CHAPTER 4

Results and Discussion

This chapter shows the results of data analysis and the study findings discussion. The results of data analysis are demonstrated in four parts: (1) the demographic characteristics of the sample, and the demographic and clinical characteristic of a critically ill child; (2) the descriptive characteristics of the study variables; (3) the relationships among five selected factors (the child's behavioral and emotional responses, sense of coherence, coping, religious belief, and social support) and psychological well-being; (4) the predictability of the child's behavioral and emotional responses, sense of coherence, coping, religious belief, and social support on psychological well-being. The discussion of the study findings are on the psychological well-being level, correlational level, and factors predicting psychological well-being among parents of a critically ill child in the PICU.

Results of the Study

Demographic Characteristics of the Sample

The sample of the present study consisted of 100 parents of a critically ill child recruited from five PICUs of five tertiary hospitals. The findings presented that the majority of the participants in the present study were mothers (79.00%) and married (82.00%). Mean parental age was 33.01 (SD = 7.85) with a range of 18 to 56 years of age. Nearly half of participants (46.00%) graduated from secondary school and 23.00% of participants were primary school graduates. Twenty-seven participants (27.00%) were laborers and 24.00% were housewives. The majority of the participants (48.00%) had monthly family income of less than 10,000 baht. With regard to the characteristics of the family, 41.00% of participants had two children under their responsibility (including the critically ill child). Seventy-six participants (76.00%) did not have prior experience in caring for a hospitalized child in PICU and 86.00% of them perceived the severity of child's illness as severe. At the time of data collection, the most frequent

number of days of child's hospitalization in PICU was 3 to 4 days (37.00%) (see Table 4.1).

Table 4.1

Demographic Characteristics of the Sample (n=100)

Demographic Characteristics	Frequency	%
Relationship with a child		
Father	21	21.00
Mother	79	79.00
Age (years) Range 18-56 years	21	
(mean = 33.49 years, SD =7.95 years)	23.	
≤ 20.00	2	2.00
20.01-30.00	37	37.00
30.01-40.00	38	38.00
40.01-50.00	22	22.00
50.01-60.00	1	1.00
Marital status	() 3	
Married	82	82.00
Widowed/ Divorced/ Separated	18	18.00
Educational background	RSI	
Primary school	23	23.00
Secondary school	46	46.00
Diploma degree	81980	9.00
Bachelor's degree	20	20.00
Master's degree	2	2.00
Occupation	SCIV	eu
Housewife	24	24.00
Laborer	27	27.00
Merchant/ Business	19	19.00
Agriculture	16	16.00
Employed	7	7.00
Government official	7	7.00

Table 4.1 (continued)

Demographic Characteristics	Frequency	%				
Family income (baht per month)						
\leq 10,000	48	48.00				
10,001-30,000	40	40.00				
> 30,000	12	12.00				
Number of children (including critically ill child)						
1	38	38.00				
2 3812126	41	41.00				
3	18	18.00				
>3	.391	3.00				
Prior experience in caring for a hospitalized child	13					
in PICU	212					
Yes	24	24.00				
No 200	76	76.00				
Perceived severity of child's illness	4					
Severe	86	86.00				
Moderate	14	14.00				
Low	0	0.00				
Day of child's PICU hospitalization	20/					
at the time of data collection						
Range 2-16 days	าเรียงใ	lan i				
(mean = 5.11 days, SD = 3.89 days)						
2 Copyright [©] by Chiang M	lai 28 nive	28.00				
3-4 All rights re	S 37 r v	37.00				
5-7	15	15.00				
> 7	20	20.00				

Note. Average monthly household income of Thai people in 2015 = 26,915 baht/month. From National Statistical Office, 2015

Demographic Characteristics of the Critically Ill Child

For demographic characteristics of critically ill child, just over half of children were boys (56.00%) and the age of children ranged from 1 month to 14.10 years (Mean = 4.10 years, SD = 4.80 years). Thirty-eight children (38.00%) were infants and 22.00% were toddlers. Most children (70.00%) were not attending school and 18.00% of them were in primary school (see Table 4.2).

