An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses' perspectives

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Thesis submitted in total fulfilment for the degree of

Doctor of Philosophy (Nursing) of the University of Newcastle,

NSW, Australia

October 2016

Declaration

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository**, subject to the provisions of the Copyright Act 1968.

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(Wilaiwan Pathike)

Acknowledgement

Conducting the PhD project over the past several years has been incredibly enjoyable, rewarding and at times a challenging endeavour. Several people are acknowledged for their support during this journey.

Firstly, my academic supervisors, Professor Anthony Paul O'Brien and Dr Sharyn Hunter are acknowledged for their tireless efforts in guiding my work, but also for helping with my enthusiasm and motivation levels during the more difficult times of the PhD process. Our continuous e-mail correspondence and countless meetings have effectively shaped my progress. For their immeasurable experience, which was always apparent, especially during the times of greatest need, I am truly thankful.

Grateful thanks to all the staff of the University of Newcastle, especially the School of Nursing and Midwifery, Faculty of Health and Medicine, the University Libraries including all of its librarians, the Graduate School, Learning Development, IT-Service, International Office, and Security for their pleasant, effective support throughout my study period.

During the data collection phase, I would like to thank Associate Professor Khanitta Nuntaboot, my study mentor from the Faculty of Nursing, Khon Kaen University, Thailand. Her suggestions were useful and her support kept me heading in the right direction during the data collection phase. I would also like to give special thanks to Roi-Et Provincial Health Office and Srisomdej District Health Office who assisted me during my research study. To the four Tambon

Health Promoting Hospitals, I offer my appreciation. I am thankful to all the participants that gave my study their full concentration in assisting with developing an understanding of the concept of resilience, as well as allowing me to observe them during their everyday lives.

My deepest thanks also go to the English language assistants, Methinee Laoprom and Thanapol Thamnuvat, who translated the Thai transcripts to accurate English, as well as Fran Flavel and Angela Smith who assisting with the editing process throughout my thesis. I appreciate their hard work and patience at the various stages throughout the completion of this research manuscript.

As I am an international student staying 4,677 miles away from home, I would like to give my sincere thanks to Dr Christian Brooks and his family, (Jeffrey, Carol, Mil, Nana-B, also the Brooks and Young family siblings) for their warmth and physical and emotional support. I also extend my thanks to the Match family (Michael, Nattakarn, George, and little Henry) for their very kind support. These families have given me a sense of belonging whilst I have been living in Australia. They helped me to feel secure and enabled me to learn and experience the Aussie culture.

Thanks also to my PhD friends for their encouragement, support, and inspiration and for sharing enjoyable times together. Thanks especially to Pe Napa, Pe Im, Pe Dit, Pe Nok and Pe Kack who were Thai students, Gary and Joanne who were domestic students, as well as the school's lecturers, and the school officers.

Importantly, I offer my sincere gratitude and appreciation to my dear parents and family who gave me strong support. My parents: my father, Veera and my mother

– Poungprai who are my central love supports. They gave me passion, inspiration, energy, tolerance, good will and pushed me to complete. I also extend my appreciation to my younger brother Nantawat who signed the documentation for being my guarantor, allowing me to come and complete my degree in Australia. As well as my other family members: my three aunties, Pa Young, Pa Pung and Pa Joy who nursed me and have taken care of me since birth. My thankfulness goes to all my kinship families: Pathike and Ponchana.

Financially, a PhD can be demanding, and I would not have been able to undertake such a project had it not been for the financial support of the University of Newcastle, School of Nursing and Midwifery, Faculty of Health and Medicine, Australia and the Srinakharinwirot University, Thailand, who authorised this support on behalf of the Thai government.

Abstract

This ethnographic doctoral research study documents and clarifies the concept of resilience among Thailand (Thai) provincial elderly. The significance of this research is highlighted by the increasing global and Thai ageing population, with a concurrent decrease in the traditional family support of older persons in provincial areas. The Thai elderly who live in rural provinces are naturally affected by challenges in their lives, which is further compounded by chronic disease and geographic isolation. Resilience however, is poorly understood in the context of the rural Thai elderly existence, particularly so in relation to the contribution of the primary health care agencies and community nurses' roles.

This study describes the concept of older people's resilience in the rural Thai community together with the perspectives obtained from their community nurses. The ethnography involved fieldwork, semi-structured interviews, and non-participant observation in four Tambon Health Promoting Hospitals (THPHs) and local villages. The study participants included 35 elderly rural Thai people who were willing to be interviewed and 7 community nurses, of which two were interviewed twice. In total, 44 semi-structured interviews and 340 hours of non-participant observation were conducted. A comprehensive qualitative thematic analysis using Nvivo10 was conducted to analyse the data collected.

The key thematic findings from the older persons included 'living well every day, 'adversity and rural Thai older people', and 'elderly resilience. In terms of the community nurses' perspectives, resilience consisted of three subthemes:

‘resilience-what is it?’, ‘overcoming adversity’, and ‘everyday nursing experience - resilience in rural Thai elders.

The thematic findings of this study clarify, interpret, and deepen the understanding of the concept of resilience among rural Thai elderly and their community nurses. Understanding and providing care to support elderly resilience can lead to better health outcomes and health prevention strategies being developed in rural Thai aged care. Resilience planning could also contribute to the promotion of healthy interventions to improve primary health care that is supportive of rural Thai elderly in their communities. This study is also considered a valuable source of information for Thailand community nurses to use in the consideration of health promotion interventions to sustain and support healthy ageing for the rural Thai elderly population.

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Research sites Map

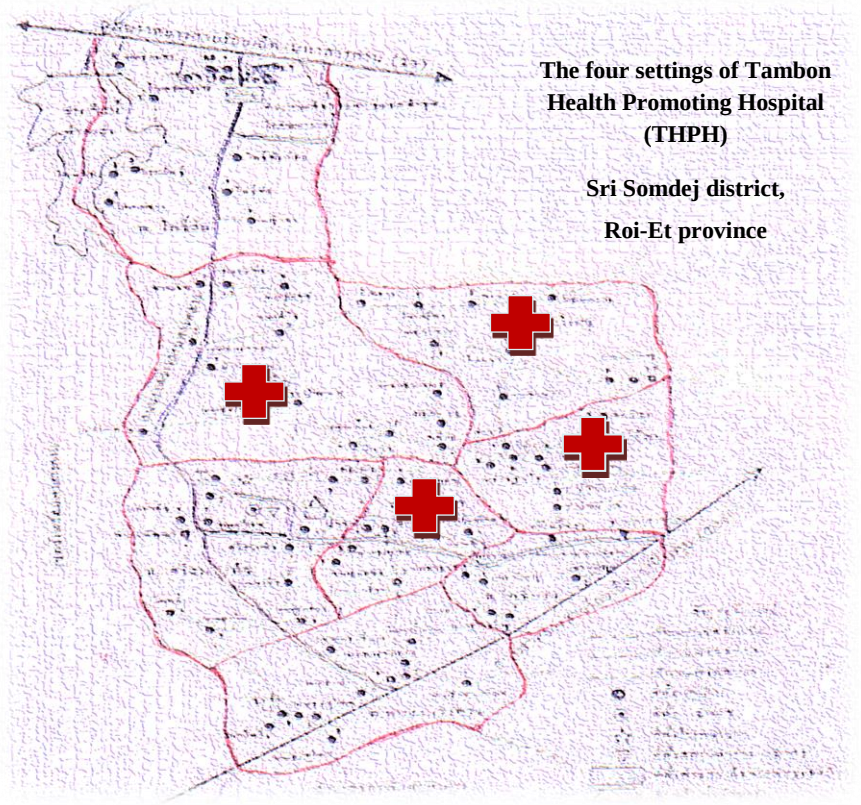
Figure 1: Research site map – provincial

Roi-Et province;

Roi-Et province is in the Northeast part of Thailand. The province is subdivided into 20 districts (*Amphoe*). The districts are further subdivided into 193 subdistricts (*Tambon*) and 2,311 villages (*Muban*).

Sources: www.websanom.com and http://en.wikipedia.org/wiki/Roi_Et_Province, retrieved August 19, 2013

Figure 2: Primary care centres (THPHs)



Glossary of terms and abbreviations used in the thesis

BNS	Bachelor of Nursing Science
BPH	Benign Prostatic Hyperplasia
CA	Cancer
CRF	Chronic Renal Failure
DM	Diabetes Mellitus
DMH	The Department of National Mental Health
HT	Hypertension
NSO	National Statistical Office
QoL	Quality of Life
PCU	Primary Care Unit
NP	Nurse Practitioner
RN	Registered Nurse
RS	Resilience Scale
TGRI	The Foundation of Thai Gerontology Research and Development Institute
THPH	Tambon Health Promoting Hospital
TNMC	Thai Nursing and Midwifery Council
WHO	World Health Organisation

Ar-Sor-Mor อสม. (อาสาสมัครสาธารณสุขประจำหมู่บ้าน): village health volunteer

Barb บาป: sin

Boon บุญ: the feelings of happiness, relaxation, and comfort attained through Buddhist practices such as donating goods or food to monks, joining-in Buddhist celebrations, listening to a monk's sermon, and avoiding sin.

Boonwassana บุญวาสนา: fortune, luck or fate to keep them well

Jai-Yai ใจใหญ่: having a big heart

Jai-Noi ใจน้อย: having a small heart

Jai-Khaeng ใจแข็ง: having a solid heart

Jeb เจ็บ: feeling of hurt, sore, ache or pain

Karm กรรม: negative results of what the person had been done

Kwam-Sa-Mard-Nai- Kan-Yurn-Yud-Pa-Chern-Wi-Grit ความสามารถในการยืนหยัดเผชิญวิกฤติ: the ability to exist despite crisis

Ktạyy̰ū ktwethī กตัญญูกตเวที: parent repayment or gratitude

Klong Yaaw กลองยาว: the local music band that mainly uses tall narrow drums combine other types of local percussion such as wooden clappers and cymbals

Lūksāw ลูกสาว: female children

LuukLaan ลูกหลาน: younger people who has age around the elderly's child and it is mainly means to younger people who has blood related: adult children and grandchildren.

LuukTaaw ลูกเต้า: adult children

Moaw หมอ: the term that the people within the study field works call the group of health care providers, including physicians, nurses, pharmacists, dentists, physiotherapists, public health staffs and so on

Mor-Lum หมอลำ: a local show with dancing and comedy performance

Ouuk-Ouung อุกอั่ง, **Ouuk-Ouung-Oout** อุกอั่งเอ้า, **Ouuk-Ouung-Oout-Jai** อุกอั่งเอ้าใจ :feelings that related to experiencing difficulty

Pa-Lung-Su-Kha-Pab-Jid พลังสุขภาพจิต: power of mental health

Poo-Suung-Ar-U ผู้สูงอายุ, **Poo-Tow** ผู้เฒ่า, **Kon-Kaa** คนแก่, **Kon-Cha-ra** คนชรา : Thai older people

Pood ปวด: pain

Plong ปลง: the feeling of fully accepting whatever happen and not thinking about it anymore

Por Yuu Por Kin พออยู่พอกิน: feeling enough and adequate portion or quantity that provides satisfactory living

Pra Bhud-Pra Tham- Pra Soong พระพุทธ พระธรรม พระสงฆ์: the three main parts of Buddhist religion that are Buddha, Dharma or a Buddhist's teaching, and monks.

Sa-Tuu สาธุ: the saying represents calling for god to be blessing or saying it for perceived *Boon.*

Sarm waan dee- See' waan kai สามวันดี สี่วันไข้: not having a good health

Tambon ตำบล: sub-district

Taam-Jai ทำใจ: being stoic and preparing one's mind for possible misfortune

Thảmboon ทำบุญ: making merit

Took-Bor-Wa-Dee Mee-Jung-Wa-Pe-Nong ทุกข์บ่ว่าดี มีจั่งว่าพี่น้อง :represents the person who has enough money and was able to help other people which will gain them respect and a good relationship with the other person.

Sùk สุข: happy

Túk ทุกข์: unhappy

Wad วัด: temples

Waan Seenn วันศีล: described by participants as a Buddhist holy day that depends on the moon. Waan Seenn generally occurs together with Waan Pra-วันพระ, which is a Buddhist Sabbath: normally 4 days a month in half- full, half- dark, full and dark moon days.

Wong Wian Cheewit วงเวียนชีวิต: a TV program shows real stories (at the real place and real person) and reflects on undesirable life in Thai society, for example, a dying older person who had no job, no money, and no one taking care of them.

Wai ไหว้: Thai greeting with putting two hands together

Wassana วาสนา: fortune, luck, or fate to keep people well

Yuu Dee Mee Haang อยู่ดีมีแฮง: living healthy

Chapter One

Introduction and background

Introduction

Globally, in 2015 there were 901 million people age 60 and over, with this figure 48 percent higher than in the year 2000, fifteen years previous. The number of older people is further predicted to grow by another 56 percent in 2030, which will see the global ageing population rise to 1.4 billion and more than doubling by 2050 (2.1 billion people) (United Nations, 2015). At least half of the global elderly population will live in less developed Asian countries (United Nations, 2012, 2015).

Thailand's rate of elderly population growth has accelerated from 1.2 million people in 1960 to 8.5 million people in 2011 (Foundation of Thai Gerontology Research and Development Institute (TGRI), 2011); and in 2014 it was 10 million people. These figures represent 14.9 percent of the total Thai population (National Statistical Office (NSO), 2014) with the majority of Thai elderly living in the rural provinces.

More recently, the unique cultural experience of the provincial rural Thai community, where family members traditionally cared for elderly people has changed (Knodel, Kepichayawattana, Saengtienchai & Wiwatwanich, 2010; Knodel & Saengtienchai, 2007). Young people are now moving away from the family home to find work in Bangkok and the other larger metropolitan centres.

Subsequently, the decline of traditional family support and the diminishing interaction time with adult children has given rise to health vulnerabilities for the older person (Knodel, 2012; Knodel & Chayovan, 2008a). Rural elderly have been found to have a lower quality of life (QoL) in terms of physical, psychological, and social well-being than their suburban elderly counterparts (Apideckul, 2011; Suttajit et al., 2010).

Thai community Registered Nurses (RNs) are the main health professionals to actively support and promote elderly wellbeing. They provide comprehensive health care services, including mental health for older persons. The concept of resilience has been identified as something that has a role in protecting against negative outcomes, such as the impact of depression, helplessness, anxiety and fear, as well as reducing the effects of physical ill-health (Wangnild, 2010). When a person has resilience it is claimed that they are able to focus on the positive aspects of life and have the ability to bounce back from adversity (Resnick, Gwyther, & Roberto, 2011).

Resilience is poorly understood in the context of rural Thai elderly's existence and particularly in relation to the community nurses' scope of practice. There have been no previous studies exploring rural Thai elderly resilience, or the community nurses' perspectives of elderly resilience. This study provides an understanding of the concept of resilience among the Thai rural elderly and from the perspective of their community nurses.

Background of the study

Thai elderly

Globally, older persons or elderly people are usually designated as being over 60 or 65 years of age (WHO, 2016). In Thailand the word elderly is used to describe people over the age of 60 years (*พระราชบัญญัติผู้สูงอายุ พ.ศ. ๒๕๔๖* (Jitapunkul & Wivatvanit, 2008). The Thai language description of an elderly person is Poo-Suung-Ar-U (ผู้สูงอายุ) and or Poo-Tow (ผู้เฒ่า), Kon-Kaa (คนแก่), or Kon-Cha-ra (คนชรา) which in English means older person.

Thailand

Thailand is known as a developing country and is located in the middle of South East Asia. Thailand borders Laos, Cambodia, Burma and Malaysia, and covers a total geographical area of 514,000 square kilometres (Ministry of Public Health, 2010). There are four geographical regions:

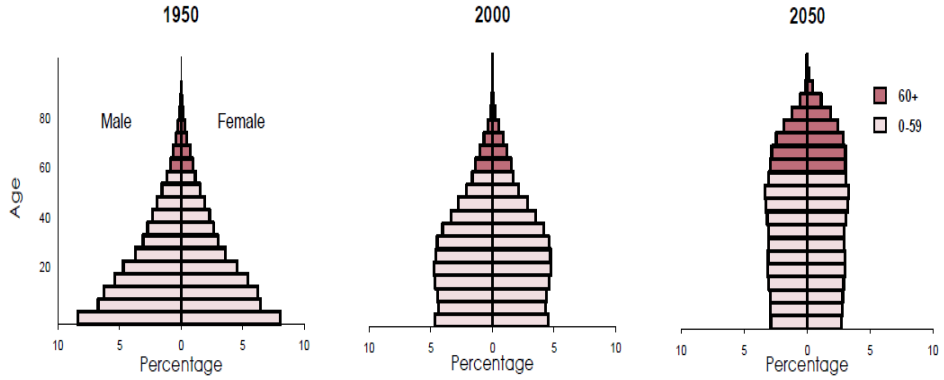
- Northern region (Nure: เหนือ):
- Northeast region (Isan: อีสาน):
- Central region (Klāng: กลาง):
- Southern region (Tie: ใต้).

The Northeast region has the greatest population, followed by Central, and the Northern and Southern regions. The majority of the population are Thai and are of the Buddhist religion (Ministry of Public Health, 2010). The Thai population is approximately 68 million people (WHO, 2015a). The pyramid of the Thai population has changed from a previously younger to an older demographic

shape, which has meant the top of the pyramid has now become wider in the last decade.

Figure 3: The pyramid of Thai population ageing

(Source:http://www.un.org/esa/population/publications/worldageing19502050/pdf/195thail.pdf.)



The Foundation of Thai Gerontology Research and Development Institute (2011) indicates the rate of increase in the elderly Thai population to be 3 percent per year while the whole population increases at only 0.7 percent a year. The population of older Thai people has increased seven times from approximately 1.2 million in 1960, to 8.6 million in 2015 (Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015). It is expected to reach almost 30 percent of the total population in 2050 (Humphreys, 2012).

The change in life expectancy at birth from 67.7 years, to 70.6 years for men, and 72.4 years to 77.7 years for women over the last two decades (1991 to 2011) has contributed to the changing shape of the pyramid. The life expectancy of Thai people is anticipated to be 72.8 years for males and 79.4 years for females by 2021 (TGRI, 2011).

Currently, the number of Thai elderly people nationally, represents around 14.9 percent (45.1 percent are male, and 54.9 percent are female) of the total population and more than half of this older group (59 percent) live in non-municipal areas (NSO, 2014) which are commonly known as provincial regions.

Thai culture and family configuration

For Thai society, a distinctive traditional hierarchy is a fundamental characteristic of the culture. Every person has grown up with the expectation of showing respect to older people and for those people who have a perceived higher status in society, including parents, grandparents, teachers and monks. The responsibility of children to take care of their parents is symbolic of this expectation and this is very important in Thailand. The process of generational respect and support is coined a 'parent repayment' or *ktạyyū:* กตัญญู (Choowattanapakorn, 1999).

Culturally, children are expected not to leave their parents alone: good children are expected to take care of their older parents (Choowattanapakorn, 1999). Co-residence with one or more adult children, in particular the youngest daughter, is a normal and traditional living arrangement. This is a central family resource to provide care for older parents when they no longer have the ability to care for themselves (Knodel, Saengtienchai, & Sittitrai, 1995).

Since the 1990's however, the Thai traditional family has been changing (Choowattanapakorn, 1999) with the average family size in Thailand now smaller, from 3.8 persons per household in 2000 to 3.1 persons in 2010 (NSO, 2010, p. 5). Older people living with children fell from 77 percent in 1986, to 57 percent in 2011, while adult children's migration to the cities increased from 28 percent in

1995, to 39 percent in 2011 (Knodel, Prachuabmoh, & Chayovan, 2013). Female children (*Lūksāw:* ลูกสาว), who have been traditionally the future caregivers of the older generations, are now taking part in employment outside the extended family home (Choowattanapakorn, 1999).

Migration from rural to urban areas has changed the demographic face of rural settings. Adult children's migration to cities has increased the risk of elders living arrangements going from co-residence to living alone without support (Qin, Punpuing, & Guest, 2008). The percentage of older persons living alone rose from 3.6 percent in 1994, to 8.6 percent in 2011 (Teerawichitchainan, Knodel, & Pothisiri, 2015) and it is higher in rural areas compared to urban areas (Knodel, Prachuabmoh, et al., 2013).

Additionally, living in skipped generation households has become the norm in rural Thailand (Chuanwan & Sakulsri, n.d.) with almost one third of the rural Thai elderly caring for grandchildren under 16 years of age (Knodel & Chayovan, 2011). Consequently, older rural people are experiencing less personal support (Sirilak, 2009), less opportunity for face-to-face interaction with family (Knodel & Saengtienchai, 2007), they have limited periods of care provided by their biological children (Knodel, et al., 2010), and they are vulnerable to an increasing risk of getting no help when they need it (Knodel, 2012).

Quality of life and the impact of culture and family configuration

Quality of life (QoL) for the rural elderly means to be free from disease, have no stress and have the ability to travel, work and carry on with their everyday lives (Somrongthong et al., 2013, p. 320). In another study, high QoL comprised the

following factors: feelings of comfort that are derived from living with family members, having their own residence, good financial status, and being mentally and physically healthy (Urairat, Choangsakul, & Panthusena, 2014).

A change in living arrangements has been noted to have an impact on the health of rural Thai older people. A national survey of self-assessed health reported that more than half of rural older people had poor health (Haseen, Adhikari, & Soonthorndhada, 2010). Functional status, chronic disease and psychological symptoms (including stress, unhappiness, moodiness, hopelessness, uselessness, lack of appetite and loneliness) were cited as the strongest determinants of poorly self-assessed health (Haseen et al., 2010).

Depression in older people is known to be an important public health problem in low and middle income countries (WHO, 2010a). One study showed the prevalence of depression among rural Thai older people age over 60 years was 27.5 percent (Haseen & Prasartkul, 2011). This study indicated disability, infirmity, and serious life events to be significantly associated with depression in the elderly. Furthermore, an older person who had three or more serious life events (consisting of illness, lack of contact with children, financial problem, accommodation, health problem of family a member(s) and care giver burden) had 5.25 times more chance of having depression than those people who had no serious life event (Haseen & Prasartkul, 2011). Therefore, the shift in the configuration of traditional Thai family has contributed to an increased risk of deteriorating health for rural Thai elderly particularly when faced with adverse circumstances.

Health care services

Health care systems in Thailand are being challenged by the growing ageing population, pandemics of chronic disease, new emerging diseases, and the impact of climate change. Of considerable concern around the globe is the cost of health care and its unavailability to many people, especially the poor (WHO, 2008). Thailand's healthcare service is divided into three levels - primary, secondary and tertiary healthcare (Hanucharurnkul, 2007), and older people are known to predominantly access provincial (rural) health services in the Tambon (sub-district) primary healthcare centres (Apidechkul, 2012; Somrongthong et al., 2013). In Thailand, this is called a *Tambon Health Promoting Hospital* (THPH). THPH's are usually small provincial health and treatment facilities that have a community approach.

The THPH is an important health promoting centre and facilitates access for all Thai to health care (Prakongsai, Srivanichakorn, & Yana, 2009; WHO, 2008). This primary health care service however has been found to focus on physical curative care and not psychological and social support (Kitreerawutiwong, Kuruchittham, Somrongthong, & Pongsupap, 2010). There has also been a lack of mental health specialists and no specific mental health practice guideline provided to the nurses or other health care providers who work in the THPH (Meebunmak, 2009).

Resilience

The concept of resilience in health science was originally developed from a longitudinal study of the stories of adults who had experienced a traumatic

childhood development but despite their upbringing were competent and caring as adults (Werner, 1993). From this perspective, resilience is described as a protective factor enabling people to ‘bounce back’ despite adversity (Dyer & McGuinness, 1996; Jacelon, 1997; Windle, 2011). The term ‘adversity’ is a distinctive aspect of resilience, referring to the challenge, change, or disruption, which triggers the resilience process (Earvolino-Ramirez, 2007, p. 78).

Adversity has been described to include parenting stress, poverty, homelessness, traumatic events, natural disasters, violence, war and physical illness (Herrman et al., 2011). Furthermore, resilience is influenced by the cultural context in which a person develops and the processes related to adherence to cultural norms and values (Cameron, Ungar, & Liebenberg, 2007; Pathike, O'Brien, & Hunter, 2015). Cultural aspects, which include spirituality and religious beliefs, are valued entities and hence can affect a person’s capacity to be resilient (Cameron et al., 2007; Gunnestad, 2006). There is however, no definitive consensus about how to describe resilience in older people (Allen, Haley, Harris, Fowler, & Pruthi, 2011; Richardson, 2002).

The Thailand Department of National Mental Health (DMH) defines resilience as a positive outcome of adaptation in spite of negative events: called the ‘Resilience Quotient’, or RQ. Presently though, there is no Thai language equivalent for the English word resilience, but there are several Thai terms being used. “*Pa-Lung-Su-Kha-Pab-Jid: พลังสุขภาพจิต*” (which is divided into the two words of “Pa-lung” meaning power and “Su-Kha-Pab-Jid” meaning mental health) and “*Kwam-Sa-Mard-Nai-Kan-Yurn-Yud-Pa-Chern-Wi-Grit:ความสามารถในการยืนหยัดเผชิญวิกฤติ*”(which

separates into the small words of “Kwam-Sa-Mard” meaning an ability or efficacy, “Yurn-Yud” means to insist or stay, “Pa-Chern” meaning experience or face and “Wi-Grit” meaning adverse events, or negative situations or crisis. Wi-grit can be an undesirable and complex event that has suddenly happened, or that has developed over a long time (Bureau of Social Mental Health, 2009; Rungreangkulkij & Kotnara, 2009).

In Thailand, resilience is a new area of health consideration and nursing research, with no previous research study related to rural Thai older people having been conducted. The perspective of elderly resilience from the community nurses’ viewpoint has also not been studied. Understanding an older person’s resilience provides important initial knowledge, especially for existing community nurses who provide rural health care from the auspice of the THPHs.

Research aims

The research aim was to conduct a qualitative ethnographic research project to clarify the concept of resilience from the perspective of rural Thai elderly and their community nurses.

Research questions

1. What does the concept of resilience mean to rural Thai elderly and their community nurses?
2. How do rural Thai elderly respond to adverse circumstances?
3. How do the social and cultural artefacts (symbols) of Thai society influence the resilience of rural Thai elderly?

4. What are the community nurses (sub-district nurses) doing to develop or maintain rural elderly resilience?

Collecting and analysing the data

The researcher stayed at four provincial THPH's over a period of three months collecting data from semi structured interviews and non-participant observation in the THPHs, local villages and participant homes. A more detailed description of the data collection and the analysis process is provided in the methodology chapter, Chapter Three: 'Finding out about resilience'.

Structure of the thesis

The thesis consists of eight chapters. The first chapter is an introduction and background chapter, which provides preliminary information, defines resilience and situates the study contextually. Chapter Two reviews the literature regarding older people, resilience, and adversity. Chapter Three is the methodology chapter, which describes the research process and how the ethnography was conducted. The chapter outlines the research questions and aims of the study. Non-participant observation and fieldwork are described including the semi-structured interviews, data analysis, ethical considerations, and research limitations.

Chapter Four is the first findings chapter. This chapter describes and interprets the fieldwork and semi-structured interview data in the context of the elder participants' everyday lives and factors contributing to resilience. Chapter Five is the second findings chapter and describes older Thai participants' adversity in terms of what adverse circumstances mean to them.

Chapter Six describes resilience from the perspective of the Thai elderly participants living in rural areas. It provides the meaning, practical and cultural events related to being resilient. Chapter Seven is the fourth findings chapter and provides the community nurse's perspectives. This chapter discusses and interprets the nature of the nursing roles when working with older people within the rural community. The chapter also defines the community nurse's perception of resilience in older people and describes the health care services provided to the participants.

Chapter Eight, the final chapter, presents a critical discussion of the findings related to the study's research questions and interprets the findings in relation to existing literature. Recommendations are provided for the consideration of other researchers, community nurses, health care providers, policy makers, and national educationalists.

The next chapter, the literature review, highlights gaps in the research about resilience and older people and outlines the study's conception of resilience.

Chapter Two

Literature review

Introduction

Resilience and the health of older people is a new domain in Thai nursing research. To provide a deeper appreciation of resilience this chapter explores the existing resilience knowledge base and identifies the gaps in resilience research. Articles relevant to resilience and older people were reviewed to uncover information pertaining to the significant issues of Thai primary health care that were related to elderly health and resilience. Grey literature was reviewed from various government sources including Thai national statistical reports, policy, and population density data, in addition to related articles and/or reports from World Health Organisation (WHO).

The search of resilience literature

An integrative review was conducted to gather diverse studies using a range of methodologies that captured the depth and breadth of the knowledge base pertaining to resilience in older people. The literature combined non-empirical, empirical-quantitative, and qualitative studies (Souza, Silva, & Carvalho, 2010; Whittemore, 2005) that addressed the topic of resilience and older people.

The search strategy to retrieve relevant articles was guided by the 12 steps of Kable, Pich, and Maslin-Prothero (2012). A search of the published literature using CINAHL, EMBASE, and MEDLINE was conducted. The search engines

utilised included articles from ThaiLIS (Thai Library Integrated System from http://tdc.thailis.or.th/tdc/) and involved manual checking for articles provided in reference lists of articles.

The key search terms included: resilience definitions, resilience related to the elderly* (age, ageing, senior, elder, later life, and older) and resilience related to health* (health status, primary health care, attitude to health, rural health, world health, suburban health, public health, health behaviour and urban health) were used to retrieve the relevant articles. The inclusion criteria were articles and studies that described, explored, and identified resilience in the context of resilience and health in older people. Articles were excluded if they addressed a specific disease(s), and did not relate to human health (Appendix 1). Various Boolean (e.g. AND, OR, NOT) combinations of the search terms were applied.

The search strategy was limited to English and Thai. Articles were restricted to those published between 2000 and 2015. Reference tracking of retrieved papers was undertaken and these were reviewed. Some primarily original articles on the subject of resilience were found from as far back as the 1990's and were retrieved. The focus of the research articles retrieved was on studies related to people over the age of 50. Papers used included only articles where full-text of the article was available. Six perspectives and reviews about resilience, and 41 studies about resilience and older people were selected for the literature review. Of those 41 studies, 14 were qualitative and 27 were quantitative research designs.

Resilience in older people

The theoretical literature review describes three divergent views of the construct of resilience and older people and they include trait, process, and ability.

Resilience as Trait

Resilience was described as an individual characteristic - a trait. It was believed to include one's personal strengths (Wagnild & Collins, 2009) and was associated with the personal characteristics of successful adaptation in the face of adversity which include self-esteem, altruism, humour, and engaged and active coping styles (Lavretsky & Irwin, 2007). Older resilient people were described as being able to enjoy their own company according to their beliefs and values. This description relates to less depression, greater optimism, and less perceived stress (Wagnild & Collins, 2009).

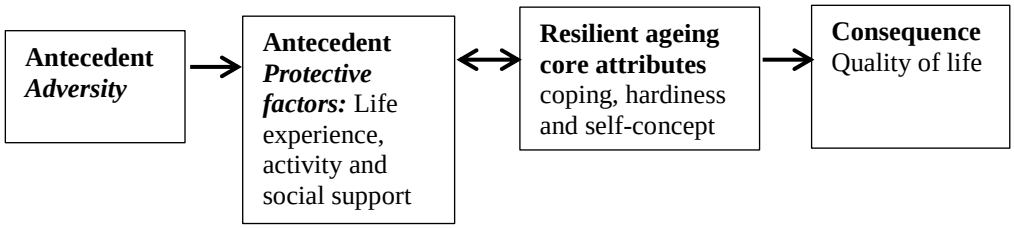
Resilience as Process

Resilience was also described as a process of adaptation that can be learned and practised across one's life span (Lavretsky & Irwin, 2007; Rosowsky, 2009). It is the process that utilises other support resources to bounce back in the face of adversity (Windle, 2011). This process involved effective negotiation, adaptation, regulation of emotions and coping skills (Rosowsky, 2009; Windle, 2012). Resilience was found to involve a process of interaction between adversity and protective factors leading to positive outcomes (quality of life) (Herrman et al., 2011; Hicks & Conner, 2013).

Hicks and Conner (2013) developed a model of resilience in the ageing process and described adversity as having a direct relationship with protective factors. The

protective factors acted directly on an elder person's 'quality of life' through 'coping', 'hardiness', and 'self-concept'.

Figure 4: The resilient ageing model by Hicks and Conner (2013)



Resilience as an ability

'Ability' has been mentioned more recently in the literature to describe the concept of resilience and it is possibly a combination of trait and process. Ability relies on two main elements; personality, and skill, in order to adapt to the different circumstances created by adversity. Kessel (2013) describes ability as a sphere of action relying on the individual's ability, as well as being influenced by a number of environmental factors. The ability includes accepting circumstances, looking to the future, caring for others, managing emotions, solving problems, and the ability to draw on spiritual strength. The environmental factors were social support from community, family, availability of resources, social policy, and social responses (Kessel, 2013). The WHO describes resilience as a reserved ability, comprising both intrinsic capacity, such as a psychological traits that helps an aged person to manage difficulty and environmental components of adversity, such as a strong social network that older persons can call upon when needed (WHO, 2015b).

Studies about resilience and older people

A number of studies have attempted to describe, identify, and characterise resilience. These studies support the concept that resilience is comprised of personal characteristics and that it is a dynamic process. Several studies describe resilience in older people as a personal characteristic (Moe, Ekker, & Enmarker, 2013; Wagnild & Young, 1990; Yang, Bao, Huang, Guo, & Smith, 2015). One key study focused on 24 older women who had successfully adapted despite major negative life events (Wagnild & Young, 1990).

Wagnild and Young (1990) highlight five domains describing resilience in older persons:

1. Equanimity (a balance of perspective of one's life and experiences);
2. Perseverance (the act of persistence despite adversity or discouragement);
3. Self-reliance (a belief in oneself and one's capabilities);
4. Meaningfulness (the realisation that life has a purpose and that one's contributions are valued) and;
5. Existential aloneness (the realisation that each person's life path is unique - some experiences can be shared, whilst others must be faced alone) (Wagnild & Young, 1990, pp. 253-254).

The findings from the Wagnild and Young's (1990) study were used to develop the Resilience Scale (RS), which has since been used to measure resilience levels. These five resilience characteristics have also been used to describe elderly resilience in other studies (Wagnild & Young, 1993).

In one study of 120 Norwegian older people with a variety of chronic diseases (diabetes, musculoskeletal disease, heart disease and chronic obstructive airways) it was found using the RS that the components of resilience 'perseverance', 'self-reliance', and 'existential aloneness' were weakly correlated to chronic diseases. While, 'meaningfulness' has been suggested to be important for the other four factors (Moe et al., 2013).

Yang et al. (2015) used the RS to examine the psychometric testing and clinical application of the Chinese version of the RS. This study tested the five RS domains in older people from six different communities in Hangzhou, China. '*Equanimity'* was only one domain that was found to be significant. The authors claimed that this result was opposite to Western older peoples experiences, where *'meaningfulness'* was the dominant factor (Yang et al., 2015).

While some resilience studies have focused on traits, other studies have focused on coping skills that are learned throughout ones' life. These coping skills help the elderly to manage a negative life situation and adapt positively. Bonanno, Wortman, and Nesse (2004) in a comparison study between resilient and depressive groups (N = 185) after bereavement from the death of spouse found significant differences between groups 18 months post death of the spouse. The resilient group of older people were found to have made an excellent adjustment and had less thoughts about grief and loss than the depression group (Bonanno et al., 2004).

Moyle et al., (2010) conducted qualitative research across four countries (N = 58) and found six themes related to the coping skills of the elderly with resilience that include the following features:

1. Keeping active (physical activities, mentally stimulating activities such as continued learning, novel activities, game playing and meaningful activities, such as being a voluntary caretaker for handicapped people);
2. Relationships (being involved and maintaining healthy family contact):
3. Community connections (continued and constant contact with all age groups and members of the community, not isolating oneself);
4. Practical coping (divided into two aspects: self-responsibility and focused coping such as setting goals or planning for the future);
5. Emotional coping (being realistic and reasonable); and
6. Spiritual coping (having faith, prayer and advice from a ministry member) (Moyle et al., 2010, pp. 118-119).

The dynamic process of resilience was found when older people adapted to negative situations and then generated positive outcomes in response to these difficult situations. Montpetit, Bergeman, Deboeck, Tiberio, and Boker (2010) considered resilience in older people as a dynamic system. Their study sought to explain resilience in older people based on 42 elders who were white, African American, Hispanic. The findings suggest that resilience is an effective process to assist with restoring equilibrium following exposure to stress. Since stress alters a person's equilibrium, resilience helps one recover and return to a typical emotional state (Montpetit et al., 2010).

Netuveli, Wiggins, Montgomery, Hildon, and Blane (2008) surveyed 3,581 participants in the British Household Panel survey, and the results indicated that

resilience was a process that converts goods (supportive resources) into positive outcomes. This study showed that elders with a high level of social support pre-adversity and during adversity had a 40-60 percent increased resilience quotient, compared with people with low social support. Therefore, resilience has the possibility to be developed, and maintained at the period before and during experiencing adversity and is stronger with support.

Strong social support has been claimed to be a positive factor facilitating resilience in older people. Martin, Distelberg, Palmer, and Jeste (2015) developed an empirical measure to assess family and individual resilience of older adults' aged 50 – 99 years old. This study of 1,006 people in San Diego was paramount to the understanding of resilience in older adults. The authors described the multidimensional factors related to family and the individual, which include eight elements:

1. Self-efficacy: an individual's ability to attain their goals or make meaning of adversity regardless of the various situations they encounter;
2. Access to support network;
3. Optimism: symbolising the ability to remain hopeful and optimistic:
4. Perceived economic and social resources;
5. Spirituality and religiosity: a person's belief in a higher power, deeper meaning, and/or a connectedness with a larger reality;
6. Relational accord: consisting of two items representing the difficulty and strain that can be experienced when family and/or close friends put high demands or pressure on a member;
7. Emotional expression and communication: the relational manner in which people interact, consideration of other people's feelings, and ability to relate to one another, and;

8. Emotional regulation: individual internal processing while problem solving (Martin et al., 2015, pp. 36-37).

Couto, Koller, and Novo (2011) conducted a study of 111 Brazilian people (aged 56 – 85 years old) who argued that resilience did not act as a buffer to the effects of stress because there was no interactional effect between stressful events and resilience, whilst higher levels of resilience were associated with a higher level of well-being. In this context, resilience was claimed to temper the impact of stressful life events and help to maintain a good level of psychological well-being.

With regard to resilience outcomes, Hildon, Montgomery, Blane, Wiggins, and Netuveli (2009) in a cohort study of 174 aged people claimed that resilience outcomes are related to QoL especially in terms of good quality relationships, integration in the community, developing mental coping and adaptive coping styles. Moreover, this study stressed that support and having a social network is a key variable to resilience in older people. Successful ageing was another positive outcome of resilience with Jeste et al. (2013) finding that resilience was associated with successful ageing through having good physical health. Other studies however, argue that even in poor health, older people can still demonstrate resilience.

Montross et al. (2006) conducted a survey of 205 older people and found that successful ageing was significantly correlated to a high level of resilience even in those that presented with chronic illness and physical vulnerability. Wells (2009) studied 106 older people in rural New York claiming that declining physical health status in old age does not directly reduce resilience levels. Both studies highlight that being successful in ageing and having a high level of resilience was

not impacted upon by chronic illness, or physical disability. For this reason, it is possible to develop resilience during one's life, even when physical function is declining, or limited.

The World Health Organisation acknowledges that resilience is a part of healthy ageing and defines resilience as: *"the ability to maintain, or improve a level of functional ability in the face of adversity either through resistance, recovery or adaptation"* (WHO, 2015b, p. 29). It is uncertain how many studies provide a clear definition of resilience in older people, as there was a lack of empirical evidence around whether or not resilience is an elder's innate ability. Predominately, studies support resilience as a dynamic process and something that is learned. Resilience as a dynamic process is argued to minimise the negative effects of adversity. Resilience outcomes are viewed to increase an elders' quality of life and contribute to healthy ageing. Adversity and protective factors have been raised in the literature as important features to triggering a need to be more resilient.

Adversity in elderly resilience

The term 'adversity' has been investigated as a trigger to develop or activate resilience in older persons. Adversity is "centred on limited circumstances and opportunities brought about by physical, mental or social losses" (Hildon, Smith, Netuveli, & Blane, 2008, p. 737). Physical limitations due to ill health, social limitations due to loss of a spouse, or loved one, and limited resources such as poverty are all examples of adverse situations (Netuveli et al., 2008).

In older people, Kessel (2013) argues that adversity tends to be more aligned to the stress of an ongoing life experience such as suffering with poor health, the experience of being old and the dying process, rather than a specific negative event. Wagnild and Collins (2009) classified adversity in older people into five responses: 1) grief, 2) loss, 3) fear, 4) confusion, and 5) anxiety; with these reactions being experienced around situations of physical illness, death of a family member, depression, loneliness, divorce, and fear of the future.

Adversity is mentioned in fewer studies when compared to studies that identify the related factors contributing to resilience. When summarising the common features of factors contributing to resilience there appear to be five common features 1) loneliness, 2) feeling of depression, 3) stress, 4) suicidal ideation and intention; and 5) vulnerability.

Table 1 identifies the adverse situations and the five major negative reactions experienced by older people to adversity that have been described in the literature.

Table 1: Identifying adverse situations and the five major negative responses

Adverse situations experienced by older people	**Negative responses to adversity**
Social isolation (Moyle et al., 2010) Grieving a loss (Adams, Sanders, & Auth, 2004)	Loneliness
Being old Grieving a recent loss Fewer neighbourhood visitors Less attendance at social activities (Adams et al., 2004) Physical ill health (Jeste et al., 2013) Reduced openness and control over future time perspectives Feelings of obsolescence Losses in coping ability (Rothermund & Brandtstadter, 2003) Economic hardship, fear, and uncertainties (Dorfman, Méndez, & Osterhaus, 2009)	Depression
Less wellbeing (Couto et al., 2011) Day–to–day negative emotion such as having fluctuating pain (Ong, Bergeman, Bisconti, & Wallace, 2006) Chronic pain (Zautra, Johnson, & Davis, 2005) Low income Widowhood Less education (Wagnild, 2003)	Stress
Physical health problems (Heisel & Flett, 2008) Higher levels of psychological distress and feelings of hopelessness, lower resilience, physical illness and financial status (Lau, Morse, & Macfarlane, 2010)	Suicidal ideation/ intention
Serious physical and memory impairments Illness (Felten, 2000)	Vulnerability

This table above brings together a combination of factors that affect older people negatively; however, there may be different combinations depending on situational context. For example, social isolation can cause loneliness and/or

feeling of depression, while illness may cause depression, stress, suicidal intention and vulnerability. Whilst loss, grief and a decline in health are obviously central, so too are other factors that can inadvertently affect older people in different cultures and social situations. Losses associated with war, flood and earthquake; for example, introduce a variety of adverse factors that depending on the social resources in the country and an individual's personal strengths can cause people to be more or less resilient (Edwards & Hall, 2012; Moyle et al., 2010; Nelson-Becker, 2006).

Protective factors of resilience in older people

Protective factors are resources that enable resilience and lead to positive outcomes (Edwards & Hall, 2012). Protective factors are those that reduce a person's vulnerability to adversity and provide protection to the person emotionally, physically, spiritually and culturally (Dyer & McGuinness, 1996; Herrman et al., 2011). Protective factors that are linked to resilience among older people are unique and in this chapter have been classified as being internal, or external.

Internal protective factors are those directly associated with the individual that positively affect the way one develops resilience. These are grouped into four categories - positive emotional responses, positive self-belief, self-behaviours; and connections with something beyond the self.

External protective factors have been identified as the social and environmental support, such as, social networks that guide elderly people through adversity and

are categorised as positive social connection, family and friends, culture, and economic status.

A summary of findings from the studies about the internal and external factors are provided in Tables 2 and 3.

Table 2: The internal protective factors related to an older person's resilience

Positive emotional responses	Positive self-belief	Behaviours	Other
The 3 feelings related to high resilience include: being connected, being independent, creating meaning in one's life (Aléx, 2010) . Low avoidance and low distraction (Bonanno et al., 2004). Trust in one's instincts and abilities, positive acceptance of change, control over self, and spiritual influences (Smith, 2012). Attitude of determination - a strong feeling of survival and in not letting illness take over their lives (Felten, 2000; Moyle et al., 2010). Inner strength to survive physically and mentally (Maneerat, Isaramalai, & Boonyasopun, 2011). Acceptance and openness about one's vulnerability (Janssen, Regenmortel, & Abma, 2011). Positive comparison with others, belief in self, determination, sense of	Having good health (Choowattanapakorn, Aléx, Lundman, Norberg, & Nygren, 2010; Dew, Llewellyn, & Gorman, 2006) Good physical health status (Wagnild, 2003; Wells, 2010; Wells, Avers, & Brooks, 2012) Good mental health status (Wells, 2009, 2010). Sense of belonging and healthy bonding with the group (Ferreira, de Castro Silva, et al., 2012). Sense of coherence, purpose in life and self-transcendence (Nygren et al., 2005). Self-acceptance and perceived meaning in life (Heisel & Flett, 2008). Self-efficacy and emotional focus (Caltabiano & Caltabiano, 2006). Self-management strategies - developed to be very sensible to their own emotion (Lou & Ng, 2012). Self-assurance: "*I think too that security is*	Healthy nutrition and healthy life style: consumed more than five servings of fruit and vegetable and having a high level of physical activity (Perna et al., 2012). Prayer, Bible reading, remain busy, talk with family or friends (Smith, 2012). Previous experience with hardship: made them stronger and able to recall those emotions related to the hardships to manage their recent problems (Felten, 2000). Be able to access care (Felten, 2000). Self-care activities: getting plenty of exercise, eating the right foods, and not smoking or drinking (Felten, 2000). Care for others: to enhanced their own well-being (Felten, 2000). Efficient working machines: participants described themselves as being like a machine which was stronger and tougher	Religiosity (Heisel & Flett, 2008), or connections with something beyond the self or extrinsic (Nelson-Becker, 2006). Woman (Caltabiano & Caltabiano, 2006)-urban Australia, & (Netuveli et al., 2008)-British.

Positive emotional responses	Positive self-belief	Behaviours	Other
humour, and faith in God (Sansuk & Kespichayawattana, 2009).	*being able to do what you want to do. (Australian Participant)"*, "*I still have the pleasure because I am able to do what I want (UK Participant)"* (Moyle et al., 2010). Self-esteem: redefinition of self and their image of who they were on a daily basis (Nelson-Becker, 2006). High level of self-ratings of successful ageing (Jeste et al., 2013). High level of self-reliance (Wells, 2009). Few depressive symptoms (Wells et al., 2012).	for being used (Felten, 2000). Proactive behaviour: reflected feelings of self-worth & a sense of control over what was going to happen through taking action, to adapt to circumstances and improve their lives (Kinsel, 2005). Ability to maintain social connection and problem management during adverse life events (Maneerat et al., 2011).	

Table 3: The external protective factors related to an older person's resilience

Positive social connections	Family and friends	Culture	Economic status
Social network (Adams et al., 2004). Social support and, relational activities (Aléx & Lundman, 2011; Kinsel, 2005). Emotional support from social network (Caltabiano & Caltabiano, 2006). Positive relationship with others (Heisel & Flett, 2008). Good quality relationships, several close confiding relationships, and social integration in the community (Hildon et al., 2009). High social support pre-adversity and during adversity (Netuveli et al., 2008). Social involvement (Wagnild, 2003). Group activity and the feeling of social belonging (Ferreira, de Castro Silva, et al., 2012). Opportunity to peer group and feeling for spiritual security (Maneerat et al., 2011).	The number of children (Heisel & Flett, 2008). Friends but not family (Wells, 2009). Stronger family networks (Wells, 2010). Enjoying support from family and friends, (Dew et al., 2006). Practical support from family, having a wide circle of family and friends, and having contact with family and friends (Hildon et al., 2009). Family support ranged from bringing them fresh fruit to in-home caregiving during illness (Felten, 2000). Receiving attention from family and friends and feeling connected (Moyle et al., 2010).	Cultural feature – Chinese older people highlighted different resilience factors to those described in Western studies (Yang et al., 2015). Cultural beliefs (health practices and healing techniques based on cultural belief) combined with sources of strength of spiritual and religious value (Felten, 2000). Cultural bond the shared experiences and histories from their ties (Grandbois & Sanders, 2009). Resisting cultural norms in order to maintain their own sense of self (Kinsel, 2005). Sources of accessibility of care, and the availability of material resources (Janssen et al., 2011). Spiritual grounding: a resource to draw upon in their daily lives (Kinsel, 2005) or to search for meaning, purpose, and morality. It may operate within a faith tradition or apart from one (Nelson-Becker, 2006).	Having money to buy what they need (Dew et al., 2006). Independent socioeconomic position (Perna et al., 2012). Lower household income (Wells, 2010).

Resilience and culture

A number of previous research studies have reported a relationship between resilience and culture for older people. In one study about older African American, Russian Jewish, Native American, German and Chinese people it was found that resilience was a skill based on personal, social and cultural factors (Felten, 2000). Cultural factors identified were elders' previous lived experiences, including racism, religious or ethnic discrimination, divorce, and domestic violence. Elders recalled the emotions about their previous experiences and used them to manage current problems. Furthermore, cultural beliefs have been mentioned in relation to elder health practices and healing techniques (Felten, 2000).

Another qualitative study investigated resilience in 58 elderly people from Australia, Germany, South Africa and the United Kingdom, and revealed six strategies that promote resilience. These were: 1) maintaining physical function, 2) keeping mentally active, 3) maintaining relationships, 4) continuing community connections, 5) practical coping in terms of emotional focus (being realistic and reasonable); and 6) spiritual coping (in which religion plays an important role) (Moyle et al., 2010). The study found that individual elderly have different ways of developing resilience. The difference depended on their place of residence, which was related to the socio-cultural and the political environment. For example, continued community connection, and social worth was associated with receiving positive attention; and feeling undervalued was related to negative societal attitudes (Moyle et al., 2010).

Yang et al. (2015) in a descriptive cross-sectional study with 461 Chinese older people examined the psychometric testing of the Resilience Scale (RS). The results found that cultural features influenced the development the RS tool. The five factors of the RS (equanimity, perseverance, self-reliance, meaningfulness, and existential aloneness) are believed to measure the level of inner strength one has to deal with adversity. Participants in the Yang et al (2015) project described a theme 'ceaseless self-improvement', which is a positive attitude toward adversity, purported to represent the essence and soul of the Chinese cultural perspective. Chinese older people provide a four-factor structure for the Chinese RS comprising of equanimity, ceaseless self- improvement, meaningfulness, and self-reliance.

Grandbois and Sanders (2009) conducted a narrative study of Native American elders to understand how they experienced resilience in their daily lives. The five major themes identified related to cultural considerations. Firstly, resilience was understood from the context of the Native American worldview, no matter how dominant mainstream culture was viewed. This point was described as different cultures manifesting different ways to interpret the value system of their own culture. The second theme, resilience is embedded within Native American culture described that culture bonds them to their tribal members through shared experiences and histories. The third theme described a Native Elder attaining their strength and resilience from each other, from their family, relatives, and tribal community. The fourth theme described resilience as arising from the oneness they felt with all creation, which the Native American Elders expressed through the land, their nature, Great Mystery and God. Lastly, resilience was described as

coming from a legacy of survival passed down by the ancient ones (Grandbois & Sanders, 2009, pp. 572-576).

Janssen et al. (2011) conducted a naturalistic inquiry to explore the sources of strength resilience in Dutch elders. One important source of resilience for older people was to access material and social support, and social policy assistance. The provision of professional attitudes by health care providers toward older people also resulted in supportive care processes and stimulated resilience in older people. In a resilience study that recruited both Thai and Swedish elderly it was highlighted that in the context of resilience there are significant differences between these cultures. A slightly higher RS total score was obtained by Thai elderly, with the authors explaining that the Thai harmonious cultural environment contributed to this higher resilience score (Choowattanapakorn et al., 2010).

The above six studies provide evidence that cultural factors including: socio-cultural, essence and soul, tribal, environment, health care resources, and national policy contribute to a sense of being resilient in older people. Culture is a manifestly different way of interpreting the resilience concept and this is because culture is believed to view everything as interconnected and interdependent (Grandbois & Sanders, 2009; Lou & Ng, 2012). Resilience in this cultural context is historical and culturally inherent, where it is based on the value and belief systems handed down by cultural generations in any particular indigenous population (Grandbois & Sanders, 2009).

Resilience and Thai elders

An understanding of resilience across an individual's life span in Thailand is still in its infancy (Hengudomsub, 2007). Choowattanapakorn et al. (2010) compared resilience in Metropolitan Thai and Swedish (N = 422) older people using the RS. The resilience level of both groups was not significantly different but Thai older people had slightly higher levels of resilience compared to their Swedish participants. The findings indicate that the definition of resilience in terms of 'individual competence' was found true only in Swedish older people, and not in Thai people. The authors explained that this was because Thai older people did not emphasise self-reliance and independence, but focused more on the value of extended family, a unique element of Thai (Choowattanapakorn et al., 2010) and other Asian cultures.

Another two studies were found that demonstrate the influence of culture on resilience for Thai older people. One study was conducted among 13 elderly people who survived the tsunami occurring on 26 December 2004 at Phangnha province.

