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Patterns of Stroke Caregiving within Thai Families

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ABSTRACT

The study explored patterns of caregivers' behaviors influenced stroke caregiving within Thai families. 40 stroke patients took part in the study. Data were obtained through use of the Barthel Index, demographic sheet, and interviews. Descriptive statistics were used to calculate the quantitative data. Qualitative data were analyzed via content analysis. The well communication caregivers were found to have effectively caregiving. Unmarried female who had a few job responsibilities were the most involved in providing caregiving. The finances played an important part in terms of paying for basic things. The satisfaction influenced how pleasurable of caregiving behavior. All participants were Buddhist, it is of great merit to pay respect to older parents and expect nothing in return. The results of this study provide nurses with a better understanding of the caregiving patterns in Thai families.

KEYWORDS: caregiving; stroke; Thai family

INTRODUCTION

In Thailand, stroke has been accepted as the leading cause of disease burden (Health Research Institute, 2006). Due to impairments of communication and activities, stroke persons need assistance from caregivers (Miller & Woo, 1999). Although previous studies have revealed the tasks caregivers perform in providing care for stroke persons (Hiruchuha, 1998; Pearlin et al., 1996), little is known about how stroke caregivers engage in caregiving behaviors. Caregivers consist of primary and non-primary caregivers. The primary caregivers are the stroke person's family members who maintain caregiving roles; the non-primary caregivers are both family members and others who provide support (Fudge et al., 1997; Horowitz, 1985). This study has explored patterns of caregivers' behaviors that influenced stroke caregiving within Thai families. Thus, the study has shown the caregivers' behaviors in terms of: their familial, social and cultural contexts; the caregivers' abilities and resources; and, the care burden.

Caregiving experiences often vary among different racial groups. For Chinese, Japanese, Korean, and Thai, elders often expect needed caregiving to be provided by their children and caregiving may be considered a woman's role (Asai & Kameoka, 2005; Kespichayawattana, 1999; Kim, 2000; Sheu, 1997). Caregiving within Thai families is based on the living arrangements, roles and responsibilities of those involved in providing care (Caffrey, 1992). Besides, stroke caregiving in Thailand is known to be shaped based on the individuals' cultural and religious backgrounds and beliefs about stroke care (Komjakraphan, 1995; Subgranon & Lund, 2000).

METHOD

Design: This study descriptive and ethnographic study sought to explore the caregiving behaviors of 40 stroke caregivers in Thai families.

Ethical Considerations: The research protocol was approved by the Institutional Review Boards (IRB). The primary investigator (PI) explained the purpose, data gathering process, benefits/risks, issues regarding confidentiality and anonymity, and right to withdraw from the study without impacts. All participants consenting to take part in the study were asked to sign a consent form.

Participants: Names of participants were obtained through the assistance of home health care nurses and the health care volunteers in a community. The criteria for selection of stroke caregivers included those who: had provided care for the last two months to a stroke person; lived in the same household as the stroke persons; was able to understand, speak, read, and write Thai; Buddhists; and, was willing to participate in the study.

Instruments: Data were obtained through use of the Barthel Index (Intarasombat et al., 1996), demographic data sheet, interviews, observations, and household assessments.

The Barthel Index consisted of ten items that addressed the extent to which an individual could carry out activities of daily living. Total scores could range from 0 to 40.

Demographic data sheet included age, gender, marital status, health care problem, and relationship to the stroke person, length of care provision, education, employment status, and income.

The interviews and observations focused on how the participants came to be caregivers and the type of caregiving activities they provided. Each interview was tape-recorded and observations were recorded in notes.

Household assessments of each stroke person's home were carried out by observation of the environment within the household and recording via field notes or photography.

Procedure: After participants consented to participate, arrangements were made to obtain demographic data and conduct interviews, observations, and household assessments, at the stroke persons' homes. Data collection took three hours per participant. Participants were observed and interviewed three times.

Data analysis: Descriptive statistics were used to calculate the quantitative data. Qualitative data were analyzed via content analysis.

RESULTS AND DISCUSSION

Demographic data of participants

Among the 40 caregivers, 21 were married, 10 were single and 9 were widowed. They ranged in age from 28-75 years (average = 52 years) and consisted of 37 females and 3 males. They had provided care for 4 months – 20 years (average 4 years). They had an income of 40 – 400 USD per month (average 120 USD per month). 18 of the caregivers completed primary school, 16 finished secondary school, 3 ended vocational schools, and 1 had a bachelor degree. However, 2 had no formal education (Table 1).

