

**FAMILY SUPPORT IN SELF-CARE OF MYOCARDIAL
INFARCTION PATIENT'S AFTER DILATE
CORONARY ARTERY**

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FAMILY SUPPORT IN SELF-CARE OF MYOCARDIAL INFARCTION PATIENTS AFTER DILATION OF THE CORONARY ARTERY

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ABSTRACT

Family support is socio-psychologically related to health and health behavior and positively affects health, particularly during sickness. This qualitative research was conducted to find an answer to the question of how important is family support in infarction patients re-admittance after their dilated coronary artery applied concept of social support of Cobb and Schaefer as approach in associate with the humanistic concept of Kleinman and Parsons. Ten purposive samples were selected using a Catheterization Laboratory of a hospital in Bangkok, during MAY- AUGUST 2004. Instrument used were in-depth interviews, observation and case study.

It was found that all samples had been supported by families in terms of emotion, affection, care, recognition, acceptance, and esteem and all members in the family had a high level of commitment. However, such support did not develop self-care behavior among samples and indeed discouraged such behavior. Self-care of patients developed from perception of their role during coma, sickness experience, and comparisons to previous disease. Self-care of all patients was similarly intended to cure or prevent the acuteness or recurrence, i.e. dose taking behavior, however, other self-care behaviors were neglected. Also, from the experience of sickness of the patients, it was found that myocardial infarction would be better dealt with and not threatening life if threatened only by a Physician. Modern medical technology allows better treatment rather than readjustment of behaviors, which is more difficult. Therefore, family support only needs to spend a little time correcting a stroke patient's behavior. Good self-care developed only when a patient suffered a serious complication such as a coma. Had there not been a serious complication during coma or stroke, the myocardial infarction patients would not be strict in their self-care behavior.

KEY WORDS: FAMILY SUPPORT/ SELF-CARE/ MYOCARDIAL INFARCTION PATIENTS/ AFTER DILATION OF THE CORONARY ARTERY

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การสนับสนุนในครอบครัวกับการดูแลตนเองของผู้ป่วยโรคกล้ามเนื้อหัวใจตาย ภายหลังได้รับการ ขยายหลอดเลือดหัวใจ (FAMILY SUPPORT IN SELF-CARE OF MYOCARDIAL INFARCTION PATIENTS AFTER DILATION OF THE CORONARY ARTERY)

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บทคัดย่อ

การสนับสนุนในครอบครัว เป็นปัจจัยทางจิตสังคมที่มีความสัมพันธ์กับสุขภาพ และพฤติกรรมอนามัย และเป็นสิ่งทีก่อให้เกิดผลดีต่อภาวะสุขภาพ โดยเฉพาะอย่างยิ่งในภาวะ เจ็บป่วย การวิจัยเชิงคุณภาพครั้งนี้มีวัตถุประสงค์เพื่อจะตอบคำถามว่าผู้ป่วยโรคกล้ามเนื้อหัวใจตาย ภายหลังได้รับการขยายหลอดเลือดหัวใจ ได้รับการสนับสนุนในครอบครัว ในการดูแลตนเอง อย่างไร โดยใช้กรอบแนวคิดทางด้านการสนับสนุนในสังคมของคอบบ์ และเซฟเฟอร์ เป็น แนวทางและแนวคิดทางด้านมนุษยวิทยาของ Kleinman และ Parsons โดยเลือกกลุ่มตัวอย่างแบบ เจาะจงตามคุณสมบัติที่กำหนด ในแผนก Catheterization Laboratory : Cath Lab ของโรงพยาบาลศูนย์ แห่งหนึ่งในกรุงเทพฯ ระหว่างเดือนพฤษภาคม – สิงหาคม พ.ศ.2547 จำนวน 10 ราย เครื่องมือที่ใช้เก็บ รวบรวมข้อมูล คือ การสัมภาษณ์แบบเจาะลึก และการสังเกต และจัดนำเสนอในรูปแบบของกรณีศึกษา (case study)

ผลการศึกษา พบว่า กลุ่มตัวอย่างทุกรายได้รับการสนับสนุนในครอบครัวในด้านอารมณ์ ความรัก การเอาใจใส่ และยกย่อง ขอมรับ เห็นในคุณค่า ทำให้ทุกคนในครอบครัวเกิดความผูกพันกัน มากขึ้น แต่การสนับสนุนดังกล่าวไม่ได้ก่อให้เกิดการมีพฤติกรรมดูแลตนเองของกลุ่มตัวอย่างที่ เปลี่ยนไปจากเดิม พฤติกรรมดูแลตนเองของกลุ่มตัวอย่างเกิดขึ้นจากการรับรู้บทบาทผู้ป่วย ในช่วงภาวะ วิกฤติของโรค และจากประสบการณ์การเจ็บป่วย เปรียบเทียบความรุนแรงของโรคที่ผ่านมา พฤติกรรม ดูแลตนเองที่กลุ่มตัวอย่างทุกรายกระทำเหมือนกันหมด เพื่อให้เกิดการหายของโรค หรือเพื่อป้องกัน ไม่ให้โรคกำเริบ ไม่กลับเป็นซ้ำ คือ พฤติกรรมด้านการรับประทานยา ทำให้ละเลยพฤติกรรมดูแล ตนเองในด้านอื่น ๆ และด้วยจากประสบการณ์การเจ็บป่วยของกลุ่มตัวอย่างที่พบว่าโรคหัวใจและหลอดเลือด คณิตนี้จะทุเลาไม่คุมคามชีวิตก็ต่อเมื่อได้รับการแก้ไขโดยแพทย์เท่านั้น รวมทั้งวิทยาการสมัยใหม่ที่เกิด จากแพทย์ ทำให้กลุ่มตัวอย่างเกิดความง่ายและชินที่จะยอมให้โรคได้รับการแก้ไขเช่นนี้ ดีกว่าการต้อง ปรับเปลี่ยนพฤติกรรมตนเอง ซึ่งทำได้ยากมาก ดังนั้นการสนับสนุนในครอบครัวมีส่วนน้อยในการทำ ให้ผู้ป่วยโรคหัวใจเกิดพฤติกรรมดูแลตนเองที่ถูกต้อง พฤติกรรมดูแลตนเองของผู้ป่วยเกิดจากการรับรู้ ต่อความรุนแรงของโรค ในช่วงภาวะวิกฤติในชีวิตเท่านั้น ถ้าโรคไม่อยู่ในภาวะวิกฤติ หรือกำเริบ ผู้ป่วยโรคหัวใจและหลอดเลือดจะไม่แสดงพฤติกรรมการดูแลตนเองที่เคร่งครัด

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CHAPTER 1

INTRODUCTION

1.1 Nature and Significance of Problem

The cardiac and arterial disease reserves its first rank to claim the lives of the Thai people for 10 years till present. The leading cause is the Myocardial Infarction. It is the health problem and critical worldwide by the increasing number of patients. It is lethal to the life amongst all cardinal diseases. Besides, it is a restenosis disease. (Briody, 1984:387 referred in Prabha Ratanamethanont, 1989). The Myocardial Infarction is caused by a coronary artery and there are many ways of treatments, i.e. PCI (percutaneous coronary intervention), or PTCA (percutaneous transluminal coronary angiography) or CABG (coronary artery bypass graft). Form studies, 400,000 cases were treated each year in the United States of America (USA) (Brain & Crossman, 1998:1375 referred in Phenroong Pholkanjanakorn, 1998). This treatment has been first used in 1987 and trends are improving. It is likely that the reticle string is potentially successful and rapidly relieves heart pain as well as viable to activate better and the patient can return to work faster than being treated by medicine (ACME. 1992cited by Mark et al., 1994:2015 referred in Phenroong Pholkanjanakorn, 1998 Phenroong Pholkanjanakorn, 1998). Comparing employing CABG, it is found that enlarging the coronary artery with reticle string allows patient to stay shorter period in the hospital with no trace of surgery and faster return to work side-effect free from operation and surgical anesthesia as well as economizing. (Allen et al., 1990:921; Fitzgerald et al., 1996:24; Mahanonda et al., 1996:454 referred in 1998 Phenroong Pholkanjanakorn, 1998)

The myocardial infarction patient treated by any approaches, the patient is still facing in the chronic condition, i.e. definitely taking doses, and under medical cares. It is not only making patient unhappy but also increasing expenses and times to the patient itself and the family. It potentially affects the physically, psychologically,

economically and socially. The myocardial infarction is acute to life and with high rate of death (Central Bureau of Statistics, 1986). In studying the long-term effects it is found that 20-30% of patients survived the myocardial infarction have met critical and prolong socio-psychological problems. (Maeland and Havik, 1989; NHS Center for Review and Dissemination, 1998). Therefore the spouse of the myocardial infarction patient with its ailments it highlights criticality of life when the patient needs both short-term and long term readjustment. (Coyne and Smith, 1991; Mecee et al. 1994; Scott and Badura 1998; Shanfield, 1990; Thompson and Meddis, 1990 referred in Elihallaraker et al., 2001:343). This group of patients needs to be aware and perceives their own health. From the study of Natsupha Chaladsunthornwathee (1996), it is found that the myocardial infarction patients less perceive their selfcare. By assessing it is necessary for selfcare activities and assessing that activities are not difficult, it is found that the patients understand and are aware of selfcare particularly after treated by PCI/ PTCA. Similarly, from the study of Phenroong Pholkanjanakorn, (1998), it is found that the result of stent treatment is leverage quality life and health condition better. However, it is still met with limitations and the most critical problem is high restenosis allowing the return of the coronary artery and the myocardial infarction. It is found form the report that PCI/ PTCA would likely meet restenosis at 30-50% during first 3-6 months. (Kotamaki et al. 1996:293; Watanabe et al. 1996:23; Selwyn and Braunwald, 1998:1372 referred in Phenroong Pholkanjanakorn, 1998). Causes of retenosis were many and self-care was one of them. In addition, from the study of Natsupha Chaladsunthornwathee (1996) related to family support, it was found that relation within family had positive relationship with necessity of self-care among patients by statistical significance.

The concept of family support related to selfcare of the stroke patients is the factor of socio-psychology related to behavior, which has been prevailed for reasearhes and popular during 1970 (referred in Benjawan Kamthornwatchara, 2002:25) . Most are surveys to find relationship between social support with health promotion, prevention and treatment referring the human nature that man is social. All born to this world cannot stay alone and y nature for survival, human needs to be collective and allocates works to invent tools and develop production technique as well as to learn how to understand nature. There should be social interaction to form

the social relation system for social collectivity counted from family, community and society, which forms social structure. The social support is counted a human action pairing with social interaction. Rationally, human has to encounter problems and limitations during living in this world but each one is differently potential to face them. Human then seeks congruent assistance for living. Attaining collaborations from societal members strengthens human to solve problems and to overcome limitations, particularly during sickness or restricted self-assisted. Social supports from surrounding individuals will lessen stress and properly be adaptable leading to good health behavior. Cobb(1976:300) defines that social support is data for human to believe that there are someone who love and concern, who recognize and who esteem, sensing the oneness with society and attaching to each other. Social support is a social behavior within the social structure and culture, which is different to each culture, i.e. coverage of social norms, system of belief, values and relation of social members. Social support is therefore positive to each matters and mechanized duty to save society.

Therefore, in this study, the researcher is interested in the family supports and the selfcare of the myocardial infarction after treated by PCI/ PTCA. Also, being allocated in the CCU ward for over 10 years, the researcher finds that such case patients have returned for medicare of heart PTCA pains, and fatigued breathing. By physical check and laboratory, it is found that it is the restenosis and diagnosed of being the myocardial infarction on type of NSTEMI (non ST elevate myocardial infarction), STEMI (ST elevate myocardial infarction) and AMI (acute elevate myocardial infarction). In stages of treatment, if there is not serious side - effect such as heart failure, arrhythmia, or acute cardialgia, the physician will prescribe the doses. If there is a side effect, the physician will provide chromatography to recheck the coronary artery and might again treated by PCI/ PTCA. Such stages are likely viewed as great loss either psychologically, or physically, or socially or economically. Each expense reaches 150,000 – 200,000 Bath and the ordinary charges for the chromatography is 28,500 Baht/ time (expenditures in the CCU manual and Cath Lab, Thonburi Hospital 1). Therefore, to prevent entering such stage or to prevent happening with other patient, the researcher is interested to investigate that besides the selfcare activities of the patient, the family support is another factor with equal

significance in the case of selfcare on the myocardial infarction after treated by PCI/ PTCA or with top significance. From the study of Farmer et al., it is found that the high and moderate family support strongly survive the myocardial infarction. Also, form many reports, e.g. Alameda County Study; The Tecumseh Michigan Study; The Evans County, Georgia Study; The Durham, North Carolina Study; The Framingham Study; and the B-Blocker Heart Attack Trial referred in Farmer et al, 1996:1). They found that the social supports have positive relationship with longer survival after attacked by the myocardial infarction. Increasing the social supports by reducing the social isolation turns to be valuable force of the community health leading to the prevention of the restenosis and reduces the death rate of the myocardial infarction patients. From the study of Wellery, Caroline, American Family Physician (2004), they found that downsindrome and low social support relate to the growing rate of disability and death among patients of CHD (coronary heart disease). The treatment of the downsindrome can reduce the risk of restenosis and death. Therefore, this research is tended to investigate the family support and selfcare of the myocardial infarction patient after treated by PCI/ PTCA.

1.2 Research Question

How are the family support and selfcare of the myocardial infarction patients after treated by PCI/ PTCA?

1.3 Research Objectives

1. To study the selfcare behavior of the myocardial infarction patients after treated by PCI/ PTCA in relation to dinning, dosing/ meeting physicians, exercising, alerting for side-effect such as arrhythmia, heart failure, cardialgia, and so on; alternative medicine e.g. herbal treatment.

2. To study the family support and the social support for patients in different areas (such as emotion – affection, and spiritual support; acceptance, recognition and esteem; advice – counseling or information and in area of materialization – money and other services)

1.4 Expectations

1. Findings would explain the social support of the family in terms of social supports for the myocardial infarction patients after treated by PCI/ PTCA in different areas, i.e. emotion, acceptance, admiration, advice and counseling, materialization of money or service affecting caring for the myocardial infarction patients after treated by PCI/ PTCA in relation to dining, dosing/ meeting physicians, exercising, alerting for side-effect such as arrhythmia, heart failure, cardialgia, and so on; alternative medicine e.g. herbal treatment. In addition, it is to know limitations of family support and selfcare of the patient.

2. It would be as databases for people of interested who are aware of the significance on the social support of the family in relation to selfcare and to reduce the restenosis and in parts of the medical personnel and public health, who might apply in planning for treatment and providing healthcare to patients and family to reduce the loss of life and property.

1.5 Scope of Study

This study is to investigate patients who are prescribed suffering the myocardial infarction (regardless being AMI: NSTEMI, STEMI, and NON Q MI) being treated by PCI/ PTCA and being rehospitalized with the symptoms of cardialgia, heart failure, and restenosis and have to provide chromatography to recheck the coronary artery and might again treated by PCI/ PTCA. Data will be collected from 10 patients of both genders from Catheterization Laboratory (Cath Lab) of Siriraj Hospital during May –August 2004 regardless age, race, religion, occupation, education and economic status.

1.6 Definition of Terms

The Myocardial Infarction Patient is referred to the sick prescribed suffering the myocardial infarction regardless being AMI: NSTEMI, STEMI, and

NON Q MI having been treated by PCI/ PTCA from the previous hospitalization.

Family is referred to members staying within the same residence of the patient who furnish the patient with social support such as parents, spouse, children, relative, kin or caretaker.

Selfcare is referred to activities taken by patient after realizing suffering from myocardial infarction and treated by PCI/ PTCA to control the symptom or treatment by the following behaving: **Dinning** is selective taken related to nutritious meals to meet the disease condition and ailment i.e. avoiding high cholesterol and food with highly saturated glycerin and should slowly take meal and each meal should be moderate. **Dosing and Meeting Physician** is regularly taken after dinning and never stop dosing if symptoms happens, after doses seeking physician's counseling and knowing how to use lozenge under the tongue if having chain pain, visiting physician should be regular for diagnosing different conditions, cautioning in daily living and should anticipate meeting physician if symptoms happen before the appointment. **Exercising** is regularly active by the patient such as jogging and physical exercises and so on. **Being Alert on Complications** is referred to is the behaving of the patient to observe mishaps of oneself after suffering from myocardial infarction and being treated by PCI/ PTCA such as arrhythmia, heart failure and chest pain and so on. **Alternative Medicine** is adopted rather than current treatment such as herbal treatment and so on.

The Family Support is referred to the assistance of the family members provide to the myocardial infarction patient after being treated by PCI/ PTCA with regard to emotion, acceptance, and esteem, advice and counseling or information and materialization or money in the selfcare activities.

Perception of the Patient's Role is referred to the patient understands his/her role and duty such as need to be completely cured, seeking treatments and cooperating with physician and being temporary exempted from routine job without reprimands.

Experience of Sickness is referred to times of indisposition admitted to the CCU (Cardiac Care Unit) or hospitalization with the symptoms of arrhythmia, heart failure and chest pain.

CHAPTER 2

LITERATURE REVIEWS

This research was to investigate the supporting force of the family, selfcare behavior of the myocardial infarction patient after stent and the relationship between the supporting force of the family and the selfcare behavior of the myocardial infarction patient after stent. The researcher had studied from textbooks and academic handouts, findings from researches to allow this investigation covered all contents as follows

- 2.1 Myocardial Infraction and Stent
- 2.2 Selfcare Behavior
- 2.3 Social Supports
- 2.4 Relationship between Family Supports and Selfcare of the Myocardial Infarction Patient after PTCA/Stent
- 2.5 Related Researches

2.1 Myocardial Infraction and Stent

The myocardial infarction had its pathology on the rapture of atherosclerosis plaque of the coronary artery and activates the cluster of platelet and coagulation formation originating thrombus to block the artery or called the occlusive coronary artery, which was divided into 2 main groups, i.e.

- 1) Transmural MI (STEMI or Q MI)
- 2) Non transmural MI (non Q MI or NSTEMI)

It was found that STEMI contains occlusive thrombus of more than 90%. But in the case of non-Q MI, it was found the occlusive thrombus of only 35%. It made the treatment of both kinds was likely different. Meaning, in the case of non-Q MI, the thrombolytic drug paid no benefits rather, but ill-effect (Pradit Panjaveenin, 1999)

Treating the myocardial infarction at present had been divided into 3 approaches, i.e.

