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FACILITATING LIVING WITH PERSONS WITH SCHIZOPHRENIA: RELATIONSHIPS BETWEEN PSYCHIATRIC NURSES AND FAMILY MEMBERS

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ผู้ป่วยจิตเภทเป็นผู้ที่มีความผิดปกติทางด้านความคิด อารมณ์และพฤติกรรม ซึ่งความผิดปกติดังกล่าวส่งผลให้เกิดความบกพร่องต่อการทำหน้าที่ประจำวันของบุคคล นั่นย่อมหมายความว่าครอบครัวที่มีสมาชิกที่เจ็บป่วยด้วยโรคจิตเภท ต้องทำหน้าที่ในการให้การดูแลและสนับสนุนสมาชิกที่เจ็บป่วยนั้นอย่างหลีกเลี่ยงไม่ได้ สมาชิกในครอบครัวต้องเผชิญกับความยุ่งยากในการดูแลผู้ป่วยจิตเภท จนบางครั้งทำให้สมาชิกในครอบครัวพยายามที่จะหลีกเลี่ยงในการดูแลผู้ป่วยจิตเภทนั้น พยาบาลจิตเวชเป็นบุคคลหนึ่งที่มีหน้าที่รับผิดชอบในการให้การช่วยเหลือสมาชิกครอบครัวให้สามารถดูแลและสนับสนุนผู้ป่วยดังกล่าว พยาบาลจิตเวชจึงจำเป็นต้องใช้วิธีการที่หลากหลายเพื่อที่จะช่วยให้สมาชิกครอบครัวสามารถดูแลผู้ป่วยจิตเภทได้ การศึกษาครั้งนี้จึงมีวัตถุประสงค์เพื่อศึกษาสัมพันธภาพที่เกิดขึ้นระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท ใช้วิธีการวิจัยเชิงคุณภาพแบบการสร้างทฤษฎีจากข้อมูลพื้นฐาน เก็บรวบรวมข้อมูลโดยการสัมภาษณ์แบบเจาะลึกและการสังเกตเป็นหลัก การศึกษาในครั้งนี้ได้ศึกษาประสบการณ์ของพยาบาลจิตเวช จำนวน 16 คน วิเคราะห์ข้อมูลด้วยการวิเคราะห์เปรียบเทียบข้อมูลตลอดกระบวนการของ Glaser (1978)

ผลการศึกษาพบว่า "การส่งเสริมการใช้ชีวิตร่วมกับผู้ป่วยจิตเภท" เป็นกระบวนการทางสังคม ที่พยาบาลจิตเวชนำมาใช้เพื่อส่งเสริมสมาชิกในครอบครัวให้สามารถดูแลและสนับสนุนผู้ป่วยจิตเภท ให้ใช้ชีวิตร่วมกับครอบครัวได้ กระบวนการนี้ประกอบด้วย ขั้นตอนต่างๆ 4 ขั้นตอน คือ การสร้างความไว้วางใจ การเสริมสร้างความผูกพันให้เข้มแข็ง การส่งเสริมความพร้อมในการดูแล และการสนับสนุน ในระยะแรกนั้นพยาบาลจิตเวชจะใช้วิธีการสร้างความไว้วางใจ เพื่อให้สมาชิกครอบครัวเกิดความไว้วางใจในพยาบาลและพร้อมที่จะพูดคุยเกี่ยวกับความกังวลและความต้องการต่างๆจากการดูแลผู้ป่วย หลังจากนั้นพยาบาลจิตเวชใช้วิธีการของการเสริมสร้างความผูกพันทั้งกับผู้ป่วยและกับพยาบาลจิตเวชให้เข้มแข็งขึ้นและส่งเสริมความพร้อมของสมาชิกครอบครัวให้สามารถดูแลผู้ป่วยได้ รวมทั้งให้การสนับสนุนในด้านต่างๆ เหล่านี้เป็นการส่งเสริมให้สมาชิกครอบครัวนั้นสามารถให้การดูแลและสนับสนุนผู้ป่วยจิตเภทกลับไปใช้ชีวิตร่วมกับครอบครัว

ทฤษฎีเชิงสาระที่ได้จากการศึกษาครั้งนี้ทำให้เกิดความรู้ และความเข้าใจกระบวนการของการส่งเสริมการใช้ชีวิตร่วมกับผู้ป่วยจิตเภท ความรู้นี้สามารถใช้เป็นแนวทางในการพัฒนาและส่งเสริมสมาชิกครอบครัวให้สามารถดูแลและสนับสนุนผู้ป่วยจิตเภทได้

สาขาวิชา.....พยาบาลศาสตร์... ลายมือชื่อนิสิต.....

ปีการศึกษา..... 2551..... ลายมือชื่อ อ. ที่ปรึกษาวิทยานิพนธ์หลัก.....

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RATCHANEEKORN KERTCHOK : FACILITATING LIVING WITH PERSONS WITH SCHIZOPHRENIA : RELATIONSHIPS BETWEEN PSYCHIATRIC NURSES AND FAMILY MEMBERS
ADVISOR : ASSOC. PROF. JINTANA YUNIBHAND, PhD.,
CO-ADVISOR : ASSOC. PROF. WARAPORN CHAIYAWAT, D.N.S.,
215 pp.

Persons with schizophrenia are persons who have disturbances of thinking mood, and behaviors that can cause serious impairment of a person's day-to-day functioning. This means that families must provide a great deal of support to their ill family members. The family members had encountered with difficulties in caring for their ill relatives. As a result of the difficulties, the family members tried to avoid involvement in caring for their patients. Psychiatric nurses have a great role in supporting families in such care. The purpose of this study was to explore the relationships between psychiatric nurses and family members of persons with schizophrenia. This research employed a qualitative research method, grounded theory. Data were collected through in-depth interviews, observations, and field notes with 16 psychiatric nurses. Data were analyzed with constant and comparative methods by Glaser (1978).

The present study revealed the basic social process of facilitating living with persons with schizophrenia. This process consists of four major stages- Establishing trust, strengthening connection, promoting readiness to care, and supporting. In the first stage, psychiatric nurses used the strategy of establishing trust to make the family members to get a sense of trust with them before talking about their concerns and needs. Later, the stages of strengthening connections, promoting readiness to care, and supporting were employed to facilitate the family members to be able to care for and support the persons with schizophrenia to live with the family.

This substantial theory suggests a new knowledge and insights into ways to help family members of persons with schizophrenia. It can be used as a basis for developing a nursing guideline for working with family members.

Field of Study : ..... Nursing Science.....
Academic Year : ..... 2008.....

Student's Signature Ratchaneekorn Kertchok.
Advisor's Signature .....
Co- advisor's Signature Waraporn Chaiyawat

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CONTENTS

Page

LIST OF TABLES

LIST OF FIGURES

Page

CHAPTER I

INTRODUCTION

1.1 Background and significance of the study

Schizophrenia is a chronic disease and consists of a large group of disorders characterized by disturbances in thinking, mood, and behavior (Barry, 2002). Schizophrenics will exhibit strange behaviors, bizarre beliefs, and often experience visual and auditory hallucinations, and the majority of persons with a diagnosis of schizophrenia experience relapse (Sutton, 2004). The relapse of schizophrenia can occur at any time during treatment and during recovery. The main reason for a relapse is noncompliance with taking medication. Other factors also contribute to a relapse, such as the degree of stigmatization, community resources, and the responsiveness of family members. There is a need to take time to recover from each relapse, and it is necessary that persons with schizophrenia get help from mental health professionals and their family members because schizophrenia is not a disease that can be treated once and then it goes away. They need someone that can care for and support them in living in the family (Boyd, 2005).

In psychiatric nursing, psychiatric nurses play a great role in caring for persons with schizophrenia and their families so that they can live together in the community under a policy that has been called “deinstitutionalization,” as many hospitalized psychiatric patients return to live with their families (Tsang et al., 2002). In order to help persons with schizophrenia to be better and to be able to return to the family, the psychiatric nurses need to work with family members because the family

is an element of the patient's environment that can contribute to the patient's recovery.

Family members play an essential role in caring for persons with schizophrenia, just like psychiatric nurses. The psychiatric nurses are in a better position than other health workers to provide professional support to the family and they play a key role in establishing sound partnerships with family members as well as patients and other health professionals. However, the mental health professionals and family members' perceptions and behaviors towards each other have not always been positive (Hatfield, 1994; Conn, 2003). Sometimes, the mental health professionals have a tendency to see the family members as problematic rather than as someone that needs their support, or as a collaborator in promoting outcomes of care for the patients (Reed & Clark, 1999). At the same time, the family members sometimes do not want to become involved in caring for patients (Jeon, 2004). Collaborating effectively with the family members necessitates involvement in the decision making process throughout the illness trajectory. Obviously, collaboration between psychiatric nurses and family members appears to be one of the major challenges in caring for patients.

In previous studies, as Jeon (2004) has noted concerning the work shared between nurses and family members, the nurses and family members can be characterized by lack of mutuality in sharing the common goal of helping the patients; especially, during the first phase of meeting, they can have passive attitudes and behaviors toward each other. Nurses sometimes try to care only for the patient and pay no attention to family members. At the same time, some nurses are concerned about the demands imposed by family members and therefore avoided meeting with them (Laakso & Routasalo, 2001). As Friendemann, Montgomery, Maiberger and

Smith (1997) have noted, staff often overlook the family's needs, exclude the family from decision making, and the nurses are exhibit an unfriendly manner. At the same time, the family members try to avoid seeking help from nurses (Jeon, 2004).

In addition, Jeon (2004) has also noted that the relationship between nurses and family members could be developed in partial mutuality; here, nurses and family members begin to share perspectives and experiences with each other, but this interaction is sometimes limited by the different perspectives they hold, and because of their experiences and attitudes, all of which may add up to important problems. Furthermore, the family members still sometimes do not expect the health professionals to have all the answers as to why the illness has happened or what the future might be (Rose, 1998). The family members then might not ask for help from the health professionals about caring for the patients or ignore problems that may occur in the future.

According to these findings, it is interesting that the relationship between the nurses and family members can affect the patients' recovery and families. As Jeon (2004) states, as a result of a negative or detached relationship, nurses often do not understand the family members' needs and problems while giving care to the patients because of miscommunication. In turn, the family members are sometimes not given the necessary information/education and are not encouraged to become involved in caring for patients. The patients would be not being better and would not be able to return home (Friendemann, Montgomery, Maiberger and Smith, 1997). The nurses then should try to understand their relationship with the family members since in the first meeting. If the nurses have this understanding, they will be able to find ways and use strategies with the family members to make them recognize their need for involvement and become collaborators in caring for the patient from the very

beginning. In addition, when the relationship is performed in partial mutuality, these findings have not discussed how the nurses encouraged the family members to share their problems and had an understanding about the illness and situations. The findings do not discuss how nurses can decrease their limitations in working with the family members in caring for the patients.

However, the nurses' and family members' relationship could be performed in terms of constructive mutuality. That means that the nurses and family members have greater understanding and work together in caring for patients. The nurse-family relationship then becomes collaborative and is based on mutual trust, respect, and understanding (Jeon, 2004); in this way, a good working relationship between nurses and family members can lead to positive outcomes. The nurses can understand the family members' needs and problems and help the family members deal with difficulties while providing care to the patients. The nurses also could understand the patients' problems in order to plan suitable care for them (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000).

In turn, the family members value their relationship with the nurses. The family members appreciated the nurses' care and attention in caring for the patients; additionally, the patients received highly competent nursing care. At the same time, the family members perceived that the nurses attended to them when they had to contact the hospital. In addition, the family members were given important information and more opportunities to ask questions and to take care of themselves in their daily activities, and they were also given suggestions about giving care to their patients. Some families expressed empathy for the nurses, helped the patients to do activities, and thought that care giving for their patients helped them to develop good and strong relationships with the nurses. In this way, they could deal with their

difficult problems. They also would have opportunities to engage in solving the patients' problems with the nurses. Therefore, the patients would be better able to return to their families (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000; Friendemann, Montgomery, Maiberger and Smith, 1997).

In working with the family members, there is a growing need to understand how the psychiatric nurses should work with them in order to help them care for their patients. The psychiatric nurses also should understand how they can educate the family members via relationships so that the family members can have the necessary information to make informed decisions about their patients' healthcare, health promotion, disease prevention, and attainment of a peaceful death (Riley, 2000; Arnold & Boggs, 2007). It is also necessary that the nurses be prepared to learn new skills and expand these appropriately to their emerging healthcare understanding and managing of technology for families and patients (Arnold & Boggs, 2007). In addition, in order to help the family members be able to care for persons with schizophrenia, the psychiatric nurses must combine scientific knowledge with critical thinking and clinical reasoning skills in helping the family members to live with their family (Arnold & Boggs, 2007). At the same time, the psychiatric nurses must help the family members be able to take care for themselves while providing care for their patients.

The studies in Thailand, however, have not discussed the relationship between nurses and family members; these studies were based on the nurse-patient relationship by studying patients' experiences in general nursing and psychiatric nursing, and most of the studies were quantitative (Sasichay, 2001; Luepongluckkana, 1992; Limvipaveanunt, 1991). These studies reflect the fact that there is no existing

knowledge on the relationship between psychiatric nurses and family members of persons with schizophrenia in Thailand.

The studies on this relationship have been conducted outside the traditional Thai context. The findings also could not specifically explain the relationship between psychiatric nurses and family members of persons with schizophrenia because those findings explained the relationships between nursing staff and family members of persons with mental illness, including schizophrenia, depression, and other diseases. The findings also reflected only certain types and phases of the relationships. The studies also explored the relationship between nurses and family members in general nursing and the community setting (Ryan & Scullion, 2000; Jeon, 2004; Sawatzky & Fowler-Kerry, 2003; Kung, 2003; Jungbauer, Wittmund, Dietrich & Angermeyer, 2004). These studies explored the relationship in different focuses and contexts of the nurses and family members, such as studying in different diseases and settings. Thus, the evidence illustrates that extensive knowledge on this relationship has not been identified in the phenomena surrounding psychiatric nursing, especially regarding psychiatric nurses and family members of persons with schizophrenia in the hospital context. Therefore, the purpose of this study was to explore substantive knowledge from the perspective of Thai psychiatric nurses, and grounded theory is well-suited to explicate the basic social processes that comprise this relationship.

This study will contribute valuable knowledge that is absent in psychiatric nursing. The researcher has explored the relationship between psychiatric nurses and family members in caring for persons with schizophrenia and has generated a substantive theory of this relationship. An account of the relationship in the Thai context will contribute to nursing science, especially to psychiatric nursing. Psychiatric nurses will then have a model of this relationship in order to help family

members care for persons with schizophrenia in living with their family. For other health professionals that work with family members of persons with schizophrenia, this study will increase their understanding of the relationship and provide them with a guideline to help the family members.

1.2 Research question

What is the relationship between psychiatric nurses and family members of persons with schizophrenia?

1.3 Purpose of the study

The purpose of the study was to explore the relationship between psychiatric nurses and family members of persons with schizophrenia. This research used a qualitative research method, grounded theory, in order to capture the nurses' perspectives.

1.4 Scope of the study

This study focuses on exploring the relationship between psychiatric nurses and family members of persons with schizophrenia. Data collection involved in-depth interviews with psychiatric nurses working in in-patient wards at psychiatric hospitals in Thailand.

1.5 Definition of the relationship

The study focused on the relationship between psychiatric nurses and family members of persons with schizophrenia. Thus, the term “relationship” was defined by the participants after this study was completed. This study provided, however, a preliminary definition of the relationships as a guide for the interviews.

Relationship in this study refers to the process of psychiatric nurses helping family members of persons with schizophrenia so that the family members would be able to care for their patients and take care of themselves while providing care for the patients. This relationship was explored through in-depth interviews from the psychiatric nurses’ perspective.

1.6 Significance of the study

Knowledge about psychiatric nurses’ experiences regarding their relationship with family members of persons with schizophrenia will shed light on the basic social process of the relationship between psychiatric nurses and these family members. The basic social process that was explored from the psychiatric nurses’ perspective was a significant guideline for helping persons with schizophrenia and their family members to live together in the community. Understanding this relationship is an advantage for psychiatric nurses and other health professionals in terms of helping family members care for persons with schizophrenia and in helping them to live with persons with schizophrenia.

The findings of the study are seen as important information for developing psychiatric nursing practices that can help family members live with persons with

schizophrenia effectively. Psychiatric nurses that are working in inpatient wards and other nurses that are working in community hospitals and other medical centers will have a model of this relationship so that they can assist family members in caring for and supporting persons with schizophrenia and in living with their family in the community. As regards educational nursing, nursing students can learn about and practice helping family members to live with persons with schizophrenia. Moreover, in terms of nursing research, the findings of this study can provide research questions for further study by exploring and developing this relationship from different perspectives.

This study contributes new knowledge to nursing science, whose goal is to promote the health and well-being of patients and families while emphasizing holistic nursing care. Psychiatric nurses are expected to be able to support and assist family members in caring for persons with schizophrenia. In Thailand, however, there are no studies that focus on the relationship between psychiatric nurses and family members of persons with schizophrenia. This study, therefore, is conducted to explore the relationship between nurses and family members of persons with schizophrenia, information about which is absent in the existing knowledge in nursing science.

1.7 Summary

The relationship between psychiatric nurses and family members of persons with schizophrenia is a nursing phenomenon that should be explored, and a substantive theory on this relationship should be generated. This chapter presents information on the background of the study, the research questions, the purposes of the study, a definition of the relationship, and the significance of the study. These are

addressed in order to help the researcher with the research process and in this way readers will understand why the study was conducted.

CHAPTER II

LITERATURE REVIEW

This chapter presents selected literature relevant to the current study. The purpose of this study was to explore substantive knowledge on the relationships between nurses and family members in caring for persons with schizophrenia. The researcher has explored the relevant literature related to the study. This chapter summarizes the reviewed literature that focuses on major four topics: (1) psychiatric nursing, (2) relationship in psychiatric nursing, and (3) grounded theory methodology. The three topics were conducted by a search from various sources in both electronic journals and through manual searches, such as books, theses, and other materials from both in Thailand, eastern, and Western contexts. The literatures were included in this study from both quantitative and qualitative studies.

2.1. Psychiatric nursing

Psychiatric nursing focuses on caring and rehabilitation of persons with mental illness. Psychiatric nursing, as a special area of nursing practice, applies the study of human behaviors to the care of people with mental illness. In addition, psychiatric nursing uses research and theory from the physiological, psychological, and social sciences to explore and respond to the needs of the clients. At the same time, psychiatric nurses aspire to provide holistic care and treating a person as a whole (Mohr, 2003). Areas of concern in psychiatric nursing are mental health problems, such as stress, emotional crisis, self-concept changes, development issues,

physical symptoms as a result of psychological changes, and mental disorders, such as psychoses (Boyd, 1998). Psychiatric services consist of primary, second, and tertiary care and focus on prevention, intervention, and health promotion. These services require psychiatric nurses, as well as other mental health professionals, to combine knowledge, experiences, and skills in the care for and/or healing of people with mental illness (Mohr, 2003; Perraud, 2006).

Psychiatric nurses use the nursing process as the foundation for making decision in clinical practices through a problem-solving approach. The nursing process in psychiatric nursing focuses on standards of care, which describe nursing activities through assessment, nursing diagnosis, planning, implementation of interventions, and evaluation (Perraud, 2006). The nursing process remains an important guide/ tool for psychiatric nurses in caring for psychiatric patients (Perraud, 2006; Mohr, 2003; Boyd, 1998). In addition, nursing care is planned to meet an individual client's unique needs and situation with respect the client's goals and preference. To meet the client's goals, nurses must provide education to clients so that the clients have necessary information to make informed decisions about their health care, health promotion, disease prevention, and attainment of a peaceful death. The nurses must also establish a partnership with clients and other health professionals (Riley, 2000; Arnold & Boggs, 2007). At the same time, the nurses must be prepared to learn new and expand skills appropriate to emerging health care understanding and managing technology for clients. Most important, the nurses have integration of scientific knowledge with critical thinking and clinical reasoning skills in caring for clients (Arnold & Boggs, 2007)

Psychiatric nurses have developed standards of practice that outline the expected competencies relevant to this specialty area. The standards of psychiatric –

mental health nursing are being developed and implemented by the representative national association. The first were published in 1994 by American Nurses Association et al. to help psychiatric nurses provide appropriate nursing practices. Each standard of care provides measurement and indicators for meeting the standards.

In psychiatric nursing, the nurse must integrate his or her skills and knowledge in providing care for the client through the process of care in an interpersonal relationship. The psychiatric nurses' roles are still predominantly in the medical specialty of psychiatry. Psychiatric nursing has practice levels that are both "basic" and "advanced practice." The basic practice level is characterized by interventions that promote and support health, assess dysfunctions, assist patients to improve their ability to cope with problems, and to prevent further disabilities. This practice level requires nurses to work with individuals, families, groups, and communities to assess mental health needs and to apply the nursing process, including nursing diagnosis, planning, implementation, and evaluation. Therefore, the functions of mental health nurses at this level must include health promotion and health maintenance, intake screening and evaluation, case management, milieu therapy, self-care activities, psychobiologic intervention, health teaching, crisis intervention, counseling, home visit, and advocacy (Boyd, 1998).

Another practice level is advanced practice. In Thailand, as in other countries such as the United States, this level requires psychiatric nurses to have earned a master's degree and to be nationally certified as a specialist in mental health and psychiatric nursing (Thai Nursing Councils, 1999). It includes, as well, nurses specialized in mental health that have earned a doctorate in Nursing Science. The functions of mental health nurses at the advanced practice level are psychotherapy, psychobiologic interventions, clinical supervision and consultation, and consultation-

liaison (Boyd, 1998). Hence, the key element at this advanced practice level is the integration of skills and knowledge in nursing practice and care provision. Furthermore, as in the north American situation, the Thai Nursing Council has developed the national standards of The National League for Nursing (ANA, 1991) that are currently in use, including quality of care, performance of appraisal, education, collegiality, ethics, collaboration, research, and resource utilization (Thai Nursing Councils, 1999). These standards, however, of professional performance must be within the area of the standards of care, and these nurse's roles and functions are expressed through the nurse-client relationship.

Furthermore, as in the North America situation, the Thai Nursing Councils has developed national standards of The National League for Nursing (ANA, 1991) that are currently in use, including quality of care, performance of appraisal, education, collegiality, ethics, collaboration, research, and resource utilization (Thai Nursing Councils, 1999). The standards, however, of professional performance must be within the area of the standards of care. In addition, holding a holistic care and an ethical care are also considered and applied during the care. Ethics principle is a significant element that psychiatric nurse should realize and apply it into all nursing practices. Within the interpersonal relationship process, there is an ethic that occurs during all the processes. The ethics is called relational ethics (Austin, Bergum & Dossetor, 2003).

"Relational Ethics", within the process of interpersonal relationships, there are ethics that occur during all of the processes. These ethics are called relational ethics (Austin, Bergum & Dossetor, 2003). Relational ethics are defined as an "action ethic" (Bergum, 2004, p. 486) that explicitly situates ethics in a relationship. Relational ethics represent a moral responsibility within the context of human

relations that emphasizes human interdependency and reciprocity within which personal autonomy is embedded. Relational ethics require health care providers to base ethical actions on relations and commitments to patients, families, and others (Bergum & Dossetor, 2005). In Canada, the Relational Ethics Project was developed by Vangie Bergum (a nurse) and John Dossetor (a physician). Their research was conducted at the University of Alberta, Canada (1993-2001). The project explored the ethical commitments required by everyday health care situation. The core elements of these relational ethics are described as mutual respect, engagement, embodiment and environment in *Relational Ethics: The Full Meaning of Respect.* These core elements, however, are not to be interpreted as final themes (Austin, 2001; Bergum & Dossetor, 2005). Descriptions of these core elements are addressed as follows.

Engagement is a central theme in relational ethics. Engagement concerns human to human connection and is situated in the commitment between individuals. Ethical professional practice requires understanding of the other's situation, perspective, and vulnerability (Austin, 2001; Austin, Bergum & Dossetor, 2003). One question that would signal a good opening for nurses in establishing relationships with family members is: "How do we engage with each other?" (Bergum & Dossetor, 2005, p. 103). The aspects of engagement include looking at a person as a whole, appropriate vulnerability, conversation, and time management. If appropriate engagement is possible, under-engagement and over-engagement will not occur (Bergum & Dossetor, 2005). A relationship can be reconstructed by an action ethics where people connect with other and have mutual respect.

Mutual respect occurs when people connect with others. This involves self-respect and respect for others and from others. This respect for something is not

easily achieved. It may depend on different attitudes, gender, experience, knowledge, beliefs, culture, power, etc. If the care provider's perspective differs from the person's viewpoint, mutual respect is made difficult (Bergum & Dossetor, 2005). The expression of respect for nurses who work with patients and families requires reflection of self-understanding and others- understanding. Mutual respect cannot occur if nurses work without family members' understanding, interdependence, personhood, and connection. If health care professionals and family members can establish mutual respect, this mutual respect will lead to mutual power and re-empowerment. Additionally, the sprit between body and mind and objectivity and subjectivity should be integrated and respected in a relationship.

In relational ethics, the role of emotion in our ethical decisions and actions is acknowledged. Relationships require both objective and subjective knowledge. That means that relationships cannot occur without embodiment. Our body is the means by which we experience the world (Merleau-Ponty, 1962). It is impossible to separate our mind from our body (Matthews, 2002). Embodiment knowledge focuses on healing the sprit between the difference between body and mind, self and others, and objective and subjective. Within relationships, we will find a relational space where the opposition between body and mind, objective and subjective, and self and others is found. This relational space in a relationship needs attention to intersubjectivity, where body and mind cannot be separated (Bergum & Dossetor, 2005).

The practice of relational ethics also requires an interdependent environment. The environment can be defined as the circumstances, objects, or conditions by which one is surrounded. Health professionals need to pay close attention to the environments surrounding individuals, including the health care system, social, and community. Ethical practices cannot occur without personal, social, or political

elements. Supportive environments not only help people who are vulnerable to cope better, but also increase their ability to relate to other people (Bergum, 2004). This type of environment requires giving freedom and choice for making decisions, which involves individual and social choice. The context of care should always be considered in clinical practice (Bergum & Dossetor, 2005).

Some studies have used relational ethics as a framework to explore human experiences and to understand clinical phenomena (Austin, 2001; Austin, Bergum & Nuttgens, 2004; Marilyn, Bergum, Bamforth & MacPhail, 2004). One study found that some of the core elements of relational ethics are mutual respect, engagement, and attention to the environment. These core elements can offer a foundation for considering ethical practice in forensic settings, for example. Nurses need to be concerned about those elements in order to provide good nursing care and to be informed about how to act in crisis situations. Relational ethics help nurses to recognize the value of opening dialogue, the consideration of diversities of perspectives (Austin, 2001). Similarly, Evans, Bergum, Bamforth and MacPhail (2004) studied relational ethics and genetic counseling. Their study was conducted in order to describe how relational ethics can enhance the effectiveness of genetic counseling and to explore the realities of counseling in order to identify effective ways of counseling. The researchers found three themes of relational ethics: engagement, dialogue, and presence, and these can improve quality and outcomes for genetic counseling. For instance, many of the participants perceived the value of friendliness from counselors; the dialogue was seen as a connection between clients and counselors; and “presence” helps clients to contact and share their experiences with someone.

Thus, relational ethics is an important component in relationship between nurses and family members, which can be a basic concept for health practitioners to know how to act ethically in complex and critical care situations: psychiatric nursing needs to establish relational ethics in order to guide the development of relationships between nurses and family members of persons with mental illness. The researcher believes that if psychiatric nurses emphasize relational ethics through interpersonal relationship processes, families will be able to deal with serious problems more effectively.

2.1.1 Nursing practice and the persons with schizophrenia

2.1.1.1 Persons with schizophrenia

There are fifty million persons with schizophrenia worldwide and thirty-three million persons with schizophrenia in developing countries; especially, in the U.S.A. approximately 1.9 million Americans suffer from schizophrenia (Sadock & Sadock, 2001). In 2001-2007 in Thailand, it was found that the number of persons with mental illness is rapidly increasing, with 449,545 persons with mental illness and 104,920 persons with schizophrenia (Mental health department, 2007). The most common symptoms appear between the ages of 15 and 35 (50 % below ages 25), and the male to female ratio is 1: 1 (Sadock & Sadock, 2001). Forty percent of persons with schizophrenia attempt suicide, 10% percent die by suicide, and 50% cannot accept or do not believe that they have a psychotic disorder. The relapse rate is approximately 40-42% within 1 or more years on medication and 80% in 2 years off medication (Torabi & Kalafi, 1996 and Andrew, 2004).

Persons with schizophrenia are diagnosed according to the criteria of The Diagnostic and Statistical Mental Disorders-fourth edition, revised (DSM IV-R) or the ICD X. Schizophrenia is commonly classified as a chronic mental illness, as sub-chronic, or in remission. Some persons with schizophrenia have been living with long-term impairment, and most likely, the schizophrenia disorder is not a single disease but consists of several distinct disorders (Barry, 2002). Persons with schizophrenia are often accompanied by acute episodes of delusions, as false beliefs that cannot be corrected by reason, hallucinations usually in the form of voices, long-term impairments such as diminished emotion, lack of environmental interest, and depressive signs. The symptoms of schizophrenia are generally classifying into two categories. First, positive symptoms include hallucinations, delusions, disorganized thinking and speech, and disorganized behavior. Second, negative symptoms include decreased emotional expressiveness or affective flattening, reduced speech, and poverty of speech, inability to conduct daily activities, loss of ability to experience pleasure, and decreased initiation of goal-directed behavior (Herz & Marder, 2002). These may be particularly stable over time and not or less responsive to treatments.

Persons with schizophrenia often go through fluctuations in terms of the severity of symptoms and it is a long-term disorder with three phases: the acute phase, the stabilized phase, and the stable phase. The signs and symptoms are described as follows: during the acute phase, lasting about 4-8 weeks, persons with schizophrenia have severe psychotic symptoms in both positive and negative symptoms, such as hallucinations, delusions, disorganized speech and behavior; furthermore, their thinking is severely disorganized and their judgment impaired (Herz, & Marder, 2002; Shean, 2004). The stabilization phase lasts about 2-6 months, when patients are recovering from the acute phase. Their symptoms are improved but the patients

remain vulnerable and sensitive to relapse if they show noncompliance in taking medicine or if they face stressful life events or environment stress. This phase is highly vulnerable to relapse. During the stable phase or indefinite, the patients may be asymptomatic or they may manifest nonpsychotic dysphonic symptoms or negative symptoms in the clinical domain, such as anxiety, tense emotion, or insomnia (Herz, & Marder, 2002).

The consequences of living with schizophrenia are described in this section. Most persons with schizophrenia that are living in the community have often encountered negative consequences of schizophrenic disorder, including suicide and other accidents which can lead to death. For example, a study revealed that 10 percent of persons with schizophrenia have a risk of suicide, which is about 12 times the general population in both developed countries and developing countries (Herz & Marder, 2002). Thus, the mortality of persons with schizophrenia has still significantly increased over time, and this is possibly related to unhealthy lifestyles and restricted access to the mental health service system; social stigma refers to negative attitudes and beliefs of a group of people in society and is a powerful barrier to courses of treatment; some patients and their families suffer from such a stigma; the impact on caregivers includes economic and economic burdens, the stress of coping with disturbed behavior, disruption of routine activities, emotional reactions such as guilt, a feeling of loss, fear about the future and disruption of social activities, and problems in coping; social costs refer to the economic impacts of schizophrenia in each country. Moreover, persons with schizophrenia have social disabilities, including psychological, physiological, and anatomical functional impairments or abnormalities as well as restrictions in decision making or lack of the attention necessary to do things (WHO, 1998; Herz & Marder, 2002; Shean, 2004).

2.1.1.2 Nursing care for the persons with schizophrenia

Schizophrenia is a psychotic disease or a severe brain disorder that can causes long-term hospitalization. The disturbances of the persons with schizophrenia sometimes lead to clinical management. Treatments for persons with schizophrenia include psychopharmacological treatments such as standard antipsychotics, and typical antipsychotics that can control both positive and negative symptoms in order to improve the quality of life of persons with schizophrenia.