Three themes of elderly resilience were articulated:

1. Living with hope - an expression of positive thinking, positive doing and positive mood which can be a driver for positive adaptation;
2. Dharma as guidance - the philosophy of Buddhist religious teaching to apply in their lives, for example, considering life-cycles which includes birth, getting older, illness and death being viewed as normal in the life span of a human; and

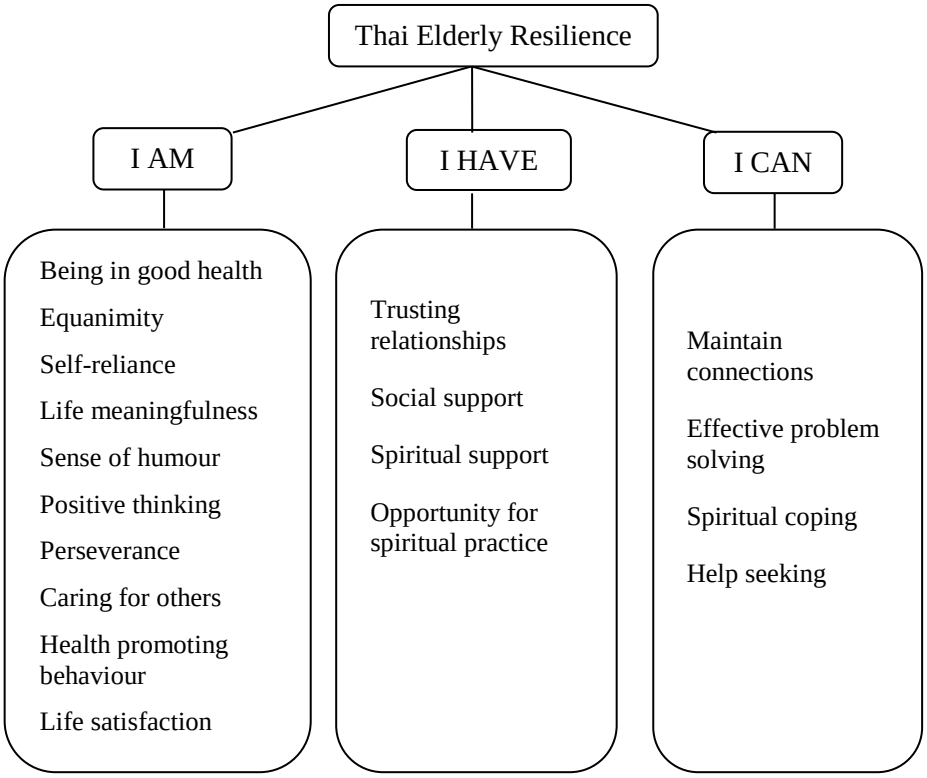
3. Living with understanding - personal responsibility and self-reliance, having a sense of humour and learning how to adapt (Sansuk & Kespichayawattana, 2009).

The study also revealed three phases of resilience which included the challenging phase (facing change), the maintaining phase (acceptance of change) and the firming phase (being settled with oneself and having purpose) (Sansuk & Kespichayawattana, 2009). Maneerat et al. (2011) gathered data from 14 elderly people to develop a concept of Thai elderly resilience from elderly people who had experienced adversity, such as, having severe chronic illness and/or had faced multiple losses. The data were collected from people located in four parts of Thailand. This mixed methods study found three themes: 'I am'; 'I have'; and 'I can'.

1. 'I am' described Thai elderly views that resilience consisted of ten components: being in good health, equanimity, self-reliance, life meaningfulness, a sense of humour, positive thinking, perseverance, caring for others, health-promoting behaviours and life satisfaction;
2. 'I have' was described as an external support system: the resources for trusting and receiving help from persons within family and their social group when needed. Four components were included in this theme: trusting relationships, social support, spiritual support and the opportunity for spiritual practice; and
3. 'I can' was the ability to make social connections and to ask for help when required. 'I can' consisted of four domains of maintaining connections, effective problem solving, spiritual coping and help seeking (Maneerat et al., 2011, p. 34).

Maneerat et al's (2011) concept of Thai elderly resilience is described in Figure 5:

Figure 5: Domains and components of resilience identified by Thai elderly (Maneerat et al., 2011)



These three studies found that Thai elderly resilience was reliant on personal traits; personal skills of learning how to adapt when faced with significant change in their lives; social connections and help seeking; and spirituality. Further, Dharma, a Buddhist philosophy, influenced older Thai to experience resilience despite adversity. Dharma is perhaps the key to spirituality in Thai elders' as it is found to exist in spiritual support, spiritual coping, and the opportunity for spiritual practice. None of these studies explored resilience for rural Thai older people, where the traditional family support is changing.

Health care and Thai elderly health

The significant issues of Thai primary health care related to elderly health and resilience were explored to clarify and provide clarity around the phenomenon of resilience in Thai older people living in the provinces.

Rural primary health care in Thailand

Rural Thai older people predominantly access THPHs (Apidechkul, 2012; Somrongthong et al., 2013) in the local community where they are available for people to access (Hanucharurnkul, 2007). Usually within 30 minutes travel, or at a distance of around 22.5 kilometres (Thai Health Coding Center, 2008).

The Thai government developed the first health care system for rural Thai communities in the 1960s (Sringernyuang, Hongvivatana, & Pradabmuk, 1995). Rural primary health care was originally provided by village health volunteers (VHV) who had been trained in drug provision; some were supplied with drugs from the government, these drugs were stored at some VHV's home to sell to their fellow villagers.

During the 7th National Health Development Plan (1992-1996), the community center for primary health care was created in order to provide supervision and technical support to the VHVs. In these centers, five VHVs responded with periodic health services. They were trained in screening procedures such as measuring blood pressure and curative care in relation to common illnesses, including diarrhoea, cold and cough, fever and headache, stomach ache and muscle pain (Sringernyuang et al., 1995).

In 1996, the Thai Ministry of public health (MOPH) regulated to authorise nurses and other health care professionals to treat minor illness and prescribe some medication under the authority of a physician. In reality however, the number of physicians was inadequate, particularly in remote areas. Registered nurses performed these duties independently to substitute for medical physician shortages (Hanucharurnkul, 2007).

Since 2002, Thailand applied the Universal Health Coverage Scheme (UHC) to care for Thai citizens (Hanucharurnkul, 2007). The UHC ensures social welfare for Thai people and covers medical fees such as drugs prescription, outpatient care, radiotherapy, surgery, critical care of accident or emergency and disease prevention funded by the public health financial system (WHO, 2010b). This policy allows patients to pay nothing at the point of health care delivery. In Thais rural primary health centers, the National Health Security Office (NHSO) funds the majority of payments. For patients visiting the primary health center in the new millennium, it is 60 baht per patient to be seen by a nurse, or 120 baht if a patient is seen by a physician (Holloway, 2012). Meantime, a physician is required to work at the primary health center for 5 hours a month (Ditton & Lehane, 2009).

Primary health care and community nurses

Primary health care in Thailand focuses on three main philosophies, involving a relationship between provider and consumer, a relationship between provider and community, and a services change from facility-based to community-based health care (Hanucharurnkul, 2007). The Rural Thai Primary Care Unit is located in a

part of sub-district (Tambon) community. This centre has recently been named Tambon Health Promoting Hospital (THPH).

The effectiveness of the THPH's care system is limited because of a lack of primary health care resources and a shortage of staff (Prakongsai et al., 2009; Wiwanitkit, 2011). There were only 2.8 health care workers per centre (the standard ratio is 1:1,250 people). Additionally, only two percent of THPHs in the nation have a medical doctor (Prakongsai et al., 2009). This was found to be most serious in the rural Northeast provinces (Leavitt, 2015), which represents the largest number of the older population nationally (NSO, 2014).

Due to the problem of a shortage in the number of physicians and health care workers (Wiwanitkit, 2011) nurses are the main health care providers in primary care (Prakongsai et al., 2009). Registered nurses are employed in THPHs in provincial Thailand because:

1. The cost of educational preparation is lower compared to medical doctors;
2. Nurses have experience in caring for people and can undergo additional primary care training;
3. Nurses are known for better communication skills since their training emphasises caring, interpersonal relationships and communication;
4. There are a greater number of nurses than other health professionals in the country;
5. Primary care requires high level interpersonal skills and ethics rather than sophisticated technology; and,
6. Nurses can more readily provide primary health care in provincial areas and can refer to specialist services if required (Hanucharurnkul, 2007, p. 85).

Community nurses are usually graduates of a four-year Bachelor of Nursing Science (BNS) qualification and work in the community primary health care services. Thai registered nurses have been trained in fundamental nursing, adult and elderly nursing, psychiatry, paediatrics, obstetrics and gynaecology, and community and public health. Following completion of their four year degree and skills training, they have to pass the national licence examination to be able to hold the professional nurse and nurse midwives licence (Phokhwang, 2008, pp. 4-8; Thailand Nursing and Midwifery Council, 2011a).

The responsibilities of community nurses include overseeing the basic health care needs of their patients, emphasising individual, family and comprehensive care, health promotion, prevention and rehabilitation, health education, home visiting and counselling. Their role particularly emphasises health promotion and illness prevention. This role is not just focussed on individual patients but also on holistic care in the communities to which they belong (Hanucharurnkul, 2007; Meebunmak, 2009). Since the Universal Health Care coverage, or Thai UC has been operating in Thailand, Registered nurses (RN) in all THPHs are expected to progress to become a nurse practitioner (NP). This is anticipated to provide an additional resource for assessing and prescribing medication for common health problems (Hanucharurnkul, 2007).

National Health Care Policies and Older Thai People

The Thai government has developed a plan to meet the needs of the rapid increase in the population of older people since 1982. The first national plan was developed as a guideline for treatment between 1982 and 2001. This plan focused

on older people who lived with their families, and on the need for their children to respect and continue to care for them. The second national elderly plan has been running since 2002 and will continue to 2021. The latter plan is based on the recommendations of the Second World Assembly on Ageing in Madrid, Spain in 2002, and the Madrid International Plan of Action on Ageing (Knodel & Chayovan, 2008b; National Committee on the Elderly, 2009).

The latest plan addresses three areas:

1. older persons and development;
2. advancing health and wellbeing into old age; and,
3. ensuring an enabling and supportive environment.

National goals and objectives were established to serve this purpose in the same year, which follows in Table 4:

Table 4: Goals and objectives of the 2nd National Plan for Elderly Persons

- Implant consciousness in members of society that older persons are a valuable group.
- Make all people realise the significance of preparation for ageing and thus preparing themselves for quality ageing.
- Encourage people, families, communities, public and private entities to participate in activities concerning the elderly.
- Establish practical criteria and guidelines for all social sectors, including public, community and government entities, to monitor collaborative practice and progress.
- Prepare the population for their quality ageing.
- Promote positive attitudes toward the elderly.
- Set up social security or a protective system for the elderly.
- Manage the development of national work on the elderly and specify personnel involved.

- Develop knowledge of the elderly, monitoring and evaluating implementation of the National Plan for Older Persons. (Jitapunkul & Wivatvanit, 2008, p. 66).

Because of the plan, the Thai government developed a number of programs for older persons. Since 2009, all Thai older persons' age 60 and over now receive a monthly pension. It is proportional to age, where 60-69 year old receives 600 baht, 70-79 years old 700 baht, 80-89 years old 800 baht and 90 and over years old is 1,000 baht (Rittirong, Prasartkul, & Rindfuss, 2014) (currency exchange rate is approximately 26-30 baht per 1 Australian dollar). Some programs focused on filial care and these were found to be an unrealistic solution for long-term care, due to declining family size and increasing adult child migration to the cities (Knodel, 2012).

The expectation of children as the main carer in today's Thailand has diminished and in some cases, parents require a live in carer, or their children pay for their residence in an aged care facility. Hiring someone to take care of older parents, or nursing home care however, is viewed negatively and tends to be seen as less favourable within Thai society (Knodel, 2012). Moving to an aged care facility is generally not anticipated as possible by the Thai elderly.

More recently, the Department of Mental Health is focusing on conducting mental health campaigns for Thai older people. There are three main objectives of these campaigns:

1. To enable older people to prepare for quality ageing;
2. To promote positive attitudes toward the elderly; and,

3. To promote and support the participation of older people in community activities (World Federation for Mental Health, 2013).

There are 122 outpatient mental health facilities located in general hospitals and 17 mental health hospitals across the country. These facilities are concentrated in the main cities and there is limited access for the rural population (Kompa, 2013; World Health Organisation, 2006).

Furthermore, the elderly care system in Thailand has no facility or supportive regulation that considers the impact of the change in the traditional Thai family structure (Peek, Im-Em, & Tangthanaseth, 2015). These changes put the elderly at a greater risk of mental health issues and consequently the task of providing mental health care to older Thai people may fall on community nurses in rural communities. Promoting resilience in older people is the key to healthy ageing, maintaining quality of life in the aged, and for preventing negative outcomes (WHO, 2015b).

The WHO's recommends that older people be supported within their own environments. Resilience is suggested to be framed as a public-health strategy that strengthens an older person's ability to navigate healthy ageing (WHO, 2015b). Furthermore, to promote resilience in older people, Windle (2012) recommends that all stakeholders must have a common understanding of what resilience is, and how it can best be promoted.

Summary

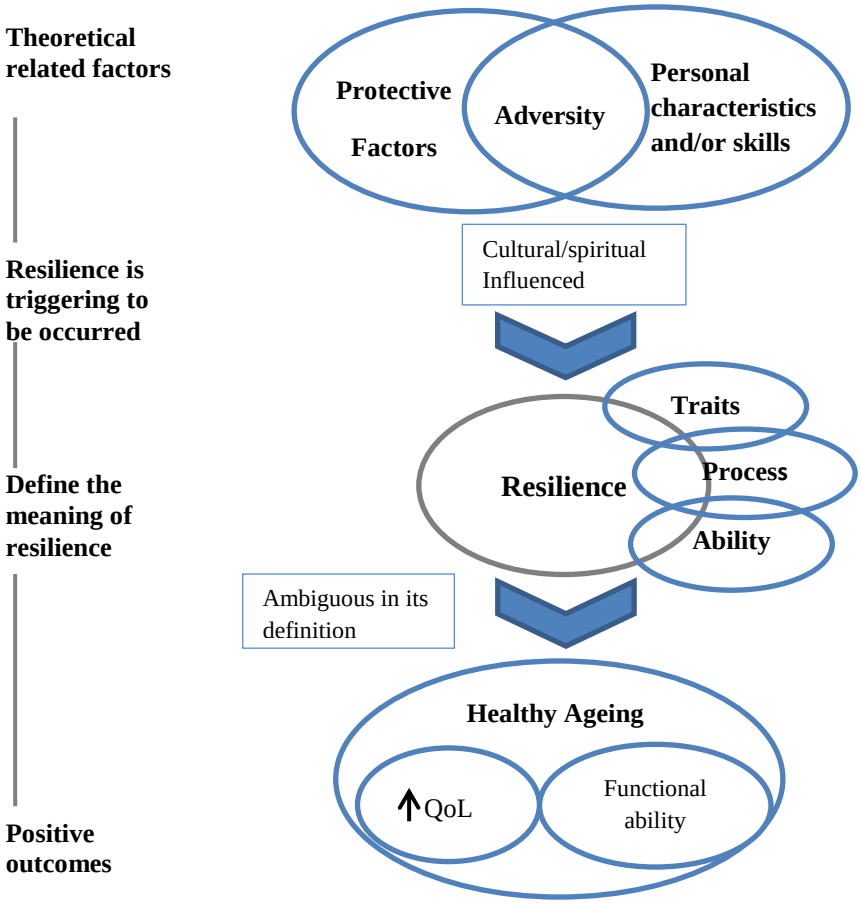
The concept of elderly resilience has been found to be ambiguous in its definition. From the literature review elderly resilience was described as being either a trait, a

process or an ability. Several elements of resilience were also described and these included adversity, protective factors, and personal characteristics and/or skills are factors that activate resilience in older people. Adversity relates to the negative experience of an elderly person's life. Resilience and old age has been discussed from the perspective of adversity directly interacting with protective factors, and yield positive outcomes. While, the personal characteristics are described through the actions of personality and the skills of adaptation to different situations stimulated by adversity. The studies reviewed have shown that cultural aspects do influence resilience in older people but most of these studies have been conducted in developed countries.

The WHO (2015) noted resilience as an important contributor to healthy ageing and conceptualised resilience in older people as the ability to improve, or maintain functional ability in the face of adversity (WHO, 2015b). Other studies linked resilience to QoL (Jeste et al., 2013; Montross et al., 2006).

The compilation of resilience in older people from the literature is presented in Figure 6.

Figure 6: Summary of elderly resilience from the literature



Based on the concept of resilience that arose from the literature about resilience and older people, resilience is therefore defined in this thesis as the ability to adapt positively to adversity (e.g. chronic illness) and other situational stressors, such as having less family support (e.g. family leaving to work in the city) and other ageing life situations.

There is also some uncertainty around the concept of elderly resilience in the context of what the triggers to stimulate a resilient response. The antecedents that activate elderly resilience are the main gaps highlighted throughout the literature. It is likely that there are many combinations of being a resilient individual, and it

is most likely that resilience is a multilayered personality attribute with each example being coloured by situation, context, culture and individual experience.

Adversity is the hallmark trigger for a resilient response. Adverse situations are mainly associated with declining health in older persons, increasing age, limitations in physical and mental function, and multiple losses. For Thai elders resilience has a small number of studies and it needs greater emphasis in rural areas to inform future understanding and guide health interventions. The protective factors, social and network supports, were found to be powerful resources that older people used to assist them overcome difficult times.

Social support within the rural Thai community however, has been found to be changing. The elderly health care system in Thailand still functions on the premise that the elderly will be supported by their children. There is no previous research has examined the construct of resilience in the rural Thai elderly population, especially from a community nursing perspective. Therefore, resilience in this context requires further exploration.

Chapter Three

Methodology - Finding out about resilience

Introduction

This study aimed to clarify the concept of resilience for rural Thai older people and to learn about their way of life in the rural villages where community nurses provided primary health care services. The data was collected in four separate rural areas and their community health centres. An ethnographic research design was conducted to capture the essence of the subculture of older Thai people located in the rural villages who shared similar patterns of behaviour, beliefs and language (Creswell, 2013b). This chapter describes the ethnographic journey to develop an understanding of the concept of resilience among Thai older people living in rural areas and attending the THPH centres.

Ethnography

Ethnography is a research methodology that contains a set of general principles to investigate topics from a qualitative perspective. The term "ethnographic" combines the Greek word 'ethnos' and the Latin word 'graphia'. 'Ethnos' means customs, races or groups. 'Graphia' means describing, drawing or writing, thus 'ethnography' literally means writing about a group or culture (Tham, 2003).

On the other hand, culture is challenging to describe, because it is the sum of the acceptable ideas, beliefs, patterns of behaviours, such as the way people talk, dress, eat, but also the history, politics, economy, religion, and environment that

characterise a group of people in any particular cultural context (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2001; Fetterman, 2010b; Howell, 2013). Fetterman (2010c, p. 18) mentioned that "no study could capture an entire culture".

Ethnographers attempt to describe as much as possible about a culture, trying to understand individual lives more deeply. They enquire into "the sacred subtle elements of culture – how people pray, how they feel about each other, and how they reinforce their own cultural practices to maintain the integrity of their system" (Fetterman, 2010a, p. 16). Additionally, ethnographers can be required to learn verbal interactions and language in order to understand the explicit meaning of the native's viewpoint (Fetterman, 2010b; Howell, 2013). The term 'ethnography' also highlights 'observing' as a distinct strategy and 'fieldwork' as a technique to deal with particular histories and traditions.

Fieldwork was conducted in the THPH community centres, participant homes and in the villages and Buddhist temples of each of the four communities involved in this study. The researcher immersed herself as the primary recording instrument into the communities of the older participants and workplaces of the community nurses (Wolcott, 1999, p. 68; 2010, p. 91). Fieldwork enabled the researcher to become familiar with the natural setting over a three-month period (Holloway & Wheeler, 2010, p. 162).

Harry Wolcott describes fieldwork as:

> *Fieldwork ought to inform us about how- and to some extent why- somebody does it, somebody whose way of thinking about things and doing things*

> *promises in some significant way to help us understand similarities and differences between their ways and our own* (Wolcott, 1995, p. 30).

Wolcott (1999) suggests that fieldwork opens up the world of the participant to the researcher. Fieldwork enables the researcher to develop a deeper understanding of participant lives on a day-to-day basis, where the unravelling of daily events provides meaning to their very existence. An ethnography is an expression of shared cultural knowledge gained throughout life between people who live within the same culture (Wolf, 2007). Therefore, ethnography is a research methodology that enables the interpretation of culture and subculture (Hampshire, O'Brien, & Cartwright, 2011; Wolcott, 1999; Wolf, 2007). It allows the voices of participants' to be heard and provides an opportunity to view social interactions within their natural setting (Goulding, 2005).

The 'natural' setting is a typical characteristic of this research approach (Hammersley & Atkinson, 2007, p. 4). Ethnographers traditionally stay for an extended time in the environment of the group being studied to pursue shared understandings and to gain meaning in their shared experience. If the place of study is related to the researcher's own environment, it is suggested that the time period undertaken for the study could be shorter because the researcher has prior knowledge of the situation but this may also be considered to be a potential source of bias (Howell, 2013, p. 116). Non-participant observation in this study incorporated the researcher examining her own presence in the research setting and being cognisant of the influence this may have had on the participants. To minimise the potential for bias in this study, the researcher ensured she worked strictly within the role as a researcher, as described on page 65.

Ethnography involves three key general data collection methods (Gobo, 2008). Firstly, participant observation exists where a researcher observes and is involved in the lives of the participants'. While, non-participation exists where the researcher observes participants' lives but does not become involved in any of their interactions. Secondly, interviews or focus group discussions can be used to collect what cannot be observed, such as events from the past and people's perceptions and opinions (Goulding, 2005; Simmel, 1908). Lastly, investigation of secondary data such as patient records, biological laboratory tests, census figures, maps and policies can also be used to corroborate other data (Cruz & Higginbottom, 2013).

In ethnographic data analysis, data is interpreted using emic and etic perspectives. Emic is the insider perspective of participants being studied, while etic is the outsider or external viewpoint of a studied phenomenon (Leininger, 1990). The outcome of ethnographic research generates a richer understanding and insight of the participants and their social interactions in their daily lives through written description, which is often referred to as a 'thick description' (Holloway & Wheeler, 2010, p. 159).

In nursing, ethnography generates knowledge through emic interpretation and via a study of a particular culture that includes people's beliefs, viewpoints and practices (Leininger, 1990). Ethnography's emphasis on cultural perspectives can contribute to patient-centred care and assist in a greater understanding of how health is valued by individuals within their environment because it facilitates an empathetic understanding of events (Robinson, 2013). Wolf (2007, p. 294) suggests that the contribution of ethnography to nursing research relates to "the

ability to generate understanding about health and illness phenomena as studied in a cultural context".

Streubert-Speziale and Carpenter (2007) claim that "ethnography gains a better understanding of social issues that affect nursing practice" (as cited in Cruz & Higginbottom, 2013, p. 37). Thus, an understanding of the milieu of human life and people's interaction within their own world makes ethnography different from other research methodologies. The distinctive approach of empirical study through participant and non-participant observation, formal and informal interviews and examination of relevant documents enhances the quality of data collection in ethnography (Savage, 2000, 2006). Moreover, the outcomes or thick descriptions can fill gaps in contextual understanding, especially if it is more recent and/or perhaps unfamiliar due to a lack of previous supporting evidence (Savage, 2006, p. 387). Resilience in older people is not clearly defined. The ethnographic approach therefore enabled the researcher to share participants' everyday lives in a natural setting, in order to capture the meaning of resilience from the perspective of rural Thai elderly participants.

The research plan

The data was collected using semi-structured interviews, non-participant observation of the community nurses and elderly patients attending the THPHs; and via fieldwork observations of elderly people in the villages. The semi-structured interview questions were developed from the concepts identified in the literature review and further inquiry was guided by the answers to these initial research questions. There were five interview questions asked of older

participants, and six primary questions for the community nurses. Additionally, probing questions were used to elicit responses to the core semi-structured interview questions if the conversation flow stopped, or if the interviewee required some encouragement.

In the semi-structured interviews of older people and community nurses, probing questions were used to seek more information and to provide clarification of apparent contradictions. Occasionally the interviewee was asked to repeat something to make sure that the researcher had understood clearly what they had said (Angrosino, 2007, pp. 42-44). The non-participant observation was collected from the primary health care units, which were Tambon Health Promoting Hospitals (THPHs) and the villages' community public places. The patterns of their shared-culture, including greeting, acting and reacting, verbal and non-verbal language and participant dressing, and were observed and recorded. Table 5 provides a summary of this doctoral study's research plan.

Table 5: Research plan for the exploration of resilience among rural Thai elderly (see data collection form in Appendix 9, 10, 11)

<table>
<tr><td colspan="4">Research aim: To clarify the concept of resilience among rural Thai elderly

Research question: What does the concept of resilience mean to rural Thai elderly and their community nurses?</td></tr>
<tr><th>Participants</th><th>Research questions</th><th>Semi-structured interview questions</th><th colspan="2">Non-participant observation</th></tr>
<tr><td rowspan="2">Older people</td><td rowspan="2">How do rural Thai elderly respond to adverse circumstances?

How do the social and cultural artefacts (symbols) of Thai society influence the resilience of rural Thai elderly?</td><td rowspan="2">1. Can you tell me what keeps you healthy as an older person?
2. Can you tell me about how you feel when faced with difficult times?
3. Can you talk about how you cope?
4. Can you talk about the things that are most helpful during difficult times?
5. What can you tell me about how those things helped you?</td><td>THPH unit</td><td>Public places</td></tr>
<tr><td>1. Older people upon entry
• Arrival
• Accompanied
• Greeting
• Body movement
• Dress
• Affect (influencing behaviour or action)

2. Interaction between community nurses and older people during the health consultation
• Language/ conversations
• Body movement</td><td>1. Upon arrival
2. Accompanied by whom
3. Greeting
4. Body movement
5. Dresses
6. Moods
7. Language/ conversations

• Five public places where older people normally visit

• Traditional events/customs occurring within the community.</td></tr>
<tr><td>Community nurses</td><td>What are the community nurses (sub-district nurses) doing to develop or maintain rural elderly resilience?</td><td>1. Can you tell me about the challenges you experience nursing older people?
2. What is your understanding of elderly resilience?
3. Can you tell me about which elderly cope better than others?
4. What do you think are the factors involved in making one older person more resilient than another?
5. Can you tell me how you nurse the elderly through adverse situations?
6. Is there anything else you would like to say about resilience and nursing the older person?</td><td colspan="2"></td></tr>
</table>

The research setting

The researcher spent time staying within the local village community and attended the community centres to gain an understanding of the participants' everyday experiences. The following section provides an overall picture of the four settings studied and the details of the local population.

Learning the language

In Thailand, over 70 spoken dialects are distinguished by region. There are four main regional dialects consisting of Central Thai (*phasa Thai*) that predominates and is the national official Thais language, Southern Thai which is spoken in the Southern provinces, Lanna spoken in the Northern provinces; and Isan (which is sometimes called Lao) spoken in the Northeast region (SpainExchange, 2016).

This ethnography was conducted in the Northeast part of Thailand where Isan is the spoken dialect. The researcher spoke Isan fluently, as did the community nurses employed in the THPHs. Isan was used in all communication including interviews and during the negotiation for access to the research locations.

The Northeast is the largest area geographically and the most densely populated area in Thailand. Despite this, Isan speakers have faced discrimination against the Isan language, especially when large numbers of Isan people began migrating to Bangkok. The people from the 'Isan region' are viewed as poor and less educated compared to people from other Thai regions (Myers, 2005). Thai-Isan people now avoid using their language and teach their younger people a mixture of Isan and Central Thai (Alexander & McCargo, 2014). Additionally, the Isan dialect cannot

be accurately written and it has no current orthography (Draper, 2010a; Draper, 2010b).

The researcher found that the Isan dialect was spoken slightly differently between older, middle age and younger people; also, some traditional words are no longer understood. Thus when interviewing the older Isan Thai person, probing questions were required to seek clarification around some words. Occasionally, the meanings of some words were clarified with Isan people from older generations and THPH staff. This was because some elderly participants used Isan words that were not used on a regular basis in the modern day.

The settings

Four rural settings, located in the Sri-somdet district, Roi-Et province, in the Northeast of Thailand were utilised as recruitment sites. These were non-municipal THPHs where each THPH acts for each sub-district (*Tambon*). The majority of people attending the THPH were Thai and Buddhist. All of the study participants spoke Isan dialect and Isan was their first language. Thai language is the official national language and is only used to contact formal organisations such as schools, or with officials, such as provincial officers.

Geographically, the landscape in provinces is separated into villages that are surrounded by farm fields. Most of the population in this setting live in their own houses with their (roots/ancestry) families around the village. For example, older sisters and younger sisters who get married and have their own families build their homes nearby or not too far away from their old family home. Then as the parents become frail, the youngest daughter generally takes their house. She is then

expected to care for her elderly parents and her own family in the parent's house. The local government have built only a few houses for very poor families or disabled people.

Generally, people work on their farms and this depends on the weather. For instance, they grow rice, once a year, which generally starts in the rainy season (around May); with harvesting from the beginning to almost the end of the cold season (around December to February). They also grow tobacco in the cold season and harvest it around mid-summer (around April), and then the same cycle will starts again when the rainy season comes.

The local people generally buy food and products from local sellers near their homes. Some villager's homes have been set-up as shop fronts; otherwise, they buy from vendors that sell out of cars, or from motorbikes. Additionally, they buy food and goods from the fresh markets, which are mostly evening markets. These markets are located in several villages and operate on different days, but not all villages have markets. For example, village A has a market on Monday afternoon and village B has it on Wednesday afternoon, thus people will come to the market at the most convenient place and time for them. People in these areas eat sticky rice with homemade dishes as their main type of food. Sitting on the ground, or at a big square table is the traditional way to eat, with the use of the hands being the usual way to eat sticky rice.

Tambon Health Promoting Hospital

Tambon Health Promoting Hospitals (THPHs) provide predominately-primary health care in Thailand. All THPHs in Thailand are organised similarly and

employ the same policies related to the health care of elderly people (Adhikari, Jampaklay, & Chamratrithirong, 2011). THPHs have been built in the central village of each sub-district. The building structure was specified by the Thai Ministry of Public Health, although they do vary. Three of the THPH buildings in this study were two-storey constructions. The ground floor is used as an area for health care services including a health assessment desk, a treatment room, a Thai traditional massage room, and a staff common room. The second floor mostly serves as a multi-function room; for example, it can be decorated as a meeting room, a visitor's room, a health education, or seminar room. One of the THPHs the researcher visited is a single storey building that included all health service areas.

Each THPH provides the health care service for the people within their sub-district, which comprises several villages catering for all age groups. The nurses primarily work in basic medical treatment that involves wound care and dressings, providing medication, measuring vital signs, also providing health education. They work five days a week (8.30am – 4.30pm) plus some extra shifts in the evening time (4.30 – 8.30pm); some staff also work shifts on weekends. There are five to seven staff, which comprise 1-3 community nurses, as well as public health staff, or an assistant public health staff person, a Thai traditional masseur, and a cleaner as illustrated in Table 6.

Table 6: Staff and health services of the four THPHs

THPHs	Number of Staff	RN	PH	DHT	DHTA	TM	C	Health care service		
								Number of Villages	Total Populace	Aged populace
1	7	3	2	-	-	1	1	14	6,154	836 (13.6%)
2	6	2	2	-	-	1	1	10	4,070	552 (13.6%)
3	7	1	2	1	1	1	1	8	2,466	452 (18.3%)
4	5	1	3	-	-	1	-	8	2,932	429 (14.6%)

*****Short form: *RN*: registered nurse, *PH*: public health technical officer and/or public health officer, *DHT*: dental health technician, *DHTA*: dental health technician assistant, *TM*: traditional Thai massager and *C*: cleaner

Research participants

The two groups of participants in this research study were rural Thai older people and their THPH community nurses. The inclusion and exclusion criteria for participants' selection are identified in Table 7.

Table 7: Inclusion and exclusion criteria of the study participants

Rural Thai older people	Community nurses
Inclusion criteria	
• Aged 60 or over • Able to communicate verbally • Willingness to be engaged in this study	• Community nurses whose work is located in the THPH • Willingness to be engaged in the study
Exclusion criteria	
• Unable to communicate verbally • Elderly who are cognitively impaired, for example, due to brain injury, or forms of dementia and Alzheimer's disease	• Unwillingness to be engaged in the study

A variation of the initial ethics approval enabled family members in the company of the participants to be involved in the semi-structured interviews. Ten participants expressed their willingness for their family member to join the semi-structured interview (Appendix 4).

Rural Thai older people

Elderly participants who met the inclusion criteria were identified and invited to participate in the research by the head supervisor(s) of each of the THPHs or the community nurse(s) who worked at the THPH. Once participants were identified and interviews commenced, elderly participants told their friends and then participant numbers snowballed with more older people asking to be interviewed. During the interview, the researcher asked participants if they would tell friends who then might express an interest in being interviewed via the THPH administration desk.

There were 36 rural Thai older people interviewed. One interview was excluded due to poor voice quality on the recording device, thus there were 35 interviews in total. Ten interviews with elders' occurred at the older persons' home and involved a family member, such as spouse, sibling or daughter. The family members were present while the interview was conducted to support and assist the participant to answer some of the questions when required.

Table 8: Participant demographic characteristics (older people)

Socio-demographic	N =35	
Gender		
Male	15	
Female	20	
Age (Mean age = 74.2)		
60-69	11	
70-79	16	
80+	9	
Marital Status		
Married	10	
Widowed	22	
Divorced	2	
Separated	1	
Career		
Farmer	14	
Trader	1	
Other	20	Not working
Income		
Not enough	10	
Enough (not for saving)	25	
Education		
Primary school	30	
High school	4	
Other	1	
Diseases diagnosed		
Yes	19	BPH, DM, HT, Asthma, CA (cervix, liver, colon), gout, CRF
No	16	
Family configuration		
Lives alone	7	
Lives with family members:	28	
2 people in the same house		
Lives with only spouse	4	
Lives with only grandchild	1	
3 and more people in the same house		
Lives with spouse	12	
Lives with adult children	17	
Lives with grandchildren	16	
With grandchildren but not adult children	6	
Lives with other (e.g. daughter /son in law)	14	

Community nurses

Flyers that introduced and described the study were posted inside the THPH buildings. The flyers were used to promote and recruit interested persons to participate in the study. The study worksites had a very small number of community nurses, a pack of information pertaining to the study, including an information statement and consent form was made available in the THPH common room. Only the THPH staff could access this room. Some community nurses made contact with the researcher by mobile phone to arrange a date and time for the semi-structured interviews. There were nine interviews with community nurses. These included seven community nurses, two of whom were re-interviewed.

All community nurse participants lived within the local provincial community, or near to their work place. They could also speak fluent Thai, as well as the Isan dialect. The two re-interviews were from community nurses who identified themselves as working closest with older people within their community. Community nurse participants in this project were all General Nurse Practitioners endorsed by the Thailand Nursing Council certification. This is a four-month graduate course managed by the Nursing Council through a nursing education provider.

Table 9: The community nurses' demographic characteristics

Socio-demographic	N =7	
Gender		
Male	1	
Female	6	
Age	35 – 47	(Mean age = 40.6)
Marital Status		
Married	6	
Single	1	
Education		
Bachelor of Nursing	7	
General Nurse Practitioner	7	
Live in the community	7	Same province
Year of work in the THPH	8-17	(Mean = 11.7 years)

Ethical considerations and approvals

The study was approved by the Human Ethics Committee of the University of Newcastle, NSW, Australia (Reference No: H-2014-0031 approval: 26-Feb-2014) and the Roi-Et Provincial Health Office Human Ethics Committee (see Appendixes 3, 4 and 5). All the participants were informed about the study objectives and data collection procedures and were asked to provide their consent to participate. Those who agreed to join this study were able to withdraw at any time. All of the questions that had the potential to breach a participant's privacy were handled with strict confidentiality.

The data collected was presented anonymously. Each participant was given a code instead of their name to ensure the data was de-identified and participant's details were not disclosed. The code name E01-E35 represented older people, and C01-C09 represented the nurses. All participants were provided a small thank you gift after the data collection finished, as this is a cultural tradition. Where a THPH

involved non-participant observation a basket of fruit was left by the researcher with a thank you letter after the event (see Appendix 24).

Confidentiality, storage and safety of data

Any data that referred to the study participants was kept secure at all times. All individual pieces of interview data (transcripts) for elderly persons and nurses were ascribed a pseudonym. The original list of participant names was kept separately to the list of transcripts, which are identified by a pseudonym. All data were accessed by only the researcher and supervisors. A password-protected Research Higher Degree provided laptop only accessed by the researcher was used to store the recorded data. The back-up data was kept in the ‘drop box' application accessed only by using the researcher's user name and password. Hand-written data was kept in a locked cabinet in the researcher's office.

Written de-identified data (transcripts and copies of field notes) to supervisors were transferred from Thailand to Australia with the permission of the study participants. All digital files, hard drives, lap top and hard copies of data were securely kept in hand held luggage which the researcher carried at all times when returning to Australia.

During the processing of the outputs from this study, all derived data from fieldwork was kept in a secure, password-protected computer and locked cabinet in the school of Nursing and Midwifery, at the University of Newcastle.

Data storage, retention and dissemination

The primary materials were stored at the University and will be destroyed in 5 years in accordance with National Statement on Ethical Conduct in Human

Research (NHMRC) and the Australian Code for the Responsible Conduct of Research guidelines (National Health and Medical Research Council, 2013). Visits to each THPH will be made by the researcher to explain the findings once she has returned to Thailand to live. This is so the THPHs staff and any elderly participants get a chance to ask questions about the study findings. The aggregated and de-identified findings and publications will also be provided to the Provincial Public Health Office.

Seeking worksites' permission

During the writing up of this research project approval to study this area had been given provisionally by phone and via a permission letter from Roi-Et provincial Health Office (see Appendix 6). The THPHs' permission agreement was processed from the provincial health office down to the district health office who allocated work down to the four THPHs. The study settings had been contacted through the Provincial Health Office and the District Health Office. Once the Human Research Ethics Committee of the University of Newcastle approved, the researcher wrote a letter to the Provincial Health Office informing them of the successful ethics application and indicated readiness to collect the data at the work sites (see Appendix 7).

Seeking consent from the participants

The participants of this study were older people in rural areas, where literacy levels were low and the older people's family members and THPHs' staff played an important role in seeking the consent from the rural older participants. The written documents, including, the Information Statement and Consent Form had

been sent off beforehand and were later read aloud to the older people by a family member and then explained in the Isan language immediately before the interview started. For the older person who lived alone, or only with their spouse, information was provided by a friend who had already participated in this study or from one of the THPH's staff.

Both groups of participants were provided with sufficient information to decide whether they wished to participate. At no stage was pressure applied by anyone, including the researcher regarding willingness to participate and the researcher was not involved directly in the recruitment process. The participants allowed the researcher to collect data by signing the Consent Form, or by providing verbal confirmation and stamping their fingerprint, as is normal practice in rural Thailand. A digital audio recording of the participant information sheets in the Isan dialect was provided for all participants to listen to before the interview. Most participants declined to listen to the recording of consent information.

The researcher verbally repeated the information again at the beginning of the interview, and only played the recording once. Brief research project information was also explained, and time was given to the participants to allow any questions to be asked. The person who wanted to participate and had earlier signed their Consent Form then met with the researcher. Verbal consent was requested again before the interview took place. One elderly person who refused to be interviewed took the researcher to observe her activities at the village temple and introduced the researcher to her friends and the village temple's monks.

Researcher's role

Entering the setting by overt technique could affect the observation process because participants might change their behaviours knowing they are being observed by a researcher (Angrosino, 2007). On the other hand, a matter of physical presence at the setting grants tacit participant permission for research to be conducted (Atkinson et al., 2001; Hammersley & Atkinson, 1983). Role conflict for this research study was related to the researcher being of Thai nationality and a registered nurse. To maintain objectivity, the researcher used self-reflection in order to consider issues related to role conflict and any potential bias. The researcher was aware that because she also spoke the Isan dialect there was some potential for bias.

The researcher is a Thai citizen making her more aware of the unique culture that relates to Thai elderly people. The researcher respected the traditional hierarchical structure of Thai culture that values and respects elderly people. While being in this role, the researcher did not have any of the identifying features of a community nurse and did not engage in any nursing roles. Informal clothes such as T-shirt and jeans were worn. All staff and residents knew that the researcher was present on any day because they were introduced to people in the setting by the community nurse in charge. In the role of a researcher, a student name badge was worn for the duration of the study.

Data collection

Prior to the commencement of data collection, one pre-visit to each of the THPH was made. A flexible plan for non-participant observation and the semi-structured

interviews conducted in the community centres and elderly participants' homes was then organised. The plan relied on each THPH's schedule and the community calendar. Fieldwork was also conducted in the villages and Buddhist temples, markets and other community public places.

The data collection methods attempted to capture the insider (emic) views and to understand the activities participants engage in at the THPHs and the villages. Over the course of each day, interviews were conducted and field notes written from non-participant observation. The researcher scheduled time away from semi-structured interview appointments, so that non-participant observation could take place. The researcher made reflective notes at the end of each day, including summaries, and used them for future interactions.

Semi-structured interviews

Prior to data collection taking place when still in Australia, the researcher undertook some practice with the interview questions with one Australian older person. The interview questions were then translated into the Isan dialect and tried with a rural Thai older person living in Australia. Neither person was included in the study, nor did they have a relationship with the people at the study worksites. This practice ensured a better understanding of the semi-structured interview process that helped the later flow of interviews. The semi-structured interview questions for community nurses were also translated into Thai, and were reviewed by three Thai community nurses who were not recruited into the study.

Semi-structured interviews were conducted concurrently with non-participant observation. Each interview was approximately 50 minutes in duration for both

older people, and community nurses. Socio-demographic questions were asked in the beginning to gather primary information from both participant groups. Starting with the socio-demographic questions was found to be useful as it allowed the researcher to develop a rapport and to warm up for the upcoming interview. The family's genogram was also described to understand the family configuration (see the elderly-interview form in Appendix 9).

For each participant, a private interviewing environment was available in a spare staff room in the THPH. The researcher also interviewed participants in their home if it was more convenient and it was requested. All interviews were conducted in Thai, or the Isan dialect to allow the best opportunity for them to express themselves in their own words. Non-verbal details were written as notes during the interviews if considered relevant. Reflective notes were also made after each interview.

Non-participant observation

During the research period, the researcher stayed in the villages and visited the THPH buildings. Non-participant observation began the moment the researcher entered the field. This technique involved observing and documenting the behaviour of the participant cohort with only minimal involvement. The researcher melded in as a resident of the THPH environment and observed daily events in the surrounding community.

Non-participant observation occurred in the THPH building and local community three to five times per week over a three-month period (three weeks in each THPH). The researcher periodically observed the daily activities of the rural

elderly participants, from sunrise (around 6.30am) until sunset (around 5pm) with additional observation of some religious and cultural activities that were held in the late afternoon and at night. Interviews also occurred during these periods. Non-participant observation included the researcher being in the THPH building and Tambon's public places where the elderly were normally engaged.

These places included:

- The THPHs;
- Village temples are places that elderly people visit often;
- Tambon Local Governance's building or village halls where traditional fair events occurred;
- Village grocery shops and local markets (*Talad-Nud*) are places which elderly people go to get food and groceries and also to exchange or sell their products such as home-grown vegetables to the local buyers; and
- Rice fields and village forests that were owned by some villagers - where belief-related events occurred (e.g. Rocket festival and *Leang-Poo-Ta* where the villagers provide foods and drink to give to the village spirit(s) believed to be living in the forest to protect villagers).

Various notes were recorded by the researcher about observation. The notes were separated into three categories: field notes, reflective notes, and diary notes.

Field notes

During the data collection, field notes were written to recall detailed descriptions of events and actions that the researcher had directly seen or heard. The field note taking did not concentrate on spelling, grammar, or languages (included English,

Thai and Isan). Diagrams were also constructed to provide cultural authenticity to the research ethnography (See Figures 7, 8, 9, and 10).

Reflective notes

"These notes are essentially questions or reflections about how to remedy the difficulties that arise in the field. They may therefore include questions to which the answers are not yet known, as well as specific evaluations, recommendations and strategies to improve the research method" (Gobo, 2008, p. 201).

Reflective notes posed further questions to be answered and enabled reflection on the overall process of the research, the setting, methodology, and the participants' experiences (Cruz & Higginbottom, 2013). Furthermore, reflection around the activities of the research enhanced the quality of the data collected (Reeves, Peller, Goldman, & Kitto, 2013).

Diary notes

As Gobo (2008) suggests, the researcher uses diary notes to capture their feelings and reactions to specific features of events that they observe. A diary records all the emotions occurring during data collection. Furthermore, in this study a calendar was kept which provided useful retrospective information about events, as well as identifying new events that formed the patterns of the community's everyday lives.

The diary notes and the calendar provided self-analysis for the researcher and remained as the researcher's private reflective materials. These notes informed the researcher about the purpose of the research, the emotional changes that took place within the research process, and recorded the distinction between the initial

perceptions and final thoughts of the researcher during the fieldwork data collection. Moreover, notes on the emotions experienced by the researcher during the data collection were written in the researcher's diary to monitor and hence minimise any influence they may have on the data interpretation process.

Serendipity

Serendipity describes an occasion where an unplanned opportunity arises to collect information and to experience an event when conducting fieldwork (Florczak, 2015).

Examples of serendipity in this study were:

In the rural Isan culture, adult children or an elder's family members might not allow an older person to tell their own story alone with a stranger. Some of the older people interviewed asked for a family member to be with them. Additionally, there were periods of the year (March to May) when the elderly were working at their home because it was the tobacco leaf-harvesting season, leaving their farm at 3 am and returning at around 9 am. They would then have to put the leaves together in lines approximately 1.5 metres each. This process takes them late into the night each day.

As some of the older participants interviews occurred at their homes, interviews involved the older person's family members, such as their spouses and their adult children. The researcher was asked by the older persons to interview them in a place where their family member was able to observe them. At the beginning of the interview, answers were prompted by the older person's family member. The family members did not answer the questions on behalf of the Thai elder but

assisted the elder to answer some of the researcher's questions such as the year they were born, the number and age of the older person's children, and the family genogram.

Data Analysis

Research quality and rigour

The quality and rigour of this study was guided by the Lincoln and Guba (1985) framework which includes credibility, dependability (reliability), confirmability and transferability (Krefting, 1990; Polit & Beck, 2010b). The table below illustrates the aspects of Lincoln and Guba's framework relevant to this study (Table 10). The researcher spent time in the research setting from the 26th February – 6th June 2014. Data saturation was reached after the 44 interviews and 340 hours of non-participant observation.

Table 10: Data analysis and rigour guided by Lincoln and Guba (1985)

Lincoln and Guba's framework	In this study
Credibility	- Sufficient time (approximately 50 minutes) for each interview and non-participant observation over 3 month's period. - Undertook reflexivity (journal) and diary notes - Peer examination by the project's supervisors and an internal university peer review
Dependability (reliability)	- Code-recode during data analysis phases (at least 2 weeks for return and re-coding the same data and comparing results) - Alternative data gathering of interview and non-participant observation and their comparisons - Observation of similar events and an analysis to provide the information about 'what is the major issue' in each event.
Confirmability	- Peer review by the project's supervisors - Data from two sources: the elderly and

Lincoln and Guba's framework	In this study
	community nurses and two types: semi-structured interview and non-participant observation - Reflexive and diary notes were analysed and compared to the findings from the semi-structured interview and non-participant observation - Participants were offered to read their transcripts - Language accuracy for all interview transcriptions was maximised with professional Thai-English translators working in conjunction with the researcher and the project's supervisors.
Transferability	- The findings will contribute to an understanding about elderly resilience and the influence of culture in the Thai rural and community THPH setting.

Semi-structured interview data

After the data was collected, all interviews were transcribed verbatim by the researcher from Isan to Thai. Then the Thai transcriptions were transcribed into English by a professional translator to ensure language accuracy. Once this occurred the researcher re-listened to each audio recording against the hard copy of each English transcription to check and ensure the Isan dialect meaning had not been altered. The English transcriptions were then peer reviewed by the researcher and project supervisors to confirm that the meaning of each transcript was not lost in the above translation process. The fact that the researcher was fluent in Isan and Thai made this stage of the translation and subsequent interpretation much more reliable.

Nvivo10 was used to organise and assist with data analysis. The data transcriptions were loaded into the Nvivo 10 software programme. The data was analysed word by word, sentence by sentence, paragraph by paragraph. Coding

and re-coding were used to refine themes. An audit trail was recorded to track the data back to the transcriptions. Despite data being collected each day of the study, a process of continuous reflection and comparison of activities and events were recorded in the researcher's field notes.

Non-participant observation data

Non-participant observation data was transferred into the NVivo program as Word notes and then analysed word for word and situationally for subthemes and themes. The non-participant data and field notes further informed the semi structured interview data from a contextual and cultural perspective and gave the emerging categories shape and deeper meaning (Gobo, 2008; Goffman, 1959).

Data analysis

After the non-participant observation, field notes and interview data was transcribed, the next stage was the data analysis. The specific process applied the six steps outlined by Creswell (2013): data organisation; reading through text and forming initial codes; describing the data; classifying the data into codes and themes; interpreting the data; and then presenting the data (Creswell, 2013a, pp. 190-191).

Step One: The two data sets were organised and separately entered into the NVivo version 10 qualitative data analysing software. It is an appropriate tool for selecting, separating and sorting rich information by coding (Bazeley & Jackson, 2013). The interview data file was divided into the two groups of participants interviewed (older people and community nurses), and separate files of the observational data created.

Step Two: A content analysis technique was used to breakdown the data to create sub-nodes. Each sub-node is a collection of references or 'coding' sources to help the researcher to see emerging patterns and ideas. In this study, each ‘sub-node’ created was equivalent to ‘open coding’, and centrally grouped and gathered the related words, sentences and paragraphs in the one place.

Step Three: The researcher read and re-read the entire data set forming sub-nodes to generate the mother-nodes that are related to the research questions. The researcher’s reflections and all of the participants’ expressions, such as, laughing or exclamations were reported into the memos. Additionally, the location, events and environmental setting were described in the memo data.

*Step Four: This step w*as conducted in two phases. Firstly, the researcher stayed close to the data and kept codes simple and precise so that the data spoke for itself (Polit & Beck, 2010a). The nodes with the most frequency were identified and initially formed into a category. Phase two was the comparative coding process used to identify the similarities and differences in the information by using significant nodes; or the codes that made the most analytical sense from the initial phase, to examine and group data into larger categories (themes) (Hammersley & Atkinson, 1983) which gave coherence to answering the research questions.

Step Five: During this step, the themes were interpreted and described. The Occam’s razor technique was utilised to interpret the data. Occam’s razor, or the law of parsimony is the principle that ‘entities should not be multiplied unnecessarily’ which means keeping the explanation as simple as possible and to substantiate assumptions with evidence (Gibbs, 1997). In this case, the evidence

was derived from the themes, subthemes, and excerpts related to interviews and observations.

Step Six: Narratives, tables, figures and sketches (or photographs) were used to report the findings. The themes provided a ‘thick description’ of what the data had provided in relation to the research aims and questions.

Table 11: Data analysis framework

<table>
<tr><th colspan="3">Comprehensive data analysis using Nvivo10 guided by the six steps of qualitative data analysis, by Creswell (2013)</th></tr>
<tr><th>Non-participant observation</th><th></th><th>Semi-structured Interviews</th></tr>
<tr><td rowspan="2">Classifying strategy for observation notes (Gobo, 2008)

Deconstruct: breaks up the natural flow of actions

1. Identifies acts
2. Identifies activities and setting
3. Locates pattern of participation
4. Link patterns into relationships and structures
5. Interpretation of meanings assigned by participations to relationships and structures (Goffman, 1959; Lofland, 1984)

I. Construction: Using the data from the deconstruction process enabled the formation of initial relating themes.</td><td rowspan="2">Thick description</td><td>I. Verbatim interview transcription from Isan to Thai, and translation from Thai to English
II. English transcriptions validated</td></tr>
<tr><td>The ‘thick description’ illustrates the findings, related to the four research questions:

• What does the concept of resilience mean to rural Thai elderly and community nurses?
• How do rural Thai elderly respond to adverse circumstances?
• How do the social and cultural artefacts (symbols) of Thai society influence the resilience of rural Thai elderly?
• What are the community nurses (sub-district nurses) doing to develop or maintain rural elderly resilience?</td></tr>
</table>

Table 12: The comprehensive qualitative thematic data analysis using Nvivo10 (guided by the six steps of qualitative data analysis by Creswell, 2013)

The process proceeded by the six steps outlined by Creswell (2013)					
Step One	**Step Two**	**Step Three**	**Step Four**	**Step Five**	**Step Six**
Data organisation: • Two data sets were organised and separately entered into the NVivo software version 10 • The interview data were divided into the two interviewed groups of older people and community nurses	*Forming initial:* • Using Nvivo to look for the substantial information • Breakdown the whole data into nodes	*Describing:* • Making nodes (sub-nodes) to form the codes (mother-nodes)	*Codes and themes*: • Identified the most frequent nodes and formed categories • Identify the similarities and differences in categories to group data into larger categories (themes)	*Interpret and describe themes*: • Employ the Occam's Razor principle	*Presenting*: • Narratives, • • s, figures and sketches • Report a 'thick description' in relation to the research aims and questions

Audit Trail

The study data was organised using Nvivo version 10, which provides an electronic audit trail. This process involves a clear series of emerging findings where active nodes link to original quotes. Each quote in an Nvivo node is provided with an active link that enables through a computer mouse click to connect to the relevant piece from the original transcript. To be reported in the findings chapters where excerpts are used to illustrate themes, an audit trail was created by interview and page (e.g. 1: 23) to enable simple tracking of the raw data. The omitted ellipsis […] was used for words and phrases like 'Umm', 'something like that', 'Err', 'Ahh', and for reactions like laughing, or pauses in conversations.

In findings that had the same content in different sentences, the researcher used three ellipsis dots **…** to identify non-relevant, sentences, or paragraphs and to bridge to track the next related context. The letter X (Y, Z) was used to anonymise the participant's name, or the third person that the participant was referring. When reporting the results from the non-participant observation data, event, date and time was recorded.

The political crisis

As Thailand was facing an internal political crisis at the time of the field research, this affected the data collection process. To ensure no conflict arose whilst collecting the data, the researcher was warned by community nurses not to express any opinions about the Thai political situation to local people while undertaking conversations in communities. A serious situation took place in the

country on 22nd of May 2014 while the researcher was working in one THPH. All television channels announced that the country had been taken over by the military. Curfews were enforced throughout the country, and all schools, colleges, universities and educational institutions were closed for three days. Public activities and broadcasting media such as television and radio were ordered to stop their programs, and Internet access was limited. News about the army attacking local people was rife within all the communities. The researcher was concerned and stayed away from crowds during this time. This situation was reported to the project supervisors. It took the researcher out of the research site for five days.