01691

Table 4.2

Demographic Characteristics	Frequency	%
Gender	1.21	
Boy	56	56.00
Girl	44	44.00
Age (Range 1 month-14.10 years)	58	3
(mean = 4.10 years, SD = 4.80 years)		
Infant (1-12.00 months)	38	38.00
Toddler (1.01-3.00 years)	22	22.00
Pre-school (3.01-6.00 years)	8	8.00
School (6.01-12.00 years)	20	20.00
Adolescence (12.01-15.00 years)	12	12.00
Educational background		o •
Not attending school	8 70 8 0	70.00
Pre-school	Aai ⁵ Inive	5.00
Primary school	18	18.00
Secondary school	serv	7.00

Demographic Characteristics of the Critically Ill Child (n=100)

Clinical Characteristics of the Critically Ill Child

With regard to the clinical characteristics of critically ill child, the most common problems for PICU admission were respiratory problems that required respiratory support (46.00%), post-operative complications that required close observation and

monitoring (14.00%), and sepsis and septic shock (12.00%). With regard to medical procedure and medicine received, most of the children had mechanical ventilatory support (77.00%), central line catheter insertion (52.00%), and Foley's catheter insertion (51.00%). Moreover, most of the children were given antibiotics (91.00%), bronchodilators (63.00%), and sedatives (55.00%). In addition, 76.00% of them were admitted to PICU for the first time (see Table 4.3).

Table 4.3

Clinical Characteristics	Frequency	%
Problems for PICU admission	10400	
Respiratory problems	46	46.00
Post-operative complication	14 3	14.00
Sepsis and septic shock	12	12.00
Cardiovascular problems	10 - 50	10.00
Neurological problems	10	10.00
Hemato-oncology problems	2 6	2.00
Renal problems	2	2.00
Other (Dengue shock syndrome,	Z & //	
near drowning)	RS 2	2.00
Gastrointestinal problems	1	1.00
Endocrine/Metabolic problems	1	1.00
Medical procedure received	ัยเชียง	เหม
Mechanical ventilatory support	Mai ⁷⁷ Inive	77.00
Central line catheter insertion	52	52.00
Foley's catheter insertion	51	51.00
Continuous renal replacement therapy	4	4.00
Medication received		
Antibiotic drugs	91	91.00
Bronchodilator drugs	63	63.00
Sedative drugs	55	55.00
Analgesic drugs	32	32.00

Clinical Characteristics of the Critically Ill Child (n=100)

Clinical Characteristics	Frequency	%
Number of PICU admission		
1	76	76.00
2	13	13.00
3	7	7.00
> 3	4	4.00

Descriptions of the Study Variables

The study variables, including the child's behavioral and emotional responses, sense of coherence, coping, religious belief, social support, and psychological wellbeing are described as follows.

Scores of the child's behavioral and emotional responses, sense of coherence, coping, and psychological well-being were at a moderate level with the mean of 29.58 (SD = 8.60), 56.64 (SD =11.61), 104.23 (SD = 15.51), and 63.08 (SD = 15.41) respectively. The scores of religious belief and social support were high with the mean of 77.78 (SD = 10.65) and 62.55 (SD = 11.90) (see Table 4.4).

Table 4.4

Possible	Actual	Moon	SD	Laval	
Score	Score	Mean	BOLU	Level	
by C	hiang	Maill	nivorci	fra.	
0-50	7-48	29.58	8.60	Moderate	
13-91	30-85	56.64	11.61	Moderate	
36-180	69-136	104.23	15.51	Moderate	
18-90	53-90	77.78	10.65	High	
0-84	36-84	62.55	11.90	High	
0-110	29-100	63.08	15.41	Moderate	
	Possible Score 0-50 13-91 36-180 18-90 0-84 0-110	Possible Actual Score Score 0-50 7-48 13-91 30-85 36-180 69-136 18-90 53-90 0-84 36-84 0-110 29-100	Possible Actual Mean Score Score Mean 0-50 7-48 29.58 13-91 30-85 56.64 36-180 69-136 104.23 18-90 53-90 77.78 0-84 36-84 62.55 0-110 29-100 63.08	Possible Actual Mean SD Score Score Mean SD 0-50 7-48 29.58 8.60 13-91 30-85 56.64 11.61 36-180 69-136 104.23 15.51 18-90 53-90 77.78 10.65 0-84 36-84 62.55 11.90 0-110 29-100 63.08 15.41	