However, treatment with medication alone is insufficient in curing persons with schizophrenia. The psychosocial treatments include individual psychotherapy, group therapy, family therapy, psychoeducation, peer support, and self-help groups; and therapeutic settings, such as hospital treatment and community settings, are also important because these can provide patients with a human connection by helping them to develop social skills and by educating them about living with their relatives and in the community, about their course of illness, about what to expect in their life, as well as offering support over the long-term. In terms of psychosocial treatment, the therapist should take care to provide the appropriate behaviors and emphasize the person's age, culture, believe, and level of symptomatology (Antai-Otong, 2003; Cutler & Marcus, 1999). The persons with schizophrenia also need caring from their families. It is necessary that the family members to learn how to care for and support their patients. To help the family members to be able to care for and support the patients, psychiatric nurses need to relate to the family members through helping the family members.

2.1.1.3 Helping family members of persons with schizophrenia

Serious mental illness as schizophrenia produces a persistent and lifelong impact on families (Rhoades, 2000). Persons with schizophrenia and families need care and support from mental health professionals. There various treatments to help the persons with schizophrenia to be better and return to families. At the same time, helping family of persons with schizophrenia is an important issue in caring for persons with schizophrenia because the family as an element the persons with schizophrenia's environment that can support the individual's recovery. There are various approaches in assisting families to be able to care for persons with schizophrenia, including strategies for improving interaction between persons with schizophrenia and family members, providing supports for families who are experiencing with a burden associated with the care of a member with schizophrenia, and educational programs that improve the families' understanding of schizophrenia, its treatments, and caring for persons with schizophrenia (Herz & Marder, 2002; Shean, 2004).

A strategy of improving the emotional climate in family is an important intervention to support both family members and persons with schizophrenia. In the families, when persons with schizophrenia returned to the families, the relapse rates were higher because of high expressed emotion in the families. The definition of high express emotion was characterized by critical comments, hostility, and emotional over-involvement (Herz & Marder, 2002). Then, the improving the emotional climate in the family was thought that can decrease high expression emotion and increase relationship between family members and persons with schizophrenia in order to living with together in community between family members and persons with

schizophrenia. Then, these strategies were based on psychodynamic theories and focused on repairing relationships that were thought to have caused the illness.

Another strategy, however, for supporting family members of persons with schizophrenia is family counseling interventions that were based on family's problems oriented. The family counseling interventions that include psychotherapy and working with family as a group can be used to support the families. Psychotherapy more often used by family therapist and counselors to provide supportive and solutions- focused intervention. The therapeutic works include the learning and reinforcement of problem-solving and community-living skills. Working with family as a group therapy can be used to help families reattribute problems behaviors to the illness as schizophrenia rather than the person. The family group will help the family members to learn and improve communication between family members, and enhance problem solving within the family. For working with family consists of single-family. The single-family therapy can help the family improve coping methods and communication with each other in the family. The therapy works include educating the family about the illness and its management, avoidance of blaming the family, and establishing hope (Rhoades, 2002). As Peplau (1991) states that in psychiatric nurses, nurses must provide education and counseling clients to make them to learn, self-awareness, and self- understanding. At the same time, nurses must take great roles in helping the clients as a counselor to help the clients to manage problems. These strategies were employed to assist family members of persons with schizophrenia in caring for and supporting the persons with schizophrenia to live in community.

In helping family members, the psychiatric nurses need to understand the family members' difficulties in caring for persons with schizophrenia. Because of

severity of symptoms and persistence of illness, persons with schizophrenia produce a significant burden on the families. When a member of the family was diagnosed schizophrenia, other family's members in the family have often been impact from caring the persons who living with schizophrenia. Many studies have been shown that family members of persons with schizophrenia are suffering from giving care for the persons with schizophrenia (Rhoades, 2000; Tsang et al., 2002; Conn, 2003; Jungbauer, Wittmund, Dietrich & Angermeyer, 2004). Not only family members are encountering difficulties in caring persons with schizophrenia, but also persons with schizophrenia are suffering while living with schizophrenia. The descriptions of living with schizophrenia of family and persons with schizophrenia are presented as follows:

The severity of symptoms and the persistence of schizophrenia in persons with this illness can be burdensome to families (Rhoades, 2000). In the 1950s, as mental health services moved away from psychiatric hospitals to community-based rehabilitation programs under a policy that called deinstitutionalization, many hospitalized psychiatric patients returned to live with their families. In fact, a study in the United States estimated that 40-60 percent of discharged patients returned to their homes (Tsang et al., 2002). Similarly, studies have reported that the burden of family members that are providing care for persons with mental illness is increasing. Family members increasingly find themselves becoming the primary source of care and social support for relatives with a mental illness such as schizophrenia, and the role of family caregivers has become an important issue (Jungbauer, Wittmund, Dietrich & Angermeyer, 2004). As well, the World Health Organization (2001) has identified the burden of caring for a family member with mental illness as a significant world problem. According to family caregivers of persons with schizophrenia became major issues, the results of a national survey of the schizophrenia society of Canada revealed

that there are many caregiver roles in providing care for persons with schizophrenia, such as emotional support, financial support, coordination of health and mental health services (making appointments and arranging services and transportation), and personal care (bathing, eating, dressing, taking medicine) (Stual, 2005).

Research indicates that most primary caregivers perceive some burden arising from caring for relatives with mental illness, including schizophrenia (Conn, 2003; Jungbauer, Wittmund, Dietrich & Angermeyer, 2004). At the time of diagnosis, some families feel shocked because of their new care giving role. Many families expect that, with treatment, their relative will have a speedy recovery from the mental illness. When a relative begins treatment, the family learns that psychiatry is not a science and that the patient may require long-term treatment. Primary caregivers consequently may suffer from the burden of long-term care giving of a relative with a mental illness.

Such a burden can be classified into two groups. First, *objective burden* refers to the practical difficulties that family members encounter while giving care to their relative with a mental illness. These difficulties include housing, food and laundry, transportation, management of medication, money management, companionship and recreation, crisis intervention, and seeking help from the police (Conn, 2003; Sawatzky & Fowler-Kerry, 2003; Kung, 2003). Second, *subjective burden* refers to the negative emotion that family members experience in response to caring for their relatives with a mental illness, including grief, fear, guilt, and anger (Conn, 2003).

Researchers in North America have found that most family members of persons with schizophrenia have experienced both the objective and subjective type of burden, including the negative impact of stigma and discrimination or social isolation,

ineffective or inadequate mental health services, unemployment and financial difficulties, the disruption of household routines, such as helping the patient to get up in the morning: bathing, dressing, cooking, and managing money; experiences of frustration and anxiety, low self-esteem and helplessness, fear, loss, and grieving (Schwartz & Gidron, 2002; Tsang et al, 2003; Sawatzky & Fowler-Kerry, 2003; Kung, 2003; Jungbauer, Wittmund, Dietrich & Angermeyer, 2004; Austin, 2005). In Thailand studies on the impact on the caregivers of psychiatric patients have found that most caregivers experience stress and perceived burden from caring for their relatives with such mental illnesses as schizophrenia (Petcharat, 2004; Thummathai, 2003; Vanaleesin, Chetchaovalit, Aowchareon & Chaimongkol, 2003; Pipatananond, 2002; Upasen, 1998). As in the North America studies, this burden is both objective and subjective in type.

The stigma of mental illness can have a strong impact on patients and family members that are far-reaching, multifaceted, and unambiguously negative (Austin, 2005). Thus, the social stigma and isolation associated with providing care for persons with schizophrenia can be a source of family stress and burden. Stigma can be defined as “a mark or label that sets an individual apart as being different in the negative sense, making them undesirable, and precipitating social rejection and discrimination” (Austin, 2005, p. 336). A study by Philo et al. (1993) identified sources of stigmatization of persons with mental illness that covered all media, including local newspapers, magazines, children’s comics, and television news. Such sources were: 1) Jokes expressed to others, when psychiatric patients are presented as the source of a joke; 2) Violence to others, as people with a mental illness are seen as being a source of violence; 3) Violence to self/suicide, with stories that mention self-harm associated with mental illness; 4) Sympathetic/positive behaviors, as some

family members experience eating disorders while giving care for persons with a mental illness; and 5) Critical representation, with stories which focus on the issues of mental illness examined in depth (Philo et al. cited in Brunton, 1997).

Other studies have also noted that many psychiatric patients and their families have a feeling of stigmatization from the behaviors and attitudes of mental health professionals, such as using inappropriate humor, separation or isolation of the person with mental illness, inattention, inadequate services, and blaming of parents and other family members (Hinshaw, 2005; Schulze & Angermeyer, 2003). Many families feel unsupported in their role of caregiver, even though health professionals believe that they have helped these patients in their caring (Rhoades, 2000). Thus, family members who live with persons with schizophrenia have encountered with disturbances of the persons with schizophrenia. In helping the family members of persons with schizophrenia to deal with the difficulties, the psychiatric nurses use strategies by via relationship. The relationship in psychiatric nursing is a powerful tool in helping the family members and their patients.

2.2 Relationship in psychiatric nursing

Relationship is an important paradigm for all nursing contexts. It can be defined as the way in which two people or two groups behave towards each other (Summers, 2001). In this context is called a helping relationship (Sudeen, Stuart, Rankin & Cohen, 1998). The nature of the relationships is established through the process of interaction between nurse and client (Raingruber, 2003). The relationship between nurse and client (patients/families/people) is an interpersonal relationship (O'Brien, 2001). There are many definition of relationship which is various meaning

in each discipline. For example, the meaning of interpersonal relationship in the encyclopedia is defined as the "social association, connection, or affiliation between two or more people who may interact overtly, covertly, face or may remain effectively unknown to each other" (Wikipedia, the free encyclopedia, 2007, p. 1). In addition, nursing in the perspective of Peplau is that "Nursing is a service for people that enhance healing and health by methods that are humanistic and primarily non-invasive" (Fitzpatrick & Whall, 2005: 48). In more specifically definition of nursing, Peplau stages that nursing is a "significantly therapeutic interpersonal process which functions cooperatively with other human processes that make health possible for individuals" (Fitzpatrick & Whall, 2005: 48). These definitions reflect that "Nursing" in psychiatric nursing can be called "Therapeutic relationship" for helping clients to meet enhance healing and health.

In the relationship, there are three types of relationship in nursing practice. Stevenson, Grieves and Stein-Parbury (2004) and Videbeck (2001), for example, state that interpersonal relationships consist of three types: social relationships, intimate relationship, and therapeutic (professional) relationship. A social relationship is "primarily initiated for the purpose of friendship, socialization, companionship, and accomplishment of a task" (p. 91). An intimate relationship can be defined as "two people who are emotionally committed to each other and are both concerned about having their needs met and helping each other" (p. 92). A therapeutic relationship focuses on the needs, experiences, feelings, and ideas of the client. Nurses need to use various skills, such as communication skills, personal strengths, and understanding of human behavior, in order to interact with the client. All these types of relationship demonstrate nurse's various roles while interacting with clients.

Relationship between nurses and clients reflects role expectations. The role of the nurse can be defined in many different ways. Peplau (1952) indicated that the roles of nurses depend on the needs of the clients and the skills and creativity of the nurses, including strangers, resource persons, teachers (educator), leaders, surrogates for significant others, counselors, arbitrators, change-agents, researchers, and experts (Peplau, 1991; Peplau, 1952 cited in Forchuk, 1993; Martin and Street, 2003). Some clients have the expectation that nurses must help them to be clinically better and more comfortable (Stevenson, Grieves & Stein-Parbury, 2004). Relationship in psychiatric nursing focuses on the nurse-client relationship.

2.2.1 The nurse-client relationship

The nurse-client relationship can be a vehicle for the application of the nursing process. The interpersonal relationships in the nurse-client relationship are essential to the practice of psychiatric and mental health nurses (Raingruber, 2003; Peplau, 1991). Peplau has studied and written about the nurse-client relationship based on the notion of interpersonal relationship, where the nurse-client relationship is considered a therapeutic one. The client will be referred to a person who is experiencing mental illness, and their families and significant others (Fontaine, 2003; Peplau, 1991). She wrote a book, *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing,* which can help nurse practitioners to deepen their understanding of interpersonal relations in the nursing situation (Peplau, 1991). Similarly, King (1990) has defined interpersonal relationship as an important element in the practice of nursing. She views the nurse-client relationship as a

learning experience involving two people that interact to face health problems, to share and to discover ways to adapt to a situation, and to resolve problems.

The nurse-client relationship is a therapeutic tool in all nursing contexts, and it is goal directed. That means that nurses and clients decide together what the goal of the relationship will be. The objectives of the relationship are focused on learning, growth promotion, and problem solving. In addition, it is an effort to change some aspects of the client's life, where the nurse and client determine together how much time they are able to spend. The nurses need to provide information based on facts and without bias or personal identification. Moreover, nurses should emphasize the client's feelings and opinions when interacting with him or her and in an atmosphere of mutual respect and understanding (Townsend, 1999; Forchuk, 1993; Eby & Brown, 2005). Moreover, Peplau (1991) noted that nurses must be aware of communication and pattern integration in this interaction.

The nurse-client relationship is also a significant tool for mental health nursing, and some studies reflect on this relationship (Martin & Street, 2003; Eby & Brown, 2005). For instance, a study reported that nurses in forensic psychiatric nursing have perceived the nurse-patient relationship as a powerful one in providing care for patients. They also recognized the value of oral communication as being more significant than written communication (Martin & Street, 2003). As well, Eby and Brown (2005) reported that nurses learn from this process how to deal with clients and how to provide nursing interventions for them. Thus, the nurse-client relationship is an important tool for helping clients in psychiatric nursing.

In the nurse-client relationship, psychiatric nurses must make therapeutic use of self in providing care for client and in the process of establishing relationships. This means that psychiatric nurses use themselves as a tool to establish relationships

with a client. The therapeutic use of self is the ability to use one's self with consciousness and with awareness in an attempt to establish nursing interventions (Eby & Brown, 2005). The therapeutic use of self requires nurses to have "a great deal of self-awareness and self-understanding, having arrived at a philosophical belief about life, death, and the overall human condition" (Townsend, 1999, p. 99). That means that the nurses must also understand their abilities and attempt to combine these abilities and emotions to help others. There is a need for nurses to have understanding. Similarly, Peplau (1952) has described the therapeutic use of self in the nurse-client relationship where nurses need to have a clear self-understanding in order to promote the client's growth and well-being (Peplau, 1952 at cited in Videbeck, 2001).

Self-awareness is another important concept in improving the therapeutic use of self: nurses must first know themselves before beginning to understand others. The important things that the nurse must know about himself or herself are their own values, thoughts, feelings, beliefs, attitudes, and strengths and weaknesses. This process has been referred to as the process of developing and understanding of self-awareness. Such self-awareness includes an understanding of the client's emotions, personality, sensitivity, motivations, ethics, philosophy of life, physical and social image, and capacities; and this self-awareness allows nurses to observe, understand, attend, reflect on and interact with clients (Videbeck, 2001). Nurses developing self-awareness and understanding can begin by using aspects of their perception, feelings, intelligence, needs, coping skills, and perception in order to create a relationship with clients (Videbeck, 2001; Townsend, 1999). Another way to learn about oneself is the Johari window, which describes a person according to four areas and reflects how well a person knows himself or herself. The four areas are: 1) the open/public area,

where a person knows about him/herself and others 2) the blind/unaware area, where a person knows only others; 3) the hidden/private area is where a person knows only him/herself; and 4) the unknown area, which is an “empty area” as undiscovered by oneself or others (Videbeck, 2001). Thus, understanding the notion of self-awareness and how to improve and develop this self-awareness on the part of psychiatric nurses are very helpful for providing effective interventions for the client through each phase of the nurse-client relationship.

2.2.1.1 Phases of the nurse-client relationship

Nurse-client relationships can be established in different forms. Peplau (1991) has identified the nurse-client relationship into four phases, including the orientation, identification, exploitation, and resolution phase. Descriptions of these relationships are as follows.

First, The orientation phase focuses on seeking assistance based on felt needs. When patients come to the hospital, they have more feelings uncertainty about their illness. They and their family may perceive and react differently to the illness. They often ask questions to the health professionals, such as “What is wrong with me or my son?,” “Why should this thing happen with me?,” “What caused it?,” and “What can the doctor do?” The psychiatric nurses adjust their behavior in terms of helping the patients and their families according to these questions encourage nurses to recognize how to help the patients and their families on the basis of needs. Peplau (1991, p. 26) mentions that “every patient needs to be assisted in harnessing energy that derives from tension and anxiety connected with felt needs to positive means for defining, understanding, and meeting productively the problem at hand.” During the

orientation phase, nurses' roles that are important include providing information and understanding the illness and treatment. Nurses will realize what education needs the patients and families have and what they need to recognize and understand about the present situation in order to resolve problems in the future. In addition, nurses will encourage the patient to fully participate and to fully integrate his or her illness into his or her life experiences (Peplau, 1991).

Second, The identification phase focuses on helping the patient/family to identify their problems. When the patient/family accepts and understands their illness and feelings, they need to identify their problems. Not all patients/families can easily identify their problems. During this phase, there is, therefore, a need for the nurse to use skills and to offer experiences as well as enable the patient/family to identify problems and sufficiently express feelings. Nursing needs to use the notion of the nurse-client relationship to be a key tool for driving the work with the patient/family, and the patient/family identifies with nurse on the basis of needs and services that are considered as useful. They also identify with the nurse on the basis of their past experience and expectation. Thus, the major function of the nurse in this phase is to make use of his or her professional education and skill in helping the patient/family (Peplau, 1991).

Third, The exploitation phase focuses on making full use of the services offered to the patient/family. When a patient/family has identified with a nurse who understands the interpersonal relations in the situation, the patient/family will perceive that the services offered to him/her are fully useful. That means that the full value that the patient/family receives comes from the relationship. In this phase, the patient/family will be exploited on the basis of self-interest and need. The patient/family may feel fully at home and participate in all of the services offered to

him/her. At the same time, he/she will explore all of the possibilities of the changing situation. Sometimes, many patients may experience a conflict with their life in terms of being unable to decide directly about something they wish for—they may try to keep a balance between dependence and independence. Nurses need to understand what happens as regards the patient/family and what should be done to change the patient's behaviors (Peplau, 1991).

Fourth, the resolution phase focuses on helping a person to develop the strength to withstand more. This outcome will be achieved when all of the earlier phases are met in terms of psychological mothering based on "unconditional acceptance in a sustaining relationship that provides fully for need-satisfaction; recognition of and responses to growth cues, however, trivial, as and when they come from the patient; shifting of power from the nurse to the patient as he becomes willing to delay gratification of his wishes and to expend his own efforts in achieving new goals" (Peplau, 1991, p. 40). This phase can view in terms of a freeing process whereby the nurse helps the patient/family to manage his/her actions while staying in the hospital and in thriving in their social life in the future.

Each phase of the relationship overlaps with others. For instance, the phase of exploitation overlaps with those of identification and resolution; and the phase of orientation overlaps with the previous social and family situations. The nurse's functions in the four phases are interlocking. The functions are: (a) the role of the resource person as giving specific and needed information to the patient/family. This information can help the patient/family understand their problems and the new situation; (b) the role of counseling in terms of understanding the events in the patient's life that made him/her come to hospital and his/her feelings; (c) the role of the surrogate mother, father, and sibling in helping the patient to re-enact and examine

generically older feelings and new feelings that involved in the patient's life; (d) the role of technical expert in terms of understanding the various professional devices and managing these devices with skills to help the patient.

Within these relationships, nurses must use their skills and utilize their existing knowledge while work on creating a relationship with the client. One previous study reflected on the integration of skills and knowledge through the process of the nurse-client relationship. Hanson and Taylor (2000) developed the model of the nurse-client relationship in terms of the I-Thou relationship (Being-with) and the I-It relationship (Doing-with) as a way of establishing the nurse-client relationship. Both being-with and doing-with relationships are considered important requirements for community mental health nursing and can also create relationships of the client with the community. The term "client" in this study can be defined as "family".

2.2.1.2 Important components in relationship

An interpersonal relationship is the result of the mutual endeavor between health care professionals and patients/families (Stevenson, Grieves & Stein-Parbury, 2004). In order to improve the nurse-client relationship, there are many components that need to be investigated. These components are described as follows:

First, Trust is an important component of the nurse-client relationship. Trust is also considered as the keystone of this relationship. Trust provides a good interpersonal climate in which the clients are comfortable when interacting with the nurses. In the context of the helping relationship, trust is defined as "the assured belief that other individuals are capable of assisting in times of distress and will probably do

so" (Travelbee, 1971 as cited in Sundeen, Stuart, Rankin & Cohen, 1998: p. 151). There are several characteristics of trusting person, including a feeling of comfort with growth in self-awareness and an ability to share this awareness with other; acceptance of others as they are without needing to change them; openness to new experiences; long-term consistency between words and action; and ability to delay gratification (Sundeen, Stuart, Rankin & Cohen, 1998). This trust however can also be replaced with mistrust between nurse and client. For the persons who tends to be distrustful generally shows opposite characteristics. Not only does mistrust impact on communication but also on the processes and outcomes of healing (Boggs, 2003). Theses characteristics can be used to be a guideline to assess the family members' ability to trusting and self-assessment.

Second, Empathy is "the ability to be sensitive to and communicate understanding of the client's feelings" (Boggs, 2003). It is a significant component that leads to a helping relationship (Ancel, 2006). An empathic nurse will perceive and understand the client's needs and feelings accurately. Sometimes, the nurse may fail to provide empathy for the client because of lack of time, lack of trust, lack of privacy, or lack of support from other professional colleagues. Some studies have noted that in psychiatric nursing the basis of therapeutic communication is important, and this includes the therapeutic use of self, listening, assertiveness, self-disclosure, rapport, genuineness, empathy, respect, and confrontation and limiting the setting in order to establish relationships with the patient/family (Videbeck, 2001; Eby & Brown, 2005; Deering, 2006; Townsend, 2000).

Third, Empowerment is defied as "assisting the client to take charge of his own life." Nurses use interpersonal processes to provide information, tools, and resources to the clients to be able to build skills that can be used for them to reach

well-being by themselves. Nurses will empower clients to feel valued, to adapt successful coping methods, and to think positively during the relationships. This means that empowerment should be achieved by clients so that they can take control of their lives (Boggs, 2003, p. 145-146). One study in Australia reported that lack of information about providing care for the patient, managing medicines, or recognizing the patient's behaviors in crisis intervention were the major impediments to empowering family members in caring for their ill relatives (Wilkes, White, & O' Riordan, 2000 cited in Boggs, 2003). Hence, nurses should empower clients by providing complete information in order to increase their power and confidence while care for persons with mental illness.

Fourth, Self-disclosure is defined as opening up ones' self to others. That means that if we self-disclose to others, we have to open our feelings, our thoughts, and some of our personal experiences. In the nurse-client relationship, nurses need to self-disclose to clients to let them to know about the nurses' thought, feelings, and experiences to show that they understand them. This self-disclosure can develop close relationships between nurses and clients. One study has demonstrated the factors that are related to positive relationships between staff and families. First, contact with purpose; each contact between nursing staff and families should identify the mutual purpose in planning to care for the patients. Frequently meetings, however, are not a reflection of such a close relationship. Knowing the purpose of contact helps family members to know how to do the right thing for their relatives and how to work with staff. Second, shared experiences; family members and staff develop their relationships by sharing experiences. Some family members are perceived to be closer to staff when they have shared their experiences in providing

care for the relative, such as medication management and in dealing with the emotional problems of the residents and others (Gladstone & Wexler, 2002).

Fifth, Respect is the acceptance of the client's ideas, feelings, and experiences. Acceptance can be shown by using verbal and non-verbal communication. Receiving respect makes people feel important, cared for, and worthwhile. When people, do not receive respect, however, they feel hurt and ignored (Riley, 2000). In the nurse-client relationship, nurses should respect clients in order to make them feel valued. Nurses can show respect to clients by the way in which they observe the clients, by offering help, maintaining eye contact, smiling, calling the client by name and introducing themselves and making contact through gentle touching. For instance, some Canadian studies reported that families were appreciative of the staff's care and respect. The patients were also given care and attention. The families felt that the staff was very warm, tolerant, and polite with their relatives and provided care with high competency. Staff also attended to family members by doing things such as stopping to say hello, knowing the family members by name, and accepting help from the families (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000).

In addition, in the nurse-client relationship, there are factors that are related to this relationship. One study reported that there are two factors: contact with purpose and shared experiences related to the relationships among staff and families (Gladstone & Wexler, 2002), and these factors are important for developing relationships between nurses and family members. First, in the relationship, the purpose of the contact between nurses and family members is an important factor. The purpose of the contact refers to determining the goals of meeting. Each time the contact between nurses and families takes place, the purposes should be determined to

be a guideline for the meeting. Nurses and family members will know what they will do. Knowing the purpose of the contact helps family members to know how to do the right things for their relatives and how to work with staff. Frequent meetings are not a reflection of a close relationship. If nurses and family members have not determined goals in the contact, the relationship will not occur. Second, family members and nurses develop their relationships by sharing experiences. Sharing experiences is an important factor in the relationship. Some family members are perceived as being closer to nurses when they have shared their experiences in providing care for the patients, such as medication management, dealing with emotional problems of the patients, and others. In addition, they learn to deal and live with the patients in their society.

Thus, relationship is an important paradigm in the practice of psychiatric nursing. The nature of the relationships is established through the process of interaction. The nurse-client relationship is considered an effective tool in providing care for individuals with mental illness and their families. Psychiatric nurses must integrate their skills and knowledge in providing care for the client and play the nurse's roles through the process of the nurse-client relationship. The nurse-client relationship is conducted in various ways. The nurse-family relationship is a concept that the psychiatric nurse should understand and be attentive to while provide nursing care for the client. Some studies have outlined the components that influence these relationships, such as trust, empathy, empowerment, self-disclosure, respect, and genuineness. Two factors are related to this relationship: contact with purpose and shared experiences. These components and factors can develop positive and close relationships between nurse and family members.

2.2.2 Relationship between nurses and family members

The nurse-family relationship refers to the nurse and family members working together to help patients (Jeon, 2004). Previous studies have discussed the relationship between nurses and family members while providing care for their patients both from the nurses' perspective and the family members' perspective. These studies are presented as follows.

2.2.2.1 Relationship between nurses and family members: the nurses' perspective

The findings of previous studies on psychiatric nursing care have shown the difficult and distant relationships between nurses and family members of persons with mental illness, including schizophrenia and depression (Ryan & Scullion, 2000; Conn, 2003; Jeon, 2004). For example, Jeon (2004) studied the relationship between community psychiatric nurses and family members of older people with mental illness and noted that there are three phases of the relationship between nurses and family members. In the first phase of the relationship, nurses and family members are characterized by lack of mutuality in sharing the common goal of helping the patients: they have passive attitudes and behaviors toward each other. Nurses tried to care only for the patient and paid no attention to the family members. At the same time, the family members tried to avoid seeking help from the nurses. Similarly, another study reported that sometimes neither nurses nor family members wanted to be involved in caring for the patients at the same time (Ryan & Scullion, 2000). The second phase of the relationship is partial mutuality; here, nurses and family members begin to share

perspectives and experiences with each other, but these are limited by the different perspectives, experiences, and attitudes that may lead to important problems. Nurses, however, still have limitations in terms of their capacity to negotiate, reflect, and respond to the needs of family members. The third phase of the relationship is constructive mutuality. In this last phase, nurses and family members have more understanding and work together in caring for patients. The key strategies that the nurses used included reflecting and validating the psychiatric nurses' attitudes, actions, and interactions; transforming their practice; and understanding the situation and validating the family members' role (Jeon, 2004).

In addition, as Hertzberg, Ekman and Axelsson (2003) have noted, the nurses perceived that the family members (relatives) were an important resource that could support their work. The majority of the nurses indicated that the family members were a resource for the patients' well-being because the family members visited the patients (residents). The nurses also said that the family members visiting the patients could contribute to the patients' psychological well-being. Furthermore, the nurses said that the family members were a support to the nurses while caring for the patients. The nurses also explained that they received necessary information from the family members.

Furthermore, Hertzberg, Ekman and Axelsson (2003) have noted that the family members were a part of the nurses' work. The nurses stated that the family members were seen as part of their job, although this was not given priority. However, in working with the family members, the nurses said that it was complicated because the nurses did not have enough time. The nurses also said that the family members' involvement made the family members feel that they were important, felt confident, and that they were taken into account as team members.

Moreover, most of the nurses said that the family members were nice, but sometimes demanding. The nurses felt that they had positive feelings towards the family members but some of the family members were rather demanding: they had their own problems or seemed to be experiencing a difficult period; some of them had inadequate knowledge of the illness but they could learn about the illness; they would not accept the patients' real conditions; they were anxious about the patients' well-being, were under severe strain, were too protective, and had feelings of guilt. The nurses also expressed the idea that some family members avoided by the nurses because the family members were complaining and demanding. The nurses explained that the illness was a strain. A consequence of this strain was that the nurses tried to avoid meeting with the family members and preferred talking with them only as much as was necessary. The nurses also said that some of the family members had bad relations that were difficult to repair (Hertzberg, Ekman & Axelsson, 2003).

2.2.2.2 Relationship between nurses and family members: the family members' perspective

Previous studies have reflected on the nature of the nurse-family relationship in nursing practice and it has been found to exhibit both positive and negative outcomes. Some studies in general nursing have discussed the relationships between staff and family members (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000; Friendemann, Montgomery, Maiberger & Smith, 1997). The findings revealed that families appreciated the staff's care and attention; the staff was warm, tolerant, gave positive verbal and non-verbal responses, and was polite with relatives as well as demonstrated highly competent nursing care. The family members also expressed that

the staff attended to them, with such activities as stopping to say hello, knowing the family members by name, and agreeing to help them. Moreover, the family members expressed that they were given important information and more opportunities to ask questions and to take care of themselves in daily activities, and they were also given suggestions about giving care to their patients (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000; Friendemann, Montgomery, Maiberger & Smith, 1997). Moreover, the family members indicated that they had opportunities to engage in joint problem-solving. The family members also stated that they had actively participated in discussions with the staff on specific care issues about their patients. The family members, therefore, said that they felt as though they were special elements in caring for the patients because they were given attention from the staff and they expressed their appreciation to the staff (Gladstone & Wexler, 2000).

For this reason, many family members tried to understand and acknowledge the staff, and some families expressed empathy for the staff by being physically demonstrative towards them by giving them a hug or shaking their hands. The family members also said that they helped the patients do activities and thought that care giving for their patients helped them to develop good and strong relationships with the staff. They tried to do the best for the staff and did not demonstrate any criticism of the staff. In this way, they tried to deal with real, potential conflicts in several ways, and with difficult problems which might have arisen in their relationship with the staff. The family members perceived that their relationships with the staff were characterized by a collegial, professional, and friendship relationship (Gladstone & Wexler, 2000).

In contrast, some studies in general nursing found instances of negativity in the relationships between nursing staff and family members, such as inattention,

inadequate health service, and discontinued care of clients (Friendemann, Montgomery, Maiberger & Smith, 1997; Gladstone & Wexler, 2000; Ryan, 2000). These studies reported that most family members described that the staff overlooked the special needs of the patient and family and gave impersonal care or showed them no compassion. The family members also stated that the staff lacked a sense of personal safety toward the patient, which means that the staff neglected or abused the patient or lacked a sense of competence or was careless. At the same time, the family members expected that they should be respected and acknowledged by the staff. The family members also needed cooperation from the staff, including open communication and the sharing of information. They needed guidance about how to care for their relatives as well as encouragement in the sharing of the care. The staff, however, still overlooked the families' needs. The families were deprived of making decisions and none of them had participated in, nor were invited to participate in, the care planning. In the same way, the family members said that some nurses did not want to include them in the process of caring. The family members also said that the staff thought that caring for the patient was their responsibility and not that of the family members (Friendemann, Montgomery, Maiberger & Smith, 1997; Gladstone & Wexler, 2000; Ryan, 2000).

Moreover, the family members stated that they were living in an environment with unanswered questions about the future and how to deal with the patient's unpredictable behavior. They also explained that they were concerned about the management of the patient's changing appearance and what it meant. They had a feeling of being stuck, even though they had been dealing with the illness for many years. They still did not receive the answers they wanted from the nurses. At the same time, they were frustrated because they were criticized by the nurses about their

behavior and were informed that they needed to change it (Rose, 1998). In this way, the family members perceived that their relationships with the nurses were characterized as tense and distant (Gladstone & Wexler, 2000).

