

ORIGINAL ARTICLE

Perception of the factors contributing to family happiness among caregivers of stroke survivors in a suburban community in Thailand: A qualitative study

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Chaknum P, Harnirattisai T, Somprasert C, Chiang LC. Perception of the factors contributing to family happiness among caregivers of stroke survivors in a suburban community in Thailand: A qualitative study. *Malays Fam Physician*. 2023;18:13. <https://doi.org/10.51866/oa.138>

Keywords:

Perceptions, Experiences,
Stroke, Caregivers, Happiness

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Abstract

Introduction: Caring for stroke survivors in primary care settings substantially impacts family life and health. Caregivers of stroke survivors have different challenging experiences in providing care in relation to family happiness. This study aimed to explore family happiness and its contributing factors among family members caring for stroke survivors in suburban Thailand.

Methods: Qualitative semi-structured interviews and observations were conducted among 54 family caregivers in suburban Thailand communities from January to July 2020. Interviews and focus group discussions were digitally recorded, independently transcribed and analysed using ATLAS.ti 8.0. Qualitative data analysis method was used.

Results: Family happiness was found to help a family function and be satisfied with caring. The analysis revealed three themes for achieving family happiness: 1) ideal caregiver characteristics: virtue, love and gratitude, experience in caring, good health and self-care ability, good management of emotions and freedom to manage problems and obstacles; 2) family function: family structure, roles and duties, relationships and management of family problems; and 3) resource support: financial, health and environmental supports.

Conclusion: The findings demonstrate how life adaptations can improve family happiness within families of stroke survivors. Understanding caregivers' perceptions of their experiences in caring for stroke survivors is a challenge for healthcare providers; overcoming this could transform an unpleasant life into caregiving happiness. Appropriate and practical support from healthcare authorities could empower families of stroke survivors to succeed in caregiving and achieve family happiness.

Introduction

The stroke burden has increased worldwide over the last three decades and is the leading cause of disability-adjusted life years.¹ Stroke is commonly caused by chronic diseases, known as non-communicable diseases (NCDs), and generally causes disability or dysfunction.^{1,2}

Thailand has been classified as one of East Asia's newly industrialised countries. People living in rural Thailand are currently moving to the country's capital or other significant cities. Families who live in urban areas encounter barriers when accessing healthcare services. In Thailand, stroke is the fourth leading cause of NCDs.³ Caring for stroke survivors can profoundly impact family life and society and lead to long-term care and suffering for patients and their families. A previous study has presented family caregivers' perceptions of their

dynamic experiences and conducted a unit of analysis among family members.⁴

Perceptions are subjective experiences based on coping strategies, past experiences with illness, beliefs and family function. For all family events after stroke, family caregiving is designated as the duty of other family members. This significant responsibility frustrates other family members. The needs of caregivers and stroke survivors have been reported to be unmet.⁵

Family caregivers must apply their problem-solving skills in unstable situations and experience reduced well-being, making them feel like prisoners. Thus, families must learn new strategies to deal with these complicated situations.⁵⁻⁸ Each family has various care methods for stroke survivors depending on the differences in context, belief and culture.

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Many qualitative and mixed-method studies have described caregivers' experiences in caring for patients with different chronic illnesses, including stroke. While most research in Thailand has previously focused on people living in rural communities who have difficulty accessing healthcare systems and lack health-related knowledge, few studies have been conducted in suburban areas.⁹ Caregivers of stroke survivors in suburban areas usually experience the same consequences as those in urban areas.¹⁰ Additionally, previous studies have shown a lack of education on the care perception for stroke survivors in families living in suburban areas. Accordingly, future research should focus on family members' health and well-being.^{6,11} The findings of this study are expected to allow healthcare professionals and policymakers to enhance the quality of stroke care in suburban areas.

Overcoming the challenges experienced when providing care might facilitate family happiness. Although caregivers face the burden of caring for stroke survivors, they could manage such burden and change their opinions towards it, which may result in family happiness. Therefore, this study aimed to assess the perception of primary caregivers when caring for stroke survivors to achieve family happiness in a suburban context.