Table 4.4	CAL	PST
Range, Mean,	Standard Deviation of Study	Variables ($n = 100$

When classifying all variables into levels of low, moderate, and high, the highest percentage of participants had a moderate level of the child's behavioral and emotional responses (63.00%), sense of coherence (72.00%), and coping (86.00%), while the highest percentage of participants had high level of religious belief (83.00%) and social support (69.00%). Finally, the highest percentage of participants had a low level of the psychological well-being (44.00%) (see Table 4.5).

Table 4.5

The Level of Study Variables (n = 100)

Variables	Low	Moderate	High	
, unidores	n (%)	n (%)	n (%)	
The child's behavioral and	Alor	2/2		
emotional responses	4 (4.00%)	63 (63.00%)	33 (33.00%)	
Sense of coherence	6 (6.00%)	72 (72.00%)	22 (22.00%)	
Coping	13 (13.00%)	86 (86.00%)	1 (1.00%)	
Religious belief	Cartan and	17 (17.00%)	83 (83.00%)	
Social support	and all	31 (31.00%)	69 (69.00%)	
Psychological well-being	44 (44.00%)	30 (30.00%)	26 (26.00%)	

Relationships Among Study Variables

With regard to the correlation among the study variables, Pearson's product moment correlation analysis was performed to examine the correlation between three variables – the child's behavioral and emotional responses, sense of coherence, social support, and psychological well-being. Meanwhile, Spearman's rank correlation analysis was used to determine the correlation between two variables: coping, religious belief, and psychological well-being. The findings demonstrated that the child's behavioral and emotional responses had a low and negative relationship with psychological well-being (r = -.20, p < .05). Sense of coherence, social support, and religious belief had a moderate and positive relationship with psychological well-being (r = .42, .36, $r_s = .27$, p < .01 respectively), while coping had a low and positive relationship with psychological well-being ($r_s = .20$, p < .05) (see Table 4.6).

Table 4.6

Variables	r	p-value
The child's behavioral and emotional responses	20	.03
Sense of coherence	.42	.00
Coping	$.20^{a}$.02
Religious belief	.27 ^a	.01
Social support	.36	.00

Relationships between Selected Factors and Psychological Well-being of Parents

Note. a =Spearman's rank correlation analysis (r_s)

Predictors of Psychological Well-being

Prior to conducting a hierarchical multiple regression, four assumptions of this analysis were tested. Each study variable was tested for normality using the Kolmogorov-Smirnov Test. The results revealed that distributions of the scores for two study variables, religious belief and coping, were not normal. Rank-based inverse normal transformation (INT) using the Blom's formula was applied on religious belief and coping to improve the normality. From the transformation, the normality of religious belief and coping was achieved. Other assumptions of linearity, multicollinearity, and homoscedasticity were all satisfied.

2/02/2

The hierarchical multiple regression was conducted to analyze the predictors of psychological well-being among parents of a critically ill child. Three sets of independent variables, which consisted of 1) the background and context of stress, including religious belief, 2) the stressors including the child's behavioral and emotional responses, and 3) the moderating resources including sense of coherence, coping, and social support, were entered into the model consequently in a series of steps. The findings revealed that religious belief that was entered in the first step could predict psychological well-being ($\beta = .32$, p < .01) which accounted for 10.00% of the variance of the total score of psychological well-being (F change = 11.35, p < .01). In the second step, the stressor variables were entered into the model. The results showed that only the child's behavioral and emotional responses could explain 7.00% of the variance of the total score of psychological well-being. Therefore, the background and context of stress

and the stressors altogether could explain 17.00% of the variance of the total score of psychological well-being (F change = 7.70, p < .01). Religious belief and the child's deviated behaviors were the predictors of psychological well-being (β = .37; -.26, p < .01).

