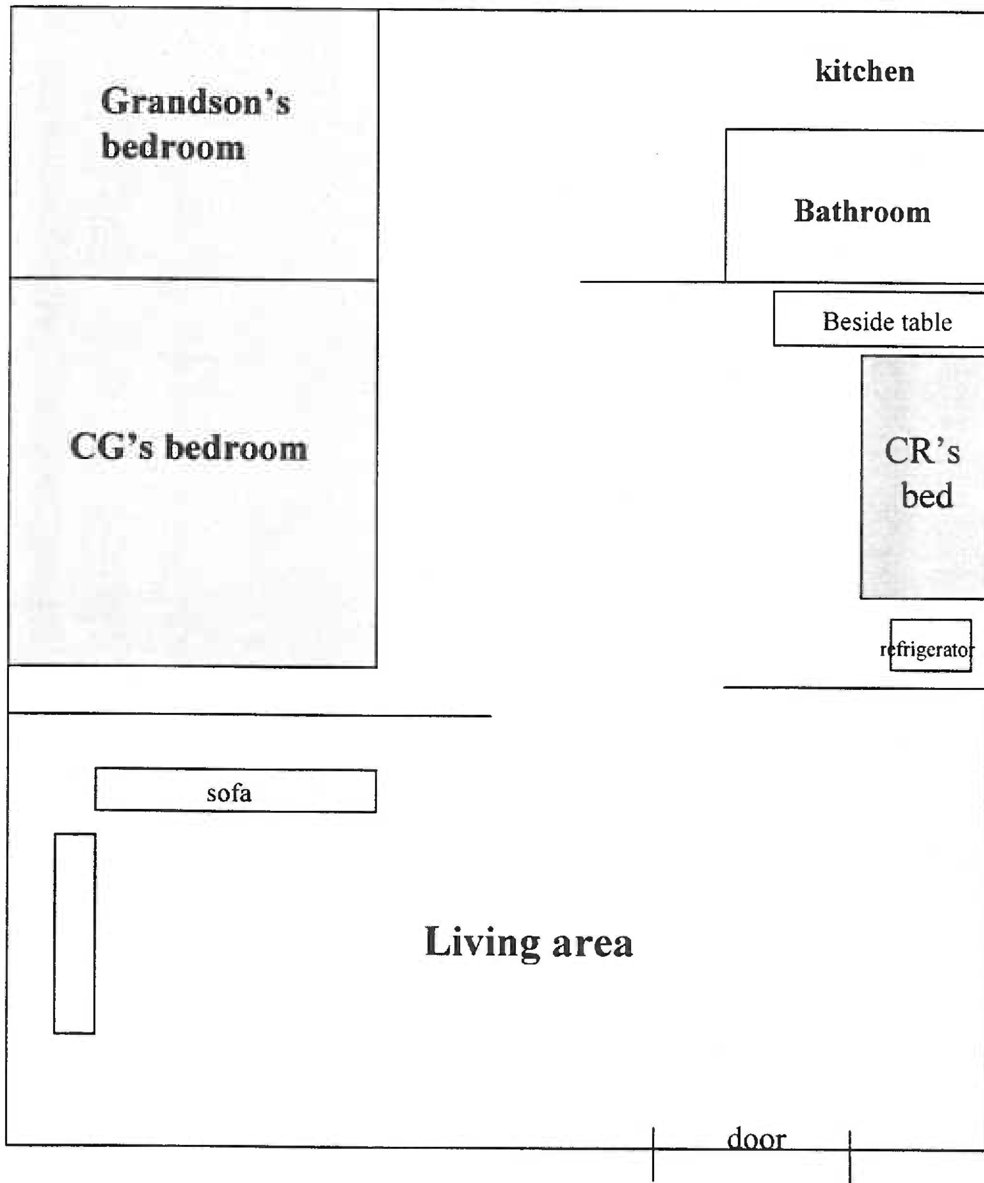
assistance with the tasks such as meal preparation, housekeeping, medications.

<u>Caregiving practice and supportive system:</u> The key informant is a primary caregiver to the frail elderly mother. She helps in caregiving activities for ADL which the care receiver could not perform herself. The caregiver's children (the grandchildren of the care receiver) usually assist in caregiving. There is no support from the care receiver's other children (a son and a daughter) in caregiving tasks. However, the youngest daughter visited or gives money to the mother from time to time.

<u>Setting:</u> The family home is a Thai style, two-story wooden house located in a very crowded area of Bangkok. The first floor includes a small living space, kitchen, two bedrooms, of which one is the bedroom of the informant and her husband. They set the space between the living room and the bedrooms as a place for the frail elderly mother. There is a full-sized wooden bed with mattress, blankets, and mosquito net for the mother's sleeping. The caregiver's children all sleep on the second floor. This area is quite dark however there is a fluorescence lamp on the wall and a small electric fan that helps this area have more ventilation.

The frail mother mostly stays in this place all day and night. Some appliances and her personal belongings that are used for her daily living such as; electric fan, cooler for water, basket containing betel leaves and areca nuts for consumption, bedpan, two buckets of water are set in areas around her for easy access.


STEM FAMILY
FA
MA(CR)
(Dead)
Dau1(CG)
Son 2
Dau3
Dau 4
ordained
as a monk
(dead)
married
moved out
married
moved out
married
moved out



Home Setting of ID #10

Family ID # 11

Information:

Family ID # 11: is a Thai Buddhist joint family whose members are a frail 81 year old mother (care receiver), a youngest daughter (caregiver), and a second son and his own family. The father died about 30 years ago. They all live in a house owned by the second son. The mother and the informant used to live together in other rented house but moved to live in this house nearly 20 years ago.

The parents has seven adult children which includes three sons and four daughters. The mother raised all children up by herself since her husband died and she did not remarry. All children are married and five of them live elsewhere with their own families. The living expenses of the household come from the second son's incomes which he runs his own business of auto and machinery repair shops at home.

Family caregiver (the key informant): is a 39 year old, divorced woman who is grade 7 (secondary level) educated. She has taken the role of primary caregivers of her mother for the past three years. She used to be married then divorced, but has no children. However, she said that she has been staying with her mother all the time even the time that she was married. Now she considers herself as a primary caregiver to her mother and gets the monthly income from her second oldest brother who asked her to help him look after his children and house chores.

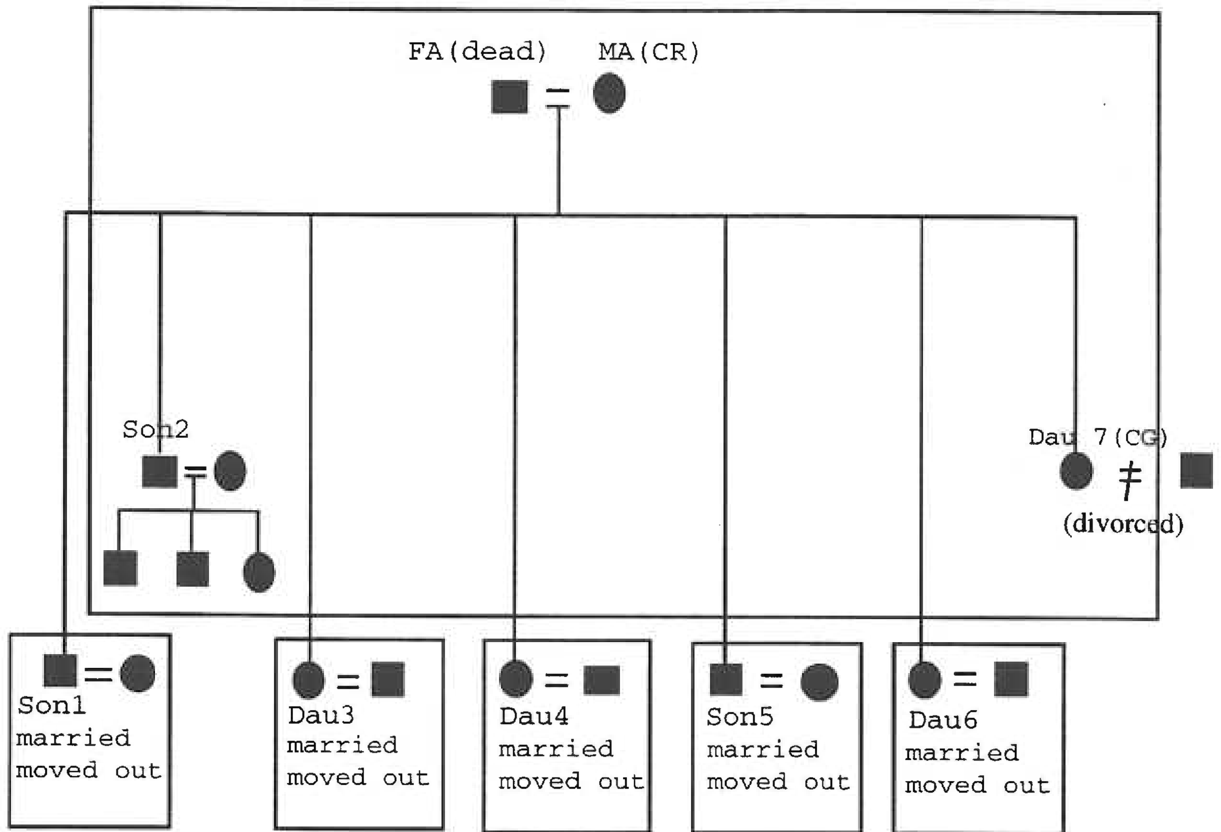
Care reciever (the mother): is a frail 81 years old woman who is semiconscious due to a cerebral atrophy. She is also has the problem of disabilty in movement due to falling which caused a fracture of her pelvic bone. She was admitted in a hospital in Bangkok for several months and was discharged after the family decided to take care of her at home. She now is semiconcious, responsing to pain and loud voices but unable to speak in a comprehensible way. She has a nasogastric tube for gavage feeding however cachexia is also present. she is completely

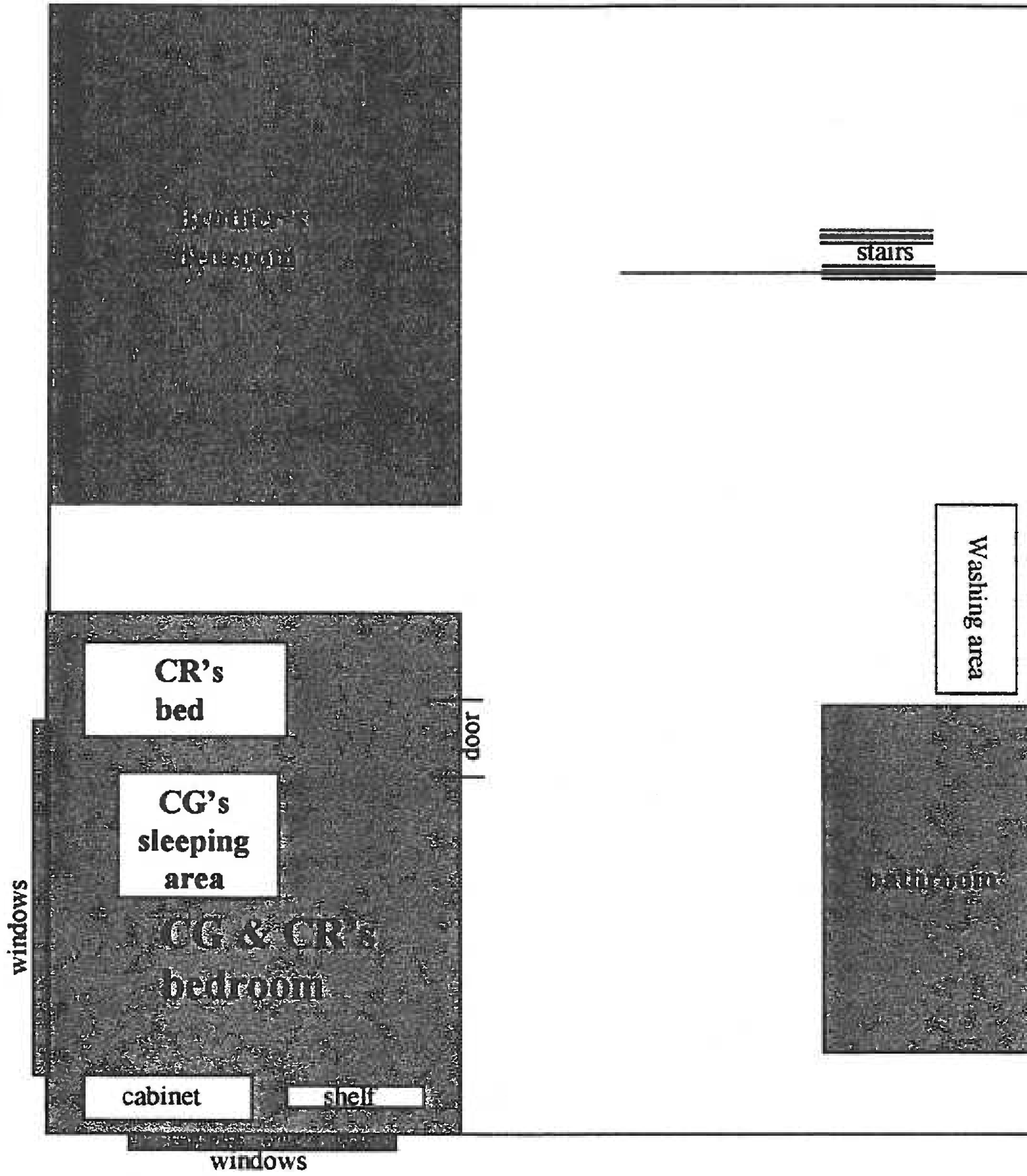
dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The key informant is a the primary caregiver to her mother. She does most of the assistance for the activities of daily livings such as feeding, bathing, bedding and toileting (evacuating, cleaning, changing clothes) for the mother. She also gets assistance in caregiving from her sister-in-law sometime. Other sisters and brothers do contribute financially for caregiving supplies or health services from time to time but not as a routine help. The second son mainly provides financial support for the mother's care needs including health services and medications. The informant pays for the mother's care supplies such as blue Chux pads, cottons, supplement feeding formula from her own money.

Setting: The house is a three-storey, contemporary style house. The first floor includes a dining area, a kitchen, and garage for the son's business.

The mother's room is on the second floor which is close to the bathroom and laundry area. The informant lives together with her mother in this room. The room is approximately 20 square meters in size. There are several windows in the room which some of them are opened for ventilation and light. The mother's bed is a Fowler's bed that was put close to the windows for ventilation and sunlight from the outside. The medical equipment such as the electric suction and blood pressure monitor are easily accessible. There is a cabinet holding stocks of medical and care supplies such as normal saline solution 0.9% for wound dressing, alcohol, blue chux pads, cotton, clothing, medicines, feeding equipment. On the wall at the side of the bed are pictures of Lord Budhha and respected Buddhist monks which are considered as the holy images. The informant usually sleeps on th floor nearby her mother every night.


JOINT FAMILY
FA(dead)
MA(CR)
Son2
Dau 7(CG)
(divorced)
Son1
married
moved out
Dau3
married
moved out
Dau4
married
moved out
Son5
married
moved out
Dau6
married
moved out



Home Setting of ID #11

Family ID # 12

Information:

Family ID # 12: is a Thai Buddhist stem family whose members are a frail 63 year old mother (care receiver), a third daughter (caregiver) her son, and a nephew (a son of the fourth daughter). The father has been dead for two years. The parents had six adult children which included five daughters and a son. Two elder sisters are married and live elsewhere with their own families. The fourth daughter died a year ago from car accident. Now her son who is seven years old also lives in with the informant. The youngest daughter and a son are not married but live elsewhere by themselves. This family lives in a small rented room on a second floor of a shared house.