Summary

This study employed conventional ethnography to explore the concept of resilience in older people living in rural Thai communities. The Human Research Ethics Committee of the University of Newcastle, (*Reference No:H-2014-0031, approval:26-Feb-2014*) and Roi-Et Provincial Health Office approved the research study. Data collection included semi-structured interview, non-participant observation in the THPHs and fieldwork. The researcher spent three months within the four rural communities. The non-participant observation was held over 340 hours. The semi-structured interviews were gathered from 35 older participants and 9 community nurses interview transcriptions (with 7 community nurses).

Comprehensive data analysis using the Nvivo software program was used to organise and analyse the data. Content analysis using Creswell (2013) approach

guided the six steps of the qualitative data analysis. The ‘thick description’ method was used to report the findings of this research study. The following chapter is the first findings chapter. This chapter discusses participant views of their everyday lives, which contribute to them being resilient in the face of adversity.

Chapter Four

Living well everyday-factors that contribute to resilience

Introduction

This chapter presents the themes obtained from interviewing Thai elderly participants combined with those revealed during non-participant observation and fieldwork in the villages. The main theme that emerged from the data described in this chapter is 'living well every day', which relates to the description of older Thai people living a healthy life. Four sub-themes are included in the main theme *living well every day* related to participants' physical health, mental health, connection to family and community, and spirituality.

Living well every day - '*Yuu Dee Mee Haang*'

When describing living well every day the participants used the phrase '*Yuu Dee Mee Haang*'. This phrase is divided into two words '*Yuu Dee*' and '*Mee Haang*'. '*Yuu Dee'* means to live, or exist in a very positive way, such as being healthy and wealthy, while, '*Mee Haang*' is about having power, energy or strength. For example, some older people described '*Mee Haang*' as having the physical strength and energy to work on the rice farm. For the participants the phrase '*Yuu Dee Mee Haang*' represented their living healthily. They described what good health was for them being older and living in rural areas.

In this context, '*Yuu Dee Mee Haang*' describes the perceptions of the Thai elders about how they remain resilient despite them getting older and sometimes facing adverse life events.

Having physical health

Having good physical health emerged from the data as a subtheme of 'living well every day'. The Thai elders described several aspects of physical health.

The participants who were rarely sick and had not been admitted to the hospital described themselves as having good health. One older person explained that she was old, however, she viewed her health as good:

> *I feel pain around my shoulder because of my work. I did massage … I don't feel pain every day, just some days … I've never been referred to stay in hospital (E33:1).*

Likewise, an older male participant said his good health related to staying away from ill health and having a normal level of blood pressure:

> *… I've just seen the doctors and they told me my blood pressure is normal, so I feel I'm healthy because of the normal blood pressure (E35:2).*

For him having a normal blood pressure meant that he was healthy.

The participants' also mentioned that regular exercise was important to keep them living well. Exercise was performed at home by themselves, or as a group in a public place. One participant explained that he exercised with a traditional style of group dancing, similar to an aerobic dance but with more traditional or local music, and only the melodies without lyrics.

The participant explained:

> *I did dancing for exercise. I did not do it on purpose, I mean dancing, but I finally found out later it really worked (E05:9).*

An older woman however revealed that she exercises by herself and it was done at home:

> *I love to do exercise … I also do aerobic dance in my room alone. It is only me at home. I can do whatever I want to do (E33:1).*

Similarly, another participant explained the way he exercises at his home:

> *When I wake up, I have to fight with the disease… 50 times for bending my waist; I do it every day… After exercising, I will open the door to take a deep breath - breathing fresh air in the morning, and then I breathe out. It is a good way to strengthen the heart muscle. It makes me breathe easier. I breathe in deeply, getting fresh air into the lungs and then I breathe out (E27:3).*

This participant was motivated to exercise because it helped him to feel well however others said that they exercise because they were advised to by health professionals. For instance, the following participant said that he exercises because the health professional that he called '*Moaw*-หมอ' asked him to do it:

> *E: I walk in the morning. They told me to exercise.*
>
> *R: Who are 'they'?*
>
> *E: 'Moaw'. They are Moaw. They told me to exercise… I have to do this when I walk and I have to take a deep breath … Then, they told me to do this like a blossom flower (breathing in and lifting both arms up, breathing out and putting both arms down) … I do when I want. If I don't want to, I don't. However, I walk along the street a lot. After I get up in the morning, I walk or ride a bicycle. I exercise. I heal myself (E32:3-4).*

Interestingly, 'Moaw-หมอ' was the term used to identify any health care provider: physicians, nurses, pharmacists, dentists, physiotherapists, and public health staff. This was observed in the THPH where all THPH providers were called 'Moaw' by their visitors.

Older participants also described that they lived a simple life and this was essential to live a healthy life. The elders' lives were focused on their work, for example, working on the rice farm, and being in contact with their extended family. The following participants clarified what the simple life meant for them:

> *Well, nothing much. I work in the farm and look after my LuukLaan (grandchildren) (E03:1).*
>
> *I lived like I do now. Nothing's special (E06:1).*

'Nothing special' described what 'simply' means to them. To clarify the term, the same participant said:

> *Doing nothing, eat, drink water, work, as usual (E06:1).*

Another participant described it similarly:

> *I live my life simple. It is Por Yuu Por Kin -*พออยู่พอกิน *(E08:3).*

'Enough or *Por-*พอ*'* refers to an adequate portion or quantity of something that provides satisfactory living. *Por Yuu Por Kin* –พออยู่พอกิน was the distinctive phrase that the participants described how they live. *Por* means to satisfy with what they have, while *Yuu* is living, or existing and *Kin* is eating. Thus, 'live simply' focused on normal living and was indicated through eating, drinking and work.

Eating simply refers to what they can find easily and usually it is local or traditional food(s) with rice.

> *I talked about myself. I can eat anything. I eat easy with every kind of food. When I watch TV and I get hungry, I will go for fermented fish. I used the spoon to take the meat, add some lime juice, sprinkle with chilli powder, add some smashed red onion and eat it with rice (E31:22-23).*

Older people who live with, or near their children would have food prepared and provided by their children.

To keep living simply, one participant described:

> *… I don't consider eating as a big deal […] I don't make my eating as a big deal for my children. I told my daughter, X that I ate what I could find and that was it. She said others' fathers were difficult about eating. But I could eat what we had even it was not tasty. You could find the tasty food next time. So I just ate it (E05:15).*

Another aspect of physical wellness, which was described, by most of the Thai elder participants was 'eating well'. Participants in this study said that they paid particular attention to their eating habits. The following participant suggested being healthy was all about his eating routine:

> *I believe it's all about eating habit. I always eat carefully. This is my priority (E05:1).*

One participant said:

> *… I won't eat too much*
> *I eat what I can find in my area*
> *I don't smoke nor drink. I don't drink soda pop, either*
> *I eat nutrient food, no drinking and smoking*
> *Eating plays important role. I eat carefully. I eat everything that cooked (E05:1).*

Eating ‘cooked’ food was mentioned by several participants, in order to keep oneself healthy. One person said he could eat everything except uncooked food:

> *But for eating, I don't selected eat. I can eat everything except uncooked food (E34:2).*

From the non-participant observation, uncooked food was identified as a unique eating style of Isan (Northeast) tradition. Uncooked beef salad was the most common dish observed during the data collection period. This type of food was provided during particular traditional ceremonies, such as a wedding party, or an ordination ceremony; or it was sold by the local shops. The following participant said that he had to ask people to fry it when he was offered uncooked food.

> *I don't eat uncooked food. I will ask people to cook the uncooked food by frying it. However, sometimes when my friends come to me with the uncooked food, I have to eat with them, I cannot refuse them (E35:4).*

It was common to see Thai people greeting each other by asking ‘Have you had a meal yet?’ at certain times, such as morning, lunch, and dinner. It is the equivalent of the western greeting ‘How are you?’ Indeed, rural Thai older people are focused on eating.

For these participants, having good physical health was about getting plenty of exercise, living simply, and eating well. Exercise is an important part of a self-care activity to enhance every function, and this was useful to helping older people to be resilient (Felten, 2000). Exercise was described by participants as an important element that kept the Thai elders healthy. However, there appeared to be no standard pattern for them to follow, and how and when they exercised mostly depended on their personal situation. Despite this variability, the Thai elders

interviewed realised that exercise was good for them. Medical advice from the health professional or '*Moaw'* was another important reason for them to continue exercising. To 'live simply' was identified by the Thai elderly as being associated with their work, family situation, and simple foods. 'Live simply' contributed to older people living well, in terms of them not trying too hard to get what they want and enjoying being satisfied with what they have.

Eating for Thai older people has been described as a fundamental priority to achieve healthy ageing (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol, & Steckler, 2009). For these participants eating well and not too much, eating the local foods, not drinking alcohol, and avoiding uncooked foods facilitated the health of elderly participants.

Poor physical health when growing older has been reported as a risk factor that challenges older peoples' resilience (Moe et al., 2013). Having good physical health was reported as a positive factor that protected against negative outcomes despite adversity (Jeste et al., 2013; Wells, 2010). Previous studies have identified better physical health is associated with higher levels of elderly resilience (Jeste et al., 2013).

Having good mental health

Having good mental health emerged from the data as a subtheme of 'living well every day'. Thai elders described a number of different aspects of good mental health. For one older person having good mental health was about releasing negative feelings and not being under pressure:

> *I find where I can express. I won't let myself being under pressure. Too many thoughts make me unhappy (E05:2).*

Another participant clarified that good mental health was not feeling depressed, and doing things that brought happiness to help him to move away from any negative feelings:

> *… I actually don't feel sad, and I don't keep the sadness to be my difficulty in my life. I do the things that make me happy and cheerful (E34:2).*

Another participant described having good mental health as being cheerful and having a positive self-image. She explained that she did not want to look as old as her age and dressing up and putting on make-up helped her feel young:

> *I thought I don't want to look old, like my age. I still want to get dressed like others […] I want to brush my hair and put make up on my face, and I want to get my hair dyed like others […] I enjoy in my beauty. It makes me want to go see my friends. I'm so happy (E24:17).*

Feeling proud of children was another source of happiness and encouragement that was linked to having good mental health. The following participant described how proud he was of the success of his children, also his grandchildren; and this encouraged him to live well in his everyday life:

> *It's (encouragement) from my family. It's from my kids. I have kids. They give me warmth. So, I have courage. I don't feel neglected. I don't feel pressure … They prepare me food. I'm happy when they come. I'm happy when we eat together. When they have money, they give some to me. I didn't even ask for it. Except that when I was in a need (E31:9-10).*

The Thai elders also said that when they were positively acknowledged by members of the community this contributed to their mental wellness. These older

people experienced this acknowledgement when they did something impressive, such as helping community members to organise cultural events. For example, the oldest man in his exercise group led other older people to perform exercises. This exercise team joined in competitions and they won first place in the districts' competitions for several years.

He expressed his feeling as:

> *I smile in my heart and my heart was fully filled. I think it's reasonable to feel good when being praised (E05:7).*

Having will power was also described as a feeling of satisfaction that contributed to good mental health. One participant described this feeling as:

> *E: The willpower is like Grandpa! can you help us […] They ask me for my help. The way they act makes me proud of myself.*
>
> *R: That's your willpower?*
>
> *E: Exactly (E08:10).*

This positive feeling was experienced by the people who had interacted with him and shared this feeling that contributed to his happiness:

> *I'm just happy with what I am doing. And people praise me what I've done (E08:14).*

Moreover, receiving respect from people in the community was a unique aspect of rural Thai culture.

One elder shared his situation:

> *People greet me and Wai me (Thai greeting with putting hands together). They also ask me about my living. That means they feel good with me, right? They always ask me how am I. That means they know me. But I don't know all of them because I see so many people. Those people recognise me, but I*

> *cannot recognise them all. Sometimes they made jokes with me that I am so arrogant because I didn't greet them. It is because they know me, but I don't know them. They all know that I'm the leader of the district (E34:7).*

The excerpts above provide an emerging picture of the cultural artefacts involved in the community lives of the elderly rural person. To be known in the village by others is an aspect of belonging to a community of people, sharing the same beliefs and values, and to be able to express gratitude for those simple things appears to lead to a stronger sense of self.

One participant discussed his sexuality. He expressed his feeling of fun and being happy with himself because of his ability to think about his sexuality. He shared this comment:

> *I would answer when I see girls; I would think about them in terms of, I would say sometimes I think about them sexually. I think this make me feel happy and cheerful. It is to make fun with my mind, just think about it in my mind to turn myself on, to make me feel fresh. I don't do anything, just think (E34:3).*

Interestingly, data emerged for male participants about sexuality and living well but not for the Thai older women who were interviewed. This may have been because Thailand traditionally, is a patriarchal society where men were generally the family leaders and where woman were the homemakers. To speak out about sexuality in traditional Thai culture is certainly not something a woman would normally be sanctioned to do.

In Thailand, there is a paucity of evidence about older persons sexuality but one study found that sexuality among older Thai people was more important for men than women (Knodel & Chayovan, 2001). Sexual expression has been linked to

emotional well-being in old age (Barrett, 2013). The WHO (2015b, p. 56) suggests that “higher levels of sexual function are important for relationship satisfaction in both older women and men”. It has been reported in one study however, that sexuality was not as important for older women (Minichiello, Ackling, Bourne, & Plummer, 2005).

Having good mental health for these participants had a significant impact on reducing depressive thoughts, or feeling stressed. Releasing unhappy thoughts, being happy, and having a cheerful mind were described by Thai elders as having good mental health. Additionally, thinking positively about oneself and expressing sexuality was described as a focus that contributed to the feeling of being happy for at least two male participants. Receiving positive recognition from the community was also reported by the Thai elders to make them feel better about themselves.

Social connectedness (elders being connected brings community stability)

Being connected to family and community emerged from the data as a subtheme of ‘living well every day’. Thai elders described a number of different ways of connecting that contributed to their healthy life and their participation helped to maintain the cultural fabric of the community. Socialising was one type of connecting described by the elders where they had the ability to go out and interact with other people. As it was explained by the participants, sharing and talking to each other made them happy.

This feeling motivated the elders to engage and get involved in community activities. Being productive and contributing to their community was what

participants described as keeping them well. The following participant identified himself as a public figure, as he was elected to be a village headman and headman assistant for the last 20 years. When he retired, he joined several committees in his village and he noticed how much self-worth he had locally through being acknowledged as village headman by the village members:

> *The villages also assigned me to be a member of several committees. The position assigned to me depended on them. They might think I was an important person, I was noticed (E08:3).*

Ageing well for some Thai older participant's involved being engaged with society and having a continued involvement in social and cultural activities (Thanakwang, Isaramalai, & Hatthakit, 2014). Receiving positive recognition from other community members facilitated the development of self-confidence and reinforced their continued participation in social activities. The following participant describes his responsibilities in a prestigious position in his rural community:

> *Yes, I was chosen to be the leader of the community, then community leaders did vote for me to be the leader of the village, and the village leaders chose me to be the leader of the district (E34:8).*

The leadership position arose from an election by the community members. The person who was chosen and was able to continue for a long time in that position was viewed as being powerful and influential. The older participants who designated themselves as leaders found this was the way to make them happy and enjoy their lives. During the time they represented their people, these elders had many good experiences. They found a sense of happiness from being involved in

the community. The same older male participant, for example, disclosed the positive side of being a leader as he has experienced it:

> *It's quite fun. Also it provides chances to see people and make relationships. I know many people especially the committees in district and provincial levels. Some people are not my friends, but we know each other. Also I can make friends with others when I have meetings in Bangkok and when we have meetings in district and provincial meetings or training. We see others then we make friends (E34:6).*

Furthermore, as they are being looked up to and followed by other members within their community, the sense of positive role modelling encouraged them to continue being involved. For example, one older woman was a leader in her community in her role as a health volunteer. She led an exercise class for others and said this responsibility led her to continue in the role:

> *I do it regularly because I am the leader of the community volunteer. I have to train other community volunteers and the elders in community, so I do it every day (E33:2).*

Additionally, personal knowledge related to social and cultural practices and activities has been found to be a distinctive feature among rural Thai elders. The knowledge of cultural practices is mostly taught to an individual by their family and passed down from generation to generation; however for some it is self-taught. Most of this essential knowledge is associated with religion and spiritual beliefs. One elderly participant explained he was a part of his community because of his ability to share knowledge and experiences to guide the younger Thai people. He said he was an important older person in his community and people

from the community paid their respects and relied on him. He described his experience when he was asked to take care of the religion for his village:

> *…Grandfather Y … He told me that I should not stop doing temple business. I have to take care of the religion, the monks, and the temple. He also suggests that I should complain the monks who commit guilty or who don't follow the Buddhist Lesson for example the monks who get relationship with female or the monks who drink alcohol. I shouldn't be afraid of them. I have to make it right (E21:28-29).*

Moreover, he was the person who had the knowledge and the responsibility of leading his community in the Buddhist faith. Each event or practice had a different purpose and required different resources. For rural Thai people in this study, it was important to do this correctly and older people who have the knowledge would lead and organise all those practices. For this older person, he was always being asked for help from his community members to get the religious events organised:

> *… people would invite me to join or called me for help. People from the Baan Taerae (next village) also invited me sometimes. That was me who help them do the religion ceremony. Other people cannot do like me. They also called me to make "Sekkasart Sarttamon (ritual materials)" and fish basket and fish trap (it's believed that these fishing equipment represent abundance. and they are used as ritual materials as well). When I went to the ceremony, I would tell people to prepare thin bamboo-stripes for me and I would make the materials for them. I always refused to get money from them. I wanted only Boon (E21:21).*

Other types of connecting were also described by the Thai elders. *Klong Yaaw* or the local music band that mainly uses tall narrow drums combined with other types of local percussion, such as wooden clappers and cymbals, was described by them as an enjoyable part of living in a rural environment. The participants'

described this in terms that made them feel a sense of joy. The music provided a means of releasing negative feelings and replacing them with feelings of fun and happiness. By joining in, the participants' indicated that it encouraged their desire to have fun.

> *It seems very enjoyable for me. I am absolutely keen to go when I was hearing the "Klong Yaaw" music (E02:18).*
>
> *If there's anything fun to do, I join it. When I hear tom-tom (KlongYaw) or music sounds, I always dance with people. Although there are a lot of guys, including my sons, I'm not shy (E17:12).*

Another type of social activity that encouraged connectivity and was fun was the local show, called *Mor-Lum* (local dancing with comedy play performance). One participant shared her positive experience with *Mor-Lum*, which she attended because of her physician's recommendation. The physician determined that she was worrying too much about her family problems and this had led to a hospitalisation. She described that:

> *The doctor said I didn't have to care about anything. I didn't have to listen to what I didn't want to. I did only what I felt like. There was a Mor Lum showing in my neighbourhood. I danced with friends (E17:10).*

The music and dance and religious gatherings all served to provide a sense of the culture surviving as one ages. For these participants to express and participate in the artefacts of culture, as they understand it, provides a generational example to younger people that such things are important historically in the development and sustainability of traditional ways. Another aspect of being connected was described by the elders using the term of '*LuukLaan*-ลูกหลาน'. The participants used

this term when they were talking about their support network. For them, LuukLaan referred to the person who was of a younger age, possibly children, or grandchildren, who were blood relatives. Some participants used the terms *LuukTaaw* and *LuukLaan* to differentiate the person that they were referring.

LuukTaaw had a closer meaning to adult children, and local people clarified that Luuk was children and *Taaw* meant to breast. Therefore, it is likely that persons referred to as LuukTaaw were adult children. However, both the children and grandchildren are carers of the older person:

> *Just live with my sister and my LuukLaan (grandchildren). It is just this …They are taking care of me very well (E02:10).*

The participant below was aged 80 and was told to stop working and receive care from his children:

> *They told me to stop working. We can't do it. Our eyes are not that good and we are getting deaf. We are not strong … They don't want us to work. They cook for us. They said we are old, they wanted us to stop…They said please stop. They will take care of me. I don't have to do anything … But the thing is we can't work anymore. We're too tired. […] The kids told us to stop because we are old. They said we don't have to work anymore (E32:17-18).*

The researcher observed that the LuukLaan (support network) provided both physical and mental support. Physical support occurred through the preparation of foods, giving money, and providing housing. The following participant, for instance, had been living alone for two months after her youngest granddaughter finished school, and moved away to live in Bangkok. She said that her two sons

always provide food for her when they visit her on weekends, or when food was sent via mail:

> *My children never cause trouble. They always feed me. Every week they would provide me some food in the fridge such as milk or others that enrich my health. I can eat them for a few weeks (E16:5).*

The participants said that they were satisfied with their life when their children were financially secure and thus were able to look after them comfortably. However, one participant described that this did not mean that the children had to be wealthy; it was more about having enough:

> *When all of them had their own families, I felt relieved. Although they are not rich, they can take care of themselves. I feel proud of them (E05:2).*

Another participant described this point in the same way. For her, what her children have now will help her to rest in peace after she dies.

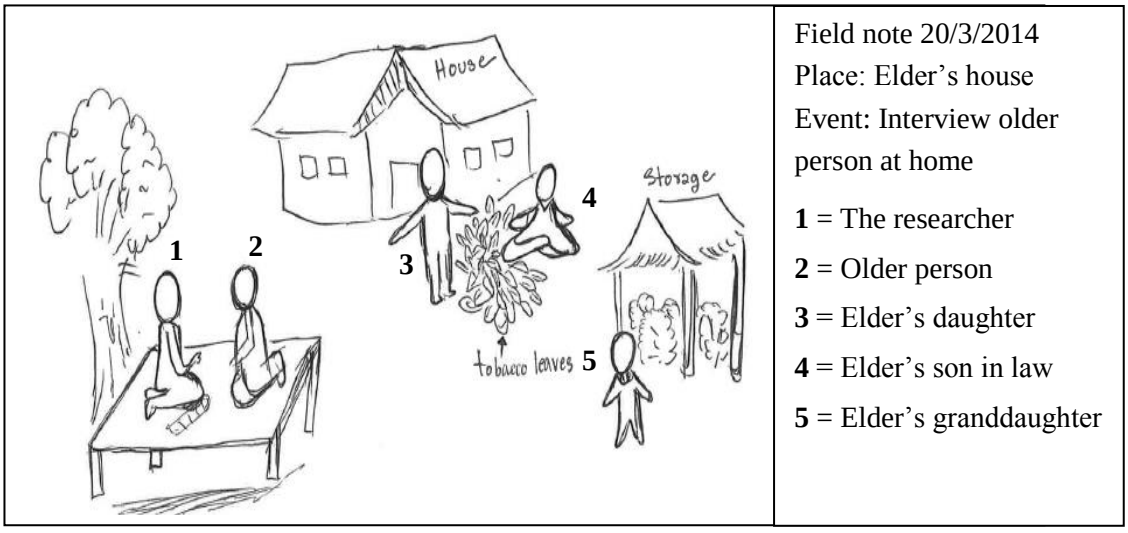
> *My children, they all are good. They have their own family. They have their land, and they don't have to ask for the land from me. They have 'Rice barn and fish hole' (having enough to eat) I think it such a happy life being like this. I would not worry about anything if I died, 'my eyes will close' (rest in peace) (E22:5-6).*

The findings highlight the support being given by the *LuukLaan* (children and grandchildren) was valued as well as generating positive feelings such as happiness in the older persons. The connections described between the children and the Thai elders were significant and assisted the elders to live well. It has been identified that in Thailand female children are preferred to give care and comfort because they are believed to better understand older people (Urairat et al., 2014). Daughters in rural Northeast Thailand for example, are also more likely to live in

the same village with their older parents than their sons (Rittirong, Prasartkul, & Rindfuss, 2013).

The findings confirm that daughters were the main carers. The observational data from home interviews confirmed the bonding of the older participants and their LuukLaan. This was observed as a willingness to stay close to their older person and listening to the interview. At the same time, the older person was always looking to their children, or grandchildren when they could not answer some of the questions asked during the interviews, sometimes requiring them (LuukLaan) to assist them. The following sketch was an example of one participant's interview with her family all around. They did not disturb the participant and only kept their eyes on the elder:

Figure 7: Elder's family member feature during interview



Being connected explained the activities that Thai elders use to engage, or be involved with others in their village. The participants described the ways that they connected to others in their community and this was intrinsically linked to their customs, religion, beliefs, and life experiences. Being in a leadership role because

of their age and knowledge about cultural events was described as a way that the rural older participants connected to other people. Other ways were to enjoy the local entertainment and to be close to their LuukLaan (children and/or grandchildren).

Being spiritual

Being spiritual emerged from the data as a subtheme of 'living well every day'. Thai elders described a number of different ways of being spiritual that contributed to their healthy life.

One participant shared his personal belief about religion:

> *Since I was a monk, I used to lead people pray and offer Sung-kha-taarn-*สังฆทาน *to monks. My master told me to pledge whatever I wanted […] First, I never missed praying during Buddhist Lent unless I was sick. I always did it. Secondly, I was stop leading people pray in the ceremony. I pledged if I could live to 80, I would lead praying again (E05:7).*

This participant believed his life as it is now was from his sworn statement in front of the temple's Buddha statue when he was a monk. He made a wish that if he lived until age 80, he would lead people to pray again. At age 76 when he was interviewed by the researcher, he was not leading people to pray. To reach 80 years old he had four more years and this belief contributed to his health.

Other participants mentioned the term '*Boonwassana-*บุญวาสนา' or '*Wassana-*วาสนา', which could mean that fortune, luck or fate kept them well.

> The following participant, for example suggested:
>
> *It might be my Was-sa-na…Before that, my leg hurt. So, I stopped doing some activities. I was fine because the master (the monk at the temple) was*

> *sacred. He led me doing things and I followed him. Then I could comfortably walk until today. Before that I couldn't (E08:4).*

For these older people living in rural areas, it was observed that religious beliefs or beliefs about magic had a significant impact on how they lived their lives. The Buddhist temple was the main meaningful place to support their religious beliefs.

The participants usually visited temples to make merit. Most Thai elderly believed in making merit (*Tamboon:* ทำบุญ), which made them happy (Danyuthasilpe et al., 2009). The village temple (*Wad:* วัด) was a central place for elderly persons, as it allowed them to make merit, as well as to pray and pay respect to Buddha's image; particularly on Buddhist holy days. They also visited the Wad to practice meditation, listen to special sermons and observed moral precepts (Pathike et al., 2015; Tongprateep, 2000).

Moral precepts dictate the way of merit making, and include five themes of not to kill, not to steal, to refrain from sexual misconduct, not to resort to falsehood and to refrain from intoxicants (Tongprateep, 2000, p. 200). Additionally, the temple was the place for funerals and cremation, and provided peace at the end of their life (Rittirong et al., 2014). A number of activities were described by Thai elders that facilitated them being spiritual and thus contributed to their living well.

Boon and Karm

Boon and Karm: '*Boon*-บุญ' refers to a practical activity that people are doing good things for oneself and/or another person. One older person explained the way that she gave, or donated something to the village's temple as the way to make *Boon:*

> *We will take something like a local handmade pillow or local satin to donate for the temple. All things that we donated will give "Boon" to our family members who passed away… People can make Boon for themselves or for their kinship that passed away (E02:8-9).*

Once the person made *Boon*, the consequence of *Boon* was described as not an objective, which could be seen or touched. The outcome of making *Boon* was the feeling of happiness, as this participant shared:

> *I have a chance to make Boon, and I offer food to monks. I get encouragement. I'm happy, and I am kind. […] Because I'm in good mood (E26:40).*

On the other hand, *Karm* indicated something opposite. One participant, for instant, described *Karm* as the result of something that he had done at a previous time. He now lives with his wife and none of his children. He believed it was because he took his wife away from her family:

> *… It's the karma that I asked my wife to be with me, so she had to leave her father with her aunt. When I have a daughter, I asked her not to study because it would take her far from home and have no one take care of us. When my daughter got married, her husband asked her to stay with his mother because her husband is the only child. So, my daughter lives at her husband place and she hardly comes for a visit. It must be the Karm that I had separated my wife with her father (E31:3).*

Boon represents doing positive activities and then receiving the positive feeling of happiness. *Karm* is opposite and comes from something negative the person has done before. For the participants, making Boon was revealed as a way of keeping their lives healthy.

They shared several ways that were based on their personal beliefs related to receiving *Boon* through the Buddhist religion practises. The following section describes the six main ways participants made Boon and these include, making a wish to get Boon, offering foods, donating their money, *Waan Seenn* (Buddhist Sabbath) occasions, listening to a monk's sermon, and avoiding sin.

1. Make a wish to get Boon

Boon is an abstract perception that the participants' expressed, they said they were unable to touch, or explain what it was, or how what it looks like to them. For them, wishing for *Boon* was seen as having been paid back for the good things that they had done previously. Importantly, the way to wish for it was through having a 'pure and delighted heart':

> *I make Boon with my pure and delighted heart (E07:7).*

The saying '*Sa-Thu-*สาธุ' was observed when older people made a wish after doing something like donating money, or joining a religious activity. It mostly occurred in the village temple, or alternatively at home. The following excerpt describes a participant's experience:

> *... I said "Sa-Thu" and I wish to live longer to make Boon (E02:16).*

Throughout the interviews and non-participant observation, most of the participants indicated that they have a small space, or shelf to house a Buddha statue in their home. Buddhist amulets and other holy pieces such as the bone ashes of family members who have died at home are also displayed. Participants showed their respect by praying and making a wish to get *Boon* to these special

spaces. They may also pay respects to Buddha by bowing three times on top of their pillow before bedtime.

2. Donating to support the Buddhist religion

Donating to support the Buddhist religion and temple is seen as a way of attaining Boon. Donations take the form of money or items such as handmade pillows, or both. The participants described this donating as the Buddhist practise of showing self-sacrifice. The action of Boon reduced dissatisfaction with what one does not have, and increased the feeling of being grateful for what one does have. A participant indicated that they gave what they had so that it did not disturb or cause difficulty in terms of living their life:

> *We share as we have. If we have much money, we pay much … If we don't have much, we pay less (E11:9).*

Apparently, this was the way to receive *Boon*:

> *Everyone will get "Boon" with whatever that they donated (E02:9).*

3. Offering food to monks

From the researcher's observations during fieldwork, older people in the village were the main group taking care of monks, as well as offering foods to the village temple. Otherwise, the village monks were walking around the village barefoot with monk's alms bowls, asking the villagers to offer them food in front of their houses in the early morning. Within the community, a village monk was always making chimes at the temple and this noise was audible from the place where the researcher was staying. At around 6 am the village monks would start walking from the village temple, going around the village and returning to the temple at

around 7 am. At the village temple, some people who preferred to offer food at the temple, or the monks that had not walked past were waiting with prepared food ready on plates.

When the monks arrived, all the food that had been offered by the villagers (in the monk's bowl) was transferred onto plates. After everything was ready and the monks were seated, people started praying, and offering food. The monks then prayed and blessed people before commencing eating their breakfast. Usually, there was food left over after the monks had completed their meal and the people who remained at the temple were able to eat the leftovers. This pattern also occurred at lunchtime but with fewer people.

The following participant explains this:

> *I offer food for monks every morning…If I go there in the morning, I won't go there at noon, but I go there every day … I offer food for monk every day, but I don't go to the temple every day (E35:6).*

This practice of supplying food to support the monks is a cultural tradition because in Thailand Buddhist monks live a monastic life and do not earn a living (Schedneck, 2011).

4. Waan Seenn Occasion

Waan Seenn-วันศีล as described by the participants as a Buddhist holy day dependent on the moon, normally occurring 4 days a month in half-full, half-dark, full and dark moon days. This is similar to the Sunday Sabbath of Western-Christianity. The following participant explained that she was reminded by her parents not to forget to go to the temple on these particular days:

> *Going to the temple, my father said. Going to the temple in the morning once a day and then it's okay not to go at 11 o'clock … I was told not to omit or forget the Waan Seenn (E11:21).*

One participant indicated *Waan Seenn* had meaning for her when she attended the temple and would undertake Buddhist practices. She said these practices were important for her, in particular the 8th month that is Buddhist lent. She said she and other villagers wore white clothes and stayed overnight at the temple on the Buddhist holy day. While staying at the temple they chanted throughout the night and prayed. They chanted to say good-bye to the monks then left the temple the next morning:

> *Normally we start Taam-Wad (chanting) around 7-8pm… I go to make a respect to Loong Poo (Budda statue) first. We dress up in the white colour. Make chanting together then … In the morning, we will give Kaan-Doakmaiy (a bowl of flowers) and chant to say good bye (E02:13-14).*

5. Listening to the monk's sermon

Listening to the monk's sermon was revealed by the participants as a key component of being spiritual. The sermons were Buddhist teachings that were passed on by monks. The consequence of listening to the sermons resulted in the Thai elders feeling happiness, as the following participant explains:

> *I listened to the monk. When he said, I followed his speech. Then I got it and I felt better … I feel blissful when I join them. The monks tell me a lot of things. When I listen to them, I feel delighted (E04:6-7).*

To explain what they had been told by monks, the participant who experienced difficult times in his life expressed that:

> *I have to try to accept it. I have to practice myself … Monk's sermon told that everything is not belong to us (E20:19).*

Similarly, one teaching, one is born and must die, helped the following participant accept the things that were happening in her life:

> *He taught us that everyone was born, and must die. We cannot escape from death … I heard the monk said like that (E24:14).*

6. Avoiding Sin

The participants of this study highlighted the importance of avoiding sin (*or Barb-*บาป) in their lives to receive Boon. The excerpt elderly participants described what sin meant to them and the ways in which an individual can inadvertently sin. One participant described that avoiding sin for her was being worried, which was caused by leaving her family member at home while she was going to make Boon. She said she felt worried and that it was a sin:

> *… because there's no one taking care of my husband. If I go to the temple, I'm afraid that I would get a sin. Every time I wanted to go to the temple, I thought like this… I'm afraid that I would worry about my family and my work … who would take care of them? […] If I have to sleep in the temple and wear white clothes … I'm afraid that it would be a sin (E24:14-15).*

Sexual contact was also considered a sin by some participants. One participant mentioned that feeling sexual would be considered a sin and this caused him to not to engage in any sexual activity with his wife. This influenced him at the temple, he attended at different times to his wife and when they were there together, they did not sit near each other.

This was his way of avoiding sin:

> *... I go to the temple to make merit because I talked to my wife that we are old, and we should go to the temple. We go to the temple together, but we go on the different time and we don't sit near each other... At night, we're not close to each other... we don't have sex anymore. It would cause me a sin (E26:47).*

Not engaging in sexual activity and not being close to, or touching his wife was linked to his religious belief, as well as his perception of culture. He shared his thoughts that he realised the way of sin was created by himself. He explained that it was okay to have sexual activity when the people were young and married. Meanwhile, it was better for older person to focus on religious practices rather than thinking about sexuality:

> *... because we already received Commandments of Buddhism. […] After receiving the Commandments of Buddhism, we can't touch each other[…] It would be immoral to have sex […] Husband and wife.[…] We can't touch each other. […] Like, if I see women who are the same age as you, I can't think about sex with them. […] We shouldn't think about sex with younger people... […] It's embarrassing to LuukLaan as I've seen other elders who are older than me, when they saw young women, they like to tease those women (E26:48-49).*

An earlier participant however, said that sexuality was an important component of living well. These confliciting opinions of sexuality may be related to the Buddhist monastic discipline in which Thai Buddhist monks are not allowed direct physical contact with the opposite gender (Terwiel, 1976).

Avoiding sin from the participants' perspective could be a personal perception or thoughts, which have been shaped by religious beliefs. Avoiding sin may have a

positive effect contributing to the feeling of calmness, being in control and harmonious with their beliefs.

Superstition and magical beliefs

The participants discussed how superstition and magical beliefs contributed to them being spiritual and living well. From the fieldwork observation, wearing superstitious items such as cotton thread were generally found on people living in the rural communities. The following participant explained that that the cotton threads were a lucky symbol generally given by monks, or someone who ran the local ceremonies.

During a special ceremony, the spirit feast that is held in June requires that all the villagers wear the cotton thread to protect them from bad luck.

> *In the month sixth, there was a feast. People were given ceremonial thread, especially my children from Bangkok. Before they went back, they would get their wrist tied by the cotton thread […] They were blessed with health and happiness (E03:14).*

One participant who was suffering from a serious illness consulted the local fortune-teller. She had cervical cancer but had difficulty accepting the illness. She indicated that she visited the fortune-teller and that she believed he could see and know what was happening to her.

She said:

> *I went to the fortune teller. He said inside my stomach is full of blood (E12:22).*

This was similar to another participant who said she suffered when her son was missing from home. She looked for him everywhere she could and finally she

went to see this fortune-teller. She said his prediction proved accurate and she got a letter in the mail from her son a day later:

> *I went for a fortune teller at Grandpa X in Ban Klang Community. He said the next days the news would come. Then, I received a letter (E13:14).*

The other participants also described their experiences with magic. Older people explained the physical health problems they face as they aged and they shared their magical beliefs regarding these experiences. One participant said she had an illness and the doctor told her surgery was required to cure the disease, however she did not want any surgery.

She indicated that she treated herself by making a wish and drinking water from boiled tree roots:

> *It's just as my wish. I don't feel any pain since I started to take it. It's good … I wish that it can cure my disease… We wrote down your name, surname and address on a notebook. Then, we made a wish – wishing that our disease will be cured (E25:17).*

The Thai elders' beliefs in magical power were revealed as something they believe protects them from bad luck. In the excerpt below, a participant shared his belief with his children. He explained that he wore a necklace made out of the lost teeth of his parents and this helped him to overcome bad things. He had his teeth removed and gave them to his children to help them get over any problems:

> *For all of my teeth removed, I gave them to my children. My teeth are the amulet worn to protect against bad luck, and to keep my children safe from harm. That's what I heard from my ancients. The elders said that we should give our children teeth to keep, so my children put my teeth in the cases, and my teeth amulets are worn as a necklace. They can put the*

> *amulet necklaces over their heads and make a wish…When they have any problems, they can put it over the heads and make a wish (E26:2).*

Superstitions related to Buddhism were also expressed by the Thai elders during the interviews. The Buddha statue or an alternative representation, for example a Buddha sticker or amulet were found to be important to the participants. Making a wish in front of the Buddha statue was described below:

> *I pray for Yuu-dee-Mee-Haang, rich, and winning a lottery …To have happy, get better life and no sickness are what I usually pray … I wish I could win a lottery, I thought (E15:23).*

These findings show two main points of view regarding religious practices. Those that were associated with making a wish to seek protection and paying for the *Yuu Dee Mee Haang (having a good health)*. These two things were purely based on personal feeling. This participant said this helped her to have a good sleep:

> *If I tie it to my wrist, it's like I was tied with Pra Bhud-Pra Tham- Pra Soong which protect me … I have a good dream tying the thread. If I don't have it, I'll have a nightmare (E03:14).*

She did not know why she wished for these, but indicated that the people within her village influenced her to perform these rituals and so she continues to do so. She believed that this is because if she has good health she can continue making Boon:

> *I pray for a Yuu-dee-mee-haang, so that I will continue making Boon (E03:11).*

Summary

This chapter described the factors that protected the rural Thai elderly from the difficulties they experienced while ageing. One major theme 'living well every day' or *Yuu Dee Mee Haang*, and four sub-themes, having good physical and mental health, being connected, and being spiritual emerged from the data. The participants described being physically well when they exercised frequently, lived simply, and ate well.

Psychological wellbeing was described as being happy, joyful and being positive by self-encouragement. A strong connection with others including family, friends and community members, was also an important aspect of living well every day. Many connections relied on the traditional customs and beliefs. Local entertainment also provided an opportunity for Thai elders to be connected.

Being spiritual provided the Thai elders with beliefs that supported them to live their lives well, irrespective of the adverse circumstances they might be facing. Their religious, magical, and superstitious beliefs provided them with feelings of protection and gave them hope of a better life. Religious symbols also provided a sense of being spiritual that led to the perception of living well every day. The level of superstition and belief in magic may perhaps wane with younger people who are more contemporary in outlook and who are often better educated than the older people are, however, this may be an avenue for further research, especially in the context of providing primary health care in a cultural context.

The combinations of the four subthemes were crucial to *Yuu Dee Mee Haang* (living healthy). In this study, the subthemes described the provincial protective

factors that enable Thai elders to live well while ageing. The factors accordingly relate to the concept of the healthy ageing where resilience was viewed as ‘the ability to maintain, or improve a level of functional ability in the face of adversity’ (WHO, 2015b, p. 29). The next chapter describes the concept of adversity as it relates to Thai elderly resilience.

Chapter Five

Adversity and rural Thai older people

Introduction

The previous chapter described participants 'living well every day' in relation to resilience. Four sub-themes related to physical health, mental health, connection to family and community, and spirituality were discussed. This chapter focuses on another element of resilience, adversity and presents findings that describe adversity from the rural Thai elderly participants' perspective. Three sub-themes emerged from the data that relate to adversity, which include the language of adversity, types of adversity, and participant reactions to adversity.

Language of adversity

Adversity can be different for everyone and in this study, it was important to obtain a meaningful way of communication with the older participants about how they cope with the adverse events in their lives and how adversity might relate to an older Thai person being resilient. At the beginning of data collection while the researcher was in the field observing, she walked around the community to post the study's flyers. This was an overt way to feature and introduce herself in the community. Some people in the fields came and asked the researcher about the flyers which were posted at THPH buildings and public places. The informal conversations grew and the word *Túk-(ทุกข์)* arose when people talked about

adversity and facing difficult times. The following notes are taken from the researcher's field notes:

> *I met local people when I went to post the project flyers. They came to me and asked what I am doing. The conversation with them was somewhat awkward. They did not really know what I was talking about. Even the THPH's staff seemed like they had never heard the term 'resilience'. From several informal conversations, the word Túk (ทุกข์) was used to express the negative feeling when people were facing crisis situations. It is a word that they used when they were talking about a group of undesirable feelings e.g. difficulty, unhappiness, joylessness, sadness, sorrow, being miserable, distressed, suffering and so on. Moreover, Túk is the opposite to sùk (สุข) which is happiness and pleasure (Field note 4/3/2014).*

Subsequently, the word *Túk* was used to ask about participant's adverse experiences. The first two of three participants expressed *Túk* as being associated with a situation where they have a lack of money.

> *After these interviews, I was asking myself why my data came out with lots of financial things. It is not too bad, because it makes them feel difficulties. But I probably need better wording that makes more sense to get to the point of my question (Reflexive note 12/3/2014).*

Gobo, (2008) states that *"... the social actors sometimes find it difficult to understand the purpose of an ethnographer's questions, so that their replies manifest"*(Gobo, 2008, p. 194). When interviewing an illiterate person this was recognised as: *"when questions requiring abstraction, generalisation, imagination were put to their subjects, they were unable to provide definition, only descriptions of concrete details"* (Luria, 1974 as cited in Gobo, 2008, p. 194).

A consultation was arranged in order to check the word *'Tuk'* with the THPH's staff, who were local people and understood the nuances of the Isan language. The local words that refer to the feelings of uneasiness, hardship, difficulty, and the feelings expressed when facing a crisis were recalled. The terms *Ouuk-Ouung (อุกอั่ง)* or *Ouuk-Ouung-Oout (อุกอั่งเอ้า)* or *Ouuk-Ouung-Oout-Jai (อุกอั่งเอ้าใจ)* were agreed as the term that provided the best fit for adversity. It was also decided to put a prefix '*Pen*-เป็น' to the term *Túk* to better represent the emotions, and use it as the word *PenTúk*-*เป็นทุกข์*. All these terms conveyed the feelings that related to experiencing difficulty. Therefore, rather than asking about adverse circumstances in the Western sense, the terms *PenTúk, Ouuk-Ouung, Ouuk-Ouung-Oout, and Ouuk-Ouung-Oout-Jai* were used.

Types of adversity

As 'adversity' is different for each person and can be perceived in different ways, the local terms noted above were used to tease out a description of a significant difficulty. During the semi-structured interviews, the participants were asked to recall their major adverse circumstances. The adverse circumstances identified by the study's participants, were then further classified into two types of adversity - intra-personal and inter-personal adversity (Table 13).

Table 13: Adverse experiences of rural Thai older people

Types of adversity	
Intra-personal (ongoing) adversity	**Inter-personal (episodic) adversity**
• Being old • I can't • Living with aches and pain • Living with illness	• Less familial support • Being without money • Loss of a loved one

Intra-personal adversity

Intra-personal adversity describes circumstances that the older Thai person experienced while ageing. The data revealed four sub- themes: 'it's hard being old'; 'I can't', 'living with aches and pain', and 'living with illnesses'.

Being old

During the interviews, the older people recalled when they first felt themselves to be an old person. Several different age ranges were presented from 45 to 60 years of age, and even older. However, the participants had a similar way of expressing 'old', saying it was when physical health and function had declined. One older participant, for instance, described when she felt old and revealed that age itself was not a concern:

> *… I started getting older when I was over 40, and I realised that I'm old when I was 45. Oh, I don't have physical strength as I was. I haven't got much of an appetite, so I don't want to go to work for wages. The lack of energy is common in the elderly… these days I can't work. I get tired quickly when I'm getting old (E28:1).*

The study participants further described the meaning of ‘being old’ and ‘feeling old’ related to their declining physical health status, rather than age associated with number of years.

> *When I get older, it’s difficult to do things … It is common for elder to get tired easily such as when walking (E04:1).*

'Getting tired easily' was explained by one participant as the ‘old’ feeling. Having the feeling of ‘*it is not the same*’ regarding their physical function, compared to when they were young was described what ‘old’ meant to them. The next participant described looking back to the days when she was stronger, when she/he could do whatever she wanted:

> *… it’s different from when I was younger that I still have physical power. When I eat, too, it’s not delicious as it is used to be … But the older I get, the more I found out I couldn’t work comfortably. I am not the same (E12:1).*

Declining physical function is a key indicator of changes associated with ageing (WHO, 2015b). The participant in the next excerpt shared her experience about when she used to see people who were older changing their posture from sitting to standing by pushing their bum up first. Nowadays, she was doing the same thing. She said this was the sign that identified her as an old person:

> *I used to joke on myself, saying maybe I was too old because when I got up I pushed my bum up first (E16:1).*

‘*Pushed my bum up first*’ was a common saying that the researcher heard within the communities used when older people want to change position from siting down to standing up. This saying was used by the Thai elderly participants to describe to themselves that they were getting old. This saying appears to derive

from rural daily life where sitting down on the floor, or on the big square flat table is part of their normal habit.

Being old was also described as a difficult time in the participants' lives. For example, the following participant expressed his current experience of being old. He had no one living with him. His daughter lived in the same village but in a different house. His daughter's house was around four or five houses from his. He was partly independent and could help himself by performing simple tasks such as boiling water, having a shower, and he could walk a very short distance.

His home was a hut with a tin roof, braced by four wooden poles at the square corners, no walls, and a big square table placed in the middle. He sat on the table all day long. During the interview, he shared how hard it was living his life. He said his place had no bathroom or toilet. To use the toilet, he had dug a hole in his backyard and filled it with soil when he had finished. When the sun went down, he had a shower by using water in the big jar near his hut. Then he had a very slow short walk of around 50 metres and climbed the four steps in his stairway to reach the room, which he said was his bedroom. He expressed his difficulty with being old:

> *… It is hard to see myself unable to do things. Others can do but I can't. Others can carry their tobacco leaves, sell them and get 5-60,000 baht. What I can do is only watching them … I lose my appetite and it's hard to put myself to sleep. […] I have no teeth now […] I don't know what to do […] I don't want to live long. Around 50 or 60 would be okay for me to leave this world (E10:2).*

Another participant described the challenges with his daily living that restricted his socialisation. He had difficulty with his urinary function and this had stopped him joining in the village temple, or the community events outside his place.

He said:

> *When I want to pee, I have to go to the restroom straightaway: otherwise, I'll just wet myself. I can't hold it. If I want to poo, I have to run to the restroom. Sometimes, I can't run fast enough to the restroom, I just do it there on the way to the restroom. Elderly life is like this. (E31:22).*

In this study, participants describe the decline in their physical function as the main adverse event that limits them from living well. Being old for these participants meant to face difficult times because of the changes, they experienced as they aged.

I can't

Another subtheme, 'I can't', related to the declining physical functions, which produced problems with everyday living. Physical health status and function for the participants were the main factors that defined 'old'. The limitations of their body caused them to express 'I can't'. Subsequently, 'I can't' for the rural Thai older person in this study was further described as, I can't walk, I can't do what I want, and I can't see things clearly.

I can't walk

Not being able to walk anywhere easily was described as a constraint, which resulted in the Thai elderly taking shorter walks and not being able to walk to their farm. As their major work is farming, they would usually walk to work. The rice farm is typically separated from the village and not far away. The villagers normally own the rice farm and usually walk to and from home comfortably.

For example, the following participant said:

> *I couldn't go anywhere. I couldn't go to the rice field two or three years ago…I can't reach the field these days…It's not far, but my children have to take me there (E14:2).*

I can't do what I want

The participants described that not being able do *what I (they) want* made their life difficult. The participants explained that they desired to do things such as working and walking as they used to do in the past, but because of limitations in their physical functioning, particularly mobility they could not.

For example, two older participants recognised themselves as being an old person with nothing to do because they felt that they were not able to do things that they were once able to do:

> *I'm always tired from doing things and it's uneasy to do things…I am unable to do that works that I used to. I can't walk that good anymore (E29:3).*

> *Yes, it is not the same. I feel tired when I work. And that makes me feel old…I think I'm healthy, but less than in the past. For example, I cannot pull the buffalo to tie (E35:1).*

Family, particularly adult children, had opinions about what older people could, or could not do. The following participant, age 80, who lived with his wife, revealed that his children thought he was old. They said to him that they did not want him to do any work. He knew that his children wanted him to live comfortably, and they asked him to do nothing. He explained that he felt he was not a disabled person, and he did not agree with what his children said and so he continued doing his regular job at home:

> *My children told me to stop doing it. I had some cows, but they forced me to sell them. I had some buffaloes: they forced me to sell them. They want me to just stay at home. How can I just stay at home? I'm not disabled. My children don't want me to work. They want me to be comfortable, but I can't. I get up at 4 or 5 in morning, and then I have to do something (E31:1).*

In this context, 'I can't do what I want' related to both physical abilities and familial beliefs held by the younger family members. Decline in physical functioning was meant that the elders could no longer do what they wanted to do, or did in the past. The beliefs held by the children regarding care of elders also contributed to the elders experiencing limitations in doing things. 'I can't do what I want' was identified as a life-limiting situation by the participants.

I can't see things clearly

Limited sight was described by the Thai elders as preventing them from engaging in regular activities. One participant explained she felt old, as she could not thread a needle:

> *My eyes are not good as they used to be…I can't even thread into a needle's hole (E12:1).*

Similarly, another older man who used to make and sell bamboo baskets was required to end the work because his eyes were not good anymore:

> *I am not doing it now…they are small pieces, I cannot see them (E01:3).*

For an older woman participant, she explained the deterioration in her eyesight was linked to her reading, she could still read but the way the alphabet appeared on the page was not the same as it once was:

> *It is quite different. When I read books, those alphabets lie on one side (E16:1).*
>
> The same participant explained further:
>
> *All of them fall down to one side. If I glimpse, the letters look okay. But if I carefully look at it, they lean to one side (E16:1).*

Listening to what participants said provided a greater understanding of the challenges that the participants' faced each day. These descriptions demonstrate how their physical decline affected their everyday life: 'I can't walk', 'I can't do what I want', and 'I can't see things clearly'. These descriptions can be reduced to the simple phrase of 'I can't', which described the daily adversities faced by the Thai elderly participants.

Living with aches and pain

In the previous subtheme, the participants described that their basic daily life activities were no longer easy to perform. While sharing this difficulty the participants used the words '*Jeb-เจ็บ*' and '*Pood-ปวด*', which meant 'hurt', 'sore', 'ache' or 'pain'. These words explained how they were feeling. Significantly, when the words, *Jeb-เจ็บ*' and '*Pood-ปวด*' (*Jeb* has a close meaning to ache and *Pood* is pain) were spoken, they also said these feelings made life difficult.

The following participants expressed their feelings about aches and pains:

> *I'm getting old every day. I have a pain here around my waist. I feel painful when I walk. I'm not that healthy (E29:16).*
>
> *I feel pain and ache as I've never had when I was young. That's why I told you I'm old. Sometimes I need to take medicine to relieve from the pain (E36:1).*

Similarly, other aged participants explained how aches and pain prevented them not carrying out normal activities:

> *I'm old now. I get backache when I twist my body or when I get up (E04:2).*
>
> *My arms are also sore. When I lifted something, such as when I tried to carry the betel nut basket, my arms were powerless and I couldn't lift it up (E12:1-2).*

Since pain is an inevitable sensory response to damaged tissues (Loeser & Melzack, 1999), older people are more likely to experience pain as part of the ageing process, particularly if they have arthritis, or other musculoskeletal problems (Kress et al., 2014). Pain has been seen as a major cause of impairment and associated in Thailand with depression in the elderly (Suttajit et al., 2010).

Living with illness

The participants described ill health as affecting their life negatively. As people are living longer, age increases the risk of several chronic illnesses, as well as a concomitant decrease in overall health (WHO, 2015b).

This next participant explained that going to hospital often caused him to feel like giving up:

> *I go to the hospital very often. "Sarm waan dee, See' waan kai-สามวันดี สี่วันไข้" (three days well, four days unwell) (E32:1).*
>
> *If one day I die, it is fine. I am old (E32:8).*

Another participant expressed how her liver disease affected her mental health. She was afraid to die but was scared to get medical treatment or surgery as well. She said her ill health was breaking her heart and it frightened her. She did not believe

what medical professionals were saying and she travelled to several hospitals and met with several doctors:

> *It was breaking my heart. I started to feel exhausted since then … A breaking heart is like my body shake when I feel afraid of the condition. I'm afraid that it can't be cured and I tremble … I'm so frightened…I went everywhere – X hospital and Y hospital. I went all. Eventually, they referred me to Khon Kaen … I went to Khon Kaen hospital. They said that I had liver tumours (E25:11-12).*

During the interview, the researcher noticed that she seemed to be still and hid her eyes by putting her head down. She said this adverse situation made her feel exhausted. She showed the researcher a small water container and told the researcher that she drank the boiled water from tree roots. The tree roots came from the magic person that her relative recommended to her. She made a wish for her disease to be cured and drank the boiled root water instead of normal water. She said that she decided not to get any modern medical treatment unless she needed a Para (paracetamol). The liver tumour that was found in 2008 needed surgical intervention and had had a significant impact on her emotional state:

> *…all the doctors came to me. They told me that I need the operation. They tried to urge me to agree to do the operation. I told them that I wanted to go home and let my kids know first… My kids were with me. I lied to them … I'm afraid that I will die. I'm afraid that I won't be conscious again (E25:12-13).*

Having severe health conditions, that required surgery for treatment had a significant impact on some of these elders. Money was described as another factor that compounded the problems experienced by the participants when they were faced with ill health.