In the third step, the moderating resources, including sense of coherence, coping, and social support, were entered into the model. The findings revealed that the moderating resources, including sense of coherence, coping, and social support, could explain 19.00% of the variance of the total score of psychological well-being. The background and context of stress, the stressors, and the moderating resources altogether accounted for 36.00% of the variance of the total score of psychological well-being (F change = 9.53, p < .01). Religious belief (β = .29, p < .01) was a predictor of the background and context of stress whereas the child's behavioral and emotional responses (β = -.24, p < .01) were a predictor of the stressors. Sense of coherence (β = .27, p < .01), social support (β = .22, p < .05), and coping (β = .17, p < .05) were the strongest predictors of the set of the moderating resources. These variables could predict psychological well-being among parents of a critically ill child in the PICU (see Table 4.7).

ลิ<mark>ขสิทธิ์มหาวิทยาลัยเชียงใหม่</mark> Copyright[©] by Chiang Mai University All rights reserved

Table 4.7

The Hierarchical Multiple Regression Analysis for Variables Predicting Psychological Well-being (n = 100)

Variables]	Model 1 Model 2			Model 3		3		
variables	В	SEB	β	В	SEB	β	В	SEB	β
Religious belief	5.19	1.54	.32**	5.94	1.51	.37**	4.59	1.37	.29**
The child's		1		1 01 9	12				
behavioral and		10	1/2	101	<i>i</i> bli	91			
emotional	// .	N	~	0,0	0	22	lan		
responses	1/2	$\sum /$	5	47	.17	26**	43	.15	24**
Sense of	a	11	1	(B)	1	>	3		
coherence			(5		8		.36	.11	.27**
Coping	部		2	a fl	y h		2.69	1.31	.17*
Social support	101			TY			.29	.11	.22*
R^2	12	.10		(Y	.17	(/	04	.36	
R ² change	1E	.10		111	.07	٩/ ١	2/	.19	
SEE	11.	14.66	-	663	14.19		~//	12.62	
F change		11.35*	** A T	TTNT	7.70**	RSY	//	9.53	**
<i>Note</i> . *p < .05; **	• p < .01			UN	IVL				

ลิขสิทธิ์มหาวิทยาลัยเชียงใหม่ Copyright[©] by Chiang Mai University All rights reserved

Discussion of the Study

The correlational study was conducted to answer the research questions and research hypotheses regarding the level of psychological well-being among parents of a critically ill child in the PICU, the relationships between the child's behavioral and emotional responses, sense of coherence, coping, religious belief, social support, and psychological well-being, and their abilities to predict psychological well-being among parents of a critically ill child in the PICU.

The Level of Psychological Well-being Among Parents of a Critically Ill Child in the PICU

The findings of the present study revealed that the psychological well-being among parents of a critically ill child was at a moderate level ($\overline{x} = 63.08$, SD = 15.41). It indicated that those parents had moderate distress while their children were admitted in PICU.

The finding of the present study showed that the parents' psychological wellbeing was moderate. Obviously, hospitalization of a child to the PICU is a lifethreatening condition and a stressful situation for both the child and his/her family. Being hospitalized often occurred suddenly due to serious physical condition (Eberly et al., 1985; Lewandoski, 1992). Nearly half of the critically ill children (49.00%) in the present study were the first child in their family and 38.00% were infants who were so vulnerable to worsening. The child's condition therefore caused stress to the parents. Moreover, when the critically ill children were admitted to the critical care setting, the parents were confronted with unfamiliar PICU environment such as high technology equipment, continuous monitor, lights all day and all night, and the medical treatment procedures done to their child to save life (Aldridge, 2005; Carter et al., 1985). Moreover, they might feel uncertain about the outcome of treatment. In the present study, most of the children had mechanical ventilator support (77.00%) and central line catheter insertion (52.00%). When seeing their child connected to tubes and a lot of medical equipment in PICU, some parents might have difficulty understanding and accepting it. They would appraise this situation as unfamiliar, uncertain, unpredictable, and uncontrollable that was a threat or harmful. All of these could originate emotional imbalance in parents and threaten their psychological well-being. Considering the parents' characteristics in the present study that might affect their psychological well-being, 76.00% of the parents had no experience in having a critically ill child in PICU and 86.00% of them perceived the child's illness as severe. Parents with no previous PICU experience showed more feeling of fear and uncertainty about their child's prognosis than parents with previous PICU experience (Kumar & Avabratha, 2015). Those parents were often aware of the fact that these children were at a high risk of death. The negative psychological states of parents during PICU admission obviously threatened their psychological well-being.

