

**CARING BEHAVIORS OF FAMILY CAREGIVERS,  
CARING NEEDS AND CARING PERCEPTIONS  
OF ADDICTED ADOLESCENTS**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT  
OF THE REQUIREMENTS FOR  
THE DEGREE OF MASTER OF NURSING SCIENCE  
(PSYCHIATRIC AND MENTAL HEALTH NURSING)  
FACULTY OF GRADUATE STUDIES  
MAHIDOL UNIVERSITY  
2003**

**ISBN 974-04-3528-9  
COPYRIGHT OF MAHIDOL UNIVERSITY**

Thesis  
Entitled

**CARING BEHAVIORS OF FAMILY CAREGIVERS,  
CARING NEEDS AND CARING PERCEPTIONS  
OF ADDICTED ADOLESCENTS**

*Choochart.D*

.....  
Mr. Choochart Deeromram  
Candidate

*Khannika Suwonnakote*

.....  
Asst. Prof. Khannika Suwonnakote,  
Ph. D.  
Major-Advisor

*Tassanee Nontasorn*

.....  
Asst. Prof. Tassanee Nontasorn,  
Ph. D.  
Co-Advisor

*Pataraumpai Pipatananond*

.....  
Assoc. Prof. Pataraumpai Pipatananond,  
D.N.S.  
Co-Advisor

*Rassmidara Hoonsawat*

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

*Yuwadee Luecha*

.....  
Assoc. Prof. Yuwadee Luecha,  
Ed. D.  
Chair  
Master of Nursing Science  
Faculty of Medicine  
Ramathibodi Hospital

Thesis  
Entitled

**CARING BEHAVIORS OF FAMILY CAREGIVERS,  
CARING NEEDS AND CARING PERCEPTIONS  
OF ADDICTED ADOLESCENTS**

was submitted to the Faculty of Graduate Studies, Mahidol University  
For the degree of Master of Nursing Science  
(Psychiatric and Mental Health Nursing)

on  
30 May, 2003

*Choochart D*

.....  
Mr. Choochart Deeromram  
Candidate

*Khannika Suwonnakote*

.....  
Asst. Prof. Khannika Suwonnakote,  
Ph. D.  
Chair

*Tassanee Tongprateep*

.....  
Lect. Tassanee Tongprateep,  
D.S.N.  
Member

*Tassanee Nontasorn*

.....  
Asst. Prof. Tassanee Nontasorn,  
Ph. D.  
Member

*Yupapin Sirapo-ngam*

.....  
Assoc. Prof. Yupapin Sirapo-ngam,  
D.S.N.  
Member

*Patarauumpai Pipatananond*

.....  
Assoc. Prof. Patarauumpai Pipatananond,  
D.N.S.  
Member

*Rassmidara Hoonsawat*

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

*Prakit Vathesatogkit*

.....  
Prof. Prakrit Vathesatogkit,  
M.D., ABIM, FRCP.  
Dean  
Faculty of Medicine  
Ramathibodi Hospital  
Mahidol University

## ACKNOWLEDGEMENT

Many individuals have contributed their time and effort toward the completion of this thesis. I, therefore, realize that my words cannot express all of my gratefulness to these people who have kindly helped me through the thesis process.

The success of this thesis can be attributed to the encouraging support and assistance from my major advisor, Asst. Prof. Dr. Khannika Suwonnakote, and my co-advisors, Asst. Prof. Dr. Tassanee Nontasorn and Assoc. Prof. Dr. Pataraumpai Pipatananond. I would like to express my sincerest gratitude and appreciation to them for their valuable advice and guidance in this research.

I wish to express my profound gratitude to all of the experts, Assoc. Prof. Dr. Yupapin Sirapo-ngam, Dr. Tassanee Tongprateep, Mr. Thana Pramukkul, M.D., and Mrs. Sutantip Nasomfun, RN, who give helpful suggestions to establish the research instrument's content validity.

I greatly appreciate the cooperation of the nurses, physicians, and other health care providers at the Khonkaen Drug Dependence Treatment Center. My special recognition also goes to all of the addicted adolescents and their significant family caregivers, who willingly contributed their time to share valuable experiences and made the completion of the present study possible.

I owe a debt of gratitude to the Maharakham University for supporting me in completing my master degree by subsidizing my study fees. My sincere gratitude also goes to my classmates at the Mahidol University and colleagues at the Faculty of Nursing, Maharakham University, for their assistance and experience sharing.

My special appreciation goes to the kind assistance, encouragement, friendship granted to me by Mr. Pravi Ampanp, M.D., who is like a brother, and also goes to my friends.

I also wish to express my thankfulness to the Deeromram, Bu-nganakorn, and Phohomsiri families. Cheerfulness and enormous support also came from the family members to whom I will always owe a lot of heartfelt thanks.

Finally, I am truly indebted to Mrs. Mukdawan Deeromram, my wife, for her invaluable assistance, understanding, as well as the gentle and kind support she has given me throughout my endurance process. The usefulness of this thesis, I dedicate to my father, my mother and all the teachers who have taught me since my childhood.

Choochart Deeromram

CARING BEHAVIORS OF FAMILY CAREGIVERS, CARING NEEDS AND  
CARING PERCEPTIONS OF ADDICTED ADOLESCENTS

CHOOCHART DEEROMRAM 4336895 RAPM/M

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

THESIS ADVISORS: KHANNIKA SUWONNAKOTE, Ph.D.,  
TASSANEE NONTASORN, Ph.D., PATARAUMPAI PIPATANANOND, D.N.S.

ABSTRACT

The purpose of this descriptive research was to study the caring behaviors of family caregivers, the caring needs and caring perceptions of addicted adolescents. The conceptual framework of this study was derived from the Watson Transpersonal Caring Theory. The population was non-psychotic addicted adolescents and their significant family caregivers at the Khonkaen Drug Dependence Treatment center. The sample size of 263 was selected from each population. Data were collected by self-administered questionnaires namely Caring Behaviors questionnaire, Caring Needs and Caring Perceptions Questionnaire, which were modified by the researcher. A panel of seven experts in the area of substance abuse did the face validity. The reliability results using Alpha Cronbach's Coefficient of these questionnaires were .93, .94, and .92 respectively. Each questionnaire consists of 36 items with a four-point rating scale. The data were analyzed using Descriptive statistics, One-way Analysis of Variance, Kruskal-Wallis H test, Mann-Whitney U test, Independent t-test, and Paired t-test.

The findings of this study revealed that the mean score of caring behaviors of family caregivers, caring needs and caring perceptions of addicted adolescents were 3.29, 3.097, and 2.942 respectively. Family caregivers, who differ in age groups, did not behave differently in caring behaviors whereas gender, education, and occupation groups were statistically significant differences ( $p < .01$ ). Addicted adolescents, who differ in education, substance abuse duration, and admission groups, were not significantly different in caring needs. The differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents were statistically significant differences ( $p < .01$ ).

As for the implications of this study, it could be used as a guideline for health care providers to develop the Caring Training Program for encouraging congruency in caring behaviors, caring needs, and caring perceptions between family caregivers and addicted patients.

KEY WORDS: CARING BEHAVIORS / CARING NEEDS /  
CARING PERCEPTIONS / FAMILY CAREGIVERS /  
ADDICTED ADOLESCENTS

123 P. ISBN 974-04-3528-9

พฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว ความต้องการความเอื้ออาทร และการรับรู้  
พฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติด (CARING BEHAVIORS OF FAMILY  
CAREGIVERS, CARING NEEDS AND CARING PERCEPTIONS OF ADDICTED  
ADOLESCENTS)

ชชาติ ติธรรมย์ 4336895 RAPM/M

พย. ม. (การพยาบาลจิตเวชและสุขภาพจิต)

คณะกรรมการควบคุมวิทยานิพนธ์ : กรรมการ สุวรรณ โศต, ค.ศ., ทศนีย์ นนทะสร, ค.ศ.,  
ภัทรอำไพ พิพัฒนานนท์, พย.ค.

#### บทคัดย่อ

การวิจัยเชิงบรรยายครั้งนี้มีวัตถุประสงค์เพื่อศึกษาและเปรียบเทียบความแตกต่างระหว่าง  
พฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว ความต้องการความเอื้ออาทร และการรับรู้  
พฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติด โดยใช้ทฤษฎีความเอื้ออาทรของวัตสันเป็นกรอบใน  
การศึกษา ประชากร คือ วัยรุ่นติดสารเสพติดที่เข้ามารับการบำบัดรักษาในศูนย์บำบัดรักษายาเสพติด  
จังหวัดขอนแก่น และญาติผู้ดูแลในครอบครัว จำนวนกลุ่มละ 263 คน เครื่องมือวิจัย ได้แก่  
แบบสอบถามพฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว แบบสอบถามความต้องการความเอื้อ  
อาทรและการรับรู้พฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติด ซึ่งผู้วิจัยปรับปรุงขึ้น หากความตรง  
ตามเนื้อหาโดยผู้ทรงคุณวุฒิและทดสอบความเชื่อมั่น ได้ค่า Alpha Cronbach's Coefficient  
เท่ากับ .93, .94 และ .92 ตามลำดับ แบบสอบถามแต่ละชุดมี 36 ข้อเป็นแบบมาตราวัด 4 ระดับ สถิติ  
ที่ใช้ในการวิเคราะห์ข้อมูลครั้งนี้ คือ Descriptive statistics, One-way Analysis of Variance,  
Kruskal-Wallis H test, Mann-Whitney U test, Independent t-test, Paired t-test

ผลการวิจัยพบว่า พฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว ความต้องการความเอื้อ  
อาทรและการรับรู้พฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติดมีค่าเฉลี่ยเท่ากับ 3.290, 3.097  
และ 2.942 ตามลำดับ ญาติผู้ดูแลในครอบครัวที่มีกลุ่มอายุแตกต่างกันจะมีพฤติกรรมเอื้ออาทรที่ไม่  
แตกต่างกัน ส่วนกลุ่มของญาติผู้ดูแลในครอบครัวที่มีเพศ ระดับการศึกษา และอาชีพแตกต่างกันนั้น  
จะมีพฤติกรรมเอื้ออาทรแตกต่างกันอย่างมีนัยสำคัญทางสถิติที่ระดับ .01 วัยรุ่นติดสารเสพติดที่มี  
ระดับการศึกษา ระยะเวลาการติดสารเสพติด และจำนวนครั้งที่เข้ารับการบำบัดรักษาแตกต่างกันจะ  
มีความต้องการความเอื้ออาทรไม่แตกต่างกัน พฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว ความ  
ต้องการความเอื้ออาทรและการรับรู้ต่อพฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติด มีความแตก  
ต่างกันอย่างมีนัยสำคัญทางสถิติที่ระดับ .01

ผลการศึกษานี้บุคคลากรในทีมสุขภาพสามารถใช้เป็นแนวทางในการส่งเสริมให้มีความ  
เอื้ออาทรระหว่างญาติผู้ดูแลในครอบครัวและวัยรุ่นที่ติดสารเสพติด ส่งเสริมให้ญาติผู้ดูแลใน  
ครอบครัวได้แสดงพฤติกรรมเอื้ออาทรที่ตอบสนองความต้องการของวัยรุ่นติดสารเสพติดให้สมบูรณ์  
และส่งเสริมการรับรู้ของวัยรุ่นให้ตรงกับการแสดงพฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว

123 หน้า ISBN 974-04-3528-9

# CONTENTS

	<b>Page</b>
<b>ACKNOWLEDGEMENTS</b>	iii
<b>ABSTRACT (English)</b>	iv
<b>ABSTRACT (Thai)</b>	v
<b>LIST OF TABLES</b>	ix
<b>LIST OF FIGURE</b>	xi
<b>CHAPTER</b>	
<b>I INTRODUCTION</b>	1
Background and significance of the study	1
Research questions	4
Purposes of the study	4
Research hypotheses	5
Scope of the study	5
Definition of variables	6
Benefits of the study	8
<b>II LITERATURE REVIEW</b>	9
<b>PART I Knowledge of Illicit Substances</b>	9
Definition	9
The process of substance dependence	10
Treatment for substance abuse	12
Impact of substance abuse on family	14
<b>PART II Theoretical Perspective on Caring and Related Factors</b>	16
Knowledge of caring	16
Watson Transpersonal Caring Theory	18
Assessment of caring behaviors	25
Factors related to caring behaviors	28

## CONTENTS (Continued)

CHAPTER	Page
<b>II LITERATURE REVIEW (Continued)</b>	
<b>PART III Family Caregivers and Addicted Adolescents</b>	30
Family caregivers	30
Addicted adolescents	32
Needs of addicted adolescent	35
Factors related to caring needs	36
Perceptions	38
<b>III MATERIALS AND METHODS</b>	41
Research design	41
Population	41
Sampling	41
Research setting	42
Research instruments	43
Protection of human subjects	46
Data collection procedure	46
Data analysis	47
<b>IV RESULTS</b>	49
Demographic characteristics of study samples	50
Caring behaviors of family caregivers	52
Caring needs of addicted adolescents	54
Caring perceptions of addicted adolescents	54
Test of normality and homogeneity of variances	57
The comparison of caring behaviors of family caregivers	60
The comparison of caring needs of addicted adolescents	64
The differences among caring behaviors of family caregivers, caring needs and caring perceptions of addicted adolescents	66

## CONTENTS (Continued)

	<b>Page</b>
<b>CHAPTER</b>	
<b>V DISCUSSION</b>	74
<b>Hypothesis I:</b> There are differences in the caring behaviors of family caregivers who differ in age, gender, education, and occupation	74
<b>Hypothesis II:</b> There are no differences in the caring needs of addicted adolescents who differ in education, substance abuse duration, and admission	78
<b>Hypothesis III:</b> There are differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents	79
<b>CHAPTER</b>	
<b>VI CONCLUSION</b>	86
Summary of the study	86
Recommendations	90
<b>BIBLIOGRAPHY</b>	93
<b>APPENDIX</b>	
<b>APPENDIX A</b> Questionnaires	105
<b>APPENDIX B</b> The modification of questionnaires	112
<b>APPENDIX C</b> List of experts for face validity	115
<b>APPENDIX D</b> Research consent form for participants	118
<b>APPENDIX E</b> The frequency and percentage of caring behaviors performed by occupation groups of family caregivers	121
<b>BIOGRAPHY</b>	123

## LIST OF TABLES

	<b>Page</b>
<b>Table 1</b> The frequency and percentage of demographic characteristics of family caregivers	50
<b>Table 2</b> The frequency and percentage of demographic characteristics of addicted adolescents	51
<b>Table 3</b> Range, mean, standard deviation (SD), and mean rank of the caring behaviors of family caregivers	53
<b>Table 4</b> Range, mean, standard deviation (SD), and mean rank of the caring needs of addicted adolescents	55
<b>Table 5</b> Range, mean, standard deviation (SD), and mean rank of the caring perceptions of addicted adolescents	56
<b>Table 6</b> Normality testing of studied dependent variables	57
<b>Table 7</b> Normality testing of caring behaviors of family caregivers in each group of age, gender, education, and occupation	58
<b>Table 8</b> Normality testing of caring needs of addicted adolescents in each group of education, substance abuse duration, and admission	59
<b>Table 9</b> Mean and standard deviation (SD) of caring behaviors of family caregivers by age groups	60
<b>Table 10</b> The comparison of caring behaviors of family caregivers by age groups using One-way Analysis of Variance	60
<b>Table 11</b> The comparison of caring behaviors of family caregivers who differ in gender by using Independent t-test	61
<b>Table 12</b> Mean and standard deviation (SD) of caring behaviors of family caregivers by education groups	61
<b>Table 13</b> The comparison of caring behaviors of family caregivers by education groups using Kruskal-Wallis H test	62
<b>Table 14</b> The pairwise comparisons of caring behaviors of family caregivers by education groups using Mann-Whitney U test	62
<b>Table 15</b> Mean and standard deviation (SD) of caring behaviors of family caregivers by occupation groups	63

## LIST OF TABLES (Continued)

		<b>Page</b>
<b>Table 16</b>	The comparison of caring behaviors of family caregivers by occupation groups using One-way Analysis of Variance	63
<b>Table 17</b>	The Post-Hoc test of caring behaviors of family caregivers by occupation groups using Sheffé test	64
<b>Table 18</b>	Mean and standard deviation (SD) of caring needs of addicted adolescents by education groups	64
<b>Table 19</b>	The comparison of caring needs of addicted adolescents by education groups using One-way Analysis of Variance	65
<b>Table 20</b>	Mean and standard deviation (SD) of caring needs of the addicted adolescents by substance abuse duration groups	65
<b>Table 21</b>	The comparison of caring needs of the addicted adolescents by substance abuse duration groups using One-way Analysis of Variance	65
<b>Table 22</b>	Mean and standard deviation (SD) of caring needs of the addicted adolescents by admission groups	66
<b>Table 23</b>	The comparison of caring needs of the addicted adolescents by admission groups using One-way Analysis of Variance	66
<b>Table 24</b>	Mean and standard deviation (SD) of caring behaviors family caregivers, caring needs and perceptions of addicted adolescents	67
<b>Table 25</b>	The differences between caring behaviors of family caregivers and caring needs of addicted adolescents by using Independent t-test	69
<b>Table 26</b>	The differences between caring behaviors of family caregivers and caring perceptions of addicted adolescents by using Independent t-test	71
<b>Table 27</b>	The differences between caring needs and caring perceptions of addicted adolescents by using Paired t-test	73
<b>Table 28</b>	The modification of questionnaires in this study	113
<b>Table 29</b>	The frequency (f) and percentage (%) of caring behaviors performed by occupation groups of family caregivers	122

## LIST OF FIGURES

		Page
<b>Figure 1</b>	Conceptual Model of the study	40



## CHAPTER I

### INTRODUCTION

#### **Background and Significance of the Study**

Substance abuse is the habitual use of a substance not needed for therapeutic purposes (Rawson, 1999: 20). The existence of substance abuse is a serious problem, which is widespread in every country in the world. The effects from this problem are numerous. They impact many social systems and the health and welfare of individuals, families and communities. The abuse of substance creates both physical and psychosocial problems (Yuttatri, P. 2001: 3-4). It threatens both physical and mental health, the economy in terms of the cost of treatment and lost productivity, societal health through criminal activity, and ultimately national stability through an unhealthy population. These problems have great potential to influence each other, with even greater consequences (Panitrat, R. 2001: 1-2). Overwhelmed by illicit substances, individuals may lose their interest in and responsibility for themselves, their families, and societies. They cannot keep good relationships with other persons around them (Yuttatri, P. 2001: 3-4).

Substance addiction is a complex phenomenon with important psychological and social causes including genetic, emotional factors and chemical effects of the substance (Rawson, 1999: 19). Although many people have tried to explain causes of substance abuse in several theories, there is no specific theory describe the substance abuse process completely (Neeskul, N. 2001: 25-26). Thailand has been facing numerous problems resulting from substance abuse pandemic. The annual statistics from the Office of the Narcotic Control Board of Thailand (ONCB, B.E. 2540-2543) indicate that substance abusers seem to be increasing.

The numbers of substance abuse cases from the years 1997 to 2000 (ONCB, B.E. 2540-2543) were 38,895, 39,714, 38,452, and 41,746 respectively. Additionally, the majority of them involve adolescents (49.80%, 52.40%, 50.43%, and 48.01% respectively). According to the Khonkaen Drug Dependence Treatment Center, the new substance abuse cases during the years 1998 to 2002 were 4,381, 3,322, 2,958, 3,295, and 3,011 respectively. And the numbers of new addicted adolescent cases were 2,622 (59.84%), 1,791 (53.91%), 1,388 (46.92%), 1,363 (41.37%), and 1,015 (33.71%) respectively, which were considered as the principal group of addiction (The Khonkaen Drug Dependence Treatment Center, B.E. 2545).

Adolescents are considered at a critical stage of human development because they are in the psychosocial stage between the morality learned by the child and the ethics to be developed by the adult. The danger of this stage is role confusion concerning ego identity miscarriage (Erikson, 1963: 261-263). Because adolescents are experiencing and have less negative attitudes about substance abuse such as low level of assertiveness, self-efficacy, self-esteem, self-confidence, social confidence and external locus of control. Therefore, it can make them are at risk for developing substance abuse more quickly than adulthood (Dusenbury, et al., In Lowinson, et al., Eds., 1992: 832-835). According to adolescents, they are the resource of power to create the progression of the country. If these great human resources become addicted to illicit substances, the future of the nation is at risk.

The family is the most important factor influencing teens' development and their health. Substance abuse in childhood and in teen years may be related to family condition such as parental substance use or abuse, poor parent-child relationships, low perceived parental support, low emotional bonding, and poor parent management of adolescent behavior. When a family has disturbance, it is a factor that has been identified in raising the risk for substance abuse in adolescents (Bukstein, 1995: 168; Neeskul, N. 2001: 30-31; Prommajit, P. 2001: iv; Vakahili, et al., 2000: 21-34). Prevention and protection of their children from substance dependence problems are serious and urgent tasks for family and social members. Especially, caring for relapse prevention is the most important, because the relapse rate in substance abusers is very

high (Dusenbury, et al., In Lowinson, et al., Eds., 1992: 839). Parents or guardian must understand and support their children when they have problems. Positive support and reinforcement from the family help substance addicts to realize their own value, accept the love from their family, and to be more decisive in addict remission (Yuttatri, P. 2001: 7-11). The family caregivers who have been involved in caregiving at home (Yupapin Sirapo-ngam, B.E. 2539: 86) have to pay high attention to do it. Parents or guardians in the role of family caregiver should create love and care among family members, because this will lead to good relationship between the youth and family (Prommajit, P. 2001: 168-169; Pathomneela, W. 2000: 129).

Nurses play a vital role in taking care of addicted adolescents when they are admitted for treatment and stay at the Drug Dependence Treatment Center. However, after discharge, they have to live with their families. The caring role then passes from nurses to family caregivers especially parents or guardians. The responsibilities of family caregivers vary according to the physical disabilities, cognitive impairment, psychological well being, and personal demands of patients (Yupapin Sirapo-ngam, B.E. 2539: 84). If family members know more about the needs of addicted adolescents they can fulfill the needs of their addicted adolescents quite easily.

Caring is an important core concept of nursing practice. The nurses' role is to help individuals, families, and groups determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work (WHO, 1996: 4-6). During the period of caring for addicted adolescents in family, nurses act to build a bridge of caring between the drug dependence treatment center and the family. The responsibility of the nurses can lead the addicted adolescents to get the high quality of care from their family caregivers. This strategy can help the addicted adolescent to successfully recover from substance abuse situations. Moreover, it will help decrease substance addict problems as well.

In this study, the researcher applies the Transpersonal Caring Theory as a theoretical framework. This theory places upon helping a person gain more self-knowledge, self-control and readiness for self-healing (Watson, 1985, 1988). Hitherto, only few studies about family caregivers of addicted patients have been

reported in Thailand. Therefore, the study of caring behaviors of family caregivers, caring needs and caring perceptions of addicted adolescents should be explored. The results of this study will provide a preliminary knowledge base and be essential for professional health care teams in dealing with the substance dependence situations and guiding the development of the Caring Training Program.

### **Research Questions**

1. What are the caring behaviors of the family caregivers and the caring needs and caring perceptions of addicted adolescents?
2. Are there the differences in caring behaviors of the family caregivers who differ in age, gender, education, and occupation?
3. Are there the differences in caring needs of the addicted adolescents who differ in education, substance abuse duration, and admission?
4. Are there the differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents?

### **Purposes of the Study**

The purposes of this study are:

1. To describe the caring behaviors of family caregivers, and the caring needs and caring perceptions of addicted adolescents.
2. To compare the differences in caring behaviors of family caregivers according to age, gender, education, and occupation.

3. To compare the differences in caring needs of addicted adolescents according to education, substance abuse duration, and admission.

4. To compare the differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents.

### **Research Hypotheses**

1. There are differences in the caring behaviors of family caregivers who differ in age, gender, education, and occupation.

2. There are no differences in the caring needs of addicted adolescents who differ in education, substance abuse duration, and admission.

3. There are differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents.

### **Scope of the Study**

The research aims to study the caring behaviors of family caregivers, the caring needs and the caring perceptions of addicted adolescents. Data were collected by self-administered questionnaires namely Caring Behaviors questionnaire and Caring Needs and Caring Perceptions Questionnaire. The researcher modified these questionnaires based on Watson's ten carative factors. The populations were addicted adolescents and family caregivers at the Khonkaen Drug Dependence Treatment Center during October 2002 to March 2003.

## Definition of Variables

**Caring behaviors** refer to the score of family caregivers' activities on Watson's ten carative factors to the physical disabilities, cognitive impairment, psychological Well-being, and personal demands of their addicted adolescents, which are measured by Caring Behaviors Questionnaire.

### **Watson's ten carative factors:**

**Factor I: Humanistic-altruistic system of values** refers to the family caregivers' activities concerning a commitment to and satisfaction through giving a set of universal human values-kindness, concern, love, extension of the sense of self to tolerate differences, view others through their own perceptual systems, and appreciate diversity and individuality.

**Factor II: Faith-hope** refers to the family caregivers' activities concerning respect to individuals' beliefs and motivations, encourage the potential to change their life, giving the various supportive comforts measures for instilling faith-hope.