1. By drug e.g. thrombolytic drug and anti thrombogenesis
2. By operation e.g. PTCA/Stent or bypass graft
3. By three approaches, i.e. drug, operation and PTCA/Stent

All the patients of the myocardial infarction would be treated with either approach prescribed by the physician under the condition of symptom and mishap found, and by the time passed and response found in each patient. Currently, the PTCA (percutaneous transluminal coronary angiography) /Stent was highly popular since it could relieve chest pain, which most affects patients. (Phenroong Pholkanjanakorn, 1998)

Percutaneous Transluminal Coronary Angioplasty: PTCA/stent

Currently treated by PTCA/Stent is most acceptable since it relieved angina pain. (Gruntzig referred in Phenroong Pholkanjanakorn, 1998). First success employed with human being was by using heart injection technique, i.e. using cardiac string to pass through the coronary artery by transporting balloon to the contracted position. However, later it was found that after PTCA, patients were found suffering from the myocardial infarction again. Then Stent had been developed but still the similar symptom had always been found later. (Phenroong Pholkanjanakorn, 1998). Thai land had first employed PTCA in 1987 and at present such approach had been more accepted particularly the satisfaction of chronic patients. PTCA applicants were statistically increasing since the rate of the myocardial infarction had been 5% increasing each year. The Wachara Hospital had employed this PTCA approach since 1987 and the number was increasing and as well as problems. Meaning patients previous treated by PTCA needed to be treated again and some need operation since the restenosis had been found after PTCA and most found under this approach. (Nithi Mahanonda et al referred in Phenroong Pholkanjanakorn, 1998).

Causes of Restenosis after PTCA/stent

Problems of having restenosis were the repayment of treatment and nutrition control after stent. It was found that the study of its etiology helps prevention of restenosis. The recent year there had been 500,000 patients and among them there were 150,000 ones suffering restenosis. If the restenosis could be reduced from 33% to 25%, it could had saved 750 million USD. (Bauter & Isner referred in Phenroong Pholkanjanakorn, 1998). Bauter & Isner (1997:27-35) concluded that the etiology of restenosis after PTCA contained:

1. The smooth muscle cell proliferation and extracellular matrix after PTCA
2. Potential regulators of healing process such as functions of thrombus and thrombotic process which happened after PTCA.
3. Hormone from the functions of renin-angiotensin aldosterone angiotensin II forming the SMC proliferation.
4. The PTCA caused the blood circulation by internal elastic lamina and causes neotimal proliferation and endothelial regeneration leading to the change of the lumen size after having PTCA following the principles of operating PTCA particularly the vascular remodeling from the restenosis.

The best prevention of the myocardial infarction was the control at the first stage, i.e. after vascular remodeling during 24-48 hours. The thrombolytic drug should be continuously provided along with other drugs. It was also found that after PTCA, some behaviors should be controlled, e.g. avoidance of high glycerin food, which would help reduce proliferation. It was part of the prevention planning. Also, exercises should be taken continuously and adequately. Appointments with physicians were also necessary on account of the patient needed the thrombolytic drug to prevent thrombus.

2.2 Selfcare Behavior

In the case of selfcare, the researcher is interested in the concepts of humanities in the context of social sciences and behavioral culture.

There are many theories of humanities and social sciences, which identify behavior of seeking medicare. What follow are the proposals on the concepts of sickness behavior related to the explanation of selfcare behavior.

2.2.1 Behavioral Model Affecting Health

2.2.1.1 Selfcare Behavior

1) Health behavior - it was the individual action or practice believing that one was healthy and sensed no symptom of sickness. Such action was aimed at good health promotion, preventing and seeking diseases., while no symptoms emerged (Kasl and Cobb, 1966 : 246, Bemard and Krapat, 1994 : 65 – 66 referred in handouts of Social Sciences and Humanities of Medicine, unit 1-5: 160)

2) Illness behavior – it was it was the individual action or practice when one was sick e.g. giddy, fever, stomachache, which might have been sick or not sick. Such action was aimed to realize and understand symptoms by visiting persons who diagnosed and provided medicare including solved and reduced such sickness wit their existing expertise and knowledge. For example, taking rest when one felt giddy; taking warm water when one got soared throat and so on. Such action was to react taken by an individual to remedy sickness, which might happen by physical irregularity. Illness behavior was a behavioral pattern of an individual Help Seeking Behavior when an irregularity was found expressible in many types. For example, one went to seek information or help in term of counseling from friends, family members, or medicare from different persons like local physicians, drug store, or medical personnel or public health including not doing anything but observing recovery or got worsened. (Bernard and Krupat, 1994 : 66 referred in handouts of Social Sciences and Humanities of Medicine, unit 1-5: 162) . In this studies concepts had been reviewed from Freidson’s, N.I.Chrisman’s and, Kleinman’s.

3) Sick Role behavior - it was it was the individual action or practice when one was accepted sick, which was often diagnosed from curer, e.g. doctor, and local physician that it was the person with bias and accepted as being a sick. Such person needed to enter the sick role behavior expected by society, e.g. temporally absent from routine work, to obey and follow orders of the persons

involved, e.g. doctor and nurse to recover. At the meantime, the person would be attended by the family and the medical personnel. (Handouts of Social Sciences and Humanities of Medicine, unit 1-5: 167). In this study, the concept of Parsons had been proposed.

Phimphawan Boonmongkhol (1999) discussed about humanity theories of selfcare behavior as follows:

1. Parson's Concepts: Patient Roles

Sicknesses were not only the biological and physiological processes but also the social phenomena. When a person got sick, he/she would develop the social role containing four (4) expected roles classified in two (2) each for the duty and for the rights, i.e.

- 1) The patient was not responsible for the sickness and disabilities in fulfilling his/her regular duties.
- 2) The patient was temporarily exempted to fulfilling duties.
- 3) The patient needed to be completely cured on account of sickness is undesired situation.
- 4) The patient was inevitable to seek treatments from the physician and cooperation to gain rapid recovery.

“Sickness is a social phenomenon rather than only a biological one. Also, it defines the roles of the patient as a pattern of bias from the norm. It leads each society to seek approaches to encounter and handle sicknesses, where it ends at the social control” Therefore, an individual entering sickness, as Parson had proposed was the realization that an individual had bias from the previous ones and needed to seek treatments for his/her own recovery.

2.2.2 Freidson's Concepts: Social Roles

It prioritizes societies, which determine patterns of sickness phenomenon of individuals or the social roles of the patient.

Freidson named this phenomenon as the “Lay Referral system”. Which engulfed an individual. Meaning, persons, whom an individual was related, i.e. relatives, family members and neighbors who had the roles to visit the patient and legitimized whether the sick was really sick and help diagnose symptom as well as introduced sources or treatments which they thought effective enough to completely cure the ailments. Therefore, consequences of the process would differently affect the responsive behavior in each individual rather than only restricted to meeting the physician. Freidson identified that generally; persons in a society closed to the patient would have roles in legitimizing, diagnosing and selecting a hospital for the sick. Freidson obviously proposed that the responsive behavior against sickness was the business of the sick and its network in diagnosing, deciding and choosing the method of treatment rather than the methods proposed by the physician and selfcare behavior. It was a method of treatment. However, it was depended on the intimate persons having knowledge and experiences would recommend treatments. What methods would be depended on cultures of the patient and the intimate persons, who would determine his/her belief on self-treatment in different forms. (Freidson, 1973:173). The second concept of Freidson was the recalls of dependency and surrender to the medical professional of people. He counted it was not right. Meaning, his concept obviously reflected the selfcare behavior of an individual when being sick. It was also corresponded the indispensable target of the public health development. Meaning, they were the self-dependency of people and the caring for personal health.

2.2.3 N.I. Chrisman’s Concepts: Health-Seeking Process

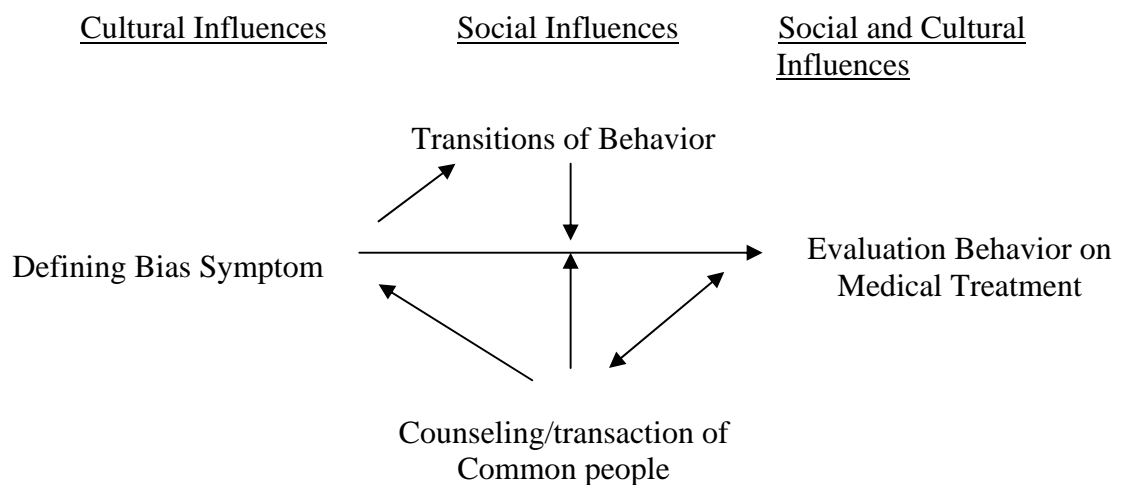
Another theory is the Health-Seeking Process of Chrisman, which emphasized the explanation of the individual and attributes where the public health system (Ethnomedical Model) influenced the individual behavior. The concept of Chrisman was based on Suchman’s related to stages of treatment but likely elaborated, i.e.

The individual illness episodes contain

1. The estimation of the problem or the symptom definition
2. Treatment action

3. Adherence and evaluation
4. The transition of daily regular roles caused by sickness
5. Lay consultation and being advised or transacted by those ones whom the patient was related.

Model of the Health-Seeking Process of Chrisman



In any illness episodes, the medical treatment process was not necessary to halt at the five (5) stages. While being sick an individual could recycle the entire stages when the sick and other related supply additional information.

1. The symptom definition

Responding to the sickness of the patient and people around was to define the symptom whether was there sickness. The sick and the visitors would estimate whether the person was sick under the cultural meaning where they possessed to explain the bias symptom adopted from the socialization or the transaction of the past knowledge.

The next stage was the disease etiology where the belief played key role in defining symptom. Such belief contained many natures, i.e.

- 1.1 Based on Humoral Pathology
- 1.2 Based on supernatural
- 1.3 Based on germ theory
- 1.4 Based on local culture

Besides, the symptom evaluation, the sick and the people surrounding roughly estimate what the disease was or what the system was. It was called the “illness categorizing”. Based on cultural meaning, an individual would stock knowledge, information, and experiences of illness since childhood through the formal and the informal socialization. For examples, they were abdominal or the head diseases. Such symptom would be estimate during suffering colic condition by oneself or by others involved using experience of learning that the stomach pain was caused by indigestion and further thinking about ferment or unhygienic food.

In summary, the symptom definition of the patient and the people surrounding estimating whether was there any illness related to any organs and linked to the disease etiology based on their belief which bridged or determine methods and sources of medical treatment for the patient. Such process was influenced by cultural factors.

2. Lay Consultation

After the symptom definition the following stage was the lay consultation with people surrounding whom the patient was related or the social network. Chrisman emphasizes those illnesses amid different social situations forming behavioral models were influenced by social relations under the social networks of the patient. Similarly, the patient estimated being sick would seek consultation from other or people surrounding. Such reaction was called the “Lay Referral System” by Friedson. At the meantime, the humanitarian used the word – the social network: parents, brothers and sisters, spouse, grand parents, neighbors, community leader and so on to plead legitimization that an individual was sick and seek the symptom definition, etiology and medical treatment.

3. Treatment Action

This stage could be categorized into two (2) parts, i.e.

3.1 Treatment Resources were divided into a) a formal service resource or by professional i.e. the physicians, and hospitals, b) a semi-professional resources, i.e. pharmacist, and midwife, 3) local physicians, e.g. sorcery, herbalist, bone experts, and monk, 4) other lay consultants and 5) selfcare.

3.2 Treatment categories, i.e. a) activities e.g. exercises, rest, hot-water bathing and so on, b) medicare e.g. injection, dosing and so on, c) ritual-based or conversation, e.g. meeting sorcery or psychiatrist, d) medicare e.g. operation

Selecting hospitalization or treatment category was reliable on the symptom definition and the social network, which was based on demand and caused by illness severity perceived by the patient and the existing resources. Therefore, illnesses in children and elders, viewed as highly critical was selectively linked to the formal hospital for treatment rather than illness suffered by the adults.

4. Adherence and Evaluation

Individuals and the social networks had always been evaluated on treatment under the following criteria, i.e.

4.1 Whether good health had been recovers?

4.2 Whether bias symptom had been lessened or cured under the cultural explanation?

4.3 The evaluation was based on relation and commitment of the physician, who would share determining the patient and the social network to whether the treatment would be continued with the physician?

Chrisman's concept of "Health-Seeking Process" did not even directly specify the selfcare behavior. However, it indicated the phenomenon of what nature did the healing process under the cultural influences of the patient, his/her role, and the social network existed counting from the process of the symptom evaluation until the treatment evaluation and the cessation of the illness or medical treatment. All these concepts had been significantly implied to the further development of the behavioral formulation to selfcare. Rationally, Chrisman's concept obviously emphasized the "Health-Seeking Process" should be actually implemented under the roles of the patient, and the social network.

2.2.4 Kleinman's Concepts: Cultural-oriented Public Health System

The public health system in society was compared with the cultural-oriented on account of the illness episodes in each society and the response to the illness were generating the social order. It generated the sub-culture or the cultural-oriented called the public health service system. Viewing the medicine and the public health system as the cultural-oriented was to view it as symbol of the social culture involving illness, response of an individual to illness, belief on the disease etiology, criteria used in optimizing resources or medical method and treatment evaluation, model of social relationship between the service provider and the patient, the social institution acting for medical and public health treatment as well as the precise social situation of illness. All mentioned were called the Cultural-oriented Public Health System.

Kleinman emphasized the ethnography approach or the medical ethnography, which was the investigation to understand what did persons living in the society or the community think about health counting from belief of illness, decision on treatment, exceptions and the estimation on helps gained from the public health system. Precise in-depth understanding of the above mentioned was to study the illness episodes.

Illness was inseparable from things the patient, the family, the neighbors and the community had defined symptoms based on cultural belief. Meaning, illness was the cultural-oriented in relation to illness etiology and its treatments.

To understand treatments, it needed to begin with the definitions of "Illness and Disease".

"Disease" by biomedical model was referred to only the biological bias needed to be appropriately treated by medical specialist.

"Illness" by ethnomedical model was referred to sickness problems, which an individual and the social network had experienced together such as suffering together, anxiety together and together evaluated its severity and illness category. Finally, they will help each other to decide effective treatment.

"Illness" in terms of the ethnomedical model was also referred to perceptions related to deviation from normality specified in the social culture and norms. The learning process of human being in a society was cultural-oriented. Meaning, what

was normality and what is deviation?. They also determined illness symptom and endure the severity of the illness.

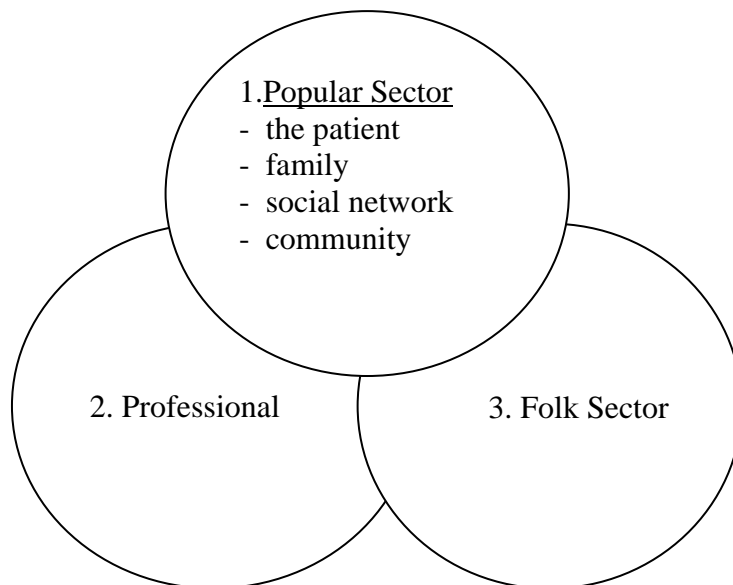
Therefore the attitudes of the ethnomedical model related to illness were:

1. Treatment by common medicine rather than formal ones
2. Self-treatment is the fundamental of people rather than immediate visit with the physician.
3. Illness phenomenon in terms of illness episode and responses are influenced by cultural-oriented.

A public health service system was referred to a culture of a society containing three (3) subsystems, i.e. 1) the Popular Health Sector, which is the largest system, 2) the Professional Health Sector, and 3) the Folk Sector of Care. The Popular Health Sector contained 4 individuals and individual groups, i.e. 1) the patient, 2) the patient’s family, 3) the patient’s social network, i.e. relatives, neighbors, colleagues and so on, and 4) the community such as the community leader.

Kleinman proposed prototype to explain the public health system as diagram followed:

Model of Kleinman’s Concepts: Cultural-oriented Public Health System



By definition, health and illness perceived together in daily life and it was normal practice or by cultural – oriented on health was what illness suffered together among these individual groups

These individuals would decide on an individual illness whether the deviation symptom is sickness and how to respond.

For example, a local disease in the northeastern Thailand called the “*Khamrerd*” which had the symptom of non-stop crying and sometimes, the child cried till green. Its etiology was from stomachache, colic/ sharp pain since the mother fed the child with plantain since birth. Otherwise, it might have been infantile tetanus since the villagers preferred laboring by ethnomedical model (*Mor Tam Yae*) who used the bamboo to cut the placenta. When the mother observed the symptom, she would bring the child to meet the witch understanding that the house-spirit would fetch the soul of the child and needed rituals to chase away the spirit. Some might estimate the symptom on its criticality and then decide to bring the child to the local public health office or a community hospital near to their home.

