

## CHAPTER 3

### RESEARCH METHODOLOGY

This chapter presents the methodology for this study. It is divided into eight sections: (1) research methodology, (2) study context, (3) selection of participants, (4) instruments, (5) ethical considerations, (6) data collection, (7) data analysis, and (8) trustworthiness of the data.

#### Research Methodology

The research methodology used in this study was hermeneutic phenomenology. This qualitative type of research referred to “the methods and techniques of observing, documenting, analyzing, and interpreting attributes, patterns, characteristics, and meanings of specific contextual features of phenomena under study” (Leininger, 1985, p. 5). This phenomenological approach was used as it provided a philosophical exploration to interpret the being of human beings; to uncover the phenomena under study; and to provide an analysis for the structure of the experience (Dreyfus, 1991). Hermeneutic phenomenology seeks to uncover the ontological significant meaning of “being”. It enabled the researcher to be in close contact with the research participants to discover insights and meanings about human health conditions and behavior, and enable the researcher to gain a more profound understanding of the field of study (Leininger, 1985). Thus, this approach guided the investigation of family caregiver’s experiences, providing a structure for revealing the

phenomena to the researcher (Boyd & Munhall, 1993) uncovering hidden as well as explicit meaning of 'caring' and their lived experiences. Hence, the researcher was able to have a deeper understanding of the meaning and the "essence" of caring experienced by family caregivers caring for members with chronic schizophrenia.

As the researcher was using the Giorgi's method as a guide, this phenomenological research started with a naïve description of the experience under study. So the researcher allowed the experience unfolded, as it existed for the participants in an unbiased way. Data gathered were in length interview of one and a half hours, in two to three sessions. The second or third session was usually used for clarification or to elicit more data that was not sufficient.

## **Study Context**

### **The State of Kelantan**

The state of Kelantan, one of the thirteen states in Malaysia, is located on the northeastern coast of Peninsula Malaysia. According to the Population and Housing Census of Malaysia, 2000, it has a population of about 1,313,014 and with very low growth rates of 0.9% (Population & Housing Census Malaysia, 2001). Of the total population 1,292,219 were Malaysian citizens while the non-Malaysian citizens accounted about 20,795. Of the total Malaysian citizens, Malays comprised of 1,216,662 (94.15 %) and was the predominant group. This was followed by Chinese 48,076 (3.79%), other Bumiputras 10,631 (0.82%), Indians 3,683 (0.28%) and others 12,176 (0.94%). It has low urbanization level of 34% compared to states of high urban population such as Wilayah Persekutuan Kuala Lumpur (100%) and Penang

(80.15%). The proportion of population below 15 years of age was high (41.5%) compared to those in Wilayah Persekutuan Kuala Lumpur (25.6%) and Penang (26.9%). There were 99 males for every 100 females indicating the ratio of males to females was relatively the same. On the other hand, women outnumbered men from the age group beginning 65-69 years and the gaps widens with age. In Kelantan Islam was the main religion, which was also the most widely professed religion in Malaysia. This was highly correlated with ethnicity. Being in a multi-religious nation, it also has other religions such as Christianity, Buddhism, Hinduism, Confucianism/Taoism/other Chinese religion (Population & Housing Census Malaysia, 2001).

In the state of Kelantan, the Malay family unit consisted of the parents and their siblings. Many Malay families still adopt the extended family system, with grandparents or relatives living together in the same household. In the urban town of Kota Bharu most Malay families were dual-career families with parents working, worked in government institutions, banks or own business. They lived in terrace houses or bungalows. On the other hand, Muslim families in the rural areas lived in houses built on stilts, with big compounds, clean pipe water and electricity supply. They worked in the rice fields, fruit orchards, or as fishermen, as hawkers and small business traders, and some also worked in government institutions. The traditional family system still hold strong for some families, whereby the mother often assumed the nurturing role and the father provides the necessary economic resources. In the rural areas, the housewives often help their spouses in the fields or do small own business such as food hawkers to provide extra income for their families. When a member of a family became ill, most seek modern medical treatment bringing their ill family member to health clinics or hospitals. Some Malay families also seek

traditional herbal healers and medicine man known as *bomohs* as alternative forms of treatment when they believe modern medicine failed to heal their illness. This kind of health practices consists using charmed water known as *air tawar*, performing certain rituals like praying. During times of crisis or stress, families derive comfort from among own family members or close relatives.