Methods

Design, participants and setting

Qualitative semi-structured interviews and observations were conducted in this study. The interview questions were developed from the theoretical underpinning of the Calgary Family Intervention Model.¹² The inquiries were reviewed on the basis of the theoretical consistency, clarity and language appropriacy by three experts. The participants were observed during interviews and focus group discussions in their homes.

Fifty-four family caregivers were approached face-to-face to participate in this study. Forty people completed one-on-one in-depth interviews, and 14 participated in focus group discussions; no caregiver withdrew from the study. The participants were selected via purposeful sampling from the list of stroke survivors and snowball sampling in primary healthcare service areas – sub-district health promoting hospitals – in suburban Thailand communities. Thai family members who were the primary caregivers providing unpaid care for stroke survivors for at least 4 h per day over a

month and who were aged at least 18 years were included. This study was conducted between January and July 2020.

Data collection and analysis

We intensely interviewed and conducted focus group discussions among the family caregivers until data reached saturation and observed them interacting and caring for stroke survivors in their home environments. The duration of the interview and focus group discussion was around 90–120 min. This process was conducted by the first author, who completed a course in qualitative research. Qualitative inquiries were used to explore the family caregivers' perceptions, including "What does the term 'family happiness' mean to you?" and "What are the factors that helped you achieve family happiness when caring for stroke survivors?"

We recorded field notes and digitally voice-recorded the in-depth interviews. All interviews were independently transcribed verbatim. Data analysis and collection were conducted concurrently, and several methods were used for the data analysis. ATLAS.ti 8.0 software program was used to assist the qualitative data analysis, arrange coding data into coding schemes and draw links and relationships of codes, sub-themes and themes. Miles et al. described qualitative data analysis as an inductive thematic content analysis.¹³ The five general processes involved were as follows: managing and organising data; reading, reading concurrently with meaning, summarising emerging ideas, reflective thinking into memos or jotting notes; describing and classifying codes into themes; assessing interpretations and explanation; and representing and visualising data with maps or diagrams. The data were analysed by the first author and then used to clarify and refine the themes generated by the corresponding authors. The internal validity of the findings was confirmed by conducting two focus group discussions. Finally, further comparison and contrast were conducted to ensure the development of distinct and saturated themes. This process reduced the bias inherent from having only one researcher's perspective in the initial analysis.

Ethical considerations

This study was approved by the Ethics Review Sub-Committee Board of Thammasat University, No. 3, Thailand (Project No.: 138/2562). We obtained the relevant local approvals before collecting data. The

participants were informed of the aims of the research and signed consent forms. Participant data were encoded and will be destroyed within 2 years after finishing the study. The findings were reported as the overall findings rather than as individual opinions.

Results

General information and area context

The survey and observation revealed that the living environments in the semi-urban areas consisted of skyscrapers, commercial buildings and crowded houses. The participants either owned or rented their homes. Many people who were living together had a variety of jobs. The relationships of the people in the suburban areas were not close. They reported

that they do not interfere with each other, as their lives are different. The requirement for competition and urgency in the daily lives of the suburbanised people impacted family members' relationships. The family members had relatively few interactions and relationships with their neighbours. Further, one person had been reported to act as the primary caregiver for most dependents and family members needing assistance. The communities still had a temple where people performed religious rituals. Forty participants underwent in-depth interviews, and 14 participated in focus group discussions. The demographic characteristics of the family caregivers are presented in **Table 1** and the level of independence of their stroke survivors in **Table 2**.

Table 1. Caregiver characteristics (N=54).

Demographic data	n	Percentage
Gender		
Male	11	20.4
Female	43	79.6
Age		
25–39 years	5	9
40–59 years	22	41
≥60 years	27	50
Mean: 57.31, SD: 12.83, Min: 25, Max: 84		
Number of family members		
2	6	11
3–5	29	54
≥6	19	35
Adequacy of income		
Saving	10	18.5
Fair	18	33.3
Indigent	15	27.8
In debt	11	20.4
Duration of caring for stroke survivors		
3 months to 1 year	15	28
2–5 years	24	44
6–10 years	9	17
>10 years	6	11
Relationship to stroke survivors		
Spouse	25	46.3
Sibling	7	13.0
Offspring	18	33.3
Other	4	7.4
Previous experience in caring for stroke survivors		
Yes	20	37
No	34	63
Responsibility for other family members		
Caring for a single stroke survivor	35	64.8
Caring for other family members	19	35.2

SD=Standard deviation

Table 2. BI of the stroke survivors (N=54).