Thus, the nurse-family relationship involves the work between the nurse and the family members of the person that is ill. Some qualitative and quantitative studies from both psychiatric nursing and general nursing reflect both positive and negative relationships between the nurses and family members, relationships that influence the nursing care of the patients and helping the families. However, in order to care for the patients and to help them to return home, psychiatric nurses need to work with family members in helping them and the patient live together as a family. In addition, these findings indicate that the nurse-family relationship is very important in helping family members to be able to care for their patients. If the nurses understand the relationship, the nurses will be able to care for the patients and families. Then, the nurse-family relationship should be explored. Grounded theory methodology was used to explore the relationship between psychiatric nurses and family members.

2.3. Grounded Theory methodology

This study aims to explore the substantive knowledge concerning the relationships between psychiatric nurses and family members in caring for persons with schizophrenia. A qualitative approach, grounded theory, was used in this study. In order to provide understanding of the grounded theory method, its historical background, the fundamental characteristics of grounded theory, and the methodological features of grounded theory, generating theory, constant comparative analysis, theoretical sampling, coding process, and memoing are described in the following.

2.3.1 Historical background of grounded theory

Grounded theory is a general research approach for behavioral science developed by two sociologists, Barney Glaser and Anselm Strauss (Strauss & Corbin, 1998: p. 9). The successful collaboration of Glaser and Strauss in their research constitutes the constant comparative method or grounded theory. Glaser and Strauss came from different backgrounds. Glaser was trained in quantitative methodologies and theory generation from Columbia University. On the other hand, Strauss was trained in qualitative approaches and was a symbolic interactionist from the Chicago school of qualitative research (Glaser, 1998: 21-23; Strauss & Corbin, 1998: 9). Strauss's perspectives on the development of the grounded method focused on (a) "the need to get out into the field to discover what is really going on; (b) the relevance of theory, grounded in data, to the development of a discipline and as a basis for social process; (c) the complexity and variability of phenomena and of human actions; (d) the belief that persons are actors who take an active role in responding to problematic situations; (e) the realization that persons act on the basis of meaning; (f) the understanding that meaning is defined and redefined through interaction; (g) a sensitivity to the evolving and unfolding nature of events; and (h) an awareness of interrelationships among conditions, actions, and consequences." Glaser's thinking, however, focused on "the need for making comparisons between data to identify, develop, and relate concepts" (Strauss & Corbin, 1998: 9-10). Even though they came from different philosophical and research traditions, their studies are acknowledged. They collaborated in developing a qualitative approach that focused on generating a substantive theory or formal theory (Glaser & Strauss, 1967: 31-34). Both of them collaborated in their writing about grounded theory, including research

on dying in the hospital, which was addressed to audiences and disciplinary colleagues (Strauss & Corbin, 1998: 10).

2.3.2 Fundamental characteristics of grounded theory

The foundation of grounded theory came from sociology and focuses on exploring basic social process. The philosophical underpinning of grounded theory is symbolic interactionism (Glaser & Strauss, 1967; Schreiber & Stern, 2001: 17; Strubert & Carpenter, 2003: 110). In symbolic interactionism theory, it is believed that "people behave and interact to object, institute, and other situations based on how they interpret or give meaning to specific symbols in their lives," such as verbal and nonverbal expressions or styles of uniforms. Another fundamental characteristic is constant comparative analysis. The constant comparative analysis consists of guideline data generation and treatment and combines an analytic process of constant comparison with a coding process for generating substantial theory (Strubert & Carpenter, 2003: 110-111). Thus, the major theme of the grounded theory method is the discovery of theory from data that are systematically obtained from the social process (Glaser & Strauss, 1967: 2).

2.3.3 Methodological features of grounded theory

The main features of grounded theory methodology are generating theory, constant comparative analysis, theoretical sampling, coding process, and memoing. All of these simultaneously occur throughout the study in order to generate a substantive or formal theory. In order to understand the main features of grounded

theory, descriptions of generating theory, constant comparative analysis, theoretical sampling, the coding process, and memoing are described as follows.

2.3.3.1 Generating theory

The grounded theory approach is focused on generating theory. The generation of theory or development of theory is a complex process. The term "theorizing" is considered as a sign of developing theory. Theorizing is a significant task that consists of both intuiting ideas and formulating data into a logical, systematic, and explanatory scheme (Strauss & Corbin 1998: 21). The generating theory in grounded theory methodology often uses the constant comparative analysis method to look for substantive knowledge or theory. The two basic kinds of theory that are developed are substantive and formal theory. Substantive theories may be referred to substantive, empirical, and areas of sociological inquiry such as family care, patient care, and race relations. On the other hand, formal theories refer to the development of a formal or conceptual area of sociological inquiry, such as stigma, deviant behavior, and authority and power. Although the generating level of substantive theory differs from formal theory, both substantive and formal theory needs to be grounded in data (Glaser & Strauss, 1967: 32-33).

2.3.3.2 Constant comparative analysis

Constant comparative analysis or comparative analysis is used to generate a substantive and formal theory. The comparative analysis is a common method for analyzing data, as with statistical analysis. Some theorists use the term "comparative

analysis" to analyze both the small social units and large social units in the world. The main purpose of comparative analysis is to generate theory from data. The specific objectives of the comparative analysis depend on the researcher's goal to in generating the theory (Glaser & Strauss, 1967: 21-23). During the data analysis, theoretical sensitivity is considered as a significant aspect of grounded theory. Hence, the researcher needs to maintain sensitivity in all research procedures. In addition, as regards comparison among codes, Strauss and Corbin (1998: 78-80) discussed two kinds of comparison. The first is the comparison of incident to incident or object to object and looking for similarities and differences in the same characteristics. The second is making a theoretical comparison; this refers to comparing categories to similar or different concepts in order to extract the possible properties and dimensions from evidence. There are four states of the constant comparative method: comparing incidents applicable to each category, integrating categories and their properties, delimiting the theory, and writing the theory. These stages will be used from the beginning of the data analysis until the analysis is completed (Glaser & Strauss, 1967: 105).

2.3.3.3 Theoretical sampling

Theoretical sampling is the simultaneous collecting, coding, and analyzing of data to generate theory. Theoretical sampling is a complex process from which categories and theories emerge (Schreiber & Stern, 2001: 64). It is defined as "sampling on the basis of emerging concepts, with the aim being to explore the dimensional range or varied conditions along which the properties of concepts vary" (Strauss & Corbin, 1998: 73). This means that the data gathering is driven by concepts derived from evolving theory and based on the concept of making a

comparison. Thus, this theoretical sampling process is controlled by emerging theory, both substantive and formal. This is carried out in order to discover categories and their properties and then to link these into a theory (Glaser & Strauss, 1967: 45). Throughout the research process, grounded theorists need to continue the theoretical sampling process until they achieve data saturation or until no new information emerges, and then the process of theoretical sampling will be completed (Strubert & Carpenter, 2003: 113).

2.3.3.4 Coding process

The coding process is an essential task in the grounded theory approach to generating theory. This coding process occurs simultaneously with data collection and analysis (Strubert & Carpenter, 2003: 116). Schreiber and Stern (2001: 67-68) noted that through coding, the researcher will transform raw data into theory. The coding consists of three levels. The first-level of coding is open coding. That means that small data will be conceptualized. As Strauss and Corbin (1998: 103) suggest, the conceptualizing process helps the researcher to identify, categorize, and conceptualize data from phenomena by naming and grouping similarities and differences of activities in the events based on a common classification. The second-level of coding consists of synthesizing, examining, and collapsing codes into categories. The third-level of coding is examining the relationship between and among categories. In addition, Glaser (1978) states that coding process consists of two types: substantive coding and theoretical coding.

Strauss and Corbin (1998) noted that the coding in grounded theory includes open coding and axial coding. Open coding is the first step in building a theory. It is

defined as “the analytic process through which concepts are identified and their properties and dimensions are discovered in data” (p. 101). This means that open coding focuses on generating categories and their properties and then trying to see how the categories vary dimensionally. Axial coding is defined as “the process of relating categories to their subcategories and linking categories at the level of properties and dimensions” or “the act of relating categories to subcategories along the lines of their properties and dimensions (p. 123). That means that the categories are systematically developed and linked with subcategories.

2.3.3.5 Memoing

Memos in grounded theory consist of “the theorizing write-up of ideas about substantive codes and their theoretically coded relationships.” It is the core stage in grounded theory methodology. Memos will occur during the coding, the collecting of data, analyzing data, and in memoing. The memos will be captured and considered to be a guideline in collecting data. The process of memoing helps the researcher to recruit participants in terms of theoretical sampling (Glaser, 1998: 177). Grounded theorists often use memos with three objectives: to make explicit the researcher’s assumptions; to record the methodological decisions in the study; and to consider and analyze the data. The researcher writes memos from the beginning plans until the study is completed. In general, the researcher writes memos in whatever form; they may be a jot of a few words, a phrase, or in the form of questions on an idea that require answers during data collection. In addition, the memos can be the researcher’s short stories based on personal experience (Schreiber & Stern, 2001: 72). Thus, the memos are anything that captures the meaning of the conceptualized ideas. There are

no forms and no requirements regarding English grammar. Glaser (1998: 178) suggests that the memos should be sorted, rewritten, and then re-sorted.

Thus, grounded theory methodology is a method that focuses on basic social processes based on symbolic interactionism. The purpose of this method is to generate a substantive theory from data. The major features of grounded theory methodology include generating theory, constant comparative analysis, theoretical sampling, the coding process, and memoing. This methodology is proper for the exploration and generation of substantive knowledge from data.

2.4 Summary

In this chapter, it has been seen that psychiatric nursing focuses on the caring for and rehabilitation of persons with mental illness as a special area of nursing practice, and applies the study of human behaviors to the care of people with mental illness, families, and communities. Relational ethics bases ethical practice in relationships, which are acknowledged as the focus of psychiatric nursing as well. It is proposed that relational ethics can be an appropriate approach and ethical guideline for mental health professionals in the improvement of the quality of nursing care and of the lives of patients, families, and nurses. It has been found that family members that have relatives with schizophrenia perceive burdens arising from providing care. Nursing care practice for the persons with schizophrenia and family members are important in helping them to live together in community. A number of studies have recommended that psychiatric nurses help family members deal with their relatives. Some studies reflected both positive and negative relationships between nurses and family members that lead to ethical problems. Grounded theory methodology is

considered an appropriate approach for the exploration and generation of substantive knowledge concerning the relationships between nurses and family members of persons with schizophrenia.

CHAPTER III

METHODOLOGY

This chapter describes the methodology used for this study. In order to gain substantive knowledge about the relationships between psychiatric nurses and family members of persons with schizophrenia, the researcher explored the perspectives of psychiatric nurses. The choice of a qualitative research method for the study, grounded theory, is discussed in the section of research design in this chapter. In addition, research setting, research participants, recruitment of the participants, instrumentation, data collection procedure, protection of human subjects, data analysis, and evaluating trustworthiness of the data concerning the research are presented.

3.1 Research design

The research question of this study was "What is the relationship between psychiatric nurses and family members of persons with schizophrenia?" The purpose was to explore the relationship between psychiatric nurses and family members of persons with schizophrenia. Therefore, the qualitative research approach of grounded theory was appropriate for this study because it allowed the researcher to explore, conceptualize, and generate substantive knowledge concerning the relationships between psychiatric nurses and family members of persons with schizophrenia. Grounded theory consists of the systematic generation of theory from data. The philosophical underpinning of grounded theory comes from sociology and is based on

symbolic interactionism (Glaser, 1998). The main purpose of grounded theory was to explore basic social processes and to generate theory from real situations and perspectives of people that are living in society (Speziale Streubert & Carpenter, 1999: 107-113).

Grounded theory is a significant methodology in qualitative research for the study of nursing phenomena. Grounded theory methodology is focused on exploring the richness of human experience in order to generate and develop middle-range theories in nursing. The emerged theories are most frequently focused on behavioral concepts, such as caring, coping, parenting, and these theories are helpful in their application to nursing practice and are applicable to the generation of theories (Glaser & Strauss, 1967).

3.1.1 Research settings

The research settings in this study were psychiatric hospitals in Bangkok and Nontaburi province, Thailand. The Psychiatric hospitals are divisional units of the Department of Mental Health, under the Ministry of Public Health. The clients that came to the hospitals were persons with mental illness and brain disease. These hospitals provide psychiatric treatments for all psychiatric patients. These psychiatric hospitals in Thailand are also large and were selected because they have psychiatric nurses that have had experience in caring for persons with schizophrenia and in relating to the family members of these persons. When persons with schizophrenia exhibit abnormal symptoms or an active phase of schizophrenia, they are taken to the hospital and are hospitalized in in-patient wards. Thus, psychiatric nurses have

experience with both persons with schizophrenia and with their family members. The participants in the study were psychiatric nurses working in such in-patient wards.

3.2 Participants

The study of the participants' experiences in relation to the relationships between psychiatric nurses and family members of persons with schizophrenia was completed with data obtained from the psychiatric nurses' perspective that could explain these relationships. The saturated data were gained through data collection from 16 psychiatric nurses that have had direct experience with family members of persons with schizophrenia. The demographic characteristics of the psychiatric nurses are described and presented in Table 1. The participants were composed of 13 females and 3 males. All of the participants work in in-patient wards. The ages of the participants ranged from 33-56 years, with the average age being 42.75 years. All 7 participants had both a master degree and a postgraduate degree in mental health and psychiatric nursing. Two had master's degrees in mental health and psychiatric nursing. In addition, 7 of the participants had completed both a bachelor degree and postgraduate degree in mental health and psychiatric nursing. The length of time the participants had worked in a psychiatric hospital ranged from 10 to 34 years. Most participants had worked in a psychiatric hospital for more than 20 years.

Table 1. Demographic data of the 16 participants

case no.	Sex	Age (years)	Education level	Length of working
1.	Female	38	RN, PG (PSY)	15
2.	Female	42	Master Degree (PSY)	18
3.	Female	52	RN, PG (PSY)	28
4.	Female	53	Master Degree, PG (PSY)	31
5.	Male	39	Master Degree, PG (PSY)	20
6.	Female	52	RN, PG (PSY)	30
7.	Female	43	RN, PG (PSY)	25
8.	Female	44	Master Degree, PG (PSY)	25
9.	Female	33	Master Degree, (PSY)	10
10.	Male	32	Master Degree, PG (PSY)	10
11.	Female	38	RN, PG (PSY)	15
12.	Male	33	Master Degree, PG (PSY)	11
13.	Female	46	Master Degree, PG (PSY)	24
14.	Female	43	RN, PG (PSY)	18
15.	Female	56	RN, PG (PSY)	34
16.	Female	40	Master Degree, (PSY)	20

3.3 Recruitment of the participants

The purpose of this study was to explore the relationships between psychiatric nurses and family members of persons with schizophrenia. The

participants in this study were psychiatric nurses that had met the following initial inclusion criteria: (a) a registered nurse that has been working in an inpatient ward for at least ten years and is currently in that position; (b) having received a master degree in mental health and psychiatric nursing, or having graduated with a postgraduate (PG) degree in mental health and psychiatric nursing; and (c) were willing to participate in the study.

The reason for selecting the nurses that had had at least ten years of experience in their current the position was that these individuals have had sufficient experience in terms of their relationships with family members of persons with schizophrenia. These psychiatric nurses have also had opportunities to relate to these family members and exhibit the ability to help them through these relationships. This reason is consistent with Benner (1984), who noted that nurses that have been on the job and in the same situation for more than five years can develop the skills, competence, and proficient performance required to become experts in providing care for clients. At the same time, the expert nurses must be able to make clinical judgments and manage complex clinical situations. Further, the expert nurse must have systematic documentation of expert clinical performance and must have provided consultation to other nurses.

The initial inclusion criteria were used to recruit research participants for four cases. Each case was analyzed to look for tentative core concepts or categories so that the next participants could be recruited. This obtained data is then guide the researcher in term of what data would be collected next, and where to find the next participants. This process is called “The theoretical sampling”. Later, the theoretical sampling method was used to recruit the next participant until the data were saturated. The theoretical sampling was simultaneously collected, coded, and the data were

analyzed in order to generate substantive knowledge on the relationships between psychiatric nurses and family members of persons with schizophrenia. The theoretical sampling consisted of data gathering driven by concept or substantive theory derived from the evolving theory and based on the concept of making comparisons among the persons, places, and events.

The inclusion criteria were still used as a means of selecting new participants in other cases. The researcher began by asking participants to think of experiences related to helping family members of persons with schizophrenia. In addition, the researcher looked for the next participants through the use of interviews while considering various aspects of the participants, such as sex, and experience in working. For example, after analyzing the data in each case, the researcher found that four psychiatric nurses who had an understanding of the family members were female. An emerging hypothesis concerned what the male participants thought about the family members. The aspect of gender was considered to be a criterion for recruitment of the next participant. The researcher then looked forward to recruiting participants that were male for the study. These participants who participated in this study were believed to have experience in working and connecting with family members of persons with schizophrenia.

At the beginning of the participant recruitment, the researcher sent a letter to the directors of the psychiatric hospitals, to the nurse director of the nursing department, and to the head nurses in each psychiatric ward to ask for permission to collect the data. The researcher approached the nurse director of the nursing department and head nurses to introduce herself and to ask about the staff nurses. The head nurses were informed of the objectives of the study and were given a brief of the research process as well as initial inclusion criteria. Later, the head nurses provided

the name lists of psychiatric nurses with the characteristics identified in the initial inclusion criteria. Then, the researcher first approached the potential participants to make an appointment for interviews. The information sheet and consent forms (in Thai version) were distributed to the potential participants (see Appendix B). The researcher also informed potential participants about the research process and selected potential participants to be interviewed for the study. After receiving written permission from the participants in the hospitals, the researcher made an appointment with them to collect the data in their wards following the participants' requirements. The date and time of the meetings with the participants depended on the participants' convenience. Most of the interviews were conducted during the daytime and during weekdays. Three of the interviews, however, were conducted during the daytime on the weekend.

3.4 Instrumentation

In this qualitative study, the important instrument was the researcher. The quality of data collection and data analysis depend upon the ability of the researcher. In this study, the researcher took a major role in the process of inquiry because the findings of the study depended on the interaction between the data and the researcher. In addition, the creative process of coding, theorizing, and generating the emerging theory was conducted by the researcher. The researcher needed to be trained in qualitative methodology as grounded theory in order to ensure that the she was able to conduct this study.

The researcher has a master's degree in mental health and psychiatric nursing, and the researcher also worked as an educator in mental health and

psychiatric nursing, teaching student nurses. She has had experience in providing care for persons with mental illness, both in the hospital and in the community. In addition, during the researcher's master's degree program, the researcher studied the role and burdens of primary caregivers of persons with schizophrenia and took a qualitative course for 3 credits in the Faculty of Nursing. She also studied a natural research that focused on a qualitative research course for 3 credits in the Faculty of Education at Chulalongkorn University that included the practice of two qualitative studies in actual settings. Moreover, the researcher attended a workshop called Thinking in Qualitative Research for five days at The International Institute for Qualitative Methodology (IIQM) at the University of Alberta in Edmonton, Alberta in Canada.

From the researcher's experience working with persons with schizophrenia, their families, and with psychiatric nurses, and from the researcher's training in qualitative research, the researcher had the ability to establish rapport with psychiatric nurses in order to gain trust in conducting the interviews for this study. In addition, the researcher was trained, supported, and supervised in doing qualitative research from her advisors, who have had experience in this methodology, throughout the research process.

3.5 Data collection procedure

Data collection began in May, 2007 and lasted until June, 2008 in three psychiatric hospitals. In-depth interviews were used to explore the relationship between psychiatric nurses and family members of persons with schizophrenia. In addition, field notes were used to record the interactions, observations, and events that

occurred during the interviews and were useful when the researcher analyzed the data. All interviews were conducted individually and privately so that they were not interrupted and so that the participants were assured of privacy. For the most part, the interviews took place in a private room in the inpatient ward in the hospital or in the head nurse's room of the participants' wards. The length of the interview was 45-60 minutes in each case. The average interview was 50 minutes. The variation of the time was due to the richness and complexity of the information provided. In this study, all participants had experience in dealing with and helping family members of persons with schizophrenia, so they were able to describe their experience in detail. The interviews were conducted only once in all participants because the gained information was complete and rich enough, so the second interview was not necessary.

An interview guideline was prepared before the interviews. The semi-structured interview consists of two parts. The first part of the semi-structured interview is the guideline for the interview. The second part of the semi-structured interview focuses on the collection of demographic data (Appendix A). The in-depth interview technique was chosen for the psychiatric nurses because it was a method from which more information could be obtained by exploring the psychiatric nurses' experiences in their contexts. The in-depth interview was conducted with both a "grand tour question" and with "probing questions." The grand tour question was characterized by being broad and unspecified. This helped the researcher in exploring the participants' experience about their relationship with family members of persons with schizophrenia; for example, "Tell me about your experiences in working with family members of persons with schizophrenia." After employing the grand tour question, the relevant probe questions were used to interview the psychiatric nurses

when the researcher wanted to understand their experience deeply and in detail; for example, “Please tell me more about that,” “How did you deal with that?,” “Why did you do that?” or “What are your concerns when you talk to family members of persons with schizophrenia?” These questions helped the psychiatric nurses to express themselves fully and in greater detail. Before the end of the interview, the psychiatric nurses were asked questions concerned with demographic data. The interview questions were used throughout the study to gain information in order to verify the working hypotheses and concepts.

During the interviews, most of the participants expressed the willingness to share and the feeling of being comfortable in sharing experiences about working and connecting with family members of persons with schizophrenia. Interviews with three participants were interrupted by other nurses that wanted to talk to the participants about caring for patients who were in the acute phase at that time, and the interviews were paused for a while. Later, the interviews were conducted again. All of the participants were able to participate so that they could continue their sharing experiences until the end of the interview. The interview data were tape recorded to assure accuracy of information and the tape recordings were transcribed. Each interview recording was transcribed verbatim for the data analysis.

3.5.1 Memo writing

Memos in grounded theory consist of “the theorizing write-up of ideas about substantive codes and their theoretically coded relationships” (Glaser, 1998: 177). It is the core stage in grounded theory methodology. For this study, the memos were written while coding, collecting, and analyzing the data. The process of

memoing helped the researcher to recruit participants in terms of theoretical sampling. The researcher used memos to make explicit her assumptions, to record the obtained data of the study, and to consider and analyze the data. The researcher wrote memos from the beginning plans until the study was completed. The memos could be a jot of a few words, a phrase, or in the form of suggestions on an idea of the researcher that required answers during the next data collection, such as “the researcher should ask and deeply explore about dealing with family members,” “male and female participant have different perspectives,” and “why did the researcher ask that?” Thus, the memos in this study captured the meaning of the conceptualizing perspectives of the researcher and helped the researcher to integrate codes and to generate a substantive theory and a model.

3.5.2 Field note writing

The researcher wrote field notes both during the interview and as soon as possible after each interview ended. The interaction, observation, and events which occurred during the interview were recorded in the field notes. These included the general appearance and non-verbal behaviors of the participants while they were involved in the interviews, such as facial expression, posture, gesture, or tone of voice. In addition, the events and other circumstances while interviewing were recorded in the field notes. The obtained information from the field notes was used to remind the researcher to think about the events, actions, and interaction between the researcher and the participants and to trigger the thinking process. For example:

> *The psychiatric nurse talked about the family member who had negative attitude towards the patient and did not understand the patient’s behaviors.*

While talking, her face looked likely unsatisfied the family member. She spoke loudly (Case 1, June 7, 07)

3.5.3 Participants-researcher relationship

The relationship between the researcher and participants profoundly influenced the nature of the data. In this study, the difference between the role of the participants and the researcher was realized during the interviews. The researcher was for the most part familiar with the participants. In the beginning of the interview, the researcher informed the participants that she was a doctoral student from the Faculty of Nursing, Chulalongkorn University, and that she was a psychiatric instructor that took nursing students for practice in the area of mental health and psychiatric nursing in the hospital. In addition, the researcher respected the participants as knowledgeable and for having experience in helping family members of persons with schizophrenia. The participants' facial expressions, gestures, and responses to the interview questions were shown with genuine sincerity during the interviews. The researcher attentively listened to what the participants said, asked for clarification and explanation, and did not assume that the meaning of the participants' words and statements was already known. The researcher also did not use questions leading to expected answers from the participants.

3.6 Protection of human subjects

The present research proposal was submitted to the Institute of Review Board on Human Subjects, the Mental Health Department of Ministry of Public Health. The research proposal was approved by the Health Ethics Review Board in

the Mental Health Department of the Ministry of Public Health. Then the approved research proposal was submitted to the Institute of Review Board on Human Subjects of the selected hospitals, Srithunya Hospital, the Institute of Psychiatry Somdet Chaopraya, and the Glanlaya Rajanakarin Institute, before recruitment of the participants (Appendix C, D, E, F). When the committee approved the proposal, seeing that there were no risks to the participants and that there were no amendments, the research process was performed. The key ethical considerations for ensuring the rights of the participants in this study were informed consent, risks and benefits, and confidentiality and anonymity. These are described as follows:

3.6.1 Informed consent

In this study, the researcher provided the participants with an informed consent form in order to protect their rights. This informed consent was used to encourage the participants to become aware of the benefits and potential risks that could occur during the study. The informed consent contained information that was provided in order to help the participants in their decision making to participate in the study. This informed consent provided information about the purpose of the study, the process of the study, and confirmation of confidential of data related to the participants' decision to participate in it or to withdraw from the study if they so wished. The written information was in Thai. The researcher received the participants' written consent before interviewing.

The information sheet in this study included the purpose of the study, the research procedure, risks and benefits, the right to participate in or withdraw from the study at any time, the confidentiality of the data, and the name and address of a person

to contact if the participants wanted to talk about the study, including questions, comments, and concerns (Appendix B). The consent form as well as an information sheets were distributed to all of the participants before data collection. The participants had a right to know and ask about the information connected with the study. Therefore, in this study, the researcher explained in detail the contents of the information sheet and the consent form in order to increase the participants' understanding and to help the participants in making their decisions. The participants had an opportunity to ask any questions about the study before they completed and signed the consent form, and at any time during the study.

3.6.2 Risks and benefits

There are both risks and benefits for participants in qualitative research. Although informed consent was a good way to protect participants from risks, the participants could have experienced risks and harm. The nature of a qualitative study makes it very difficult to predict what might happen. Unexpected events might occur at any time. In this study, psychological and emotional problems did not occur during the research process. The researcher provided information about risks and benefits to the participants so that they could be comfortable during all of the processes of the research, such as providing them with a brief on the research process and about keeping the obtained data from the study. In addition, the methods for reducing any risk to anonymity were clearly mentioned in the consent form, such as letting the participants ask any question at any time and letting the participants stop the interview or not answering the interview question when they were uncomfortable. However, the participants had some questions for the researcher concerning the research process.

The researcher had answered their questions clearly, and the participants understood the research process. They answered all of the researcher's questions. Moreover, the researcher provided a resource for the participants that could help them if they experienced distress during the data collection; but in this study, no harm to the participants was exhibited. The researcher identified and informed them of the expected benefits prior to their decision to participate in the study before the consent forms were completed. In this study, the participants did not directly receive these benefits.

3.6.3 Confidentiality and anonymity

A significant role of the researcher in a qualitative study is providing confidentiality and anonymity to the participants. The researcher held and applied the principles of beneficence and justice in confidentiality regarding the people being studied. In this study, the researcher informed the participants of their right to confidentiality and that their personal identification would not be publicly reported. The researcher also informed the participants that all obtained information and all obtained data recorded would be kept in a cabinet that would be locked in the researcher's house and known only to the researcher. The researcher did not mention the participant's name during the interview nor in the transcripts or the findings. Use of a pseudonym hid the identity of any quotes. During the data analysis, the data were sent to dissertation advisors by hard copy without the name of the participants in order to check and confirm the accuracy of the data analysis and findings. After the researcher checked and completed the transcripts, the data were analyzed.

3.7 Data analysis

The data for the qualitative research were collected from interview observation and field notes. The data collection occurred at the same time as the data analysis and the recruitment of participants. The data analysis was completed by the researcher with the audit trail of the co-advisor throughout the process of the study. The data analysis in this study used the constant comparative analysis method described by Glaser and Strauss (1978). The constant comparative method and coding process, substantive coding (open coding and selective coding) and theoretical coding, were employed to manage the data analysis in this study.

3.7.1 The constant comparison analysis

The constant comparison method was employed to analyze the data in this study. It was used in each line, sentence, and paragraph from the transcriptions to look for concepts emerging from the data. Each code was compared to all codes to look for similarities, differences, and general patterns. This method helped the researcher to gain insight into the relationships of the concepts in each event of the interviewing. The data analysis procedure in grounded theory is a tool by which new knowledge from data from the phenomena of interest can be generated. In this study, the data analysis procedure began after the first interview was transcribed verbatim and lasted until the writing of the data was completed.

3.7.2 Coding process

In the procedure of the data analysis, the process of collection, coding, memoing, and analysis was carried out simultaneously. The coding process is used in a grounded theory investigation and is a method of delimiting raw data into concepts that were developed into categories. Then, the categories are integrated into a theory (Schreiber & Stern, 2001). The coding process in this study was comprised of open coding, theoretical coding, and selective coding. The descriptions of each coding are presented as follows:

3.7.2.1 Open coding

The coding consisted of three levels. The first-level was the open coding. That means that raw data were conceptualized. The conceptualizing process helped the researcher to identify, categorize, and conceptualize the data from the phenomena by naming and grouping similarities and differences of activities in relation to the events based on a common classification. The second level of coding consisted of synthesizing, examining, and collapsing the codes into categories. The third level of coding consisted of examining the relationships among each category. In this study, the researcher analyzed the data with the dissertation advisors throughout the research process. The dissertation advisors and the researcher opened the codes separately. The researcher opened the codes by “breaking” the raw data and reading the transcriptions of each participant line-by-line, including words, phrases, sentences, and paragraphs. The data were then conceptualized into a substantive or vivo code. In addition, the researcher identified the types of events, activities, and behaviors that the

participants experienced. Then, the researcher coded the data and compared them with other data within the same or different incidents and contexts in order to identify similarities and differences; then similar events were grouped together to form the same name or category. In this open coding, the initial concepts were formed and developed into categories that reflected concepts that were more abstract but which were based on the obtained data. The categories were then assigned to a cluster according to their properties.

In order to demonstrate the coding process, an example is given here: The words of the participants were: *"I give time for family members to speak, to share problems, I only had to listen to her speaking."* This statement clearly indicates "open coding,", such as "Giving time, Sharing problems, and Listening." Another example is: *"I used easy words when talking about disease, and I told her that there are three causes of this disease."* Such sentiments showed "Using easy language, Telling disease, and telling the causes of the disease." As the amount of the open coding proliferated, the researcher examined and collapsed the codes into categories or more abstract concepts in the next stage of the data analysis.

3.7.2.2 Theoretical coding

Theoretical coding is a process of systematically linking categories and developing their properties. Theoretical coding, however, is based on sorting memos, not based on sorting data. Theoretical coding is also abstract at a second and higher, conceptual level than from raw data (Glaser, 2005). At this level, categories were related to each other by applying theoretical codes from the coding families to help conceptualize how those categories were related to each other as hypotheses to be

integrated into a theory. This stage was begun after the researcher analyzed the data and received a group of codes that had emerged. Then, the researcher took some of the families' codes that fit the understanding of the linkage among the codes in order to integrate them into a theory. For example, after the categories emerged, the phases and chains in the process family were applied to link the categories of *establishing trust, strengthening connections, promoting readiness to care, and supporting* together as a core category called *facilitating living with schizophrenia*. The process family: phasing and staging could conceptualize how those categories were linked to each other. That means that the hypotheses were integrated into the substantive theory of *facilitating living with persons with schizophrenia.* The researcher also applied the strategy family and the Six C's to describe and develop the properties of each sub-category. The strategy families included strategies, tactics, mechanisms, methods of management, way, dealing with, manipulation, etc. The Six C's included causes, context, contingencies, consequences, covariance, and conditions (Glaser, 1978: 7-76). The Six C's also provided an explanation of the relationships among the categories. For instance, the promoting care ability was a reason why the psychiatric nurses were able to help family members care for and support persons with schizophrenia. Thus, the strategy families and the Six C's were methods which the researcher employed to develop properties and dimensions of establishing trust, strengthening connections, promoting readiness to care, and supporting.