In the case of diarrhea, the eastern villagers, the mother would observe the stool of the child. If it were more than 3-4 times with no other symptoms, the mother would pick the guava or tea leaves or the mangosteens’ cover and boil with water for the child to drink. All three (3) medicines had been believed by villagers that these herbs cure diarrhea. But if the mother observed its criticality with other symptoms, i.e. frequent stool, rice water stool or mucosanguineous or vomiting with fever, the family member would discuss, i.e. the husband or the grandmother or the social network-neighbor would meet and finally decide to send the child to the hospital. (Atchara Uamkrua, 1986)

In summary the responsive behavior and the use of the public health service of people in society was the role of the patient and the members of the social network. It was counted the occurrence within the Popular Sector rather than within the Professional Sector. Rationally, the patient and the social network were defining the symptom, perceiving its criticality, and deciding to select methods and resources for treatment.

However, different medical treatments happened in the popular sector had been transited from the folk sector and the professional sector by exchanging

knowledge and methods among the popular sector, the folk sector and the professional sector

Therefore, treatments by the popular sector were numerous, e.g. avoid some food understood as noxious, taking some special food to heal the disease, physical exercise, taking herbs, rest, buying oneself medicine, selecting hospital and so on.

The folk sector by summary was referred to ethnomedical approach, which was not professional, non-organization and risk of illegitimate such as injection physician or medicine originated from the local culture such as witch, and sorcery. The professional sector was the organized professional medicine, bureaucratically complicated strongly sophisticated practices and westernization approaches such as hospitals.

In summary, Cultural-oriented Public Health System has been directly developed into selfcare. Kleinman believes that all health behaviors have been managed by the patient's family and the social network and they perceive the illness and seek treatments by cultural-oriented and to employ the accumulated knowledge and experiences from the past, which originates into the folk sector that they treat each illness episode.

In the dimension of humanities investigated by the researcher, the patients perceived their own roles and needed to seek treatments. Treatments began form selfcare and form the social network. Meaning, when there was illness, the people surrounding and friends play roles of visiting and diagnosing symptom as well as consultation. It was the transaction from the past accumulated and learned and if it was ineffective, the approach would be changed such as employing the professional sector. From the conceptual review, it was found that the concepts of Parsons and of Kleinman had attracted the researcher and views as relevant to the selfcare beginning from the popular sector. For example, the patient needed to realize oneself the roles of illness of the patient, of the family, of the social network and of the community. Later, it would involve the folk sector or the professional sector. Viewing the popular sector, it was found that the family, the social network and the community needed to share in selfcare of the patient, which was corresponded with what the researcher had been pursuing particularly, how the family supported and the selfcare of the myocardial infarction patient after PTCA/stent related.

2.3 Social Supports

It was the sociopsychological factors related between health and health behavior and it contributed positive effect to health conditions, particularly in the situation of illness or helplessness. The social supports was gained from surrounding people to relieve stress and a being appropriately adjustable leading to positive health behavior. (Tilden & Weinert, 1987:613).

Cobb (1976:300) defined that the social support was the information allowing people believe that there were people, who loved and were interested, recognizing and admiring, being part of the society and mutual commitment.

Kaplan, Cassel and Gore (1977:50-51) referred to the support that it was the satisfaction of social basics an individual received from a social environments of the individual by interacting with the social group. Or it might be referred to the existing and lost relationship of the resources, which provided support or from individuals significant to the individual

Kahn (1979:80) stated that the social support was the targeted interaction between individuals originating positive attachment form an individual to the other. There should be legitimizing or admittance with the other behavior, and mutual assistance. This support might either one happen or otherwise.

Hubbard, Muhlenkamp and Brown (1984:266) stated about concepts of those who studied the social supports and concluded that the social support was the multi dimension structure containing positive communication, sensing commitment and part of the society and exchange each other realizing the resource of the support.

Weiss (1974 cited in Diamond: 1979:101) defines that it was the fulfillment or the satisfaction of need originated from interpersonal in a society containing attachment, social integration, opportunity of nurturance, reassurance of worth, a sense of reliable alliance and assistance / guidance.

Barrera (1981:70) stated that the social support was referred to intimacy, material support, workforce, guidance and information, feedback and social participation.

Thoits (1982:147-148) defined that it was an individual being emotionally and socially assisted and by materials or information. Such supports helped an individual to faster encounter and respond illness or stress.

Boonyiam Trakulwong (1985:171) defined that it was the support of information, materials or the spiritual support from an individual or group and resulted the receiver applied to what one need, which was healthiness.

It was concluded that the social support was the targeted interaction between individuals expressing interest, mutual assistance and originate attachment believing that there was one who loved and was interested in recognizing and admiring. At the meantime, in relation to health and illness causing stress, the social support furnished would help handling stress originating good health and good healthcare.(Brain Lakey, Sheldon Cohen, 2000:31) or being supported by society to sense self-esteem resulted a better behavioral health.

Key Principles of the Social Supports (Kesorn Suwittayasiri, 1993:29)

They contain following key factors.

1. Needed to be the communication between the “giver” and the “recipient” of the supporting force
2. Nature of communication contain
 - 2.1 The “recipient” realized self-esteem and social acceptance.
 - 2.2 The “recipient” believed being part society and able to provide benefit for society.
 - 2.3 The “recipient” believe there was genuine attentiveness and affection and well wishes.
3. The input of support might be in form of information, material or spiritual support.
4. It should help the “recipient” achieved what one needed –good health.

Two Types of the Social Supports

Weiss (1974:17-26) divided the social supports into six (six) aspects, i.e.

1. *Attachment* – it entirely affected emotion causing an individual secure and warm, preventing the sense of loneliness. Such relation was found among married couples, friends, and the family members.

2. *Social Integration* – it turned an individual sense the target, ownership and being accepted and worth for the group. If it was lacked, it made an individual being separated from the society.

3. *Opportunity of Nurture* – it made the superior became responsible to the subordinates and turned oneself being needed by others and dependable. If this had not been fulfilled, it would make uneasiness, incomplete life and aimless.

4. *Reassurance of Worth* – it was being accepted by family or friendship institution. When an individual was able to express the social roles, they might have been the family or occupation roles. If a person were not accepted, the confidence or self – esteem would have been reduced.

5. *A Sense of Reliable Alliance* – an individual expected to gain continuous assistance and if one did not receive, one would feel isolated.

6. *Assistance / Guidance* – it was the assistance by guidance or spiritual support applicable to handle problems.

Cobb (1979:33) divided the social supports into 3 aspects, i.e.

1. *Emotional Support* – it was the information allowing an individual felt that one was concerned and cared, which was likely receiving intimacy and attachment.

2. *Esteem Support* – it was an information allowing one sensed worthiness and recognized by individuals of the social group one involves.

3. *Network of Communication* – it was an information to admit that an individual was the member or part of the social network and attachment.

Kahn (1979:85) divided the social supports into 3 aspects, i.e.

1. *Affection* – it was the expression of the positive emotion of one toward other illustrated in form of attachment, respect or love

2. *Affirmation* – it was an expression of consent, acceptance of accuracy in both action and thinking.

3. *Aid* – it was the interaction with other by directly contributing materials or assistance. Such aid might be materials, money, data, information and time.

Schaefer et al. (1981 cited in Tilden, 1985:201) divided the social supports into 3 aspects, i.e.

1. *Emotional Supports* – it was referred to attachment, affection, and trust recalling that one is loved.

2. *Information Support* – it was a guidance in handling problems or feedback of one's behavior and action

3. *Tangible Support* – it was the material assistance, i.e. things, money and including services.

Cronenwett (1984:9); **Tilden** (1985:199-206) divided the social supports into 4 aspects, i.e.

1. *Emotional Support* – it was referred to recognition, trust, affection, sincerity, attentiveness and concerns

2. *Appraisal Support* – it was to provide information of self-actualization or information to assess oneself to reassure confidence and to compare oneself with the persons in society as well as to provide opportunity for comments.

3. *Information Support* – it was referred to receiving guidance, recommendation and direction and information applicable to handle the encountering problems.

4. *Instrument Support* – it was referred to the direct assistance to the needs in terms of materials, money and workforce.

In this research, the researcher selected the conceptual frameworks of Cobb (1979) and Schaefer et al. (1981) which were found that they covered and responded the basic needs of the myocardial infarction patients after PTCA classified into 4 aspects, i.e.

1. Emotional Supports

From the changes physically, psychologically and socially happened with the patients, it turned the patient feels distrust and insecure in life leading to emotional changes which gave way to down syndrome. Further, the patient was anxious about chest pain, feared about suffering symptom, which potentially reduced ability to act. These made the patient needs fostering on emotion, affection and caretaker. The patient needed to release uneasiness with trustful individuals within the family to bear emotional stability, warmth and security as well as increasing self-esteem

2. Esteem Supports

Disease-effect turned the patient feeling helpless and being the burden to others unable to retain the previous role. Such feelings made the patient realized that one was worthless and isolated oneself and might be followed by the down syndrome. If there were surrounding people understood, accepted the patient's opinions, and allowing opportunity to release suffering, such behaviors of the surrounding people would make the patient feel capable and needed by them. It originated confidence and spiritual supports in controlling disease.

3. Guidance and Information Supports

After the condition of the myocardial infarction and returning home, the patient needed to behave to control risk factors of restenosis. Therefore, the patient needed to readjust the life plan to meet the difficulties resulted by the disease. Sometimes, the patient might feel boring to follow the instruction or surrenders to the illness, which might considerably, deteriorates the health. If the patient received information and guidance related to properly behaving from the surrounding people, it helped the patient successful in treatment and prolonged one's life.

4. Tangible Supports

Effects from disease caused deteriorated work potentials. The patient was unable to work or tedious ones, which reduced incomes. Besides, treatment needed continuity and expenses to meet the physician, and drug cost. All these things restricted the patient to express role for the family and the society as before.

Therefore, if the patient had been supported with money from the surrounding people, or having ones to share the burden in working, it would have made the patient reduce stress, anxieties leading better condition of the heart.

Social Supports and Human Health

With the popularity of the concepts of the social supports, many theorists attempted to study and explained the work mechanism or results of the social supports to the health conditions and illness, such as

Berkman and Syme (1979:202) proposed the concept of relationship between the social supports and the human health., i.e.

1. Isolating oneself from society would meet with less social support and chance to misconducting on health.
2. Isolating oneself from society would affect mental such as downs syndrome allowing one to change the counter mechanism leading to risk disease or accident.
3. Isolating oneself from society would make one physiologically changes affecting exposure to disease.

Wortman (1984:253) concluded the study of the social supports as follows:

1. The social support received might encourage one to encounter stress by self-esteem.
2. The social support received might allow one change measures to encounter stress.
3. The social support received might allow one to better encounter stress with receiving information to leverage one's perception.
4. The social support received might allow one receive guidance how to encounter stress with new model which is unknown before.
5. The social support received might motivate one to change one's behavior.

Crowford (1987:41) concluded the social supports and the health promotion as follows:

1. *The Buffering Hypothesis* - the social support help ease to encounter crisis and reduce its criticality. In particular, being supported by information and the

appraisal on behavior and emotion helped individual feel self-esteem and affectionate and need hope to be as supporting force to encounter crisis by attempting to handle the problems. Besides the emotion support and feeling to be part of the society, family would help individual ready to appropriately readjust for further change.

2. *Direct Effect to Health Condition*, which was not related to crisis. The regular supports from spouse would endlessly make individual feel self-esteem. Also, being part of the family and being accepted would directly affect the happiness in life.

Cohen and Willis (1985:310-357) studied mechanism of the social support to physically and psychologically explained the human health condition. They concluded into 2 ways, i.e.

1. The social support allowed an individual better experience, stable emotion affecting thyroid, neuroendocrine and immune system better functioning or better health. Such direct positive effect from the social support encouraged better encountering each problem and reduced problems.

2. The social support helped decrease life crisis. It reduced stress leading to crisis. Such stress happened because of helplessness and low self-esteem. Such conditions would retaliate the balance of neuroendocrine and immune systems, which was risky to disease. At the meantime, it turned individual ignore the health of oneself at risk to disease.

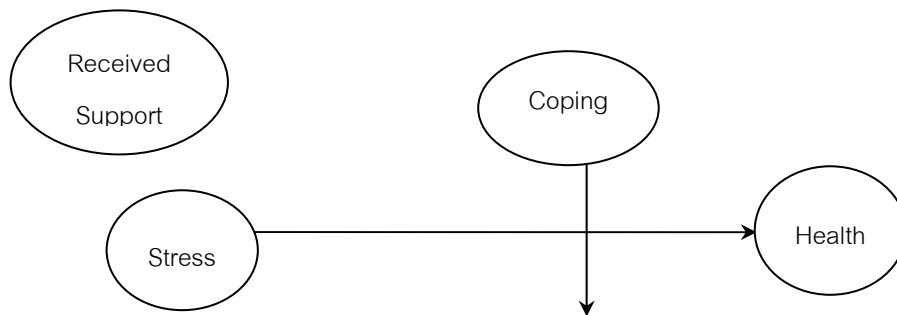
From the attempts of many theorists to study and to explain the mechanism of work or the effect of the social support affecting health condition and illness, it was concluded into 2 main issues, i.e.

1. *The Direct Effect on Health* – it was the direct result between the physical and psychological social support. Its effects were not related to stress. The social support might directly affect human health, i.e. it helped sense the self-esteem. Also, being part in sharing or involving with society, it helped arouse or encourage normal condition from being guided by correctly and beneficially behaving including following the social norms.

2. *Modifying the Deleterious Effect of Stress or the Buffering Hypothesis* – the social support might directly reduce stress or helped and individual bravely

encounters stress and finally affecting the health condition. (Pender, 1982:336). From the study of Kaplan (1977:7) on the emotion Support to reduce stress affecting body and mind allowing an individual better endurance to problem, it was found that individuals having low social support such as among workers encountering much stress will be more risky to high blood pressure and heart disease than individual with social support. Therefore, roles to prevent illness to the health condition physically and psychologically were with coping process. Rationally, stress was the reaction of an individual toward environments – endangering life and harmful or challenging where an individual needed to balance oneself using behavior or coping process. Using the precise coping process generated readjustment. However, if misapplication to coping process, it turned to physical and psychological bias. Therefore, the social support was the force existing in a society. It worked as if an assistance individuals in changing situation and its meaning or emotional state reacting to the situation or it might have changes all the three 3 aspects as in the below diagram: *illustration of the social support to coping with stress and brought back good health and changing behavior.*

A Prototype of Social Support and Health used to cope with stress to gain healthiness and readjusted health behavior



Source: Copland B.H., et. Al “Social Support and Health” *Medical care* 15 (1977) : 50-51

It was found that the social support i.e. family, surrounding people, relatives, community and so on, were related to human health behavior. One who was well support by societies found itself esteem, strong morale, and able to cope with illness or physical irregularities, which physically and mentally created stresses to the person. Had there been good spiritual supports, selfcare, prevention and health enhancement, one could enter the patient's role effectively following the process and fast recovery. Had there been low spiritual supports, it would find that chance of illness risk would have been easily found and misbehaved one self during entering the patient's role caused by inability to cope with stress, insecure in one's values and so on. Therefore, the researcher, viewed that the social support was vital to human health behavior in selfcare, i.e. Health Behavior, Illness Behavior, and Behavior of Patient's Role affecting healthiness and followed by quality life.

2.4 Relationship between Family Supports and Selfcare of the Myocardial Infarction Patient after PTCA/Stent

The social support shared the succor of the individual selfcare. Orem (1985:110) stated that human being was formed within himself with body and mind while environments were internal factors. Man and environments needed to always interact. Therefore, interactions of individuals in society allowed them to gain useful information, assistance of sharing burden and necessary materials for selfcare. The social support was the psychological factor essential for the human living in a society. Such social life needed reciprocal dependency, exchanges of idea and sentiment. Human being therefore endlessly needed social support and much more during illness or life crises.

After the myocardial infarction patient being treated with PTCA, he/she needed readjustment of life plan. This turned the patient succumb the self-esteem and mental stability, downsyndrome, and isolation from society. What critically needed were concerns, interest in listening to his/her suffering, spiritual support and assistance in different areas what were needed. Had supports from surrounding people failed, isolated, or excluded from decision-making or planning activities, it would have

turned the patient depressed and worthless, irritated, anxious, down syndrome and some bias would have been expressed to the surrounding people and health problems would have been ensuing. From literature review on the concepts of humanities related to selfcare, it was found that Kleiman's theory has prioritized the popular sector, i.e. the patient, the family members, the social network and the community. All these were necessary and affecting behavior and selfcare of the patient, i.e. lessening the stress of illness. Sickness created stresses but having people to understand and to be aware of the problems, self-esteem and caring for all things regarding medical treatment, behaving and facilities for the faster recovery, these would help the patient better selfcare. From review literature of the social support, it was found that roles of family members shared significantly in selfcare of the patient. Rationally, there was intimacy and appropriation to provide better support. Significantly, it was the patient who should have been furnished with support from intimate persons when being in crisis or illness.