### **Outpatient Psychiatric-Mental Health Clinic, Hospital University Sains Malaysia (HUSM)**

The actual setting for this research study was the homes of the participants. However, the researcher used the Outpatient Psychiatric-Mental Health Clinic, HUSM to look for potential and eligible participants. The Outpatient Psychiatric-Mental Health Clinic is a follow-up clinic for discharge of psychiatric mental health patients from the psychiatric wards of this hospital. It is also a referral center for psychiatric-mental health patients referred from the private clinics and community health centers within the state of Kelantan, and also from the Psychiatric Hospital Kota Bharu, Kelantan. It is a five days' morning clinic for follow-up care, acute symptoms, for referrals, and for new cases. From the five days clinic, three days are allocated for general psychiatry, one day for child psychiatry and one day for clinical psychology. The clinic also provides treatment services such as giving injections scheduled monthly, counseling and home visiting.

The clinic is under the Head of the Psychiatric Department. It is managed by one sister-in charge, six registered nurses, and four assisted nurses. It receives about 30-40 patients per day and had four psychiatrists, one clinical psychologist, and about 10 medical officers.

## **Selection of Participants**

The selection criteria for inclusion of participants in the study were as follows:

1. Primary family caregivers, caring for a family member who has been diagnosed as having chronic schizophrenia (DSM-IV and International Classification of Disease –10 [ICD-10])
2. Male or female
3. 18 years or older
4. Malay ethnicity and communicate in Malay language
5. Good consciousness and having ability to communicate verbally
6. Willing to participate in the study
7. Continuous co-residence with the care-recipient for at least 6 months prior to time of interview, but not more than 10 years

The participants of the study consisted of purposive sampling of 10 primary family caregivers who were caring for members with chronic schizophrenia, living in Kelantan, Malaysia. This method of sampling was used because it selected individuals for study participation based on their particular knowledge of the phenomena under study (Streubert & Carpenter, 1995) and provided rich-information cases (Patton, 1990 cited in Streubert & Carpenter, 1995). The participants were in caregiving role for at least six months but not more than 10 years. This range of time would allow the participants to recall and reflect their experiences caring for their members with chronic schizophrenia.

## **Instruments**

Indepth-interviews as well as observations were performed to collect data using: (1) Demographic Data Record Form, (2) Interview Guide, (3) Observation Guide, and (4) researcher-as-an-instrument. All the tools were developed by the researcher through literature review, and nursing experience. Content validity was established through review by three experts from the Nursing Faculty, Prince of Songkla University and via pilot testing.

### **1. Demographic Data Record Form**

The Demographic Data Record Form had three parts: caregiver characteristics, care-recipient characteristics and situational characteristics. The caregiver characteristics consisted of 16 items of a mixture of open-ended and close-ended questions, which included caregiver's age, gender, religion, marital status, educational level, occupation before and after taking over the role of caring, duration of caregiving (years), knowledge of mental illness of the 'sick' member, conditions of the caregiver (personality, physical, emotional and social), other roles/responsibilities in the family, relationship to care-recipient, and monthly income. The care-recipient characteristics consisted of 14 items, which are also a combination of open-ended and close-ended questions. They included care-recipient's age, gender, marital status, educational level, occupation before and after mental illness, medical diagnosis, duration of mental illness, other medical problems, number of admissions to hospitals, present condition (physical self-care hygiene, cognitive, emotional and social), medication received, requiring any supervision, and other care needs. The situational characteristics consisted of five questions of both open-ended and close-ended, related

to number of household members, types of family, another role or responsibilities, and assistance in caring. A combination of both open-ended and close-ended questions was used so as to offset the strength and weaknesses of the other (Polit & Hungler, 1999). This form would be completed first by the researcher before the interview guide in order to establish rapport with the participants so as to make them feel more at ease. It took about 30-45 minutes to administer .The Demographic Data Record Form is shown in Appendix C.