> *My disease costs a lot of money … It's normal to think about money but I'm afraid I can't get well from sickness (E07:6).*

Chronic illness in older people was viewed by this participant as a negative life event resulting in a vulnerable outcome. Chronic illness not only affected the elder's physical health but it had a negative impact on the participant's mental health (Hildon et al., 2009; Hildon et al., 2008). Many participants felt like giving up, and were afraid to die, but they were also scared to receive medical treatment. These factors were complicated by the financial hardship caused by chronic illness.

Inter-personal adversity

Inter-personal adversity relates to circumstances that were not within the person but outside of the person. This type of adversity related to family, social, and environmental situations that affected and resulted in an adverse situation. Two sub-themes emerged from the participants' interviews.

Less familial support

In Thai society the older parents hope their children will be successful and return to look after them as they age (Rittirong et al., 2014), however, if their children do not provide them with support this created hardship.

For example, a woman who lived alone even though she had thirteen children, described feelings of the deep hurt and a broken heart, as well as somatic symptoms such as bad headaches:

> *I'm afraid that my children left me … They didn't send me money. It's just good that I have elderly money. I didn't eat with them…Sometimes I*

> *thought I was like the elders in "Wong Wian Cheewit" (The TV program) […] My children left me. I kept thinking until I got a headache (E17:3).*
> *I had a bad headache. I couldn't stay. My heart was breaking (E17:4).*

The participant was comparing herself with other older people she had seen on the Television (TV) program called *Wong Wian Cheewit-วงเวียนชีวิต*. This television program showed real stories (real places and real people), and reflected an undesirable life in Thai society. It showed miserable people who lacked opportunity, and who lived difficult lives, for example, a dying older person who had no job, no money, and no one taking care of them. The TV show carried the feelings of sadness and sorrow for the character playing the role. Moreover, the TV show reinforced the participant's feeling that she was not appreciated by her children and this was the cause of her adverse situation. She explained that she was raising her granddaughters while her daughter was working in Bangkok. She had raised them since they were babies until they were teenagers, on her own. She pointed out that her daughter did not send money to her, and did not help to pay for any living expenses.

Moreover, they (daughter and granddaughters) were disrespectful to her, and told her to go to die. She felt that she did not get appropriate recognition, respect, and appreciation from her children and grandchildren. She decided to ask her daughter to take her children back to live in Bangkok and the elder decided to live alone:

> *They told me to go to die. I was with them until they grew up and had family. Other people never say this to their parent. My children and grandchildren never think about what I have done for them. They work and earn money but never give me anything, not even once (E17:7).*

Other types of difficulty were described that related to children. An older woman shared the challenges she experienced with her son. The son did not respect her and acted inappropriately toward her. Once again, this participant said her son told her to go and die. She explained how hard it was for her to live her life:

> *He sometimes scolded me, and he told me to die … I cried when I was so hurt in my heart (E23:4).*

Her son lived in the same house and he was present at the beginning of the interview. The researcher took field notes and recorded this event while waiting for the participant to come home. The researcher observed the son shouting at his mother, while the other villagers were in their houses but they were quiet. This interaction between mother and son seemed to be normal occurrence in her daily life.

From the researcher's field notes, the following excerpt is shared:

> *Her son was a middle-aged man and had no shirt on. He shouted out loud to find where his mother was. He looked around the house then grabbed a motor bike and told me to wait here. I was sitting at the big square table under the house. I heard loud voices of people talking mixed with the motor bike noise around five minutes later. Within the village it was quiet so I heard them talking very loudly. My participant was walking towards me. I could see her at the corner and that motor bike came quickly and the man who drove it told me with a hard voice that his mother coming over there (Field note: Beginning of the older interview, 2/5/2014).*

This participant explained that her son had no job and not enough to live on. He was a gambler. The loss of his money from gambling brought him back home with a lot of anger and he projected that emotion onto his mother.

This was the major adversity in her life:

> *He buys underground lottery and engages in gambling, so his money is not enough to pay his living expenses. Then finally he has to get money from me, … he spent all money for gambling. I scolded him and told him to stop doing like that … He scolded me, and I was furious […] He said to not bother him. … He's spent as much money as he has on gambling (E23:20-21).*

The money she loaned to her son was gambled away rather than spent on living her own life. The descriptions of her life with her gambling son revealed a complex situation, which affected her health negatively. She described her feelings '*I cried when I was so hurt in my heart*' indicating that she was unable to share her burden and seek outside help. The environment or social support such as her neighbourhood may be aware of what is occurring in her home and yet she felt she did not have their support. This was experienced by the elders who did not receive traditional 'parent repayment' from their children. Adversity in this instance took the form of being without care from children, and experiencing anger and disrespectful behaviour from them.

Some participants described that the children's inability to provide a sufficient living and earn their own money created tension for the parents. The children's lack of financial resources meant that the parents were not being supported. Being worried about their child's life caused heartache for the older Thai.

The following participant expressed her unease when she did not want her son to marry her daughter-in-law. She had never told her son about her feelings but did not go to his wedding day. She explained that it was because her daughter in law had siblings living in the same house. When her son married, he had to move into his

wife's house. It was obvious to her that her son did all the hard work and had to look after his wife and the wife's relatives:

> *I felt very difficult, and I cried…He wanted to marry this woman, but I didn't want him to marry her because she has a lot of relatives at her house. I wasn't happy, and I cried alone. Even these days they've lived together well. I didn't want him to marry her because I was afraid that my son would be a servant at her house (E22:6-7).*

Adult children not being able to support themselves created further stress for some elderly participants. Another participant said that she had to pay money for her son to get a job. Her son used to work in Bangkok then came back home and worked on the rice farm.

Not long afterwards, he asked her for help:

> *He asked me to help him to find a new job. I didn't want to pay money for him to get the new job. But if I didn't pay a bribe, he would not be entered to work at the Subdistrict Administrative Organisation (SAO) … They came to talk to us. They asked me if I wanted my son to do rescue job in the SAO… They gave us 1-2 months to think about it. So I thought I wanted him to leave the old job, and work there instead … I spent my savings around 70,000-80,000 Baht (E24:21).*

Thai adult children that were experiencing financial difficulties caused the Thai elders' anxiety. In this situation, the Thai elders took responsibility for their child's situation and used their personal resources to improve the child's situation.

Being without money

Lack of money and the difficulty of not being able to earn a living were described as adverse hardships. In Thai rural areas most older people do not work

(Hongthong, Somrongthong, & Ward, 2015) and their main income comes from the government social welfare system, and their children (Hongthong et al., 2015; Somrongthong et al., 2013). The average income that older rural Thai people receive is approximately 500 to 1,000 Thai Baht (26 Baht per 1 Australian dollars) per month (Somrongthong et al., 2013).

The participants faced hardship about money associated with medical fees and debt. They described being ill with a chronic disease that required continual treatment, such as chronic renal failure being costly. The money that was needed to live was mentioned to come from a senior's pension, funded by the government and sometimes supplemented by their family members. Lack of money brought discomfort and insecurity in their lives.

The following participant, for example, revealed her experience when faced with end stage renal failure and having kidney dialysis twice a week. The treatment cost a lot and her life depended on it.

She shared that the end of her life would come when she ran out of money:

> *My disease costs a lot of money I think … I think I cannot afford kidney dialysis. Each time costs fifteen hundred … When I'm running out of money, I'll die that day (E07:6).*

Debt was expressed as a hardship for living in later life. Older people who did not have enough became debtors and shared their experience:

> *I feel uncomfortable about my debts […] I want to get out of the debt. It will make me feel comfortable and no heavier in my heart … We can't live without money, because money talks … Everything depends on money (E28:11).*

The same participant described what money meant to her, in terms of it contributing to a good relationship with her family members and other people:

> *If I have money, I would easy to buy things, hire people to do something for me. A person who doesn't have money would be depressed. That is why there is a saying "Took-Bor-Wa-Dee-Mee-Jung-Wa-Pe-Nong-ทุกข์บ่ว่าดี มีจั่งว่าพี่น่อง". If I have money, when relatives ask me for help, I can spend money for them. So, with money, my family is happy (E28:20).*

"Took-Bor-Wa-Dee-Mee-Jung-Wa-Pe-Nong-ทุกข์บ่ว่าดี มีจั่งว่าพี่น้อง" in Isan means money is important. This saying divides into two parts, *Took-Bor-Wa-Dee* and *Mee-Jung-Wa-Pe-Non. Took-Bor-Wa-Dee* means to lack money is not good. *Mee-Jung-Wa-Pe-Nong* means to have money will make that person acceptable to another person. Being acceptable, becoming 'Pe-Nong พี่น้อง' opens the possibility of becoming like a relative, that means, that the person will get pleasure, be gratified, receive good help, and so on. On the other hand, without money, that person will be ignored, abandoned and not be rewarded.

Another participant shared the experience of lacking money:

> *I was deeply distressed. I met friends who have a lot of money: I had to hide myself from them because I didn't have any money. I felt so embarrassed […] My friends, they drank alcohol, and they called me to join them. I couldn't join them because I didn't have any money. Keep in your mind, if you didn't have any money, you would feel so embarrassed when you meet your friends (E26:20-21).*

Having enough money, for the older rural Thai, represents acceptability in the eyes of community members. Money symbolises a comfortable and secure life with an ability to pay for medical fees, ensured greater convenience for family members and

facilitated a better relationship with others. A lack of money leads to becoming depressed, and can result in isolation, hiding from their social and community networks, including their friends.

Loss of loved one

Being without a loved one, that is, a loved one who has died was expressed as an adversity. A significant loss was described by the older participants as multiple losses within the family, the loss of a child or a life partner. The following participant revealed that she had lost her mother, and then her second daughter not long after.

More recently, she lost her eldest daughter:

> *My Mom had just died and was taken out from the town (normally the hospital is located in town). It wasn't long after that when my daughters passed away as well (E02:2).*

The participant described the 'greatest loss' was experienced when her children died. The participant lost her son when he committed suicide at home while she was working in the paddy field.

She spent three or four years coming to terms with what had happened:

> *He committed suicide. It occurred when I was not at home. I cried and cried until I was exhausted (E24:1).*
> *I was so sad, and I could do nothing. I didn't go to work or grow tobacco. I had spent 3-4 years trying to accept that he's gone* (E24:2).

Similarly, another elder faced a difficult time when her daughter had HIV, and died at home of an AIDS related illness. This older person expressed that if only it was possible, she would have wanted to die instead of her daughter. These

experiences were recalled in very vivid detail, even though much time had passed since the loss. The feeling of sadness and hurt is described below:

> *When my beloved person passed away, I wish I had died instead of her, and I wish that she was still alive … I said to her "if you will not be with me and not really be alive, when it rains, you have to shelter from the rain. If you're not under a big tree, you have to go somewhere to shelter." She was crying, and I was crying, too. It was like that…At first I thought that she just had the normal illness. She just gave a birth to her youngest son, and may be the cause of her being unwell, but when I saw her, she was so thin. I took her to treat at home, and then I knew what disease she had, but I didn't say anything to her because I was afraid I would make her feel sad. She wanted to tell me about her disease too, but she was afraid to make me feel discouraged. So I said "I never let you alone no matter what happened to you, I'm not afraid or want to put you away from me my dear" (E28:9-10).*

For the participants' who had lost their spouse they described the difficult times they experienced when their wife or husband passed away. The following participant shared that he could not forget his wife and the responsibility of looking after their children now rested solely with him:

> *Nothing could compare. When she'd gone, the loads about children and everything were on me. I took care of them both living and eating. When she was with me, we helped each other (E05:2).*

> *I felt deeply sorry and depressed … It was a very big under pressure feeling. I was unhappy everywhere I went. […] I thought of her all the time, when I drank water, when I ate, and when I went to the field. At the field, I was so depressed that I thought of her when looking at the places we used to be together. When I was busy, I could lessen my thoughts. But when I saw the places we'd been together, I couldn't forget her again, even right now (E05:3-4).*

Another older woman whose husband died at home shared the difficult time she experienced when she stayed beside her husband when he died:

> *He left me alone in this world now. I don't know who to live with. I was looking at him until he became 'Klum Khuew' […] It means the coldness appearing when the body's dying. The coldness would start from legs and arms and spread all over the body until the last breath stops (E16:5).*

Losing a loved one had a significant impact on these participants. They expressed a feeling that nothing could be compared to this loss. The participants who identified loss of their loved one as their most adverse experience could recall the experience vividly, as though it only happened yesterday. Losing their loved one and grieving, was an elder adversity that has been identified around the globe as a natural ageing experience (Bonanno, 2004; Hardy, Concato, & Gill, 2004; Hildon et al., 2008). This type of adverse situation is important to older Thai people living in rural areas.

Reactions to adversity

How the older participants dealt with adverse situations provided a greater understanding of resilience. Thirty-four participants indicated that they had experienced adversity and described their reactions to those events. The most commonly described reaction to adverse circumstances was sadness. In particular, the adversity of losing a partner caused great sadness for the surviving partner.

The following participant described the sadness when his wife passed away.

> *… I felt sad, really sad. We used to go to the temple together, but one day I had to go alone. I didn't know what to do then. I didn't know what and who I could talk to. I looked at myself those days compared to the other who went to the temple … We used to go to the temple together. Other people also went there with their wife or husband and sat together. I looked at them*

> *sometimes and thought much. I felt jealous but I didn't say anything. It was difficult in my heart (E35:9-10).*

The feeling of sadness was not only expressed when faced with loss, it was also described when desires, or wishes were not achieved; especially when their children could not take care of them. For instance, one participant, an older woman who had three children, but none of these children co-resided, or lived nearby her place, made the following comment:

> *The time is over now. It's useless to think because I can't depend on anyone. It's like I have no LuukLaan-ลูกหลาน. They never care for me. Even one grain of rice was never given to me. I have no children … I never think that I will rely on my sibling or my relative. No one will help (E09:6-7).*

It is a tradition in rural Thai society for elders to receive care from their children or kin (Nantsupawat, Kamnuansilapa, Sritanyarat, & Wongthanawasu, 2010) that can involve meal preparation, personal care, such as feeding and medicating, emotional support, transportation assistance, and financial support (Rittirong et al., 2014). From the field work observations, this cultural practice was found when older people presented themselves in public places and were generally accompanied by a younger person and the elder called them 'LuukLaan'.

Having no children to take care of them was a significant burden for some of the participants. One participant (75 years old) indicated that she lived alone for two years. She shared the sense of her sadness and revealed how hard it was. She described other older people being accompanied by their LuukLaan, sharing their experiences about how good they were and that when she heard this, she felt different and disconnected with the group:

> *… The other elders think that their children should take care of the elders. They sometimes asked why my children don't take care of me. They said like that until I felt I don't want to hear it anymore. It really ruins my mind (E33:18).*

In everyday life when older Thai experienced the loss of their loved one, or children not caring for them this led to worry and agonising over the situation. From what participants have described these thought processes then caused them sleep disturbance and other symptoms.

The following participant, for example, said that worrying about losing her husband caused her not to sleep well for a while:

> *I couldn't forget him. We used to be together. We used to talk to each other then we are not. I couldn't put myself to sleep. I could sleep once in a while (E04:3).*

Another elder said that she got a bad headache when she was thinking about her difficult times. She was an older woman living alone and worked for wages, employed doing little jobs around the village. She said that she would did every job that people asked her to do so that she could earn enough money to live her life. She compared herself to other elders within her village who had children taking care of them. She kept thinking about how hard her living was and this caused her a headache and led to a hospital admission:

> *I felt tense … When I think too much, I have a headache. I want to get out of thinking (E17:8).*

Feeling discouraged was another reaction to adversity and one older man shared that he felt too old and alone to live his life. He was dependent on others in order to provide him with everyday food. A sticky rice basket with some food was

brought to him in the morning and again in the evening. He perceived that his carers did not like to do this and he was no longer experiencing an enjoyable life and did not see a reason to continue:

> *I don't know why I should live. I'd rather die. I don't enjoy eating. People said taking care of elders is hard. They said they didn't like this (E10:7).*

Being discouraged was also described when the participants were faced with the ill health of their loved one. The following participant, for example, explained that his wife had been suffering from asthma and had experienced asthma attacks. He said he had no one else to rely on, only his wife. He admitted being fearful and felt discouraged when thinking about his wife leaving him:

> *Sometimes I feel discouraged when she is sick. If my wife passed away, who would cook for me? For my children, they just not good enough (E19:16).*

Another reaction to difficult experiences that was described by six participants was waiting for the day to die. The following participant described this feeling when he was faced with the difficulty of chronic pain in his leg:

> *Just stay, keep existing life and wait to the day of death (E01:8).*

A similar feeling was described by an elderly woman who expressed that death was fine for her. She was a person that had identified her life as having multiple difficulties. Her difficulties were associated with her husband's type two diabetes and she herself had mild diabetes and a hip fracture in the past. They were living with each other and could not rely on any children, siblings or other relatives. She hoped for nothing except a coffin to put her body in at her own house:

> *Death is like when you sleep. Nothing's strange. It just comes and we leave. It's good not to have pain or illness anymore (E09:16).*

One participant shared a phrase that was commonly spoken by older people within his community, which described being old: the 'three waits' (3Ws): wait to eat, wait to sleep, and wait to die.

> *It's 3 Ws. […] You just wait to eat, wait to die and wait to sleep. That's it […] We just think of it. We are old. We don't think too much. We are getting older every day. We just wait for the time to come. We just wait. We just think of it. As we can't go now, we can just wait. Wait for the luck. Wait to die. When it gets dark, we wait for the time to go to bed. If we are hungry, we eat (E32:14-15).*

This participant explained that the three waits related to the elders' everyday life where they wait for each meal that is usually cooked by their family members, three meals a day, when the sun sets, they wait for the time to sleep, and finally, they wait for the time of death.

Summary

This chapter described the meaning of adversity from the perspectives of the elderly participants living in the rural provinces. The terms *PenTúk, Ouuk-Ouung, Ouuk-Ouung-Oout, and Ouuk-Ouung-Oout-Jai* were found to be local terms that enabled the description of adverse circumstances, by the rural Thai elders. Different types of adversity were identified that related to their everyday lives. Intra-personal adversity was described as the physical functioning associated with the ageing process.

This description included the four subthemes: 1) 'it's hard being old', 2) 'I can't', 3) 'living with aches and pain'; and 4) 'living with illness'. Inter-personal adversity was described the difficulties experienced between older people and

others, and these difficulties were often connected to cultural beliefs. Issues pertaining to the role and relationships with adult children emerged as significant and caused the participants' to experience tough times. Moreover, being without money and loss of their loved ones were further problems experienced.

The participants' shared their reactions to adversity, which included the feeling of sadness, too much thinking and worrying, feeling discouraged and waiting for the day to die. It is entirely possible that some of the elderly participants based on their descriptions about adversity were experiencing clinical signs of depression. The nurses however, were not able to provide adequate care for older people living with depression in their community because mental health was not part of their usual scope of practice.

This chapter provides clarity around what adversity means for the older Isan (Thai) participants. Adversity in the context of understanding resilience for these participants has multiple components, some of which seem to be natural processes and expected outcomes, and others that are unexpected and situationally related to other people. The next chapter explores the meaning of resilience for Thai rural elders.

Chapter Six

Elderly resilience – Moving on

Introduction

This chapter describes how the Thai older participants maintained their equilibrium despite adverse circumstances. Moving on describes the capacity of the participants to be resilient and resourceful, as well as how they individually responded to difficult situations. The theme 'Moving on' includes seven subthemes, which are listed in Table 14.

Table 14: The sub-themes related to overcoming adverse experiences

Elderly resilience	
Moving on	1. Keep doing a job and earning a living 2. Having Jai-Yai to fight for life *3.* Accepting a situation: *Plong* and *Taam-Jai* 4. Let it be and be patient 5. Staying on top of it 6. Expressing difficulty: speak it out, and crying 7. Connecting with people, and beliefs and customs

Keep doing a job and earning a living

This subtheme relates to the participants being able to continue to do their job and earn a living despite being faced with adverse situations. One participant, who lived alone, explained that she did not think much about her future.

She said the following:

> *... I don't think much about my future. I will do my work what I can do until the last day of my life (E36:28).*

Similarly, another participant who was living with liver cirrhosis described that doing his job, living independently, and having enough money were the only desires he had left:

> *I hope nothing, but I just hope that I can work for a living, and I have money to buy what I want (E20:10).*

Being resilient promotes continuity in life and keeps older people in roles that give them a sense of being connected, independent, and meaningful (Aléx, 2010). This helps to minimise the negative impact of adversity and provides stability in their changing lives (Blane, Wiggins, Montgomery, Hildon, & Netuveli, 2011). To be able to keep working and earn a living was an active process that participants employed to assist them to face life challenges. The following participant described the loss of his wife, in continuing to do the things he normally would do, he found it helped him to move on after her death:

> *I did what I needed to do ... I continued what I needed to do ... I had to do things I used to do (E05:4).*

The participant, despite the loss of his wife, had chosen to move on from this adverse event and get back into his normal routine. Such resilient outlooks of the Thai participants were commonplace and a symbol of their strength to go forward with their everyday responsibilities. Working on a job and earning a living were expressed in terms of being able to make money to feed oneself, and this helped maintain a healthy life.

The following participant described her experience:

> *I absolutely cannot stay without doing anything. My mouth still eats and my body still stands. That's why I must have something to do (E12:16).*

The saying *'mouth still eats and body still stands'* represents the sense of continuing to live life. Doing the things that they used to do and doing what they needed to do were keys to maintaining health and overcoming adverse situations.

Having Jai-Yai to fight for life

Managing adverse situations pushed the participants to live their lives with meaningful intent. 'Having Jai-Yai to fight for life' is illustrated in the following section. One participant described this experience when she lost her son through suicide. She continued to work to earn a living and it helped her. This maintained her cycle of life, which was to work, sleep, and wake; and to start each new day again:

> *I can get through it because I keep fighting. I fight for this life, and I work for my family (E24:26).*

The courage evident in the elderly participants' stories revealed essential personal characteristics required to fight against adversity. A dominant expression of *'Jai-Yai-ใจใหญ่'* emerged from the data analysis where the participants shared their experiences of fighting against tough and challenging personal crises.

The following participants, for example, explained the term:

> *I was Jai-Yai and fight with it. I use it to fight with whatever that will happen (E12:4).*

> *My heart is wilful. I have a Jai-Yai. I'm not afraid of anything (E16:25).*

'Jai-Yai' translates to English as having a big heart where *Jai* is heart and *Yai* means big. The elders' shared their experiences of *Jai-Yai*, they were not discouraged but were fearless and self-reliant.

The next participant described Jai-Yai using the term *Jai-Noi*:

> *Yes, I'm Jai-Yai … I don't get Jai-Noi, and I don't be discouraged. If I worry about anything, I grab the hoe and start to work. Then, I'll forget all. If I sat and stay still, I can think all thing in the whole world (E31:19).*

Noi in Thai means small. Not being Jai-Noi forced him to grab the hoe and do some jobs, keeping busy kept him from contemplating his adversity. Previous studies have found that older people who organise their environment are able to minimise the negative aspects and making the most of keeping their routine consistent (Ferreira, Santos, & Maia, 2012).

Another participant, described having Jai-Yai as being fearless. He was 65 years of age and living with end-stage renal failure. He said he was not afraid to die because he did not pay any money to be born:

> *… I'm 'Jai-Yai' and fearless. I just think that I didn't pay any money to buy the birth of my life … I'm not afraid to die… Because of that reason, I'm very 'Jai-Yai'. I've never thought too much about anything (E26:43).*

This helped him to fight against disease, as it was his desire to live longer with his family. Both himself and his family decided to have him undergo kidney dialysis at home twice a day. His two daughters lived close to his house and they assigned themselves on day and night shift as caregivers in order to take care of the intake and output of the dialysis fluid.

An additional meaning for Jai-Yai emerged from the older participants, and described self-reliance. The following participant recalled her experience since her husband had left. She said her husband left home and did not want to look after her and their children.

She found inner strength and decided not only to rely on him:

> *I thought I was Jai-Yai. I didn't want to bring my children to follow him because I'm afraid people would gossip about me ... I just thought I needed to be Jai-Yai. I didn't have to care that he didn't want to look after or taking care of me ... I thought I must having a big-heart and not a small-heart (E03:6).*

For this participant, having Jai-Yai was related to being self-reliant. An older woman aged 77 years and living alone, expressed that:

> *I didn't feel uncomfortable when there was no person beside me. I'm a Jai-Khaeng woman. I didn't think that I have to depend on others. I can live alone like this (E36:17).*

The participant shared her experiences, having 'Jai-Khaeng (ใจแข็ง)' is a different term used to exemplify the toughness required to survive the difficult times. It directly converts to English, *Jai* is heart, and *Khaeng* is solid. This participant was asked what 'Jai-Keang' (solid heart) meant to her. She clarified that it represented a strong mind and protected her from mental health problems:

> *I'm strong minded. I'm not that weak. I don't think much. This is called strong. The weak people are people who think too much. When they think too much, they get sick. But if you are strong minded, then you don't get bad mental health (E36:17).*

Jai-Khaeng was similar to Jai-Yai and with both terms there emerged the same sense of personal self-reliance to withstand adverse situations in order to achieve a positive life adaptation.

The self-reliance of older people living in rural Thai areas was expressed by the next participant. She was an older woman living alone but previously a village health volunteer working as a Thai masseuse in the THPH for six years. At age 75 years, she identified herself as a healthy person. She was still cycling to and from her home to her workplace. Her self-reliance was expressed through working to earn her own living. She gave the following reason for this, as she was conscious of what her children thought about her:

> *I don't want them to think like I am always sick or I always asked for money. If it is not necessary, I won't ask them for money. But if it is the time to pay back the money I borrow, I will ask them for money sometimes. I want them to not worry about me. I don't want them to think that I have bad health. I want them to think that I'm healthy. When they ask me about my health, I will tell them that I'm fine (E33:15).*

The participant indicated that she would help herself first and would continue to do so as long as she was able. She elaborated on the three stages of an elder's life, which was firstly, the time that an older person was able to leave the house and enjoy meeting people. Secondly, when an older person was only able to walk around their house and the final stage was when the elder lay still on their bed. She identified being in the second stage and asking for help from her children would occur in the last stage:

> *I think the day when I will ask for help from my children is the day when I'm weak. ….Now, I'm at stage two … When I get into the weakest stage, laying on my bed, I will miss them (her children) that time (E33:19).*

Both terms, Jai-Yai and Jai-Khaeng, describe the courage required to resist and cope with adverse situations. Jai-Yai was the local word used to express a belief in personal bravery. This word is significant for older people who fight against life crises and continue living. This study demonstrated that Jai-Yai had three meanings: not being discouraged, fearless, or not afraid to die, and to be self-reliant and not put ones' life in another person's hands. The other word Jai-Khaeng represented a perception of toughness, which was part of being self-reliant. Jai-Khaeng referred to having a strong mind, and not thinking too much, which consequently protected the elder participant from any mental health problems.

Accepting a situation (Plong – ปลง and Taam-Jai – ทำใจ)

Two words were used by the older participants to describe the sub theme 'Accepting a situation': *Plong* – ปลง and *Taam-Jai* – ทำใจ. The word *Plong* in English means not thinking about anything anymore. The following participant mentioned that *Plong* set him free from his crisis:

> *I'm "Plong" I don't think about anything at all … I just keep feeling relaxed like there's nothing happen […] I can accept it, and I can do it now […] I don't think too much about anything […] I'm afraid I will get mental illness, so I try to relax (E19:20).*

The term *Plong* in this study represented the feeling of being completely accepting of the circumstances. This was similar to what the following participant

described as *Taam-Jai* while she had spent time in the hospice with her daughter who was dying. She indicated that she had to accept it: saying *Taam-Jai* meant that everyone who is born has to die. She said this about not only her daughter, but also about herself and that one-day, she must die too:

> *I was so sad, but I had to accept it. 'Taam-Jai' I have to do that and I just thought that one day I must die like her, too. We were born, and then everyone has to die. It's not just her, but everyone (E28:9).*

The participant further explained that:

> *I've realised that we must get sick, and eventually die. It's sad, but it's not only us, someone else has the same too, isn't it? Someone else would suffer from losing father and mother like I did … After seeing her, I had already 'Taam-Jai'. She is so thin, and she can't eat anything … A person who has the disease like this can't eat. I thought she must die because she can't eat and sleep. I had to accept that she must die someday (E28:10, 13-14).*

As this participant was involved from the beginning in her daughter's illness, she realised and understood that her daughter was dying. For the Thai people, *Plong* and *Taam Jai* are Buddhist beliefs. These words are associated with a sense of "let it be as it actually is" as well as "being stoic and preparing one's mind for possible misfortune" (Sowattanangoon, Kotchabhakdi, & Petrie, 2009, p. 249).

Another participant used the term '*Karma*', which is the core of Buddhist teaching '*we will get what we give*' and this helped him accept whatever was going to happen to him.

> *What is supposed to happen, happens. I thought it's karma … We will get what we give (E32:11).*

The following participant described her belief in a fortune-teller. The participant was an older woman living with end stage cervical cancer. She was diagnosed with cervical cancer and the medical profession predicted that she would live for five years. At the time of the interview, she was in her fifth year. She said to help her to accept her situation she went to see a fortune-teller and asked him to predict her life:

> *The fortune teller said I wouldn't become normal again. And he wouldn't tell me the death date (E12:23).*

After she saw the fortune-teller, she believed that she was getting the same information as the physician told her about her disease. This confirmed the diagnosis from the medical profession and helped her to accept that she could not change the outcome. Accepting the situation enabled the participant to understand that there were circumstances that cannot be changed, or that something was going to be, or had happened already. It was perceived as personal fate and Karma.

The participants referred to *Plong* and *Taam-Jai* as the attitudes that helped them overcome adverse situations and enabling them to let go of the life crisis they were facing and to continue moving onward. The words Plong and Taam-Jai in this study described being completely accepting of a situation. However, *Plong* was referred to as 'not thinking about that thing and keeping relaxed' while *Taam-Jai* was referred to as 'being stoic and preparing one's mind for possible misfortune'.

Let it be and be patient

The subtheme, let it be and be patient, described the way participants dealt with and managed the crisis. 'Let it be' described the feeling of 'having to carry on' because 'if anything can go wrong, it will'.

The participant expressed these words to describe handling her adverse situation:

> *I didn't think that I won't pass it. I felt that I have to carry on. If anything can go wrong, it will. I can't escape it, so I have to let it be (E28:14).*

'Let it be' related to a situation where the participant could not escape, in other words, it was a traumatic situation that she had to get through. Another participant identified herself as having a hard life because she lived with only her husband and not with any of her children. She said she could not depend on anyone and could not ask for any help from any of her relatives, siblings, or children. She had to accept the feeling of difficulty and be patient; she described this as taking nothing to heart, and keeping her heart empty:

> *... I didn't take it into my heart. I let my mind empty and do not care about people's talk ... Whatever happens, I don't care or feel anything. It's like I am heartless (E09:8).*

The phrase, 'let the heart empty', represents a feeling of 'I don't care or feel anything'. As she was living without children, she indicated other villagers talked about her business or gossiped and that this occupied her thoughts. However, she let them do it while letting her heart empty, so that she no longer cared about what others said about her. Similarly, another participant explained that she could not control what might happen:

> *What I mean is I just let it be. I can't order anything to be happened (E20:26)*

'Let it be' was a response to a life crisis, which the participants dealt with by choosing to ignore it or not to worry about it. 'Not taking it personally' and 'turn a deaf ear to it' were explained by one participant who looked after her

grandchildren as her way of managing village gossip. The participant had lost her daughter because of HIV and now she raises her daughter's children. One of them is a 16-year-old girl living with HIV. This participant was faced with the situation that people in her community were gossiping about her business. To deal with this, she took the attitude of 'let it be', 'not take it personally' as well as 'turn a deaf ear' to it:

> *If I don't take it personally, I will live comfortably: on the other hand, if I take it personally, I will feel depressed. So I just ignore it … I don't keep it in my heart. If I take it personally, I will feel down. It makes us cannot go future. So I just turn a deaf ear to it (E28:19).*

To overcome negative perceptions, participants referred to the term 'be patient'. 'Be patient' was described as the period of time that they dealt with their feelings when things were most problematic for them. The participants' had to hang on and wait for things to change.

In a further example, a participant experienced a falling out with her younger sister. They had had an argument and the case was presented in court. She said that this took a month and she could do nothing about the situation, except to pray to her parents who had already passed away:

> *I thought we almost killed each other. We brought the case to court […] Oh I was not at ease. I felt hatred […] What I did was only raise my hands over my head and had no word to say, saying 'Sa-Tuu'. Please, papa and mama, look at this. You know who's right and who's wrong. That's what I said (E11:6).*

Being patient connected participants' back to their everyday lives. Being patient for one participant helped her to continue to be strong while she was grieving for her son after his sudden death:

> *It's not whoever, but me. I just thought about it by myself. As he passed away, he doesn't have any pain or suffering anymore. But for us, we have to work, and we still have to face with various difficulties, and we have to be patient (E24:7).*

'Let it be' was described as a situation where the participant could not escape from a difficulty and they responded to this situation with being patient. 'Being patient' enabled participants to endure until the problem passed. Being patient encouraged them to continue with their everyday lives by doing jobs, which they had to pay attention to, such as growing rice in their farm and doing their tobacco plant job.

Staying on top of it

The subtheme, staying on top of it, described the activities that the participants involved themselves with to help them move on despite having trouble. The researcher observed this behaviour in the community and recorded this in her reflective notes.

> *While interviewing I also conducted non-participant observation, it showed that the participants who carried something inside tried to put something else on top of it (Reflexive note 25/4/2014).*

This was again noted in the reflective notes at the completion of the interviews:

> *From the data that I took from the elderly it seems like something keeps them going or living on top of difficulty. It is not dealing directly, but something they put it on top and they were living above (Reflexive note 2/6/14).*

Accordingly, a participant described his actions when experiencing adverse circumstances, such as keeping himself cheerful and speaking about only positive things, this helped him to cope with his disease (colon cancer):

> *I tried to be cheerful to fight with the disease. My willpower was strong. Everybody must die. I just try to be cheerful and that was not hard ... I spoke only good things. When we speak good things, it helps our mind (E18:7).*

Another participant kept fighting and watching TV helped her to express the emotional turmoil she was experiencing:

> *When I was so worried, I kept fighting by watching TV to forget it day by day. I cried when they (performers on TV) cried, and I laughed when they laughed. It made me not feel worried about anything, and I can live my life until now (E22:12).*

This participant kept searching for reasons and this helped her to stay on top and move on:

> *I search for a reason. I put reason after reason into my thoughts. When day passed by, the sorrow has decreased: the suffering has been dry out (E16:8).*

Staying on top was not a process of directly dealing with the adverse situation. The participants would add something on top of the adversity usually doing something they enjoyed to distract them from the adverse situation they were experiencing.

Expressing difficulty: speak it out and crying

Two subthemes emerged from the data that described the direct actions participants took to deal with the difficult times they faced, speaking it out and crying.

Speak it out

The participants explained that having to avoid other people talking about their business stopped them from talking about their adverse situation, or expressing their feelings about their difficulties. A participant said that it was better to speak about her worries with someone who did not live nearby, than to talk with her local villagers:

> *E: If I want to tell someone, I won't choose ones that live nearby me. But I will tell those who come from somewhere else.*
> *R: Why won't you tell your story to the ones who live nearby you?*
> *E: They will keep telling my business to other and other […] I don't want that to happen because I don't want to get stress (E17:17).*

The participants' described that if they spoke about their worries in their community this would result in stress and concern about their situation being discussed by the community. However, 'speak it out' was expressed as a strategy to relieve hardship. The participants' indicated that when they 'speak it out' it had to be undertaken with the right person.

This participant said that talking about the difficulties helped to empty his feelings; however, seeking the right person who was safe to talk to very was important:

> *…I talk to my siblings, some of them […] I talk to someone who's close to me, and I'm familiar with that one … I talk to empty my feelings (E20:14).*

This participant said that he talked with friends while working in the temple; he mentioned that they were a regular group of volunteers that worked together at the village temple. The participant revealed that because of a difficulty within his

family, he could not talk about it directly to the researcher. He did not identify his problem, and instead he indicated that he felt better if he could express his feelings with his friend:

> *E: I let my worries out while talking.*
>
> *R: And did you feel better?*
>
> *E: Yeah, kind of better. Or if I didn't feel better, it was okay talking with them … When I let the worries out, I felt good and happy (E06:5).*

Thee participants explained that speaking out about difficulties within the Thai rural community required considerable thought about who they could trust to share the situation with. The older participants disclosed their preference was to avoid discussing their difficulties.

Crying

The subtheme crying was described mostly when the participants spoke of losing a loved one. Sometimes crying was the only response that the participants used to express their feelings.

A participant shared this story after losing his wife:

> *I cried, I would say this. I thought I feel really sad with that moment that she and I would not be together anymore. That was only thing I can do (E35:9).*

Feeling free to cry and grieve in front of other people was emphasised by the participants as being important. One participant said she was lucky in that she has a very good family and support from her children and grandchildren.

She could cry in front of her grandchild.

> *I did nothing. When I thought of him, I just cried … Yeah. I cried in front of them and they laughed, saying "Wooo! Grandma cried again!" (E07:4).*

Crying also occurred when the participants reminisced about losing a loved one. This participant explained that when it was raining it was a trigger to make her cry:

> *I kept thinking much. I cried when it rained, when the lightning occurred. Every time it rained, I cried (E33:9).*

Even though the participants found that crying helped them cope with difficult situations, they were told to stop crying as crying was to curse the dead:

> *I cried for every one of them, my husband, my son-in-law, and my mother … People told me to stop. They believe crying is like cursing to the dead. Is this true? (E11:19).*

Another participant was told to stop crying because it is believed to be a sin:

> *I cried but not that much. I was told that crying was a sin. I don't know if it's true (E14:21).*

Descriptions of crying related to the need to express the feelings of having lost a loved one (grief). From the perspective of the participants, crying was also linked to cultural beliefs. The previous example described a participant who was part of a very good family in which she felt she could cry openly in front of her children and grandchildren.

A situation described by a 75-year-old woman living alone in her house however was the opposite. She indicated that crying in public was seen as not acceptable by others, due to the belief it is a curse on the dead. From the stories told by participants about loss, crying was an expression of grief; in some sense, others

tried to encourage them to be strong by using superstition to moderate their behaviour. Cursing the dead and being sinful are perhaps a cultural means to help people cope with a major loss in their lives.

Crying however is an emotional response to helplessness and hopelessness, an outpouring of grief, and it can be a sign of depression. In older people, feeling low and tearful over a loss could be a normal human emotion unless it causes disruption to their usual activities of daily living (Barker, Heaslip, & Chelvanayagam, 2014).

The strategies participants used to deal with adverse situations highlight how older people individually react to adverse circumstances. ‘Speak it out’ was not easy for the participants who wanted to avoid gossip even though it was indicated as a strategy to help release the elder’s tension. Future research clarifying the impact of ‘village gossiping’ on the mental health of older people will help to develop further empathy for their situation. Crying provides an opportunity for family to ensure older people feel comfortable to express their feelings. Crying is an expression of sadness and indicative of resolving a loss, or remembering a moment of connectedness with another person.

Connect with people, beliefs and customs

The subtheme, connect with people, beliefs, and customs is related to the cultural artefacts that provided support to Thai elders in times of trouble.

Connecting with people

When dealing with adversity regardless of its type, the connection with friends, and family members was identified as being important to the participants. Good social relationships enabled the participants to manage stress. A participant

expressed that in her experience spending time and talking with friends helped her forget the hardship of losing her son:

> *I've spent time with friends, talked to them, and when I came back home, I did my housework like cooking rice and cooking some food. I sometimes went to work for wages. I did everything to forget it (E24:7).*

It has been reported that a positive relationship with neighbours and friends prior to any adversity occurring plays a crucial role in receiving social support at the time (Blane et al., 2011). For this participant getting together with her friends and doing activities together was fun and helped her to cope since her husband had died:

> *We laughed so hard. It was fun, listening to the songs and jokes conducted by Poyai Tick (Radio DJ). He is talkative … We eat sour snack. Sometimes I join their meals … And the missing feeling has just gone (E16:10).*

Being together with their friends occurred in the village temple, which was identified as the main place for them to connect with each other, to talk, to make Boon, to listen to the sermon, and pray. A participant described going to the temple in the morning as his routine. At the village temple, there was time for him to have a chat and share everyday life experiences:

> *I go there in the morning and offer foods to the monks. Then, I talk with friends … I go there during breakfast time. I go there every day for a few years. But during the eighth month is Buddhist Lent period. Most elders would stay at the temple and practice the dharma on Buddhist Days. I do this, too, with my friends (E18:3).*

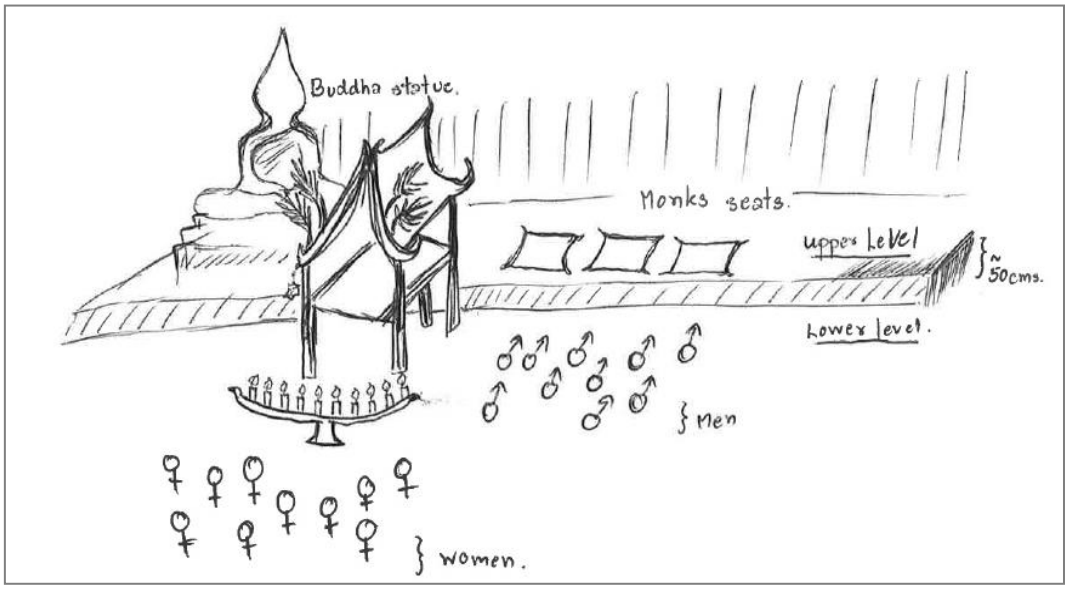
The participant explained that the older people come together after the religious ritual was finished to share fun and food. He had colon cancer and did not like eating at home; however, he enjoyed eating at the temple:

> *When I finish offering food, I always chat with my friends. We have fun, laughing together. When the monks finish eating, I will eat the rest of the food. The women are in one group, and the men in another. We talk and laugh during the meal. This makes me eat much. Normally I don't eat much at home (E18:2).*

The sketch below illustrates a religious ceremony that occurred in March 2014. This was an early morning ceremony that started at 3.30 am. The village elders organised and led the ceremony. When they got together in the village temple, the men and women sat separately. The men were also more likely to sit as a group closer to the monks, which perhaps is indicative of the paternalistic nature of Thai culture.

Figure 8: Group of elderly in religion ceremony

(*Field note 27/3/14, 3.30- 6 am, at one village temple – religious ceremony, around 30 people participated and almost of them were older people)*



Rather than being with a group of friends, the participants mentioned they were also together with their siblings and relatives. The following participant lived alone and said that she occasionally spent time with her sister at her sister's house where it was not far to walk.

> *I spend time with my older sisters. I go to talk to them, and I sleep in a hammock. I spend time with my older sisters and my niece at the space under a house. I didn't go to anywhere else. I've been to my sister's house. I eat food with my older sisters and my niece: like this morning, we had breakfast together (E22:4).*

Having a good relationship with family was acknowledged as an important resource in maintaining resilience.

For example, this older participant expressed that she had difficulty with her youngest son's situation. She said it was fortunate that she had her oldest son supporting her because he gave her comforting words.

> *My older son told me to think nothing. Just let my mind blank. Don't think about X (youngest son) in anything. Just let him be what he wants (E09:8).*

Similarly, an older participant who faced end stage cervical cancer said her body was so painful. Once she had a visit from her grandson, raised by her since he was a child, and this visit helped her to cope with the adverse situation. She said the grandson called her 'mom' rather 'grandma' and described that one day he visited her and brought a huge box of Dharma books, tapes, and CDs.

She said he wanted her to be calm and told her to do meditation:

> *He wanted me to make a meditation because he did it. He said the monk preached no matter how much you pained… My grandson said mom, please get better and he said you just make a meditation three times a day … I listen to him. I asked him how I am going to be. He said my pain would gradually be gone… While I making a meditation, closing my eyes, the pain is gradually gone, and this is true (E12:4-5).*

The participants' stories highlight the importance of the connection between older

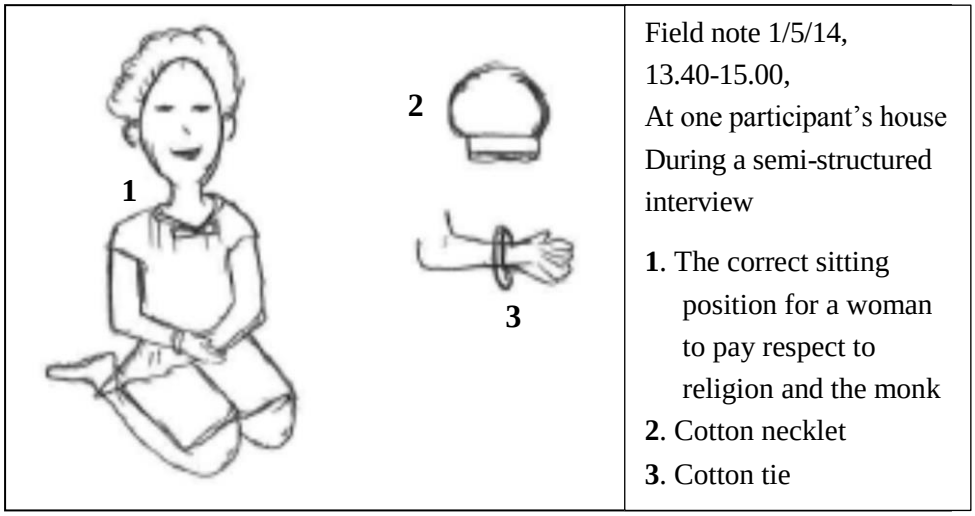
people and their friends, siblings, and family members (Rittirong et al., 2014). An elder's ability to maintain effective relationships with their family members has been described to be crucial to recovery from adverse situations (Kessel, 2013).

Connecting with beliefs and customs

The sketch below captures one example of a participant who believed in superstition, its association with religious beliefs and its importance when she was faced with a stressful event. She said she was staying alone at home and felt like her house was being blown away by a very strong wind. Someone took her to hospital and she was told that she had very high blood pressure. She said she was wondering about what was happening and went to ask a fortune-teller and this made her feel scared and insecure, so she went to see a monk at the village temple. The monk gave her a cotton necklet and cotton tie, and told her that it would help protect her from something that might take her away. She wore these things all the time and never took them off.

The participant demonstrated the sitting position that people should observe when attending religious events in the temple, or when visiting the monk or listening to a sermon. The aim of this was that people must sit and stay still. She indicated that the longer one could stay still, the closer one would get to Boon. If someone was not still and was frequently moving, or stretching their body it meant that they were not paying attention. They would then feel burning in the heart and this would be a sin.

Figure 9: The sitting position of woman attending religious events and superstition relating religion belief



Field note 1/5/14,
13.40-15.00,
At one participant's house
During a semi-structured interview

1. The correct sitting position for a woman to pay respect to religion and the monk
2. Cotton necklet
3. Cotton tie

Table 15 summarises the data that emerged in the community around the relationship of the older participants and the socio-cultural impact on being resilient and overcoming adverse situations. The four related cultural factors including religion, family, community, and belief in superstition are described below:

Table 15: The relationship between resilience and the cultural artefacts

	Relation	**Influences on resilience**
Religion	• The Buddhist belief, including the way to being *'Plong'* and the Buddhist teaching of the core of *Karma*	• Help to accept the situation • Preparing one's mind to be ready for possible misfortune
Family	• Sufficient support e.g. money and kind words	• Living costs and travelling support • Feeling comfortable to have their children (and/or grandchildren) looked after

Community	*Positive*: • Talking and having a laugh • Enjoyed local entertainment *Negative*: don't want their personal business talked about by others	*Positive*: enjoyment in their life *Negative*: afraid to talk or release their feelings
Having a belief in superstition	• Seeking support from fortune teller • Wearing good luck symbols • Wishes will come true after they make merits	• Helps them to accept the difficult times • Be happy and secure • Their wishes have been fulfilled

Summary

Older Thai people who are resilient have the ability to continue their lives even when faced with adverse situations. The theme 'moving on' provides an understanding about the older Thai participants' capacity to survive in the face of adversity and to continue with an active life despite having trouble. Moving on indicates the participants' appreciation for existence, earning a living, being courageous, being able to accept things and move forward, express their feelings and to connect with people, beliefs and customs.

In the next chapter, the resilience of older people is explored through the perspective of the community nurses. The community nurses are the key health care professionals who work in the THPHs and care for older people in the rural community. They work closely with Thai elders and therefore an understanding of the older person's health and the activities of their daily lives can further assist to enhance their clinical practice.

Chapter Seven

Resilience in older Thai people – Community Nurse's Perspectives

Introduction

In Thailand, registered nurses (RNs) provide care for elderly people in rural Thai communities. This chapter presents the community nurses perceptions about rural Thai elders and resilience in the context of care provided in the community health centres (THPH). The findings have been classified into three sub-themes. Firstly, the concept of resilience in older Thai people from the community nurses' perspective. Secondly, Thai elders' responses to experiencing adversity and the third theme is focused on the everyday experiences of the community nurses while they are caring for older Thai villagers. A number of key attributes described by participants for the three sub-themes are provided as subcategories (see Table 16).

Table 16: Community nurse's perspectives of resilience in rural Thai older people

Resilience in older Thai- community nurses' perspectives	
Resilience-What is it?	
Overcoming adversity	1. Living on their own legs 2. Expressing feelings 3. Valuing self 4. Possessing religious beliefs

Resilience in older Thai- community nurses' perspectives	
Everyday nursing experience - resilience in rural Thai elders	• Positive nursing experiences: 1. Attending health activities • Negative nursing experiences: 1. Limited knowledge 2. Less elderly home visits 3. Thai older people are not easy to please 4. They don't tell us the real reason

Resilience-What is it?

'Resilience' was found to be an unfamiliar word for the community nurses who participated in this study, as it was for the older participants. The following community nurse expressed that he had heard this term briefly but understood it only on a superficial level:

> *To be honest, I have just heard it now. As for the Pa-Lung-Su-Kha-Pab-Jid, I think I have heard briefly about it before, but I don't have an in-depth understanding of it (C01:9).*

Five out of seven participants mentioned they had not heard of this English word and expressed doubt as to whether it was associated with their nursing experiences. The following participant said she might have heard about it but could not recall its meaning.

> *We never experience this case before…I might have heard about it […] but I didn't pay attention or […] I don't know […] no, I never heard of it (C05:14).*

The following excerpt suggests that the word 'resilience' was likely to be an abstract term that may not be easy for people to identify. The community nurses sought clarification from the researcher:

> *It's never been explained. People may have heard about it, but don't know exactly what it is. It is like and abstract. It'd better be defined (C02:13).*

The researcher translated resilience to Thai, but even then, the word resilience and its corresponding Thai term remained unfamiliar to them:

> *"Pa-Lung-Su-Kha-Pab-Jid", […] why I don't know this (C07:9).*

This event indicated that ‘resilience’ was not a familiar term in these rural areas at the primary health care level. Thus, the term ‘resilience’ and its Thai equivalent once explained and agreed upon, *Pa-Lung-Su-Kha-Pab-Jid, and Kwam-Sa-Mard-Nai-Kan-Yurn-Yud-Pa-Chern-Wi-Grit* was used throughout the semi-structured interviews.

During the interviews, the community nurses recalled examples of older people who faced significant negative life situations. The word ‘Wi-Grit’ (in Thai) was used by them to refer to a ‘crisis. The following nurse participant shared her perception of working with older people and indicated ill health, loss of a loved one, sickness of a loved one; and work or family issues as adverse situations in the elderly:

> *I think it’s the condition that is suffering from illness… Losing someone we love or love us, the sickness of our love one or the problems like […] work or family affair (C06:14-15).*

The community nurse participants recalled particular cases where their clients had been faced with adversity and described how the person was able to overcome it.

Overcoming adversity

The community nurses' perspectives of resilience among rural Thai older people were discovered by asking them about the Thai elderly overcoming adversity. Because of those descriptions, the characteristics of older people living with resilience emerged into four sub-categories, 1) living on their own legs, 2) expressing feelings, 3) valuing self, and 4) possessing religious beliefs.