Compared with a previous study, the study of Vrolan (1992) showed that three quarters of parents with a critically ill child (75.00%) had psychological well-being at a low level. The present study showed a small number of parents (44.00%) who had a low level of psychological well-being, which could be explained by preparation for a PICU admission using family-centered care (FCC) concept. The finding revealed a better condition of parents currently compared to that studied eight years ago which was the time when the previous study was conducted. At all hospitals in the present study, FCC was adopted in the policy for pediatric care, and was introduced at Ramathibodi Hospital in 1998. The core concepts of FCC, including dignity and respect, information sharing, participation, and collaboration (Institute for Patient- and Family-Centered Care, 2017) were implemented into daily care activity. According to a study of Cutis, Foster, Mitchell, and Van (2016), an integrative review showed that the core elements of FCC were implemented in many models of care to reduce parental stress, anxiety, and negative mood, and to increase confidence in parental role. Each model of care involved one or two elements of FCC, such as providing parental education with written and verbal information (Melnyk et al., 2007), providing parental education, shared care and mutual participation interventions (Curley & Wallace, 1992; Hughes, 2007; Keatinge & Gilmore, 1996), and involving parental participation in ward rounds (Kuo, Sisterhen, Sigrrest, Biazo, Aitken, & Smith, 2012; Selts, Zimmer, Ochoa-Nunez, Rustici, Brynt, & Fox, 2011; Uhl, Fisher, Docherty, & Brandon, 2013; Walker-Vischer, Hill, & Mendez, 2015). However, due to some limitation, not all concepts of care were completely implemented at all the hospitals in the present study, while others were minimally used. Information sharing, and facilitating family participation were reported to be effective in reducing parental stress and anxiety in some Thai studies (Damrongrak, Prasopkittikun, Tilokskulchai, & Ngerncham, 2012; Kuntaros, Wichiencharoen, Prasopkittikun, & Staworn, 2007; Senawong, 2007). Therefore, due to effect of FCC implementation, a smaller number of parents in the present study had low psychological well-being than before.

Interestingly, some parents (26.00%) showed high psychological well-being. This might be due to strong religious belief among these parents. Religious belief was found to play an important role in parents facing the crisis situations. In Buddhism, the focus is on the use of individual's wisdom to achieve the truth of nature and eliminate suffering (Payutto, 2003). Koenig (2007) mentioned that the emotional suffering caused by loss or change may be diminished through religious beliefs or practices. Another reason may be adequacy of social support. McCubbin, McCubbin, and Thompson (1996) proposed that social support was a buffer against family crisis factor or a mediator of family stresses. In the present study, 26.00% of parents had high social support; therefore, their psychological well-being was high.

The Relationships between Selected Factors and Psychological Well-being Among Parents of a Critically III Child in the PICU

The findings revealed the relationship between the child's behavioral and emotional responses, sense of coherence, coping, religious belief, and social support and psychological well-being that support the hypotheses and conceptual framework.

The child's behavioral and emotional responses had a slightly low negative relationship with psychological well-being. According to Pearlin and colleagues (1990), the child's behavioral and emotional responses were one of the greatest stressors for parents in the PICU. When the child manifested more uncomfortable behavior, their parents expressed more negative feeling. The critically ill infant and children in the critical setting often showed crying, frightening, anger, sadness, restless, confusion, rebellion, whining, demanding behavior, uncooperative behavior, and inability to talk (Miles & Carter, 1982). Most parents expressed the highest level of stress from not knowing how to help their child, seeing their child frightened or in pain, and not being able to be with their crying

child. Parents might be frightened by some of the behaviors their child displayed (Jones, 2015; Seideman et al., 1997). In the past, the negative aspects of psychological state were focused in several prior studies, especially stress, anxiety and depression that were related to the critical care setting. The finding was consistent with a previous study done in Gallegos (2010) that found a high positive relationship between the child's behavioral and emotional responses. Thus, the child's behavioral and emotional responses might affect the psychological well-being of parents.