In order to demonstrate employing the strategy family to link the properties of each category, an example is given here: the researcher developed the properties and dimensions of t*he establishing trust category* by looking for strategies that the psychiatric nurses used to build trust with family members of persons with schizophrenia. The strategies for establishing trust were found, including making an

acquaintance, showing respect, prolonging engagement, communicating understanding, and ensuring good care and patient safety. These strategies also helped the psychiatric nurses to assist the family members living with persons with schizophrenia.

3.7.2.3 Selective Coding

Selective coding is a process of delimiting codes by looking for a core variable. The core variable then becomes a guide to further data collection and theoretical sampling. In this study, selective coding also was applied to look for a core category. The categories were then integrated to form a large theoretical scheme, and the research findings would be called a theory or model. The core category was a central phenomenon that could group other categories together to form an explanatory model. The core category can be cast in more abstract terms than all of the other categories. In this study, the core category was obtained through delimiting the coding, drawing diagrams, and sorting through memos as well as by consulting the dissertation advisors. Finally, the core category was determined to be a basic social process that explained the process of helping people that are living with persons with schizophrenia.

3.7.3 Comparison findings with existing theories

The final stage was comparison the findings with the existing theories. This comparison was used in the end of the study to minimize the risk of the imposition of preconceived ideas of the researcher on data analysis. In this study, the researcher

compared the substantive knowledge developed from the study with critically reviewing theories and concepts, such as the researcher compared the concept of strengthening connection and improving the emotional climate, promoting care ability and educational program, and supporting and providing support. This comparison can help the researcher to explain the variations of concepts. These concepts are described in chapter five.

The researcher's learning from data analysis process

During data analysis process**,** the researcher has learned about data analysis process in term of grounded theory. For example, in the process of open coding, theoretical coding, and selective coding, the researcher compared and discussed the codes with her dissertation advisors in order to look for correctness in the coding process. In the discussion, the researcher found that some codes did not reflect the facilitating activities that the participants employed with family members of persons with schizophrenia. As a result, the researcher needed to revise the opened codes by rereading the transcriptions numerous times and by re-opening the coding based on the research question and purpose of the study. During this process, it was learned that the researcher always needed to think about what the research question in the study was and what the purpose of the study was. The research questions and purpose of the study could then be a guideline for the analysis of the data. The researcher also tried to ascertain the relationship among categories. During the open coding process, memo writing was carried out to make explicit the researcher's assumptions, the methodological decisions of the study, and to remind the researcher to explore correctly and deeply the phenomena of interest in order to analyze the data.

During the data analysis, the researcher was attentive to evaluating the trustworthiness of the data and to making the data fit and is workable, relevant, and modifiable.

3.8 Evaluating trustworthiness

The researcher was also attentive to maintaining the trustworthiness of the data in order to establish the quality of this qualitative research. An important component of establishing trustworthiness is that the researcher emphasized the personal cultural perspective, the possible bias, and the agenda of the participants. Regarding grounded theory, Glaser and Strauss (1967) stated that the proper criteria for judging the credibility, fittingness, and stability of findings are based on flexible research. These criteria of judgment should be based on the element of actual strategies used for collecting data, and for coding, analyzing, and presenting the data. The researcher enhanced the credibility, fittingness, and stability of the findings of this study as follows:

3.8.1 Credibility

In this study, trustworthiness was of concern throughout the research process. The credibility of the study was mentioned in the study. Credibility can be evaluated through the vividness and faithfulness of the description of a phenomenon. In order to increase the credibility of this study, the researcher controlled and enhanced the credibility of the findings as follows:

First, the researcher selected the appropriate participants—psychiatric nurses that have had experience supporting and helping family members of persons with schizophrenia. Various personal information about the participants was used in the study, including age, gender, and position or responsibility in working with the family members. In this study, all of the participants that were of different ages and genders, and that had different responsibilities, could share their experiences with the researcher about supporting and helping family members fully.

Second, prolonged engagement, persistent attention, and observation in the field were considered and attempted throughout this research process in order to provide more time to gain more information about the multiple realities that the participants had experienced. In this study, the researcher took time for engaging in the field: from May, 2007 to June, 2008. In this way, the researcher was able to perceive the truth of the experiences of the participants' support and help with family members of persons with schizophrenia.

Third, the researcher attempted to establish a good relationship with the participants in order to build trust and rapport before collecting the data. The researcher had good relations with all of the participants. The researcher also perceived the participants' facial expressions, gestures, and good responses during the interview questions with genuine sincerity during the interviews.

Fourth, in order to be sure that all data were complete and true, member checking was employed. This is a way to increase the rigor in a qualitative study. If the researcher was not sure about some of the words that the participants said, the researcher returned some of the findings to nine of the participants for validation and confirmation. After validation from the participants, they acknowledged that the findings were true to their experience, and the researcher then revised the

transcription for completion. For example, the researcher did not understand the following: *I have to see whether "the giver has sufficient knowledge or not?"* According to this statement, the researcher was not sure who the giver was that was mentioned. The researcher returned this finding then to the participant to be checked and confirmed. After that, the research knew that the giver was a family member (the receiver), not the participant. Moreover, the participant gave information to the researcher. For example, the participant said that "*the psychiatric nurse should not express high authority with the family members, and that the nurse should be friendly and collaborative with them*". Then, the researcher revised and added this information to the transcription in order to analyze the data again.

Fifth, other methods were used to increase the trustworthiness of the study. The researcher used various data collecting methods, such as in-depth interviews, observations, and field notes, to make sure that the findings from each methods of collecting the data were not different. In addition, the researcher promoted the credibility by collecting data with the theoretical sampling method, which verified information from various sources, such as the data setting.

3.8.2 Fittingness of findings

Fittingness is an interchangeable term of transferability or generalization. It refers to the application of a set of findings to another setting. Fittingness is judged based on a "thick description" about the time and context of the findings that are provided by the researchers (Carpenter, 1995 & Beck, 1993). This means that the findings of the study will be strengthened by providing rich, thick slices of data in order to make transferable judgments. In addition, a test of fittingness will be passed

when the findings reflect the phenomena being studied. Moreover, if the readers of the explanation of the theory derived from the data find them meaningful in terms of their own or other familiar contexts, this reflects the fittingness of the findings. In order to ensure that fittingness was accomplished in this study, the researcher respected the participant's responsibility during the interviews and accepted the responsibility of explicating the settings of the study, the sampling methods, and the characteristics of the participants. Then, theoretical sampling was employed to recruit participants that had had direct experience in helping with family members of persons with schizophrenia. The researcher found that the participants were able to share their experiences with the researcher completely and with richness. The researcher also found that each category included properties that were rich and thick descriptions of data.

3.8.3 Stability of findings

Dependability and confirmability constitute the stability of findings. The evaluation of confirmability is based on the characteristics of the data rather than on the researcher's characteristics. A good way of enhancing the stability or confirmability of findings is through the "audit," which is a major technique of establishing the stability of data (Burns & Grove, 2003). In this study, two dissertation advisors were debriefers and audit trials. One advisor was available for ongoing consultation related to mental health and psychiatric nursing. She shared her ideas with the researcher and was available for ongoing discussion related to substantive areas. Another advisor was available for ongoing consultation related to grounded theory methodology. She opened codes independently. Then, she discussed

about coding with the researcher and talked about the coding process. The coding, concepts, and the preliminary categories were compared and discussed for agreement between the researcher and the advisors regarding the preliminary categories or core categories of the relationships between psychiatric nurses and family members of persons with schizophrenia.

In conclusion, the trustworthiness of the data in this qualitative study was addressed in order to ensure the validity and accuracy of this qualitative study. Especially, the credibility, fittingness, and stability of the study have been considered carefully in the study. In addition, the researcher had to understand the findings regarding the entire study, including actions, events, and other relevant contextual factors and strategies in order to establish the trustworthiness of this qualitative research.

3.9 Summary

This chapter discussed some of the methodological issues that are involved in a grounded theory study. The methodology of the grounded theory, the researcher's roles, the participants, the research design, and data collection, analysis, and evaluation of trustworthiness were defined, explained, discussed, and described in order to develop a good design for generating an emerging theory. In addition, the attempt to control the quality of the research by emphasizing ethical considerations throughout the research process and the protection of the human subjects was discussed as well.

CHAPTER IV

FINDINGS

This study aimed at exploring the relationship between psychiatric nurses and family members of persons with schizophrenia. This chapter describes the processes that psychiatric nurses used with family members of persons with schizophrenia to help them care for and support their patients. This chapter also begins with an explanation of four strategies that comprised the model of "Facilitating living with persons with schizophrenia," including establishing trust, strengthening connections, promoting readiness to care, and supporting. Within the explanation of the four major strategies, direct quotations from the participants have been included to make the emergent model more clear. The next section provides a summary of the findings, which focus on the emergent process of "Facilitating living with persons with schizophrenia."

4.1 The findings

This study investigated the process of facilitating living with persons with schizophrenia among sixteen psychiatric nurses. The obtained data from in-depth interviews with the 16 psychiatric nurses were analyzed by using the constant comparative analysis method. Facilitating living with persons with schizophrenia was the process that the psychiatric nurses employed to help the family members be able to care for and support the persons with schizophrenia in living with the family. This process is composed of four major stages: establishing trust, strengthening

connections, promoting readiness to care, and supporting. The explanations of the four major stages are presented as follows.

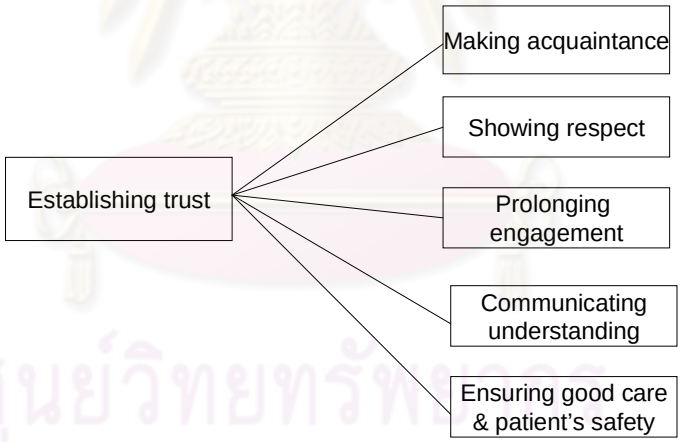
4.1.1 Establishing trust

Establishing trust was the first stage that the psychiatric nurses employed with family members of persons with schizophrenia. When the psychiatric nurses met with family members while they were visiting with the patients in the in-patient wards, the psychiatric talked with them. The psychiatric nurses encountered the fact that the family members had a sense of mistrust, incomplete trust, or complete trust with them. The psychiatric nurses tried to establish trust with the family members so that they might be comfortable in talking about problems, needs, and other concerns while giving care to their patients and before helping with other stages. At the first meeting, the family members were anxious about how their patients would do while hospitalized. The family members also had concerns about the patients' symptoms. The family members' concerns reflected that they felt unsure about whether the patients would receive good care and be safe. In addition, some of the family members were afraid of telling the truth about their problems to the psychiatric nurses when in reality they did not want to take the patients home.

The psychiatric nurses realized that the family members were afraid of asking about the caring for the patients and speaking the truth about their concerns to the psychiatric nurses and avoided being involved in caring for the patients because of these problems. The psychiatric nurses used five strategies to build trust with the family members, who had either a sense of mistrust, incomplete trust, or complete trust according to different patterns, in order to make them more comfortable with the

patients while hospitalized and so that they could share their concerns about the patients' needs. The findings in this study revealed that the psychiatric nurses established trust with the family members beginning when they first met them, using the following five strategies: making their acquaintance, showing respect, prolonging engagement, communicating understanding, and ensuring good care and the patient's safety. These strategies allowed the psychiatric nurses to build trust with the family members of the schizophrenic patient. Thus, the psychiatric nurses could employ these strategies to establish trust with family members before helping at other stages, including strengthening connections, promoting readiness to care, and supporting. The concept of establishing trust that emerged in this study, as presented in Figure I

Figure I: A summary of *establishing trust* concept



4.1.1.1 Making acquaintance

Making the acquaintance of the family members was a strategy that the psychiatric nurses employed with family members of persons with schizophrenia to make the family members familiar with the psychiatric nurses before talking about

their concerns and needs as well as caring for their patients. This making their acquaintance could be called a strategy for establishing trust between psychiatric nurses and family members of persons with schizophrenia. The psychiatric nurses used this strategy with all family members; especially, the family members that had a sense of mistrust or incomplete trust towards them. The psychiatric nurses also used smiling and small talk with the family members that had a sense of complete trust. Even with the family members had complete trust with the psychiatric nurses, the psychiatric nurses still used smiling and small talk strategies with them during all meetings in order to maintain a good relationship.

Each method was used to make the acquaintance of the family members when the family members took patients to the hospital, and the use of these methods depended on the psychiatric nurses' personality. As a consequence, after making their acquaintance, the family members were comfortable in talking with, and were familiar with, the psychiatric nurses. Thus, becoming familiar with each other created trust while they were talking.

In meeting with the family members that had a sense of mistrust or incomplete trust, the psychiatric nurses and family members were not familiar with each other, especially during the first meeting in the hospital. Most of the psychiatric nurses and the family members did not know each other. When they saw the family members, they greeted them by smiling and saying "hello." Even though the psychiatric nurses were working, they would stop their work and then extend a greeting to the family members by smiling and speaking with. At every meeting with the family members, not only did they smile with them but the psychiatric nurses used small talk to make the family members be familiar with them before asking about their problems or needs in caring for their patients. The general topics that were mentioned in the small

talk included their transportation, atmosphere while being on the way, and others. These methods were used by the psychiatric nurses to make the acquaintance of the family members that had a sense of mistrust and incomplete trust towards them. This means that smiling and small talk can be a cause of familiarity and trust between psychiatric nurses and family members. The following quotation illustrates the point:

> *…Greeting with saying "hello" and smiling to the family members. (Case 3, line 215, p. 8)*

> *... The first time I saw the family member, I greeted the family member and smiled at her to make her acquaintance. My opening question was to ask the family member what the family members wanted help with and what they were worrying about. (Case 1, line 205-208, p. 8)*

> *...The first time we met, I talked about general topics. It seems that...talking of general topics, such as "how are you?" and asking about their relationship with the patient because sometimes, there are many issues. We may make the family members feel like we are listening to them so they trust us. We will not speak formally... (Case 14, line 89-96, p. 3-4)*

At the same time, using dialect is an important element of talking with the family members. This is a method that some psychiatric nurses used to make the acquaintance of the family members. Some of the psychiatric nurses sometimes had to use dialect and simple words when they talked to the family members who spoke a different dialect. The family members, therefore, accepted talking with the psychiatric nurses. Most importantly, the psychiatric nurses could communicate directly with the family members. The psychiatric nurses needed to learn to speak in the dialect that the family members used. The method of using dialect with the family members allowed some of the psychiatric nurses used to the make their acquaintance strategy. As one of the psychiatric nurse said,

> *….I used dialect with the family members. I could communicate with the family members. Sometimes, the family members would not talk to us if I did not use dialect with them. My thought was that it seemed that I could not establish a relationship with the family members. I would use easy words when I talked to them. (Case 11, line 389-394, p. 13)*

> *…I tried to speak with the family member using local language so that the family member would understand our information directly. If I spoke with the family member in this dialect, the family member could speak or gave us information better. (Case 10, line 346-349, p. 11)*

In terms of meeting with family members that had a sense of complete trust, most of the psychiatric nurses still used the smiling technique when they saw the family members. However, according to the familiarity between some psychiatric nurses and the family members, sometimes the psychiatric nurses just smiled at the family members. The psychiatric nurses did not use small talk with the family members because they and the family members were familiar with each other. They were able to understand the family members' problems. Then, when they saw the family members, they smiled and asked the family members about the patients or other problems. As one psychiatric nurse said,

> *….I and the family member were familiarity with each other. At the beginning of each meeting, sometimes I smiled and asked the family members why they did not take the patient home. (Case 7, line 44-54, p. 2)*

The strategy of smiling and small talk can be used at the same time, depending on the psychiatric nurses' personality. The means that some psychiatric nurses might smile before the small talk with the family members, but some might use both smiling and small talk together. At the same time, the psychiatric nurses could use the

showing respect strategy to demonstrate that they were willing to help the family members and patients in order to establish trust with them.

4.1.1.2. Showing respect

While making the acquaintance of the family members, showing respect was a strategy that the psychiatric nurses used while talking with the family members in order to establish trust with them, trust that was important particularly since they were taking care of a schizophrenic patient. The psychiatric nurses showed respect to all family members to express their recognition to the family members' human being. Every time the psychiatric nurses met with the family members, most of them encountered both family members that had positive feelings and some that had negative feelings of the issues surrounding the care of their patients and the situations that related to the patients. The family members showed their feelings and behaviors in different manner towards the psychiatric nurses. Sometimes, the family members demonstrated mistrust or incomplete trust to wards the psychiatric nurses. Some of them showed complete trust with the psychiatric nurses. The psychiatric nurses realized this. They showed their respect to the family members in two patterns: showing respect with the family members that demonstrated mistrust or incomplete trust, and showing respect with the family members that had complete trust.

Some of the psychiatric nurses gave examples of using the strategy of showing respect with the family member that had a sense of mistrust with them. When the family members came to the hospital, the family members felt unsure about caring for their patients, such as why the patients were not better, why the patient had physical problems, and why the patients were restrained. The family members showed their

behaviors by characterized of making loud noise, arguing with the psychiatric nurses, and often asking about patient's caring. This situation illustrated that the family members mistrusted the psychiatric nurses in terms of their ability to care for the patients. For instance, when the family members saw that the patient was restrained, they did not understand why and they had arguments with the psychiatric nurses. In this situation, the psychiatric nurses had to think carefully about what happened and how to deal with the family members. Later, they tried to deal with the family members by listening to them, being calm and very polite, and by avoiding expressing authority over the family members and avoiding arguing with them every time they spoke with them. The psychiatric nurses let the family members complain until they calmed down, and then the psychiatric nurses explained the situation clearly. This behavior on the part of the psychiatric nurses indicated that they accepted the family members' behaviors, feelings, ideas, and experiences. The following quotation illustrates this point:

> *…. Sometimes, I felt why the family member does not accept the patient after our suggestions. I felt that but I tried to be good in speaking… Because in this special ward, sometimes, we were calm and only listened to what the family members wanted and what problems they had so that we could help they directly based on their problems. (Case 7, line 464-474, p. 15)*

> *….I needed to speak softly and was polite with the family member. I know that the family member was unsatisfied with our services. I gave him information in order to make him understand that now the patient was not better really… so the patient was restrained. It was difficult to communicate to make him understand. (Case 3, line 328-347, p. 12)*

Most of the psychiatric nurses still used this strategy with all the family members during meetings, even if the family members had complete trust with them

or incomplete trust with them. The psychiatric nurses realized that showing respect would make the family members accept the psychiatric nurses and feel important in caring for patients, which led to building trust with them. The psychiatric nurses still always used the being polite strategy, being good in speaking, and listening to the family members while talking with them. Some of the psychiatric nurses gave examples about showing respect to the family members that had complete trust in them at every meeting, and they showed respect by both speaking directly and through non-verbal expressions with the family members, such as saying "Always welcome," using eye contact, opening the door and inviting them into the ward, and providing nurse's assistance to continue to welcome the family members. These nurses' expressions reinforced the family members' perception that the psychiatric nurses understood, and this led to trust in the psychiatric nurses. The following quotation illustrates the point:

> *…They have come several times, and I always saw this family member. When the family member saw me, she said "I came again." I said to the family member …"That's ok. If your family member is ill, come here. We always welcome you." (Case3, line 32-34, p. 2)*

> *… We went out to bring the family member in.... I said "Wait a moment," told the family member to take a seat," And later I prepared information and other documents to inform the family member about what he should know. (Case 9, line 484-492, p. 16)*

The evidence above indicated that showing respect to the family members could make them feel important in order to build trust with the psychiatric nurses while providing care for and supporting persons with schizophrenia. Thus, showing respect refers to the manner in which the psychiatric nurses accepted the family

members' behaviors, ideas, and experiences. The family members, therefore, listened to the psychiatric nurses and accepted them as on the first day. The showing of respect in a short time might be not be effective enough for establishing trust with the family members. Prolonged engagement, then, is a strategy that allows the psychiatric nurses to have time to show respect towards the family members.

4.1.1.3. Prolonging engagement

At the same time, prolonging engagement was a strategy that helped the psychiatric nurses and family members have an opportunity to learn about each other. All the psychiatric nurses realized that in meeting with family members, providing time for them was important. During providing care for the persons with schizophrenia, most of the family members had more concerns about caring for their patients and needed to receive help from the psychiatric nurses. The psychiatric nurses tried to prolong their engagement with them by being with and talking to the family members several times. In talking and being with just once might not make the family members feel belief in the psychiatric nurses. Then, the psychiatric nurses tried to be with and talk to the family members many times. This strategy also helped the family members perceived that there would have the psychiatric nurses keep helping them. While talking with the family members, the psychiatric nurses received information about both the patients and family members' problems and needs. The psychiatric nurses had more opportunities to explore the family's background.

Most of the psychiatric nurses tried to prolong their engagement with all family members that visited the patients in the hospital by staying to talk with them directly as long as possible. However, the amount of time they stayed with the family

members depended on the family members' needs or distress. The psychiatric nurses could provide time for talking with the family members. As the psychiatric nurses stated,

> *….The time for talking depended on the distress of the family members, I listened … she said her nephew was stubborn or something. She wanted to tell me. I had time; I sat down and listened to her. (Case 7, line 345-347, p. 11-12)*

> *…I tried to be with the family members to talk with them. When they visited their patients, I provided time for talking between the family members and patients. Later, I invited the family members to talk, to ask about preparing taking the patients to return home or meeting with them. (Case 5, line 227-229, p. 8)*

However, it might always be not possible for the family members to visit the patients. The psychiatric nurses understood the family members' limitations. They had decided to use the strategy of calling the family members when they wanted to inform them about the patients, treatment, and support. Every time they called the family members, they would ask the family members where the family members preferred to receive the call because some family members did not want other family's members or relatives to know about the patients. Those family members did not want the psychiatric nurses to call them at home. Then, the psychiatric nurses needed to call the family members where they felt that it was convenient to receive a call. The psychiatric nurses called the family members to make an appointment for meeting, to ask for some information, and to follow up on how they and their patients were. As one psychiatric nurse said,

> *….I contacted the family members to ask about the patient by calling her at her workplace. I would not disturb her at home. The family members preferred me to call her at her office. (Case 4, line 326-327, p. 11)*

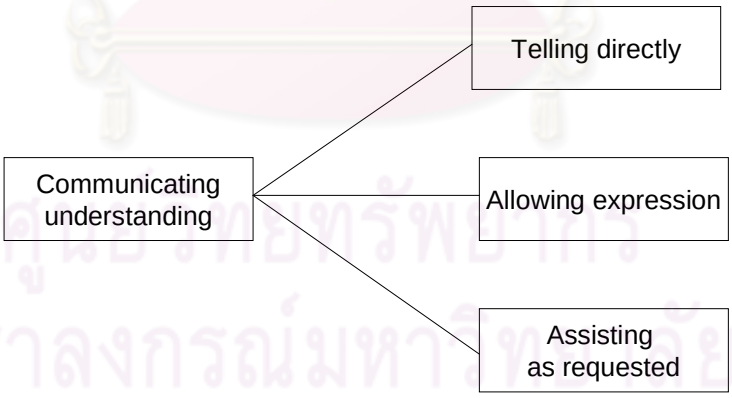
This evidence indicates that the prolonging engagement strategy was an important on in terms of building trust with the family members of persons with schizophrenia. Having prolonged engagement with them like this would help the family members felt that the psychiatric nurses always were with them. Prolonging their engagement also made the family members feel that the psychiatric nurses could keep helping them. Moreover, this prolonging engagement helped the psychiatric nurses to have more time for showing respect to the family members. At the same time, the psychiatric nurses needed to use the strategy of communicating understanding with the family members while prolonging their engagement with them. That means that these strategies could be used simultaneously. The length of prolonging engagement employed for talking with family members, however, depended on the family members' problems.

4.1.1.4. Communicating understanding

While prolonging their engagement with the family members, communicating understanding was also used with them. It was an expression of understanding which the psychiatric nurses showed toward the family members of persons with schizophrenia. Most psychiatric nurses tried to communicate their understanding of the family members in order to demonstrate that they understood the family members while caring for and supporting them: the psychiatric nurses understood that the family members were suffering with difficulties while caring for their patients, such as being afraid of the patient's violent behaviors, not having time for caring for the patients, financial problems, and physical health problems.

The psychiatric nurses also communicated their understanding about difficulties and needs while providing care for the patients of the family members when the family members visited the patients in the hospital or called them. This communicating of understanding was an important strategy for establishing trust between the psychiatric nurses and the family members. The methods that the psychiatric nurses used to communicate understanding consisted of both verbal and non-verbal communication, including telling directly, allowing expression, and assisting as requested. These methods were used with all family members. While using this method, the psychiatric nurses could use the strategies of showing respect and prolonging engagement with the family members simultaneously. The communicating of understanding concept emerged in this study is presented in Figure II.

Figure II: A summary of communicating understanding



First, with reference to the “telling directly” strategy, in communicating their understanding of the family members of persons with schizophrenia, most of the psychiatric nurses spoke with them directly in order to show that they understood the

family members' difficulties and needs. The psychiatric nurses spoke about their understanding of the family members, including saying "I do understand" and "I know you are tired." The psychiatric nurses always communicated their understanding, it reflected that the psychiatric nurses accepted and understood the family members. Therefore, the family members would get the feeling that there was someone that understood them. Most important, the family members would trust and always participate in caring for their patients. In this way, the psychiatric nurses established trust with the family members. The following quotation illustrates this point:

> *….While listening to the family members, we supported them, saying "I do understand" and "You might be tired." It was a reflection that we accepted and understood them. It is a concept of psychiatric nursing. If we apply the concept, I can say that we will get a good response. The family members will get a feeling of understanding and they will know that we will keep helping them. (Case 4, line 81-85, p. 3)*

> *….Support by speaking: "I understand you" (because the family member was very old). You must be tired and have health problems. It was understood that if she took the patient home, there would be no caregiver for the patient. "We do understand." (Case 2, line 134-137, p. 5)*

This evidence indicated that most psychiatric nurses communicated understanding with the family members that were suffering with difficulties while caring for their patients. Telling directly was a method of communicating understanding of the psychiatric nurses with the family members when the family members visited the patients in the hospital or called the nurses. It helped the psychiatric nurses to express their feelings towards the family members. Not only could the psychiatric nurses communicate understanding by speaking to them directly,

but the psychiatric nurses could also express their help by assisting of the family members as requested.

Second**,** in terms of "assisting as requested," this was a way of communicating understanding through helping behaviors. Not only using direct speech to communicate understanding with the family members, but also using the assisting behaviors was an important way to communicate understanding. Assisting as requested reflected that the psychiatric nurses had understanding and were willing to do everything they could for the family members.

Some of the psychiatric nurses always provided help for the family members while visiting the patients, such as transportation of the family members, foods, money, and other belongings for the patients. As the psychiatric nurses said,

> *….When she came to the hospital in the morning, sometimes we provided a nurse aide who took her from outside the ward in to the ward. After she finished visiting, we took her to a taxi; we called a taxi for her. (Case 2, line 188-189, p. 7)*

> *….The family member left some food, such as soft drinks and deserts, for the patient… I gave the food to the patient. (Case 11, line 205-210, p. 7)*

One psychiatric nurse provided nurse aides for buying medicine for the patient instead of the family member each time because the family member had physical problems. The family member could not walk to another building, so the psychiatric nurse helped her. This was done when the psychiatric nurse assessed that the family member could not take care of herself because of her health problems. The data reflected that the psychiatric nurse had assisted the family member to do all that they

could for caring for the patients and for the family members. As the psychiatric nurse said,

> *….I did understand the family member, when the family member contacted us in this ward; we helped her to do activities, for example, the family member had to go to another building to pay for the patient's treatments. I provided a nurse's aide to help the family member do those. (Case 2, line 30-32, p. 2)*

The evidence indicates that the psychiatric nurses used the strategy of assisting as requested to make the family members perceive that the psychiatric nurses could do all things for them and that they were willing to help them without conditions. This perception on the part of the family members led the family members to trust the psychiatric nurses. Thus, the psychiatric nurses' keep helping the family members in doing activities for giving care to the patients and this helped the family members establish trust with the psychiatric nurses. Later, the psychiatric nurses used the strategy of allowing expression with the family members to make them perceive that the psychiatric nurses always had understanding them.

The third strategy, "allowing expression," was employed when the nurses perceived that the family members were suffering with problems in caring for their patients. They would provide time and allowed the family members to talk about their problems, concerns, and feelings. Allowing expression was a way that the psychiatric nurses used to show that they understood the family members and that they were willing to listen to them to help relieve their concerns and feelings. This helped the psychiatric nurses to be able to communicate understanding to the family members. The following quotation illustrates the point:

> *….Letting him talks and express himself. …I used a method of ventilation by encouraging the family members to talk… "How are you doing at home?" and*

kept supporting the family member, saying "I understand you," "I understand a family member like you that has such a burden". (Case 12, line 160-165, 171-173, p. 6)

In addition, some of the psychiatric nurses used the strategy of allowing expression with the family members that had a feeling of anger about and dissatisfaction with the nursing care services. The psychiatric nurses allowed the family members to express their feelings of anger and dissatisfaction with them. They, however, did not argue with the family members. They understood that the family members were feeling angry and dissatisfied about the nursing care of the patient. They tried to be good in speaking and calming down the family members. As one psychiatric nurse said,

…I know that the family member was feeling angry. I did not pay attention to the family member's emotion. I understood. It might be a feeling of anger of the family member. The family member might be worrying why the patient was not better. I listened to him and was good in speaking with him. I know I must be conscientious and help the patient to calm down. (Case 10, line 200-204, p. 7)

….The family member made a loud noise with dissatisfaction…The family members did not want to take the patient home. The family member also said, "I am not ready to pick the patient up to go home. I did not prepare anything for the patient." Later, the family member went out of the ward. We did not say anything. After a day, we tried to be good in speaking. We informed the family member that the patient was better and was discharged. (Case 4, line 558-565, p. 18-19)

This evidence illustrates that the psychiatric nurses used the strategy of allowing expression with the family members to encourage the family members to ventilate their feelings and behaviors. The psychiatric nurses used this strategy with

all the family members, especially, the family members that were suffering with caring for their patients. Even though the psychiatric nurses used this strategy with the family members to relieve their concerns, the family members might still want to know that their patients would receive good care and be safe. The psychiatric nurses needed to use the strategy of ensuring good care and the patient's safety with the family members to make them confident that the psychiatric nurses could help them and their patients.

4.1.1.5. Ensuring good care and the patient's safety

Another strategy of establishing trust was ensuring good care and the patient's safety, which the psychiatric nurses employed with all family members of persons with schizophrenia. In meeting with the family members, most of the psychiatric nurses had understanding that the family members were worried about the patients, especially the family members that had just come to the hospital for the first time. They did not know how the patients would be if they stayed in the hospital. They tried to ask the psychiatric nurses how the patients were many times during the day and sometimes, they asked the psychiatric nurses directly or called at the ward to ask about the patient's condition. The psychiatric nurses tried to deal with the family members in their ability to care for the patients. Then, the psychiatric nurses informed the family members about the nursing care for the patients and the activities during hospitalization. As the psychiatric nurses said,

> *….We provided information for the family member and patient. For example, from 5:00 AM we would encourage the patient to do daily activities for himself. We told the family member later at about 7 AM, that the patient was taking his medicine, having breakfast or something like that and informed the family*

member about the need to keep the patient in the ward because the patient often escaped from it. (Case 1, line 78-85, p. 3)

….We explained that there would be nurses to care for the patient 24 hours, including caring, having food, taking a bath. We always care. We do that. Later, we provided time for asking questions. (Case 10, line 124-127, p. 4-5)

Some of the psychiatric nurses had to encounter with some family members who were afraid of asking about the patient's illness. The family members asked the psychiatric nurses just once on the first day of admission, and they were worried about the patients because the family members often visited them. The psychiatric nurses had also informed all of the family members that all patients receive good care while staying in the hospital. The psychiatric nurses used this strategy to make the family members believe that the psychiatric nurses could care for their patients and receive good care and be safe. The psychiatric nurses also informed the family members that the patients were prepared before returning home. They, therefore, would be able to take care of themselves. As the psychiatric nurses said,

….I informed the family members about activities that we provided for all patients, such as therapy, taking medicine, exercises, and managing the environment for the patients. (Case 16, line 67-71, p. 3)

….I told the family member that I could take care of the patient. I advised the family member to go home or stay over night at the OPD. (Case 10, line 94-95, p. 4)

These data indicated that the psychiatric nurses tried to tell all family members regarding the psychiatric nurses' ability to care for the patients that the psychiatric nurses could help the patients to become better. This strategy helped the psychiatric nurses to show that the patients would receive good care and be safe while being

hospitalized in order to gain the trust of the family members and to ease their minds about leaving the patients in the hospital.