1. Living on their own legs

Living their own legs was how the community nurses described older people who were able to overcome adversity. Irrespective of the cause of the adversity, resilience in Thai rural elders was something that enabled them to lead a normal life. The nurse participants' revealed that the elders they viewed as being resilient demonstrated a strong desire to be alive and to continue to do what they wanted. This community nurse described one older person overcoming adverse situations by *'living on their own legs';* and said:

> *I think it is the ability of living on their own legs and doing anything by themselves. It maybe because there is no one left in their family, or their relatives don't live with them or hardly visit them. However, they can depend on their own (C02:3).*

Relying on themselves and doing their own activities, for instance exercise, eating the right food and not smoking have been found to bolster an older person's resilience (Felten, 2000). Another nurse participant described an older person she knew who was dealing with several challenging situations, and the way this person had to *'fight-สู้'* to continue with their life:

> *She has to fight for her living so much these days … Her "fight" means that she doesn't want to stop working. She doesn't want to stop doing things (C07:8).*

The same participant explained her perception of 'fight' was a fight against old age. '*Fight*' was used deliberately to describe the older person's mindset of being 'determined' (มุ่งมั่น) which meant this older person showed a strong desire to be living and to do everything that she wanted to do:

> *I mean that she seems not to think that she is old. She said she is determined. She will do anything she wants. She always said that to herself and to everyone. So, I think she is the kind of person that fights against her age. Although her physical ability might not be as good as the past, her mind is really ambitious. That is the reason to make her dare to do anything she wants. I think the problems that she had faced were really hard for her, but she can overcome them (C07:12).*

Similarly, another nurse described her experience about resilience in older people as:

> *Fought with it and got through it well (C06:15).*

The next participant described an older woman who lost both of her adult sons, one to trauma and the other to illness. She recalled that despite this significant loss the elder did not succumb to the overwhelming loss.

> *She can lead her life. She doesn't need to take sleeping pills. She doesn't weep. It's like she doesn't want to be in trouble […] She came to us…She has high blood pressure […]So, she came to get her medicine […]…I asked how she is doing, can she sleep, is she missing her sons. She said she misses them sometimes […] She can sleep because she could "Plong" (C06:17).*

The Thai word '*Plong*' (accepting whatever happens and not thinking about it anymore) relates to being resilient. This word also emerged in the previous chapter where it was used by the elders to describe the way they accepted a situation, which then helped them to move on.

The nurse participant describes *Plong*:

> *Even when she's in a hard time, she doesn't think about any other things that stress her. When she takes care of the children (grandchildren), she takes them to school (in the morning), then prepares food to go to the temple (offer food to village temple monks, at lunch time). She isn't free (keeps busy all the time) (C06:25).*

Resilience in rural Thai older people was viewed by nurse participants as the ability to live their own lives by relying on themselves. The actions of 'fight' against their adverse situation or '*fought with it and got through it well*' revealed a strong desire for living. '*Plong*' was an essential outcome if one was able to accept the negative impacts of adversity. Resilient elders were described as people who continued with their normal routines, and maintained a busy but simple life. Following their daily routine was a way that an elder 'got through it well'.

Ong et al. (2006) suggest that successful adaptation represents an ability to maintain and regain emotional health in the face of daily stress. The notion of being 'self-reliant' is the hallmark of resilience in older people. Previous research describes self-reliance as a belief in one's capabilities (Wagnild & Young, 1990). In terms of Thai older people, this was the belief of having the confidence to handle hardship and the ability to grow from these negative experiences (Maneerat et al., 2011). As described by participants, resilience included an

elder's own way of thinking, how they adjusted and continued to live a normal life, despite adversity. Significantly, things may be different after an adverse situation; however, the nurses described the older Thai people with resilience as those who are able to rely on themselves.

2. Expressing feelings

The community nurses spoke about the importance of helping older people to talk about their difficulties. The first step was encouraging the older Thai to express their thoughts to either the nurse participants, or someone else that they trusted. A participant spoke of this in the following terms:

> *First of all…they must open up their mind to us. They must be able to reveal what they are suffering from. They must not hide anything from us and tell us everything (C05:20).*

The same participant gave an example of an older person who lost her younger brother and came to the THPH with physical symptoms of sleeplessness and loss of appetite. The nurse performed a health assessment and then she focused on asking about her mental health. The elder revealed that the real cause of her symptoms was the loss of her loved one. This nurse participant reflected that the ability to encourage older people to speak about their feelings helped them to cope and assisted the community nurse to support them through difficult times:

> *To talk about this, the patient has to accept that they are sick. Then, they have to figure-out the cause of their illness. A good example is the grandma who lost her brother. If she just came to us for dizziness and didn't accept the truth that she was stressed, couldn't sleep and couldn't eat, we wouldn't be able to find the cause of her illness. We wouldn't be able to give suggestions to the patient (C05:21-22).*

Similarly, another participant was involved with an older person who had experienced a stressful situation within her family. The elder visited the THPH, spoke to the nurse about this event, and suggested it had led to her current illness:

> *She faces the problem of her daughter who has just remarried because she doesn't like her daughter's new husband. She thinks that the man has nothing (is not rich). That's why she worried about her. She also mentioned that she got a stomach-ache because she was stressed about this (C07:18).*

On the other hand, many older people who were facing problems did not discuss them with the nurse. One participant nurse said that the elder's adverse situation was shared with her by someone else, not by the person who was facing it. Hence, the community nurse could only observe the physical condition. She said she was only able to know about an issue if someone came to tell her:

> *She didn't tell anybody about her problems. I know what happened to her from people who are close to her (C03:7).*

The observational data confirmed this situation where older people would visit the THPH but not always to talk, or express their feelings. Older people predominantly came to see a nurse, or other public health staff and pointed out where they were sore, aching, or in pain. Otherwise, they talked about their common health problems, such as runny noses, itchy skin, or having a wound dressed.

The non-participant observation episodes at the THPHs confirmed that older people came to the THPHs for their physical health problems, not to talk about their adversity. It was observed that there was little time spent by the nurses in

conversation with the clients about the older persons' lives. This may be one area for increasing scope of practice around interpersonal and therapeutic interaction and learning to listen actively to client concerns creating a more holistic approach to older person resilience support. In particular, it would be important for the nurses to be able to provide counselling services, or to refer clients to mental health services to support their psychological needs. It may also be useful to teach older people about the importance of sharing their concerns with the nurses so that they can help them to maintain emotional wellbeing as well as physical wellbeing (Caris-Verhallen, Gruijter, Kerkstra, & Bensing, 1999).

The non-participant observation revealed that most of the older people visiting the THPH spend around five minutes (on average) at the health care desk, and then they carry a plastic bag containing medicine and walk out of the building. The community nurses were only able to help those elders who would freely express their adverse feelings. The elder's ability to express feelings of difficulty was not uniform amongst all the clients attending the THPH.

3. Valuing self

The importance of seeing the value in oneself during adverse situations was mentioned by the nurse participants' in reference to older Thai clients.

The following participant said:

> *If they realised their own value, they would take care of themselves (C03:9).*

A participant reflected that the elderly who saw themselves as having value were the ones that have resilience. She described that all older people were faced with decline in physical function and concurrent ill health such as chronic diseases (e.g.

hypertension, kidney disease, and diabetes mellitus). Realising how important they were and by valuing themselves enabled them to live productively.

> *It's like when you are sick, no one can help. Your body might get weaker every single day. However, what we have left behind? It's the rest of life. So, you (older people) have to think how to live your life productively. What you should do is to make it a good life. So, I'm thinking that whether this concept is the same as 'Pa-Lung-Su-Kha-Pab-Jid' (C05:28).*

The participants mentioned that value of the self by the elder was influenced by other people particularly family members and community nurses. The same nurse participant revealed that the reaction of elder's family member toward them was a significant aspect of assisting the elderly people to value themselves:

> *I think in the case of Grandma X, when her son-in-law takes her to the hospital, it's like it made her feel that she's valuable. At least he still notices her presence (C05:9-10).*

Another participant gave an example of her actions and said she found out about the elder's abilities and assigned them a job that they were capable of doing:

> *I also tried to bring her to the community meetings to do what she is capable of doing for the meetings. That can make her positive enforcement (C07:17).*

Previous research supports the premise that feeling good about oneself and having a goal in life is linked to resilience, with benefits to psychological wellbeing and purposeful physical activities (Wiles, Wild, Kerse, & Allen, 2012). Elders with high resilience levels were able to attribute meaning to their lives (Aléx, 2010).

4. Possessing religious beliefs

It was recognised by the nurse participants that elders with religious beliefs were able to recover from and move on from adversity. The community nurses observed that the temple was a place that supported older people through in difficult times. One participant mentioned that most people in her community were Buddhists. Thus, the temple was the first place village people thought of when faced with an adverse experience. The Thai term *Su-Kha-Pab-Jid* describes mental health as being directly associated which personal beliefs, which impacts on a person's overall health.

The nurse said Buddhist thinking contributed to a healthy mind:

> *In Buddhism, Su-Kha-Pab-Jid refers to mind. I think it's like we have a healthy mind […] it's like your mind has 'Pa-Lung' or positive thinking. You think positively, then your mind has positive power (C05:27).*

The community nurses agreed that the older people who overcame significant adverse events were people who possessed religious beliefs. Wiles et al. (2012) argue that religious beliefs contribute to recognition of the good things in the elder's life and that this then leads to a greater sense of purpose. The following participant described resilience in one older person who had died with cancer. She said the elder was a village headman and always went to the temple when he was alive.

> *When I come to think of it, grandpa X who had passed away, always went to the temple. He had something to hold on to. He had temple, Dharma and meditation (C04:14).*

Visiting the village temple played an important role in the elder's ability to cope. A nurse participant described an example she observed of an elder's condition. Some villagers visited the THPH and told her about their neighbour, an elder who was experiencing multiple problems at the same time. The community nurse said she wondered whether this elderly person visited the THPH for medication, however, this person did not visit the THPH; instead, the older person often went to the village temple.

> *She (older person) often goes to the temple. It's like she can live with it, or whatever, I don't know. She can restore her mental health by herself. I didn't ask her what happened. She didn't tell anybody else about her problems. I know what happened to her from people who are close to her, and I observed her condition … She didn't let herself feel stressed … She's never had any problems like coming to ask for medicine (C03:7).*

Temples were described as places to assist people to get through their suffering. This nurse participant shared her experience of an elderly woman who was suffering from a difficult family situation. The participant said the older client joined her elderly friends and travelled to several temples around various communities.

Generally, in the temple, there are several activities going on, several village temples were organising religious ceremonies during the data collection and one of those was mentioned as a ceremony to remove bad luck and a consecration ceremony for Buddhist images.

> *I met a grandma. She's stressed because her son divorced his wife. She went to the temple. And when she's there, there are different activities for them. They do not go to the temple just because they are preparing (to*

> *die). There are activities like a ceremony to remove the bad luck,… the ceremony where people wear white costumes, the consecration ceremony for Buddha images (C09:9-10).*

Another participant revealed that the temple was a symbol of goodness:

> *I think it is a metaphor or symbol of goodness. When people think about goodness, they will think of the temple and the monks (C02:13).*

The same participant observed that many rural communities have family members living away from their home and for the people who did not have family the temple was a place to find some happiness.

> *Sometimes people in the family have to work far away and hardly visit home. Then, another source of happiness for the elderly might be the temple (C02:14).*

The temple was a special place that held superstitious and holy significance. A participant indicated that the people in her community normally visited a particular temple to visit one monk when they are experiencing a particularly difficult time. She described that some people believed the adverse situation was caused by a ghost and that this monk could help to banish the ghost by spraying his holy water. Then people would get better:

> *There is a monk there. They believe that this monk can expel the bad luck from a person. The bad luck isn't good, right? So, they want to get rid of it. Some of them believe that they are possessed by a ghost and this ghost does bad things to them. They said this monk can exorcise the ghost with holy water … The monk will spray the holy water on them. They believe that after he does so, it helps them recover from the suffering (C09:11).*

Religious practices such as talking about spiritual matters, praying or visiting a holy place have been cited previously as ways to maintain resilience (Felten,

2000; Maneerat et al., 2011). This is an important cultural aspect for Thai elders living in the rural village community in this study.

The following sub-theme describes the everyday nursing experiences with their older clients.

Everyday nursing experience - resilience in rural Thai elders

The community nurse participants had many interactions with Thai elders that provided insight into their personal aspects of resilience. This section aims to describe the everyday interactions that the community nurses experienced when nursing their older clients. Understanding these experiences could lead to the identification of strategies to maintain resilience in Thai older people living in rural environments. These experiences were classified as being positive or negative perceptions.

Positive nursing experiences

1. Attending health activities

The THPH is a community health centre that provides care at a primary level, with an emphasis on health promotion and disease prevention. The non-participant observations revealed monthly plans and activities of health promotion and prevention activities for the community (e.g. health education around foods for the prevention of kidney disease). The community nurses' reported that older people were seen as the group who most actively attended health education activities organised by the THPHs. The following nurse explained that when the THPH organised health activities and asked older people to be participants, they were always eager to come:

> *They are very interested in the meeting that we arrange. They pay attention to what we are talking about at the meeting and ask questions (C04:2).*

Another nurse indicated this was because older people were not working during the daytime, therefore they could come if they could walk, or if someone was able to drop them there.

> *This age group joins the registration training more than the working group because they don't work (C06:7).*

> *… There're a lot of them joining us. Those who can't walk don't come. Those who can still walk come or some of them were dropped off by their children (C06:8).*

The participant further indicated that at times people attend the health activity or event because of incentives such as money help to subsidise their transportation, or because of snacks, or other foods being provided.

> *It's 50 baht for example. If they stay at home, they can't get it … We also provide them with food and milk. If we arrange this stuff for them, then they come (C06:7).*

Another reason for the high attendance by Thai elders was due to the large number diagnosed with non-communicable diseases (NCD) that required continuing check-ups and medications. The older people with chronic illness normally visited the THPH once every month and did not access health services from the district or provincial hospital.

> *Most of the elderly here are facing with NCD (non-communicable diseases) like diabetes and hypertension. They always come as their appointment […] The medical checking appointment is important to them (C04:1-2).*

The following descriptions refer to non-participant observation occasions where community nurses and older people interacted with each other. The observations revealed that all NCD (Non-Communicable Diseases) patients were recorded in the patient system, which linked online to the district hospital. NCD patients in each sub-district who required continuing medication had appointments to come to the THPH for check-ups, as well as to receive the hospital medication that had been packed in a bag labelled with the patient's name. This method assisted elders to decrease their travelling distance, costs, and time, as well as reducing their demand for services at the district hospital. During this time the community nurses at the THPH interacted with older people within their community, whilst simultaneously, older people were getting together as a group and sharing their daily lives.

Figure 10: Non-participant observation at the THPH

Non-participant observation
17/3/2014, 7.30-10.25am
Place: THPH building
Event: NCD patients' appointment
Participants: CN,
And ~ 30 older (women > man)

1. ***Waiting area***- most of the older people were sitting down on the floor and having a noisy chat whilst waiting. They were getting there, waiting, seeing a nurse, and then leaving.
2. ***NCD patients*** name was called and they sat on a chair and had their blood pressure taken, glucose test (some of them) and received a bag (medication).
3. ***Community nurse*** sat on a chair
4. ***Big box*** carried many bags of NCD medication that had been prepared from the district hospital
5. ***Researcher***

During these NCD appointments, interactions were observed between the community nurse and the older person, and the older person with other older people. The following four excerpts from field notes describe these two types of interactions. Although these excerpts are from one THPH, the interactions observed were similar for the other three THPH.

1. Community nurse and older person:

Excerpt one - An older woman with a flower screened shirt and long black pants was sitting down with the community nurse (CN). She received tests for diabetes (DM) and hypertension (HT). She always smiled and her fasting blood sugar level was 108 mg/dL (within normal range FBS < 110 mg/dL). CN said it was good and

asked her for any different symptoms. The older woman smiled and had no words to answer the question. The CN asked how many pills she had left. The older women said there were only two tablets left. The older woman gave her medication bag from last month to a CN to have a good look. Then the CN found her a bag in the big box. While doing that, the CN talked to this older woman gently and patiently. The CN spoke slowly and made all her words clear. The CN gave the older woman a bag of her medicine. Then the CN went into the staff room to work with a computer to record the visit and the older woman left the building.

Excerpt two- The conversation within the group of older people in the waiting area was loud enough for the researcher to hear. The group was talking about the pain that one person had mentioned. While the CN was with one patient at her desk she overheard that the discussion. She said to the group that she would give her a Thai massage. That older woman who was sitting in the group replied to the CN that she didn't want one, because she had walked there, and didn't want not to be able to walk back home after a massage. The older Thai laughed at this response. Several topics of conversation were raised among the older people while they were waiting. Once when the group conversation changed to discussions about food, the CN spoke to them. The CN indicated this was a week for renal disease and that the THPH would provide information about food with low salt. Then, it was silent until one older Thai spoke about another topic.

2. Older person with another older person:

Excerpt one – Two older women arrived and walked to a nurse's table, which had a Money tree-ต้นดอกเงิน (a fake tree created for people to donate their money on its leaves) and it was located near the big box of medication. One person gave money to put on the Money tree and said "*Tam Boon-ทำบุญ*". She said that she had won the lotto yesterday. They talked about how she won and she said her little grandson told her that particular number, and she won 20,000 baht.

Excerpt two – Within the group, there was a conversation about 'not eating and drinking after midnight' or fasting before coming to get a check up and get their pills. Some of them said they do not have DM, but they also fasted. Someone said she did not know and she would not do it next time. Another one said they would come later than this time to give a chance for DM patients to be seen first.

These interactions described from the field notes demonstrate the supportive relationship between the nurses and the older people and the way that the nurse(s) interacted with the older people was friendly and professional. The CN in every THPH recognised their patients and called them by their correct name. Older people raised several topics with each other, in particular those concerning their health and exchanged information around what they do in their life to maintain blood pressure and sugar levels.

One community nurse mentioned that older women were more likely to participate in health care events than men were.

The participant said:

> *Most of the active group are female. The old women always participate in any activities including health check-up or health promotion activities (C07:1).*

To illustrate this situation, she said that:

> *… when we ask the elderly to the behaviour changing program, all women will join us … for men, not many of them come. When we told a hundred to come, only 50 came. If it's for women, about 80 of them joined us (C07:3).*

Older people in rural areas were viewed as more cooperative than any other age group. Money for travelling was mentioned as increasing the attendance rate for some health training programs. The NCD medical appointments that occurred once a month were found to be the event that brought the largest group of older people from around the community to visit the THPH.

These descriptions demonstrate that older people (mostly women) were active participants in health events that were organised by the THPH and that they had positive experiences with both the community nurses and other older people. However, the nurse participants revealed some barriers when working with older people, which prevented them from always supporting an elders' resilience.

Negative nursing experiences

The community nurses working with older people within the rural Thai communities identified several barriers. The first was that they considered themselves as not having enough knowledge about elderly health care, and secondly that they had limited time to care for older people. The community nurses also described Thai older people as not being easy to please and that they were reluctant to talk about their family business.

1. Limited knowledge

Three out of seven community nurses said that the provision of health care for older people requires specialised knowledge and practical skills and they believed that their nursing skills were inadequate. The following participant revealed that he did not have expertise in the area of elder health care and that the most challenging part of nursing older people for him was providing holistic care. He said he felt confident only when dealing with physical health, not mental, social, and spiritual health.

> *… we can only do it at certain of all levels ... it may be possible for physical health and not for other issues like mental health, social problems, or spiritual health. This is because we don't have the expertise in analysing them (C01:4).*

'We don't have the expertise in analysing them' indicating that limited knowledge reduced the community nurses' confidence and restricted them from assisting with the overall health problems of older people. The participant further expressed that it was hard to ask for support due to being in a remote area where there were no elderly health care specialists. Another community nurse indicated that an older person's health information could come from anyone within the community. She revealed that at times she learnt about an elder's problem from the elder's neighbour; however, she did not feel skilled enough to deal with it:

> *They told me about that. But it's me who can't get along well with elderly. I'm not good enough for it (C03:2).*

The following participant, worked at the THPH where they have two community nurses. She was the one who provided the care for the older people and revealed that it was hard to approach some older people within her community:

The challenge is that they are difficult to approach (C04:2).

Conducting a comprehensive nursing assessment and sharing the information with the older person was suggested as the hardest aspect of working with older people. The study participants reported they were comfortable dealing with issues pertaining to physical health, however they were uneasy working on mental, social and spiritual health assessments. In particular, enhancing resilience in older people and promoting positive thinking to empower them requires someone skilled and experienced.

As was suggested by the following participant:

> *... it would need someone who is very good at talking to encourage others in changing their point of view from negative to positive ... it must be something that can actually be done ... based on reality ... Not something out of fantasy world (C01:16).*

Regarding Thai nursing practice, the Thailand Nursing and Midwifery Council (2011b) outlines four actions of professional practice in nursing:

1. Providing education, advice, counselling, as well as solving health problems;
2. Assisting individuals both physically and mentally;
3. Providing primary medical care treatment (e.g. wound treatment, wound dressing, suturing, stitch removal, abscess excision*, nail removal, wart and corn removal, incision with removal of foreign body*) and immunisation. *that does not endanger vital organ; and
4. Assist physicians in performing treatment.

Limited knowledge around the specialist health care of older people was identified as a concern for the community nurses. Assistance from a gerontologist for

example, to provide support, or having more specific knowledge about elderly health care was also identified as an area of further need for the community nurses.

The study participants recommended that they also needed to know what resilience is before finding ways to support the older patients in their communities:

> *In terms of application, nurses must be provided with further knowledge in nursing the elderly. They need to first know what it actually means… I believe if the staffs understand the subject and can perform it, they can successfully apply it with the elderly patients and their daily routine (C01:16).*

Knowledge around resilience was found lacking and important for nursing practices especially if they were to incorporate a resilience approach in primary health care within the rural Thai community.

2. Less elder home visits

The study participants reflected that they provided less elderly home visits than they should. The participants indicated that home visits were a primary part of their responsibilities in their primary health care role. It also formed part of a registered nurse's competency in terms of continuity of care and home health care principles (Thailand Nursing and Midwifery Council, 2011a). One participant explained that the health care policy required her to be involved with health promotion and disease prevention, and not treatment, however, this was the opposite to her daily practice. She revealed that she was rarely able to leave the THPH for home visiting:

> *Yes, that's my main responsibility. They (policy maker) said it's not important for me to give them (patients) treatment. I should visit the community. In reality, it's impossible (C06:37).*

This finding is similar to the Thai national primary health care information that reported many primary health care providers understood primary health care as simple curative care instead of being inclusive of health prevention and promotion (Institute of Community Based Health care research and Development, 2007). It was observed by the researcher that the time plan sheet that was fixed on the wall of some THPH indicated a work plan to visit the community every weekday afternoon. This plan however, was frequently replaced by paper work, monthly staff documentation, and other work such as report writing and conducting audits. The following community nurse said he was thinking about going out to see his patients, but he was stuck at the THPH because he had no time and had a heavy workload.

> *I'm not only working as a nurse but also doing academic work, paper work, financial work, and administrative work. I mean these works would just keep coming in and I didn't have the time to visit the patients (C01:7).*

Limited time to deal with the THPH work was frequently mentioned. It has been reported that the health care worker at the primary care level spends 40 percent of their work hours on data management and reports (Kijsanayotin, 2009). On the other hand, the THPH, which has only one nurse said she could not leave the THPH in case she was reported for not being there, therefore she mainly works in the THPH building to avoid being called to account:

> *… I hardly do it […] Because […] I am alone. I can't go anywhere. I can't just leave it (THPH) […] They (patients) come all the time. It's more*

> *important to be here than to visit a house. If I am not here at the THPH…, I'll get reported… but they don't do that if I don't visit house (C06:36).*

This data reveals that the THPH has been utilised to provide health treatment rather than health promotion and disease prevention.

She gave more explanation that:

> *People in the community more expected that they can get treatment from here (C06:37).*

Community nurse's responsibilities centred around curative care and providing medical prescriptions (Kitreerawutiwong et al., 2010; Nontapet, Isaramalai, Petpichatchain, & Brooks, 2008). The need for clarification around the future of their role was highlighted, as they believed the expectation was for them to present themselves to the THPH and wait to treat walk-in patients, or risk being reported despite part of their role requiring them to conduct home visits.

Additionally, public health volunteers, made up of local villagers or 'Ar-Sor-Mor (อสม.: อาสาสมัครสาธารณสุขประจำหมู่บ้าน)', assisted with health care business for their village members. The community nurse's work role was suggested as being more of a coordinator's role than as a health care provider for older people. Once again, limited time was described as a factor:

> *…We are like a coordinator… We are better let the community volunteer to give the help instead of us because we have less time to look after the elderly than the community volunteer (C02:12).*

The community nurses in this study identified that the home visit was a key responsibility, however, limited time and having a heavy workload restricted them

to sitting inside the THPH's building rather than performing community home visits.

Another barrier described by the nurse participants centred on cultural expectations. The Thai culture has a very strong age and positional hierarchy that drives the behaviour of young people towards older Thai people and can generate some uneasiness.

The following sub-theme of 'older Thai are not easy to please' describes this perception.

3. Thai older people are not easy to please

Thai cultural practices and norms dictate that a younger person is expected to please and respect older people and the nurse participants revealed this as a barrier. The following community nurse expressed this feeling when she was interacting with older people who visited the THPH. For her, an older person sometimes expected a high level of health service but did not take the health care advice when given:

> *They are not easy to please. Some of them are too kind…And some it seems don't understand us, don't accept us, and sometimes they feel unhappy when we ask them (for chief complain that brought older people visited the THPH) […] … When they get services from us, they want us to please them (C02:1).*

When interacting with older people it was expected that the community nurse would act as a professional health care person, being polite and respectful of older people and this was mentioned as being a challenge for community nurses. These cultural norms influenced the health care practices of nurses. Finding the right

approach to please, to make them happy and ready to listen to health care advice was seen as a challenge.

The participant said:

> *The elderly living here, in this village are very nice and easy to talk to but it's difficult to please them (C08:17).*

The next participant gave a reason why it was hard for them to please their older people. She said it was because older people believed that they were a person that carried more knowledge of living than a younger person like the community nurse. It was difficult to make them follow or comply with a younger person's suggestion:

> *…when I tell them to do something, they just say no, don't do like that, and teach me to follow them. Then they just say what they want us to do (C02:2).*

As was the case for the following participant, she considered her younger age compared to the older people in her care. She expressed the life experiences of older people were barriers:

> *Sometimes I can't teach them so much. I can't blame them. I can't say anything too much: moreover, they said they were born before me (C03:10).*

Additionally, as older people have past health experiences and changing their beliefs presents the community nurse with another challenge.

The next participant suggests:

> *It's never easy to change what people believe. When you tell them to do this, they still have doubts about what we have told them (C06:2).*

In order to assess an elder's health, the participants said that the older people visited the THPHs chiefly because of physical complaints. Some of the physical symptoms

were related to, or caused by the state of their mental health and presented as physical conditions. However, the older person would rarely share the real reason behind these complaints. The following sub-category describes this experience.

4. They don't tell us the real reason (mental health)

Within the rural community, an awkward space between health policy and practised reality was identified. Community nurses were more focused on treatment rather than health promotion or mental health. The reason may be that the villagers did not know that they could come to visit the THPH for assistance with their mental health issues.

The following participant said:

> *They don't know that if they have problem with their mental health, they can come […] to consult with us when they are suffering from distress (C09:17).*

Therefore, the challenge for the nurses was attributed to the reluctance of older people to talk about, or discuss the underlying reason for their health concerns:

> *In most cases they don't tell us… Most of them come to us because they suffer with something … They come for some medicines because they can't sleep, they have a headache, they can't eat, or things like that (C09:4).*

Apart from the NCD problems of the elderly, sleeplessness and having a headache were often reasons why older people visited the THPH, rather than requiring help with their life problems. If their visitor was not prepared to share their situation with the community nurse, even if they may already know about the issues from someone else, they were unable to address it:

> *Suppose they're sleepless, I will ask them what makes them feel uneasy. They rarely tell me about that … But their neighbours told me about them, I felt that they have a problem but they didn't tell me (C03:2).*

Sensitive situations that older people did not share with the community nurses were reported to the researcher during this study. It was sometimes a family issue and this caused them to experience physical symptoms, particularly sleeplessness and headaches. The next participant said older people may share something about a difficulty, but not all of them were prepared to do so. Sometimes, an older person might just mutter quietly and this required further questioning:

> *… mostly they mutter about their children who don't pay attention to them and don't take care of them much. They said that their children just go out to work in the morning and go back home in the late evening and hardly have dinner together. This makes them get less chance to talk to each other. Then they feel like they don't get enough attention from their children (C02:1-2).*

Once again, limits on specific knowledge related to older people's health care, particularly assessing, as well as limited access to health expertise and support prevented community nurses effectively approaching situations. Moreover, it seemed more difficult if those matters occurred within an elder's family:

> *I'm not sure if I could analyse it because most patients would not want to talk about it … The community can't help them neither because this kind of problem is more like a family problem which only family members can help each other solve it (C01:15).*

Significantly, family issues were revealed as a sensitive matter and community nurses found it difficult to get involved with these.

These findings highlight two significant points. Firstly, villagers do not know about the THPH's responsibility in terms of mental health support and they only expect services for physical ill health. Secondly, the community nurses believed that they could not access and assist older people during times of hardship, particularly if this was the result of a family issue.

Summary

The findings stemming from the perceptions of the community nurses' and their everyday nursing experiences highlight a limited understanding of the concept of resilience in older people. The findings demonstrate that community nurses working in the THPHs were among the health professionals closest to Thai communities and understood the influence of culture and its meaning to the health of older people.

The adverse situations faced by older people, from the community nurses' perspective, consisted of suffering an illness, losing their loved one, the sickness of a loved one, and the problems of work, or a family situation. Resilience was viewed simplistically as the characteristics of older people that enabled them to deal with personal adverse situations, their self-reliance, being able to express their negative feelings, valuing themselves and in the possession of religious beliefs.

With respect to nursing older people, Thai older people were identified as the group most willing to attend health activities, compared to other age groups. The reason behind this was largely attributed by the nurses to their availability during the daytime. At times, they were provided a secondary motivation such as money

to assist with the cost of travelling and provision of food. Older people also importantly maintained self-awareness around issues pertaining to their health.

The health care responses of community nurses were mainly focused on physical symptoms and physical health treatment. The participants highlighted that it was difficult to assist with mental, social and spiritual issues and therefore to provide theoretical holistic nursing care. Assessing an elder's health problems was a challenge, coupled with not having enough knowledge around elder health care and having no elder health specialist support, such as a gerontologist or Clinical Nurse Consultant as in a developed country like Australia.

Additionally, less home visits being performed was raised as a possible reason for having trouble in assessing the older person. Limited time and a heavy workload restricted their role to one as a health coordinator, rather than the lead provider of direct nursing care. Moreover, cultural practices and norms were raised as another area of concern. The nurses were younger than their older clients, which created some tension around respect (both ways) between older clients and the younger nurses.

The nurse participants found some older people reluctant to talk about their mental health and this made it difficult to provide specific care for undisclosed problems. Trying to find a suitable way to approach and assess their older clients, such as asking more questions relating to their health condition, or providing nursing advice appeared to be difficult for them. The final chapter discusses the combined findings of the ethnography and provides a number of key

recommendations for community nurse practice and older person care in rural areas.

Chapter Eight

Discussion – Thai Elderly and Resilience

Introduction

In this final chapter, the concept of resilience is critically discussed in relation to the thematic development of Thai elderly resilience from the perspectives and experiences of Thai elderly and community nurse participants. The research literature validates many of the study findings and new concepts have emerged in this previously under-studied Thai older person domain. This is especially so in relation to the cultural nature and understanding of the concept of resilience from a Thai perspective in the four THPH sites and villages visited by the researcher.

Resilience is described and defined from the participants' perspective and from the researchers' non-participant observation field notes and reflections. The chapter synthesises all of the qualitative findings (themes and subthemes) in responding to each of the research questions. For the purpose of the structure of the final chapter, the aims and research questions are once again provided below.

Research aim

The research aim was to conduct a qualitative ethnographic research project to clarify the concept of resilience from the perspective of rural Thai elderly and their community nurses.

Research questions

1. What does the concept of resilience mean to rural Thai elderly and their community nurses?
2. How do rural Thai elderly respond to adverse circumstances?
3. How do the social and cultural artefacts (symbols) of Thai society influence the resilience of rural Thai elderly?
4. What are the community nurses (sub-district nurses) doing to develop or maintain rural elderly resilience?

Resilience defined (Thai terms that relate to resilience)

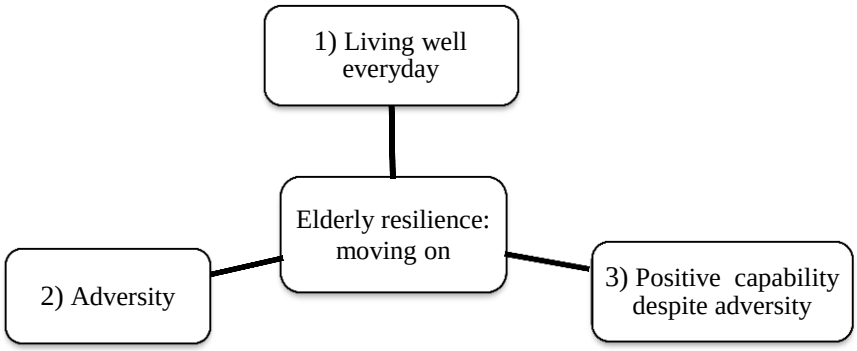
When starting out in the community centres and villages where participants were recruited, the researcher found that there was very little understanding of the concept of resilience. The researcher was thus required upon entering the research field to describe her study in Thai language (Isan dialect) to both the nurses and elderly participants. The term resilience and its Thai equivalents including, *Kwam-Sa-Mard-Nai-Kan-Yurn-Yud-Pa-Chern-Wi-Grit (ความสามารถในการยืนหยัดเผชิญวิกฤติ-* the ability to exist despite crisis*))*, and *Pa-Lung-Su-Kha-Pab-Jid (พลังสุขภาพจิต-* power of mental health*)* were used to describe and define the meaning of resilience in words participants could understand. *Pa-Lung-Su-Kha-Pab-Jid* was the remaining term used by participants to understand the term resilience. Once the term resilience and its Thai equivalents were clearly understood in the context of their own language where participants could engage in a conversation about the resilience concept, the participants were then asked about their personal experiences.

Once simplified, it was possible to discuss resilience in separate semi structured interviews with the elderly and community nurses. The researcher used non-participant observation in the THPHs and the village communities during fieldwork to look for examples of the types of adversity participants related to resilience, which were described in the semi-structured interviews. This was especially important because participants explained they understood resilience to mean coping with adverse life events and hardships. In relation to the thematic development of the data, the following research questions are discussed.

Question one - The concept of resilience and its meaning to rural Thai elderly and their community nurses

This research question was answered by synthesising the major findings from Chapters Four, Five, Six, and Seven. The characteristics of resilience in rural Thai older people was clarified as an elder person's ability to keep moving on with life, irrespective of a variety of adverse circumstances. Resilience in the context of rural Thai older people appeared to depend on three elements: 1) living well every day, 2) adversity, and 3) the positive capabilities of each participant as they responded to adverse life circumstances. The elements of resilience are illustrated in Figure 11 and are further discussed in the section going forward.

Figure 11: The elements of rural Thai elderly resilience



Living well everyday

Living well everyday provided protection against adversity and helped the older people to maintain their resilience. Four subthemes of 'living well everyday' enabled the Thai elders to sustain health.

These are summarised in Table 17.

Table 17: Elderly's resilience protective health factors through living well every day (Yuu Dee Mee Haang -อยู่ดีมีแฮง)

Living well every day: the elder's everyday life protective health factors	
Physical	Rarely sick, no illness, having a normal level of blood pressure, regular exercise, eating well (not eating too much, eating good food which older participants could find in their village, not smoking or drinking alcohol, eating cooked food), and living a simple life.
Mental	Being able to release negative feelings and not being under pressure, doing things that bring happiness, being cheerful, having a positive self-image, feeling proud of their children and grandchildren, receiving positive respect from community members, having will power, and being aware of their sexuality.

Living well every day: the elder's everyday life protective health factors	
Social	• Being connected to children and/or grandchildren, family, and community • Productive involvement in community activities such as being a headman of their village, and leading a cultural/religious practice. • Enjoying local music and/or a local show.
Spiritual	• Visiting the temple to make merit (Boon) and engaging in religious activities such as meditation, praying, listening to monks' sermons, and observing the moral precepts. • Belief in the Buddhist Karma • Belief in magical powers, and superstitions

Physical health was described by the older participants as being rarely sick, having normal blood pressure, exercising regularly, and eating well. Previous studies reinforce that when an older person exercises, eats well and has purposeful activities that they are more resilient (Felten, 2000; Jeste et al., 2013; Perna et al., 2012). Pertinent to this particular cultural setting living a simple life was achieved by eating and drinking well, and continuing to do their usual work. Being part of a rural community and participating in village activities involving the Buddhist temple and other meeting places are part of the cultural artefacts that supported resilience in this sample of Thai older people.

Living a simple life can be seen as a link to the Thai rural elder's cultural beliefs, as Buddhist teaching emphasises living life in the 'middle path', which focuses on the way of 'not too much', or 'not too little' (Sriwarakuel, Dy, Haryatmoko, Chuan, & Yiheang, 2005). 'Middle path' also refers to an understanding of life by self-monitoring emotions, such as greed, hatred, pride, arrogance, and overcoming these emotions with the feeling of being not too happy, or not too sad (Sriwarakuel et al., 2005). Living life in the middle aligns with the description of

Living a simple life where older Thai people revealed that they were living with nothing special. The philosophy of the Sufficiency Economy, created by the Thai King, Bhumibol Adulyadej (King Rama 9), supports living simply (Mongsawad, 2010). This philosophy fosters an appreciation of what a person has by balancing existing resources and local knowledge in order to live their own lives, rather than relying on outside assistance (Chalapati, 2008; Williams, 2013).

Mental health was another everyday protective factor that was described by participants and occurred because of doing things that brought the older participants happiness. These things included not experiencing feelings of depression, being cheerful, and being motivated to participate in daily events. Happiness was experienced when the older participants felt proud of their children (and/or grandchildren), when they were positively acknowledged by other community members, and when they received respect from others, particularly younger people within their village. The attributes of positive mental health are not unique to Thai society, where older participants receive a higher level of respect and positive acknowledgement from younger people (Choowattanapakorn, 1999) as other Buddhist cultures also hold similar beliefs. A high level of mental health and self-regard facilitated by positive affirmation from others and having a life full of activity has previously been identified as a strong predictor of elderly resilience (Wells, 2009, 2010).

Furthermore, some Thai elders described the importance of having fun, and being happy with their sexuality and gender. The role of sexuality for older people in other older persons' research for example has been found to be associated with a significantly better life stage adaptation through increased communication, trust,

sharing, pleasure, love, and intimacy (Kalra, Subramanyam, & Pinto, 2011; Touhy, 2008). Furthermore, expressing sexuality has been found to enhance an older persons' quality of life (Deacon, Minichiello, & Plummer, 1995). For at least one male participant in this study thinking about his sexuality contributed to his sense of well-being but this was not a topic discussed by the women at all.

Older participants not openly discussing sexuality may be an artefact of the traditional paternalistic nature of Thai society, where men's viewpoints are predominant. Women on the other hand are encouraged to keep quiet about such things. The lack of discussion about sexuality by older women in this study may be related to the traditional view of a good Thai woman being seen to be passive and dependent on a man for sexual initiation (Deacon et al., 1995). Perhaps also, it is related to biological decline and feeling less interested in sexuality (Buttaro, Koeniger-Donohue, & Hawkins, 2014). In previous elderly 'resilience' studies predominantly with Western and Caucasian women, sexuality and its contribution to being resilient has not been mentioned. Further research of gender, resilience and sexuality from a holistic cultural perspective in Thai older people and its relationship to living well, is worthy of further investigation.

Social health linked to social activities and social support was another health protective factor. Social activities provided an opportunity for the older participants to be a leader, share their personal knowledge and experiences about cultural practices, and to enjoy local music and traditional cultural shows. Social support was described as being related to the Thai tradition of filial support, support provided by children and grandchildren, that included preparing meals and assisting with transportation (Knodel, 2012; Knodel, Kespichayawattana,

Wivatvanit, & Saengtienchai, 2013). Social support also included community support, such as the community members showing respect for older people and praising them.

Social activities and social supports are known to contribute to the feeling of belonging and increased feelings of security (Maneerat et al., 2011; Pathike et al., 2015). Having positive social supports and connections has been identified as protective factors that contribute to maintaining resilience in the elderly (Heisel & Flett, 2008; Hildon et al., 2009).

Spiritual health in this study was related to Buddhist practices, community activities, and a belief in magic, and superstition. The Buddhist practices associated with making merit at the village temples were offering food to monks, listening to a monk's sermon, and avoiding sin. These activities helped the Thai elder participants to achieve control over stressful situations through their belief in Lord Buddha. Allen et al. (2011, p. 8) state, "spiritual/religious resilience represents one aspect of meaning based coping that leads to positive outcomes in adverse situations". Older people in the study by Aléx and Lundman (2011) were found to have lower levels of resilience when older people did not have any substantive religious beliefs.

Fortune-tellers and good-luck symbols were described by the Thai participants as contributing to the spiritual health of the Thai elders. The older participants revealed that they felt protected, and believed that they experienced a better life because of the power of magic and superstition. Moreover, the community nurse participants revealed that a belief in the magical power of a monk, such as holy

water, assisted the older people within the rural community to overcome adverse circumstances.

Spiritual symbols and cultural artefacts linked to religious beliefs and values appear to connect the older person to their sense of self. Being Buddhist in this study represents a shared meaning associated with belonging to a group of older people who believe in the same things (Mackinlay, 2010). Spiritual health for these participants was seen to influence the acceptance of change and to assist overcoming adversity, because spirituality is shared in the community (Smith, 2012).

The four protective 'living well every day' subthemes of physical, mental, social and spiritual health reported by the Thai older participants have been referred to in other studies. These studies have found that a high level of resilience in older people is associated with being healthy when combined with high levels of wellbeing, and having good mental health status (Choowattanapakorn et al., 2010; Couto et al., 2011; Wells, 2009). Older people who perceived themselves as being healthy were found to have higher levels of resilience (Wells et al., 2012). Furthermore, mental health status has been found as one of the strongest predictors of resilience in older people (Wells, 2009, 2010). Social connectedness and social support have also been reported to be associated with resilience (Adams et al., 2004; Aléx & Lundman, 2011; Caltabiano & Caltabiano, 2006; Ferreira, de Castro Silva, et al., 2012; Heisel & Flett, 2008; Kinsel, 2005; Maneerat et al., 2011; Netuveli et al., 2008). The source of spiritual health has been linked to religious beliefs (Felten, 2000; Nelson-Becker, 2006; Smith, 2012)

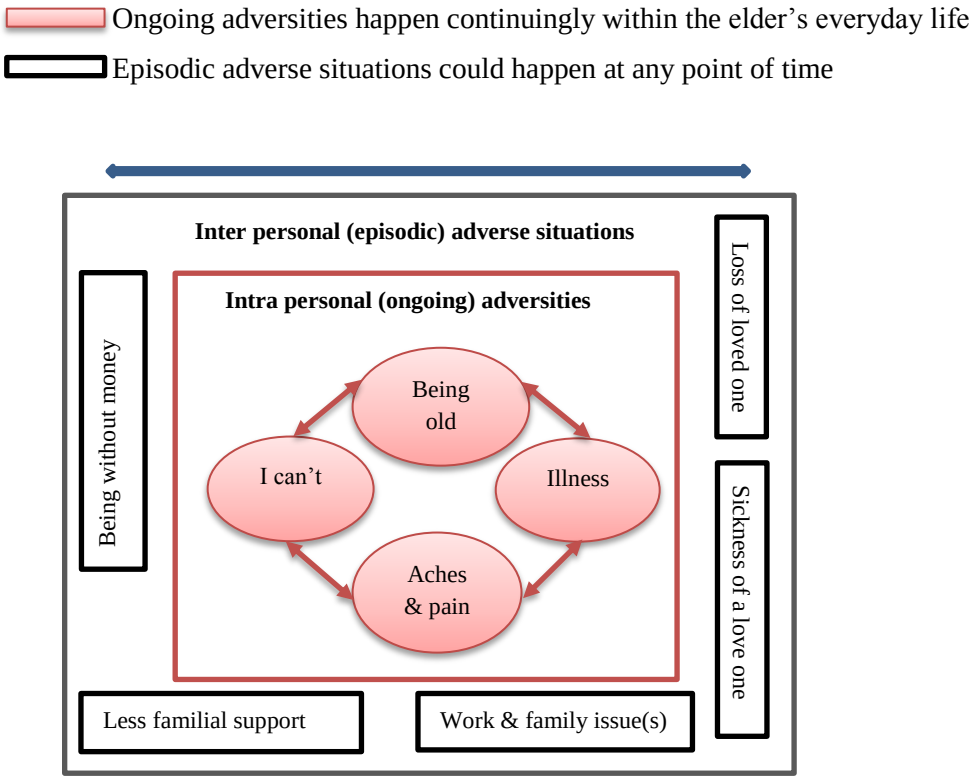
and the features of religious belief and social participation have been shown to support, enhance, and sustain resilience in older people.

Adversity

Adversity is another major element of the elderly resilience construct emerging from the elders in Chapter Five and from the community nurses in Chapter Seven. As mentioned previously, the older participants found it difficult to understand the English term, or its Thai equivalent to describe their adverse experiences. The word adversity to make it understood by participants was translated to its Isan dialect equivalent as *Ouuk-Ouung (อุกอั่ง)), Ouuk-Ouung-Oout (อุกอั่งเอ้า)* or *Ouuk-Ouung-Oout-Jai (อุกอั่งเอ้าใจ).*

The Isan translation enabled the older participants to describe their adverse situations and clarified the meaning of resilience. Adversity was described by the older participants as being part of ongoing life experiences (intrapersonal) where it related to growing old with poor health. Episodic adversity was described as an inter-personal adverse situation, which could happen at any time (see Figure 12).

Figure 12: Ongoing and episodic adversity in the rural Thai elderly



Other older person studies identify being old to include illness, physical impairment, having day-to-day fluctuating pain, and living with chronic pain (Adams et al., 2004; Felten, 2000; Jeste et al., 2013; Ong et al., 2006; Zautra et al., 2005). Ongoing adversity has been further recognised in the literature as a central feeling of being under stress that includes depression, suicidality, being vulnerable and living with physical health problems (Adams et al., 2004; Couto et al., 2011; Felten, 2000; Heisel & Flett, 2008; Jeste et al., 2013; Ong et al., 2006; Zautra et al., 2005).

The episodic adversity identified by participants has some similarity to studies where grieving has been found to contribute to feelings of loneliness (Adams et al., 2004), and economic hardship and depression (Dorfman et al., 2009). In this

study, less familial support and being without money to live were found to be significant unanticipated negative life events for the older participants. Thai elders were stigmatised in their village when they lived alone and/or lived with no children because it is expected in Thailand that children will support their parents.

Being without family support is viewed by the Thai village community as a negative situation. Such stigma caused the older participants to walk away from social activities, particularly when they heard other people talk about how good their own children were. In this context, the community nurses could help the older persons in their community to be more open about their lives and this approach may enable the village community to become more accepting of rural family configuration changes.

It is clear that when the older participants did not have adequate familial support this contributed to their developing physical and mental health problems. Inadequate familial support is a possible cause of social isolation and is known to lead to a sense of disconnection, loss of coping support, feelings of being undervalued, or disregarded and also financial hardship (Moyle et al., 2010; Rothermund & Brandtstadter, 2003).

Positive capability despite adversity

Positive capabilities despite adversity were identified by the elderly and community nurse participants in Chapters Six and Seven. Seven subthemes were described by the older participants, and four others by the community nurses. The features of positive capabilities are displayed in the table below to demonstrate the

relationship between positive personal and social capabilities, which facilitate resilience in older people (see Table 18).

Table 18: The positive capabilities (despite adversity) that facilitated resilience in rural Thai older people

	Older people	Community nurses perspectives
Personal	1. Keep doing a job and earning a living 2. Having Jai-Yai to fight for life	1. Living on their own legs (a strong desire to be alive)
	3. Accepting a situation 4. Let it be and be patient 5. Staying on top of it	2. Valuing self (saw themselves as having value and take care of themselves)
Social	6. Expressing difficulty: speak it out and crying	3. Expressing feelings
	7. Connecting with people, beliefs and customs	4. Possessing religious beliefs

Living on your own legs was described by the community nurse participants as the elderly having a strong desire to continue living and to keep doing things that they wanted to do. This is similar to older participants describing the themes of *doing a job and earning a living*, and *having Jai-Yai to fight for life*. This similarity between what the older participants and community nurses identify as capabilities may be reflective of aspects of rural Thai culture. In most situations to be able to fight for life or to live on your own legs meant the elderly needed to keep working to supplement their pension income. The pension is only the equivalent of 39 Australian dollars a month. The senior pension is much lower than the national minimum wage, which is approximately 300 baht a day (15,000 baht per month, which is around 577 AUD) (Freehills, 2015). Activities such as growing and

selling rice and tobacco, working for wages and growing vegetables to sell at the local markets supplemented their income. The elders demonstrated personal courage when they fought against adversity, and they described themselves as being fearless, tough, and of strong of mind.

Valuing self, mentioned by the community nurse participants is described as the feeling of being valuable as a person and taking good care of himself or herself. The sub-themes that arose from the older participants that were similar to valuing self were *accepting a situation, let it be and be patient,* and *stay on top of it*. The resilient elderly participants said that they accepted that adversity was something that they could not avoid. They accepted the difficulty however and realised that with patience they would overcome it. The capability, *stay on top of it,* represents not allowing adversity to overwhelm them. Staying on top of it is similar to the religious and spiritual belief about *'Plong'* in Thailand. *Plong* is the ability to let it be as it actually is, but not to admit to it damaging a living life (Sowattanangoon et al., 2009).

Community nurse participants described two particular social capabilities of '*expressing feelings'* and '*possessing religious beliefs'*. Community nurses stated that if the older person who visited the THPHs could express their feelings or talk about their difficulties then the community nurses could support and help them through adversity. Expressing difficulty through talking and crying was also mentioned by the older participants as being consequential to dealing with adversity.

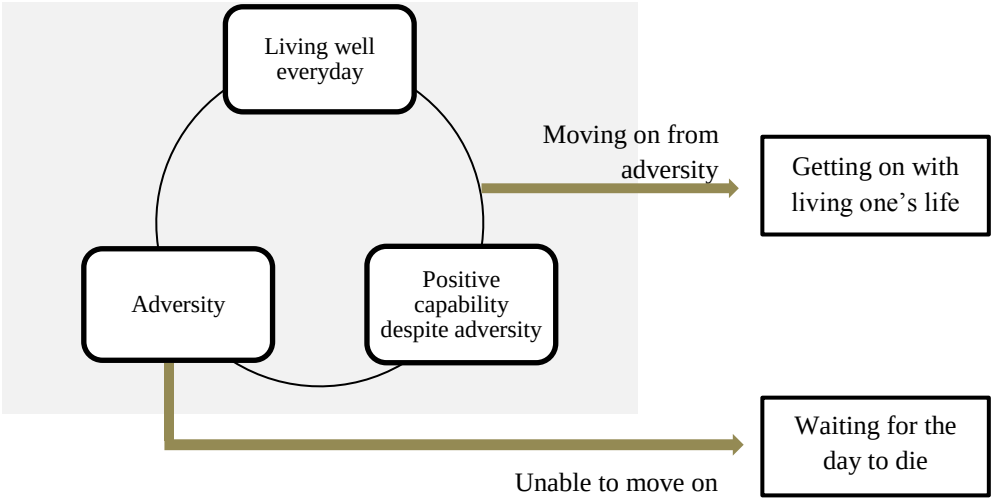
Older participants shared experiences in which they felt they could only speak about with the right person. The older participants described feeling worried and this led to feeling stressed if their situation was openly discussed by other persons in the village. Subsequently, most of the older Thai participants avoided talking about their adverse situations in their local network and this included discussing it with community health care providers. An opportunity exists for the community nurses to engage with older persons about their problems, as it appears that addressing elders' mental health concerns is not a high priority. In particular, a focus on therapeutic engagement and interaction for mental health concerns could become part of the THPH nurses' scope of practice.

Both the Thai elders and the community nurse participants identified that the Buddhist temples were an important source of support for rural Thai elders during times of stressful life events. Within a village temple, older Thai not only received Buddhist teaching and practices, but also experienced the pleasant feelings, such as good luck and protection from bad things (including superstition and ghosts). The temple provides an opportunity for older people to connect with other elders, and enables them to socialise, generating a sense of belonging and wellbeing. Religion has been identified as a key component of elderly spirituality (Jewell, 2010). Religion enables older people to have a greater sense of purpose (Wiles et al., 2012) and contributes to resilience (Felten, 2000; Moyle et al., 2010). Possessing religious beliefs and its cultural interactions within the village community supported older participants being more resilient.

Question two -Responding to adverse circumstances

The adverse situations older Thai participants experienced were discussed in the previous section, while this section discusses how they reacted to adversity. *Moving on* from adversity was perceived by the study participants as being at the core of elderly resilience for this Thai sub-cultural group. Moving on from adversity highlighted how the elderly participants positively responded to their adverse circumstances. Being 'unable to move on' was what happened to elders who could not respond positively to adversity. These two reactions to adversity are illustrated below in Figure 13.

Figure 13: Rural Thai elderly responses to adverse circumstances



Moving on from adversity

The older participants spoke about being able to move forward and to continue their daily existence despite difficult life circumstances. Windle (2011, p. 152) describes resilience in older people as an "effective process of negotiating, adapting or managing significant resources of stress and trauma". Janssen et al.

(2011) further states that older people often experience stressful life events, and when they do- they mobilise different sources of strength to help them constructively adapt to life's problems.

A similar notion has been described by Kinsel (2005) in a qualitative study where 'moving forward with life' was one factor found to move past adversity; and to get on with life was described as a repeated cycle; "…challenge occurred, dealt with the situation, and transcended it" (Kinsel, 2005, p. 30). The ability to move past adversity and to get on with life is comparable to the description of the broader concept of resilience. Where adversity is a trigger for participants to get on with their lives, it is those elderly people who do not have the resources and previous coping strengths that the community nurses may need to provide greater support.

