

Self-Care among Thai People with Heart Failure

Juntima Rerkluenrit, Orasa Panpakdee, Porntip Malathum, Margarete Sandelowski, Supachai Tanomsup

Abstract: This grounded theory study aimed to explore self-care management among Thai people with heart failure. The participants were 35 Thais with heart failure. In-depth interviews were the method of data collection. Constant comparison and a coding process were the basic analysis methods.

The study findings shed light on “the process of self-care management to live with heart failure.” This process consisted of three phases, including: Phase 1- Before becoming a person with heart failure; Phase 2 - Becoming a person with heart failure; and, Phase 3 - Living with heart failure. In Phase 1, the participants perceived they had an underlying disease, but lacked an awareness of the consequences of having the disease. Thus, they abandoned adhering to the medical treatment regimens when they no longer experienced symptoms. Moreover, they sought assistance both from complementary therapies and modern medical treatments. Finally, each accepted that s/he became a person with heart failure. In Phase 2, the participants adjusted their lifestyles so as to strictly follow the medical treatment regimens. They became dependent on others, which made their self-worth decrease. However, support from family and friends encouraged them to live with heart failure, and they then moved to Phase 3. In the last phase, the participants adjusted the medical treatment regimens to suit their lives and found out how they could reconstruct their self-worth.

The findings offer a new insight into the process of self-care management among Thais with heart failure, which can be used as basic information to: (a) develop a specific intervention program for people with heart failure; and, (b) motivate patients to engage in effective self-care.

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Background and Significance

of the Problem

Heart failure has become a major health problem and a serious source of human suffering during the past three decades.^{1, 2} Because it is incurable, with a threatening prognosis, heart failure usually contributes to the death and disability of millions of people.³⁻⁵ Mortality rates of heart failure are as high as 10–20 %, within the first year, and nearly 50 %, within five

Correspondence to: *Juntima Rerkluenrit, RN, PhD Candidate, Department of Nursing, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand.*

*E-mail: juntima@swu.ac.th; aee_swu@hotmail.com
Orasa Panpakdee, RN, DNS, Associate Professor, Department of Nursing, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand.*

Porntip Malathum, RN, PhD, Assistant Professor, Department of Nursing, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand.

Margarete Sandelowski, RN, PhD, FAAN, Boshamer Distinguished Professor, School of Nursing, University of North Carolina at Chapel Hill, U.S.A.

Supachai Tanomsup, MD, FRCPC, FRGC, FSCAI, Associate Professor, Department of Medicine, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Thailand.

years, of the onset of symptoms.^{6, 7} Survivors of heart failure continue to live with anguish, limited functional capacity and poor quality of life.⁸⁻¹³ In addition, the increasing incidence and prevalence of heart failure have been steady, for several years, in all countries.¹⁴ In Thailand, heart failure is a disease that is becoming a focus for health care services. More than one million Thais have heart failure, with roughly 100,000 new cases annually diagnosed.¹⁵

The diagnosis of heart failure refers to the inability of the heart to pump adequate blood to meet the oxygen and nutrient consumption of bodily tissues.¹⁶ Therefore, the life situation, physical functioning and emotional well-being of people with heart failure are impaired.¹⁷⁻¹⁹ Such individuals tend to face fear, anxiety, depression and uncertainty regarding their future, health and families' future.²⁰⁻²⁴ Moreover, when compared with people who have other chronic illnesses, those with heart failure have demonstrated poorer social and role functioning, as well as a staggering rate of hospital readmission.^{16, 25}

In Thailand, governmental care policies focus on discouraging readmission. Under the 8th-9th National Economic and Social Development Plans (1998-2002; 2002-2006), the Thai government launched, in April 2001, the Universal Health Care Coverage Policy dubbed the "30 Baht Health Scheme."^{26, 27} Using this scheme, people pay 30 Baht (USD 0.92) for each visit.²⁸ This policy aims at providing Thais access to a standard of health care. The Universal Health Care Coverage aims not only to provide curative care, but also disease prevention and health promotion. The concept of self-care has been promoted actively for Thais.²⁷