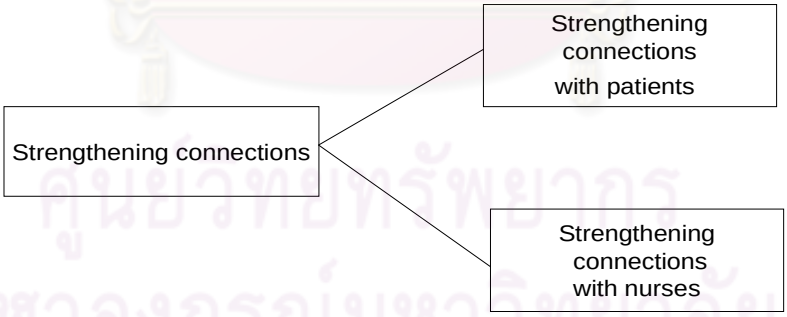
In meeting with the family members of persons with schizophrenia, psychiatric nurses can use some of the above strategies, or all of the strategies, to build trust. These strategies include making their acquaintance, showing respect, prolonging engagement, communicating understanding, and ensuring good care and the patient's safety. These strategies allow the psychiatric nurses to establish trust with the family members in order to participate in caring for them before moving on to the next stages, including the stage of strengthening connections with the patient, promoting care ability, and support in helping the family members to live with persons with schizophrenia.

4.1.2 Strengthening connections

After establishing trust with family members, psychiatric nurses needed to strengthen their connections with the family members. In meeting with the family members, the psychiatric nurses had encountered with most of the family members avoided visiting their patients; some of the family members did not want the patients to visit home or return to home after they were discharged. Some of the family members did not want to participate or become involved in caring for the patients or in doing activities with the patients. The psychiatric nurses realized that these problems that might affect the care of the patients. If the family members tried to go away from the patients, the nurses, or avoid caring for the patients, it is difficult for the patients to return home.

The psychiatric nurses realized that the strength of the connections would help the family members have positive feelings in caring for the patients and living together. The strengthening of connections was an important strategy that the psychiatric nurses used with family members of persons with schizophrenia to increase the connections between the family members and their patients. However, the psychiatric nurses also realized that the family members have the strength of the connections with psychiatric nurses was an important as well. If the family members did not have the strength of the connections with the nurses, the family members would not become involved in caring for the patients. The family members might try to get away from the psychiatric nurses because they did not to involve in caring for their patients. The psychiatric nurses used the strategies of strengthening connections with patients and strengthening connections with nurses with the family members. A summary of the strengthening connections concept is presented in Figure III.

Figure III: A summary of strengthening connections category



4.1.2.1 Strengthening connections with the patients

Strengthening connections with patients was an important strategy that most of the psychiatric nurses used with family members of persons with schizophrenia to

improve their relationship with them. In meeting with the family members, some of the family members tried to avoid caring for their patients—they refused to take the patients home, they did not visit the patients, and refused to participate in activities with the patients. The psychiatric nurses understood the reasons why the family members refused or avoided visiting the patients and becoming involved in caring for their patients: that the family members were afraid of the patient's violent behaviors, they had to work, or they did not have other family's members to help them in caring for the patients.

The psychiatric nurses tried to use various methods to strengthen the connections between the family members and patients. The methods of strengthening the connections with patients consisted of increasing understanding and promoting re-acquaintance with the patients. Increasing understanding was a method that the psychiatric nurses used with all family members. It was used to create understanding on the part of the family members about the patient, his or her disease, and treatment. Promoting re-acquaintance with the patient was another method that the psychiatric nurses employed with family members. It was used to encourage the family members to participate in doing activities with their patients in order to reacquaint the family members and patients. These methods would then be helpful in strengthening the connections between the family members and the persons with schizophrenia. In this way, the strengthening of connections would help the persons with schizophrenia to become better. At the same time, the family members would be able to accept taking the patients home and living together.

"Increasing understanding" was a strategy that the psychiatric nurses used with the family members of persons with schizophrenia to strengthen their

connections with the patient. In this study, the psychiatric nurses had assessed the family members and then, they found that some of family members tried to avoid caring for the patients, refused to take the patient home when the patients were better and discharged, and had no time to visit the patients while they were in the hospital. The psychiatric nurses understood that the causes of having avoidance to care for the patients and to involve in caring of the family members because of the difficulties of the family members in caring for the patients were the bad behaviors of the patients, being with stubborn patients, the patients returning to drug use, and the patients denied listening to the family members. According to the causes of the family members' having avoidance to care for the patients, it reflected that the family members had no understanding about the patients' illness; the family members did not know why the patients were with bad or strange behaviors and why the patients did not listen of the family members' advising. Therefore, the family members did not recognize the patients and paid less attention to caring for the patients.

These data indicated that most family members did not have an understanding of the patients' illness. Such an understanding can lead to strengthening connections between family members and persons with schizophrenia. The psychiatric nurses realized that when the family members learned about the patients' disease, symptoms, and treatments. Later, the family members would have positive feelings toward the patients and pay attention to caring for them. In addition, the family members would get the answers why the patients were with the strange behaviors. For this reason, the psychiatric nurses tried to increase their understanding of the family members by giving them information. After that, the family members better understood the disease, its treatment, and the patients, and this led to a strengthening of the connections with the patient.

In providing this information, the psychiatric nurses gave information both to the individual and to the family members. In giving information to the family members that had a low education and that had no knowledge about the disease and its treatments and patients was different from giving information to the family members that had high education and that had some information about the disease and its treatments and the patients' symptoms. The methods for conveying this information included the following: (1) assessing the family member's understanding before giving the information, (2) using easy terms for giving the information, such selecting appropriate words and avoiding difficult words, (3) taking more time to explain, especially regarding information about hospitalization, legal issues, the court's decisions, the patient's safety, and visiting the patient, (4) using precise speech, and (5) using dialect. These methods were useful in making the family members understand the disease and its treatment and the patients.

In giving this information, the psychiatric nurses used the methods of explaining directly to all family members. Major contents that were mentioned included information about the disease, the course of schizophrenia, the symptoms, and its treatments. For example, the psychiatric nurses explained about the causes of schizophrenia, about the importance of continuing to take medication, medicine modification, and the length of treatment of the patients. The psychiatric nurses also discussed the signs and symptoms that occurred with the patients to inform the family members about how the patients were while staying in the hospital, for example, whether the patients were better while staying there. Even though the family members and patients had been in the hospital many times, the psychiatric nurses always spent time giving information about medicine and managing or controlling the medicine to the patient. The reason why the psychiatric nurses always spent more time in giving

this information was that the patients often experienced fluctuation of symptoms and for this reason the patients' treatments might have been modified many times. The psychiatric nurses needed to give this information numerous times. The following quotation illustrates the point:

> *.... We said there might 3 causes; it might be the environment or genetics. Later his father told us that the patient's mother had had a mental illness, but she died. It might be genetic. We told the family member several times that the patient might not be the same, even though the patient always took medicine. The family member had more understanding. (Case 6, line 100-105, p. 4)*

> *...I explained how we looked after the patients. After the patients were treated for a week, we had to explain to family members that the patients still were being treated and that their medication might be modified. The patients' symptoms might be not seen clearly and how they were becoming better. It might take more time. Treatment must take more time. We explained this to the family members. (Case 1, line 27-32, p. 1-2)*

However, in increasing the understanding of the family members, some of the family members were persons that had a high education and had some knowledge of the disease and its treatments and of the patients' symptoms. The family members would ask deep questions about the disease or other issues. The methods that some psychiatric nurses used to increase the understanding of these family members were a little bit different then from giving information to family members that had little or not knowledge of the disease. The methods that were added with the family members included: using technical terms for giving the information and explaining with logical thinking, especially regarding information about legal issues, the court's decisions, and the patient's safety. These methods illustrate that the psychiatric nurses needed to learn ways to increase the understanding of the family members. However, the topics for increasing understanding like the topics that the psychiatric nurses talked with the

family members who had no knowledge, such as the causes of schizophrenia, continuing to take medication, medicine modification, the length of treatment of the patients, and signs and symptoms. As the psychiatric nurses said,

> *…Some family members who have high education asked us deeply about the disease. Then, I needed to give them information deeply and clearly, such as the causes of the illness. I think that we should give information clearly with the family members. It was different from giving information with some family members. (Case 9, line 467-471, p. 15)*

> *…Some family members who have knowledge, I talked with them using technical terms, such as when I mentioned about medicine and the disease and its symptoms. The family members are persons who work in the Ministry of Public Health. (Case 10, line 361-363, p. 12)*

After providing this information, the psychiatric nurses found that the family members understood the disease and its treatments, the patient, and the nursing care system. The most important things were that the family members paid attention to and became involved in caring for and supporting the patients. Thus, the connections between the family members and patients were strengthened. However, increasing understanding might not be enough for strengthening the connections between the family members and their patients. Even if the family members were given information to create a better understanding, if the family members and patients had no opportunity to be close with each other, it was difficult for their connections to increase or deepen. The psychiatric nurses needed to promote re-acquaintance between the family members and patients.

"Promoting re-acquaintance with the patient" was a strategy that most of the psychiatric nurses used for strengthening the connection of the family member with

the patients. This strategy was used with all the family members to help them and the persons with schizophrenia to have time to be together so that they all could be familiar with each other again. When the family members and patients were familiar with each other, the connections among them were strengthened. The methods for promoting re-acquaintance with patient included encouraging visiting, facilitating spending time, and encouraging home visit trials. This means that the family members and their patients had an opportunity to spend time together in doing activities within in the hospital and outside the hospital. The family members also had opportunities to learn about and understand the patient's behaviors and capabilities while doing activities in order to increase the connection between the family members and the patient.

First, "encouraging visiting**"** was a method of promoting re-acquaintance with the patient that some psychiatric nurses used to strengthen the connections between the family members and their schizophrenic patients. In meeting with the family members, some of the psychiatric nurses found that in the past, the family members were acquainted with the patients. However, after the patients developed schizophrenia, some family members had no understanding about why the patients exhibited abnormal symptoms or behaviors. The family members tried to get away from the patients and they avoided visiting them. Then, in promoting re-acquaintance with the patient, the psychiatric nurses encouraged the family members to visit their patients while in the hospital.

In encouraging them to visit the patients, some of psychiatric nurses needed to think carefully about whether the family could communicate with the patient. Some family members were the loved persons of the patients. The patients wanted to see,

talk to, and live with the family members. However, the family members avoided visiting the patients. The family members often told the psychiatric nurses that they did not have time to visit the patients because they had to work and had physical problems. Then, the psychiatric nurses tried to encourage visiting. At the same time, the psychiatric nurses informed the family members about the patient's feelings if the family members did not visit him or her. As the psychiatric nurses said,

> *…I said that "You visited the patient and that was good." We thought that the patient felt good. Most psychotic patients would stay here for a long time. We did not want the family members to leave the patient in the hospital. We wanted the family members to visit the patients. Most of patients have a feeling of fear in being left in hospital. (Case 4, line 123- 125, p. 5)*

One of the psychiatric nurses encouraged the family members to visit their patients. The nurse advised the family members to invite other family's members to visit the patients. However, before giving this advice, the psychiatric nurse needed to assess the relationship between the patients and other family members. This was an important issue. If the family's members were persons whom the patients disliked, the patients would argue with them. The psychiatric nurse also informed the family members about why the patients needed the family members to visit them while the patients were in the hospital. The following quotation illustrates this point:

> *…We said that the "family member should visit the patient each time or come together to visit this patient. Now the patient is not allowed to go home. On the weekend, you could visit the patient. You could invite other family members to come here or something like that to make the patient feel that the family members had not left him". (Case 13, line 679-684, p. 22)*

Second, the "Facilitating spending time together" was another method that some psychiatric nurses used to establish re-acquaintance of the family members

and persons with schizophrenia. Some family members avoid participating in activities with the patients. The family members, sometimes, refused to take the patients back to the family. Facilitating spending time together was a method of making the family members and patients become familiar with each other again. The psychiatric nurses realized that when the family members and patients spent time doing activities together, they would have connections with each other.

The psychiatric nurses employed the method of facilitate spending time together included on the phone them, speaking to them directly, writing letters to the family members to visit the patients, and helping the family members and patients to spend time together, such as traveling with the patients and nurses. For example, the psychiatric nurses provided projects so that the patients and family members could spend time with each other, including going shopping, going to a temple, and attending the skill training of the patients. After participating in the projects, both family members and patients were satisfied with spending time with each other, and the family members learned that the patients were better and had more social skills. The family members also learned that the participation of the patients and nurses had more importance and benefits for both the patients and their family. The following quotation illustrates this point:

> *…I invited the family member to participate in our activities. Another activity was "family day," and the day consisted of 4-5 activities that were conducted in which the family member participated in this ward. The activities that the family members could participate in included training the patient in life skills in order to live in the community. (Case 8, line 75-80, p. 3)*

> *…We focused on increasing the relationships among them by setting activities to go out of the hospital. In the past, we did set many activities, such as taking the patients on a study tour and inviting family members to participate. We*

had always set a project such as a study tour at a temple before setting other activities. It was easy to do. (Case 8, line 83-89, p. 3)

In addition, the findings above indicated that the psychiatric nurses made time for the family members and the person with schizophrenia to be together. One of the psychiatric nurses found a connection that occurred between the family members and the persons with schizophrenia after making time for them; that is, the family members were satisfied in helping and had a good connection with the persons with schizophrenia. As the psychiatric nurse said,

…It was a connection where the family member participated in doing activities. The family member had lunch with the patient. The family member told us that she was fully satisfied and happy and had a good time having lunch with her son. The family member did not have time to talk to her son like that because the family member had to work. The patient had no time to eat food with his parents. At that time, the family member cried and said that she was very glad. (Case 8, line 115-124, p. 4)

Third, in terms of the "encouraging home visit trials" category, most of the psychiatric nurses used this to promote re-acquaintance between the family members and persons with schizophrenia in order to strengthen the connection between the family members and their patients. When the patients were better, the psychiatric nurses tried to bargain with the family members to take the patients to visit their home. The methods for this establishing re-acquaintance with the patient included using simple words to describe the benefits of a home visit trial and visiting the patients, always trying to bargain with the family members while visiting the patient, and speaking several times with the family members; all were used with the family members. At the same time, the psychiatric nurses informed the family members of the purposes of the home visit and of visiting the patients in the hospital;

that is, to promote the patients' development, to help the patients to begin living with their family and in society, and to prevent the patients from depending on the hospital. After encouraging the family members to take the patients on a trial home visit, the family members began to accept and agreed with this. In addition, the family members were delighted that the patients were better and were allowed to visit their home. The following quotation illustrates the point:

> *…I tried to tell the family member several times to take the patient home, but the family member tried to bargain about that, and we reported to the physician that the family member wanted to postpone it for one or two weeks. (Case, 7, line 421-427, p. 14)*

> *…I tried to tell the family member that the patient needed to return to society, to live there, and not stay for a long time in the hospital. We told them the reasons why the patient needed to return home. (Case 7, line 451-456, p. 15)*

However, in using the method of encouraging home visit trials, some of the family members refused to take the patients home even for one or two days. Even though the psychiatric nurses informed the family members about the purpose and various reasons for home visiting, the family members still refused to take the patient home for a visit. Then, the psychiatric nurses tried to invite and encourage them to take the patients to visit home for just a day. The family members accepted the patients leaving the hospital in the morning and coming back in the evening. As one psychiatric nurse said,

> *…I spoke about the home visit trial with the family members, We wanted the family members to take the patients to visit home because our project focused on home visit trials; at least the patient could visit home for one or two days in order to be evaluated. Mostly, the family members took the patients to eat out and then took them back to the hospital. (Case 8, line 328-334, p. 110)*

This evidence illustrates that the psychiatric nurses used the strategy of increasing understanding and promoting re-acquaintance with the patient to strengthen the connections between the family members and patients and also with the psychiatric nurses. However, while strengthening these connections, the psychiatric nurses could use the strategy of strengthening connections with nurses.

4.1.2.2 Strengthening connections with nurses

While the psychiatric nurses tried to strengthen the connections between the family members and their patient, the strengthening of connections with nurses by way of clarifying the situation was employed to help family members have stronger connections with the psychiatric nurses as well. Having strong connections with the psychiatric nurses could make the family members talking with and doing activities with the psychiatric nurses in caring for the patients. At the same time, the family members had opportunities to spend time and do activities with their patients which led to strengthening connections among them.

Some family members did not understand the situations that related to the patients: why the psychiatric nurses cared for the patients, and then the patients were not better; why the patients had physical problems; and why the psychiatric nurses tried to make them take the patient home. Most of the psychiatric nurses realized that these problems might make the family members avoid becoming involved in caring for the patients if they did not understand the nurses. In addition, these problems could make the family members have a sense of mistrust towards the psychiatric nurses. Then, while strengthening connections with the nurses, the psychiatric nurses could employ the strategies of establishing trust with the family members. Most of the

psychiatric nurses clarified some of the situations regarding the patients where the family members might have misunderstood the psychiatric nurses. The family members' misunderstood with the psychiatric nurses led the family members had negative attitude or feelings towards the psychiatric nurses. Therefore, the family members might try to avoid meeting the psychiatric nurses.

The methods that were used for clarifying these situations included explaining and informing reasons about the situations with the family members. These methods helped the family members had understanding the psychiatric nurses that the nurses had more attention to care for the patients. Moreover, while clarifying the situation, the psychiatric nurses could use methods of providing information to increase the understanding of the family members, such as using simple words, being precise in speaking, and other ways.

In the case of moving the patient to another ward, the family members did not understand what had happened and why the patient was moved. The family members complained about the situation with the psychiatric nurses and the psychiatric nurses clarified the situation to the family members. The psychiatric nurses informed them of the reasons for moving the patient to a rehabilitation ward. The psychiatric nurses had explained about the situation to make the family members understand the nurses, and this lead to the strengthening of the connections with each other. As one psychiatric nurse explained,

> *…I explained that "because the patient must be hospitalized for a long time, we needed to move the patient to the rehabilitation ward"… we informed the family members. The first time of visiting we said, that if "you are not ready to take the patient home, he might be moved to the rehabilitation ward the next time." We said that because after the assessment, the patient had to be hospital for a long time, and the patient should be there to be trained in social and occupational skills. (Case 13, line 142-151, p. 5)*

The situation that some of the psychiatric nurses tried to explain to the family members concerned expectations regarding the length of stay in the hospital and the period before the medication took effect. Some of the psychiatric nurses tried to clarify these situations with all family members, especially at the first meeting. However, some family members that had been to the hospital might ask again and some might not ask about the situations that they had misunderstood. The psychiatric nurses would always provide a clarification in order the help the family members understand because some family members did not understand and complained about why the psychiatric nurses cared for the patient and he or she was not getting better quickly. There is a need for the psychiatric nurses to use their knowledge for answering questions and clarifying issues, such as the length of stay in the hospital and other nursing care issues, for the patients in order to help the family members better understand the situation.. As one psychiatric nurse explained,

> *…I explained that this time, the patient must stay on treatments and that the patient's medicine might be modified, so the patient's symptoms might be not better. It takes time. The patient was with ill for a long time. The patient's treatments might take more time. I explained to the family member. (Case 1, line 28-32, p. 1-2)*

One of the psychiatric nurses had explained to the family member about the nursing care for the patient that had physical health problems. When the family members visited the patient, the psychiatric nurse had informed him or her about the patient's condition during hospitalization, including physical health problems. After providing this information, the family members did not understand and complained about her nursing care. They did not understand why the patients were not better, why the patient had physical health problems, and why the psychiatric nurse did not tell the physician about the patients' symptoms. The psychiatric nurse had clarified the

situation to the family members in order to make the family members feel more comfortable about the patient. As the psychiatric nurse explained,

> *…We said that we have stages of working when the patients were not better or have problems. We have a process when we have to report to the physician because we have to report to the physician. For example, in the evening, he came here; he saw that the patient had gotten a cold. At that time, the physician was not in the hospital. It was over for working on that day. We would tell the in-charge ward. The family member asked us why we did that and why we did not tell the physician directly. It was a process of our working. (Case 1, line 95-101, p. 4)*

This evidence indicates that the psychiatric nurses tried to increase the family members' understanding of these situations by clarifying the situations with reason. The psychiatric nurses did this in order to make the family members understand why the psychiatric nurses cared for the patients. The psychiatric nurses realized that if the family members understood the psychiatric nurses, the family members would recognize and have strong connections with the nurses. Obviously, when the family members have good and strong connections with the nurses, the family members will acknowledge help from the psychiatric nurses. Not only could the strategy of strengthening connections help the family members live with their patients, but also the strategy of promoting readiness to care could help the family members live with the patients.

4.1.3 Promoting readiness to care

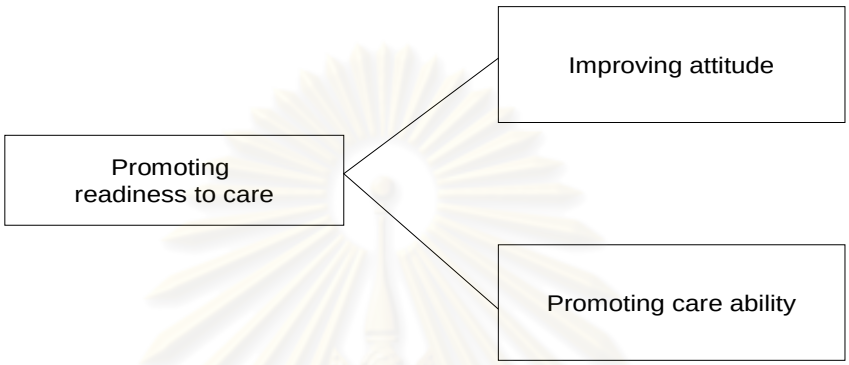
While psychiatric nurses strengthened the connections between family members and patients and also with psychiatric nurses, the psychiatric nurses could

promote the family members' readiness to care. The psychiatric nurses realized that it was important that the family members be ready to care for their patients and have strong connections both with the patients and nurses. Promoting readiness to care was a strategy that was used to prepare the family members to care for and support the persons with schizophrenia. It could be a significant strategy that helped the family members and their patients live together in the family. In talking with the family members, most of the family members were anxious to care for or support their patients. In addition, the family members, sometimes, wanted to abandon their patients in the hospital. They had often mentioned the patients' violent behaviors and difficulties in caring for them. At the same time, they talked about their suffering while caring for the patients. They lacked of confidence in their ability to provide care. Therefore, the family members did not want to take the patients home.

The psychiatric nurses, however, had a great role in caring for the patients: to make them better and to be able to return to live with their families. The psychiatric nurses realized that the family members' willingness and care ability had an influence on the patients' symptoms. There was a need for the psychiatric nurses to inform the family members about the patients' ability before leaving the hospital. The psychiatric nurses used two strategies to promote the family members' readiness to care for the patient: by improving their attitude and by promoting their care ability. These strategies made the family members understand the patients' symptoms and behaviors and have a positive attitude towards their patients. In addition, the family members developed the ability to care for the patients. The psychiatric nurses tried to promote the readiness to care on the part of all family members when the family members visited their patients in the hospital and when the family members called the psychiatric nurses while giving care to their patients at home. Some psychiatric nurses

also called the family members, they promoted the readiness of the family members to provide care as well. The concept of promoting readiness to care that emerged in this study is presented in Figure IV.

Figure IV: A summary of promoting readiness to care category



4.1.3.1 Improving attitude

Improving their attitude was a strategy that psychiatric nurses used to promote family members' readiness to care for and support their schizophrenic patient. In meeting with family members, the psychiatric nurses had assessed the bonding between the family members and the persons with schizophrenia; the psychiatric nurses knew that the family members had a negative attitude towards the patients. Some family members tried to abandon the patients in the hospital because they always thought that the patient would never be better, the patient often exhibited bizarre and violent behaviors, and the patients could not take care of themselves. The psychiatric nurses tried to adjust and improve the family member's attitude to be positive with the patients. A method of adjusting and improving this attitude was informing the family of the patient's behavior and discussing the patient's good

characteristics so that the family members would modify their attitude towards the patients in order to help the family members accept the them. The psychiatric nurses tried to tell the family members that the patients were better and were ready for living in the family and in the community, and that the patients were able to take care of themselves and were strong enough to live in their family and the community. After speaking with them, the family members understood their patients' behaviors and felt sure that the patients were better and ready to return to the family. These methods allowed the psychiatric nurses to be able to help the family members have a positive attitude, acceptance, and the willingness to return the patient to the family. The following quotation illustrates this point:

> *….At first, the family member had a negative attitude toward the patient. I gave the following information: "Actually, when the patient stayed in the hospital, he had no symptoms, and the patient calmed down. He could live in society. I explained that during treatments, the patient was better. I suggested this to the family member. I also educated the family member about the disease and taking medicine and having a positive attitude toward the patient. (Case 2, line 24-29, p. 1-2)*

> *….I tried to make the family members understand the patient's behaviors and that it was a disease. So, the family members had to try to adapt themselves to the patient's emotion. Some were better when I said that… The family member complained, but the family member accepted taking the patient home. (Case 10, line 438-443, p. 14)*

In addition, some of the psychiatric nurses also tried to use the strategy of promoting love and bonding with the family members who had a negative attitude towards the patients, such as avoid visiting the patients and refusing to take the patient home. The psychiatric nurses believed that if the family members love and bonded with their patients, the family members would have a positive attitude towards them.

The psychiatric nurses said that an important way that was used was talking about love and bonding between the family members and the patients. They had talked with the family members about connections since the family members lived with their patients so that the family members would have love and care for the patients in order to establish a positive attitude towards the patients. While talking with, the psychiatric nurses also provided emotional support for the family members and suggested that the family members talk about the patients with other family members as well. Then, the family members understood and agreed with the psychiatric nurses. The following quotation illustrates this point:

> *…I talked with the family member and I had a question: "Do you think that you can help your younger sister or not? The family member began crying. I also said, "I do understand your feelings. Actually, you love and connect with the patient because you are the closer person to the patient. But you don't have and opportunity to provide care; you work in America. I will not press you. I want you to think carefully and talk to other family members about how to help your younger sister." (Case 4, line 190-200, p. 7)*

In the same way, some of the psychiatric nurses also used the strategy of promoting love and bonding with the family members who had a positive attitude towards the patients. The psychiatric nurses tried to tell the family members about the love between them and the patients in order to make the family members develop a positive attitude. As one psychiatric nurse said,

> *…We told all family members that "It is very important that the patients want to get love and understanding from you. So, the family members should make the patients felt important by visiting them and care them." (Case 8, line 66-70, p. 3)*

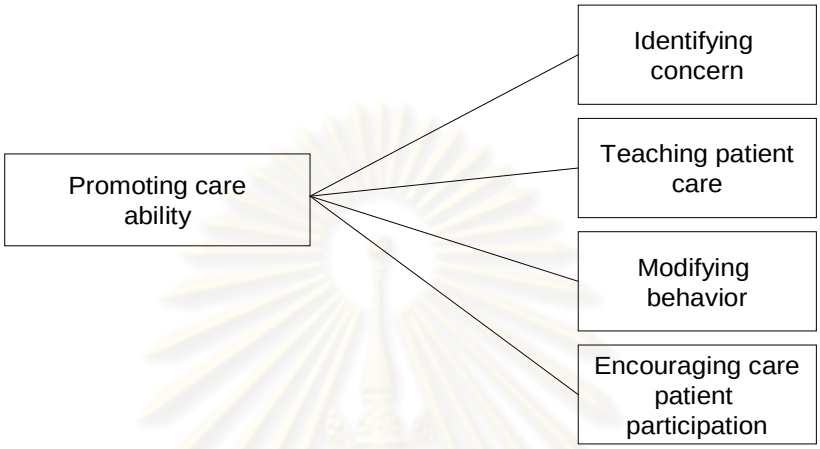
As the evidence presented above shows, the psychiatric nurses used the strategy of improving the attitude of the family members so that they could have a positive attitude towards the patient by informing them of the patient's ability and talking about the love and bonding between the family members and the schizophrenic patient. These strategies allowed the psychiatric nurses to improve the family members' attitude towards the patients. The psychiatric nurses realized that when the family members have a positive towards the patients, the family members will be willing to care for their patients. Not only should the family members improve their attitude, but they should also increase their care ability so that the family members can be ready to care for their patients.

4.1.3.2 Promoting care ability

Promoting care ability was a strategy that the psychiatric nurses used to help family members care for and support their patient. In talking with most of the family members, the family member had more anxiety/tension while providing care for their patient. The psychiatric nurses perceived that the family members lacked confidence in caring for and supporting their patients because the family members did not understand the patients' symptoms or the strategies needed for caring. For this reason, the psychiatric nurses tried to promote the family members' care ability so that the family members would have the skills and strategies and confidence in caring for and supporting their patients. Most of the psychiatric nurses promoted the care ability of the family members while visiting the patients and participating in activities in the hospital. Then, the psychiatric nurses promoted the care ability of the family members through the strategies of identifying concerns, teaching about patient care, modifying

their behavior, and encouraging patient participation. The concept of promoting care ability that emerged in this study is presented in Figure V.

Figure V: A summary of promoting care ability

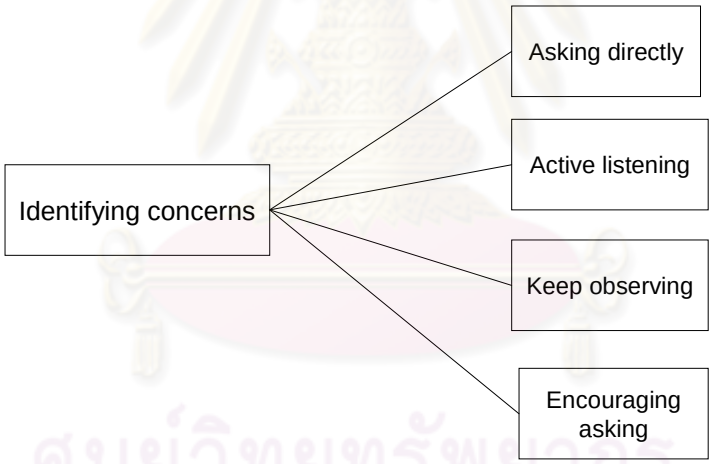


First, in “identifying concerns” when the family members arrived at the hospital with their patients or visited the patients, they had anxiety about them. They did not know why the patients had abnormal symptoms or how to care for the patients and control their symptoms. Most of the family members often asked the psychiatric nurses, “When will the patient’s symptoms go away?” Some family members suffered and were embarrassed about talking with others about their patients’ symptoms and cried with the psychiatric nurse. The anxiety/tension of the family members caused the psychiatric nurses to find ways to help them. In addition, the family members had concerns about the patients’ symptoms, the ways of caring for their patients, financial problems, and how to live with the patients by identifying these concerns. The methods that most psychiatric nurses used for identifying the concerns included direct asking, actively listening and through continual observation, and encouraging asking. The psychiatric nurses used these strategies with all family members at all meetings because each time, the family members might have new concerns. It was necessary

for the psychiatric nurses to identify the family's concerns in order to plan for helping them.

Therefore, the identifying of the family's concerns can make both the psychiatric nurses and the family members of persons with schizophrenia understand the problems and needs of the schizophrenic patients. Most important, the family members recognized their problems and needs in order to find ways to resolve their problems and support their needs effectively. In addition, the family members had an opportunity to talk about their concerns with the psychiatric nurses. The concept of identifying concerns that emerged in this study is presented in Figure VI.