2.5 Related Researches

Hubbard, Muhlenkamp & Brown (1986:127-150) studied the relationship between social supports and selfcare. Two groups of normal people were investigated and it was found that the social supports had positive relationship with selfcare. *Schaefer, McCaul and Glasgow* (referred in Ruamporn Khongkhamnerd, 1993:23) studied relationship between the attained social supports and the unattained social supports from family with behaving by treatment plan and disease control among diabetes mellitus patients effective to insulin. Samples were 54 adults and 18 youth under nineteen (19) years of age. It was found that among the youth families with negative adjustment and among adults without social supports from families, patients would unlikely follow the prescriptions, which increased the glycaemia. *Nittaya Bhasunant* (1986:A-D) studied relationship between belief of health and knowledge of selfcare with cooperation in treating cardiac patients. From 100 samples, they were found that the general health motivation, perceptions on risk opportunity to side-effect, perceptions on usefulness of treatment, perceptions on limitations in behaving and belief of health in general had significantly positive relationship with the cooperation

of treatment ($P < 0.01$). Also, patients with equal education and economic status had statistically significant difference of knowledge on selfcare. ($P < 0.01$). Gender, age, education, economic status, illness period and mature of disease had no statistically significant difference related to cooperation. ($P < 0.05$). *Jirapha Phongtrakul* (1988) studied relationship of some factors between the social supports and ability of selfcare among 100 patients of high blood pressure on unknown cause in Ramathibordi Hospital. It was found that the social support was the best predictor of capability in selfcare. *Somjai Yimwilai* (1988:3) found that selfcare of the asthma patient had positive relationship with the social supports of the family members. *Wattanan Kalidee* (1988:129) studied the diabetes mellitus patients and found that behaving in nutrition control, exercises, medicine and cautions on wounds at feet and meeting the physician by appointment after health instructions among patients receiving social supports from families were far better behaving than the groups of not receiving social supports from families. *Atchara O-prasertsawadhi* (1988) studied relationship between the social supports and health behaving among 120 chronic bronchoblennorrhoea patient using the social support instrument modified from the instrument of Schaefer et al. It was found that the social support had positive relationship with health behaving. Moreover, *Praewraphee Ruangdej* (1991) studied the relationship between the ego- perceptions on the social support and selfcare of 60 patients implanted with permanent cardiokinetic equipment. Also, *Saowabha Wichitwathee* (1991) studied the relationship between self-esteem, the social support and selfcare of 100 limped organ patients. Both studies were corresponded and found that the social support had positive relationship with selfcare and was the remarkable predictor of selfcare. *Prabha Rattanamethanont* (1989) found that education, family income, severity of physical duty loss, and attitudes toward disease had relationship with quality life. All together, attitudes toward disease, perceptions of social support, and education could predict the quality life of the myocardial infarction patients. The researcher recommended that the nurses should seek ways to enhance patients for better attitudes toward disease with knowledge and understanding about the disease, being aware of the patients' backgrounds and advocated in introducing family to properly help and to care the patients. *Atchariya Pathumwan* (1991) found that age, time for study, time for caring and social support had positive relationship with the

ability of the caretaker in caring children. The social support was the best predictor. *Pathumphan Manokul-anant* (1992:A) found that the social support from family members was the factor to determine selfcare in terms of nutrition control and medicine. *Kulthida Panichkul* (1993) found that the social support, time for study, time of illness, and average monthly family income had statistically positive relationship with adjustment. Age and marital status had no statistically positive relationship with adjustment. The social support and time of illness were the groups best predicting and explaining the variations of the adjustment at 43.26%. *Janthip Wongwiwat* (1993) found that samples with low level of uncertain sentiment on illness in general, had top scores of unpredictability of the function and disease. Useful resources the patients gained the social support on emotion and materials most were from the family while the health personnel provided most information. In relation to readjustment of the samples, it was found that the score was likely high with top score on health readjustment. By qualitative data, it was found that many patients needed to change the job or deserted private business in order to avoid stress, which was the risk factor for restenosis, reducing or discarding sexual affairs. Encountering problems of selfcare or routine life would be met with readjustment of pre-experiment. Encountering chest pain, the patients would avoid or stop the actions. The uncertain sentiment was the direct affecting readjustment and education was directly and indirectly influenced the readjustment passing through the uncertain sentiment in the illness. Therefore, reducing uncertain sentiment in illness would help patients better readjustment. Jariya Tantidham (1993) found that samples responded the myocardial infarction in 5 natures, i.e. 1) fear of death, 2) fear of potentials' loss, 3) fear of restenosis, 4) uncertainty of one's illness and 5) difficulties in selfcare to control and to reduce risk factors of diseases. Fundamental factors affecting ability development in selfcare and needs of selfcare contain 7 things, i.e. health condition, health service system, family system, useful resources, personality, education and essential experience in life.

There were 3 models of assistance in ability development in selfcare of the acute myocardial infarction patient since admission stage into the hospital till returning home after 8 weeks. They were the entire substitution, partial substitution, and supports and educating. Each model contain 8 ways of assistance, i.e. 1) acting

for, 2) guiding, 3) supporting, 4) educating, 5) building environment to enhance patient develop ability to respond selfcare, 6) skill development to negotiate with government officials, 7) enhancing good relations within family, and 8) following up and arousing motivations in selfcare. *Anchalee Thitapura* (1993) found that relation within family had positive relationship with cardialvulitis patient.

It is concluded that the social support form family is inevitable for readjustment, expression, and better care of the patient. Besides, the researcher investigate more on selfcare, perceptions of one's health condition in order to reduce risk factors of restenosis.. For example, *Linjong Podhiban* (1995:1) studied the multiplicity of risk factors, risk condition and perceptions of risk condition of the cardiovascular disease among Thai elders. Samples were 200 elders in Chiangmai. 101 elders were male and 99 elders were females. Data collections were employed with measuring of interviews, blood pressure, weighing, height scaling, and glucose and cholesterol check. It was found that there is multiplicity of inadequate exercises, high blood pressure, smoking, high rate of cholesterol, fat, and diabetes mellitus by 81.5%, 30.8%, 25.5%, 15.0%, 4.0% and 2.0% respectively. Risk of suffering cardiovascular disease, it was found that the samples were met with risk at the level of moderate and high. Perceptions of risk condition were low level. There is no relationship between age, gender, income, education with perceptions of risk condition, risk situation and perceptions. *Thanomkwan Pandam* (1996:A-B) had applied the theory of motivation to prevent disease in order to reduce risk of cardiovascular disease among female at the age between 35-54 years in the Municipality of Rayong Province. A semi-experiment approach had been conducted with 40 samples and with another 40 comparative samples. After experiment, it was found that the experiment group had found changes in relation to perception of acuteness, perceptions of risk opportunity, expectation of self-capacity, expectation of consequences, attentiveness, and better behaving than before the experiment and better than the comparative group. It was also found that after experiment, the weight and cholesterol had been more drastically reduced than the comparative group. The expectation of self-capacity and experience of exercises had self-capacity influenced the behaving in order to reduce risk of cardiovascular disease. *Yureephan Chaidaisook* (1996:A-B) studied the consequences of exercises and level of cholesterol in elders aged 60-72 years. The first group of 30

elders had more exercises or equivalent to 120 minutes a week. The second group of 27 elders had less exercise than 120 minutes a week. It was found that the level of cholesterol among the group with exercise more than or equivalent to 120 minutes had their cholesterol reduced while the non-exercise group had their level increased significantly by statistics. Levels of triglycerine and LDL-cholesterol of the exercise group had reduced by average but with no statistical significance. It is concluded that the exercise group tended to have better positively changed levels of cholesterol than the other group. *Atjariya Swingkaew* (1997) found that the health behavior was indispensable in disease controls, prevention to be infected and side-effect. It was also found that income and perceptions of health conditions had positive relationship with health behavior. *Rajja Srisuthep* (1999) found that gender, migration, heart disease and cardiovascular disease of parents, residence, occupation, perceptions of one's health condition, and perceptions of self-capacity had relationship with lifestyle in relation to health of the cardiovascular patient. Variables directly affected patients were health responsibility, perceptions of symptoms, exercises, and illness/death by myocardial infarction patients.

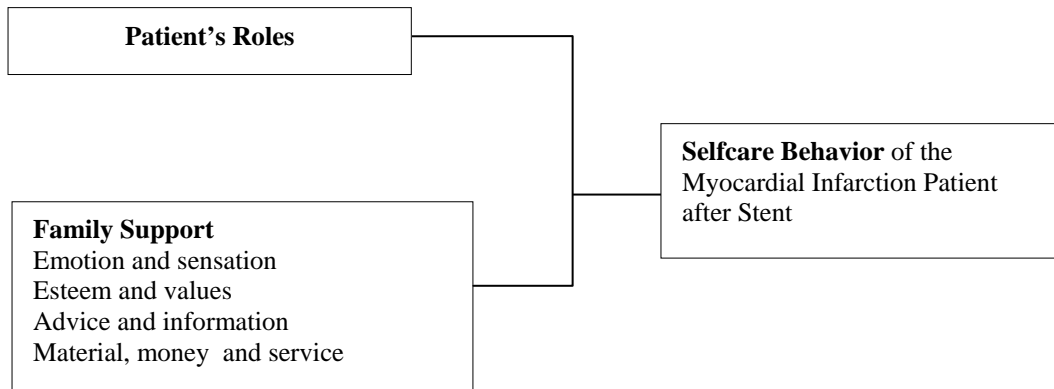
2.6 Research Conceptual Framework

From literature reviews and related researches, it had been conceptualized as follows:

Social supports are the socio-psychology related to health and hygienic behavior and positively affect health state particularly during sickness or restricted self-assisted. Social supports from surrounding individuals will lessen stress and properly be adaptable leading to good health behavior. Cobb(1976:300) Social supports from surrounding individuals will lessen stress and properly be adaptable leading to good health behavior. Cobb (1976:300) and Schacfer (1981) allowing the conceptual framework of family support covers and responds the basic needs of the myocardial infarction patients after stent in 4 areas, i.e.

1. Emotional Support refers to recognition, trust, affection, sincerity, attentiveness and empathy.
2. Appraisal Support refers to supplying information of self-learning or information implemented for evaluation verifying confidence and to compare oneself with co-dwellers in society as well as giving opportunity to raise comments.
3. Information Support refers to attaining suggestions, directions, and information enabling to solve the encountering problem.
4. Instrument Support refers to direct help to the necessity in relation to material, money and man.

From reviewing concepts of seeking treatment behavior developed to the concepts prioritizing selfcare behavior; Kleinmen believes that all health and hygienic behaviors has been managed by the patient, family and social network where the patient has been connecting by way of perceiving and seeking solutions to handle health problems. It was by means of culture they adhere and experiences accumulated from the past and developed into the local medicine, which is used in each medication. Based on Parson's concept of manners among patients, it was found that they perceive their roles of sickness and need medication to be recovered from the sickness. Seeking medication begins form selfcare and care from social network as well as transmission medication, which is from the past accumulation on learning and if a medication does not viable, the new one would be attempted, such as the western medicine. By the concepts of Kleinmen and Parsons, it was seen relevant to selfcare behavior beginning from local medication system i.e. selfcare in perceiving of one's sickness, family care, social and community network. Then it is followed by the local medication and modern treatment. From literature reviews, it is found that family, social and community network played key role in the patient's selfcare. It is consistent to the approach the researcher is interested to investigate how do the myocardial infarction patient after stent and gaining family support behave in selfcare.



CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research Design

This study is to illustrate the model of the social support, which covers the entire process. A qualitative research is therefore employed to explain behavior of selfcare of the myocardial infarction patient after PTCA as well as model of the social support from family. Presentations will be in a case study.

3.2 Site and Duration of Study

A Catheterization Laboratory (Cath Lab) of a Pathology in a 1000 bed size hospital has been selected for fieldwork. 10 purposive samples were patients admitted to the Lab during May – August 2004. Later appointment had been made with patients and relatives for home-visits as stated duration.

3.3 Samples and Resources

In this study, samples were the myocardial infarction patient after PTCA and being medicated more than once

The data from patients are key to investigate selfcare behavior and social support. The purposive sampling is employed by nature of interest for opaque injection in the Cath Lab of Siriraj Hospital by appointment.

For efficiency of data collection, prioritized samples were patients living in Bangkok as following criteria.

1. Being the myocardial infarction patient after PTCA
2. This treatment, patients had been prescribed as suffering the myocardial infarction regardless types of ST Elevate MI or Non ST Elevate MI and having been under new PTCA again.
3. Person of full consciousness and cooperation in data collection

Other resources supporting this investigation, which were the patients' records

In this investigation, the researcher select samples by interest but the content of the investigation involved selfcare, and family support related to sickness. Some unlikely decline to give information or other details. Some are target group by period of investigation with distant residence and traveling. With the restricted time, the samples were few. Therefore 10 were selected, who are found perfect to give information and viable for research. In addition, the researcher had been advised to select 10 cases by 7 males and 3 females with average aged of 60 years. 4 earned bachelor degree, 6 earned primary level 4 with income by average of 10,000 Baht a month averaged form 7 cases since another 3 cases have no income because 2 case are elders and one case is a housewife. Among 10 samples, 3 were widow and the rest are staying with their spouses.

3.4 Research Ethics

This investigation has been permitted by the chief of the cath lab. Data has been collected from the patient's records and home-visits with interviews. The researcher contacts patients by phone and introduce herself on occupation, workplace, educational institution and inform the objectives of research to the patient and relatives. Had the patients and their relatives agreed to give information, the researcher would make appointment for interviews and familiarizes with the patients at home.

3.5 Reliability of Data

Data are collected from home-visits and interview patients as well as observing surrounding and lifestyle, behavior, and expression of the patients and family members during visits. Data are found evident and accountable.

Being the nurse by profession attending the myocardial infarction patients find information on symptoms, recurrence, and medication are consistent to medical treatments. From patients' records on the past sickness till present, it is found that the patients have got precise information and from 2-3 conversing with patients in each case as well as prevailing trust among patients, data collected are accurate, evident and credible.

Conserving with patients' relatives or family members, it leverages data reliability.

3.6 Problems and Solutions

1. Cases by interest are few during the period of investigation from the records of Catheterization Laboratory (Cath lab) , Siriraj Hospital and some cases have distant residence and inconvenient to collect data

Solution: 10 purposive samples are active and a Case study is applied.

2. Some selected cases contained not obvious data yielding likely imperfections of data and details.

Solution: the researcher employs observations and repeats issues of interviews till gaining sufficiently evident data.

3. Some cases are found on rest or preoccupation or on emergencies and needed to wait, therefore, re-appointment has been made for the following day such as the case of Mr. Somchai, who takes rest after lunch. Most are at siesta during the visits and re-appointment has often been made often. For example, the case of Mr. Somsakdi who has to attend customers during the time of visit, then the research has to wait till the patient finishes his work or make a new appointment.

Solution: the case of Mr. Somchai has been arranged for the new appointment to his convenience or after his siesta time, while Mr. Somsakdi is by his convenience and he fixes the appointment time.

3.7 Data Collection

Methodology is as follows:

1. Study information from documents, textbooks, researches, reports related to basic data essential to content of investigation, conceptual framework, and sample group, particularly from the patients' historical records to be references of data credibility from the samples.
2. The in-depth interviews involved with personal information, records of past sickness and stroke, selfcare before and after sickness and after PTCA, attendance of the family members upon knowing about heart disease, and undergoing PTCA
3. Observing surroundings and association of family members to be additional data for investigation.

Interviews:

It is a semi-structured model

Samples are interviews applying modified guidelines treated to myocardial infarction patient after PTCA as follows:

- 1) Personal Background, encompassing nature of family, and relation within the family,
- 2) Roles of patient, experience of sickness and selfcare,
- 3) Social support related to selfcare of myocardial infarction patient after PTCA.

Interview Questions for the Myocardial Infarction Patients after PTCA

It was divided into 4 sections as follows:

Part 1: Personal Background, encompassing the demographic details i.e. age, gender, marital status, occupation, income and education.

Part 2: Nature of the Family encompassing number of family members, relation within the family, such as conversation, discussion when having family problem, and common activities within the family., realization of patient's role, and illness experience.

Part 3: Family supports contained emotion, acceptance, recognition, esteem, counseling and information related to materials, money or service.

Part 4: Selfcare of the myocardial infarction patient after PTCA in relation to

1. Eating
2. Using medicine
3. Exercises
4. Alert on complications
5. Alternative medicine

3.8 Observation

This research was every time employed observations during home-visits, i.e. environments, lifestyle of the patient and selfcare behavior such as eating, using medicine, exercise, alert for complication. Further observations were used with what should be related such as nature of wording, facial expression, gestures, family members, expression in treating the patient during visits, association of family members.

3.9 Data Collection

An in-depth-interview was mainly used in this research along with observations with the following details:

Preparation Stage

The researcher approached the Chief of Cath Lab to request cooperation for data collection and to study the patients' records so as to employ the purposive sampling and to make appointment with patients.

Steps of Data Collection

1. The researcher the patients' records and their brief history from the Cath Lab

2. Familiarizing and building trust with patients and their relatives when they visited the hospital by introducing herself and discussed about the selfcare behavior, the social support form the family and asked about intimate persons to the family so as to make an appointment for home-interviews. Further, routes also had been inquired, for the purpose of the in-depth interviews with the patient and relatives.

3. The in-depth interviews with the patient and relatives at home – it was completed at the home of the patient following the modified in-depth-interviews in relation to the social support from the family and selfcare of the patient. Further, intimate persons of the patient had also been interviewed in relation to the social support from the family and selfcare of the patient. In-depth observations had also been conducted in relation to the social support from the family and caring by relatives/ intimate persons. Two (2) days had been spent on both approaches.

4. Checking of the validity of the data – after interviews the patient each day, the researcher would note the data in the interview format and each day checked their validity. Records would be decoded during nighttime to meet the completeness and to find any missing issues or additional details required with each patient for data validity

3.10 Data Analysis

1. Data Preparation for Analyses

Data collection was complete as well as analyses during researching. Meaning, each day after data had been collected, the researcher would return to record the data in details to check their validity and to be aware that which part should be additionally collected.

2. Filing

The objectives of the data collection in order to distinguish and categorize data attained from interviews and observations by descriptive approach for the purpose of search benefit for analyses. Filing is categorized into:

- 2.1. General File i.e. demographic variables of the patients
- 2.2. Primary analyses, which were collected from each night analyses to seek the model of the social support affecting the selfcare behavior
- 2.3. Fieldwork Files, which were the files of procedures and methods of data collection in each procedure of performances including problems and solution of each day during data collection.

3. Data Grouping

Categorizing data were begun since each night after data collection each day. Details had been noted and elaborated for clarity, additional question and analyzing data in each day. By this method, the researcher would have found factors or variables or models of the social support from the family in relation to selfcare of the myocardial infarction patients and after PTCA. Categorizing of major variables would be related to the nature of the family, sorts of the social support from the family, and the selfcare behavior of the patient

4. Data Analyses and Presentation

After categorizing all data, the analyses had been divided into 4 parts as follows:

Part 1: *The Demographic Data*, which evolved gender, age, marital status, occupation, economic status and presented in descriptive approach with Tables. This part would be the foundation in analyzing the selfcare behavior of the myocardial infarction patients and after PTCA.

Part 2: *The Nature of the Patient's Health*, which evolved the past illness, the current illness and its period and drew summary of the logical relationship of the data. Presentations were in descriptive approach with Tables. This part would be the foundation in analyzing the selfcare behavior of the myocardial infarction patients and after PTCA.

Part 3: the Selfcare Behavior of the Myocardial Infarction Patients and after PTCA in relation to eating, medicine, meeting the physician, exercise, alert for implications and the alternative medicine. This part drew summary of the logical relationship of each behavior .

Part 4: The family support , which the patient attained. This party would seek the relationship between the family support affecting the selfcare behavior of the myocardial infarction patients and after PTCA. Common and different natures of the social support were sought by using data form Parts 1- 4 for re-examination. Then the model of the social support of the family affecting the selfcare behavior of the myocardial infarction patients and after PTCA would be summarized in different models. This part would add case study during the descriptive presentation.