The living expenses of the household come from the caregiver's earning, financial support from elder sisters sometimes, and support from a brother-in-law (husband of the fourth daughter).

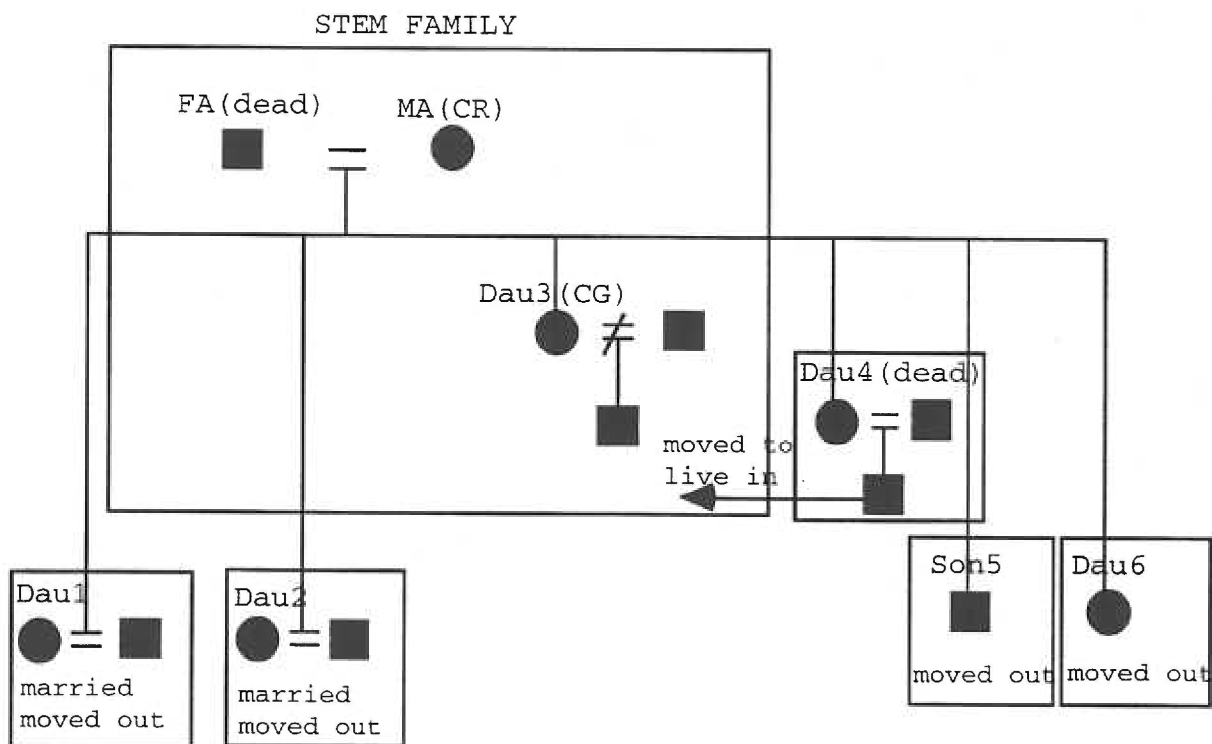
Family caregiver (the key informant): is a 34 years old divorced woman, the third daughter, and has the education level of primary school (grade 4). The informant has been worked as a temporary employee for several kinds of jobs. Now she makes her living from washing and ironing cloth for people in the neighborhood. She married tweleve years ago and has a son who is now 10 years old. However, she is now divorced and takes care of her son by herself. The informant has taken the role of primary caregiver for her mother for about a year because her mother became very frail and lost ability to take care for herself..

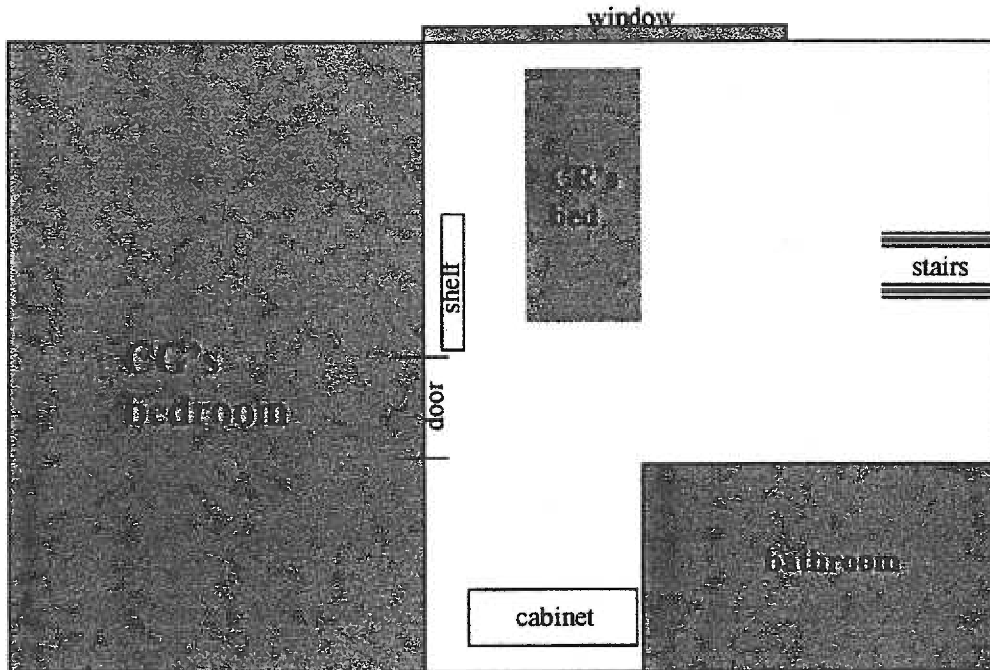
Care receiver (the mother): is a frail 63 years old woman who is completely dependent due to a stroke a year ago. She now is conscious, hemiplegic on the left side, aphasic, and still has the problem of incontinence. She needs total assistance in all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly mother. She takes all the responsibilities in caregiving activities for ADL

such as feeding, bathing, toileting, changing bedding due to incontinence, and position changing. The elder sisters visit the mother from time to time and provide financial support occasionally (which the informant said is still not adequate for caregiving expenses) but do not provide help in caregiving activities.

Setting: The rented room is a small compartment on the second floor of a shared, rented house. There is a small bedroom (approximate 15 square meters in size), a tiny living space close to a stairway which is used as a kitchen and the frail mother's unit. The mother lives in this small unit in which there are a small mattress, a mosquito net, an electric fan, a small shelf holding care supplies such as clothings, medicines, blue Chux pads, a plastic basin and wash cloth. There is a window at one side of this unit which is opened for ventilation and sun light from outside.


STEM FAMILY
FA(dead)
MA(CR)
Dau3(CG)
Dau4(dead)
moved to
live in
Dau1
married
moved out
Dau2
married
moved out
Son5
moved out
Dau6
moved out



Home Setting of ID #12

Family ID # 13

Information:

Family ID # 13: is a Thai Buddhist joint family whose members are an 80 year old mother (care receiver), a second daughter (caregiver), and the youngest daughter and her family. The father passed away about a year ago. They all live together in a small rented shared house located in a low income, working class community of Bangkok. The family used to live in a rural area where they worked in farm land; but they moved and moved to Bangkok nearly 20 years ago.

The parents have four adult children which includes three daughters and one son. The eldest daughter and son are married and live elsewhere with their own families. The caregiver and her youngest sister (and the sister's family: her husband and three children) live together in this house. The living expenses of the household comes from both of these two daughters in the household. The informant earns her living by selling juice and drinks (vendor cart) at a market near by her house. Her youngest sister used to work as a construction worker but now is laid off due to the economic recession in Thailand.

Family caregiver (the key informant): is the 50 years old, unmarried, second daughter of the family. She said that she did not finish her primary school because of her parents' poverty. She has taken the role of primary caregivers for her elderly mother for the past 5 years and also took care of her father before he died. He passed away about a year ago in this house.

Care receiver (the mother): is a 80 year old woman who could maintain all the activities of daily living by herself. However, for the IADL such as preparing meals, housework, getting about the community are the tasks that the mother has difficulties in doing herself. Thus, it is difficult for the mother to live alone because she no longer could maintain the household chores or prepare food for herself. The mother is very thin but has no major health problem. However, the informant said the mother's heath

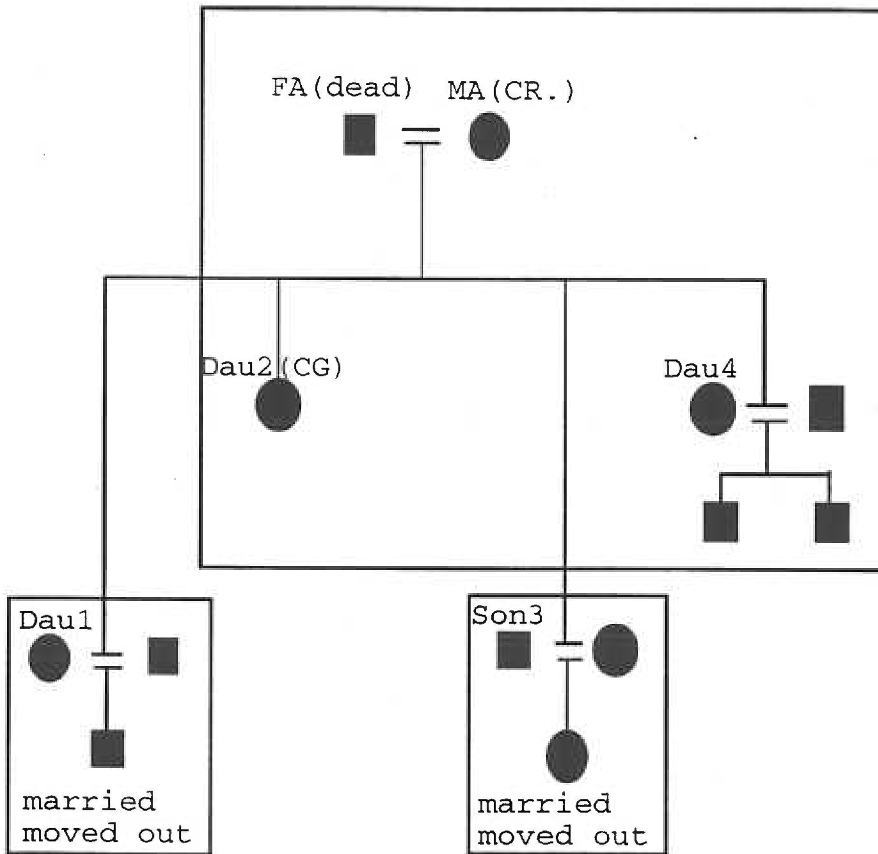
status is not quite stable because she sometimes develops problems of diarrhea or fever.

Care giving practice and supportive system: The key informant defined herself as a primary caregiver to her elderly mother. She helps in caregiving activities for IADL which the care receiver could not perform herself such as meal preparation, housekeeping, and transportation. The younger sister assists her sometimes in taking the mother to see the doctor or buying medicines for her.

Setting: The rented house is a one floor house with three small compartments (the informant and mother's shared room, the sister's room, and the nephews' room). The informant lives in the same room (bedroom) with her mother.

The informant and mother's room is about 12 square metres. There is not much furniture in this room only a plastic wardrobe, a television, and an electric fan. At one side of the room, there are a thin mattress and blankets for bedding. One side of the partitions that devide the room has sheves that carry Buddha statues, spiritual items (i.e. pictures, cabalistic writing), and also a picture of the dead father. The informant said that every morning her mother must do her religious practice at this area.

Outside the house there is a space which is set up to be a place that the mother can stay during the daytime. It's an area under a mango tree which has a wooden, raised-up floor. Although a small puddle is nearby this area, there is no disturbing smell. The ventilation is good in the outdoor area. The mother usually spends her leisure time in this area, sometimes just sitting and relaxing or doing her bamboo weaving (hat making) here.



JOINT FAMILY
FA(dead)
MA(CR.)
Dau2(CG)
Dau4
Dau1
married
moved out
Son3
married
moved out

windows

windows

Mother & CG's bedroom

Nephew's bedroom

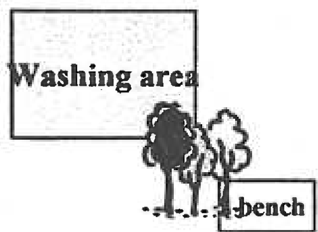
Religious activity area

Living area

Kitchen

Sister's bedroom

Wood pathway



Home Setting of ID #13

Family ID # 14

Information:

Family ID # 14: is a Thai Buddhist stem family whose members are a frail 83 year old mother (care receiver), a widowed daughter (caregiver), and her own family. The father died about 5 years ago. They all live in a house owned by the caregiver. The daughter's husband died 17 years ago. She reared her three children (two daughters and a son) by herself and has not remarried. One of the caregiver's daughter is now married and resides in this house.

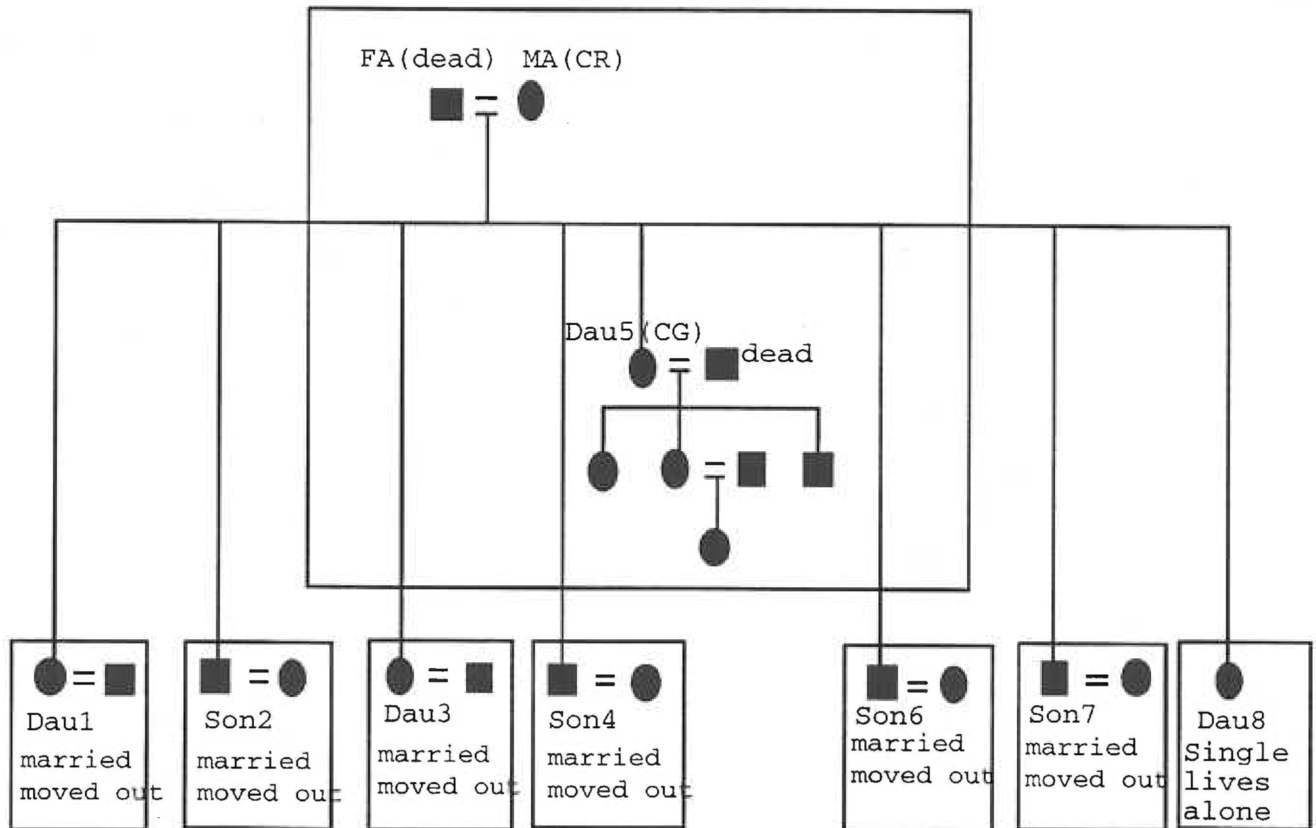
The parents has eight adult children which includes four sons and four daughters. They used to live in Nakorn Prathom province which is about 40 kilometers from Bangkok. Almost all of the children are married except the youngest daughter who is not married but lives by herself in a house not far away from this family. Other married children live elselwhere with their own families. The living expenses of the household come from the caregiver's saving, caregiver's children contribution, and financial support from the caregiver's brothers and sisters.