**Factor III: Sensitivity to self and others** refers to the family caregivers' activities concerning recognizing, feel feelings, accept feelings, and be willing to explore one's own and others feelings.

**Factor VI: Helping-trusting, human care relationship** refers to the family caregivers' activities concerning create helping relationships which involves congruence, empathy, non-possessive warmth, and effective communication.

**Factor V: Expressing positive and negative feelings** refers to the family caregivers' activities concerning the promotion to express negative and positive feelings by taking awareness of feelings with understanding and accept the feelings as a universal one without feeling defensive in oneself and others.

**Factor VI: Creative problem-solving caring process** refers to the family caregivers' activities concerning the problem-solving process, which consists of assessment, plan, intervention, and evaluation in stress situation.

**Factor VII: Transpersonal teaching-learning** refers to the family caregivers' activities concerning promoting the imparting of information as well as consideration of the nature of learning and what interpersonal processes facilitate learning to reduce stress, fear and anxiety for helping the person to find alternate solutions when undergoing stress.

**Factor VIII: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments** refers to the family caregivers' activities concerning provision of internal environments; a person's mental, spiritual, and sociocultural harmony and well-being; and external environments include stress-change, comfort, privacy, safety, and clean-esthetic surroundings.

**Factor IV: Human needs assistance** refers to the family caregivers' activities concerning assistance with the gratification of the lower and higher order of human needs which consist of the need for food, fluid, elimination, ventilation, activity-inactivity, sexuality, achievement, affiliation, and self-actualization.

**Factor X: Existential-phenomenological-spiritual forces** refers to the family caregivers' activities concerning allowing a person to understand the phenomena when they have stress, fear and anxiety, which brings personal meaning to the human predicament as well as providing a thought-provoking experience leading to a better understanding of others and ourselves.

**Caring needs** refers to the score of physical disabilities, cognitive impairment, psychological well-being, and personal needs on the Watson's ten carative factors of the addicted adolescents, which is measured by Caring Needs Questionnaire.

**Caring perceptions** refers to the score of caring perceived on Watson's ten carative factors to the physical disabilities, cognitive impairment, psychological Well-being, and personal needs of the addicted adolescents, which is measured by Caring Perceptions Questionnaire.

**Age** means the age of the family caregiver in full years; classified as 21-40 years, 41-60 years, and over 60 years.

**Gender** refers to male and female.

**Education** refers to elementary education, secondary education, and higher education.

**Occupation** refers to worker, agriculturist, merchant, and official/state enterprise employee.

**Substance abuse duration** refers to time length from starting using the illicit substances until recently admitted to the Khonkaen Drug Dependence Treatment Center; classified as less than 1 year, 1-3 years, and more than 3 years.

**Admission** refers to the first, the second, and the third or more admission by either an Out-Patient Department (OPD) or In-Patient Department (IPD) in any Drug Dependence Treatment Center of the addicted adolescents.

## **Benefits of the Study**

### **Nursing Practice**

Nurses can apply the knowledge from this study for the prevention of substance addiction, suggest how family caregivers should take care of the addicted family members, and enable them to meet caring needs after their treatment has finished and they have been discharged from the Drug Dependence Treatment Center.

### **Nursing Administration**

The results of this study can be used to develop a Caring Training Program for family caregivers that are appropriate to the caring needs of addicted adolescents.

### **Nursing Research**

The result of this research can be used as preliminary step for further study especially about caring behaviors of family caregivers, caring needs and caring perceptions in another age groups of substance abuse patient.

## CHAPTER II

### LITERATURE REVIEW

The purpose of this research was to study the caring behaviors of family caregivers, caring needs, and caring perceptions of addicted adolescents. The review of theoretical and empirical literature was organized into three major parts: knowledge of illicit substances, theoretical perspective on caring and related factors, and family caregivers and addicted adolescents.

#### Part I: Knowledge of Illicit Substances

##### Definition

**Substance abuse** is the harmful use of a specific psychoactive substance (s) (Sullivan, 1995: 8). The habitual use of the substance not needed for therapeutic purposes and the continued abuse of a substance may lead to adverse physiological, behavioral, and social consequences. Persons who are substance-dependent will continue their use despite these adverse consequences. Moderate chronic use or severe short-term use of substances may lead to abuse, which may eventually lead to addiction (Rawson, 1999: 20).

**Addiction** is the disease process characterized by continued use of a specific substance, which involves a biological process, with important psychological and social causes and consequences (Rawson, 1999: 20; Sullivan, 1995: 8).

**Dependence** may be categorized in two ways: physical and psychological. *Physical dependence* is the physiological state of adaptation to a specific psychoactive substance.

It is characterized by emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. *Psychological dependence* is a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its absence. To meet the criteria for substance dependence, the physiological and psychological dependence must occur together (Sullivan, 1995: 9).

### **The Process of Substance Dependence**

Substance dependence refers to the step-by-step and continuous consumption of addictive substances or certain drugs, which are physically and mentally harmful to users and their community. The Institute of Medicine and The Centre for Substance Abuse Prevention (1990, 1994 cited by Yuttatri, P. 2001: 39-43) classified four stages of addiction that being different in terms of the frequency of usage and behaviors of the user include experimental use or use for social purposes, frequent use or abuse, addiction or dependency, and recovery stage.

During the first stage, the addict uses substances most of time among friends on weekends or when alone. Behavioral changes during this stage are hardly noticeable. Later in the second stage, substances are used more often with frequency of many times. Users at this stage become uneasy when they are without the substance and they need it to manage their life. The indicative behaviors of users are the lack of responsibility, mood swings, personality changes, telling lies often and speaking negatively against other people. They mostly stay with friends who also use substances and pay less attention to activities they used to do. They start quarreling with family members, and protest against or threaten others. Their main focus is to find and use drugs. The *craving* for substances occurs more often than in the first stage.

The craving for substances is a bio-psychological arousal and strong learned responses with powerful motivational properties often associated with specific memories to later trigger desire for the substance and urge to return to addictive behavior.

(Rawson, 1999: 21)

In the third stage, users consume substances every day. The symptoms of addiction are obvious such as nervousness, frustration, mood swings, desire to commit suicide, and other health problems. Users, who use too many substance or use it over a long period of time are possibly skeptical of mood swings and may have psychological problems. The craving forces the users to do anything to get substances and ignores the fear of being caught with substances. If the use continues without being stopped, physical problems will increase. Conversely, if users want to abstain from substances and receive assistance, they enter the fourth stage, the recovery stage. Recovery refers to the stage of emotional change. Substance users will succeed, or not, depending on how far they stop their earlier behavior and behaving appropriately relating to substances.

Between the dependency and recovery stages, gradual behavioral changes until the maintenance of abstinence occurs. Each step, which consists of five steps, can be passed satisfactorily because of the patient's proper reactions (Prochaska, DiClemente & Norcross, 1992: 1102-1113).

**1. Pre-contemplation stage.** This is the stage when drug users do not really consider addiction a problem and they do not consider that abstinence is important. They will then probably refuse to stop. The proper reaction of people around them is to give information about the problems caused by addiction.

**2. Contemplation stage.** At this stage, substance users become aware of the effect of substances but they are still ambivalent. The supporting people therefore should underline the advantage of living without substances and encourage planning for abstinence and convince the users that they are able to change their behavior in order to enjoy a better life.

**3. Planning or preparation.** Substance users try to avoid unpleasant behaviors and behave the way they used to before addiction. They always promise themselves to abstain.

**4. Action stage.** Substance users accept treatment or are interested in meeting others in a group. Users gradually reduce the amount of substances

consumed until they stop consumption and they can maintain the situation of being a non-user of substances.

**5. Maintenance stage.** Users who reach this stage require huge and continuous effort in order to prolong and maintain positive behavior. This stage will be completed once substance users achieve stable abstinence. Unfortunately, a number of substance users relapse, which means that they once again begin the early stages of addiction.

All substance users can relapse as addiction is like a chronic disease, but relapse does not mean failure. Nursing staff and family caregivers, therefore, should view relapse positively because substance users can achieve the recovery stage again regardless of the number of times they relapse.

### **Treatment for Substance Abuse**

There are many different models and interventions of substance abuse approaches to treat individuals with addictive disorders. Each of these models has philosophical differences, but some approaches overlap in perspective. No one philosophy fully or adequately explains the range of addiction problems, and no one philosophy suggests the correct treatment approach (Sullivan, 1995: 72). This study has reviewed the literature by focusing on the treatment setting, treatment modalities, and related studies as follows:

#### **Treatment Settings**

There are many settings in several modes of substance abuse treatment, including crisis intervention, inpatient treatment, outpatient treatment, residential care, and therapeutic communities. Crisis intervention and evaluation require at least a screening evaluation for possible substance involvement. Inpatient or short-term treatment is seen as the preferred setting for most addicted adolescents. They are related to preventing the adolescent from inappropriate environments, separate from problematic family circumstances, and increasing the intensity of

treatment. Contrasting to the outpatient treatment, the primary advantage is the participation in treatment while remaining in community. In remaining treatment settings, residential care or intermediate care, there are a more diverse range of treatment approaches than is found in short-term setting, including group and individual counseling, substance education, and educational as well as recreational activities. Most long-term programs require previous treatment in a short-term or rehab setting (Bukstein, 1995: 143-146).

### **Treatment Modalities**

Traditional methods based on the philosophy and principles of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) programs include group therapy, lectures, work assignments including 12-steps work, a therapeutic milieu, attendance at AA/NA meetings, family therapy, or counseling, and recreational activities. In view of the variety of environmental and learning factors, behavioral therapists and other professionals have developed a variety of behavioral and cognitive-behavioral methods to target both substance use behaviors and a host of associated behavioral and emotional problems. Most commonly used are social skills training. Within most substance abuse treatment programs, medication has recently become a viable treatment option. Despite the change in attitudes of many treatment professionals, there remain individuals who strongly believe that medications should be used in addicted individuals only in cases of medical life or death emergency (Bukstein, 1995: 161-179).

The involvement and attitudes of the patient's significant friends and family members will either enhance or interfere with the therapeutic effort. Many risk factors for the etiology and maintenance of substance abuse are related to the family such as parental substance use or abuse, poor parent-child relationships, low perceived parental support, low emotional bonding, and poor parent management of the adolescent's behavior. These factors have been identified as raising the risk for substance abuse in adolescents. On the other hand, both family and social support can help protect substance addicts from critical crises through enhancing their abilities to adjust themselves to existing changes according to the individual needs. If the

substance users gained the family and social support, they would be proud and improve their modification behaviors. Family treatment offers the opportunity to improve communication between family members and increase structure, limits, and supervision with the household; it allows the constituent family members to better function in their appropriate family roles. The realistic attitudes and expectations of family members become high level when they understand better the process of addiction and recovery. The therapist, therefore, who is able to engage the family in the appropriate parts of the program while maintaining rapport with the patient will earn and maintain the family's trust and optimize the chance of a successful recovery of family member addiction (Bukstein, 1995: 161-183; Kwanhathai Rongkoptawanich, B.E. 2544; Obert, et al., 2000: 158-159; Praneeporn Boonruang, B.E. 2545: 65-67; Teravit Chienpradit, B.E. 2540: 3-4; Vachiraporn Sribenjakul, B.E. 2543: 3-4).

Despite originating from varied theoretical orientations, traditional treatment methods, family treatment, cognitive-behavioral methods, and medication are not inherently incompatible. However, using a comprehensive approach of these modalities is potentially complementary (Bukstein, 1995: 182-183).

### **Impact of Substance Abuse on Family**

Substance abuse is a systemic process that affects and is affected by the interaction that occurs between the person who abuses a substance, the substance itself, the person and the substance, and others such as colleagues, friends and family members. It is evident that there are interrelated alterations in management of feelings, role structures, communication, and need fulfillment within the family system (Haber, In Naegle & D'Avanzo, Eds., 2001: 315). Substance abuse is associated with low levels of satisfaction with family relationships (Dixon, et al., 1995: 456-458). In addition, the family factors: love & warmth, time-sharing, and mutual communication fairly are related to drug addiction. The important aspects influencing drug using are the aspects of caring from parents and time for talking in family (Vachiraporn Sribenjakul, B.E. 2543: 3-4). The study of Hoffman & Johnson (1998: 633-645) found that the risk of problem drug use was highest among

adolescents in father-custody families (father-only and father-stepmother families), but was lowest in mother-father families.

The effects of substance abuse result in adaptive changes at all systemic levels and reflect an imbalance in the functioning of the total family system (Haber, In Naegle & D'Avanzo, Eds., 2001: 315). Dysfunction of family relationship system can lead family members especially adolescents to use the illicit substances and addiction (Umaporn Trangkasombat, B.E. 2542: 267-269). Additionally, maladaptive family functioning had been linked to adolescent drug use and delinquent behaviors (Santisteban, et al., 1999: 197-206). Clark, et al. (1998: 81-92) found, by mother reports, that families of adolescents with alcohol use disorders functioned less well than did families of adolescents with other mental disorders. Likewise, current alcohol use was related to poorer family functioning, lower quality of parental intellectual stimulation, and higher levels of domestic violence. Current drinking predicted a less cohesive and organized family environment and higher levels of domestic violence (Jester, et al. 2000: 1187-1197). Furthermore, the family task in the aspect of providing biological needs, maintaining the communication and family relationships, and teaching of social role were related to addiction characteristics of adolescents (Sumnao Makban, B.E. 2542: 109-123).

The findings of Clark (2001: 93-101) suggested that direct family support from informal (family) caregivers might help addicted patients reduce or eliminate their substance use. Families, therefore, should be strengthened by love, understanding, and time-sharing among family members (Vachiraporn Sribenjakul, B.E. 2543: 3-4) because the adverse effects of family illegal drug use on adolescent drug use could be buffered by protective parental child-rearing practices and environmental factors, leading to less adolescent illegal drug use (Brook, et al., 2001: 183-203).

## **Part II: Theoretical Perspective on Caring and Related Factors**

### **Knowledge of Caring**

Caring is, to feel interest or concern (Merriam-Webster's Collegiate Dictionary, 1996: 173), to feel a lot of affection for (Collins Cobuild English Dictionary, 1998: 240). The term caring is used appropriately to describe a wide range of involvement, from romantic love to parental love to friendship (Benner & Wrubel, 1989: 1). It is addressed as the basic constitutive phenomenon of human existence, which acts as an essential ingredient in human development and survival (Euswas, P. 1991: 11-14). Mayeroff (1971 cited by Wolf, 1986: 87-88) gave a general meaning of caring as the process of helping another grow and actualize which consists of eight essential caring ingredients: knowledge, alternating rhythms, patience, honesty, trust, humility, hope, and courage. This process is the common basic pattern of care in any context in which it occurs. Caring is an innate human trait, the human mode of being, a part of human nature, and essential to human existence (Roach, 1987; Leininger, 1985, 1988 cited by Morse, et al., 1990: 4). It is a basic way of being in the world (Benner & Wrubel, 1989: 398). Care is viewed as an essential component of psychosocial development occurring over a person's life span and is considered as to be concern for what has been generated through love of parents toward their children. It is an adult virtue that is necessary for growth and development of the individual, the coming generation and society as a whole. As a sense of concern for another, care is fundamental to entering into a relationship (Erikson, 1963: 247-274; 1968: 91-141; 1982: 55-82). Non-possessive care consists of empathy, unconditional positive regard, and congruence. It is identified as the fundamental aspect of therapeutic relationships between the therapist and the participants, which is aimed at bringing about a desired personality change in the later (Roger, 1958, 1965 cited by Euswas, P. 1991: 14). Caring has existed in every society. Genes do not transmit a caring attitude from generation to generation, but it is transmitted by the culture of the profession as a unique way of coping with its environment (Watson, 1985: 8).

Concerning with promoting health, preventing illness, caring for the sick, and restoring health in the light of nursing (Watson, 1985: 7), caring is the every

day sanitary knowledge of how to put the constitution in such a state that it will have no disease, or that it can recover from disease, and taking a higher place (Nightingale, 1969: 3). Peplau (1952: 16) proposed the notion of the relationship between the nurse and the patient as the central characteristic of nursing. Nursing is viewed as a significant therapeutic interpersonal process. It is an educative instrument and a maturing force that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living. The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he/she would perform unaided if he/she had the necessary strength, will or knowledge, and to do this in such a way as to help him regain independence as soon as possible (Henderson, 1961 cited by WHO, 1996: 3).

Care is based on knowledge of the patient's needs, and how to fulfill those needs in the way that promotes self-help and growth towards independence (Henderson, 1966 cited by Euswas, P. 1991: 14). Leininger (1981a, 1984 cited by Kyle, 1995: 506-507) identified caring as the essence and the central unifying and dominant domain to characterize nursing. These characteristics involve assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or way of life. Helping people in time of need to achieve their daily living needs appears to be the essence of caring (Leininger, 1981 cited by Euswas, P. 1991: 16). According to the goal of nursing, caring placed upon helping persons gain a higher degree of harmony within the mind, body, and soul (Watson, 1988: 49). There are five categories of caring: caring as a human trait, caring as a moral imperative or ideal, caring as an affect, caring as an interpersonal relationship, and caring as a therapeutic intervention. In addition to these categories, two outcomes that are also identified: caring as the subjective experience of patient and caring as a physical response (Morse, et al., 1990: 1-14). Caring is an important part of nursing practice. The nurse carries out tasks in the context of a relationship with an individuals, families, and communities (WHO, 1996: 6).

## Watson Transpersonal Caring Theory

Human care or caring is viewed as the moral ideal rather than a task-oriented behavior and includes such elusive aspects of the actual caring occasion as the transpersonal caring relationship between two persons. It consists of transpersonal human-to-human attempts to protect, enhance, and preserve human dignity and humanity in the health care system by helping a person find meaning in illness, suffering, pain, and existence. Caring helps individuals gain self-knowledge, control, and self-healing wherein a sense of inner harmony is restored regardless of the external circumstances (Watson, 1988: 54). The basic assumptions for the science of caring are as follows:

1. Caring can be effectively demonstrated and practiced only interpersonally.
2. Caring consists of carative factors that result in the satisfaction of certain human needs.
3. Effective caring promotes health and individual or family growth.
4. Caring responses accept a person not only as he or she is now but as what he or she may become.
5. A caring environment is one that offers the development of potential while allowing the person to choose the best action for him or herself at a given point in time.
6. Caring is more “healthogenic” than is curing. The practice of caring integrates biophysical knowledge with knowledge of human behavior to generate or promote health and to provide ministrations to those who are ill. A science of caring is therefore complementary to the science of curing.
7. The practice of caring is central to nursing.

(Watson, 1985: 8-9)

Watson (1988: 48) viewed illness as subjective turmoil or disharmony within a person’s inner self or soul, whereas health was viewed as the unity and harmony within the mind, body, and soul. Illness connotes a felt incongruence within the person such as incongruence between the self as perceived and the self as experienced. Helping persons gain a higher degree of harmony is

pursued through the human-to human caring process (Watson, 1988: 49). Transpersonal human care and caring transactions are those scientific, professional, ethical, yet esthetic, creative and personalized giving/receiving moments between two people that allow for contact between the subjective world and consciousness of the two (Watson, 1999: 115). Transpersonal refers to an intersubjective human-to-human relationship in which the person of the one caring affects and is affected by the person of the other one being cared for. Both are fully present in the moment and feel a union with the other. They share a phenomenal field, which becomes part of the life history of both and are co-participants in becoming in the now and the future. The caring can help person attain health or die a peaceful death (Watson, 1985: 7; 1988: 58).

The value system of Transpersonal Caring Theory is blended with Watson's ten carative factors, developed from a humanistic philosophy that is central to caring for another human being and that is founded on a steadily growing scientific base, which nurse use in the delivery care to the clients, as follow:

### **1. Humanistic-altruistic system of values**

Caring must be grounded on a set of universal human values: kindness, concern, and love of self and others. A humanistic-altruistic system of values is a qualitative philosophy that guides one's mature life. It is the commitment to and satisfaction of receiving through giving. It involves the capacity to view humanity with love and to appreciate diversity and individuality. Such a value system helps one to tolerate differences and to view others through their own perceptual systems rather than through one's own. Altruistic values and behavior bring meaning to one's life through relationships with other people. A humanistic-altruistic value system encompasses the concept of maturity. Caring consists of humanistic-altruistic feelings and acts that promote the best professional care and the most mature social contributions (Watson, 1985: 10-12).

### **2. Faith-hope**

Faith-hope traditionally has been important in treatment to relieve the symptoms of illness. The power of suggestion and relationship are related to the effective of treatment, especially the power of suggestion (the power of positive

feeling) is linked to the instillation of faith-hope. Faith-hope is so basic that it can affect the healing process and the outcome of illness. The interaction within a personal relationship is an important factor for a faith-hope instilling framework to take care of other; moreover, the healing power of belief should never be overlooked. The holistic nature of responding to another person justifies faith-hope as a contributing influence in people's lives. Faith builds on and draws from a humanistic-altruistic system of values to promote holistic professional care and produce positive health. Furthermore, they together contribute to the third curative factor: Sensitivity to self and others (Watson, 1985: 12-16).

### **3. Sensitivity to self and others**

The only way to develop sensitivity to self and others is to recognize and feel feelings - painful ones as well as happy ones. The development of self and the nurturing of judgment, taste, values, and sensitivity in human relationships evolve from emotional states. The humanity and compassionate life experiences encourage the development of feelings. The recognition and development of feelings lead to self-actualization through self-acceptance and psychological growth. The balanced sensitivity of one's feelings gives one a foundation for empathy with other and authenticity with self and others. It is the foundation for integrity. The sensitivity to feeling of person is able to make another person feel understood, accepted, and capable of moving toward a more mature level of function and growth. Sensitivity to self and others builds on the humanistic-altruistic system of values and faith hope, and it commits to helping people achieve such goals as satisfaction, comfort, freedom from pain and suffering, and higher level wellness (Watson, 1985: 16-19).

### **4. Helping-trusting, human care relationship**

Watson (1985: 23-41) stated that the development of the helping-trusting human care relationship is crucial for transpersonal caring because it is closely related to the promotion and acceptance of the expressing positive and negative feelings. The development of a helping-trusting human care relationship must be acknowledged as an important curative factor that makes a difference in the quality of care. This factor involves congruence, empathy, non-possessive warmth,

and effective communication. Congruence involves openness with the feelings and attitudes that are within what at a given moment. It can be equated with genuineness, which means being real, honest, and authentic. Empathy means the ability to experience the other person's private world and feelings and to communicate to the other person some significant degree of that understanding. It is one of the basic elements necessary for working effectively with others in a helping relationship. Regarding non-possessive warmth, it is an interpersonal condition in a helping relationship that, along with congruence and empathy, promotes growth in another person. Non-possessive warmth is related to unconditional positive regard, which is communicated through variety of behaviors. These behaviors include maintenance of eye contact during an interaction, use of a moderate volume in speaking, being relaxed and at ease with oneself, facing the other person, having an open posture rather than a closed one, leaning toward the other person, having a facial expression that is congruent with the other person's emotional state (Watson, 1985: 32-33).

Effective communication consists of verbal cognitive responses, nonverbal behavior, and affective (emotional) responses. People receive and give messages to connect themselves with others through three processes of cognitive, affective, and behavioral. Effective communication is linked within the context of this curative factor. Theorists state that only about 35 percent of communication is language and the remaining is nonverbal behaviors. Thus, the accuracy in understanding the messages, meanings, and feelings of another is basic to the three core ingredients: congruence, empathy and non-possessive warmth (Watson, 1985: 35).

### **5. Expressing positive and negative feelings**

Emotion plays a central role in people's behavior. Both a rational factor and an emotional factor influence thinking, decision-making, and behavior. An inconsistency between thoughts and feelings can lead to anxiety, stress, confusion, or even fear because the intellectual understanding and the emotional understanding of the same information are quite different. An awareness of one's feelings may eliminate some of the irrationality of feelings and give one more control

over one's thoughts and behavior. If person is made aware of their feelings, he/she may understand what triggered the anger and accept the feelings as a universal one common to others in similar situations. This realization may free the person to respond to the feeling with a sense of relief and to respond to a situation in a more appropriate manner. In contrast, the person who tries to hide from his or her inner self and feelings may lead destructively in a relationship with other person. Even though his or her action may be unintentional and protective, it can negatively affect the quality of care. The science of caring allows for promoting and accepting the expression of positive and negative feelings in self and others. Feelings can change thoughts and influence behavior. Therefore, the science and practice of caring must be systematically attended to responses in the maintenance and promotion of people's health and illness because it improves one's level of awareness and internal control over one's behavior and actions (Watson, 1985: 41-48).

#### **6. Creative problem-solving caring process**

Creative problem-solving caring process is just as important as a humanistic approach for the science of caring. It is necessary for the science of caring to study, guide, direct, and research knowledge and practice. The science of caring practice draws on a basic knowledge of the behavioral sciences that provide an understanding of how people feel and behave when under stress, well, well but worried, or sick by using the scientific problem-solving method. Application of this method allows a person to draw on a common data base to problem solve systematically to make a decision, obtain new knowledge, and evaluate or develop something. It is same as nursing process including assessing, planning, intervening, and evaluating (Watson, 1985: 51-66).