Each part brought about for analyses would be presented in different Chapters, i.e. Sections 1-3 would be presented Chapter 4. Section 4 would be presented in Chapter 5 as detail follows:

Chapter 4: Past sickness and Selfcare Behavior of the Myocardial Infarction Patients and after PTCA

Chapter 5: Model of the Social Support in the Selfcare of the Myocardial Infarction Patients and after PTCA

Chapter 6: Research Conclusion and Recommendation

CHAPTER 4

PAST AILING LIFE AND SELFCARE OF THE MYOCARDIAL INFARCTION PATIENT AFTER PCI/ PTCA

In this Chapter, it would be presented on the past ailing life and selfcare of the myocardial infarction patients after PCI/ PTCA in a case study model as following:

4.1 The Vendor Life

Khun Wan a widow of 56 years with primary level 4 education, a ready food hawker in Banglamphoo market. Her husband died 10 years ago. She had 4 children 2 males and 2 females. All were ready food vendor like her. Every morning, she purchased all raw materials and cooked , then her children brought food for sell. She had high blood pressure for 2 years been suffering on myocardial infarction. She was throughout treated in Siriraj Hospital spending on 30 Bath Health Allowance, no self-support, non-avoidance of salty food, no records of self-support, only realizing to take medicine and kept appointment and her blood pressure was volatile.

Her myocardial infarction began on June 2, 2003 with cardialgia, and exhaustion. Her children took her to check in Wichaiyuth Hospital since being recommended that expert physicians were there. The physician assumed of myocardial infarction and might need coronary intervention but considerable expensiveness for expenses. Informing of unaffordability and had rights of 30 Bath Health Allowance, the physician recommended Siriraj Hospital. Chemopallidotomy and coronary intervention had immediately been used. After being better, the physicians had instructed and recommended many things but neglected. Six months later, the same symptoms returned, exhausted respiration and cardialgia; she was brought to the hospital and treated with chemo-test. It was found that the same coronary artery was contracted and the dilation had been re-applied. Both physicians and nurses recommended self-cares avoiding cholesterol food with some exercises but being a

vendor; she had no time and had to wake at 3-4 a.m. to the Sala-nam-ron market to buy raw foodstuff for cooking. By 5 a.m., she had to cook and restlessly walk believing that it was the exercises as well as uncontrolling on food even realizing that being prohibited by physicians. Contradictorily, neighbors flocked to enjoy meals together and was tempted why she had to starve since death was so near. Her children forbade her particularly the fourth one who always remarked and was sarcastic but she never heard. Having to work hard and tiresome, there were no reasons to not to eat whatever wanted. Normally, she never cared herself, eat whatever being tempted, food of high cholesterol and sugary and having to work to earn a living, and there was no choice. After the first treatment, she assumed that her ailment had already been treated since the physician said it had been remedied. She said she knew her sickness well and needed to take medicine otherwise it would recur. She said she wanted to be healed, always took medicine, never missed the appointment and it recurred, she would take rest. Some time during cooking she felt fatigue, she would sit, took isosorbide dinitrate tablet, and in no time she felt better. During the time for PTCA, she had to stop work and all her children also stopped for 2-3 days and waited till her recovery.

In the past Khun Wan behaved herself nothing when got myocardial infarction. One should be aware of doctor's instructions but she could not except taking medicine and kept the appointment. She viewed heart disease would be critical only it recurred and hospitalization and stopped working for PTCA. However, if it was successful and felt normal, enabled to resume normal work, she thought the disease was curable.

Being ill of myocardial infarction and being treated with/ PTCA, she had been aware of the medical instruction to behave oneself such as avoidance of 4 means; food, and stress and so on. But she could not follow because of economic conditions, misdefining exercises, eating, and self-indulgence. Selfcare had not been changed and entering the role of patient when it recurred, which was only hospitalization. Her selfcare understood as regular taking medicine, keeping appointment, and viewing recurrence of not strictly following medical instruction. She still prioritized taking medicine rather than selfcare on the other health areas. She viewed family supports that she sensed concerns of her children but they did not verbally expressing particularly her sons. They only told her to feel comfortable and took more rest. Only

her third daughter insisted her to avoid prohibited food because she took her to the hospital. She knew more than the others and always sarcastically cautioned her mother that if she did not love herself who else would love.

Khun Wan: since having personal sickness of high blood pressure, she never behaved to heal herself such as avoid salty food, and stress and when she has heart disease, she behaved the same.

“ My self-care is the same and I have to work hard as ever. When I get this symptom, my children tell me to avoid high cholesterol food and exercising is out of question by working hard. Stress is untold since they know I have to take all responsibility, deciding by myself, even the treatment, they have no comments. I have done everything to my self-care. If I were tired, I would stop. If I got chest pain, I would take isosorbide dinitrate tablet and recovered. I am conscious but know their concerns. They always emphasize on self-care and if I do not love myself, who will love me.”

“ When the symptom grows and hospitalized with dilation, my children usher me to the hospital and return to work. They visit in the evening because they have to help themselves. I was hospitalized for 2 days and returned home. After arriving home, first I avoid hard work and often take often but later it is the same. I feel that I do not change or so much take self-care as before I get myocardial infarction and after treating dilation. I behave the same but only increase tablets with prohibitions of eating but I do not follow because of unfamiliarity. I think I am not sick but if the symptom does not worsen, there is no chest pain and if I am tired I stop, and my children know well.”

Summary: selfcare of K.Wan was far fetched because of occupation, time, and self-indulgence, *“When one work hard, one feel hungry, one must eat since no eating after death.”* In exercise, she defined that her routine works were counted.

In taking medicine and keeping appointment, she prioritizes then because of the past sickness. She related that

“The first one was so acute with cardialgia, so exhausted as never before, so threatened when being hospitalized in Wichaiyuth Hospital knowing affected by myocardial infarction. I tell the doctor of using 30 Bath Health Allowance and have

been recommended to Siriraj Hospital. The doctor treats with the chemo-test and dilation and has to spend some amount to help the hospital. At that time, there were no problems and not so much pain. After two days of hospitalization and returning home, I fear to work at first because of my wound and have to take medicine. Then I was not so much worry fearing the ailment. The second time, it was likely the same as the first time but not so exhausted, the doctor found the same spot had been infected. This time the doctor demand to pay for the special stent, I am so worry with the large sum of money but can't help. Now, I am so cautious and if I feel tired I must stop and take pills and never miss the appointment with doctor except cholesterol control. When one work hard, one feel hungry, one must eat since no eating after death. This ailment shows nothing, but if not worsened one can normally work only if tired, one needs to rest.”

Therefore, the family supports, she had been blessed on affection, attentiveness, esteems as being parenthood, household leader and what should be returned to their parents by her sons and daughters.

4.2 Previous Early Retired State Enterprise Employee

Khun Somchai a man of 58 years, married and earned a bachelor degree, the previous early retirees of the state enterprise with an engineering position. He needed rest at home living with his wife, his 90 years old mother and his only son who was studying in abroad. The residence area was spacious and shady with trees look calm and fresh. His 2-floor home was modern, neat and clean, which was cared by his wife.

Khun Somchai was sick by high blood pressure for over 10 years and hospitalized in Wachira Hospital with taking pills and had ever checked and found affected by myocardial infarction. He had also been treated for over 9 years in Wachira Hospital. With good care of oneself, taking good rest, selective to food and wishing to avoid stress with private illness, he signed for early retirement to stay at home. Later finding that he got often chest pain, so then he visit Wachira Hospital for electrocardiographing and found himself negative. He then counseled his sister a doctress in Siriraj Hospital who recommended chromic test and it was found an artery got myocardial infarction and treated the dilation. Also he was prescribed to take

medicine at home. Later, he felt well at first, free, relief, completely cured and no chest pain but tiresome. The doctor commented to avoid many types of food, such as, high cholesterol, sugary but unlikely followed because of temptations, thinking that a little but taking tablets by prescriptions by craving but never stop taking pills because he had to take pills of blood pressure. A month later, he felt again chest pain but milder than the first time. He got Chemopallidotomy and dilation of another 2 arteries. This time he took more caution not to take salty, or cholesterol food and emphasized plain food under the care of his wife. His exercise was walking around the house, planting and not so toilsome fearing another chest pain. Normally, he unlikely worked except some hobbies such as planting, washing and so on. If he felt unwell any day with exhaustion or chest pain, he would sleep and visit the doctor. During PTCA, he took rest and after arriving home he felt normal without hard work since less job at home. HE spent more time on sleeping feeling drowsy all the time.

The case of *K. Somchai*: from the past sickness till affected by myocardial infarction and being treated with/ PTCA, he never behave for health, never restricted on food because of self-indulgence. After experiencing the recurrence, he became aware of selfcare for health to prevent recurrence. He prioritized taking medicine believing that the previous ailments were high blood pressure and it was recurring. If it were acute, he would admit for hospitalization till being well. He emphasized medical instruction particularly taking medicine and keeping medical appointment.

It was found in the case of *K. Somchai*, that he was aware of selfcare in eating by avoiding fatty food still he prioritized taking medicine believing that it prevent recurrence and got pain. Attention was part from family, which provide affection, attentiveness and particularly his wife who helped on eating, and his son as spiritual support. The patient said, it was indispensable especially during hospitalization that his son did not know and did not attend him. He said he feared he would not see his son's face again but still kept inside himself and did not want to inform his wife fearing she would be sorry. Upon knowing that his son would return to stay in Thailand, he was exalted (smile) and started counting the day of arrival. His wife said that he loved his only son so much and he was fresh like a tree getting shower learning that his son would be back soon.

The case of *K. Somchai*: affected by myocardial infarction and being treated with/ PTCA , doctor instructed many things but some he was unable to follow particularly food but later he took plain food. He realized later that food was vital to disease but he trusted the doctor and took pills because fearing pains. He attempted to control food fearing death and arteriostenosis. He demanded his wife not tot tell anyone what he avoided regarding food fearing other to take interest and worry, but when eating out with friends by avoiding some and selective.

Since affected by heart disease till dilation, he was unlikely working. After the dilation, he rested and easily slept.

He better took well care of himself, less toilsome since realizing of having heart disease and enthusiastic to seek books about the disease for reading.

His wife took care of everything particularly food and doses. His con called often, which made him sense their concerns and he also longed to meet his son because of never met each other for quite some times.

It was found with the case of *Khun Somchai* that the patient began better being aware of self-care after being affected by myocardial infarction and being treated with/ PTCA. Whereas, exercising had not been correctly defined, i.e. unlikely exercise thinking that having the heart disease and should not work. Behavior of taking medicine had been prioritized. He said that if any day he did not take piles, he felt something missing but he felt it not a burden but fearing worsening and taking chemo-test again. Regarding alert of complications, K. Somchai said he could notice if there were chest-pain and difficult to breath. Then he would take isosorbide dinitrate tablet or immediately met the doctor. From the past 2 experiences, he became more cautious on food, exercise, taking rest and essentially, and taking medicine. The recent one, he felt easily exhausted even only lifting a flowerpot. Then, he went for medical check for chemo-test and found another infection. From this experience, he strictly followed the medical instructions attempting to avoid fatty food. His wife prepared food but significantly he had to take medicine by medical instructions. In relation to the alternative medicine, such as herbal medicine; K. Somchai rejected because he never believed it potentiality to treat modern disease. Therefore, it needed modern medicine to cure. Related to family support, MR. Somchai said, he got distinct

affection, attention, and esteem from family members, whereas money and advice, he attended and decided them by himself.

4.3 A Tough Elder

Khun Lek an elder of 73 years looked infirm and unable to walk far easily exhausted and knees pains. He needed supporters during walking, bad sight, kind, and earned only primary level 4. At that moment, he stayed with his youngest daughter with 5 members, i.e. his wife, his daughter, his son- in-law, and a niece. His house was one floor with high raised floor. Mr. Lek said, he earned no income, jobless and relied on his daughter for medicine, and daily living. He felt burdensome because each payment visiting the doctor quite large sum to buy some heart disease medicine. Now his wife got diabetes and knowing that it was incurable and it added another burden to his daughter. She was a general labor in a housing gestate such as laundry, cut grass, housework and earn 150 Baht a day.

Khun Lek was affected by heart disease for 5 years, previously he got airbag disease for over 10 years since young he was chain smoker and had been common labor to earn the living for his family. Later he was affected by gout and joint-pains unable to work because of smoking effect. He needed medicine for bronchial dilation and sprays because of easily exhausted. He had no time to care himself but his nephews and attended small jobs to help the family. He needed opened space with good airflow and had to sleep at the balcony. He got chest pain and more exhausted. In August 2003, he took chemo-test and found vasoconstriction and needed two dilations.

Normally, he rejected cholesterol food but chilly paste and vegetables. Even affected by heart disease, he still take normal meal and exercised around the house or visiting neighbors. The doctor suggested taking a walk-exercise because of airbag disease. After affected by heart disease and vasodilation, he still normally lived but never failed to take pills believing that pills helped. If he got sharp pain, he would meet the doctor ushered by his daughter.

During young, he drank and smoked and affected by asthmatic disease, and airbag disease. The doctor asked him to quit smoking for many years still he was easily fatigued. He carried spray and unable to do heavy job. Finally, he could not help

the family but his children did and he had to take care his 4 nephews. At that moment, he stayed with his youngest daughter with 5 members, i.e. his wife, his daughter, his son-in-law, and a niece.

From the case of Khun Lek, he was aware of self-care and even affected by heart disease his previous disease had never change. He paid attention to self-care, no cholesterol food, took the same exercise and family roles. Normally, he was not the household head but the center of family members. Part of self-care was from his daughter. Family supports most were affection, attentiveness, and esteem. He said he tried to look after himself and did not wish to be the burden to his daughter, regularly taking pills. What he did he avoid exhausted work, such as sleep at he terrace getting fresh air, taking a walk around the house because the doctor said it helped lungs, and heart to be fit.

The case of K. Lek: regarding selfcare, he said that after having myocardial infarction and being treated with/ PTCA, he unlikely changed. He said he rejected cholesterol food but chilly paste and vegetables. Even affected by heart disease, he still take normal meal and exercised around the house or visiting neighbors. The doctor suggested taking a walk-exercise because of airbag disease. After affected by heart disease and vasodilation, he still normally lived but never failed to take pills believing that pills helped. Alerting the complications, K. Lek said, if there were chest pain or fatigue, he would rush to the doctor since he had got experience. Regarding the alternative medicine, he believed that it could not help since form the past experience the disease need PCTA. Therefore, he strictly followed the medical instructions to prevent recurrence better than other techniques.

Summary, regarding selfcare of Mr. Lek, it was found he had not changed eating and was aware of taking slightly more exercises from the existing one. He emphasized regular taking medicine. While his family paid affection, and attentiveness to him as a family member should get, what advantages he should gain, members would gladly handle it to him such as sleeping in an airy space, which his son-in-law and daughter provided and facilitated him

4.4 Diabetes Surpassed Heart

Kkun Sunee at the age of 53 year, married, earned primary level 4 and a housewife. She had 3 children. The eldest son drove taxi like his father as well as being the government official, the second child was a daughter working in the office of Bangkok Administration district, while the youngest son was studying in a senior secondary level 6. She lived in a single floor house with wide space in front of her house for parking taxi and during day time she raised her nephews and doing housework.

Khun Sunee got heart disease for a year and three months before this she got diabetes. She never failed to follow the doctor and her son's instruction, food control, stopped sugary food or carbohydrates. She took care herself well and never thought of getting diabetes, and neglected health. Affected by diabetes, she needed food control otherwise the level would high and bashful when the doctor knew of not controlling food. She never realized affected by heart disease. The time she had menstruation thinking of over aged but later felt fatigued and collapsed, her son bought her to hospital and found she was affected by heart disease and needed dilation. 7-8 months later, her respiratory system was defected, easily tired; she was found the same vasoconstriction and got dilation again.

Before affected by diabetes, she never controlled eating but when affected by heart disease, the doctor demanded cholesterol food free but vegetables and fruits. She unlikely followed but strict with the diabetes. It was tangible with high sugar level and needed readjustment of medicine after meeting doctor. Exercises were recommended after affected by heart disease. Her son usually reminded her and suggested to take aerobic dance near his home rather she took a walk around the house.

The case of *K. Sunee*: after affected by myocardial infarction and being treated with/ PTCA for twice, she took good care of herself, looked strong, began to attend the diabetes by avoiding sugary food. This recent sickens made her avoid cholesterol food. But she was not so strict and took meal with others but only attentive to the medical instruction to regularly take medicine and to rush to the hospital if felt sick. After being treated she returned home to resume her work as normal as if she was not a sick person. She said when she was normal, she felt nothing but took pills as

before if it were the heart disease or diabetes. It recurred and felt sick, she firmly believed the doctor. She said at the first return from the hospital, her son was so worried and did not allow her to do anything fearing the operation wound infected. All family members concerned about her. As time passed, they saw she seemed strong as before and stopped worrying and asked her to take good selfcare. The youngest son reminded her about food and books to tell her to follow especially taking exercises.

In Khun Sunee's case, her heart disease was caused by negligence of self-care on food with risk of affected by diabetes. Caring oneself from diseases was not different from self-care when being found affected by diabetes. Cholesterol food was unlikely controlled, seeing no significant of such food to hear disease but weighed much on diabetes and pill-taking. Pills were all things to control diseases. Family roles were not changed of being a housewife.

In Khun Sunee's case, her selfcare was focused on taking medicine because of the past experience and she had to take dilation twice. Taking pills was believed to get cured and lessen pain. Being aware of selfcare in other areas was eating, which she was not strict and by her own understanding, it was unlikely and being the housewife duty, she had to cook for other family members. The food could not be separated and all ate together. Relating to exercises, she said being a housewife, it should not be necessary like other people in city, with the housework, it was already sweat her, which she counted as exercise. In terms of alternative medicine, she rejected this belief and in noticing the complications, she could sense the changes by shallow breathing, easily fatigue then she would rush to see the doctor.

Summary: in her selfcare, she prioritized taking medicine rather than external perception. She was strict only with food for her diabetes. She commented on family supports that her son was so concerned about her and by being a book-lover he read about heart disease and related to her. Her husband and others always reminded her to take medicine and selfcare, following the medical instruction. She admitted that family members concerned her particularly during the recurrence, she would not be allowed to do house work.

