

**STRESS ,SOCIAL SUPPORT AND COPING OF FAMILIES
AFTER THE DEATH OF AIDS PATIENT**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT
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THE DEGREE OF MASTER OF NURSING SCIENCE
(PSYCHIATRIC – MENTAL HEALTH NURSING)
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Entitled

**STRESS, SOCIAL SUPPORT AND COPING OF FAMILIES
AFTER THE DEATH OF AIDS PATIENT**

Niramon Jitsook

Miss. Niramon Jitsook
Candidate

Atirat Wattanapailin

Asst. Prof. Atirat Wattanapailin,
Ed.D.
Major - Advisor

Chomchuen Somprasert

Asst. Prof. Chomchuen Somprasert, .
Ph.D.
Co- Advisor

Rungnapa Panitrat

Asst. Prof. Rungnapa Panitrat,
Ph.D.
Co- Advisor

Rassmidara Hoonsawat

Assoc. Prof. Rassmidara Hoonsawat,
Ph.D.
Dean
Faculty of Graduate Studies

Kobkul Phanchareonworakul

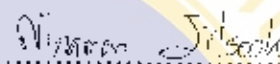
Assoc. Prof. Kobkul Phanchareonworakul,
Ph.D.
Chair
Master of Nursing Science
Faculty of Nursing

Thesis
Entitled

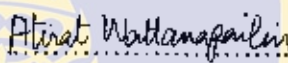
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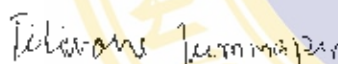
on
20 August, 2003



Miss. Niramom Jitsook
Candidate



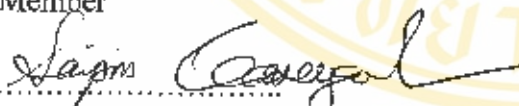
Asst. Prof. Atirat Wattanapailin,
Ed.D
Chair



Assoc. Prof. Titiwone Tummapiroj,
M.Ed.
Member



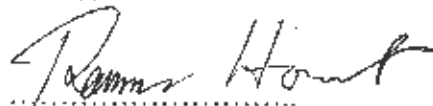
Asst. Prof. Chomchuen Somprasert,
Ph.D.
Member



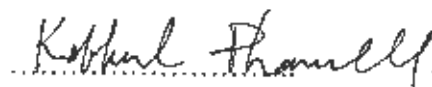
Assoc. Prof. Saipin Gasemgitvatana,
D.N.S.
Member



Asst. Prof. Rungnapa Panitrat,
Ph.D.
Member



Assoc. Prof. Rassmidara Hoonsawat,
Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University



Assoc. Prof. Kobkul Phanchareonworakul,
Ph.D.
Dean
Faculty of Nursing
Mahidol University

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Niramon Jitsook

STRESS, SOCIAL SUPPORT AND COPING OF FAMILIES AFTER THE DEATH OF AIDS PATIENTS

NIRAMON JITSOOK 4237241 NSPS / M

M.N.S. (PSYCHIATRIC- MENTAL HEALTH NURSING)

**THESIS ADVISORS : ATIRAT WATTANAPAILIN, Ed.D,
CHOMCHUEN SOMPRASERT, Ph.D, RUNGNAPA PANITRAT, Ph.D.**

ABSTRACT

The present study was descriptive research aiming at investigating stress, social support and coping of families after the death of AIDS patients. The subjects were 100 family members of deceased AIDS patients living in Pranburi District, Guiburi District, and Samroiord Sub-district in Prachuabkheereekhan Province. The subjects were selected by means of convenience sampling, and data were collected based on the Demographic Characteristic Questionnaire, Stress Causing Situations Questionnaire, Coping Questionnaire, and Social Support Questionnaire. Data were analyzed in terms of percentage, mean, and standard deviation.

The findings revealed that the situations which caused a high level of stress to surviving family members of deceased AIDS patients : were missing the patients, having to be responsible for the surviving children of the patients , losing the leader of the family, and losing hopes and goals in life once shared with the patient. The subjects used more emotion-focused stress coping than problem-focused stress coping. The subjects received a high level of social support from their own family members, but they received a low level of social support from healthcare providers in the community.

Based on these findings, it is recommended that nurses and others involved with the families of AIDS patients should realize the significance of the surviving family members of deceased AIDS patients, especially their children. The mental well-being of the family members needs to be promoted, and they should be taught how to appropriately deal with stress to prevent chronic and abnormally long grieving processes. Also, surviving family members need to learn to benefit from the existing resources available to them so as to enable them to the practice appropriate self-care, leading to mental well-being of individuals, families, and the community at large.

**KEY WORDS : SOCIAL SUPPORT / AIDS / STRESS MANAGEMENT /
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ความเครียด การสนับสนุนทางสังคม และการเผชิญความเครียด ของครอบครัวผู้ป่วยเอดส์ ภายหลังผู้ป่วยเอดส์เสียชีวิต (STRESS , SOCIAL SUPPORT AND COPING OF FAMILIES AFTER THE DEATH OF AIDS PATIENTS)

นิรมล จิตต์สุข 4237241 NSPS / M

พย.ม. (สุขภาพจิตและการพยาบาลจิตเวชศาสตร์)

คณะกรรมการควบคุมวิทยานิพนธ์ : อติรัตน์ วัฒนไพลิน , Ed . D., ชมชื่น สมประเสริฐ , Ph. D., รุ่งนภา พาณิชย์รัตน์ , Ph . D.

บทคัดย่อ

การศึกษานี้เป็นการวิจัยเชิงบรรยายเพื่อศึกษาความเครียด การสนับสนุนทางสังคมและการเผชิญความเครียด ของครอบครัวผู้ป่วยเอดส์ภายหลังผู้ป่วยเอดส์เสียชีวิต กลุ่มตัวอย่าง คือ สมาชิกในครอบครัวผู้ป่วยเอดส์ที่เสียชีวิตแล้วที่เคยให้การดูแลผู้ป่วยเอดส์ในอำเภอปรางบุรี อำเภอกุยบุรี และกิ่งอำเภอสามร้อยยอด จังหวัดประจวบคีรีขันธ์ เป็นการเลือกแบบ Convenience Sampling จำนวน 100 ราย เก็บรวบรวมข้อมูลโดยใช้แบบสัมภาษณ์ตามแบบสอบถามข้อมูลส่วนบุคคล แบบสัมภาษณ์ตามแบบสอบถามสถานการณ์ที่ก่อให้เกิดความเครียด แบบสัมภาษณ์ตามแบบสอบถามการเผชิญความเครียด และแบบสัมภาษณ์ตามแบบสอบถามการสนับสนุนทางสังคม วิเคราะห์ข้อมูลโดยคำนวณร้อยละ ค่าเฉลี่ย และส่วนเบี่ยงเบนมาตรฐาน

ผลการศึกษาพบว่า สมาชิกครอบครัวผู้ป่วยเอดส์ที่เสียชีวิตแล้วพบสถานการณ์ที่ก่อให้เกิดความเครียด ระดับมาก คือ การคิดถึงผู้ตาย การรับผิดชอบดูแลบุตรของผู้ตายเมื่อสมาชิกครอบครัวผู้ป่วยเอดส์ที่เหลืออยู่เป็นกลุ่มสมรสและบิดามารดาของผู้ตาย การขาดผู้นำครอบครัว และการสูญเสียความหวังและเป้าหมายในชีวิตที่เคยมีกับผู้ตาย สมาชิกครอบครัวผู้ป่วยเอดส์ที่เสียชีวิตแล้วใช้การเผชิญความเครียดโดยการปรับเปลี่ยนอารมณ์มากกว่าการแก้ปัญหา ได้รับการสนับสนุนทางสังคมจากสมาชิกครอบครัวของตนเองในระดับมาก และได้รับการสนับสนุนทางสังคมจากทีมสุขภาพในระดับน้อย

จากการศึกษานี้มีข้อเสนอแนะว่า พยาบาลและบุคลากรที่เกี่ยวข้องกับครอบครัวผู้ป่วยเอดส์ควรตระหนักและให้ความสำคัญแก่สมาชิกครอบครัวผู้ป่วยเอดส์ที่เหลืออยู่โดยเฉพาะอย่างยิ่งบุตรของผู้ป่วยเอดส์ที่เสียชีวิต ส่งเสริมสุขภาพจิต สนับสนุนให้มีการเผชิญความเครียดที่เหมาะสม ป้องกันกระบวนการความโศกเศร้าที่เรื้อรังและผิดปกติ และนำแหล่งสนับสนุนที่มีอยู่มาใช้ให้เกิดประโยชน์มากที่สุด นำไปสู่พฤติกรรมการดูแลตนเองและส่งเสริมสุขภาพจิตของบุคคล ครอบครัว และชุมชนได้อย่างมีประสิทธิภาพ

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CHAPTER I

INTRODUCTION

Background and Significance of the Study

AIDS is an important social and public health problem both on a national and an international level. This is because AIDS is a contagious disease which is incurable and life-threatening. In Thailand, AIDS has rapidly become widespread since the first case of HIV infection was detected in September 1984. Up until April 30, 2001, there were 168,463 cases of AIDS in Thailand. Among these, 46,564 patients had passed away. In addition, there were 63,658 cases of symptomatic HIV cases; of these, 6,564 were already deceased (AIDS Control Division, April 30, 2001). Among the patients who live with AIDS, the largest group, or 28.5%, are those in their working ages between 20 and 39 years old, and almost half (44.2%) are employees. It has also been found that the most significant risk factor is sexual intercourse (83.1%) (AIDS, 2000: 171-172). Based on these statistics, it could clearly be seen that the spread of AIDS and the mortality rate caused by AIDS has posed a great concern.

The AIDS patients who are in their symptomatic phase or last phase of the disease will show different symptoms of different bodily systems. These symptoms include chronic fever, weight loss, diarrhea, tuberculosis infection, meningitis, impaired memory, confusion, paralysis, and convulsion. These patients are unable to take care of themselves and require physical care and moral and spiritual support from others (AIDS Division, Ministry of Public Health, 1995: 7). Families, therefore, have to provide close and continuous care to these patients. Unfortunately, the family members themselves have to face with the risk of infection, stress, and the feeling of despair, as well as social stigma, fear, and loss.

After AIDS patients have passed away, their family members have to face with three major impacts (Arunrat Watanapalin,1999:2):1)The family structure is destroyed as the illness or the death of the AIDS patient makes the family disabled (Uthai Hirunto, 1983: 85-87), 2) The family loses its ability to perform different duties, so it may be impossible to raise children to become quality members, both physically and

mentally, of the society, and 3) Not only are AIDS patients unable to work as they used to in the past, but their family members who become caregivers may have to give up their job; thus, the family's financial status is affected. The expenses for the treatment of HIV-infected patients or AIDS patients are tremendous, and some families have to spend their entire life savings on expensive medication and treatment. Besides, some families may have to obtain a loan; as a result, they have to bear a long-term financial burden. It could be said that after the AIDS patients have died, their families are left with a high risk of mental illnesses. This is because they have to face with seriously stressful life events including untimely death of loved ones, changes in roles of family members to retain balance in the family, responsibility for parents or children of AIDS patients, debts incurred by AIDS treatment provided to the patients, and loss of job due to the time devoted to provide care to the patients. In addition, since they have a risk of HIV infection, they may become discriminated by other members of the society.

When the families of AIDS patients have to deal with such problems and consider the situations as stressful, they could use different coping to deal with stress. Lazarus & Folkman (1984) have divided coping into two patterns. The first is problem-focused coping, which refers to an attempt to better the situation and deal with the source of stress including confrontive coping and planning problem solving. The second is emotion-focused coping, which means adjusting the incurred feelings without directly dealing with the cause of the problems or trying to solve the problems such as making a positive reappraisal, accepting responsibility, self - control, seeking social support, distancing, and escape-avoidance. In dealing with stress in each situation, either one of the coping or both may be used.

Social support acts as a buffer for individuals. Individuals who receive sufficient social support are likely to develop self-pride, reduce stress, and appropriately deal with stress. The social support the AIDS patients receive includes their families' and their being assisted and taken care of by close persons, relatives, social networks, private organizations, and healthcare providers. Such support can be in the forms of information, emotion and love, care, attention, sympathy, and concern. Furthermore, more tangible support can also be provided in the forms of materials and

money. Such social support will enable families of AIDS patients to deal with stress, thus reducing the likelihood of a critical condition (Lazarus & Folkman, 1984: 250).

However, when the families of AIDS patients are unable to cope with these situations, or when they do not receive appropriate and sufficient social support, they will have a higher risk of mental health problems which could eventually become social problems due to inappropriate coping of the families. The mental health problems include depression, suicidal thoughts, and alcohol or drug addiction, all of which are unwittingly chosen as a coping. Some family members may also face with physical symptoms due to stress and worries. Furthermore, the children of the AIDS patients are discriminated against, and they may not be raised properly or lovingly. As a consequence, they may unnecessarily lose a chance to continue their education or receive job training, leading to further social problems such as disobedience or burglary. However, if AIDS patients' families receive suitable and sufficient social support, they are expected to undergo coping procedures with efficiency. This will make them able to regain and/or retain their physical and spiritual well-being, giving them a will and determination to live a normal life happily in the society.

Two of the main responsibilities of community mental health nurses are to promote mental health and prevent mental illnesses or mental health problems of community members who are service receivers. Nurses can provide different services to promote community members' well-being, happiness, self-pride, potential, and ability to adjust themselves. They should identify stressful events which can lead to critical situations and offer programs to reduce or eliminate the threat of such situations. Moreover, nurses should identify at-risk community members who have a risk of either maturational crises or situational crises, assess these individuals' strength and ability to cope with stress, and offer assistance so as to enable them to deal with stress effectively. Nurses should also teach them to learn to ask for help and make use of resources in the community to prevent and reduce the impact of crises, as well as physical, mental, and social problems caused by inappropriate coping (Rowlins et al., 1993: 526-530; Townsend, 1996: 786-784; Johhson, 1997: 22-26).

After the AIDS patients have died, their families have a high risk of developing mental health problems as they have to deal with chronic stress due to caregiving duties. AIDS is an incurable disease, and its duration varies. Also, it is a disease which

is seen as unacceptable by society. Even after the death of the patients, their families continue to face with stressful events caused by untimely loss of loved ones and hope in life, loss of a functioning family member, debts incurred by the treatment of AIDS, and social discrimination. Therefore, community mental health nurses whose main responsibilities include promoting mental health and preventing mental illnesses should pay particular attention to the families of AIDS patients after the death of the patients. They should facilitate the families of AIDS patients to cope with stress effectively and teach them how to seek for assistance from various resources in the community so as to continue living peacefully in society and being valuable citizens necessary in developing the society and country at large.

Promotion of coping among family members of AIDS patients could only result after nurses have a thorough understanding of coping which can be utilized by family members after the death of the patients. Also, nurses need to be well informed of social support the family members receive before giving out assistance. At present, the number of research studies investigating stressful situations, coping, and social support of family members of deceased AIDS patients is still too limited to yield insightful information about the issues. The researcher of the present study is a community mental health nurse who has provided healthcare services to community members in Pranburi District, Prachuabkhirikhand Province, where a total of 1,465 cases of AIDS were reported between 1989 and the end of 2000, with the death toll of 486 (Prachuabkhirikhand Public Health, 2000: 11). Thus, the researcher was interested in studying stressful events, coping, and social support of family members of deceased AIDS patients. In the present study, Lazarus and Folkman's theory was used as a theoretical framework. It was anticipated that the findings of the study would enable community mental health nurses to assist the families of AIDS patients to effectively cope with stress to reduce the impact of the death of the AIDS patients.

Research Questions

1. After the death of the AIDS patients, what situations do their families find themselves in which cause them stress, and what is the level of the stress they have?

2. After the death of the AIDS patients, how do their families cope with the resulting stressful situations?
3. After the death of the AIDS patients, what kind of social support do their families receive and how much?

Objective

The present study aimed at investigating stressful situations, social support and coping, of family members of deceased AIDS patients.

Theoretical Framework

The theoretical framework of the present study regarding stressful situations, social support and coping, of families of deceased AIDS patients was derived from the theory of Lazarus and Folkman (1984) as well as the body of knowledge generated based on a review of related literature as follows:

After the AIDS patients died, their families may have to encounter the following stressful situations:

1. The loss of a family member which may be a spouse, parent, child, or sibling,
2. The loss of a functioning family member who could be the breadwinner, childcare provider, or elderly care provider, as well as the loss of a family member who helped sustain family structure such as family task manager or creator of family bonding,
3. The subsequent byproducts of AIDS which include AIDS infection, debts incurred by treatment, social stigma, and social discrimination, and
4. The loss of hopes and life goals the families used to share with the deceased AIDS patients.