#### **7. Transpersonal teaching learning**

The imparting of information is an explicit way to reduce fear and anxiety in stress situations related to uncertainty and seriousness. The way in which the role of information operates to reduce stress includes the following generalities about the transpersonal teaching learning carative factor:

1. That information promotes accurate expectations and reduces discomforting discrepancies between the degree of stress expected and the degree of stress experienced.
2. That information increases the ability to predict what will happen, leading to the feeling of being in control, and reducing associated fears.
3. That information fosters the realistic worry and mental rehearsal necessary for emotional acceptance of stress.
4. That information changes beliefs and reduces the dreadful fantasies that may be caused by the impending stress.
5. That information leads to intellectual understanding that may constitute a method of dealing with the illness and conceptualizing it in a less stressful way.
6. That information is intimately involved in the evaluation of situations as threatening and the evaluation of ways of reducing threat.

(Watson, 1985:71)

One of the best adaptive responses to stress both in general and health-illness is to have accurate information as well as available alternate responses. A person needs information for controlling a situation that interrupts his or her plans and events caused by stress. Therefore, helping the person to find alternate solutions when undergoing stress must be emphasized because of its importance in transpersonal teaching learning and the role that it play in adaptation to stress (Watson, 1985: 69-79).

#### **8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments**

Both internal and external environments influence health and illness. The concepts relevant to internal environments include the mental and spiritual well-being and socio-cultural beliefs. The concepts relevant to external environments involve such factors as stress-change, comfort, privacy, safety, and clean-esthetic surroundings. The manipulations of physical or social environment activities that individual uses to provide the supportive, protective, and/or corrective

activities to another person can contribute a physical, mental, spiritual, and socio-cultural harmony as well as well-being (Watson, 1985: 81-101).

### **9. Human needs assistance**

Human needs consist of the need to be loved and cared for and about, the need for positive regard and the need to be accepted, understood, and valued. They can be classified into lower and higher order needs. The lower order needs involve biophysical or survival needs and psychophysical or functional needs. Food, fluid, elimination, and ventilation are examples of lower order biophysical needs, and activity/inactivity and sexuality are considered as lower order psychophysical needs. The higher order needs classify into psychosocial or integrative needs namely the need for achievement and affiliation, and intrapersonal-interpersonal or growth-seeking needs namely the need for self-actualization. Individuals must satisfy lower order needs before attempting to attain higher order needs ones. One need should never be completely separated from another. Rather, they should all operate dynamically as a whole. Every person has needs that must be gratified in order to grow and develop their potentialities (Watson, 1985: 105-111; 1988: 57).

### **10. Existential-phenomenological-spiritual forces**

Phenomenology describes data of the immediate situation that help people understand the phenomena in question. Existential psychology is a science of human existence that uses phenomenological analysis. Existential psychologies is a science of human existence that brings personal meaning to the human predicament as well as providing a thought-provoking experience leading to a better understanding of others and ourselves (Watson, 1985: 205-215).

Caring, in nursing practice, is a therapeutic interpersonal process, making the assumption that “caring can be effectively demonstrated and practiced only interpersonally” (Watson, 1985: 8). Nurses have the responsibility to go beyond the ten carative factors and facilitate patients’ development in the area of health promotion through preventive health actions. Watson identifies ten carative factors that combine to make up the caring process through which the patient is helped to attain health or die a peaceful death. These factors include both personal

characteristics and actions by the nurse (Patton, et al., In Tomey & Alligood, Eds., 1998: 146; Watson, 1979 cited by Brown, 1986: 58). The human care process between a one caring and another one being cared for is a special, delicate gift to be cherished. The human care transactions provide a coming together and establishment of contact between persons (one's mind-body-soul engages with another's mind-body-soul) in a lived moment. The shared moment of the present has the potential to transcend time and space and the physical, concrete world as we generally view it in the traditional nurse-patient relationship. The goal of nursing is to help persons gain a higher harmony of the mind, body and soul, which generates self-knowledge, self-reverence, self-healing, and self-care processes while allowing increasing diversity (Watson, 1988: 47-49).

### **Assessment of Caring Behaviors**

Behavioral assessments are considered to be a necessary part of behavioral studies helping to find out the meaning of human behaviors. The methods of behavioral assessments are classified as direct and indirect methods of assessment (Cone, 1978 cited by Sompoch Aiamsupasit, B.E. 2539: 61-104). Direct assessment is the most popular method of behavioral psychologists. This method, which consists of observation, self-monitoring, measurement of product, and physiological measures, can identify the characteristics of behaviors without interpretation process. Indirect methods of assessment consist of interview, information from other people, and self-report. This method, the gathered data itself have no meaning, therefore, it must be taken into the process of interpretation for seeking the meaning. The meanings reliable of the data are correlated with validity and reliability of instrument.

There have been a number of caring studies conducted by several researchers, which have focused on caring in nursing practice. These studies have investigated nurses' and patients' perceptions of effective caring. The details of the studies reported in the literature have adopted both qualitative and quantitative approaches, emphasizing the importance of identifying specific behaviors that

communicate caring. It is pertinent to add that the vast majority of studies on caring to be discussed as the followings.

One of the earliest researchers to use a qualitative approach in the study of caring was Henry (1975 cited by Kyle, 1995: 511), who explored the perceptions of fifty home-care patients of what nurses do to indicate caring. Henry, using open-ended interviews, reported that ‘extra thing’ was the most frequent response that made patients feel cared for by the nurse. Henry classified the responses into three main categories: what the nurse does; how the nurse does; and how much the nurse does. Similarly to Henry, Brown (1981 cited by Kyle, 1995: 511) conducted a study to identify, describe, and classify nursing behaviors perceived by patients. The results concluded that the behaviors perceived to be fundamental to caring focused on physical well-being, and the affective component of care was also considered important. The qualitative studies on caring, additionally, were conducted by several researchers (Forrest, 1989; Swanson-Kauffman’s, 1986, 1988 cited by Euswas, P. 1991: 21-30; Morrison, 1991; Reiman, 1986 cited Kyle, 1995: 506-514).

The instruments of quantitative approach caring including Caring Assessment Report Evaluation Q-sort: CARE-Q (Larson, 1984, 1986, 1987); Caring Behaviors Inventory: CBI (Wolf, 1986); Caring Behaviors Assessment: CBA (Cronin & Harrison, 1988); Caring Dimensions Inventory: CDI (Watson & Lea, 1997, Lea & Watson, 1998); and related caring questionnaire in other populations were mentioned in this topic.

### **1. Caring Assessment Report Evaluation Q-sort (CARE-Q)**

In the development of the CARE-Q instrument, Larson (1984, 1986 cited by Kyle, 1995: 509) has attempted to establish reliability and validity. Face and content validity were established in two earlier studies by identifying and developing the behavioral items from the perspective of both nurse and patient. Despite the limitations highlighted by Larson, several nurse researchers proceeded to use the CARE-Q instrument in further studies on caring. The studies, using this instrument, include comparing oncology nurses’ and cancer patients’ perceptions of nurse caring behaviors (Mayer, 1987: 48-52), similarly study involving

patients and nurses working in a rehabilitation setting (Keane, et al., 1987: 182-184), perceptions of caring by nurse educators (Komorita, et al., 1991: 23-29), perceptions of senior nursing students and professional nurses on caring (Mangold, 1991: 134-139), and comparing patients' and staffs' perceptions of caring in medical and surgical specialties (Von Essen & Sjöden, 1991: 1363-1374). In Thailand, Pranom Poostritong (B.E. 2536: 60-62) conducted a study to determine nurse caring behaviors as perceived by parturients. The instrument consists of 40 items and was developed from Larson's instrument with the alpha Cronbach's coefficient of .88. Likewise, Bualuang Samdaengrit (B.E. 2538: 61-66) studied the perception of patients with cervical cancer treated by radiotherapy on caring needs and caring received from nurses. The caring assessment tool consisted of 50 items with a Kuder-Richardson (KR-20) of .75, which modified from CARE-Q (Larson, 1984) was used to assess the caring need and caring received from nurses.

## **2. Caring Behaviors Inventory (CBI)**

Wolf (1986: 84-93), using a similar quantitative approach but different instruments, devised Caring Behaviors Inventory (CBI) by selecting words or phrases that represented caring from the literatures. The 75 caring words and phrases were statistically analyzed using the factor analysis technique, but no pattern emerged. Consequently, Wolf reduced the overall list by selecting the 10 highest ranked words or phrases on CBI. The highest ranked caring behavior was identified as attentive listening, comparable with the findings in studies using the CARE-Q instrument.

## **3. Caring Behaviors Assessment (CBA)**

Cronin & Harrison (1988: 374-380) conducted a study to identify nursing behaviors perceived as indicators of caring by patients who had had a myocardial infarction. The Caring Behaviors Assessment (CBA) was used, which was developed by the investigators. The CBA lists 61 nursing behaviors ordered in 7 subscales that are congruent with Watson's ten carative factors. In Thailand, there were several studies using the Watson's Theory developed the instrument. These studies include the study on caring in nursing practice that instrument consists of 69 items

with the alpha Cronbach's coefficient of .94 (Yisun Jaidee, B.E. 2540: 69-73), the study on caring behaviors as perceived by nurses and clients that instruments consist of 65 items with the alpha Cronbach's coefficient in each questionnaire of .95 and .92, respectively (Ichaya Suwanakul and Nongnutch Chowsilpa, B.E. 2542: 59-66). In perspective of family caregivers, Parichat Wanwaisart (B.E. 2543: 92-103) developed the 32 items Caring Behaviors in Caregivers of Amphetamine Users Questionnaire to study about mental health and caring behaviors of caregivers with the alpha Cronbach's coefficient of .86.

#### **4. Caring Dimensions Inventory (CDI)**

Watson & Lea (1997: 87-94) developed the Caring Dimensions Inventory (CDI) to study nurses' caring perceptions. The aim of this study was to design an inventory which could be applied to a large sample of nurses in order to gather their perceptions of caring. The CDI was content validated in terms of existing conceptualizations of caring, research in this area, terms of a nursing taxonomy, and its representation in popular United Kingdom nursing publications. The CDI scale was related to the constructs of ages and gender of respondents.

#### **Factors related to caring behaviors**

Human behavior is basically the goal-directed attempt of a person to satisfy needs as experienced in the perceived phenomenal field (Watson, 1988: 57). Human perception mediates human behavior and is therefore of major interest in understanding such behavior. Individual perceptions are frequently influenced or altered by individually acquired motives, values, expectations, or personality characteristics that produce perceptual tendencies within the individual (Moskowitz & Orgel, 1969: 180-181).

##### **Age**

Age might be associated with the behavior of individuals. Personal maturation and organic, psychic, and intellectual functioning vary with the

periods of the human life cycle. Erikson (1963: 247-274, 1968: 91-141, 1982: 55-82) proposed eight stages of human development namely: infancy (oral sensory), early childhood (muscular-anal), play age (locomotors-genital), school age (latency), puberty and adolescence, young adulthood, adulthood, and old age (maturity) respectively. Each phase had a specific developmental task to achieve or solve for reaching the human strengths or ego qualities namely: hope, will, purpose, competence, fidelity, love, care, and wisdom respectively. These tasks describe the order and sequence of human development and the conditions necessary to accomplish them. The study of Cook, et al. (1994: 435-447) in age range of parent from 36 to 84 years found that younger parents were more troubled by their offspring's behaviors than were older parents.

### **Gender**

According to caregiving phenomena, women generally assume the responsibilities of care. In the Thai culture, this kind of task also relates to the gender role for women are more often expected to care for sick family members than men. The caregiving role in Thai families has been assigned traditionally to women. Therefore, women are more affected by multiple roles such as employment responsibilities, household tasks, and caregiver responsibilities. Furthermore, they are more expected to focus their values and beliefs pertaining to family life by sacrificing their efforts for family members than men (Pipatananond, P. 2001: 25-26).

### **Education**

Education allows a person to have full growth of intelligence and knowledge, which results in perception of information about health and illness better and allows them to decide to carry out health behavior appropriately. Pender's notion (1987) concerning the process of values clarification in the field of education stated that values clarification was attested to the centrality of values in understanding human behavior. It can facilitate problem solving in the area of health by promoting behavior consistent with health-related values. Education provides a basis for making decisions and choices. It is critical in mediating variables in human actions and reactions to environmental stimuli (Pender, 1987: 159-162).

## **Occupation**

Hitherto, no evidence reported the influencing of occupation factor on caring behaviors of family caregivers. However, the related study concerning the impact of chronic illness on patients found that occupation was important factor relative to social functioning (Hwu, 1995: 221-225).

## **Part III: Family Caregivers and Addicted Adolescents**

### **Family Caregivers**

The term “caregiver” refers to a person who provides direct care (Merriam-Webster’s Collegiate Dictionary, 1996: 173) or to someone who is responsible for looking after another person (Collins Cobuild English Dictionary, 1998: 240). Every society has had some people who have cared for others (Watson, 1985: 8). Human beings are viewed as needing continuous self-maintenance and self-regulation through a type of action named self-care. However, their ability to meet these needs can vary according to different circumstances. Caregivers may be required to perform specific actions to assist their carereceivers in meeting their self-care requisites because caregiving consists of actions by others that become necessary when self-care requisites cannot be met. (Orem, 2001: 149). These actions not only show in a parent, adult, towards a child or adolescent but also show in one adult towards another especially in times of ill health, stress or old age (Bowlby, 1980 cited by Wolf, 1986: 84-85).

An informal caregiver is the relative, friend, or significant other of a care recipient. The defining characteristic of these caregivers is that they provide unpaid but important components of care to an ill, infirm, or dependent care recipient in the home or community.

(Davis, 1992: 2)

From literature reviews, identifying informal caregivers is complicated. Several researchers defined the caregiver in various meaning such as restrict the caregiver definition to family member, dependent individual’s friend,

neighbor, or acquaintance. Moreover, some studies attempt to differentiate primary caregivers from secondary caregivers on basis of whether the caregiver lives with the care recipient (Davis, 1992: 2). The family caregivers' responsibilities concerned with the physical disabilities, cognitive impairment, personal demands, and psychological and emotional change of recipient (Yupapin Sirapo-ngam, B.E. 2539: 87-88). Horowitz has proposed four types of services that informal caregivers provide the caring activities. There are direct care services, emotional support, mediating with formal organizations, and financial assistance (Horowitz, 1985 cited by Davis, 1992: 2-3). Family caregivers are persons who have been involved in caregiving at home and qualify the following criteria (Yupapin Sirapo-ngam, B.E. 2539: 86).

1. The person can be a father, mother, wife, husband, son or daughter, sister or brother, friend or significant other.
2. The patient must be a person whose health status has been changed according to the disease, disability, and deterioration of physical, emotional, and mind resulting in the limitations in activity of daily living or needs for specific treatment. Nevertheless those needs must be responded continually.
3. The caring activity specifically focuses on the caregiving without wages or rewards. It occurs at home or in a community setting but not in a hospital or health service.

Hitherto, only a few studies about caring behaviors of family caregivers of substance addict patients have been reported. Parichat Wanwaisart (B.E. 2543: 92-103), the earliest researcher, conducted a study about mental health and the caring behaviors of caregivers of amphetamine users. The objectives of this study were to study the mental health and caring behaviors of caregivers of amphetamine users as well as the relationship between mental health and caring behaviors. The results of this study showed that family caregivers had caring behaviors at a moderate level and that there was no significant relationship between mental health and caring behaviors of caregivers of amphetamine users.

## **Addicted Adolescents**

Erikson proposed eight stages of human development, namely: oral sensory, muscular-anal, locomotors-genital, latency, puberty and adolescence, young adulthood, adulthood, and maturity respectively. This theory explains step-by-step unfolding of emotional development and social characteristics during encounters with the environment. Each phase has a specific developmental task to achieve or solve (Erikson, 1963: 247-274, 1968: 91-141, 1982: 55-82). Adolescence is a time of transition and critical period of cognitive developmental with eventual progress to adult capacities. It may be considered as a critical stage of human development that marks the end of childhood and sets the foundation of maturity. The adolescent is labeled as having to resolve the identity versus role confusion stage. This stage is a time of major testing as people try to determine what is unique and special about them. They attempt to discover who they are, what their strengths are, and what kinds of roles they are best suited to play for the rest of their lives. Confusion over the most appropriate role to follow in life can lead to lack of a stable identity and adoption of a socially unacceptable role. Children in this stage obtain pleasure from work completion. If they fail, on the other hand, they will develop a sense of inadequacy and inferiority. They may feel that they have no meaningful role in society.

Adolescence is a period of great physical, psychosocial, emotional, and cognitive changes. It is most commonly described as a time of experimental behavior, independence from parents and importance of being a part of a peer group. During this period, major events occur and attempts to resolve these events are made. Adolescent development tasks which uniquely adolescent result in behavior should be accomplished in the adolescence period as follows:

Achieving new and more mature relations with age mates of both sexes. Achieving masculine or feminine social roles. Accepting oneself physique and using the body effectively. Achieving emotional independence from parents and other adults. Preparing for marriage and family life. Preparing for an economic career. Acquiring a set of values and an ethical system as a guide to behavior and developing an ideology.

(Redston-Iselin, In Stuart & Sundeen, Eds., 1991: 880)

Adolescence is a period of the rapid changes. Adolescents are experiencing and have a less negative attitude about substance abuse as well as believe that substance use is normal or something most people do. These reasons make them at risk of developing substance abuse more quickly than adults (Dusenbury, et al., In Lowinson, et al., Eds., 1992: 832-835). Substance abuse adolescents must be considered within a developmental context given the social, cognitive tasks of adolescence, as well as the drive toward maturation and adulthood. Adolescents attempt to achieve independence from parents. However, their limited judgment, cognitive development, and experiences with a variety of perceived adult behaviors such as substance use place them at risk for certain problem consequences of substance use. These consequences may inhibit further maturation or development and successful transition into young adulthood. Other developmentally specific factors, the increased frequency of psychiatric disorders, may also place the adolescent at risk of substance abuse. Characteristics of the adolescents, peers, families, and their social milieux appear to be predictive of further substance abuse problems in young adulthood and beyond (Bukstein, 1995: 71-72). Adolescents may turn to use the substance to relieve tension when pressures are intense. The types of substance users are as follows:

**1. Casual users “the experimenters.”** These adolescents use mostly alcohol or marijuana in small quantities to maintain their position in the peer group and to decrease the anxieties experienced by their movement away from the family.

**2. Sociological users “the seekers.”** These adolescents are aware of social realities and they want to be active participants in the social process. They tend to form separate communities in which they attempt to create a society free of social conventions. Many seek relief from boredom through substances and membership in this society.

**3. Sick users “the heads.”** These adolescents use substances to mask or correct maturational problems. This distinction is difficult to make. Those with serious interpersonal difficulties often are in a group that is bonded together by a high frequency of substance use. They turn to use the illicit substance in time of stress and prefer substance-induced pleasures to those arising from interpersonal relationships and competitive effects.

(Meeks, 1980 cited by Redston-Iselin, In Stuart & Sundeen, 1991: 891-892)

Adolescence is a critical period of cognitive development with eventual progress to adult capacities (Bukstein, 1995: 54). In this stage, adolescent children attempt to establish an identity with the social environment. Prolonged use of illicit substances may result in a tolerance for those substances and increased use at higher levels. Using the illicit substances with little or no sleep leads to extreme irritableness, a paranoid state, depression, fatigue, anergia, and cognitive impairment (Anglin, et al., 2000: 139). Giancola, et al. (1999: 22-32) found that such cognitive distortions were positively related to drug use in adolescents. Teenagers who are long-term users tend to develop careless behaviors so that they are prone to both accidents and sexual practice infection as well as leading to restlessness, aggression, paranoia, hostility, and depression (Yuttatri, P. 2001: 3-4). The results of Stice, et al. (1998: 136-146) study supported the assertion that antisocial pathology fosters problem substance use. Delinquency moderated the relation between consumption and problem use, with high-delinquent teens showing consistently elevated levels of use-related problems across all levels of substance use and non-delinquent teens showing a stronger correspondence between use levels and problems. Overholser, et al. (1997: 402-408) found that the emotional distress includes depression and hopelessness, as well as substance abuse, was inter-correlated. Among adolescent females, both depression and hopelessness were significantly related to suicidal intent, whereas among adolescent males, only depression was related to suicidal intent. Also, alcohol abuse was significantly related to depression and hopelessness in adolescent males.

The changes in adolescent individuation were related to either increases or decreases in substance abuse. The personality characteristics of adolescents includes low assertiveness, low self-efficacy, low self-esteem, low self and social-confidence, as well as low external locus of control have been linked to substance abuse (Dusenbury, et al., In Lowinson, et al., Eds., 1992: 835; Fontaine, 1999; Jessor, et al., 1972 cited by Naegle & D'Avanzo, Eds., 2001: 204; Sukuma Saengduenchai, B.E. 2542). Adolescent initiation of substance use was influenced primarily by environment rather than genetic factors (Han, et al. 1999: 981-993). According to the study results of Prommajit, P. (2001: 161-172), most of the illicit substance use was found in children who had been rigidly brought up with inflexible

and inconsistent discipline without regard for the student maturity. The parents did not pay attention to their psychological development and they did not search for a cause of problems that arose in their families, so that many of the difficulties of every life remained. By contrast, in families where the children did not use illicit substances, the children were brought up in a flexible manner by their parents who took part in activities together and shared their opinions. The parents lived with sufficient economy and took good care of their children by giving them regular discipline. They acted as mediators when there were opinion differences among family members. They complemented their children when they behaved well and they tried to reduce conflicts. These practices allowed them to live as happy families.

Environmental factors such as low family support, low family control, unsupportive home environment, peer pressure and peer drug use, and an indifferent parental attitude, were all linked to higher levels of substance abuse (Farrell & White, 1998: 248-258; Foxcroft & Lowe, 1997: 215-229; Glendinning, et al., 1997: 93-101). The study of Bray, et al. (2001: 301-314) found that separation and family conflict were related to increases in alcohol use, whereas intergenerational individuation and family cohesion were related to decreases in alcohol use. Brook, et al. (2001: 183-203) found that the certain environmental factors (e.g. violence, drug availability and machismo, family drug use, a distant parent-child relationship, and unconventional behavior) were risk factors for adolescent illegal substance use.

### **Needs of Addicted Adolescent**

Maslow (1970) developed the theory of human motivation, which provides the health care professionals with a dynamic approach to identifying and assisting patients in meeting their basic needs. Man is a wanting animal and rarely reaches a state of complete satisfaction except for a short time. Oxygen, liquid, food, shelter, sex, and sleep are the most basic, powerful, and obvious human needs which will take precedence over needs for safety, love, affection and belonging, self-respect and esteem, esthetic values, and self-actualization. This hierarchy of needs has at its pinnacle the human needs for continued personal growth, developmental as well as

utilization of potential. As one desire is satisfied, another pops up to take its place, which is a lifelong characteristic of the human. The fundamental or ultimate desires of all human beings do not differ because human beings are more alike than one would think at first. The classification of basic needs as the physiological needs, the safety needs, the belongingness and love needs, the esteem needs, and the needs for self-actualization makes some attempt to take account of the relative unity behind the superficial differences in specific desires from one culture to another. It is relatively more ultimate, more universal, and more basic than the superficial desires, and makes a closer approach to common human characteristics (Maslow, 1970: 22-24, 54-55).

Human needs can be classified into lower and higher order needs. The lower order needs are designated as biophysical or survival needs (food and fluid, elimination, and ventilation) and psychophysical or functional needs (activity-inactivity, sexuality). In the same way, the higher order needs are divided into psychosocial or integrative needs (achievement, affiliation) and intrapersonal-interpersonal or growth-seeking needs (self-actualization). Although most behaviors symbolize a fusion of needs and drives, a dominant need towards which the behavior is goal-directed is usually most apparent and observable. In general, behavior is aimed toward reducing tensions arising from needs that are often identified through inference (Watson, 1985: 105-111).

### **Factors Related to Caring Needs**

Humans need to achieve union, transcend one's individual life, and find harmony with life. These needs consist of the need to be loved and cared for and about, the need for positive regard and the need to be accepted, understood, and valued (Watson, 1988: 57). Fagerstrom, et al. (1999: 199-208) conducted the study to elucidate the phenomenon of the caring need in the life-world of the patient. The results revealed that the patients experienced themselves as an indivisible unit that contained existential/spiritual needs and desires. The patients' caring needs were constituted from their problems, needs and desires where human desire for life, love and meaningfulness may express it as bodily, psychical and existential/spiritual needs.

Human needs are complex and they have different meaning and purposes for different individuals and groups (Watson, 1985: 109). Hallstrom & Elander (2001: 409-418) interviewed and asked the patients to give a definition of need and to describe their needs while hospitalized. Ten groups of needs were identified as communication, basic care, and contact with other people, behavior of staff, empathy, competent caregivers, continuity, integrity, participation in decision making, and pain relief.

The attributes and experience of individuals might influence caring needs that were dynamic within the patients' conditions and treatment modalities (Bualuang Samdaengrit, B.E. 2538: 61-66). Chamaiporn Sathiraleela (B.E. 2541: 78-81) conducted a study of caring needs and nursing care to meet needs. The results revealed that patients had high levels of caring needs and that needs were higher than nursing care provided to meet those needs. On the contrary, a study of caring behaviors for patients as perceived by nurses and patients of Ichaya Suwanakul and Nongnutch Chowsilpa (B.E. 2542: 59-66) indicated that the nurses significantly perceived caring behaviors higher than patients.