4.5 Diabetes Hybridized to Heart Disease

Khun Nit, a man of 84 years and an official retiree, the academician of Bangkok, in general, he looked strong and attentive to his health. He lived with his wife and 2 attendees. His house area was spacious, and shady. He had 2 children and both taught in Chulalongkorn University. Normally, he needed not work and spent most of this time to read and study texts at home.

Khun Nit was affected by diabetes for 30 years, took pills and self-caring and restricted sugary eating on carbohydrate. It was unlikely but never failed taking pills. Before affected by diabetes, she never cared her health. Her heart disease was fund in 1998 from the symptom of chest pain, fatigued at walking, got chemo-test and stent vasodilatation. She felt better and never failed to take pills since difficult to food control. When time permit, she took vegetables and fruit or health food. The second time affected made her so fatigued. At Siriraj, she got chemo-test and another vasodilatation on August 23, 2004.

He said, “Realizing the cholesterol food causes disease and never take exercise, after vasodilatation, I take often exercises and walk inside the home or in the lane but critically, it needs peaceful mind and not stressful.”, He further observed,

“Always caring myself since I am an official and academician. I read book and have less time to care my health thinking I am healthy. I know diabetes will not be cured so I take cholesterol and reduce sugary food. I have 2 children both have their own home staying with his wife and mother in-law. I have to take care and assess myself. If it is not worsen, I look like normal, all are the same, attending everyone and take decision.”

Heart disease should happen because of having diabetes for 30 years. He tried to take pill and believed that both ailing were equally acute. Meaning, fatigue, chest pain and after Medicare, it was better. So, he tried best to follow the doctor’s instruction. After Medicare, it was better. Selfcare was similar to attending the diabetes by taking pills, and rejected cholesterol food but it was unlikely, he still like it but minimized them. Family supports helped selfcare (to stop cholesterol food, regular taking pills) because, the family accommodated only elders and feared to be burden of

each other. His Children separated to have their own family but still they never fail to love and concern him.

In the case of Khun Nit, it was believed that the heart disease was caused by diabetes since she was affected by diabetes so long. She knew that the cholesterol food caused disease but unlikely followed after the 2nd vasodilatation. It was believed that exercises and peace of mind could better the condition. She prioritized taking pills, role of self-care after being affected by heart disease. Previously, she changed so little because of self-care even affected by diabetes. Her family roles were the identical and felt nothing if the condition was not worsened.

In the case of Khun Nit: His selfcare after having heart disease had unlikely changed because he got diabetes before and needed food controls with regular taking pills. Therefore, in hear disease, he needed food controls but unlikely strict. Normally, at home he had a housewife to handle with the guide of his wife on what food should be avoided. But outside home, he was unlikely control but strict to take pills believing to prevent recurrence. In exercises, he believed that it helped preventing recurrence after he was twice affected but it should not be stressful. Regarding the alternative medicine, he did not believe in it potentiality to treat heart disease. He could indicate the alert of the complication after being twice affected.

4.6 Life Be Heart

Khun Cherdsak, a Thai-Chinese of 53 years looked strong, active and earned a bachelor degree but he was a merchant at home. His home was redesigned to be a warehouse with many employees but his residence was separated built into a modern two floor house and he lived with his wife and 3 children.

Khun Cherdsak was sick for 10 years and high cholesterol and high blood pressure being a businessman, trading and used too much brain, easy to get stressed but tried not to. It was impossible because his business demanded it. He was 45 years when he got heart disease and his first dilation was in 1997 because of acute chest pain and more fatigue. Later he was better till this year; the symptom began and found many vasoconstrictions after chemo-test. The doctor operated to for by-pass. Late February, it was better at first but later he felt chest pain till July, he was under chemo-

test and found another vasoconstriction. The dilation had been undertaken but after newly operations, it was better. At the moment, when weather changed, and driving, he felt chest pain particularly after meals.

He observed that, “The doctor says high blood pressure and cholesterol cause heart disease and recommends exercises, stopping cholesterol food and order medicine for both conditions. Normally, I reject cholesterol stuff and every Wednesday I practice vegetarian at home. I have 3 children and home leader who decide everything and self-care. My children and my wife share some but I know what to do or what I should do.” It was seen that Khun Cherdasak with his past sickness of heart disease with having dilation, he realized good selfcare by regularly taking exercises and taking pills, avoid cholesterol food. His family shared in taking care and his wife tried to reduce cholesterol food. All loved and concerned him especially he often visit the hospital. He himself said he had to look after himself.

After bypass he became aware of selfcare, avoiding cholesterol food and saw the more vitality of exercise but emphasized regular taking pills believing that it could cure his sickness. His role was the same and did not change.

He further observed, “After operation, I begin cautious on eating sometimes, I cannot avoid during the party but I take exercise everyday at night, it makes me sleep better and never fail to take pills. Comparing acuteness, at first it was weakened but after dilation, it is better but weakening when starting walking. This chemo-test shows many constriction and I get by-pass. At first, it is better but chest begins paining and need new chemo-test. Many constrictions are found. It becomes chronic and after operation, it seems better but I have to observe myself and believe the doctor or fast to the hospital and food control because it often happens and I fear. Someday, I and my family practice vegetarian.” After bypass he became aware of selfcare in all aspects except rejected alternative medicine. He said selfcare was vital and necessary to prevent recurrence, never failed to take pills and kept appointment believing that doctor should treat recurrences and the rest was his duty.

4.7 Messenger Life after Survived Death

Khun Chalerm, a Thai of a bit stout with 53 years, earned primary level 4. He was a messenger lived in a two storey row house likely congested. He had 5 children. The eldest one 24 years worked in a company and the youngest one studied in junior secondary level 3. His wife was a housewife and during Saturday and Sunday she was employed to sell clothes in Banglamphoo.

Khun Chalerm just found his Heart disease since June 2004. He got acute chest pain and breathless and blue face arriving Krungthon Hospital and needed heart pump. He was transferred to Siriraj Hospital and used social security card with immediate dilation. After operations, he felt likely chest pain and in July 2004, he got another chemo-test and found that the previous dilation got constriction.

He said, “I am never sick before thinking healthy and no self-care and eat everything since I do labor work. Now I take pills but feel also boring but wish to be cured and do not want my family to suffer. Being the leader and the home earning is relying on my labor.”

He continued observe that, “I never know heart disease before. Normally, I like cholesterol food such as stew pork rice, chicken rice and desserts, occasionally smoking and quit by the request of my children. I never take exercises because hard working and walking up and down the office.”

“ After dilation twice, now I take rice soup for fast digestion and no constipation. I now feel more weight since workless and fear fatigue. Now, I do not work and normally, I was messenger among offices earning no income. My 5 children help since all work and the youngest one is studying in K. 9”

In case of Khun Chalerm, no personal ailment had been found but by consumption behavior, it might lead to heart disease, high cholesterol, high blood pressure and diabetes. After dilation with awareness of self-care on eating, and redefining exercises rather than working, and with the changes of family roles when being worsened, Khun Chalerm felt free from it for a time and was able to resume his earning. He felt bored of taking pills but craved to be cured so he never failed to take them.

In case of Khun Chalerm, after dilation, he took selfcare, which he never did it before because of felt that he was strong but emphasized taking pills. “I feel it stops disease or recurrence and try to take soft food after dilation for better defecation after doctor’s instruction rather than extraction of defecation. If I do not take exercise, thinking that often walk up and down offices is like exercising. It was observed that he prioritized taking pills while with food he avoided fatigue rather than preventing recurrences of disease yielded from food. He also misunderstood on exercises thinking that working was exercising. Regarding complications, he asserted that it was clear to him from survival of the past event, in never left him. Related to alternative medicine, he rejected it potentiality and by experience only the modern medicine and specialist could handle this sickness.

4.8 Diseases from Risk of Discontinued Medicare

Grandma Lamai an elder of 74 years and a widow living with her 4 daughter and the house area was similar to a orchard with countless trees. It was a two-storey house. She earned primary level 4 and previously she was a housewife later did not work because her 3 daughters were government officials.

Grandma Lamai was affected by high blood pressure, cholesterol for many years but under regular medicare when got headache or medical check and found high blood pressure. Tablets were taken at first and if there were no symptoms she would skip. There was no special attention since she ate only chilly paste and vegetables. The heart disease came with high blood pressure and high cholesterol with irregular Medicare as instructed by the doctor. In 1993, she got dilation and felt better but not so strict in eating sometimes cholesterol food. The second time, she felt again chest pain and fatigue, and in Siriraj Hospital, she was found with new coronary vasoconstriction and got dilation. After this she fear hard work and fatigue began to be strict on food and regularly took pills to stop worsening condition and being burden to her children. Currently, she stayed with her daughter with 4 children and one had moved out by marriage. So her children took care expenses and she did no work.

She observed that “I do not know heart disease but having it, I have to take pills regularly to stop worsening. I do not take exercises fearing fatigue. Exercising causes exhaustion. Thinking that the second one is more acute because of too much pain, breathless, and fear. After meeting the doctor, I feel better but I must take pills regularly to stop the symptom.”

In the case of Grandma Lamai, this heart disease changed her more attentive to self-care but her eating was unlikely, negligence to exercises fearing fatigue. She was the center of the family and need not take responsibility of her expenses.

4.9 Workaholic

Khun Pradit with the age of 50 years and married, earned a bachelor degree working in the Cooperative Bank and lived in a two-storey house had 2 children and his wife worked in a company. Normally, he was healthy and took some exercises during Saturday and Sunday. He had no personal sickness before, drank and smoked sometimes and ate everything. His office was very far, which he had to spend 2 hours drive and return home almost dark.

His hear disease began in 2000 by chest pain, easily tired, taking chemo-test and slightly constricted. The doctor prescribed him pills but in July 2002, he often visited hospital because of fatigue and chest pain. After chemo-test, the dilation was made and regularly took pills, till currently he easily felt fatigue and the doctor recommended running stand but he was found the constriction with the previous one so he took another dilation. He observed, “By first treatment, I avoid cholesterol food and take exercises. Since my home is too far, I could sometime afford and play badminton during weekends. I control eating but regular in take pills fearing worsening and meet the doctor if I feel irregularity.”

“ If it is not worsened, I feel normal, able to work and being the leader with 2 children. Decision and self-care are under my responsibility. My wife works in a company and attends cooking, she also guides me on eating.” Khun Pradit said.

In the case of Khun Pradit, his heart disease had no relationship with the past ailment but from self-care behavior, eating, and wrong exercises. Having heart disease and high blood pressure, he got high cholesterol. His awareness of self-care was

increased but still not so strict. He prioritized taking pills by prescription. After ailment, his roles were never changed with responsibility over the family and himself.

In the case of Khun Pradit: after the past sickness and having many dilation, he became aware of selfcare particularly medication and meeting the doctor. By experience he could notice the symptom starting from chest pain and many time exhausted breathing. Concerning eating, he tried to control but here were limitations since he had to attend socialization among colleagues at office and outside. He could not sometimes control his self-indulgence but thinking that regular taking pills, it could prevent recurrences. HE saw necessity of exercise but he had restrictions on time and office. He could not take regular exercise. Related to the alternative medicine, he thought it could not heal his sickness since it needed modern medicine only.

4.10 Too Many Diseases Overshadowed Self-care

Khun Somphop a Thai-Chinese of 65 years, his stature seemed fragile had likely helpless with 2 swollen legs, easy to get tired. He lived with his son and daughter-in-law in a two-storey house with good space. He earned primary level 4 and currently he did not work but his son ran company for him

Khun Somphop was affected by airbag disease, diabetes, high blood pressure, and high cholesterol for over 10 years and ever been operated on coronary artery in 1994. I needed spraying after that and stop cholesterol food as instructed but he more easily felt fatigue and weakening. So he thought to eat more to recover his strength. Later, he lost control on food and by the early of this year he felt tired and chest pain. He needed re-dilation and became burden to himself and the family regarding expenses, pain and spiritual support. Since the first time till the current one, he failed on food control by misunderstanding and no exercising fearing fatigue only regularly took pills to control symptoms. His children prepared him pills and he did not work but stayed with his son and daughter in-law with 2 nephews and a caretaker. Both acuteness were equal said Khun Somphop particularly, when being weakened and easily fatigued.

In the case of Khun Somphop when the heart disease appeared with other personal ailments and had to take self-care without food control, not exercising both and after, he had dilation, took responsibility over the family, was part of the member and was the center of the members.

In the case of Khun Somphop: with many diseases such as airbag disease, diabetes, high blood pressure, and high cholesterol, it made him bored to take selfcare. Therefore, his behavior was unlikely counting from eating, which he never restricted since it would make him weak and fatigue more. He prioritized taking pills believing that medical instruction would lessen the symptoms. Concerning the alternative medicine, he rejected it and to notice complications, he could notice since he has many time experience the symptoms.

4.10.1 Past Sickness and State of Having Heart Disease

From the investigation of 10 cases, it was found that all cases had 1-2 personal disease and most were high blood pressure, cholesterol, diabetes and so on. This content covered background of the patients, having heart disease in the past, role of the patients, and selfcare awareness, avoidance of recurrence and family support upon being sick.

Summary form 10 cases, it was found that the past ailment had relationship with the heart disease. Some cases had no past ailments but when the heart disease was found it was associated with high blood pressure, high cholesterol in all cases. In Medicare, the re-treatment of myocardial infarction required controls of cholesterol condition and blood pressure to reduce hear function. Heart disease was treated in associated with high blood pressure, and cholesterol. Self-care after affected by heart disease and the past ailments were found din some cases to be more aware of self-care and taking more pills, which most misunderstood that, the pills helped subside symptoms. Other areas of self-care some failed. It was found from the study that most patients less understood definition of self-care behavior linking with the heart disease. Therefore, they paid less attention to strictness. Comparing experiences of patients by acuteness, most were found that the first time was more acute since being without experience of sharp pain and needed emergency care, no time to reflect and all were at

the hand of the doctor. After returning home, it therefore believed on taking pills and being cured, and preventing restenosis. It made patients strongly reflecting that they were careless at first about self-care even some were aware. By the 2nd one, all viewed medical treatment steps, experience of worsening condition by self-evaluation, which allowed to correctly manage by meeting the doctor and followed the previous steps of treatment. So, they were more cautious on taking pills. The more they felt insecure, the more they believed the doctors regarding medicine. IT was emphasized that the heart disease needed advance sciences for treatment. When crisis had past, it seemed nothing happened. All returned to their roles least aware of bedding only the period of worsening. It was chronic and only needed regularly taking pills.

Whether to have past ailment reflections, it was not experience to directly be applied with the heart disease. It was counted from its own experience till being cured and its restenosis. Perspective of ailment returned to the same systems and the management was left to the doctor only. The patient had no authority to decide and Medicare model was determined by doctor. From the studies of the past sickness and having heart disease, it was found that in case of sickness duration from the past to present of the patient and selfcare after being sick was not depended on sickness duration. Prolong sickness or recently sick caused no differences to selfcare but it depended on sickness experiences encountered, which led the patient to become aware of the acuteness and affected the patient to begin selfcare. The researcher grouped duration of suffering into 2 natures, i.e. A group since having heart disease of not more than 5 years and the group of more than 5 years had found relationship of selfcare of the patient after dilation as follows:

The group having heart disease of not more than 5 years was the cases of Khun Wan, Khun Lek, Khun Sunee, Khun Chalerm, and Khun Pradit. All the 5 cases informed, *“at first, it was horrifying and I got menstruation and felt collapsed. Later my children brought me to hospital and told me I was affected by heart disease and badly needed immediate dilation. Later, I have to look after myself by instruction on controlling cholesterol exercises, which I unlikely complete but never fail taking pills fearing worsened condition.”* *“ At first, I felt acute chest pain, exhausted, blacken face and arrive hospital and got heart pump before dilation. At the time, I never got sick and found controlling both food and attempts of exercises. At the moment, I took soft*

food but cannot exercise. I work as messenger among offices and often going up and down the offices, which was counted as exercising.” “ During the time, I felt chest pain all the time and exhausted and visiting hospital often but never stopped. After dilation, it was better. Less exhaustion and chest pain. I work in the Agriculture and Corporative Bank, which made me also stresses. Food needed control but unknown what to eat e.g. avoiding deep-fried, oily, even shrimp, and squid, which I didn’t know and it was hard.” “ I was horrified at the at time since never been sick before but I have to take selfcare and unable to do. Food cannot be reduced since tired. Thinking that whatever wanted to eat then eat it since after death none is found.” In summary, this group, the patient since began having heart disease had been recommended to change selfcare behavior. Most were aware of such but not strict to follow. Some suffered with other diseases before heart disease, it needed more selfcare but unlikely better in part of the heart disease. In this part, at first sickness with selfcare had been viewed of reciprocal affecting. Some cases had other personal sickness needed to be aware before to such.

The group having heart disease of more than 5 years was Khun Somchai, Khun Nit, Khun Cherdsak and Khun Somphop. This group informed that, *“Having high blood pressure and heart disease for long time, and regularly taking pills and never bored, a day without it seemed lacked something in life. Salty and fatty food was avoided only insipid food but sometimes it was unlikely. After dilation, I followed the doctor’s instruction but sometimes, it was unlikely and feared exercising because of fatigue.” “At home, I never take high cholesterol foods but vegetarian ones.” “ Realizing to stop cholesterol food, now I take health food, which are vegetables, and many fruits, some exercises by walking in front of my home.” “It has been very long and never medicated, always tired, less working fearing fatigue, less walking, never stop eating but tired. If I stop eating, I would be dead and I am weakened.”* It was observe among this group that even being sick for so long with other personal sickness, it never turned selfcare better. All were aware of instructions but sometime it was unlikely.

Therefore, it observed that duration of sickness and selfcare were not depended on having disease but the first experience of sickness, and different acuteness turned the patients to be aware of increasing selfcare.