Sense of coherence (SOC) was found to have a moderately positive relationship with psychological well-being. SOC in the SPM is an internal resource with which persons are able to understand the child's illness situations and can use to cope with stress (Wheaton, 2010). The persons with a strong SOC are more likely to judge a stressful situation as controllable. SOC can help persons in choosing the available resources and behaviors to cope with many stressors in their lives (Antonovsky, 1987). The finding was consistent with a study of Forsberg-Warleby and colleagues (2002), which showed that SOC had a positive relationship with psychological well-being in a sample of 83 spouses of stroke victims. According to Antonovsky (1987), SOC is often considered to be a stable entity that is developed initially in childhood and early adulthood, stabilizing in adulthood (around the age of 30). Thus, the parents with a strong sense of coherence are more likely to judge a stressful situation or a seriously ill child in the PICU as predictable, controllable, and meaningful. Moreover, the parents with a strong SOC might perceive this situation as a challenge, and they might understand what has happened to their child. It could be concluded that sense of coherence (SOC) was positively correlated with psychological well-being of parents.

Coping is another variable that showed a slightly low positive relationship with psychological well-being. In the SPM, coping is one of the moderating resources leading to a positive outcome of caregiving situation (Pearlin et al., 1990). When the parents were confronted with the stressful situation such as having a child in the PICU, they appraised that this situation was a threat and danger. Consequently, they often used several coping strategies to deal with this situation. The finding was consistent with the finding of Hayat and Zafar (2015) who explored relationship between psychological well-being and coping strategies among a sample of 120 parents with Down's syndrome

children and found that coping strategies (problem-focused coping and positive coping) were negatively associated with depression, anxiety, and stress. It meant that parents with low levels of depression, anxiety and stress indicated a higher level of psychological well-being. In PICU, a prior study showed that all parents used a combination of both problem-focused and emotion-focused forms of coping when they were confronted with life-threatening events of their child (LaMontagne & Pawlak, 1990). Thus, coping could affect psychological state of parents.

Religious belief was found to have a moderately positive relationship with psychological well-being. According to Pearlin and colleagues (1990), religious belief were one of the background and context of stress process in the SPM. It could be explained that a child's PICU hospitalization was regarded as life-threatening condition for the child and his/her family. Believed in the four components saddhā and the three characteristics of existence helped the parents accept and understand a child's illness as an unavoidable situation caused by kamma (Payutto, 2002). The parents with a strong religious belief can possibly reduce anxiety, fear, and uncertainty in child conditions. Moreover, Colón-Bacó (2010) proposed that stronger religious beliefs were positively correlated with subjective well-being (SWB). Moreover, the finding of Koenig (2007) proposed that the emotional suffering caused by loss or change may be diminished through religious beliefs or practices. This finding could not be compared with any previous study because none were similarly conducted to explore this relationship. However, a study of Kaliampos and Roussi (2015) suggested that there were trends indicating that religious beliefs negatively predicted psychological distress in subgroups of Greek cancer patients such as stage IV cancer patients and patients who did not undergo surgery. Therefore, the religious belief could affect psychological well-being of parents.

For social support, social support had a moderately positive relationship with psychological well-being. It was one of the significant moderating resources in the SPM that played an important role in protecting persons from their stressful events and maintaining their well-being (Pearlin, et al., 1999). The finding was consistent with previous studies of Boonyawat and Sunsern (2005), Chappell and Reid (2002), and Daonophakao (2004). These studies showed that social support had a positive

relationship with the well-being of caregivers. An explanation for these findings is that when the persons had sufficient social support from social networks, including family members, friends, money, time, professionals and other resources, they could deal with their problem or stressful situations. In the present study, most of the participants were married (82.00%). They might receive emotional, instrumental, and informational support from their spouse or wives. Moreover, Family-Centered Care (FCC) is widely accepted as the good practice in pediatric nursing that provides holistic care for children and their families. Health care providers are the key persons providing emotional and informational support to the parents. This support can help parents gain more confidence in caring, understanding their children's condition, reducing stress, and enhancing their coping abilities. Similarly, the results of previous studies found that the information and emotion support could reduce stress and anxiety among parents whose children were being hospitalized in the PICU. (Abdeyazdan, Shahkolahi, Mehrabi, & Hajiheidari, 2014; Aksornsri et al., 2012; Beheshtipour et al., 2014; Melnyk et al., 1997; 2006; Vongpanich & Tangsatitporn, 2005). Thus, social support could affect psychological well-being of parents.