The families of deceased AIDS patients have different cognitive appraisals of the situations they find themselves in. Put another way, they define stressful situations differently. However, stressful situations can pose a threat to mental balance, and once the family members of AIDS patients have to deal with stress, they have to choose

appropriate coping in order to deal with it. The two coping they can choose from are as follows:

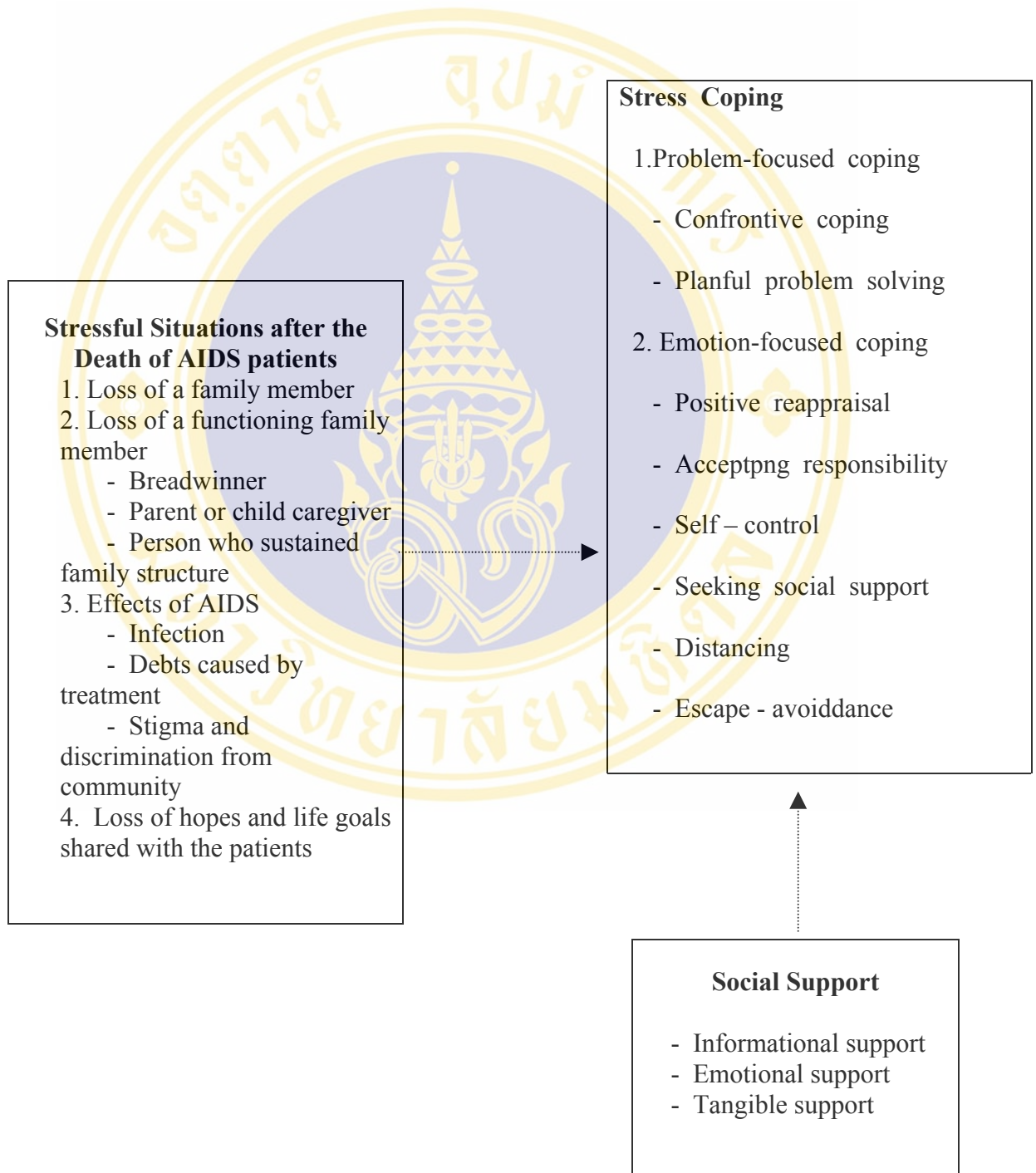
1. Problem-focused coping is a coping that involves considering the situation thoroughly for improvement. It can be further divided into: 1. Confrontive coping — a thinking process or behavior expressed when confronting the situation to make the situation better, and 2. Planning problem solving — an attempt to handle the situation by systematically analyzing the problem.

2. Emotion-focused coping is a coping which refers to facing stress by adjusting sad or suffering emotions and feelings. It can be categorized as follows: 1. Positive reappraisal — a thinking process and behavior in trying to give a more positive meaning to the situation, 2. Accepting responsibility — a thinking process and behavior in an attempt to accept that ones are actually the cause of the problems, 3. Self-control — a thinking process and behavior in trying to retain the consistency of one's emotion or to rely on oneself to solve the problem, 4. Seeking social support — a thinking process and behavior of individuals who are trying to seek for sources of social support, 5. Distancing — a mental attempt to reduce the significance of the situation by stepping back from the situation one is facing, and 6. Escape-avoidance — a thinking process and behavior taking place when individuals are trying to escape from the problem temporarily (Lazarus, 1967: 145-158; Lazarus & Folkman, 1984: 150-153; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986, cited in Taylor 1991: 233; Lazarus, 1991: 449).

Social support is generally defined as what individuals receive from different members of the society. Social support involves provision of assistance regarding information, emotion, love, attention, bonding, acceptance, as well as more tangible help in the form of materials, money, and labor (Schaefer, Coyne & Lazarus, 1982, cited in Lazarus & Folkman, 1984: 250). As they have to deal with the stressful situations after the death of the patients, the families of AIDS patients are in great needs of social support from relatives, community networks, and different organization in the community. The assistance provided by these sources would enable the family members of deceased AIDS patients to acknowledge the situation better and to increase their ability to deal with stress. However, since the community tends to have a negative attitude towards AIDS and to be afraid of HIV infection, the families

of deceased AIDS patients may not have enough chance to receive the support they desperately need. This may lead to disheartened feelings, boredom, and despair, all of which could make the families of AIDS patients unable to continue their family life.

The above discussion could be summarized as shown in Figure 1 below:



Scope of the Study

This study was survey research which aimed to describe stressful situations, social support and coping of the family members of deceased AIDS patients. The subjects who took part in the study resided in Pranburi District, Kuiburi District, and Samroiyord Subdistrict in Prachaubkheereekhan Province, and the data collection was conducted from December 2001 to February 2002.

Definition of Terms

1. Stressful situations refer to situations which occurred to the families of AIDS patients after the patients had passed away. The families assessed these situations as affecting their mental condition and leading to stress, worries, and concerns. They were measured by a questionnaire specially developed by the researcher to explore the following stressful situations:

- 1) A loss of a family member—spouse, parent, child, or sibling,
- 2) A loss of a functioning family member—breadwinner, child caregiver, parent caregiver, as well as a loss of a person who sustained the family structure—manager of the family tasks or creator of bonding in the family,
- 3) Consequences of AIDS—AIDS infection from the patients, debts incurred from treatment and care of the patients, social stigma, and discrimination in the community, and
- 4) A loss of hopes and goals in life shared with the patients.

2. Social support was defined as various forms of help the family members of deceased AIDS patients received from close persons and individuals in their social network including family members, relatives, neighbors, colleagues, private organizations, and healthcare providers. Social support could further be divided into informational support, emotional support, and tangible support such as materials, labors, and money. In the present study, social support was measured using the Social Support Questionnaire (SSQ) designed by Schaefer, Coyne, and Lazarus (1981).

3. Coping refer to thinking processes and behaviors of the family members of deceased AIDS patients used to deal with stressful situations to reduce sufferings. They were measured using the Ways of Coping Questionnaire constructed by Lazarus and Folkman (1984: 328-333). This questionnaire was translated into the Thai language by the researcher. In this questionnaire, coping were divided into two patterns as follows:

- i. Problem-focused coping—thinking processes and behaviors of family members of deceased AIDS patients after the patients' death to deal with, adjust to, and improve stressful situations they were facing. It consisted of two components: confrontive coping and planning problem solving.
- ii. Emotion-focused coping—thinking processes and behaviors of family members of deceased AIDS patients after the patients' death to relieve the stressful situations they were positive reappraisal, accepting responsibility, self-control, seeking social support, distancing, and escape - avoidance.

Expected Outcomes and Benefits

1. The findings of the present study could be used as preliminary data for community mental health nurses and other healthcare teams to better understand different types of stress that can occur to the family members of deceased AIDS patients. Moreover, more knowledge on such related issues as coping and social support family members of deceased patients would also be generated.

2. The findings of this study could be baseline data for community mental health nurses who wish to initiate the project to directly assist the family members of AIDS patients to better serve their needs.

3. The data concerning stressful situations, stress coping, and social support could be used to promote social support of family members of deceased patients with AIDS living in other communities.

CHAPTER II

LITERATURE REVIEW

This study was survey research which aimed to describe stressful situations, social support and coping of the family members of deceased AIDS patients. The narrative description of stressful situations, social support and coping of the family members of deceased AIDS patients was intended to provide fundamental information needed in providing continuing care to the family members of deceased AIDS patients. In this chapter, a review of existing research literature and academic texts is summarized in the following topics:

1. Stressful situations of the family members of deceased AIDS patients
 - 1.1 Stress
 - 1.1.1 Concepts regarding stress
 - 1.1.2 Cognitive appraisal
 - 1.1.3 Effects of stress on health
 - 1.2 Effects of having a family member with AIDS
 - 1.2.1 The meaning of AIDS
 - 1.2.2 The role of the family
 - 1.3 Stress of the family members of deceased AIDS patients
2. Social support of the family members of deceased AIDS patients
3. Coping of the family members of deceased AIDS patients
4. Community mental health nursing

1. Stressful situations of the family members of deceased AIDS patients

1.1 Stress

1.1.1 Concepts regarding stress

Stress means sufferings and worries when individuals perceive that the situation they are facing is not what they have expected it to be or the situation has threatened or can threaten their happiness. This is an unavoidable situation for everyone. In fact, little stress is good as it stimulates individuals' way of life. If individuals are able to cope with stress effectively, they will be able to maintain their good health, being able to fulfill their personal and social duties and to be aware of their self-worth and life goals. However, if individuals fail to handle their stress effectively, they may have to suffer from sickness or have inappropriate behaviors, emotions, and ideas, all of which could eventually have an effect on the society.

Lazarus & Folkman (1984: 21) have defined stress as follows:

1. Response definitions of stress

Stress means individuals' reactions to stimuli which are seen as dangerous or threatening. This can be measured from physiological responses to stress such as faster heartbeat, trembling hands, indigestion, restlessness, muscle spasm, and sweating.

2. Stimulus definitions of stress

Stress means individuals' encounter with major changes in life which bring about stress such as death of loved ones, being laid off from work, or divorce.

3. Person-environment relationship definitions of stress

Stress means individuals' interaction with their environment and their cognitive appraisal of such environment. When individuals appraise that their resources are not sufficient and need to pull off reserved resources, they can develop stress. In fact, this is what Lazarus uses to define stress.

1.1.2 Cognitive appraisal

When facing a situation, whether individuals will become stressed or not depends on their cognitive appraisal of their own demand and resources through their own thinking process (Somjit Hanucharoenkul, 1997: 106). In other words, they have to undergo the cognitive appraisal process which is a dynamic process. Individuals undergo this process

process (Somjit Hanucharoenkul, 1997: 106). In other words, they have to undergo the cognitive appraisal process which is a dynamic process. Individuals undergo this process to appraise the significance and the meaning of the situation (Somjit Hanucharoenkul, 1997: 106-109; Lazarus & Folkman, 1984: 31-35). There are two phrases of the cognitive appraisal process—primary appraisal and secondary appraisal.

Primary appraisal is to appraise whether or not the situation is important or critical to individuals both at the present time and in the future. There are three types of appraisals: 1. Irrelevant situation means the situation does not affect individuals' well-being, 2. Benign positive situation means the individuals are satisfied, and 3. Stressful situation means individuals appraising the situation and perceiving that it can cause harm and loss or it poses itself as a threat. Predicting beforehand that a situation can cause harm and loss can make individuals feel afraid, worried, or angry. However, individuals can perceive the situation as a challenge if they appraise that though the situation brings about negative results, they can still somehow control the situation, thus making it more enthusiastic or exciting.

Secondary appraisal means the appraisal of existing resources and available alternatives to deal with the situation that causes stress. It can take place at the same time as or after the primary appraisal.

In addition, when individuals have a new perception, reappraisal will take place. This is a change in the original appraisal of individuals by giving meaning to the situation to reduce stress, thus altering the decision of the relationship between individuals and the environment (Somjit Hanucharoenkul, 1997: 108). Thus, reappraisal is a medium of individuals, their environment, and the primary and secondary appraisals (Lazarus & Folkman, 1984: 38).

The factors which affect individuals' cognitive appraisal consist of personal factors and situational factors (Somjit Hanucharoenkul, 1997: 108; Lazarus & Folkman, 1984: 80-81).

Personal factors influencing appraisals are the following: 1) Commitment—a consideration of how the situation is important or meaningful. The more important or meaningful the situation is, the more individuals see the situation as threatening. By the same token, the more commitment individuals have, the more drive they have to correct

or better the situation; 2) Belief—when individuals feel that the situation is controllable, they will see it as challenging. However, if the situation is seen as uncontrollable, individuals will see it as loss or threat; 3) Intellect—intellectual individuals will be able to appraise the situation accurately; thus, they are likely to have less stress than those who are unable to do so.

Situational factors influencing appraisal include: 1) The severity of the situation—serious sickness which threatens individuals are seen as stress which can cause considerable damage and loss both at present and in the future; 2) The predictability of the situation—If it is a new situation individuals have never faced before, individuals can have more stress; 3) Uncertainty of the situation—If the situation is unclear or ambiguous, individuals may see it as stress. This is because lack of clarity or presence of ambiguity makes individuals unable to predict whether they can control the situation or not. They may be unable to find suitable ways to deal with the situation as well.

1.1.3 The effect of stress on health

When individuals are stressed, different systems in the body will be stimulated to work rapidly to counteract stress, leading to the following changes (Ellis & Nowlis, 1985: 106):

1) Physical changes

-Circulation and heart system

When individuals are stressed, the heart will be stimulated to pump the blood faster and beat faster. This can result in high blood pressure. Part of the heart muscles may die, and heart disease and heart attack may eventually set in.

-Alimentary and Digestive systems

Stress causes individuals to lose appetite. Abnormal digestive system leads to malnutrition or anorexia nervosa. Also, chronic constipation or diarrhea may result in more acid in the stomach, causing peptic ulcer.

-Immune system

Stress makes T-lymphocytes work less, and so does the immune system. Thus, individuals have more risks of being infected, especially those who are HIV-positive. Their conditions can deteriorate more rapidly.

-Muscular system

If there is continued muscle spasm, individuals will experience headache, back pain, and aching all over the body. In addition, some tissues are digested to turn them into energy, so the muscles will reduce in size, and osteoporosis can take place.

-Endocrine system

The body will excrete more sugar into the bloodstream as a source of energy, so there is more chance of occurrence of diabetes mellitus and thyroid toxicity.

-Urogenital system

When stress occurs, the vessels nurturing the kidneys can be affected. In addition to this, abnormal electrolyte can take place. As a result, there may be too much waste accumulated in the system, and individuals may suffer from kidney disease.

2) Psychological and emotional changes

Psychological and emotional changes that occur as a result of stress are as follows:

- The sensory perception will deteriorate or be distorted. Affected individuals will develop surreal or supernatural ideas, and their intellectuality will also be affected. Thus, they become unable to solve problems effectively.

- Individuals will develop confusion or obsessive thinking. Memory and decision-making will also be adversely affected.

- Concentration ability will decrease, and categorization of events will be ineffective, if not impossible.

- Stunted behavior will also occur. Thus, individuals are unable to solve problems. Otherwise, they may not try to deal with the problems, becoming disheartened or desperate with life.

- Finally, individuals may become compulsive-obsessive, fearful, restless, or worried. If their conditions fluctuate greatly, they may eventually be mentally sick.

1.2 Effects of having a family member with AIDS

1.2.1 Meaning of AIDS

AIDS is an important social and public health problem both on a national and an international level. This is because AIDS, a contagious disease which is incurable and life-threatening, is caused by the Human Immunodeficiency Virus (HIV). In

Thailand, AIDS has rapidly become widespread since the first case of HIV infection was detected in September 1984 in a homosexual male. From 1987-1988, it was found that HIV infection began to spread among the drug addicts who shared needles. In 1989, AIDS began to be detected among heterosexual couples, especially among prostitutes and males who were customers. The number of HIV-infected persons who were prostitutes and males who used services of prostitutes increased rapidly, whereas the number of those who were homosexuals or drug addicts remained constant (Thapanee Jaruwat, 1997: 1). Most of HIV-infected persons will eventually develop AIDS. At present, the spread of AIDS is not limited to certain groups of population. Rather, it has spread among people from all walks of life including housewives, students, and children. More importantly, the numbers of HIV-infected persons and AIDS patients have continuously increased. The problems of AIDS do not cause great stress only on the patients themselves, but also on their families, communities, medical and public health, society, and national economics.

In terms of society and culture, AIDS is seen as very threatening. It is perceived as the disease of those who are promiscuous or sexually deviant. There is no cure for AIDS, and all patients eventually die. Thus, AIDS comes with a stigma, and AIDS patients are generally rejected by society. In fact, they are generally perceived as being immoral and dangerous to society (Saowapa Pornsiripong, 1997: 113-114).

Psychologically, HIV-infection does not mean only physical problems, but also mental, emotional, and psychological problems. Psychosocially, HIV-infection and AIDS mean hopelessness as AIDS is incurable, helplessness as other people are afraid of contracting AIDS, and worthlessness as the patients are disgusted and rejected by others (Piyarat Nilayaga, 1994: 212).

Bumpenjit Sangchart (1998: 97-98) studied meaning giving of AIDS among HIV-infected persons and AIDS patients and found that AIDS combined the pathological knowledge and biomedical knowledge with emotional feelings. That is, AIDS is threatening as it is a serious contagious disease, spreads quickly, and is incurable. Also, it is seen as a disgusting disease as it is caused by sexual behaviors and it is a disease of loss. Patients lose everything including their own life and the reputation of their family.

When individuals are HIV-infected, HIV viruses will attach themselves to the wall of white blood cells called CD4 or Lymphocytes which function to protect the body from

infections. When CD4 cells are destroyed by HIV viruses, the efficiency of the immune system decreases, and it is easier for the body to be invaded by viruses or bacteria. The symptoms after HIV infection are as follows (Ornanong Indravichit & Narin Garinchai, 1982:12; Vicharn Vithayasai & Prakong Vithayasai, 1997: 61-189; Yong Rongrungrueng, 1998: 18.0-18.2; Falskerud, 1992, cited in Piyarat Nilayaga, 1994: 188):

1. Acute or Primary HIV infection. This period takes about one to six months after receiving HIV viruses into the body. The symptoms are similar to those of the flu, including fever, sore throat, swollen lymph nodes, aching in the muscles and joints, and headache. These symptoms generally last one to two weeks before going back to normal. HIV antibody can be detected from eight days to ten weeks after being firstly infected.