Therefore, it was seen that duration of sickness and selfcare were not depended on disease but first experience of sickness, and different acuteness, which made patients aware of more selfcare. All cases after dilation, there were no acuteness left to threaten to change the routine life of patients. *“Had it not been recurrent, it were normal and act as normal but only taking pills regularly, control cholesterol food and exercises.”* It was therefore observed that level of acuteness had relationship with selfcare. Had there not been any acuteness left or inrecurrent, strict selfcare would not have been developed. There were certain levels of awareness viewing that, had it not been threatening life at the moment, strict selfcare behaving would not have also been developed. Selfcare would have been the same in daily living without any more specialties. With the experience from the first sickness till the moment, it made patients able to estimate their sickness status. The management would be differed on selfcare such as alertness of complications. *“At first it was terribly fatigue and chest pain visiting the doctor and told him that I got heart disease and need immediate dilation. I was shock at the moment. But after treatment I feel much better, no fatigue, no chest pain and never fail to take pills. The second time feeling chest pain, I rushed to the doctor. He recommends the chemo-test and it found the same one got extract, which needed dilation.”* *“Feeling chest pain, I rush to the doctor knowing that this disease has to be near the doctor, and it is healed by the doctor only.”* *“ since getting sick and having dilation, I always take selfcare, especially the second time, I am really cautious about cholesterol food and I take light exercise fearing tired.”* *“ Fearing much walking and the wound will not close.”* *“In the second dilation, I get infected and still tired unlikely to walk, never fast, since I have no strength. If I fast I would die. First time I fast and I feel that I have no strength.”* It was seen that selfcare after got experience was different, which caused different care. Some were attentive particularly the complications. Some misunderstood it because of believing and mis-defining it on eating and exercise. Therefore, some cases were applicable and unstrict to some matters. Significantly, all prioritized taking pills believing that otherwise it would be recurrent. It was concluded that the past sickness till the moment of the heart disease, the patient did not increase selfcare even after dilation. The patients saw that to become aware of sickness and needed strict selfcare when there was recurrence and hospitalized in the hospital. Had the disease been treated and left the hospital, it

seemed not being sick, normality, then selfcare would not be stricter or even none at all

4.10.2 The Selfcare Behavior of Myocardial Infarction Patients after PCI/ PTCA/ CABG

From the investigation of selfcare behavior of myocardial infarction patients after PCI/ PTCA/ CABG in 5 areas, it was concluded as follows:

In the study, the patients informed that in **Eating**, the selfcare before dilation there was no controls excepted diabetes containing methods of nutrition by rejecting carbohydrate and sugary food. After dilation, all cases became aware of controlling cholesterol food but unlikely so strict. *“After dilation, I still eat the same oily food, deep-fried, and coconut milk curry. Actually, the doctor forbids, it may cause restenosis but it is difficult since after death I will not have chance.”* *“ I have ever rejected fatty food, meat y instruction but I find myself weakened than before so I stop food control.”* *“Normally, I dislike fatty food and unlikely to change. I do not know what were fatty foods. Sometimes I stop eating pork, but the doctor forbids shrimp, squid, which also contain high cholesterol. Now, I try to avoid all these but unlikely. After finding out being heart disease, I attempt health food, vegetables, fruits and stop deep-fried and fatty stuffs.”* *“ Later, I take insipid food, fat-free and not so full. After dilation, I take rice soup it is better for digestion and avoid constipation. I also avoid salty food.”* *“ Normally, I have diabetes and stop carbohydrate food and dessert. After realizing being heart disease, my son stop fatty food but only fishes.”* *“After being sick, I automatically reduce food and stop prohibited food and every Wednesday we take vegetarian food, the whole family.”* *“ After being sick, I reduce all cholesterol food.”* *“Goals of selfcare on eating after dilation is to prevent restenosis by doctor’s instruction, and by medical staff. Actually, the patient never understand why such food had to be avoided and there is no obvious explanation, no connections with disease that the patient should be aware of.”* Therefore, eating behavior of the patient was not so strict but realized it benefited if possible. The restenosis was inexplicable because food control was not the only thing. The patient believed that there could be restenosis as met before without knowing the cause. Some suffered many personal diseases.

Therefore, food could not clearly explain the restenosis. The patient then took less attentive on this part. In **Using Medicine/ Meeting Doctor** - before dilation, medicine use behavior when there was personal sickness/ disease. It was treated by symptom. *“I regularly take medicine being high blood pressure for 10 years. Any days without taking, I feel missing something. After dilation, all patients prioritized selfcare and strict in using medicine aiming to get cured and controlling symptom, fearing death. In particular the 2nd and 3rd dilations, all patient prioritized taking pills understanding that the heart disease required only modern medication and new sciences and significantly taking medicine by prescriptions to prevent worsening condition and restenosis.”* *“ Taking medicine to get cured and regularly taking otherwise feeling missing something.”* *“Taking pills helps better condition and never forget it.”* *“We can’t avoid food so taking medicine as remedy of restenosis and relief and not tiring, workable and reduce conditions.”*

It was therefore, using medicine/ meeting doctor tuned patient to better be aware after sickness and dilation aiming to be cured, relief from disease, and not worsened. In relation to exercises, most patients had never before thought of taking them. They saw no necessity of them to health. Some thought that daily works was exercising after dilation. The patients gained more knowledge of exercising that it helped better medicating heart disease, healthiness and preventing restenosis. But patients could not explain which type of exercises should the patients aim at an how it related to the heart disease, with clarity, simplicity from doctors trusted, accepted and reliable by patients? Most patient said, doctors rarely conversed and informed and entering for diagnosis, they listened the related symptom and prescribed only. Sometimes, patients were unlikely informing or asking and no time for asking or sometime had to hold the doctor’s shirt for asking. Therefore, managing selfcare behavior on exercise after dilation was not so strict and clear. Some took no exercise but only walking. Some feared tiresomeness. *“Normally, it is tired, unable to walk and how to exercise even unable to walk.”* Some case had high responsibility and unable to exercise even being aware. *“ Office and home are far and time spent with no time for exercise.”* Some case did not take exercise because of misunderstanding seeing that *“normal working is similar to working. Some think good exercise makes sound sleep.”*

Caution of Complication – after affected by heart disease and twice dilation, most

patients informed that the symptom changed or worsened and how it threatened their normality and how they handled. *“If it were too tired and unable to sleep at night, with swollen feet, I tell children to bring me to hospital, it can’t leave there.” “If I feel chest pain, unable to breathe, there, I need doctor.” “ If being tired at work, I shall sit and wait for a while, and if it’s alright, I shall continue my work, if not I hurry to meet the doctor.”* All patients related symptom changes of the complication such as chest pain, exhausted breathing, and throbbing. All told the same thing that if not recover from tiresomeness, they had to see doctor. From previous experiences, it was foresaw that such symptom only being medicated by doctor. Meaning, to evaluate oneself in order to avoid acute sickness before reaching the doctor, it was better to prevent suffering during its worsened stage. Had it been so tiresome and chest pain as before, it was better to see the doctor without delay since it was known what followed. *“if wait, it become worse, such sickness, it needs to be hurry, we had experienced it.”*

Alternative Medicine – before dilation, some used herbal medicine by being recommended from neighbor. The patient bought it 500 Baht by himself and took for 2 sets but the symptoms were still worsened till he was medicated and got dilation. Those 2 cases stopped using herbal medicine believing that such disease needed modern medication only and never believed that herbal medicine could heal but if not intoxicating, it should be experimented such as safflower, and ancient Chinese herbal medicine, which was informed this set helped hemagogue by boiling black and white auricularia auricula-jadae (Jew’s ear), ginger, pork, black jujuba to get 5 bowls and continued to boil for 1 bowl. It helped excretion and able to take with medicine. However, it should be after dilation. All patients saw that the alternative medicine could not help medication and this method was rejected. But some observed that, it was not toxic and hurting and the alternative medicine should share medication.

Selfcare was containing action or behaving of a healthy person and showed no sign of sickness aiming to always keep healthiness by views of social, and culture. In view of sociologists, it was a behavior of an individual in being well. Therefore, it was behavior attempted to act to prevent sickness. Sick behavior related to sentiment and emotional changes were to seek varieties of medications under the medical pluralism. It was to seek medication relying on personal belief, family and society of residing including situations. By humanists, they viewed that it was not necessary to

separate health behavior and sick behavior. The definition of the health behavior should cover all both prevention behavior, health enhancement, and behavior of seeking medication.

It was found from the study that selfcare behavior defined by the myocardial infarction patients was strictly behaving by doctor's instruction, meeting the appointment, and avoiding cholesterol food. Further, problems were analyzed, and co-evaluating symptoms of the patient, relatives and caretaker, or visiting neighbors to seek proper selfcare via social methods in a community inherited through generations. It was to introduce expert doctor, word of mouth on medication from the patients' relatives to raise confidence of medication. "When I feel fatigue and chest pain, my friends and children recommended me to Wichaiyut Hospital where I shall find experts. So, I go there and realize of heart disease." "At first, neighbor recommended the Folk Sector of Care to find set of herbal medicine of 500 Baht in Nakhon Pathom. I took 2-3 sets but not yet recover. So, I go to Siriraj Hospital." It was observed that the definition of selfcare behavior was corresponded with Kleinman that it was sickness and individual and social network shared common experience such as shared suffering, shared worries and shared evaluating of its acuteness and helped optimize effective medication. Kleinman studied public health of a society, which meant cultural systems of a society containing 3 sub-systems connected, i.e. 1) the Popular Health Sector, which was the biggest system containing patient, patient's family, patient's social network e.g. relatives, neighbors, and community such as community leader, 2) The Professional Health Sector, and 3) the Folk Sector of Care. Therefore, when there was a patient, all these three sectors involved beginning with the Popular Health Sector – the patient, relatives, and family, followed by the Folk Sector of Care to share relying on sickness where society helped each other to define the meaning and medicated approaches. If it were not found, then the Professional Health Sector would be applied. In the heart disease of 10 cases investigated, were agreeing with the Professional Health Sector and some cases relied on community or the Folk Sector of Care and not medicated. Being medicated by the Professional Health Sector, it obviously turned patients better and made them believed more in Medicare rather than selfcare and prioritizing taking medicine and meeting the medical appointment.

4.10.3 Roles of Patient after PCI/ PTCA/ CABG and the

This investigation was to test whether did the patients understand definition and perception of their roles and affected their self-care behavior. They were grouped into well understanding definition, and well perceiving roles causing better self-caring, not understanding definition, and not perceiving roles causing mal self-caring, and well understanding definition, and well perceiving roles causing mal self-caring.

1. Well understanding definition, and well perceiving roles causing better self-caring

This group understood definition of disease and roles well when being sick and better self-caring. The doctor instructed that disease was caused by stenosis. If being diabetes and high cholesterol in associated with high blood pressure, there were high risks to the disease. It needed to be quick meeting the doctor; it endangered when being worsened. Had such condition been passed, the patient was like normal. It needed cooperation with doctor, an incurable disease, and regular pill taking. It seemed lack something if not taking pills and craving for remedy to subside it. Cholesterol food were needed avoiding but vegetables, fruits, exercises, peaceful mind were required. One was to be able on self-evaluation, had symptom been arisen, one needed to visit the doctor without delay.

2. Well understanding definition, and well perceiving roles causing mal self-caring.

It was found with this group that all understood well about stenosis and after being treated it would disappear but they needed to follow the doctors' instructions, regular took pills and needless to be in the patient roles since after crisis they could work as normal. Defect found only when they were admitted in hospital when becoming worsened only. Taking pills regularly was not a burden since all needed being cured. Meaning, not allowing worsening but having normal life and able to self-evaluating if becoming worsened. First they would use isosorbide dinitrate tablet by instruction and take rest. If it were not better, they would meet doctor. With other self-cares on food controls, exercises and the patient was unable to follow because of

misunderstanding the definition of eating. They viewed that being hard working, one should eat what one wanted. Or, daily working was counted an exercise neglecting exercising helped cure disease or lessening symptom. Missing correct instructions in association with low economic situation and needed earning to the family, it caused stress and no time for exercising.

It was concluded that the definition of the heart disease was found that, it coexisted with diversity of other diseases turning difficulties to attend health behavior. The medicare was accepted on pills taking and meeting the appointment. Another definition was it was a specific stenosis without knowing causes. Doctors determined treatments and if symptoms found it was needed to meet doctor. Self-caring was therefore unstrict or likely ambiguous.

3. Not understanding definition, and not perceiving roles causing mal self-caring

This group viewed that the disease was caused by many past diseases. Roles of the patients were therefore avoiding exercise, it cause fatigue, less job, less walk, uncontrolled on eating but follow doctors' instruction. They felt still weakening, and strengthless. Therefore, they think of no control on eating and no exercises since being too fatigued. Normally, they themselves were easily tired, so self-care was not happening. They believed in Medicare and emphasized that some doctors were not serious to cure the patients and unlikely giving explanation.

4.10.4 Perceiving Roles of the Myocardial Infarction Patient after PCI/PTCA/ CABG

Investigating 10 cases, it was found that all perceived their roles as patients – **no responsibility on being sick:** no members reprimanded of the sickness. All their children said none but concerned saying to take good care oneself well, to avoid hard working and taking rest. As for me I could work though it might easily fatigued but able to take rest. We know ourselves and were responsible to earn living. **Permission on Temporary Off-duty** – after being sick and absent many days from work, most took rest feared fatigue and wound was not medicated. Previously, the patient took rest

till being well and returned to work. At home none remarked. If it were worsened, it needed immediate Medicare. Had it been dilated, it would be normal and able to return to work as before. **Craving to be well and seeking to find Medicare and cooperation with doctor to recover** – this disease could not completely medicated and always cared oneself, critically on pills taking and under doctor's supervision to avoid suffering from worsening condition. I knew it never completely medicated but needed pills taking and regularly met the doctor to take pills so that I won't be tired. It needed to trust the doctor and fast to meet the doctor if something changed.

CHAPTER 5

FAMILY SUPPORT AND SELFCARE OF MYOCARDIAL INFARCTION PATIENT AFTER PCI/ PTCA/CABG

In this Chapter 6, the researcher would investigate the family support for the Myocardial Infarction Patients after dilation in different areas, i.e. emotional supports: affection, spiritual support, acceptance, recognition and seeing value; the area of counseling or information; the areas of material, money or service to respond the research question how were the family support and selfcare of the patients. Among 10 cases investigated, it was found that

5.1 Family Support among Samples

- supported by wife +sibling ———→ patient (family leader)
- supported by sibling ———→ patient (house leader) Notes : widow
- supported by husband +sibling ———→ patient (housewife)

Family supports were yielded among family members of lineage without relative groups or others

- **Supported by wife +sibling ———→ patient (family leader)**: there were 7 cases under the duty of being a spouse and sibling to treat husband and the father. Most were emotional supports, affections, attentiveness, recognition and esteem. In areas of counseling, material, money or services among this group were unlikely. *“Even we are poor, we give moral support and always are attentive to him, no burden and he is the good leader, he decides everything himself even money, he earns and saves it.”* Reasons of non-participative of the family regarding counseling, materials and money were that the patient was the family leader authorized to decide on himself about sickness and expenses. The patient earned and was responsible. Such supports were unlikely and the patient refused. *“ They cannot help on this matter, I*

decide it myself. Who would better know? I see expenses myself since I earn it. They mostly give spiritual supports, concerns, asking conditions and advise to take selfcare, regularly remind taking pills and food controls. The wife has duty in cooking. She knows what food to avoid, and stop. I see to exercise myself only I have unlikely no time and easy to get tired.” There was a case of Khun Lek, who needed family supports on expenses and advice since she was an elder without income and relied on her sibling. *“My daughter pays everything, medicine, doctor, transportation and tells me not to worry. She always encourages me. I sympathize her; she has to suffer, and to work hard. If I do not have her, I would be suffering.”*

- Supported by sibling —→ patient (house leader and a widow):

there were 2 cases of being widows but with different family situations. The case of Khun Wan a family leader earning family income, and was responsible in all expenses. Supports of counseling and money were unlikely and the patient handled all. The emotional supports, affection, esteem, recognition, acceptance of leader even during sickness were maintained, had disease were not worsened. All her siblings were also worry but implicitly, particularly, her son. She had her youngest daughter took care of her, ushered her to doctor and inquired information from doctor. The case of Khun Lamai, even being the leader and had no need to handle expenses or decision because she was an elder and had sibling to attend her. Even she had no need to earn family income she was the spiritual resort for them. The family support during sickness in part of esteem, affection, and attentiveness to the patient from the family never failed because the patient needed all 4 areas of supports from the family.

- Supported by husband +sibling —→ patient (housewife): Khun Sunee was only the case in this study who gained 4 areas of family supports: beginning from getting sick till returning home as normal. Members never counted as burden, no remarked. Her husband and sibling loved and concerned, gave advice for selfcare. Being the housewife, she worked as before as if never sick, had there been no worsened condition. Expenses were handled by her husband and reimbursable because being the state employee.

By 3 models of family supports, it was observed that the patients were family leaders and earned family income. Therefore, supports of counseling and materials were not necessary for the sick because earning family income and being responsible for decision. Had the patient been leader but no roles in family earning, then supports of materials, money, and counseling were from members to the patient. It was similar with the housewife. In emotional supports, affections, recognition and esteem when being sick, it was found that all samples had received from the families regardless being the male patients as family leaders or female patient as being the housewife or even the family member.

5.2 Whether Did Family Support Create Selfcare on 5 Areas? Had it been Happened, Was Selfcare Increased or Decreased, and/ or did Selfcare Happen through either Role Perceptions or by Previous Experience of the Patients.