Adolescent patients needed their rights, which consist of rights to health care, privacy rights, rights to information, rights of self determination, rights to live in a healthy environment, and developmental rights (Patcharapa Kanchanaudom, B.E. 2544: 71-78). The needs of addicted adolescents were mental needs including: getting good jobs, trust and reason speaking from families (Jiraporn Chatsupakul, B.E. 2544: 57-59). A feeling of unfulfilled needs might propel adolescents into the destructive behavior of substance use. The state of high wants and needs that cannot be gratified simply in a complex society may be a precursor of substance use (Mainous, et al. 1996: 807-815). To help them meet their needs, the family has to encourage and motivate addicted adolescents to have a good attitude toward the society and contribute their faith-hope and the potential to change their life (Umaporn Trangkasombat, B.E. 2542: 282) by promoting the belongingness among family members and friends. Moreover, addicted adolescents must be encouraged to feel that they are part of the society as well as being able to solve the social problems. Family members have to create a family atmosphere full of love, warmth, good relationships as well as living with reasoning and understand rather than feeling (Aiamma, C. 2001;

Kasem Juntasorn, B.E. 2541; Navanun Kitthavee, B.E. 2541; Neeskul, N. 2001; Nuttapol Hansopee, B.E. 2540; Prommajit, P. 2001; Puttarawaun Tongprem, B.E. 2543; Umaporn Trangkasombat, B.E. 2542; Varisara Piengsook, B.E. 2540).

## Perceptions

Perception is a broader response of ordering, categorizing, and giving meaning to situations by utilizing information from sources other than the specific stimulus. Individual perceptions are frequently influenced or altered by individually acquired motives, values, expectations, or personality characteristics, which produce perceptual tendencies within the individual. The characteristics of the individual perceiver (motives, values, and all of the past conditioning) are major determiners of perception. Whenever the available cues are too numerous or conflict, or whenever these cues are too limited or vague, the habitual tendency toward immediate perception forces the observer to use their inner resources to help them structure and give meaning to the situation (Moskowitz & Ogel, 1969: 177-181).

Human behavior is basically the goal-directed attempt of the person to satisfy needs as experienced in the perceived phenomenal field (Watson, 1988: 57). The concept of perception is implicit mentioned in transpersonal caring moment perspective of the Watson's Theory of Human Care.

An actual caring occasion or transpersonal caring moment involves action and choice by both the one-caring and the one-being-cared-for. The moment of coming together in a caring moment, in a given occasion, presents the two with the opportunity to decide how to be in the relationship and what to do with the moment. Whatever is decided involves one manner and not another. If the caring moment is indeed transpersonal-it allows for the presence of the spirit of both-then the even of the moment expands the limits of openness and has the ability to expand human capabilities.

(Watson, 1999: 116-117)

Transpersonal refers to human-to-human relationships, which encompass two individuals in a given moment. The two individuals who come together in a caring moment are both in process of being and becoming. This caring

moment can release inner power and strength and help the person gain a sense of inner harmony as well as generating and potential the self-healing processes (Watson, 1999: 115-116). When two persons come together in a given moment an actual occasion for human caring is created. This moment is a focal point in space and time in which experience and perception take place. In this kind of transpersonal caring moment or transpersonal caring relationship, the one-caring can enter into the experience of another, and the other can enter into the experience of the one-caring. This aspect of transpersonal incorporates a metaphysical, spiritual dimension that transcends time, space and physicality (Watson, 1999: 115-117).

Caring is a moral ideal. It is viewed as attempts to protect, enhance, and preserve humanity by helping a person find meaning in illness, suffering, pain, and existence. The value system regarding a theory of human care consists of value associated with deep respect for the wonders and mysteries of life, acknowledgement of a spiritual dimension to life and internal power of the human care process. This theory places a high value on the subjective-internal world of the experiencing person and how the person perceiving and experiencing health-illness conditions. Moreover, the emphasizing of the theory is placed upon helping a person gain more self-knowledge, self-control, and readiness for self-healing, regardless of the external health condition (Watson, 1988: 31-77).

From the literature reviews mentioned above, although several studies (Bualuang Samdaengrit, B.E. 2538; Huggins, et al., 1993; Ichaya Suwanakul and Nongnutch Chowsilpa, B.E. 2542; Rosenthal, 1992; Scharf & Caley, 1993; Williams, 1998) reported results about the perceptions of patients concerning caring behaviors in general, most study nurse caring behaviors. Additionally, hitherto, there were few studies on caring behaviors of family caregivers, caring needs, and caring perceptions of substance addicted adolescents. Therefore, the study of caring behaviors of family caregivers, caring needs and caring perceptions of addicted adolescents should be explored for seeking more evidence to explain it. The researcher eventually generates the conceptual model of the study as showed that in figure 1.

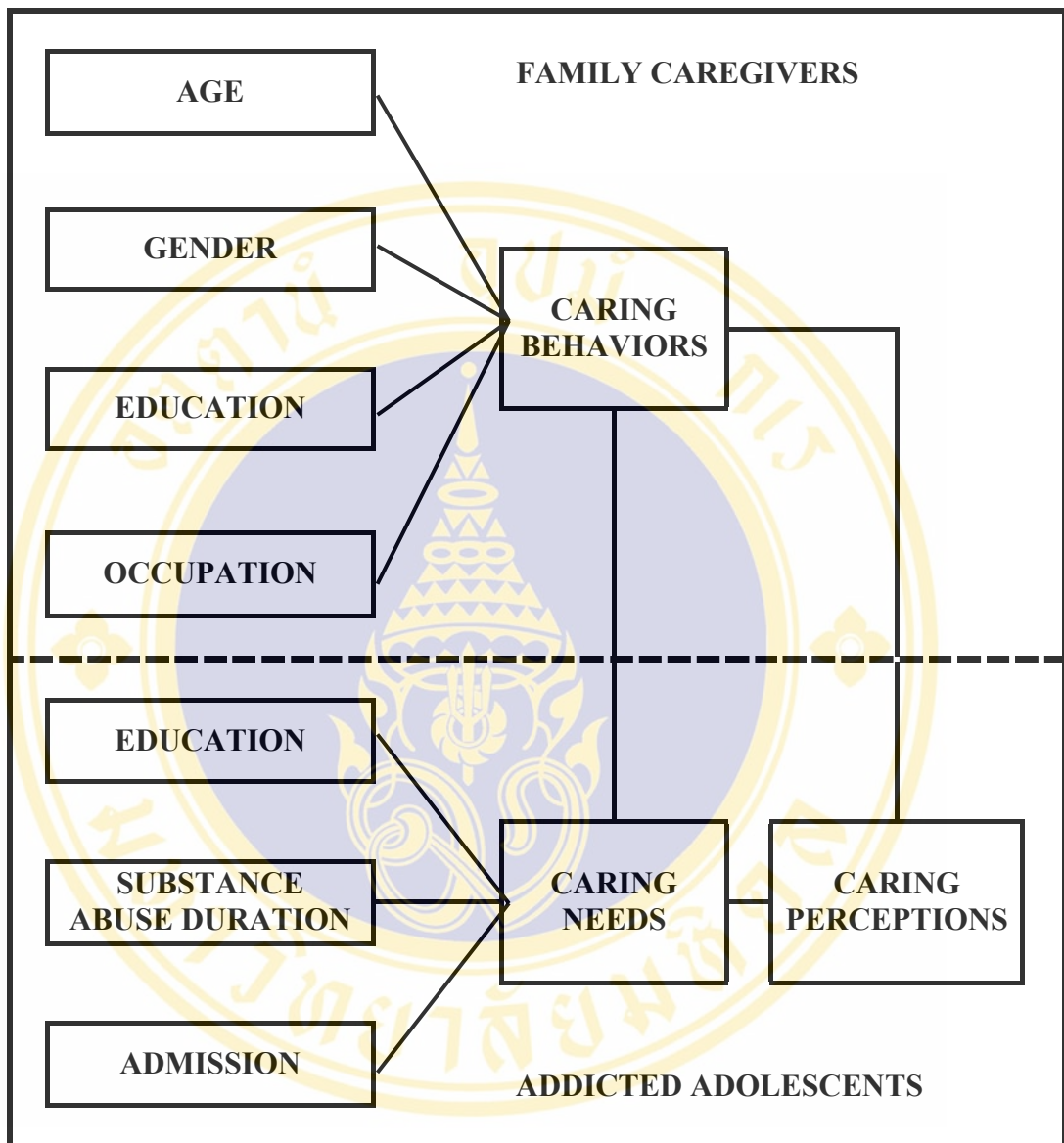


Figure 1: The Conceptual Model of the Study

## CHAPTER III

### MATERIALS AND METHODS

#### Research Design

This descriptive research design was used to describe the characteristics of caring behaviors of family caregivers, caring needs and caring perceptions of addicted adolescents. Moreover, the differences between caring behaviors of family caregivers and caring needs of addicted adolescents, caring behavior of family caregivers and caring perceptions of addicted adolescents, and caring needs and caring perceptions of the addicted adolescents were described.

#### Population

The two groups of population were non-psychotic addicted adolescents and their family caregivers at the Khonkaen Drug Dependence Treatment Center.

#### Sampling

Accidental sampling was used for sampling selection in the non-psychotic addicted adolescents who were at the Khonkaen Drug Dependence Treatment Center as inpatients or outpatients during the data collection period. The family caregivers were selected by the non-psychotic addicted adolescents in the selected sample according to the criteria of the most significant relatives who had been taking care of the adolescent for at least 1 month.

In this study, the appropriate sample size was estimated according to Yamane (1973:1088) based on the following formula:

$$n = \frac{N}{1 + Ne^2} \quad (\text{Yamane, 1973:1088})$$

Determination the sample size, when:

$n$  = Sample size

$N$  = The new cases of non-psychotic addicted adolescent population in the year 2002 at the Khonkaen Drug Dependence Treatment Center about 760 cases.

$e$  = The precision; error allowed for estimation  
= 5% = .05

Hence, the calculation of the formula is

$$n = \frac{760}{1 + [(760)(0.05)^2]} = 262.07$$

The actual sample of this study comprised of 263 pairs of subjects.

## Research Setting

This research was conducted at the Khonkaen Drug Dependence Treatment Center. This center provides for drug dependence patients of all ages and gender from the North East region of Thailand. They were admitted to get treatments including inpatient and outpatient treatment programs and other combined group activities such as work assignments, therapeutic milieus, family counseling, recreational activities, and Matrix Program. Typical in this center, all patients were classified in to either psychotic or non-psychotic symptom groups by a psychiatrist on their first visit.

## **Research Instruments**

The research instruments comprised 3 sets of questionnaires: Demographic Data Questionnaires of addicted adolescents and family caregivers, Caring Behaviors Questionnaire, and Caring Needs and Caring Perceptions Questionnaire (Appendix A).

### **1. Demographic Data Questionnaire**

The Demographic Data Questionnaires consists of 2 sets of questionnaire as following: 1) The Demographic Data Questionnaire of Addicted Adolescents contains checklists demographic characteristics of addicted adolescents, which consist of age, gender, education, substance abuse duration, admission, and indicated their significant family caregiver. 2) The Demographic Data Questionnaire of Family Caregivers contains checklists of demographic and socioeconomic characteristics including age, gender, education, and occupation.

### **2. Caring Behaviors Questionnaire**

Although there were several instruments to evaluate caring behaviors, there was no specific tool to assess the family caregiver's caring behaviors of addicted patients in general. Therefore, in this study, the researcher modified the questionnaires from the originally developed Caring Behaviors in Caregivers of Amphetamine Users Questionnaire of Parichat Wanwaisart (B.E. 2543) and the Needs of Amphetamine Addicted Repeat Treatment Adolescents Questionnaire of Jiraporn Chatsupakul (B.E. 2544). Moreover, the clinical practice of the researcher was also applied to modify the questionnaires for congruence to the situation of either the caring behaviors of family caregivers or the caring needs and caring perceptions of addicted adolescents.

Parichat Wanwaisart (B.E. 2543) used the major framework of the Watson Trans Personal Caring Theory (1985, 1988) to develop 32 items of the Caring Behaviors in Caregivers of Amphetamine Users Questionnaire. The reported Alpha Cronbach's Coefficient was .86, and the experts in the areas of caring, medicine, substance abuse nurse specialist, and psychologist did the face validity.

Jiraporn Chatsupakul (B.E. 2544) used the Bio-psycho-social theory (Allen, 1996) to develop 33 items of the Needs of Amphetamine Addicted Repeat Treatment Adolescents Questionnaire accordance with biological, psychological, and sociological factors. The reported Alpha Cronbach's Coefficient was .97. Experts in the areas of nursing, medicine, psychologist, and social worker did the face validity.

Upon the completion of modification (Appendix B), the Caring Behaviors Questionnaire contained 36 items of family caregiver activities. The number of items in each the Watson's ten carative factor was distributed as following:

**Factor I:** Humanistic-altruistic system of values

Items Number 1, 2, 3, 4

**Factor II:** Faith-hope

Items Number 5, 6, 7

**Factor III:** Sensitivity to self and others

Items Number 8, 9, 10, 11

**Factor IV:** Helping-trusting, human care relationship.

Items Number 12, 13, 14

**Factor V:** Expressing positive and negative feelings.

Items Number 15, 16, 17, 18

**Factor VI:** Creative problem-solving caring process

Items Number 19, 20, 21

**Factor VII:** Transpersonal teaching learning

Items Number 22, 23, 24, 25

**Factor VIII:** Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment

Items Number 26, 27, 28

**Factor IX:** Human needs assistance

Items Number 29, 30, 31, 32

**Factor X:** Existential-phenomenological-spiritual forces

Items Number 33, 34, 35, 36

A four-point rating scale was used to assign the scoring in each item of this questionnaire. The assigned number of caring behaviors was as follows: not at all = 1, a little = 2, quite a bit = 3, and a great deal = 4. High score in each item reflected the high level to perform the caring behaviors for their addicted adolescents of family caregivers.

### **3. Caring Needs and Caring Perceptions Questionnaire**

The Caring Needs and Caring Perceptions Questionnaire was generated from the Caring Behaviors Questionnaire by researcher to measure the caring needs and caring perceptions of addicted adolescents. The statements in all items were congruent with the Caring Behaviors Questionnaire. A four-point rating scale was used to assign the scoring in each item of this questionnaire. The assigned number of caring needs and caring perceptions were as follows: not at all = 1, a little = 2, quite a bit = 3, and a great deal = 4. High score in each item reflected the high level of needs and perceived caring behaviors from their significant family caregivers.

Face validity was done by the panel of seven experts, two of them are substance abuse physician and substance abuse nurse in Drug Dependence Treatment Center and the other five are doctoral prepared nurses in areas of psychosocial nursing, caring behaviors, psychiatric and mental health nursing, family caregivers of elderly, and spiritual care respectively (Appendix C). The reliability testing was assessed in both groups of 30 addicted adolescents and 30 family caregivers who had the similar characteristics as the study samples from the Khonkaen Drug Dependence Treatment Center. The Alpha Cronbach's coefficient of the Caring Behaviors, Caring Needs and Caring Perceptions Questionnaires were .93, .94, and .92 respectively.

## **Protection of Human Subjects**

This study was conducted based on the protection of human rights. Eligible subjects were approached and asked to participate in the study. The researcher explained the purposes of the study, the research process, benefits, length of time required for completing the questionnaire, and right to refuse to participate in the study. The subjects who agreed to participate were informed and assured that data would be kept confidential and reported only as aggregated data. In addition, participants were informed that they could withdraw from the study at any time (Appendix D).

## **Data Collection Procedure**

1. The researcher contacted the Khonkaen Drug Dependence Treatment Center to explain the purposes and process of the study by using formal letter from the Faculty of Graduate Studies, Mahidol University. Permission to conduct the study was obtained from Director of the Khonkaen Drug Dependence Treatment Center.

2. The researcher collected the data on Monday through Friday from 08:30 a.m. to 04:30 p.m. during October 2002 to March 2003 when the addicted adolescents and their family caregivers came to the Khonkaen Drug Dependence Treatment Center.

3. The researcher approached and explained the objectives and procedure of this study to the non-psychotic addicted adolescents. When the subjects were willing to participate in this study, the researcher asked them to read and fill in the research consent form (Appendix D). In case of the subjects were willing to participate in this study but they did not need to sign their names on the consent form. The oral consent was assumed that practical. Then, the researcher distributed the Demographic Data and the Caring Needs and Caring Perceptions Questionnaires to the addicted adolescents and allowed them about 30 minutes to complete the questionnaire in the counseling room of the outpatient area. The researcher checked the completion of

answer to all items of questionnaires. If a questionnaire was incomplete, the researcher asked the respondent to complete it again.

4. The researcher approached the family caregivers who were indicated by non-psychotic addicted adolescents to be significant persons continually caring for them for at least 1 month and explained the objectives and procedure of this study. The researcher asked them to read and fill in the research consent form (Appendix D). If the subjects were willing to participate in this study but they did not need to sign their names on the consent form the oral consent was assumed that practical. The researcher gave the Demographic Data and the Caring Behaviors Questionnaire to the family caregivers and allowed them about 30 minutes to complete it in the counseling room of the outpatient area. The researcher checked the completion of answer to all items of questionnaire and asked them to complete it again in cases of incomplete.

5. If the indicated family caregiver did not come together to the Khonkaen Drug Dependence Treatment Center. The Caring Behaviors Questionnaire was delivered to each of them with the returned envelope by accompanied relative who came with non-psychotic addicted adolescents. The follow-up questionnaire was done at the end of the second and the fourth weeks later for the non-respondent group. In case of the subjects sent the returned questionnaire to the researcher but they did not sign their names on the consent form. This questionnaire was assumed that practical.

## **Data Analysis**

The SPSS for Windows was used for data analysis.

1. Descriptive statistics, frequency and percentage, were used to summarize the demographic data of both family caregivers and addicted adolescents.

2. Range, means, standard deviation, and rank were used to describe characteristics of caring behaviors in family caregivers, caring needs and caring perceptions of addicted adolescents.

3. One-way Analysis of Variance (ANOVA) was selected to examine the differences in caring behaviors among family caregivers who are different in age, education, and occupation as well as to examine the differences in caring needs among addicted adolescents who are different in education, substance abuse duration, and admission. The Sheffé test was chosen for the Post-Hoc test. In case of the unmet the assumption, Kruskal-Wallis H test and Mann-Whitney U test which were the nonparametric analog of the One-way Analysis of Variance and t-test respectively (Argyrous, 2000: 387-390; Munro, 2001: 112; Polit, 1996: 203-206), were chosen to analyze in this study.

4. Independent t-test was selected to examine the difference in caring behaviors of family caregivers who are different in gender and to analyze the differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, and caring behaviors of the family caregivers and caring perceptions of the addicted adolescents.

5. Paired t-test was used to analyze the difference between caring needs and caring perceptions of the addicted adolescents.

The significant levels of this study were set at .01.

## CHAPTER IV

### RESULTS

Demographic characteristics of both family caregivers and addicted adolescents are firstly presented. Next, the research results are presented in sequence of the study purposes as the following topics:

1. The caring behaviors of family caregivers, caring needs, and caring perceptions of addicted adolescents.
2. The comparison of caring behaviors among family caregivers, who were different in age, gender, education, and occupation.
3. The comparison of caring needs among addicted adolescents, who were different in education, substance abuse duration, and admission.
4. The differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents.

Approximately, 300 cases of addicted adolescents were approached. All of them volunteered to participate in this study. Fifty cases of addicted adolescents, the indicated family caregiver did not come together to the Khonkaen Drug Dependence Treatment Center. The Caring Behaviors Questionnaire was delivered to each of them with the returned envelope by accompanied relative. These groups sent back 13 completed questionnaires out of 20 returned questionnaires to the researcher. Therefore, the samples of this study consist of 263 dyads of family caregivers and addicted adolescents, a response rate of 87.7%.

## Demographic Characteristics of Study Samples

### Family Caregivers

A sample of 263 family caregivers of the addicted adolescents was recruited from the Khonkaen Drug Dependence Treatment Center. The majority age-ranged group was the group of 41 to 60 years (61.6%). Most of them (57.8%) were female. Slightly more than half of the family caregivers of addicted adolescent (54.4%) had only elementary education. Regarding occupation, most of them (41.8%) were agriculturists (Table 1).

**Table 1** The frequency and percentage of demographic characteristics of family caregivers (n = 263)

Demographic characteristics	Frequency	Percentage
<b>Age</b>		
21-40 years	91	34.6
41-60 years	162	61.6
Over 60 years	10	3.8
<b>Gender</b>		
Male	111	42.2
Female	152	57.8
<b>Education</b>		
Elementary education	143	54.4
Secondary education	71	27.0
Higher education	49	18.6
<b>Occupation</b>		
Worker	30	11.4
Agriculturist	110	41.8
Merchant	62	23.6
Official/state enterprise employee	61	23.2

### Addicted Adolescents

The addicted adolescents, matching with their indicated family caregivers, were recruited from the Khonkaen Drug Dependence Treatment Center. The age of the addicted adolescents ranged from 12 to 20 years and a mean of 17.38 (SD = 1.96). Most of them (93.5%) were male. The majority of them (84.8%) only had secondary education. According to substance abuse duration, the majority of them (55.9%) reported 1 to 3 years. Most admissions of the addicted adolescents were first time admission (71.5%). Finally, the addicted adolescents indicated that mothers (49.4%) were the majority group of their significant family caregivers (Table 2).

**Table 2** The frequency and percentage of demographic characteristics of addicted adolescents (n = 263)

Demographic characteristics	Frequency	Percentage
<b>Gender</b>		
Male	246	93.5
Female	17	6.5
<b>Education</b>		
Elementary education	30	11.4
Secondary education	223	84.8
Higher education	10	3.8
<b>Substance abuse duration</b>		
Less than 1 year	53	20.2
1-3 years	147	55.9
More than 3 years	63	24.0
<b>Admission</b>		
The first	188	71.5
The second	42	16.0
The third or more	33	12.5

**Table 2** The frequency and percentage of demographic characteristics of addicted adolescents (continued)

Personal characteristics	Frequency	Percentage
<b>Significant family caregiver</b>		
Father	102	38.8
Mother	130	49.4
Other relative	31	11.8

### Caring Behaviors of Family Caregivers

Family caregivers reported their caring behaviors with an actual range of average total score between 2.25 to 4.00, with the mean of 3.290 (SD = .387). The mean of total score of caring behaviors and all ten factors were over 3.00 in the four-point scale. The three highest means were factor 7: Transpersonal teaching learning (Mean = 3.513, SD = .477), factor 9: Human needs assistance (Mean = 3.490, SD = .479), and factor 10: Existential-phenomenological-spiritual forces (Mean = 3.460, SD = .505) respectively. Furthermore, the three lowest means were factor 6: Creative problem-solving caring process (Mean = 3.007, SD = .812), factor 5: Expressing positive and negative feelings (Mean = 3.085, SD = .567), and factor 1: Humanistic-altruistic system of values (Mean = 3.116, SD = .518) respectively (Table 3).

**Table 3** Range, mean, standard deviation (SD), and mean rank of the caring behaviors of family caregivers (n = 263)

Carative factors	Caring behaviors			
	Range	Mean	SD	Mean rank
7: Transpersonal teaching learning	1.75 – 4.00	3.513	.477	1
9: Human needs assistance	1.25 – 4.00	3.490	.479	2
10: Existential-phenomenological-spiritual forces	2.00 – 4.00	3.460	.505	3
3: Sensitivity to self and others	1.50 – 4.00	3.366	.531	4
4: Helping-trusting, human care relationship	2.00 – 4.00	3.361	.505	5
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	1.33 – 4.00	3.230	.581	6
2: Faith-hope	1.00 – 4.00	3.172	.547	7
1: Humanistic-altruistic system of values	1.75 – 4.00	3.116	.518	8
5: Expressing positive and negative feelings	1.50 – 4.00	3.085	.567	9
6: Creative problem-solving caring process	1.00 – 4.00	3.007	.812	10
<b>Total</b>	<b>2.25 – 4.00</b>	<b>3.290</b>	<b>.387</b>	

## **Caring Needs of Addicted Adolescents**

Addicted adolescents reported their caring needs with an actual range of average total score from 1.00 to 4.00, with the mean of 3.097 (SD = .518). The three highest means of caring needs were factor 2: Faith-hope (Mean = 3.197, SD = .665), factor 4: Helping trusting, human care relationship (Mean = 3.164, SD = .658), and factor 10: Existential-phenomenological-spiritual forces (Mean = 3.154, SD = .640) respectively. Additionally, the three lowest means of caring needs were factor 3: Sensitivity to self and others (Mean = 2.982, SD = .650), factor 6: Creative problem-solving caring process (Mean = 2.988, SD = .729), and factor 5: Expressing positive and negative feelings (Mean = 3.024, SD = .674) respectively (Table 4).

## **Caring Perceptions of Addicted Adolescents**

Regarding the caring perceptions, the addicted adolescents reported with an actual range of average total score from 1.00 to 4.00, with the mean of 2.942 (SD = .480). The three highest means of caring perceptions were factor 10: Existential-phenomenological-spiritual forces (Mean = 3.098, SD = .572), factor 7: Transpersonal teaching learning (Mean = 3.077, SD = .664), and factor 9: Human needs assistance (Mean = 3.013, SD = .620) respectively. The three lowest means of caring perceptions were factor 5: Expressing positive and negative feelings (Mean = 2.797, SD = .662), factor 1: Humanistic-altruistic system of values (Mean = 2.839, SD = .583), and factor 6: Creative problem-solving caring process (Mean = 2.853, SD = .713) respectively (Table 5).