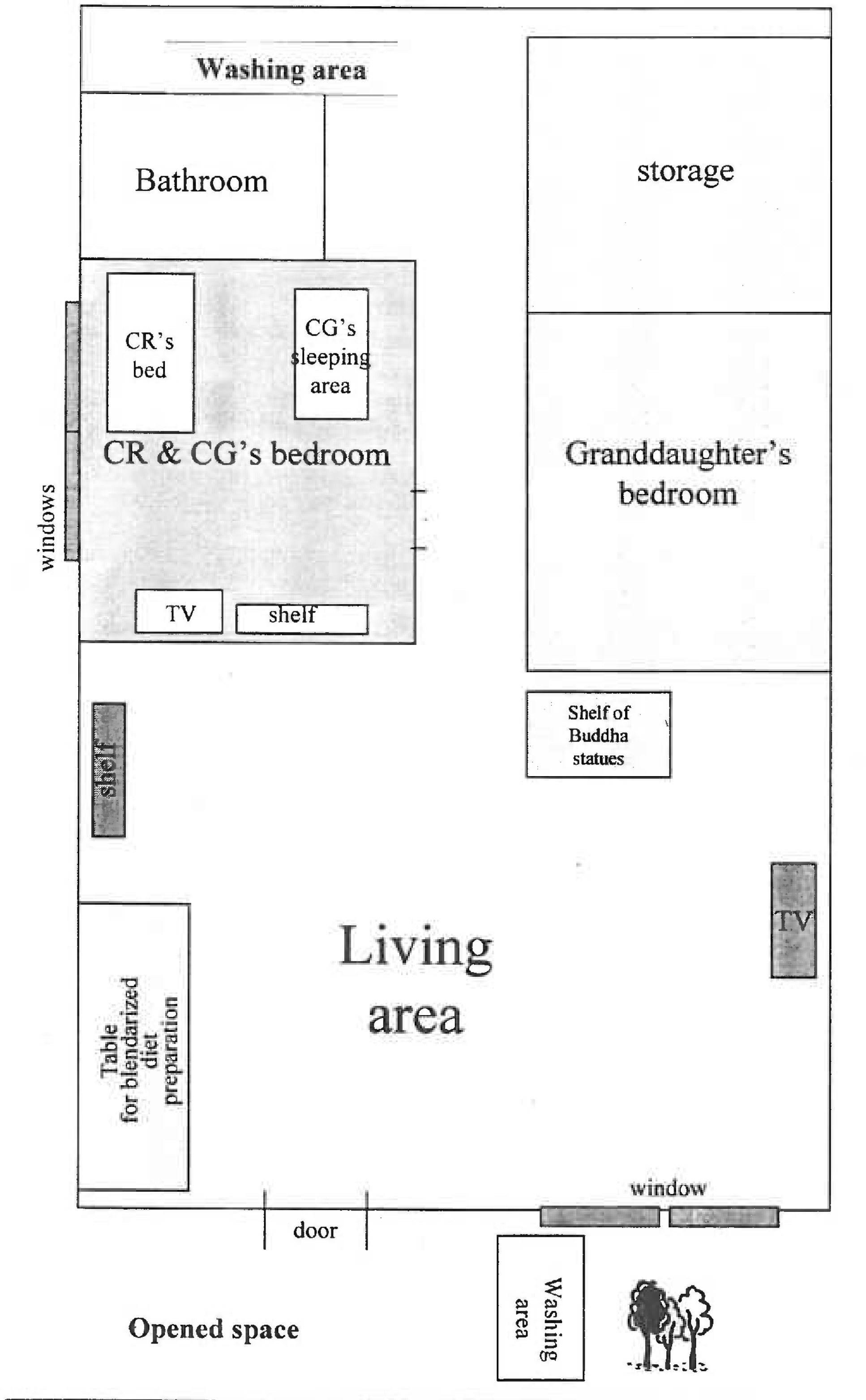
Family caregiver (the key informant): is a 52 year old, fifth child, widow who is grade 4 (primary level) educated. She has taken the role of primary caregivers of her mother for about a year since the mother started to have problems of dementia. She used to run her own business by selling fresh seafoods at a market but stopped the business about ten months ago after she had a hysterectomy. Now, she considers herself to be a primary caregiver to her mother.

Care reciever (the mother): is a frail 83 years old woman who is semiconscious due to a cerebral infarct. Six months ago she was admitted in a hospital in Bangkok for a month and was discharged after the family decided to take care her at home. She now is semiconcious, aphasic, and responds to pain and loud voices. She has a nasogastric tube for gavage feeding however cachexia is also present. she is completely dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The key informant is a primary caregiver to her mother. She does most of the assistance for the activities of daily livings such as feeding, bathing, bedding and toileting (evacuating, cleaning, changing clothes) for the mother. She also gets assistance in caregiving from both of her daughters such as preparation of the blendarized feeding diet and taking care while the key informant goes outside. Other sisters and brothers regularly contribute financially for caregiving supplies, medications, and all health services.

Setting: The house is a two-story, wooden house. The first floor includes a dining area, a kitchen, a bathroom, two bedrooms. The mother's room is on the first floor which close to the bathroom. The informant lives together with her mother in this room. The mother's room is the only room that has air conditioning and is approximately 20 square meters in size. There are several windows in the room of which some are opened for ventilation and light during the day time. The mother sleeps on an electric air bed for which the children collected money to buy for her. There is a shelf holding stocks of medical and care supplies such as normal saline solution 0.9% for wound dressing, alcohol, blue Chux pads, cotton, clothing, medicines, and feeding equipment.
On the wall at the side of the bed are pictures of Lord Budhha and respected Buddhist monks which are considered as the holy images. The informant usually sleeps on the floor nearby her mother every night.


STEM FAMILY
FA(dead) MA(CR)
Dau5 (CG)
dead
Dau1
married
moved out
Son2
married
moved out
Dau3
married
moved out
Son4
married
moved out
Son6
married
moved out
Son7
married
moved out
Dau8
Single
lives
alone



Home Setting of ID #14

Family ID # 15

Information:

Family ID # 15: is a Thai Buddhist stem family whose members are a 90 year old frail father (care receiver), a son (caregiver), and his youngest daughter. The mother died about five years ago. They all live in a small rented room in a shared, rented house. The family moved from Suphanburi province to live in Bangkok more than twenty years ago when the key informant got a job as a bus driver in the city.

The parents have seven adult children which includes three sons and four daughters. Two of the elder daughters died a couple of years ago. The other adult children are all married and live elsewhere with their own families. The living expenses of the household come from the caregiver's income and financial support from the caregiver's grown children sometimes.

Family caregiver (the key informant): is a 57 year old, fourth child (the first son), divorced man who is grade 10 (secondary level) educated. He has taken the role of primary caregiver to his father for the past seven years. He used to be married, then divorced, and has three adult children, two sons and a daughter. Now his youngest daughter, who is sixteen years old, also lives within this family home. His grown sons live elsewhere. He considers himself to be the primary caregiver to his father with the assistance from his daughter. He has worked as a bus driver for the Department of Public Transportation since he moved to live in Bangkok. His working hour is 12 PM to 8 PM. During the time of 12 PM to 3 PM, the care receiver is at home alone until the caregiver's daughter comes back from school and looks after him. However, the informant said that during the absence of family members, his neighbors usually look after the old father.

Care reciever (the father): is a 90 years old man who is conscious and still can maintain the activities of daily living by himself. However, because of his age and deterioration of his physical abilities such as his eyesight, mobility, and movement the care receiver needs assistance based on the functional

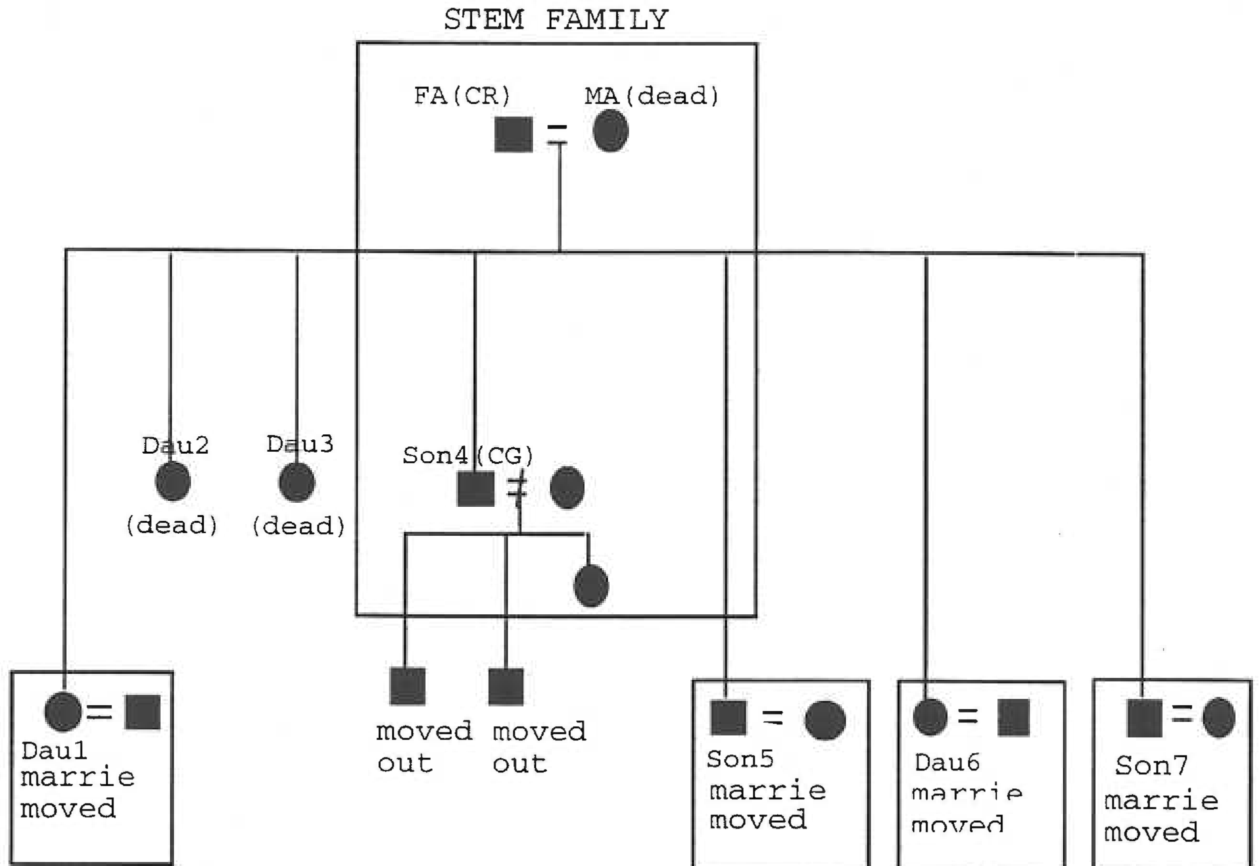
assessment of IADL such as preparing meals, housework, and getting about the community. The elderly father can no longer maintain the house chores or prepare foods for himself. He is very thin but has no major health problem.

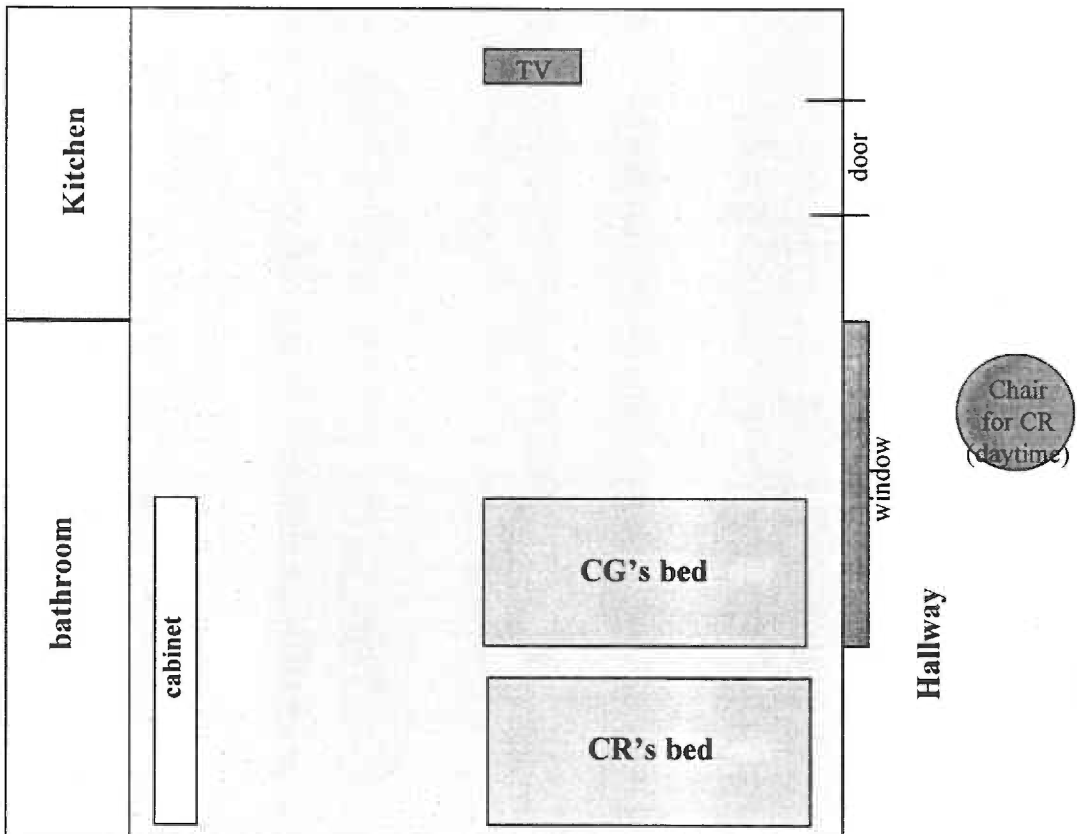
Care giving practice and supportive system: The key informant defined himself as a primary caregiver to his elderly father. He helps in caregiving activities for IADL which the care receiver could not performed himself such as meal preparation, housekeeping, and transportation. The caregiver's youngest daughter also assists in caregiving activities and looks after the care receiver part of the time while the informant is working.

Other sisters and brothers do contribute financially for caregiving supplies from time to time but not as a routine. Nearly all of the expenses for caregiving of the father are paid by the primary caregiver.