From this issue, It was found from the investigation that

1. Family and the perception of the patient role and sick experiences found from interviewing the family members, it was found that all perceived roles of the patients when the conditions were worsened and followed the doctor's instruction without responsible for one's sickness on medicare, family burden, working and so on. *“ Helping when seeing symptom and prohibit her not to work and replace her. When she is admitted in the hospital, we stop work and attend her. No one blames her sickness, It's impossible to tell. She tries best to care herself and never fails to take pills.”* (The family of Khun Wan). *“ During his sickness, we request leave for him till he recovers and returns to work. We never demoralize him. This disease is incurable and he suffers many times. We encourage and give him spiritual supports.”* (The family of Khun Pradit). The family gave full support to the sick. *“We bring him to the doctor if he informs of being unwell. Sometimes, I have to stop work realizing that this disease is critical.”*(The family of Khun Lek)

2. Family supports on 4 areas by interviewing the family of the patients were as follows

- In emotional supports, affection, and concerns; all concerned the patients and regularly helped by observing that this disease was not critical, even incurable but required selfcare, acted normally, and not being the family burden. *“We give spiritual support and are always willing to take care of him never think he is a burden. He is the good family leader.”* (The family of Khun Pradit). *“ We love and give him spiritual support since he begins sick. He himself still hopes and to stay for his children. Spiritual support form children was vital. Our son is returning from abroad. (The family of Khun Somchai). “My son expressed his concerns. I acknowledge their concerns. My daughter gives moral supports and cautious prohibiting. If I refuse, she would be furious and sarcastic know and realize her concerns.”*

- In recognition and esteem and acceptance by definition among family members, it was observed that being able to maintain previous role after sickness. It was viewed that the heart disease did not change values in the patient. The family state was the same and unanimously agrees that the disease condition was not chronic or threatening the patient or the patient had to play being sick all the time. Besides, the patient was normal as common people. *“It seems she is well had symptom not been worsened. She can return to her work as normal only additional care of taking medicine.”* (The family of Khun Wan). *“ Normally, he doesn’t work only being the family leader and advising his sibling, had symptoms been not worsened. He looks the same but easily tired, less walking but affected not so much.”*

- Regarding counseling, the family informed that the patient had received considerable data on disease and selfcare from the hospital where the patient got medicare form the doctor and nurses on selfcare e.g. cholesterol control, exercise, taking medicine as prescription, observing unfamiliarity of oneself and behaving and the family was unlikely guiding. *“ He knows better what he should do.”* (The family of Khun Nit): *he is unlikely guided and he mostly decides by himself, followed the prescription. Leave it to him as well as money, he handles all and he is the family leader.”* (The family of Khun Cherdsak). In matters needed no decision or minor things, the family might help. *“I always visit the doctor with her and what the doctor instructs we will inform family members. (The family of Khun Wan). “ Mostly, in the*

hospital, there are leaflets about the disease, food control and exercise. We often study and observe the conditions. “ (the family of Khun Chalerm)

- Regarding materials and money, the support as reported by the family, there was unlikely because the patient was the family leader and was responsible on money and medical charges. *“The medical charges, my husband handles them. He earns and decides and I need not help.* (The family of Khun Pradit). *“ Mom, decides herself since she save it. I share nothing here. Sometimes, I see her stress and tells me her savings was gone.”*(The family of Khun Wan). Some families the patients were not responsible on earning and not working, the family vitally shared on this part. *“Now, Dad does not work and I have to handle doctor’s fees and medical charges. It is tough since little income. I am a wage earner.* “ (The family of Khun Lek). *“ I sympathize my children, they have to pay for my medicare. If she is unavailable, I would have been suffering she handles everything and now I cannot do anything.* “ (Khun Lek)

3. The family supports on emotion, affection, concerns esteem and acceptance allowed the patient after dilation became aware and create selfcare in eating, using medicine/ meeting doctor, exercises and alert on complication excepted the alternative medicine.

“I sometimes feel down to take pills but seeing my wife and children’s worries then I effort and need to stay with them longer.” “ Sometimes, he less speaks. When his son will not return from abroad, he seems down, takes less meal, not fresh, and spends most in sleeping. Knowing that, his son will return to attend him, he looks fresh as if a tree refreshed by water.” “Nowadays, taking selfcare because wishing to be cured fearing my children become worrying, and no one to attend. I know they concern but unexpressed. I try to regularly take medicine. Food is less controlled but I know what to avoid.” “ At home, none believes in herbal medicine. They never recommend and I do also not believe. Such disease, it needs the doctor.” “ My son suggests me to take aerobic dance near the Temple, I never take but walk around the front of the house. They prepared only fish for me. Arriving home, they will always ask my conditions, I know they are worry. I try to handle myself.” Family concerns and supports both were counted foundation of family furnishing for members when being

sick. Therefore, all had been supported and became aware of more selfcare. However, it does gain all well for patients, some were not serious but only awareness.

4. The family supports of money and materials or service and counseling of information played no part in selfcare of 5 areas. It was found from the study that most had no support on this part because the patient handled the family earning. Decision and expenses had been handled by the patients. *“In medical charges, my husband sees to it all. He earns and decides and I do not share this part.”* *“ Mom decides, it is her saving. I share nothing here.”* Regarding 5 areas of selfcare the family had not shared. Some cases who were family members needed it such as the case of Khun Lek. *“ Try my best, taking some exercises knowing that it their burden and dislike to see the symptom worsened and they will not have to pay more. Each time, they pay much in meeting the doctor.”* It was the financial supports and advice in selfcare in case the patient decided for the family.

5. The family support on emotion, attentiveness, affection, acceptance and recognition, and esteem were needed by the stroke patient, which affected taking care the patient. From interviewing 10 cases, they critically needed family supports on emotion, attentiveness, affection, and acceptance, esteem, by encouragement from family members. It was needed to be viewed that the patients did not fail in their existing duties, not being burden and if the stroke showed no symptoms to being admitted into the hospital, the patients were similar to common people. They could do their duty as before but needed for selfcare like common people, i.e. food control, regularly taking pills and the family support. The patients informed that they were certain to selfcare following the doctor's instructions, perceiving that they were still the beloved to the family. *“ Seeing their concerns by asking, I know that they love me so I follow every doctor's prescriptions.”*

6. The family supports on materials, money or service, which were least needed by the stroke patient and did not affect selfcare of the patient. From the investigation, patients needed no family supports of materials, money or service because they handled these responsibilities. So, selfcare yielded from this area of

family support was unlikely. Mostly, patients told that it was the patients to perceive their own sickness and evaluated their own experiences, which would be followed by selfcare. In case, the patients were not responsible on the family earning, it was critical, which might turn the patient to prefer death rather than to be burden. Therefore, proper selfcare behavior was yielded.

7. The selfcare of the stroke patient on 5 areas was originated from the perception of the patients' roles and their first and the existing experiences. Samples informed that selfcare began from the patient realized they were unwell of what disease. It originated selfcare as instructed by the doctor. Had it been evaluated that the disease was controllable and not worsened, the selfcare would not be strict. *" I know myself and if tired, I shall rest and there is no control because I work hard and need eating. After my death, I cannot eat. I need to control the cholesterol food."* *"Food is uncontrollable but it must be controlled. Now, I feel well, workable but my home and my office is too distant. I reach home at dark and no time to take exercise. But I evaluate that the disease is acute, worsened, then the selfcare will be strict because of needed cured, fearing death, fearing pain. So, the patient will control food. Understanding and see that he takes some exercises since he fears fatigue. But he regularly takes pills without fail. If he did not take any, he feels he lacks something."* *" This is the 2nd dilation. Now I am not working the wound is not well closed. I wait to be well avoiding salty and oily food. I try to take rice soup for better digestion and excretion."* Besides, evaluating acuteness of the disease, it made selfcare different. The past experience also made the patient form the selfcare behavior. *"At first feeling chest pain, tired, blacken, the doctor needs to pump the heart with chemo-test, the doctor find the stenosis and needed dilation. Then I shall return home. My children ask me to quit smoking, and I quit since the doctor says it can cause this disease. I try to control eating and take some exercises. But I think that exercises are with working since I have to go up and down offices as if I take exercise. Lately, I get only chest pain and just take chemo-test. Now I am not working fearing fatigue. If I am well, I shall go to work but I need to control eating more. Critically, I must regularly take medicine as prescription."* Investigating patients, it was found that had they were

normal with no worsened condition, most informed that they unlikely take care of themselves but only regularly took medicine without fail.

CHAPTER 6

CONCLUSION, DISCUSSIONS AND RECOMMENDATIONS

This study was to investigate the selfcare behavior of the myocardial infarction patients after treated by PCI/ PTCA in relation to dining, dosing/ meeting physicians, exercising, alerting for complication such as arrhythmia, heart failure, cardialgia, and so on; alternative medicine e.g. herbal treatment. It was also to study the family support and the social support for patients in different areas such as emotion – affection, and spiritual support; acceptance, recognition and admiration; advice – counseling or information and in area of materialization – money or service in association with selfcare of the myocardial infarction patients after treated by PCI/ PTCA. This was a qualitative research on a case study selectively investigating the myocardial infarction patients after treated by PCI/ PTCA from Cath. Lab of the Siriraj Hospital. Samples were 10 cases being pursued for in-depth interviews on both patients and their families at home as well as observations. 10 weeks had been spent for data collection.

6.1 Perception of the Myocardial Infarction after Treated by PCI/ PTCA on Selfcare

The patient after dilation viewed that it was an incurable disease, chronic, regular medicine needed, and following doctor's instruction on taking medicine. It threatened and changed life when the symptom was worsened and needed being admitted in the hospital for medicare. Had the symptom was normal and looked as common people, it was possible to play roles of family responsibility and society as usual. Therefore, it reflected the selfcare of patients defining the medicationization of the disease that during the symptom was worsened, the patient was leaving to the patient's roles. Meaning, playing the patient's roles at worsened condition till being admitted to hospital. When, the condition was not worsened, the selfcare was unlikely

viewing that they were not patients and needed no playing of the patient's roles. Therefore, the selfcare was unlikely critical to be strict on eating and in particular the exercising, which was seen insignificant to the disease because of likely misunderstanding the definition of the disease, i.e. being the myocardial infarction patient, selfcare and particularly health promotion and prevention, which were unlikely in the thought of the patients. They saw as minor things affecting the disease. This sickness required regular medicine taking. Medicine helped mitigate the conditions important to medicare, and got cured. The worsened conditions caused treatment to chest pain was taking isosorbide dinitrate tablet helping immediate dilation. Therefore, when having chest pain, it signaled stenosis and taking such tablet it immediately mitigated the patient's symptom. The patients believed that, such disease required taking medicine, prioritized it and meeting the doctor. Selfcaring in other parts as proposed by the researcher was unlikely or least happened. However, all were aware of this part but it was unlikely meaningful, therefore behaving was not so strict and selfcare was unlikely happening.

6.2 Perception of Patients' Roles

The myocardial infarction patients after dilation perceived the patient's roles when the symptom was worsened and threatening their lives in terms of rejecting responsibility of pains, avoidance of routine work, aspiration to get cured and cooperation with doctor in medicare and seek treatment and so on. Had the patient was in the normal state without worsened condition, such perception on this part was unlikely. It was viewed that it was the chronic but only taking medicine, which was not chronic to the patient's role, had it was not in the worsened condition. Selfcare was therefore neglected in part of daily behaving to be cured from the disease. However, it was viewed as the patient rejected rights of suffering on account of economic status and family cares but collaborated with the doctor by attempting to at least caring oneself to further play normal role.

6.3 Model of Family Supports

It was found that they were mostly the supports of emotion, affection, concern, recognition and esteem. Such supports were from families with social contract such as marriage roles, lineage attachment such as sibling roles toward parents. The supports of this part were therefore automatically yielded within the family where the patient should be treated. The stroke, which was counted chronic, required the family to handle as duty to care the patient. It was a support as in the nuclear family, i.e. the sibling took care parents and so on. The support of counseling on materials, and money were not happened in the family because most patients were the family leaders. Expenses, decision for the family and even for oneself had been completed without the family member sharing. Selfcare behavior through family supports derived from social roles and lineage roles were not so rigid. The patients counted as a member in a family and deserved it. In some cases, such deserved turned the patients became aware of selfcare for the families. Some were likely neglect and unlikely had family attachment. Most selfcare behavior was yielded from the patients themselves to decide for oneself. Most attended selfcare for not to suffer on worsened conditions, avoiding pain, feared death viewing that the family least participated comparing to oneself.

6.4 Medicalized Model

From the studies of 10 cases, it was found that vital selfcare behavior of all myocardial infarction patients after dilation was taking pills. All told what could lessen the symptom, no recurrence, and no suffering from this disease was to take pills as prescriptions. The researcher viewed that what all these perceived was the modern medicine dependency particularly, the Medicalized Model. The society of disease patients was influenced by medicalization with principles that had this not been followed, it would not be completely cured and likely aggravating and recurring as well.

6.5 From Studies

It was found that selfcare from family members, affection, attentiveness, and esteem under sickness state, it created more lineage ties of affection, strengthened the family, and reduced individual stresses especially during sickness, when stresses were ever oppressing. In this investigation, it was found the family support was unlikely affecting the patients but it was vital to create more love, ties of affection, and understanding, which could reduce stresses in families and societies.

6.6 Conclusion and Discussions

It was found that selfcare behavior of the stroke patient after dilation among 5 areas of eating, and exercising, which the patients were unlikely rigid because the incorrectness in defining eating and exercising. There was misunderstanding on why to take exercises and food controls, which should clearly mitigate the symptoms. The medicine taking and meeting the doctor had been most prioritized and adopted as indispensable and affecting most the disease. The patients with more than 2 times experiences was therefore so rigid in part of complication alert. They could evaluate definition of the complication and alertness. Regarding the alternative medicine, all did not prioritize and took selfcare on this area.

The family supports were happened by the families themselves with attachment of duties, and lineage such as supports of emotion, affection, attentiveness, recognition, acceptance, and esteem, which the spouse should pay to the husband, sibling to parents, and so on. Regarding counseling on information of the disease, materials, money or service were yielded because the patients were the family leaders themselves. The families share no supports in this part with the roles of followers among the spouse and children. the family support and selfcare of the patient after dilation were therefore having less relationship and unlikely affect selfcare of the patients. Selfcare among patients originated from perceiving self-roles was from the previous sickness experiences to get cured, fearing death and prioritized medicine taking, meeting doctor and only medication would mitigate such symptoms. To attend the stroke patients after dilation was a medicationization applying knowledge of

medicine and medical technology to control societies turning societies could not reject the influence of medical knowledge. The researcher viewed that the selfcare behavior of the stroke patient after dilation was originated from the patients themselves. But in the state of frustration or worsened conditions they required the family supports of emotion, affection, attentiveness, recognition, esteem and acceptance as another power to encourage the patients to win the sickness even with weakened condition. However, being the spiritual center for the family, it might motivate the patient to continue taking selfcare. IT was corresponded with the study of Farmer et al, who found that the social supports at high and moderate level strongly helped survive the stroke patients. From any studies of Alameda Country Study; the Tecumseh, Michigan study referred in Farmer et al (1996 : 1), it was found that the social support had positive relationship with prolong survival after getting the stroke. Strengthening social supports by reducing isolation from society created valuable force of community health yielding prevention of restenosis and reducing death-rate of this disease. There was an investigation in families indispensable to the chronic illness among diseases with high desperation such as cancer, acute stress such as diabetes, which were corresponded with the study of Little Field; et al. (1990 : 737 – 749) that the diabetes patients adequately supported by social could prevent stress. On the contrary, patients with low social supports were at risk to stress and increase acuteness. Besides, the patients perceiving their own roles, some part of family supports, and medical staff; the hospital was also important to create understanding on the precise definition of the disease, which significantly yielded selfcare and prevention of the restenosis. The researcher viewed that the medical staff and the hospital had not completely fulfill this part of duties but created dysfunctions in the activities of medicare, prevention and promotion of health to the patients. With the situation of overloaded patients and limited numbers of medical staff turned this duty into dysfunctions and made patient lacked understanding in terms of health behavior affecting patients' diseases.

6.7 Recommendations

By Policy

1. It was found in this investigation that patients and families prioritized medicine taking, and medicare rather than correct selfcare behavior where it turned this disease become more treatment rather than prevention for people in communities. Health policy on heart should therefore emphasize the correct selfcare behavior contributing people simple understanding for application.

2. Exercises and the myocardial infarction were misunderstood by patients, which in turn, they did not see significance and unlikely follow, inadequate of promotion on correct knowledge. It should therefore prioritize and show the benefits of exercises beginning from recuperation in the hospital because the patients would hear and follow the doctor's instructions more. Policy of promoting exercises among patients should be more evident and consistent.

3. The medical service centers should provide counseling section for the patients and their families for further care at home not only the chronic diseases of helplessness. Prioritizing selfcare behavior of the chronic patients who never returned contact but able to help oneself such as heart disease and Cardiovascular disease

6.8 Recommendations for Further Studies

1. Study other factors potential to influence selfcare such as belief, intrinsic-extrinsic power of oneself

2. Study eating behavior of stroke patients and their awareness whether would it e able to change their behaviors?

3. Study selfcare among the single having Myocardial Infarction after dilation

4. Study factors why did the males get Myocardial Infarction more than females.

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APPENDIX

Table 1 : Demographic Population

Patients	Gender	Age	Marital status	Education	Occupation	Income/salary
1. Mrs. Wan	F	56	widow	Primary 4	Vendor	approximate 3,000 – 5,000 Baht
2. Mr. Somchai	M	58	Married	Bachelor degree	State enterprise retiree	15,000 Baht
3. Mr. Lek	M	73	Married	Primary 4	unemployment	-
4. Mrs. Sunee	F	53	Married	Primary 4	Housewife	-
5. Mr. Nit	M	84	Married	Bachelor degree	Pension government official	10,000 Baht
6. Mr. Chersakdi	M	53	Married	Bachelor degree	Private business	30,000 Baht
7. Mr. Chalerm	M	53	Married	Primary 4	employee	3,000 Baht
8. Mrs. Lamai	F	74	Widow	Primary 4	unemployment	-
9. Mr.Pradit	M	50	Married	Bachelor degree	Bank employee	20,000 Baht
10. Mr. Somphop	M	65	widow	Primary 4	Vendor	10,000 Baht

Table 2: Records of Myocardial Infarction and Dilation and other Personal Diseases of the Samples

Patients	Dilations			Other Personal Diseases
	First	Second	Third	
Mrs. Wan :Ac. AWTMI	June 2003 PCILAD	October 2004 LAD (ISR)	August 2004 LAD (ISR)	HT, DLP
Mr. Somchai : AWTMI	July 2004 PCILAD	August 2004 LAD (ISR)		HT, DLP
Mr. Lek : Unstable Angina (UA)	January 2003 PCILAD	August 17,2004 LCX	August 24, 2004 RCA	COPD, GOUT, HT
Mrs. Suneer : NSTEMI	February 2004 LAD	August 2004 LAD (ISR)		DM, HT, DLP
Mr. Nit : Unstable Angina	December 1998 RCA	August 23,2004 RCA, PD 1	July 2003 NORMAL	DM, DLP
Mr. Chersakdi : NSTEMI	November 1997 LAD	February 2004 CABG	July 2004 LIMA	HT, DLP
Mr. Chalerm : NONQ MI \bar{C} CHF	June 22, 2004 LAD D ₁	August 26, 2004 LAD D ₁ (ISR)		DM, HT, DLP
Mrs. Lamai : NSTEMI	June 1993 RCA	July 2004 LCX		HT, DLP
Mr.Pradit : Unstable Angina	January 2002 LCX	August 17, 2004 LCX (ISR), OM		HT, DLP
Mr. Somphop : CHF \bar{C} Unstable Angina	July 1994 CABG	February 2004 PCI LAD	July 2004 PCI LAD	DM, HT, COPD, DLP

Notes:

ISR = In stent restenosis

DM = Diabetic Millitus

HT = hypertension

DLP = Dyslipidemia

COPD = Chronic Obstructive Pulmonary

CHF = Congestive Heart Failure

Disease

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