However, self-care in heart failure is complex, because it involves several aspects, taken simultaneously, including pharmacologic, dietary and self-monitoring regimens regarding daily weighing and seeking assistance when symptoms occur.¹³ In previous studies, researchers have emphasized parts

of self-care, including determinants of adherence to prescribed regimens, ability to identify signs and symptoms and factors influencing self-care, rather than the whole picture of self-care management.^{13, 29-32} Several investigations have been conducted to elicit the perspectives of those with heart failure regarding their experiences with the condition.^{5, 33-36} In addition, most studies have used instruments and quantitative methods constructed from the researchers' perspective, rather than the patients' perspectives. Thus, the results have not been grounded in individual data. Missing from the literature is descriptive information from the Thai people's perspectives of the effect of heart failure on their lives, and the identification of what they are doing on their own behalf. The present study aimed to fill this gap.

Knowledge obtained from this study may lead nurses and other health care providers to gain insight and better understanding about patients' perceptions of heart failure, as well as the ability to provide meaningful care in order to help people manage their illness. In addition, this information will assist in designing and testing interventions to facilitate better care, in the future, of patients with heart failure.

The Purpose of the Study

The purpose of this study was to explore self-care management among Thai people with heart failure and then generate a substantive theory of self-care management of Thai people with heart failure.

Method

Design: The grounded theory method, as described and interpreted by Strauss and Corbin,³⁷ was used. The grounded theory method was selected, since it generates a substantive theory grounded in empirical data and is derived from the participants' perspectives. The study was conducted over a period of 14 months (November 2006 to December 2007)

in three tertiary care hospitals. Two of the hospitals were located in Bangkok and one was located in Nakorn-Nayok. These hospitals were selected because they were able to provide an adequate number of participants with heart failure.

Participants: All participants were recruited, using purposive selection, from the list of patient names in the cardiac clinics at the three data gathering sites. They were selected based upon their willingness to participate and communicate their ideas and feelings. Both criterion and theoretical sampling were employed. The selection criteria included individuals who were: 1) diagnosed with heart failure by a cardiologist; 2) over 18 years old; and, 3) born, raised and presently living in Thailand. In addition, theoretical sampling was employed to achieve a theoretically complete account of self-care management among Thais with heart failure. Thirty-five Thais (16 women and 19 men) were interviewed to achieve theoretical saturation.

Data Collection: Data collection occurred after approval was received from the Research Committee for Ethics of each hospital and the primary investigator's academic institution, and each participant gave written informed consent. The participants were informed about the: objectives of the study; interview process; possible number of interviews involved; and, fact they could withdraw from the study at any time without any negative repercussions. A guide was used for in-depth interviewing. To maintain confidentiality and privacy of the participants, all were interviewed individually, by the primary researcher, in their respective homes. Interviews were tape-recorded, with each participant's permission. In addition, non-verbal behaviors were recorded in process notes.

Data Analysis: Data collection and analysis were carried out in parallel, starting with the first interview. The Strauss and Corbin analysis method³⁷ was used as a framework to guide data analysis. The audio-taped interviews were transcribed verbatim. During the analysis process, which consisted of open, axial and selective coding, transcripts were repeatedly

read line-by-line and coded. After coding, information from interviews, memos and field notes were analyzed to identify the categories and themes. Constant comparisons were made to identify differences and similarities of themes within and between participants. Similar data were grouped and conceptually labeled. Concepts were categorized. Categories that were linked and organized by relationship, conditions and dimensions were developed. A model of self-care management of Thais with heart failure was constructed. Elements of this model were reviewed by the participants and members of the research team, in order to optimize validity of the study.

Findings

Self-care management was identified as a process taken by participants, with or without assistance, from others and related to their perception about heart failure. The self-care management process (see **Figure 1**) is composed of: causal conditions; meanings of events to people with heart failure; series of actions taken; intervening conditions; and, consequences of actions. Causal conditions and meanings of events, as antecedents of self-care performances, guided the participants in how to take self-care actions. In addition, self-care performances also depended on intervening conditions, which referred to facilitators or barriers associated with self-care. Self-care management consisted of three phases: Phase 1 - *Before becoming a person with heart failure*; Phase 2 - *Becoming a person with heart failure*; and, Phase 3 - *Living with heart failure*.