Independence level	n	Percentage
Independent (BI: 80–100)	28	51.8
Needs minimal help (BI: 60–79)	7	13.0
Needs some help (BI: 40–59)	3	5.6
Needs great help (BI: 20–39)	8	14.8
Dependent (BI: <20)	8	14.8

The BI is an ordinal parameter used to measure performance of activities of daily living.

BI=Barthel index

Perception of family happiness and its contributing factors

The participants felt that family happiness could encourage caregivers and family members to function in daily life and be satisfied in caring for stroke survivors.

Ideal caregiver characteristics

A caregiver is a key person who contributes to the specific needs of patients with stroke. Therefore, the caregiver must have the following characteristics:

Full of love and gratitude: This concept resides in Buddhism teachings, which have embodied the social and cultural identities of Thai families for many years. A moral caregiver of a stroke survivor has a sense of duty and responsibility, which is one of the reasons why the caregiver takes reasonable care and treats his or her parents and benefactors well. Thus, the caregiver must adapt and put in effort and patience to help, care for and meet the needs of stroke survivors. Such actions are representative of gratitude and are performed with grace.

‘The virtue is already with me. If there was no virtue, I would have been slapped. Sometimes I was angry, sometimes I was hurt’. (Niece, 46 years old)

Having experiences in caring: The caregiver should learn through reflection on stroke-related experiences and provide care based on self-observation and self-learning. Each caregiver has different expertise resulting in caring behaviours based on past experiences.

‘If I am asked whether I have the knowledge to care for my brother. I do not have it, but I have been trained in first aid. I sought advice from a nurse, so I gained a little knowledge’. (Older sister, 41 years old)

Having good health and taking care of oneself: Most caregivers also have health problems and congenital diseases that reduce their ability to perform daily activities, manage their health and

have social interactions. Improving, changing and managing caregivers’ health by changing health habits in daily life will keep them healthy and self-reliant, resulting in a better quality of life for patients with stroke and improved health for all family members.

‘We must be able to stand strong. We cannot rely on anyone, must be able to live and have to be strong. If no one cares for us anymore, we have to take care of ourselves’. (Daughter and wife, 54 years old)

Dealing with emotions well: Caregivers experience many challenging emotions, such as stress, anger, suffering and conflicts with family members, which sometimes arise from avoiding problems. Caregivers manage these emotions by recognising problems, thinking about reasons, accepting what has happened, living in the present moment and following their own beliefs and faith in matters of religion and spirituality. This helps reduce violence and conflicts in the family.

‘I am discouraged, but I think that those who are affected more than me can still live. If they can survive, I have to survive’. (Wife, 50 years old)

Freedom to manage problems and obstacles: Family caregivers need time to perform activities and take care of their physical and mental health to reduce anxiety and be more confident in providing care. Family caregivers struggle to earn enough income to cover expenses in a highly competitive, semi-urban way of life with limited relationships with neighbours, so they have to be more self-reliant.

‘Money is an essential factor for each family. In the past, in the countryside, we could share with each other. But nowadays, I cannot ask for food like that’. (Wife, 58 years old)

Family function

A family can face critical situations that change the family members’ structure, roles and responsibilities. In some families, caregivers are responsible for overseeing members other

than the patient with stroke, and more care activities are required owing to complications. Additionally, family members can deal with their problems and perform their functions as follows:

Family structure: This concept describes the family's roles in caring for members who experienced stroke. Family members are closely related and bonded and help each other care for stroke survivors.

'There are seven people in the family. The younger sister will help with money because she is not good at taking care of him. Most of the caring will be done by older sisters and my mother. Grandchildren will do housework. We relieve the burdens of one another'. (Older sister, 41 years old)

Roles and responsibilities of caring members: To help lighten caregivers' burdens and help patients with stroke complete daily activities, other family members help with fundamental activities, such as dining, taking a bath, cleaning their body and helping with movement and excretion.