Figure VI: A summary of identifying concerns concept



"Asking directly" was a method that the psychiatric nurses used to identify the family's concerns. In meeting with family members of persons with schizophrenia, the psychiatric nurses always needed to use directly questions with the family members in order to make them understand what concerns the family members had in giving care to their patients. The topics included the following needs and questions of the family members: why the family member did not want to take the

patient home; their feelings while giving care to the patient, such as feeling unsure and suffering in caring for the patient; the family member's readiness to provide care at home, taking the patient home, meeting with the physician, and the patient's behaviors while living at home; their attitude towards the patient and caring for the patient while living at home. The following quotation illustrates this point:

> *...Most family members will be asked information about their problems about what happened in the past and why the family member took the patient to the hospital, and other histories. I found that the family member had no time for taking care of the patient, so the patient had to take medicine by herself or sometimes took care of herself in daily activities. The family member has often said that she had no time. When the patient returned home, the patient would be alone. (Case 3, line 13-20, p. 1)*

> *…We asked the family member why they refused to take the patient home. We found that the family member had no confidence in caring for the patient, so we needed to ask what the family member lacked confidence about. (Case 9, line 9-16, p. 1)*

The evidence presented above indicates that psychiatric nurses need to use the strategy of asking directly in order to identify the family's concerns every time they meet with family members of persons with schizophrenia or when the family members call the psychiatric nurses. At the same time, the psychiatric nurses need to actively listen to the family members' in order to make them understand their concerns and in order to plan for promoting care ability.

"Actively listening" to the family member's concerns is a method that all psychiatric nurses used while talking with the family members of persons with schizophrenia. While asking the family members about their concerns, most of the psychiatric nurses tried to listen to the family members' speech. In this way, actively

listening made the psychiatric nurses understand the family's concerns and this led to identifying the concerns in order to plan for suitable help based on their needs and problems. It also shows that the psychiatric nurses paid attention to the family members. The family members would say something, the psychiatric nurses needed to listen carefully. The psychiatric nurses have learned that it is necessary to try to listen to the family members' concerns as much as possible when they have time. In this way the psychiatric nurses would learn about and understand the family members' concerns. For example, the psychiatric nurses actively listened to the family members regarding their difficulties in caring for the patient, such as living with blockages, burdens, counterforce, and lack of energy sources while caring for them, including avoiding taking the patient home, refusing to care for the patient, and the need to postpone taking the patient home. It was important that the psychiatric nurses always listened to what the family members had to say. The psychiatric nurses' listening also encouraged the family members to share deeply their problems, which reflected trusting the psychiatric nurses. The following quotations illustrate the point:

> *…We needed to be calm and listen to the family members and what they want and what problems they have in order to help the family members directly based on their needs or problems. (Case 7, line 471-474, p. 15)*

> *…We listened to the family member's problems. Mostly family members who come here like to share their problems about what the patient's behaviors were while living at home. (Case 13, line 204-207, p. 7)*

> *…We only listened. The most important things were that we listened to the family member and thought about one, two, and three problems. When they say anything, we must listen carefully to each issue. (Case 15, line 594-599, p. 19)*

The evidence from this study indicates that the psychiatric nurses used the strategy of active listening to identify the family's concerns. While actively listening to the family members, the psychiatric nurses also needed to keep observing the family members in order to monitor their behaviors; this is related to problems occurring while giving care to persons with schizophrenia.

In terms of the "keep observing" method, during asking and actively listening to the family members, the psychiatric nurses needed to keep observing them and their behaviors, their health, and paying attention to caring for their patient, as well as learning about the disease. Continuing to observe while talking to family members helped the psychiatric nurses acquire information for planning to help them. The psychiatric nurses needed to keep observing the family member's behaviors while talking with the nurse in order to determine if the family members were anxious, satisfied, or unsatisfied with the nursing service system, as well as concerns while giving care to the patients. This observation helped the psychiatric nurses understand how the family members were as they spoke.

Some of the family members did not listen to the nurses while they gave them information. In addition, the family members paid less attention to giving information and that some were good at providing information. Then, the psychiatric nurses tried to give information several times to the family members. As one psychiatric nurse said,

> *…I tried to tell the family member about the patient many times. The family member did not listen to me and did not open her mind to accept the information that I gave her. She still had thought that the patient was not better. Even though I tried to give her information, she refused the information. (Case 2, line 201-204, p. 8)*

Some of the psychiatric nurses kept observing the family members' speech and they found that the family members did not speak the truth about the patient's problems or problems in the family. This observation helped the psychiatric nurses identify the family's concerns and why the family members behaved in the way they did, why the family members did not tell the truth with the psychiatric nurses, and why the family member paid less attention to receiving information from them. The following quotation illustrates the point:

> *…I felt that some family members felt that they were suffering with the patients and did not tell the truth about their patients. Some family members cried and always asked when the patient would be fine…I found that the family member had often asked and seemed to be worried. The family members would ask, "When will the patient be fine?" We tried to support and give information and give reassurance. (Case 10, line 69-74, p. 3)*

While talking with the family member, some psychiatric nurses observed that the family members were very worried about the patient. The family members were very worried at every meeting and later the family members began getting health problems, such as hypertension and heart disease. However, the psychiatric nurses also observed that the family members did not monitor or help the patient. This observing helped the psychiatric nurses had an understanding that the family members lacked attention in monitoring the patient's symptom and behavior. As the psychiatric nurses stated,

> *…I saw that he was very worried. The family members seemed to manipulate the patient. If the patient had a little disturbance, the family members would take the patient to the hospital as soon as possible. He did not observe or assess the patient concerning what to do or how to help the patient at first. (Case 9, line 320-329, p. 11)*

…I found that the family member was very worried about the patient's symptoms and illness. The family member came here 3 times, and she still was worried about the patient. However, the family member would ask less about the patient. I think the family member was worried and concerned every time. The family member began to be not fine. (Case 1, line, 61-64, p. 3)

…I saw that the family member was very old. She could not walk well and has physical health problems, such as hypertension and heart disease. She still visited the patient and kept taking care of the patient. (Case 2, line 179-181, p. 7)

The evidence above indicates that the psychiatric nurses used the method of continual observation of the family members in order to identify the family's concerns. Continuing to observe is another important way of identifying the family's concerns in addition to directly asking questions and actively listening. The psychiatric nurses would understand the family members' concerns, including anxiety, health problems, and being afraid of telling the truth, in order to plan for promoting care ability in caring for persons with schizophrenia. Moreover, the psychiatric nurses needed to use the method of encouraging questions in order to persuade the family members to ask about everything that they did not understand.

"Encouraging asking questions" was a method that the psychiatric nurses used with the family members of persons with schizophrenia in order to identify the family's concerns. Most of the psychiatric nurses encouraged the family members to ask about everything that they wanted to know. Encouraging questions helped the family members to have an opportunity to ask about something that the family members did not understand or were worried about. In talking, some family members were afraid of asking physicians about the patient's disease and his or her

symptoms and treatments. For this reason the family members had anxiety/tension in caring for their patients. This was a reason why the psychiatric nurses tried to encourage the family members to ask questions about the patient's illness all the time, both with the nurses and the physicians, by talking to them directly and by providing time for asking these questions. The following quotation illustrates the point:

> *…I suggested to the family members and asked them, "Have you ever asked the physician about this disease?" Some family members were afraid of asking because they did not want to disturb the nurse. When I asked, they said that they did not. They came many times. So, I provided information to them. (Case 10, line 235-239, p. 8)*

> *…We provided time for questions from both family members and patients. (Case 13, line 468-473, p. 15)*

> *…I wanted to talk to the family member. When the family member arrived, we provided time for asking. In our ward, we did not limit time for visiting. (Case 5, line 165-167, p. 6)*

Second, in "teaching about patient care," the psychiatric nurses tried to promote care ability that most family members had no confidence in caring for persons with schizophrenia because the family members did not know how to care for or support their patients, or how to behave and act with the patients when they exhibited abnormal symptoms. The psychiatric nurses had tried to improve the care ability of the family members by teaching them about patient care strategies. Teaching patient care was a strategy that the psychiatric nurses used to increase the family members' care ability. However, in teaching the family members, the psychiatric nurses tried to teach with various methods or techniques in caring for the

patients as well as giving examples for dealing with the patients. The various methods helped the family members had understanding how to care for their patients.

In meeting with the family members, most family members lacked confidence because they did not know how to care for or support persons with schizophrenia if the patients exhibited abnormal symptoms. The psychiatric nurses, therefore, taught the family members about care strategies for caring and supporting the patients. Teaching patient care was a strategy to help the family members learn how to manage and deal with the patients' symptoms, how to control the patients' bizarre behaviors, and how to manage the environment of the patients. Topics that were taught to the family members included symptom management, medication administration, promoting self-care, monitoring the patient's symptoms, managing the environment, and psychological support. After teaching them, the family members better understood how to care for and support their patients.

Symptom management was a way of increasing the care ability of the family members. In meeting with family members, some of the family members did not understand the patient's symptoms. Especially, when the patient had abnormal symptoms, including hallucinations and delusions, the family members did not know how to manage them and so the psychiatric nurses tried to teach them about symptom management. In addition, the family members lacked confidence in dealing with the patients' psychotic symptoms, such as how to deal with and how to manage the patients' violent or inappropriate behaviors, and what to do when the patient did not sleep. The psychiatric nurses also used these teaching care strategies in dealing with the patient's symptoms and behaviors in order to make the family members be able to care for the patients and be comfortable in caring for them at home. The following quotation illustrates this point:

…We told the family member that, the patient has thoughts which we could not control. For example, when the patient talked about seeing a ghost, we had to tell the family member to ask the patient, "Where is the ghost?" and tell the patient to mark where the ghost was. Later I invited others to see it and explained to the patient. We would explain to the family member what it was. (Case 15, line 670-676, p. 22)

…I told the family member to say "Now mom did not see anything" and told the family member to say this. "If mom sees it, mom will tell you" and "What did you see?," like that., "Mom will make you safe" and I told the family member that if she/he saw the patient have an hallucination, don't be afraid, the patient will do harm. But the family member should say, "Mom will take care of you." (Case 15, line 690-696, p. 22)

…We told the family member that there are many ways to take the patient to the hospital, such as telling a policeman to take the patient. The patient will be afraid of the policeman. I also told the family members to find someone who can bring the patient here. (Case 7, line 285-288, p. 10)

Medication management was a topic that some psychiatric nurses mentioned in dealing with the family members of persons with schizophrenia. In caring for persons with schizophrenia, medication administration is an important way to make the persons be able to live in the community effectively. Most family members were anxious about the patients taking medicine. The family members often said that they could not manage the medication for the patients because they had to work outside the home and the patients often refused to take the medicine. Then, the psychiatric nurses taught the family members about this with various strategies, including continuing to observe the side effects of the medicine and to remind the patient to always take his or her medicine and avoid smoking, drinking, or using drugs. The following quotation illustrates the point:

…Mostly we talked about taking medicine and what to do when the patient had to go home. Both family members and patients were informed about what to do, such as decreasing smoking; sometimes it was impossible because it was a problem that couldn't be resolved. We talked about trying to decrease or avoid using drugs. It would be good. It was talking to reassure the family member to encourage the patient to try to do activities with good concentration. (Case 10, line 379-388, p. 12-13)

…I explained that the family member must participate in giving medicine to the patient, such as this medicine must be taken in the morning, it is an antidote medicine, and it might make the patient have some symptoms. I said that it was needed but that it might make the patient feel uncomfortable, that is, we had to explain the side effects as with the patient. The family member must observe, for example, the warning signs of psychosis, and side effects, such as more saliva. About continuing to take the medicine, what to do and how to remind the patient to not forget to take the medicine or how to persuade the patient to take medicine. (Case 9, line 270-284, p. 9)

The patient's self-care ability promotion was another topic that some psychiatric nurses taught to family members of persons with schizophrenia. The psychiatric nurses realized that teaching the patient how to care for themselves was an important issue in helping the family members care for the patient. Sometimes, the family members often complained that the patients could not any work or help them to do housework. The psychiatric nurses taught the family members about teaching the patient to do house chores, encouraging the patient to do daily activities by themselves, and to avoid drug abuse (drinking and smoking). As well, the psychiatric nurses advised family members to encourage their patients to do activities to develop social skills for living in the family and in the community, and to prevent regression of the patients ability to do other activities, such as continuing to encourage them to read books if the patients could. The psychiatric nurses also told the family members

to look for jobs that were appropriate for the patients in order to train them in occupational skills and life skills in their community. The psychiatric nurses used the method of teaching the patient self-care ability with the family members while visiting the patients or while calling the family members. The following quotation illustrates the point:

> *…I told them that they should keep caring about medicine, doing daily activities by letting the patient do them for him or herself as usual. (Case 7, line 268-269, p. 9)*
>
> *….We suggested about letting the patient work as usual, but not to work with machines because the patient took medicine and the patient might be sleepy. (Case 6, line 218-220, p. 7)*
>
> *….I talked about communication with the patients and encouraging the patients to work because if we did not allow the patient to do anything, the patient would regress; at least the patient will know how to take care of him or herself. Here we trained patients to be able to care for themselves. Some family members ignored this because the patients were stubborn. The family members expected the patients just to know how to take medicine. Sometimes, we talked about the patient's competence, saying for example that the patients could arrange their bed and bedding in the morning, and that the family member should let them arrange the bedding and wash plates after eating and do hygiene care for themselves. (Case 8, line 691-701, p. 22)*

Monitoring the patient's symptoms was a topic that some psychiatric nurses taught the family members in order to improve their ability to care for persons with schizophrenia. In talking with family members, the psychiatric nurses had an understanding that some family members were afraid of the patient's symptoms. The family members did not know what the symptoms were. Sometimes, the family members did not keep observing the patients' symptoms and they often took the

patients to the hospital as soon as possible when they found that the patients were not better. Then, caring for persons with schizophrenia was explained to the family members to help the family members had understanding how to deal with the patients' symptoms. The information that was mentioned to the family members before visiting home or going home concerned the reasons why the patient was discharged. In addition, the family members were given information so that they could keep observing the patient's symptoms, for example, suicide behavior, sleeping, etc. The following quotation illustrates this point:

> *…We suggested about the side effects of the medicine. We also said, "the patient will not do harm to others," but if the patient has symptoms, he must observe the patient's abnormal symptoms, such as if the patient did not sleep without cause, he should take the patient to see a doctor or bring the patient here. It depended on the family members and we suggested them to call us too. (Case 6, line 220-224, p. 7-8)*

> *…I advised that "At night if the patient did not sleep, you have medicine for the patient. If the patient has stress or feels upset, you can bring the patient here; don't ignore the patient until the appointment time. (Case 7, line 271-274, p. 9)*

Psychological support was something that some of the psychiatric nurses had advised family members on to help them provide care for persons with schizophrenia. In talking with the family members, some family members paid less attention to being with or talking to the patients. Then, the psychiatric nurses advised the family members always to give mental support to their patients to promote the patients' mental health in order to decrease their acute symptoms. The psychiatric nurses also suggested that the family members give psychological support to their patients at any time, such as giving praise to the patients when they did good things, giving courage

to the patients, and providing time for talking to them. In addition, the psychiatric nurses advised the family members to find ways to decrease the patients' stress by encouraging them to participate in the stress relaxation programs that the family members selected for them. As the psychiatric nurses stated,

> *…I told the family member, "You should give courage and praise the patient." "Did you do that?" The family member smiled; that means that they might never have done that. "You know that when we do something, we hope that there will be someone to say that it is good, not only comment, or it's not like that, it's not correct. So you should give courage to the patient," and the family member began to understand. (Case 13, line 528-535, p. 17)*

> *…I told the family member, "You must keep greeting the patient and provide time for him" and saying "How are you?" Observe his face; if he seems that he is not fine, you should ask, "Do you have any problems?" "Does mom need to help you?" What about your stress?" The family member must observe like that. (Case 13, line 310-314, p. 10)*

Preparing the environment was another topic that some psychiatric nurses had talked to the family members about in preparing and managing the environment for the patients. Some family members did not know how to prepare the environment for the patients. The psychiatric nurses had advised the family members by preparing an appropriate place for the patient, providing belongings, and preparing the community where the patients were to live as usual with the family. In addition, the psychiatric nurses told the family members to distribute information advising other family members and friends. However, in providing this information to the family members and friends, the psychiatric nurses had asked the family members if they had no feelings of stigmatization. The psychiatric nurses also used the strategy of forming

networks; the psychiatric nurses had coordinated with the community mental health nurses to support the family.

The environment that the psychiatric nurses mentioned with the family members for preparing and managing was comprised of persons, things, and the community. For example, the psychiatric nurses offered choices for the family members, such as looking for a new community and preparing other family members and neighbors to understand the patients' behavior and illness. However, in advising, the psychiatric nurses were concerned about the family's stigmatization. The psychiatric nurses advised these choices to some family members that did not have a problem with this. After advising them, the psychiatric nurses reported that the family members agreed with the suggestions. The following quotation illustrates the point:

> *…We advised the following; "Try to look for other family members to take care of the patient." We observed the family member; she could not look after the patient. But she had choices. The head of the community might help the family member and patient. The patient might stay at a social work institute in the province. The patient's parents could visit easily. (Case 13, line 121-127, p. 4-5)*

> *…I advised all things to the family member, and the family member has knowledge. He works at the Ministry of Public Health. He loves his kids and family. Some patients were discharged and returned home, while other family members disliked the patient. The patient was sent to the hospital again because of psychosis. In this case, the other family members live in another house. These family members could take care of the patient. The family and the people in the community could more greatly influence the patient. (Case 6, line 490-496, p. 16-17)*

The evidence above indicates that the psychiatric nurses used the strategy of teaching patient care with the family members. There are many patient care strategies

that were mentioned to the family members, including dealing with the patient's symptoms and behaviors, medication management, promoting the patient's self-care, psychological support, and preparing the environment for the patient. These teaching patient care strategies helped the psychiatric nurses to be able to promote the care ability of the family members of persons with schizophrenia. At the same time, the psychiatric nurses needed to persuade the family members to modify their behaviors while giving care to the patients.

Third, "modifying behavior" was a strategy that some of the psychiatric nurses employed to promote the care ability of the family members in caring for their patients. In talking with family members of persons with schizophrenia, some of the family members exhibited behaviors that affected the patients, such as manipulating, causing stress, controlling, and neglecting the patient. The patients, therefore, exhibited stress, sadness, anxiety, and lack of continued care. That means that the family members' behaviors influenced the patients in both physical and psychological aspects. The psychiatric nurses tried to make the family members understand their behaviors several times that could influence the patients. The psychiatric nurses also had persuaded the family members to modify their behavior while caring for the patients because appropriate behavior on the part of the family members could support the patient's feelings, make the patient better, and promote the patient's quality of life. Most important, the family members would be able to understand the strategies of approaching, supporting, and caring for their patients with using themselves as a treatment. The methods of this modifying included talking to them, explaining, and advising. The topics for modifying the family members' behaviors focused on emphasizing appropriate behaviors while giving care to their patient, such

as avoiding manipulation, not neglecting him or her, not being too close to the patient, and not pressing the patient.

The psychiatric nurses used various methods to modify the family members' behavior so that the family members would try to adjust their behavior while giving care for the patients. After persuading them several time, the family members understood and listened to the psychiatric nurses' suggestions. However, modifying the family members' behaviors was an important issue. The psychiatric nurses had to be careful while reflecting or in providing feedback on the family members' behaviors. Some family members might have been upset if the psychiatric nurses talked about their behavior. Consequently, the psychiatric nurses tried to select appropriate words for talking with the family members in order to make them understand and accept them and not blame them. The following quotations illustrate the point:

> *...I suggested about continuing care, such as observing the patient's behaviors. Another thing was accepting the patient and trying to give spirit to the patient. The family member must educate the patient as well. The family member must keep talking to and advising the patient. For example, if the patient exhibits inappropriate behaviors, don't reproach the patient because the patient might be sad. About communication with the patient, and speaking with patient, don't blame the patient. (Case 8, line 488-497, p. 16)*

> *…We told him "Calm down; sometimes the patient might be stressed, and you must be calm him down. Don't have high emotion with him." I tried to tell the family member to calm down, and later the family member was comfortable and listened to us. (Case 13, line 414-420, p. 14)*

The evidence above indicates that the psychiatric nurses used the method of encouraging behavior modification with the family members. This allowed the psychiatric nurses to promote the care ability of the family members by using themselves as a treatment for caring and supporting persons with schizophrenia.

Another means of promoting care ability was encouraging the family members' participation in care.

Fourth, "encouraging patient care participation**"** was another strategy for promoting the care ability of the family members in caring for persons with schizophrenia. Most family members lacked confidence in caring for persons with schizophrenia because they did not understand how to care for the patients. Then, the family members tried to abandon or leave the patients in the hospital. In addition, the family members did not want to be involved in or participate in the care. Therefore, most of the psychiatric nurses tried to encourage the family members to participate in the care. In order to achieve this the family members had to learn about the strategies needed for caring for the patients and they had to have confidence in caring for them, for example in being co-assessors.

Some psychiatric nurses encouraged the family members several times to participate in the care by inviting them to be co-assessors in assessing the patients' symptoms, behaviors, and thinking. When the family members visited the patients while in the hospital, the psychiatric nurses tried to invite the family members to assess the patients by allowing them and the patients to talk and participate in activities together. In addition, the psychiatric nurses taught the family members about assessing the patients, such as teaching the family members about observing the patient's behavior, speaking to them, and other behaviors. After that, the psychiatric nurses and family members talked together about the patients and whether the patients were better or not in order to prepare them for the return home. As the psychiatric nurses said,

> *…We provided time for the family member to assess the patient for him or herself—to see how the patient was. After that we would talk together about the patient. We said, "The patient was better and the patient was staying on*

medicine modification. The physician modified the medication for the patient, so the patient might be here a while, and later the patient might be able to return home. You must prepare for taking the patient home." (Case 3, line 136-142, p. 5)

…We let the family members observe the patients' behaviors and talk to the patients. The family members were then able to understand how the patients were today. (Case 8, line 311-316, p. 10)

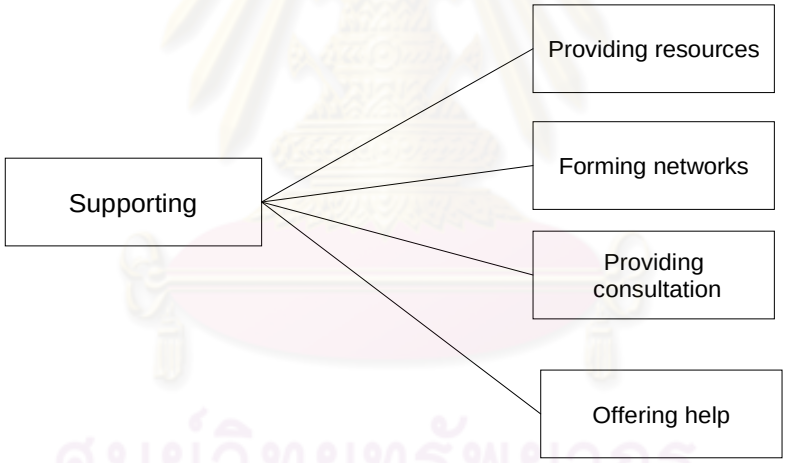
The findings above indicate that most psychiatric nurses used the method of encouraging patient care participation to help the family members be able to care for and support persons with schizophrenia. This method was used with all family members when they visited the patients. The psychiatric nurses also explained that some family members that understood how to care for the patients and that were ready to care for the patients were invited to be co-assessors as well. The psychiatric nurses invited the family members just once, and the family members accepted to be co-assessors in assessing the patients' symptoms, behavior, and thinking. As well, the strategies of teaching care ability and modifying behaviors helped the psychiatric nurses to be able to promote the care ability of the family members of persons with schizophrenia. While promoting the readiness of the family members to provide care, the psychiatric nurses could provide support to the family members so that they had the opportunity to ask for help from various resources.

4.1.4 Supporting

"Supporting" was another stage that the psychiatric nurses used to help family members successfully live with persons with schizophrenia. The psychiatric nurses provided support to help the family members have opportunities or choices in

healthcare services and other resources both within and outside the hospital while giving care to their patients. The strategy of supporting was used by the psychiatric nurses with all family members when they visited their patients or called the psychiatric nurses. The methods of supporting the family members included providing resources, forming them of networks, providing consultations, and offering help. While providing support for the family members, the psychiatric nurses employed the strategies of strengthening connections with the patient, promoting readiness to care, or returning to establishing trust if the family members felt unsure about their patients. The concept of supporting that emerged in this study is presented in Figure VII.

Figure VII: A summary of supporting concept



4.1.4.1 Providing resources

In meeting with the family members of persons with schizophrenia, the psychiatric nurses suggested resources to help the family members have more opportunities to ask for help for their patients. Providing resources was a strategy that most of the psychiatric nurses used to help the family members and patients get help

while living in community. The psychiatric nurses suggested that the family members participate in health resources that took place in the hospital and to look for other resources in the community. However, in advising the family members, the psychiatric nurses let the family members make decision independently. The family members were given information about the resources.

Most of the psychiatric nurses had advised all family members to participate in the family group sessions that took place within the hospital to provide help in caring for persons with schizophrenia. Some family members might participate or not in these groups; however, the psychiatric nurses informed the family members about the purposes and activities of the family groups. As one psychiatric nurse said,

> *…We invited the family members to participate in family group therapy. The group focused on counseling families to better understand why the patients still had problems and why the family members could not take the patient home. (Case 8, line 311-316, p. 10)*

Some of the psychiatric nurses had suggested the family members that live far away from the hospital to look for a hospital that was near the patients' home where they could be hospitalized when the patients exhibited active psychotic symptoms; additionally, calling policemen to help take the patients to the hospital was mentioned. As the psychiatric nurses explained,

> *…We suggested to everyone that "when the medicine has finished, which we provided for one month, you can go to another hospital. However, you can come back any time; we will not forbid it. You might be inconvenienced because it is so far." (Case 6, line 283-286, p. 10)*

> *...I told the family members that "there are many ways for taking the patient hospital. You can call policemen to help you to take the patient to come here. The patients would be afraid of the policemen. (Case 7, line 285-287, p. 10)*

Moreover, in case of the family members and their patients were stigmatized from other people in community and about using drugs, two of the psychiatric nurses suggested that the family members look for a new community where the patient could live, such as taking the patients to live with other relatives who live in another community. However, the psychiatric nurses also suggested the family members live with the patients in the new community. The psychiatric nurses also informed the family members that sometimes, by living in a new community, the patients might be better because they could learn to live in a new society. In the new community, the patients would be not stigmatized from other people. After suggesting other resources, the family members accepted the suggestions. The following quotation illustrates the point:

> *...I advised the family member to look for other community so that the patients would get away from using drugs or smoking… I had informed the family member that changing community or society might not help the patient avoid using drugs. It was a choice for the family member and patient. (Case 5, line 245-251)*

The evidence above indicates that the psychiatric nurses used the strategy of providing resources for the family members before the family members took the patients to visit the home or returned home, along with advising the family members about participating in family groups, going to a hospital near home, calling policemen for help, and looking for a new community for the patients. At the same time, the strategy of forming networks was used to help the family members and patients live together.

4.1.4.2. Forming networks

"Forming networks" was a strategy that some psychiatric nurses employed with family members of persons with schizophrenia to help the family members live with their patients. In helping the family members of persons with schizophrenia, some psychiatric nurses also needed to coordinate with other health resources as a multidisciplinary team to help the family members and persons with schizophrenia when the patients were discharged from the hospital, when they returned home, or went home to visit. Additionally, forming networks was a strategy that the psychiatric nurses employed to help the family members and persons with schizophrenia live in society as usual. The psychiatric nurses formed these networks both in the hospital and in the community, including coordinating with the community psychiatric nurses, physicians, and social workers. In forming networks, the psychiatric nurses informed about the family members' problems and needs. Then, the networks would know how the family members' problems and needs in order to plan helping with the family members. At the same time, the family members had resources for helping them. The family members could ask for help from those networks when they had to deal with difficulties while caring for the patients.

Some family members had financial problems. The family members were suffering about financial problems, and this might be related to caring for their patients. The psychiatric nurses coordinated with social workers to help the family members and took them to meet with social workers to talk about payments. However, before coordinating with social workers, the psychiatric nurses had asked about the family members' willingness. If the family members agreed with the psychiatric

nurses, coordinating with the social workers proceeded. As one psychiatric nurse explained,

> *…If the family members have real problems, we took them to meet with a social worker each time they had to make a payment. The payment for treatment was discounted by 15% for the family members. The social worker would interview the family members about their distress. (Case 8, line 927-930, p. 29-30)*

In addition, some of the psychiatric nurses had coordinated with community psychiatric nurses to visit the family members and patients while visiting home or living in the community, where the family members could consult the community psychiatric nurses when they had problems in caring for persons with schizophrenia at home. The psychiatric nurses also had advised the family members to tell the patients to take their medicine or get shots at the primary healthcare center where the community psychiatric nurses were working. In addition, the psychiatric nurses coordinated with community psychiatric nurses to help other people understand the patients, the disease, and how to care for persons with schizophrenia. As one psychiatric nurse said,

> *…We told the health care providers in the community to provide care, not us. We coordinated with the community psychiatric nurses. They would talk with people in the community by explaining what the disease was and how to care for the patients and something like that… after that the people in the community accepted the patients. (Case 15, line 837-849, p. 27)*

The evidence above indicates that the psychiatric nurses used the strategy of forming networks to help the family members of persons with schizophrenia. The forming of networks by the psychiatric nurses included coordinating with health

teams both in the hospital and in the community. At the same time, the psychiatric nurses could provide consultation for the family members.

4.14.3 Providing consultation

"Providing consultation" was a strategy that most of the psychiatric nurses used to create confidence on the part of family members in caring for persons with schizophrenia. In talking with the family members, the psychiatric nurses perceived that the family members, sometimes, could not make decisions or resolve their problems while giving care to their patient at home. The psychiatric nurses provided consultation by directly talking with them while the family members visited the patient in the hospital and giving their telephone number to the family members to call anytime that the family members wanted to consult about their concerns while caring for the patients and other problems. The topics of consultation included laws that related to the patient, meeting with the physician, costs and special nurse's fees, and paying for treatment. The psychiatric nurses provided this consultation for all family members so that the family members could have another choice in caring for their patients. Some family members, therefore, called the psychiatric nurses to ask them how to solve their problems. The following quotation illustrates the point:

> *…We gave them our telephone numbers so that the family members would feel that they had resources. They had our telephone number, they could call this ward. Here we provide telephone numbers for consultation. We told the family member that for two weeks, we called the family members. We said that "If you have any problems, you can call. We are happy to help you." (Case 8, line 760-768, p. 24)*

…About the process of law and the process of bail, the family members did not know or understand really…We told the family member, you must go first to the hospital because the patient was there and had a history over there; go there. She said that "is not it here?" So we advised the family member to "go to a lawyer and take his telephone number with you." She did not know about that, and it will be helpful for the family member. (Case 14, line 1083-1098, p. 34-35)

...The family members call here, sometimes, and we found that the family member could not care for the patient. The family member had more burdens or lacked confidence, so could not care for the patient. We advised him to see the physician with the right to get emergency care and to contact us as well. (Case 5, line 361-367, p. 12)

The evidence above illustrates the fact those most psychiatric nurses in this study provided consultation to all family members. The methods of providing this consultation included talking directly with the family members while the family members were visiting the patients in the hospital and giving their telephone number to the family members. While providing the consultation, the psychiatric nurses employed the strategy of offering help to the family members.

4.1.4.4. Offering help

While providing resources and providing consultation to the family members of persons with schizophrenia, all of the psychiatric nurses employed the strategy of offering help as another choice in caring for them. The psychiatric nurses offered themselves to help the family members by talking to the family members directly while both visiting the patient in the hospital and while living at home. The psychiatric nurses employed this strategy with all family members at almost all

meetings. Additionally, in offering help, the psychiatric nurses said that they gave the family their wards' telephone number so that they could call the psychiatric nurses when they had encountered with problems. The psychiatric nurses also told the family members directly that they were always willing to provide assistance to the family members. This strategy could also help the family members to have a choice in providing care for and supporting their patients. The following quotation illustrates this point:

> *…I wanted the family member to talk about his or her problems or about how the family member needed me to help. I offered myself to help the family member. (Case 12, line 180-185, p. 6),*
>
> *…I gave a telephone number that they could call anytime. (Case 4, line 308, p. 11)*
>
> *….Several times, I said that "if you have problems, you can call us to consult us. You can call us at any time. If you cannot talk to me, you can talk to other nurses. Everybody is ready to help you." (Case 13, line 36-41, p. 2)*

The findings above indicate that the psychiatric nurses used the strategy of supporting family members of persons with schizophrenia to help the family members obtain help from resources in caring for the patient. Strategies of supporting included providing resources, forming networks, providing consultation, and offering help. While supporting the family members, the psychiatric nurses could return to the strategies of strengthening connections, promoting readiness to care, or establishing trust in order to help the family members be able to live with persons with schizophrenia.