**Table 4** Range, mean, standard deviation (SD), and mean rank of the caring needs of addicted adolescents (n = 263)

Carative factors	Caring needs			
	Range	Mean	SD	Mean rank
2: Faith-hope	1.00 – 4.00	3.197	.665	1
4: Helping-trusting, human care relationship	1.00 – 4.00	3.164	.658	2
10: Existential-phenomenological-spiritual forces	1.00 – 4.00	3.154	.640	3
9: Human needs assistance	1.00 – 4.00	3.142	.654	4
7: Transpersonal teaching learning	1.00 – 4.00	3.139	.673	5
1: Humanistic-altruistic system of values	1.00 – 4.00	3.107	.559	6
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	1.00 – 4.00	3.077	.648	7
5: Expressing positive and negative feelings	1.00 – 4.00	3.024	.674	8
6: Creative problem-solving caring process	1.00 – 4.00	2.988	.729	9
3: Sensitivity to self and others	1.00 – 4.00	2.982	.650	10
<b>Total</b>	<b>1.00 – 4.00</b>	<b>3.097</b>	<b>.518</b>	

**Table 5** Range, mean, standard deviation (SD), and mean rank of the caring perceptions of addicted adolescents (n = 263)

Carative factors	Caring perceptions			
	Range	Mean	SD	Mean rank
10: Existential-phenomenological-spiritual forces	1.00 – 4.00	3.098	.572	1
7: Transpersonal teaching learning	1.00 – 4.00	3.077	.664	2
9: Human needs assistance	1.00 – 4.00	3.013	.620	3
4: Helping-trusting, human care relationship	1.00 – 4.00	2.994	.654	4
2: Faith-hope	1.00 – 4.00	2.969	.692	5
3: Sensitivity to self and others	1.00 – 4.00	2.932	.639	6
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	1.00 – 4.00	2.861	.667	7
6: Creative problem-solving caring process	1.00 – 4.00	2.853	.713	8
1: Humanistic-altruistic system of values	1.00 – 4.00	2.839	.583	9
5: Expressing positive and negative feelings	1.00 – 4.00	2.797	.662	10
<b>Total</b>	<b>1.00 – 4.00</b>	<b>2.942</b>	<b>.480</b>	

## Test of Normality and Homogeneity of Variances

With regard to data analyses of this study, One-way Analysis of Variance (ANOVA) and t-test were selected to analyze the differences of data. The assumptions for One-way Analysis of Variance (ANOVA) are the same as those for the t-test that is, (1) the dependent variable should be a continuous variable that is normally distributed, (2) the groups should have equal variances, and (3) the groups should be mutually exclusive (Munro, 2001: 140). To comply with the first and the second assumptions, therefore, both the test of normality and the test of homogeneity of variances were conducted before the test of the differences. In this study, the significant levels were set at .01.

Schumaker & Lomax (1996: 105) have indicated that only when skewness and kurtosis are within the range of  $-1.0$  to  $+1.0$  should normal theory of estimation be used. However, the values of distribution testing by using Kolmogorov-Smirnov test suggested that the caring behaviors of family caregivers in total and in each group of age, gender, education, and occupation, and the caring needs of addicted adolescents in total and in each group of education, substance abuse duration, and admission as well as caring perceptions of addicted adolescents was normal (Table 6-8).

**Table 6** Normality testing of studied dependent variables (n = 263)

Variables	Normality testing values		
	Skewness	Kurtosis	Kolmogorov-Smirnov Test
Caring behaviors of family caregivers	-.300	-.603	.967 <sup>ns</sup>
Caring needs of addicted adolescents	-.610	.704	.942 <sup>ns</sup>
Caring perceptions of addicted adolescents	-.322	.385	.883 <sup>ns</sup>

Note: ns = not significant

**Table 7** Normality testing of caring behaviors of family caregivers in each group of age, gender, education, and occupation

Variables	Normality testing values			
	n	Skewness	Kurtosis	Kolmogorov-Smirnov Test
<b>Age</b>				
21-40 years	91	-.408	-.602	.885 <sup>ns</sup>
41-60 years	162	-.161	-.727	.738 <sup>ns</sup>
Over 60 years	10	.107	-.528	.349 <sup>ns</sup>
<b>Gender</b>				
Male	111	.032	-.526	.710 <sup>ns</sup>
Female	152	-.527	-.363	1.055 <sup>ns</sup>
<b>Education</b>				
Elementary education	143	-.477	-.469	.954 <sup>ns</sup>
Secondary education	71	-.130	-.865	.805 <sup>ns</sup>
Higher education	49	-.048	-.211	.371 <sup>ns</sup>
<b>Occupation</b>				
Worker	30	-.795	-.307	.884 <sup>ns</sup>
Agriculturist	110	-.538	-.277	.807 <sup>ns</sup>
Merchant	62	.100	-.754	.828 <sup>ns</sup>
Official/state enterprise employee	61	-.442	.012	.657 <sup>ns</sup>

Note: ns = not significant

**Table 8** Normality testing of caring needs of addicted adolescents in each group of education, substance abuse duration, and admission (n = 263)

Variables	Normality testing values			
	n	Skewness	Kurtosis	Kolmogorov-Smirnov Test
<b>Education</b>				
Elementary education	30	.147	-.818	.716 <sup>ns</sup>
Secondary education	223	-.722	.925	.927 <sup>ns</sup>
Higher education	10	-.044	-.564	.503 <sup>ns</sup>
<b>Substance abuse duration</b>				
Less than 1 year	53	-.542	.343	.539 <sup>ns</sup>
1-3 years	147	-.690	1.098	.608 <sup>ns</sup>
More than 3 years	63	-.391	-.331	.665 <sup>ns</sup>
<b>Admission</b>				
The first	188	-.601	.631	.771 <sup>ns</sup>
The second	42	-.121	-.482	.545 <sup>ns</sup>
The third or more	33	-1.170	2.641	.629 <sup>ns</sup>

Note: ns = not significant

Levene's test was used to examine for homogeneity of variances. The results of homogeneity testing of variances among each group of gender, age, education, and occupation of family caregivers as well as each group of education, substance abuse duration, and admission of addicted adolescents suggested that only education of family caregivers had unequal of variances. The remaining had equal of variances, which met the assumption of One-way Analysis of Variance. Education of family caregivers, which unmet the assumption of homogeneity of variances, Kruskal-Wallis H test and Mann-Whitney U test were chosen to analyze the difference of caring behaviors.

## The Comparison of Caring Behaviors of Family Caregiver

The different comparison results in caring behaviors of the family caregivers who differ in age, gender, education, and occupation. The statistical analysis showed as follows:

1. There was no significant difference in caring behaviors of the family caregivers by age groups (Table 9-10).

**Table 9** Mean and standard deviation (SD) of caring behaviors of family caregivers by age groups (n = 263)

Age groups	Caring behaviors		
	n	Mean	SD
21-40 years	91	3.27	.41
41-60 years	162	3.28	.37
Over 60 years	10	3.46	.23

Levene statistic = 3.020, not significant

**Table 10** The comparison of caring behaviors of family caregivers by age groups using One-way Analysis of Variance (n = 263)

Source of variance	SS	df	MS	F
Between groups	.329	2	.165	1.095 <sup>ns</sup>
Within groups	39.076	260	.150	
<b>Total</b>	<b>39.405</b>	<b>262</b>		

Note: ns = not significant

2. There was significantly difference in caring behaviors of the family caregivers by gender groups ( $t = -4.072, p < .01$ ). The female family caregivers had the mean score of caring behaviors higher than male (Table 11).

**Table 11** The comparison of caring behaviors of family caregivers who differ in **gender** by using Independent t-test ( $n = 263$ )

Gender groups	Caring behaviors			t
	n	Mean	SD	
Male	111	3.179	.398	-4.072 *
Female	152	3.371	.360	

Note: \* =  $p < .01$

3. There was significant difference in the caring behaviors of family caregivers by education groups ( $H = 21.082, p < .01$ ). According to the results in Table 12, the family caregivers who had elementary education behaved caring behaviors significantly different from those who had secondary education ( $U = 3434.000, p < .01$ ) and higher education ( $U = 2326.500, p < .01$ ). Additionally, there was no significant difference in caring behaviors between family caregivers who finished secondary education and those who finished higher education (Table 12-14).

**Table 12** Mean and standard deviation (SD) of caring behaviors of family caregivers by **education** groups ( $n = 263$ )

Education groups	Caring behaviors		
	n	Mean	SD
Elementary education	143	3.390	.372
Secondary education	71	3.153	.419
Higher education	49	3.195	.297

Levene statistic = 5.015,  $p < .01$

**Table 13** The comparison of caring behaviors of family caregivers by **education** groups using Kruskal-Wallis H test (n = 263)

Education groups	Caring behaviors			H
	n	Mean rank	df	
Elementary education	143	151.720		
Secondary education	71	107.890	2	21.082*
Higher education	49	109.400		
<b>Total</b>	<b>263</b>			

Note: \* =  $p < .01$

**Table 14** The pairwise comparisons of caring behaviors of family caregivers by **education** groups using Mann-Whitney U test (n = 263)

Pairs of education	Caring behaviors			U
	n	Mean rank	Sum of mean	
1	Elementary education	143	118.990	17015.000
	Secondary education	71	84.370	5990.000
	<b>Total</b>	<b>214</b>		
2	Elementary education	143	104.730	14976.500
	Higher education	49	72.480	3551.500
	<b>Total</b>	<b>192</b>		
3	Secondary education	71	59.520	4226.000
	Higher education	49	61.920	3034.000
	<b>Total</b>	<b>120</b>		

Note: ns = not significant, \* =  $p < .01$

4. There was significant difference in caring behaviors of the family caregivers by occupation groups ( $F = 7.945$ ,  $p < .01$ ). The Sheffé tests indicated that the worker group and agriculturist group of family caregiver was not significantly different in caring behaviors whereas these both groups behaved caring behaviors significantly different from the official/state enterprise employee groups ( $p < .01$ ). Although the score of caring behaviors in merchant group was different from other groups, there was not significantly difference in caring behaviors by these groups (Table 15-17).

**Table 15** Mean and standard deviation (SD) of caring behaviors of family caregivers by **occupation** groups (n = 263)

Occupation groups	Caring behaviors		
	n	Mean	SD
Worker	30	3.452	.372
Agriculturist	110	3.377	.379
Merchant	62	3.177	.396
Official/state enterprise employee	61	3.168	.337

Levene statistic = .672, not significant

**Table 16** The comparison of caring behaviors of family caregivers by **occupation** groups using One-way Analysis of Variance (n = 263)

Source of variance	SS	df	MS	F
Between groups	3.321	3	1.107	7.945 *
Within groups	36.084	259	.139	
<b>Total</b>	<b>39.405</b>	<b>262</b>		

Note: \* =  $p < .01$

**Table 17** The Post-Hoc test of caring behaviors of family caregivers by **occupation** groups using Sheffé test (n = 263)

Occupation groups	Mean	Mean difference			
		1	2	3	4
1 Worker	3.452	-	.075 <sup>ns</sup>	.275 <sup>ns</sup>	.284 <sup>*</sup>
2 Agriculturist	3.377		-	.200 <sup>ns</sup>	.208 <sup>*</sup>
3 Merchant	3.177			-	.008 <sup>ns</sup>
4 Official/state enterprise employee	3.168				-

Note: ns = not significant, \* =  $p < .01$

### The Comparison of Caring Needs of Addicted Adolescents

The different comparison results in caring needs of the addicted adolescents who differ in education, substance abuse duration, and admission. The statistical analysis illustrated as follows:

1. There was no significant difference in caring needs of the addicted adolescents by education groups (Table 18-19).

**Table 18** Mean and standard deviation (SD) of caring needs of addicted adolescents by **education** groups (n = 263)

Education groups	Caring needs		
	n	Mean	SD
Elementary education	30	2.985	.529
Secondary education	223	3.114	.526
Higher education	10	3.036	.207

Levene statistic = 3.643, not significant

**Table 19** The comparison of caring needs of addicted adolescents by **education** groups using One-way Analysis of Variance (n = 263)

Source of variance	SS	df	MS	F
Between groups	.482	2	.241	.895 <sup>ns</sup>
Within groups	70.076	260	.270	
<b>Total</b>	<b>70.558</b>	<b>262</b>		

Note: ns = not significant

2. There was no significant difference in caring needs of the addicted adolescents by substance abuse duration groups (Table 20-21).

**Table 20** Mean and standard deviation (SD) of caring needs of the addicted adolescents by **substance abuse duration** groups (n = 263)

Substance abuse duration groups	Caring needs		
	n	Mean	SD
Less than 1 year	53	3.132	.483
1-3 years	147	3.069	.538
More than 3 years	63	3.130	.505

Levene statistic = .296, not significant

**Table 21** The comparison of caring needs of the addicted adolescents by **substance abuse duration** groups using One-way Analysis of Variance (n = 263)

Source of variance	SS	df	MS	F
Between groups	.244	2	.122	.451 <sup>ns</sup>
Within groups	70.315	260	.270	
<b>Total</b>	<b>70.558</b>	<b>262</b>		

Note: ns = not significant

3. There was no significant difference in caring needs of the addicted adolescents by admission groups (Table 22-23).

**Table 22** Mean and standard deviation (SD) of caring needs of the addicted adolescents by **admission** groups (n = 263)

Admission groups	Caring needs		
	n	Mean	SD
The first	188	3.105	.519
The second	42	3.047	.490
The third or more	33	3.110	.564

Levene statistic = .176, not significant

**Table 23** The comparison of caring needs of the addicted adolescents by **admission** groups using One-way Analysis of Variance (n = 263)

Source of variance	SS	df	MS	F
Between groups	.126	2	.062	.232 <sup>ns</sup>
Within groups	70.433	260	.271	
<b>Total</b>	<b>70.558</b>	<b>262</b>		

Note: ns = not significant

### The Differences among Caring Behaviors of Family Caregivers, Caring Needs and Caring Perceptions of Addicted Adolescents

Both caring behaviors of the family caregivers and caring needs of the addicted adolescents had the total mean score over 3.00 whereas caring perceptions of the addicted adolescents had lower than 3.00 in the four-point scale. All factors of caring behaviors of the family caregivers had mean score more than 3.00. Concerning caring needs of the addicted adolescents, only factor 2: Faith-hope and factor 3: Sensitivity to self and others had mean score lower than 3.00. Seven out of 10 factors in caring perceptions of the addicted adolescents had mean score lower 3.00 (Table 24).

**Table 24** The mean, and standard deviation (SD) of caring behaviors family caregivers, caring needs and perceptions of addicted adolescents (n = 263)

Carative factors	Caring behaviors		Caring needs		Caring perceptions	
	Mean	SD	Mean	SD	Mean	SD
1: Humanistic-altruistic system of values	3.116	.518	3.107	.559	2.839	.583
2: Faith-hope	3.172	.547	3.197	.665	2.969	.692
3: Sensitivity to self and others	3.366	.531	2.982	.650	2.932	.639
4: Helping-trusting, human care relationship	3.361	.505	3.164	.658	2.944	.654
5: Expressing positive and negative feelings	3.085	.567	3.024	.674	2.797	.662
6: Creative problem-solving caring process	3.007	.812	2.988	.729	2.853	.713
7: Transpersonal teaching learning	3.513	.477	3.139	.673	3.077	.664
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	3.230	.581	3.077	.648	2.861	.667
9: Human needs assistance	3.490	.479	3.142	.654	3.013	.620
10: Existential-phenomenological-spiritual forces	3.460	.505	3.154	.640	3.098	.572
<b>Total</b>	<b>3.290</b>	<b>.387</b>	<b>3.097</b>	<b>.518</b>	<b>2.942</b>	<b>.480</b>

The statistical analyses of the different comparison results between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents revealed as follows:

### **The differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents**

The mean difference between caring behaviors of the family caregivers and caring needs of the addicted adolescents in total was -.193 and range of mean differences in the 6 significantly different factors was -.383 to -.153. There were significant differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents in total ( $t = -4.836$ ,  $p < .01$ ) and in 6 out of 10 factors ( $p < .01$ ). These factors were factor 3: Sensitivity to self and others ( $t = -7.393$ ), factor 4: Helping-trusting, human care relationship ( $t = -3.837$ ), factor 7: Transpersonal teaching learning ( $t = -7.342$ ), factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments ( $t = -2.855$ ), factor 9: Human needs assistance ( $t = -6.951$ ), and factor 10: Existential-phenomenological-spiritual forces ( $t = -6.085$ ). The remaining includes factor 1: Humanistic-altruistic system of values, factor 2: Faith-hope, factor 5: Expressing positive and negative feelings, and factor 6: Creative problem-solving caring process were no significant differences that reflected the congruency between caring behaviors of family caregivers and caring needs of addicted adolescents (Table 25).

**Table 25** The differences between caring behaviors of family caregivers and caring needs of addicted adolescent by using Independent t-test (n = 263)

Carative factors	Caring behaviors		Caring needs		Mean difference	t
	Mean	SD	Mean	SD		
1: Humanistic-altruistic system of values	3.116	.518	3.107	.559	-.009	-.202 <sup>ns</sup>
2: Faith-hope	3.172	.547	3.197	.665	.025	.477 <sup>ns</sup>
3: Sensitivity to self and others	3.366	.531	2.982	.650	-.383	-7.393 <sup>*</sup>
4: Helping-trusting, human care relationship	3.361	.505	3.164	.658	-.196	-3.837 <sup>*</sup>
5: Expressing positive and negative feelings	3.085	.567	3.024	.674	-.060	-1.119 <sup>ns</sup>
6: Creative problem-solving caring process	3.007	.812	2.988	.729	-.019	-.282 <sup>ns</sup>
7: Transpersonal teaching learning	3.513	.477	3.139	.673	-.373	-7.342 <sup>*</sup>
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	3.230	.581	3.077	.648	-.153	-2.855 <sup>*</sup>
9: Human needs assistance	3.490	.479	3.142	.654	-.347	-6.951 <sup>*</sup>
10: Existential-phenomenological-spiritual forces	3.460	.505	3.154	.640	-.306	-6.085 <sup>*</sup>
<b>Total</b>	<b>3.290</b>	<b>.387</b>	<b>3.097</b>	<b>.518</b>	<b>-.193</b>	<b>-4.836<sup>*</sup></b>

Note: ns = not significant, \* = p < .01

### **The differences between caring behaviors of the family caregivers and caring perceptions of the addicted adolescents**

The mean difference between caring behaviors of the family caregivers and caring perceptions of the addicted adolescents in total was -.347 and range of mean differences in the 9 significantly different factors was -.477 to -.202. There were significant differences between caring behaviors of family caregivers and the caring perceptions of the addicted adolescents in total ( $t = -9.136$ ,  $p < .01$ ) and in 9 out of 10 factors ( $p < .01$ ). These factors were factor 1: Humanistic-altruistic system of values ( $t = -5.767$ ), factor 2: Faith-hope ( $t = -3.723$ ), factor 3: Sensitivity to self and others ( $t = -8.450$ ), factor 4: Helping-trusting, human care relationship ( $t = -8.182$ ), factor 5: Expressing positive and negative feelings ( $t = -5.353$ ), factor 7: Transpersonal teaching learning ( $t = -8.653$ ), factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments ( $t = -6.757$ ), factor 9: Human needs assistance ( $t = -9.863$ ), and factor 10: Existential-phenomenological-spiritual forces ( $t = -7.672$ ). Only factor 6: Creative problem-solving caring process, the analysis result demonstrated that there was no significant difference that reflected the congruency between caring behaviors of family caregivers and caring perceptions of addicted adolescents (Table 26).

**Table 26** The differences between caring behaviors family caregivers and caring perceptions of addicted adolescents by using Independent t-test (n = 263)

Carative factors	Caring behaviors		Caring perceptions		Mean difference	t
	Mean	SD	Mean	SD		
1: Humanistic-altruistic system of values	3.116	.518	2.839	.583	-.277	-5.767 *
2: Faith-hope	3.172	.547	2.969	.692	-.202	-3.723 *
3: Sensitivity to self and others	3.366	.531	2.932	.639	-.433	-8.450 *
4: Helping-trusting, human care relationship	3.361	.505	2.944	.654	-.417	-8.182 *
5: Expressing positive and negative feelings	3.085	.567	2.797	.662	-.288	-5.353 *
6: Creative problem-solving caring process	3.007	.812	2.853	.713	-.154	-2.318 <sup>ns</sup>
7: Transpersonal teaching learning	3.513	.477	3.077	.664	-.436	-8.653 *
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	3.230	.581	2.861	.667	-.368	-6.757 *
9: Human needs assistance	3.490	.479	3.013	.620	-.477	-9.863 *
10: Existential-phenomenological-spiritual forces	3.460	.505	3.098	.572	-.361	-7.672 *
<b>Total</b>	<b>3.290</b>	<b>.387</b>	<b>2.942</b>	<b>.480</b>	<b>-.347</b>	<b>-9.136 *</b>

Note: ns = not significant, \* =  $p < .01$

### **The differences between caring needs and caring perceptions of the addicted adolescents**

The mean difference between caring needs and caring perceptions of addicted adolescents in total was .154 and range of mean differences in the 7 significantly different factors was .129 to .268. There were significant differences between caring needs and caring perceptions of the addicted adolescents in total ( $t = 4.551$ ,  $p < .01$ ) and in 7 out of 10 factors ( $p < .01$ ). These factors were factor 1: Humanistic-altruistic system of values ( $t = 6.368$ ), factor 2: Faith-hope ( $t = 4.435$ ), factor 4: Helping-trusting, human care relationship ( $t = 4.601$ ), factor 5: Expressing positive and negative feelings ( $t = 4.355$ ), factor 6: Creative problem-solving caring process ( $t = 2.892$ ), factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments ( $t = 4.437$ ), and factor 9: Human needs assistance ( $t = 3.304$ ). The remaining includes factor 3: Sensitivity to self and others, factor 7: Transpersonal teaching learning, and factor 10: Existential-phenomenological-spiritual forces were no significant differences that reflecting the congruency between caring needs and caring perceptions of the addicted adolescents (Table 27).

**Table 27** The differences between caring needs and caring perceptions of addicted adolescents by using Paired t-test (n = 263)

Carative factors	Caring needs		Caring perceptions		Mean difference	Paired-t
	Mean	SD	Mean	SD		
1: Humanistic-altruistic system of values	3.107	.559	2.839	.583	.268	6.368 *
2: Faith-hope	3.197	.665	2.969	.692	.228	4.435 *
3: Sensitivity to self and others	2.982	.650	2.932	.639	.050	1.102 <sup>ns</sup>
4: Helping-trusting, human care relationship	3.164	.658	2.944	.654	.220	4.601 *
5: Expressing positive and negative feelings	3.024	.674	2.797	.662	.227	4.355 *
6: Creative problem-solving caring process	2.988	.729	2.853	.713	.135	2.892 *
7: Transpersonal teaching learning	3.139	.673	3.077	.664	.062	1.414 <sup>ns</sup>
8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments	3.077	.648	2.861	.667	.215	4.437 *
9: Human needs assistance	3.142	.654	3.013	.620	.129	3.304 *
10: Existential-phenomenological-spiritual forces	3.154	.640	3.098	.572	.055	1.365 <sup>ns</sup>
<b>Total</b>	<b>3.097</b>	<b>.518</b>	<b>2.942</b>	<b>.480</b>	<b>.154</b>	<b>4.551 *</b>

Note: ns = not significant, \* =  $p < .01$

## CHAPTER V

### DISCUSSION

In this chapter, the interpretation and discussion of the data are presented in sequence of the study hypotheses as following topics:

1. The comparison of caring behaviors of family caregivers, who differ in age, gender, education, and occupation.
2. The comparison of caring needs of addicted adolescents, who differ in education, substance abuse duration, and admission.
3. The differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents.

#### **Hypothesis I:**

**There are differences in the caring behaviors of family caregivers who differ in age, gender, education, and occupation.**

With regard to the comparison of caring behaviors of family caregivers, the results revealed that there was no significant difference in age groups whereas in the gender, education, and occupation groups there were significant differences in caring behaviors of the family caregivers ( $p < .01$ ). These findings except the result of age groups supported the first hypothesis, which were discussed as the following:

## Age

With regard to the comparison of caring behaviors of addicted adolescents' family caregivers by age groups, there was no significant difference in caring behaviors of family caregivers. Possible reason to explanation the age group in this study was divided into 3 groups according the unique characteristics of love, care and wisdom in psychosocial development of Erikson Theory (1963: 247-274, 1968: 91-141, 1982: 55-82). These characteristics may all influence caring behaviors. This finding might be reflecting the existence of caring in person's life span and supported the notions that caring is addressed as the basic constitutive phenomenon of human existence. It acts as an essential ingredient in human development and survival (Euswas, P. 1991: 11-14). Caring is an innate human trait, the human mode of being, a part of human nature, essential to human existence, and existed in every society (Morse, et al., 1990: 4; Watson, 1985: 8). Furthermore, caring is a basic way of being in the world (Benner & Wrubel, 1989: 398). It is viewed as the moral ideal of human care in psychosocial and spiritual aspects, which consists of transpersonal human-to-human attempts to protect, enhance and preserve humanity by helping a person find meaning in illness, suffering, pain, and existence; to help another gain self-knowledge, control, self-healing (Watson, 1988: 54).