2. Asymptomatic infection. This period begins after HIV antibody is detected. It can last from eight to ten years before developing into full-blown AIDS, depending on the decrease in CD4 cells. The health conditions of the infected individuals become unbalanced, depending on the severity of the disease. For some HIV-infected persons, they may have no symptoms at all even though they have HIV viruses in their body. As their infection status is unknown, they can easily spread HIV viruses to other people. Thus, this period is considered a main mechanism in the spread of HIV viruses. If the individuals' HIV antibody is detected during this period, they may react with denial, followed by anger, guilt, and depression. Some may become compulsive-obsessive and lose sexual interests for fear that they would harm themselves and others; others may entertain a suicidal thought.

3. Early symptomatic HIV infection is AIDS related complex. When the immunity system of the body is weakened, certain symptoms begin to show up continuously for no more than three months, and any bodily systems can be affected. For example, individuals may have a fever higher than 37.8° Celsius either intermittently or continuously, the body weight may be reduced by more than 10% of the original weight, periorbit may occur and the eyes become dry, there may be blood spots in the eyes, the eyelids become swollen, skin rashes appear, skin can be infected with fungi or parasites, severe skin blisters develop, the patients may experience pain when swallowing, wounds appear on the esophagus, the stomach becomes infected, the patients may have diarrhea, endocarditis may take place and the heart muscles may be infected, and a condition of an enlarged

heart may result. In general, the abnormality of the cardiovascular system is accompanied with the abnormality of other bodily systems. In addition, the lymph nodes may be affected as well, leading to rather serious opportunistic infections such as herpetic and mycobacterium tuberculosis. Other bacteria may be the cause of other forms of opportunistic infections such as pneumonia, while viral infection may lead to visceropleural infection. As a result, the infected individuals may have a high level of worry and anxiety due to uncertainty of the disease. They can be sad, depressed, desperate, lethargic, afraid of pain, afraid of image change, and highly dependent on medical professionals.

4. The full-blown AIDS period is characterized by all the symptoms and diseases considered to be AIDS symptoms including infection in the respiratory system, chronic cough, panting, cryptococcosis, canida infection of the esophagus, and infection in the alimentary system leading to chronic diarrhea. In addition, the abnormality of the nutritional system is frequently found, and it is a factor leading to other abnormalities. Generally, the AIDS patients are easily infected. They can have painful inflamed joints when the bacteria affect the joints. There can also be abnormality of the circulation system; thus, the patients become pale, anemic, and easily exhausted. They can have blood spots on the skin, their white blood cells and red blood cells are lowered, and their urination can be abnormal. Finally, kidney failure may result. Therefore, the patients can be hopeless to live, lose their self-worth, be afraid that physicians and nurses would neglect them as their conditions are incurable, avoid association with others, and entertain a suicidal thought.

4. Final stage AIDS in the period in which the patients' CD4 and T-Lymphocytes are lowered than 50 cells than cubic milliliters. The patients may have different opportunistic infections at the same time even on the same organ. Also, the patients may suffer from physical deterioration and are unable to perform self-care. Some patients' neurological system may be infected, leading to AIDS Dementia Complex or ADC (Piyarat Nilayaga, 1994: 214). When having this condition, the patients become forgetful, sad, depressed, anxious, and confused. They can also be affected with memory loss, loss of interest, severe malnutrition, weight loss, vulnerability to fungus infection, anemia, imbalance of water and pH levels, and organ failure.

1.2.2 The role of the family

The family is the smallest social unit, but it is one of the most important institutions. In general, family members have strong bond, closeness, and love for each other. It is a social institution with which individuals spend the longest time, from birth to death. The main responsibilities of the family are raising children, providing new members to society, being an initial institution which educates and develops behaviors and personality of individuals, and conserving and passing on cultures from one generation to another (Ruja Pupaiboon, 1998: 3-4).

The family is an origin of new members in society. It is the unit which provides care to family members, both in sickness and in health. Thus, the family has a great influence on individuals' health condition. If individuals are well cared for and their health is well promoted, they have less chance to become sick. And when they are sick, family is an important factor which can help restore their health.

Furthermore, the family acts as a buffer between each member and the environment. It can be seen that when something wrong happens with certain individuals, they tend to ask their family for assistance. The fact that the family is the smallest social unit which continuously satisfies the needs of its members makes it be considered the primary group which is a significant social environment of each member until death (Ruja Pupaiboon, 1998: 10).

When AIDS patients are faced with physical, mental, and social problems, family members are important persons who provide them with support. Jitra Charoenpatpesat (1994) found that the relationships in the family of AIDS patients were mostly at the middle level, and the members supported the patients by giving them sympathy, understanding, and acceptance that they were important to the family. Likewise, Thapanee Jaruwat (1997) pointed out that families could provide care to HIV-infected persons or AIDS patients to a rather good level, and mothers and wives were the most important caregivers. In addition, Sutheera Huntrakool (1992) discovered that wives and mothers were the persons who spiritually motivated the patients not to give up, to fight, and not to become hopeless. Thus, the patients who received good family support could continue to live happily. The same conclusion was provided by Taweethong Hongwiwat et al. (1993) who studied problem-coping and self-adjustment strategies of HIV-infected persons and

found that those who lacked family support would be more stressed and had more difficulty adjusting themselves. Based on these findings, it could be concluded that family members need to adjust their own roles to comply with the problems that have occurred to the AIDS patients and provide them with the help and care they need, which can be done as follows:

1. The role concerning care of daily living activities to satisfy basic human needs in living a daily life such as needs for food, water, rest, shelter, and exercise.
2. The role concerning care of mental and emotional well-being to mentally support AIDS patients. AIDS patients have to deal with different health complications and they may be desperate and hopeless in life, especially the patients in the last stage who have to deal with great physical sufferings. Thus, they are in need of love and care from their family members, and the family members have an important role in showering them with moral support, confidence, and advice to keep up their mental strength enabling them to deal with their situation.
3. The role concerning care of economic status. As AIDS is incurable, the chances of complications and hospitalization are high. The family members have to be responsible for medical expenses. In addition, most of the patients are still in their working years or the head of the family, when they are sick and unable to work, the family members have to take care of family expenses.
4. The role concerning social care. The family members should support AIDS patients and encourage them to perform their daily self-care by themselves. They should also try to include the patients in the family's activities so as to make them confident and have proper social adjustment.
5. The role concerning medical care. The family members should seek knowledge about AIDS, proper care and treatment for AIDS patients, and follow-ups on physicians' care plans.

The family members who provide care to AIDS patients have to deal with different situations, so they need cognitive appraisal of the situations. If they feel that the situations can cause stress, they may have to appraise the existing resources to relieve the situations. In terms of emotional reaction and adjustment, they tend to be initially shocked from learning that the patients are stricken with AIDS, and they may also have to learn

about the behaviors leading to the disease such as promiscuity. In addition, they have to witness physical and mental changes the patients undergo such as skin problems, weight loss, malnutrition, or inability to think as fast as used to. Besides, the family members may have to learn to cope with the fact that the disease is incurable, the uncertainty in the ability to provide needed care, the uncertainty to disclose the condition to others, the uncertainty about ability to pay for medical expenses, and the inability to plan for the future. These all make the family feel hopeless. Also, they may become angry to think that they have lost their life quality and family reputation, that the patients are unable to earn their own living, that the patients had behaviors resulting in the disease, that they may be the cause of the patient's infection, that there is insufficient public health care, that the disease is incurable, and that they have to become caregivers. Family members can also be afraid of losing the patients, afraid of contracting the disease, worried about the caregiving duties, and worried about the family's economic status (Vicharn Witayasai and Prakong Witayasai, 1992: 192; Sasima Kusuma and Orathai Soamnarin, 1997: 17; Lovejoy, 1988: 22).

Based on the aforementioned problems, the family may turn to denial which is a technique used to deal with unacceptable situations causing ineffective coping. Family members may have physical symptoms which are caused by psychological reasons such as insomnia, overeating or loss of appetite, headache, and migraine headache. The deteriorating physical and mental health, the guilt feeling that ones may be the cause of the patients' infection, the anger that the patients are sick, and the new burdens of providing care to the patients may make the family members become obsessed with caregiving and overlook taking care of themselves (Vicharn Witayasai and Prakong Witayasai, 1992: 192; Sasima Kusuma and Orathai Soamnarin, 1997: 17).

1.3 Stress of the family members of deceased AIDS patients

When a family member is sick, the other family members have to adjust their roles and duties to provide care to the sick person. However, when a family member is sick with AIDS in particular, other members may be afraid that they themselves may contract AIDS. Some may be worried about medical expenses and caregiving duties. Thus, they find themselves under stress. The severity of the impact depends on the roles and

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When the AIDS patients are unable to restore their health due to repetitive opportunistic infections of different organs, the family members have to provide care during the last stage of the disease until they finally pass away. After having to adjust themselves to various impacts of caregiving responsibilities, the family now have to endure more changes resulting from the patients' death as follows:

1. Loss of a family member

The first change the family members have to encounter is the loss of a family member. This is considered a great loss because of the bonding they had shared for a long time. The loss of the patients forces the family to deal with sadness and loss of hope in life. Chekryn (1989: 30-32) conducted a study interviewing five families of AIDS patients. The findings revealed that there was anger, fear, despair, and loss, as well as inability to accept that death was approaching among these families. Thus, they had spiritual pressure and saw the death of the patients as a painful life event. Similarly, Brown & Powell-Cope (1993, cited in Nongnuch Punjathamcharoen, 1997: 20) conducted a study with 53 caregivers to explore the feelings of loss and the death of the patients.

They found that caregivers felt that they lost their freedom and the way of life they formerly had. As for the loss of the patients' life, most of the caregivers felt saddened, lost, suppressed, and they did not want to wait for death. Furthermore, Mellins & Ehrhardt (1994, cited in Wantana Supaseemanon, 1996: 22) studied sources of stress and stress coping strategies of the families whose children were sick with AIDS. The interviews revealed that what caused stress among the sick children and their siblings was the loss of family members who died from AIDS. Another source of stress of the siblings of the young AIDS patients was the caregiving burden of the sick siblings or parents.

2. The loss of persons who perform different roles in the family

As most of the AIDS patients are still in their working years or are the head of the family, they are an important force that drives the family forward. When they become sick and die prematurely, there are significant changes occurring in the family—loss of breadwinners, loss of caregivers of parents or children, or loss of persons who used to perform different roles in the family such as managers of family matters or linkers of family members.

In the case that the deceased AIDS patients used to play significant roles in the family such as breadwinners or leaders, the changes that take place can be more serious. When the family loses the persons who used to provide financial stability, other members have to work harder to cover family expenses or to take care of the surviving children and/or parents of the deceased patients. These can be perceived as increased burdens of family members which they cannot avoid. Kanokwan Piengkate (1998) studied the roles of the elderly who had to take care of children affected by AIDS in Sanpatong District, Chiang Mai Province, and found that the elderly tended to have health problems which required care and assistance from others. When they had to become caregivers of children, they had more problems, especially those who had to take care of preschool children. In other words, these elderly people were too weak to take care of young children who were so full of energy. Moreover, there had to deal with the problems caused by generation gap which could be more serious as the children grew older.

Apiradee Thammakul (1998) investigated ways to provide facilities to orphaned children whose parents died from AIDS in Chiang Mai Province. She reported that most of the caregivers were paternal and maternal grandparents who did not have a stable job

or income while they had continuous daily expenses. They had to buy food, give some allowances to the children to go to school, pay for transportation from home to school and back to home, and pay for other household utilities and expenses such as electricity or running water. Put another way, the main problem resulted from lack of persons who could earn money to pay for their living. Besides, some children were under the care of the relatives of their parents such as their aunts or uncles. They still did not receive proper care as their relatives had to work hard to support the family or were engaged with other responsibilities. Paul Saoke, Roselyn Mutenmi, and Caroline Blair (1996) studied the families of HIV-infected persons and AIDS patients and found that in many families, grandparents were caregivers, and in others children aged ten to twelve years old were either raised by other families or neglected and had to live on the street. These children had to endure malnutrition, and they lacked attention and physical and social protection. Some of the girls may have sexual intercourse prematurely and be at a high risk of becoming HIV infected themselves.

3. The effects of AIDS

As AIDS is incurable and all patients eventually die from it, it is considered dreadful and disgusting by society. The families of AIDS patients have to deal with the patients' condition, and they have no hope that they can help the patients recover, so they become desperate and hopeless. In addition, AIDS gradually debilitates the patients' health, and they need to receive continuous treatment. However, most of the patients are not strong enough to work normally, or they lose their job because other people are afraid of getting the disease from them. As a consequence, they lack income and may have to use their savings or loans to pay for the medical treatment. In general, the treatment of AIDS is costly, and the duration of the disease is long. Thus, families, especially those with a low income, have to suffer to carry on their living (Piyarat Nilayaga, 1994: 225).

After the AIDS patients have passed away, the family members still have to face with the consequences. These consequences include fear of contracting the disease, mental exhaustion and despair, debts incurred by treatment, revelation of the patients' condition to others, social stigma, and isolation of society due to lack of proper understanding of AIDS on part of the family and community. Even though knowledge and information concerning AIDS has been widely disseminated, there are still a large number of families

and community members who lack proper understanding and still fear that close caregiving would lead to infection (Piyarat Nilayaga, 1994:225). For example, if children of AIDS parents go to school with rashes on their body, friends would stay away from them and make fun of them that they are having AIDS. After the rashes are gone, things go back to normal (Kanokwan Piengkate, 1998: 63).

Wantana Supaseemanon (1997) studied stress and stress coping strategies of families providing care to the AIDS patients. The findings revealed that the incidents which caused considerable stress to the families included increased financial responsibilities to cover medical treatment, sorrow caused by seeing the patients' sufferings, fear of being disgusted by others who knew the actual cause of the patients' condition, acknowledgement of the symptoms of the patients, and frequent hospitalizations of the patients.

4. Loss of hopes and goals in life used to share with the AIDS patients

Hope is a mental condition which is expressed in terms of desire to gain something or achieve something. When a working family member is sick with AIDS, the family members lose the hope they used to have. For instance, elderly parents may hope to depend on their children when they are too frail and old to take care of themselves. Once the children become sick with AIDS and the parents have to take care of them instead, they feel that they have a new burden which destroys their hopes. The feeling of hopelessness brings about pain and suffering, and it makes individuals feel that life no longer has its meaning (Ubol Niwatchai, 1992: 1092).

In summary, stress is individuals' reaction against the situation they are facing. It has an impact on individuals' security and stability. Stress also causes physical, mental, emotional, and social changes. Thus, when a family member becomes stricken with AIDS, the families have to face with various stressful situations. They have to accept that even though all AIDS patients eventually die from the disease, it does not cause a sudden death. Also, they have to deal with their fear of infection, loss of income, and social rejection. Consequently, families of AIDS patients need proper stress coping strategies that enable them to continue living their lives.

After the death of the AIDS patients, their families have to appraise the situations that have occurred since. These situations are new to them, and they have never

experienced how much effect on their lives the situations would cause. They may have to use existing resources to its full potential or more to deal with those situations. Cognitive appraisal is a thinking process individuals use to appraise whether the situation they are dealing with is stressful or not. The levels of stress depend on each individual's personality and the meaning given to the situation. Individuals try to reduce or eliminate stress by using different stress coping strategies to handle the situations they are facing.

2. Social support of family members of deceased AIDS patients

Studies have indicated that the concept of social support is a psychosocial variable which both directly and indirectly affects health and sickness of individuals as well as their behaviors. Numerous researchers have defined the concept of social support as follows:

Cobb (1976: 30) has defined social support as the fact that individuals perceive information which makes them believe that they are loved, cared for, valued, and highly regarded by others, hence making them feel that they are part of society with bonding and warmth.

According to Kahn (1979: 85), social support means having a meaningful interaction among individuals, leading to bonding and help for one another.

House (1981, cited in Sumontha Kabilpat, 1998: 39) asserts that social support is an interaction among individuals which consists of love, caring, trust, assistance in the form of money or labor, information sharing, and feedback for self-learning and self-assessment.

Schaefer et al. (1981, cited by Taylor, 1991: 244) defines social support as something that nurtures individuals when they are facing with stress in life.

Thoits (1982: 147-148) points out that social support exists when individuals in a social network receives help in the forms of morale, materials, or information, which enables them to encounter and respond to sickness or stress in a shorter time.

For Lazarus & Folkman (1984: 164), social support refers to individuals' reception of assistance and nurturing from others in their social network in such aspects as materials, services, and emotions, making individuals feel that they are loved and part of

the society. Information and advice given to solve the problems can boost up the individuals' spirits and increase their sense of self-worth.

Finally, Pender (1996: 257) states that social support gives individuals the sense of belonging, high regards, and self-worth.

Social support is a process which takes place all the time with the individuals who perceive or appraise that they have assistance and that their physical, mental, emotional, and social needs are satisfied. Social support has a direct role in promoting health, development, and well-being of individuals. Families and family members are fundamental sources of social support. Families which have resources, strength, and stability can help members deal with stress effectively and flexibly. Moreover, members can learn to adjust and readjust their behavior when the firstly-selected stress coping does not work. In addition, individuals who share the same problems can become one another's primary resources in dealing with stress or crises.

Social support has an influence on health condition and physical and mental sickness because of the following reasons: 1) Social support plays a direct role to promote health and well-being regardless of levels of stress. Social support is an important factor that creates a positive feeling about self and living. Consistent relationships within a social network make individuals feel that they are trusted, have self-pride, and feel uplifted and stable; 2) Social support is a barrier to stressful conditions and whatever has a negative effect on health. In other words, its function is to prevent individuals from discomfort that has resulted (Lazarus & Folkman, 1984: 245-256). Schaefer, Coyne & Lazarus (1982, cited in Lazarus & Folkman, 1984: 250) divide social support into three aspects:

1. Informational support means information which individuals can use to solve their problems. It acts as a guideline in facing with the problem, points out other resources, and suggests alternatives which can be utilized to solve the problem.

2. Emotional support refers to reception of love, attention, and care. It also means individuals' ability to release their uneasy or suppressed feelings to relieve their mental sufferings, thus leading to psychological stability.

3. Tangible support means directly receiving the help that individuals need such as materials, money, or labor.

The groups which are sources of social support for AIDS patients are family members including parents and siblings, neighbors, colleagues, organizations / clubs / associations in the community, and healthcare team including physicians, nurses, and public health officials. Each type of social support enables individuals to deal with stressful situations. When social support specifically serves the stressful situations individuals are facing and individuals are satisfied, they can adopt appropriate stress coping techniques and ensure their good health behaviors.