## **2. Interview Guide**

The Interview Guide consisted of five semi open-ended questions about major components of experience of family caregivers: meaning of 'caring', caring experiences (what happened to them during caring and their feelings), impacts of caring, and their needs as caregivers. It was only an outline to focus the interview, thus, it was not necessarily for the researcher to adhere strictly to the questions. In addition, a set of probes concerning each questions were also developed to ensure data for the concept of each component were obtained. This interview guide was administered in two to three interview sessions. Technical and medical terms were avoided during the interview unless the participants used them. The interview protocol is shown in Appendix D.

## **3. Observation Guide**

The Observation Guide consisted of unstructured observations of four sections: (1) overview of environment surrounding the house, which had two main items, (2) overview of environment within the house with six main items, (3) caregiver characteristics/situations, with seven items, and (4) care-recipient

characteristics/situations also with seven items. This Observation Guide was an outline for the researcher to focus her non-participant observation:

The first section on overview of environment surrounding the house included observing the presence of main features such as any mosque, public transportation, community health centers, shops or stores, housing units, public transportation, roads, and any main activities going on. The second section on overview of environment within the house included observation on main features of the physical setting, major activities going on, number of households present, presence of things that specify belief/religious system, safety hazards, and cleanliness of the house. Both these environmental characteristics were important as they have a profound effect on the participant's behavior and needs (Polit & Hungler, 1999).

Observation on caregiver characteristics/situations consisted of general appearance of caregiver, activities and interactions going on, verbal and noncommunication behaviors, types of affect manifested during interactions, when activities began and when scheduled to end, and events that were disruptive to the activities or situation. Observation on care-recipient characteristics/situations included general appearance of care-recipient, activities and interactions going on, verbal and noncommunication behaviors, types of affect manifested during interactions, when activities began and when scheduled to end, and presence of any disruptive behaviors during the activities or situation. These observations were gathered throughout data collection process and were recorded in the field notes. The observation protocol is shown in Appendix E.

#### **4. Researcher-as-an -Instrument**

The researcher is a very important data collecting instrument as well as creator of data analytic process in any qualitative studies (Polit & Hungler, 1999). The credibility of the data under study depended greatly on his/her training, qualifications and experience (Polit & Hungler, 1999). The researcher in this study had been staying in Kelantan, the area under study for about 15 years and had good understanding of the Malay culture and tradition being practiced in that area. The researcher shared the same background, culture and social values as the participants in the study, spoke and understood the Malay language as used by the participants. She had experience as a nurse for 15 years and 5 years as a clinical nurse educator teaching mental health and psychiatry to undergraduate students in Diploma Nursing.

However being the sole researcher, there might be biases from data collection and data analysis. There was the danger that the pre-understanding and experiences may influence the way experience is described and the way the day are interpreted. The prolonged engagement and becoming oriented to the situation as what Lincoln and Guba (1985) stated, “soaking into the culture through his or her pores” (p. 302) would result in the researcher “going native” as described by some anthropologist, and failure to see objectively what an uninvolved researcher would see. Therefore, the researcher had taken the necessary measures to prepare herself as follows:

1. The researcher was aware of the danger of “going native” and kept herself being aware of this aspect from the beginning till the end of data collecting process (Lincoln & Guba, 1985).

2. Regarding having pre-understandings (fore-conception) and experiences, the researcher was also aware of this issue and she approached the phenomenon with an open-mind and willingness to be informed by the participants. Probes were used in caution, mostly for clarification, eliciting narrative data and not to direct or structured the interview in a predetermined way (Cohen, Kahn & Steeves, 2000). Field notes were used to record substantive ideas, hunches, insights, as well as personal feelings, views and own expectations. The researcher using Giorgi's method has provided valuable guidelines on the task of interpretation, though reflection of essential themes, clarification, and relating meaning units to each other and to a sense of the whole. This systematic approach has enabled the researcher to capture the meaning of the lived experiences without misinterpreting the data.

3. Being a novice researcher, a pilot study was carried out on two participants to gain confidence and skills in interviewing, listening, observing, writing and reflection. This was to familiarize herself with the discipline required to construct an adequate field text before entering the study field. All these were necessary to the whole process of hermeneutic phenomenology.