The resilience literature presents a contrasting conceptualisation of resilience. The term 'bounce-back' is frequently used to describe the process of resilience in older people (Kessel, 2013; Wagnild & Collins, 2009; Windle, 2012) which is different to the moving on view that emerged in this qualitative study. 'Bounce-back' was originally conceived from early resilience studies about children who adapted to hardships and developed into caring and competent adults (Werner, 1993). 'Bounce-back' is described as the action of an individual rebounding from adversity, and returning to a stage of healthy equilibrium (Edward, 2005). 'Bouncing back' describes the process of 'rebounding' and 'reintegration' which are positive processes after a situational disruption (Earvolino-Ramirez, 2007).

The concept of resilience in older people though, particularly in relation to 'bouncing back from adversity' has been disputed, mainly due to the process of ageing (growing older). Older people with concomitant chronic illnesses and having less physical and mental wellbeing are the most vulnerable (Couto et al., 2011; Felten, 2000; Heisel & Flett, 2008; Jeste et al., 2013; Moe et al., 2013). All of these factors interfere with an older person's rebounding capacity. Netuveli et al. (2008, p. 990) for example found that "bouncing back after exposure to a major adversity is a relatively rare phenomenon in older age groups".

Unable to move on

In the previous section, resilient older people were able to continue to live well everyday despite the adversity of ageing and situational stress. The older participants who were not resilient revealed that ageing and other adversities contributed to ill health and some focused on death, rather than to continue with living. Some participants revealed that since they no longer found life enjoyable that they did not see a reason to continue living. Some described waiting for the day to die as the three waits: 1) waiting to eat, 2) waiting to sleep, and 3) waiting for the time of death.

An inability to move on due to overwhelming adversity has been found to lead to feelings of hopelessness and physical illness, and is associated with lower levels of resilience (Aléx, 2010; Aléx & Lundman, 2011; Lau et al., 2010). The two reactions to adversity, moving on and the inability to move on in these older Thai participants expands on the previous research understandings of the concept of resilience in a cultural context. Older people in this study revealed that the seven positive capabilities and the four protective health factors enabled them to

continue to move on with their lives despite adverse circumstances. On the other hand, the older participants who were unable to move on said they were waiting for the day to die. These elders were not resilient, and required more support to increase their resilience levels. Perhaps community nurses could be of greater support to those community elders who are not as resilient as others are by being more assertive in their home visiting and health promoting activities. For this to occur the Thai government may need to provide greater human resources and funding support for the THPHs.

Research question three - Social and cultural artefacts (symbols) of Thai society and the resilience of rural Thai elderly

The social and cultural artefacts of Thai society related to elderly resilience were reported in Chapters Four, Five, Six, and Seven. This section discusses the significant elements that arose from all the descriptions of resilience described by Thai elders and their community nurses. The social and cultural artefacts that emerged from the findings were social support, family configuration, and the Buddhist culture.

Social support

During the period of time that the data was collected, it was observed that older people were paid respect to, and looked up to by younger people. From the semi-structured interviews, the older Thai participants revealed that they used their personal knowledge, particularly the knowledge that related to social and cultural practices, such as praying and performing spiritual activities, to connect them with their village community. Because of these interactions, they felt productive and

that they were still contributing to their community. Receiving positive recognition from the villagers contributed to their feelings of enjoyment and facilitated their participation in local activities.

In rural Thai society, the local social activities- *Klong Yaw* a traditional music band and *Mor-Lum* a local show were mentioned by the elderly participants as encouraging them to engage with one another. The Thai elders said they enjoyed these activities, because they brought them happiness. *Klong Yaaw* and *Mor-Lum* generally happen at events such as religious celebrations, e.g. being ordained as a monk, making merit to family predecessors, and weddings. The ability to go out, and talking and sharing life experiences with friends was another important factor that kept them well, and in-turn contributed to their overall resilience, health and wellbeing.

Being continually involved in social and cultural activities was important to maintain resilience for these elderly participants. These findings are similar to previous studies in which resilience has been associated with feelings of connectedness, which contributes to a meaningful life (Aléx, 2010). A social network has been reported to be an important resource to promote social connectedness and for providing opportunities for the elderly to engage with other people (Adams et al., 2004; Caltabiano & Caltabiano, 2006; Dew et al., 2006; Maneerat et al., 2011; Wagnild, 2003). Furthermore, other studies have found that a social network, measured by the frequency of social contacts, can protect against loneliness and depression (Adams et al., 2004). By engaging in social and cultural activities, Ong et al. (2006) found that activity helps people to manage the daily stressors and adversity in their lives.

The older participants did not mention that health care services were one of their social supports even though they attended the THPHs for health services. This was different to a previous study from the Netherlands where accessing care and available material resources gave rise to resilience in older people (Janssen et al., 2011). It can be argued that elderly resilience and its relationship to health support is different in eastern-developing and western-developed countries.

In developed countries, resilience is reported to be more closely aligned to individual competence and self-belief, including self-reliance, self-assurance and self-esteem (Choowattanapakorn et al., 2010; Moyle et al., 2010; Nelson-Becker, 2006; Wells, 2009). Whereas, in Asian countries like Thailand and China there is evidence to suggest that they rely more on familial support than health services (Choowattanapakorn et al., 2010; Yang et al., 2015).

Family configuration

Family support was identified as an important resource for the elderly and their community nurses. '*LuukLaan*' a term used by the participants referred mainly to an elder's adult children and grandchildren, predominantly daughters, who were the main traditional carers providing physical and mental support. Physical assistance was provided around food preparation, the provision of financial support, transportation, and housing. Mental health support was identified in terms of an elder person's satisfaction with their children being able to look after them comfortably. Additionally, feelings of happiness related to seeing their children being financially secure was expressed in terms of having enough money rather than being wealthy.

In relation to adversity, the responses of feeling worried and dissatisfied with their children were the elderly having *'less familial support'* and *'being without money'*. The elders who did not reside with their adult children, or who were with their children but the children were less caring also described that they felt more vulnerable as they aged. The number of children and strong family support have been identified as factors that contribute to resilience being sustained for older people (Felten, 2000; Heisel & Flett, 2008; Wells, 2010).

Family support however, is different across cultures, especially in relation to traditional cultural viewpoints. In Thailand, there is a strong expectation that older people will be cared for by their children and children have a sense of sincere gratitude and obligation toward caring for their parents (Tongprateep, 2000). Children therefore are a central resource in the provision of care for their older parents (Knodel et al., 1995). The elderly participants who resided with their adult children referred to the ability to maintain a good relationship with their children as being highly valued. Thai older people who are on good terms with their family were more likely to have physical and emotional support (Maneerat et al., 2011).

The Chinese also have deep cultural traditions associated with keeping the family together and for caring for the elderly within the extended family, similar to the Thai culture. However, a study in China found that resilience in older persons living alone was facilitated by an elders' ability to take care of themselves, developing self-management strategies, and keeping an appropriate distance between themselves and their supporter (Lou & Ng, 2012).

Family configuration was an important contributor to resilience in the older Thai participant. Family members, particularly the elders' adult children, remained the main carers and represented the social and cultural fabric that supported resilience in older Thai participants. This is a key finding, which needs to be considered by the community nurses in terms of how they continue to provide care due to the diminishing levels of traditional family support.

The Buddhist culture

Buddhist culture is linked to resilience in the Thai older participants and their village communities. Buddhism determines the elders' superstitions and magical beliefs. Boon (บุญ), Karm (กรรม), and sin (or Barb-บาป) are the religious tenets of Buddhism and shape Thai thinking, and behaviour. Superstition was related to some of the religious ceremonies and occurred in the temple that were led by the monks. The elders also believe in religious magic in the form of Buddha amulets and stickers, holy water, and a belief in fortune-tellers (Chinnawong, 2007; Lundberg & Kerdonfag, 2010; Pincharoen & Congdon, 2003; Sriwarakuel et al., 2005).

It was found from the researcher's observations at the temples and because she is a Thai person that emotional stability and physical health are strongly associated with Boon, Karm and Sin. Boon refers to the feeling of happiness and having no worries after making good things, which is equivalent to the word 'merit'. While, Karm or the law of Karma, the major principle of Buddhist teaching, is the law that every cause has an effect, where good returns good, whilst bad returns bad (Tongprateep, 2000, p. 200). Sin is based on personal beliefs, and is led by

personal thought. Sin is understood as something that the Thai elders avoided doing, as they believed it resulted in bad luck, unhappiness, or living with discomfort.

The religious activities, the researcher observed as a Thai person are known to sustain hope in the Thai participants and other Thai people (Maneerat et al., 2011; Tongprateep, 2000). Buddhist religious beliefs support striving to attain Nirvana (Tongprateep, 2000). Nirvana involves the performing of rites such as offering food to monks, donating to support the religion, or having an ordained (monk) in the family (Tongprateep, 2000). In previous resilience studies conducted in Western cultures, religion has also been reported to contribute to resilience in older people and it does this through purposive activities such as prayer, bible reading, and a belief in something beyond self (Heisel & Flett, 2008; Nelson-Becker, 2006; Smith, 2012). The Thai community nurses understood the importance of Buddhist culture supporting older people when they had trouble.

Research question four - The community nurses (sub-district nurses) and rural elderly resilience

The community nurses were an educated participant group and provided more detail about the particular attributes of resilience from their cultural experiences and because they were health professionals. The three subthemes presented in Chapter Seven, 1) *Resilience-What is it?*, 2) *Overcoming adversity*; and 3) *Everyday nursing experience - resilience in rural Thai elders* provide further detail about their unique perspectives.

An understanding about what elderly adversity is, and how their older clients overcome adversity, is important so that community nurses can support an elder to be more resilient. However most nurse participants revealed that the term ‘resilience’ was unknown to them. Since there have been no previous studies exploring rural Thai elderly resilience in relation to the practice of community nursing, an understanding of what elderly adversity is, and how their older clients overcome adversity is important.

Regarding everyday nursing experiences, nurse participants described strategies related to supporting and maintaining the resilience of their older Thai clients when they were faced with difficulties. Strategies they used to support and maintain resilience in older Thai people included: encouraging villagers to pay attention to their older people, putting older people into a suitable job, promoting their success in public, and attempting to develop an elderly club within the community.

The nurses described situations that prevented them from supporting elders’ resilience. Community nurses complained they needed more specific aged person education and specialist geriatric support for clients who were more dependent on health care. Obtaining support from elderly health care experts was difficult in remote areas. Furthermore, the ability of the community nurses to assess the health problems of older people was challenging when the older Thai would often refuse to discuss the cause of their health issue.

The nurses noted that this refusal was often related to situations about an elder’s family issues and clients would visit the THPHs with the physical symptoms of

headache, sleeplessness, and loss of appetite. In this context, the Thai elders felt that their issue was too sensitive to be handled by the nurse and were reluctant to share because the nurse was younger. In Thailand, young people have to pay respect and behave politely to please an older person and this was mentioned as a challenging aspect of the nurse patient interaction in the rural community centres visited.

Community nurse participants found themselves mainly responding to physical curative issues such as measuring blood pressure, taking glucose blood tests, or providing medical prescriptions and distributing medicines to the villagers. Accordingly, they had less time for home visits and felt like they were failing to have a role in health promotion and disease prevention. The community nurse participants reported that the rural villagers expected a one-stop service from health assessment through to the provision of medicine.

This expectation appears to be related to Thailand's national health policy calling for equity and efficiency towards maintaining people's health. The equity and efficiency for people's health has resulted in a system of universal coverage since 2002, to ensure equitable access to health care (Hanucharurnkul, 2007; WHO, 2010b). Around 10,000 primary health care units nationally have required nurse practitioners (Hanucharurnkul, 2007) and all of the community nurse participants interviewed had received an additional four months training as general nurse practitioner (General NP).

The nursing staff said their busy workloads, which also included administrative work, prevented them from leaving the THPH building to conduct regular home visits. Rather, they mainly responded to physical curative care, and found

themselves working in general office jobs such as documenting patients' folders, doing staffs' monthly administration, and other secretarial jobs.

It has been identified that the community nursing role in Thailand still lacks clarity and an adequate job description (Nontapet et al., 2008). This lack of clarity surrounding the role may be a factor that has contributed to a practice that emphasises treatment rather than health promotion. As well, the nurses' workloads require further consideration, and an audit of the primary nursing care role could assist to further support nurses in the rural sector.

To understand resilience and promote it in older people, the World Health Organisation argues that the physical environment presents multiple barriers to the health of older people, as well, social change is ongoing and unpredictable (WHO, 2015b). Globally, the health care systems for older people, particularly in developing country rural areas have been found to be ineffective, poorly aligned, and unsustainable. The WHO suggests, to help the aged is to *"... look to strengthen the ability of older people to thrive in the turbulent environment they are likely to live in*" (WHO, 2015b, p. 18). This is important consideration for the health of rural Thai elders where their community nurses are well positioned to provide support for the elderly living in the villages, particularly if the practice barriers are addressed.

Summary

This ethnographic study has found that resilience for Thai elders was not so much about bouncing back, as other research has previously indicated, but more about the ability of older people to move on. In this sense, it was about moving forward

rather than picking one's self up from adversity and trying again. To move on implies a continuous process of overcoming things against the tide of life's unforeseen and predictable problems. Critical aspects of cultural support for resilience were found from the Thai elders and community nurses' interviews, and fieldwork. The social support, older persons family configuration, and being Buddhist, were major reasons for the subculture of rural Thai elderly being more or less resilient.

The community nurses disclosed that they did not understand the English construct of resilience in relation to older people. This finding is not surprising given that there is no consensus around the definition of the concept in the Thai context. Resilience in older people in this study has been seen through the older client's eyes from their personal experiences of overcoming adversity.

The community nurses revealed that they were less involved in assisting their older clients both when the older person was experiencing adversity and when they were overcoming it. The community nurses described barriers that prevented them from supporting and maintaining resilience in the older Thai. These barriers were identified as having a lack of aged care knowledge, which often meant they could not assess an elder's health problem, especially if it did not present as a physical symptom because their job focused on physical health and delivered medical curative care, rather than health promotion and disease prevention.

The findings from this study provide preliminary evidence that it is important to promote and support resilience in the rural Thai community to support healthy ageing for Thai elders. These findings are useful to consider in relation to health

care policy to improve and strengthen effective health services in rural Thai primary health care. Addressing the barriers in everyday rural community nursing care could also lead to a redefining of the community nurses scope of practice within a review of the structure and function and continued support for the THPH concept.

Limitations

- The study was focused on resilience in older people and community nurses' perspectives within the rural Thai sub-culture, any generalisation of resilience to other populations, ethnic and religious backgrounds, and cultures is limited but perhaps only tentatively warranted.
- The researcher is a Thai person and being a Thai RN required her to be reflective so as not to introduce personal bias.
- The data analysis was conducted in Australia while the data was collected in rural Thai Isan (Northeast) areas. As well, the study's supervisors were Australian and using English as the first language. The language barriers between Isan, Thai, and English during the process of data analysis potentially limited an in-depth understanding of the data despite a rigorous translation and interpretation process.

Recommendations

Recommendations made from the data collected in fieldwork, semi structured interviews, and non-participant observations have highlighted a number of key issues worthy of deeper consideration. The findings have provided clarity about resilience for these older people living in rural areas. Such findings are relevant to

the rural setting and participants involved in the study; however, it can be seen that cautiously such issues may have weight in other regions where the cultural situation is slightly different.

Older people require more strategies to help them to maintain their capability for living as long as possible. The findings from this study revealed that ‘resilience’ has not been acknowledged in the rural Thai community centers visited. The concept of elderly resilience could therefore be promoted to community nurses and health agencies and the study recommendations targeted at health care providers, nursing educationalists, policy makers, and future researchers.

Health care providers promotion of resilience in rural primary health care

- Being resilient in older people emerged from the positive capabilities of moving on despite adversity. Language translation from this English thesis to a simple-local language is an important process to ensure this concept is understandable. The translation of this concept should be conducted by a professional translator and local health care provider.

- Resilience was not acknowledged in the rural Thai community. Giving older clients a verbal health education regarding adversity in ageing, highlighting strategies to deal with adverse situations is recommended. This health education could be delivered verbally to older people who have limited literacy in a local dialect and by providing more time to talk if they have further enquiries.

- The four resilience protective health factors (physical, mental, social, and spiritual health) should be promoted within the THPHs and villages. These

four protective health factors could help elders gain a greater opportunity to experience resilience and assist them to ready themselves to face ageing adversity. Workshops with the community nurses addressing these concepts of healthy ageing could lead to local interventions of value.

- Encouraging the community nurses to collaborate with other sectors of the community, such as the village temples, could be addressed to promote the four resilience protective health factors.

- To sustain elderly resilience in the rural Thai community, confidentiality needs to be promoted. This will ensure that older people will be provided with full privacy and their personal business will not be discussed by others, or spread within their community.

Nursing education and strategies to promote resilience and ageing health care

- Community nurse participants revealed a lack of knowledge about ageing and this included a lack of understanding around the elderly resilience concept. There is a need for further aged care education of community nurses at the primary health care level.
- Increasing the ageing health care component in community nursing and undergraduate curricula is a key priority for Thai nursing education and placement training.
- Scope of nursing practice articulation in primary nursing roles for the Nurse Practitioner (NPs) requires a clearer practical guideline, particularly for the community nurses who work in rural (sub-district) Thai areas.

Policy makers in relation to the promotion of resilience and primary aged care

- Attention toward resilience could increase the likelihood of maintaining good health in the elderly. The concept of rural Thai elderly resilience could be used (in part) to guide primary health care knowledge around the areas of ageing and health promotion.

- Less familial support was one adversity faced by the rural Thai elders. This diminished traditional care resource should be considered in further national aged care service management and resourcing. Preparing an accessible public aged care facility, particularly for older people who live alone is strongly recommended.

- The participants of this study revealed that the villagers did not know that they could receive mental health care from the THPHs. Addressing and promoting community mental health nursing in relation to elderly health care should be a key priority for primary health care in Thailand.
- Providing elderly health care specialists located in remote areas to assist, supervise and consult for the community nurses and their older clients is recommended.

Future research development

- Using the concepts from this study to research scales or measuring tools for assessing elderly resilience is suggested.
- Research to gain a greater understanding of sexuality and resilience in older Thai people is desirable.

- Community nurses in terms of health promotion and health prevention were found to be struggling under the weight of the treatment workload inside the THPHs. Future studies are suggested to focus on developing interventions to assist community nurses to manage their workload and enhance the quality of their health promotion and health prevention role. For example, a program to audit nursing practice and review clinical supervision together with promoting leadership skills in the primary health care nursing role could be warranted.

Conclusion

This rural Thai ethnography has provided a window into what resilience is for older Thai people and their community nurses. The study has explored the concept and provided a sub-cultural picture of aged care in rural Thailand where resilience was previously poorly understood. Its findings provide a snapshot about what life is like for older Thai people, with and without family support, rural aged care, and how their community nurses perceive resilience. The results of this study clarify, interpret, and deepen the understanding of the concept of resilience among rural Thai elderly.

While resilience was not acknowledged initially by the nurses and the elderly the study has thematically presented three elements of the resilience construct, living well every day, adversity and positive capabilities. Moving on from adversity was the central concept of rural Thai elderly resilience. Resilience from the community nurses' perspective was understood through their older clients' capability to overcome adversity. Despite sustaining resilience in older people,

community nurse participants revealed their primary nursing work roles were restricted by their everyday nursing experiences including limited knowledge, less elderly home visits, their respectful relationship with these elders, and a need to understand the elder's adverse situation.

Culture in rural Thailand plays a major role in the promotion and maintenance of elderly resilience. Older Thai people and their community nurses mentioned local resources, for example, Buddhist temples, as well as traditional norms such as younger people paying respect to older people, their shared beliefs in religion and superstition, and traditional familial support of extended family, such as assisting older Thai people overcome adversity. Furthermore, living well in their everyday lives within their own community and environment contributed to the ability of the elderly participants to resist the negative effects of adversity while ageing.

This study builds on the knowledge around elderly resilience as one factor that sustains healthy ageing. The results of the study provide significant fundamental information contributing to nursing and other research literature on healthy ageing. Greater understanding of resilience in Thailand can contribute to assessments of elderly resilience for better health promotion and health prevention strategies. The findings of this study provide information for community nurses to use when developing appropriate health promotion interventions to sustain and support resilience for their rural Thai elderly clients.

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Appendix 1 Searched strategies

Aim: Interrogate the existing resilience knowledge in older people

Inclusion criteria:

- Published in English and Thai language between 2000 and 2015.
- Be able to retrieve a full paper
- Every study that identified, explored and described resilience related to human health, in elderly people, age 50 and over years old

Exclusion criteria:

- The studies which specific in the particular disease(s), and disaster(s)
- The studies that not related to human' health, such as resilience in organisation.
- Not be able to be retrieved a full paper

Database	Search terms	Retrieved	Met the inclusion criteria
CINAHL	**Resilience** AND **Elderly*** (*age, ageing, senior, elder, later life, and older*) AND **Health*** (*health status, primary health care, attitude to health, rural health, world health, suburban health, public health, health behaviour and urban health*)	124	18
EMBASE		48	14
MEDLINE		96	10
ThaiLis		39	2
Referenced checking			3
Total		307	47

Appendix 2 Summary table of the literature: resilience knowledge in older people

	Non-empirical Study		
	Authors/year/aim	**Method**	**Result**
1	**Hicks and Conner (2013)** To report an analysis of the concept of resilient ageing, and a comparison with other healthy ageing concepts.	N = 46 Integrative research review	• Resilient antecedents in ageing were **adversity or risk** , and **protective factors** (life experience, activity, social support); • Core attributes were **coping**, **hardiness**, and **self-concept.**
2	**Kessel (2013)** Explore the validity of the current understanding of resilience as it applies to older people and its application as guide for interventions.	Literature review 42 papers: 9 databases	• Resilience in older people = the ability to bounce back and recover physical and psychological health in the face of adversity; • The elderly resilience construct contains 2 keys of **adversity** and **ability**.
3	**Lavretsky and Irwin (2007)** Summarises the literature on resilience to stress and ageing.	Literature review	• Resilience is a continuum of adaptation, considered on personal characteristics to moderate the negative effects of stress, and promotes adaptation.
4	**Rosowsky (2009)** Speculates on resilience around how some older adapt well to large challenges and why others deal less effectively with small problems.	Opinion and review American elders	• Resilience as a trait influenced by biological, psychological and social contribution; • Resilience as a process is an ability to regulate emotions, coping skill and call for other resources when necessary.
5	**Wagnild and Collins (2009)** Present a framework of resilience assessment among middle-aged and older adults.	Opinion and review	• Resilience is the ability to adapt or 'bounce back' following adversity; • Most resilience assessments focus on the problems of grief, loss, fear, confusion, anxiety, physical illness, death of a family member, depression, loneliness, divorce, and fear of the future.
6	**Windle (2012)** Give an opinion to look at resilience in healthy ageing.	Opinion and review	• The role of resilience is to enhance healthy ageing and reduce public spending on health services; • Resilience in ageing requires current evidence to guide a specific strategy.

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
7	**Adams et al. (2004)** Examined data on loneliness and depressive symptoms from older adults aged 60-98, residing in two age-segregated independent living facilities (risk and resilience factors).	Survey questionnaires In two different independent living apartments	N=234 159 female 56 male 19 not report gender United States	• Depression was influenced by being older, the number of chronic health conditions, grieving a recent loss, fewer neighbour visitors, less participation in organised social activities and less church attendance; • Loneliness directly contributed to depression; • The social network was a resilience factor.
8	**Aléx (2010)** Explores how the elderly with estimated high resilience talk about their experience of becoming and being old and analyse the concept of resilience scale.	Mixed-method RS rating scale and Interview	N=24 17 women 7 men Northern Sweden	• High resilience is related to the following 3 themes; i. Feeling connected ii. Feeling independent iii. Creating meaning of lives.
9	**Bonanno et al. (2004)** To identify psychosocial resources that predict	Prospective longitudinal data	N = 185 161 Women	• Pairwise comparisons at 18 months indicated that the chronic grief and chronic depression groups thought more about the loss than the resilient

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
	resilience in the face of spousal loss and to assess the role of various coping resources in preventing or reversing declines in heath among the bereaved.	Measured at 6 and 18 months after the spouse's death	24 Men Average age 69 years old (6-month post-loss) US	and common grief groups; • Resilient individuals had lower avoidance/distraction than grievers; • The resilient and depressed–improved group respondents made an excellent adjustment to their loss..
10	**Caltabiano and Caltabiano (2006)** Identify the variables which act as protective factors during the adversity of transitional change in old age	Survey by 5 tools of Resilience scale, SF-36, Self-efficacy scale, Social support, Geriatric coping Schedule	N=155 Aged 65-93 year-old Cairns, Australia (urban)	• Women scored resilience higher than men; • Age had no significant in resilience; • Resilience associated with self-efficacy; • MANOVA found high resilience engaged in more problems coping strategies and emotional focus; • One way ANOWA showed older person with high-resilience tended to receive more emotional support from social network.
11	**Choowattanapakorn et al. (2010)** To compare the level of resilience of people aged 60 years and over. .	Comparative and descriptive Used Resilience Scale (RS)	N= 422 **Thailand** & Sweden	• Participants' background showed significant differences • Mean RS score of Swedish =144, Thai = 146 (moderately high to high level of resilience); • Good health significant to resilience in Swedish sample, not in Thai; • Values and norms of the extended family were more important than individual health in Thai sample.
12	**Couto et al. (2011)** To identify the most frequent stressful life events that older persons experience while identifying the most stressful ones; To test the hypothesis that resilience moderates the impact of stressful events on older persons' well-being.	Use of the Brazilian version of the Resilience Scale (RS)	N = 111 Aged 56 -85 years old Predominantly Catholic (77%) Brazilian	• The most frequent were memory deterioration, deterioration in health/behaviour of a family member, death of a friend/family member, decrease in recreational activities, and personal injury/illness; • The most stressful events were divorce/marital separation, parent institutionalization, and child, spouse or parent death; • High-resilience associated with high level of well-being.
13	**Heisel and Flett (2008)** Investigated associations between suicide ideation and a set of potential risk and resiliency factors in a heterogeneous sample	Cross-sectional	N=107 Age 67-98, Mean age 81.5 North America	• Suicide ideation positively associated with depression and physical health problems; • It's negatively associated with psychological well-being including positive relations with others , self-acceptance, perceived meaning in life, number of children, and perceived religiosity.
14	**Hildon et al. (2009)** To identify (a) the basis of adversity, (b) the characteristics of resilient individuals, and (c) the attributes that attenuate the full impact of adversity.	Quantitative Cohort study Secondary data of the Boyd Orr cohort using questionnaire data	N= 174 Aged between 70 and 84 years Participants were classified into resilient and vulnerable groups	• Adversity related to worse health, stress, and experiencing a negative life event; • Resilient outcomes related to QoL(good quality relationships, integration in the community, develop mental coping, and adaptive coping styles); • Social relations were more prevalent among the resilient than the vulnerable group.
15	**Jeste et al. (2013)** To study self- rated successful aging along with several specific domains of aging and positive psychological traits in randomly selected, community-based middle-aged and older adults.	Quantitative Multi-cohort design cross- sectional and use of self-report	N=1,006 ages 50–99 years, with an over-sampling of people over age 80 Mean age of 77.3 years San Diego America	• Older age had higher self-ratings of successful aging, despite worse physical and cognitive dysfunction; • Depression effects on successful aging regarding physical health.

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
16	**Lau et al. (2010)** Measure range of psychological factors identified as resilience, psychological distress, feelings of hopelessness, personal and interpersonal control.	Quantitative Cross-sectional	N= 62 Elderly women Melbourne Australia	• Elderly women with suicidal intention experienced higher levels of psychological distress and feelings of hopelessness; • Lower resilience related to physical illness and financial status.
17	**Martin et al. (2015)** Develop an empirically grounded measure that can be used to assess family and individual resilience in a population of older adults (aged 50–99).	Quantitative Cross-sectional, self-report	N=1,006 Ages of 50 and 99 years old Mean age 77.3 years San Diego	• Multidimensional resilience related to 8 factors; Self-efficacy, access to support network, optimism, perceived economic and social resources, spirituality and religiosity, relational accord, emotional expression and communication, emotional regulation.
18	**Moe et al. (2013)** To describe and compare the characteristics of resilience in two different age groups of chronically ill older persons living at home and who needed help from home nursing care.	Quantitative Cross-sectional : Resilience characteristics were measured by Resilience Scale (RS)	N=120 with a variety of diagnoses women (n = 79) and men (n = 41) Mean age of 87.5 years (range 80 - 101 years) separated in two age groups, aged 80 - 89 and 90+ years Norway	• Age not related to the characteristics of Resilience Scale (RS); • 'Perseverance' and 'self- reliance' were found weak with regard to age and health problems; • 'Existential aloneness' regarded as a functional disorder meant the sample could not live independently; • 'Equanimity' was well understood by the participants; • 'Meaningful life' entails a sense of purpose and found important for the other four characteristics.
19	**Montross et al. (2006)** Hypothesized that self-ratings of successful aging would significantly correlate with age, marital status, living situation, education, income, levels of activity, degree of everyday functioning, health related quality of life, and resilience.	Quantitative A questionnaire survey	N=205 community-dwelling adults age 60+	• Successful aging significantly correlated with resilience; • Successful aging found in older people who had chronic medical illness and physical disability; • Successful aging **was not** related to chronologic age, gender, ethnicity, current marital status, level of education, or income.
20	**Montpetit et al. (2010)** Examined possible protective factors to identify resilience resources related to reliable inter-individual differences in coupling and damping between stress and negative affect. The basic premise was '*resilience as part of a dynamic process is demonstrated when individuals disentangle the experience of stress from the experience of negative affect*'.	Coupled damped linear oscillator models	N = 42 Age 65-92 years old Mean age 78.8 years 90% white 5% African American 5% Hispanic	• Resilience = maintaining or returning to an equilibrium mood state; • Resilience is adaptive, contributing to salubrious outcomes with respect to both physical health and well-being; • Family support did not predict inter-individual differences in damping; • Greater friend support associated with less damping in negative affect; • Stress pushes one's affect away from equilibrium, while exhibiting dispositional resilience helps one to recover, or to return more quickly to typical emotional states.
21	**Netuveli et al. (2008)** (1) to identify those members of a panel survey who demonstrated resilience; (2) to identify the characteristics of the resilient individuals and the predictors of their resilience	Survey Used descriptive statistics to describe the resilient and non- resilient at three time points	N=3581 3581 participants in the British Household Panel Survey, selected from waves 1–14, who exposure to an adversity: aged 50 or more years.	• 60% of the resilient were women; • The prevalence of resilience increased with age; • The resilient have high social support; • High social support at pre-adversity and during adversity increased the likelihood of resilience by 40–60%; • None of the factors were significant in the post- adversity period; • Resilience is a process to convert goods into good outcomes.

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
22	**Nygren et al. (2005)** To describe resilience, sense of coherence, purpose in life and self-transcendence in relation to perceived physical and mental health in a sample of the oldest old.	Cross-sectional Used of RS, Sense of Coherence Scale, Purpose in Life Scale, Self-Transcendence Scale, and SF-36	N =125 Age 85+ Northern Sweden	• Perceived physical health status not correlated to resilience; • Good mental health helps people overcome negative experiences; • Inner strength was the connection between resilience, sense of coherence, purpose in life and self-transcendence.
23	**Ong et al. (2006)** Examine how different protective factors shape and modify the unfolding experience of daily stress and emotion in later adulthood.	Multilevel daily process design (45 days study) Used Ego-Resilience Scale	N= 27 Age 62-80 Mean age 72.09 European American 95.7% African American 4.3%	• Resilience was a trait and correlated with positive emotion ($p<.05$) and stress ($p< .05$); • High resilient widowhoods more likely to selectively mobilise positive emotions to recover and bounce back from daily stress; • Positive emotions were a prominent feature of psychological resilience.
24	**Ong, Zautra, and Reid (2010)** Examine the role of psychological resilience and positive emotions in the day-to-day experience of pain catastrophising.	A daily process design The most common pain confirmed by interview with participants' physicians, included low back pain and osteoarthritis of the hip and/or knee	N =95 72 women 23 men Age 52 – 95 years old Mean age 76.3 New York City	• Psychological resilience predicts increases in daily positive emotions; • The increase in day-to-day pain catastrophising was .21 units lower among high-resilient individuals compared with low-resilient; • Positive emotions mediate the influence of psychological resilience on changes in day-to-day pain catastrophising.
25	**Perna et al. (2012)** Explores whether resilience is positively associated with elderly health behaviour and whether the association differs in different socioeconomic groups.	Cohort study Used RS	N= 3,942 Elderly age 65+ years old Germany	• Resilient people consume more than five servings of fruit and vegetable and do more physical activities; • Resilience related to health behaviours, and not to socioeconomic position.
26	**Rothermund and Brandtstadter (2003)** Investigate the relationship between age and depression to approach resilience in later life.	Quantitative Cross-sectional and a 8 years Longitudinal questionnaire study	N= 690 aged 54–77 years Urban area Southwest Germany	• Age related to losses in health status, everyday functioning, number of friends, internal control beliefs, and openness of future time perspective; • Increasing age reduced openness and controllability of future time perspectives, and induced feelings of obsolescence; • Losses in coping resources stand out as factors that are associated with the development of depressive problems.
27	**Smith (2012)** Aims targeted associations among depressive symptoms, resilience, stigma and willingness, predictors of willingness, and estimated causal effects.	Cross-sectional Multivariate analyses of variance and multiple regression data analyses	N=158 Older African Americans	• Significant correlations between depressive symptoms and stigma ($p < 0.05$), resilience and willingness ($p < 0.0001$); • Resilience influenced older African American's willingness to seek care for depressive symptoms; • Behaviours that contribute to building resilience were prayer, Bible reading, remaining busy, and talking with family or friends; • Trust in one's instincts and abilities, positive acceptance of change, control over self and spiritual influences significantly correlated with resilience.

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
28	**Wagnild (2003)** Examine whether resilience scores and relationships between resilience and health-related variables would be similar or different among older adults reporting either low or high incomes.	Cross- sectional	N = 43 (Low income) + 810 +776 (high income) United States	• Resilience correlated with morale in low-income samples, but not in the higher income sample; • Resilience correlated with life satisfaction in both low and high- income samples; • Resilience was positively and significantly associated with indicators of successful aging; • Lower income individuals reported lower resilience; • Successful ageing tend to report better health, a positive outlook, and social involvement.
29	**Wells (2009)** To determine the resilience level of rural community-dwelling older adults and to determine if socio-demographic factors, social networks, and health status are associated with resilience.	Cross- sectional Use of Resiliency Scale, the SF-12v2, and the Lubben Social Network Scale-Revised	N = 106 Age 65+ Female 54% Rural area in New York State	• The mean resilience level was high; • Resilience was not correlated with gender, age, income, education, marital, and employment status; • Physical and mental health status positively correlated with resilience; • High resilience levels tend to have high levels of self-reliance; • Social networks consisting of friends, but not family; • The correlation between resilience and physical health was weak; • Mental health status had the strongest association with resilience.
30	**Wells (2010)** 1. Determine if resilience levels vary in older adults living in rural, urban, or suburban areas; 2. Determine if the relationships of socio-demographic factors (age, income, education, marital and employment status), social networks, health status, and resilience vary with the location in which older adults live.	Cross-sectional design Used of Resilience Scale, the SF-12v2, and the Lubben Social Network Scale-revised	N = 277 Age 65+ Female 53% Not employed 80% New York	• Mental health status was the strongest predictor of resilience; • Better perceived physical health status and income were associated with resilience; • Only social networks consisting of family were found to significantly predict resilience; • In Chi-square analysis, rural dwellers had the strongest family networks.
31	**Wells et al. (2012)** To investigate the resilience level in a convenience sample of older women who happened to be Roman Catholic nuns; Explore the relationships of resilience with specific physical performance measures, self-perceived physical and mental health status, and depressive symptoms.	Descriptive correlational cross-sectional. Bivariate associations between resilience and self-rated depression score, SF-12 PCS and MCS, total SPPB score, and fast gait speed	N = 54 Aged 55- 94 years Roman Catholic nuns	• This sample had moderate levels of resilience; • The most commonly reported chronic disease was arthritis (57.1%), diabetes (28.6%), heart disease (19.6%), lung disease (12.5%), and cancer (5.4%); • Participants with higher resilience levels were found to have fewer depressive symptoms, better subjective physical health, and faster gait speeds.
32	**Yang et al. (2015)** To examine the psychometric testing and clinical application of the Chinese version of the Resilience Scale (RS) in Chinese older people : forward- and back- translate the RS and to evaluate the psychometric properties of the Chinese version.	Descriptive cross-sectional study Used RS	N=461 Age 60 -88 years old Chinese older people from Six different community districts in Hangzhou, China	• Factor construction of resilience reflected on the cultural features; • Chinese older people provide a four-factor structure for the RS-CN: equanimity, ceaseless self- improvement, meaningfulness and self-reliance; • The major factor was factor 1 (equanimity), which proportion of the explained variance was 44.79%; • Ceaseless self-improvement (factor 2) *represented generally positive attitude towards adverse situations and stressful events and reflected the*

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
				essence and soul of cultural perspective of Chinese characteristics; • Meaningful (factor 3) and self-reliance (factor 4) have accounted for a small proportion in Chinese older people; • The original factor 4 (perseverance) and factor 5 (existential aloneness) did not emerge as independent factors, but appear as an incorporated construct in the new structure; • The location of residence (rural, urban) had no impact on the levels of resilience in community-based Chinese older people.
33	**Zautra et al. (2005)** 1. Pain elevations will increase negative affect less when weekly positive affect is high; 2. Stress elevations will increase negative affect less when weekly positive affect is high; 3. Pain elevations will increase negative affect less for participants who have higher overall levels of positive affect; 4. Stress elevations will increase negative affect less for participants who have higher overall levels of positive affect; 5. Weekly negative affect will increase the likelihood of pain elevations on subsequent weeks.	Weekly interview Multilevel modelling analyses	N = 124 Women with osteoarthritis or fibromyalgia, or both Mean age 54.6 years	• People with greater positive affect were less likely to show higher negative affect during high pain; • High positive affect were participants who had more resilience in the face of both increased bodily pain and mounting interpersonal conflict; • When positive affect is low at the same time that pain or stress is elevated, people were much more likely to experience negative affective states than with either condition alone; • The development of chronic pain conditions not only rely on sources of stress but also on failures of resilience, that may arise from a relative deficit of positive emotional resources; • Chronic pain involves failures of emotion regulation, specifically in individuals' ability to reduce negative affect and mount positive affect.
34	**Aléx and Lundman (2011)** To illuminate experiences about becoming and being old among very **old women and men with <u>low</u> resilience.**	Qualitative Gender analysis	N=24 age 85+ years old Sweden	• Women were more vulnerable than men; • The feeling of loneliness and loss; • Emphasising life experiences from the past in positive way; • Religious doubting; • Accepting age.
35	**Dew et al. (2006)** Add to the limited knowledge about how women with intellectual disability grow older and how they perceive their lives.	Qualitative Structured interview Data analysed by compared with literature of successful ageing and resilience.	N=13 (Mean age = 68) Australian women with mild intellectual disabilities Metropolitan Sydney, Australia	• **Category of internal traits** 1."*It's just who I am*"; 2."*Feeling healthy*". • **Category of External traits** 3."*Enjoying support from family and friends*"; 4."*Being part of the community*"; 5." Having enough money to buy what I need". (italics)
36	**Dorfman et al. (2009)** To identify: (a) stresses associated with major historical events that affected the lives of rural older women, and; (b) strategies they use to deal with those stresses.	Qualitative - Oral histories Content analysis, method of constant comparison (Glaser & Straus, 1967)	N = 25 Women Rural Midwestern community	• <u>Great Depression</u>; economic hardship, disruption of family life, fears and uncertainties, and World War 2; • <u>Resilience</u>: accepted the reality because they were not able to change it (n = 6, 24%); • Rural older women likewise described family and community support helped alleviate stress during the Great Depression.
37	**Felten (2000)**	Qualitative - Grounded	N= 7	• <u>Frailty</u>: serious physical impairments-memory, illness;

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
	To explore characteristics of resilience in community-dwelling women older than age 85; How do older community-dwelling women describe their experience of resilience, and what similarities exist in these experiences?	theory Interview Using the constant comparison method	Women Mean age 85 Russian Jewish, African American, Native American (First Nation), Chinese, and German 7 community-dwelling women representing various socioeconomic, religious, ethnic, and cultural backgrounds Urban	• Determination: strong to survive; • Previous experience with hardship: made them stronger and able to recall those emotions to manage their recent problems; • Access to care: they knew where to find services; • Culture: aiding in the process of resilience (health practices and healing techniques). • Family support: the support ranged from bringing them fresh fruit to in-home caregiving during illness. • Self-care activities: getting plenty of exercise, eating the right foods, and not smoking or drinking; • Care for others: provided care for others enhanced their own well-being. Working *with others* allowed participants to focus their attention away from daily aches and pains; • Efficient working machines: Participants told themselves they were like machines which related to being stronger and tougher by being used;
38	**Ferreira, de Castro Silva, et al. (2012)** Identify the contribution of the elderly group to strengthen the resilience of its participants : The elderly group "Healthy Aging" has enabled the strengthening of resilience in its participants?	Qualitative Content analysis of categorical themes proposed by Bardin.	N=13 Age 71-83 years old Brazil	• From healthy bonds between group members emerged a sense of belonging and increase in self-esteem; • Healthy ageing group was a promoter of self-esteem, demonstrating positive effectiveness in maintaining the physical and psychological well-being of its members; • Group activities contribute positively to the participants' health, demonstrating the capacity to face and win over the daily adversities.
39	**Grandbois and Sanders (2009)** Understand how Native American elders have experienced resilience in the context of the adversity and challenges they have had to confront (in their daily lives).	Qualitative – story telling	N=8 5 men and 3 women Native American elders	There are **5 themes** identified. 1. Resilience must be studied and understood within the context of the Native American Worldview; 2. Resilience is embedded within Native American culture; 3. Native elders attain their strength and resilience from each other, their family, relatives and tribal communities; 4. Resilience comes from the Oneness they feel with all creation; 5. Resilience comes from a legacy of survival passed down by the ancient ones.
40	**Janssen et al. (2011)** Seeks to explore the sources of strength giving rise to resilience among older people.	Qualitative - A naturalistic inquiry (Lincoln and Guba 1985) In-depth interviews Thematic content analysis	N=29 All were white Dutch nationality and background Netherlands	**3 domains**: the individual, interactional and contextual domain. • The individual domain was the qualities within older people and comprise three sub- domains; beliefs about one's competence, efforts to exert control and the capacity to analyse and understand one's situation; • The interact sources of strength were empowering formal/informal relationships and the power of giving; • Contextual was a broader political-societal level included sources of the accessibility of care, the availability of material resources and social policy.

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
41	**Kinsel (2005)** Discusses factors that contribute to resilience in older women.	Qualitative - Face-to-face audio taped interviews: open-ended questions related to the experience of advantage and adversity across the life span The constant comparative method as described by Glaser and Strauss (1967)	N = 17 Women Age 70- 80 years old Average age = 74.5 years 12 women were Caucasian 5 were African American	• Childhood adversity: parental absence, alcoholism, and physical, sexual, or emotional abuse; • Young adulthood adversity: marital discord, racial discrimination, and serious personal illness; • Later year adversity: ill spouses or other family members who subsequently died; • The factors related to being resilient; - *social connectedness* - *Extending Self to Others* - *Moving Forward with Life* - *Sense of curiosity* - *Proactive behaviour* - *"Maverick"* - being manifested in behaviour. They took steps to remove themselves from stressful situations or unhealthy relationships - *Spiritual Grounding.*; • External resources or protective factors: relationships with family, friends from all generations, and contacts with social groups.
42	**Lou and Ng (2012)** To investigate resilience factors that help Chinese older adults living alone cope with a sense of loneliness.	Qualitative In-depth interviews Data analysis guided by five steps of Alvesson & Skoldberg, 2009: Willis, Willis, Jost, & Nilakanta, 2007	N=13 purposeful sampling: older adults living alone in the community who did not show severe loneliness Mean aged 75.5, (62 to 88) Experience of living alone lasted from 2 to 20+ years China	• Living alone was chosen (as opposed to the Chinese cultural expectation) to benefit family well-being; • **Self and personality resilience**: developed adaptive self-management strategies; • **Social relations resilience**: aware of different boundaries of kin and non-kin; • **Resilience in personal**: linked to their behaviours e.g. taking care of themselves with intended benefits for the family; • **Self-management strategies**: self-management for the sake of collective well-being, which enhanced self-esteem; • **Benefit from social networks**: engaged in maintaining such networks (non-kin) to avoid feeling depressed.
43	**Maneerat et al. (2011)** Develop a conceptual structure of Thai elderly resilience by the domain of 'I AM': Inner strengths, 'I HAVE': External support and 'I CAN': Interpersonal and problem-solving skill (Groberg,2003).	Qualitative - Interview and focus group Note: TMHI (Thai Mental Health Indicator) was used to include mentally healthy participants.	N=14 Represented 4 part of **Thailand**: Northern, Northeast, Middle & Southern	Under the concept of **I am, I have** and **I can;** 1. I am: inner strength which can improve to survive physically and mentally; 2. I have: external support such as people, opportunity, peer group and feelings of spiritual security; 3. I can: an ability to maintain social connection and problem management during adverse life events; **'I am'**: being in good health, equanimity, self-reliance, life meaningfulness, sense of humour, positive thinking, perseverance,

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
				caring for others, health promoting behaviours, and life satisfaction; **'I have'**: trusting relationship, social support, spiritual support, and opportunity for spiritual practice; **'I can';** maintaining social connection, effective problem solving skills, spiritual coping, ability to seek help.
44	**Moyle et al. (2010)** To explore the experience and strategies of mental health well-being through resilience in older people across the four participating countries.	Qualitative - An Appreciative Inquiry approach 12 individual interviews-in South Africa Focus group in Aus, UK and Germany Thematic analysis	N = 58 Australia = 21, Germany = 9, South Africa = 18, UK = 10 Age of 65+ years old Australia, UK, Germany, and South Africa	**6 themes of strategies to promote resilience;** Keeping active Relationships Community connections Practical coping Emotional focused coping Spiritual coping **4 themes of the impacts of mental health on well-being;** Social Isolation and loneliness Social worth Self-determination Security
45	**Nelson-Becker (2006)** Build a framework about what helps hospice clients achieve resilience and meet psychosocial and spiritual needs. This will help the social work and aging community look for what is effective in helping older adults lead satisfying lives while dying by asking individuals in the midst of this process.	Qualitative - Grounded theory method of Strauss and Corbin (1990)	N = 30 29 European Americans and 1 African American Kansas and Illinois	4 themes: Redefinition of self; Religion/spirituality or uncertainty; Ongoing social investment ; Independence.
46	**Sansuk and Kespichayawattana (2009)** Explored the meaning and experience of resilience among 13 elderly people who faced the tsunami.	Qualitative - Interview	N=13 Older Thai people **Thailand**	**3 themes**: Living with hope, Dharma as guidance, and living with understanding; **3 phases**: the challenging phase, the maintaining phase and the firming phase.
47	**Wagnild and Young (1990)** Describe the qualities that characterise elderly women who can adjust successfully to major life losses.	Qualitative used Grounded theory Themes analysis	N= 24 Aged 67-92 years Caucasian women	• **The major loss**: loss of a significant person-spouse and child, relocation, loss employment, and loss of good health; • **Initial responses**: shock and numbness, then resignation and determination; • **5 resilience characteristics**: Equanimity, perseverance, self-reliance, meaningfulness, and existential aloneness; • The things in general that get them through difficult times; Internal i.e. a positive comparison with other, belief in self, determination, sense of humour, and faith in God; External i.e. family and friends, and meaningful works and activities.

	Empirical Study			
	Author/year/aim	**Study design**	**Sample / site**	**Result**
				• Resilience defined as the *'mechanism of flexibility and the ability to restore balance following a difficult experience and continuing to have a life purpose' p.255;* • The participants "did not consider the loss event itself as an opportunity for growth… *but the personal growth and development is an adjustment to the loss." p.255.*

Appendix 3 HREC initial approval

HUMAN RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Associate Professor Tony O'Brien**
Cc Co-investigators / Research Students:	**Doctor Sharyn Hunter** **Miss Wilaiwan Pathike**
Re Protocol:	**An Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurses perspectives**
Date:	**26-Feb-2014**
Reference No:	**H-2014-0031**
Date of Initial Approval:	**26-Feb-2014**

Appendix 4 HREC variation approval

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Associate Professor Tony O'Brien**
Cc Co-investigators / Research Students:	**Doctor Sharyn Hunter** **Miss Wilaiwan Pathike**
Re Protocol:	**An Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurses perspectives**
Date:	**17-Apr-2014**
Reference No:	**H-2014-0031**

Appendix 5 Roi-Et provincial health office - Human Ethic approval

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สำนักงานสาธารณสุขจังหวัดร้อยเอ็ด
ถนนเทวาภิบาล รอ ๔๕๐๐๐

๒๕ มีนาคม ๒๕๕๗

เรื่อง ขอรับพิจารณาจริยธรรมการวิจัย

เรียน นางสาววิไลวรรณ ปะธิเก

อ้างถึง หนังสือโรงเรียนการพยาบาลและผดุงครรภ์ คณะการแพทย์และสุขภาพ
มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย ๒๓๐๘

ตามหนังสือที่อ้างถึง นางสาววิไลวรรณ ปะธิเก นักศึกษาระดับปริญญาเอก โรงเรียนการพยาบาลและผดุงครรภ์ คณะการแพทย์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย ได้ทำการศึกษาวิจัยในประเด็นของพลังสุขภาพจิต หรือความสามารถในการเผชิญวิกฤต (Resilience)ในผู้สูงอายุในเขตชนบท โดยเป็นการศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจถึงแนวคิดของผู้สูงอายุและพยาบาลชุมชน ภายใต้หัวข้อวิจัยAn Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurses perspectives การศึกษาวิจัยในครั้งนี้มีพื้นที่เป้าหมายในพื้นที่รับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพตำบล (รพ.สต.) ตำบลสวนจิก หนองใหญ่ เมืองเปลือย และบ้านบาก ในเขตพื้นที่อำเภอศรีสมเด็จ จังหวัดร้อยเอ็ด โดยวิธีการสัมภาษณ์เชิงลึกแบบหนึ่งต่อหนึ่ง (in-depth interview) และการสังเกตแบบไม่มีส่วนร่วม (non-participant observation)ในโรงพยาบาลส่งเสริมสุขภาพตำบล และพื้นที่โดยรอบของชุมชน ทั้งนี้หัวข้อโครงการศึกษาวิจัยข้างในต้นได้ผ่านการอนุมัติจริยธรรมการวิจัยในมนุษย์ โดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย เลขที่ H-๒๐๑๔-๐๐๓๑ นับจากวันที่ ๒๖ กุมภาพันธ์ ๒๕๕๗ เรียบร้อยแล้ว รายละเอียดดังสิ่งที่ส่งมาด้วย

ในการนี้ สำนักงานสาธารณสุขจังหวัดร้อยเอ็ด ได้ตรวจสอบโครงการวิจัยฉบับย่อภาคภาษาไทย และโครงการวิจัยฉบับเต็มภาคภาษาอังกฤษ แล้วเห็นว่าไม่ผิดจริยธรรมในการวิจัยต่อคณะกรรมการจริยธรรมการวิจัยในมนุษย์

จึงเรียนมาเพื่อทราบ

ขอแสดงความนับถือ

(นายวัชระ เอี่ยมรัศมีกุล)
นายแพทย์เชี่ยวชาญ (ด้านเวชกรรมป้องกัน)
รักษาราชการแทน นายแพทย์สาธารณสุขจังหวัดร้อยเอ็ด

กลุ่มงานพัฒนาคุณภาพและรูปแบบบริการ
โทร. ๐ ๔๓๕๑ ๑๗๕๔ ต่อ ๑๑๔
โทรสาร. ๐ ๔๓๕๑ ๑๐๘๗

Appendix 6 Roi-Et provincial health office – Permission for data collection

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

โรงเรียนการพยาบาลผดุงครรภ์และอนามัย
คณะการแพทย์และสุขภาพ
มหาวิทยาลัยนิวคาสเซิล
ออสเตรเลีย, ๒๓๐๘

๒๙ ตุลาคม ๒๕๕๖

เรื่อง ขอความร่วมมือ และสนับสนุนในการเก็บข้อมูลวิจัย

เรียน นายแพทย์สาธารณสุขจังหวัดร้อยเอ็ด

ด้วยข้าพเจ้า นางสาววิไลวรรณ ปะธิเก พยาบาลวิชาชีพ ตำแหน่งบุคคลภายนอกรับทุน สังกัดสาขาการพยาบาลชุมชน คณะพยาบาลศาสตร์ มหาวิทยาลัยศรีนครินทรวิโรฒ ขณะนี้กำลังศึกษาต่อระดับปริญญาเอก ณ โรงเรียนการพยาบาลผดุงครรภ์และอนามัยคณะการแพทย์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย ซึ่งการศึกษาในครั้งนี้ ข้าพเจ้าได้ทำการศึกษาวิจัยในประเด็นของพลังสุขภาพจิต หรือความสามารถในการเผชิญวิกฤต (Resilience) ในผู้สูงอายุชนบทโดยเป็นการศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจแนวคิดของผู้สูงอายุและพยาบาลชุมชน เกี่ยวกับพลังสุขภาพจิตในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทย อันจะเป็นพื้นฐานข้อมูลความรู้ที่สำคัญในการพัฒนาเครื่องมือ และระบบการดูแลผู้สูงอายุในชนบทในอนาคต ภายใต้หัวข้อวิจัยเรื่อง *An Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurse perspectives*

การศึกษาวิจัยในครั้งนี้ มีพื้นที่เป้าหมายเพื่อเก็บรวบรวมข้อมูลในพื้นที่รับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพตำบล(รพ.สต.) ตำบลสวนจิก หนองใหญ่ เมืองเปลือย และ บ้านบาก ในเขตพื้นที่อำเภอศรีสมเด็จ จังหวัดร้อยเอ็ด โดยมีกลุ่มประชากรศึกษาเป็นผู้สูงอายุที่อาศัยอยู่ในท้องถิ่นดังกล่าวจำนวน 20 - 30 คน และ พยาบาลชุมชนที่ปฏิบัติหน้าที่ใน รพ.สต. ข้างต้น จำนวน 8-10 คน ซึ่งการเก็บรวบรวมข้อมูลจากประชากรศึกษานั้น จะใช้วิธีการสัมภาษณ์แบบกึ่งโครงสร้าง และการสังเกตแบบไม่มีส่วนร่วม ใน รพ.สต. ศาลาประชาคม หรือ ศูนย์ผู้สูงอายุ ตลาด หรือ ร้านค้า ที่เป็นจุดรวมของผู้สูงอายุ และวัด หรือ สถานที่ประกอบพิธีกรรม โดยการศึกษาครั้งนี้จะใช้ระยะเวลาประมาณ ๑๒ สัปดาห์ โดยแบ่งเป็นพื้นที่ รพ.สต. ละ ๓ สัปดาห์ (เนื่องจากการศึกษาในการครั้งนี้เป็นการศึกษาเชิงคุณภาพ จึงไม่สามารถกำหนดระยะเวลาที่แน่นอนได้)

เพื่อให้การศึกษาในครั้งนี้มีความถูกต้องและสมบูรณ์ ข้าพเจ้าจะต้องยื่นเอกสารและข้อมูลทั้งหมดที่เกี่ยวข้องกับการศึกษาวิจัยในครั้งนี้ เพื่อขอจริยธรรมในการวิจัยต่อคณะกรรมการจริยธรรมการวิจัยในมนุษย์

แห่งมหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย ข้าพเจ้าจึงใคร่ขอการสนับสนุน และประสานขอความร่วมมือจากพื้นที่ศึกษาวิจัย เพื่อให้การศึกษาครั้งนี้สามารถดำเนินการได้อย่างถูกต้องเหมาะสม และลุล่วงไปได้ด้วยดี ทั้งนี้ข้าพเจ้าไม่สามารถลงพื้นที่เพื่อเก็บข้อมูลได้ จนกว่าคณะกรรมการจริยธรรมจะอนุมัติการดำเนินการวิจัย

ด้วยประการที่กล่าวในข้างต้น ข้าพเจ้าจึงใคร่ขอประสานขอความร่วมมือ และเอกสารตอบรับความร่วมมือเพื่อเป็นส่วนหนึ่งในการยื่นขอจริยธรรม และเมื่อคณะกรรมการจริยธรรมพิจารณาอนุมัติ ข้าพเจ้าจะนำเรียนความก้าวหน้า และประสานงานขอลงพื้นที่เพื่อเก็บข้อมูลในลำดับต่อไป

จึงเรียนมาเพื่อโปรดพิจารณา และอนุมัติ

ขอแสดงความนับถือ

(นางสาววิไลวรรณ ปะธิเก)

โทรศัพท์ : +612 49215585 | มือถือ: +61478733839 |
E-mail: c3157325@uon.edu.au , pathike@gmail.com

๑ เรียน นพ.สสจ.รอ.
- นศ.ป.เอก จากมหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย ขอความร่วมมือในการเก็บข้อมูล การวิจัยในพื้นที่ รพ.สต. [illegible] ของ อ.ศรีสมเด็จ เป็นเวลา 12 สัปดาห์
- เพื่อโปรดพิจารณาอนุญาต และลงนามในหนังสือตอบรับความร่วมมือ ที่แนบเรียนมาพร้อมนี้
[signature] 29 ต.ค. 56.