Phase 1: Before Becoming a Person with Heart Failure

This phase involved the self-care management process in the pre-diagnosis stage of heart failure. It consisted of two sub-phases: Sub-phase 1.1: *Having underlying diseases*; and, Sub-phase 1.2: *Confronting Worsening Symptoms*.

Sub-phase 1.1: Having Underlying Diseases

This sub-phase referred to a situation where participants perceived they had become persons with illnesses, such as myocardial infarction, hypertension and coronary artery disease. They gave meaning to their underlying health problems as a life-threatening disease, a disease without complications and a curable disease. In addition, they wanted to return to normal. Participants realized adherence to medical treatment regimens enabled them to achieve their goal. However, they did not understand that their health problems could have lead to heart failure, or that they needed to take care of themselves. Intervening conditions, such as educational level, socioeconomic status, family support and the participants' beliefs, served as either facilitators or barriers associated with self-care.

Self-care action in this sub-phase consisted of two performances: adhering to medical treatment regimens, while experiencing symptoms; and, abandoning adherence to the medical treatment regimens, due to having no symptoms. As a consequence of abandoning adherence to medical treatment regimens, confronting worsening symptoms was unavoidable. A 61 year old woman indicated:

At that time, I thought my disease [coronary artery disease] had already been cured after following the medical treatment regimens for years. I thought no symptoms occurred; it meant I did not have any illness. Consequently, I stopped adhering to the medical treatment regimens ... Later on I found that I became more easily tired. I did not look like I used to... before stopping my medical treatment regimens.

Sub-phase 1.2: Confronting Worsening Symptoms

The participants perceived that symptoms, such as shortness of breath, lack of energy (fatigue) and

shivering heart (palpitation), threatened their lives. They realized that more serious symptoms happened frequently, and they could not control them. In addition, worsening symptoms disturbed their abilities and tolerance to carry out day-to-day activities. Therefore, the participants gave two meanings of worsening symptoms as: Something unknown and critical, and something bothering day-to-day life. A 59 year old woman stated:

I felt as if I was drowning in my sleep. I had to get up several times a lot of nights. I tried to use three pillows for sleeping, but I didn't feel better ... I didn't know what happened to me ... Just climbing up stairs made me so exhausted ... I had to decrease my activities.

Participants had ways to manage worsening symptoms which consisted of four performances: 1) alleviating symptoms by oneself; 2) seeking assistance; 3) searching around for the diagnosis; and, 4) appraising the effectiveness of medical treatment regimens. When symptoms first occurred, participants tried to explain away the causes and independently manage the symptoms. However, they could not control the symptoms using previously effective methods. Thus, based on their symptoms, they used complementary therapies and modern medical treatments. When they received a diagnosis of heart failure, they did not readily accept it. Rather, they asked for a retest and/or sought a second opinion. One of the barriers (intervening condition) to accepting the diagnosis of heart failure was the participant's age at diagnosis. A 34 year old woman shared her story as follows:

I didn't believe the physician's diagnosis of heart failure. I'm too young to be sick with heart failure and nobody in my family has had heart failure.

However, the participants acknowledged that worsening symptoms required immediate treatment. Upon following medical treatment regimens, they experienced positive outcomes. Finally, perception and acceptance of becoming a person with heart failure occurred. A 52 year old woman reflected:

It was difficult to tam-jai [accept] that I had a serious health problem. It took me a long time to ask the doctor ... Finally, I accepted I had heart failure because I felt better after following the medical treatment regimens.

Phase 2: Becoming a Person with Heart Failure

This phase referred to the situation where each participant became a person with heart failure. As demonstrated in the following statements, made by a 68 year old man, participants began trusting physicians, and strictly followed, as if they were robots, prescribed medical treatment regimens:

I thought I became a robot because I trusted in the doctor. When the doctor said, "Turn right," I turned right. When he said, "Turn left," I turned left.

Because they were inexperienced with their illness, the participants called themselves "novices about heart failure." A 62 year old man commented:

Heart failure was like a broken car—an expensive car, and I was a novice mechanic. I had no skill whatsoever to take care of it.