Setting: The rented room is a small compartment on the first floor of a shared, rented house. There is a small room which is approximate 16 square meters in size that this family lives in. In this room, there is not much furniture only a small wardrobe, a television and a video player, and an electric fan. At one side of the room, there are mattresses and blankets for bedding. A small kitchen and a bathroom are in the open space outside of this room.

During the daytime, the elderly father usually sit in his wooden couch in front of the room outside of the house. The informant will set up this couch and place a small chair by his side so the care receiver can put his belongings on this table. This setting is in the opened area with good ventilation and moderate temperature. Their neighbors can walk by and see the elderly father easily or can stop by to chat with him.


STEM FAMILY
FA(CR)
MA(dead)
Dau2
(dead)
Dau3
(dead)
Son4(CG)
moved out
moved out
Dau1 marrie moved
Son5 marrie moved
Dau6 marrie moved
Son7 marrie moved



Home Setting of ID #15

APPENDIX D

Initial Inventory of Keywords

Inventory of Keywords Related to filial relationships and caregiving from English Literature Reviews

Keyword	Meaning & observing symbollic actions	Source
Filial	-bearing the relationship of a child or issuing from as offspring	Webster's New Universal Dict. (1983)
Filial responsibility expectations	-common responsibilities that children should do to parents by •live near their parents •take care of parents when they are sick •give financial help •frequent visit and contact (e.g., writing, visiting) •feel responsible for their parents	Seelbach (1981)
Filial responsibility expectations	•affection •thoughtfulness •opened communications between parents and children	Blieszner & Mancini (1987)
Filial responsibility expectations	-the extent to which adult children are believed to be obligated to support their aging parents •shared activity •live nearby/ visit •live close so be able to help each other •sacrifice and support aging parents •parents are entitled to some return of their sacrifice to their children	Lee, Netzer, & Coward (1994)
Filial responsibility	-the responsibility for parents exercised by children including expectations for care and support of parents •financial and material aid •personal care (sick care, grooming, dressing, bathing) •service provision (laundry, food preparation, shopping, house cleaning, escorting) •respect (consulting, listening)	Novero Blust, & Scheidt (1988)

Keyword	Meaning & observing symbollic actions	Source
	•warmth and affection (gift giving, visiting, touching, hugging)	
Shared filial responsibility	-filial responsibility is the shared and organized of providing adequate care among siblings to meet the needs of elderly parents -types of participation •routine •backup •circumscribed •sporadic •dissociation -factors affect type of participation are family structure, family history, family ties	Matthews & Rosner (1988)
Obligation	-a duty imposed legally or socially; thing that one is bound to do as a result of a contract, promise, moral responsibility -the condition or fact of being in-debted to another for a favor or service received	Webster's New Universal Unabridged Dict. (1983)
Filial obligation	-obligation based on socialization to a cultural standard or expected socially responsible to elderly parents' dependency	Cicirelli (1993)
Filial obligation	-the repayment of a debt to the parent or to caring someone who is considered a part of one self •caregiving as a return to one's parent •caregiving as caring for a part of oneself •the impaired parent as an ill person •the impaired parent as a child	Albert (1990)

Keyword	Meaning/ observing symbollic actions	Source
Attachment		Webster' New Universal Unabridged Dict. (1983)
Filial attachment	-an internal feeling that parents and children feel for one another. -attachment behaviors included: •residential proximity •frequent visits •letter writing •caregiving -basic aspects of attachment are: •feeling of love •feeling of security or comfort •distress on separation •joy of reunion	Cicirelli (1983)
Solidarity	-combination or agreement of all elements or individuals, as of a group, complete unity as of opinion, purpose, interest, feeling etc.	Webster's New Universal Unabridged Dict.
Intergenerational solidarity	-the adult child/ children relationships with their parents which measured in term of •affect (feelings of closeness) •association (frequency of contact) •exchange (helping each other) •consensus (agreement concerning values and attitude) •norms of familial responsibility •structural of family	Bengtson & Robert (1991)

Keyword	**Meaning/ observing symbillic actions**	**Source**
Piety	-loyalty and devotion to parents, family, etc.	Webster's New Universal Unabridged Dict.
Filial piety	-a virtue of cultural norms in Confucian for child (especially a married son and his wife) to deeply commit or follow traditional expectations in providing normative obligation to parents by: •physical care •social-psychological comfort •respect and consult •honoring and glorify parents •faithful observance of important ceremonies	Him, Kim, Hurh (1991)
Filial piety	-duties or expectations of children to oblige to parents by •support parents (financially & morally) •continue the family line •obey and respect •self-sacrifice •attend parents all time especially when parents are sick or old •honor parent and ancestors	Tsai (1997)
Filial motivations	-the motivations reflect the adult children's willingness to care for their aged parents •respect to parent •filial responsibility •care with sacrifice •filial sympathy •harmonization of family •compensation for unaccomplished matters •desire to repay •religious belief •love of parent	

Keyword	Meaning/ observing symbollic actions	Source
Motivations for caregiving (in Thai culture)	•fulfilling the expected cultural norm of filial obligation •love or affection to the elders •a desire to reciprocate for past services and to build up future merit for themselves	Caffrey (1992)
Reciprocity	-reciprocal stage or relationship; mutual action, dependence etc. -a reciprocating; interchange; mutual exchange	Webster's New Universal Unabridged Dict. (1983)
Reciprocity	-the exchange of assistance between elderly and informal helpers (children, relative, friends, and neighbors)	Stoller (1985)
Reciprocity	-an intergenerational exchanges of assistance and support between an adult child and parent •warmth and regards •intrinsic rewards of giving •love and affection •balance within family caregiving	Carruth (1996)
Mutuality	in a mutual manner; in the manner of giving and receiving	Webster's New Universal Unabridged Dict. (1983)
Mutuality	-caregiver's ability to find gratification in the relationship with the impaired person and could perceive reciprocal between self and dementia elders	Hirschfeld (1983)
Mutuality	-positive quality of the relationship between a family caregiver and care receiver •love and affection •shared pleasurable activities •shared values •reciprocity	Archbold, Stewart, Greenlick, & Harvath (1990)

Keyword	Meaning/ observing symbollic actions	Source
Family caregiving	-caregiving is the intergenerational caring focused by purpose or meaning of behavior •anticipatory caregiving •preventive caregiving •supervisory caregiving •instrumental caregiving •protective caregiving	Bowers (1987)
Family caregiving	-caregiving as the invisible works from caregiver's framework •sense of self •sense of managing •sense of future •sense of fear and risk •sense of change in role and responsibility •tension	Hasselkus (1988)
Family caregiving	-caregiving is defined as system of caregiving which are: •primary caregiver •partnership •team	Keith (1995)
Family caregiving	-caregiving is viewed as a role which described in relation to which tasks or activities done by caregivers •personal care •house keeping •protection •transportation •behavior problems •financial, legal & health decisions •medically related •little extra •managed care	Archbold, Stewart, Harvath, & Lucas (1986)
Family caregiving	-caregiving is a cultural phenomenon occuring within the context of shared norms, values, and beliefs	Caffrey (1992)

<u>Inventory of keywords Related to Katanyu katavedi and Caregiving from Thai Literature Reviews and Linguistic Experts</u>

Keyword	Meaning/ observing symbollic actions	Source
katanyu katavedi (Thai language)	*Katanyu* = a sense of awareness and gratitude toward someone who has done something that benefits *Katavedi* = doing something in return for those benefits	Royal Thai Scholars Dictionary (1982) **Will ask linguistic experts to get the insider's perspective and linguistic expression to mediate symbollic actions that are simply observable
Bun khun or Phra khun	any good thing. help or favor done by someone which results in gratitude and obligation on the part of the beneficiary	Podhisita (1985)
Bun-bap		
Louk katanyu		
Louk a-katanyu		
Tod tan phra khun		
Kar nam noum		
Karn doo lae por mae		
Par ra		
Nar tee		

APPENDIX E

Initial Observational Guide

Note for Investigator

- Introduce self, status, background, training, area of inquiry, purpose and nature of the study to the respondent, telling how or through whom he/she came to be selected

- Explain the study and assure confidentiality of participant, explain about the need for written consent from the participants (key informants). Then review the consent form (Thai version) together between investigator and participant and answer questions in case participant is not clear in some points. Give investigator's telephone number in case the participant wants to contact.

- Explain rights of the participant in joining the study

- Explain ways of doing the study (by interview and participant observation) using simple and understandable words to explain. Inform the participant that there is no right or wrong with the answers. Investigator will be an observer or a student to learn from participant's experience.

- Ask about the convenient time for the participant to do the interview and observation. Describe the timing and length of time that investigator will take for each visit.

- Ask permission to tape-record the interviews and assure the participant about the confidentiality.

Observational Guide

Categories:

1. Physical settings

- survey general features of the setting, physical land space, type of building, environment, space organization, map drawing of the setting might be helpful
- physical environment where caregiving take place

2. General care (physical care and general activities)

- people involved, physical objects involved
- bathing, grooming, bedding, feeding, giving medicine etc. (sequencing of all actions)
- general routine

3. Interaction between caregiver and care receiver

- intimacy actions (e.g., touch, caress, eye contact, tone of voice)
- style of verbal communication
- nonverbal communication or body language such as facial expression, movement, distant interaction, emotional feeling and how it appears to be experienced by members of the interaction

4. Family structure

- relationships in family (hierarchical practice, closeness in family, authority, etc.)
- family activities (activities of family together)
- family norms, beliefs, ritual, and value (worship, religious activity)

5. General appearance of family members whose actions research has been observing (might be key informants, elders, or other family members)

- age and appearance, congruency
- personal hygiene
- physical health and strength
- personal behaviors

6. Materials or objects (that might lead to understanding the relationships or setting or lead to probing questions)

- photographs
- pictures
- spiritual figures or materials (Buddha statue, locket, books, flowers, etc.)

APPENDIX F

Initial Interview Guide (English Version)

Guideline for Interviews

Strategies/ Purposes	**Interview Questions**	**Research questions expected to be answered**
1. Start with grand tour interview Purposes •get information about participant in general •make participant to feel comfortable and relaxed in answer the simply questions first •gain data and information that will guide researcher to other questions or guide obseravation, such as: members in family, status, role, responsibilty in family, relations, etc.	Ask participant by using face sheet as a guideline such as: -How old are you?...etc. -How many people are there in the family? -Who you do consider to be head of the family? -How do you define? -Whose does this house belong to? -Number of elder's sons and daughters, where are you in family? -Are there any others or persons that you consider having caregiving relations with your parents (e.g., neighbors, other relatives) but might not live in the same household with you and your parents? -Can you explain what they do? How often? -How do the family members decide who will take care of parent? If the caregiving is shared, how does family justify who will do which parts?	- Demographic Data - Question 2 - Question 2 - Question 2

Strategies/ Purposes	**Interview Questions**	**Research Questions expected to be answered**
2. Use mini tour questions Purposes: •to lead the conversation to the specific issues of interest •to gain more detailed exploration of particular matter	Being a caregivers & caregiving practices in families	
	-Could you start by telling me a little bit about yourself?	- Question 2
	-How you describe yourself now as a caregiver to the your parent, when did it start?	
	-What are the reasons for you taking responsibilty for caregiving with your frail parent?	- Question 1, 2
	-What do you think are the sources or reasons that make your parent more frail and needing your assistances?	- Question 2
	-What was your status at that time before caregiving?	- Question 2
	-Can you tell me a little bit about the care you give to your parent?	- Question 2
	-Can you tell me about your day and your life during this time of taking care of your parent?	- Question 2
	-What is your experience and feeling now about doing this?	- Question 2, 4
	-Are there any other people in family that help you in this caregiving activities? Who and how?	- Question 2

Strategies/ Purposes	Interview Questions	Questions of research expected to be answered
	<u>Dail accounting care</u> (ask for example incident) -What happened? What should have happened? -How did your parent respond? -How did you feel? -Is there anything you wish were different about it? (the incident) -Is this incident typical? Unusual? -How does it affect your relationships with parent? with other family members? -How will it change what you do tomorrow, next week, etc.	- Question 2 - Question 4
	<u>Filial relationships</u> -Can you tell me about your family relationships since you were young? (with parents, siblings, etc.) -How about your relationships with parent before he/ she became frail? -How about the realtionship now?	- Question 1, 2 - Question 1, 2
	<u>Filial responsibilitis & motivations & obligation</u> -What kinds of things do you consider as responsibilties of child or children in taking care of older parents?	- Question 1, 2 - Question 1

Strategies/ Purposes	Interview Questions	Questions of research expected to be answered
	-What things should children do for them when they become old but are still healthy? What about when they are frail or sick?	- Question 1
	-What are your motivations for taking care of your parent?	- Question 1
	-What do you think about obligation (paying back) to parents when they become old? How about your case?	- Question 1
	<u>*Katanyu katavedi*</u>	
	-Do you believe in religious (Buddhist) precepts and teaching about responsibility of children to parent -What do you think about it?	- Question 1
	-What is *katanyu katavedi* in your opinion? Does it influence how you take care of your parents?	- Question 1
	-Are there any other things that you think are related to *katanyu katavedi*?	- Question 1
	<u>Impact of social changes</u>	
	-How do you think changes in modern Thai society affect the caregiving of children to their parents?	- Question 3
	-How about the changes that affect your caregiving situation, can you tell me about your case?	- Question 2, 3

Strategies/ Purposes	**Interview Questions**	**Questions of research expected to be answered**
	-How do you think the traditional concept of *katanyu katavedi* will be affected by the social changes in Thailand?	- Question 3
3. Request for clarification (probing) of particular terms, situations, themes, concepts, key words that might be used by informant or from the field context <u>Purposes:</u> •to clarify the meanings from the informant's own words •Help gain clarity of the exploration	-Examples of keywords or key concepts that found in review of literature are: filial responsibilty, obligation, duty, motivation, merit and demerit, *bun khun, katanyu katavedi*, burden, stress, coping, adjustment -Using native-language questions/ words and combined with probing questions such as: •Tell me about...... •Can you clarify what...means to you •Give me an example or a situation that you mentioned about......... -Use general probe or restate terms or sentences that were mentioned such as: •It seems to me you are saying..... •So you mean..........	- Question 1, 2, 3,4

APPENDIX G

Interview Guide (Thai Version)

แบบสัมภาษณ์ (เบื้องต้น)
สำหรับ
งานวิจัยวิทยานิพนธ์ ระดับดุษฎีบัณฑิต
เรื่อง
"ความกตัญญูกตเวที และการดูแลบิดามารดา ที่ต้องการดูแล
ด้านสุขภาพ จากข้อคิดเห็นของครอบครัวไทย
ในเขตกรุงเทพมหานครประเทศไทย"
โดย
นางสาวจิราพร เกศพิชญวัฒนา