Predictors of Psychological Well-being Among Parents of a Critically Ill Child in the PICU

In the present study, the results revealed that religious belief, the child's behavioral and emotional responses, sense of coherence, coping, and social support altogether could explain 36.00% of the variance in psychological well-being among parents of a critically ill child. This finding supported the third research hypothesis and study framework, which explained that the child's behavioral and emotional responses were one of the greatest stressors for parents in the PICU. The behaviors included the child's physical and emotional responses to pain relating to various intrusive procedures, discomfort or other critical states, including crying, frightening, restlessness, demanding behavior, acting or looking as if in pain, uncooperativeness, inability to talk or cry, anger, and sadness. These behaviors were found to be related to parental stress that reflected their psychological well-being (Miles & Carter, 1982; Nizam & Norzila, 2001). For religious belief, religious belief of Buddhists helped the parents understand and accept the child's illness situation as unavoidably caused by

"kamma" of both the child and the parents themselves (Payutto, 2002). Feeling of guilt from not taking very good care of the child leading to the child's illness may be less. The higher the religious belief, the higher the psychological well-being. For Buddhist caregivers, religious belief could minimize anxiety (Ellison, 1991), and promote wellbeing (Disayavanish & Disayavanish, 2007).

Regarding sense of coherence (SOC), SOC as mentioned in the SPM is an internal resource and the parents with high SOC are able to understand the child's illness situations and explain what has occurred. Then, these situations deserve to be well managed (Antonovsky, 1987). For social support in the SPM, it plays an important role in protecting persons from their stressful events and maintaining their well-being (Pearlin, et al., 1999). The parents with available social support helped them deal with the stressful situations. Moreover, most previous studies showed that effectiveness of some types of social support, particularly information support, had effects on psychological state of parents who had a severely ill child in PICU (Aksornsri et al., 2012; Beheshtipour et al., 2014; Vongpanich & Tangsatitporn, 2005). The findings showed that parental anxiety and stress were significantly decreased after receiving information support (p < .05). Regarding coping, coping is one of the moderating resources leading to a positive outcome of caregiving situation (Pearlin et al., 1990). When the parents were confronted with the stressful situation in the PICU, they used cognitive process or stress appraisal to evaluate this situation. Stress appraisal can be harm/loss, threatening or challenge. Interestingly, a high level of sense of coherence, religious belief, and social support had an effect on the outcome of coping and psychological well-being of parents. Consequently, they were more likely to use coping strategies, both emotion- and problem-focused coping, appropriately (LaMontagne & Pawlak, 1990; Wonginchan, 2003).

As the present study demonstrated that only 36.00% of the variance in psychological well-being of parents was explained by the five variables. Therefore, there were still other potential variables in this phenomenon that influenced psychological well-being among parents of a critically ill child in the PICU. The study of Vrolarn (1992) showed that duration of education, perception of uncertainty in illness, and emotional-focused coping were important predictors and accounted for

38.81% of the variance in psychological well-being of parents with children admitted in intensive care unit. Also a study by Cheon (2012) in American mothers with preterm infants revealed that maternal stress could explain the variance (43.00% of the variance for anxiety, 22.00% for depression, and 24.00% for general well-being). Therefore, the duration of parental education, perception of uncertainty in illness, and emotional-focused coping, and maternal stress might be significant factors that could predict psychological well-being of parents whose child was hospitalized in PICU and need to be further examined.



ลิขสิทธิมหาวิทยาลัยเชียงไหม Copyright[©] by Chiang Mai University All rights reserved