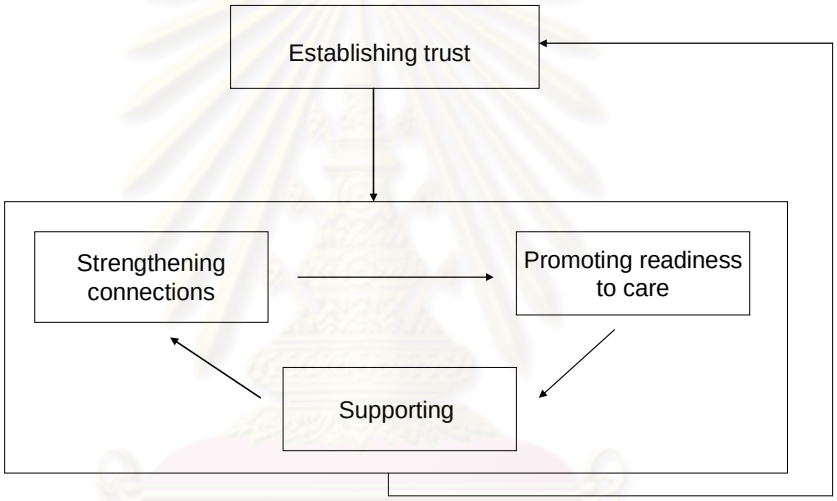
4.2 The emergence of "facilitating living with persons with schizophrenia"

"Facilitating living with persons with schizophrenia" is the core category that emerged in this study. This process is seen as a basic social process which is undertaken by psychiatric nurses who are working with family members of persons with schizophrenia. The "Facilitating" refers to enabling family members to work in the ways that suit them best. The facilitating living with persons with schizophrenia is a model that psychiatric nurses used with family members to help them be able to care for and support their patients and to live together. This process occurred when the psychiatric nurses recognized the need to help the family members care for and support persons with schizophrenia; then, the psychiatric nurses created the four strategies, comprised of establishing trust, strengthening connections, promoting readiness to care, and supporting. These strategies could help family members be able to care for and support their patients.

Establishing trust was the first strategy that the psychiatric nurses employed with the family members to make the family members feel comfortable and trusting with the psychiatric nurses before moving on to other stages. Later, the strategies of strengthening connections, promoting readiness to care, and supporting were also employed with the family members. The psychiatric nurses, however, could return to using the strategy of establishing trust again in order to maintain trust with the family members, and then, return to the strategy 2, 3, or 4 again until the family members accepted their patients returning to the family. In addition, while the strategy of supporting was used, the strategies of promoting readiness to care for and to strengthen connections were also used with the family members. Thus, the end point of the process of facilitating living with persons with schizophrenia is the family

members successfully living with persons with schizophrenia in their community. Throughout this process, the psychiatric nurse-family relationship is not linear. In this process of facilitation, nurses return to the stages necessary to help the family members in being able to care for persons with schizophrenia. The concept of facilitating living with persons with schizophrenia that emerged in this study is presented in Figure VIII.

Figure VIII: The process of facilitating living with persons with schizophrenia



The process of “Facilitating living with persons with schizophrenia” is comprised of four major stages. The first stage of facilitation involves psychiatric nurses’ attempt to establish trust with family members so that they might be comfortable in talking about problems, other concerns, and needs while providing care to their patient. The psychiatric nurses established trust with the family members by making their acquaintance, having prolong engagements with them, showing them respect, communicating understanding, and ensuring good patient care, as well as with patient safety. These strategies allowed the psychiatric nurses to establish trust with the family members of persons with schizophrenia. After establishing this trust

with the family members, the psychiatric nurses could create strong connections, promoting readiness to care and supporting the family members. However, the psychiatric nurses still used the strategy of establishing trust throughout the process of facilitating living with persons with schizophrenia.

The second stage was strengthening connections. This was a stage that the psychiatric nurses employed in order to increase the connections between the family members and patients and also with psychiatric nurses. The strategies of strengthening connections included strengthening connections with patients and strengthening connections with nurses. These strategies allowed the psychiatric nurses promoted positive feelings among them. While strengthening these connections, the psychiatric nurses also used the strategy of promoting readiness to care, supporting, and returning to the stage of establishing trust in order to help the family members be able to care for and support persons with schizophrenia so that the family members and the patients could live together.

The third stage was promoting readiness to care. This stage was used to improve the family members' ability in caring for and supporting persons with schizophrenia. The strategies for promoting readiness to care included improving attitude and promoting care ability. These strategies allowed the psychiatric nurses to promote readiness to care regarding the family members of persons with schizophrenia. This stage also allowed the psychiatric nurses to employ the strategy of supporting and returning to the stage of strengthening connections, or returning to the stage of establishing trust, to help the family members care for their patients.

The fourth stage is comprised of support, which the psychiatric nurses used to support the family members while giving care to their patients. The four strategies for supporting the family members included proving resources, forming networks,

providing consultations, and offering help. These strategies allowed the psychiatric nurses to support the family members in caring for and supporting the patients so that they could live with their family in the community. While supporting the family members, the psychiatric nurses could return to employing the strategy of strengthening connections, promoting readiness to care, and establishing trust again in order to help the family members.

4.3 Summary

The study is aimed at exploring the relationship between psychiatric nurses and family members of persons with schizophrenia. The “Facilitating living with persons with schizophrenia” emerged from the study, which focused on psychiatric nurses that are working with the family members of persons with schizophrenia. This process was carried out when the psychiatric nurses realized that caring for persons with schizophrenia and helping them to live with their family is a goal of psychiatric nursing in this context. This process illustrated the fact that the psychiatric nurses in this study used four major strategies to help the family members be able to care for and support persons with schizophrenia: “establishing trust,” “strengthening connections,” “promoting readiness to care,” and “supporting.” These strategies helped family members successfully to live with persons with schizophrenia.

CHAPTER V

SUMMARY DISCUSSION AND RECOMMENDATIONS

Qualitative research and grounded theory methodology was used in this study. The model of “Facilitating living with persons with schizophrenia” was generated based on the psychiatric nurses’ perspective. The model was composed of four major stages of facilitating living with persons with schizophrenia. This chapter summarizes the research findings and discussions, the strengths and limitations of the study, the contribution of the findings to nursing practice, implications for mental health care policy, implications for education policy, and suggestions for future research.

5.1 Summary of the research findings

The purpose of this study was to explore the relationship between psychiatric nurses and family members of persons with schizophrenia. The qualitative grounded theory was used as the research methodology. The research participants were 16 psychiatric nurses who have been working in in-patient wards. The participants’ ages ranged from 33-56 years. The average age of the participants was 42.75 years. The level of education of the participants ranged from a bachelor’s, master’s degree and postgraduate degrees in mental health and psychiatric nursing. The length of employment in the psychiatric hospital of the participants ranged from 10 to 34 years, and most were over 20 years.

The core category emerging from the data analysis was the process of facilitating living with schizophrenia. The facilitation of living with persons with

schizophrenia is a basic social process, which occurred from how the psychiatric nurses developed their clinical nursing practice to help the family members to be able to care for and support persons with schizophrenia to live with family. The findings revealed four major stages in the process of facilitating living with persons with schizophrenia. This dynamic process includes; establishing trust, strengthening connections, promoting readiness to care and support with all of these stages being related to each other.

The first stage in the process of facilitating living with persons with schizophrenia was establishing trust. Psychiatric nurses established trust with family members of persons with schizophrenia by making their acquaintance, prolonging their engagement with them, showing respect, communicating understanding, and ensuring good care and the patient's safety. Psychiatric nurses used the making an acquaintance strategy with family members in order to get to know them more personally, to make the family members comfortable, and to help the family members to relax in meetings by smiling and making small talk. The psychiatric nurses also used the showing respect strategy to make the family members feel important by being calm, polite, and using eye contact while meeting with the family members. The prolonging engagement strategy was used to make the family members feel that there are nurses that can be with them and help them to care for the patients. Communicating understanding was another strategy that the psychiatric nurses used with the family members to show that the psychiatric nurses understand the family members by caring for the patients and telling them directly, allowing expression, and assisting as requested. Moreover, the strategy of ensuring good care and patient safety was used to demonstrate that the patients would be safe and receiving good care while

staying in the hospital. These strategies allowed the psychiatric nurses and family members to trust each other before moving on to the next stage.

The second stage was strengthening connections. This was a stage that the psychiatric nurses used to increase connections between family members and persons with schizophrenia and with psychiatric nurses. The stage of strengthening connections included strengthening connections with patients and strengthening connections with nurses. For the strategy of strengthening connections with patients, the psychiatric nurses helped them understand the patients and disease and its treatments. Another strategy that was used for strengthening the connection was promoting re-acquaintance with the patient. It was used to help the family members and their patients to acquaint themselves with each other again in order to strengthen connections among them. For strengthening connections with nurses, the psychiatric nurses used the strategy of clarifying situations which the family members did not understand that related to caring for the patients. These strategies allowed the psychiatric nurses to strengthen connections with the persons with schizophrenia.

The third stage was promoting readiness to care for the patient who psychiatric nurses used to improve the family members' ability to care for and support persons with schizophrenia. Strategies for promoting readiness to care for the patient included improving attitude and promoting ability. The psychiatric nurses promote the ability for care for the patient by family members by identifying concerns, teaching patient care, modifying behavior, and encouraging patient care participation. These strategies allowed the psychiatric nurses to promote readiness to care for the patient by the family members of persons with schizophrenia.

The fourth stage was supporting. Psychiatric nurses used this stage to support the family members by providing resources, forming networks, providing

consultation, and offering help. Theses strategies allowed the psychiatric nurses to support the family members in caring for and supporting persons with schizophrenia so that they could live with their family and in society. While supporting the family members, the psychiatric nurses could return to the use of the stages of strengthening connections, or promoting readiness to care for the patient, or return to establishing trust in order to help the family members care for persons with schizophrenia.

Facilitating living with persons with schizophrenia is a core category which was performed through the psychiatric nurses' experience in helping family members of the persons with schizophrenia. Establishing trust was the first stage that psychiatric nurses used with family members of persons with schizophrenia. The strategies of strengthening connections, promoting readiness to care for the patient, and support were also employed with the family members. The psychiatric nurses could return to employ establishing trust again if the family members were seen to not trust them until the family members accepted their patients returning to their families and living together in the community. Thus, the end point of this process is that the family members were able to care for and support their patients and live together in the community.

5.2 Discussion of the findings

Schizophrenia is a major mental illness. The literature has identified many consequences of schizophrenia, to individuals, families, and/or the community. It has been found that family members that have relatives with schizophrenia perceive burdens arising from providing care (Conn, 2003; Jungbauer, Wittmund, Dietrich & Angermeyer, 2004). A number of studies have recommended that psychiatric nurses

need to help the family members deal with their relatives (Tsang, Pearson & Yuen, 2002; Boyd, 2005; Herz & Marder, 2002).

Thailand, however, has not developed its own theories and concepts on this relationship in terms of the process of helping family members of persons with schizophrenia. This study, consequently, was aimed at exploring the relationship between psychiatric nurses and family members of persons with schizophrenia. The relationship in this study refers to the process of helping psychiatric nurses assist these family members while providing care and helping the families and persons with schizophrenia in terms of health and well-being. The researcher interviewed psychiatric nurses working at in-patient wards in psychiatric hospitals in Thailand who truly experienced the significance of the role that family members play in dealing with persons with schizophrenia. All of the participants had experience in caring for persons with schizophrenia and in helping the family members in this regard.

The constant comparative analysis in this study helped the researcher to discover substantive knowledge in the relationship model, which is here termed "Facilitating living with persons with schizophrenia," In Thai it is called "Karn Song Serm Karn Chai Chee Vit Reum Kap Poo Peauy Jitapet": this was derived from the description of the participants. This finding can explain how the psychiatric nurses employed strategies to help the family members to care for and support persons with schizophrenia. This finding also suggests a guideline so that psychiatric nurses can assist the families and enhance the well-being of persons with schizophrenia. Thus, this finding can be considered a helping process that psychiatric nurses can employ with the family members in caring for their patients.

The experiences of the sixteen participants in this study demonstrated the complexity of the process of facilitating living with persons with schizophrenia. The

study revealed that the psychiatric nurses not only provided care for persons with schizophrenia, but they also played a great role in helping the family members to be able to care for and support the persons living with the schizophrenic patients. The psychiatric nurse, therefore, tried to help the family members by establishing trust, strengthening connections, promoting readiness to care for the patient, and by supporting them, all of which had a strong effect on caring for persons with schizophrenia. Thus, this process of facilitating was performed to help the family members to be able to care for and support their patients.

The model of facilitating living with persons with schizophrenia is consistent with other empirical studies that focused on dealing with family members of people with seriously mental illness such as schizophrenia in some part of the findings (Boggs, 2003; Donovan & Dupuis, 2000; Herz & Marder, 2002). Especially, as Herz and Marder (2000) state that more recent studies have focused on the family of the patient because the family is recognized as important in the patient's environment, which can support the patients' recovery. Therefore, approaches were developed to assist families that have included strategies of improving interactions between patients and family members, providing support for families who are suffering with a burden while giving care for the patients, and educational programs that improve the families' understanding of schizophrenia and its treatments. These empirical findings are congruent with the model of "facilitating living" in terms of the categories of strengthening connections, promoting readiness to care, and supporting the patient.

In terms of "facilitating living" and "assisting families" it is recognized that they are a similar concept is that focused on helping the families while providing care for the persons with schizophrenia. The part of strengthening connection developed in this study is congruent with the strategy of improving interactions between patients

and family members in the study of Herz and Marder (2002). The strengthening connection was the strategy where the psychiatric nurses tried to adjust and improve connections between the family members and their patients and with nurses. As Herz and Marder (2002) proposed in their study that there is a strategy of assisting families by improving interaction between patients and family members, which is focused on improving the emotional climate in the families of patients with schizophrenia. For the promoting readiness to care for the patient is similar to a strategy in assisting families through educational programs, which are focused on improving the families' understanding of schizophrenia and its treatments. However, in this study, the promoting readiness to care is focused on improving the attitude of the family members because the family members' readiness to care for the patient should include both having psychological readiness and practical readiness. The psychiatric nurses tried to improve family members' attitude as well as promoting readiness to care for the patient. Another strategy in this study that is the strategy of supporting, which is congruent with the strategy of providing support for the family members as well.

This study revealed four stages of facilitating living with persons with schizophrenia, developed from the psychiatric nurses' experience which combined their knowledge and skills in helping the family members of persons with schizophrenia. The first stage of facilitating shows that psychiatric nurses tried to establish trust with the family members so that they could be comfortable before talking about problems, and needs while providing care for persons with schizophrenia. This stage was recognized as the basic stage for helping the family members. As Arnold and Boggs (2007) stated, "trust is the foundation in all relationships and the key to establishing a workable relationship." The data in the study supports that establishing a trust strategy that was used with family members of

persons with schizophrenia in the first stage is a good strategy for helping the family members throughout the process.

In this study the psychiatric nurses demonstrated that at the first meeting. They needed to established trust with the family members because the psychiatric nurses and family members had a detached relationship. The family members did not want to share their problems or concerns while caring for the patients because they felt guilty and embarrassed about the patients having abnormal symptoms. They were also afraid of asking about or communicating their true concerns with the psychiatric nurses. The psychiatric nurses and family members looked like strangers to each other. The family members did not understand the illness, the patient's behaviors, or how to care for them. The family members also felt unsure about whether the psychiatric nurses would be able to help them and that they might admit the patients to the hospital if they spoke the truth about the family's concerns/problems. At the same time, on the first approach, the psychiatric nurses did not understand what the family's true concerns were, what had happened within the family and what the family's limitations and needs were in caring for the patients. These relationships between the psychiatric nurses and family members could be considered distant.

Another reason why the family members did not ask about or tell the truth about their problems was that in Thai culture, respect is shown to persons that are older and have more knowledge (Sirilai, 2008). The clients often have perception of the healthcare providers as persons who have more authority than themselves. Therefore the family members might be afraid of asking or sharing their concerns/problems if the healthcare providers did not ask them. They were also afraid of the nurses not admitting the patients to the hospital. If not, a consequence was that the family members had to take the patient home and provide care for them

themselves. They would then have to encounter difficulties in caring for and supporting the persons with schizophrenia again. Theses findings illustrate the idea that family members sometimes mistrust psychiatric nurses, and mistrust can lead to negative communication and negative impacts regarding the processes and outcomes of healing (Boggs, 2003).

Nurses have beliefs, patterns, attitudes, needs, and values like any other people with clients. If nurses have self-awareness while providing help for their clients, the nurses will understand others. The nurses also can select a pattern of interaction with others (Sirilai, 2008). In this study, the psychiatric nurses tried to establish trust with the family members by becoming familiar with them, showing respect, engaging in small talk, prolonging engagement, communicating understanding, and ensuring good care and the patient's safety during meetings with family members. These strategies were performed to make the psychiatric nurses and the family members trust each other. These findings are consistent with Boggs (2003) and Sirilai (2008), who state that trust can make people self-disclose and ask for help which can be useful to the nurses. As in other studies (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000; Friendemann, Montgomery, Maiberger & Smith, 1997), the present studies illustrate the idea that staff had attended to family members, such as always greeting to family members with saying "hello", knowing the family members by name, and agreeing to help them and this made the family members appreciate the staff. That means that trust also allowed the psychiatric nurses leading the family members to move on to other states of facilitating living with persons with schizophrenia.

In addition, this substantial theory revealed the strengthening connections was a strategy of helping family members of persons with schizophrenia. This stage indicates that psychiatric nurses tried to increase the connection between family

members and their patients and with nurses by increasing the understanding and promoting re-acquaintance with the patients. These strategies were performed because the psychiatric nurses assessed that the family members did not want to take the patients home, did not understand why the nurses cared for the patient that was not better, and paid less attention in visiting patient. They also did not want to encounter stress and difficulties in caring for the patients again. For this reason, the psychiatric nurses tried to make the family members understand the patients and their illness. These findings are congruent with the study of Herz and Marder (2000) who state that the strategy of improving interaction between patients and family members was used to improve the emotional climate in the families of patients with schizophrenia. This strategy helped the families have positive feelings with patients.

Furthermore, promoting readiness to care was used to improve family members' ability in caring for and supporting persons with schizophrenia as well. Strategies for promoting readiness to care for the patient included improving attitude and promoting ability. For the part of improving attitude of the family members, the psychiatric nurses tried to improve the family members' attitude. This strategy allowed the family members and patients to have a positive attitude, and to be loving and to bond with each other, thus leading to living together. The positive attitude, being loved, and the bonding of the family members toward their patients were thought to create an alignment of caring toward persons with schizophrenia on the part of the family members. Similarly, these findings are consistent with Watson's perspective, that the relationship between love and caring can create an opening and access for healing of self and others. Love is also considered as the greatest source of all healing in the world (Watson, 2008). The findings in this study reflected that the psychiatric nurses realized that by improving attitude and increasing love and bonding

between family members and patients the family members would care for and support their patients.

The psychiatric nurses also perceived that family members of persons with schizophrenia had concerns in caring for their patients because of a lack of understanding and ability about caring for persons with schizophrenia. For this reason, the psychiatric nurses encouraged the family members to identify the family's concerns. This means that the psychiatric nurses tried to understand the family members' situations by directly asking them questions, by actively listening, through continual observation, and encouraging asking. Also, Austin (2001) and Austin, Bergum & Dossetor (2003) proposed their ideas that health professionals need to understand the clients' condition, perspective, and vulnerability. This understanding of health professionals indicates that they have ethical and professional practice while providing helps for the family members directly and effectively. The psychiatric nurses also taught patient care strategies, modifying behavior, and encouraging participation in caring for the persons with schizophrenia and in this way the family members became comfortable and better understood how to deal with their patients. Like previous studies that illustrated the notion that nursing staff should provide important information about care giving to patients with relatives, so that the relatives will be able to deal with difficult problems. Therefore, the relatives developed good and strong relationships with the nursing staff (Gladstone & Wexler, 2000; Donovan & Dupuis, 2000).

Moreover, supporting family members was an important means of facilitating living with persons with schizophrenia. Psychiatric nurses used strategies to support the family members by proving resources, forming networks, providing consultation, and offering help. These strategies helped the family members to have more

opportunities to engage resources for giving care to their patients, such as asking for help in dealing with the problems. These findings indicate that the psychiatric nurses paid more attention to the environment surrounding families, including the healthcare system, and the society and the community. The psychiatric nurses tried to create an interdependent environment among the family members while providing care for their patients. Bergum (2004) states as well that supportive environment not only help a person who vulnerable to cope better, but also increases their ability to relate to other people. That means that these findings revealed that the family members were given freedom in making their own decisions through the psychiatric nurses' support in order to be good care givers for the persons with schizophrenia.

In addition, the findings show that psychiatric nurses have a duty to provide information about resources so that family members can make informed choices about caring for and supporting their patients. Along these lines, Bergum and Dossetor (2005) stated that in the notion of relational ethics, healthcare providers have a responsibility to give adequate information about the environment as resources to clients and families so that the clients and families can make good choices. Then, the choices were informed by the healthcare providers to the clients and their families. The healthcare providers provided freedom to the family members in decision making about the choices.

5.3 Strengths of the study

The strengths of the study required the researcher to present the research process to display its reliability and completeness. In this study, the researcher collected data through various techniques, including in-depth interviews, observation,

and field notes, which took place in the hospital environment and provided the obtained data. A good relationship between the researcher and the participants helped to create openness regarding the participants' experiences. The researcher developed concepts that emerged under the supervision of the dissertation advisors. Heterogeneous samplings were performed to seek variations in the information in order to increase the application of the study. Heterogeneous samplings were carried out by searching for personal information about the participants and their experiences in working with family members of persons with schizophrenia. There were differences in age, sex, and experience in working with the family members. The interviews took about 45-60 minutes, and the participants described both rich and dense information.

5.4 Contribution the findings to nursing practice

The specification of basic social processes from the viewpoint of psychiatric nurses can assist in developing a greater understanding of the complex nurse-family relationship within the context of hospitalization. The findings of this study have shown that the relationship between psychiatric nurses and family members of persons with schizophrenia are very important in caring for persons with schizophrenia. This relationship reflects the process of facilitating living with persons with schizophrenia. This process is very powerful as a guideline so that the psychiatric nurses can help the family members of persons with schizophrenia, which often have complicated problems, living with persons with schizophrenia. Most importantly is that the family members can give care for and support persons with schizophrenia so that they can live with their families in the community. The

psychiatric nurses are capable of having a better understanding of family members' difficulties and needs, and can provide direct information and suggestions to assist the family members in living with persons with schizophrenia.

The process of facilitating living with persons with schizophrenia could be a guideline for psychiatric nurses to help the family members be able to care for and support persons with schizophrenia to live with their family. Meaning that psychiatric nurses can apply the process of facilitating living with persons with schizophrenia to helping family members to be able to care for persons with schizophrenia by establishing trust with the family members before strengthening connections, promoting readiness to care, and supporting the family members in living with the patients in the family.

Not only can psychiatric nurses use the substantial theory for helping family members of persons with schizophrenia, but also other healthcare providers who are dealing with family members can employ this model in helping family members. Establishing trust was an important strategy to make the family members comfortable in sharing their problems or concerns in caring for the patients. After the family members develop trust for the healthcare providers, the healthcare providers can move on to another state, for example strengthening connections. The strengthening of connections with the patient and with nurses can help the healthcare providers perform the strengthening connection between family members and persons with schizophrenia as well as between the family members and psychiatric nurses. Promoting readiness to care also was used to improve the family members' attitude and the ability to care for the patient of the family members. Then, the healthcare providers can support the family members by providing resources, forming networks,

providing consultation, and offering help. This process can help the healthcare provider assist family members in living with their patients.

5.5 Implications for mental healthcare policy

Mental healthcare policy could develop a specific section that focuses on the promotion of relationships in terms of helping psychiatric nurses or other mental health professionals deal with family members of psychiatric patients. These psychiatric nurses or other mental health professionals may develop a relationship with family members of the patients, where these relationships can be a vehicle for helping family members live with their patients in the community.

5.6 Implications for education policy

Nursing education could possibly include content about facilitating living with persons with schizophrenia: relationship between nurses and family members in the curriculum in order to increase understanding and to emphasize relationship with family members of students. The model of facilitating living with persons with schizophrenia can be a guideline for nurses in helping family members of patients

5.7 Suggestions for future research

In this study a number of research recommendations arose for further research. The recommendations for further studies based on findings of this study presented as follows.

5.7.1. The “facilitating living with persons with schizophrenia” emerged in this study. It should be refined with theory-testing methods with a large population. In addition, the relationships among concepts that emerged in this model needed to be identified.

5.7.2 The findings in this study illustrate that the psychiatric nurses had coordinated with the community mental health nurses who could help the family members and patients in community. The relationship between community mental health nurses and family members is interesting as well. This study recommends that other settings, such as in community, should be explored concerning the relationships between psychiatric nurses in the community and family members.

5.7.3. The findings in this study indicated that family members of persons with schizophrenia had opportunities to contact and ask for help with other healthcare professionals, such as social workers, physicians, and occupational therapists. These healthcare professionals have opportunities to work with the family members of persons with schizophrenia. They may have relationships with family members of different types. Then, the relationship between these healthcare professionals with family members should be studied.

5.7.4. This study revealed that the psychiatric nurses used strategies for helping the family members to be able to care for their patients. To confirm that the psychiatric nurses are helping, the family members’ perspective on their relationships with psychiatric nurses should be studied.

5.7.5. This study explored the relationship between psychiatric nurses and family members of persons with schizophrenia. The findings of this study indicated that the psychiatric nurses used various strategies to help the family members to be able to care for the persons with schizophrenia. It would be interesting to see in the

family members of patients with other disorders, how the psychiatric nurses should support or help. Relationship between psychiatric nurses and family members of persons with depression, persons with bipolar disorder, and other psychotic diseases should be studied in order to determine whether the patients' symptoms are related to the relationship between psychiatric nurses and family members.

5.7.6. To test the theory with quantitative methodology, the measurement of various categories in this study should be developed, such as "facilitating living with persons with schizophrenia", "establishing trust" "strengthening connections," promoting readiness to care for the patients," and "supporting." The sub-categories and codes of these categories may be a guideline for developing the measurement.

5.7.7. According to the inclusion criteria of psychiatric nurses, this study focused on exploring the psychiatric nurses who have a length of employment more than ten years. Psychiatric nurses who have been working in a psychiatric hospital less than 10 years should be studied for how their relationships with family members are. Those psychiatric nurses should also have experience working with family members of persons with schizophrenia.

These suggestions will be useful for researchers that are interested in doing further research related to the relationships between health professionals and family members of patients.

5.8 Limitations of the study

The researcher makes no claims about the generalization of the findings, but the findings of this study provide the process of facilitating living with persons with schizophrenia that may be a guideline for psychiatric nurses in working with family

members of patients. However, the limitations of this grounded theory study are as follows:

First, the findings are limited by the research participants, sample size, and setting. The findings in this study are limited also by the fact that the participants were 16 psychiatric nurses working at only psychiatric hospitals in the central part of Thailand. The results may not transfer to psychiatric nurses working in the community.

Second, according to the objective of the study, it is aimed at exploring the substantive theory of the relationship between psychiatric nurses and family members of persons with schizophrenia in terms of the process of helping psychiatric nurses employed with family members. Thus, the findings of the study reflect the substantive theory of the relationship only in the psychiatric nurses' perspectives. Therefore, the findings may not imply the meaning of the relationship occurring in both perspectives. For further research, the idea of exploring family members of persons with schizophrenia should be extended.

5.9 Summary

These research findings could increase our understanding of the relationship in terms of the process of helping family members of persons with schizophrenia. The substantive knowledge developed in this study's concerned with the process of helping psychiatric nurses help family members to live with persons with schizophrenia during hospitalization. The major role of psychiatric nurses in this study was that the psychiatric nurses should establish trust with the family members before performing the three major nursing interventions of strengthening connections, promoting readiness to care, and supporting them. Although these findings are limited

to psychiatric nurses working at in-patient wards, the findings can contribute to ongoing development and understanding in the meaning of the relationships between psychiatric nurses and family members of persons with schizophrenia, as well as the significance to the organization of psychiatric care. The nurses within the healthcare team in a psychiatric context have to be flexible, providing both in-patient and out-patient care for persons with schizophrenia and their family members. These findings may be a guideline for psychiatric nurses to help family members live with persons with schizophrenia.

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APPENDIX

APPENDIX A

Interview Guideline

Interview Guideline

(English version)

The in-depth interview process in this study consists of three stages that are described as follows:

The first state begins with a dialogue

The researcher introduces herself to the participants. In addition, the researcher will talk and ask the participants about general topics in order to become familiar with the participants before asking the grand tour question. The researcher also explains about taking time, the purpose of the study, and the process of the in-depth interview as well as participants' rights while being interviewed.

The second stages is interviewing

During this state/stage, the researcher asks the participants a grand tour question and then uses probe questions and encourages questions in order to explore the psychiatric nurses' experiences, as follows:

1. A grand tour question:

1.1 Tell me about your experience working with family members of persons with schizophrenia (you can talk about your work with each family member that is related to you).

2. Probe questions:

2.1 How did you help family members of persons with schizophrenia?

2.2 What are ways you used to contact the family members?

2.3 How did you deal with situations/conditions while helping the family members?

2.4 How did you coordinate with healthcare teams to help the family members?

2.5 How did you evaluate your working with the family members?

2.6 How did you feel about the family members?

3. Encouraging questions:

3.1 Please give me more information…… (issues that you want to understand)

3.2 What do you mean? You mean that…….

3.3 What is it?

3.4 How did deal with the problem?

3.5 In that situation, "What did you think about that? What should you do?"

The third stage is closing the dialogue

Before closing the dialogue, the researcher will provide time for the participants to ask questions or talk about something that they wanted to discuss in more detail. The researcher used the following questions:

1. What do you want to say more about working with family members?
2. Do you have any questions?
3. If the participants don't have any questions, the researcher will ask about the participants' demographic data, as follows:

3.1 How old are you? 3.2 What your highest grade level?

3.3 What was your major? 3.4 What is your marital status?

3.5 How long have you worked in this hospital?

After interviewing, the researcher will summarize the interview and say thank you to the participants for participating in the study. The researcher may make an appointment with the participants if the researcher wants to get more detailed information.

Demographic Data Form

Participant number……

Sex……age……years

Marital status……position……

Educational background……

Length of employment…….

Field Note Form

Number of the participant…….

Interviewing number…….Date…….Time……

Place of interview …...…….

Thoughts, feelings, situations, problems and barriers, and problems solving

……

……

……

……

……

……

……

……

……

……

Next appointment Date……..Time……

Place……..