ข้อสังเกต

- แนะนำตัว, สถานะ, พื้นฐานการศึกษา, สิ่งที่ต้องการศึกษา, วัตถุประสงค์ และลักษณะของงานวิจัย แก่ผู้ที่จะเข้าร่วมงานวิจัย อธิบายด้วยว่าทำไมเขาถึงได้รับเลือกให้เป็นกลุ่มตัวอย่าง
- อธิบายถึงงานวิจัยและข้อมูลความลับของผู้ร่วมวิจัยที่จะไม่ถูกเปิดเผย
- อธิบายถึงความจำเป็นที่ต้องได้รับการยินยอมจากผู้ร่วมวิจัย
- ให้ผู้ร่วมวิจัยมีโอกาสอ่านเพื่อทำความเข้าใจเกี่ยวกับการยินยอมเข้าร่วมวิจัยพร้อมกับนักวิจัย ทั้งนี้เพื่อผู้วิจัยสามารถตอบคำถาม หรืออธิบายให้ความกระจ่างในกรณีที่ผู้ร่วมวิจัยไม่เข้าใจ
- ให้เบอร์โทรศัพท์แก่ผู้ร่วมวิจัยในการต้องการติดต่อ
- อธิบายถึงสิทธิของผู้เข้าร่วมวิจัย
- อธิบายถึงวิธีการเก็บข้อมูลของงานวิจัย (ซึ่งใช้การสัมภาษณ์และการเข้าร่วมสังเกตการณ์) พยายามใช้คำพูดที่ง่าย เข้าใจได้ บอกผู้ร่วมวิจัยว่าในการตอบคำถามจะไม่มีคำตอบที่ถือว่าผิดหรือถูก ผู้วิจัยจะเป็นผู้สังเกตการณ์และทำการเรียนรู้จากประสบการณ์ของผู้ร่วมวิจัย
- ถามถึงเวลาที่ผู้ร่วมวิจัยสะดวกในการที่ผู้วิจัยจะเก็บข้อมูล เยี่ยม อธิบายถึงระยะเวลาในการสัมภาษณ์ และเยี่ยม
- ขออนุญาติผู้ร่วมวิจัยในการอัดเทประหว่างสัมภาษณ์ และยืนยันในเรื่องความลับส่วนบุคคลของผู้ร่วมวิจัย

สิ่งที่ต้องทำระหว่างเก็บข้อมูล

1. แนะนำตัว, แสดงบัตรประจำตัวข้าราชการ, นักวิจัย, (พื้นฐาน, สถานะ, การวิจัยที่จะทำ)
2. แจ้งวัตถุประสงค์การวิจัย
3. อธิบายเหตุผลที่ผู้เข้าร่วมวิจัยได้รับเลือกเข้าเป็นกลุ่มศึกษา
4. วิธีการวิจัย (ง่ายๆ เข้าใจได้)
5. ใบยินยอม, ข้อมูลความลับ, ตอบคำถาม
6. สิทธิ์ของผู้ร่วมวิจัย
7. บทบาทของนักวิจัยในการเรียนรู้, สังเกตการณ์, ที่ปรึกษาและให้ความช่วยเหลือ
8. คำตอบ-เป็นสิทธิของผู้ร่วมวิจัยที่จะตอบ ไม่มีผิด-ถูก
9. ขออนุญาตอัดเทป
10. นัดหมายเวลา
11. แจ้งเวลาที่จะมาเยี่ยม, ระยะเวลาที่ใช้
12. เบอร์โทรศัพท์ของผู้วิจัย

หมายเลขครอบครัว______________

หมายเลขผู้ถูกวิจัย______________

แผ่นหน้า

วันสัมภาษณ์______________

ระยะเวลาสัมภาษณ์______________

เริ่มสัมภาษณ์เวลา______________

สัมภาษณ์เสร็จเวลา______________

สถานที่ๆสัมภาษณ์______________

ผู้อยู่ในระหว่างสัมภาษณ์______________

<u>ข้อมูลของผู้ถูกสัมภาษณ์</u>

อายุ______________

เพศ______________

การศึกษา______________

เชื้อสายบรรพบุรุษ______________

สถานที่ๆ พำนัก______________

เกิดที่______________

อาชีพ______________

ศาสนา______________

สถานภาพสมรส / ปี______________

จำนวนบุตร______________

จำนวนคนในครอบครัว (อาศัยอยู่ในบ้านเดียวกัน)______________

ระยะเวลาของการเป็นผู้ดูแล______________

ความสัมพันธ์กับผู้สูงอายุ (ที่ดูแลอยู่)______________

<u>ข้อมูลเกี่ยวกับผู้สูงอายุ</u>

ข้อมูลนี้อาจถามจากตัวผู้สูงอายุเอง, หากผู้สูงอายุไม่สามารถให้ข้อมูลได้ อาจสอบถามข้อมูลจากผู้ดูแล หรือสมาชิกอื่นในครอบครัว

อายุ______________

เพศ______________

การศึกษา______________

เชื้อสายบรรพบุรุษ______________

สถานที่พำนักอาศัย______________

เกิดที่______________

ระยะเวลาที่อาศัยอยู่ในครอบครัวกับผู้ดูแล______________

อาชีพ______________

ศาสนา________________________________

ความเจ็บป่วย หรือโรคประจำตัวที่เป็นอยู่________________________________

ปัญหาสุขภาพ (ประเมินโดยใช้ แบบประเมินADL & IADLและความต้องการดูแล

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รายละเอียดเกี่ยวกับโครงสร้าง/ความเกี่ยวเนื่องในครอบครัว

แบบแนวทางการสัมภาษณ์

เริ่มจากการสัมภาษณ์เรื่องทั่วๆ ไป : ใช้แผ่นหน้าในการถามรายละเอียดข้อมูล

1. - อายุเท่าไร
- มีคนในครอบครัวทั้งหมดกี่คน
- ใครที่เป็นหัวหน้าครอบครัว
- อะไรที่ทำให้คุณถึงคิดว่าคุณเป็นหัวหน้าครอบครัว
- บ้านนี้เป็นของใคร
- คุณ(ชื่อ)____________มีลูกทั้งหมด เป็นลูกผู้ชาย_________คน ลูกผู้หญิง____________คน
- คุณเป็นลูกคนที่เท่าไร
- มีใครคนอื่นในครอบครัวที่มีส่วนช่วยในการดูแล(ชื่อ)________ด้วย

บุคคลอื่นที่ไม่ใช่ครอบครัว เช่น เพื่อนบ้าน, ญาติพี่น้องคนอื่นๆที่ไม่ได้อยู่ในครอบครัวกับคุณ แต่ช่วยคุณในการดูแล มีใครบ้าง เขาช่วยอย่างไรบ้าง

- พี่น้องบุคคลในครอบครัว ตัดสินอย่างไรว่าใครจะเป็นคนดูแลคุณ
- ในกรณีที่คนดูแลคุณ_______เป็นการช่วยกันดูแลจากหลายคนในครอบครัว มีการแบ่งภาระหน้าที่กันอย่างไรว่าใครจะรับผิดชอบในเรื่องใด

2. ใช้คำถามแบบกว้างๆ ในประเด็นที่เข้าใจเพื่อฟังการสนทนาเข้าสู่ประเด็นที่สนใจศึกษา

<u>บทบาทการเป็นผู้ดูแล และการดูแลผู้สูงอายุในครอบครัว</u>

- อยากให้คุณเริ่มโดยเล่าให้ฟังเกี่ยวกับตัวคุณ
- อยากให้เล่าถึงความเป็นมาของการที่คุณมาเป็นผู้ดูแลคุณ___________
- เริ่มตั้งแต่เมื่อไร
- อะไรที่ทำให้คุณรับผิดชอบบทบาทในการดูแลคุณ____________
- อะไรที่ทำให้คุณ (พ่อ/แม่) ของคุณช่วยเหลือตัวเองได้น้อยลงและอยู่ในสภาพที่ต้องการการดูแลจากคุณ
- ก่อนที่คุณจะเข้ามารับบทบาทเป็นผู้ดูแลคุณ_________คุณมีบทบาทอย่างไรในครอบครัว (เช่น หน้าที่ความรับผิดชอบในครอบครัว)
- ลองเล่าให้ฟังเกี่ยวกับการดูแล การพยาบาลที่คุณทำให้แก่คุณ (ชื่อ)__________
- ลองเล่าให้ฟังว่าในวันหนึ่งๆ คุณมีกิจวัตรอะไรบ้างที่ต้องทำเป็นประจำแก่คุณ (ชื่อ)______________
- ชีวิตคุณเป็นอย่างไร ในการที่คุณดำเนินชีวิตเช่นนี้
- คุณรู้สึกเป็นอย่างไร คิดอย่างไร กับสิ่งที่คุณทำให้แก่คุณ (ชื่อ)_________
- มีใครคนอื่นในครอบครัวไหม? ที่ช่วยคุณในกิจกรรมการดูแล ลองบอกชื่อและสิ่งที่เขาช่วยคุณ

<u>กิจวัตรที่เกี่ยวกับการดูแล (ถามโดยให้ลองยกตัวอย่าง เหตุการณ์)</u>

- ลองเล่าให้ฟังถึงเหตุการณ์.........(ที่คุณกล่าวมา)
- เกิดอะไรขึ้น
- คุณ (ชื่อบิดา หรือมารดาที่รับการดูแล) แสดงปฏิกิริยาอย่างไรต่อเหตุการณ์นั้น
- คุณรู้สึกอย่างไร
- หากให้ย้อนเวลากลับไปคุณอยากจะให้เปลี่ยนอะไร
- เหตุการณ์ที่คุณเล่ามาเป็นสิ่งที่เกิดขึ้นบ่อยๆ ประจำ หรือ เป็นเหตุการณ์พิเศษค่ะ
- เหตุการณ์ดังกล่าว ส่งผลกระทบต่อความสัมพันธ์ระหว่างตัวคุณและคุณ (ชื่อ)_______________อย่างไร หรือไม่ ส่งผลกระทบต่อคนอื่นด้วยหรือไม่
- ถ้าเป็นไปได้ คุณคิดว่าเหตุการณ์ดังกล่าว ส่งผลกระทบต่อคุณอย่างไรในอนาคตวันข้างหน้า

<u>ความสัมพันธ์ ผูกพันธ์ระหว่าง บิดา-มารดา-บุตร</u>

- ลองเล่าให้ฟังถึงความสัมพันธ์ระหว่างพ่อ-แม่-ลูก ภายในครอบครัวท่านตั้งแต่ท่านเด็กๆ
- ความสัมพันธ์ระหว่างท่านกับคุณ(ชื่อ)________ก่อนหน้านี้ (ก่อนที่คุณ ___________จะป่วย) เป็นอย่างไร
- ความสัมพันธ์ตอนนั้น เป็นอย่างไร

<u>ความรับผิดชอบในการดูแลบิดา มารดา และแรงจูงใจ การทดแทนบุญคุณ</u>

- คุณคิดว่าอะไรเป็นสิ่งที่เป็นหน้าที่ๆ ลูก หลาน ควรจะรับผิดชอบในการดูแลบิดายามแก่ชรา
- คุณคิดว่าลูก หลาน ควรทำเช่นไรที่จะตอบแทนบุญคุณแก่บิดา มารดา ในยามที่แก่ชราแต่ยังแข็งแรง หรือ ควรทำอย่างไรหาก บิดา มารดาเจ็บป่วย ไม่สามารถช่วยเหลือตัวเองได้ดังเดิม
- อะไรที่คุณคิดว่าลูก หลาน จะต้องดูแลตอบแทน ทดแทนบุญคุณ บิดา มารดา
- คุณคิดว่าจำเป็นไหมที่ลูก หลาน ต้องดูแลตอบแทน ทดแทนบุญคุณ บิดา มารดา เมื่อแก่ชรา ในกรณีของคุณ คุณคิดอย่างไร

<u>ความกตัญญูกตเวที</u>

- คุณเชื่อในเรื่องศาสนาพุทธ คำสอน ที่สอนให้เราต้องตอบแทน ทดแทนบุญคุณ แด่บิดา มารดา หรือไม่
- คุณคิดเกี่ยวกับเรื่องนี้อย่างไร

- ในความคิดเห็นของท่าน "ความกตัญญูกตเวที" คืออะไร ต้องทำเช่นไร ถึงจะกล่าวได้ว่ามีความกตัญญูกตเวที ต่อบิดา มารดา สิ่งนี้มีส่วนในการทำให้ท่านดูแล บิดา มารดา ท่านหรือไม่
- มีสิ่งอื่นที่ท่านคิดว่าเกี่ยวข้องกับความกตัญญูกตเวทีอีกไหม

<u>ผลกระทบทางการเปลี่ยนแปลงของสังคมไทย</u>

- คุณคิดว่าการเปลี่ยนแปลงของสังคมไทยสมัยใหม่ ส่งผลกระทบต่อการดูแลที่ลูกหลานจะตอบแทนแก่ บิดา มารดา อย่างไร
- การเปลี่ยนแปลงดังกล่าว ส่งผลกระทบต่อการดูแลในกรณีของท่านอย่างไร ลองเล่าถึงกรณีของคุณที่คุณประสบมา
- คุณคิดว่า การเปลี่ยนแปลงในสังคมไทยดังกล่าว ส่งผลกระทบต่อความกตัญญูกตเวทีอย่างไร

*

พยายามถาม, ขอคำอธิบายให้ผู้ถูกสัมภาษณ์เล่าถึงเหตุการณ์ หรือความหมายของคำที่เกี่ยวข้องกับงานวิจัยนี้ จากความเข้าใจของเขาเอง เช่น ความรับผิดชอบ, การทดแทนพระคุณ, หน้าที่, ความรับผิดชอบ, การทำบุญ-บาป, บุญคุณ, ภาระ, ความเครียด, การปรับตัว พยายามใช้คำที่ผู้ถูกสัมภาษณ์ใช้ เพื่อย้อนภาพให้ผู้ถูกสัมภาษณ์เล่า หรืออธิบายขยายความต่อ เช่น

- ลองเล่าเกี่ยวกับเรื่องที่คุณพูดถึง
- ที่คุณพูดถึง_____________ลองอธิบายหรือยกตัวอย่างให้อีกหน่อยนะค่ะ
- ดูเหมือนคุณจะพูดว่า_________________
- คุณหมายความว่า___________________

แบบประเมินกิจกรรมของกิจวัตรประจำวัน ADL

กิจกรรม	ทำเองได้	ต้องการช่วยเหลือ	รายละเอียด
อาบน้ำ			- เตรียมเริ่มการอาบน้ำได้ - ชนิดการอาบน้ำ(ตักอาบในห้องน้ำเอง, ฝักบัว, เช็ดตัว) - การเตรียม - สามารถทำความสะอาดด้วยตนเอง - สระผม
แต่งตัว			- เลือกเสื้อผ้า - สวมเสื้อผ้า - ติดกระดุม - แต่งตัวได้ถูกต้อง - ถอดเสื้อผ้าได้เอง - ซักเสื้อผ้า
การเคลื่อนย้าย			- จากเตียง-มายังเก้าอี้ - จากเก้าอี้-มายืน - จากยืน-นั่งไปยังเตียง
การเข้าห้องน้ำ			- ไปห้องน้ำได้ - ใช้ห้องน้ำได้ถูกต้อง
การขับถ่ายอุจจาระ/ปัสสาวะ			- ความถี่-และการควบคุมการขับถ่าย - ท้องผูก(การควบคุมการถ่ายอุจจาระ) - การควบคุมการถ่ายปัสสาวะ

แบบประเมินกิจกรรมของกิจวัตรประจำวันที่เกี่ยวกับอุปกรณ์ IADL

กิจกรรม	ทำเองได้	ต้องช่วย	ไม่เคยทำ	ไม่ได้ทำอีกต่อไป
โทรศัพท์				- ค้นหาเบอร์โทรศัพท์ได้ - หมุนโทรศัพท์เอง
การใช้ยา				- การเตรียม - การใช้
กิจกรรมนอกบ้าน				- จัดการ/จัดเตรียมด้วยตนเองได้ - หลงทาง (ช่วยตัวเองได้)
ขับรถ				
งานบ้าน				- ดูแลกิจการภายในบ้าน กิจกรรมที่ทำได้ (ระบุกิจกรรม)
การเตรียมอาหาร				- การจัดเตรียม - ไปจ่ายตลาด - เตรียมอาหารได้
การทำ/ดูแลเกี่ยวกับเงินทอง				- จัดการเรื่องการเงินของตนเอง/ครอบครัว - ดูแลค่าใช้จ่ายต่างๆ
กิจกรรมทางศาสนา				- ไปวัด - จัดเตรียม/กิจกรรมทางศาสนา-ตักบาตร-ทำบุญ - สวดมนต์ไหว้พระ