This result was incongruent with the study of age and family burden among parents of offspring with severe mental illness (Cook, et al., 1994: 435-447) in age range of parent from 36 to 84 years, which found that younger parents were more troubled by their offspring's behaviors than were older parents. The contradiction in this finding might be due to the different situations and the states of patients. Cook, et al. (1994: 435-447) conducted the study with parents of offspring with severe mental illness that reflected the hardship experience of giving care, whereas this investigation was conducted with caregivers of non-psychotic addicted adolescent samples that was no severe symptom and need the less special activities for caring.

## **Gender**

With regard to the comparison of caring behaviors of family caregivers by gender groups, there were significant differences in caring behaviors of the family caregivers ( $p < .01$ ). The female family caregivers had mean score of caring behaviors higher than male. Possible reason to explain this finding concerning gender of caregivers might be related to the caregiving role in family because gender is one of the most significant factors determining selection of the caregiver. Women are expected to focus their value and beliefs pertaining to family life by sacrificing their efforts for family members (Pipatananond, P. 2001: 25-26). They continuously perform the caregiving role with the influence of social values, norms, and role expectations (Cain & Wicks, 2000: 61). Women more typically expect to accept the caregiving role than men (Hoyert & Seltzer, 1992: 74) who are expected to focus on employment responsibilities especially in the traditionally Thai culture. Hence, this kind of task related to gender role likely in general might be reflecting the difference in caring behaviors between the gender groups of the family caregivers in the present study.

## **Education**

With regard to the comparison of caring behaviors of family caregivers by education groups, there were significant differences in caring behaviors of family caregivers ( $p < .01$ ). The three pairwise comparisons by using Mann-Whitney U test the family caregivers who had elementary education behaved caring behaviors significantly different from those who had secondary education and higher education ( $p < .01$ ). Additionally, there was no significant difference in caring behaviors between family caregivers who finished secondary education and those who finished higher education. A possible explanation for this finding these caring behaviors might be performed by using an innate human trait, human nature, and human mode of being without the effect of knowledge and intellectuality. Thus, it could be stated that the caring behaviors in this situation might not be influenced by their cognitive capacities including knowledge and intellectuality. The caring behaviors mean score of family caregivers could remark the supported evidence of this explanation. The family caregivers reported the score over 3.00 in the four-point scale in every education groups. Moreover, the family caregivers

might exposure to the information in other methods of learning include information medias from mass communication in daily life, peer group discussion, and health providers advising in either treatment setting or communities. Thus, it might have been possible that learning of family caregivers might influence to the caring behaviors.

### **Occupation**

With regard to the comparison of caring behaviors of family caregivers by occupation groups, there were significant differences in caring behaviors of the family caregivers ( $p < .01$ ). The Sheffé tests demonstrated that the worker and agriculturist groups of family caregiver were no significant difference in caring behaviors whereas these both groups behaved caring behaviors significantly different from the official/state enterprise employee groups ( $p < .01$ ). One possible reason to explain the comparison's result of caring behaviors of family caregivers by occupation groups might be due to the time spent in caring for their addicted adolescents in common daily life. The family caregivers who were workers and agriculturists could be considered to have more time to care for their addicted adolescents in common daily life than the official/state enterprise employee groups, most of whom had to go outside the family home to work. The supporting evidence of study samples to this explanation could be remarked by the percentage of caring behaviors that family caregivers performed (Appendix E). A great deal point of scale (4) in this study, the family caregivers of addicted adolescents who were workers (60.2%) and agriculturists (55.9%) reported the percentage of performance caring behaviors higher than those family caregivers who were merchant (41.2%) and official/state enterprise employee (35.8%). Therefore, workers and agriculturists could be considered as having a chance to perform higher caring behaviors than other groups of family caregivers.

Concerning the merchant group, the score of caring behaviors of family caregivers was lower than either worker or agriculturist groups and higher than the official/state enterprise employee group. Although it was different from other groups there was no significant difference in caring behaviors among these groups. It might be due to merchant group had high task variation which could be leading to no uniqueness of characteristic of time to live with their addicted adolescent in common daily life.

## Hypothesis II:

**There are no differences in the caring needs of the addicted adolescents who differ in education, substance abuse duration, and admission.**

With regard to the comparisons of caring needs of addicted adolescents by education, substance abuse duration, and admission groups, the analysis results revealed that there were no significant differences in caring needs of the addicted adolescents in all domain groups. Therefore, these findings supported the second hypothesis, which were explained altogether of the independent variables include education, substance abuse duration, and admission by using Maslow's Theory (1970) and Watson's Theory (1985). One possible explanation of the lack of significant differences in caring needs of addicted adolescents by education, substance abuse duration, and admission groups might be related to the same basic human needs. The human needs assistance in Watson's ten carative factors derived from Maslow's Theory (1970). Most of human beings seemed to have the basic needs because they are a wanting animal (Maslow, 1970: 24). They need to achieve union, transcend one's individual life, and find harmony with life (Watson, 1988: 57). Therefore, the basic human needs could be viewed as essential to life of all human beings. The fundamental desires of all human beings do not differ because of human beings are much more alike than one would think at first contact even in different societies. They are relatively more ultimate and universal, more basic than the superficial desires, and makes a closer approach to common human characteristics (Maslow, 1970: 54-55). Apparently ends in basic human needs are far more universal than the ways taken to achieve those ends. Consequently, this reason might be reflecting the no significant differences in caring needs of addicted adolescents in this study.

Another possible reason to explain this finding of the study, despite difference in groups concerning the education, substance abuse duration, and admission of adolescents, they could be considered that those were all addicted patients in the same period of adolescent development that supported by psychosocial development of Erikson Theory (1963: 247-274, 1968: 91-141, 1982: 55-82). This theory explained step-by-step unfolding of emotional development and social

characteristics during encounters with the environment, which each phase had a specific developmental task to achieve or solve for reaching the human strengths or ego qualities. It could be assumed that the addicted adolescent of this study were the same developmental tasks, therefore, this finding might be reflecting the no significant differences in caring needs of the addicted adolescents in all domain groups.

### **Hypothesis III:**

**There are differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents.**

With regard to the comparison in 3 pairwises include caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents, the mean differences in total factors were -.193, -.347, and .154 respectively. Although the different sizes were very small, there were significant differences in all pairwises comparison ( $p < .01$ ). Therefore, these findings supported the third hypothesis which were discussed in the sequences of the pairwises dependent variables accordingly this hypothesis as follows:

#### **Caring behaviors of the family caregivers and caring needs of the addicted adolescents**

The mean difference between caring behaviors of the family caregivers and caring needs of the addicted adolescents in total was -.193 and range of mean differences in the 6 significantly different factors was -.383 to -.153. There were significant differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents in 6 out of 10 factors ( $p < .01$ ). These factors include factor 3: Sensitivity to self and others, factor 4: Helping-trusting, human care relationship, factor 7: Transpersonal teaching learning, factor 8:

Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, factor 9: Human needs assistance, and factor 10: Existential-phenomenological-spiritual forces. The remaining includes factor 1: Humanistic-altruistic system of values, factor 2: Faith-hope, factor 5: Expressing positive and negative feelings, and factor 6: Creative problem-solving caring process were no significant differences that reflected the congruency between caring behaviors of family caregivers and caring needs of addicted adolescents. These congruencies reflect that the family caregivers could fulfill the caring needs of addicted adolescents in these 4 factors. These results of the study were congruent with the previous findings in perspective of nursing which found that the nurses significantly perceived caring behaviors higher than patients (Ichaya Suwanakul & Nongnutch Chowsilpa, B.E. 2542: 59-66).

The family caregivers reported their performance of caring behaviors higher than the caring needs of addicted adolescents. The possible explanation for this finding was supported by the motives and values in perception, which was that the characteristics of the individual perceivers (motives, values, and all of the past conditioning) are major determiners of perception (Moskowitz & Orgel, 1969: 177). In case a substance abuse, it might be the reason that the family caregivers of addicted adolescents identified themselves by emphasizing the motives and values as love, care, and wisdom of human strengths accordingly Erikson's theory (1963: 247-274, 1968: 91-141, 1982: 55-82) for one love who was viewed as patient. Moreover, they identified the caregiving role for leading their addicted adolescents to have a better understanding of the meaning of life and meeting human needs. Thus, this reason might lead them to concentrate on the caring role and reflecting the exertion to perform their caring behaviors at higher levels.

#### **Caring behaviors of the family caregivers and caring perceptions of the addicted adolescents**

The mean difference between caring behaviors of the family caregivers and caring perceptions of the addicted adolescents in total was -.347 and range of mean differences in the 9 significantly different factors was -.477 to -.202.

There were significant differences between caring behaviors of the family caregivers and caring perceptions of the addicted adolescents in 9 out of 10 factors ( $p < .01$ ). These factors include factor 1: Humanistic-altruistic system of values, factor 2: Faith-hope, factor 3: Sensitivity to self and others, factor 4: Helping-trusting, human care relationship, factor 5: Expressing positive and negative feelings, factor 7: Transpersonal teaching learning, factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, factor 9: Human needs assistance, and factor 10: Existential-phenomenological-spiritual forces. Only factor 6: Creative problem-solving caring process, the analysis result demonstrated that there was no significant difference between caring behaviors of family caregivers and caring perceptions of addicted adolescents. Considered to the caring perceptions, it was found that addicted adolescents perceived caring behaviors lower than those family caregivers reported their performances. Moreover, it was lower than the caring needs of them as well.

Although family caregivers reported their total caring behaviors (Mean = 3.290, SD = .387) higher than caring needs (Mean = 3.097, SD = .518), the caring needs of addicted adolescents were not met because addicted adolescents still perceived these caring behaviors (Mean = 2.942, SD = .480) lower than their needs. The family caregivers and their addicted adolescents indicated the significant caring factors in different manners, which might be reflecting the partially created transpersonal caring relationship between family caregivers and their addicted adolescents. The Transpersonal Caring Theory (Watson, 1988: 47-49) supported the possible explanation of this finding. Human care transactions provide a coming together and establishment of contact between persons as one's mind-body-soul engages with another's mind-body-soul in a lived moment. In this moment, two people come together in a given moment and an actual occasion of human caring is created and it is a focal point in space and time that both experience and perception take place (Watson, 1999: 115-117). Furthermore, this finding might be reflecting the state of unfulfilled needs of addicted adolescents that leading the low efficiency of care because this study was conducted in situation of substance abuse problem that reflected to the disharmony in addicted adolescent. Disharmony within a

person's inner self or subjective turmoil related to specific experiences include developmental conflicts, inner suffering, guilt, self-blame, despair, loss, grief, as well as general and specific stress can lead to illness. Moreover, illness can produce disease (Watson, 1988: 48). Remarkably, the assigned significant caring activities according to Watson's ten carative factors of either family caregiver or addicted adolescent were contrast in perspective. Whereas addicted adolescents indicated their caring needs in psychological perspective their family caregivers emphasized the caring activities in physiological aspect. Hence, it might be reflect the low quality care and leading to partly incongruence between these two persons in caring behaviors, caring needs, and caring perceptions.

### **Caring needs and caring perceptions of the addicted adolescents**

The mean difference between caring needs and caring perceptions of addicted adolescents in total was .154 and range of mean differences in the 7 significantly different factors was .129 to .268. There were significant differences between caring needs and caring perceptions of addicted adolescents in 7 out of 10 factors ( $p < .01$ ). These factors include factor 1: Humanistic-altruistic system of values factor, 2: Faith-hope, factor 4: Helping-trusting, human care relationship, factor 5: Expressing positive and negative feelings, factor 6: Creative problem-solving caring process, factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, and factor 9: Human needs assistance. The remaining includes factor 3: Sensitivity to self and others, factor 7: Transpersonal teaching learning, and factor 10: Existential-phenomenological-spiritual forces were no significant differences that reflecting the congruency between caring needs and caring perceptions of the addicted adolescents. The finding concerning the significant differences between caring needs and caring perceptions of the addicted adolescents in total and those 7 factors that mentioned above might be reflecting the state of unfulfilled needs of addicted adolescents. Moreover, it was congruent with the previous findings in perspective of nursing which found that the patients had a high level of caring needs and that their needs were higher than perceived nursing care provided to meet those needs (Chamaiporn Sathiraleela, B.E. 2541: 78-81).

The possible explanation of this finding was supported by the motives and values in perception (Moskowitz & Orgel, 1969) that the individual perceptions are frequently influenced or altered by individually acquired motives, values, expectations, or personality characteristics, which produce perceptual tendencies within the individual (Moskowitz & Orgel, 1969: 181). The findings of this study that addicted adolescent perceived the caring behaviors of family caregivers lower than their caring needs might be due to caring behaviors that emphasized psychosocial and spiritual aspects is more likely abstract than concrete. Although the family caregivers paid highly their exertion to do it, it might be difficult to perceive especially in addicted adolescent. The typical personality characteristics of substance abuse patients include low assertiveness, low self-esteem, low self-efficacy, low social confidence, and low external locus of control could lead to a feeling state of unfulfilled needs in the addicted adolescents (Naegle & D'Avanzo, Eds., 2001: 204). Moreover, specific experiences include developmental conflicts, inner suffering, guilt, self-blame, despair, loss, grief, and general and specific stress could reflect the disharmony of person in the substance abuse phenomena (Watson, 1988: 48). So, it might influence the individual perceptions and propel the addicted adolescents into the destructive behavior of substance use (Mainous, et al. 1996: 807-815).

However, there was congruency between caring needs and caring perceptions of addicted adolescents in factor 3: Sensitivity to self and others, factor 7: Transpersonal teaching learning, and factor 10: Existential-phenomenological-spiritual forces. This finding might assume that the caring needs of addicted adolescents in these factors were met. Therefore, the health care providers should recognize by encouraging the family caregivers to maintain the caring behaviors in these factors. Moreover, they should promote caring behaviors in the remaining factors to meet the caring needs of their addicted adolescents.

Interestingly, the statistical analysis of each factor revealed that factor 3: Sensitivity to self and others, factor 7: Transpersonal teaching learning and factor 10: Existential-phenomenological-spiritual forces were no significantly different between caring needs and caring perceptions of addicted adolescents. Especially

factor 10: Existential-phenomenological-spiritual forces it was indicated by either family caregivers or addicted adolescents as 1 out of 3 highest factors of caring behaviors and caring needs respectively. Furthermore, the addicted adolescents perceived caring behaviors in this factor from their family caregiver as the highest score of caring perceptions. Hence, it could be considered that these findings reflected the caring needs of addicted adolescents in these factors were met. Additionally, although there was significant difference between caring needs and caring perceptions of the addicted adolescents in factor 6: Creative problem-solving caring process ( $p < .01$ ), the analysis result demonstrated that there were no significant differences between either caring behaviors of family caregivers and caring needs of addicted adolescents or caring behaviors of family caregivers and caring perceptions of addicted adolescents. This finding might reflect the caring behaviors that family caregivers performed could lead the addicted adolescents to meet their needs. The addicted adolescents perceived caring behaviors of family caregivers in this factors difference from their caring needs might be due to the motives, values, expectations, and personality characteristics of them.

However, consideration of the difference of mean between caring behaviors of the family caregivers and caring needs of the addicted adolescents, caring behaviors of the family caregivers and caring perceptions of the addicted adolescents, and caring needs and caring perceptions of the addicted adolescents in total and in those factors which were significantly differences. It was found that they were less than .5 in the four-point scale of this study. It might be assumed that these mean differences were too small values that could found in general situations according to the motives, values, and all of the past conditioning influenced in perception of individual (Moskowitz & Orgel, 1969: 181). One possible explanation of this finding might be that due to some of the addicted adolescents and their family caregivers of this study were in the second and the third or more admission groups (16.0% and 12.5% respectively) and that they had joined the several treatment programs. So, the past experiences of addicted adolescents and their family caregivers might have affected the results of the study.

In conclusion, the Watson Transpersonal Caring Theory (Watson, 1985, 1988, 1999) could support this study results in characteristics of human care transactions provide a coming together and establishment of contact between persons as one's mind-body-soul engages with another's mind-body-soul in a lived moment. Family caregivers, who differ in the age groups, did not behave differently in caring behaviors whereas in the gender, education, and occupation groups were statistically differences at significant level .01. Addicted adolescents, who differ in the education, substance abuse duration, and admission groups, were not significantly differences in caring needs. Not only nurse can express caring behaviors, but also the family caregivers can do. To test the congruency among caring behaviors, caring needs, and caring perceptions of the family caregivers and carereceivers, the addicted adolescents, it revealed the differences among pairwises were very minimal. However, there were statistically different at significant level .01. This finding could be the results of individual differences, a selective perception nature of man, and some difficulty areas in fulfillment of other person's needs.

## CHAPTER VI

### CONCLUSION

This chapter consists of two sections. The first section presents a summary of the study and includes sample characteristics, instruments, and research findings. The implications and recommendations of the research findings are then discussed in the second section.

#### **Summary of the Study**

This research studied the caring behaviors of family caregivers, and caring needs and caring perceptions of addicted adolescents at the Khonkaen Drug Dependence Treatment Center during the year 2003. The Transpersonal Caring Theory (Watson, 1985, 1988, 1999), which places upon helping a person gain more self-knowledge, self-control and readiness for self-healing, was applied as a theoretical framework for this study.

#### **Sample Characteristics**

A sample of 263 family caregivers of addicted adolescent was recruited from the Khonkaen Drug Dependence Treatment Center. The biggest age-ranged group was the group of 41 to 60 years (61.6%). The majority of them (57.8%) were female. Slightly more than half of the family caregivers of addicted adolescents (54.4%) had only elementary education. Regarding occupations, most family caregivers of addicted adolescents (41.8%) were agriculturist.

The addicted adolescents, matching with their indicated family caregivers, were recruited from the Khonkaen Drug Dependence Treatment Center. The age of the addicted adolescents ranged from 12 to 20 years with a mean of 17.38 (SD = 1.96). Most of them (93.5%) were male. The majority of them (84.8%) had secondary education. According to substance abuse duration, the majority of them (55.9%) reported 1 to 3 years. The most admission of addicted adolescents was the first time (71.5%). Finally, 49.4% of addicted adolescents indicated that their mothers their significant family caregivers.

### **Instruments**

The researcher modified the questionnaires from the originally developed Caring Behaviors in Caregivers of Amphetamine Users Questionnaire of Parichat Wanwaisart (B.E. 2543) and the Needs of Amphetamine Addicted Repeat Treatment Adolescents Questionnaire of Jiraporn Chatsupakul (B.E. 2544). Moreover, the clinical practice of the researcher was also applied to modify the questionnaires for congruence to the situation of either the caring behaviors of family caregivers or the caring needs and caring perceptions of addicted adolescents. Face validity was done by the panel of seven experts, two of them are substance abuse physician and substance abuse nurse in Drug Dependence Treatment Center and the other five are doctoral prepared nurses in areas of psychosocial nursing, caring behaviors, psychiatric and mental health nursing, family caregivers of elderly, and spiritual care respectively. The reliability testing was assessed by alpha Cronbach's coefficient in these instruments that comprised of 4 sets questionnaire namely:

1. The Demographic Data Questionnaires of Addicted Adolescents.
2. The Demographic Data Questionnaires of Family Caregivers.
3. The Caring Behaviors Questionnaires consist of 36 items; with the alpha Cronbach's coefficient was .93.
4. Caring Needs and Caring Perceptions Questionnaire consisting of 36 items that congruent with the Caring Behaviors Questionnaires. The alpha Cronbach's coefficients were .94 and .92 respectively.

### Research Findings

The family caregivers of addicted adolescents reported their caring behaviors with an actual range of average total score between 2.25 to 4.00, with a mean of 3.290 (SD = .387). The addicted adolescents reported their caring needs with an actual range of average total score from 1.00 to 4.00 with the mean of 3.097 (SD = .518) and reported the caring perceptions with an actual range of average total score from 1.00 to 4.00 with the mean of 2.942 (SD = .480).

The family caregivers, who differ in the age range of 21-40 years, 41-60 years, and over 60 years, did not behave differently in caring behaviors. In the opposite, caring behaviors were significantly different among family caregivers who differ in gender, education, and occupation ( $p < .01$ ). The female family caregivers had mean score of caring behaviors higher than male. In education groups, the family caregivers who had elementary education behaved caring behaviors significantly different from those who had secondary education and higher education ( $p < .01$ ). However, there was no significant difference in caring behaviors between secondary education and higher education groups of family caregivers. With regard to occupation, the worker and agriculturist groups of family caregiver were no significant difference in caring behaviors whereas these both groups behaved caring behaviors significantly different from the official/state enterprise employee groups ( $p < .01$ ). Concerning the merchant group, there was no significant difference in caring behaviors among the other occupation groups.

There were no significant differences in caring needs of the addicted adolescents who differ in education, substance abuse duration, and admission groups.

There were significant differences among caring behaviors of the family caregivers, caring needs of the addicted adolescents, and caring perceptions of the addicted adolescents in total and in 3 out of 10 factors include factor 4: Helping-trusting, human care relationship, factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, factor 9: Human needs assistance ( $p < .01$ ).

The mean difference between caring behaviors of the family caregivers and caring needs of the addicted adolescents in total was -.193 and range of mean differences in the 6 significantly different factors was -.383 to -.153. There were significant differences between caring behaviors of the family caregivers and caring needs of the addicted adolescents in 6 out of 10 factors ( $p < .01$ ). These factors include factor 3: Sensitivity to self and others, factor 4: Helping-trusting, human care relationship, factor 7: Transpersonal teaching learning, factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, factor 9: Human needs assistance, and factor 10: Existential-phenomenological-spiritual forces. The remaining includes factor 1: Humanistic-altruistic system of values, factor 2: Faith-hope, factor 5: Expressing positive and negative feelings, and factor 6: Creative problem-solving caring process were no significant differences that reflected the congruency between caring behaviors of family caregivers and caring needs of addicted adolescents.

The mean difference between caring behaviors of the family caregivers and caring perceptions of the addicted adolescents in total was -.347 and range of mean differences in the 9 significantly different factors was -.477 to -.202. There were significant differences between caring behaviors of the family caregivers and caring perceptions of the addicted adolescents in 9 out of 10 factors ( $p < .01$ ). These factors include factor 1: Humanistic-altruistic system of values, factor 2: Faith-hope, factor 3: Sensitivity to self and others, factor 4: Helping-trusting, human care relationship, factor 5: Expressing positive and negative feelings, factor 7: Transpersonal teaching learning, factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, factor 9: Human needs assistance, and factor 10: Existential-phenomenological-spiritual forces. Only factor 6: Creative problem-solving caring process, the analysis result demonstrated that there was no significant difference between caring behaviors of family caregivers and caring perceptions of addicted adolescents.

The mean difference between caring needs and caring perceptions of addicted adolescents in total was .154 and range of mean differences in the 7 significantly different factors was .129 to .268. There were significant differences

between caring needs and caring perceptions of addicted adolescents in 7 out of 10 factors ( $p < .01$ ). These factors include factor 1: Humanistic-altruistic system of values factor, 2: Faith-hope, factor 4: Helping-trusting, human care relationship, factor 5: Expressing positive and negative feelings, factor 6: Creative problem-solving caring process, factor 8: Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments, and factor 9: Human needs assistance. The remaining includes factor 3: Sensitivity to self and others, factor 7: Transpersonal teaching learning, and factor 10: Existential-phenomenological-spiritual forces were no significant differences that reflecting the congruency between caring needs and caring perceptions of the addicted adolescents.

## **Recommendations**

The research findings from this study have several implications for nursing practice, nursing administration, and nursing research.

### **Implications for Nursing Practice**

1. Nurses can apply the caring behaviors questionnaire, and caring needs and caring perceptions questionnaire of this study as clinical practice tools in health care settings to assess addicted patients and their family caregivers. Moreover, the knowledge generated by this study can be applied for the prevention of substance addiction thereby suggest. It also show family caregivers should take care of the addicted family members and enable them to meet caring needs after treatment has finished and discharge from the Drug Dependence Treatment Center.

2. According to the results of this study, nurses can be used to develop a Caring Training Program base on Watson's ten carative factors for family caregivers that cover how to assess and fulfill the needs of addicted patients.

3. The results of this study found that male family caregivers had a lower score of caring behaviors than females. Therefore, nurses should recognize this by encouraging male family caregivers to take care of addicted adolescents and advising them how to meet the caring needs of their children.

### **Implications for Nursing Administration**

The knowledge generated by this study concerning the caring needs of addicted adolescents can provide empirical support for policy makers and health care providers, especially nurses. It could serve as a valuable basis from which to develop policy and intervention procedures, which will create and strengthen transpersonal relationships in health care institutes, family environments, and in wider communities.