Report date……

Time……

Interviewing Report

The participant number……Date……

Dialogue	Open coding
1 2 3 4 5 6 7 8 9 10	

แนวทางการสัมภาษณ์

(Thai version)

การสัมภาษณ์เชิงลึกในการศึกษาครั้งนี้ ประกอบด้วย 3 ขั้นตอน ดังนี้

1. ขั้นเริ่มสนทนา

ผู้วิจัยจะแนะนำตัวเองกับผู้ให้ข้อมูล พูดคุยและซักถามเรื่องทั่วไป เพื่อเป็นการสร้างสัมพันธภาพและความรู้สึกที่ดีกับผู้ให้ข้อมูลก่อนการซักถามเพื่อเข้าสู่ประเด็นหลัก พร้อมทั้งอธิบายระยะเวลาและเป้าหมายการสัมภาษณ์ กระบวนการสัมภาษณ์และสิทธิของผู้ให้ข้อมูล

2. ขั้นเข้าสู่ประเด็นที่ต้องการศึกษา

ในขั้นตอนของการสัมภาษณ์เชิงลึกเพื่อเข้าสู่ประเด็นที่ต้องการศึกษา ประกอบด้วยแนวคำถามที่เป็นแนวคำถามหลัก คำถามเจาะลึกและคำถามกระตุ้น ดังนี้

<u>คำถามหลัก</u>

ช่วยเล่าประสบการณ์การทำงานที่เกี่ยวข้องกับสมาชิกครอบครัวของผู้ป่วยจิตเภท ให้ฟังได้ไหมคะ ว่าเป็นอย่างไรบ้าง (เล่าถึงสมาชิกครอบครัว(ญาติ) รายใดรายหนึ่ง)

<u>คำถามเจาะลึก</u>

1. ท่านให้การช่วยเหลือสมาชิกครอบครัว ของผู้ป่วยจิตเภทรายนี้
2. ท่านมีวิธีการติดต่อ สมาชิกครอบครัวของผู้ป่วยจิตเภทรายนี้ อย่างไรบ้าง
3. ท่านได้จัดการกับสถานการณ์ที่เกิดขึ้นกับสมาชิกครอบครัวของผู้ป่วยจิตเภทรายนี้ อย่างไรบ้าง
4. ท่านประสานงานกับทีมสุขภาพ เพื่อให้การช่วยเหลือญาติรายนี้อย่างไร
5. ท่านมีการประเมินผลการทำงาน เพื่อให้การช่วยเหลือสมาชิกครอบครัวรายนี้อย่างไรบ้าง ผลเป็นอย่างไร
6. ท่านรู้สึกอย่างไรกับญาติผู้ป่วยรายนี้

<u>คำถามกระตุ้น</u>

1. ช่วยกรุณาเล่าเพิ่มเติมเกี่ยวกับ.....(ประเด็นที่ต้องการ)
2. ท่านหมายความว่าอย่างไรคะ
3. ที่ท่านเล่าหมายถึง.....ใช่ไหมคะ
4. เพราะเหตุใดคะ
5. ท่านมีวิธีการเผชิญกับเหตุการณ์นั้นอย่างไร

6. ในเหตุการณ์นั้น ท่านคิดว่า ท่านควรจะทำย่างไร

3. ขั้นปิดการสนทนา

ก่อนปิดการสัมภาษณ์ผู้วิจัยเปิดโอกาสให้ผู้ให้ข้อมูลได้ซักถามหรือกล่าวในสิ่งที่ต้องการพูดเพิ่มเติม ผู้วิจัยมีแนวคำถาม ดังนี้

1. ท่านมีอะไรจะพูดอีกหรือไม่เกี่ยวกับสัมพันธภาพที่เกิดขึ้น ที่ท่านยังไม่ได้เล่าหรืออยากเล่าเพิ่มเติม

2. ท่านต้องการจะซักถามผู้วิจัยหรือไม่ ท่านสามารถพูดได้ตามความรู้สึก นึกคิดของท่าน

3. ถ้าผู้ให้ข้อมูลไม่มีข้อซักถามใดๆ ผู้วิจัยจะถามข้อมูลส่วนบุคคล ดังนี้

3.1 ขณะนี้ท่านอายุเท่าไร

3.2. การศึกษาสูงสุดของท่านอยู่ในระดับใด

3.3 สถานภาพสมรสของท่านคืออะไร

3.4. ท่านทำงานมานานเพียงใด

หลังจากนั้นผู้วิจัยกล่าวสรุปการสัมภาษณ์และกล่าวขอบคุณผู้ให้ข้อมูลและอาจมีการนัดหมายอีกครั้งถ้าจำเป็น

แบบบันทึกข้อมูลส่วนบุคคล

หมายเลขผู้ให้ข้อมูล.....

เพศ.....อายุ.....ปี

สถานภาพ.....ตำแหน่ง.....

ระดับการศึกษา.....

ระยะเวลาในการทำงาน

.....

แบบบันทึกภาคสนาม

หมายเลขผู้ให้ข้อมูล.....

การสัมภาษณ์ครั้งที่.....ลงวันที่.....เวลา.....

สถานที่

.....

ความคิด ความรู้สึก เหตการณ์ ปัญหาและอุปสรรค การแก้ไขปัญหา

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นัดหมายการสัมภาษณ์ครั้งต่อไป วันที่.....เวลา.....สถานที่

.....

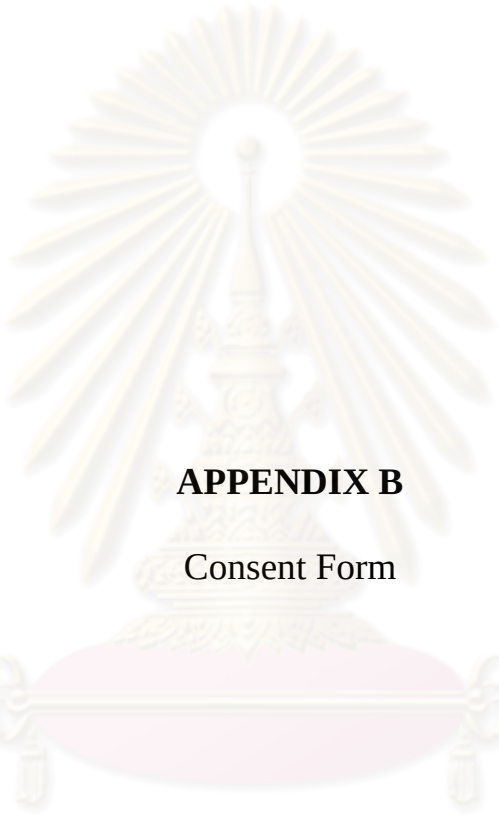
บันทึกเมื่อวันที่.....

เวลาบันทึก.....

บันทึกการสัมภาษณ์

ผู้ให้ข้อมูล รายที่.....**……**วันที่.....เดือน.....พ.ศ.....

บทสนทนา	Open coding
1. R (Researcher): 2. I (Informant): 3. 4. 5. 6 7 8 9 10 11 12 13 14 15	



APPENDIX B

Consent Form

Participant Information Sheet

(English version)

1. **Project title**: Facilitating living with persons with schizophrenia: Relationships between psychiatric nurses and family members
2. **Principal investigator**: Mrs. Ratchaneekorn Kertchok
   Position: Doctoral student, Faculty of Nursing, Chulalongkorn University
3. **Contact address:** Faculty of Nursing, Chulalongkorn University
   Telephone number: office Tel. 02-2189826 Mobile phone: 083-7855517 Email address: Kratchanee @ yahoo.com
4. **Information for participants to make an informed decision on their participation in this study**

4.1 Reasons and need for the study

This project involves the study of the relationships between psychiatric nurses and family members of persons with schizophrenia. Schizophrenia is a major mental illness that can cause serious impairment of a person's day-to-day functioning. This means that families must give a great deal of support to their ill family members. Nurses also have a role in supporting families in such caring. The nurse-family member relationship and the establishment of a partnership of care based on a sound, interpersonal relationship requires special analysis. There is a need to generate and explore a model of this relationship.

4.2 The purpose of the study is to explore the relationship between psychiatric nurses and family members of persons with schizophrenia.

4.3 This project is a qualitative study using a qualitative research method and grounded theory to capture the nurses' perspectives. In-depth interviews will be used to explore the relationship between psychiatric nurses and family members of persons with schizophrenia.

4.4 The participants in this study were interviewed 1-2 times. Each interview took 45-60 minutes.

4.5 The expected benefits from this study may not relate to the participants directly. However, the findings of the study represent important information for developing psychiatric nursing systems effectively. Psychiatric nurses that are working in inpatient wards and other nurses working in community hospitals and other medical centers will have a model of the relationship for dealing with family

members and for supporting the family members' health and well-being. In addition, the findings will provide suggestions for further research into related variables concerning the relationships between nurses and family members.

4.6 No harm will come to any of the participants in this study. If any questions make the participants feel upset, the participants do no have to answer these questions. All data will be coded. Everything that the participants say will be held confidential. The researcher will not use the individual's real name in the written report. If the name of anyone is mentioned in the report, it will be deleted. Written copies and tapes will be kept in a locked cabinet in a locked house.

4.7 In order to prevent any harm or risk from this study for the participants, the consent form will inform the participants that if they want to withdrawal from the study, they can do so at any time without informing the researcher of the reasons. The participants' rejection will not affect the participants' work.

4.8 During the interviewing, the participants can ask questions about the research process.

4.9 The researcher will make an appointment before interviewing so that the participants can take their time in making the decision to participate in the study or not. The researcher will call the participants to confirm their decision.

4.10 If the researcher obtains information about potential benefits and harm or risk from the study, the researcher will inform the participants immediately.

4.11 The findings of the study will be summarized as a whole and not specific to each participant. The obtained data will be kept confidential except in the case where the participants agree to present it. The data will be destroyed after the research findings are published.

4.12 There are expected to be approximated 15-20 participants in this study.

4.13 In case the participants have encountered negative feelings from the interviewing, the researcher will do the following:

1) Stop the interview and support the participants or

2) Coordinate with a psychologist to support the participants or

3) Coordinate with a psychiatrist to care for the participants

4.14 The participants can contact the researcher at any time if they so desire by calling Mrs. Ratchaneekorn Kertchok, Tel. 083-7855517, or the dissertation advisor: Assoc. Prof. Dr. Jintana Yunibhand, Tel. 02-2189828.

Informed Consent Form

(English version)

Project Title: Facilitating living with persons with schizophrenia: Relationships between psychiatric nurses and family members

Date …….....

Before signing my name on this consent form to participate in the study, I was given information about the purpose of the study, the methodology used, and the potential harm or risks that might occur from the study. In addition, I was clearly informed of the benefits of the study and understand them.

The researcher welcomes any questions without exception.

I am glad to participate in this study. I have a right to withdrawal from the study without telling the reasons at any time if I want. In addition, if I cancel my participation in this study, I will not receive any negative consequences.

The researcher confirms that the obtained data from the interviewing will be held confidential. This obtained data will be presented only to the research committee, which supports and controls the research process. The findings of the study will be presented in summary form.

I have read the information above and I understand all of the information discussed. Below I sign my name in consent to participate in this study**.**

Signature……..Participant

Signature……..Researcher

Signature…… Witness

ข้อมูลสำหรับประชากรตัวอย่างหรือผู้มีส่วนร่วมในการวิจัย
(Patient/Participant Information Sheet)

(Thai version)

1. ชื่อเรื่อง การส่งเสริมการใช้ชีวิตร่วมกับผู้ป่วยจิตเภท: สัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกในครอบครัว

2. ชื่อผู้วิจัย รัชนีกร เกิดโชค

ตำแหน่ง นิสิตปริญญาเอก คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย

3. สถานที่ปฏิบัติงาน

คณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
เบอร์โทรติดต่อที่บ้าน (02) 906-5526 โทรศัพท์เคลื่อนที่ 083-785-5517
E-mail: Toysnc@yahoo.com, Kratchanee@yahoo.com

4. เนื้อหาสาระของโครงการและความเกี่ยวข้องของอาสาสมัคร ได้แก่

4.1 เหตุผลและความจำเป็นที่ต้องศึกษาวิจัย

โครงการวิจัยนี้ศึกษาสัมพันธภาพที่เกิดขึ้นระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท โรคจิตเภทเป็นภาวะการเจ็บป่วยทางจิตที่เป็นสาเหตุสำคัญของความบกพร่องในการทำหน้าที่ในชีวิตประจำวันของบุคคล ซึ่งหลายครอบครัวต้องให้การดูแลเอาใจใส่และสนับสนุนในการบำบัดรักษาสมาชิกที่เจ็บป่วยด้วยโรคจิตเภทนั้นอย่างหลีกเลี่ยงไม่ได้ พยาบาลเป็นบุคคลหนึ่งที่จะมีส่วนในการสนับสนุนและช่วยเหลือสมาชิกครอบครัวในการทำหน้าที่ดูแลผู้ป่วยจิตเภทที่บ้าน ดังนั้นจึงมีความจำเป็นอย่างยิ่งที่พยาบาลจิตเวชจะต้องมีความเข้าใจอย่างลึกซึ้งในกระบวนการของความช่วยเหลือที่เกิดขึ้นระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท และเพื่อค้นหาสัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกครอบครัว อันจะนำไปสู่การค้นหาวิธีการที่จะสนับสนุนและส่งเสริมสัมพันธภาพนั้นให้ดียิ่งขึ้น ซึ่งจะนำไปสู่การดูแลผู้ป่วยจิตเภทที่มีประสิทธิภาพต่อไป

4.2 วัตถุประสงค์ของการวิจัยเพื่อศึกษาสัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวผู้ป่วยจิตเภท

4.3 โครงการวิจัยนี้ เป็นการวิจัยเชิงคุณภาพโดยวิธีการศึกษาทฤษฎีพื้นฐาน ซึ่งเป็นวิธีการศึกษาเพื่อค้นหาความเข้าใจสถานการณ์ทางการพยาบาลที่ต้องการศึกษา และเพื่อสร้างรูปแบบของแนวคิดที่เกิดขึ้นจากการศึกษา ในงานวิจัยนี้จะใช้วิธีการเก็บรวบรวมข้อมูลด้วยวิธีการสัมภาษณ์เชิงลึก

4.4 ระยะเวลาที่อาสาสมัครต้องเกี่ยวข้องในการศึกษาวิจัยนี้ ประมาณ 1-2 ครั้งของการสัมภาษณ์เชิงลึก โดยแต่ละครั้งของการสัมภาษณ์จะใช้เวลาประมาณ 45-60 นาที

4.5 ประโยชน์ที่คาดว่าจะเกิดขึ้นจากโครงการวิจัยนี้ อาจจะไม่เกิดขึ้นโดยตรงต่ออาสาสมัคร แต่อย่างไรก็ตามงานวิจัยนี้จะได้รูปแบบหรือทฤษฎีพื้นฐานของสัมพันธภาพที่เกิดขึ้นระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวผู้ป่วยจิตเภท ซึ่งจะเป็นประโยชน์อย่างมากสำหรับพยาบาลจิตเวช นักการศึกษา นักศึกษาพยาบาล และบุคลากรทางด้านสุขภาพอื่นๆที่เกี่ยวข้องในการวางแผนเพื่อที่จะกำหนดวิธีการในการที่จะสร้างและส่งเสริมสัมพันธภาพกับสมาชิกครอบครัวของผู้ป่วยต่อไป อีกทั้งเป็นแนวทางในการวิจัยเกี่ยวกับตัวแปรอื่นที่เกี่ยวข้องกับสัมพันธภาพระหว่างพยาบาลและสมาชิกครอบครัว เพื่อค้นหาวิธีการช่วยเหลือและส่งเสริมสัมพันธภาพที่เกิดขึ้นนั้นให้ดียิ่งขึ้น

4.6 การวิจัยนี้เป็นการวิจัยเชิงคุณภาพ ที่กระทำในพยาบาลจิตเวช โดยที่ผู้วิจัยคาดว่าจะไม่มีความเสี่ยงใดๆเกิดขึ้นกับผู้เข้าร่วมการวิจัย แม้ว่าข้อมูลที่ได้จากการสัมภาษณ์นั้นจะถูกระบุหรือเชื่อมโยงถึงพยาบาลจิตเวชและสมาชิกครอบครัวผู้ป่วยจิตเภทด้วยการเข้ารหัส แถบบันทึกเสียงและเอกสารบันทึกการถอดเทป ข้อมูลเหล่านั้นจะถูกจัดเก็บไว้ในที่ปลอดภัยและมิดชิด โดยแยกจากรหัสที่ใช้แทนชื่อผู้ป่วย

4.7 เพื่อลดและป้องกันความเสี่ยงอันตรายต่อผู้เข้าร่วมการวิจัย ใบยินยอมของผู้มีส่วนร่วมในการทำวิจัยจะระบุไว้ว่าผู้เข้าร่วมการวิจัยสามารถปฏิเสธที่จะเข้าร่วมหรือสามารถถอนตัวจากโครงการวิจัยได้ตลอดเวลา และการปฏิเสธเข้าร่วมการวิจัยในครั้งนี้จะไม่มีผลต่อการปฏิบัติงานของท่านแต่อย่างใด

4.8 ระหว่างการดำเนินการสัมภาษณ์ ผู้ร่วมวิจัยสามารถซักถามหรือปฏิเสธการตอบคำถามได้

4.9 ผู้วิจัยมีการนัดหมายล่วงหน้าก่อนดำเนินการสัมภาษณ์ และเพื่อเปิดโอกาสให้ผู้ร่วมวิจัยตัดสินใจเข้าร่วมหรือปฏิเสธ ผู้วิจัยจะโทรศัพท์เพื่อติดต่อการยืนยันและการตัดสินใจ

4.10 หากผู้วิจัยมีข้อมูลเกี่ยวกับประโยชน์และโทษเกี่ยวกับการวิจัยครั้งนี้ ผู้วิจัยจะแจ้งให้ผู้ร่วมวิจัยทราบทันทีโดยไม่ขัดข้อง

4.11 ผลการวิจัยจะนำเสนอในภาพรวม ส่วนชื่อและที่อยู่ของผู้ร่วมวิจัยจะได้รับการปกปิดอยู่เสมอ ยกเว้นว่าได้รับคำยินยอมไว้ โดยระเบียบและกฎหมายที่เกี่ยวข้องเท่านั้น จึงเปิดเผยต่อสาธารณชนได้ในกรณีที่ผลวิจัยได้รับการตีพิมพ์

4.12 จำนวนผู้เข้าร่วมการวิจัยโดยประมาณ 15-20 คน

4.13 ในกรณีผู้เข้าร่วมวิจัยได้รับผลกระทบด้านจิตใจจากการสัมภาษณ์ ผู้วิจัยจะดำเนินการดังนี้

1) ยุติการสัมภาษณ์และให้การประคับประคองด้านจิตใจ

2) ประสานงานกับนักจิตวิทยาเพื่อประเมินสภาวะจิตใจและวางแผนให้การช่วยเหลือ

3) ประสานงานกับจิตแพทย์เพื่อรับการบำบัดที่เหมาะสม

4.14 การติดต่อกับผู้วิจัยในกรณีที่ผู้ร่วมวิจัยมีปัญหา สามารถติดต่อได้ตลอด 24 ชั่วโมงกับผู้วิจัย คือ รัชนีกร เกิดโชค เบอร์โทรติดต่อ 083-7855517 และรองศาสตราจารย์ ดร.จินตนา ยูนิพันธุ์ อาจารย์ที่ปรึกษาโครงการวิจัย เบอร์โทรติดต่อ 02-2189800

ใบยินยอมด้วยความสมัครใจ
(Informed Consent Form)

(Thai version)

การวิจัยเรื่อง การส่งเสริมการใช้ชีวิตร่วมกับผู้ป่วยจิตเภท: สัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกในครอบครัว

วันให้คำยินยอม วันที่.....เดือน..... พ.ศ. .....

ก่อนที่จะลงนามในใบยินยอมให้ทำการวิจัยนี้ ข้าพเจ้าได้รับการอภิปรายจากผู้วิจัยถึงวัตถุประสงค์ของการวิจัย วิธีการวิจัย อันตรายหรืออาการที่อาจเกิดขึ้นจากการวิจัย รวมทั้งประโยชน์ที่จะเกิดขึ้นจากการวิจัยอย่างละเอียด และมีความเข้าใจดีแล้ว

ผู้วิจัยรับรองว่าจะตอบคำถามต่าง ๆ ที่ข้าพเจ้าสงสัยด้วยความเต็มใจ ไม่ปิดบัง ซ่อนเร้น จนข้าพเจ้าพอใจ

ข้าพเจ้ายินดีเข้าร่วมการวิจัยครั้งนี้ด้วยความสมัครใจ ข้าพเจ้ามีสิทธิที่จะบอกเลิกการเข้าร่วมในโครงการวิจัยนี้เมื่อใดก็ได้ ซึ่งข้าพเจ้าไม่จำเป็นต้องแจ้งเหตุผล และเข้าร่วมโครงการวิจัยนี้โดยสมัครใจ และการบอกเลิกการเข้าร่วมการวิจัยนี้ จะไม่มีผลต่อการปฏิบัติงานของข้าพเจ้าแต่อย่างใด

ผู้วิจัยรับรองว่าจะเก็บข้อมูลเฉพาะเกี่ยวกับตัวข้าพเจ้าเป็นความลับและจะเปิดเผยได้เฉพาะในรูปที่เป็นสรุปผลการวิจัย หรือการเปิดเผยข้อมูลต่อผู้มีหน้าที่ที่เกี่ยวข้องกับการสนับสนุนและกำกับดูแลการวิจัย

ข้าพเจ้าได้อ่านข้อความข้างต้นแล้ว และความเข้าใจดีทุกประการ และได้ลงนามในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม.....ผู้ยินยอม
ลงนาม.....ผู้วิจัย
ลงนาม.....พยาน

APPENDIX C

Approval document of the Ethical Review Committee for Research Involving Human Subject and/or Use of Animal, In Research, Department of Mental health, Ministry of Public Health

เอกสารหมายเลข ๐๙/๒๕๕๐

เอกสารรับรองโครงการวิจัย

โดย

คณะกรรมการพิจารณาการศึกษาวิจัยในคน(ด้านสุขภาพจิตและจิตเวช)

กรมสุขภาพจิต

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คณะกรรมการพิจารณาการศึกษาวิจัยในคน (ด้านสุขภาพจิตและจิตเวช) กรมสุขภาพจิต ขอรับรองว่า

โครงการวิจัยเรื่อง

"สัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท"

ดำเนินการวิจัยโดย

นางรัชนีกร เกิดโชค (ผู้วิจัยหลัก)

ได้ผ่านการพิจารณาแล้ว และเห็นว่าไม่มีการล่วงละเมิดสิทธิ สวัสดิภาพ และไม่ก่อให้เกิดภยันตรายแก่ผู้ถูกวิจัย จึงเห็นสมควรให้ดำเนินการวิจัยในขอบข่ายของโครงการวิจัยที่เสนอได้ ตั้งแต่วันที่ออกหนังสือรับรองฉบับนี้ จนถึงวันที่ ๑๐ กันยายน ๒๕๕๑

หนังสือออกวันที่ ๑๐ กันยายน ๒๕๕๐

(นายแพทย์หม่อมหลวงสมชาย จักรพันธุ์)

ประธานคณะกรรมการพิจารณาการศึกษาวิจัยคน (ด้านสุขภาพจิตและจิตเวช)

กรมสุขภาพจิต

APPENDIX D

Approval document of the Ethical Review Committee
for Research Involving Human Subject and/or Use
of Animal In Research, Srithunya Hospital

บันทึกข้อความ

ส่วนราชการ คณะกรรมการด้านการวิจัยโรงพยาบาลศรีธัญญา ต่อ ๒๑๗๘,๒๗๐๘

ที่ สธ. ๐๔๐๗.๒๐๑/๒๕๓ **วันที่** ๒๖ เมษายน ๒๕๕๐

เรื่อง การแจ้งผลการพิจารณาเก็บข้อมูลเพื่อการวิจัย

เรียน หัวหน้ากลุ่มการพยาบาล

ตามหนังสือเลขที่ ศธ ๐๕๑๒.๑๑ / ๐๔๗๑ ลงวันที่ ๒๖ เมษายน ๒๕๕๐ จากคณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย ได้ขอความอนุเคราะห์ให้ นางรัชนีกร เกิดโชค ซึ่งทำการศึกษาวิจัยเรื่อง สัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท

☑ ซึ่ง ได้ผ่านการพิจารณาจากคณะกรรมการวิจัยในคน ของกระทรวงสาธารณสุขแล้ว

☐ ซึ่ง ไม่ต้องผ่านการอนุมัติการทำวิจัยในคน

บัดนี้ คณะกรรมการด้านการวิจัยโรงพยาบาลศรีธัญญา ขอแจ้งว่าเรื่องของ นางรัชนีกร เกิดโชค ได้ผ่านการพิจารณาจากคณะกรรมการด้านการวิจัยโรงพยาบาลศรีธัญญาแล้ว จึงขอแจ้งผลการพิจารณาดังนี้

☑ อนุญาตให้ดำเนินการเก็บข้อมูลได้ ตั้งแต่วันที่ ๑๖ เมษายน ๒๕๕๐ ถึง ๑๕ เมษายน ๒๕๕๑

☐ อนุญาต แต่มีเงื่อนไขดังนี้.....

☐ ไม่อนุญาต เนื่องจาก.....

ลงนาม.....

แพทย์หญิงอรวรรณ ศิลปกิจ

ประธานคณะกรรมการด้านการวิจัย

โรงพยาบาลศรีธัญญา

วันที่ ๒๖ เมษายน ๒๕๕๐

APPENDIX E

Approval document of the Ethical Review Committee
for Research Involving Human Subject and/or Use
of Animal In Research, Institute of psychiatry
Somdet Chaopraya

ที่ สช ๐๔๐๙/๒๒๗

สถาบันจิตเวชศาสตร์สมเด็จเจ้าพระยา กรมสุขภาพจิต
๑๑๒ ถนนสมเด็จเจ้าพระยา คลองสาน
กรุงเทพฯ ๑๐๖๐๐

๗ มิถุนายน ๒๕๕๐

เรื่อง อนุมัติการเก็บข้อมูลการทำวิจัย

เรียน คณบดีคณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย

อ้างถึง หนังสือ จุฬาลงกรณ์มหาวิทยาลัย ที่ ศธ ๐๕๑๒.๑๑/๑๐๙๔ ลงวันที่ ๑๙ พฤษภาคม ๒๕๕๐

ตามหนังสือที่อ้างถึง ขออนุญาตให้ นางวิชนีกร เกิดไชค นิสิตชั้นปริญญาศุนฎีบัณฑิต ทำการวิจัย เรื่อง " สัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท : การศึกษาทฤษฎีพื้นฐาน " โดยเก็บข้อมูลจาก กลุ่มงานการพยาบาล สถาบันจิตเวชศาสตร์สมเด็จเจ้าพระยา นั้น

สถาบันจิตเวชศาสตร์สมเด็จเจ้าพระยาพิจารณาแล้ว เห็นสมควรอนุญาตให้ดำเนินการวิจัยดังกล่าวได้ และเมื่อดำเนินการวิจัยเสร็จสิ้นแล้วขอให้ส่งผลการวิจัยให้แก่สถาบันจิตเวชศาสตร์สมเด็จเจ้าพระยา จำนวน ๒ เล่ม

จึงเรียนมาเพื่อทราบ

ขอแสดงความนับถือ

(นายบุญชัย นวมงคลวิมนา)
ผู้อำนวยการสถาบันจิตเวชศาสตร์สมเด็จเจ้าพระยา

ศูนย์วิจัยและพัฒนา
โทร. ๐ ๒๔๓๗ ๐๒๐๐ - ๙ ต่อ ๔๒๗๗,๔๒๘๖
โทรสาร. ๐ ๒๔๓๗ ๗๐๕๒

APPENDIX F

Approval document of the Ethical Review Committee
for Research Involving Human Subject
and /or Use of Animal, In Research,
Galya Rajanagarindra Institute

สรุปผลการประชุมโครงการวิจัย
เพื่อพิจารณาอนุญาตให้ นางรัชนีกร เกิดโชค
นักศึกษาหลักสูตรปริญญาดุษฎีนิพนธ์ คณะพยาบาลศาสตร์
จุฬาลงกรณ์มหาวิทยาลัย
ดำเนินการเก็บข้อมูลประกอบการทำวิทยานิพนธ์
เรื่อง สัมพันธภาพระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวของผู้ป่วยจิตเภท
: การศึกษาทฤษฎีพื้นฐาน
ในวันที่ ๑๓ มีนาคม ๒๕๕๑ เวลา ๑๓.๐๐ - ๑๓.๔๐ น.
ณ ห้องประชุมนายแพทย์สุจริต สุวรรณชีพ ตึกอำนวยการ สถาบันกัลยาณ์ราชนครินทร์

ผลการพิจารณา

คณะกรรมการวิจัยของสถาบันกัลยาณ์ราชนครินทร์ มีมติเห็นควรอนุญาตให้นิสิตดังรายนามข้างต้นเข้าดำเนินการเก็บข้อมูลเพื่อประกอบการทำวิทยานิพนธ์ โดยการเก็บข้อมูลจะเก็บจากพยาบาลวิชาชีพที่ทำงานในหอผู้ป่วยในตั้งแต่ ๑๐ ปี ขึ้นไป เป็นพยาบาลที่สำเร็จการศึกษาในระดับพยาบาลศาสตร์มหาบัณฑิตสาขาการพยาบาลสุขภาพจิตและจิตเวชหรืออบรมระยะสั้นเฉพาะทางการพยาบาลสาขาการพยาบาลสุขภาพจิตและจิตเวช จำนวน ๙ คน วิธีการเก็บข้อมูลใช้วิธีการสัมภาษณ์แบบเชิงลึก

เหตุผล

๑. เป็นการศึกษาที่มีประโยชน์ในการสร้างทฤษฎีพื้นฐานของสัมพันธภาพที่เกิดขึ้นระหว่างพยาบาลจิตเวชและสมาชิกครอบครัวผู้ป่วยจิตเภท

๒. มีการพิทักษ์สิทธิผู้เข้าร่วมโครงการเป็นลายลักษณ์อักษร

๓. ผู้ดำเนินการวิจัยได้เข้าร่วมประชุมและรับทราบข้อเสนอแนะจากคณะกรรมการวิจัยของสถาบันกัลยาณ์ราชนครินทร์

ข้อเสนอแนะเพิ่มเติมจากคณะกรรมการวิจัย

๑. กลุ่มตัวอย่างคัดเลือกตามคุณสมบัติที่กำหนดไว้ คือพยาบาลที่ทำงานในหอผู้ป่วยในตั้งแต่ ๑๐ ปีขึ้นไป เป็นพยาบาลที่สำเร็จการศึกษาในระดับมหาบัณฑิตสาขาการพยาบาลสุขภาพจิตและจิตเวช หรืออบรมระยะสั้นเฉพาะทางการพยาบาลสาขาการพยาบาลสุขภาพจิตและจิตเวชการพยาบาล โดยในการสัมภาษณ์เชิงลึกแบ่งพยาบาลที่ผู้วิจัยจะทำการเก็บข้อมูลประกอบด้วยหัวหน้าตึกและพยาบาลระดับปฏิบัติการจำนวน ๔ คน

๒. ผู้ดำเนินการวิจัยทำการสัมภาษณ์พยาบาลวิชาชีพในสถาบันกัลยาณ์ราชนครินทร์ โดยผู้วิจัยจะนัดหมายการสัมภาษณ์กับบุคลากรที่คัดเลือกไว้ โดยมีระยะเวลาการสัมภาษณ์ประมาณ ๔๕-๖๐ นาที

๓.ดำเนินการวิจัยเสร็จสมบูรณ์แล้วขอความร่วมมือส่งงานวิจัยให้สถาบันกัลยาณ์ราชนครินทร์
จำนวน ๓ เล่ม

ลงนามคณะกรรมการวิจัย

(นางสาวอรพรรณ เสนาะ)
คณะกรรมการวิจัย

(นางสาวเพ็ญพรรณ ชิดวร)
คณะกรรมการวิจัย

(นางสาวภาวินี บุตรแสน)
คณะกรรมการวิจัย

(นางสาวอินทิรา อะตะมะ)
คณะกรรมการวิจัย

(แพทย์หญิงวนัทดา ถมค้าพาณิชย์)
ประธานคณะกรรมการวิจัย

ลงนามรับทราบ

(นางรัชนีกร เกิดโชค)
นักศึกษาหลักสูตรปริญญาดุษฎีบัณฑิต คณะพยาบาลศาสตร์
จุฬาลงกรณ์มหาวิทยาลัย

BIOGRAPHY

I am Mrs. Ratchaneekorn Kertchok. I was born on January 5, 1971 in Mukdaharn Province in the northeast part of Thailand. I finished my B.S. (Nursing and Midwifery) at Boromarajonnani Surin Nursing College in 1992-1996, and I worked as an instructor at Boromarajonnani Nakorn Phanom Nursing College from 1996 to 2002.

During 1995-1997, I studied for a master's degree in Mental Health and Psychiatric Nursing in the Faculty of Nursing at Khon-Khaen University.

During 2003-2004, I worked as an instructor at Boromarajonnani Suphanburi Nursing College. From 2004 to the present, I have worked as a faculty member in the Faculty of Nursing at Chulalongkorn University.

In June of 2005, I started my doctoral degree in nursing science in the Faculty of Nursing at Chulalongkorn University and have graduated and recently obtained the Ph.D. in Nursing Science there. After graduation, I returned to work in the Faculty of Nursing at Chulalongkorn University.

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