As for becoming a person with heart failure, participants confronted: 1) physical limitations; 2) difficulty following medical treatment regimens; 3) negative emotional responses; 4) financial problems; and, 5) unpleasant experiences at the hospital. A 46 year old man remarked:

My life turned from white to black overnight. I can't work ... I no longer think of sexual activities ... During my hospital stay at night, I was irritated by whispers between nurses and other patients, and by fear of ghosts.

According to their unpleasant experiences, the participants gave five meanings of heart failure, including a disease of: life or death; dependency on medications; social functional limitation; karma; and, an uncertain situation. A 41 year old woman reflected on her experiences:

Heart failure threatened life. I couldn't predict when symptoms would happen ... When they occurred; it seemed as if I were standing on the edge of a cliff.

Because of previously mentioned antecedents, the participants in this phase used self-care actions in four ways: 1) learning about heart failure; 2) seeking and simultaneously utilizing complementary therapies together with modern medical treatment regimens; 3) seeking support; and, 4) adjusting life to strictly follow the medical treatment regimens. They learned about heart failure and how to take care of themselves by reading books and talking with health care providers. Participants learned they needed life-long treatment, however, they still believed it was possible to return to normal. As noted by a 47 year old woman, who followed her medical treatment regimen, but also sought traditional healers:

I took ya-mor [Thai medications] together with the modern medical treatment because the local healer guaranteed I would return to normal after taking it.

Moreover, participants sought support from many sources. Their primary source of health

information and support was their cardiologist and other health care providers. In addition, practicing religious activities also gave them emotional and spiritual support. The participants indicated they would calm down when meditating. Their beliefs on making “merit” seemed to facilitate their self-care. As expected, family members provided material support (finance, transportation and house cleaning). A 45 year old woman remarked:

My husband always encouraged me to get treatment, even though it meant spending a lot of money.

Finally, those in phase 2 adopted new lifestyles by closely adhering to prescribed medical treatment regimens, such as taking medications on time, altering eating habits and changing role functions. These changes are reflected in the statements of a 58 year old man, “*I set an alarm clock to remind me of my medication intake,*” as well as in those of a 45 year old woman, “*I really loved to drink a soft drink, but now I absolutely do not drink it because it contains salt.*”

Consequently, since they never had considered salt and sodium to be synonymous, and did not know which foods contained sodium, they received information about: strategies to use; side effects of diuretics; and, how to adhere to a low-sodium diet. Because the physicians trusting them to make their own decisions regarding taking diuretics, the participants had to learn when and how to make needed adjustments. A 47 year old woman described the process as follows:

The doctor told me that I could adjust the dose of water pills [diuretic] by myself, but it was difficult. Sometimes, I thought I should stop taking it, but my legs swelled-up ... I had to gradually learn how to adjust the dose.

Having become a burden on others, their self-worth was decreased, even though they were not completely disabled. A 41 year old man lamented:

My life was not my own life. It depended on others ... I couldn't work as I used to ... I had once entertained a suicidal thought.

However, the participants did not perceive only negative consequences. They realized that when they were stressed, sad or discouraged, family and friends still were there to stand by them. A 34-year-old woman stated:

Like others, I knew my mom and dad loved me, but nobody showed it until I became a person with heart failure. I clearly remember that my mom hugged me tightly, and my dad never let me go to see the doctor alone. He was always concerned with my safety.

Phase 3: Living with Heart Failure

Living with heart failure was the 3rd phase and the one in which participants developed self-perception and got on with their lives. All participants understood heart failure more than they originally had. As explained by a 62 year old woman, their perceptions about heart failure gradually changed as they learned about and experienced heart failure and self-care strategies used in the two prior phases:

My thoughts of heart failure were changed ... Although persons had the same disease, they might experience consequences of the disease in different ways.

As previously mentioned, participants gained from their family support, more self-worth and

understanding about the value and truth of life. Their key persons motivated them to take care of themselves and made them confident in the effectiveness of strategies used to manage heart failure. A 49 year old woman stated:

My mom always prayed for me. She wanted me to get better soon. She told me she loved me so much. She made me realize the worth of my life. I would take good care of myself ... I learned that I should adjust my performances according to my health status ... Now I am confident in taking care of myself.