### **Implications for Nursing Education**

Nurses play a vital role in taking care of addicted adolescents when they are admitted for treatment and stay at the Drug Dependence Treatment Center. When addicted adolescents are cared for in families, nurses also act to build a bridge of caring between the drug dependence treatment center and the family. The actions of nurses can lead addicted adolescents to get high quality care from their family caregivers. Therefore, in order to prepare student nurses to fulfill these roles more effectively, the nursing curriculum should allocate an appropriate number of additional hours for teaching about substance addiction and to allow student nurses to train at the Drug Dependence Treatment Center.

### **Implications for Nursing Research**

1. This study is the first of its kind and considered only a limited number of variables. For better understanding about the caring behaviors, caring needs, and caring perceptions, therefore, additional research is desirable which considers other factors and characteristics of both family caregivers and addicted adolescents such as personal belief, types of family, income, characteristic of work that influenced time spent for caring, and the sequence of addicted children in family.

2. An experimental study should also be carried out to create the congruence relationship between family caregivers and their addicted adolescents through the development of the Caring Training Program. Moreover, the caring behaviors questionnaire, and the caring needs and caring perceptions questionnaire that were developed in this study can be used to measure the outcome of this program.

3. The mean differences among caring behaviors, caring needs, and caring perceptions in this study were less than .5 in the four-point scale, which might be found in general situations according to the experiences of individual. Moreover, some of the addicted adolescents and their family caregivers of this study were in the second and the third or more admission groups. They had joined several treatment programs such as work assignments, therapeutic milieus, family counseling, recreational activities, and Matrix Program. Therefore, further study should be conducted with uncontaminated samples such as newly addicted patients who have never joined with any of these several substance dependence treatment programs.

4. Regarding the results of the study concerning caring perceptions, individual perceptions were frequently influenced or altered by individually acquired motives, values, expectations, or personality characteristics, which produce perceptual tendencies within the individual. Therefore, further study should be conducted about this aspect of satisfaction of addicted adolescents. Moreover, comparison of the results between satisfaction and perceptions of addicted adolescents should be done for clarifying in the substance addicted adolescents aspect.

## BIBLIOGRAPHY

- Aiamma, C. (2001). The Effectiveness of Empowerment in Cessation of Amphetamine Abuse among Probationers in Phichit Province. Master's thesis in health education and behavioral sciences, Faculty of Graduate Studies, Mahidol University.
- Anglin, M.D., Burke, C., Perrochet, B., Stamper, E. & Dawud-Noursi, S. (2000). History of the Methamphetamine problem. Journal of Psychoactive Drugs, 32(2), 137-141.
- Argyrous, G. (2000). Statistics for Social & Health Research with a Guide to SPSS. London: SAGE.
- Benner, P. & Wrubel, J. (1989). The Primacy of Caring: Stress and Coping in Health Illness. Menlo Park, CA: Addison-Wesley Publishing Company.
- Bray, J.H., Adams, G.J., Greg Getz, J. & Baer, P.E. (2001). Developmental, family, and ethnic influences on adolescent alcohol usage: A growth curve approach. Journal of Family Psychology, 15(2), 301-314.
- Brook, J.S., Balka, E.B. & Whiteman, M. (1999). The risks for late adolescence of early adolescent marijuana use. American Journal of Public Health, 89(10), 1549-1554.
- Brook, J.S., Brook, D.W., De La Rosa, M., Whiteman, M., Johnson, E. & Montoya, I. (2001). Adolescent illegal drug use: The impact of personality, family, and environmental factors. Journal of Behavioral Medicine, 24(2), 183-203.
- Bukstein, O.G. (1995). Adolescent Substance Abuse: Assessment, Prevention, and Treatment. New York: John Wiley & Sons.

- Burns, N. & Grove, S.K. (1993). The Practice of Nursing Research: Conduct Critique and Utilization. (2nd. ed.). Philadelphia: W.B. Saunders.
- Cain, C.J. & Wicks, M.N. (2000). Caregiving attitudes as correlates of burden in family caregivers coping with chronic obstructive pulmonary disease. Journal of Family Nursing, 6(1), 46-67.
- Clark, D.B., Neighbors, B.D., Lesnick, L.A., Lynch, K.G. & Donovan, J.E. (1998). Family functioning and adolescent alcohol use disorders. Journal of Family Psychology, 12(1), 81-92.
- Clark, R.E. (2001). Family support and substance use outcomes for persons with mental illness and substance use disorders. Schizophrenia Bulletin, 27(1), 93-101.
- Collins Cobuild English Dictionary. (1998). Collins Cobuild English Dictionary (4th ed.). London: HarperCollins Publishers.
- Cook, J.A., Lefley, H.P., Pickett, S.A. & Cohler, B.J. (1994). Age and family burden among parents of offspring with severe mental illness. American Journal of Orthopsychiatry, 64(3), 435-447.
- Cronin, S.N. & Harrison, B. (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. Heart & Lung, 17(4), 374-380.
- Davis, L.L. (1992). Building a science of caring for caregivers. Family & Community Health, 15(2), 1-9.
- Dixon, L., McNary, S. & Lehman, A. (1995). Substance abuse and family relations of persons with severe mental illness. American Journal of Psychiatry, 152(3), 456-458.
- Dusenbury, L., Khuri, E. & Millman, R.B. (1992). Adolescent substance abuse: A sociodevelopmental perspective. In J.H. Lowinson, P. Ruiz, R.B. Millman & J.G. Langrod (Eds.), Substance Abuse: A Comprehensive Textbook (2nd ed., pp. 832-842). Baltimore: Williams & Wilkins.

- Erikson, E.H. (1963). Childhood and Society (2nd ed.). New York: W.W. Norton & Company.
- \_\_\_\_\_. (1968). Identity Youth and Crisis. New York: W.W. Norton & Company.
- \_\_\_\_\_. (1982). The Life Cycle Completed. New York: W.W. Norton & Company.
- Euswas, P. (1991). The Actualized Caring Moment: A Grounded Theory of Caring in Nursing Practice. Doctoral dissertation, Massey University New Zealand.
- Fagerstrom, L., Eriksson, K. & Engberg, I.B. (1999). The patient's perceived caring needs: measuring the unmeasurable. International Journal of Nursing Practice, 5(4), 199-208.
- Farrell, A.D. & White, K.S. (1998). Peer influences and drug use among urban adolescents: Family structure and parent-adolescent relationship as protective factors. Journal of Consulting and Clinical Psychology, 66(2), 248-258.
- Foxcroft, D.R. & Lowe, G. (1997). Adolescents' alcohol use and misuse: The socializing influence of perceived family life. Drugs: education, prevention and policy, 4(2), 215-229.
- Giancola, P.R., Mezzich, A.C., Clark, D.B. & Tarter, R.E. (1999). Cognitive distortions, aggressive behavior, and drug use in adolescent boys with and without a family history of a substance use disorder. Psychology of Addictive Behaviors, 13(1), 22-32.
- Glendinning, A., Shucksmith, J & Hendry, L. (1997). Family life and smoking in adolescence. Social Science and Medicine, 44(1), 93-101.
- Haber, J. (2001). Management of substance abuse and dependence problem in families. In M.A. Naegle & C.E. D'Avanzo (Eds.), Addictions and Substance Abuse: Strategies for Advanced Practice Nursing (pp. 305-331). Upper Saddle River, NJ: Prentice-Hall.

- Hallstrom, I. & Elander, G. (2001). Needs during hospitalization: Definitions and descriptions made by patients. Nursing Ethics: An International Journal for Health Care Professionals, 8(5), 409-418.
- Harris, M.B. (1995). Basic Statistic for Behavioral Science Research. USA: A Simon & Schuster.
- Hoffman, J.P. & Johnson, R.A. (1998). A national portrait of family structure and adolescent drug use. Journal of Marriage and the Family, 60(3), 633-645.
- Hoyert, D.L. & Seltzer, M.M. (1992). Factors related to the well-being and life activities of family caregivers. Family Relations, 41, 74-81.
- Huggins, K.N., Gandy, W.M. & Kohut, C.D. (1993). Emergency department patients' perception of nurse caring behaviors. Heart & Lung, 22(4), 356-364.
- Hwu, Y.J. (1995). The impact of chronic illness on patients. Rehability Nursing, 20(4), 221-225.
- Jester, J.M., Jacobson, S.W., Sokol, R.J., Tuttle, B.S. & Jacobson, J.L. (2000). The influence of maternal drinking and drug use on the quality of the home environment of school-aged children. Alcoholism: Clinical and Experimental Research, 24(8), 1187-1197.
- Keane, S.M., Chastain, B. & Rudisill, K. (1987). Caring: Nurse-patient perceptions. Rehabilitation Nursing, 12(4), 182-184.
- King, I.M. (1981). A Theory for Nursing. New York: John Wiley & Sons.
- Komorita, N.I., Doehring, K.M. & Hirschert, P.W. (1991). Perceptions of caring by nurse educators. Journal of Nursing Education, 30(1), 23-29.
- Kyle, T.V. (1995). The concept of caring: A review of the literature. Journal of Advanced Nursing, 21, 506-514.
- Lason, P.J. (1984). Important nurse caring behaviors perceived by patients with cancer. Oncology Nursing Forum, 11(6), 46-50.

- Lason, P.J. (1986). Cancer nurses' perceptions of caring. Cancer Nursing, 9(2), 86-91.
- \_\_\_\_\_. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviors. Heart & Lung, 16(2), 187-193.
- Lea, A. & Watson, R. (1998). Caring in nursing: A multivariate analysis. Journal of Advanced Nursing, 28(3), 662-671.
- Lubkin, I.M. & Larsen, P.D. (1998). Chronic Illness: Impact and Interventions (4th ed.). USA: Jones and Bartlett.
- Mainous, A.G., Martin, C.A., Oler, M.J., Richardson, E.T. & Haney, A.S. (1996). Substance use among adolescents: Fulfilling a need state. Adolescence, 31(124), 807-815.
- Manfreda, M.L. (1973). Psychiatric Nursing (9th ed.). Philadelphia: F.A. Davis.
- Manfreda, M.L. & Krampitz, S.D. (1977). Psychiatric Nursing (10th ed.). Philadelphia: F.A. Davis.
- Mangold, A.M. (1991). Senior nursing students' and professional nurses' perceptions of effective caring behaviors: A comparative study. Journal of Nursing Education, 30(3), 134-139.
- Mayer, D.K. (1987). Oncology nurses' versus cancer patients' perceptions of nurse caring behaviors: A replication study. Oncology Nursing Forum, 14(3), 48-52.
- Merriam-Webster's Collegiate Dictionary. (1996). Merriam-Webster's Collegiate Dictionary (10th ed.). Springfield, MA: Merriam-Webster.
- Morse, J.M., Solberg, S.M., Neander, W.L., Bottorff, J.L. & Johnson, J.L. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13(1), 1-14.
- Munro, B.O. (2001). Statistical Methods for Health Care Research (4th ed.). Philadelphia: Lippincott.

- Murray, R.B. & Zentner, J.P. (1997). Health Assessment Promotion Strategies through the Life Span (6th ed.). Stamford, CT: Appleton & Lange.
- Naegle, M.A., & D'Avanzo, C.E. (Eds.). (2001). Addictions and Substance Abuse: Strategies for Advanced Practice Nursing. Upper Saddle River, NJ: Prentice-Hall.
- Neeskul, N. (2001). Development of the Service Model for Amphetamine Addicted Youths in Thanyarak Hospital. Doctoral dissertation, Faculty of Graduate Studies, Mahidol University.
- Nietzel, M.T., Bernstein, D.A. & Milich, R. (1994). Introduction to Clinical Psychology (4th ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Nightingale, F. (1969). Note on Nursing: What It Is, and What It Is Not (Reprint of the 1860 ed.). New York: Dover.
- Norusis, M.J. (2002). SPSS 11.0: Guide to Data Analysis. NJ: Prentice-Hall.
- Obert, J. L., et al. (2000). The Matrix Model of outpatient stimulant abuse treatment: History and description. Journal of Psychoactive Drugs, 32(2), 157-164.
- Orem, D.E. (2001). Nursing Concepts of Practice. St. Louis: Mosby.
- Overholser, J.C., Freiheit, S.R. & DiFlippo, J.M. (1997). Emotional distress and substance abuse as risk factors for suicide attempts. Canadian Journal of Psychiatry, 42(4), 402-408.
- Panirat, R. (2001). The Relationships among Dysfunctional Attitudes, Learned Resourcefulness, and Amphetamine Use in Thai Adolescents. Doctoral dissertation, Frances Pyne Bolton School of Nursing, Case Western Reserve University.
- Pathomneela, W. (2000). Factors Affecting the Male Adolescence's Drug Use (amphetamine) in the Medical Correctional Institution in Pathumthani. Master's thesis in criminology and criminal justice, Faculty of Graduate Studies, Mahidol University.

- Patton, T.J., Barnhart, D.A., Bennett, P.M., Porter, B.D. & Sloan, R.S. (1998). Philosophy and science of caring. In A.M. Tomey & M.R. Alligood (Eds.), Nursing Theorists and their Work (4th ed., pp. 142-156). St. Louis, MO: Mosby-Year Book.
- Pender, N.J. (1987). Health Promotion in Nursing Practice (2nd ed.). Connecticut: Appleton & Lange.
- Peplau, H. (1952). Interpersonal Relationships in Nursing. New York: Putnum & Sons.
- Pipatananond, P. (2001). Caregiver Burden Predictive Model: An Empirical Test among Caregivers for the Schizophrenic. Doctoral dissertation, Faculty of Graduate Studies, Mahidol University.
- Polit, D.F. (1996). Data Analysis & Statistics for Nursing Research. USA: Appleton & Lange.
- Polit, D.F. & Hungler, B.P. (1999). Nursing Research: Principles and Methods. (6th. ed.). Philadelphia: J.B. Lippincott.
- Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992). Applications to addictive behaviors. American Psychologist, 47, 1102-1113.
- Prommajit, P. (2001). Preventive Strategies in a Family Context for Methamphetamines Abuse: A Case Study of Students in Public Secondary Schools in One Northern Province. Doctoral dissertation, Faculty of Graduate Studies, Mahidol University.
- Rawson, R.A. (1999). Treatment for Stimulant Use Disorders Treatment Improvement Protocol (TIP) Series 33. Center for Abuse Treatment. DHHS Pub..No. (SMS)99-3296. Rockville, MD: CSAT, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

- Redston-Iselin, A. (1991). Adolescent psychiatric nursing. In G.W. Stuart & S.J. Sundeen (Eds.), Principles and Practice of Psychiatric Nursing (4th ed., pp. 878-905). St. Louis, MO: Mosby-Year Book.
- Rosenthal, K.A. (1992). Coronary care patients' and nurses' perceptions of important nurse caring behaviors. Heart & Lung, 21(6), 536-539.
- Santisteban, D.A., Tejada, M., Dominicis, C. & Szapocznik, J. (1999). An efficient tool for screening for maladaptive family functioning in adolescent drug abusers: The problem oriented screening instrument for teenagers. American Journal of drug and Alcohol Abuse, 25(2), 197-206.
- Scharf, L. & Caley, L. (1993). Patients', nurses', and physicians' perceptions of nurses' caring behaviors. Nursing Connections, 6(1), 3-12.
- Schumaker, R.E. & Lomax, R.G. (1996). A Beginner's Guide to Structural Equation Modeling. NJ: Lawrence Erlbaum Associates.
- Seeman, H. (1997). Adolescents' Coping after Parental Divorce: Depression, High-risk Behaviors, and Suicidality. Doctoral dissertation, University of California [CD-ROM]. Abstract from: CINAHL (R) Database 1998-2000/08.
- Siegel, S. (1988). Nonparametric Statistics for the Behavioral Sciences (2nd. ed.). Singapore: McGraw-Hill.
- Stice, E., Myers, M. G. & Brown, S.A. (1998). Relation of delinquency to adolescent substance use and problem use: A prospective study. Psychology of Addictive Behaviors, 12(2), 136-146.
- Sullivan, E.J. (1995). Nursing Care of Clients with Substance Abuse. St. Louis: Mosby-Year Book.
- Thipsamniag, T. (2000). Caregiving Demands of Stroke Patients, Patient-caregiver Relationships, and Caregivers' Life Satisfaction. Master's thesis in adult nursing, Faculty of Graduate Studies, Mahidol University.

- Vakahili, H.F., Harrison, R.S. & Janzen, F.V. (2000). The influence of family-based risk and protective factors on adolescent substance use. Journal of Family Social Worker, 4(1), 21-34.
- Von Essen, L. & Sjöden, P.O. (1991). Patient and staff perceptions of caring: Review and replication. Journal of Advanced Nursing, 16(11), 1363-1374.
- Watson, J. (1985). The Philosophy and Science of Caring (2nd ed.). Niwot, CO: The University Press of Colorado.
- \_\_\_\_\_. (1988). Nursing: Human Sciences and Human care. New York: National League for Nursing.
- \_\_\_\_\_. (1999). Postmodern Nursing and Beyond. London: Harcourt Brace and Company.
- Watson, R. & Lea, A. (1997). The caring dimensions inventory (CDI): Content validity, reliability and scaling. Journal of Advanced Nursing, 25, 87-94.
- WHO. (1996). Nursing Practice: Report of a WHO Expert Committee. Geneva, Switzerland: World Health Organization Technical Report Series, No. 860.
- Williams, S.A. (1998). Quality and care: patients' perceptions. Journal of Nursing Care Quality, 12(6), 18-25.
- Wolf, Z.R. (1986). The caring concept and nurse identified caring behaviors. Topics in Clinical Nursing, 8(2), 84-93.
- Yamane, T. (1973). Statistics: An Introductory Analysis (3rd. ed.). Tokyo: Harper.
- Yuttatri, P. (2001). The Effects of the Application of a Relapse Prevention Program on Self-control and Remission from Methamphetamine Dependence among Teenagers. Doctoral dissertation, Faculty of Graduate Studies, Mahidol University.

- เกษม จันทร. (2541). (Kasem Juntasorn, B.E. 2541). ปัจจัยทางจิตสังคมที่เกี่ยวข้องกับการ  
ด้านทันตการเสพยาบ้าของนักเรียนมัธยมศึกษาตอนต้น. ภาคนิพนธ์ปริญญาพัฒนบริหาร  
ศาสตรมหาบัณฑิต (พัฒนาสังคม), คณะพัฒนาสังคม สถาบันบัณฑิตพัฒนบริหารศาสตร์.
- ขวัญหทัย รงคุปตวนิช (2544). (Kwanhathai Rongkoptawanich, B.E. 2544). การสนับสนุน  
ทางสังคมเกี่ยวกับการเลิกหรือการกลับมาเสพยาของผู้ติดยาเสพติด. วิทยานิพนธ์ปริญญา  
ศึกษาศาสตรมหาบัณฑิต, สาขาวิชาการส่งเสริมสุขภาพ บัณฑิตวิทยาลัย มหาวิทยาลัย  
เชียงใหม่.
- จิราภรณ์ ฉัตรศุกกุล. (2544). (Jiraporn Chatsupakul, B.E. 2544). ปัญหาและความต้องการของ  
ครอบครัวและวัยรุ่นติดยาบ้าที่กลับมารักษาย้ำ. วิทยานิพนธ์ปริญญาพยาบาลศาสตร  
มหาบัณฑิต, สาขาวิชาการพยาบาลครอบครัว บัณฑิตวิทยาลัย มหาวิทยาลัยขอนแก่น.
- ชไมพร สติริลลา. (2541). (Chamaiporn Sathiraleela, B.E. 2541). การศึกษาความต้องการการ  
ดูแล และ การได้รับจากพยาบาลของผู้ป่วยที่หน่วยพักค้างรอดูอาการ ติ๊กผู้ป่วยนอก  
โรงพยาบาลศิริราช. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการ  
พยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ณัฐพล หาญโสภี. (2540). (Nuttapol Hansopee, B.E. 2540). โปรแกรมการสร้างพลังในการส่งเสริม  
พฤติกรรมการป้องกันการเสพยาแอมเฟตามีนของนักเรียนระดับมัธยมศึกษาปีที่ 2  
จังหวัดสระบุรี. วิทยานิพนธ์ปริญญา วิทยาศาสตร์มหาบัณฑิต (สาธารณสุขศาสตร์),  
สาขาวิชาเอกสุขภาพ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ธีรวิทย์ เจียรประดิษฐ์. (2540). (Teravit Chienpradit, B.E. 2540). การแพร่ระบาดของแอมเฟตา  
มีน (ยาบ้า) ในกลุ่มนักเรียน นักศึกษา ระหว่างปี พ.ศ. 2534-2538. ภาคนิพนธ์ปริญญา  
พัฒนบริหารศาสตรมหาบัณฑิต (พัฒนาสังคม), คณะพัฒนาสังคม สถาบันบัณฑิตพัฒน  
บริหารศาสตร์.
- นวนันท์ กิจทวี่. (2541). (Navanun Kitthavee, B.E. 2541). ประสิทธิผลของโปรแกรมสร้าง  
เสริมทักษะชีวิตเพื่อป้องกันการเสพยาบ้าในนักเรียนมัธยมศึกษา สังกัดกรมสามัญศึกษา  
จังหวัดนนทบุรี. วิทยานิพนธ์ปริญญา วิทยาศาสตร์มหาบัณฑิต (สาธารณสุขศาสตร์),  
สาขาวิชาเอกสุขภาพ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- บัวหลวง สำแดงฤทธิ์. (2538). (Bualuang Samdaengrit, B.E. 2538). ความต้องการการดูแลและ  
การได้รับการดูแลจากพยาบาล ตามการรับรู้ของผู้ป่วยมะเร็งปากมดลูกที่ได้รับการรักษา  
ด้วยรังสีในโรงพยาบาลรามธิบดี. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต,  
สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

- ปาริชาติ แว่นไวศาสตร์. (2543). (Parichat Wanwaisart, B.E. 2543). สุขภาพจิตและพฤติกรรมกรรมการดูแลผู้เสพยาบ้าของผู้ดูแล. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาสุขภาพจิตและการพยาบาลจิตเวชศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ประนอม ภูศรีทอง. (2536). (Pranom Poosritong, B.E. 2536). พฤติกรรมกรรมการดูแลของพยาบาลตามการรับรู้ของผู้คลอดในโรงพยาบาลรามาชิตี. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลมารดาและทารก บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ปราณีพร บุญเรือง. (2545). (Praneeporn Boonruang, B.E. 2545). ผลของกลุ่มปรับพฤติกรรมทางปัญญาของวัยรุ่นที่ติดยาบ้าต่อการป้องกันการกลับไปเสพยา. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลสุขภาพจิตและจิตเวช บัณฑิตวิทยาลัย มหาวิทยาลัยขอนแก่น.
- ภัทรวรรณ ทองเปรม. (2543). (Puttarawaun Tongprem, B.E. 2543). สภาพทางสังคมของผู้ป่วยโรคจิตที่มีประวัติการเสพยาบ้า: ศึกษาเฉพาะกรณี โรงพยาบาลศรีธัญญา. ภาคนิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต (พัฒนาสังคม), คณะพัฒนาสังคม สถาบันบัณฑิตพัฒนบริหารศาสตร์.
- ยี่สุน ใจดี. (2540). (Yisun Jaidee, B.E. 2540). ปฏิบัติการพยาบาลที่เป็นการดูแลในโรงพยาบาลรามาชิตี. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลมารดาและทารก บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ยุพาพิน ศิริโพธิ์งาม. (2539). (Yupapin Sirapo-ngam, B.E. 2539). ญาติผู้ดูแลที่บ้าน. รามาชิตีพยาบาลสาร, 2(1), 84-94.
- ยุวดี ภาษา. (2543). (Yuwadee Luecha, B.E. 2543). วิจัยทางการพยาบาล. (พิมพ์ครั้งที่ 7). กรุงเทพฯ: บริษัทสยามศิลปการพิมพ์จำกัด.
- วชิราภรณ์ ศรีเบญจกุล. (2543). (Vachiraporn Sribenjagul, B.E. 2543). ปัจจัยของครอบครัวต่อการเสพยาบ้าในทัศนะของวัยรุ่น: ศึกษาเฉพาะกรณี โรงพยาบาลพระนั่งเกล้า จังหวัดนนทบุรี. วิทยานิพนธ์ปริญญาสังคมสงเคราะห์ศาสตรมหาบัณฑิต, คณะสังคมสงเคราะห์ศาสตร์ มหาวิทยาลัยธรรมศาสตร์.
- วริศรา เพียงสุข. (2540). (Varisara Piengsook, B.E. 2540). ปัจจัยที่เกี่ยวข้องกับพฤติกรรมกรรมการเสพยาบ้าของเยาวชน: ศึกษาเปรียบเทียบเยาวชนในสถานฝึกและอบรมเด็กและเยาวชนบ้านอุเบกขา, บ้านปรานี และนักเรียนชั้นมัธยมศึกษาตอนปลาย. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (จิตวิทยาการให้คำปรึกษา), มหาวิทยาลัยรามคำแหง.