### **Ethical Considerations**

Prior to conducting the research, the study plan and protection of human rights of the participants were assured. This study was approved by the Research Proposal Committee, Faculty of Nursing, Prince of Songkla University. The researcher gave full explanation of the study to the participants regarding the purpose of the study, the procedure, the possible benefits and risks. Possible benefits such as value of reflecting

and discussing their experiences, and experiencing some satisfaction from participating were noted to participants. On the other hand, risks such inconveniences of time in interviewing, and feelings of discomforts or sadness that might be experienced during discussing this sensitive topic were noted to them. They were told of their rights to participate in the study and that they could withdraw from the study anytime, even after they had consented to participate in the study. There will be no penalty if they decide not to participate. They were also ensured of their confidentiality and anonymity. Neither names nor identifying information would be used in reports of the study and that coding and was used instead. Pseudonyms were used instead of real names of participants in the excerpts of research findings. The tapes containing the interview data and all notes were stored in a safe place and erased after the data were no longer needed. Explanation was in Malay. Verbal consent was first obtained from every participant. The informed consent forms were then given to the participants to be signed, after, which were returned to the researcher. The informed consent form can be found in Appendix B.

However additional ethical issues, which surfaced during the course of the investigation, were taken. During this study, there was an ethical concern involving the boundaries between the role of a researcher and a clinical nurse. This occurred in situations when caregivers reported not understanding the name and actions of psychotropic medications taken by the care-recipient and wanted to know more on how to manage the care-recipient "laziness" attitude. This reflected the lack of knowledge of medications and the illness. This indeed placed the researcher in a difficult position of not wanting to bias the data but also wanting to provide advice to help. This was because giving advice during the interview might influence the

originality of the information regarding management of medication. To avoid acting as clinical nurse, advice was reserved until the interview session ended. Caregivers were given general explanation and were advised to enquire more information on this matter during the next follow-up visit at the psychiatric Mental Health Clinic, HUSM.

Two caregivers experienced discomforts and sadness when sharing about their hardships and difficulties when managing disruptive, aggressive behaviors of their care-recipient. During this time researcher stopped the interview, provided assurance and allowed the caregivers to express and relieve the intense emotions of “talking it out”. Then researcher continued the interview when participant felt better. Some participants experienced satisfaction and happy participating as the interviews allowed them to discuss their experiences, which they feel proud to share with health personals and nurses.

## **Data Collection**

Data were collected during a 3-month period and it consisted of two phases: preparation phase and the collection phase.

### **Preparation Phase**

Firstly, permission was obtained from the Head of Psychiatric-Mental Health Department, and the Head Nurse of the Outpatient Psychiatric-Mental Health Clinic at HUSM, Kelantan.

Then the researcher spent about 2 weeks in Outpatient Psychiatric-Mental Health Clinic to review and collect demographic data of each eligible care-recipient. Then the researcher approached potential participants who accompanied care-

recipients to clinic for follow-up care or for acute symptoms at the Outpatient Psychiatric-Mental Health Clinic, HUSM. Information on the study and its objectives were provided and any questions put forward were answered. After permission granted to participate in the study, the researcher scheduled the interview appointments at mutually agreeable date and time. When potential care-recipient did not turn up at the clinic, the researcher telephoned to participant's house and explained about the study and objectives. If participants agreed, the researcher scheduled the interview appointments at mutually agreeable date and time and also for direction and address of the house.

A pilot test was carried out to test the appropriateness of data collection technique. The pilot study was carried out on two participants whom were used for the subsequent study, because revision of data approved unnecessary. This pilot study enabled the researcher to gain experience in the necessary skills required to conduct interviews. This was important because the quality of data generated largely depended on the skills and experts of the interviewer (Lincoln & Guba, 1985).

### **Collection Phase**

As phenomenological research aimed to explicate a deeper understanding of the lived experience of caring by reflecting from the caregiver's point of view, this phase required the researcher to enter the field and make contact with the original experience. The researcher conducted the study using in-depth interviewing method at the participant's home in the presence of the care-recipient and the other household family members, if they were present.

Before the interview started, the researcher spent about 20 to 30 minutes observing activities in the house, collecting demographic data and evaluating the care-recipient. This was important as it provided an overview of the environment, a preliminary personal tour to gain familiarity of the environment, and to note major activities, transactions and events (Streubert & Carpenter, 1995). All aspects of observation were carefully and immediately documented in the Observation Guide Form and the Demographic Data Record Form. All these helped the researcher to understand better the physical and the social context of participants being studied.