๒

อนุมัติ

[signature]

(นายสุระ วิเศษศักดิ์)
นายแพทย์สาธารณสุขจังหวัดร้อยเอ็ด
30 ต.ค. 2556

โครงการวิจัยนี้อยู่ภายใต้การกำกับดูแลของ

รองศาสตราจารย์ Anthony Paul O'Brien (อาจารย์ที่ปรึกษาหลัก)

โทรศัพท์ : +612 4985 4368 | แฟกซ์ +612 4921 6031 | มือถือ: +61448 941 943 |

E-mail: Tony.O ' Brien@hnehealth.nsw.gov.au

ดร. Sharyn Hunter (อาจารย์ที่ปรึกษาร่วม)

โทรศัพท์ : +612 4921 5957 | E-mail: Sharyn.Hunter newcastle.edu.au @uon.edu.au

Dear Miss Wilaiwan Pathike,

We at the Roi et Provincial Health Office are more than happy to grant you permission to undertake your research project across the four Tambon Health Promotion Hospitals in the Si-Somdet district.

We grant you permission to interview both the elderly study participants and the community nurses as per your letter of request, providing, naturally, that they do not object to being involved in your research, for whatever personal reason they may have.

Please let us at the office know when you have a start-date. We look forward to hearing from you.

Regards,

(Sura Wisedsak ,MD.)

Roi et Provincial Chief Medical Officer

Appendix 7 Letter to the Provincial Health Office to collect the data at the work sites

โรงเรียนการพยาบาลและผดุงครรภ์
คณะการแพทย์และสุขภาพ
มหาวิทยาลัยนิวคาสเซิล
ออสเตรเลียม ๒๓๐๘

๒๗ กุมภาพันธ์ ๒๕๕๗

เรื่อง ๑. การขอลงพื้นที่เพื่อการเก็บข้อมูลวิจัย

๒. ขอความร่วมมือในการรับเรื่องร้องเรียน หากผู้เข้าร่วมวิจัยต้องการร้องเรียนอันเกี่ยวเนื่องกับ โครงการวิจัย

เรียน นายแพทย์สาธารณสุขจังหวัดร้อยเอ็ด

อ้างถึง หนังสือสำนักงานสาธาณสุขจังหวัดร้อยเอ็ด เลขรับที่ ๑๔๓๕๗ ลงวันที่ ๒๕ ต.ค. ๒๕๕๖

สิ่งที่แนบมาด้วย หนังสืออนุมัติจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย และ เอกสารชี้แจงโครงการ และ ใบยินยอมเพื่อใช้ในการวิจัย ฉบับต้นฉบับ

๑. ด้วยข้าพเจ้า นางสาววิไลวรรณ ปะธิเก นักศึกษาระดับปริญญาเอก โรงเรียนการพยาบาลและผดุงครรภ์ คณะการแพทย์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล ประเทศออสเตรเลีย ได้ทำการศึกษาวิจัยในประเด็นของพลังสุขภาพจิต หรือความสามารถในการเผชิญวิกฤต (Resilience) ในผู้สูงอายุชนบท โดยเป็นการศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจถึงแนวคิดของผู้สูงอายุและพยาบาลชุมชน ภายใต้หัวข้อวิจัย An Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurses perspectives นั้น บัดนี้กระบวนการเพื่อการวิจัยได้ดำเนินการมาถึงขั้นตอนของการเก็บรวบรวมข้อมูลจากกลุ่มเป้าหมาย อันประกอบด้วย ผู้สูงอายุ และพยาบาลชุมชน ในพื้นที่รับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพตำบล (รพ.สต.) ตำบลสวนจิก หนองใหญ่ เมืองเปลือย และบ้านบาก ในเขตพื้นที่อำเภอศรีสมเด็จ จังหวัดร้อยเอ็ด ทั้งนี้หัวข้อวิจัยข้างต้นได้ผ่านการอนุมัติจริยธรรมการวิจัยในมนุษย์ โดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย เลขที่ H-๒๐๑๔-๐๐๓๑ นับจากวันที่ ๒๖ กุมภาพันธ์ ๒๕๕๗

เพื่อให้การดำเนินการวิจัยเป็นไปตามวัตถุประสงค์ของการศึกษา ข้าพเจ้าจึงขอความอนุเคราะห์ในการลงพื้นที่เพื่อเก็บข้อมูล ระหว่าง วันจันทร์ที่ ๑๐ มีนาคม ถึง วันอังคารที่ ๑๐ มิถุนายน ๒๕๕๗ ซึ่งข้าพเจ้าจะใช้ระยะเวลา ๓ สัปดาห์โดยประมาณ ในการเก็บข้อมูลในแต่ละพื้นที่ตามลำดับ และเนื่องจากการวิจัยในครั้งนี้เป็นการศึกษาเชิงคุณภาพ ระยะเวลาที่กำหนดอาจมีการเปลี่ยนแปลง ขึ้นกับความสมบูรณ์ (หรือความอิ่มตัว) ของข้อมูล โดยข้าพเจ้าจะแจ้งความก้าวหน้าของโครงการให้ทราบ หากมีการเปลี่ยนแปลง

๒. สืบเนื่องจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล ออสเตรเลีย ให้ความสำคัญถึงสิทธิเสรีภาพของผู้ถูกวิจัย และเห็นชอบให้ผู้เข้าร่วมวิจัยสามารถร้องเรียนผู้วิจัย รวมถึงโครงการวิจัย อันสืบเนื่องจากการเข้าร่วมเป็นส่วนหนึ่งของการศึกษาในครั้งนี้ โดยคณะกรรมการจริยธรรมได้แนะนำให้องค์กร หรือบุคคลอิสระ อันมิใช่ส่วนหนึ่งของผู้วิจัยและผู้เข้าร่วมโครงการวิจัย ในพื้นที่ เป็นผู้รับเรื่องร้องเรียนดังกล่าว

เพื่อให้การดำเนินการวิจัยในครั้งนี้เป็นไปอย่างถูกต้อง และลุล่วงไปได้ด้วยดี ข้าพเจ้าจึงใคร่ขอความร่วมมือในการรับเรื่องร้องเรียน อันเกี่ยวข้องกับการศึกษาวิจัยในครั้งนี้ โดยข้าพเจ้าขออนุญาตพิมพ์นามของสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด และหมายเลขโทรศัพท์ ลงในเอกสารคำชี้แจงโครงการ และใบยินยอม ซึ่งผู้ที่เกี่ยวข้องในการรับเรื่องร้องเรียนดังกล่าว สามารถติดต่อข้าพเจ้าได้โดยตรง โดยติดต่อ นางสาววิไลวรรณ ปะธิเก หมายเลขโทรศัพท์ ๐๙๔-๘๓๗๐๘๖๗ หรือจดหมายอิเลกทรอนิกส์ wilaiwan.pathike@uon.edu.au เพื่อข้าพเจ้าจะได้รายงานถึงอาจารย์ที่ปรึกษา และคณะกรรมการจริยธรรมต้นสังกัดในลำดับต่อไป

จึงเรียนมาเพื่อโปรดพิจารณา และอนุมัติ

ขอแสดงความนับถือ

(นางสาววิไลวรรณ ปะธิเก)

โทรศัพท์ ๐๙๔-๘๓๗๐๘๖๗

อีเมลล์: wilaiwan.pathike@uon.edu.au

Appendix 8 The letter of mentor invitation

School of Nursing and Midwifery
Faculty of Health and Medicine,
The University of Newcastle
Callaghan NSW,
Australia, 2308.

28 January 2014

Dear Associate Professor Khanitta Nuntaboot,

Miss Wilaiwan Pathike will be coming to Thailand soon to collect data for her PhD project - *'An Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurses' perspectives'*. It was been suggested by her supervisors and supported by a research review panel that it would be helpful to have a Thai nursing academic for Wilaiwan to talk to when she is home.

Wilaiwan has mentioned you would be a person with the expertise who could provide collegial support from Khon Kaen University. Khon Kaen is only 2 hours' drive from Wilaiwan's fieldwork. As her supervisors, we are most grateful to you for supporting her (if this is possible?) especially when there is no fee for this. Wilaiwan would however like to offer you the opportunity to contribute to at least one refereed journal publication from the doctoral research.

We would like to meet you either on Skype, or via e-mail to discuss Wilaiwan's study. With this collaboration I am hoping that we might be able to work on a subject of research and or publication other than Wilaiwan's study in the near future.

Yours sincerely,

Associate Professor Anthony O'Brien (Supervisor)
Phone: +612 4985 4368 | Fax +612 4921 6031| Mobile: +61448 941 943 |
E-mail: Tony.O'Brien@hnehealth.nsw.gov.au

.....
Dr Sharyn Hunter (Co-supervisor)
Phone: +612 4921 5957
E-mail: Sharyn.Hunter@newcastle.edu.au

Miss Wilaiwan Pathike
Student researcher
Phone: +612 49215585 | Mobile: +61478733839
E-mail: c3157325@uon.edu.au, pathike@gmail.com

Cc… Head of School

Appendix 9 Data collection- Interview form for elderly

Semi-structured interview - Elderly

Date & Time…… **Place**……

Part 1: Socio-demographic background

Name …… **Code-name** ……

Age …… **Gender** ◯ male ◯ female

Marital status

◯ Single ◯ Married ◯ Widowed

◯ Divorced ◯ Separation ◯ Other

Career ……..

Income

◯ Not enough ◯ Enough

◯ Not enough for saving (Monthly amount estimation ……Baht)

Education background ◯ Primary school …… ◯ High school…….

◯ Bachelor…… ◯ Others …….

Diseases diagnosed by physician

◯ No ◯ Yes ……

Family configuration

Part 2	
Research question	Interview questions
1) What does the concept of resilience mean to rural Thai elderly and their community nurses? 2) How do rural Thai elderly respond to adverse circumstances?	Can you tell me what keeps you healthy as an older person? Can you tell me about how you feel when faced with difficult times? Can you talk about how you cope?
3) How do the social and cultural artefacts (symbols) of Thai society influence the resilience of rural Thai elderly?	Can you talk about the things that are most helpful during difficult times? What can you tell me about how those things helped you?

Appendix 10 Data collection- Interview form for Community Nurse

Semi-structured interview – Community Nurse

Date & Time…… **Place**……

Part 1: Socio-demographic background

Name …… **Code-name** ……

Age …… **Gender** ◯ male ◯ female

Marital status

◯ Single ◯ Married ◯ Widowed

◯ Divorced ◯ Separation ◯ Other

Education background

◯ Bachelor…….. ◯ Master/ Nurse practitioner…….◯ Doctoral…….

◯ Others …….. ◯ Continuing education …… ◯ Specialist…….

Home town …….

Years of working in PCU …….

Part 2	
Research question	Interview questions
What are the community nurses (sub-district nurses) doing to develop or maintain rural elderly resilience?	1. Can you tell me about the challenges you experience nursing older people? 2. What is your understanding of elderly resilience? 3. Can you tell me about which elderly cope better than others? 4. What do you think are the factors involved in making one older person more resilient than another? 5. Can you tell me how you nurse the elderly through adverse situations? 6. Is there anything else you would like to say about resilience and nursing the older person?

Appendix 11 Data collection- Non-participant observation form

Field note form/ non-participant observation

Date & Time…….

Place……. **Event** …….

People present

…….

Notes	**Reflexivity**

Appendix 12 Information Statement (English) – for THPH

Associate Professor Anthony Paul O'Brien (Chief investigator)
School of Nursing and Midwifery,
Faculty of Health and Medicine
The University of Newcastle,
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Ph: +612 4985 4368
Mobile: +61448 941 943
Email: Tony.OBrien@newcastle.edu.au

Information Statement for the Research Project (Organisational Participant):

An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives.

English Version [1], dated [22 February 2014]

Dear Head of…..……. Tambon Health Promotion Hospital

Your organisation is invited to participate in the research project above which is being conducted by a researcher, Miss Wilaiwan Pathike, PhD candidate from the school of Nursing and Midwifery at the University of Newcastle. The research is part of a doctoral research study and is supervised by Associate Professor Anthony O'Brien and Dr Sharyn Hunter. Wilaiwan will be in Thailand and visiting a number of PCUs over a three month period in 2014. The information below is to let you know more about the study.

Why is the research being done?

The Thai elderly population is increasing and for rural Thai elderly this has meant that traditional supports such as children are less available to help and support. Many family members have moved to the cities to work. Research studies in Thailand have shown that this decrease in traditional support can directly affect the health status of elderly people, particularly their mental health. As a nurse researcher I am interested in learning about how Thai elderly people manage their

everyday lives and how community nurses can provide care that helps to maintain and build upon personal resilience.

Thus, this study will aim to identify and explore elderly resilience and how community nurses who are the main health support resources can contribute to resilience. Therefore the purpose of this doctoral research study is to understand the concept of rural Thai elderly resilience by observing the everyday lives of the elderly in the PCUs and the rural communities that they live in.

Who can participate in the research?

The study will collect data from rural elderly people who have been cared for by four PCUs (or Tambon Health Promotion Hospital, THPH) located in rural areas of Thailand.

This study will enrol two groups:

1) People aged 60 years and over that attend the rural Primary Health Care Unit and who are able to communicate verbally, with no cognitive impairment for example due to brain injury or forms of dementia and Alzheimer disease, and have no a major sensory deficit e.g. deaf and blind

2) Community nurses who work in Primary Health Care Units (PCU) and who are willing to be engaged in this study.

What choice do the participants have?

Only those people who give their informed consent after the research project has been carefully explained to them and they have had time to ask questions and have them answered will they be included in the project. Whether or not they decide to participate will not disadvantage them in any way and will not affect the treatment that you provide to the people at the PCU and your community.

What would you be asked to do?

As a part of the setting of the study, you will be asked to

1. Provide the elderly general demographic data in your community to be studied.
2. Seeking the permission to conduct the research with interested staff and elderly people based on the criteria conditions.
3. Provide a general privacy room where will be used for one face-to-face interview.
4. The researcher will be visiting the PCU regularly when she is in Thailand and during that time she will be interviewing the participants and observing what community nurses and elderly people do in the PCU and the surrounding community e.g. temples, elderly centres or village halls, local grocery shops, local or fresh markets and the places where the elderly are normally engaged.
5. The researcher may interview participants at their house if the participant is not comfortable being interviewed at the PCU however the researcher will not attend any private residence alone but only in the company of the community nurse.

6. Photographs of the research setting will be taken to capture the setting details and to provide cultural authenticity to add value and clarity about where the research has taken place. Photographs will NOT identify any participant or PCU by name, or building characteristic.

How much time will it take?

1. The interview will probably be for 60–90 minutes per one case. The interview will be during the business day time, with not more than 3 interviews a day.
2. Non-participant observation will be conducted three to five times per week over the 3 month period (three weeks in each PCU). The researcher will periodically observe the daily activities of the rural elderly during the day and into the evening, with additional observation of some religious events that are held in the night time.

What are the risks and benefits of participating?

This study has no risk to you and your employment. The information from this study will benefit the rural elderly in terms of health promotion, intervention and health care policy to promote elderly wellbeing in the future.

How will your privacy be protected?

Any information which might identify your staffs and your elderly will not be published. If I am referring to any participants in any publication(s) a false name will be used to protect their identity. Your organisation's name will appear in the researcher data but will only be used by the researcher and research supervisors to track back to particular interview transcripts and observation field notes. All data collected such as field notes and interview tapes and transcripts will be kept secure at all times in a locked cabinet and on a password protected hard drive.

How will the information collected be used?

The data collected from this study will be reported in the doctoral thesis of the University of Newcastle, under the name of Wilaiwan Pathike. This information will also be used for scientific publications and at health care conferences.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its' contents before you consent to participate. If there is anything you do not understand, or if you have any questions please ask the researcher. She will explain all the details to you in your own language at a time convenient to you.

Further information

If you would like future information please contact Wilaiwan Pathike (in Thailand), phone number 0948370867, Address: 15 Moo 13 Ban Suan Chik Si-somdet Roi-Et,

Email: Wilaiwan.Pathike@uon.edu.au or directly contact Associate Professor Anthony Paul O'Brien (Chief investigator), School of Nursing and Midwifery, Faculty of Health and Medicine

The University of Newcastle, Callaghan NSW, Australia 2308, Phone +612 4985 4368, Email: Tony.OBrien@newcastle.edu.au

Thank you for your consideration

Associate Professor Anthony Paul O'Brien

(Chief investigator)

Other members of my team will be involved in this project:

Dr Sharyn Hunter (**Co-supervisor)**
Phone: +612 4921 5957
E-mail: Sharyn.Hunter@newcastle.edu.au
Miss Wilaiwan Pathike (PhD student candidate)
Phone: +61478733839 (Australia), +66948370867 (Thailand)
Email: Wilaiwan.Pathike@uon.edu.au

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2014-0031

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, Roi-Et Provincial Health Office, telephone +6643 511754, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (+612) 49216333,

Email: Human-Ethics@newcastle.edu.au.

Appendix 13 Information Statement (English) – for elderly

Associate Professor Anthony Paul O'Brien (Chief investigator)
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Information Statement for the Research Project (Elderly):

An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives

English Version [6], dated [25 February 2014]

Dear Participant,

You are invited to participate in the research project above which is being conducted by Miss Wilaiwan Pathike, PhD candidate from the school of Nursing and Midwifery at the University of Newcastle. The research is part of a doctoral research study and is supervised by Associate Professor Anthony O'Brien and Dr Sharyn Hunter. She will be in Thailand and visiting a number of PCUs over a three month period in 2014. The information below is to let you know more about the study. I hope you might be interested in participating.

Why is the research being done?

The Thai elderly population is increasing and for rural Thai elderly this has meant that traditional supports such as children are less available to help and support. Many family members have moved to the cities to work. Research studies in Thailand have shown that this decrease in traditional support can directly affect the health status of elderly people, particularly their mental health. As a nurse researcher I am interested in learning about how Thai elderly people manage their everyday lives and how community nurses can provide care that helps to maintain and build upon

personal resilience. Thus, this study will aim to identify and explore elderly resilience and how community nurses who are the main health support resources can contribute to resilience.

Therefore the purpose of this doctoral research study is to understand the concept of rural Thai elderly resilience by observing the everyday lives of the elderly in the PCUs and the rural communities that they live in. I understand that sometimes family will be with you at the PCU and when at home they also might be interested in our conversation. When I am interviewing you, you may also involve your family if they request to speak to me in your presence and with your permission. The purpose of the research however is to learn from the older person what resilience is and how this might contribute to health ageing.

Who can participate in the research?

This study will enrol two groups primarily but family can also be involved if they request it or you as the older person require this involvement:

1) People aged 60 years and over that attend the rural Primary Health Care Unit and who are able to communicate verbally, with no cognitive impairment.

2) Community nurses who work in Primary Health Care Units (PCU) and who are willing to be engaged in this study.

3) Family members with your permission and their signed consent

You have been invited because you are a suitable candidate to participate in this study.

What choice do you have?

You do not have to participate in this research if you do not want to and participation is entirely voluntary. This means it is your choice to participate or not participate. Only those people who give their informed consent after the research project has been carefully explained to them with sufficient time to ask questions and have them answered will be included in the project. Whether or not you decide to participate will not disadvantage you in any way and will NOT affect the treatment you receive from the PCU.

If you decide to participate you can withdraw from the project at any time if you want and you will also have the option of withdrawing any data (recorded interview) related to you.

What would you be asked to do?

If you agree to participate, you will be asked to:

1. Provide your contact details to organise a time for you to be interviewed.
2. Provide general demographic information followed by a face-to-face interview which will be digitally audio-recorded by the researcher and then transcribed from Thai into English.
3. One by one interviewing and private environment will be provided in a spare staff room in the PCU. The researcher may do interview at your house if you are not comfortable being

interviewed at the PCU however the researcher will not attend any private residence alone but only in the company of the community nurse. All interviews will be conducted in Thai, or the Thai-Isan language to make interviewees feel comfortable.

4. Face-to-face interview can be stopped because of your physical limitation such as being tired or emotions such as sadness, then you can be continuing or arranging another time with the researcher.
5. The researcher will be visiting the PCU regularly when she is in Thailand and during that time she will be observing what community nurses and elderly people do in the PCU and the surrounding community.
6. If the interview occurs in your home, or at the PCU and your family want to contribute they will also need to sign the consent form. This is so they have consented to my using their information when I write up the thesis for publication. I understand that in Thailand families are important to older persons. It might be just that the family are keeping you company. I welcome their involvement if it is requested by you during the interview.
7. A copy of the interview transcripts in Thai and in English will be made available to you at your request. You are able to directly request it from the researcher. If you are illiterate, you will be provided with the opportunity to have a summary of the key points in your interview read to you by the researcher. Then they will be asked to give your signature or your finger print stamp to confirm that the transcription has been deemed accurate. All documents pertaining to you can be destroyed at your request if you decide not to participate in the project after you have been interviewed.

How much time will it take?

1. The interview will probably be for 60–90 minutes unless you are fatigued and want to stop, then you will be asked if you want to continue, or, for the researcher to return another day to complete the interview.
2. A home visit with the researcher and the community nurse can occur, or if it suits you better I can visit your home at your convenience. I understand that some periods of the year (during April) the elderly are working at their home because of tobacco leaf harvesting season and that they leave for their farm at 3am and return around 9am. Then they have to put the leaves together in lines around 1.5 metres each, and that this takes them till late at night every day.

What are the risks and benefits of participating?

This study is of low risk to you. It is possible that by the telling of stories related to your life that you may recall a difficult time however it is not intended to dwell or focus on moments of discomfort. All your data will be aggregated and anonymous. This means the information will be themed and put into categories where a single person cannot be identified. The information from this study aims to benefit the rural elderly in terms of health promotion, intervention and health care policy to promote elderly wellbeing in the future.

How will your privacy be protected?

Any information which might identify you will not be published and your name will not be used in any aspect of the study. If I am referring to any participants in any publication(s) a false name will be used to protect their identity. Your name will appear in my data file but will only be used by myself and my research supervisors to track back to particular interview transcripts. You will have a personal pseudonym created for all data related to you. All data collected such as field notes and interview tapes and transcripts will be kept secure at all times in a locked cabinet and on a password protected hard drive.

How will the collected information be used?

The data collected from this study will be reported in the doctoral thesis of the University of Newcastle, under the name of Wilaiwan Pathike. This information will also be used for scientific publications and at health care conferences.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its' contents before you consent to participate. If there is anything you do not understand, or if you have any questions please ask me. I will explain all the details to you in your own language at a time convenient to you.

If you would like to participate, please complete the consent form and return it to secretary at the PCU. The secretary will directly pass your consent on to Miss Wilaiwan Pathike. She will then contact you at the phone number you provide or when you attend the PCU for your next visit to organise a time for interview.

Further information

If you would like future information please contact Wilaiwan Pathike (in Thailand), phone number 0948370867, Address: 15 Moo 13 Ban Suan Chik Si-somdet Roi-Et,

Email: Wilaiwan.Pathike@uon.edu.au or directly contact Associate Professor Anthony Paul O'Brien (Chief investigator), School of Nursing and Midwifery, Faculty of Health and Medicine

The University of Newcastle, Callaghan NSW, Australia 2308, Phone +612 4985 4368, Email: Tony.OBrien@newcastle.edu.au

Thank you for your consideration

Associate Professor Anthony Paul O'Brien

(Chief investigator)

Other members of my team will be involved in this project:

Dr Sharyn Hunter (**Co-supervisor)**

Phone: +612 4921 5957

E-mail: Sharyn.Hunter@newcastle.edu.au

Miss Wilaiwan Pathike (PhD student candidate)

Phone: +61478733839 (Australia), +66948370867 (Thailand)

Email: Wilaiwan.Pathike@uon.edu.au

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2014-0031

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, Roi-Et Provincial Health Office, telephone +6643 511754, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (+612) 49216333,

Email Human-Ethics@newcastle.edu.au.

Appendix 14 Information Statement (English) – for community nurse

Associate Professor Anthony Paul O'Brien (Chief investigator)
School of Nursing and Midwifery,
Faculty of Health and Medicine
The University of Newcastle,
Callaghan NSW, Australia 2308
Ph: +612 4985 4368
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Email: Tony.OBrien@newcastle.edu.au

Information Statement for the Research Project (community nurses):

An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives

English Version [5], dated [21 February 2014]

Dear Participant,

You are invited to participate in the research project above which is being conducted by a researcher, Miss Wilaiwan Pathike, PhD candidate from the school of Nursing and Midwifery at the University of Newcastle. The research is part of a doctoral research study and is supervised by Associate Professor Anthony O'Brien and Dr Sharyn Hunter. She will be in Thailand and visiting a number of PCUs over a three month period in 2014. The information below is to let you know more about the study. I hope you might be interested in participating.

Why is the research being done?

The Thai elderly population is increasing and for rural Thai elderly this has meant that traditional supports such as children are less available to help and support. Many family members have moved to the cities to work. Research studies in Thailand have shown that this decrease in traditional support can directly affect the health status of elderly people, particularly their mental

health. As a nurse researcher I am interested in learning about how Thai elderly people manage their everyday lives and how community nurses can provide care that helps to maintain and build upon personal resilience. Thus, this study will aim to identify and explore elderly resilience and how community nurses who are the main health support resources can contribute to resilience. Therefore the purpose of this doctoral research study is to understand the concept of rural Thai elderly resilience by observing the everyday lives of the elderly in the PCUs and the rural communities that they live in.

Who can participate in the research?

This study will enrol two groups:

1) People aged 60 years and over that attend the rural Primary Health Care Unit and who are able to communicate verbally, with no cognitive impairment.

2) Community nurses who work in Primary Health Care Units (PCU) and who are willing to be engaged in this study.

You have been invited because you are a suitable candidate to participate in this study.

What choice do you have?

You do not have to participate in this research if you do not want to and participation is entirely voluntary. This means it is your choice to participate or not participate. Only those people who give their informed consent after the research project has been carefully explained to them and they have had time to ask questions and have them answered will they be included in the project. Whether or not you decide to participate will not disadvantage you in any way and will not affect your employment, the treatment that you provide to the people at the PCU and your community.

If you decide to participate you can withdraw from the project at any time if you want and you will also have the option of withdrawing any data (record of interview) related to you.

What would you be asked to do?

If you agree to participate, you will be asked to

7. Provide your contact details to organise a time for you to be interviewed.
8. Provide general demographic information followed by a face-to-face interview which will be digitally audio-recorded by the researcher and then transcribed from Thai into English.
9. One by one interviewing and private environment will be provided in a spare staff room in the PCU. All interviews will be conducted in Thai, or the Thai-Isan language to make interviewees feel comfortable.
10. If you are a key person who has been given rich information, you may require for the second interview to add significance value which related to the study.

11. The researcher will be visiting the PCU regularly when she is in Thailand and during that time she will be observing what community nurses and elderly people do in the PCU and the surrounding community.
12. A copy of the interview transcripts in Thai and in English will be made available to you at your request. You are able to directly require it from the researcher to be read, edited and ensure all data is accurate. All documents pertaining to you can be destroyed at your request if you decide not to participate in the project after you have been interviewed.

How much time will it take?

3. The interview will probably be for 60–90 minutes
4. During the time that elderly visit the PCU and when you visit their home will be observing and make notes of what happens during a typical day in the PCU and what occurs during a home visit.

What are the risks and benefits of participating?

This study has no risk to you and your employment will not be affected and you will be de-identified in any publications. All data will be aggregated and anonymous. The information from this study will benefit the rural elderly in terms of health promotion, intervention and health care policy to promote elderly wellbeing in the future.

How will your privacy be protected?

Any information which might identify you will not be published and your name will not be used in any aspect of the study. If I am referring to any participants in any publication(s) a false name will be used to protect their identity. Your name will appear in the researcher data file interviewing but will only be used by the researcher and research supervisors to track back to particular interview transcripts. You will have a personal code name. All data collected such as field notes and interview tapes and transcripts will be kept secure at all times in a locked cabinet and on a password protected hard drive.

How will the information collected be used?

The data collected from this study will be reported in the doctoral thesis of the University of Newcastle, under the name of Wilaiwan Pathike. This information will also be used for scientific publications and at health care conferences.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its' contents before you consent to participate. If there is anything you do not understand, or if you have any questions please ask me. I will explain all the details to you in your own language at a time convenient to you.

If you would like to participate, please complete the consent form and contact me. I will then contact you at the phone number you provide to organise a time for interview.

Further information

If you would like future information please contact Wilaiwan Pathike (in Thailand), phone number 0948370867, Address: 15 Moo 13 Ban Suan Chik Si-somdet Roi-Et,

Email: Wilaiwan.Pathike@uon.edu.au or directly contact Associate Professor Anthony Paul O'Brien (Chief investigator), School of Nursing and Midwifery, Faculty of Health and Medicine

The University of Newcastle, Callaghan NSW, Australia 2308, Phone +612 4985 4368, Email: Tony.OBrien@newcastle.edu.au

Thank you for your consideration

Associate Professor Anthony Paul O'Brien

(Chief investigator)

Other members of my team will be involved in this project:

Dr Sharyn Hunter (**Co-supervisor)**
Phone: +612 4921 5957
E-mail: Sharyn.Hunter@newcastle.edu.au
Miss Wilaiwan Pathike (PhD student candidate)
Phone: +61478733839 (Australia), +66948370867 (Thailand)
Email: Wilaiwan.Pathike@uon.edu.au

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2014-0031

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, Roi-Et Provincial Health Office, telephone +6643 511754, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (+612) 49216333,

Email Human-Ethics@newcastle.edu.au.

Appendix 15 Consent form (English) – for THPH

Associate Professor Anthony Paul O'Brien (Chief investigator)
School of Nursing and Midwifery,
Faculty of Health and Medicine
The University of Newcastle,
Callaghan NSW, Australia 2308
Ph: +612 4985 4368
Mobile: +61448 941 943
Email: Tony.OBrien@newcastle.edu.au

Consent Form for the Research Project (Organisational Participant):

An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives

Version [1], dated [22 February 2014]

I agree to participate and co-ordinate in the above research project by freely consent.

I understand the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand the researcher will be visiting the PCU regularly and she will be interviewing the participants and observing what community nurses and elderly people do in the PCU and the surrounding community e.g. temples, elderly centres or village halls, local grocery shops, local or fresh markets and the places where the elderly are normally engaged.

I understand the researcher will not attend any private residence alone but only in the company of the community nurse.

I understand that the researcher wills take digital photographs to capture the environment for cultural authenticity.

I consent to (check the circle below):

- ○ Disclosure the general elderly demographic data to be studied by the researcher:
- ○ During working time at the PCU and your community will be observed and make notes of what happens during a typical day in the PCU and what occurs during a home visit:
- ○ All of the recorded data can be descripted and translated from Thai language to English language:
- ○ The PCU environment photographs will be taken if the researcher requires:
- ○ The results of the research data can be published in a thesis, journals, reports and conferences.

Print name: ……..

Behalf of the PCU: ……

Signature: ……. **Date:** ……

Address: ……

Telephone: …….

Other members of my team will be involved in this project:

Dr Sharyn Hunter (**Co-supervisor)**
Phone: +612 4921 5957
E-mail: Sharyn.Hunter@newcastle.edu.au
Miss Wilaiwan Pathike (PhD student candidate)
Phone: +61478733839 (Australia), +66948370867 (Thailand)
Email: Wilaiwan.Pathike@uon.edu.au

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2014-0031

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, Roi-Et Provincial Health Office, telephone +6643 511754, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (+612) 49216333,

Email Human-Ethics@newcastle.edu.au.

Appendix 16 Consent form (English) – for elderly

Associate Professor Anthony Paul O'Brien (Chief investigator)
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Consent Form for the Research Project- Elderly

An ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives

Version [5], dated [21 February 2014]

I agree to participate in the above study and give my consent freely.

I understand the study will be conducted as described in the Information Statement, and I have a copy.

I understand I can withdraw from the study at any time and do not have to give any reason for withdrawing.

I understand that my personal information will remain private (confidential) to the researchers.

I understand I will be given the opportunity to review the interview record during or following the interview.

I have had the opportunity to have questions answered to my satisfaction.

I understand that my face-to-face interview can be stopped because of my physical limitation such as being tired or emotions such as sadness, I am willing to do it again by arranging another time with the researcher. I understand that I will be observed by the researcher and that the researcher will make notes about what happens while I am at the PCU.

I consent to (check the circle below):

- ○ giving the researcher my personal information and participating in a face-to-face interview and to have the interview recorded digitally by the researcher:
- ○ another time to continue the interview if the interview was stopped because I was unable to continue or an additional interview if the researcher requires this:
- ○ all of the recorded information being copied and translated from Thai language to English language:
- ○ being observed by the researcher while I am at the PCU and that the researcher will make notes about my activities:
- ○ the results of this study being published in a thesis, journals, reports and conferences.

Older person - print name: ……..

Signature: ……. **Date:** ……

Address: ……

Telephone: …….

Family member(s)

Signature: ……. **Date:** ……

Address: ……

Telephone:

Finger print stamp

Other members of my team will be involved in this project:

Dr Sharyn Hunter (**Co-supervisor)**
Phone: +612 4921 5957
E-mail: Sharyn.Hunter@newcastle.edu.au

Miss Wilaiwan Pathike (PhD student candidate)
Phone: +61478733839 (Australia), +66948370867 (Thailand)
Email: Wilaiwan.Pathike@uon.edu.au

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2014-0031

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, Roi-Et Provincial Health Office, telephone +6643 511754, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (+612) 49216333,

Email: Human-Ethics@newcastle.edu.au.

Appendix 17 Consent form (English) – for community nurse

Associate Professor Anthony Paul O'Brien (Chief investigator)
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Mobile: +61448 941 943
Email: Tony.OBrien@newcastle.edu.au

Consent Form for the Research Project - Community nurses:

An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives

Version [5], dated [21 February 2014]

I agree to participate in the above research project and give my consent freely.

I understand the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I understand that my personal information will remain confidential to the researchers.

I understand that the second interview, to add significance value which related to the study, may require.

I understand I will be offered the opportunity to review, edit and erase the record during or following an interview.

I have had the opportunity to have questions answered to my satisfaction.

I consent to (check the circle below):

- ○ Disclosure of personal information and to one face-to-face semi-structured interview and to have any dialogue digitally audio recorded by the researcher:
- ○ The second interview will be granted if the researcher required:
- ○ All of the recorded data can be descripted and translated from Thai language to English language:
- ○ During this time that you are working at the PCU and your community will be observed and make notes of what happens during a typical day in the PCU and what occurs during a home visit:
- ○ The results of the research data can be published in a thesis, journals, reports and conferences.

Print name: ……..

Signature: ……. **Date:** ……

Address: ……

Telephone: …….

Other members of my team will be involved in this project:

Dr Sharyn Hunter (**Co-supervisor)**
Phone: +612 4921 5957
E-mail: Sharyn.Hunter@newcastle.edu.au
Miss Wilaiwan Pathike (PhD student candidate)
Phone: +61478733839 (Australia), +66948370867 (Thailand)
Email: Wilaiwan.Pathike@uon.edu.au

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H- 2014-0031

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, Roi-Et Provincial Health Office, telephone +6643 511754, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (+612) 49216333,

Email Human-Ethics@newcastle.edu.au.

Appendix 18 Information Statement (Thai) – for THPH

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล (หัวหน้าโครงการวิจัย)
โรงเรียนการพยาบาลและการผดุงครรภ์
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เอกสารคำชี้แจงสำหรับหน่วยงานที่เข้าร่วมโครงการวิจัย

การศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจหลักแนวคิดและความหมายของพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต
ในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทย ในมุมมองของผู้สูงอายุชนบทและพยาบาลชุมชน

(An Ethnographic study to understand the concept of rural Thai elderly resilience:
Rural elderly and community nurses perspectives)

เอกสารฉบับที่ 1 , วันที่ 22 กุมภาพันธ์ 2557

เรียน ผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบล .....

หน่วยงานภายใต้การกำกับดูแลของท่านได้รับเชิญเพื่อเข้าร่วมโครงการวิจัยนี้ ซึ่งจะมีการดำเนินการวิจัยโดย นางสาว วิไลวรรณ ปะธิเก นักศึกษาปริญญาเอก โรงเรียนการพยาบาลและผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล โดยการศึกษาวิจัยนี้ เป็นส่วนหนึ่งของวิทยานิพนธ์ระดับปริญญาเอก ซึ่งอยู่ภายใต้การกำกับดูแลของ รองศาสตราจารย์แอนโทนี พอล โอไบรอัล และ ดร.ชารอล ฮันเตอร์ ทั้งนี้ผู้วิจัยจะดำเนินการวิจัยโดยใช้พื้นที่ศึกษาในความรับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพประจำตำบล จำนวน 4 แห่ง เป็นระยะเวลาทั้งสิ้น 3 เดือนโดยประมาณ ดังรายละเอียดจะกล่าวต่อไปนี้ ข้าพเจ้าหวังเป็นอย่างยิ่งว่าท่านจะให้ความสนใจ และร่วมมือในการเป็นส่วนหนึ่งของโครงการวิจัยในครั้งนี้

ที่มาและความสำคัญ

ในสภาวะการณ์ปัจจุบันที่มีจำนวนผู้สูงอายุมีอัตราเพิ่มมากขึ้น ซึ่งทำให้ผู้สูงอายุในชนบทที่ได้รับการดูแลจากลูกหลานดังเช่นในอดีตมีสัดส่วนลดน้อยลง เช่น การมีเวลาในการดูแลเอาใจใส่ต่อผู้สูงอายุ ของลูกหลานมีเวลาน้อยลง รวมถึงหลายครอบครัวมีการอพยพย้ายถิ่นของลูกหลานเข้าสู่เมืองใหญ่เพื่อการประกอบอาชีพ ทั้งนี้การศึกษาในประเทศไทย พบว่า การลดลงของอัตราการดูแลผู้สูงอายุโดยลูกหลานนั้นส่งผลกระทบโดยตรงต่อสภาวะสุขภาพของผู้สูงอายุ โดยเฉพาะอย่างยิ่งในส่วนของสุขภาพจิต

ในฐานะบทบาทของพยาบาล ผู้ศึกษาวิจัยจึงมีความสนใจเป็นอย่างยิ่งในการที่จะศึกษาว่าผู้สูงอายุในชนบทของไทยนั้นมีการจัดการและบริหารชีวิตประจำได้อย่างไร รวมถึงพยาบาลชุมชน ผู้ซึ่งมีความใกล้ชิดกับผู้สูงอายุในชนบทสามารถให้ความช่วยเหลือด้านสุขภาพเพื่อการสร้าง และการรักษาไว้ซึ่งพลังสุขภาพจิตให้กับผู้สูงอายุได้อย่างไร

ดังนั้นการศึกษาวิจัยในครั้งนี้จึงมีวัตถุประสงค์เพื่อศึกษาพลังสุขภาพจิตในผู้สูงอายุในเขตชนบท และความสามารถของพยาบาลชุมชนในการเสริมสร้างพลังสุขภาพจิต โดยมีจุดมุ่งหมายอันสำคัญของการศึกษาวิจัยระดับปริญญาเอกในครั้งนี้เพื่อเข้าใจในหลักแนวคิดและความหมายของพลังสุขภาพจิตในผู้สูงอายุในเขตชนบทไทย ผ่านการสัมภาษณ์ และสังเกตชีวิตประจำวันของผู้สูงอายุในโรงพยาบาลส่งเสริมสุขภาพประจำตำบล รวมไปถึงสถานที่ในชุมชน อันเป็นสถานที่ที่ผู้สูงอายุใช้เวลาในการทำกิจวัตร หรือกิจกกรรมในแต่ละวัน

ผู้เข้าร่วมโครงการวิจัย

การศึกษาวิจัยในครั้งนี้ ผู้เข้าร่วมโครงการวิจัยประกอบด้วย

1) ผู้สูงอายุ ที่มีอายุ 60 ปีขึ้นไป ที่ใช้บริการสุขภาพในโรงพยาบาลส่งเสริมสุขภาพประจำตำบล ซึ่งสามารถสื่อสารทางวาจาได้ และไม่มีความผิดปกติของการรับรู้และตอบสนอง (brain injury or forms of dementia and Alzheimer disease)
2) พยาบาลวิชาชีพ ที่ปฏิบัติงานอยู่ในหน่วยต่างๆ ของโรงพยาบาลส่งเสริมสุขภาพ และมีความประสงค์ที่จะเข้าร่วมในโครงการวิจัย

สิทธิในการเข้าร่วมโครงการวิจัยของอาสาสมัคร

ท่านมีสิทธิในการเลือกที่จะร่วมเป็นส่วนหนึ่งของโครงการวิจัยในครั้งนี้หรือไม่ก็ได้ หากท่านได้รับทราบและเข้าใจในรายละเอียดของโครงการอย่างชัดเจน หรือได้มีการสอบถามข้อสงสัยต่างๆ อันเกี่ยวข้องกับโครงการวิจัยในครั้งนี้ ได้ให้การยินยอมและลงชื่อในเอกสารใบยินยอมเพื่อเข้าร่วมโครงการวิจัยโดยสมัครใจ จึงจะถือว่าท่านได้เข้าร่วมโครงการวิจัยโดยสมบูรณ์ ทั้งนี้ การตัดสินใจที่จะเข้าร่วมหรือไม่นั้น จะไม่มีผลกระทบใดๆ กับงานหน่วยงานท่าน

การเข้าร่วมโครงการวิจัย

หากท่านสมัครใจในการเข้าร่วมโครงการวิจัยในครั้งนี้ ท่านจะได้รับการขอความร่วมมือ ดังต่อไปนี้

1. ท่านจะได้รับการร้องขอให้จัดเตรียมข้อมูลพื้นฐานเกี่ยวกับประชากรผู้สูงอายุ ในพื้นที่รับผิดชอบของท่าน เพื่อให้ผู้วิจัยทำการศึกษาข้อมูลเบื้องต้นโดยละเอียด
2. ค้นหาอาสาสมัครที่มีความเหมาะสมตามเงื่อนไข และสมัครใจในการเข้าร่วมโครงการ
3. จัดเตรียมสถานที่ เพื่อใช้ในการสัมภาษณ์เชิงลึกแบบหนึ่งต่อหนึ่ง สำหรับผู้วิจัยและอาสาสมัคร
4. ผู้วิจัยจะมีการสังเกต และจดบันทึก อันเกี่ยวข้องกับการปฏิสัมพันธ์ระหว่างผู้สูงอายุและพยาบาลชุมชนในพื้นที่ของโรงพยาบาลส่งเสริมสุขภาพตำบล รวมถึงพื้นที่โดยรอบของชุมชน ในพื้นที่รับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพตำบลนั้นๆ ได้แก่ วัด ศูนย์ผู้สูงอายุในชุมชน ร้านค้า ตลาด รวมถึงสถานที่ ที่ผู้สูงอายุใช้ร่วมกันเพื่อประกอบกิจกรรมต่างๆ
5. ผู้วิจัยจะทำการสัมภาษณ์ที่บ้านของอาสาสมัคร ในกรณีที่อาสาสมัครไม่สะดวกที่จะให้สัมภาษณ์ในสถานที่ที่ได้จัดเตรียมไว้ภายใน รพ.สต. แต่ทั้งนี้ผู้วิจัยจะทำการสัมภาษณ์ และเข้าถึงบ้านของอาสาสมัครภายใต้การกำกับดูแลของพยาบาลวิชาชีพผู้ปฏิบัติงานอยู่ใน รพ.สต. ดังกล่าวเท่านั้น
6. ผู้วิจัยอาจทำการถ่ายภาพพื้นที่ ที่ทำการวิจัย เพื่อให้สามารถอธิบายและให้คุณค่าในเนื้อหาด้านสังคมและวัฒนธรรมได้อย่างชัดเจน โดยภาพถ่ายดังกล่าวจะไม่มีการระบุตัวตนของบุคคล รวมถึงไม่ระบุชื่อของสถานที่ในภาพถ่ายด้วย

ระยะเวลาในการวิจัย

1. การสัมภาษณ์แบบหนึ่งต่อหนึ่ง จะใช้เวลาประมาณ 60 – 90 นาที โดยผู้วิจัยจะทำการสัมภาษณ์อาสาสมัครในเวลาราชการ และไม่เกิน 3 รายต่อวัน
2. ระยะเวลาที่ผู้สูงอายุเข้ารับบริการในโรงพยาบาลส่งเสริมสุขภาพตำบล และระยะเวลาที่พยาบาลชุมชนออกเยี่ยมบ้านผู้สูงอายุ จะได้รับการสังเกตและจดบันทึกโดยผู้วิจัย 3-5 ครั้งต่อสัปดาห์ รวมเป็นระยะเวลาทั้งสิ้น 12 สัปดาห์โดยประมาณ (โดยแบ่งเป็น รพ.สต. ละ 3 สัปดาห์) โดยการสังเกตและบันทึกนั้น จะประกอบไปด้วยเหตุการณ์ต่างๆ ที่เกิดขึ้นระหว่างวันในโรงพยาบาลส่งเสริมสุขภาพตำบล และเหตุการณ์ต่างๆ ที่เกิดขึ้นระหว่างการเยี่ยมบ้านผู้สูงอายุ ทั้งนี้อาจรวมถึงกิจกรรมทางศาสนาหรือความเชื่อที่จะอาจมีการจัดขึ้นในช่วงเวลากลางคืนด้วย

ความเสี่ยง และผลประโยชน์ต่อผู้เข้าร่วมโครงการวิจัย

การศึกษาวิจัยในครั้งนี้ไม่มีความเสี่ยงใดๆ อันจะเกิดขึ้นต่อหน่วยงานที่เข้าร่วมโครงการ ทั้งนี้ข้อมูลที่ได้จากการศึกษาจะเป็นประโยชน์ต่อการส่งเสริมสุขภาพผู้สูงอายุในชนบท รวมไปถึงการพัฒนารูปแบบการดูแลผู้สูงอายุ และนโยบายเพื่อให้ผู้สูงอายุมีสุขภาพที่ดีในอนาคตอีกด้วย

การปกป้องความเป็นส่วนตัวของผู้เข้าร่วมโครงการวิจัย

ข้อมูลทั้งหมดที่สามารถระบุตัวตนของอาสาสมัครที่เป็นผู้เข้าร่วมโครงการวิจัยจากหน่วยงานของท่านจะไม่ถูกเปิดเผยต่อสาธารณะ และหากแม้ว่าผู้วิจัยได้กล่าวถึงอาสาสมัครเพื่อการเผยแพร่หรือตีพิมพ์ อาสาสมัครจะถูกระบุเพียงนามสมมติ ทั้งนี้ชื่อหน่วยงานของท่านจะปรากฏอยู่ในเฉพาะเอกสารที่เป็นฐานข้อมูลและสามารถเข้าถึงเอกสารดังกล่าวได้เฉพาะตัวผู้วิจัยและอาจารย์ที่ปรึกษาเท่านั้น โดยการเข้าถึงเอกสารดังกล่าวจะทำเฉพาะเมื่อต้องการเชื่อมโยงข้อมูลเอกสารจากการถอดเทปไปยังตัวตนของบุคคลซึ่งจะระบุด้วยอักษรภาษาอังกฤษและตัวเลขเท่านั้น

ข้อมูลทั้งหมดที่ได้จากการสัมภาษณ์ และการสังเกตุ จะถูกเก็บอย่างปลอดภัยในตู้เก็บเอกสารที่สามารถล็อกได้ รวมไปถึงข้อมูลในคอมพิวเตอร์ทั้งหมดจะถูกเก็บในฮาร์ดไดรฟ์ที่เข้าถึงได้โดยใช้เฉพาะรหัสผ่านของผู้วิจัยเท่านั้น

การใช้ข้อมูลจากการศึกษาวิจัย

ข้อมูลทั้งหมดที่ได้จากการศึกษาวิจัยในครั้งนี้จะถูกนำไปรายงานในวิทยานิพนธ์ระดับปริญญาเอก แห่งมหาวิทยาลัยนิวคาสเซิลภายใต้ชื่อของ นางสาววิไลวรรณ ปะธิเก ทั้งนี้ข้อมูลดังกล่าวยังจะถูกนำไปเผยแพร่เพื่อการแลกเปลี่ยนเรียนรู้ในเชิงวิทยาศาสตร์และสุขภาพด้วย

การเข้าร่วมในโครงการวิจัย

โปรดอ่านและทำความเข้าใจข้อมูลข้างต้นก่อนลงชื่อในเอกสารใบยินยอม หากท่านมีข้อสงสัยหรือข้อคำถาม โปรดซักถามผู้วิจัย ซึ่งผู้วิจัยมีความยินดีเป็นอย่างยิ่งในการอธิบายข้อซักถามของท่าน ในทุกเวลาที่ท่านสะดวก

ข้อมูลเพิ่มเติม

หากท่านต้องการข้อมูลเพิ่มเติมเกี่ยวกับโครงการวิจัย กรุณาติดต่อ นางสาววิไลวรรณ ปะธิเก หมายเลขโทรศัพท์ 0948370867 ที่อยู่ 15 หมู่ 13 บ้านสวนจิก ตำบลสวนจิก อำเภอศรีสมเด็จ จังหวัดร้อยเอ็ด อีเมลล์ Wilaiwan.Pathike@uon.edu.au หรือท่านสามารถติดต่อโดยตรงได้ที่ รองศาสตราจารย์ แอนโทนี พอล โอไบรอัล, School of Nursing and Midwifery, Faculty of Health and Medicine, The University of Newcastle, Callaghan NSW, Australia 2308 หมายเลขโทรศัพท์ +612 4985 4368 อีเมลล์ Tony.OBrien@newcastle.edu.au

ด้วยความเคารพ

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล
(หัวหน้าโครงการวิจัย)

สมาชิกผู้ดำเนินโครงการวิจัย

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หากท่านมีข้อร้องเรียนอันเกี่ยวข้องกับโครงการวิจัย

โครงการวิจัยนี้ได้รับการอนุมัติโดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล เลขที่อนุมัติ H-2014-0031

หากท่านมีความสงสัยในสิทธิของผู้เข้าร่วมวิจัย หรือผู้วิจัยไม่สุภาพ ท่านสามารถร้องเรียนได้โดยตรงกับผู้วิจัย หรือสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด หมายเลขโทรศัพท์ +6643 511754 *หรือที่ คณะกรรมการจริยธรรมการวิจัยในมนุษย์แห่งมหาวิทยาลัยนิวคาสเซิล The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, หมายเลขโทรศัพท์ (+612) 49216333, อีเมลล์ Human-Ethics@newcastle.edu.au.*