- ศูนย์บำบัดรักษายาเสพติดจังหวัดขอนแก่น. (2545). (The Khonkaen Drug Dependence Treatment Center, B.E. 25455). สถิติผู้ป่วยศูนย์บำบัดรักษายาเสพติดจังหวัดขอนแก่น กรมการแพทย์ กระทรวงสาธารณสุข ปีงบประมาณ 2541-2545. ขอนแก่น: ศูนย์บำบัดรักษายาเสพติดจังหวัดขอนแก่น. อัดสำเนา.
- สมโภชน์ เอี่ยมสุภาษิต. (2539). (Sompoch Aiamsupasit, B.E. 2539). ทฤษฎีและเทคนิคการปรับพฤติกรรม (พิมพ์ครั้งที่ 2). กรุงเทพมหานคร: โรงพิมพ์จุฬาลงกรณ์มหาวิทยาลัย.
- สุกมา แสงเดือนฉาย. (2542). (Sukuma Saengduenchai, B.E. 2542). ประสิทธิผลของการสร้างพลังเพื่อป้องกันการติดยาของผู้เสพ แอมเฟตามีนที่เข้ารับการรักษาในโรงพยาบาลรัฐ. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต (สาธารณสุขศาสตร์), สาขาวิชาเอกพยาบาลสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- สำนักงานคณะกรรมการป้องกันและปราบปรามยาเสพติด. (2540-2543). (ONCB, B.E. 2540-2543). ข้อมูลผู้เข้ารับการรักษา ปีปฏิทิน 2540 ประเทศไทย. กรุงเทพฯ: สำนักงานคณะกรรมการป้องกันและปราบปรามยาเสพติด. อัดสำเนา.
- สำเนา มากแบน. (2542). (Sumnao Makban, B.E. 2542). ความสัมพันธ์ระหว่างปัจจัยด้านครอบครัวและการปฏิบัติของครอบครัวกับลักษณะการเสพยาบ้าของวัยรุ่นที่เข้ารับการรักษาในแผนกผู้ป่วยนอกโรงพยาบาลรัฐ. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการบริหารการพยาบาล บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.
- อุมาพร ตรังคสมบัติ. (2542). (Umaporn Trangkasombat, B.E. 2542). จิตบำบัดและการให้คำปรึกษาครอบครัว (พิมพ์ครั้งที่ 3). กรุงเทพมหานคร: ชันดำการพิมพ์.
- อิชยา สุวรรณกุล และ นงนุช เซาว์นศิลป์ (2542). (Ichaya Suwanakul and Nongnutch Chowsilpa, B.E. 2542). พฤติกรรมการดูแลผู้ป่วยตามการรับรู้ของพยาบาลและผู้ให้บริการ. ระยอง: กลุ่มงานการพยาบาล, โรงพยาบาลระยอง.



แบบสอบถามเลขที่ CBQ.....

**แบบสอบถามพฤติกรรมเอื้ออาทร  
(Caring Behaviors Questionnaire)**

**ส่วนที่ 1 ข้อมูลส่วนบุคคล**

**คำชี้แจง** โปรดทำเครื่องหมายถูก (✓) หรือเติมคำลงในช่องว่าง ซึ่งเป็นข้อมูลที่ตรงกับความเป็นจริงของตัวเอง

1. อายุ.....ปี (นับอายุปีเต็ม)

2. เพศ

ชาย

หญิง

3. ระดับการศึกษา (ระบุวุฒิทางการศึกษาสูงสุด)

ชั้นประถมศึกษาปีที่.....

ชั้นมัธยมศึกษาปีที่..... (หรือเทียบเท่า)

ตั้งแต่ระดับอนุปริญญาขึ้นไป

4. อาชีพหลัก

รับจ้าง

เกษตรกร

ค้าขาย

รับราชการ/รัฐวิสาหกิจ

5. ความสัมพันธ์กับผู้ติดสารเสพติด

บิดา

มารดา

ญาติ โปรดระบุ.....

## ส่วนที่ 2 แบบสอบถามพฤติกรรมเอื้ออาทร

ขอให้ท่านอ่านข้อความในแบบสอบถามฉบับนี้แล้วพิจารณาว่า ในรอบ 1 เดือนที่ผ่านมา ท่านได้ปฏิบัติในแต่ละข้อความนี้มากน้อยเพียงใด โปรดตอบโดยการทำเครื่องหมายถูก (✓) ลงในช่องการปฏิบัติของข้อความนั้นๆ ตามความหมายต่อไปนี้

ไม่เคย	หมายถึง ท่านไม่ได้ปฏิบัติเลย
เล็กน้อย	หมายถึง ท่านปฏิบัติเพียงบางครั้ง
ค่อนข้างมาก	หมายถึง ท่านปฏิบัติบ่อยครั้ง
มากที่สุด	หมายถึง ท่านปฏิบัติเป็นประจำ

### ตัวอย่าง

ในรอบ 1 เดือนที่ผ่านมา ถ้าท่านได้พูดคุยกับบุตรหลานของท่านด้วยน้ำเสียงที่นุ่มนวล อ่อนโยน และแสดงสีหน้ากิริยาท่าทางที่ยิ้มแย้มแจ่มใส เพียงบางครั้ง ให้เลือกตอบโดยการทำเครื่องหมายถูก (✓) ลงในช่อง เล็กน้อย ดังตัวอย่างในตารางด้านล่างนี้

ข้อที่	ข้อความ	การปฏิบัติ			
		ไม่เคย	เล็กน้อย	ค่อนข้างมาก	มากที่สุด
1	ท่านพูดคุยกับบุตรหลานของท่านด้วยน้ำเสียงที่นุ่มนวล อ่อนโยน และแสดงสีหน้ากิริยาท่าทางที่ยิ้มแย้มแจ่มใส		✓		

(ข้อความมีทั้งหมด 36 ข้อ โปรดตอบให้ครบทุกข้อ)

ข้อที่	ข้อความ	การปฏิบัติ			
		ไม่เคย	เล็กน้อย	ค่อนข้างมาก	มากที่สุด
1	ท่านใช้คำพูดที่มีน้ำเสียงนุ่มนวล อ่อนโยน และแสดงสีหน้ากิริยาท่าทางที่ยิ้มแย้มแจ่มใสกับบุตรหลาน				
2	ท่านแสดงความห่วงใยบุตรหลาน โดยให้เวลาในการพูดคุยและช่วยเหลือในเรื่องต่างๆ				
3	ท่านบอกให้บุตรหลานทราบถึงความรักที่มีต่อตัวเขา				
	.....				
	.....				
	.....				
34	ท่านช่วยให้บุตรหลานได้มีความเข้าใจในปรากฏการณ์ต่างๆ ของชีวิต ซึ่งเขาอาจจะต้องเผชิญทั้งกับความเครียด ความกลัว และความวิตกกังวล				
35	ท่านช่วยให้บุตรหลานมีความเข้าใจถึงธรรมชาติของชีวิต				
36	ท่านช่วยให้บุตรหลานมีความเข้าใจในตนเอง เข้มแข็งอดทน และเชื่อมั่นว่าอุปสรรคต่างๆ จะพ่ายแพ้แก่ความพยายามและผ่านพ้นไปได้ด้วยดีในที่สุด				

แบบสอบถามเลขที่ CNPQ.....

**แบบสอบถามความต้องการความเอื้ออาทร  
และการรับรู้พฤติกรรมเอื้ออาทร  
(Caring Needs and Caring Perceptions Questionnaire)**

**ส่วนที่ 1 ข้อมูลส่วนบุคคล**

**คำชี้แจง** โปรดทำเครื่องหมายถูก ( ✓ ) หรือเติมค่าลงในช่องว่าง ซึ่งเป็นข้อมูลที่ตรงกับความเป็นจริงของตัวเอง

1. อายุ.....ปี (นับอายุปีเต็ม)
2. เพศ
  - ชาย
  - หญิง
3. ระดับการศึกษา (ระบุวุฒิการศึกษาสูงสุด)
  - ชั้นประถมศึกษาปีที่.....
  - ชั้นมัธยมศึกษาปีที่..... (หรือเทียบเท่า)
  - ตั้งแต่ระดับอนุปริญญาขึ้นไป
4. ระยะเวลาการใช้สารเสพติด.....ปี.....เดือน
5. เข้ารับการบำบัดรักษาครั้งที่.....(นับรวมการเข้ารับการบำบัดรักษาครั้งนี้ด้วย)
6. ผู้ที่มีบทบาทมากที่สุดในการดูแลท่านที่บ้าน
  - บิดา
  - มารดา
  - ญาติ โปรรระบุ.....

**ส่วนที่ 2 ความต้องการความเอื้ออาทรและการรับรู้พฤติกรรมเอื้ออาทร**

ขอให้ท่านอ่านข้อความในแบบสอบถามฉบับนี้ ซึ่งมีทั้งหมด 36 ข้อ แล้วพิจารณาว่าใน รอบ 1 เดือนที่ผ่านมา ท่านต้องการและได้รับการปฏิบัติในแต่ละข้อความนี้มากน้อยเพียงใด โปรด ตอบโดยการทำเครื่องหมายถูก (✓) ลงในช่องของความต้องการและการได้รับการปฏิบัติด้วย ข้อความนั้นๆ ตามความหมายต่อไปนี้

**ระดับความต้องการพฤติกรรมเอื้ออาทร**

- ไม่ต้องการ** หมายถึง ท่านไม่ต้องการการดูแลด้วยพฤติกรรมนั้นเลย
- เล็กน้อย** หมายถึง ท่านต้องการการดูแลด้วยพฤติกรรมนั้นเพียงบางครั้ง
- ค่อนข้างมาก** หมายถึง ท่านต้องการการดูแลด้วยพฤติกรรมนั้นบ่อยครั้ง
- มากที่สุด** หมายถึง ท่านต้องการการดูแลด้วยพฤติกรรมนั้นเป็นประจำ

**ระดับการรับรู้พฤติกรรมเอื้ออาทร**

- ไม่ได้รับ** หมายถึง ท่านไม่ได้รับการดูแลด้วยพฤติกรรมนั้นเลย
- เล็กน้อย** หมายถึง ท่านได้รับการดูแลด้วยพฤติกรรมนั้นเพียงบางครั้ง
- ค่อนข้างมาก** หมายถึง ท่านได้รับการดูแลด้วยพฤติกรรมนั้นบ่อยครั้ง
- มากที่สุด** หมายถึง ท่านได้รับการดูแลด้วยพฤติกรรมนั้นเป็นประจำ

**ตัวอย่าง**

ในรอบ 1 เดือนที่ผ่านมา ถ้าท่าน **ต้องการ** ให้ผู้ปกครองพูดคุยกับท่านด้วยน้ำเสียงที่นุ่มนวล อ่อนโยน และแสดงสีหน้ากิริยาท่าทางที่ยิ้มแย้มแจ่มใส **เป็นประจำ** แต่ท่าน **ได้รับเพียงบางครั้ง** ให้เลือกตอบโดยการทำเครื่องหมายถูก (✓) ลงในช่อง ดังตัวอย่างในตารางด้านล่างนี้

ข้อที่	ข้อความ	ความต้องการการดูแล				การได้รับการดูแล			
		ไม่ต้องการ	เล็กน้อย	ค่อนข้างมาก	มากที่สุด	ไม่ได้รับ	เล็กน้อย	ค่อนข้างมาก	มากที่สุด
1	ผู้ปกครองพูดคุยกับท่านด้วยน้ำเสียงที่นุ่มนวล อ่อนโยน และแสดงสีหน้ากิริยาท่าทางที่ยิ้มแย้มแจ่มใส				✓		✓		

(ข้อความมีทั้งหมด 36 ข้อ โปรดตอบให้ครบทุกข้อ)

ข้อที่	ข้อความ	ความต้องการการดูแล				การได้รับการดูแล			
		ไม่ต้องการ	เล็กน้อย	ค่อนข้างมาก	มากที่สุด	ไม่ได้รับ	เล็กน้อย	ค่อนข้างมาก	มากที่สุด
1	ผู้ปกครองใช้คำพูดที่มีน้ำเสียงนุ่มนวล อ่อนโยน และแสดงสีหน้ากิริยาท่าทางที่ยิ้มแย้มแจ่มใสกับท่าน								
2	ผู้ปกครองแสดงความห่วงใยท่าน โดยให้เวลาในการพูดคุยและช่วยเหลือในเรื่องต่างๆ								
3	ผู้ปกครองบอกให้ทราบถึงความรักที่เขา มีต่อท่าน								
	.....								
	.....								
	.....								
34	ผู้ปกครองช่วยให้ท่านได้มีความเข้าใจในปรากฏการณ์ต่างๆ ของชีวิต ซึ่งท่านอาจจะต้องเผชิญทั้งกับความเครียด ความกลัว และความวิตกกังวล								
35	ผู้ปกครองช่วยให้ท่านมีความเข้าใจถึงธรรมชาติของชีวิต								
36	ผู้ปกครองช่วยให้ท่านมีความเข้าใจในตนเอง เข้มแข็งอดทน และเชื่อมั่นว่าอุปสรรคต่างๆ จะพ่ายแพ้แก่ความพยายามและผ่านพ้นไปได้ด้วยดีในที่สุด								



**Table 28** The modification of questionnaires in this study

Item number of these study questionnaires	Item number of the original questionnaires	
	Parichat Wanwaisart (2000)	Jiraporn Chatsupakul (2001)
1	1	-
2	2	3
3	4	-
4	-	9, 10
5	-	7
6	5, 6, 8	-
7	3	6
8	9	1
9	10	1
10	11	1, 26
11	Literature review and clinical practice of the researcher	
12	12, 13	11
13	Literature review and clinical practice of the researcher	
14	-	30
15	Literature review and clinical practice of the researcher	
16	-	2, 29
17	17	-
18	16	-
19	18, 20, 21	-
20	7, 19	24
21	Literature review and clinical practice of the researcher	

**Table 28** The modification of questionnaires in this study (continued)

Item number of these study questionnaires	Item number of the original questionnaires	
	Parichat Wanwaisart (2000)	Jiraporn Chatsupakul (2001)
22	22, 23	17, 18, 21, 23, 25, 28, 31
23	-	22
24	Literature review and clinical practice of the researcher	
25	-	27
26	24	-
27	14, 15, 25	32
28	-	4, 5, 8
29	26	-
30	27	12, 33
31	28	-
32	Literature review and clinical practice of the researcher	
33	29	-
34	30	-
35	32	-
36	31	-



## List of Experts

### 1. ผู้ช่วยศาสตราจารย์ ดร. กรรณิการ์ สุวรรณโคต

วุฒิการศึกษา	:	ครุศาสตรดุษฎีบัณฑิต
สถานที่ปฏิบัติงาน	:	ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามธิบดี มหาวิทยาลัยมหิดล
ความเชี่ยวชาญ	:	Psychosocial nursing

### 2. ผู้ช่วยศาสตราจารย์ ดร. ทศนีย์ นนทะสร

วุฒิการศึกษา	:	ครุศาสตรดุษฎีบัณฑิต
สถานที่ปฏิบัติงาน	:	ภาควิชาการพยาบาลสาธารณสุข คณะสาธารณสุขศาสตร์ มหาวิทยาลัยมหิดล
ความเชี่ยวชาญ	:	Caring behaviors

### 3. รองศาสตราจารย์ ดร. ภัทรอำไพ พิพัฒนานนท์

วุฒิการศึกษา	:	พยาบาลศาสตรดุษฎีบัณฑิต
สถานที่ปฏิบัติงาน	:	ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามธิบดี มหาวิทยาลัยมหิดล
ความเชี่ยวชาญ	:	Psychiatric and mental health nursing

### 4. รองศาสตราจารย์ ดร. ยูพาพิน สิริโพธิ์งาม

วุฒิการศึกษา	:	Doctor of science in nursing
สถานที่ปฏิบัติงาน	:	ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามธิบดี มหาวิทยาลัยมหิดล
ความเชี่ยวชาญ	:	Family caregiver of elderly

### 5. อาจารย์ ดร. ทศนีย์ ทองประทีป

วุฒิการศึกษา	:	Doctor of science in nursing
สถานที่ปฏิบัติงาน	:	ภาควิชาการพยาบาลอายุรศาสตร์ – ศัลยศาสตร์ วิทยาลัยพยาบาลเกื้อการุณย์ กรุงเทพมหานคร
ความเชี่ยวชาญ	:	Spiritual Care

### List of Experts (Continued)

#### 6. นายแพทย์ ธนา ประมุขกุล

วุฒิการศึกษา	:	แพทยศาสตรบัณฑิต
สถานที่ปฏิบัติงาน	:	รองผู้อำนวยการฝ่ายการแพทย์ ศูนย์บำบัดรักษายาเสพติด จังหวัดขอนแก่น
ความเชี่ยวชาญ	:	Substance abuse physician

#### 7. นางสุรัชฎทิพ นาสมนีน

วุฒิการศึกษา	:	พยาบาลศาสตรมหาบัณฑิต
สถานที่ปฏิบัติงาน	:	ศูนย์บำบัดรักษายาเสพติด จังหวัดขอนแก่น
ความเชี่ยวชาญ	:	Substance abuse nurse



## Research Consent Form for Addicted Adolescents

(แบบพิทักษ์สิทธิของผู้เข้าร่วมการวิจัยสำหรับวัยรุ่นที่ติดสารเสพติด)

.....

ข้าพเจ้า นายชูชาติ ศิริมรัมย์ เป็นอาจารย์ประจำกลุ่มวิชาการพยาบาลชุมชนและสุขภาพจิต คณะพยาบาลศาสตร์ มหาวิทยาลัยมหาสารคาม ขณะนี้ลาศึกษาต่อในระดับปริญญาโท สาขาการพยาบาลจิตเวชและสุขภาพจิต ที่ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล และกำลังศึกษาเรื่อง พฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว ความต้องการความเอื้ออาทรและการรับรู้พฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติด

ข้าพเจ้าใคร่ขอเชิญท่านเป็นผู้ให้ข้อมูลในการศึกษาค้างนี้ ในฐานะที่ท่านเป็นบุคคลหนึ่งที่อยู่ในกลุ่มที่ข้าพเจ้าสนใจจะศึกษา และท่านจะเป็นบุคคลหนึ่งในจำนวน 263 คน ที่ได้รับเชิญเข้าร่วมในการศึกษาค้างนี้

ถ้าท่านยินดีที่จะให้ข้อมูล ข้าพเจ้าขอความกรุณาให้ท่านตอบแบบสอบถามจำนวน 1 ชุด ซึ่งประกอบด้วย 2 ส่วน คือ 1) ข้อมูลส่วนบุคคลเกี่ยวกับตัวท่าน 2) แบบสอบถามความต้องการความเอื้ออาทรและการรับรู้พฤติกรรมเอื้ออาทรที่ญาติผู้ดูแลในครอบครัวปฏิบัติต่อท่านในขณะที่อยู่ที่บ้านในรอบ 1 เดือนที่ผ่านมา โดยจะใช้เวลาตอบทั้งหมดประมาณ 30 นาที ข้อมูลที่ท่านได้ให้จะเป็นประโยชน์ในการจัดระบบในการให้การดูแลท่านในครอบครัว ต่อไป

ข้อมูลทั้งหมดที่ได้จากท่านจะเก็บเป็นความลับ โดยจะรายงานผลการศึกษาในลักษณะของภาพรวมของผู้ให้ข้อมูลทุกท่าน ถ้าท่านมีข้อสงสัยใดๆ ท่านสามารถที่จะสอบถามข้าพเจ้าได้ตลอดเวลา หากท่านรู้สึกไม่สะดวกใจหรือมีข้อขัดข้องใดๆ ท่านสามารถยุติการตอบแบบสอบถามได้ทันที การบอกยุติการตอบแบบสอบถามจะไม่มีผลกระทบใดๆ ต่อตัวท่านทั้งสิ้น

ชูชาติ ศิริมรัมย์

(นักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต มหาวิทยาลัยมหิดล)

.....

### สำหรับผู้ร่วมวิจัย

ข้าพเจ้าทราบรายละเอียดเกี่ยวกับการให้ข้อมูลและสิทธิในการให้ข้อมูลข้างต้นแล้ว มีความเข้าใจและสมัครใจที่จะให้ข้อมูล เพื่อเป็นประโยชน์ต่อการศึกษาครั้งนี้

ลงชื่อ .....

วันที่.....เดือน.....พ.ศ. ....

## Research Consent Form for Family Caregivers

(แบบพิทักษ์สิทธิของผู้เข้าร่วมการวิจัยสำหรับญาติผู้ดูแลในครอบครัว)

.....

ข้าพเจ้า นายชูชาติ ติธรรมรัมย์ เป็นอาจารย์ประจำกลุ่มวิชาการพยาบาลชุมชนและสุขภาพจิต คณะพยาบาลศาสตร์ มหาวิทยาลัยมหาสารคาม ขณะนี้ลาศึกษาต่อในระดับปริญญาโท สาขาการพยาบาลจิตเวชและสุขภาพจิต ที่ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล และกำลังศึกษาเรื่อง พฤติกรรมเอื้ออาทรของญาติผู้ดูแลในครอบครัว ความต้องการความเอื้ออาทรและการรับรู้พฤติกรรมเอื้ออาทรของวัยรุ่นที่ติดสารเสพติด

ข้าพเจ้าใคร่ขอเชิญท่านเป็นผู้ให้ข้อมูลในการศึกษาครั้งนี้ เนื่องจากท่านเป็นญาติผู้ดูแลในครอบครัวที่ได้รับการระบุจากผู้ป่วยว่าเป็นบุคคลที่มีบทบาทสำคัญในการดูแลเขาที่บ้านมากที่สุด และท่านจะเป็นบุคคลหนึ่งในจำนวนญาติของผู้ดูแลในครอบครัว 263 คน ที่ได้รับเชิญเข้าร่วมในการศึกษาครั้งนี้

ถ้าท่านยินดีที่จะให้ข้อมูล ข้าพเจ้าขอความกรุณาให้ท่านตอบแบบสอบถามจำนวน 1 ชุด ซึ่งประกอบด้วย 2 ส่วน คือ 1) ข้อมูลส่วนบุคคลเกี่ยวกับตัวท่าน 2) แบบสอบถามพฤติกรรมเอื้ออาทรที่ท่านปฏิบัติต่อผู้ป่วยที่ติดสารเสพติดขณะอยู่ที่บ้าน ในรอบ 1 เดือนที่ผ่านมา โดยจะใช้เวลาตอบทั้งหมดประมาณ 30 นาที ข้อมูลที่ท่านได้ให้จะเป็นประโยชน์ในการจัดระบบการให้การดูแลในครอบครัวที่สามารถตอบสนองความต้องการของผู้ป่วยที่ติดสารเสพติดได้ ต่อไป

ข้อมูลทั้งหมดที่ได้จากท่านจะเก็บเป็นความลับ โดยจะรายงานผลการศึกษาในลักษณะของภาพรวมของผู้ให้ข้อมูลทุกท่าน ถ้าท่านมีข้อสงสัยใดๆ ท่านสามารถที่จะสอบถามข้าพเจ้าได้ตลอดเวลา หากท่านรู้สึกไม่สะดวกใจหรือมีข้อขัดข้องใดๆ ท่านสามารถยุติการตอบแบบสอบถามได้ทันที การบอกยุติการตอบแบบสอบถามจะไม่มีผลกระทบใดๆ ต่อตัวท่านและผู้ป่วยทั้งสิ้น

ชูชาติ ติธรรมรัมย์

(นักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต มหาวิทยาลัยมหิดล)

.....

### สำหรับผู้ร่วมวิจัย

ข้าพเจ้าทราบรายละเอียดเกี่ยวกับการให้ข้อมูลและสิทธิในการให้ข้อมูลข้างต้นแล้ว มีความเข้าใจและสมัครใจที่จะให้ข้อมูล เพื่อเป็นประโยชน์ต่อการศึกษาครั้งนี้

ลงชื่อ .....

วันที่.....เดือน.....พ.ศ. ....



**Table 29** The frequency (f) and percentage (%) of caring behaviors performed by **occupation** groups of family caregivers (n = 263)

Occupation groups	n	Caring behaviors performed							
		Not at all		A little		Quite a bit		A great deal	
		f	%	f	%	f	%	f	%
Worker	30	23	2.1	115	10.7	292	27.0	650	60.2
Agriculturist	110	107	2.7	505	12.7	1136	28.7	2212	55.9
Merchant	62	75	3.4	375	16.8	862	38.6	920	41.2
Official/state enterprise employee	61	56	2.6	305	13.9	1048	47.7	787	35.8

## BIOGRAPHY

**NAME:** Mr. Choochart Deeromram

**DATE OF BIRTH:** 02 June 1972

**PLACE OF BIRTH:** Buriram, Thailand

**EDUCATION:**

1990-1994	Diploma in Nursing Science Equivalent to Bachelor of Science in Nursing, Second Distinction (Silver Medal) Boromarajonani College of Nursing, Sappasithiprasong Praboromarajchanok Institute, Ministry of Public Health, Thailand
2000-2003	M.N.S. (Psychiatric and Mental Health Nursing) School of Nursing, Ramathibodi Faculty of Medicine, Mahidol University, Bangkok, Thailand

**POSITION:**

1994-1999	Nurse Lecturer Boromarajonani College of Nursing, Sappasithiprasong Praboromarajchanok Institute, Ministry of Public Health, Thailand
1999 - Present	Nurse Lecturer Faculty of Nursing, Maharakham University, Thailand

**ADDRESS:**

Office	Faculty of Nursing, Maharakham University Kantaravichai, Maharakham, Thailand Tel. 0-4375-4357
Home	118/8 Thinanond Rd., Muang, Kalasin 46000 Tel. 0-4382-1960 (Home), 0-1601-4229 (Portable) E-mail: Choochartdmsu@yahoo.com