Then the researcher proceeded to the actual interview by first developing a trusting relationship with the participants. During this time, researcher asked non-threatening questions such as, "Tell me what do you usually do for your son in the morning, evening and before he goes to sleep?" before touching into the more personal and sensitive issues.

The researcher used semi-structured questions as a guide when interviewing the participants regarding their lived experience in caring. For example, "When caring for your son (daughter, sister or relative) with this chronic mental illness, what does 'caring' mean to you?" The participant narrated their experiences. The researcher interrupted only for the purpose of clarification or probing for further information. The participants were invited to elaborate on the description where the researcher required more information or more clarification. The interviews were conducted in Malay language and were tape-recorded. The time set for each interview lasted approximately 60 to 90 minutes. This was to allow the participant to interpret, demonstrate, clarify, verify or confirm data. According to Leininger (1985) this was very essential in an open-ended structured interview method. The interviews ranged in

length from 60 minutes to 2 hours. The average length was one hour and 15 minutes. In general the interviews with the 10 participants were conducted mostly in the afternoons and evenings between 3.00-6.00 pm. This time was considered appropriate, as they were free during these times at their homes.

Throughout the interview sessions, although the researcher remained centered on the data, listened tentatively and treated the participant with respect, the researcher was also observing activities and events that were going on within the environment. Field notes were written to capture nonverbal communication and other important relevant information beyond the interview questions, during the interview. Objective descriptions of events, place, time, activities, and dialogue were recorded as completely and objectively in the observational notes. It was important to record observations while still in the process of collecting data because memory was bound to fail if too long a delay (Polit & Hungler, 1999). The second interview session was mainly to review and clarify the draft text of previous interview and participants were encouraged to make corrections if necessary.

Data collection continued until the researcher believed data saturation had been achieved. This was carried out by reviewing the data collected after each interview session, and checking the data collected with the research questions in the study. The researcher also used different styles of asking during the next interview session, till the same data was collected and no new data appeared, and also checking with experts. Then data saturation was said to be achieved (Polit & Hungler, 1999; Streubert & Carpenter, 1995). Overall stories became somewhat repetitive by the eighth case. Data saturation was completed when 10 cases were analyzed.

## Data Analysis

The process of data analysis and hermeneutic interpretation were executed in two phases. The first phase was conducted concurrently with the data collection. The purpose was to identify and reflect on the preliminary themes and the structure of the experiences of caring by the caregivers for their family members with chronic schizophrenia. This involved manual exploration of the preliminary themes and structure of the studied experience and returning to validate preliminary insights with caregivers. Sometimes validation of data was carried out via telephones.

During this phase, the audiotaped interviews were transcribed verbatim into written language first in Malay and then translated into English. Each line of the transcription was numbered, field notes were added at appropriate place of each typed transcription. An experienced language teacher and translator with proficiency on both languages, that is, English and Malay, and in medical terms, from the Language and translation Unit, USM, was invited to review the transcripts. All transcribed interviews in this study were kept within the source language (Malay) during open coding, in order to keep the original meaning of the narrative. Some of the transcriptions were translated and renamed for better understanding within the English language.

The second phase of data analysis and hermeneutic interpretation were conducted after the researcher had withdrawn from the fieldwork. The analysis task in this phase consisted of developing family profiles for each caregiver based upon demographic variables descriptive analysis. Then the researcher proceeded to manual data analysis. Using Giorgi's method as a guide, the data collected were analyzed in

five stages: reading the interviews, rereading the interview, examining previous meaning units or themes, reflecting upon the meaning units or themes, and formalizing a consistent description of the structure of the phenomena under study.

### **Step 1: Reading the Interviews**

Reading the interviews meant reading the entire description of the 10 cases of verbatim transcriptions. The purpose of reading the interviews was to obtain an overall picture or to get the sense of the whole of the caring experience (Giorgi, 1970, cited in Burns & Grove, 1997)

### **Step 2: Rereading the Interviews**

Each interview transcription was then read again in a purposeful manner to delineate each time that a transition in meaning occurs. This was done with the intention of discovering the essence of lived experience of caring by the caregivers. The end result was a series of meaning units or themes (Giorgi, 1970 cited in Burns & Grove, 1997). A meaning unit was “a coherent expression of meaning comprising one or usually more sentences” (Natterlund & Ahlstrom, 1999, p. 1332).