Appendix 19 Information Statement (Thai) – for elderly

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล (หัวหน้าโครงการวิจัย)
โรงเรียนการพยาบาลและการผดุงครรภ์
คณะการแพทย์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล
คอลลาฮาน รัฐนิวเซาท์เวล ออสเตรเลีย 2308
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เอกสารคำชี้แจงสำหรับผู้เข้าร่วมโครงการวิจัย (ผู้สูงอายุ):

การศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจหลักแนวคิดและความหมายของพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทย ในมุมมองของผู้สูงอายุ ในเขตชนบทและพยาบาลชุมชน

(An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives)

เอกสารฉบับที่ 6 , วันที่ 25 มีนาคม 2557

เรียน ผู้เข้าร่วมโครงการวิจัย

ท่านได้รับการเรียนเชิญเพื่อเข้าร่วมโครงการวิจัยในข้างต้น ซึ่งมี นางสาว วิไลวรรณ ปะธิเก นักศึกษาระดับปริญญาเอก โรงเรียนการพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นผู้ดำเนินการวิจัย โดยการศึกษาวิจัยนี้เป็นส่วนหนึ่งของวิทยานิพนธ์ระดับปริญญาเอก ซึ่งอยู่ภายใต้การกำกับดูแลของ รองศาสตราจารย์แอนโทนี พอล โอไบรอัล และ ดร.ชารอล ฮันเตอร์ ทั้งนี้ผู้วิจัยจะดำเนินการวิจัยในพื้นที่ความรับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพประจำตำบล 4 แห่ง รวมระยะเวลาทั้งสิ้น 3 เดือนโดยประมาณ ดังรายละเอียดที่จะกล่าวต่อไปนี้ ข้าพเจ้าหวังเป็นอย่างยิ่งว่าท่านจะให้ความสนใจ และร่วมเป็นส่วนหนึ่งของโครงการวิจัยในครั้งนี้

ที่มาและความสำคัญ

ในสภาวะการณ์ปัจจุบันที่จำนวนผู้สูงอายุมีอัตราเพิ่มมากขึ้น ซึ่งทำให้ผู้สูงอายุในชนบทที่ได้รับการดูแลจากลูกหลานดังเช่นในอดีตมีสัดส่วนลดน้อยลง เช่น การมีเวลาในการดูแลเอาใจใส่ต่อผู้สูงอายุของลูกหลานมีเวลาน้อยลง รวมถึงหลายครอบครัวมีการอพยพย้ายถิ่นของลูกหลานเข้าสู่เมืองใหญ่เพื่อการประกอบอาชีพ ทั้งนี้การศึกษาในประเทศไทยพบว่า การลดลงของอัตราการดูแลผู้สูงอายุโดยลูกหลานนั้น ส่งผลกระทบโดยตรงต่อสภาวะสุขภาพของผู้สูงอายุ โดยเฉพาะอย่างยิ่งในส่วนของสุขภาพจิต

ในฐานะของพยาบาล ผู้ศึกษาวิจัยจึงมีความสนใจเป็นอย่างยิ่งในการศึกษาว่าผู้สูงอายุในชนบทของไทยมีการจัดการและบริหารชีวิตประจำวัน อันเกี่ยวข้องกับการเผชิญปัญหา วิกฤต หรือความยากลำบากได้อย่างไร รวมถึงพยาบาลชุมชน ผู้ซึ่งมีความใกล้ชิดกับผู้สูงอายุในชนบทสามารถให้ความช่วยเหลือเพื่อการสร้างและการรักษาไว้ซึ่งพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤตให้กับผู้สูงอายุได้อย่างไร

ดังนั้นการศึกษาวิจัยในครั้งนี้จึงมีวัตถุประสงค์เพื่อศึกษาพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุในเขตชนบท และความสามารถของพยาบาลชุมชนในการเสริมสร้างพลังสุขภาพจิตดังกล่าว โดยมีจุดมุ่งหมายอันสำคัญเพื่อเข้าใจในหลักแนวคิดและความหมายของพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤตในผู้สูงอายุในเขตชนบทของไทย ผ่านการสัมภาษณ์ และสังเกตชีวิตประจำวันของผู้สูงอายุในโรงพยาบาลส่งเสริมสุขภาพประจำตำบล รวมไปถึงสถานที่ในชุมชน อันเป็นสถานที่ที่ผู้สูงอายุใช้เวลาในการทำกิจวัตร หรือกิจกรรมในแต่ละวัน

ผู้วิจัยได้เล็งเห็นถึงความสำคัญของสมาชิกในครอบครัวของท่าน ซึ่งในบางครั้งบุคคลเหล่านั้นอาจเป็นผู้พาท่านมายัง รพ.สต. และอาจมีความสนใจที่จะร่วมสนทนาในครั้งนี้เมื่อผู้วิจัยทำการสัมภาษณ์ในบริเวณบ้านของท่าน ดังนั้นหากครอบครัวของท่านต้องการมีส่วนร่วมในการให้สัมภาษณ์จึงสามารถกระทำได้ภายใต้การกำกับและการอนุญาตของท่าน แต่ทั้งนี้การศึกษาวิจัยในครั้งนี้มีจุดมุ่งหมายหลักเพื่อศึกษาพลังสุขภาพจิต หรือความสามารถในการยืนหยัดเผชิญวิกฤติจากตัวของผู้สูงอายุ อันนำไปสู่การเป็นผู้สูงอายุสุขภาพดีได้อย่างไร

ผู้เข้าร่วมโครงการวิจัย

การศึกษาวิจัยในครั้งนี้ ผู้เข้าร่วมโครงการวิจัยประกอบด้วย

1. ผู้สูงอายุ ที่มีอายุ 60 ปีขึ้นไป ที่ใช้บริการสุขภาพในโรงพยาบาลส่งเสริมสุขภาพตำบล ซึ่งสามารถสื่อสารทางวาจาได้ ไม่มีความผิดปกติของการรับรู้และตอบสนอง และมีความประสงค์ที่จะเข้าร่วมโครงการวิจัย
2. พยาบาลวิชาชีพ ที่ปฏิบัติงานอยู่ในหน่วยต่างๆ ของโรงพยาบาลส่งเสริมสุขภาพตำบล และมีความประสงค์ที่จะเข้าร่วมโครงการวิจัย
3. สมาชิกในครอบครัวของผู้สูงอายุภายใต้การอนุญาตของผู้สูงอายุที่ให้สัมภาษณ์ และบุคคลดังกล่าวลงนามในเอกสารใบยินยอม

ซึ่งท่าน ได้รับการเรียนเชิญให้เข้าร่วมโครงการวิจัยในครั้งนี้ด้วย

สิทธิในการเข้าร่วมโครงการวิจัย

ท่านสามารถเลือกที่จะร่วมเป็นส่วนหนึ่งของโครงการวิจัยในครั้งนี้หรือไม่ก็ได้ เฉพาะท่านที่ทราบและเข้าใจในรายละเอียดของโครงการอย่างชัดเจน หรือมีการสอบถามข้อสงสัยต่างๆ อันเกี่ยวข้องกับโครงการวิจัย ได้ให้การยินยอม และลงชื่อในเอกสารใบยินยอมเพื่อเข้าร่วมโครงการวิจัยโดยสมัครใจ จึงจะถือว่าท่านได้เข้าร่วมโครงการวิจัยโดยสมบูรณ์ ทั้งนี้ การตัดสินใจที่จะเข้าร่วมหรือไม่นั้น จะไม่มีผลกระทบใดๆ กับตัวท่าน และไม่ส่งผลกระทบใดๆ ต่อการรับบริการจากโรงพยาบาลส่งเสริมสุขภาพตำบลด้วย

หากท่านตัดสินใจที่จะเข้าร่วมโครงการวิจัยในครั้งนี้แล้ว ท่านสามารถขอยกเลิก หรือถอนตัวจากการเข้าร่วมโครงการในครั้งนี้ได้ในทุกเวลาที่ท่านต้องการ รวมถึงท่านสามารถขอยกเลิกข้อมูลที่เกี่ยวข้องกับตัวท่านได้ทั้งหมดด้วย

การเข้าร่วมโครงการวิจัย

หากท่านสมัครใจในการเข้าร่วมโครงการวิจัยในครั้งนี้ ท่านจะได้รับการขอความร่วมมือ ดังต่อไปนี้

1) ให้ข้อมูลการติดต่อตัวท่านกับผู้วิจัย เพื่อนัดหมายเวลา และทำการสัมภาษณ์
2) ท่านจะได้รับการสอบถามข้อมูลพื้นฐาน และตามด้วยการสัมภาษณ์โดยผู้วิจัย ซึ่งการสัมภาษณ์ในครั้งนี้ ผู้วิจัยจะขออนุญาตผู้เข้าร่วมวิจัยในการบันทึกเทปบทสนทนา ถอดเทปเป็นลายลักษณ์อักษร และแปลจากภาษาไทย เป็นภาษาอังกฤษด้วย
3) การสัมภาษณ์แบบหนึ่งต่อหนึ่ง อันประกอบด้วยผู้วิจัยและผู้ร่วมโครงการวิจัย จะดำเนินการในห้องที่เป็นส่วนตัว โดยจะมีการเตรียมห้องไว้ในส่วนของอาคารของโรงพยาบาลส่งเสริมสุขภาพตำบล รวมไปถึงในกรณีที่ท่านไม่สะดวกในการให้สัมภาษณ์ในพื้นที่ ที่ได้จัดเตรียมไว้ ผู้วิจัยอาจมีการทำการสัมภาษณ์ ณ บริเวณบ้านของท่าน ทั้งนี้ผู้วิจัยจะไม่เข้าถึงบ้านของท่านเพียงลำพัง แต่จะอยู่ภายใต้การดูแลของพยาบาลชุมชนเจ้าของพื้นที่ และผู้วิจัยจะใช้ภาษาไทย และภาษาอีสาน ตลอดการสัมภาษณ์
4) ในระหว่างกระบวนการสัมภาษณ์ ท่านสามารถหยุดหรือพักการให้สัมภาษณ์ อันเนื่องมาจากข้อจำกัดทางด้านร่างกาย เช่น เหนื่อยล้า หรือรู้สึกเศร้าเสียใจ ทั้งนี้ท่านสามารถให้สัมภาษณ์ต่อ หรือนัดหมายการสัมภาษณ์วันถัดไป
5) ผู้วิจัยจะมีการสังเกต และจดบันทึก อันเกี่ยวข้องกับการปฏิสัมพันธ์ระหว่างผู้สูงอายุและพยาบาลชุมชนในพื้นที่ของโรงพยาบาลส่งเสริมสุขภาพตำบล รวมถึงพื้นที่โดยรอบของชุมชน ในพื้นที่รับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพตำบลนั้นๆ
6) หากสมาชิกในครอบครัวของท่านต้องการมีส่วนร่วมในการให้สัมภาษณ์ทั้งในบริเวณบ้านของท่าน และที่ รพ.สต. บุคคลดังกล่าวจำเป็นต้องลงนามในเอกสารใบยินยอม ซึ่งเป็นข้อกำหนดในการเขียนวิทยานิพนธ์เพื่อการตีพิมพ์เผยแพร่ของผู้วิจัยด้วย โดยผู้วิจัยเข้าใจถึงความสำคัญของครอบครัวที่มีต่อท่าน และผู้วิจัยยินดีให้ครอบครัวของท่านร่วมเป็นส่วนหนึ่งในการให้สัมภาษณ์หากท่านต้องการ
7) ท่านจะได้รับผลการวิจัยโดยย่อจากผู้วิจัย และในกรณีที่ท่านไม่สามารถอ่านแบบบันทึกได้ด้วยตนเอง ข้อมูลดังกล่าวจะถูกแจ้งให้ท่านทราบด้วยวาจาโดยพยาบาล หรือเจ้าหน้าที่ ที่ปฏิบัติงานอยู่ในโรงพยาบาลส่งเสริมสุขภาพตำบล ทั้งนี้ข้อมูลที่ได้จากการถอดเทปบทสัมภาษณ์นั้น ผู้วิจัยจะบอกท่านด้วยวาจา และท่านสามารถร้องขอแบบบันทึกที่เป็นลายลักษณ์อักษร เพื่อตรวจสอบความถูกต้องได้ โดยเอกสารดังกล่าวจะไม่มีการระบุชื่อ หรือสิ่งต่างๆ ที่สามารถเชื่อมโยงไปถึงผู้ร่วมโครงการวิจัย ทั้งนี้หลังจากเสร็จสิ้นกระบวนการส่งเล่มวิทยานิพนธ์ของผู้วิจัยแล้ว ผู้วิจัยจะนำผลการวิจัยทั้งหมดรายงานต่อโรงพยาบาลส่งเสริมสุขภาพตำบล รวมถึงการนำเสนอผลการวิจัยต่อผู้สูงอายุ และพยาบาลชุมชนเมื่อผู้วิจัยสำเร็จการศึกษาและเดินทางกลับมายังประเทศไทย รวมไปถึงผู้วิจัยจะนำผลการวิจัยดังกล่าวรายงานต่อสำนักงานสาธารณสุขจังหวัดร้อยเอ็ดด้วย (โดยผลการวิจัยทั้งหมดจะไม่มีการระบุตัวตน ชื่อผู้เข้าร่วมวิจัย หรือชื่อหน่วยงาน)

ระยะเวลาในการวิจัย

1. การสัมภาษณ์แบบหนึ่งต่อหนึ่ง จะใช้เวลาประมาณ 60 – 90 นาที ยกเว้นในกรณีที่ท่านเหนื่อยล้า และต้องการหยุดให้สัมภาษณ์ ท่านจะได้รับการสอบถามว่าต้องการให้สัมภาษณ์ต่อหรือไม่ เพื่อผู้วิจัยจะได้ทำการสัมภาษณ์อีกครั้งในวันถัดไป
2. อาจมีการเยี่ยมบ้านของท่านโดยผู้วิจัยและพยาบาลชุมชนในกรณีที่สะดวกต่อตัวของท่าน อันสืบเนื่องมาจากผู้วิจัยเข้าใจถึงภาระ และความยุ่งยาก อันเกี่ยวกับการทำงานตามฤดูกาลของท่าน

ความเสี่ยง และผลประโยชน์ต่อผู้เข้าร่วมโครงการวิจัย

การศึกษาวิจัยในครั้งนี้มีความเสี่ยงที่น้อยมากต่อตัวท่าน ซึ่งความเสี่ยงดังกล่าวอาจเกิดขึ้นการเล่าถึงเรื่องราวในชีวิตที่ผ่านมา อันอาจจะนำท่านกลับไปสู่ความทุกข์ยากในอดีต ทั้งนี้ชื่อและนามสกุลของท่านจะถูกปกปิดในทุกรายงาน หรือสิ่งพิมพ์ต่างๆ นั่นหมายถึงข้อมูลทั้งหมดจะถูกรายงานในรูปแบบของกลุ่มบทความที่ไม่สามารถอ้างถึงบุคคลใดบุคคลหนึ่งได้

ข้อมูลที่ได้จากการศึกษาในครั้งนี้จะเป็นประโยชน์ในการส่งเสริมสุขภาพผู้สูงอายุในชนบท รวมไปถึงการพัฒนารูปแบบการดูแลผู้สูงอายุ และนโยบายเพื่อให้ผู้สูงอายุมีสุขภาพที่ดีในอนาคตอีกด้วย

การปกป้องความเป็นส่วนตัวของผู้เข้าร่วมโครงการวิจัย

ข้อมูลทั้งหมดที่สามารถระบุตัวตนของท่านจะไม่ถูกเปิดเผยต่อสาธารณะ และชื่อ – นามสกุลจริงของท่านจะไม่ถูกนำไปใช้ในทุกกระบวนการของการวิจัยในครั้งนี้ และหากแม้ว่าผู้วิจัยได้กล่าวถึงท่านเพื่อการเผยแพร่หรือตีพิมพ์ ท่านจะถูกระบุเพียงนามสมมติ ทั้งนี้ชื่อจริงของท่านจะปรากฏอยู่ในเฉพาะเอกสารที่เป็นฐานข้อมูลและเฉพาะตัวผู้วิจัยและอาจารย์ที่ปรึกษาเท่านั้นที่สามารถเข้าถึงเอกสารดังกล่าวได้ โดยการเข้าถึงเอกสารดังกล่าวจะทำเฉพาะเมื่อต้องการเชื่อมโยงข้อมูลเอกสารจากการถอดเทปไปยังตัวตนของบุคคลซึ่งจะระบุด้วยอักษรภาษาอังกฤษและตัวเลขเท่านั้น

ข้อมูลทั้งหมดที่ได้จากการสัมภาษณ์ และการสังเกตุ จะถูกเก็บอย่างปลอดภัยในตู้เก็บเอกสารที่สามารถล็อกได้ รวมไปถึงข้อมูลในคอมพิวเตอร์ทั้งหมดจะถูกเก็บในฮาร์ดไดรฟ์ที่เข้าถึงได้โดยใช้เฉพาะรหัสผ่านของผู้วิจัยเท่านั้น

การใช้ข้อมูลจากการศึกษาวิจัย

ข้อมูลทั้งหมดที่ได้จากการศึกษาวิจัยในครั้งนี้จะถูกนำไปรายงานในวิทยานิพนธ์ระดับปริญญาเอก แห่งมหาวิทยาลัยนิวคาสเซิล ภายใต้ชื่อของ นางสาววิไลวรรณ ปะธิเก ทั้งนี้ข้อมูลดังกล่าวจะถูกนำไปเผยแพร่เพื่อการแลกเปลี่ยนเรียนรู้ในเชิงวิทยาศาสตร์และสุขภาพด้วย

การเข้าร่วมในโครงการวิจัย

โปรดอ่านและทำความเข้าใจข้อมูลข้างต้นก่อนลงชื่อในเอกสารใบยินยอม หากท่านมีข้อสงสัยหรือคำถาม โปรดซักถามผู้วิจัย ซึ่งผู้วิจัยมีความยินดีเป็นอย่างยิ่งในการอธิบายข้อซักถามของท่าน ได้ในทุกเวลาที่ท่านสะดวก

หากท่านต้องการเข้าร่วมโครงการวิจัยในครั้งนี้ กรุณากรอกข้อมูลของท่านในเอกสารใบยินยอม เพื่อผู้วิจัยจะได้ติดต่อกลับและนัดหมายการสัมภาษณ์ในลำดับต่อไป

ข้อมูลเพิ่มเติม

หากท่านต้องการข้อมูลเพิ่มเติมเกี่ยวกับโครงการวิจัย กรุณาติดต่อ นางสาววิไลวรรณ ปะธิเก หมายเลขโทรศัพท์ 0948370867 ที่อยู่ 15 หมู่ 13 บ้านสวนจิก ตำบลสวนจิก อำเภอศรีสมเด็จ จังหวัดร้อยเอ็ด อีเมลล์ Wilaiwan.Pathike@uon.edu.au หรือท่านสามารถติดต่อโดยตรงได้ที่ รองศาสตราจารย์ แอนโทนี พอล โอไบรอัล, School of Nursing and Midwifery, Faculty of Health and Medicine, The University of Newcastle, Callaghan NSW, Australia 2308 หมายเลขโทรศัพท์ +612 4985 4368 อีเมลล์ Tony.OBrien@newcastle.edu.au

ด้วยความเคารพ

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล

(หัวหน้าโครงการวิจัย)

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นางสาววิไลวรรณ ปะธิเก

นักศึกษาผู้ดำเนินโครงการวิจัย

(ในนามตัวแทนของหัวหน้าโครงการวิจัย)

สมาชิกผู้ดำเนินโครงการวิจัย

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หากท่านมีข้อร้องเรียนอันเกี่ยวข้องกับโครงการวิจัย

โครงการวิจัยนี้ได้รับการอนุมัติโดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล เลขที่อนุมัติ H-2014-0031

หากท่านมีความสงสัยในสิทธิของผู้เข้าร่วมวิจัย หรือผู้วิจัยไม่สุภาพ ท่านสามารถร้องเรียนได้โดยตรงกับผู้วิจัย หรือสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด หมายเลขโทรศัพท์ +6643 511754 *หรือที่ คณะกรรมการจริยธรรมการวิจัยในมนุษย์แห่งมหาวิทยาลัยนิวคาสเซิล The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, หมายเลขโทรศัพท์* (+612) 49216333, *อีเมลล์ Human-Ethics@newcastle.edu.au.*

Appendix 20 Information Statement (Thai) – for community nurse

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล (หัวหน้าโครงการวิจัย)
โรงเรียนการพยาบาลและการผดุงครรภ์
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เอกสารคำชี้แจงสำหรับผู้เข้าร่วมโครงการวิจัย (พยาบาลชุมชน):

การศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจหลักแนวคิดและความหมายของพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทย ในมุมมองของผู้สูงอายุในเขตชนบทและพยาบาลชุมชน

(An Ethnographic study to understand the concept of rural Thai elderly resilience:
Rural elderly and community nurses perspectives)

เอกสารฉบับที่ 5 , วันที่ 21 กุมภาพันธ์ 2557

เรียน ผู้เข้าร่วมโครงการวิจัย

ท่านได้รับการเรียนเชิญเพื่อเข้าร่วมโครงการวิจัยในข้างต้น ซึ่งมี นางสาว วิไลวรรณ ปะธิเก นักศึกษาระดับปริญญาเอก โรงเรียนการพยาบาลและการผดุงครรภ์ มหาวิทยาลัยนิวคาสเซิล เป็นผู้ดำเนินการวิจัย โดยการศึกษาวิจัยนี้เป็นส่วนหนึ่งของวิทยานิพนธ์ระดับปริญญาเอก ซึ่งอยู่ภายใต้การกำกับดูแลของ รองศาสตราจารย์แอนโทนี พอล โอไบรอัล และ ดร.ชารอล ฮันเตอร์ ทั้งนี้ผู้วิจัยจะดำเนินการวิจัยในพื้นที่ความรับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพประจำตำบล 4 แห่ง รวมระยะเวลาทั้งสิ้น 3 เดือน โดยประมาณ ดังรายละเอียดที่จะกล่าวต่อไปนี้ ข้าพเจ้าหวังเป็นอย่างยิ่งว่าท่านจะให้ความสนใจ และร่วมเป็นส่วนหนึ่งของโครงการวิจัยในครั้งนี้

ที่มาและความสำคัญ

ในสภาวะการณ์ปัจจุบันที่จำนวนผู้สูงอายุมีอัตราเพิ่มมากขึ้น ซึ่งทำให้ผู้สูงอายุในชนบทที่ได้รับการดูแลจากลูกหลานดังเช่นในอดีตมีสัดส่วนลดน้อยลง เช่น การมีเวลาในการดูแลเอาใจใส่ต่อผู้สูงอายุของลูกหลานมีเวลาน้อยลง รวมถึงหลายครอบครัวมีการอพยพย้ายถิ่นของลูกหลานเข้าสู่เมืองใหญ่เพื่อการประกอบอาชีพ ทั้งนี้การศึกษาในประเทศไทยพบว่า การลดลงของอัตราการดูแลผู้สูงอายุโดยลูกหลานนั้น ส่งผลกระทบโดยตรงต่อสภาวะสุขภาพของผู้สูงอายุ โดยเฉพาะอย่างยิ่งในส่วนของสุขภาพจิต

ในฐานะของพยาบาล ผู้ศึกษาวิจัยจึงมีความสนใจเป็นอย่างยิ่งในการศึกษาว่าผู้สูงอายุในชนบทของไทยมีการจัดการและบริหารชีวิตประจำวัน อันเกี่ยวข้องกับการเผชิญปัญหา วิกฤต หรือความยากลำบากได้อย่างไร รวมถึงพยาบาลชุมชน ผู้ซึ่งมีความใกล้ชิดกับผู้สูงอายุในชนบทสามารถให้ความช่วยเหลือเพื่อการสร้างและการรักษาไว้ซึ่งพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ให้กับผู้สูงอายุได้อย่างไร

ดังนั้นการศึกษาวิจัยในครั้งนี้จึงมีวัตถุประสงค์เพื่อศึกษาพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุในเขตชนบท และความสามารถของพยาบาลชุมชนในการเสริมสร้างพลังสุขภาพจิตดังกล่าว โดยมีจุดมุ่งหมายอันสำคัญเพื่อเข้าใจในหลักแนวคิดและความหมายของพลังสุขภาพจิต หรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุในเขตชนบทของไทย ผ่านการสัมภาษณ์ และสังเกตชีวิตประจำวันของผู้สูงอายุในโรงพยาบาลส่งเสริมสุขภาพประจำตำบล รวมไปถึงสถานที่ในชุมชน อันเป็นสถานที่ที่ผู้สูงอายุใช้เวลาในการทำกิจวัตร หรือกิจกรรมในแต่ละวัน

ผู้เข้าร่วมโครงการวิจัย

การศึกษาวิจัยในครั้งนี้ ผู้เข้าร่วมโครงการวิจัยประกอบด้วย

1) ผู้สูงอายุ ที่มีอายุ 60 ปีขึ้นไป ที่ใช้บริการสุขภาพในโรงพยาบาลส่งเสริมสุขภาพตำบล ซึ่งสามารถสื่อสารทางวาจาได้ ไม่มีความผิดปกติของการรับรู้และตอบสนอง และมีความประสงค์ที่จะเข้าร่วมโครงการวิจัย
2) พยาบาลวิชาชีพ ที่ปฏิบัติงานอยู่ในหน่วยต่างๆ ของโรงพยาบาลส่งเสริมสุขภาพตำบล และมีความประสงค์ที่จะเข้าร่วมโครงการวิจัย

ซึ่งท่าน ได้รับการเรียนเชิญให้เข้าร่วมโครงการวิจัยในครั้งนี้ด้วย

สิทธิในการเข้าร่วมโครงการวิจัย

ท่านสามารถเลือกที่จะร่วมเป็นส่วนหนึ่งของโครงการวิจัยในครั้งนี้หรือไม่ก็ได้ เฉพาะท่านที่ทราบและเข้าใจในรายละเอียดของโครงการอย่างชัดเจน หรือมีการสอบถามข้อสงสัยต่างๆ อันเกี่ยวข้องกับโครงการวิจัย ได้ให้การยินยอม และลงชื่อในเอกสารใบยินยอมเพื่อเข้าร่วมโครงการวิจัยโดยสมัครใจ จึงจะถือว่าท่านได้เข้าร่วมโครงการวิจัยโดยสมบูรณ์ ทั้งนี้ การตัดสินใจที่จะเข้าร่วมหรือไม่นั้น จะไม่มีผลกระทบใดๆ กับตัวท่าน หรือในส่วนงานที่ท่านรับผิดชอบ

หากท่านตัดสินใจที่จะเข้าร่วมโครงการวิจัยในครั้งนี้แล้ว ท่านสามารถขอยกเลิก หรือถอนตัวจากการเข้าร่วมโครงการในครั้งนี้ได้ในทุกเวลาที่ท่านต้องการ รวมถึงท่านสามารถขอยกเลิกข้อมูลที่เกี่ยวข้องกับตัวท่านได้ทั้งหมดด้วย

การเข้าร่วมโครงการวิจัย

หากท่านสมัครใจในการเข้าร่วมโครงการวิจัยในครั้งนี้ ท่านจะได้รับการขอความร่วมมือ ดังต่อไปนี้

1. ให้ข้อมูลการติดต่อตัวท่านกับผู้วิจัย เพื่อนัดหมายเวลา และทำการสัมภาษณ์
2. ท่านจะได้รับการสอบถามข้อมูลพื้นฐาน และตามด้วยการสัมภาษณ์โดยผู้วิจัย ซึ่งการสัมภาษณ์ในครั้งนี้ ผู้วิจัยจะขออนุญาตผู้เข้าร่วมวิจัยในการบันทึกเทปบทสนทนา ถอดเทปเป็นลายลักษณ์อักษร และแปลจากภาษาไทย เป็นภาษาอังกฤษด้วย
3. การสัมภาษณ์แบบหนึ่งต่อหนึ่ง อันประกอบด้วยผู้วิจัยและผู้ร่วมโครงการวิจัย จะดำเนินการในห้องที่เป็นส่วนตัว โดยจะมีการเตรียมห้องไว้ในส่วนของอาคารของโรงพยาบาลส่งเสริมสุขภาพตำบล ทั้งนี้ผู้วิจัยจะใช้ภาษาไทย และภาษาอีสาน ตลอดการสัมภาษณ์
4. หากท่านคือผู้รู้ และมีการให้ข้อมูลที่มีคุณค่าอันเกี่ยวข้องกับหัวข้อการศึกษาในครั้งนี้ ท่านอาจได้รับการเรียนเชิญเพื่อเข้าสัมภาษณ์ในครั้งที่สอง เพื่อให้ข้อมูลอันเป็นประโยชน์เพิ่มเติมแก่ผู้วิจัย

5. ผู้วิจัยจะมีการสังเกต และจดบันทึก อันเกี่ยวข้องกับการปฏิสัมพันธ์ระหว่างผู้สูงอายุและพยาบาลชุมชนในพื้นที่ของโรงพยาบาลส่งเสริมสุขภาพตำบล รวมถึงพื้นที่โดยรอบของชุมชน ในพื้นที่รับผิดชอบของโรงพยาบาลส่งเสริมสุขภาพตำบลนั้นๆ
6. ท่านจะได้รับผลการวิจัยโดยย่อจากผู้วิจัย โดยข้อมูลที่ได้จากการถอดเทปนั้น ผู้วิจัยจะบอกท่านด้วยวาจา และท่านสามารถร้องขอแบบบันทึกที่เป็นลายลักษณ์อักษรที่ได้จากการถอดเทปบทสัมภาษณ์ เพื่อตรวจสอบความถูกต้อง โดยเอกสารดังกล่าวจะไม่มีการระบุชื่อ หรือสิ่งต่างๆ ที่สามารถเชื่อมโยงไปถึงผู้ร่วมโครงการวิจัยในครั้งนี้ได้ ทั้งนี้หลังจากเสร็จสิ้นกระบวนการส่งเล่มวิทยานิพนธ์ของผู้วิจัยแล้ว ผู้วิจัยจะนำผลการวิจัยทั้งหมดรายงานต่อโรงพยาบาลส่งเสริมสุขภาพตำบล รวมถึงการนำเสนอผลการวิจัยต่อผู้สูงอายุ และพยาบาลชุมชนเมื่อผู้วิจัยสำเร็จการศึกษาและเดินทางกลับมายังประเทศไทย ซึ่งผู้วิจัยจะนำผลการวิจัยดังกล่าวรายงานต่อสำนักงานสาธารณสุขจังหวัดร้อยเอ็ดด้วย (โดยผลการวิจัยทั้งหมดจะไม่มีการระบุตัวตัว ชื่อผู้เข้าร่วมวิจัย หรือชื่อหน่วยงาน)

ระยะเวลาในการวิจัย

1. การสัมภาษณ์แบบหนึ่งต่อหนึ่ง จะใช้เวลาประมาณ 60 – 90 นาที
2. ระยะเวลาที่ผู้สูงอายุเข้ารับบริการในโรงพยาบาลส่งเสริมสุขภาพตำบล และระยะเวลาที่พยาบาลชุมชนออกเยี่ยมบ้านผู้สูงอายุ ผู้วิจัยจะสังเกตและจดบันทึกเหตุการณ์ต่างๆ ที่เกิดขึ้นระหว่างวันในโรงพยาบาลส่งเสริมสุขภาพตำบล และเหตุการณ์ต่างๆ ที่เกิดขึ้นระหว่างการเยี่ยมบ้านผู้สูงอายุ

ความเสี่ยง และผลประโยชน์ต่อผู้เข้าร่วมโครงการวิจัย

การศึกษาวิจัยในครั้งนี้ไม่มีความเสี่ยงใดๆ อันจะเกิดขึ้นต่อตัวผู้เข้าร่วมโครงการวิจัย ชื่อ-นามสกุล และที่อยู่ ของผู้เข้าร่วมโครงการวิจัยจะถูกปกปิดในทุกรายงาน หรือสิ่งพิมพ์ต่างๆ โดยผู้เข้าร่วมวิจัยทุกท่านจะได้รับการสมมติชื่อโดยการใช้ตัวอักษรภาษาอังกฤษและตัวเลข ทั้งนี้ข้อมูลที่ได้จากการศึกษาในครั้งนี้จะเป็นประโยชน์ในการส่งเสริมสุขภาพผู้สูงอายุในชนบท รวมไปถึงการพัฒนารูปแบบการดูแลผู้สูงอายุ และนโยบายเพื่อให้ผู้สูงอายุมีสุขภาพที่ดีในอนาคตอีกด้วย

การปกป้องความเป็นส่วนตัวของผู้เข้าร่วมโครงการวิจัย

ข้อมูลทั้งหมดที่สามารถระบุตัวตนของท่านจะไม่ถูกเปิดเผยต่อสาธารณะ และชื่อ – นามสกุลจริงของท่านจะ ไม่ถูกนำไปใช้ในทุกกระบวนการของการวิจัยในครั้งนี้ และหากแม้ว่าผู้วิจัยได้กล่าวถึงท่านเพื่อการเผยแพร่หรือตีพิมพ์ ท่านจะถูกระบุเพียงนามสมมติ ทั้งนี้ชื่อจริงของท่านจะปรากฏอยู่ในเฉพาะเอกสารที่เป็นฐานข้อมูลและสามารถเข้าถึงเอกสารดังกล่าวได้เฉพาะตัวผู้วิจัยและอาจารย์ที่ปรึกษาเท่านั้น โดยการเข้าถึงเอกสารดังกล่าวจะทำเฉพาะเมื่อต้องการเชื่อมโยงข้อมูลเอกสารจากการถอดเทปไปยังตัวตนของบุคคลซึ่งจะระบุด้วยอักษรภาษาอังกฤษและตัวเลขเท่านั้น

ข้อมูลทั้งหมดที่ได้จากการสัมภาษณ์ และการสังเกตุ จะถูกเก็บอย่างปลอดภัยในตู้เก็บเอกสารที่สามารถล็อกได้ รวมไปถึงข้อมูลในคอมพิวเตอร์ทั้งหมดจะถูกเก็บในฮาร์ดไดรฟ์ที่เข้าถึงได้โดยใช้เฉพาะรหัสผ่านของผู้วิจัย

การใช้ข้อมูลจากการศึกษาวิจัย

ข้อมูลทั้งหมดที่ได้จากการศึกษาวิจัยในครั้งนี้จะถูกนำไปรายงานในวิทยานิพนธ์ระดับปริญญาเอก แห่งมหาวิทยาลัยนิวคาสเซิล ภายใต้ชื่อของ นางสาววิไลวรรณ ปะธิเก ทั้งนี้ข้อมูลดังกล่าวยังจะถูกนำไปเผยแพร่เพื่อการแลกเปลี่ยนเรียนรู้ในเชิงวิทยาศาสตร์และสุขภาพด้วย

การเข้าร่วมในโครงการวิจัย

โปรดอ่านและทำความเข้าใจข้อมูลข้างต้นก่อนลงชื่อในเอกสารใบยินยอม หากท่านมีข้อสงสัยหรือคำถาม โปรดซักถามผู้วิจัย ซึ่งผู้วิจัยมีความยินดีเป็นอย่างยิ่งในการอธิบายข้อซักถามของท่าน ได้ในทุกเวลาที่ท่านสะดวก

หากท่านต้องการเข้าร่วมโครงการวิจัยในครั้งนี้ กรุณากรอกข้อมูลของท่านในเอกสารใบยินยอม และติดต่อกับผู้วิจัย เพื่อผู้วิจัยจะได้ติดต่อกลับที่หมายเลขโทรศัพท์ที่ท่านได้ให้ไว้ ในการนัดหมายการสัมภาษณ์ในลำดับต่อไป

ข้อมูลเพิ่มเติม

หากท่านต้องการข้อมูลเพิ่มเติมเกี่ยวกับโครงการวิจัย กรุณาติดต่อ นางสาววิไลวรรณ ปะธิเก หมายเลขโทรศัพท์ 0948370867 ที่อยู่ 15 หมู่ 13 บ้านสวนจิก ตำบลสวนจิก อำเภอศรีสมเด็จ จังหวัดร้อยเอ็ด อีเมลล์ Wilaiwan.Pathike@uon.edu.au หรือท่านสามารถติดต่อโดยตรงได้ที่ รองศาสตราจารย์ แอนโทนี พอล โอไบรอัล, School of Nursing and Midwifery, Faculty of Health and Medicine, The University of Newcastle, Callaghan NSW, Australia 2308 หมายเลขโทรศัพท์ +612 4985 4368 อีเมลล์ Tony.OBrien@newcastle.edu.au

ด้วยความเคารพ
รองศาสตราจารย์แอนโทนี พอล โอไบรอัล
(หัวหน้าโครงการวิจัย)

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นางสาววิไลวรรณ ปะธิเก
นักศึกษาผู้ดำเนินโครงการวิจัย
(ในนามตัวแทนของหัวหน้าโครงการวิจัย)

สมาชิกผู้ดำเนินโครงการวิจัย

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หากท่านมีข้อร้องเรียนอันเกี่ยวข้องกับโครงการวิจัย

โครงการวิจัยนี้ได้รับการอนุมัติโดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล เลขที่อนุมัติ H-2014-0031

หากท่านมีความสงสัยในสิทธิของผู้เข้าร่วมวิจัย หรือผู้วิจัยไม่สุภาพ ท่านสามารถร้องเรียนได้โดยตรงกับผู้วิจัย หรือสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด หมายเลขโทรศัพท์ +6643 511754 หรือที่ คณะกรรมการจริยธรรมการวิจัยในมนุษย์แห่งมหาวิทยาลัยนิวคาสเซิล The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, หมายเลขโทรศัพท์ *(+612) 49216333, อีเมลล์ Human-Ethics@newcastle.edu.au.*

Appendix 21 Consent form (Thai) – for THPH

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล (หัวหน้าโครงการวิจัย)
โรงเรียนการพยาบาลและการผดุงครรภ์
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เอกสารใบยินยอมสำหรับหน่วยงานที่เข้าร่วมโครงการวิจัย

การศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจหลักแนวคิดและความหมายของพลังสุขภาพจิตในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทยในมุมมองของผู้สูงอายุชนบทและพยาบาลชุมชน

(An Ethnographic study to understand the concept of rural Thai elderly resilience:

Rural elderly and community nurses perspectives)

เอกสารฉบับที่ 1 , วันที่ 22 กุมภาพันธ์ 2557

ข้าพเจ้ายินดี และให้ความร่วมมือในโครงการวิจัยนี้ด้วยความสมัครใจ

ข้าพเจ้าเข้าใจในรายละเอียดของโครงการวิจัยนี้ และมีสำเนาเอกสารคำชี้แจงโครงการวิจัยไว้กับตัวของข้าพเจ้า

ข้าพเจ้าเข้าใจว่าผู้วิจัยจะดำเนินการวิจัยการสัมภาษณ์อาสาสมัครแบบหนึ่งต่อหนึ่ง และสังเกตการปฏิสัมพันธ์ของพยาบาลชุมช และผู้สูงอายุในโรงพยาบาลส่งเสริมสุขภาพตำบล รวมถึงการสังเกต และจดบันทึกกิจกรรมต่างๆ ในพื้นที่ชุมชนโดยรอบ ได้แก่ วัด ศูนย์ผู้สูงอายุ ร้านค้า ตลาด หรือสถานที่อื่นๆ ซึ่งเป็นสถานที่ที่ผู้สูงอายุอยู่รวมกันเพื่อทำกิจกรรม

ข้าพเจ้าเข้าใจว่าผู้วิจัยจะไม่เข้าถึงที่พักอาศัยของอาสาสมัครเพียงลำพัง โดยจะเข้าถึงพื้นที่ดังกล่าวภายใต้การกำกับดูแลของพยาบาลวิชาชีพที่ปฏิบัติงานอยู่ในพื้นที่วิจัยเท่านั้น

ข้าพเจ้าเข้าใจว่าผู้วิจัยอาจมีการบันทึกภาพสถานที่ที่ทำการศึกษาวิจัย เพื่อใช้ในการประกอบการอธิบายถึงสิ่งแวดล้อมทางวัฒนธรรม

ข้าพเจ้ายินยอม (โปรดทำเครื่องหมาย ✓ ในช่องด้านล่าง)

- ○ เปิดเผยข้อมูลประชากรผู้สูงอายุ ในพื้นที่รับผิดชอบเพื่อให้ผู้วิจัยได้ทำการศึกษา
- ○ ยินดีให้มีการสังเกต และจดบันทึกการปฏิสัมพันธ์ระหว่างที่ผู้สูงอายุ และพยาบาลวิชาชีพที่ปฏิบัติงานอยู่ใน รพ.สต. ในช่วงเวลาทำการของ รพ.สต. และการเยี่ยมบ้านผู้สูงอายุ
- ○ ข้อมูลที่มีการบันทึกทั้งหมดของหน่วยงาน ข้าพเจ้ายินดีให้มีการทำสำเนา และแปลจากภาษาไทยเป็นภาษาอังกฤษ
- ○ ข้าพเจ้ายินดีให้ผู้วิจัยทำการถ่ายภาพของ รพ.สต. หากผู้วิจัยร้องขอ
- ○ ข้าพเจ้ายินดีให้มีการเผยแพร่ผลการวิจัยในครั้งนี้ ในวิทยานิพนธ์ วารสารวิชาการ รายงาน และการสัมมนาวิชาการต่างๆ

ชื่อ –นามสกุล .....
ในนามตัวแทนของ .....
ลายมือชื่อ..... วันที่ .....
ที่อยู่ .....
หมายเลขโทรศัพท์ .....

สมาชิกผู้ดำเนินโครงการวิจัย

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หมายเลขโทรศัพท์: +61478733839 (ประเทศออสเตรเลีย), +66948370867 (ประเทศไทย)
อีเมลล์: Wilaiwan.Pathike@uon.edu.au

หากท่านมีข้อร้องเรียนอันเกี่ยวข้องกับโครงการวิจัย

โครงการวิจัยนี้ได้รับการอนุมัติโดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล เลขที่อนุมัติ H-2014-0031

หากท่านมีความสงสัยในสิทธิของผู้เข้าร่วมวิจัย หรือผู้วิจัยไม่สุภาพ ท่านสามารถร้องเรียนได้โดยตรงกับผู้วิจัย หรือสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด หมายเลขโทรศัพท์ +6643 511754 *หรือที่ คณะกรรมการจริยธรรมการวิจัยในมนุษย์แห่งมหาวิทยาลัยนิวคาสเซิล The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, หมายเลขโทรศัพท์ (+612) 49216333,* อีเมลล์ *Human-Ethics@newcastle.edu.au.*

Appendix 22 Consent form (Thai) – for elderly

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล (หัวหน้าโครงการวิจัย)
โรงเรียนการพยาบาลและการผดุงครรภ์
คณะการแพทย์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล
คอลลาฮาน รัฐนิวเซาท์เวล ออสเตรเลีย 2308
หมายเลขโทรศัพท์ +612 4985 4368
หมายเลขโทรศัพท์มือถือ +61448 941 943
อีเมลล์ Tony.OBrien@newcastle.edu.au

เอกสารใบยินยอมสำหรับผู้เข้าร่วมโครงการวิจัย (ผู้สูงอายุ):

การศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจหลักแนวคิดและความหมายของพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทย
ในมุมมองของผู้สูงอายุในเขตชนบทและพยาบาลชุมชน

(An Ethnographic study to understand the concept of rural Thai elderly resilience:
Rural elderly and community nurses perspectives)

เอกสารฉบับที่ 5 , วันที่ 21 กุมภาพันธ์ 2557

ข้าพเจ้าสมัครใจและยินดีเข้าร่วมในโครงการวิจัยนี้

ข้าพเจ้าเข้าใจในรายละเอียดของโครงการวิจัยนี้ และมีสำเนาเอกสารคำชี้แจงโครงการวิจัยไว้กับตัวของข้าพเจ้า

ข้าพเจ้าเข้าใจว่าข้าพเจ้ามีสิทธิ์ในการขอยกเลิกการร่วมโครงการวิจัยในทุกเวลา และไม่จำเป็นต้องให้เหตุผลของการยกเลิกดังกล่าว

ข้าพเจ้ามั่นใจว่าข้อมูลส่วนตัวของข้าพเจ้าจะถูปิดเป็นความลับ

ข้าพเจ้ามีสิทธิในการร้องขอเอกสารที่บันทึกบทสนทนา ทั้งในระหว่างหรือหลังการให้สัมภาษณ์ เพื่อตรวจสอบความถูกต้องของข้อมูล

ข้าพเจ้าสามารถสอบถามข้อสงสัยในประเด็นต่างๆ กับผู้วิจัย

การให้สัมภาษณ์ของข้าพเจ้าสามารถหยุดได้อันเนื่องมาจากข้อจำกัดทางด้านสุขภาพร่างกาย หรือความโศกเศร้าเสียใจ โดยข้าพเจ้ายินดีให้การสัมภาษณ์ต่อ โดยจะนัดหมายวัน เวลา กับผู้วิจัยอีกครั้ง

ข้าพเจ้าเข้าใจในกระบวนการวิจัยว่าผู้วิจัยจะทำการสังเกต และจดบันทึกในระหว่างที่ข้าพเจ้ามารับบริการด้านสุขภาพ หรือมีปฏิสัมพันธ์ต่างๆ ที่เกิดขึ้นในบริเวณพื้นที่ของโรงพยาบาลส่งเสริมสุขภาพตำบล

ข้าพเจ้ายินยอม (โปรดทำเครื่องหมาย ✓ ในช่องด้านล่าง)

- ○ เปิดเผยข้อมูลส่วนตัวและให้สัมภาษณ์แบบหนึ่งต่อหนึ่งแก่ผู้วิจัย รวมถึงอนุญาตให้มีการบันทึกเทปบทสนทนาได้
- ○ ข้าพเจ้ายินดีให้สัมภาษณ์เป็นครั้งที่สอง หากการสัมภาษณ์ครั้งนี้มีการยุติลง อันเนื่องมาจากข้าพเจ้าไม่สามารถให้สัมภาษณ์ต่อได้ รวมถึงหากผู้วิจัยร้องขอให้ข้าพเจ้าให้สัมภาษณ์อีกครั้ง
- ○ ข้อมูลที่มีการบันทึกทั้งหมดของข้าพเจ้า ข้าพเจ้ายินดีให้มีการทำสำเนา และแปลจากภาษาไทยเป็นภาษาอังกฤษ
- ○ ข้าพเจ้ายินดีให้ผู้วิจัยทำการสังเกต และจดบันทึกกิจกรรมต่างๆ ของข้าพเจ้าที่เกิดขึ้นในโรงพยาบาลส่งเสริมสุขภาพตำบล
- ○ ข้าพเจ้ายินดีให้มีการเผยแพร่ผลการวิจัยในครั้งนี้ ในวิทยานิพนธ์ วารสารวิชาการ รายงาน และการสัมมนาวิชาการต่างๆ

ชื่อ -นามสกุล: ……..

ลายมือชื่อ: ……..... **วันที่:** ……

ที่อยู่: ……..

หมายเลขโทรศัพท์ติดต่อ: ……..

สมาชิกในครอบครัว

ลายมือชื่อ: ..... **วันที่:** .....

ที่อยู่:.....

หมายเลขโทรศัพท์ติดต่อ:.....

ลายนิ้วมือ

สมาชิกผู้ดำเนินโครงการวิจัย

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อีเมลล์: Wilaiwan.Pathike@uon.edu.au

หากท่านมีข้อร้องเรียนอันเกี่ยวข้องกับโครงการวิจัย

โครงการวิจัยนี้ได้รับการอนุมัติโดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล เลขที่อนุมัติ H-2014-0031

หากท่านมีความสงสัยในสิทธิของผู้เข้าร่วมวิจัย หรือผู้วิจัยไม่สุภาพ ท่านสามารถร้องเรียนได้โดยตรงกับผู้วิจัย หรือสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด หมายเลขโทรศัพท์ +6643 511754 หรือที่ คณะกรรมการจริยธรรมการวิจัยในมนุษย์แห่งมหาวิทยาลัยนิวคาสเซิล The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, หมายเลขโทรศัพท์ (+612) 49216333, อีเมลล์ Human-Ethics@newcastle.edu.au.

Appendix 23 Consent form (Thai) – for community nurse

รองศาสตราจารย์แอนโทนี พอล โอไบรอัล (หัวหน้าโครงการวิจัย)
โรงเรียนการพยาบาลและการผดุงครรภ์
คณะการแพทย์และสุขภาพ มหาวิทยาลัยนิวคาสเซิล
คอลลาฮาน รัฐนิวเซาท์เวล ออสเตรเลีย 2308
หมายเลขโทรศัพท์ +612 4985 4368
หมายเลขโทรศัพท์มือถือ +61448 941 943
อีเมลล์ Tony.OBrien@newcastle.edu.au

เอกสารใบยินยอมสำหรับผู้เข้าร่วมโครงการวิจัย (พยาบาลชุมชน):

การศึกษาเชิงชาติพันธุ์วรรณา เพื่อเข้าใจหลักแนวคิดและความหมายของพลังสุขภาพจิตหรือความสามารถในการยืนหยัดเผชิญวิกฤต ในผู้สูงอายุที่อาศัยอยู่ในพื้นที่ชนบทของประเทศไทย
ในมุมมองของผู้สูงอายุในเขตชนบทและพยาบาลชุมชน

(An Ethnographic study to understand the concept of rural Thai elderly resilience:
Rural elderly and community nurses perspectives)

เอกสารฉบับที่ 5 , วันที่ 21 กุมภาพันธ์ 2557

ข้าพเจ้าสมัครใจและยินดีเข้าร่วมในโครงการวิจัยนี้

ข้าพเจ้าเข้าใจในรายละเอียดของโครงการวิจัยนี้ และมีสำเนาเอกสารคำชี้แจงโครงการวิจัยไว้กับตัวของข้าพเจ้า

ข้าพเจ้าเข้าใจว่าข้าพเจ้ามีสิทธิ์ในการขอยกเลิกการร่วมโครงการวิจัยในทุกเวลา โดยไม่จำเป็นต้องแจ้งเหตุผลของการยกเลิกดังกล่าว

ข้าพเจ้ามั่นใจว่าข้อมูลส่วนตัวของข้าพเจ้าจะถูกปิดเป็นความลับ

ข้าพเจ้าเข้าใจว่าผู้วิจัยอาจร้องขอเพื่อให้ข้าพเจ้าให้สัมภาษณ์เพื่อให้ข้อมูลเพิ่มเติมเป็นครั้งที่สอง

ข้าพเจ้ามีสิทธิในการร้องขอเอกสารที่บันทึกบทสนทนา ทั้งในระหว่างหรือหลังการให้สัมภาษณ์ เพื่อตรวจสอบความถูกต้อง แก้ไข หรือลบข้อมูล

ข้าพเจ้าสามารถสอบถามข้อสงสัยในประเด็นต่างๆ กับผู้วิจัยได้

ข้าพเจ้ายินยอม (โปรดทำเครื่องหมาย ✓ ในช่องด้านล่าง)

- ○ เปิดเผยข้อมูลส่วนตัวและให้สัมภาษณ์แบบหนึ่งต่อหนึ่งแก่ผู้วิจัย รวมถึงอนุญาตให้มีการบันทึกเทปบทสนทนาได้
- ○ ข้าพเจ้ายินดีให้สัมภาษณ์เป็นครั้งที่สอง หากผู้วิจัยร้องขอ
- ○ ข้อมูลที่มีการบันทึกทั้งหมดของข้าพเจ้า ข้าพเจ้ายินดีให้มีการทำสำเนา และแปลจากภาษาไทยเป็นภาษาอังกฤษ
- ○ ข้าพเจ้ายินดีให้ผู้วิจัยทำการสังเกต และจดบันทึกกิจกรรมต่างๆ ของข้าพเจ้าที่เกิดขึ้นในโรงพยาบาลส่งเสริมสุขภาพตำบล
- ○ ข้าพเจ้ายินดีให้มีการเผยแพร่ผลการวิจัยในครั้งนี้ ในวิทยานิพนธ์ วารสารวิชาการ รายงาน และการสัมมนาวิชาการต่างๆ

ชื่อ -นามสกุล: ……..
ลายมือชื่อ: ……..... **วันที่:** ……
ที่อยู่: …….....

สมาชิกผู้ดำเนินโครงการวิจัย

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หากท่านมีข้อร้องเรียนอันเกี่ยวข้องกับโครงการวิจัย

โครงการวิจัยนี้ได้รับการอนุมัติโดยคณะกรรมการจริยธรรมการวิจัยในมนุษย์ แห่งมหาวิทยาลัยนิวคาสเซิล เลขที่อนุมัติ H-2014-0031

หากท่านมีความสงสัยในสิทธิของผู้เข้าร่วมวิจัย หรือผู้วิจัยไม่สุภาพ ท่านสามารถร้องเรียนได้โดยตรงกับผู้วิจัย หรือสำนักงานสาธารณสุขจังหวัดร้อยเอ็ด หมายเลขโทรศัพท์ +6643 511754 หรือที่ คณะกรรมการจริยธรรมการวิจัยในมนุษย์แห่งมหาวิทยาลัยนิวคาสเซิล The Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, หมายเลขโทรศัพท์ *(+612) 49216333, อีเมลล์ Human-Ethics@newcastle.edu.au.*

Appendix 24 The Thank you letter

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Thank you letter

June 5, 2014

Associate Professor Anthony Paul O'Brien

School of Nursing and Midwifery,

Faculty of Health and Medicine

The University of Newcastle,

Callaghan NSW, Australia 2308

Dear Sura Wisedsak MD, Head of Roiet Provincial Public Health Office
and passed to head of Tambon Health Promotion Hospitals of
Saun Chik, Nong Yai, Mueang Plueai and Ban Bak.

On behalf of the University of Newcastle, School of Nursing and Midwifery, Faculty of Health and Medicine, my colleague Dr. Sharyn Hunter and I both personally thank you for support of our PhD student Wilaiwan Pathike in choosing to be involved in the PhD project – 'An Ethnographic study to understand the concept of rural Thai elderly resilience: Rural elderly and community nurses' perspectives'.

It is our hope that the results of her PhD research project once transferred into clinical practice will deepen the understanding of resilience in the elderly, and lead to better health outcomes for older people.

Thank you for your contribution to this overall process.

Yours sincerely,

Associate Professor Anthony O'Brien (Chief investigator)

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