Individuals have an interaction with people in society all through their lives, and the interactions change in accordance with developmental phases or arising situations. These interactions form an interdependence social network which allows individuals to fulfill their daily life duties and face with stress (Jariyawat Khompayak, 1988: 96). At this point, it is worth noting that different researchers have attempted to group social support differently as follows:

McElveen (1979, cited in Angkana Nualyong, 1992: 61) has divided individuals who provide social support into two groups:

1. Groups of relatives are those who consistently share a strong bond and different types of interactions. They spend most of the time together and have frequent interactions with one another.
2. Groups of non-relatives consist of individuals who choose to keep in touch with one another based on personal reasons. They tend to share similar interests or values. Also, the members are likely to be friends who are of the same age and live similar ways of life.

Based on the concept of Kaplan (1977), Ubol Niwatchai (1984: 285) classifies social support into three groups:

1. Spontaneous or natural supportive system consists of two groups of individuals. The former is composed of direct family members such as grandmothers, grandfathers, parents, children, and grandchildren; the latter consists of close persons including friends, neighbors, acquaintances, and colleagues.
2. Organized support means groups of individuals who gather together to form units, clubs, or associations, which are not those organized by professional healthcare

teams, such as elderly clubs or religious groups. They mostly provide help by pampering individuals' spiritual well-being and emotions.

3. Professional healthcare workers refer to individuals who are professionally involved in the line of work providing protection, prevention, treatment, and rehabilitation of the public.

Jariyawat Khompayak (1988: 99-100) maintains that families are an important source of social support and the source closest to individuals. However, needs for social support from different sources depend on individuals' health condition and personal needs.

House (1981, cited in Katekaew Jindaroj, 1993: 27) has classified individuals who are sources of social support into two groups based on the characteristics of the interaction:

1. Those with no formal relationship refer to individuals who provide help to others who are naturally related, but not related to roles fulfilled in their daily work. These include spouses, relatives, or friends.

2. Those with formal relationship refer to individuals who provide help and care to others as required by their line of work or their profession. The help provided is mostly specific such as self-help groups, health groups, etc.

According to Pender (1987: 396-397), social support falls into five categories:

1. Natural support system consists of family members and relatives who are very important to the patients because they have shared strong bonding since they were very young. The natural support system is a source which passes on values, beliefs, behavioral patterns, interactions, and various life experiences which are important tools to support the patients.

2. Peer support system is support the patients receive from individuals who are experienced and skillful in seeking needs and convincing the patients, thus enabling them to deal with different crises in life successfully.

3. Religious organization or denomination support system is the source of support which allows the patients to exchange beliefs, values, teachings, and advice about ways of living and various cultures and traditions.

4. Health professional support system is the first source of support for the patients after the natural support system and peer support system have failed.

5. Organized support system not directed by health professionals is the support from service providing groups, volunteers, or self-help groups acting as the medium allowing the patients to adjust their behaviors to suit changing situations in life.

There are numerous studies which have investigated different aspects of social support, especially the effect of social support on health condition. The findings confirm that social support is an important psychosocial variable which has an influence on individuals' health or well-being. Directly receiving social support makes individuals emotionally stable towards the arising situation and leads them to the realization of their self-worth. This is because when receiving social support, individuals would feel that no matter what happens to them, there will always be someone who can help better the situation or relieve their stress, so they feel empowered, thinking that they are able to control the situation and are better motivated to try to handle stress. The final outcomes also include individuals' preferable hygiene and health-related behaviors (Cohen & Wills, 1985: 310-357).

Individuals have personal needs. When they lack physical balance, this can lead to stress. In particular, family members of AIDS patients tend to have more stress than family members who provide care to the patients of other diseases. This is because the duration of care is long, there is no hope for recovery, the caregivers are afraid to get infected, and the caregivers have to deal with social disgust and social stigma. Also, the resources of the family can gradually decrease and finally run out after sometime. When the families have severe and chronic stress, their problem-solving abilities will decrease, and they need social support in different matters including information, services, materials, and advice. In addition, they also need to feel that they are loved, cared for, accepted, and that they belong to the society. Such feelings will help sustain their spirits and morale, as well as the feelings of self-worth, thus enhancing their problem-solving abilities.

Matocha (1992, cited in Puangpen Chunhapran, 1998: 26) studied the effects of AIDS on American families and found the following results:

1. The most important support the families needed was environmental support. Caregivers needed space in which caregivers and patients could cohabit, keep their belongings, and rest when they were exhausted from providing care.

2. The second most important support was mental support. Caregivers had the need to express their feelings about the situation they were facing and to release their fear, anger, and anxiety. Caregivers needed someone to help uplift their spirit even though it might not help much. Furthermore, caregivers felt that they had to live their lives one day at a time and became stressed when they thought of their future. Also, they felt that they needed to make all the decisions while the patients were still alive.

3. The third most important support these American caregivers needed was social support. These caregivers needed to keep in contact with family members and friends all through the duration when the patients were sick and after they were dead. They also wanted to reveal their secret which was a difficult thing to do. It was found that the caregivers who wanted to keep the patients' sickness a secret would try to isolate themselves from their family and friends.

4. The fourth most important social support was economic support. Caregivers had to pay for increased expenses due to long-lasting sickness. They also needed to spend money on the funeral for the patients, so their savings may be used up.

3. Coping of family members of deceased AIDS patients

When individuals are threatened by different situations, their balanced state would be disrupted. The individuals have to develop coping and problem solving techniques to restore their balance. Lazarus & Folkman (1984: 141) explain that coping means the thinking and behavioral processes which reflect the abnormally higher continuous exertion of energy to adjust to and deal with the stressors that come from either internal or external factors resulting from cognitive appraisals. Coping consists of four specific characteristics as follows:

1. It is more process-oriented rather than trait-oriented, responding dynamically to specific stressors.

2. It has special characteristics as it is appraised as the energy to be exerted or the individuals' existing resources to be utilized to deal with mental stress. It is not a normal and automatic stress coping behavior individuals have.

3. It is managed with energy, relating to thinking and behavioral processes to assess and determine whether it is good or not.

4. Management here means reducing stressors as much as possible, avoiding or accepting stress, or trying to control the situations or the environments that cause stress.

In the present study, the researcher utilized Lazarus & Folkman's coping which divides coping into two patterns as follows (Lazarus, 1967: 145-148; Lazarus & Folkman, 1984: 150-153; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986, cited in Taylor, 1991: 233; Lazarus, 1991: 449):

1. Problem-focused coping

This reflects an attempt to directly deal with the causes or problems that lead to stress. It resembles scientific problem solving in which problems are identified, different possible solutions are considered for their strengths and weaknesses, and the most appropriate method is finally chosen. However, problem-focused coping is different from scientific problem solving in that it includes various methods and is more continuous in nature. These forms of coping help reduce mental stress and stimulating arousal as they enable individuals to adjust their thinking process. For example, individuals learn to adjust the level of their personal needs to suit their own potential, seek for various alternatives, develop different types of behaviors, and learn different skills needed. A number of previous studies have indicated that problem-focused coping helps reduce mental and emotional stress (Mitchell, Cronkite & Moos, 1983; Mitchell & Hodson, 1983; Felton & Revenson, 1984, cited in Mathurin Kumwongpin, 2000: 36). However, there are some studies which revealed contradictory results, suggesting that problem-focused forms of coping can only reduce little mental stress, but they are more helpful in preventing problems that would follow.

Problem-focused forms of coping are generally used in the situations in which individuals are confident that they can still make a change, which can further be divided as follows:

1.1 Confrontive coping is a direct expression of ideas or behaviors to confront the situation as it really is. It is a form of fight to get rid of the problems, leading to the feeling of satisfaction. Individuals who make use of this form of coping will not avoid or step back from the problem without giving it much thought.

1.2 Planful problem solving is a method to deal with the problem in the situation in which it takes place. Individuals who use this technique try to better the situation and follow the necessary steps, analyzing the problem, impartially considering the problem, and seeking for more than one alternative or using past experience to improve the outcome.

2. Emotion-focused coping

Emotion-focused coping reflects individuals' attempt to control and adjust their emotions to relieve or reduce stress. These forms of coping are generally used when individuals feel that they cannot do anything to change the situation. For instance, individuals may feel that the situation they are facing is dangerous, threatening, or challenging. In fact, emotion-focused coping is used to sustain individuals' hope. In addition, individuals learn to look also at the good points of the situation, not just the bad sides. They avoid actually accepting themselves in a straightforward manner but adjust the meaning they give to the reality without any distortion. In particular, this coping does not directly deal with the problem, so when the problem is left unsolved, it could increase emotional stress the individuals have. Moreover, if individuals lack self-awareness, they may develop self-deception and reality distortion, leading to mental problems including anxiety, depression, and suicidal thoughts. Emotion-focused coping falls into the following categories:

2.1 Positive reappraisal is a thought and behavior in trying to give better meaning to the situation to benefit themselves by reducing the emotional stress and using better stress coping strategies including new or religious perspectives.

2.2 Accepting responsibility is a thought and behavior in which individuals realize that they cause their own problems and those problems cannot be changed. Thus, this is their acceptance of the responsibility for the problems.

2.3 Self-control is a thought and behavior which individuals have to try to control their own consistency such as being alone to think of solutions for problems or comparing with others who can be good role models.

2.4 Seeking social support is a thought and behavior in which individuals try to learn about the problems and their solutions by seeking social support in the form of information, material, or morale.

2.5 Distancing is an attempt of individuals to give less significance to the situation by distancing themselves from the situation they are facing using such techniques as being indifferent or forgetting everything.

2.6 Escape-avoidance is a thought and behavior in which individuals are trying to temporarily avoid the problems such as by giving no attention to them, seeking consolation, drinking alcohol, smoking, working out, or thinking that time will heal all.

The objectives of coping are to enable individuals to cope with the situations appropriately. In order to cope with stress well, individuals have to be able to appraise the situation as accurately as possible and know how to use appropriate coping techniques, both problem-focused coping and emotion-focused coping. According to Miller (1992: 587), facing with stress in everyday life has different effects on individuals' health. In addition, problem-focused coping tends to enable individuals to solve problems, while emotion-focused coping does not directly solve the problems and could have adverse effects on health.

3.1 Coping resources

Coping individuals use to deal with stress vary depending on coping resources they have which consist of the following (Lazarus & Folkman, 1984: 157-164):

1. Health and energy facilitates attempts to deal with stressful situations. Individuals who are physically healthy are able to handle stressful situations more effectively than those who are sick, tired, or exhausted.

2. Positive beliefs have an influence on individuals' thinking in terms of perception and appraisal of the situation or arousal, thus enabling them to overcome it. Positive beliefs include beliefs in one's potential or capability, one's control over the situation, justice, God or supernatural beings, and internal locus of control rather than

external locus of control, all of which give individuals hope and perseverance to fight the problems.

3. Problem-solving skills are individual abilities such as abilities to seek for information, to analyze problems, to choose solutions, to plan for solutions with consideration of positive and negative consequences that will arise. These skills depend on individuals' experiences, intellectuality, knowledge, and capability which are used to solve the problems. In addition, other factors can affect problem-solving skills as well.

4. Social skills are individuals' capability in communicating and establishing relationships with others. They are skills used in appropriately expressing ones' feelings and asking for help and cooperation from others. Moreover, social skills can better help solve problems if they are regularly practiced in daily life, and they can help prevent failure in individuals' adjustment as well.

5. Social support is support and assistance received from resources such as surrounding people, family members, different groups of individuals in society, etc. These persons can provide support in the form of information, morale, and advice. When individuals perceive that they have sufficient social support, they can face with stressful situations more effectively.

6. Material resources include money, objects, and services in daily life which can be bought with money. Individuals who have sufficient material resources, especially those effectively utilized, will have better alternatives in adjusting themselves when compared to those who do not.

3.2 Constraints in making use of coping resources to deal with stress

Coping with stress requires individuals' use of coping resources. However, there are different factors which prevent individuals from making a full use of their coping resources as follows (Lazarus & Folkman, 1984: 165-167):

1. Individual constraints include beliefs, values, or attitudes which result from individuals' personal development. For instance, individuals who do not want to bother others, trust others, or are afraid that others may have ill thoughts about them may not dare to ask for help from others.

2. Environmental constraints result from having limited coping resources and competition. They can affect adjustment.

3. Levels of threat. When individuals are scared, their thinking and problem-solving processes will be affected. The more individuals are threatened, the more they tend to rely on emotion-focused coping.

Coping is both behavioral and thinking attempts to deal with the stress that has occurred, which is specific in each situation. Individuals may have to use their intellectuality and resources more than they would normally do (Lazarus & Folkman, 1984: 141). Generally, individuals tend to use both forms of coping. On the one hand, problem-focused coping allows individuals to use reasons to better the situation, empowers the individuals to have control over the situation, and reduces the feeling of helplessness and hopelessness of individuals who are having critical situations. On the other hand, individuals can use emotion-focused coping to adjust their emotions to reduce the tension of the situation. However, adjustment of emotion does not solve the problem, but it can lead to reappraisal (Lazarus & Folkman, 1984: 151). When stress is reduced, individuals can then come back to face reality and reappraise whether the coping already used would help solve the problem or not. Individuals can then find new solutions or use old and effective strategies. Also, this would help individuals change the meaning or have better perceptions. Therefore, if families can relieve their stress and handle the problems effectively, it means families have effective coping (Lazarus & Folkman, 1984: 188). Whether individuals can effectively deal with stress depends on their existing coping resources. However, some individual and environmental constraints as well as the level of threat of the situation may prevent individuals from making the full use of their coping resources.

There is little research regarding coping of families of deceased AIDS patients. However, a study of McShane, Bumbalo & Patsdaughter (1994) investigating stress coping of caregivers of living AIDS patients revealed that most of the caregivers had high levels of stress, adversely affecting their life quality and stability and relationship in the family who may not accept or feel disappointed with the patients. Likewise, Trice (1988) found that mothers whose children were HIV-infected felt isolated, lonely, discriminated against, or were fired from their job. In fact, as many as 80% of them had a severe mental

condition after providing care to the patients for three weeks, and they needed to use medication or alcohol to reduce their anxiety, especially when the patients were hospitalized. In addition, Kittikorn Nilmanat (1995) discovered that the most frequently used strategy by caregivers was confrontation with the problem, followed by relief of stress and dealing with emotions. When HIV-infected patients developed full-blown AIDS, Stetz & Brown (1997) found that the roles of caregivers included strategies, consequences, and interactions. First of all, caregiving strategies consisted of management of the sickness, confrontation with and acceptance of death, and management of the environment. Secondly, consequences of caregiving included awareness of inner strength and own sufferings. Finally, interactions were composed of responses to reactions among family members and lack of convenience in provision of public healthcare. This research indicated that caregivers of AIDS and cancer patients had to dedicate most of the lives in taking care of sick family members as well as witness sufferings of their loved ones. However, some felt that such experience helped create their inner strength.

If families of AIDS patients have effective coping methods, they could change their perspectives of the situation to relieve the situation or eliminate the situation by relieving their emotions and sufferings by sharing them with trustworthy persons or asking for help from others so as to maintain their strength to continue dealing with stress. Exercises and hobbies can also help relieve stress, and individuals can learn to understand themselves, seek the cause of stress, and arrive at solutions to stressful situations. There can be more than one way to do this, and individuals can choose the best or most appropriate way based on their judgment and past experiences. They can also seek mental strength from religion. These coping techniques are helpful in bettering the situations and relieving the families of AIDS patients from their sufferings until they are again able to perform normal daily life activities. Thus, family members of AIDS patients can be satisfied with the fact that they can adjust themselves to stressful situations without causing the family or community any further problem. They can be proud that they are able to successfully fulfill their roles in the family and community, causing no one trouble or burden and being able to live with others happily and peacefully. They can also have social activities and maintain relationships with others, thus establishing and sustaining harmony and stability in both their family and their community (Ubol Niwatchai, 1984:

103-105; Cholada Puntusena, 1993: 29-41; Chaweewan Satayatham, 1997: 34-35; Sasima Kusuma and Orathai Somnarin, 1997: 14-15; Somjit Hanucharoenkul, 1997: 113; Rawlin et al., 1993: 33; Carson et al., 1996: 676-677; Townsend, 1996: 8-10; Johnson, 1997: 9; Auerbach & Gramling, 1998: 30-31).

If the families of AIDS patients use ineffective, they may feel better for only a short period of time. These ineffective coping techniques include denying the truth, crying, sleeping, developing a false hope, daydreaming, smoking, drinking alcohol, using drugs, going out more often, eating more food, seeing a fortune teller, praying to supernatural beings, showing aggression, or having fear. For example, if they smoke, drink alcohol, or use drugs for a continuing period of time without trying to better the situation, they may have psychological distress, leading to failure in life and inappropriate emotional and behavioral expressions (Kelter, 1999: 41). Furthermore, their ability to solve the problem and be independent will be reduced, rendering them unable to perform their roles in the family or earn their living to support the family. They will then be seen as a trouble-maker, and this can change the expectation the family used to have from them. As a result, the relationship in the family will be affected and the family may lose its balance. The family, therefore, has to adjust the roles and structures so as to live on. If the family cannot change the roles and structures, family members can become stressed. If the stress lasts for a long period of time, the quality of life of all family members will be reduced and the risk of mental health problems will increase. In the end, the family will become a family with no quality and inevitably a community's burden (Ubol Niwatchai, 1984: 103-105; Cholada Puntusena, 1993: 29-41; Chaweewan Satayatham, 1997: 34-35; Sasima Kusuma and Orathai Somnarin, 1997: 14-15; Somjit Hanucharoenkul, 1997: 113; Rawlin et al., 1993: 33; Johnson, 1997: 9; Auerbach & Gramling, 1998: 30-31; Varcarolis, 1998: 337).