### **Step 3: Examining Previous Meaning Units or Themes**

Each meaning unit or theme was systematically examined for redundancy, clarification, or elaboration by relating meaning units to each other and to a sense of the whole. Categories were developed which represented a higher level of abstraction. Meaning units or themes not related were also categorized appropriately. The result was an intensive listing of categories (Giorgi, 1970 cited in Burns & Grove, 1997).

#### **Step 4: Reflecting Upon the Meaning Units or Themes**

The meaning units or themes were reflected upon and the essence of the experiences of caring were extrapolated for each caregiver. During this step, each unit was transformed into the language or concepts of science (Giorgi, 1970 cited in Burns & Grove, 1997).

#### **Step 5: Formalizing a Consistent Description of the Structure of the Phenomena Under Study**

The final step involved formalizing a consistent description of the structure of the experiences of caring by caregivers for members with chronic schizophrenia. This was done by synthesizing and integrating the insights achieved in the previous steps into the descriptive structure of the meaning of the experience (Giorgi, 1970 cited in Burns & Grove, 1997).

Throughout the process of data analysis and hermeneutic interpretation to develop the structure themes, major themes were identified and were used to describe the structure of the lived experiences of family caregivers caring for members with chronic schizophrenia.

The researcher began by reading the entire descriptions of the 10 cases verbatim transcriptions. This reading gave the researcher an overall picture or sense of the whole of the caring experiences by the 10 family caregivers.

Then the researcher read the interviewed transcriptions of her first case, this time in a purposeful manner with the intention to discover the essence of the lived experience by the family caregiver. During this time, original tape of this case which consisted of three interview sessions were replayed in order to provide a picture and memory of the atmosphere of interview. The researcher listened and thought about the

meaning that was being said. Once an understanding of the overall text data of this case was obtained, data were examined line by line. All important phrases in the text that revealed the essence of the experience were underlined and labeled with tentative theme names on the text margin. Tentative theme names that have similar meanings were named as meaning units. A meaning unit is “a coherent expression of meaning comprising one or (usually) more sentences” (Natterlund & Ahlstrom, 1999, p. 1335).

Next the researcher extracted passages that have similar meaning units to be able to look at them together. Each meaning unit was systematically examined for redundancy, clarification, or elaboration by relating meaning units to each other and to a sense of the whole. Categories were developed from these similar or recurrent meaning units. Meaning units not related were also categorized appropriately. The result was an intensive listing of categories (Giorgi, 1970 cited in Burns & Grove, 1997). Categories were defined and researcher proposed preliminary tentative themes in which meanings were kept as close as possible to the original data. Similar categories were grouped together and coded.

The next two cases of transcribed interviews were repeated each using the same steps, to bring out a comprehensive sense of data as a whole and to compare with the emerged themes of each case. This resulted a set of preliminary tentative themes of the first three cases. The researcher repeated the steps for each transcribed interview for the last seven cases. The tentative themes that emerged from these seven cases were linked and compared across the preliminary tentative themes of the first three cases. The exemplars or particular incidents were identified to support the identification of the common themes. The researcher then cited constitutive patterns and illustrated the relationships of themes to one another into categories.

The final step involved formalizing a consistent description of the structure of the experiences of caring by caregivers for members with chronic schizophrenia. The researcher synthesized and integrated the insights achieved in the previous steps into the descriptive structure of the meaning of the experience. Here the researcher collected categories into clusters under specific headings, which were guided and linked, to other categories and sub-categories. For example, the structure of “meaning of caring” reflected the relationship of within three sub-categories: “caring for the well-being”, “responsibility as a parent”, and “being a burden”. The sub-category “responsibility as a parent” was linked to two other sub-categories: “caring for the sick child” and “providing unconditional love”.

Throughout the process of data analysis to develop the structure of themes using hermeneutic interpretation and Giorgi’s analysis as a guide, 20 major themes were identified and used to describe the lived experiences of family caregivers caring for members with chronic schizophrenia.