Based on their experiences, participants gave two meanings to living with heart failure: living with a manageable situation; and, living with a chronic disease. Intervening conditions (good relationships with health care providers and the presence of social support) facilitated the participants' intent to live normally with heart failure.

With regard to the participants' desire, five self-care actions were carried out: 1) engaging in self-care; 2) reconstructing and improving self-worth; 3) adjusting the medical treatment regimens to fit life; 4) alleviating negative feelings; and, 5) planning for the rest of life. Based on family support, the participants attempted to protect themselves from danger or severity of symptoms. For example, they took note of their daily weight and, if it abnormally increased, immediately went to see the doctor. They did not buy medications, at the drug store, without a prescription. As for reconstruction of their self-worth, they maintained their independence by returning to work, doing day-to-day activities and adapting their environment to their physical limitations. A 62-year-old woman commented:

Now I can take my medications by myself by writing the instructions on the container of medications. I am not dependent on others now ... My son prepared a chair for me in the bathroom. It made things convenient for me.

In addition, participants tried living with heart failure by adjusting medical treatment regimens to fit their lives. They maintained flexibility in managing their medication consumption (i.e. diuretics) diets, daily weighing and exercise. If negative feelings occurred, they ventilated them by practicing religious worship, listening to music and talking to others (monks and psychologists). A 45-year-old woman stated:

I believe that if I make merits, my symptoms will be better because I felt better and relaxed ... I loved to talk to a monk because it reminds me of awareness and consciousness.

Lastly, participants prepared themselves and their families to ensure readiness to face the rest of life. As such, they planned for everything they wanted to do for their families. A stable and secure occupation, based on His Majesty King Bhumibol Adulyadej's principle of "sufficiency economy," was sought for their families. In addition, a number made a photo album, so, after their death, when others thought of them, they could be viewed. As revealed, by a 59 year old man, some donated their body to a hospital:

I saved an amount of money for my family to make sure that they will have a good future ... My family and I always created good memories together. My children took photographs of our family and kept them in albums ... I prepared my picture for the funeral and already donated my body to this hospital.

Because they could return to work, control the severity of symptoms and live happily with family and/or live normally with heart failure, the consequences of self-care actions, for the participants, in Phase 3, was their satisfaction with life. When heart failure became a part of their life, they felt confident about living, even though they had heart failure. A 67 year old woman shared:

I have more confidence about living with this disease [heart failure]. It may be a consequence of my experiences. Now my health status is good. I can work more than in the past. I can climb up stairs without having to rest frequently. I am happy and satisfied with my life.

Discussion and Conclusion

The model of self-care management, in this study, provides a better understanding of self-care among Thais with heart failure. Self-care management was identified as a process taken by participants with or without assistance from others. Although their families and friends were a part of their decision-making, the participants played the most important role in making decisions and taking care of themselves. This finding is similar to Orem's definition of self-care,³⁸ wherein self-care is viewed as the practice of activities that individuals initiate and perform themselves to maintain their life, health and well-being. The findings, of this study, also are similar to Orem's Self-Care Deficit Nursing Theory,³⁸ with two periods: 1) consideration and decision-making; and, 2) action and consequences of actions. In this study, the causal conditions and meanings of events, of the self-care management process, acting as antecedents of self-care actions, are congruent with a period of consideration and decision-making. A series of self-care actions and consequences of self-care performances are similar

to a period of action and consequences of actions. Intervening conditions, in the present study, such as age, gender and socioeconomic levels, are congruent with Basic Conditioning Factors in Orem's Self-Care Deficit Nursing Theory.³⁸

In addition to being similar to Orem's Self-Care Deficit Nursing Theory,³⁸ self-care management, in this study, resembles the Health Belief Model.³⁹ The findings reveal that when participants had underlying diseases, they did not regard themselves as susceptible to these diseases. Therefore, when they did not have symptoms, they abandoned adherence to treatment regimens and returned to previous lifestyles. Findings are congruent with the concept of perceived susceptibility in the Health Belief Model.³⁹ After abandoning adherence to medical treatment regimens, participants confronted worsening symptoms, which they could not manage. They perceived their lives were threatened, so they sought assistance from others and, finally, adhered to the medical treatment regimens. These findings are similar to "perception of illness threat" in the Health Belief Model.³⁹

Because the unfamiliar treatments were incongruent with their previous lifestyles, participants perceived it was not easy to adjust their lives to follow the treatment regimens. However, after learning about their heart failure, they developed confidence that they could live with it. These results are similar to the Health Belief Model³⁹ concepts, perceived benefits, perceived barriers and confidence in one's ability to take actions.