APPENDIX H

H1: Approval of the Proposal Study by IRB, OHSU

H2: Approval of the Proposal by Office of the National Research Committee of Thailand

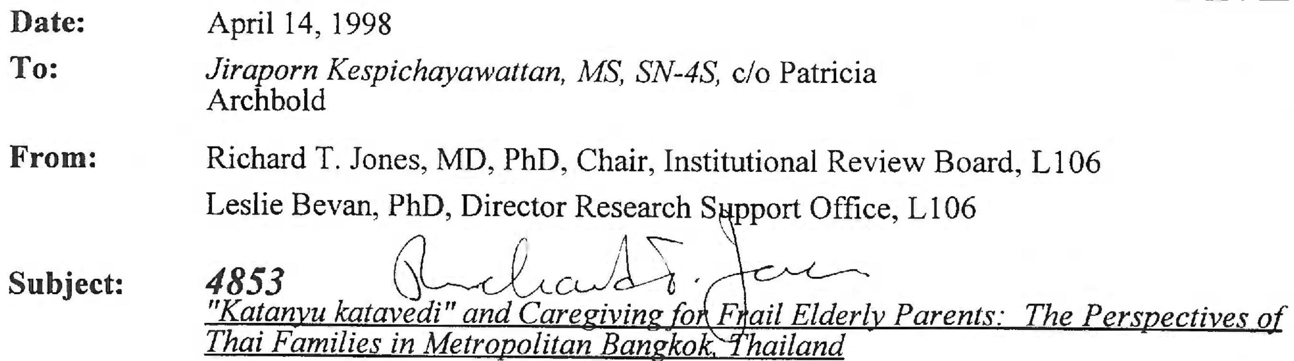
H3: Letter of Support for Access to Families in Communities from Department of Health, Bangkok Metropolitan Bangkok

OREGON HEALTH SCIENCES UNIVERSITY

Research Support Office (RSO), L106 (503) 494-7887

MEMO

302



Date: April 14, 1998

To: *Jiraporn Kespichayawattan, MS, SN-4S,* c/o Patricia Archbold

From: Richard T. Jones, MD, PhD, Chair, Institutional Review Board, L106

Leslie Bevan, PhD, Director Research Support Office, L106

Subject: *4853*

"Katanyu katavedi" and Caregiving for Frail Elderly Parents: The Perspectives of Thai Families in Metropolitan Bangkok, Thailand

Protocol/Consent Form Approval

We received your response to the IRB recommendation(s) on 4/13/98.

Your protocol/consent form is approved for One Year effective 4/14/98.

The IRB# and the date of this approval should be placed at the top right corner of the first page of the consent form.

Investigators must provide subjects with a copy of the consent form, keep a copy of the signed consent form with the research records, and place a signed copy in the patient's hospital/clinical medical record (if applicable).

If this project involves the use of an Investigational New Drug, a copy of the approved protocol must be forwarded to the Pharmacy and Therapeutics Committee (Pharmacy Services - Investigational Drugs, OP-16A).

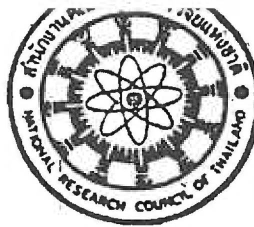
If this is a cancer study, we will notify the Oregon Cancer Center (OCC) of the IRB approval. As the PI, you are responsible for providing the OCC with copies of the final approved protocol/consent form.

If other levels of review and approval are required, the project should not be started until all required approvals have been obtained. In addition, studies funded by external sources must be covered by an agreement signed by the sponsor and the Oregon Health Sciences University. Principal Investigators are not authorized to sign on behalf of the University.

Thank you.

(rev.12/97)

สำนักงานคณะกรรมการวิจัยแห่งชาติ
196 ถนนพหลโยธิน เขตจตุจักร
กรุงเทพฯ 10900
โทรศัพท์ 579-0593
โทรสาร 579 2283



Cable Address : NRC

NATIONAL RESEARCH CO
196 PHAHOLYOTHIN RD., CHAT
BANGKOK 10900, THAILAN
Telephone 579-0593
Telex 82213 NARECOU TH
Fax. (662) 579 2283

No.0705/300

9 March B.E. 2541 (1998)

Dear Prof.Archbold,

Kindly refer to your letter dated February 4,1998 requesting for our evaluation of Ms.Jiraporn Kespichayawattana's dissertation research which focuses on family care to frail elders in the metropolitan Bangkok community.

The NRCT Disciplinary Committee on Sociology has examined Ms.Kespichayawattana's dissertation research and is pleased to inform you that the NRCT approves of Ms.Kespichayawattana's proposed study plan regarding the protection of participants and the consent process and risks associated with breach of confidentiality of research finding that both of which have been satisfactorily addressed in a culturally appropriate manner.

The NRCT, in addition, would like to express its sincere thanks for your kind assistance to Ms.Kespichayawattana regarding her study and avail itself of any cooperation needed by the OHSU.

Best regards,

Yours sincerely,

C. Arthachinta

(Mr. Chirapandh Arthachinta)
Secretary-General

Department of Health

Bangkok Metropolitan Administration

Mit Maitri Road, Din Daeng

Bangkok 10320

4 February, 1998

Prof. Dr. Patricia G.Archbold

School of Nursing

Oregon Health Sciences University

Portland, Oregon

U.S.A.

Dear Prof. P. Archbold,

This is in reply to your letter dated January 5, 1998 requesting Ms. Kespichayawattana to carry out her research on family care to frail elders in the Metropolitan Bangkok Community.

I am happy to inform you that Ms. Kespichayawattana is given permission to carry out her study in the area of Health Center # 15, 25 and 52.

Sincerely Yours,

Suwanee Raktham

Dr.Suwanee Raktham

Director General

Department of Health

School of Nursing
Oregon Health Sciences University
Portland, Oregon, U.S.A.

16 มกราคม 2541

เรื่อง ขออนุมัติให้ทำการวิจัย และเก็บข้อมูลในพื้นที่
เรียน ผู้อำนวยการสำนักอนามัย กรุงเทพมหานคร
สิ่งที่ส่งมาด้วย: 1. จดหมายจากอาจารย์ที่ปรึกษา
2. โครงร่างงานวิจัยฉบับย่อ และแบบสัมภาษณ์เบื้องต้น (ภาษาไทย)

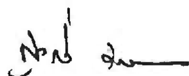
เนื่องด้วยดิฉัน น.ส. จิราพร เกศพิชญวัฒนา นักศึกษาระดับปริญญาเอก คณะพยาบาลศาสตร์ การพยาบาลผู้สูงอายุ มหาวิทยาลัยโอเรกอน สหรัฐอเมริกา จะได้ทำงานวิจัยในระดับปริญญาเอกในหัวข้อ "ความกตัญญูกตเวที และการดูแลบิดามารดาที่ต้องการการดูแลด้านสุขภาพ จากข้อคิดเห็นของครอบครัวไทย ในเขตกรุงเทพมหานคร" ในการนี้ดิฉันจะดำเนินการเก็บข้อมูลในเชิงลึกโดยลงศึกษาในพื้นที่เขตกรุงเทพมหานคร ทั้งนี้ดิฉันจะทำการประสานงานกับ พยาบาลชุมชนประจำศูนย์บริการสาธารณสุข 15, 25, และ 52 ซึ่งเยี่ยมบ้านในพื้นที่ที่จะทำการศึกษา

ตามระเบียบของมหาวิทยาลัยโอเรกอน ดิฉันจำเป็นต้องได้รับการรับรองและอนุมัติให้ทำการวิจัยจากหน่วยงานที่มีส่วนรับผิดชอบดูแลในพื้นที่เสียก่อน ดังนั้นจึงเรียนมาเพื่อโปรดพิจารณาอนุมัติให้ทำการวิจัย และเก็บข้อมูลในพื้นที่ หากได้พิจารณาเห็นชอบแล้ว กรุณาแจ้งการรับรองและอนุมัติในการทำวิจัยเป็นลายลักษณ์อักษรไปยังมหาวิทยาลัยของดิฉันด้วย จักเป็นพระคุณยิ่ง

ขอแสดงความนับถือ

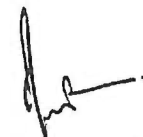
(นางสาวจิราพร เกศพิชญวัฒนา)

เรียน ผอ.ฝ.ปง 2
แจ้ง ผอ.ศบส 15, 25 และ 52
เห็นสมควรให้ความอนุเคราะห์



(นางสุวณี รักธรรม)
ผู้อำนวยการสำนักอนามัย

เรียน ผอ. ศูนย์ฯ 15
โปรดให้ความร่วมมือ



10 ก.พ. 41

โครงร่างงานวิจัย ของ อ.จิราพร เกศพิชญวัฒนา
นักศึกษาระดับปริญญาเอก คณะพยาบาลศาสตร์ Oregon Health Sciences University Portland , U.S.A.

เรื่อง "ความกตัญญูกตเวที และการดูแลบิดามารดาที่ต้องการการดูแลด้านสุขภาพ จากข้อคิดเห็นของครอบครัวไทยในเขต กรุงเทพมหานคร"

ลักษณะของงานวิจัย : เป็นการวิจัยเชิงคุณภาพ (Qualitative Research) โดยการสัมภาษณ์และลงพื้นที่เพื่อสังเกตพฤติกรรมการดูแลบิดา หรือมารดาที่ต้องการการดูแลภายในครอบครัว

ความสำคัญและความเป็นมา

ความกตัญญูกตเวที เป็นคำสอนทางศาสนาพุทธ ที่กล่าวได้ว่าเป็นสิ่งที่ฝังลึกอยู่ในสามัญสำนึกที่บุตร หลานพึงมีต่อบุพการีโดยเฉพาะบิดามารดายามแก่ชรา อย่างใดก็ตามลักษณะเฉพาะดังกล่าวของการดูแลผู้สูงอายุในครอบครัว และความกตัญญูกตเวที ยังมิได้มีผู้ใดศึกษา หรืออธิบายในแง่พรรณาความ เพื่อให้ลักษณะเฉพาะนี้เป็นที่เข้าใจ และสามารถอธิบายเกี่ยวกับสังคมไทยที่มีลักษณะเด่นเฉพาะตัวในเรื่องที่บุตร หลาน และครอบครัว มีบทบาทในการดูแลเพื่อทดแทนพระคุณบิดามารดา โดยเฉพาะแก่ชาวต่างชาติที่ยังไม่เข้าใจถึงลักษณะไทย ดังนั้นการวิจัยจึงมุ่งหวังที่จะศึกษา และนำลักษณะพิเศษนี้รวบรวมเป็นงานที่สามารถเผยแพร่ได้

วัตถุประสงค์การวิจัย

1. ศึกษาถึงความหมายของคำว่ากตัญญูกตเวที โดยเฉพาะที่เกี่ยวเนื่องกับการดูแลบิดา มารดาที่ต้องการการดูแลเกี่ยวกับสุขภาพ ของครอบครัวไทย ในเขตสังคมเมืองกรุงเทพมหานคร

2. อธิบายถึงการดูแลบิดา มารดา ที่ต้องการการดูแลด้านสุขภาพ ที่เป็นอยู่ในสภาพปัจจุบัน ของครอบครัวไทย ในเขตกรุงเทพมหานคร

3. ศึกษาถึงข้อคิดเห็นของครอบครัวต่อการเปลี่ยนแปลงในสังคมไทยในยุคปัจจุบัน โดยเฉพาะต่อความกตัญญูกตเวทีและการดูแลบิดา มารดา

4. อธิบายถึงผลของการดูแลบิดา มารดาที่เจ็บป่วยต้องการการดูแลด้านสุขภาพ ต่อครอบครัวและตัวผู้ดูแลเอง

วิธีวิจัย

ใช้วิธีการสัมภาษณ์แบบเจาะลึก และการสังเกตโดยการมีส่วนร่วมในกลุ่มที่ศึกษา

กลุ่มตัวอย่างที่จะศึกษา

ครอบครัวในเขตกรุงเทพมหานคร ที่มีบุตรเป็นผู้ดูแลบิดา หรือ มารดาที่ชรา, เจ็บป่วยและต้องการการพยาบาลดูแลในครอบครัว

ผู้ที่จะเป็นกลุ่มตัวอย่างในการสัมภาษณ์จะต้องอายุอย่างน้อยครบ 18 ปีบริบูรณ์ ไม่จำกัดเพศ ไม่จำกัดการศึกษา หรือเศรษฐานะ แต่จะต้องเป็นบุตรที่มีบทบาทเป็นผู้ดูแลบิดาหรือมารดาเอง คาดว่าจะทำการศึกษาจากครอบครัวทั้งหมด 10-12 ครอบครัว ทั้งนี้จะทำการหากลุ่มตัวอย่าง โดยขอความร่วมมือ และการช่วยเหลือในการเสาะหากลุ่มตัวอย่างในชุมชน จากพยาบาลสาธารณสุข ของศูนย์อนามัย กรุงเทพมหานคร ผู้ที่จะเข้าร่วมเป็นกลุ่มตัวอย่างจะต้องยินยอมเป็นลายลักษณ์อักษร หรือ ตอบรับที่จะเข้าร่วมงานวิจัยนี้โดยความสมัครใจ คาดว่าระยะเวลาที่ใช้ในการศึกษา เก็บข้อมูล และลงทำความคุ้นเคยกับผู้ร่วมวิจัยและพื้นที่ประมาณ 2 เดือน ถึง 3 เดือน

APPENDIX I

I1: Consent Form (English Version)

I2: Consent Form (Thai Version)

IRB #________________
Approved________________

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form

TITLE
"*KATANYU KATAVEDI*" AND CAREGIVING FOR FRAIL ELDERLY PARENTS: THE PERSPECTIVES OF THAI FAMILIES IN METROPOLITAN BANGKOK, THAILAND

PRINCIPAL INVESTIGATOR

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Phone: (662) 278-2411 (Bangkok, Thailand)

ADVISOR

Patricia G. Archbold, RN, DNSc, FAAN
Professor, School of Nursing,
Oregon Health Sciences University

CONSENT FORM

To be used for interviews with and observations of family members who provide care to the frail elderly members in families.

PURPOSE

You have been invited to participate in this research study because of your experiences as a caregiver for the frail elder in your family. The purpose of this study is to learn about the meanings of katanyu katavedi and caregiving practices in Thai culture. Your participation in this research study could last up to one month.

PROCEDURES

If you agree to participate in this study, you will be interviewed twice by the investigator in your home or another place you choose. The interview will be audiotaped and will take about 45 minutes to one hour. For the first interview, the investigator will ask general information about you and the frail elder such as age, education, and relationships. Then, you will be asked about your perspectives of katanyu katavedi and caregiving responsibilities, what you do in everyday caregiving life, the things you do to provide care to the frail elder in the family, your view of being a caregiver during this time of social change, and the impact of caregiving to your life. These two interviews will be conducted so as to let you tell information from your perspective as much as possible. The investigator will also observe the environment in which care occurs and care activities if they arise during the interviews. At the end of the study, the

investigator will show you the summary of the information from her interviews with you. You will be able to confirm that she has understood your meaning and you will be able to clarify and correct the information if it is not what you meant.

The investigator may ask permission to take photographs of the family setting, activities or the caregiving practices that you do to your parent. These pictures will be used as additional data and help in illustrating Thai family settings to my professors who are foreigners and not familiar with Thai ways of life. Copies of photographs will also be offered to you.