'Aunt can have food by herself. When taking a shower, she will sit on a chair then I pour water for her. She can wear clothes herself. If she wants to defecate, I will help take her to the bathroom, she can clean by herself'. (Husband, 68 years old)

Relationships among family members: Good relationships comprise good bonds and positive communications, including initiating eye contact, smiling, hugging, talking and listening. This support shows mutual encouragement and care between family members. Good family relationships encourage family members to care for patients with stroke with understanding and willingness, resulting in more effective care.

'Relationship, compassion is what makes us look after each other. I want him to be better [and] help himself as much as I can do for him'. (Wife, 60 years old)

Family problem management: This concept includes managing the roles and responsibilities of family members, leisure time and conflict to maintain the family's ability to take care of members to maintain good relationships.

'After my husband got sick, I had to become the head of the family instead and do everything'. (Daughter and wife, 54 years old)

Resource support

Family care for patients with stroke requires support and assistance from family members and external supporters.

Financial support: Families caring for patients with stroke in semi-urban communities can have insufficient income to cover the high cost of living and daily expenses, leading to financial hardship. Some families also have debts from borrowing and must earn more to meet their living costs and medical expenses. Some of the families' financial burdens are alleviated by state welfare payments, such as elderly allowance, disability allowance, state welfare card for low-income families and right to free medical care for elderly individuals and those with disabilities. Living in a semi-urban society forces families to adjust to earn enough money to spend.

'The expenses are too much, [income] is not enough, father's medicines cannot be reimbursed. Tens of thousands per month that I have to pay. The cost is very high'. (Daughter, 56 years old)

Health support: Health insurance and healthcare services provide family members access to basic medical and public health services that enhance health, prevent diseases and provide treatment and rehabilitation. These supports benefit everyone and secure life and well-being, including the rights to medical treatment and the rights of persons with disabilities. However, some families still lack knowledge of these services and do not have access rights.

'Now we use the thirty-baht card [Universal coverage card]. When going to request the right, the doctor said that he did not know how long the privilege could be used. He said that if he [the uncle] wanted to exercise the rights at this hospital, he had to transfer his name to show in a copy of the house registration of this province. In fact, the uncle can register as a disabled person, but the private hospital cannot do that'. (Wife, 50 years old)

Support from environmental factors: This type of support includes physical support for the family to manage sick family members' daily life, including rehabilitation for stroke survivors, provide caregivers time to take care of themselves and allow a patient to relieve stress and feel dependent. This support also includes providing essential assistive devices used in the daily life of stroke survivors, such as a wheelchair, walking stick, walker and

rehabilitation equipment. The family must arrange for a secondary caregiver to allow the primary caregiver to rest or perform their activities.

'There is an exercise bike. There is a pulley for arm exercises. [My husband] is diligent to exercise. [He] wakes up in the morning and ties his arms to the pulley, do exercises, do walking exercise under the flats. [But] since moving here, he does not do anything, just sits, eats and goes to bed. He said he was better and did nothing'. (Daughter and wife, 54 years old)

The perceptions of the caring experiences concerning family happiness of the caregivers are presented in [Table 3](#).

Table 3. Caring experiences concerning family happiness of the caregivers of stroke survivors