TABLE – 1
DEMOGRAPHIC DATA OF THE PARTICIPANTS (N = 40)

Personal Information	Frequency	Percent	Cumulative Percent
Gender			
Male	3	7.5	7.5
Female	37	92.5	100.0
Age			
20-60 years	29	72.5	72.5
61-80 years	11	27.5	100.0
Mean = 52, Min-Max = 28-75, SD = 5.643			
Married Status			
Married	21	52.5	52.5
Single	10	25.0	77.5
Widow	9	22.5	100.0
Religion			

Personal Information	Frequency	Percent	Cumulative Percent
Buddhist	40	100.0	100.0
Education Level			
No education	2	5.0	5.0
Primary level	18	45.0	50.0
Secondary	16	40.0	90.0
Vocational	3	7.5	97.5
Bachelor level	1	2.5	100.0
Income per Month			
40 – 200 USD	3	7.5	7.5
201 – 400 USD	37	92.5	100.0
Mean = 120, Min-Max = 40-400, SD = 3.182			
Time of provided care			
4 mths-10 yrs	27	67.5	67.5
11-20 yrs	13	32.5	100.0
Mean = 4, Min-Max = 0.34-20, SD = 5.652			

Description of stroke caregivers

Communication: Caregivers that had the best developed forms of communication were found to be effective caregiving. 18 caregivers prepared blenderized diet and bathed the stroke persons. They assigned these tasks to other members in their family by providing suggestion for care. For example, a participant provided caregiving while her younger sister cleaned the room and washed the clothes. Sometimes, she reminded her sister about the medications she has to give. She would remind her and ask her if she did this or that.

Time: Time influences one's availability to engage in caregiving activities. Caregivers who had fewer personal and family responsibilities were found to be the ones most involved providing caregiving. Duration can influence to what degree a specific individual, within a community, is willing to participate in caregiving activities. Individuals whose families had resided, for several generations, within the community were found to be more willing to participate in caregiving activities than those who had recently moved into the community. For instance, 5 caregivers worked on balancing their schedules, while three provided care only when they had available time.

Finances: Finances played an important part in stroke caregiving in terms of adequate funds to pay bills and meet the basic needs of self. For example, 4 caregivers had consistent financial support, while others received only occasional support. The caregivers that had consistent financial support were found to engage, on a regular basis, in sharing the caregiving compared to those who had only occasional financial support. Most likely this was due to the fact that caregivers with financial support were more able to pay for services that could assist caregiving.

Relationship: The relationship influenced how pleasurable the caregivers participate in caregiving. However, in some caregivers who were siblings often engage in conflict when providing care to an elderly parent.

Belief: All caregivers were Buddhists. It would have had an influence on their willingness to engage in caring (Krause & Sugisawa, 1999). According to Buddhism, it is of great merit to give and expect nothing in return (Buddhad Asa Bhikkhu, 1993).

Culture: Within the Thai culture, if a spouse caregiver is unable to provide care, the adult children are considered to take on the task of providing care for elderly parents (Stuifbergen et al., 2008) (Table 2).

TABLE – 2
PATTERNS OF CAREGIVING

Factors	Patterns of Caregiving
Communication	Caregivers who had the best developed forms of communication were found to be effective caregiving.
Time	Caregivers who had fewer personal and family responsibilities were found to be the ones most involved providing caregiving. Individuals whose families had resided, for several generations, within the community were found to be more willing to participate in caregiving activities than those who had recently moved into the community.
Finances	The caregivers who had consistent financial support were found to engage, on a regular basis, in sharing the caregiving compared to those who had only occasional financial support.
Relationship	Caregivers who were siblings often engage in conflict when providing care to an elderly parent.
Belief	All caregivers were Buddhists. It would have had an influence on their willingness to engage in careging. According to Buddhism, it is of great merit to give and expect nothing in return.
Culture	Within the Thai culture, if a spouse caregiver is unable to provide care, the adult children are considered to take on the task of providing care for elderly parents.

LIMITATIONS AND RECOMMENDATIONS

Due to the study design, it was not possible to observe caregiving activities all of the time. Thus, validation of the consistency of behaviors of the caregivers could not be made. Future studies need to consider examination the impact of stressors placed upon the stroke caregivers, how they cope with the daily demands of caregiving and what community resources are needed to assist them with their caregiving activities.

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