With regard to the definition of self-care, self-care management, in this study, is congruent with the definition of self-care in previous studies. Panpakdee⁴⁰ defined self-care management, among individuals with hypertension, as "a process of engaging in various activities to manage hypertension" (p.125). In addition, Sritanyarat⁴¹ viewed self-care management, among diabetics, to be a process of interaction of self and others, regarding perceptions about diabetes,

within one's own cultural health care system.

In accord with premises in grounded theory, Blumer⁴² suggests that people create meaning through self and social interaction in relation to their beliefs. In this study, participants reacted toward underlying diseases and heart failure in accordance with the meanings their diseases had to them. The meanings of their illnesses or conditions were derived from social interaction they had with others, such as health care providers, family members and others with the same illnesses. These meanings were modified through an interpretive process used by the participants when dealing with underlying diseases, worsening symptoms and heart failure. Although people with an illness already have some notion of health and illness, as a result of their experience and interactions with others, new meanings always could emerge. As presented in **Figure 1**, when meanings of health conditions are changed, self-care performances are modified.

Limitations

All studies have limitations and this study is no exception. Participants in the study were being treated in one of three hospitals in the greater Bangkok area, with the majority of them experiencing New York Heart Association (NYHA), Class III heart failure. With this classification of heart failure, the afflicted individuals had marked limitations in physical activity with comfort at rest. Thus, the generalizability of the findings is limited to individuals with the same classification of heart failure, who are being treated at a hospital in a major metropolitan area.

Implications and Recommendations

The findings of this study have implications for nursing care and research. To provide appropriate

nursing care, based upon these findings, nurses should assess people with heart failure to determine the phase of self-care management they are experiencing. The self-care approach must be tailored to each person's specific heart failure needs in each phase. For example, in Phase 1 – *Before becoming a person with heart failure*, nurses need to provide information about illnesses that can contribute to heart failure, and encourage the individual to adhere to all prescribed medical treatment regimens. However, in Phase 2 – *Becoming a person with heart failure*, when a person has just become “a person with heart failure,” nursing interventions should aim to disseminate knowledge about heart failure and its management. In addition, nursing interventions should aim to relieve negative feelings and to assist the person in realizing his/her self-worth, so as to decrease the likelihood of suicidal ideations. With respect to Phase 3 – *Living with heart failure*, nurses should realize that individuals with heart failure often have vision and hearing problems, as well as other co-morbid conditions. Therefore, nursing interventions should address the increasing need for repetitive instructions and nursing evaluation regarding integration of self-care regimens into usual daily activities.

Further nursing research is required to clinically and empirically validate the model developed in this study. Research is needed to test the concepts of the self-care management model and to assess the relationships among the concepts. In order to increase the explanatory power of the substantive theory, research should be conducted, with theoretical sampling under different conditions, such as among persons who have failed to follow-up on health care appointments. Moreover, research on the role religious beliefs play, in regards to dealing with the self-care management of heart failure, needs to be conducted.

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การดูแลตนเองของคนไทยที่มีภาวะหัวใจวาย

จันทินา ฤกษ์เลื่อนฤทธิ์, อรสา พันธ์ภัคดี, พรทิพย์ มาลาธรรม, Margarete Sandelowski,
ศุภชัย อนอมทรัพย์,

บทคัดย่อ: การวิจัยเชิงคุณภาพแบบการสร้างทฤษฎีจากข้อมูลพื้นฐาน(Grounded theory) ครั้งนี้มีวัตถุประสงค์เพื่อศึกษากระบวนการจัดการดูแลตนเองของคนไทยที่มีภาวะหัวใจวาย ข้อมูลหลักได้จากการสัมภาษณ์เชิงเจาะลึกจากผู้ที่มีภาวะหัวใจวาย จำนวน 35 คน และวิเคราะห์ข้อมูลเชิงเปรียบเทียบข้อมูลร่วมกับกระบวนการให้รหัส