### **Trustworthiness of the Data**

The purpose of the hermeneutic phenomenological approach is to achieve understanding through interpretation of the phenomena under study (Allen & Jesen, 1990). The researcher serves as a means to transfer to the reader the participant’s life world related to experience of caring, and being the sole instrument for data collection and analysis, biases might be created. Thus, to establish trustworthiness in this study the researcher will select the evaluation criteria based on the work of Lincoln and Guba (1985) and Sandelowski (1986). The criterias were: (1) truth value or

credibility, (2) applicability or transferability, (3) consistency or dependability, and (4) neutrality or confirmability.

### **1. Truth Value or Credibility**

Truth value or credibility refers to how accurately the descriptions of an individual's experiences are revealed to the researcher (Lincoln & Guba, 1985). The researcher had been staying in Kelantan for about 15 years. She had experience as a nurse for 15 years and 5 years as a clinical nurse educator teaching nursing related to psychiatric mental health. Thus, she had fore-structure of understanding related to the participants' culture, tradition, language, dialect, life styles, and their social values. She would not be a stranger to the participants, and this had helped her to build close relationship and trust with the participants in the study (Lincoln & Guba, 1985). This intuitive process greatly helped the researcher to be immersed in the phenomenon under study (Polit & Hungler, 1999). Using the same language as the participants meant greater accuracy of the interpretations of the situation (Field & Morse, 1990). Hence, increasing the probability that the findings and interpretation were more credible (Lincoln & Guba, 1985).

The researcher used interviewing and non-participant observation as data collection modes. Using these two methods the researcher sort out "true" information from "error" information (Polit & Hungler, 1999). The researcher also used field notes to record findings, activities and any relevant issues that were not asked during the interview such as body language, tone of voice and environmental distractions. The fieldnotes were used by researcher for reflection and self-evaluation and served as a record for researcher own construction of meaning. Medical records with information such as history of the care-recipient's illness, and duration of diagnosis

were used to help to contribute to the credibility of the information for each participant. The participants were asked to respond to summaries of their comments and to note whether these summaries were correct. According to Lincoln and Guba (1985) this member check was the most important technique for establishing credibility of qualitative data.

## **2. Applicability or Transferability**

Applicability or transferability refers to the probability that the findings of the study had meaning to others in similar situations or in other words, generalizability of the data. (Lincoln & Guba, 1985; Streubert & Carpenter, 1995). According to Lincoln and Guba (1985) “it is not the naturalist’s task to provide an index of transferability; it is his or her responsibility to provide the *data base* that makes transferability judgments possible on the part of potential appliers” (p. 316). In view of this, the researcher provided “proper” thick description or sufficient data of the research settings, contexts and reports of this study so that those who were interested could evaluate the applicability of the data to other contexts.

## **3. Consistency or Dependability**

It is a criterion, which is met through obtaining credibility of the findings (Streubert & Carpenter, 1995). The researcher had invited a trained language teacher, proficiency in both English and Malay to examine translations of data from Malay to English. Two expert researchers, who were advisor and co-advisors of this research, checked the interpretations of the data and findings. This helped to reduce the possibility of biased or one-sided analysis and interpretation of the data (Polit & Hungler, 1999; Streubert & Carpenter, 1995). On the part of the researcher, she ensured that all records and notes were properly and accurately filed and coded to

ease reporting problem. The researcher maintained the reports as close to the participant's words, and maintaining the metaphors used by participants. The themes that emerged from the study would be supported by exemplars for each participant in the study.

Any interested researcher who may wish to replicate this study can achieve dependability or consistency by carrying out a new study, following the research process in this study, from beginning till the end. The findings should be expected to be similar with the research results of the same phenomena.

#### **4. Neutrality or Confirmability**

Due to the nature of hermeneutic phenomenological approach of this study, the researcher would try to eliminate any biases in all the stages of the research process. According to Oiler (1989) the credibility of the data depends on the researcher's interviewing skill. Thus, to gain experience in interviewing skills, the researcher had conducted a pilot study on two participants using the interview guide. Also, during all the interviews a tape recorder was used to record the conversations, which were transcribed verbatim in Malay, thereby increasing the accuracy of the data. Throughout the process of data collection and data analysis, the researcher continued to address personal bias, assumptions and pre-understanding of these beliefs by writing down information about self, any ideas, feelings, or responses that emerged, any information about methodological decisions and the rationale for making them, on field notes and personal notes as reflexive journal (Lincoln & Guba, 1985).