4. Community mental health nursing

Community mental health is an application in which knowledge is disseminated among the people of the community to promote and maintain mental health, rehabilitate the target group who might have some mental symptoms left, and follow up on psychiatric patients who have already been discharged from the hospital. The emphasis is

placed on care provided to individuals and their environment, as well as on providing community with an opportunity to make some social and environmental changes for further benefits. Community mental health is provision of services which emphasizes prevention, especially by giving advice and knowledge, rather than treatment. However, in terms of treatment, it is believed that those who have problems need to receive help immediately before mental sickness fully develops (Suwanee Kiewkingkaew, 1984: 264-275; Ladda Sanseeaha, 1997: 343-352).

Community mental health nurses are those who work closely to the people in the community. Their main responsibilities include maintaining mental health, preventing occurrence of mental problems, and rehabilitating those who still have some mental conditions left with the goals as follows:

1. Primary prevention of mental health problems and promotion of mental health is carried out through providing mental health education to the target groups, eliminating the causes of mental health problems of the people in the community, encouraging people to take good care of themselves, and motivating them to use resources available in the community appropriately.
- 2) Secondary prevention is carried out by reducing the number of psychiatric patients, decreasing the severity of mental illness, and finding out early cases of psychiatric patients to ensure timely diagnosis and treatment.
- 3) Tertiary prevention consists of rehabilitating patients, preventing deterioration from mental illness, providing continuous care, and educating the patients' relatives about care and symptom management (Suwanee Kiewkingkaew, 1984: 264-275; Pajit Kasiwat, 1997: 694-701; Ladda Sanseeaha, 1997: 343-352; Rowlin et al., 1993: 526-530; Townsend, 1996: 783-784; Johnson, 1997: 22-26).

Thus, community mental health nurses have to work closely with members in the community to provide assistance and services to prevent mental health problems in these three phases, with the community as service receivers. The continuous care provided consists of 1.inpatient service, 2.outpatient service, 3.partial hospitalization, 4.emergency service, and 5.consultation and education (Suwanee Kiewkingkaew, 1984: 272-275; Ladda Sanseeaha, 1997:348-352; Rowlin et al., 1993:526-527; Townsend, 1996: 783-784).

Primary prevention is an attempt carried out with a goal to reduce the severity of the stressful situation caused by the environment which can lead to individuals' mental

illness. It also includes promotion of adjustment and reduction of emotional and mental problem among the people who are at risk of developing mental illness. Family members of AIDS patients are those who have a high risk of experiencing a mental problem as they have to provide care to the AIDS patients for a long time before the patients die. Such caregiving duties mean that their economic and health resources can easily be used up, and they have to face several losses due to the patients' death. In addition, as they are stigmatized by the community members who think that AIDS is disgusting, family members lack sufficient social support for a long time. As a result, after the death of the patients, they have to adjust themselves to the new situations. It could be seen then that family members of AIDS patients have to continuously face with situational crises caused by AIDS.

After the AIDS patients have died, their families become an important target group to which community mental health nurses should pay attention. Nurses need to offer understanding, assistance, and support to these people to reduce their stress and to equip them with appropriate stress coping strategies to enable them to continue fulfilling their roles and responsibilities in the family and society. This can help promote mental health and prevent mental illness, the initial goal of community mental health work.

There is little research conducted with family members of deceased AIDS patients, and most of the studies dealt with stress coping strategies of the AIDS patients themselves or the family members when the patients were still alive. Therefore, understanding the stress situations of family members of deceased AIDS patients, their stress, coping, and the social support they receive is deemed important for community mental health nursing.

CHAPTER III

METHODOLOGY

The present study was survey research describing stress, social support, and coping of family members of deceased AIDS patients.

Population and sampling

Population

The population of the present study was family members of deceased AIDS patients who used to be caregivers of the patients and knew that the patients were stricken with AIDS and who lived in Pranburi District, Guiburi District, and Samroiord Sub-District in Prachuabkheereekhan Province. The numbers of deceased AIDS patients in these three districts and sub-district were 91, 52, and 48, respectively.

Sample

The researcher was a community psychiatric nurse working at Pranburi Hospital, Pranburi Province. She chose to collect data from as many family members of deceased AIDS patients who were willing to cooperate and who could communicate in the standard Thai language as possible. After that, data were collected from family members of deceased AIDS patients who lived in Guiburi District and Samroiord Sub-District until the total of 100 subjects were obtained. It is worth noting here that most of the family members of deceased AIDS patients were unwilling to participate in the study as they were afraid that the infection status and the actual cause of death of the patients would be revealed to the public who might shun them. Therefore, the subjects in the present research were recruited by means of convenience sampling.

The researcher proceeded with the family members of deceased AIDS patients including spouses, parents, and children in the following order:

Step one: The researcher asked to talk to spouses of deceased AIDS patients who did not show any symptoms of AIDS. If they did have AIDS-related symptoms or the spouses had already died, the researcher moved to the next step.

Step two: The researcher talked to either the mother or the father of deceased AIDS patients. If they could not be reached for any reason, the researcher proceeded to the next step.

Step three: The researcher talked to the children of deceased AIDS patients who were older than 18 years old and already worked to financially support themselves.

Setting

Most of the residents of these three districts and sub-district worked as pineapple growers. The second most popular occupation in the area was fishery, but most of the residents with this occupation were not originally local residents, and a large number of them were Burmese. There were altogether 383 AIDS patients, and 191 of them had already passed away. Most of the AIDS patients were aged between 25 to 29 years, and they were wage earners.

The Department of Social Welfare has imposed a regulation regarding financial support and facilities of AIDS patients in the community since 1996. According to this regulation, AIDS patients who live in these three districts and sub-district could ask for assistance from the Department of Social Welfare situated in the province. They are required to submit the blood examination result and the house registration to public health officials in the districts and sub-district. After that, the public health officials would gather the evidence, ask for further information, and transfer the cases to the Department of Social Welfare Office in the province for consideration of assistance, conducted based on the burden the AIDS patients have toward their families. Initially, the Department would give a lump sum of 1,000 to 5,000 baht to the AIDS patients, followed by a monthly payment of 500 baht. However, after the patients die, there will be no organization, public or private, that offers assistance to the patients' surviving family members.

Research instruments

The instruments used in data collection consisted of the following:

1. The Demographic Characteristic Questionnaire consisted of twelve items.
2. The Stress Causing Situations Questionnaire was constructed by the researcher based on a review of related literature and existing research. It consisted of 15 items regarding stress which may result after the death of the AIDS patients aiming to elicit information whether the subjects had previously faced such situations in their lives or not.
3. The Assessment of Stress Levels Questionnaire consisted of 15 items asking whether the subjects had ever faced any of the situations and how much stress each situation could cause to them using a four-point rating scale as follows:

Not stressed meant the situation they faced did not make them unhappy, miserable, or worried (totaling 0 point).

Slightly stressed meant the situation they faced made them slightly unhappy, miserable, or worried (totaling 1 point).

Moderately stressed meant the situation they faced made them moderately unhappy, miserable, or worried (totaling 2 points).

Very stressed meant the situation they faced made them very unhappy, miserable, or worried (totaling 3 points).

The interpretation of scores could be done item by item, with the lowest score equal to 0 and highest score equal to 3 as shown in the following criteria:

The mean scores between 0.00 and 1.00 meant the subjects were slightly stressed.

The mean scores between 1.01 - 2.00 meant the subjects were moderately stressed.

The mean scores between 2.01 - 3.00 meant the subjects were very stressed.

4. Social support questionnaire (SSQ) was originally developed by Schaefer, Coyne, and Lazarus (1981) and translated into Thai by Hanucharoenkul (1988). Chanpen Saewoon (1988) subsequently adapted and revised the questionnaire, dividing social support into three aspects: information support (item 1), emotional support (items 2 – 5), and tangible support (items 6 and 7), totaling seven items. The

items in this questionnaire were questions asking the subjects about different kinds of support they had received since the death of the AIDS patients from family members including parents, children, relatives; neighbors; colleagues; organizations, clubs, and associations in the community; and healthcare providers including physicians, nurses, and public health officials. The items were arranged in a five-point rating scale as follows:

Not helpful at all	meant the subjects perceived that they did not receive any help (totaling 0 point).
Slightly helpful	meant the subjects perceived that they received a little help (totaling 1 point).
Somewhat helpful	meant the subjects perceived that they received help occasionally (totaling 2 points).
Rather helpful	meant the subjects perceived that they received quite a lot of help (totaling 3 points).
Very helpful	meant the subjects perceived that they received a lot of help (totaling 4 points).

The interpretation of scoring could be done for the scores of each item or for the overall scores for all items. The highest score was equal to 74, and the lowest score was 0.

5. The Coping Questionnaire was translated by the researcher from the stress coping of Folkman & Lazarus (1984). The interpretation of scores was based on Lazarus (1988). In this questionnaire, coping was divided into two types, with eight coping techniques in 66 items. In particular, there were twelve items regarding problem-focused coping, with six items regarding confrontive coping (items 6, 7, 17,

28, 34, and 46) and the other six concerning planning problem solving (items 1, 26, 39, 48, 49, and 52). In addition to this, there were 38 items regarding emotion-focused coping which could further be categorized into six techniques: having positive reappraisal (seven items: items 20, 23, 30, 36, 38, 56, and 60), accepting responsibility (four items: items 9, 25, 29, and 51), having self-control (seven items: items 10, 14, 35, 43, 54, 62, and 63), seeking social support (six items: items 8, 18, 22, 31, 42, and 45), distancing (six items: items 12, 13, 15, 21, 41, and 44), and escape - avoiding (eight items: items 11, 16, 33, 40, 47, 50, 58, and 59). Also, there were 16

items which were not categorized under any of these eight techniques, but they were included to increase naturalness of the questionnaire. However, these 16 items were not included when calculating the total scores. Thus, the total scores came from 50 items arranged in a four-point rating scale as follows:

Never	meant the subjects had never used this technique in coping with stress (totaling 0 point).
Sometimes	meant the subjects had sometimes used this technique in coping with stress (totaling 1 point).
Often	meant the subjects had often used this technique in coping with stress (totaling 2 points).
Always	meant the subjects had always used this technique in coping with stress (totaling 3 points).

The interpretation of scores could be conducted for each of the items or for the overall scores of all items. The highest score was 150, and the lowest score was 0. In addition, the calculation for relative scores was required as each technique contained different number of items, which could lead to bias in interpretation. Vitaliano et al. (1987, cited in Yupapin Sirabhongam, 1997: 9) suggest that the relative score of each technique could be calculated by calculating the mean score of each technique and divide it with the sum of the means of all techniques

Validity and reliability of instruments

1. Validity

The following experts were asked to review and validate the content validity of the stress causing situation questionnaire, the stress coping questionnaire, and the social support questionnaire:

Two mental health nursing and psychiatric nursing instructors

One nursing instructor who was an expert in stress and adjustment

The questionnaires were then revised according to these experts' comments and suggestions.

2. Reliability

The social support questionnaire of Hanucharoenkul (1988) was tried out with 112 cancer patients undergoing chemotherapy. The alpha coefficient was 0.97.

In the present study, the stress causing situation questionnaire, the coping questionnaire, and the social support questionnaire were tried out with 30 family members of deceased AIDS patients living in Hua Hin District. The scores obtained were then calculated with the Cronbach's Alpha Coefficient formula as follows (Yuwadee Ruecha et al., 1997: 127-129):

$$\alpha = \frac{n}{n - 1} \left[1 - \frac{\sum Si}{St} \right]$$

When α = reliability coefficient of the questionnaire
 n = number of items of the questionnaire
 Si = variance of score of each item
 St = variance of overall score

The reliability of the questionnaires was as follows:

- | | | |
|---|---|------|
| 1. The stress causing situation questionnaire | = | 0.87 |
| 2. The social support questionnaire | = | 0.91 |
| 3. The coping questionnaire | = | 0.92 |

Data collection

Data collection was conducted by the researcher in the following sequence:

1. A letter issued by the School of Graduate Studies, Mahidol University, was sent to the Public Health Physician of Prachuabkheereekhan Province asking for cooperation in data collection through collaboration with the Director of District Public Health Hospital and the Heads of Public Health Stations in Pranburi District, Guiburi District, and Samroiord Sub-District.

2. After permission to collect data was granted, the researcher met the Director of District Public Health Hospital and the Heads of Public Health Stations in Pranburi District, Guiburi District, and Samroiord Sub-District to introduce herself and ask for permission to commence data collection.

3. The researcher introduced herself to officials and staff of the District Public Health Hospital and Public Health Stations in each district and sub-district.

4. The researcher reviewed the medical history of deceased AIDS patients from the files kept at the District Public Health Hospital and Public Health Stations in each district and sub-district to select the sample.

5. The researcher approached the potential subjects at their houses, introduced herself, established a relationship with them, explained the purposes of the research, and asked for cooperation to participate in the study. The researcher assured the would-be subjects that the data obtained from them would be kept strictly confidential and would be used only as research data. The researcher finally asked the subjects to read the human protection form before they could make the decision whether to participate in the study or not.

6. After the subjects agreed to take part in the study, the researcher explained how to respond to the questionnaires until they understood the procedure clearly. After that, the subjects were asked to respond to the questionnaires which were read out loud to them by the researcher in the following order: the demographic characteristic questionnaire, the stress causing situation questionnaire, the stress coping questionnaire, and the social support questionnaire. It took approximately 30 to 45 minutes to complete all of the questionnaires.

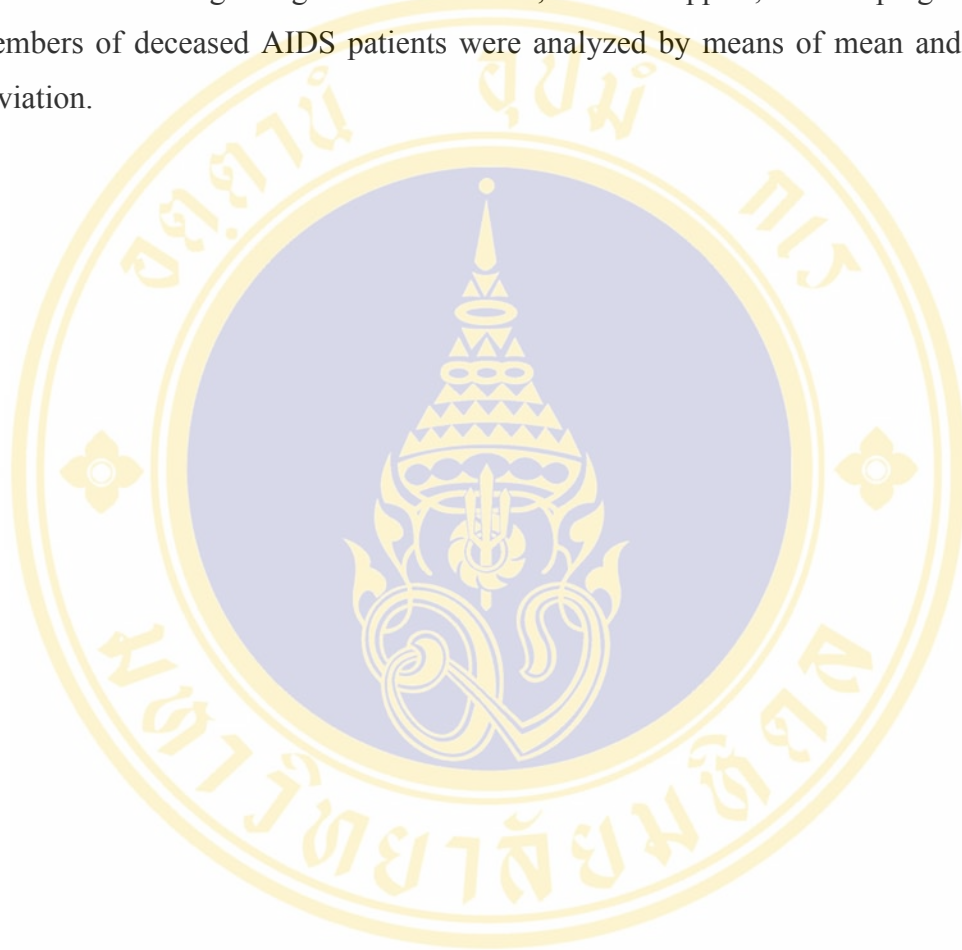
Protection of human subjects

The researcher provided the subjects with a written document involving details regarding the objectives of the present study and asking them for cooperation in the study. The subjects were assured that they had the right to agree to take part in the study or refuse to cooperate. They were also confirmed that they were able to withdraw their participation at any time if they wished and that data obtained from them would be kept strictly confidential.

Data analysis

Data analysis was conducted with the SPSS for Windows Program as follows:

1. Frequency distribution including percentage was used to analyze data concerning demographic characteristics of the subjects.
2. Data regarding levels of stress, social support, and coping of family members of deceased AIDS patients were analyzed by means of mean and standard deviation.



CHAPTER IV

RESULTS

The present research aimed at investigating stress, social support , and coping of family members of deceased AIDS patients. The subjects were 100 family members of deceased AIDS patients residing in Pranburi District, Guiburi District, and Samroiord Sub-district in Prachuabkheereekhan Province. The findings of this study are presented in this chapter.