RISK AND DISCOMFORTS

There is no risk to you from participating in this study. However, some of questions might touch on sensitive experiences or may be difficult for you to answer. You are free to decline to discuss any topics which are uncomfortable to you.

BENEFITS

You may not personally benefit from being part of this study. However, your contribution in joining this study will help develop new information and knowledge which may benefit Thai families and caregiving in the future.

CONFIDENTIALITY

Neither your name nor any information identifying you will be used for publication or publicity purposes. Your name will not appear on the records and confidentiality will be assured by the use of code numbers.
The interview will be audio-tape recorded and written notes will be kept. The taped recordings will be listened to by the investigator and trained assistants who will type them. Then, the tapes will be translated into English. Thai and English transcripts will be identified with code number only. All the personally identifying information will be deleted in the transcription process by the investigator. The audio-tapes will be destroyed after the transcription is complete. The information you share with the investigator will be handled in a manner to ensure confidentiality.

In the event that the investigator observes elder abuse or need for health care services such as referral to in-service care, the investigator is required by her school's (Oregon Health Sciences University) policies to report this to the community health nurse who takes responsibility in this area.

COST

There is no cost to you for participating in this study. There will be no payment to you as a result of being part of this study.

LIABILITY

The Oregon Health Sciences University, as a public corporation, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. However, you have not waived your legal rights by signing this form. If you have further questions, please call the Medical Services Director at 001-503-494-8014.

PARTICIPATION

Participation in this study is completely voluntary. You may refuse to participate and may withdrawn from this study at any time without affecting your relationship with or services you received from community health center. You may refuse to answer individual questions, you may discontinue the interview at any time, or you may choose not to be interviewed at a second time.
You will receive a copy of this consent form or this consent narrative will be read to you. Your signature below or your verbal agreement that will be tape recorded indicates that you have read the foregoing and agree to participate in this study.

If you have any questions regarding your rights as a research participant or questions about this research, you may contact Ms. Jiraporn Kespichayawattana at (662) 278-2411 (Bangkok). The investigator has offered to answer any questions that you may have.

Your signature below indicates that:

__________ I have read what is written above and agree to be part of this study.

__________ I have had read to me what is written above and agree to be part of this study

__________ Participant gave verbal agreement to be a part of this study. The agreement is recorded in audiotape before starting the first interview.

Participant Signature	Date
Investigator Signature	Date
Witness	Date

มหาวิทยาลัย โอเรกอน
ใบอนุญาตการทำวิจัย

งานวิจัยเรื่อง

ความกตัญญูกตเวที และการดูแลบิดามารดา ที่ต้องการการดูแลด้านสุขภาพ จากข้อคิดเห็นของครอบครัวไทยในเขต กรุงเทพมหานคร

ผู้ทำการวิจัย น.ส. จิราพร เกศพิชญวัฒนา
นักศึกษาระดับปริญญาเอก คณะพยาบาลศาสตร์
โทร 662-539-8511, 662-298-2411

อาจารย์ที่ปรึกษา แพทริเซีย จี อาร์ชโบลด์
ศาสตราจารย์ ประจำคณะพยาบาลศาสตร์

ใบยินยอมร่วมงานวิจัย

ใช้เพื่อขอความร่วมมือ ในการสัมภาษณ์สมาชิกในครอบครัว ที่มีส่วนในการดูแลให้การพยาบาลช่วยเหลือผู้สูงอายุที่อยู่ในครอบครัว (ครัวเรือน)

วัตถุประสงค์

ผู้เข้าร่วมงานวิจัย ถือว่าเป็นผู้มีประสบการณ์ในการเป็นผู้ดูแลให้การพยาบาลแก่ผู้สูงอายุในครอบครัว งานวัจัยนี้มีวัตถุประสงค์ที่จะศึกษาเรียนรู้ เกี่ยวกับความหมายของกตัญญูกตเวที และศึกษาการดูแลที่ให้แก่ผู้สูงอายุในครอบครัวของท่านตามที่เป็นอยู่ งานวิจัยนี้ คาดว่าจะใช้เวลาในการศึกษาประมาณ 2 เดือน

ขั้นตอนของวิธีการทำวิจัย

หากท่านตกลงที่จะมีส่วนร่วมในงานวิจัยศึกษานี้ ผู้วิจัยจะทำการสัมภาษณ์ท่านอย่างน้อย 2 ครั้ง โดยการสัมภาษณ์จะกระทำในสถานที่ที่ สะดวกแก่ท่าน หรือที่บ้านของท่านตามที่ท่านตัดสินเลือก ระหว่างสัมภาษณ์ผู้วิจัยจะขออนุญาตอัดเทป และคาดว่าระยะเวลาสัมภาษณ์จะใช้เวลาประมาณ 45 ถึง 1 ชม. การสัมภาษณ์ครั้งแรกจะเป็นการถามข้อมูลทั่วไปเกี่ยวกับตัวท่านและผู้สูงอายุที่รับการดูแล
ตย. เช่น อายุ ระดับการศึกษา และความสัมพันธ์ระหว่างท่านกับผู้สูงอายุ ต่อจากนั้น จะถามเกี่ยวกับข้อคิดเห็นของท่านเกี่ยวกับความกตัญญูกตเวที และความรับผิดชอบในการดูแลการดูแลผู้สูงอายุที่ปฏิบัติอยู่ในปัจจุบัน การเป็นผู้ดูแลในยุคที่สังคมมีการเปลี่ยนแปลงและผลของการดูแลที่มีต่อชีวิตของท่าน ตลอดจนสิ่งที่ท่านให้การดูแล และการพยาบาลแก่ผู้สูงอายุในครอบครัว

การสัมภาษณ์ทั้ง 2 ครั้งนี้ ดำเนินขึ้นทั้งนี้เพื่อให้ท่านได้เล่าข้อมูลจากความคิดเห็นจากตัวท่านเองให้มากที่สุดเท่าที่จะทำให้ ในระยะสุดท้ายของการวิจัยนี้ ข้าพเจ้าจะสรุปข้อมูลจากสิ่งที่ได้ศึกษาและรวบรวมได้จากการสัมภาษณ์ เสนอให้ท่าน ทั้งนี้เพื่อจะได้ตรวจสอบและยืนยันว่า สิ่งที่ศึกษามีความกระจ่าง ถูกต้องตรงตามที่ท่านหมายความหรือไม่

ความเสี่ยงและความไม่สะดวก จากการเข้าร่วมวิจัย

ในการศึกษาจะไม่ก่อให้เกิดอันตรายใดๆ ทั้งสิ้น แก่ท่านเมื่อเข้าร่วมเป็นผู้ให้ข้อมูล อย่างไรก็ตาม ในบางคำถาม อาจก่อให้เกิดความรู้สึกไม่สบายใจหรือ ทำให้ท่านลำบากใจในการตอบท่านสามารถหยุดหรือปฏิเสธที่จะตอบ หรือพูดคุยในเรื่องนั้นๆ ที่ก่อให้เกิดความไม่สบายใจแก่ท่านได้

ประโยชน์ที่จะได้รับ

การเข้าร่วมเป็นกลุ่มศึกษาใน งานวิจัยนี้ จะไม่สามารถให้ประโยชน์ หรือมีการตอบแทนใดๆ แก่ท่านเป็นการส่วนตัว แต่ความร่วมมือในการเข้าร่วมงานวิจัยของท่านนี้ จะช่วยในการพัฒนาความรู้ข้อมูลที่ยังไม่มีผู้ใดศึกษามาก่อน อันจะเป็นประโยชน์ในการเรียนรู้ลักษณะสังคมครอบครัวไทย และการดูแลผู้สูงอายุในครอบครัวในอนาคต

ความลับส่วนบุคคล

ชื่อ นามสกุล ตลอดจนข้อมูลส่วนตัว ที่จะเปิดเผยตัวท่าน จะไม่มีการเปิดเผยไม่ว่าโดยการพิมพ์เผยแพร่ หรือ เปิดเผยแก่สาธารณชน ชื่อของท่านจะไม่ถูกบันทึกอยู่ในข้อมูล และจะใช้ระหัสตัวเลขแทนตัวท่าน เพื่อเป็นการปกปิดความลับ

การสัมภาษณ์จะดำเนินโดยมีการอัดบันทึกเสียงระหว่างสัมภาษณ์ และบันทึกข้อมูลลงในสมุดบันทึก เทปที่บันทึกจะถูกศึกษาโดยการฟังและถอดเทปโดยผู้วิจัยและผู้ช่วยวิจัยที่ได้รับการอบรมเกี่ยวกับงานวิจัยนี้ หลังจากถอดเทปภาษาไทยแล้วจะมีการแปลข้อมูลเป็นภาษาอังกฤษอีกครั้ง โดยใช้หมายเลขระบุถึงข้อมูลที่แปล ข้อมูลที่จะแสดงหรือเปิดเผยตัวท่านจะถูกลบออกจากเอกสารที่แปลโดยผู้วิจัยอีกครั้ง เทปอัดการสัมภาษณ์ทั้งหมดจะถูกทำลายหลังถอดเทปเรียบร้อย ผู้วัจัยจะระมัดระวังในเรื่อง ความเป็นส่วนตัว ความลับของท่านให้มากที่สุด

ในกรณีที่หากผู้วิจัย พบกรณีผู้สูงอายุเจ็บป่วยต้องการการรักษาพยาบาล การส่งต่อหรือมีปัญหาเรื่องการทารุณ หรือปัญหาการละเลยการดูแล อันอาจก่อให้เกิดอันตรายต่อผู้สูงอายุ ผู้วิจัยจำเป็นต้องแจ้งต่อหน่วยงานที่เหมาะสมทั้งนี้ ตามกฎบังคับของมหาวิทยาลัย ที่ผู้วิจัยศึกษาอยู่

ค่าใช้จ่ายในการร่วมวิจัย

ผู้เข้าร่วมวิจัยในครั้งนี้ ไม่ต้องเสียค่าใช้จ่ายใดๆ ทั้งสิ้น และงานวิจัยนี้จะไม่มีค่าตอบแทนใดๆ

ผู้รับผิดชอบ

การทำวิจัยครั้งนี้ อยู่ในความรับผิดชอบของ OHSU หากท่านได้รับความเสียหายหรือเจ็บป่วยจากการเข้าร่วมงานวิจัยครั้งนี้ ท่านจะได้รับค่าตอบแทน (การคุ้มครอง) จากการเสียหายซึ่งเกิดจากความผิดพลาดของผู้กระทำวิจัย ถ้าท่านมีข้อสงสัยในการคุ้มครอง (ประกัน) ต่อการเสียหาย ท่านสามารถติดติดต่อได้ที่ Dr.______________ ณ OHSU หมายเลยโทร 001-503-494-8014

การเข้าร่วมวิจัย

การเข้าร่วมวิจัยครั้งนี้ ถือว่าเป็นความสมัครใจของท่าน ท่านสามารถจะปฏิเสธต่อการเข้าร่วมวิจัย หรือหยุดในระหว่างการทำวิจัย โดยจะไม่มีผลเสียหายใดๆ

ต่อการเข้ารับบริการสุขภาพ จากศูนย์สาธารณสุขในเขตของท่าน ท่านสามารถปฏิเสธไม่ตอบคำถามที่ท่านคิดว่าเป็นข้อมูลส่วนตัว หยุดให้การสัมภาษณ์หากท่านเห็นสมควร หรือจะปฏิเสธไม่ให้สัมภาษณ์ครั้งที่ 2 ก็ได้

ท่านจะได้รับเอกสารเกี่ยวกับใบอนุญาติในการทำวิจัย หรือใบอนุญาตที่จะถูกอ่านและอธิบายให้แก่ท่านโดยผู้วิจัย

ลายเซ็นยินยอมเข้าร่วมวิจัย หรือการตอบรับโดยวาจา ซึ่งได้ถูกบันทึกเสียงไว้จะแสดงว่าท่านสมัครใจที่จะมีส่วนร่วมในงานวิจัยนี้ เกี่ยวกับงานวิจัยนี้ ท่านสามารถติดต่อผู้วิจัย คือ น.ส. จิราพร เกศพิชญวัฒนา ได้ ณ หมายเลขโทรศัพท์ 662-539-8511 ผู้วิจัยยินดีที่จะให้ความกระจ่าง และตอบคำถามแก่ท่านเสมอ

ลายเซ็นข้างล่างนี้แสดงว่า :

__________ข้าพเจ้าได้อ่านรายละเอียดข้อมูลข้างต้น และตกลงที่จะเข้าร่วมกับงานวิจัยนี้

__________ข้าพเจ้าได้รับฟังข้อมูลการร่วมวิจัย จากการอ่านเอกสาร ใบย่อย โดยผู้วิจัยได้อ่านให้ฟัง และตกลงที่จะเข้าร่วมกับงานวิจัยนี้

__________ผู้ร่วมวิจัยตอบตกลงที่จะเข้าร่วมงานวิจัยนี้ การตอบรับตกลงได้ถูกบันทึกลงในเทปบันทึกเสียง ก่อนที่จะมีการเริ่มต้นสัมภาษณ์

สายเซ็น ผู้เข้าร่วมวิจัย______________________วัน/เดือน/ปี________________

ลายเซ็น ผู้ทำการวิจัย_______________________วัน/เดือน/ปี________________

APPENDIX J

Trustworthiness of the Study

Criterion/ meaning	Methodological Soundness	Proposed Plan
Credibility is the merit of any inquiry and is related to the degree of confidence about the truth and the context existing in the setting being studied	-prolonged engagement -persistent observation -triangulation (multiple sources of data e.g., time, space, method, person) -referential adequacy materials -peer debriefing -member checking	•Interviews and observations will occur over a series of visits with the participants to achieve prolonged engagement in data collection and build trust between the informants and investigator. •will extend the visits depends on situation or circumstance which might give richness of observation •combine informal interviews with other family members to add multiple sources of data •triangulation will be achieved using multiple data collection sources (different members, different visiting times that could see family interactions, different methods of formal interviews/ informal interviews/ observation) •All data collection will be in written forms (e.g., interviews transcripts, brief notes, memo, fieldnotes) in sequential and organized way as the fieldnote evidence provided the basis for the referencial adequacy of materials

Criterion/ meaning	Methodological Soundness	Proposed Plan
Credibility (Cont.)		•All additional data or materials that get from the field such as pictures, photographs that participants allow investigator to have will be added as additional data •Will take part in family activities or events that the family allow or ask investigator to join since it may provide additional data that may be meaningful to the study •Will participate in caregiving activities since the investigator has background in gerontological nursing and has experiences in community care in Thailand •Peer debriefing will be achieved through ongoing discussions with advisor and dissertation committee, and 2 Thai experts by using e-mail, Fax and telephone •Memos, fieldnotes, and transcripts will be discussed in terms of the clarity, cohesiveness, and reasonableness of developing ideas •During the data analysis stage, the analysis will be discussed and confirmed by dissertation committee,

Criterion/ meaning	**Methodological Soundness**	**Proposed Plan**
		gero seminar group, and 2 Thai experts •Will check the finding with participants to confirm the adequacy and rightness of representation of the situation from the participants' perspectives
Transferability is judged by the extent to which its findings can be applied in other contexts or with other respondents because of the shared characteristics.	-Thick description -Purposive sampling	•Thick description will be achieved by comprehensive fieldnotes and memos as well as the verbatim transcription in both Thai and English of all the formal inteviews •All detailed information during observations and interviews in setting will be jotted down after finish the visit to prevent data from being lost due to forgetfulness •Transcriptions will include reporting of pauses, voices, emotional tone in an attempt to capture participants' meaning •Purposive sampling for this study will be done by finding the adult children who take role as primary caregivers since it is very specific group who devote themselves to taking care of frail elderly parent

Criterion/ meaning	Methodological Soundness	Proposed Plan
		•Key informants who will be included in this study must be assessed by investigator for being good informants
Dependability reflects a concern for reliability which refers to a study's consistency, stability, or accuracy.	-Dependability audit through comprehensive reviews of documents, memos, fieldnotes, etc.	•All the documents e.g., transcripts, memos, fieldnotes will be selected but comprehensive review by dissertion committee or 2 Thai experts. •The summary of case visit of each will be documented and reported to disseration committee every time. •Plan to have conference with committee (via the telephone conference) approximately every two weeks to get feedback at regular intervals throughout the data collection and analysis phases •Plan to meet with 2 Thai experts approximately every two weeks to get feedback, consult in case of finding any problems

Criterion/ meaning	Methodological Soundness	Proposed Plan
Confirmability is the test of rigor of the study in terms of the degree to which the findings arethe product of the focus of its inquiry, not of the biases of the researcher.	-Audit trail	•An audit trail will be established by maintaining detailed written recordings of data, memos, fieldnotes, decision made, interviewing schedules and analysis processes during the interview. •The investigator will reflect thoughts and ideas in the journal of the case (family#). This journal will start with the first day of of approaching case and will keep record until the last day with that case

APPENDIX K

Summary of the Modification of This Study

Proposed Plan	Modification and Actual Implementation	Rationale of Modification
	Purposes	
1. explore the concept of *katanyu katavedi* in relation to caregiving for frail elderly parents in families of urban, Thailand; 2. describe current status of caregiving for frail elderly parents of Thai families in Metropolitan Bangkok; 3. identify the perspectives of the Thai families regarding the effects of social changes in modern Thailand on *katanyu katavedi* and caregiving for frail elderly parents; 4. describe the effects of caregiving for frail elderly parents on families and caregivers.	- Purposes #1, and #4 remain the same as originally proposed. - Purpose #2, has been evaluated and changed "current status of caregiving" to "caregiving practices". - Purpose #3, however, has been evaluated and changed from identifying "the effects from social changes on *katanyu katavedi* and caregiving for frail elderly parents" to "contextual factors which influence caregiving in Thai society" instead. - *Katanyu katavedi* is a social cultural value. Most Thais who use Thai as their native language understand the meaning of this term. However, when asked about the meaning people are sometimes unable to elaborate or explain the meaning. Because the concept of *katanyu katavedi* is strongly related to Thai social norms and religious teachings, especially Buddhism, the investigator decided to discuss the concept with three Thai scholars in Thai linguistics, culture, and Buddhism to obtain their perspective about concept as a framework in identifying the meaning from lay people.	- The proposed study used "current status of caregiving" for Purpose 2 which is too broad and not specific enough. So, changing to "caregiving practices" is clearer for the purpose of this study. - The effects from social changes need a period of times before their effects can be observed. The actual findings yielded some contextual factors which influence caregiving in Thai society. - Discussing the concept of *katanyu katavedi* with Thai scholars helped formulate the domains of meaning of *katanyu katavedi*. The perspectives of these scholars, combined with the information from literature reviews, was used to inform the interview guide for family caregivers and confirm about their understanding of the concept.

Proposed Plan	Modification	Rationale of Modification
Design		
A qualitative, exploratory design will be used in this study.	Implement as proposed	
The study was proposed to be done in Metropolitan Bangkok, Thailand with the help and supervision of the Department of Health, Metropolitan Bangkok. The Department of Health is a public sector under Metropolitan Bangkok Administration which take responsibility for providing health care services and home visiting for people in Bangkok areas through 64 Health Centers.	- The proposed study was approved by Director of Department of Health. The investigator was permitted to approach three Health Centers, The investigator met with head nurses of three Health Centers to inform about the proposed study and criteria of case selection.	- The three Health Centers were selected to be approached because of: variety of ethnic background and socioeconomic status •transportation feasibility •high density of population in these areas - After visiting cases with public health nurses, families were assessed and selected for the sample if they met the criteria of case selection. Two cases that were dropped from the sample because they lived in areas that were not safe for the investigator to go into.

Proposed Plan	Modification and Actual	Rationale of Modification
	Setting	
The investigator proposed to access families through Health Center 15, 25, and 52 accompany with public health nurses on family visit.	-same as proposed	
Interviews with key informants included informal interviews with other family members and observations were planed to take place in the home setting unless the key informants choose another setting to preserve confidentiality.	- same as proposed	- Most of the informants preferred to be interviewed at home and feel comfortable of being in their own setting. There is less problem about the privacy or confidential concern because the informants selected time and find spaces by themselves. The interviews were all done during daytime while other family members were out to work or there is less people around. However, during one interview of case ID #13, there is a friend of the informant accidentally joined the conversation. But her talk is meaningful and useful to enrich the interviews. So the investigator kept her part as additional information.

Proposed Plan	Modification	Rationale of Modification
Sampling		
The purposeful sampling of approximate 12-15 families was proposed to be studied.		
Family eligibility criteria included: a) families in stem, joint or extended family structures, b) families residing in Metropolitan Bangkok, c) families in which one or more children share a household with their frail elderly parent/s and provide care for them, and d) families in which the elderly parent/s is age 60 or older - Inclusion criteria for key informants were: a) age 18 years or older, b) adult children who take responsibility in caregiving activities or defined themselves as primary caregivers for frail elderly parents, c) consent to participate the study, and d) able to articulate their experience and perspectives about *katanyu katavedi* and the caregiving in the families.	-The final sample included 15 families that were studied. Thirteen daughters and two sons were recruited and interviewed as key informants.	-The investigator decided to interview only these fifteen cases because of the richness of data and repeated categories in these informative cases which represented the saturation and adequacy of the study.

Proposed Plan	Modification and Actual Implementation	Rationale of Modification
Sample access		
- Approach the Director of Department of Health of Metropolitan Bangkok to a) inform about the study and criteria for sample selection and b) get the approval of the proposed study	- The investigator summarized and translated the proposed study, interview and observation guide, and consent form into Thai then attached the proposal (English) to get the approval and permission to do the study from the Director of Department of Health.	- In the proposed plan, the investigator did not plan about summarizing the proposed study and translating it into Thai. However, the summarized proposed study in Thai was helpful in approaching those Thai agencies when discussing the study.
- The final sample selection will be done by the investigator to obtain families with different socioeconomic status, age and gender of the key informants, and ancestor origin. The families which are eligible to be included in the sample and the key informants agree to participate in the study the investigator will obtain the agreement either by written or verbal consent.	- Practically, the families visited by public health nurses were middle class to low income groups. Families with higher incomes usually get health care services from hospitals (public or private) or private clinics - Out of 22 families, seven families were dropped out from my study. The reasons are: three families refused to join the study because of time constraints, two families were excluded because the investigator was concerned about safety issue. One family, the mother (care receiver) was dead and one family moved.	

Proposed Plan	Modification	Rationale of Modification
	Protection of Human Subjects	
<u>consent process</u> - The proposed study and the consent forms (both in English and in Thai) will be reviewed and approved by agencies responsible for human subjects protection both in the U.S. and Thailand (the IRB of the Oregon Health Sciences University and Ministry of Public Health)	- The proposed study and the consent forms (English and Thai version) was reviewed and approved by the National Research Council of Thailand (NRCT) and the IRB of the Oregon Health Sciences University.	- The approval body for proposed study was changed from the Ministry of Public Health to the NRCT because the study was classified as an international project. The NRCT is the agency which coordinates and reviews international studies
- Each participant must sign a consent or give verbal agreement which will be tape recorded as the confirmation for their voluntary decision to join the study.	- All the participant gave verbal agreement at the beginning of the first formal interview.	- In Thailand, people usually prefer and feel more comfortable in giving verbal agreement than giving their signature in the documents.
- The investigator must have deep respect, full sympathy, authentic caring and courtesy towards informants.	- During the interviews, four caregivers become emotionally upset while talking about the deterioration of their parent's health status. The psychological discomfort was minimized by the investigator's attention to the participants and allowing them to express their feelings.	- The caregivers were satisfied and willing to be interviewed and studied. They expressed their feelings of satisfaction and pride that their caregiving responsibility is valued and understood by others. The investigator also provided knowledge and answered questions about caregiving for them. All the caregivers participated in this study gained indirect benefits by gaining appreciation of their own caregiving situation.

Proposed Plan	Modification	Rationale of Modification
	Data Collection Procedures	
<u>Observations</u> The observation will take place the first day that the investigator approaches the family and through out the study.	- Each family was visited by the investigator at least three times up to five times. Some of the visiting were informal to create the interpersonal relationships between the investigator and the informants as well as the family members. Totally, there are 55 visits (15 families) that I'd made during my data collecting period. I also participated in caregiving activities. For example, one of my cases, the frail father had the problem of bedsores at his buttock and left heel. I helped and taught the informant to do the dressing. The key informants were informed that I am a nurse so they respected in my professional knowledge. Some cases consulted me about their caregiving problems or asked for my suggestions. All these personal contacts helped in making the families and informants acquaint to me and have no boundary of my presence.	- Lofland & Lofland (1995) described process of "getting in" in a naturalistic investigation by gaining the acceptance of the people being studied which is crucial. By having •deep respect •full sympathy •authentic caring helped the investigator to gain trust from the informants.

Proposed Plan	Modification	Rationale of Modification
	Data Collection Process	
The Initial Inventory of Keywords and Initial Observational Guide were developed by the investigator to used as guidelines for the observations.	All studied cases were observed by following categories of the observational guide. After each visit, I jotted down all my observation in the fieldnotes. Then, I wrote down some points that I might overlook and needed to be focused or asked in next visit. - I was also cautious about my appearance (dress and groom) when I get into the setting. When I visited my cases I usually dressed in a clean, casual and not so colorful clothes (most white, blue or khaki).	Being nonthreatening also means being sensitive and attentive to matters of appropriate grooming and dress (Lofland & Lofland, 1995). One of my cases told me that she felt more comfortable at my second visit than the first visit when I was there with public health nurses. (In my first visit, I had to dress up since I must contact people at Health Center first.) It makes the informant more relaxed and lessen the feeling of being threatened.

Proposed Plan	Modification	Rationale of Modification
	Data Collection Process	
	- The Initial Observational Guide is helpful in checking all the points that needed to be focused. However, the Initial Inventory of Keywords is more complicated and difficult to follow because in my proposal all these keywords are English terms. Finally, I decided to combine some aspects or keywords that I got from the three Thai scholars and some translated English keywords, and, used this Thai inventory keywords as my guideline.	
<u>Interviews</u> - the investigator do the first visit with public health nurses then will introduce self and explain the purposes and methods of the study to key informants,	- Proceeded as proposed	
- at least two in-depth interviews will be done with each key informant. The interview estimated to take about 45 minutes to an hour.	- Two in-depth interviews were done with each key informants. Totally, there were 30 formal interviews with 15 key informants. All these interviews were audio taped and transcribed verbatim in Thai.	

Proposed Plan	Modification	Rationale of Modification
Data Collection Procedures		
-the in-depth interviews with audio-taped record will be conducted with key informants in Thai in the place most convenient to participants which also protect the privacy during the interviews. - the interview will use the Initial Interview Guide which is developed in English as the guideline in asking the questions. The interview will begin with grand tour questions to make key informants feel relaxed and comfortable. - the initial interview guide with topic areas and some probes may be modified during the interviews depended on the participants' responses and ongoing analysis	-The Initial Interview Guide was translated into Thai (see Appendix) because the interviews were done in Thai. - The trial of interview by using the interview guide (Thai version) was done with ID #2. - The modification of the interview by using the semi-structured approach without presence of the written script was considered to help the investigator to succeed in gaining fully information and experiences from the key informants. - The investigator used a small notebook which jotted down some points, keywords, and topics that need to be discussed instead of using the completed form the interview guide. - The interviews were more flexible by starting of varied topics or issues	Despite the script and structure of interview guide which start from grand tour questions, it was found that the key informant felt tense and could not elaborate much to response the questions. However, when the conversation was informal without the presence of the interview guide, ID #2 was more relaxed and could express more detail. -To make the informants feel relaxed and the conversation flowed in the way that there was more congenial and friendly environment. I found this way made the informants trusted and felt that the investigator really wanted to listen to their stories or experiences. Nonetheless, I did not let the

Proposed Plan	Modification	Rationale of Modification
Data Collection Procedures		
	depend on the circumstance or situation of each individual case	informants talked or lead the discussions until I could not get the points that I wanted. The investigator controlled and kept track of the concern by checking the topics being discussed and further asked for the issues which need to be discoursed.
- data or information from informal interviews or group discussion will be included as data in memos or fieldnotes	- The investigator had the summary of fieldnotes and memo (which included all information from informal interviews, observations, and the investigator's reflection from the case visiting) of each case to follow as the idea trail for probing and analyzing the findings.	

Proposed Plan	Modification	Rationale of Modification
	Analysis of Data	
Transcription and translation - Taped data will be transcribed in Thai by the investigator and trained research assistants and verified by the investigator while listening to the tape. - the interviews of the first two families and selected transcripts will be translated into English by the investigator and a linguistic professor at Linguistic Institute, Chulalongkorn University.	- Taped data were transcribed in Thai by the investigator and the trained research assistants. and were verified by the investigator. - The interviews of two selected informative informants (ID #1, ID #13) were translated into English by the investigator and verified by a professor from Linguistic Institute at Chulalongkorn University. -The investigator worked with an American nurse who is fluent in Thai language to confirm the translation of data bits and also to validate the coding categories.	- Case ID #1 and ID#13 were selected to be translated as representative cases because they were informative and showed examples of variety in coding categories. - This American nurse used to live in Thailand for several years. She can read and speaks Thai fluently, and also is accustomed to Thai culture. This helped to confirm the equivalency of the translation of Thai data to English.
Analytic methods - Using Lofland and Lofland (1995) six types of strategies of analysis: framing, contrasting, coding, memoing, diagraming, and thinking flexibility.	- All the six strategies were applied and done by the investigator. However, the Ethnograph 4.0 (Thai version) was used to organized and retrieved the coded categories. - Content analysis of all data was done by the investigator during the coding process.	- The computer program was used in order to make the coding and retrieving process more systematic. - Content analysis was considered to achieve analytic thoroughness.

Proposed Plan	Modification and Actual Implementation	Rationale of Modification
- Peer debriefing through ongoing discussions with dissertation committee and with two Thai expert consultants in Bangkok.	- Peer debriefing by the dissertation committee and consultants was done as proposed. However, the additional peer debriefing by a group of Thai doctoral students at School of Nursing, OHSU was also done during the process of analysis.	- To confirm the credibility of the coding method and analysis of data in Thai. These doctoral students were culturally and natively born and reared in Thailand. All of them are well grounded in Thai culture and language, yet have experiences and advanced education in different culture.
- Using the strategy of diagraming by develop the matrix, concept chart or typology of the concepts from data.	- The investigator formulated concepts (or propositions) which summed up and provided from major portions of coding categories. Several diagrams were developed to displayed the relationships among the concepts. Then, the final conceptual model was proposed and confirmed by the dissertation committee. - Each family's data were reviewed and used to identify the concepts and propositions that were present in their data. A matrix was developed by having the different families on one axis and the concepts and propositions along the other axis. The frequencies of support for each concept and proposition were filled in for each family's data.	- To represent the analysis of data of this study, a conceptual model helped the investigator and the dissertation committee to visualize the information systematically. The matrix of concepts found in each family case also allowed the investigator to compare across families, looking for similarities and differences in family data being present to support these various concepts and propositions.