ผลการศึกษาพบว่าการดูแลตนเองของผู้ที่มีภาวะหัวใจวายเป็น “กระบวนการจัดการดูแลตนเองเพื่อการมีชีวิตอยู่ในภาวะหัวใจวาย” โดยแบ่งออกเป็น 3 ระยะคือ ระยะที่ 1 “ระยะก่อนมีภาวะหัวใจวาย” ในระยะนี้ผู้ที่มีภาวะหัวใจวายไม่ทราบว่าโรคที่ตนอาจเป็นนั้นสามารถนำไปสู่ภาวะหัวใจวายได้ จึงเข้ารับการรักษาไม่ส่วนมากและลองใช้วิธีการรักษาที่หลากหลายทั้งการรักษาแบบพื้นบ้านและการรักษาแผนปัจจุบัน จนยอมรับว่าตนอาจมีภาวะหัวใจวาย ในระยะที่ 2 “ระยะมีภาวะหัวใจวาย” ในระยะนี้ผู้ที่มีภาวะหัวใจวายปรับเปลี่ยนวิถีชีวิตของตนอาจใหม่เพื่อให้สอดคล้องกับแผนการรักษาอย่างเคร่งครัด แต่รู้สึกว่าความมีคุณค่าของตนอาจลดลงเนื่องจากต้องพยายามพากเพียรอย่างไรก็ตามผู้ที่มีภาวะหัวใจวายได้พยายามลีบสันสนับสนุนจากครอบครัวและเพื่อน จึงทำให้มีกำลังใจในการดูแลตนเอง ในระยะที่ 3 “ระยะของการมีชีวิตอยู่อย่างปกติในภาวะหัวใจวาย” เป็นระยะที่เกี่ยวข้องกับการควบคุมภาวะหัวใจวายและการสร้างเสริมความมีคุณค่าของตนอาจเพื่อการมีชีวิตอยู่ร่วมกับภาวะหัวใจวาย ผู้ที่มีภาวะหัวใจวายปรับแผนการรักษาให้เหมาะสมกับวิถีชีวิตของตนเอง โดยมีลักษณะส่วนบุคคล ลักษณะทางคลินิก และความเชื่อเป็นทั้งสิ่งที่สนับสนุนหรือเป็นอุปสรรคในการดูแลตนเองในแต่ละระยะ

ผลการศึกษาครั้งนี้ชี้ให้เห็นกระบวนการจัดการดูแลตนเองของผู้ที่มีภาวะหัวใจวายในแต่ละระยะเพื่อเป็นข้อมูลพื้นฐานให้แก่แพทย์และพยาบาลเข้าใจและวางแผนการดูแลทั้งด้านการป้องกันภาวะแทรกซ้อน และการจัดการกับอาการในแต่ละระยะ เพื่อส่งเสริมคุณภาพชีวิตของผู้ที่มีภาวะหัวใจวายให้ดีขึ้นตามศักยภาพ

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คำสำคัญ: การจัดการดูแลตนเอง คนไทย ภาวะหัวใจวาย การสร้างทฤษฎีจากข้อมูลพื้นฐาน (Grounded theory)

ติดต่อที่: จันทินา ฤกษ์เลื่อนฤทธิ์, RN, PhD Candidate ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล ประเทศไทย E-mail:juntima@swu.ac.th; aee_swu@hotmail.com
อรสา พันธ์ภัคดี, RN, DNS, รองศาสตราจารย์ ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล ประเทศไทย
พรทิพย์ มาลาธรรม, RN, PhD, ผู้ช่วยศาสตราจารย์ ภาควิชาพยาบาลศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล ประเทศไทย
Margarete Sandelowski, RN, PhD, FAAN, Boshamer Distinguished Professor, School of Nursing, University of North Carolina at Chapel Hill, U.S.A.
ศุภชัย อนอมทรัพย์, MD, FRCPC, FRGC, FSCAI, รองศาสตราจารย์ ภาควิชาอายุรศาสตร์ คณะแพทยศาสตร์โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล