RELATIONSHIPS AMONG HOPE, SOCIAL SUPPORT AND QUALITY OF LIFE OF THE ELDERLY WITH STROKE

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RELATIONSHIPS AMONG HOPE, SOCIAL SUPPORT, AND QUALITY OF LIFE OF THE ELDERLY WITH STROKE

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ABSTRACT

The purpose of the study was to examine the relationships among hope, social support, and quality of life of the elderly with stroke. The conceptual framework of Lazarus and Folkman (1984) was used to guide this study. The sample of this study was selected with purposive sampling method. The sample was composed of 100 elderly people with stroke who came for follow up treatment at the Prasat Neurological Institute outpatient departments, Bangkok during June to September, 2004. The instruments were the demographic characteristics questionnaire, Herth Hope Index, Social Support Questionnaire, and the Quality of Life Measurement. Data were analyzed by using descriptive statistics. The Pearson's product moment correlation was also used for further analysis of data.

The findings revealed that hope has a positive correlation with quality of life of the elderly with stroke ($r = .725$, $p < .01$) and social support has a positive correlation with quality of life of the elderly with stroke ($r = .367$, $p < .01$)

Based on these findings, the psychiatric-mental health nurse should encourage the hope of the elderly with stroke and support the families to participate in caring for the elderly with stroke to improve the quality of life.

KEY WORDS: HOPE / SOCIAL SUPPORT / QUALITY OF LIFE / THE ELDERLY WITH STROKE

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ความสัมพันธ์ระหว่างความหวัง การสนับสนุนทางสังคมและคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง (RELATIONSHIPS AMONG HOPE, SOCIAL SUPPORT, AND QUALITY OF LIFE OF THE ELDERLY WITH STROKE)

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บทคัดย่อ

การวิจัยเชิงบรรยายครั้งนี้มีวัตถุประสงค์เพื่อศึกษาความสัมพันธ์ระหว่างความหวัง การสนับสนุนทางสังคมและคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง โดยใช้ทฤษฎีความเครียดและการเผชิญความเครียดของลาซารัสและโฟร์คแมนเป็นกรอบแนวคิดในการศึกษา กลุ่มตัวอย่างได้จากการสุ่มแบบเจาะจงในผู้สูงอายุโรคหลอดเลือดสมอง ที่มารับบริการที่สถาบันประสาทวิทยา กรมการแพทย์ กรุงเทพมหานคร จำนวน 100 ราย ระหว่างเดือนกรกฎาคมถึงเดือนกันยายน พ.ศ. 2547 ผู้วิจัยเก็บรวบรวมข้อมูลโดยการสัมภาษณ์ตามเครื่องมือวิจัย ซึ่งประกอบด้วยแบบสอบถามข้อมูลส่วนบุคคล แบบวัดความหวัง แบบวัดการสนับสนุนทางสังคม และแบบวัดคุณภาพชีวิต วิเคราะห์ข้อมูลด้วยสถิติเชิงพรรณนา ค่าสัมประสิทธิ์สหสัมพันธ์เพียร์สัน

ผลการศึกษาพบว่า ความหวังมีความสัมพันธ์ทางบวกกับคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง ($r = .725$, $p < .01$) และการสนับสนุนทางสังคมมีความสัมพันธ์ทางบวกกับคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง ($r = .367$, $p < .01$)

จากการวิจัยครั้งนี้ให้ข้อเสนอแนะว่าพยาบาลสุขภาพจิตและจิตเวชควรส่งเสริมความหวังของผู้สูงอายุโรคหลอดเลือดสมอง และสนับสนุนให้ครอบครัวมีส่วนร่วมในการดูแลผู้สูงอายุโรคหลอดเลือดสมองเพื่อพัฒนาคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมองต่อไป

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INTRODUCTION

Background and significance of the study

Old age is the age of changes in bio-psycho-social aspects. The elderly experience changes in body strength on account of the deterioration of organs functioning, and their appearances also alter. The loss of spouse and significant others, in addition to the decrease in work capacity and the changes in family and social role, induces the sense of loneliness, despair, and reduced self-esteem in the elderly (Karl and Cavanaugh, 2000). Physical changes lead to decreased body functioning and increased health problems. Most elderly people suffer at least one chronic illness and stroke, which induces long-term disability, is a common illness among the elderly (Hilton, 2002). In the USA, there are more than 600,000 people suffering from stroke each year (Bays, 2001). It is estimated that stroke will become the second most common cause of death worldwide in 20 years (Hachinski, 2002). In Thailand, the incidence rate of stroke is 92.7 per 100,000 people and the mortality tends to increase with cumulative ages (Department of Statistical Record, Ministry of Public Health, 2001).

Stroke is the illness of cerebral blood flow disorder, which may result from vascular obstruction, constriction, or rupture. As a consequence, patients with stroke may have paralysis, hemiplegia, or hemiparesis (Puangwarin, 2001). The elderly with these symptoms are unable to independently conduct daily activities and become dependent on other people, mostly their family members, for the delivery of care and responses to their basic needs (Puangwarin, 2001; Lincoln et al., 2003). This condition, therefore, induces stress, anxiety, worry, fear, uncertainty, and loss of life goals and self-esteem in the affected people. As a result, the elderly with stroke feel insecure and hopeless (Stanley and Guantlett, 1999; Hilton, 2002). Eventually, they need to cope with stress to sustain quality of life (Kottket, 1982).

Quality of life is an essential and desired goal for any individual (Miller, 2000). For the elderly with stroke, quality of life indicates living well with the illness (Shaw, 1999; Clarke et al., 2002). A person's quality of life is an interaction between that person and the environment, The important factors influence quality of life are life events, stressful situation, goals, and the confrontation with problems (Niemi, 1988; Ventegodt et al., 2003; Rapkin, 2004). It also involves the person's assessment of life in various aspects on including health condition, body functioning, material sufficiency, relationship with family and friends, and social participation (The WHOQOL group, 1996). Quality of life is an outcome of appropriate stress coping (Lazarus and Folkman, 1984). Lazarus and Folkman (1984) said that effective coping person will have good quality of life.

In coping with stress or consequences of illness, the elderly with stroke need both personal and environment coping resources for suitable adapting. The resources comprise health and energy, positive beliefs, problem-solving skills, social skills, social support, and material resources. Hope is a kind of positive belief (Miller, 2000; Bay, 2001). Family support is a kind of social support resource (Sutherland and Murphy, 1995; Miller, 2000; Yeh, 2001). These two factors are significant resources that have effects on stress coping in the elderly with stroke.

Hope is a personal resource that helps a person to appropriately cope with stress, leading to positive outcome (Lazarus and Folkman, 1984; Bronstein, 1991). Herth (1990) said hope is feeling and ideas, which have internal power from the certainty of positive expectancy. Hope is essential for every human being (Ferran et al., 1990). It generates the response to basic needs of everybody at every stage of life (Fischer, 1988 cited in Forbes, 1994). According to Erickson, hope is necessary at any age (Erickson, 1964 cited in Forbes, 1994). It prevents the physical and psychological problems that may result from despair during the time of illness (Miller, 1985). It is a significant and essential factor in helping a patient to recover from illness (Adam and Partee, 1998). If the elderly with stroke who experience the illness and changing situation can sustain their hope, they belief that the threats from illness and problems, as well as the consequent difficulties, are solvable (Bays, 2001). The elderly with stroke will be determined to take care of themselves, adjust their lifestyle, and rehabilitate their physical condition to its full potential (Beckerman and Northrop, 1996). On the contrary, if the elderly with stroke have been chronically ill for a long time, feel hopeless and desperate, and perceive decreasing social support, they will

discourage to self care and rehabilitate and let their condition deteriorates (Beckerman and Northorp, 1996; Leelapattanapanitch, 1998).

Social support means a person or a group of people who help an individual to achieve their needs of dependency by sharing love and respecting the value of their relationship thus providing sufficient love to the individual. It is an important environment resource that has effects on stress coping in the elderly with stroke (Miller, 2000; Adam, 2003), especially support from family and relatives (Pollock, 1989; Han and Haley, 1999). Such support helps the elderly with stroke in coping with stress (Narayavasamy, 2002). Because family is a social unit that is closest to the elderly with stroke (Iveson and Iveson, 1983). Social support also helps in reducing stress and enhances capacity in coping with stress. Family members play important role in giving mental support and care to the elderly, especially at the rehabilitation stage (Kluinark, 1997). As a result, the elderly would be able to quickly rehabilitate (Baker, 1993; Glass et al., 1993). The elderly with stroke will recognize their self-esteem and have more hope.

It is evident that to appropriately cope with stress from the symptoms of stroke and its consequences, the elderly with stroke need to utilize personal and environmental resources, comprising hope and social support. These resources will provide them with courage and self-efficacy, as well as various appropriate strategies for coping with stress that lead to well-being or quality of life in the elderly with stroke (Pilkington, 1999). Referring to a study conducted by Rustoen (1995), hope is the most important component that helps a patient to remain strong and to cope well. It also helps people to survive while confronting with loss. A study conducted by Lincoln et al., (2003) found that the elderly with stroke whose family participate in caring and rehabilitating can cope better and present higher potentiality. It is social support especially from families essential for the elderly with stroke and enhances capacity in coping with stress. As previously mentioned, the elderly with stroke need both personal and environment coping resources. These two factors are significant resources that have effects on stress coping in the elderly with stroke. Nevertheless, the relationships between personal and environment resources, comprising hope and social support have effects an quality of life in the elderly with stroke.

This study is aimed at investigating the relationships among hope, social support, and quality of life of the elderly with stroke. The result of this study can be used as basic information for promoting ability to cope with stress for the elderly with stroke in order to improve quality of life or to promote well living with stroke.

Conceptual framework of the study

The Stress, Appraisal and Coping Model of Lazarus and Folkman (1984) was used as a conceptual framework of this study. The model was used as a conceptual framework to explain the relationships among hope, social support, and quality of life of the elderly with stroke.

According to Lazarus and Folkman's stress, appraisal and coping model, stress is an interaction between a person and the environment, which have influence on each other. A person makes cognitive appraisal to judge how the confronting situation has effect on his or her well-being and whether he or she need to use coping resources fully or overly in coping with stress (Lazarus and Folkman, 1984: 19).

Cognitive appraisal consists of primary appraisal and secondary appraisal. Primary appraisal is the appraisal of significance and severity of the situation in relation to one's well being. The situation may be present in three ways: irrelevant, benign positive, and stressful when a person perceives that the situation may lead to 1) harm and loss, 2) threat, an anticipation of dangerous events that may lead to the loss of life and assets, and 3) challenge. For secondary appraisal, the person will appraise the existing resources and available choices for the management of the situation. Second appraisal may take place at the same time or close time to the primary appraisal. When the person judges the situation as stressful, coping occurs as a result. Coping is the attempt in both cognitive and behavior to manage stress (Lazarus and Folkman, 1984: 151–152). It is divided into two types, comprising 1) problem-focused coping, which is a confrontation to correct the situation with problem-solving process in addition to the attempt for self-alteration in both cognitive and motive aspects, and 2) emotion-focused coping, which aims to reduce or adjust the unhappy feeling from stress in order to maintain hope and optimism rather than changing the situation. A person should utilize both personal resources and environmental resources in coping with stress.

Personal resources for coping with stress consist of 1) health and energy, which induce an individual's effort for coping, 2) positive beliefs, either general or specific beliefs, that help an individual coping with stress, 3) problem-solving skills including skill in searching for information and seeking alterative courses of action, which help the individual to have appropriate coping, and 4) social skills, which refer to the ability to live with other people and support individual's coping.

Environmental resources for coping with stress comprise the following: 1) social support, which provide help from social network to support the person's coping; and 2) material resources including money, goods and chargeable services, which provide the person with a variety of option for problem solving and stress coping (Lazarus and Folkman, 1984: 159).

The process of appraisal and stress coping has effect on adaptational outcomes in three aspects, comprising social function, morale or life satisfaction, and somatic health. Social function refers to persons' sustenance of various roles and of their satisfaction toward interpersonal relationship. The effectiveness of appraisal and stress coping will determine the sustenance of roles and function that are beneficial to the persons, their family, the society, and their interpersonal relationships. Morale and life satisfaction refers to the persons' satisfaction toward their actions and the achievement of desired goals for long-term outcomes. In short-term, the outcomes involve particular emotion arising while confronting situations, which constantly change. Somatic health refers to the physical condition after having appraisal and coping with stress. Ineffective coping may result in illness. For the evaluation of adaptational outcomes, these three aspects must be taken into consideration. The persons who effective cope are those whose appraisal is relevant or close to the reality; in addition, their internal and external needs are consistent with the existing resources. On the contrary, if the appraisal is inaccurate and the persons do not know how to utilize the existing resources, they will not be able to cope with stress, leading to illness, loss of self-esteem, anxiety and depression; finally, they will have poor quality of life. Social function, morale or life satisfaction, and somatic health are indicators of quality of life (Lazarus and Folkman, 1984: 224–225). Coping with stress presents the different behavior, depend on the situation as stressful and coping resource.

Hope is a positive belief, as it is a personal resource. Hope is an individual's belief that the outcome, which is beneficial and answers to one's needs, is possible even though it is yet to come. Hope is a positive belief and significant resources in coping with stress. It encourages the individuals to seek various ways to achieve the desired outcomes (Lazarus, 1999).

Hope contributes quality of life (Lazarus, 1999). However, Lazarus and Folkman did not give details about hope and hope measurement. Hence the researcher of this study reviewed a number of literatures concerning hope and found that Herth's concept of hope is consistent

with Lazarus and Folkman's. According to Herth (1990: 1256), hope is feelings and ideas, which have internal power from the certainty of positive expectancy. Hope consists of three components: inner sense of temporality and future, inner positive readiness and expectancy, and interconnectedness with self and other. The level of hope constantly varies in each individual. However, a person always has some hope for self-consolation, no matter how difficult the situation is. The three components of hope are detailed below (Herth, 1991: 39–51): 1) Inner sense of temporality and future. This component involves internal perception of present and future situation, which is positive because the person feels that the desired outcomes can come true in either near or even very far future. 2) Inner positive readiness and expectancy. This component is the sense of self-confidence and positive expectancy toward the future thus the person feels ready to carry out a plan for achieving goals or obtaining desired objects. It also induces the feeling that every trouble has a way out. 3) Interconnectedness with self and others. This component indicates perceived significance of interdependency, having commitment to one's self, other people, and sacred objects, as well as spiritual belief thus the person can regain strength to overcome troubles and difficulties. And Herth's concept (1992) in used Herth Hope Index (HHI) is an adaptation of the Herth Hope Scale (HHS) (Herth, 1991). Hope consists of three components. In this study, hope was assessed with the 12-item Herth Hope Index developed by Herth (1992).

According to Schaefer, Coyne, and Lazarus (1981), Social support refers to an individual or a group of individuals who provide helps in response to the need for interdependency, sense of self-esteem, and social participation. It consists of the provision of love and care with respect and perceived value, information, financial help, materials, and labor. These components help in problem solving and, as a result, the person will be able to appropriately cope with stress. Efficient support system, which leads to quality of life, is composed of the following three components: emotional support, informative support, tangible support. Social support from family is a kind of social support, referring to the reception of help and support from family members in all aforementioned aspects. In this study, social support was assessed with the 7-item social support questionnaire, which was developed by Schaefer, Coyne, and Lazarus (1981)

Lazarus and Folkman's concept of quality of life, which states that quality of life is an adaptational outcome (Lazarus and Folkman, 1984). The adaptational outcome is evaluated in three aspects: social function, morale and life satisfaction, and somatic health thus being

consistent with the WHOQOL group (1994: 354–356) concept of quality of life refers to a person's perception of six domains: physical domain, psychological domain, level of independency, social relationship, environment, spirituality, religion, and personal beliefs. The WHOQOL group (1994) consists of six components. In this study, quality of life was assessed with the 26-items WHOQOL-BREF designed by The WHOQOL group (1994).

The elderly with stroke suffer from hemiparesis (Puangwarin, 2001); as a result, they cannot conduct daily activities on their own and need to rely on other people in responding to their daily needs (Puangwarin, 2001; Lincoln et al., 2003). This condition, therefore, stressful and threatening situation on the elderly, causing the senses of anxiety, stress, insecurity, loss of pride and life goals, and hopelessness (Stanley and Guantlet, 1999; Hilton, 2002). Hence stroke and its consequences induce stressful situation that requires the elderly to employ various strategies for stress coping with either personal or environmental coping resources.

Hope in the elderly with stroke is positive belief and a significant personal resource. It helps the elderly with stroke to believe that there is a way out of the stressful situation resulting from stroke and its consequences. The perception of possible solution leads to commitment and courage to adapt and accept the reality. Moreover, the elderly will learn and make plan for self-care in order to live in the society with quality of life (Niemi, 1998; Ventegodt et al., 2003; Rapkin, 2004). According to a study conducted by Rusteon (1995), hope is a significant component that provides patients with strength to cope with stress effectively and it also reduces the severity of illness thus extending the patients' life.

Social support that the elderly with stroke receive from the family is an environmental resource that is essential for stress coping because the elderly with stroke need to rely on other people in doing activities. Family members play significant role in giving care, mental support. They can also help in reducing stress and promoting ability for coping with stress (Pollock, 1989; Han and Harley, 1999; Narayavasamy, 2002). Such help and support provide the sense of hope and self-esteem to the elderly with stroke, leading to compliance with self care and rehabilitation of well-being (Weinert, 2000).

The elderly with stroke who appraise the stressful situation resulting from stroke and its consequences with relevance to the reality and can utilize the existing resources to cope with stress along with effective strategies will gain strength and power to rehabilitate soon after having the attack (Leelapattanapanitch, 1998; Jatupornpipat, 2000). In such case, the elderly

with stroke can accept their disability and make efforts to help themselves as much as the remained capacity allows. They will rely on the help from family members in some situations only. Such approach induces the sense of self-esteem and not being a burden to the family. Moreover, the elderly will perceive their self-esteem, have positive attitude toward themselves, and can live well in the society. These are indications of quality of life (Lazarus and Folkman, 1984; Pilkington, 1999).

This study was based on the stress, appraisal and coping model designed by Lazarus and Folkman (1984). But does not study to cope with stress. However this conceptual beliefs relationships among hope, social support, and coping with stress. The high level of hope and social support result to the elderly with stroke effective cope with stress and adaptational, which is quality of life.

Referring to the aforementioned framework, the relationship of variables being examined in this study is shown in the following figure.

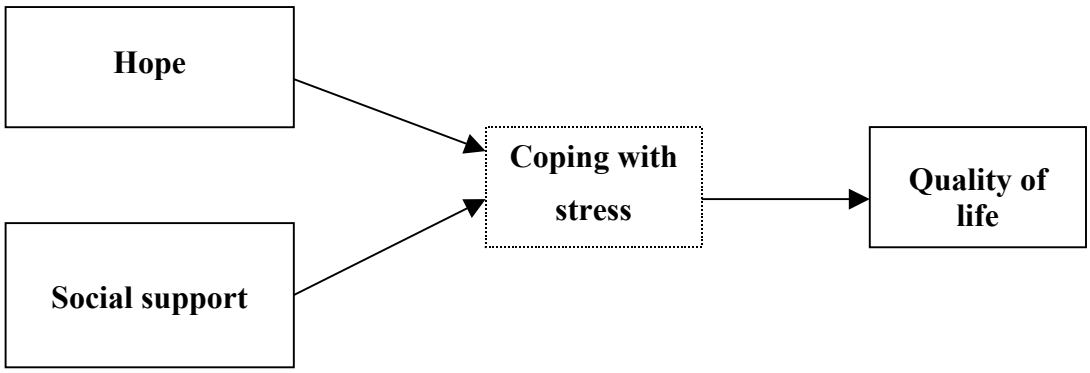

Figure 1. Conceptual framework: hope, social support, and quality of life of the elderly with stroke

Research question

1. Do hope has a positive correlation with quality of life of the elderly with stroke?
2. Do social support has a positive correlation with quality of life of the elderly with stroke?

Purposes of the study

1. To examine the relationships between hope, and quality of life of the elderly with stroke.
2. To examine the relationships between social support, and quality of life of the elderly with stroke.

Research hypothesis

1. Hope has a positive correlation with quality of life of the elderly with stroke at the statistically significant level .05.
2. Social support has a positive correlation with quality of life of the elderly with stroke at the statistically significant level .05.

Scope of the study

This study was a descriptive research, aiming to examine the relationships among hope, social support, and quality of life of the elderly with stroke who came for follow up treatment at the Prasat Neurological Institute outpatient departments, Bangkok during June to September, 2004.

Definition of terms

Hope refers to feelings, thoughts, and expectation of the future goals. It is an internal power for the elderly with stroke, who are certain that they can achieve good outcome in the future. Hope consists of three components comprising 1) inner sense of temporality and future, 2) inner positive readiness and expectancy, and 3) interconnectedness with self and other. In this study, hope was assessed with the 12-item Herth Hope Index developed by Herth (1992) and translated into Thai by Kannika Pawapaiboon (2003). The three components of hope are detailed below:

1. Inner sense of temporality and future. This component involves internal perception of present and future situation, which is positive because the person feels that the desired outcomes can come true in either near or even very far future.

2. Inner positive readiness and expectancy. This component is the sense of self-confidence and positive expectancy toward the future thus the person feels ready to carry out

a plan for achieving goals or obtaining desired objects. It also induces the feeling that every trouble has a way out.

3. Interconnectedness with self and others. This component indicates perceived significance of interdependency, having commitment to one's self, other people, and sacred objects, as well as spiritual belief thus the person can regain strength to overcome troubles and difficulties.

Social support refers to the perception of the elderly with stroke toward help and support from family members regarding love and care, respect, perceived value, information provision, and social participation in their coping with stress from stroke and its consequences. In this study, social support from family was assessed with the 7-item Social Support Questionnaire, which was developed by Schaefer, Coyne, and Lazarus (1981) and was later translated and adapted for Thai by Somchit Hanucharurnkul (1988).

Quality of life refers to the perception of self-satisfaction of the elderly with stroke toward physical and psychological condition, social relationship, and environment on the basis of their culture, value, and life goals. In this study, quality of life was assessed with the 26-item WHOQOL-BREF designed by the World Health Organization and translated into Thai by the Department of Mental Health (1996)

Expected outcomes and benefits

1. The finding of this study could be used as guidelines for nurses and other professionals concerning in the delivery of care, development, and rehabilitation for improved quality of life of the elderly with stroke.

2. Finding of this study could be applied to experimental nursing research to promote hope, social support, and quality of life of the elderly with stroke.

3. Finding of this study could be used as basic information for promoting quality of life and encouraging family of the elderly with stroke.

CHAPTER II
LITERATURE REVIEW

The related literature and research reviewed for the study of the relationships among hope, social support, and quality of life of the elderly with stroke are presented in the following topics:

1. Lazarus and Folkman's concept of stress, coping with stress, and adaptational outcomes
2. The elderly with stroke
3. The concept of hope
4. The concept of social support
5. The concept of quality of life
6. Relationships between hope, and quality of life of the elderly with stroke
7. Relationships between social support, and quality of life of the elderly with stroke

Lazarus and Folkman's concept of stress, coping with stress, and adaptational outcomes

Stress commonly occurs in daily living because people are bound to constantly experience internal and external changes especially the changes from illness, which is significant cause if stress (Hanucharurnkul, 1994). Lazarus and Folkman have defined stress as a reaction between a person and the environment, which is influential to each other. The person will appraise how the confronting situation affects his or her well-being and whether it is taxing or exceeding his or her resources in adapting to the situation (Lazarus and Folkman, 1984: 19).

Lazarus and Folkman's concept of coping with stress (Lazarus and Folkman, 1984: 23–225)

Lazarus and Folkman stated that stress coping is cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding one's resources (Lazarus and Folkman, 1984: 141).Stress coping is a process of constant changes, focusing on cognitive appraisal and the balance between demands and existing resources. Lazarus and Folkman (1984) described two steps of stress coping, as reviewed below:

1. Cognitive appraisal. The appraisal of threatening situation is very important. This step, according to Lazarus and Folkman, involves cognitive process, in which the stimulus and behavioral and emotional responses will be related. The person will consider the significant of the situation before choosing the management strategies. The appraisal is usually done in three steps, as follows:

1.1 Primary appraisal: the person appraises how the confronting situation affects his or her living. Three kinds can be distinguished:

1.1.1 Irrelevant: the situation has no effect on the person's well-being, causing no demand, having no value, and causing no disturbance to the person's responsibilities.

1.1.2 Benign positive: the situation appraised promote and maintain on the person's well-being.

1.1.3 Stressful: the situations appraised as stressful can be classified into three types, comprising:

1.1.3.1 Harm and loss: the situation causing injuries, illness, loss of self-esteem, and loss of significant others.

1.1.3.2 Threat: the anticipation of harm and loss that have not yet occurred but induce negative affect such as anxiety, fear, or anger.

1.1.3.3 Challenge: the mildly disturbing situation that induces pleasurable emotions such as hope or esteem, leading to the planning for proper utilization of existing resources. This sense of challenge may occur along with the sense of threat.

1.2 Secondary appraisal: the person makes decision about problem management, which is usually the application of previous successful strategies in

combination with the strategies that are judged as most suitable for the present situation. This appraisal, therefore, is the person's coping behavior. The environment or personal characteristics may be modified, leading to the appraisal in the next step.

1.3 Reappraisal: the situation is reappraised with the application of additional information obtained from previous stress coping.

Each step of appraisal is related with each other in determining the amount and intensity of stress, as well as the consequences of emotional responses and adaptational efforts. And the person will appraisal the stimulus and situation as stressful and choosing the management strategy. Several factors are influential in the appraisal of stressful situation, as listed below (Lazarus and Folkman, 1984):

1. Personal factor:

1.1 Commitment: the factor underlying the motivation and the sense of self-esteem that promotes adaptational efforts. Responsibility motivates a person to confront with challenging and rewarding situations and to avoid threatening or harmful situations. It provides the person with direction and sensitivity for physical changes. In a situation that a person with high level of responsibility is likely to several physical changes, such situation could be a cause of physical weakness.

1.2 Beliefs: the factor helping a person to understand the situation and explaining reality beliefs can be classified into three types, as follows:

1.2.1 Belief in personal control of certain situation and its consequences. It is a general beliefs about control and situational control appraisals. In an uncertain situation, the persons who believe in their self-control tend to feel more confident in controlling the situation than those who believe in external power. In a certain definite situation, a person will participate and behave confidently when having the sense that he or she can control the situation. On the contrary, a person will be afraid of and avoid the situation that he or she cannot control.

1.2.2 Existential Beliefs: the factor involving the belief in gods, nature, and environment, leading to participation and affective state.

1.2.3 General beliefs and specific beliefs, e.g. belief in the doctor.

2. Situational factor:

2.1 Novelty: The situation that a person has never experienced before can be either threatening or challenging for him or her but the person will not appraise such situation as a stressful situation. Nevertheless, the reception of information from hearing, viewing, and reading in addition to the application of general knowledge to comprehend and interpret has induced basic elements that help in transferring and connecting one situation with another. Hence several situations are not actually new experience to a person unless the situation is so unclear that the person is not certain of its significance and meaning. Sometimes general knowledge is adequate for understanding the situation but not adequate for one's adaptation. Once the person realizes of the inadequate situation he or she will feel increasingly threatened.

2.2 Predictability: prediction of certain time of stressful situation allows a person to make a plan in advance or to be aware of the safe period prior to the situation. Nevertheless, each person applies his or her individuality to appraise the probability of the situation differently.

2.3 Event Uncertainty: most life events that are uncertain and vague or carries inadequate information are usually appraised as threatening situation and the person needs to make an effort to comprehend the situation.

2.4 The Timing of Stressful Events in Relation to the Life cycle: Every person anticipates certain situations at certain periods of his or her life and the person will be prepared for the anticipated situations. If the situation is not consistent with one's anticipation, the person will feel stressed or experience crisis of that period since he or she is not prepared for the new role and lacks support from people with similar experience.

2. Coping with stress. There are two types of coping as reviewed below (Lazarus and Folkman, 1984: 150).

2.1 Problem-focused coping refers to the management or modification of problems that cause stress. It is like using problem-solving strategies by focusing on the problem, generating alterative solutions, weighting the alternatives in terms of their costs and benefits, choosing among them, and acting. The coping is focused on

the environment comprising modifying the situation to eliminate the threatening force, assessing the constraints and the resources find appropriate solutions, learn new skills or new strategies, or seek more resources to cope with stress and evaluating the strategies; these activities are conducted with an aim to solve the problem. The person may seek more information, develop new behavior.

2.2 Emotion-focused coping refers to one's adaptation to difficult situation by reducing negative moods without modifying the environment. The person uses psychological mechanism or thinking process at either conscious or subconscious level, as described below:

2.2.1 Modifying the meaning of the situation: this is similar to cognitive reappraisal, as the person redefines the confronting situation on the ground of reality through thinking process. For instance, some people may compare situations to get positive results. However, some people may refuse to accept the reality and lie to themselves about the situation.

2.2.2 Not modifying the meaning but choosing to view the situation from a different point of view: a person may choose to focus on some certain aspects and deliberately ignore other aspects of the situation. The meaning of the situation, however, remains the same. The person may use this technique to avoid being confronted with difficult situation for a period of time.

2.2.3 Behavioral strategy: e.g. having exercise, being hypnotized, drinking alcohol, expressing anger, and seeking emotional support from other people.

In coping with stress both problem-focused and emotion-focused coping are usually employed. Nevertheless, in a very stressful situation a person tends to use emotion-focused coping more than the problem-focused strategy. On the contrary, if a person's cognitive appraisal judges the situation as mildly stressful, he or she is more likely to use problem-focused coping behavior (Lazarus and Folkman, 1984: 81–94).

The factors Influencing Appraisal, as listed below:

1. Personal resources, comprising:

1.1 Health and energy: healthy people can cope with stress better than unhealthy people.

1.2 Positive beliefs: beliefs in one's inner power and positive beliefs toward justice and religions, in addition to hope, contribute to effective stress coping.

1.3 Problem-solving skill: this skill involves capacity for seeking information, analyzing the situation, and identifying options. Problem-solving skill is intangible and it derives from the accumulation of knowledge and wide experience, intellectual capacity in applying knowledge and experience to the confronting situation, and ability to control one's self in order to achieve the desired outcome–appropriate stress coping.

1.4 Social skill: this skill is essential for appropriate adaptation regarding communications and interpersonal behaviors, which should be appropriate and effective.

2. Environmental resources, comprising:

2.1 Social support: the provision of help from social network. Social support consists of three aspects, as follows:

2.1.1 Emotional support: the provision of commitment, confidence, trust, or belief from other people leading to one's sense of being loved and cared for.

2.1.2 Information support: the provision of information, advice, and feedback on one's action thus helping the person sustaining his or her social identity, as well as the sense of belonging to a society.

2.1.3 Tangible support: the provision of materials, money, and services, including care giving, helping with one's work. Such help also has emotional effect as the receiver will feel valued and cared for.

2.2 Material resources, including financial resource: these resources help increasing the options for problem solving.

Constraints of resource utilization

Stress coping induces demands for the utilization of resources. It is frequently found that a person cannot fully utilize the resources even though he or she has adequate resources. This is probably due to the inner conflicts and distresses arising in the confronting situation. Constraints of resource utilization may be personal or environmental. Personal constraints include culture, social values, and beliefs; for

instance, a person may interpret the social support as an indication of dependency and poverty thus refusing helps from other people. Environmental constraints involve the stimulus and situation as stressful in the same time, severe and long-term stress that requires high energy for adaptation.

Adaptational Outcomes

Adaptational outcomes are consequences of situational appraisal, resources utilization, and effective coping. Both short-term and long-term outcomes should be taken into consideration, in aspects of work, family and social life, morale, life satisfaction and somatic health. The confrontation of severe stress or crisis in some people may lead to the discovery of adaptational resources that are not recognized before. As a result, the persons are stronger and have development from stress and their coping skills are also improved from the learning in daily living. In the evaluation of adaptational outcomes, the following areas are to be considered (Lazarus and Folkman, 1984: 81):

1. Social function refers to the person's ability to completely perform his or her social roles. Social function is influenced by several factors including the person's past experience: being dependent or independent, having trust or belief in other people, being close to other people, etc. Social function is an adaptational outcome. A person experiencing a stressful situation is likely to perform social function poorly and person appraises the situation as threatening as one tends to use psychological mechanism or avoid threatening situations and may express aggressive coping behavior. On the other hand, if the situation is appraised as challenging, the person should perform social function well as challenging situation tends to encourage persons to cope the problem with courage, openness, and increased opportunities for communications.

2. Morale or life satisfaction refers to people's attitude toward themselves and their well-being with happy and satisfying life. In a short term morale and life satisfaction can be evaluated from positive and negative affect during the adaptation process, such as satisfying or dissatisfying, happy or unhappy, hopeful or fear, challenging or threatening, and confident or hesitated. A person's coping with an aim to modify his or her emotion should result in wellness. Likewise, if one considers one's self successful and has achieved the desired goal, he or she will be satisfied. The affect state resulted from each adaptation will accumulate and become a ground for

long-term well-being or morale and life satisfaction. The sense of belonging to a society, beliefs, and life condition evaluation either in positive or negative aspects, also serve as a ground for appraising particular situation.

3. Somatic health refers to physical efforts in adjusting to various situations. Emotion is a key factor involving in the occurrence of illness whereas physical adaptation is directly related to the environment. These components are related to adaptational outcomes as reviewed below.

3.1 Coping in unchangeable environment. A person may not be able to modify his or her negative affect resulting from the confrontation with uncontrollable situation. As a result, the person may react with inappropriate behavior such as blaming one's self or withdrawing from other people. Such behaviors will increase stress in all aspects–frequency, duration, and intensity. Finally, the person may suffer from physical illness.

3.2 Coping with negative effects on health. Such coping increases risks for morbidity and mortality. A person may use alcohol, drugs, or other addictive substances to relieve stress instead of performing health promotion behaviors such as exercise, weight-control, smoke cessation, having small amount of alcohol, or having sufficient rest.

3.3 Coping with mood alteration. This adaptation may have negative effect on somatic health if it interferes appropriate behaviors and may finally lead to illness. For instance, a person may refuse reality and try to suppress the problem from their thought. Such strategy may help eliminating negative affect but it inhibits the recognition of reality for further appropriate management of the situation.

The concept of hope

Hope is essential for every human being (Ferran et al., 1990). Hope generates the response to basic needs of everybody at every stage of life (Fischer, 1988 cited in Forbes, 1994).There is an expression 'Where there's life, there's hope (Forbes, 1994: 5), reflecting that hope is critical to one's living and the desire to live (Miller, 1985). It is influential to the healing process (Herth, 1991). It prevents physical and psychological deterioration thus helping the person to effectively cope with stress (Miller, 1985).

Every individual has a certain level of hope no matter how difficult the situation is and whether the person is ill or healthy.

Definition and attributes of hope

Dufault and Martocchio (1985: 380) defined hope as a multidimensional dynamic life force that is characterized by the confident but uncertain idea about achievement in the future.

According to Dufault and Martocchio (1985: 380–389), hope can be classified into two types particularized and generalized hope, and it is composed of six dimensions, as reviewed below:

Particularized hope is identifiable and involves a specific goal that may be concrete or abstract and can be prioritized. Particularized hope encourages a person to think about the meaning of life, inducing motivations and efforts to take action in order to achieve the desired goals despite constrains or obstacles. For instance, the patients may have hopes for being able to walk again or for returning to work.

Generalized hope is unspecific and can be vague and abstract. It is important in preventing the sense of despair or discouragement when the person is disappointed from particularized hope. Generalized hope can be the last hope that one can hang on for the rest of their life. For instance, a person may hope for recovery to normal condition or for having a long life with his or her offspring.

The six dimensions of hope are concerned with affection, cognition, behavior, affinity, time, and context, as described below (Dufault and Martocchio, 1985):

1. Affective dimension: this dimension of hope focuses on emotions and sensation that are part of the hoping process. Hopeful individuals have positive attitude and feel confident in their hopes thus sensing the success, fulfillment and happiness even though they may feel uncertain and, as a result, become anxious and worried sometimes. The reception of support for maintaining confidence in their hope will provide the individuals with increasing sense of warmth, strength, and trust in their surroundings. Consequently, they will regain their hope.

While individuals are trying to change or overcome difficulties or threatening situation, the hoping process will be triggered and utilized with an involvement of affective dimension in every step of the process.

2. Cognitive dimension: this dimension results from one's thinking and decision making quality. It focuses on process by which individuals wish, imagine, think, remember, learn, generalize, interpret, and judge in relation to hope. In this dimension, individuals' hope is based on reality, depending on their perception of the present situation and the duration of time. Moreover, it is also related to the assessment of reality and one's desire, depending on the assessment of the situation, personal limitations and external resources. Cognitive dimension contributes to individuals' realistic hope and abandonment of unlikely possible hope.

3. Behavioral dimension: this dimension focuses on one's expression in relation to hope. Individuals usually choose to express themselves in a way that is likely to fulfill their hope. The behavior may be physical, psychological, social, or religious expression, as in the following examples:

Physical expression such as having healthy diet and adequate rest with the hope that these activities will improve health condition.

Psychological expression such as organizing thoughts, making plan, making decision, waiting for appropriate time and getting ready to take some action.

Social expression, concerning with other people such as asking for help from medical professionals with the hope that they could help curing the illness.

Religious expression, involving one's belief in supernatural power as seen in one's praying or participating in religious activities.

4. Affiliative dimension: this dimension focuses on the relation with other people. The feature of this dimension is one's interaction with other people in the society, relatedness and self trancendence. In addition to the relation with other people, this dimension includes affinities with other living things such as pets or plants and also the affinity with supernatural power such as some magical power.

The affilitative dimension includes the reception of help from other people that increases one's hope; for example, hoping for the best treatment from physicians, and hoping for family care, etc.

5. Temporal dimension: This dimension of hope is concerned with the future and it takes the combination of past and present events into consideration. Past hope is influential to future hope. Individuals whose past hope was fulfilled are more likely to have the future hope fulfilled. For those who experienced disappointment in the past,

they hope that such events will not occur again. Present hope may contribute to expectation for the future, as one may hope that present situation will lead to a good future.

6. Contextual dimension: this dimension focuses on how the context of life has effect on one's hope. Such context is mainly the situation in which the person experiences loss. Other contexts include sharing opportunities, experience, idea, and feelings with other people. The contextual dimension is also concerned with the alteration of life goal, and judgment of individuals' values and meaning of life.

Stephenson (1991: 1456) defined hope as a process of anticipation involving the interaction of thought process, behavior, feeling, and relationship. It is directed toward one's future success.

According to Stephenson, the conceptual attributes of hope are the following (1991: 1456–1461):a) responding to human's basic needs, b) providing certain life goal, c) being a process, e) being dynamic, f) having a plan for the future, g) having an element of anticipation, h) being a multidimensional concept.

Farran et al., (1995: 6) stated than hope is human's basic experience concerned with emotions, ideas, behavior, interpersonal relation, and environment. It is the idea and action that are changeable when the person is confronted with difficult situations or undesired outcomes. Hope helps individuals to overcome such constraints. They have described the attributes of hope as follows (Farran et al., 1995: 6–10):

1. Experiential process: hope arises when an individual is confronted with an unavoidable situation such as a stressful life event.

2. A spiritual process: hope is characterized with individuals' belief and faith in something and their senses of certainty in uncertainty.

3. A rational thought process: Hope is associated with individuals' goals and motivations; however, the goal must be based on realistic ground.

4. A relational process: hope occurs in interpersonal relations and it is inspired by love. Individuals can develop the sense of hope and the confidence in their abilities to overcome difficulties from personal acceptance.

Herth (1990: 1256) defined hope as an inner feeling that provides individuals with internal energy thus giving them confidence in achieving good results in the future. Hope is expressed in individuals' emotion and behavior with three elements:

inner sense of temporality and future, inner positive readiness and expectancy, and interconnectedness with self and other. The level of hope constantly changes; however, individuals always have hope at a certain level to comfort themselves no matter how difficult the confronting situation is.

Herth later studied Dufault and Martocchio's model of hope and found overlaps among different dimensions, He then proposed a new model of hope with three dimensions as follows (Herth, 1991: 39–51):

1. Inners sense of temporality and future: this dimension combines cognitive and temporal elements together. It is the inner sense of present situation and the future. It is positive perception, sensing that the desired outcome is possible in the near or distant future.

2. Inner positive readiness and expectancy: this dimension is a combination of the affective and behavioral dimensions. It is the sense of confidence and positive expectancy, thus initiating the sense of readiness for following the plan to achieve the desired goal and encouraging the individuals as they could see the way out of difficulties.

3. Interconnectedness with self and other: this dimension is the combination of affiliative and contextual dimensions. It presents the importance of interdependence and the interconnectedness within one's self, as well as between one and other people and between self and spirit. As a result, individuals will gain strength for the confrontation with difficult situation.

In summary, hope is a person's idea, feeling, and expectancy of future goal, including the expectancy to overcome various distresses. Hope is like an inner readiness to respond to the situation in order to achieve the desired goal. It is a positive energy that induces the sense of safety, courage, and solid with the energy to take action for obtaining the desire outcome. It also increases patience even though the person is in the situation that is full of uncertainty.

Hope Measurement

Herth's concept of Hope (Herth, 1991), which is developed from Dufault and Martocchio's model (Dufault and Martocchio, 1985), was applied to hope measurement in this study. The concept is well developed with the integration of philosophical, sociological, and psychological issues. Moreover, Herth has altered the

attribute in each dimension to reduce overlaps and has later developed Herth Hope Index (HHI) from the adaptation of Herth Hope Sacle (HHS) (Herth, 1992). This index can measure individual's hope in a shorter time but with a good coverage of three components comprising 1) inner sense of temporality and future 2) inner positive readiness and expectancy, and 3) interconnectedness with self and other. The index is composed of 12 question items, four items for each attribute of hope. Herth examined the reliability of this measurement with 20 patients with acute illness and the reliability value was 0.94. For the use in Thailand, Kannika Pawapaiboon (2003) examined the reliability of HHI by using it with 30 elderly people in the Rasadorn Yindee Community, Muang District, Ratchaburi Province. She then measured the reliability value with the Cronbach's alpha coefficient equation and found reliability value 0.85.

The concept of social support

Social support is a kind of environment coping resources and it is a significant factor contributing to one's ability in coping with stress (Miller, 2000). Moreover, social support helps individuals in adapting themselves appropriately to various stimuli, resulting in good health. Ill people or people with limited ability to take care of themselves should receive help concerning health care, including the promotion and support of their self-esteem, selection of stress management strategies, and prevention of negative impact of stress (Lazarus and Folkman, 1984).

Hence social support means the reception of support from family members in various aspects. The support includes love, care, respectfulness, information, financial and other tangible helps, and acceptance as part of the social network.

McCubbin and McCubbin (1993) have divided the family's potentiality in coping with stress into two domains comprising resources and family strength and the adaptation behavior or strategies in the family. Family resources comprise the following:

1. Family cohesion: trust, help and support, compliment, and mutual respect.
2. Family adaptability or the members' capacity in coping with stress.
3. Family organization, including agreements within the family, clear and consistent roles and rules in the family.

4. Communicative skill, accurate and clear communication with relevance in feelings, expression, words and body language.

5. Family hardiness, meaning the inner strength concerning the lasting of the family and the feeling of being able to control life events.

6. Family time together and family routines in daily living.

Definition and type of social support

Cobb (1976 cited in Hinson, 1996: 147) defined social support as the information that leads the person to believe that he or she is loved, cared, valued, and belongs to social network and mutual obligation.

Social support consists of three types of support, as follows:

1. Emotion support: the provision of love and care.

2. Esteem support: the assurance of one's value and acceptance from other people.

3. Social support or network: the assurance of one's belonging to the social network and assistance from other social members.

Referring to House (1981: 24–25), social support is an interpersonal reaction, consisting of love, care, interdependency, and material and information support, including taking back information in order to learn and have self-assessment. House has classified social support into four types:

1. Emotional support: providing empathy, caring, love, and trust.

2. Instrumental support: providing of support directly relevant to one's needs such as money, labor, time, and modifying environment.

3. Informational support: providing information, suggestion, or direction so that can be used in coping with the present problems.

4. Appraisal support: providing of information for self-assessment and learning about one's self; this includes agreement, reassurance, and feedback that will increase one's esteem thus this type of support enhances social power.

Schaefer et al., (1981: 385–386) stated that social support provides mental assistance to a social member when the person is confronted with stress. They have proposed three types of social support, as follows:

1. Emotional support: the attachment and reassurance of being loved and cared.

2. Informational support: the provision of information that a person can use for problem solving, including feedback information about how the person is behaving or performing.

3. Tangible support: the provision of direct aids, materials, or services.

Social support refers to an individual or a group of individuals who provide helps in response to the need for interdependency, sense of self esteem, and social participation. It consists of the provision of love and care with respect and perceived value, information, financial help, materials, and labor. These components help in problem solving. Therefore, is a factor that promotes appropriate adaptation (Adam, 2003). The patient who receives social support will be calm and feel emotionally stable, resulting in several positive outcomes especially in the neurological and endocrine systems. Consequently, the patient will have reduced affective responses and improved stress coping (Wortman, 1984).

Social support measurement

In this study, the researcher used the Social support Questionnaire (SSQ) proposed by Schaefer, Coyne, and Lazarus (1981), which was later adapted and translated into Thai by Somchit Hanoucharoenkul (1988). The questionnaire measures social support in three domains: information, emotion, and tangible support. It was tried out with 112 patients with cancer receiving chemotherapy and the reliability was examined with Cronbach's alpha coefficient with result at 0.97. Niramon Chittsuk (2003) tried this questionnaire out with families of 30 patients with HIV positive in Huahin District and the result of Cronbach's alpha coefficient for reliability was 0.91. Kannikar Pawapaiboon (2003) examined the reliability of SSQ with 30 elderly people in the Rasadorn Yindee Community, Muang District, Ratchaburi Province and the result of Cronbach's alpha coefficient was 0.90.

The concept of quality of life

Quality of life is an essential element desired by every human being. According to Lazarus and Folkman (1984), quality of life is the outcomes of effectively coping in three inter related aspects comprising 1) social function; 2) morale, which may be a long-term outcome from the sense of satisfaction toward one's action or may be a short-term outcome of modified emotion in response to the altered situation; and 3) somatic health. In summary, quality of life in Lazarus and Folkman's definition consists of physical, psychological, and social well-being which results from effective stress coping.

Quality of life is an adaptational outcomes. It is a major goal in the development of human resource in every age group due to its essentiality in human living. A person with quality of life will have quick and effective development in every aspect. The term 'quality of life' does not refer to only one's lack of illness or disability, but also includes the one's balance in physical, psychological, and social domains. Every person has the rights to receive psychosocial care and have quality of life along with physical care (Cooley, 1998). As for people with chronic illness or disability, they should have the quality of life that is nearest to their condition prior to the illness or disability even though they cannot have the same quality of life anymore (Charngkaew, 2002).

Quality of life is a word, which has been defined in many ways, which people have studied and given much definition to it. Most definitions given were similar and consistent with one another as follows.

Ferrans (1990: 15-21) stated that quality of life is the perception of well being, whether living in a satisfactory or unsatisfactory situation in life. It is an individual value.

The WHOQOL group (1996: 354-356) defined quality of life as a conceptual framework which has many dimension that links an individual perception on the body, mind, the level of freedom, not having to rely on social relationship, environment, personal belief under the influence of culture, values and goals in life of each individual.

Puawilai, and Napapong (2000) defined quality of life as a condition which an individual feel, perceive, experience that they still have the necessary components of life at a satisfactory level.

Hanucharurnkul (2000) stated that quality of life refers to perception of well being, happiness, and life satisfaction even though an individual may be ill or affected by medication.

Meeberg (1993) stated that quality of life refers to the feeling of satisfaction in life in general, assessment of the condition of mental health of an individual on satisfaction in life or others, physical condition, psychosocial condition and emotional condition which an individual decide in health area as acceptable and evaluated by others whether that individual is living in an appropriate condition and their life is not in threat.

Quality of life is therefore an important issue of living. It is something which human beings want which these want is consistent with human needs which according to Maslow, include air, food, water, medicine, clothing, shelter and sexual need, safety need, love and belonging need, and self-actualization. If these needs are well responded it will bring about satisfaction in an individual's life, or express out in a good quality of life. Improvement on the quality of life is still the main goal in the population development of many nations at present (Charngkaew, 2002)

Components of the Quality of Life

According to Ferrans (1990: 15–21): Quality of life has four underlying domains, as follows:

1. Health and functioning domain: this domain is concerned with one's usefulness to others, physical independence, responsibilities, health condition, stress, leisure activities, retirement, health care, and discomfort or pain.

2. Social and economic domain: this domain involves standard of living, financial independence, home, job and employment, social support, and education.

3. Psychological and spiritual domain: This domain involves life satisfaction, life goal, peace of mind, faith, and control over one's life.

4. Family domain: This is concerned with family happiness, children, spouse, and family health.

According to The WHOQOL group (1996: 354–356): The global construct of quality of life is composed of six major underlying domains, as follows:

1. Physical domain: perceived physical conditions that have effect on daily life such as healthy condition, wellness, or pain. The person should perceive his or her capacity for physical pain management, physical strength for daily living, sleep and rest, and sexual activities. Such perception affects one's daily living.

2. Psychological domain: perceived mental status such as perceived positive feelings toward one's self, perceived self-image, perceived self-esteem, and pride. The perception should include one's thinking, memory, concentration, decision, and ability for learning about one's self and for managing anxiety or depression.

3. Level of independence domain: the perception of independence, including perceived mobility, capacity for daily activities, working capacity, and dependence on medications or treatments.

4. Social relationships domain: perceived personal relationships, social support, and also one's ability to help other people in the society.

5. Environment domain: the perception of environment that has effect on one's living such as free living environment with safety and security, pollution-free environment, convenient transport, financial resources, available health care service and social welfare, and opportunities for acquiring new information and skill, as well as participation in recreational or leisure activities.

6. Spiritual and personal belief domain: the perception of one's beliefs that have effect on daily living such as spiritual and religious belief, belief about the meaning of life, and other personal beliefs that help the person to overcome barriers.

Referring to the literature previously reviewed, quality of life refers to the perception of self-satisfaction of a person toward physical and psychological condition, social relationship, and environment on the basis of their culture, value, and life goals.

Quality of life measurement

Researchers have developed a number of instruments for measuring quality of life. A particular instrument is appropriate for a particular target group such as patients with cancer, patients with osteoarthritis or population of certain country. However, a measuring instrument should not be used with people in different country or different culture and the results of different measurements are incomparable. The World Health Organization (WHO), an organization with direct responsibilities on global development and global health index, has defined the term 'health' as physical, psychological, and social completed condition that is not only the illness-free or non-disable condition (The WHOQOL group, 1996). From this definition of health, the measurement of health condition and health care outcomes does not involve only the numbers and severity of morbidity but includes quality of life. The major goal in health care, therefore, is the patient's well-being or quality of life (The WHOQOL group, 1996).

There are two measurements designed by the WHO that are currently used for quality of life assessment: the WHOQOL–100, consisting of 100 question items, and the WHOQOL-BREF, consisting of 26 question items. The WHOQOL-BREF is an abstracted version of the WHOQOL-100, which needs a long time for assessment and may bore the respondent. The number of questions in WHOQOL-100 is reduced to 25 items so that it is simpler and more convenient, leading to better response and cooperation from the respondent (The WHOQOL group, 1996).

Measurement of the WHOQOL-BREF

Jolunda (1995) examined the quality of the WHOQOL-100 with 300 elderly people in the Netherlands and the resultant Cronbach's alpha coefficient was 0.76. In Thailand, Yaowalak Klinhorm conducted the WHOQOL trial with families of schizophrenic patients in Maharaj Nakhorn Chiengmai Hospital, Chiengmai and the result of reliability was 0.9. Chanthana Chanthawong (1998) used the WHOQOL with patients with breast cancer at the Maharaj Nakhorn Chiengmai Hospital, Chiengmai and the resultant reliability was 0.83. The Department of Mental Health examined the reliability of the WHOQOL-BREF and the Cronbach's alpha coefficient was 0.84.

The WHOQOL-BREF measurement

The WHOQOL-BREF consists of four major domains, as reviewed below (The WHOQOL group, 1996):

1. Physical domain

This domain is concerned with perceived physical condition that has effect on daily life such as perceived physical health, wellness, and no sense of pain. It includes perceived ability for the management of physical pain, perceived physical strength for daily activities, perceived independence, mobility, capacity for daily activities, working performance and independence from medications or any medical treatments.

2. Psychological domain

This domain involves the perceived mental status such as positive feeling toward one's self, self-image, self-esteem, and sense of pride. It includes one's perception of his or her thinking, memory, concentration, decision-making, and ability to learn about one's self. In addition, the person should perceive his or her ability in managing depression of anxiety and the beliefs that have effects on his or her living such as religious or spiritual beliefs and definition of life, including other personal beliefs that have positive effect on the living and on overcoming obstacles.

3. Social relationships domain

This refers to the person's relationships with other people, perceived social support, and the perception of one's self as assistance to other social members. It also includes sexual desires or sexual activities.

4. Environment domain

This domain is concerned with the perception of environment that has effect on daily living; for example, one's perception of free living with no confinement, perceived safety and security. A person should also perceive good physical environment that is pollution-free, and has convenient transport, financial resource, health care and social welfare service, plus perceived opportunities for new information and skills and for having recreational or leisure activities.

Hence quality of life is one's perception of life in relation to the value and culture of the society in which the person lives. It is associated with goals, expectancy, standard and interests of that person. Quality of life is composed of six major domains comprising physical domain, psychological domain, level of independence, social relationships, environment, and personal beliefs on the basis of each individual's culture, value, and life goal. This study followed the WHO's concept of quality of life (1996), which states that although patients with chronic illness cannot develop their quality of life to be as good as before the illness, they can concentrate on having the quality of life that is closest to the previous condition.

The elderly with stroke

Old age is the age of transition in bio-psycho-social aspects (Estes and Binney, 1989 cited in Swanson and Tripp Reiner, 1996). According to Erikson, people constantly change their personality throughout their life. Human development progresses in stages and one needs to overcome certain crisis and complete key performance before advancing to the next developmental stage. Failure at certain stage will inhibit the progress or have negative effect on the nest developmental stage. For people at old age, they are confronted with problems from physical and psychological deteriorations, the decrease in social role and function, and the loss of significant others (Miller, 2000). The capacity for coping with stress of old people depends on the intensity of the present crisis. The elderly who can adapt to old age with integrity will be able to maintain the balance between their demands and the outside world thus they can live a happy and respected life. On the contrary, the elderly who cannot cope with their changing conditions will feel despaired and may express anger, hatred, and fear of dying (Kail and Cavanagh, 2000).

At old age, physical strength and various organs functioning deteriorate. Physical impairments in combination with changes in appearance and the loss of spouse and significant others along with social and family role contribute to the sense of loneliness, despaired and decreased self-esteem in the elderly (Kail and Cavanagh, 2000). Most elderly people have at least one chronic illness and stroke, which is a

major cause of long-term disability, is a common illness among the elderly (Hilton, 2002).

Stroke results from cerebrovascular disorders that have effect on blood supply to the brain and the brain stem. The disorders may be vasoconstriction, vascular rupture, or vascular obstruction, which leads to rapid occurrence of abnormal neurological signs and symptoms that last for longer than 24 hours, As a consequence, the patient may lose their physical functioning temporarily or permanently. Stroke is a major cause of death and disability and it requires constant treatment and rehabilitation in the hospital and at home. There are two types of stroke: 1) stroke from vascular constriction, causing insufficient blood supply to certain brain areas and occurring to approximately 80–85 percent of all patients with stroke; and 2) stroke from intracerebral hemorrhage, of which the incidence rate is approximately 15–20 percent (Puangwarin, 2001).

Stage of stroke

There are three stages of stroke (Watson and Quinn, 1998; Puangwarin, 2001): acute stage, post-acute stage, and recovery stage.

1. Acute stage. This stage starts from the onset of stroke until the condition is stable. After the occurrence of stroke, the patients may be paralyzed immediately, with the coexistence of unconsciousness; or they may be well conscious but the affected limbs become weakened. This stage lasts for about 1–14 days, mostly about 48 hours. The significant problems that may lead to death are unconsciousness, high intracranial pressure, cardiovascular disorders, and respiratory disorders. Thus it is important to sustain organs functioning in order to save the patient's life (Phipps, 1991; Puangwarin, 2001). Low level of consciousness in this stage indicates low chance of survival.

2. Post-acute stage. In this stage, the patients' condition is relatively stable as they have survived from the acute stage: the level of consciousness does not change toward negative direction, the Glasgow Coma Scale is 7 or higher, and the blood pressure is in normal range (Puangwarin, 2001). Common problems in this stage include disorders in swallowing, moving, and talking, which may lead to pneumonia or nutritional deficiencies (Phipps, 1991).

3. Recovery stage. The patients' condition is stable in this stage. The patients can have rehabilitation activity to reduce the disability and to increase self-care ability as much as possible at home (Puangwarin, 2001). This stage is divided into two sub-stages, as follows (Astrom et al., 1992):

3.1 Early recovery: various organs functioning are recovered along with the rehabilitation of self-care ability. This stage is in the first three months after the occurrence of stroke (Phipps, 1991).

3.2 Later recovery: the patients receive care continuously from the early recovery stage and should have improved ability in speaking, using language, and self caring. However, elderly patients with heart problems are found to have low chance of survival in this stage (Phipps, 1991).

Impacts of stroke

Physical, psychological and social problems are common among the stroke elderly, as reviewed below:

1. Physical impacts. The most common physical problems among the elderly with stroke are hemipegia, muscular spasm, and body balance disorders. Moreover, the patients may not be able to speak, or cannot make a clear speech. They may be able to give verbal response but the response does not carry meaning. The patients may have difficulties in chewing and swallowing and may be choked while eating. They may also have intellectual impairments such as forgetfulness or lack of concentration. The physical problems may also involve excretory system such as incontinent or constipation (Stanley and Gauntlett, 1999).

2. Psychological impact. The elderly with stroke who experience changes in appearance, images and lifestyle and become dependent on other people will feel stressed, anxious, and afraid of uncertainty. Also, they loss their life goal and self-esteem thus feeling unsecured (Hilton, 2002).

3. Social impact. The change in physical appearance with noticeable disability induces the sense of losing self-image and shamefulness. The elderly with stroke may also lose the sense of self-worth, as they have to change from previous role to be more dependent on other family members. Moreover, they are not able to participate in social activity thus they feel isolated from family and friends, lonely, and, finally, lose their spirits and life goal (Stanley and Gauntlett, 1999; Hilton, 2002).

The pathogenesis of stroke causes disabilities or organ dysfunctions thus the stroke elderly cannot conduct activities as usual. It has been found that the elderly with stroke who can continue doing daily activities will have more hope and perform better rehabilitation than those who cannot do the activities (Leelapattanapanich, 1998; Chatupornpipat, 2000).However, the elderly with stroke in this study were selected on the basis that their capacity for daily activities met the total 20 points of the Barthel ADL Scale and the 9 points of Chula ADL Scale. The Barthel ADL Scale assesses the performance of 10 basic daily activities comprising eating, grooming (i.e. washing face, combing, brushing teeth, and shaving), mobility (getting out of bed or moving from bed to chair), using toilet, mobility within the house, getting dress, going up and down a stair, having a shower, and controlling excretion. The Chula ADL Scale is the assessment of the performance of five continuous daily activities comprising walking outside the houses, cooking, houses cleaning, changing money, and using public transport. The elderly with stroke who are independent and can do daily activities on their own do not feel that they are burdens to other people, especially family members, thus they feel self-esteemed and valued (Chatupornpipat, 2000), As a result, they can cope with stress more effectively (Singkhamfoo, 1989), leading to quality of life. A study by Ahlsio et al., (1984) has found that the elderly with stroke who can perform daily activities by themselves have better quality of life than those who need help from other people in performing daily activities.

Relationships between hope and quality of life of the elderly with stroke

The elderly have physical deteriorations thus the occurrence of chronic illness is quite common. One of the common illnesses among the elderly is stroke, which causes long term disability. The elderly with stroke have to deal with various consequent changes in physical, psychological and social aspects, as they cannot conduct various activities by themselves and had to depend on other people. As a result, the elderly with stroke have psychological problem, such as anxiety and loss of self-esteem, leading to stress among themselves and their family. In coping with stress, the elderly with stroke should be personal resources.

Hope is a personal resource (Lazarus and Folkman, 1984). It is also an important factor for sustaining health condition (Stephenson, 1991). It is essential for the well being of the elderly with stroke and it helps the elderly to cope with stress effectively. With hope, the elderly with stroke will believe that there are solutions for the problems resulting from stroke thus having strength and mental spirits for adapting and modifying their life goal in relevance to the reality in the future. Also, they accept the reality of their condition, thus learning and making a plan to help themselves living in the society. Therefore, hope is a factor motivating the elderly with stroke to have a direction for their life goal. A qualitative research by Bay (2001: 23), entitled "Older Adults' Description of Hope after Stroke" found the following 12 elements in the hope of the stroke elderly: a) positive anticipation, b) active participation, c) a forward moving process, d) inner sense/ strength, e) faith in God, f) continuing to hope, g) relative comparison, h) life sustaining, i) realistic possibilities, j) connectedness, k) previous abilities, and l) mobility. A study by Narayavasamy (2002) has demonstrated that the search for meaning and goal of life is a way to deal with chronic illness. Which demonstrate that the elderly with stroke who have spiritual support and perform religious activities such as praying or reading religious books tend to be calm, serene, and hopeful. A systematic review by McKevitte (2004) has shown that stroke patients who had spiritual practice (Lincoln, 1997) or who received psychosocial intervention (M-Kelly, 1989 cited in Smith, 2000) are likely to have better quality of life and less depression.

Relationships between social support, and quality of life of the elderly with stroke

Family is a group of people that encourages and helps a person to complete the need for dependency by giving love and respect and by recognizing the value of interpersonal relationship thus the elderly will receive adequate mental support (Limsakul, 2002). And basic source of social support is essential in contributing support to a person confronting stress and illness (Connell et al., 2003). When a family member gets ill, other members should assist the ill person in performing daily

activities and solving problems so that the person can recover to normal condition as soon as possible. For the elderly with stroke, they cannot perform daily activities on their own. This condition, therefore, stressful situation on the elderly with stroke, need mental support for living well with the illness, and need social support, especially family support, is essential for the elderly with stroke (Sritharase, 2003; Han and Haley, 1999; Narayavasamy, 2002). It helps the elderly with stroke to cope with stress (Narayavasamy, 2002). The family's care and responses to the needs of the elderly with stroke induces mental strength and willpower for the rehabilitation as the elderly have the sense of self-esteem and hopefulness, leading to compliance with treatment and maintaining of well-being (Weinert, 2000). They will have quality of life (Lazarus and Folkman, 1984; Hinson, 1996; King, 1996).

Referring to the above reviewed literature, the elderly with stroke experience a number of physical changes that have strong impacts on their living. The elderly then become more dependent thus having the feeling that they are burdens to the family and developing the sense of low self-esteem. Such feelings, in addition to physical impairments, induce stress to the elderly, affecting their living and their quality of life. Nevertheless, hope, social support, and quality of life were investigated separately in previous studies, which are conducted on either the elderly or stroke patients. The relationships of these variables, especially in the elderly with stroke had not been investigated before thus becoming the subjects of interest for the researcher of this study with an expectation that the findings could be used for the development of holistic nursing approach. In addition, the results of this study would help in the promotion of hope and encouraging the family to participate in caregiving and in rehabilitation activities, as well as giving mental support to the elderly with stroke so that the elderly could accept reality and learn to take care of themselves in order to live in the society with mostly level of independence and capacity for self-caring, leading to the prevention or reduction of possible psychological problems.

CHAPTER III
METHODOLOGY

This study was a descriptive research, aiming to investigate the relationships among hope, social support, and quality of life of the elderly with stroke.

Population and Sampling

The population of this study were people older than 60 years of age who were diagnosed with stroke and follow up treatment at the Prasat Neurological Institute outpatient departments, Bangkok during June to September, 2004.

Study Sample

The sample of this study was purposive selected with the inclusion criteria as follows:

1. able to communicate verbally.
2. able to perform daily activities, as the measurement of capacity for basic activities performance of the Thai elderly showed results of Barthel ADL Index score equal to 20 and Chula ADL Index score equal to 9
3. not present with cognitive or mental impairments, as the result of Thai Mental State Exam (TMSE) was 24 or higher out of 30 (The Brain Rehabilitation Group, 1993).
4. living with their family.

The sample size was determined with an estimation of sample's distribution, calculated with the Thorndike's Formula (Thorndike, 1978 cited in Woraponsathorn, 1986) as shown below:

$$\begin{aligned} \text{Sample size} &\geq (10 \times \text{number of independent variables}) + 50 \\ &\geq (10 \times 2) + 50 \\ &\geq 70 \end{aligned}$$

In this study, the sample was composed of 100 elderly people with stroke. It should be prevented incomplete data.

Setting

The setting of the study was at the Prasat Neurological Institute, Bangkok that operates under the Medical Department. It provides medical service at a tertiary care level. The institute provides treatment, care and rehabilitation for neurological patients who suffer from stroke, Parkinson's disease, dementia etc. There are specialists and special clinics to treat rehabilitate stroke patients. There are 300-400 patients using the service at the institute each day. Approximately 100-200 elderly stroke patients use the service at the institute each day. In 2003 there was a total of 9,726 patients who used the service at the Prasat Neurological Institute.

Research Instrument

The research instruments comprised the following:

1. The demographic characteristics questionnaire. The information recorded with this form included gender, age, marital status, education level, monthly family income, family pattern, and duration of having stroke.

2. Hope measurement. This study used Hope Herth Index (HHI), which was developed from the model proposed by Dufault and Martocchio (1985) that has good coverage of all relating issues with an integration of philosophical, sociological, and psychological concepts. Herth modified the Dufault and Martocchio's model to reduce overlaps among dimensions and designed Herth Hope Scale (HHS) (Herth, 1992). The HHS was then developed into the HHI, which measures hope in a shorter time with good coverage of all attributes of hope. Kannikar Pawapaiboon (2003) translated the HHI into Thai and tested for content validity by three expert as follows one nursing instructor who is an expert in adult nursing, one nursing instructor who is an expert in psychiatric-mental health nursing, and one nursing instructor who is an expert in geriatric nursing. Based on the recommendations of the expert, the instruments were revised to improve the clarity of the statements, to provide more appropriate order of the statements, and to ensure appropriate use of language and tried the instrument out with 30 elderly people in the Rassadornyindee Community, Muang District, Ratchaburi Province. The reliability value was Cronbach's alpha coefficient 0.85. The HHI was composed of 12 question items: four items for measuring the inner sense of temporality and future (item 1,4,6, and 11), four items for inner positive readiness and expectancy (item 2, 7, 8,

and 10), and the other four for interconnectedness with self and others (item 3, 5, 9, and 12). The following 4 level scale was given as responses for each item:

- Mostly agree means the respondent very much agreed with the statement
- Agree means the respondent agreed with the statement
- Disagree means the respondent disagreed with the statement
- Mostly disagree means the respondent very much disagreed with the statement

The scoring criteria for each level of responses are listed below:

Level of response	Positive item (point)	Negative item (point)
- Mostly agree	4	1
- Agree	3	2
- Disagree	2	3
- Mostly disagree	1	4

The results was interpreted from the obtained total score, as follows:

- Low score indicated low level of hope.
- High score indicated high level of hope.

3. Social support measurement. This study used the Social Support Questionnaire (SSQ), designed by Schaefer, Coyne, and Lazarus (1981). The questionnaire was modified and translated into Thai by Somchit Hanucharurnkul (1986) and the trial with 112 patients with cancer receiving chemotherapy gave result of the Chronbach's alpha coefficient 0.97. Niramon Chittsuk (2003) used the SSQ with the families of 30 patients with HIV positive and the resultant Cronbach's alpha coefficient was 0.91. Kannikar Pawapaiboon (2003) examined the reliability of this questionnaire with 30 elderly people in the Rassadornyindee Community, Muang District, Ratchaburi Province and the result of Cronbach's alpha coefficient was 0.90. The SSQ investigates social support in three domains: information, emotion, and tangible support. The questionnaire consists of one question about informational support (item 1), four questions about emotional support (item 2–5), and two questions about tangible support (item 6 and 7).

The responses were given in a 5-level scale, which were scored and interpreted, as follows:

- Never means the respondent felt that he/she never received that support (0 point)
- Rare means the respondent felt that he/she rarely received that support (1 point)
- Sometimes means the respondent felt that he/she received that support occasionally (2 point)
- Often means the respondent felt that he/she received that support frequently (3 points)
- Always means the respondent felt that he/she received that support most of the times (4 points)

4. Quality of life measurement. The WHOQOL-BREF was utilized in this study. The questionnaire was translated into Thai by the Department of Mental Health (1998) and was examined for reliability with people aged between 20–60 years. The resultant Cronbach's alpha coefficient was 0.84. The SSQ consists of 26 questions; 23 of them were positive question and the other three were negative. The questions cover four major domains of social support, as follows:

- Physical domain: item 2, 3, 4, 10, 11, 12, and 24
- Psychological domain: item 5, 6, 7, 8, 9, and 23
- Social relationship domain: item 13, 14, and 25
- Environmental domain: item 15, 16, 17, 18, 19, 20, 21, and 22

The responses for each item were presented in a 5-level scale, as listed below with the scoring criteria:

Frequency of action/ occurrence	Positive item (point)	Negative item (point)
- Most often	5	1
- Often	4	2
- Fairly often	3	3
- Rare	2	4
- Never	1	5

Reliability

The research instrument was tried out with 30 elderly people with stroke who were people older than 60 years of age, diagnosed with stroke and follow up treatment at the Prasat Neurological Institute outpatient departments. The Cronbach's alpha coefficient for each measurement is listed below:

1. Hope measurement = 0.81
2. Social support measurement = 0.90
3. Quality of life measurement = 0. 82

The Cronbach's alpha coefficient for each measurement in this present sample is listed below:

1. Hope measurement = 0.82
2. Social support measurement = 0.92
3. Quality of life measurement = 0. 94

Data Collection

Data were collected through the following process:

1. The researcher submitted an introduction letter from the Faculty of Graduate Studies, Mahidol University to the Director of the Prasat Neurological Institute to explain the objectives of this study and to ask for permission for collecting data at the outpatient department of the institute.

2. The researcher met the head nurse of the Prasat Neurological Institute to provide information about objectives of the study and to ask for cooperation.

3. The researcher collected data at the Prasat Neurological Institute from Monday to Friday at 8.00 to 12.00 a.m.

4. Before collecting data, the researcher approached the elderly with stroke receiving medical care at the outpatient department of the Prasat Neurological Institute, introduced herself to the elderly, explained the objectives of this study, and invited them to participate in the study. This step was carried out with a full awareness of the subjects' rights in making decision independently.

5. The researcher selected the elderly whose characteristics met the inclusion criteria and, after they willingly and independently agreed to participate in the study, asked them to sign the consent letters.

6. Data were then collected with interviewing method. The researcher conducted the interview with the elderly with stroke, using**.** The demographic characteristics questionnaire, hope measurement, social support measurement, and quality of life measurement. The interview took approximately 45–60 minutes per one respondent. During the interview, the stroke elderly answered the question independently and they might ask for more explanation or clarification of questions should they did not fully understand the questions. Nevertheless, the researcher would not direct or guide the sample's responses to the questions.

7. After the interview, the researcher might give advice or mental support to the elderly with stroke or their caregivers who expressed stress or troubles concerning the illness. The elderly and/or caregivers were allowed to ask questions or talk about their problems until they felt better. The interview was then finished.

8. The researcher checked the completeness of information in the questionnaire and thanked the elderly for their participation and cooperation.

9. Data were then gathered for further analysis.

Protection of Human Rights

The researcher introduced herself and submitted the research proposal to the Ethical committee of the Prasat Neurological Institute. After receiving approvals at 20 July 2004. the researcher introduced herself to the elderly and gave details about objectives of the study and the process of data collection before asking for their participation. The elderly were also informed that they could either agree or refuse to participate in the study independently and their decision would have no impact on medical services they were receiving from the institute. Data obtained from this study would be kept confidential and would be used for academic purpose only. The collection of data would start only after receiving consent from the sample.

Data analysis

Data were analyzed with the SPSS/FW computer program, as detailed below:

1. Data concerning personal information of the elderly with stroke were analyzed with the frequency count method.

2. Data concerning hope, social support, and quality of life of the elderly with stroke were calculated for mean and standard deviation.

3. The relationships among hope, social support, and quality of life of the elderly with stroke were analyzed with Pearson's product moment correlations.

CHAPTER IV
RESULTS

Research finding

This study was a descriptive research, aiming to investigate the relationships among hope, social support, and quality of life of the elderly with stroke. The population of this study were people older than 60 years of age who were diagnosed with stroke and received medical care at the Prasat Neurological Institute outpatient departments, Bangkok during June to September, 2004. The sample of this study was selected with purposive sampling method with the inclusion criteria that the sample was older than 60 years of age, diagnosed with stroke, able to communicate verbally, able to perform daily activities, as the measurement of capacity for basic activities performance of the Thai elderly showed results of Barthel ADL Index score equal to 20 and Chula ADL Index score equal to 9, not present with cognitive or mental impairments, as the result of Thai Mental State Exam (TMSE) was 24 or higher out of 30 (The Brain Rehabilitation Group, 1993), living with their family. The sample was composed of 100 elderly people with stroke. Data were then collected with interviewing method. The research conducted the interview with the elderly with stroke using the demographic characteristics, Herth Hope Index, Social Support Questionnaire, and WHOQOL-BREF measurement. The data collected from 100 subjects were analyzed with the statistical package for the social science for windows (SPSS/FW). The results are presented in tables as follow:

Part 1: Demographic characteristics of the sample groups.

Part 2: Hope, Social support, and Quality of life.

Part 3: Relationships among hope, social support, and quality of life of the elderly with stroke.

Table 1 Demographic characteristics of the sample (N = 100)

Characteristics	Frequency (N)	Percentage (%)
Gender		
Female	39	39.0
Male	61	61.0
Age (Years)		**Mean = 67.45 S.D. = 6.26**
60-69	65	65.0
70-79	30	30.0
80-89	5	5.0
		Max = 84, Min = 60
Marital Status		
Single	1	1.0
Married	70	70.0
Widow, Divorce, Separated	29	29.0
Family Status		
Nuclear	38	38.0
Extended	62	62.0
Level of education		
No education	10	10.0
Primary school	68	68.0
Secondary school	18	18.0
Diploma	1	1.0
Bachelor	3	3.0

Table 1 Demographic characteristics of the sample (continued)

Characteristics	Frequency (N)	Percentage (%)
Income (bath/month)		**Median= 4,500**
No income	18	18.0
≤ 5,000	43	43.0
5,001-10,000	18	18.0
10,001-15,000	7	7.0
15,001-20,000	9	9.0
> 20,000	5	5.0
		Max = 30,000, Min = 0
Duration of illness with Stroke (years)		**Median= 2**
≤ 1 year	27	27.0
1 year 1 month -5 years	52	52.0
5 years 1 month -10 years	13	13.0
> 10 years	8	8.0
		Max = 30, Min= 1

According to Table 1, the sample consisted of 61 males (61%) and 39 females (39%). Most subjects were aged between 60-69 years old (65%), with the overall mean age of 67.47 years. Seventy percent were single and most subjects lived with extended family (62%). Sixty-eight percent of the sample had completed the primary school. Most subjects earned income in less than 5,000 bath/month (61%), with the median income 7,156 bath/month and fifty-two percent of the sample had been ill for 1 year 1 month -5 years, with a median duration of 4 years

Table 2 Possible Range, Actual Range, Mean and Standard deviation total of Hope, Social Support and Quality of Life Scores (N = 100)

Variables	Possible Range	Actual Range	Mean	S.D.
Hope	12-48	21-44	34.65	5.86
Social Support	0-28	0 - 28	17.31	6.50
Quality of life	26-130	37-114	85.16	17.20

According to Table 2, the overall mean score of hope was 34.65 (S.D. = 5.86) , the overall mean score of social support was 17.31 (S.D. = 6.508) and the overall mean score of quality of life was 85.16 (S.D. = 17.20)

Table 3 Correlation matrix between Hope, Social Support and Quality of Life among the elderly with stroke (N = 100)

Variables	1	2	3
1. Hope	1		
2. Social Support	.408**	1	
3. Quality of life	.725**	.367**	1

** p < .01

According to Table 3, the coefficient of correlation between hope and quality of life was .725 at the statistically significant level of .01, and the coefficient of correlation between social support and quality of life was .367 at the statistically significant level of .01.

CHAPTER V
DISCUSSION

This study is a descriptive research aimed to study the relationships among hope, social support, and the quality of life of the elderly with stroke. The subjects were 100 the elderly with stroke who came to used the service at the Prasat Neurological Institute outpatient department, Bangkok. It was found that hope and social support has positive correlation with the quality of life of the elderly with stroke at a statistically significant level .05. Which the result support the hypothesis which is: hope and social support has positive correlation with the quality of life of the elderly with stroke at a statistically significant level ($r=0.725, 0.367, p<.01$). This means that the elderly with stroke who have hope and receive high social support are likely to have a quality of life, while those who have low hope and receive low amount of social support are likely to have a poor quality of life. The research results can be discussed based on the research hypotheses as follows:

Hypothesis I: Hope has a positive correlation with quality of life of the elderly with stroke at the statistically significant level ($r=0.725, p <.01$).

Hope of the elderly with stroke mean score was 34.65 (S.D.=5.86, Range=21-44) which is slightly higher than mean. The result is consistent Pawapaiboon, (2003) who studied normal elderly people who did not join the elderly club and found that the mean score for hope was at 2.34 which is equal to 36.24. This may be due to the elderly with stroke in this study were able to take care of themselves when doing different activities including, daily chores, and are less dependent. They are not many differences between them and the normal elderly person. Therefore the elderly with stroke have the hope to continue living. Moreover, an elderly person, partly due to their age and experience accept the changes and reality in life more easily than people

in other age groups (Ubonwan, 1997). They tend to view that being ill as a normal part of living, therefore they accept their illness more easily and are determine to continue living. But their plan in life and future is still short-term. Siriwarasai, (1993) found that hope and expectation of the elderly people is their day to day goal. Future for the elderly people is not a matter of years view but just days (Beckerman and Northop, 1996). This view helps the elderly with stroke to be at peace with themselves, confident, viewing at their life in a meaningful way and with hope. This study also found that elderly with stroke usually have things to cling on to or put their faith in. They are usually engage in religious activities and meditation. Having faith in something helps them to be spiritually and mentally strong, peaceful, relax, firm and not feeling lonely. It helps them to clearly visualize their goal in life and help prepare them to deal with life obstacles and enable them to move towards their goal. This is consistent with Dufault and Martocchio (1985) who stated that as an individual grows older he usually develops faith in his belief and religion. This belief helps increase their level of hope. This is consistent with Herth (1993) who studied hope of elderly people living in the society and found that a factor that help support the level of hope of an individual is having faith in a religion. Nukra, (1999) and Techakruh, (1997) found that the stroke patients have something to cling on to and follow religious practices such as praying, reading holy writings. These things can help an individual to be calm and at peace which in-turn uplifts hope.

The interview of the elderly with stroke in this study shows that the patients accepted the condition they are in and perceive their ability according to the reality. They have confidence in their own ability in looking after themselves, and positive thinking. These help the elderly with stroke to feel good, confidant about their hope, happy, proud and confident that they are able to take care of themselves and improve their health. It helps them feel that their life is worth living and meaningful. These feeling is a motivation for them to express their eagerness to reach their expectation, guided and set behavior, have confidence, try to take care of themselves.

It was found that most (61%) the elderly with stroke in this study have an average income about 5,000 Baht per month and from the interview it was found that part of the subjects were retired government officials who were able to reimburse their medical expenditures. They also have other sources of income and have no problem with family

expenditure. This help give them the opportunity to find things which benefit their self-care. Moreover they can also adjust the environment to suit their condition, give their corporation during the treatment process and behave appropriately during adaptation. This gave them hope to continue to take care of themselves. On the contrary there were other patients who were having problem with trying to meet their family expenditures due to the extra traveling medical expenses which they have to pay. Some of the elderly with stroke also were unable to continue working the same way as they used to which make they feel worry and insecure. This is consistent with Friedland (1992) and Hilton (2002) who found that elderly with stroke patient who could not work usually feel worry and insecure. Therefore having hope can help boost their confidence, motivate them in planning their goal and work towards it. Accomplishing their goal will then create confidence in their action and make them value their lives. This is consistent with Pilkington (1999) who found that the quality of life of the stroke with patients continue to improve in time due to the patient can see the improvement in their life as a result of their hard work.

Hope is one of an important factors that is related to the quality of life of the elderly with stroke due to hope is thought and feeling within the elderly with stroke which encourage the elderly with stroke to believe that they will have a belief in life and not be afraid of their future, set a goal and plan their action to achieve the goal. Hope is therefore an importance resource in stress coping of the elderly with stroke and besides this, memory of good times and having faith in a religion can also help the elderly with stroke relax, feel calm and encourage them in their strength, patience and complience in the treatment and the recovery process by perceiving that suffering from stroke and other illnesses which follows is not something beyond their capacity to handle, they have the strength and assurance and readiness to face different problems, they accept the reality, learn from their illnesses and plan on ways which they can be self-support and evaluate the condition of their illness on the basis of positive thinking and possibility of recovering, calmly perceived events around themselves, always have a vision of success to appropriately adapt themselves, have satisfaction in life and a good qualities (Lazarus, 1984). The finding is consistent with the qualitative research of Pilkington (1999) who found that stroke patients with hope of recovery are more patient and try harder to recover. They also have dreams of possibility in changing

themselves so they could have a better quality of life. The result is also consistent with Ventegodt et al., (2003) who found that hope is an important factor in an individual life, which can help the elderly stroke patient to have goal, which can lead to have a better quality of life. At the same time elderly stroke patient who feel hopeless, lack of purpose in life and depress are likely to have a poor quality of life. (Ahmed, 2004; Kauhanen, 2000; Moon, 2004)

Hypothesis II: Social support has a positive correlation with quality of life of the elderly with stroke at the statistically significant level ($r=0.367$, $p<.01$).

Social support that the elderly with stroke receive from family in this study was at 17.31 level (S.D.=6.508, Range =0-28) which is slightly higher than mean is due to most subject (70%) in this study were married and living with their spouse. Their spouse is the one that stays by them, encourages them, support and consult and advice them in different issue. They also help the patient with caring, clothing and goods (Manohan, 1993). Therefore the elderly with strokes who are living with of their spouse is likely to receive the support, and care from their spouse making it easier for them to cope with the illness and disability allowing them to keep their role in the society. Panichakul, (1993) found that heart attack patients living with their spouse are found to have received more help and support than those who are widows, separated or living separately. This is consistent with Ratanawijit, (1999) who found that marital status is positively related to quality of life. Spouse support and care is a form of social support, which is important. It can help the elderly with stroke in the area of personal care, encouragement, consultation, and reduce physical, mental, emotional and social problems. It supports the elderly with stroke to learn how to think and solve their problem in a better way, have more encouragement to fight the problem and obstacles. Encourage the patients to try to look after themselves including support the perception of the quality of life.

Most subject (62%) living in an extended family receive help and support from their family members in doing their daily chores. The subjects were confident that family members would continue to support them whenever help is needed. This is

consistent with Manohan, (1993) who found that elderly patient living in an extended family is unable to perform their role in the family, other members will help take that role instead. Moreover Thai culture has a high respect for elder people and strongly teaches loyal to the family. Children are expected to look after their parents when their parents are not well (Panichakul, 1993) and according to Mingkwan, (1999), it was found that the elderly with stroke are confident that their family members can support their needs.

The elderly with stroke in this study are from the sample group, who are independent and can do daily activities. They are able to travel by themselves and have a low level of dependency so they naturally have more interest and concentration in doing different kinds of things. They are able to socialize, meet and make new friends. This is consistent with Ahlsio et al., (1984) and Robinson-Smith et al., (2000) who found that stroke patients who are independent and can do daily activities usually have a better life than those who are not, therefore having been able to help themselves the elderly with stroke feel satisfied with their health condition.

The elderly with stroke in this study were still participating in different activities and interact with other individuals in the society. They often meet up with their friends. This made them believe that they are still people who love, care and see value in their lives. It made them feel important to be a part of the society. This is consistent with Julmet, (1997) who found that social relationship helps create a warm and secure feeling. It provided them with opportunities to receive information and news on how to look after their health, self control in problem-solving which bring about power and encouragement to the patient in going though pain and obstacles in life. Therefore the elderly with stroke who has good social relationship will likely feel that their life is valuable and have a positive view about themselves. This is consistent with Watee, (2001) who found that the source of social support is one of the factors, which influences the quality of life. This is due to the source of social support can help the patients in facing obstacles in life and adapt themselves. Therefore when the elderly with stroke who are able to perceive social support will less likely go through loneliness and increase their quality of life.

From the interview with the elderly with stroke it was found that most the elderly patent felt that they have security in life, sufficient money to spend, and able to adapt

themselves to the necessary check-ups. They are able to get information which are important daily living, so they are not lonely, sad, feeling down or worry but instead they feel that their life is meaningful and satisfaction. Smith (2000) found that stroke patient who received social support on emotion and shelter will have a good life. Stroke patients living alone have a high risk of having depression. From this study it was found that most the elderly with stroke patients do not feel that they are lonely. They still have friends and family who helps look after them. This helps encourage them to continually look after themselves.

Social support is one of the factors that relate the quality of life. Social support that the elderly with stroke receive from the family such as love, care and support can help the elderly with stroke feel that they are accepted by others, they are a part of the society, and that their life is valuable. This helps stabilize the emotion of the elderly with stroke, help them not to be discourage or lonely, feel encouraged and energetic in coping with the problem from their illness. Moreover, receiving social support also satisfies an individual's basic need, provide assistance for what the patients can't do or find it difficult to carry out. Promoting learning and skills, which are necessary for, providing care and rehabilitation, can help elderly with stroke cope with obstacles in their lives better. They can correctly practice disease control measures and accept their physical condition which may have been changed. These things can help elderly stroke patient to be satisfied with their lives and have a better life. The finding is consistent with the study of Robinson-Smith et al., (2000) who found that elderly with stroke having high quality life is likely to have emotional support, shelter, and relationship with family member. The result is also consistent with the qualitative research of Pikington, (1999) who found that receiving love, valuable relationship with family, can help the elderly with stroke feel the comfort and encouragement, made life more present and help them deal with problem. This is consistent Herman et al., (1994) who stated that social support is one of the factors, which are influential to the quality of life. This is due to social support helps provide the patient with love, care, and encouragement which respond to the needs of the elderly with stroke. The elderly with stroke who received support and assistance in different areas from their spouse, from a caring, and understanding family are less likely to feel left out. They tend to feel that

their life is valuable and have a stable emotion which helps bring about happiness in their life (Panitchakul, 1993; Clarke 2002).

Conclusion

After stroke, the elderly suffers from disability, muscle weakness, and reduction in capability to work and move, making it impossible or hard for them to do their normal activities. Thus, the elderly with stroke often have to be dependent on their family members. This creates stress, anxiety, and uncomfortable that they must depend on others. The elderly with stroke should try hard to properly deal with these stresses. Hope and social support is an important source of benefit in coping with stress of the elderly with stroke.

Hope is the source of benefit within an individual. It is an encouragement for the elderly with stroke to want to and try to continue to go on with their life. Believe that their condition will improve, accept their condition, seek for assistant from others, and change their life style to be according to their limitation. In being able to visualize the happiness in the past life the patients have faith and feel that life is still valuable and meaningful. These things show that hope is actually an inner strength of an individual, which helps us to be strong when having to cope with a problem. It leads to good quality of life.

Social support is a source of benefit, which can be found in the environment. It helps and supports the elderly with stroke in different areas making them feel firm and safe, and encouraged and able to deal with stress by able to appropriately use different strategies. This helps an individual to be strong, valuable and emotionally stable which lead to happiness in their lives.

CHAPTER VI
CONCLUSION

This study was a descriptive research, aiming to examine the relationships among hope, social support, and quality of life of the elderly with stroke based on the concept of the Stress, Appraisal, and Coping Model proposed by Lazarus and Folkman (1984). The population of this study was composed of patients older than 60 years of age who were diagnosed with stroke and received medical care at the Prasat Neurology Institute outpatient department, Bangkok during July to September 2004. The researcher selected a sample of 100 patients.

The research instrument was an interview questionnaire, which was composed of four major parts: Part 1–the demographic characteristics; Part 2–Herth Hope Index, adapted and translated into Thai by Kannikar Pawapaiboon (2003); Part 3–Social Support Questionnaire (SSQ), which was designed by Schaefer, Coyne, and Lazarus, and later adapted and translated into Thai by Somchit Hanucharurnkul (1998); and Part 4–the quality of life measurement–WHOQOL-BREF, translated into Thai by the Department of Mental Health (1998). The instrument was tried out with the elderly with stroke at the Prasat of Neurology Institute of outpatient department, Bangkok and the reliability was then examined with the Cronbach's alpha coefficient. The results show that the reliability value of the Herth Hope index was 0.81, the SSQ was 0.90, and the WHOQOL-BREF was 0.82. The instrument was then used for the collection of data and interview with the sample. The obtained data were analyzed with the SPSS/FW computer program, as follows:

1. Personal information data were analyzed with the frequency count method.

2. Data regarding hope, social support, and quality of life of the elderly with stroke were calculated for mean values and standard deviations.

3. Relationships among hope, social support, and quality of life of the elderly with stroke were analyzed with the Pearson's product moment correlation coefficient.

Findings

The results of this study have shown that:

1. Hope has a positive correlation with quality of life of the elderly with stroke ($r = .725$, $p < .01$)

2. Social support has a positive correlation with quality of life of the elderly with stroke ($r = .367$, $p < .01$)

The findings of this study support the Stress, Appraisal and Coping model proposed by Lazarus and Folkman, which states that individuals will use personal resources and environmental resources in coping with stress in order to achieve appropriate adaptational outcomes. Hope is a personal resource whereas social support is an environmental resource thus they are positively related to quality of life.

Implication of nursing practice

1. The findings of this study are evidence that hope has a positive relationship with quality of life of the elderly with stroke. Nurses, therefore, should seek strategies to increase hope in the elderly with stroke so that they will believe that there are solutions for the problems resulting from stroke, modified their life goal in according to the reality and cope with stress effectively, leading to the well-being in living with stroke and, eventually, good quality of life.

2. The finding of this study are evidence that social support has a positive relationship with quality of life of the elderly with stroke. Therefore, Nurses should be promoted to the family concern in the delivery of care, development, and rehabilitation. Moreover, nurses should be a resource of information and support in guiding family to deal with the elderly with stroke. The elderly with stroke and families could maintain appropriate stress coping and adaptation, they will have quality of life.

Implication of research finding on further research

1. Experimental research to evaluate the effectiveness of nursing intervention to promote hope, social support, and used as guidelines for improve quality of life of the elderly with stroke.

2. There should be studies on the relationship between personal factors and the quality of life of the elderly with stroke.

3. Their should be comparitive among hope, social support, and quality of life between the different groups of the elderly with stroke at different severity.

4. Due to the Hope measurement and Quality of life measurement in this study have similar questions, Studies about the relationships between hope and quality of life in the future should choose forms which does not none similar questions.

Limitations of the study

1. This research was a study of the relationships among hope, social support and quality of life of the elderly with stroke receiving care from the Prasat Neurology Institute outpatient department, Bangkok only. Therefore, the findings may have limitations in applying to general population of the elderly with stroke.

2. As this study was conducted with the elderly with stroke who were able to self care (achieving 20 points from the total 20 points of the Barthel ADL and 9 point from the total 9 of the Chula ADL), the level of dependency among the sample was low. The findings of this study, therefore, could only be applicable to the elderly with stroke who fall into the same scope of dependency level.

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APPENDIX

APPENDIX A

แบบประเมินสมรรถภาพในเชิงปฏิบัติกิจกรรมของผู้สูงอายุ

คำชี้แจง : ผู้สัมภาษณ์ทำการสัมภาษณ์ผู้สูงอายุโรคหลอดเลือดสมองเพื่อประเมินสมรรถภาพในเชิงปฏิบัติกิจกรรมของผู้สูงอายุโรคหลอดเลือดสมอง ตามข้อความต่อไปนี้ แล้วให้คะแนนในแต่ละข้อตามตัวเลขที่อยู่หน้าข้อความที่ตรงกับคำตอบของผู้สูงอายุโรคหลอดเลือดสมอง โดยในส่วนที่ 1 ต้องได้คะแนน 20 คะแนนขึ้นไป และในส่วนที่ 2 ต้องได้คะแนน 9 คะแนนขึ้นไป จึงจะทำการเก็บข้อมูลในการวิจัยต่อไป

ส่วนที่ 1 การประเมินกิจวัตรประจำวันพื้นฐาน (Barthel ADL Index)

1. การรับประทานอาหาร
   - ( ) 0. ไม่สามารถตักอาหารเข้าปากได้ ต้องมีคนช่วยป้อนให้
   - ( ) 1 ตักอาหารเองได้ แต่ต้องมีคนช่วย เช่นช่วยตักเตรียมไว้ให้ หรือตัดให้เป็นชิ้นเล็กๆ ไว้ล่วงหน้า
   - ( ) 2. ตักอาหารและช่วยตัวเองได้ปกติ
2. การแต่งตัว (ล้างหน้า, หวีผม, แปรงฟัน, โกนหนวด)
   - ( ) 0. ต้องการความช่วยเหลือ
   - ( ) 1. ทำได้เอง
3. การเคลื่อนไหว (ลุกนั่งจากที่นอน หรือจากเตียงไปยังเก้าอี้)
   - ( ) 0. ไม่สามารถนั่งได้ (นั่งแล้วจะล้มเสมอ) หรือต้องใช้คนสองคนช่วยกันยกขึ้น
   - ( ) 1. ต้องการความช่วยเหลืออย่างมากจึงจะนั่งได้ เช่นต้องใช้คนที่แข็งแรงหรือมีทักษะ 1 คน หรือคนทั่วไป 2 คนพยุง หรือช่วยดันตัวขึ้นจึงจะนั่งอยู่ได้
   - ( ) 2. ต้องการความช่วยเหลือบ้าง เช่นบอกให้ทำตาม หรือช่วยพยุงเล็กน้อย หรือต้องมีคนดูแลเพื่อความปลอดภัย
   - ( ) 3. ทำได้เอง
4. การใช้สุขา
   - ( ) 0. ช่วยตัวเองไม่ได้
   - ( ) 1. ทำเองได้บ้าง (อย่างน้อยทำความสะอาดได้หลังเสร็จธุระ) แต่ยังต้องการความช่วยเหลือในบางสิ่ง
   - ( ) 2. ช่วยตัวเองได้ดี (ขึ้นนั่งและลงจากโถส้วมได้เอง, ทำความสะอาดได้เรียบร้อยหลังเสร็จธุระ, ถอดเสื้อผ้าได้เรียบร้อย)

5. การเคลื่อนที่ภายในห้องหรือบ้าน
   ( ) 0. เคลื่อนที่ไปไหนไม่ได้
   ( ) 1. ต้องใช้รถเข็นช่วยตัวเองให้เคลื่อนที่ได้เอง (ไม่ต้องมีคนเข็นให้)
   ( ) 2. เดินหรือเคลื่อนที่โดยมีคนช่วย เช่น พยุง หรือบอกให้ทำตาม หรือต้องให้ความสนใจดูแลเพื่อความปลอดภัย
   ( ) 3. เดินหรือเคลื่อนที่ได้เอง
6. การสวมใส่เสื้อผ้า
   ( ) 0. ต้องมีคนสวมใส่ให้ ช่วยตัวเองแทบไม่ได้ หรือได้น้อย
   ( ) 1. ช่วยตัวเองได้ราวร้อยละ 50 ที่เหลือต้องมีคนช่วย
   ( ) 2. ช่วยตัวเองได้ดี (รวมทั้งการติดกระดุม รูดซิป หรือใช้เสื้อผ้าที่ดัดแปลงให้เหมาะสมได้)
7. การขึ้นลงบันได 1 ขั้น
   ( ) 0. ไม่สามารถทำได้
   ( ) 1. ต้องการคนช่วย
   ( ) 2. ขึ้นลงได้เอง
8. การอาบน้ำ
   ( ) 0. ต้องมีคนช่วยหรือทำให้
   ( ) 1. อาบน้ำได้เอง
9. การกลั้นอุจจาระ
   ( ) 0. กลั้นไม่ได้ หรือต้องการการสวนอุจจาระอยู่เสมอ
   ( ) 1. กลั้นไม่ได้เป็นบางครั้ง (เป็นน้อยกว่า 1 ครั้งต่อสัปดาห์)
   ( ) 2. กลั้นได้ปกติ
10. การกลั้นปัสสาวะ
   ( ) 0. กลั้นไม่ได้ หรือใส่สายสวนปัสสาวะ แต่ไม่สามารถดูแลเองได้
   ( ) 1. กลั้นไม่ได้บางครั้ง (เป็นน้อยกว่าวันละ 1 ครั้ง)
   ( ) 2. กลั้นได้ปกติ

รวมคะแนน.....

<u>ส่วนที่ 2</u> การประเมินกิจวัตรประจำวันต่อเนื่อง (Chula ADL Index)

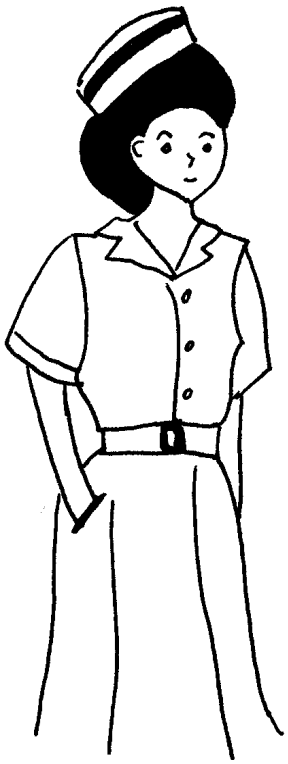
1. เดินหรือเคลื่อนที่นอกบ้าน
   ( ) 0. เดินไม่ได้
   ( ) 1. ใช้รถเข็น และช่วยตัวเองได้ หรือต้องการคนประคอง 2 ข้าง
   ( ) 2. ต้องการคนช่วยพยุง หรือไปด้วยตลอด
   ( ) 3. เดินได้เอง
2. การทำอาหาร
   ( ) 0. ทำไม่ได้
   ( ) 1. ต้องการคนช่วยในการทำ หรือจัดเตรียมบางอย่างไว้ล่วงหน้าจึงจะทำได้
   ( ) 2. ทำได้เอง
3. ทำความสะอาดบ้าน
   ( ) 0. ทำไม่ได้/ต้องมีคนช่วย
   ( ) 1. ทำได้เอง
4. การทอนเงิน/แลกเงิน
   ( ) 0. ทำไม่ได้/ต้องมีคนช่วย
   ( ) 1. ทำได้เอง
5. การใช้บริการรถเมล์/รถสองแถว
   ( ) 0. ไม่สามารถทำได้
   ( ) 1. ทำได้แต่ต้องมีคนช่วยดูแลไปด้วย
   ( ) 2. ไปมาได้เอง

รวมคะแนน.....

แบบทดสอบสภาพสมองของไทย
Thai Mental State Exam (TMSE)

1. Orientation (6 คะแนน)

คะแนนเต็ม	คำถาม	คำตอบ	คะแนนที่ได้
1	วันนี้ วันอะไรของสัปดาห์ (จันทร์ อังคาร พุธ พฤหัส ฯลฯ)	_____	_____
1	วันนี้ วันที่เท่าไร	_____	_____
1	เดือนนี้ เดือนอะไร	_____	_____
1	ขณะนี้เป็นช่วง (ตอน) ไหนของวัน (เช้า เที่ยง บ่าย เย็น)	_____	_____
1	ที่นี่ที่ไหน (บริเวณที่ตรวจ)	_____	_____
1	คนที่เห็นในภาพนี้มีอาชีพอะไร	_____	_____



2. Registration (3 คะแนน)

คะแนนเต็ม	คำถาม	คำตอบ	คะแนนที่ได้
3	ผู้ทดสอบบอกชื่อของ 3 อย่าง โดยพูดห่างกันครั้งละ 1 วินาที (ต้น ไม้ รถยนต์ มือ) เพียงครั้งเดียว แล้วจึงให้ผู้ถูกทดสอบบอกให้ครบตามที่ผู้ทดสอบบอกในครั้งแรก ให้ 1 คะแนน ในแต่ละคำตอบที่ตอบถูก * หมายเหตุ หลังจากให้คะแนนแล้วให้บอกซ้ำ จนผู้ถูกทดสอบจำได้ทั้ง 3 อย่าง และบอกให้ผู้ถูกทดสอบทราบว่าสักครู่จะกลับมาถามใหม่	_____ _____ _____	_____ _____ _____

3. Attention (5 คะแนน)

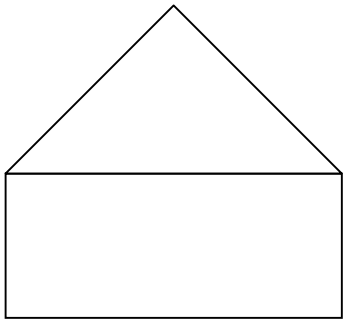
คะแนนเต็ม	คำถาม	คำตอบ	คะแนนที่ได้
	ให้บอกวันอาทิตย์–วันเสาร์ ย้อนหลังให้ครบสัปดาห์ (ให้บอกซ้ำได้ 1 ครั้ง)		
1	ศุกร์	_____	_____
1	พฤหัสบดี	_____	_____
1	พุธ	_____	_____
1	อังคาร	_____	_____
1	จันทร์	_____	_____

4. Calculation (3 คะแนน)

คะแนนเต็ม	คำถาม	คำตอบ	คะแนนที่ได้
	ให้คำนวณ 100-7 ไปเรื่อยๆ 3 ครั้ง(ให้ 1 คะแนน ในแต่ละครั้งที่ตอบถูกใช้เวลาคิดในแต่ละช่วงคำตอบไม่เกิน1นาทีหลังจากจบคำถาม) ถ้าผู้ถูกทดสอบไม่ตอบคำถามที่ 1 ให้ตั้งเลข 93-7 ลองทำในการคำนวณครั้งต่อไป และ86-7 ในครั้งสุดท้าย		
1	100-7	_____	_____
1	93-7	_____	_____
1	86-7	_____	_____

5. Language (10 คะแนน)

คะแนนเต็ม	คำถาม	คำตอบ	คะแนนที่ได้
1	ผู้ทดสอบชี้ไปที่นาฬิกาข้อมือ แล้วถามผู้ถูกทดสอบว่า โดยทั่วไป “เราเรียกสิ่งนี้ว่าอะไร” (นาฬิกา)	_____	_____
1	ผู้ทดสอบชี้ไปที่เสื้อของตนเอง แล้วถามผู้ถูกทดสอบว่า โดยทั่วไป “เราเรียกสิ่งนี้ว่าอะไร (เสื้อ, ผ้า)	_____	_____
1	ผู้ทดสอบถามผู้ถูกทดสอบว่า จงฟังประโยคต่อไปนี้ให้ดี แล้วจำไว้ จากนั้นให้พูดตาม “ยายพาหลานไปซื้อขนมที่ตลาด”		
	จงทำตามคำสั่งต่อไปนี้ (มี 3 ขั้นตอนคำสั่ง) ให้ผู้ทดสอบพูดต่อกันไปให้ครบประโยคทั้ง 3 ขั้นตอน ให้คะแนนขั้นตอนละ 1 คะแนน	_____	_____
	(ใช้กระดาษเปล่าแผ่นหลังสุดให้ผู้ถูกทดสอบทำ)		
1	หยิบกระดาษด้วยมือขวา		
1	พับกระดาษเป็นครึ่งแผ่น	_____	_____
1	แล้วส่งกระดาษให้ผู้ตรวจ	_____	_____
1	ให้ผู้ถูกทดสอบอ่านแล้วทำตาม “หลับตา”	_____	_____
	(มีแผ่นป้ายข้อความดังกล่าวให้อ่านอยู่ในแบบทดสอบหน้าต่อไป)		
2	จงวาดภาพต่อไปนี้ให้เหมือนตัวอย่างมากที่สุด เท่าที่ท่านจะสามารถทำได้	_____	_____
	(ให้ผู้ถูกทดสอบดูตัวอย่างตลอดเวลาที่วาด)		
1	กล้วยกับส้มเหมือนกัน คือเป็นผลไม้	_____	_____
	แมวกับสุนัขเหมือนกัน คือ.....		
	(เป็นสัตว์, เป็นสิ่งมีชีวิต)	_____	_____



“ หลับตา ”

6. Recall (3 คะแนน)

คะแนนเต็ม	คำถาม	คำตอบ	คะแนนที่ได้
	สิ่งของ 3 อย่างที่บอกให้จำเมื่อสักครู่ มีอะไรบ้าง		
1	ต้นไม้	_____	_____
1	รถยนต์	_____	_____
1	มือ	_____	_____

คะแนนเต็ม 30 คะแนน

คะแนนรวมที่ได้.....คะแนน

ชื่อผู้ตรวจ.....

เครื่องมือที่ใช้ในการวิจัย

เลขที่แบบสอบถาม ☒ ☒ ☒

สถานที่.....

วันที่.....

ความสัมพันธ์ระหว่าง ความหวัง การสนับสนุนทางสังคม
และคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง

.....

<u>คำชี้แจง</u> : แบบสัมภาษณ์นี้ ประกอบด้วย 4 ส่วน ได้แก่

ส่วนที่ 1	แบบบันทึกข้อมูลส่วนบุคคลของผู้สูงอายุโรคหลอดเลือดสมอง	จำนวน 7 ข้อ
ส่วนที่ 2	แบบวัดความหวังของผู้สูงอายุโรคหลอดเลือดสมอง	จำนวน 12 ข้อ
ส่วนที่ 3	แบบวัดการสนับสนุนทางสังคมของผู้สูงอายุโรคหลอดเลือดสมอง	จำนวน 7 ข้อ
ส่วนที่ 4	แบบวัดคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง	จำนวน 26 ข้อ

ส่วนที่ 1 แบบบันทึกข้อมูลส่วนบุคคลของผู้สูงอายุโรคหลอดเลือดสมอง

<u>คำชี้แจง</u> : ผู้สัมภาษณ์ทำการสัมภาษณ์ผู้สูงอายุโรคหลอดเลือดสมองเกี่ยวกับข้อมูลส่วนบุคคล ตามข้อคำถามที่กำหนดไว้ต่อไปนี้ สำหรับผู้วิจัย

1. เพศ ( ) 1. ชาย ( ) 2. หญิง 4 ☒

2. อายุ.....ปี 5 ☒☒

3. สถานภาพสมรส
( ) 1. โสด
( ) 2. คู่ 6 ☒
( ) 3. ม่าย, หย่า, แยกกันอยู่

4. ระดับการศึกษา
( ) 1. ไม่ได้เรียนหนังสือ
( ) 2. ประถมศึกษาตอนต้น 7 ☒
( ) 3. ประถมศึกษาตอนปลาย
( ) 4. มัธยมศึกษาตอนต้น
( ) 5. มัธยมศึกษาตอนปลาย
( ) 6. อนุปริญญา
( ) 7. ปริญญาตรี/เทียบเท่า
( ) 8. ปริญญาโท/สูงกว่า

5. รายได้ปัจจุบันของท่าน.....บาทต่อเดือน 8 ☒

6. ลักษณะครอบครัวของท่าน
( ) 1. ครอบครัวเดี่ยว (ประกอบด้วยตัวท่าน, คู่สมรส, บุตร รวมทั้งหมด.....คน) 9 ☒
( ) 2. ครอบครัวขยาย (ประกอบด้วยตัวท่าน, คู่สมรส, บุตร และครอบครัวบุตร หรือ ญาติพี่น้อง รวมทั้งหมด.....คน)

7. ระยะเวลาการเจ็บป่วยด้วยโรคหลอดเลือดสมอง.....ปี.....เดือน 10 ☒

ส่วนที่ 2 แบบวัดความหวังของผู้สูงอายุโรคหลอดเลือดสมอง

<u>คำชี้แจง</u> : เมื่อท่านฟังข้อความต่อไปนี้แล้ว ให้ท่านบอกถึงระดับความรู้สึกของท่าน ว่าเห็นด้วย หรือไม่เห็นด้วยโดยคำตอบที่ได้จะไม่มีถูกหรือผิด โปรดพิจารณาแต่ละข้อความก่อนตอบโดยการเลือกตอบให้ถือเกณฑ์ ดังนี้

เห็นด้วยอย่างยิ่ง หมายถึง ผู้ตอบรู้สึกเห็นด้วยอย่างยิ่งกับข้อความในประโยค
เห็นด้วย หมายถึง ผู้ตอบรู้สึกเห็นด้วยกับข้อความในประโยค
ไม่เห็นด้วย หมายถึง ผู้ตอบรู้สึกไม่เห็นด้วยกับข้อความในประโยค
ไม่เห็นด้วยอย่างยิ่ง หมายถึง ผู้ตอบรู้สึกไม่เห็นอย่างยิ่งด้วยกับข้อความในประโยค

ข้อความ	ระดับความรู้สึก			
	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
1. ท่านจะมีชีวิตที่ดีในอนาคต				
2. ท่านมีจุดมุ่งหมายในชีวิต ทั้งในระยะสั้น ระยะกลาง และ/หรือในระยะยาว				
. .				
. .				
. .				
. .				
. .				
11. ท่านเชื่อว่าในแต่ละวันที่ผ่านไปจะมีสิ่งดีๆ เกิดขึ้น				
12. ท่านรู้สึกว่ามีชีวิตยังมีคุณค่าและมีความหมาย				

ส่วนที่ 3 แบบวัดการสนับสนุนทางสังคมของผู้สูงอายุโรคหลอดเลือดสมอง

<u>คำชี้แจง</u> : แบบวัดนี้มีวัตถุประสงค์เพื่อสัมภาษณ์ถึงความช่วยเหลือที่ท่านได้รับจากสมาชิกในครอบครัว (ได้แก่ สามี ภรรยา บุตรหลาน ญาติพี่น้อง) โปรดพิจารณาแต่ละข้อความก่อนตอบโดยการเลือกตอบให้ถือเกณฑ์ ดังนี้

ไม่ได้รับเลย	หมายถึง	ข้อความนั้นท่านไม่ได้รับการช่วยเหลือ
ได้รับเล็กน้อย	หมายถึง	ข้อความนั้นท่านได้รับการช่วยเหลือเล็กน้อย
ได้รับบ้างบางครั้ง	หมายถึง	ข้อความนั้นท่านได้รับการช่วยเหลือเป็นครั้งคราว
ได้รับค่อนข้างมาก	หมายถึง	ข้อความนั้นท่านได้รับการช่วยเหลือค่อนข้างมาก
ได้รับมากที่สุด	หมายถึง	ข้อความนั้นท่านได้รับการช่วยเหลือมากที่สุด

ข้อความ	ไม่ได้รับเลย	ได้รับเล็กน้อย	ได้รับบ้างบางครั้ง	ได้รับค่อนข้างมาก	ได้รับมากที่สุด
1.ให้คำแนะนำและแนวทางการปฏิบัติตัวที่เป็นประโยชน์					
2.ให้ความมั่นใจว่าเขาจะอยู่ช่วยเหลือเมื่อท่านต้องการ					
. .					
. .					
. .					
6.ให้ความช่วยเหลือเมื่อท่านต้องการเงินหรือต้องการความช่วยเหลือที่รีบด่วน					
7.ให้ความช่วยเหลือในการทำกิจวัตรประจำวัน					

ส่วนที่ 4 แบบวัดคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง

<u>คำชี้แจง</u> :แบบวัดนี้มีวัตถุประสงค์เพื่อสัมภาษณ์ ประสบการณ์ของบุคคลถึงสภาวะของตนในด้านร่างกาย ด้านจิตใจ ด้านระดับความเป็นอิสระไม่ต้องพึ่งพา ด้านความสัมพันธ์ทางสังคม ด้านสิ่งแวดล้อม และด้านความเชื่อส่วนบุคคล ภายใต้วัฒนธรรม ค่านิยมและเป้าหมายในชีวิตของแต่ละบุคคลในช่วง 2 สัปดาห์ที่ผ่านมา โดยให้ท่านสำรวจตัวท่านเอง คำตอบของท่านไม่มีถูกหรือผิด จึงขอให้ท่านตอบโดยคำนึงถึงการกระทำกิจกรรมต่างๆ ตามที่เป็นจริงมากที่สุด โปรดพิจารณาแต่ละข้อความก่อนตอบโดยการเลือกตอบให้ถือเกณฑ์ดังนี้

มากที่สุด	หมายถึง	ท่านมีความรู้สึกเช่นนั้นเสมอ รู้สึกเช่นนั้นมากที่สุด หรือรู้สึกพอใจมาก
มาก	หมายถึง	ท่านมีความรู้สึกเช่นนั้นบ่อยๆ รู้สึกพอใจหรือรู้สึกดี
ปานกลาง	หมายถึง	ท่านมีความรู้สึกเช่นนั้นปานกลาง รู้สึกพอใจระดับกลางๆ หรือรู้สึกไม่พอใจระดับกลางๆ
เล็กน้อย	หมายถึง	ท่านมีความรู้สึกเช่นนั้นนานๆ ครั้ง รู้สึกเช่นนั้นเล็กน้อย รู้สึกไม่พอใจ
ไม่เลย	หมายถึง	ท่านไม่มีความรู้สึกเช่นนั้นเลย รู้สึกไม่พอใจมาก

ในช่วง 2 สัปดาห์ที่ผ่านมา	มากที่สุด	มาก	ปานกลาง	เล็กน้อย	ไม่เลย
1.ท่านพอใจกับสุขภาพของท่านในตอนนี้					
2.การเจ็บปวดตามร่างกาย เช่น ปวดหัว ปวดท้อง ปวดตามตัว ทำให้ท่านไม่สามารถทำในสิ่งที่ต้องการ					
. .					
. .					
24.ท่านสามารถไปไหนมาไหนได้ด้วยตนเอง					
25.ท่านพอใจในชีวิตทางเพศของท่าน					
26.ท่านคิดว่าชีวิตความเป็นอยู่ อยู่ในระดับดี					

APPENDIX B

Consent From

คำชี้แจงและพิทักษ์สิทธิ์กลุ่มตัวอย่าง

ดิฉันชื่อนางสาวสุจรรยา โลหาชีวะ เป็นนักศึกษาปริญญาโท สาขาสุขภาพจิตและการพยาบาลจิตเวชศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล ขณะนี้ดิฉันกำลังทำวิทยานิพนธ์เรื่อง “ความสัมพันธ์ระหว่าง ความหวัง การสนับสนุนทางสังคม และคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง” โดยมีวัตถุประสงค์เพื่อศึกษาความสัมพันธ์ระหว่าง ความหวัง การสนับสนุนทางสังคม และคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง ทั้งนี้ผลการศึกษาที่ได้จะเป็นข้อมูลพื้นฐานในการส่งเสริม ป้องกัน ฟื้นฟูสภาพจิตและคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมองเพื่อให้สามารถดำรงชีวิตต่อไปอย่างผาสุก

หากท่านยินดีที่จะเข้าร่วมในการวิจัยครั้งนี้ กรุณาตอบคำถามตามแบบสัมภาษณ์ที่ผู้วิจัยได้เตรียมไว้ ซึ่งจะใช้เวลาประมาณ 45-60 นาที ทั้งนี้ข้อมูลต่างๆ ที่ได้จากการสัมภาษณ์ จะถูกเก็บไว้เป็นความลับ โดยจะแสดงให้ผู้อื่นทราบเป็นภาพรวมของการวิจัยเท่านั้น

อย่างไรก็ดีท่านมีสิทธิที่จะตอบรับหรือปฏิเสธการเข้าร่วมในการวิจัยครั้งนี้ได้ และถึงแม้ท่านจะตัดสินใจเข้าร่วมแล้วแต่หากต้องการยุติการให้สัมภาษณ์ ท่านสามารถกระทำได้โดยจะไม่เกิดผลใดๆ ต่อท่านทั้งสิ้น

ขอขอบพระคุณเป็นอย่างสูง ที่ท่านให้ความกรุณาเข้าร่วมในการวิจัยครั้งนี้

สุจรรยา โลหาชีวะ

ผู้วิจัย

เอกสารยินยอมเข้าร่วมการวิจัย

การวิจัยเรื่อง “ความสัมพันธ์ระหว่างความหวัง การสนับสนุนทางสังคมและคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง”

วันให้คำยินยอม วันที่..... เดือน..... พ.ศ. .....

ก่อนที่จะลงนามในใบยินยอมให้ทำการวิจัยนี้ ข้าพเจ้าได้รับการอธิบายจากผู้วิจัยถึงวัตถุประสงค์ของการวิจัย วิธีการวิจัย รวมทั้งประโยชน์ที่จะเกิดขึ้นจากการวิจัยอย่างละเอียด และมีความเข้าใจดีแล้ว

ผู้วิจัยรับรองว่าจะตอบคำถามต่างๆ ที่ข้าพเจ้าสงสัยด้วยความเต็มใจ ไม่ปิดบัง ซ่อนเร้น จนข้าพเจ้าพอใจ

ข้าพเจ้ามีสิทธิที่จะบอกเลิกการเข้าร่วมในโครงการวิจัยนี้เมื่อใดก็ได้ และเข้าร่วมโครงการวิจัยนี้โดยสมัครใจและการบอกเลิกการเข้าร่วมการวิจัยนี้ จะไม่มีผลต่อการรักษาโรคที่ข้าพเจ้าจะพึงได้รับต่อไป

ผู้วิจัยรับรองว่าจะเก็บข้อมูลเฉพาะเกี่ยวกับตัวข้าพเจ้าเป็นความลับ และจะเปิดเผยได้เฉพาะในรูปที่เป็นสรุปผลการวิจัย การเปิดเผยข้อมูลเกี่ยวกับตัวข้าพเจ้าต่อหน่วยงานต่างๆ ที่เกี่ยวข้อง กระทำได้เฉพาะกรณีที่จำเป็นด้วยเหตุผลทางวิชาการเท่านั้น

ผู้วิจัยรับรองว่าหากมีข้อมูลเพิ่มเติมที่ส่งผลกระทบต่อการวิจัย ข้าพเจ้าจะได้รับการแจ้งให้ทราบโดยไม่ปิดบัง ซ่อนเร้น

ข้าพเจ้าได้อ่านข้อความข้างต้นแล้ว และมีความเข้าใจดีทุกประการ และได้ลงนามในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม ..... ผู้ยินยอม

ข้าพเจ้าไม่สามารถอ่านหนังสือได้ แต่ผู้วิจัยได้อ่านข้อความในใบยินยอมนี้ให้แก่ข้าพเจ้าฟังจนเข้าใจดีแล้ว ข้าพเจ้าจึงลงนาม หรือประทับลายนิ้วมือของข้าพเจ้าในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม ..... ผู้ยินยอม

(หรือประทับลายนิ้วมือ)

APPENDIX C

Permission Letters for Data Collection

ที่ สธ 0313/

สถาบันประสาทวิทยา
312 ถนนราชวิถี ราชเทวี
กรุงเทพฯ 10400

๒๑ กรกฎาคม 2547

เรื่อง อนุมัติให้ดำเนินการวิจัยในสถาบันประสาทวิทยา

เรียน คณบดีคณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

ตามหนังสือ ที่ ศธ 0517.05(พย.ม.)/231 ลงวันที่ 26 เมษายน 2547 เรื่อง ความหวัง พฤติกรรมการดูแลตนเองด้านสุขภาพจิต และคุณภาพชีวิตของผู้สูงอายุโรคหลอดเลือดสมอง ของ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล ได้ขอความอนุเคราะห์ทางสถาบันประสาทวิทยา ให้ นางสาวสุจรรยา โลหาชีวะ ทำการวิจัยในสถาบันประสาทวิทยานั้น

ในการนี้สถาบันประสาทวิทยา โดยคณะอนุกรรมการวิจัยได้พิจารณาแล้ว มีมติอนุมัติ ให้ดำเนินการดังกล่าวได้ จึงขอส่งใบรับรองการอนุมัติดังกล่าว เพื่อโปรดจัดส่งให้ผู้วิจัยต่อไป

จึงเรียนมาเพื่อโปรดทราบ และพิจารณาดำเนินการต่อไป

ขอแสดงความนับถือ

(นายมัยธัช สามเสน)
ผู้อำนวยการสถาบันประสาทวิทยา

- ทราบ
- ฝ่ายเกี่ยวข้อง Major advisor
- เรื่องส่ง มคร. เพื่อทราบ

กลุ่มวิจัยและพัฒนา
โทร.0-2354-7076 ต่อ 2176, 2402
โทรสาร 0-2354-7085 ต่อ 2402

6 ส.ค. 2547

APPENDIX D

More Results

สรุปผลการวิจัย

1. **ความหวัง** เรียงตามลำดับตามความมากน้อยของจำนวนในรายด้าน

1.1. ความหวังด้านความรู้สึกภายในที่เกิดขึ้นชั่วคราวและในอนาคต

ข้อ	ข้อความ	ค่าเฉลี่ย
4	ท่านมองเห็นแสงสว่างท่ามกลาง ความทุกข์ยากของชีวิต	3.16
11	ท่านเชื่อว่าในแต่ละวันที่ผ่านไปจะมีสิ่งดีๆ เกิดขึ้น	3.00
6	ท่านกลัวชีวิตในอนาคตข้างหน้า	2.71
1	ท่านจะมีชีวิตที่ดีในอนาคต	2.39

1.2. ความหวังด้านความรู้สึกพร้อมภายในและความคาดหวังทางบวก

ข้อ	ข้อความ	ค่าเฉลี่ย
7	ท่านยังนึกถึงความสุขในชีวิตที่ผ่านมาได้	3.21
8	ท่านมีจิตใจที่เข้มแข็ง	3.11
2	ท่านมีจุดมุ่งหมายในชีวิตทั้งในระยะสั้น ระยะกลาง และ/หรือในระยะยาว	2.12
10	ท่านมีแผนการกระทำเพื่อให้บรรลุเป้าหมายในชีวิต	1.99

1.3. ความหวังด้านความสัมพันธ์ระหว่างตนเองและบุคคลอื่น

ข้อ	ข้อความ	ค่าเฉลี่ย
5	ความศรัทธาในบางสิ่งทำให้ท่าน รู้สึกสบายใจ	3.31
3	ท่านรู้สึกเหมือนอยู่ตัวคนเดียวในโลก	3.26
9	ท่านสามารถให้และรับความรัก และความเอื้ออาทรกับบุคคลอื่น	3.25
12	ท่านรู้สึกว่ามีชีวิตยังมีคุณค่า และมีความหมาย	3.14

2. **การสนับสนุนทางสังคม** เรียงตามลำดับตามความมากน้อยของจำนวนในรายด้าน

2.1. การสนับสนุนทางสังคมด้านข้อมูลข่าวสาร

ข้อ	ข้อความ	ค่าเฉลี่ย
1	ให้คำแนะนำและแนวทางการปฏิบัติ ตัวที่เป็นประโยชน์	2.28

2.2. การสนับสนุนทางสังคมด้านอารมณ์

ข้อ	ข้อความ	ค่าเฉลี่ย
4	ให้ความสนใจ เอาใจใส่ใน ทุกข์สุข	2.52
2	ให้ความมั่นใจว่าเขาจะอยู่ช่วยเหลือ เมื่อท่านต้องการ	2.60
3	ช่วยให้ท่านมีขวัญและกำลังใจ เมื่อท้อแท้	2.42
5	ท่านรู้สึกว่าท่านสามารถให้ความไว้วางใจ สามารถปรับทุกข์บอกความในใจได้	1.98

2.3. การสนับสนุนทางสังคมด้านรูปธรรม

ข้อ	ข้อความ	ค่าเฉลี่ย
7	ให้ความช่วยเหลือในการทำกิจวัตรประจำวัน	2.94
6	ให้ความช่วยเหลือเมื่อท่านต้องการเงินหรือต้องการความช่วยเหลือที่รีบด่วน	2.57

3. **คุณภาพชีวิต** เรียงตามลำดับตามความมากน้อยของจำนวนในรายด้าน

3.1. คุณภาพชีวิตด้านร่างกาย

ข้อ	ข้อความ	ค่าเฉลี่ย
24	ท่านสามารถไปไหนมาไหน ได้ด้วยตนเอง	3.24
10	ท่านรู้สึกพอใจที่สามารถทำอะไรๆ ผ่านไปได้ในแต่ละวัน	3.14
12	ท่านพอใจกับความสามารถในการทำงานได้อย่างที่เคยทำ	2.96
4	ท่านพอใจกับการนอนหลับของท่าน	2.91
2	การเจ็บปวดตามร่างกาย เช่น ปวดหัว ปวดท้อง ปวดตามตัว ทำให้ท่านไม่สามารถทำในสิ่งที่ต้องการ	2.88
3	ท่านมีกำลังเพียงพอที่จะทำสิ่งต่างๆ ในแต่ละวัน(ทั้งเรื่องงาน หรือการดำเนินชีวิตประจำวัน)	2.79
1	ท่านพอใจกับสุขภาพของท่านในตอนนี้	2.56
11	ท่านจำเป็นต้องไปรับการรักษาพยาบาลเพื่อที่จะทำงานหรือมีชีวิตอยู่ไปได้ในแต่ละวัน	2.56

3.2. คุณภาพชีวิตด้านจิตใจ

ข้อ	ข้อความ	ค่าเฉลี่ย
9	ท่านมีความรู้สึกไม่ดี เช่น รู้สึกเหงา เศร้า หดหู่ สิ้นหวัง วิตกกังวล	3.73
23	ท่านรู้สึกว่าชีวิตของท่านมีความหมาย	3.48
5	ท่านรู้สึกพึงพอใจในชีวิต (เช่นมีความสุข ความสงบ มีความหวัง)	3.19
7	ท่านรู้สึกพอใจในตนเอง	2.96
8	ท่านยอมรับรูปร่างหน้าตาของตนเอง	2.85
6	ท่านมีสมาธิในการทำงานต่างๆ ดี	2.78

3.3. คุณภาพชีวิตด้านสัมพันธภาพทางสังคม

ข้อ	ข้อความ	ค่าเฉลี่ย
13	เท่าที่ผ่านมาท่านพอใจกับการผูกมิตร หรือเข้ากับคนอื่น	3.85
14	ท่านพอใจกับการช่วยเหลือที่เคยได้รับจากเพื่อนๆ	3.80
26	ท่านคิดว่าชีวิตความเป็นอยู่ อยู่ในระดับดี	3.23
25	ท่านพอใจในชีวิตทางเพศของท่าน	2.98

3.4. คุณภาพชีวิตด้านสิ่งแวดล้อม

ข้อ	ข้อความ	ค่าเฉลี่ย
16	ท่านพอใจกับสภาพบ้านเรือน ที่อยู่ตอนนี้	4.08
18	ท่านพอใจที่จะสามารถไปใช้บริการสาธารณสุขได้ตามความจำเป็น	3.89
17	ท่านมีเงินพอใช้จ่ายตามความจำเป็น	3.87
19	ท่านได้รู้เรื่องราวข่าวสารที่จำเป็นในชีวิตแต่ละวัน	3.75
15	ท่านรู้สึกว่าชีวิตมีความมั่นคง ปลอดภัย	3.74
21	สภาพแวดล้อมดีต่อสุขภาพของท่าน	3.69
22	ท่านพอใจกับการเดินทาง(การคมนาคม) ของท่าน	3.29
20	ท่านมีโอกาสได้พักผ่อนคลายเครียด	2.96

BIOGRAPHY

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