1. Demographic characteristics

Table 1 Number and percentage of family members of deceased AIDS patients categorized according to general data

Data	Number
Gender	
Male	20
Female	80
Age (years)	
20 – 39	24
40 – 59	41
60 and older	35
Marital status	
Single	2
Married	40
Separated / Divorced	7
Widowed	51
Religion	
Buddhism	100

Table 1 Number and percentage of family members of deceased AIDS patients categorized according to general data (continued)

Data	Number
Education	
No formal education	14
Primary education	75
Secondary education	7
Diploma, undergraduate, or equivalent	4
Occupation	
Government official	3
Housewife	30
Trader	16
Agriculturist	22
Wage earner	24
Others	5
Family monthly income (Baht)	
4,000 or lower	16
4,001 – 8,000	28
8,001 – 12,000	10
12,001 – 16,000	5
unstable income	41
Adequacy of family income	
Adequate	37
Inadequate	3
Indebted	32
Adequate with saving	28
Type of family	
Nuclear	50
Extended	50
Number of family members (persons)	
1 – 4	56
5 – 8	36
9 – 12	8

Table 1 Number and percentage of family members of deceased AIDS patients categorized according to general data (continued)

Data	Number
Period of time since the death of the patient	
1 day – 6 months	17
7 months – 12 months	7
1 year 1 month – 3 year	54
3 years 1 month – 6 years	22
Relationship with the deceased patient	
Husband	2
Wife	25
Father	16
Mother	52
Child	5
Period of time providing care to the deceased patient	
1 day – 6 months	40
7 months – 12 months	26
1 year 1 month – 3 years	24
3 years 1 month – 6 years	6
Longer than 6 years	4

As shown in Table 1, 80% of the family members of deceased AIDS patients were female, and the largest group of the subjects (41%) were between 40 – 59 years old. About half (51%) were widowed, and all of them were Buddhists. Three-quarters of the subjects completed elementary education. Almost half of them, or 41%, had unstable income, and 37% had adequate income. Furthermore, half lived in a nuclear family, whereas the other half lived in an extended family. More than half, or 56% of them, had one to four members in the family. When considering the period of time since the AIDS patients passed away, it was found that more than half of the subjects, or 54%, had to live with the death of the AIDS patients for one year one month to three years. Finally, regarding the relationship with the AIDS patients, approximately half, or 52%, were mothers of the AIDS patients, and close to half, or 40%, had provided care to the AIDS patients for 1 day to 6 months.

2. Stress-causing situations

Table 2 Mean and standard deviation of stress-causing situations of family members of deceased AIDS patients (n = 100) (The possible range of stress-causing situations was from 0 to 3 , with the actual range of 0.39 – 2.90)

Stress-causing situations	Stressful condition Found	Mean	S.D.	Level of stress
Loss of a member				
1. Missing deceased patient	100	2.54	0.64	Very stressed
Loss of an individual...				
2. Taking care of deceased patients' Children when family member being deceased patients' spouse (n = 27)	21	2.90	0.29	Very stressed
3. Taking care of deceased patients' Children when being their parent (n = 68)	33	2.48	0.91	Very stressed
4. Losing head of family	54	2.19	2.12	Very stressed
5. Losing head of family	90	1.89	1.18	Moderately stressed
6. Losing breadwinner	89	1.88	1.13	Moderately stressed
7. Losing persons who took care	87	1.85	1.14	Moderately stressed
8. Taking care of deceased patients' parents when family member being deceased patients' spouse (n = 27)	18	1.28	1.12	Moderately stressed
9. Taking care of deceased patients' spouses when family member being deceased patients' child (n = 5)	2	1.15	0.70	Slightly stressed

Table 2 Mean and standard deviation of stress-causing situations of family members of deceased AIDS patients (n = 100) (The possible range of stress-causing situations was from 0 to 3 , with the actual range of 0.39 – 2.90) (continued)

Stress-causing situations	Stressful condition Found	Mean	S.D.	Level of stress
10. Taking care of deceased patients' parents when family member being deceased patients' child (n = 5)	2	1	-	Slightly stressed
11. Taking care of deceased patients' spouses when family member being deceased patients' parents (n = 68)	10	0.90	1.10	Slightly stressed
Effects of AIDS				
12. Being asked by neighbors	99	1.86	0.67	Moderately stressed
13. Being responsible for paying ...	63	1.38	1.04	Moderately stressed
14. Family member being infected...	87	1.24	1.12	Moderately stressed
15. Being unsure whether oneself ...	89	1.17	1.10	Moderately stressed
16. Neighbors and villagers...	95	1.15	0.74	Moderately stressed
17. Being asked by relatives	95	0.88	0.68	Slightly stressed
18. Family members and relatives...	72	0.39	0.57	Slightly stressed
Loss of hope				
19. Losing hope and goals in...	99	2.26	0.78	Very stressed

According to Table 2, when considering each item of stress-causing situations regarding loss of a family member, it was found that for all family members of deceased AIDS patients, the mean score for the item ‘missing the deceased AIDS patients’ was equal to 2.54 and the standard deviation was 0.64, meaning that this situation caused them a great deal of stress. As regards loss of an individual who performed different functions in the family, of all 27 subjects who were spouses of deceased AIDS patients, 21 (77.78%) had to take care of the deceased AIDS patients’ children. Their mean stress score was 2.90, with the standard deviation of 0.29. Next, 33 or 48.53% of 68 parents of deceased AIDS patients had to take care of the deceased AIDS patients’ children, and their mean stress score was 2.48, with the standard deviation of 0.91. Also, the mean score for the situation concerning loss of the head of the family was 2.19, with the standard deviation of 1.12. Moreover, with regards to consequences of having AIDS, various situations that caused the subjects a moderate level of stress were found. Almost all of the family members, or 99%, had to deal with the situations in which neighbors and villagers asked for the actual cause of the patients’ death. For them, their mean stress score was 1.86 and the standard deviation was 0.67. Second came paying back debts incurred by the patients’ treatment, with the mean stress score of 1.38 and the standard deviation of 1.04. Then, the mean stress score of contracting HIV from the deceased AIDS patients was 1.24, with the standard deviation of 1.12, while the mean stress score of being unsure whether having contracted HIV from the deceased AIDS patients was 1.17, with the standard deviation of 1.10. Finally, the mean stress score of being disgusted by neighbors and villagers was equal to 1.15, and the standard deviation was equal to 0.74. Last but not least, when it came to loss of hope and goals in life used to share with the deceased AIDS patients, 99% of the subjects had this experience. Their mean stress score was equal to 2.26, and the standard deviation was 0.78, meaning that the family members of deceased AIDS patients were very stressed.

3. Social support scores

Table 3 Mean and standard deviation of social support family members of deceased AIDS patients received from their own family members in each item (n = 100)

Social support	Possible range	Actual range	Mean	S.D
Informational support	0 – 4	0 – 4	3.22	1.22
Emotional support	0 – 16	0 – 16	13.55	3.90
Tangible support	0 – 8	0 – 8	6.42	2.27
Total	0 - 28	0 - 28	23.46	6.96

As depicted in Table 3, when considering each aspect of the social support the family members of deceased AIDS patients received from their own family members, it was found that the mean score of informational support was 3.22 and the standard deviation was equal to 1.22. As for emotional support, the mean score was 13.55 and the standard deviation was 3.90. In addition, the mean score for tangible support was 6.42, with the standard deviation of 2.27. Finally, the mean score for overall social support was equal to 23.46, and the standard deviation was 6.96.

Table 4 Mean and standard deviation of social support the family members of deceased AIDS patients received from neighbors, colleagues, and organizations / clubs / associations in the community in each aspect and overall (n = 100)

Social support	Possible range	Actual range	Mean	S.D
Informational support	0 – 4	0 – 4	1.50	1.23
Emotional support	0 – 16	0 – 16	5.91	4.68
Tangible support	0 – 8	0 – 6	1.36	1.62
Total	0 - 28	0 - 27	8.77	6.94

According to Table 4, when considering social support the family members of deceased AIDS patients received from their neighbors, colleagues, or organizations, clubs, and associations in the community, it was found that in terms of informational support, the mean score was equal to 1.50 and the standard deviation was 1.23. As regards emotional support, the mean score was 5.91 and the standard deviation was 4.68. Moreover, the mean score for tangible support was 1.36, with the standard deviation of 1.62. Finally, the mean score for the overall social support the family members of deceased AIDS patients received from neighbors, colleagues, or organizations, clubs, and associations in the community was 8.77, with the standard deviation equal to 6.94.

Table 5 Mean and standard deviation of social support family members of deceased AIDS patients received from healthcare providers (n = 100)

Social support	Possible range	Actual range	Mean	S.D
Informational support	0 – 4	0 – 3	0.59	0.98
Emotional support	0 – 16	0 – 8	0.67	1.69
Tangible support	0 – 8	0 – 2	0.05	0.26
Total	0 - 28	0 - 14	1.15	2.36

Table 5 indicates that when considering social support the family members of deceased AIDS patients received from healthcare providers, it was found that the mean score for informational support was equal to 0.59 and the standard deviation was 0.98. In addition, the mean score for emotional support was 0.67, with the standard deviation of 1.69, while the mean score for tangible support was 0.05, with the standard deviation of 0.26. Finally, the mean score for the overall social support family members of deceased AIDS patients received from healthcare providers was 1.15, and the standard deviation was equal to 2.36.

4. Coping scores

Table 6 Mean and standard deviation of coping of family members of deceased AIDS patients in each form of coping (n = 100)

Coping	Possible range	Actual range	Mean	S.D	Propotion
Problem-focused coping	0 - 36	6 - 29	16.71	4.82	0.25
Emotion-focused coping	0 - 114	21 - 69	49.01	11.60	0.75
Total	0 - 150	28 - 96	65.05	16.58	

Table 6 reveals that when considering each aspect of coping, it was found that the mean score of problem-focused coping used by family members of deceased AIDS patients was equal to 16.71, with the standard deviation of 4.82, accounting for 25% of the total coping scores. On the other hand, the mean score of emotion-focused coping of family members of deceased AIDS patients was 49.01, with the standard deviation of 11.60, making up the other 75% of the total coping scores.

Table 7 Mean and standard deviation of coping of family members of deceased AIDS patients categorized according to each strategy employed (n = 100)

Coping	Possible range	Actual range	Mean	S.D	Propotion
Problem-focused coping					
- Confrontive Coping	0 – 18	3 – 5	7.72	2.46	0.12
- Planful problem solving	0 – 18	1 – 16	8.40	3.37	0.13
Emotion-focused coping					
- Positive reappraisal	0 – 21	2 – 15	7.83	3.11	0.12
- Accepting responsibility	0 – 12	0 – 8	3.72	2.01	0.06
- Self – control	0 – 21	4 – 18	12.72	2.77	0.20
- Seeking social support	0 – 18	0 – 15	6.76	3.02	0.10
- Distancing	0 – 18	3 – 15	9.81	2.26	0.15
- Escape - Avoidance	0 – 24	2 – 17	8.16	3.62	0.13

According to Table 7, when considering each aspect of problem-focused coping of family members of deceased AIDS patients, it was found that the mean score for the ‘confrontive coping’ aspect was equal to 7.72, with the standard deviation of 2.46, thus making up 12% of the total coping scores. In addition, the mean score for the ‘planful problem solving’ aspect was 8.40, with the standard deviation of 3.37, accounting for another 13% of the total coping scores. As for emotion-focused stress coping, the mean score for the ‘positive reappraisal’ aspect was 7.83, with the standard deviation of 3.11, or 12% of the total coping scores. Furthermore, the mean score for the ‘Accepting responsibility’ aspect was 3.72, with the standard deviation of 2.01, or 6% of the total coping scores, while the mean score for the ‘self-control’ aspect was 12.72, with the standard deviation of 2.77. contributing another 20% of the total coping scores. Besides, the mean score for the ‘seeking social support’ aspect was 6.76, with the standard deviation of 3.02, totaling 10% of the total coping scores, whereas the mean score of the

‘distancing ’ aspect was 9.81, with the standard deviation of 2.26, or 15% of the total coping scores. Finally, the mean score for the ‘escape - Avoidance’ aspect was equal to 8.16, and the standard deviation for this item was equal to 3.62, or the remaining 13% of the total coping scores.



CHAPTER V

DISCUSSION

The present study aimed to investigate stress, social support and coping, of 100 family members of deceased AIDS patients living in Pranburi District, Guiburi District, and Samroiord Sub-district, Prachuabkheereekhan Province. In this chapter, the findings of the study are discussed.

Stress of family members of deceased AIDS patients

When considering the stress levels of family members of deceased AIDS patients which was caused by assessment of different situations that had occurred to them after the death of the patients, it was found that the subjects' stress levels could be considered high, moderate, or low depending on the situations seen as the cause of stress of family members of deceased AIDS patients as follows:

As regards the loss of a family member, the mean score of stress caused by missing the patients was 2.54 (Table 2), which was considered a high level of stress. This is because the relationship with the deceased patients was one factor affecting the level of the feeling of loss (Stuart & Lararia, 2001: 357). In this study, the family members had a very close relationship with the patients as 52% of them were mothers, 25% were wives, and 16% were fathers (See Table 1). According to the interview conducted with surviving family members of the AIDS patients', most of the deceased AIDS patients were still in their early adulthood. This age period is generally considered a time when the individuals have their prime physical fitness enabling them to be significant resources of the family (Jaruwan T.Sakul, 1987: 68-72). Naturally, older family members should pass away before them (Sunisa Suktrakool, 2001: 16-17). When the AIDS patients died, the surviving family members had to face with untimely loss of loved ones who had long shared love, attachment, and bonding. Worse yet, such loss was complete and permanent. Thus, their stress level was high even though more than a year had passed since the patients passed away (In this study, 54% of the AIDS patients had died for one year one month up to three years, and 22%

for three years one month up to six years). According to Shives (1994: 257), a loss of valued and loved ones can eventually lead to pathologic grief of individuals.

In terms of loss of an individual who performed different functions in the family, it was found that of all the 27 spouses of the deceased AIDS patients, 21 had to take care of the patients' surviving children, which caused them a high level of stress, as clearly indicated by the mean stress score of 2.90 (Table 2). Likewise, of 68 parents of the patients, 33 of them had to take care of the deceased patients' surviving children, which also caused them a high level of stress, and their mean stress score was 2.48 (Table 2). In addition, 54% of the family members of deceased AIDS patients suffered the loss of the leader of the family, with the mean score of 2.19, which was again a high level of stress. This may be because of the 80% of female family members of deceased AIDS patients, 52% were mothers and 25% were spouses (Table 1). According to the interview, most of the children of the patients went to a kindergarten or an elementary school, so they were still young children who had considerable needs for quality nutrition and hygiene appropriate for growth and development. Also, they needed proper intellectual, social, mental, and emotional care which would enable them to develop to their fullest potential, and they needed education to become quality adults who would could live a respectable life in the future (Jarawan T.Sakul, 1987: 59-61; Patchara Soonthrachun, 1998: 28-29). At the same time, about half (51%) of the caregivers of the deceased patients' surviving children were widowed, 35% were older than 60 years of age, 30% were housewives, 41% had unstable family income, and 32% were indebted. Therefore, these factors could greatly contribute to their stress. Generally, when people get older, their capacity to work to earn their living decreases. Thus, the subjects had to bear a great responsibility of raising the deceased patients' children who were still unable to look after themselves and required age-appropriate care from adults to become quality individuals when they grew up. This was consistent with the findings of Apiradee Thanmathikul (1998) which found that caregivers of deceased AIDS patients' children were grandparents who did not have stable income and were in a desperate need for financial support for both daily living and future education of the children. Besides, surviving children of deceased AIDS patients also require assistance from adults to learn to accept their parents' untimely death, to recover from loss and grief, and to

continue age-appropriate development (Shives, 1994: 262-263; Jacik 1998 cited in Carson, 2000: 583).

Ninety percent of the family members of deceased AIDS patients had to endure the loss of a family consultant, with the mean score of 1.89, or a moderate level of stress. In addition, 89% faced the loss of a breadwinner, with the mean score of 1.88 or a moderate level of stress, whereas 87% experienced the loss of a person who took care of family members' well-being, with the mean score of 1.85, or again another moderate level of stress. Furthermore, of the 27 spouses of deceased AIDS patients, 18 of them had to take care of the patients' surviving parents. Their mean stress score was 1.28, or a moderate level of stress. Similarly, two out of five of the children of the deceased AIDS patients had to be responsible for the deceased AIDS patients' surviving spouses. For them, the mean stress score was equal to 1.15, which was seen as a moderate level of stress as well (Table 2). One possible explanation is that in the Thai society, males play a role of the leader of the family who have to earn money to support the family. They are also expected to be protective of their wives and children, develop a close relationship with them, take care of their elderly parents, and make all family members feel warm and secure (Supatra Suparp, 1989: 3-5; Ruja Poopai boon, 1998: 37-38; Andrew & Roy, 1991: 385-900). The interviews conducted in the present study revealed that most of the patients were in their early adulthood when they were supposed to enjoy their prime physical fitness which was abruptly ended with an incurable disease and an untimely death. About 80% of the surviving family members were female (Table 1) , 68% had a close relationship with the deceased patients as parents (Table 1). Also, 30% of the subjects had an unstable income and needed financial support from others (Table 1). Thus, when the patients died, these family members were greatly affected by the loss of caretakers, leaders, breadwinners, and consultants they used to rely on.

When considering the consequences of AIDS that followed, it was found that almost all, or 99%, of the family members had to deal with the neighbors and villagers who asked them about the actual cause of the patients' death. Their mean stress score was 1.86, which was seen as a moderate level of stress (Table 2). According to the interviews, most of the patients died during their early adulthood, a period of time when they should have had prime physical condition and begun to build their own

families (Jarawan T.Sakul, 1987: 68-72). Instead, they were destined to an untimely death. Besides, the period of time when the patients were unable to care for themselves ranged from one day to six months (40%) (Table 1). On top of this, the society generally regards HIV infection and AIDS as a dreadful and disgusting disease of people who have immoral or sinful behaviors (Patchara Soonthrachun, 1998: 46-64; Udomsak Mahaweerawat, 1998: 10-15). As a consequence, it was not surprising that the subjects in the present study had to deal with neighbors and villagers who were concerned about HIV infection which made the patients die prematurely after a short period of sickness. This led to the subjects' moderate level of stress when they were asked about the actual cause of the patients' death by the neighbors and villagers. By the same token, 63% of the subjects had to be responsible for the debts incurred by the patients' treatment. Their mean stress score was equal to 1.38, yet another moderate level of stress. Moreover, 87% contracted HIV infection from the deceased patients, with the mean stress score of 1.38, or a moderate level of stress, whereas 89% of the subjects were not certain whether they themselves became HIV infected due to caregiving duties, and their stress score was 1.17, also a moderate level of stress. Finally, 95% had to deal with social stigma of AIDS from neighbors and fellow villagers, with the mean stress score of 1.15, or a moderate level of stress. The interviews conducted with these subjects revealed that during the deceased patients' period of sickness, the caregivers periodically received information and advice from medical personnel, so they were able to accept the patients' infection status to a certain extent, to adjust themselves, and to solve some of the problems that caused them stress. In addition, as the patients were sick between one day and six months, which was not a long period of time, the burdens caused by provision of care such as transportation fares to and from the hospital, medical bills, and leaves taken from work did not last long or cause a high level of stress. Some subjects indicated that when the patients were not too seriously ill, they went to work somewhere else and came home only after they were too sick to take care of themselves. They died not long after coming back home. Some subjects also stated that they did not think too much about the patients' disease as they were informed by the physicians that it was rather difficult to contract AIDS while performing their caregiving duties. Only at the times when

they made a mistake such as forgetting to wear gloves that the subjects were worried about being infected.