Theme	Category	Sub-category
Ideal caregiver characteristics	Nobility, full of love and gratitude	<ul style="list-style-type: none"> • Gratitude • Sense of duty and responsibility
	Having experience in caring	<ul style="list-style-type: none"> • Patience • Direct experience
	Having good health and taking care of oneself	<ul style="list-style-type: none"> • Learned and transferred from others • Observations and trying it themselves • Changing health behaviours in daily life
	Dealing with emotions well	<ul style="list-style-type: none"> • Being self-reliant • Letting it be • Avoiding confrontation • Thinking it is normal • Accepting what happened
Family function	Freedom to manage problems and obstacles	<ul style="list-style-type: none"> • Following their beliefs and faiths in matters of religion and spirituality • Ready to provide care
	Family structure	<ul style="list-style-type: none"> • Self-reliant
	Roles and responsibilities of caring members	<ul style="list-style-type: none"> • Having private time • High income • Shared responsibility for care • Helping lighten the burden of caregivers • Helping patients with stroke complete daily activities
	Relationships among family members	<ul style="list-style-type: none"> • Having knowledge and skills in caring
Resource support	Family problem management	<ul style="list-style-type: none"> • Good bonds
	Financial support	<ul style="list-style-type: none"> • Positive communication • Managing the roles and responsibilities of family members
	Health support	<ul style="list-style-type: none"> • Managing leisure time • Conflict management • Insufficient income for expenses • Debt • State welfare • Having enough money • Health insurance • Healthcare services • Essential assistive devices used in daily life
	Support from environmental factors	<ul style="list-style-type: none"> • Secondary caregivers

Discussion

The study revealed three themes that contribute to family happiness of the primary caregivers of stroke survivors in suburban Thailand: 1) ideal caregiver characteristics, 2) family function and 3) resource support.

The participants believed that the ideal caregiver characteristics were related to how caregivers provide care to stroke survivors as also reported by Ribé et al.¹⁴ These authors mentioned the association between caregivers' characteristics

and quality of care.¹⁴ Macchi et al. also demonstrated that caregivers' characteristics are related to the burden of caregiving.¹⁵

Our study also showed that family function had an important role in caring for stroke survivors. Each family member has some responsibilities in providing care and helping solve problems that arise. Previous studies have stated that other family members can help reduce a caregiver's burden by helping provide care for patients.^{15–20}

Finally, this study illustrated that the caregivers needed help from healthcare providers and family members. This finding is similar to that by Zawawi et al. that family caregivers require information to support their physical and mental health when providing care for stroke survivors and themselves.^{5,21} We also found that the caregivers needed financial support from other family members. Similarly, previous studies have reported that caregivers in families with good financial management and support to cover the necessary care costs feel relaxed and experience significantly less stress.^{16,22}

Study limitations

One limitation of this study was that it was conducted in the central part of Thailand with Thai people only. Therefore, the results may not be generalisable to other diseases or situations, including places with different languages, cultures and beliefs.

Conclusion

Our findings enhance the understanding of family caregivers' perspectives and adaptation processes required to achieve family happiness while living with stroke survivors. They can be applied to create better care strategies in primary healthcare and robust family systems in semi-urban areas. Appropriate and practical support from healthcare authorities can also promote family happiness in families living with a stroke survivor. This study revealed how family caregivers adopted life tactics that enhanced family happiness while caring for stroke survivors. Healthcare providers should provide suitable strategies to remedy and promote families' happiness and health. The findings can also be used to develop a caregiving model for families providing long-term care for stroke survivors in the future.

Implications for clinical practice and further research

We suggest using primary nursing research

results to promote family happiness among stroke survivors' families, including long-term care. In our future research, we will develop a family-based caring model to enhance the health of stroke survivors' families, especially those living in semi-urban areas in Thailand.

Acknowledgements

We would like to thank all family caregivers who willingly participated in this research and all collaborating sub-district health promoting hospitals and health volunteers in the urban areas.

Author contributions

Chaknum P, Harnirattisai T, Somprasert C, Chiang LC contributed to the design, conduct of the research, and analysis of the results. All authors discussed the results and commented on the manuscript.

Ethical approval

The Ethics Review Sub-Committee Board permitted the study for Human Research Involving Sciences, Thammasat University, No.3, Thailand (Project No.: 138/2562 Approved date: 4 November 2019 and renewed for the first time on November 4, 2020)

Conflicts of interest

We declare no conflicts of interest, either financial or otherwise.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Data sharing statement

The authors confirm that the data supporting the finding of the study are available within the article.

How does this paper make a difference in general practice?

- The findings enhance the understanding of the perceptions of family caregivers when caring for stroke survivors, which can be used as a basis to achieve family happiness.
- The study describes ways to promote family happiness in the families of stroke survivors receiving primary care in suburban areas.

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