Regarding loss of hope and goals in life, as high as 99% of the subjects felt the loss of hope and goals in life they once shared with the patients, and their mean stress score was 2.26, a high level of stress (Table 2). One plausible explanation is that the death of the AIDS patients was seen as an unexpected loss which was difficult to face, so the surviving family members needed a long period of time to recover (Jacik, 1998, cited in Carson, 2000: 583). Also, 68% of the family members were the patients' parents and 27% were spouses (Table 1). Generally, when individuals become old, their ability to earn their living decreases and their need to depend on others increases (Jaruwan T.Sakul, 1987: 74-76; Roongtip Pangjai, 1999: 29). The elderly individuals tend to have a hope in their children who they expect to take care of them in various aspects including financial status, healthcare, and general well-being (Roongtip Pangjai, 1999: 24-25). By the same token, when individuals lose their spouses, they experience the feelings of desertion and loneliness and they have to carry on living with old memories. They also have to live with the loss of close persons who used to be their advisor, morale supporter, idea sharer, and persons who once aimed to build a loving family with them. Consequently, loss of hope and goals in life once shared with the deceased AIDS patients caused a high level of stress to the surviving family members as they were now unable to accomplish the aims in life they once set their eyes on.

Thus, it could be concluded that surviving family members had ways to assess different situations which caused them stress and their stress levels varied depending on how much they thought such situations affected them. This yielded support to the theory of stress of Lazarus and Folkman (1984: 55-85) which points out that assessment of stressful situations depends on immediate factors such as seriousness, predictability, and uncertainty of the situations. The more serious, unpredictable, and uncertain the situation is, the higher level of stress it can cause.

Social support from family members of AIDS patients

Individuals who are grieving over their losses could more easily and quickly recover if they receive kindness and compassion from others (Jacik, 2000, cited in Carson, 2000: 583). At the same time, grief-stricken individuals who lack social support from their networks would be unable to overcome their grief (Fulton & Metress, 1995: 346; Stuart & Laraia, 2001: 357). In the present study, the mean score of social support the family members of deceased AIDS patients received from their family was 23.46, a score higher than the mid point of the possible range of 0 to 28 (or 14) (Table 5). This is because Thai society is generally considered consisting of close-knit families with natural and profound bonding, attachment, closeness, trust, and dependability. Furthermore, 35% of the subjects in this study were older than 60 years old (Table 1). This is the time when individuals' social network becomes smaller due to retirement from work, reduced income, relocation, and death of people of the same age (Pranee Mingkwan, 1999: 60; Roongtip Pangjai, 1999: 24-25). Thus, family becomes the main source of social support in different aspects of life. In addition, as half of the subjects lived in an extended family (Table 1), they had sufficient warmth and care from members of the family, so they had a source of mental strength that enabled them to appropriately deal with the problems and obstacles in life (Sirisuda Chaokumkhet, 1998: 63). As a consequence, when the subjects had interaction with the remaining family members, they could experience the feeling of warmth, assurance, and security (Ruja Poopaiboon, 1998: 37-38; Brown, 1986: 72-76). Besides, the fact that the subjects had undergone different problems and situations since they first learned about the infection status of the patients enabled them to understand and sympathize each other. Therefore, they had the mean scores for informational equal to 3.22, which was higher than the mid point of the range of possible scores of 0-4, or 2. As regards emotional support, their mean score was equal to 13.55, a score higher than the mid point of the possible range of scores of 0-16, or 8, while the mean score of tangible support was 6.42, once again higher than the mid point of the possible range of scores of 0-8, or 4 (Table 5). This was consistent with the findings of Sirisuda Chaokumkhet (1998), Roongtip Pangjai (1999), and Maturin Kumwongpin (2000) which indicated that families play an important role in taking care of and responding to physical, mental, and emotional needs of individuals at a

high level. Thus, it could be concluded that the subjects in this study received social support from their family members at a high level.

Social support from neighbors, colleagues, and organizations/clubs/associations in the community

The mean score of this aspect of social support was equal to 8.77, which was lower than the mid point of the possible score range of 0-28, or 14 (Table 6). This may be because AIDS is an incurable contagious disease that is seen as unacceptable to the society. Consequently, the family members of deceased AIDS patients concealed the patients' actual cause of death from the people in the community as they were afraid that they themselves would be shunned by others. As such, their neighbors and other villagers did not know their condition or provide assistance and support. In addition, there was no organization, club, or association in the community that directly provided help to the family members of deceased AIDS patients. According to the interviews, some of the children of deceased AIDS patients were teased or shunned by their schoolmates, and they had to quit school as a result of this. Also, the neighbors refused to enter some of the surviving family members' houses for fear of contracting AIDS. It was not surprising, therefore, that the family members of deceased AIDS patients had less interaction with people in their community, and their mean scores of informational support, emotional support, and tangible support were 1.50, 5.91, and 1.36, all of which lower than the mid point of the possible score ranges of 0-4 (or 2), 0-16 (or 8), and 0-8 (or 4), respectively.

Social support from healthcare providers

Psychiatric and mental health nurses play a significant role in facilitating surviving family members to cope with their losses and overcome their grief (Varcanolis, 1998: 549). In doing so, they need to understand the relationship between the deceased patients and the surviving family members, develop the perception of the preventability of the loss (Stuart & Laraia, 2001: 357), give them permission to grieve in their own way, and provide needed helping responses (Fulton & Metress, 1995: 346). According to Fulton & Metress (1995: 372), the principles necessary in proving assistance to individuals enduring losses are as follows:

1. Do not rush someone through grief.
2. Do not trivialize someone's grief.
3. Make support available especially beyond the funeral period.
4. Allow the deceased to be important during the grieving process.
5. Give permission to grieve.
6. Help the bereaved deal with any guilt or anger.
7. Realize the importance of obsessive review.
8. Remember that grief is highly individual.
9. Help the bereaved to get on with living and to form new relationships.

The findings of the present study revealed that the mean score of social support the family members of deceased AIDS patients received from healthcare providers was 1.15, which was again lower than the mid point of the possible score range of 0-28 or 14 (Table 7). One plausible explanation was that the services offered by healthcare providers were mostly concerned with medical treatment provided at the hospital, not in the community. Even though both the public and private sectors had tried to speed up development of service provisions and offer more assistance including funds for surviving family members, hotline services, stress relieving clinics, hospital consultation services, etc., these services were not yet accessible to all family members of deceased AIDS patients. The interviews conducted in this study indicated that most of the family members of deceased AIDS patients did not know about different services provided by the government and private organizations. In addition, for those who knew and had tried to gain access to these services, they faced various difficulties regarding service provision. For example, when asking for funding for surviving children of deceased AIDS patients, family members needed to show evidence indicating that the patients actually died from AIDS such as a death certificate specifying AIDS as the cause of death or a medical record showing results of blood examinations issued by the hospital. After submitting the evidence, they had to wait for consideration whether the documents were complete and they had no way to know when they would finally receive the help they needed, which they believed would take a long period of time. As AIDS is generally considered disgusting and unacceptable by society, the family members were also afraid that asking for services from the healthcare institutions would reveal the infection status of the deceased

patients to society, leading to social stigma and disgust from other people. In addition, 65% of the subjects in the present study worked to earn their living, 28% had their own income ranging from 4,000 to 8,000 baht per month, 37% had adequate income, and 28% had adequate income with savings (Table 1), so they may not have attempted to seek social support from healthcare teams. Thus, their mean scores for informational support, emotional support, and tangible support were equal to 0.59, 0.67, and 0.05, all of which lower than the mid point of the possible score ranges of 0-4 or 2, 0-16 or 8, and 0-8 or 4, respectively. Besides, a review of research reports did not yield a study particularly investigating social support provided to family members of deceased AIDS patients by healthcare providers. Instead, most of the studies dealt with social support provided directly to the patients themselves or to the caregivers of the patients while the patients were still alive.

Coping

Loss is a process which is time-consuming and requires self-adjustment. Acknowledgement of reality of loss is a painful experience, and different individuals need different time to cope with loss and grief and adjust, probably taking eight to ten months or longer. Factors which have an influence on coping due to loss are as follows (Jacik, 2000, cited in Carson, 2000: 583; Fulton & Meltress, 1995: 345):

1. The level of dependency in the relationship
2. The degree of ambivalence in the relationship
3. The age of the deceased
4. The bereaved person's support system
5. The number of previous losses
6. The physical and psychological health of the person grieving

In the present study, it was found that the mean score of overall coping of the family members of deceased AIDS patients was 65.05 and the standard deviation was 16.58 (Table 3). The mean score of problem-focused coping was 16.71 and the standard deviation was 4.82, making up 25% of the total mean score of coping. On the other hand, the mean score of emotion-focused coping was 49.0, accounting for the remaining 75% of the total coping score (Table 3). It could be explained that the subjects may have to endure different stressful situations, they selected coping based

on their personality, preference, and effort to assess the effectiveness of the selected strategy (Menaghan, 1983, cited in C. Shaw, 1999: 1246-1255). In general, social support received from own family members also play a role in individuals' selection of coping as it enables individuals to adjust themselves and accept different changing situations, as well as make the most use of available resources to deal with stress. Lazarus and Folkman (1984) have pointed out that individuals could face different situations that have arisen with different strategies depending on the assessment of how the situations affect them. In daily living, individuals tend to make use of both copings, possibly interchangeably and continuously, depending on their assessment of the situation, their powerful resources, and their own potential. If individuals feel that they are unable to adjust themselves to suit the situation or the arousal that has caused stress, whether it is seen as dangerous, threatening, or challenging, individuals tend to cope with stress by adjusting their emotion or use emotion-focused coping. On the other hand, if individuals feel that they are able to adjust, control, or relieve the arousal to make it less threatening, they tend to choose problem-focused coping. This is because problem solving stimulates motivation to adjust the thinking process. Smith et al. (cited in C. Shaw, 1999: 1246-1255) maintain that some situations should be handled by using problem-focused coping, while others are better dealt with by emotion-focused coping, depending on individuals' assessment of the situation.

When considering each aspect of coping, it was found that using self-control was the most frequently used coping, with the mean score of 12.72, accounting for 20% of the total coping scores (Table 4). This can be explained that self-control is a thinking and behavioral process which individuals use in an attempt to maintain the stability of their own emotion. Put another way, it is individuals' effort to be self-reliant to solve the problem that has arisen. As AIDS is seen as an unacceptable disease in society, the surviving family members of the patients tended to struggle to be self-reliant rather than asking for help from others when they were faced with a stressful situation. Furthermore, as about three-quarters or 76% of the family members of the deceased AIDS patients were older than 40 years old (Table 1), they had accumulated sufficient experiences which enabled them to control themselves to a certain extent. In addition, three-quarters of them completed primary education (Table 1), so they had enough knowledge to seek other helpful resources to deal with stress

and to gain access to information enabling them to better understand all the problems that have taken place. Also, as 51% of the surviving family members of AIDS patients were widowed (Table 1), they lacked their partner who could provide them with helpful advice. As a result, they needed to cope with stress by using emotion-focused coping to control themselves. This is consistent with Burke & Flaherty (1993, cited in Downe-Wamboldt & Melanson, 1998: 1109-1116) who claim that older females who were educated chose self-control as their means to deal with stress. Similarly, Pratum Sukmee (1999) found that individuals who had attempted suicide chose self-control as their first technique to gain self-control. Finally, Ponglada Brahman (1999) found that caregivers of AIDS patients with tuberculosis also used self-control as their first attempt to deal with stress.

Second came using regression. The mean score of using regression was equal to 9.81, accounting for 15% of the total coping scores (Table 4). This could be explained that regression is individuals' thinking attempt to reduce the significance of the situation they are facing by stepping back from it. When the family members of AIDS patients endured stress due to the death of the patients, they used regression to relieve their sufferings. In this study, the interviews revealed that the subjects tried to adjust their emotions by trying to think that nothing had happened, that life went on as it normally was, and that religious teaching could be used to lessen the stress caused by difficult situations in life (Pranee Mingkwan, 1999: 62-63). This agreed with the study of Siriluck Watanapong (1996) which found that HIV-infected patients used regression to reduce the significance of the situation they were facing by trying to forget and pretending that nothing serious had indeed happened to them.

Furthermore, family members of deceased AIDS patients used planning for solutions and avoiding the problem as their coping, with the mean scores of 8.40 and 8.16, respectively, making up 13% of the total coping scores. In addition, they used positive reappraisal and facing the problem, with the mean scores of 7.83 and 7.72, respectively, contributing another 12% of the total coping scores. Finally, they used the 'seeking social support' coping with the mean score of 6.76, accounting for 10% of the total coping scores (Table 4). One plausible explanation is that planning for solutions is an attempt determined to deal with the problems by trying to better the situation with systematic analysis of the situation. On the other hand, avoiding the

problem is individuals' attempt to temporarily stay away from the problem to relieve their stress, while using positive reappraisal is an attempt to give a new and better meaning to the situation to improve coping. Moreover, facing the problems is a thinking or behavioral process directly expressed toward the stress causing situation without avoiding it, and seeking social support is a thinking and behavioral process in which individuals are trying to learn about the problem and solutions necessary to deal with it from others' support. In the present study, more than half of the surviving family members of deceased AIDS patients, or 54%, had to live with the death of the patients for one year one month up to three years (Table 1), so they had already passed the critical point of the loss. They had become more emotionally stable and were better able to control their emotions and feelings. Besides, they had come to a realization that what had already happened could not be changed, they had learned to accept it as it was, and they had sought support from others in society. According to the interviews conducted with these family members of deceased AIDS patients, the surviving family members tried to talk to other people or take up new activities to temporarily stay away from the problems to relieve themselves from stress. After that, they would consider the problems and reviewed the solutions one more time. This finding was in agreement with the findings of Siriluck Watanapong (1996), Pratum Sukmee (1999), and Ponglada Promchan (1999) which suggested that most of the subjects chose emotion-focused coping before using problem-focused coping when dealing with stressful situations. Likewise, Folkman and Lazarus (1980, cited in L.F. Gramling et al., 1998: 1082-1091) contend that females use fewer problem-focused coping to deal with problems in their work. However, Gramling et al. (1998: 1081-1091) found that younger females used more problem-focused coping than older females. It is worth noting that in the present study, 80% of the subjects were female and more than three-quarters (76%) were older than 40 years old.

Finally, having responsibility for the problem was the last coping used by the family members of deceased AIDS patients, with the mean score of 3.72 or 6% of the total coping scores (Table 4). Having responsibility for the problem is a thought and behavior indicating that they themselves are the cause of the problem which could not be changed. In the present study, the interviews revealed that the surviving family members of the deceased AIDS patients did not believe that they themselves were the

persons who caused the problems. Rather, they were affected by having AIDS patients who eventually died in their family. As a result, having responsibility for the problem came last.

These findings led to a conclusion that the family members of deceased AIDS patients assessed the situations that took place after the death of the patients as stressful to a certain degree and they used both problem-focused and emotion-focused coping to deal with their problems. Lazarus and Folkman (1984: 154-157) point out that when individuals are stressed, they use both coping interchangeably and inseparably as these two strategies are intertwined. However, in order to be able to deal with stress, individuals need to be able to assess the situation as realistically and accurately as possible before selecting the most appropriate strategy to deal with it. Using beneficial strategies enables the surviving family members of deceased AIDS patients to effectively cope with the situations that cause them stress, making them able to achieve mental balance and to successfully carry on living their normal life.

CHAPTER VI

CONCLUSION

The present study was survey research which aimed to describe stress, social support and coping, of family members of deceased AIDS patients. The subjects consisted of 100 family members who used to be caregivers of deceased AIDS patients, and they were selected by means of convenience sampling. They lived in Pramburi District, Guiburi District, and Samroiord Sub-District in Prachuabkhirikhan Province.

The instruments used in the present research were composed of five parts: 1) Demographic characteristic questionnaire, 2) Stress-causing situation questionnaire, 3) Assessment of stress levels questionnaire, 4) Social support questionnaire and. 5) Coping questionnaire The reliability of the instruments was tested with Cronbach's Alpha Coefficient, with the reliability of the second, fourth, and fifth parts of the instruments equal to 0.87, 0.91, and 0.92, respectively. Data were collected by the researcher who interviewed the subjects based on the questionnaires, and data were analyzed using the SPSS Program for Windows.

Research findings

In terms of demographic characteristics of the subjects, 80% of the family members of deceased AIDS patients were female, and the largest group of the subjects (41%) were between 40 – 59 years old. About half (51%) were widowed, and all of them were Buddhists. Three-quarters of the subjects completed elementary education. Almost half of them, or 41%, had unstable income, and 37% had adequate income. Half lived in a nuclear family, whereas the other half lived in an extended family. More than half, or 56% of the subjects, had one to four members in the family. In addition, when considering the period of time since the AIDS patients passed away, it was found that more than half of the subjects, or 54%, had to live with the death of the AIDS patients for one year one month up to three years. Finally, regarding relationship

with the AIDS patients, approximately half, or 52%, were mothers of the AIDS patients, and close to half, or 40%, had provided care to the AIDS patients for one day to six months.

In this study, different situations that were seen as causing a high level of stress to the subjects were analyzed. As regards the loss of a family member, the mean stress score for the 'missing the deceased patients' aspect was equal to 2.54 (Table 2). As for the loss of a family member who performed different functions in the family, when the subjects were spouses or parents of the deceased AIDS patients, the mean stress scores for the 'taking care of deceased patients' surviving children' aspect were equal to 2.90 and 2.48, respectively (Table 2). In addition, the mean score for the 'losing the head of the family' aspect was equal to 2.19 (Table 2). In terms of loss of hopes and goals in life once shared with deceased AIDS patients, the mean stress score was 2.26 (Table 2). It was found that the surviving family members of the deceased AIDS patients used two forms of coping, and their overall coping score was equal to 65.05 (Table 4). When considering each aspect, the mean score of problem-focused coping was 16.71, accounting for 25% of the total stress score, while the mean score of emotion-focused coping was equal to 49.01, making up the remaining 75% of the total coping score (Table 4). Besides, the family members received social support from fellow family members of deceased AIDS patients—informational support, emotional support, and tangible support—with the mean score of 23.46 (Table 5). On the other hand, the mean score of social support received from neighbors, coworkers, and organizations, clubs, or associations in the community was 8.77 (Table 6), whereas the mean score of social support received from healthcare providers was 1.15 (Table 7).

Implications of research findings

Based on the findings of the present study, the following recommendations could be made:

For nursing practice

The findings of the present study revealed that significant situations which caused a considerable amount of stress to surviving family members of deceased AIDS patients were missing the deceased patients, losing the leader of the family, having to be responsible for surviving children of the patients, and losing hopes and

goals in life once shared with the patients. Therefore, nurses need to follow up on surviving family members of deceased AIDS patients in the community, providing proactive nursing services rather than waiting for them to come and seek services at the hospital. Besides, nurses should come up with a collaborative plan to work with public healthcare providers working in each area where family members of deceased AIDS patients reside so as to provide appropriate care that would enable parents, spouses, or children of deceased AIDS patients overcome their grief. This is considered one of the most important roles of psychiatric nurses. In addition to this, nurses need to provide education and correct understanding about AIDS including its transmission to the members of the community.

For administration

The present study indicated that healthcare providers offered only a little amount of assistance and care to the surviving family members of deceased AIDS patients. Therefore, nursing administrators need to realized the significance of nursing instruction and training to equip nurses with knowledge and skills necessary in helping surviving family members of deceased AIDS patients deal with their loss and grief. Proactive assistance provided to the family members of deceased AIDS patients is believed to be one important preventive measure of mental illnesses in the community.

Recommendations for further research

1. A study should be conducted with the population residing in an urban community.
2. A longitudinal study should be carried out to consistently and continuously follow up on the surviving family members of deceased AIDS patients, especially during the first year after the patients passed away.
3. A qualitative study should be conducted to investigate stress of spouses and parents of deceased AIDS patients.
4. Further research should explore perception of loss, coping with loss, development, and social support of surviving children of deceased AIDS patients.

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รายนามผู้ทรงคุณวุฒิ

รศ.ดร.สายพิน เกษมกิจวัฒนา

ปฏิบัติงานตำแหน่งอาจารย์ ภาควิชาการพยาบาลศัลยศาสตร์
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

ผศ.ดร.ยาใจ สิทธิมงคล

ปฏิบัติงานตำแหน่งอาจารย์ ภาควิชาสุขภาพจิตการพยาบาลจิตเวชศาสตร์
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

ผศ.ดร.ประภา ยุทธไตร

ปฏิบัติงานตำแหน่งอาจารย์ ภาควิชาสุขภาพจิตการพยาบาลจิตเวชศาสตร์
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล



การพิทักษ์สิทธิของกลุ่มตัวอย่าง

ดิฉัน นางสาวนิรมล จิตต์สุข นักศึกษาปริญญาโท สาขาสุขภาพจิตและการพยาบาลจิตเวชศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล กำลังศึกษาวิจัยเกี่ยวกับสถานการณ์ความเครียด วิธีการเผชิญความเครียดและการสนับสนุนทางสังคมของครอบครัวผู้ป่วยเอดส์ภายหลังผู้ป่วยเอดส์เสียชีวิต โดยมีวัตถุประสงค์เพื่อเป็นแนวทางในการประเมินและวางแผนพยาบาลส่งเสริมให้ครอบครัวผู้ป่วยเอดส์มีวิธีการเผชิญความเครียดที่เหมาะสมและมีประสิทธิภาพมากที่สุด

ถ้าท่านยินดีที่จะเข้าร่วมการวิจัยครั้งนี้ ดิฉันขอให้ท่านกรุณาตอบแบบสอบถามเกี่ยวกับข้อมูลส่วนบุคคล สถานการณ์ที่ก่อให้เกิดความเครียด วิธีการเผชิญความเครียดและการสนับสนุนทางสังคมของครอบครัวผู้ป่วยเอดส์ภายหลังผู้ป่วยเอดส์เสียชีวิต โดยใช้เวลาประมาณ 30-45 นาที และข้อมูลที่ได้จากท่านทั้งหมดจะได้รับการปิดเป็นความลับ การรายงานผลการศึกษาวิจัยจะรายงานเป็นผลสรุปของการศึกษา ซึ่งข้อมูลที่ได้จากท่านจะเป็นประโยชน์สำหรับใช้เป็นแนวทางการศึกษา และการให้บริการสุขภาพเพื่อช่วยเหลือครอบครัวผู้ป่วยเอดส์ต่อไป

หากท่านมีข้อสงสัยประการใดเกี่ยวกับการวิจัยครั้งนี้ ดิฉันยินดีตอบข้อสงสัยของท่านตลอดเวลา และท่านมีสิทธิ์จะตอบรับหรือปฏิเสธเข้าร่วมวิจัยครั้งนี้ ถึงแม้ว่าท่านยินดีที่จะเข้าร่วมในการวิจัยแล้ว ท่านก็ยังมีสิทธิ์ที่จะยกเลิกการเข้าร่วมการวิจัยครั้งนี้ได้ตลอดเวลา โดยท่านจะไม่ได้รับผลกระทบใดๆทั้งสิ้น

งานวิจัยครั้งนี้จะสำเร็จได้ตามวัตถุประสงค์ด้วยความอนุเคราะห์และความร่วมมือจากทุกท่านที่กรุณาสละเวลาตอบแบบสอบถามในครั้งนี้ ผู้วิจัยขอขอบคุณมา ณ โอกาสนี้เป็นอย่างสูง

นิรมล จิตต์สุข

ผู้วิจัย

ยินดีที่ให้ความร่วมมือ

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ผู้เข้าร่วมวิจัย

The background of the page features a large, faint, circular seal of Mahidol University. The seal is gold-colored and contains a central emblem with a crown and Thai script. The text 'APPENDIX C' is centered over the seal.

APPENDIX C

RESEARCH INSTRUMENT

1. Demographic characteristic questionnaire
2. Stress causing situation questionnaire
3. Assessment of stress levels questionnaire
4. Social support questionnaire
5. Coping questionnaire

1. Demographic characteristic questionnaire

แบบสอบถาม

ส่วนที่ 1 ข้อมูลทั่วไปส่วนบุคคล

1. เพศ

1. () ชาย

2. () หญิง

2. อายุ ปี (นับอายุเต็มในวันที่สัมภาษณ์)

3. สถานภาพสมรส

1. () โสด

2. () คู่

3. () หย่า, แยก

4. () หม้าย

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10. ระยะเวลาที่ผู้ป่วยเสียชีวิต ปี เดือน (นับถึงวันที่สัมภาษณ์)

11. ความสัมพันธ์กับผู้ป่วยเอดส์

1. ()สามี

2. () ภรรยา

3. () บิดา

4. () มารดา

5. () บุตร

12. ระยะเวลาที่เคยให้การดูแลช่วยเหลือผู้ป่วยเอดส์ ปี เดือน

2. Stress causing situation questionnaire and assessment of stress levels questionnaire

แบบสอบถามสถานการณ์ที่ก่อให้เกิดความเครียด

คำชี้แจง : แบบสอบถามนี้ประกอบด้วย 2 คำถาม คือ

คำถามที่ 1 เมื่อผู้ป่วยเอดส์เสียชีวิต ท่านพบกับสถานการณ์ต่อไปนี้หรือไม่ โดยทำเครื่องหมาย ✓ ลงในช่องให้ตรงกับความเป็นจริงของท่านมากที่สุด

คำถามที่ 2 แบบสอบถามนี้ต้องการทราบว่า สถานการณ์ต่างๆต่อไปนี้ เป็นสาเหตุทำให้ท่านเกิดความเครียดในระดับใดภายหลังผู้ป่วยเอดส์เสียชีวิต โดยทำเครื่องหมาย ✓ ลงในช่องข้อความของแต่ละข้อความให้ตรงกับความเป็นจริงความรู้สึกของท่านมากที่สุด การเลือกตอบให้ถือเกณฑ์ดังนี้

ไม่เครียด	หมายถึง เหตุการณ์ตามข้อความนั้นๆ ไม่ทำให้ท่านเกิดความรู้สึกไม่สบายใจ / ทุกข์ใจ คับข้องใจ หนักใจ
เครียดเล็กน้อย	หมายถึง เหตุการณ์ตามข้อความนั้นๆ ทำให้ท่านเกิดความรู้สึกไม่สบายใจ / ทุกข์ใจ คับข้องใจ หนักใจเพียงเล็กน้อย
เครียดปานกลาง	หมายถึง เหตุการณ์ตามข้อความนั้นๆ ทำให้ท่านเกิดความรู้สึกไม่สบายใจ / ทุกข์ใจ คับข้องใจ หนักใจปานกลาง
เครียดมาก	หมายถึง เหตุการณ์ตามข้อความนั้นๆ ทำให้ท่านเกิดความรู้สึกไม่สบายใจ / ทุกข์ใจ คับข้องใจ หนักใจมาก

ความเครียด หมายถึง ปฏิกริยาตอบสนองด้านอารมณ์และรู้สึกนึกคิดของท่านที่เกิดขึ้น เมื่อท่านพบสถานการณ์ต่างๆภายหลังผู้ป่วยเอดส์เสียชีวิต ได้แก่ ความรู้สึกวิตกกังวล ไม่สบายใจ เป็นทุกข์ใจ

คำถาม	ไม่ พบ	พบ	ไม่ เครียด	เครียด		
				เล็กน้อย	ปานกลาง	มาก
1. คิดถึงผู้ตาย						
2. ขาดผู้ดูแลความเป็นอยู่ของสมาชิกครอบครัว						
3. ขาดผู้นำครอบครัว						
4. ขาดผู้หารายได้มาสู่ครอบครัว						
5. ขาดที่ปรึกษาของครอบครัว						
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14. ญาติพี่น้องสอบถามถึงสาเหตุของการเสียชีวิตของผู้ตาย						
15. สูญเสียความหวังและเป้าหมายในชีวิตที่เคยมีกับผู้ตาย						

3. Social support questionnaire

แบบสอบถามการสนับสนุนทางสังคม

คำชี้แจง : แบบสอบถามนี้ต้องการทราบถึงความช่วยเหลือที่ท่านได้รับภายหลังผู้ป่วยเอดส์เสียชีวิต
 มากน้อยเพียงใด จากบุคคล 3 กลุ่ม คือ กลุ่มสมาชิกในครอบครัว กลุ่มเพื่อนบ้าน เพื่อนร่วมงาน
 และกลุ่มเจ้าหน้าที่ที่มรสุมภาพโดยทำเครื่องหมาย ✓ ลงในช่องแต่ละข้อความ การเลือกตอบให้ถือ
 เกณฑ์ ดังนี้

ไม่ช่วยเหลือเลย หมายถึง ข้อความนั้นท่านไม่ได้รับความช่วยเหลือ
 ช่วยเหลือเล็กน้อย หมายถึง ข้อความนั้นได้รับการช่วยเหลือเล็กน้อย
 ช่วยเหลือบ้างบางครั้ง หมายถึง ข้อความนั้นได้รับการช่วยเหลือเป็นครั้งคราว
 ช่วยเหลือค่อนข้างมาก หมายถึง ข้อความนั้นได้รับการช่วยเหลือค่อนข้างมาก
 ช่วยเหลือมากที่สุด หมายถึง ข้อความนั้นได้รับการช่วยเหลือมากที่สุด

กลุ่มสมาชิกในครอบครัว ได้แก่ บิดามารดา บุตร ญาติพี่น้อง

การช่วยเหลือที่ได้รับ	ไม่ช่วย เหลือเลย	ช่วยเหลือ			
		เล็กน้อย	บ้างบางครั้ง	ค่อนข้างมาก	มากที่สุด
1. ให้คำแนะนำและแนวทางการปฏิบัติตัว ที่เป็นประโยชน์					
2. ให้ความมั่นใจว่าเขาจะอยู่ช่วยเหลือเมื่อ ท่านต้องการ					
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7. ให้ความช่วยเหลือในการทำกิจวัตร ประจำวัน					

กลุ่มเพื่อนบ้าน เพื่อนร่วมงาน องค์กร / ชมรม / สมาคมของชุมชน

การช่วยเหลือที่ได้รับ	ไม่ช่วย เหลือเลย	ช่วยเหลือ			
		เล็กน้อย	บ้างบางครั้ง	ค่อนข้างมาก	มากที่สุด
1. ให้คำแนะนำและแนวทางการปฏิบัติตัวที่เป็นประโยชน์					
2. ให้ความมั่นใจว่าเขาจะอยู่ช่วยเหลือเมื่อท่านต้องการ					
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7. ให้ความช่วยเหลือในการทำกิจวัตรประจำวัน					

กลุ่มเจ้าหน้าที่ในทีมสุขภาพ ได้แก่ แพทย์ พยาบาล เจ้าหน้าที่สาธารณสุข

การช่วยเหลือที่ได้รับ	ไม่ช่วย เหลือเลย	ช่วยเหลือ			
		เล็กน้อย	บ้างบางครั้ง	ค่อนข้างมาก	มากที่สุด
1. ให้คำแนะนำและแนวทางการปฏิบัติตัวที่เป็นประโยชน์					
2. ให้ความมั่นใจว่าเขาจะอยู่ช่วยเหลือเมื่อท่านต้องการ					
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7. ให้ความช่วยเหลือในการทำกิจวัตรประจำวัน					

4. Coping questionnaire

แบบสอบถามวิธีการเผชิญความเครียด

คำชี้แจง : แบบสอบถามนี้ ประกอบด้วยข้อคำถามเกี่ยวกับความคิดและพฤติกรรมที่ท่านใช้เมื่อมีสถานการณ์ที่ก่อให้เกิดภาวะเครียดทางจิตใจ โดยภาวะเครียดทางจิตใจ หมายถึง ท่านได้พบกับสถานการณ์ที่ถูกประเมินค่าว่าก่อให้เกิดความยุ่งยากหรือเป็นปัญหาสำหรับท่าน เพราะทำให้ท่านรู้สึกไม่สบายใจต่อสิ่งที่เกิดขึ้น หรือเพราะท่านต้องใช้ความพยายามที่จะจัดการกับสถานการณ์นั้น และสถานการณ์ที่เกิดขึ้นนี้จะส่งผลถึงครอบครัว หน้าที่การงาน เพื่อน หรือบางสิ่งบางอย่างที่สำคัญสำหรับท่าน

ขอให้ท่านนึกถึงเหตุการณ์เดียวที่ก่อให้เกิดความเครียดมากที่สุดภายหลังที่ผู้ป่วยเอดส์เสียชีวิต ท่านมีความคิดและพฤติกรรมอย่างไรบ้างในการจัดการกับสถานการณ์ที่ก่อให้เกิดภาวะเครียดทางจิตใจนั้น โดยก่อนที่ท่านจะตอบข้อคำถามขอให้ท่านพยายามนึกถึงรายละเอียดของสถานการณ์เป็นต้นว่า เกิดขึ้น ณ ที่ใด มีใครเกี่ยวข้อง ท่านกระทำอย่างไรและทำไมจึงมีความสำคัญสำหรับท่าน

ท่านใช้วิธีการต่อไปนี้มาน้อยเพียงใด ให้ทำเครื่องหมาย ✓ ลงในช่องแต่ละข้อความที่ท่านเลือกใช้ซึ่งเป็นคำตอบที่ถูกต้องกับความเป็นจริงมากที่สุด โดยเลือกตอบตามเกณฑ์ดังนี้

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|-----------|---------|---|
| ไม่เคย | หมายถึง | ข้อความนั้นท่านไม่ได้ใช้เป็นวิธีการทำให้ความทุกข์ใจ ความไม่สบายใจลดลง |
| บางครั้ง | หมายถึง | ข้อความนั้นท่านได้ใช้เป็นวิธีการทำให้ความทุกข์ใจ ความไม่สบายใจลดลงบางครั้ง |
| บ่อยครั้ง | หมายถึง | ข้อความนั้นท่านได้ใช้เป็นวิธีการทำให้ความทุกข์ใจ ความไม่สบายใจลดลงบ่อยครั้ง |
| เป็นประจำ | หมายถึง | ข้อความนั้นท่านได้ใช้เป็นวิธีการทำให้ความทุกข์ใจ ความไม่สบายใจลดลงเป็นประจำ |

ข้อความ	ไม่เคย	บางครั้ง	บ่อยครั้ง	เป็นประจำ
1. ฉันเอาใจจดจ่อกับสิ่งที่ฉันต้องทำต่อไป				
2. ฉันพยายามวิเคราะห์ปัญหาเพื่อให้เกิดความเข้าใจสาเหตุของปัญหาได้ดีขึ้น				
3. ฉันหันเหความสนใจไปทำงานหรือกิจกรรมอื่นแทน เพื่อให้ลืมความไม่สบายใจ				
4. ฉันรอกอย่ว่าเวลาจะทำให้ทุกอย่างดีขึ้น				
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64. ฉันพยายามมองเหตุการณ์ที่เกิดขึ้นจากมุมมองของผู้อื่น				
65. ฉันคอยเตือนตนเองว่าอาจมีสิ่งเลวร้ายที่อาจจะเกิดขึ้นได้อีก				
66. ฉันทำกิจกรรมที่ต้องออกแรงหรือออกกำลังกาย				

BIOGRAPHY

NAME	Miss. Niramon Jitsook
DATE OF BIRTH	28 April 1970
PLACE OF BIRTH	Chonburi, Thailand
INSTITUTIONS ATTENDED	Boromarajonani College of Nursing , Bangkok 1988 – 1992 Diploma in Nursing Science Equivalent to Bachelor of Science in Nursing Mahidol University, 1999 – 2003 : Master of Nursing Science (Psychiatric – Mental Health Nursing)
POSITION & OFFICE	1992 – Present, Department of Nursing, Pranburi Hospital. Position : Professional Nurse