The Influence of Basic Conditioning Factors and Self-Care Agency on Self-Care Behaviors in Thais with Hypertension

Ladda Saleema, Orasa Panpakdee, Manee Arpanantikul, Teeradej Chai-Aroon

Abstract: Individuals with uncontrolled hypertension have a high risk for heart disease, stroke, and renal diseases. Self-care behavior is important for hypertension control. This study aimed to test the Self-Care Deficit Nursing Theory by exploring the pattern of relationship among basic conditioning factors, self-care agencies, and self-care behaviors regarding hypertension control. The participants consisted of 402 people with hypertension who received treatment at outpatient medical clinics of three regional hospitals in the central part of Thailand. In addition to the Demographic and Health Information Sheet, the Chronic Illness Resources Survey, the Revised Illness Perceptions Questionnaire, the Knowledge of Self-Care Demands Questionnaire, and the Self-Care Behavior Questionnaire were used for data collection. The data were analyzed using Structural Equation Modelling.

Results showed that the modified hypothesized model of self-care behaviors for hypertension controls fitted with the empirical data and explained 49% of variance in the self-care behaviors regarding hypertension control. Patient-provider communication had positive direct and indirect effects on self-care behaviors for hypertension control through knowledge about hypertension, knowledge about self-care demands, and perception about hypertension.

The results supported the Self-Care Deficit Nursing Theory regarding the influence of basic conditioning factors on self-care agency. They provide evidence for the development of a nursing intervention program to promote patient-provider communication for helping individuals with hypertension to increase self-care behaviors regarding hypertension control.


Keywords: Hypertension, Knowledge, Patient-provider communication, Perception, Self-care behaviors, Self-Care Deficit Nursing Theory, Theory testing

Introduction

Uncontrolled hypertension is a major global health problem and a cause of cardiovascular disease, which is a leading cause of death worldwide.1 Less than half of people with hypertension successfully control their hypertension.1 Approximately 3.5 million people aged ≥60 years have hypertension.2 The number

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of people with hypertension, people with the disease related to hypertension (e.g., stroke, heart disease), and hospitalized people with hypertension increase in each year. Only one-seventh of Thai males, and one-fourth of Thai females within the country succeed in controlling their blood pressure to within normal limits. People with hypertension cannot control their blood pressure if they do not regularly practice self-care by medication taking and lifestyle modification. These self-care behaviors take time and much effort, and most people cannot sustain these behaviors over a long period. A systematic review and a meta-analysis showed that previous interventions were effective in increasing self-care behaviors for hypertension control. However, most of the interventions were based on social cognitive learning theory such as the Health Belief Model, Self-efficacy construct, or Self-Regulation Theory. Even though Orem’s Self-Care Theory placed an emphasis on self-care, it is rarely used to guide intervention research, since it is very abstract. We argue that the middle range theory, which is derived from Orem’s Self-Care Theory, is needed to guide interventions because the concepts of the theory are relevant with the concepts used in this study. Thus, the purpose of this study was to develop middle theory from Orem’s Self-Care Theory, which specifies the pattern of relationships among the relevant concepts when predicting self-care behaviors among people with hypertension. The study not only provides the benefits of guiding the intervention but also in the expansion of nursing science in explaining how each concept influence self-care.

Conceptual Framework and Literature Review

In Self-Care Deficit Nursing Theory (SCDNT), Orem proposes relationships among the four major concepts namely; self-care, self-care agency, self-care demands, and nursing agency as well as one peripheral concept, basic conditioning factors.

Self-care is practicing an activity in which people initiate and undertake themselves in order to maintain life, health, and well-being. Self-care is a series of complex deliberate actions with the intention of achieving a specific goal and seeking results, which are determined before performing the actions. Self-care agency is the ability of a person to know and to perform self-care actions to meet self-care demands. Self-care agency consists of many levels; foundational capabilities and dispositions, ten power components and operational capabilities. Operational capabilities involve the ability to perform deliberate actions, which includes estimative, transitional, and productive operation. Estimative operation is seeking knowledge and understanding about a situation and what should be done to control that situation. Transitional operation is making a decision about self-care and productive operation is actions for meeting self-care demands, monitoring self-care practice (i.e., actions, results, effects), and decisions about subsequence actions. People can make a decision (transitional operation) to begin and maintain self-care actions (productive operation) if they have success in their self-investigation about their self-care (estimative operation). According to Orem, self-care requires learning and the use of knowledge. Knowledge includes both scientific and commonsense knowledge. People use scientific and commonsense knowledge along the state of deliberate action of self-care. However, most studies related to self-care of people with hypertension are focused on scientific knowledge but not include perception. Perception is formed based on knowledge receiving from health-care providers and other sources such as family, media, friend, and illness experience of a person. A person uses perception to making decision about self-care. In psychology theories, perception of illness influenced personal behaviors in responding to a health threat such as following with the treatment regimens.

Knowledge about hypertension and self-care demands, and perception about hypertension are
important self-care agency of people with hypertension. Previous studies supported the relationships between self-care behaviors for hypertension control and other factors, including knowledge about hypertension,\textsuperscript{14-16} knowledge about self-care demands\textsuperscript{17}, and perceptions about hypertension,\textsuperscript{12,18-20}

The basic conditioning factors are personal conditions and circumstances which affect self-care demands and self-care agency or self-care behaviors. Basic conditioning factors are related to age, gender, developmental state, state of health, socio-cultural orientation, healthcare system factors, family system factors, patterns of living, environmental factors, and resource availability and adequacy.\textsuperscript{11} An understanding is required of the types of specific basic conditioning factors and their patterns of relationships affecting person’s self-care behaviors and health status. In addition, people with hypertension live with the disease over a long period, do daily activities with their family, and communicate with healthcare providers about treatments and self-care. Therefore, the duration of hypertension, family support, and patient–provider communications are the basic conditioning factors that affect their self-care behavior. Patient–provider communication, duration of hypertension, and family support are health-care system factors, health state, and family system factors, respectively. Previous evidence supports the relationships between self-care behaviors for hypertension control and the basic conditioning factors, including patient–provider communication,\textsuperscript{18,21,22} duration of hypertension,\textsuperscript{23,24} and family support.\textsuperscript{14,25} However, how all aforementioned factors work to influence self-care behaviors is not known. Thus this study aimed to develop a causal model, to specify the pattern of relationships among the basic conditioning factors (patient–provider communication, duration of hypertension duration, and family support), self-care agency (knowledge about hypertension, knowledge about self-care demands, and perception about hypertension), and self-care behaviors for hypertension control. The hypothesized model is shown in Figure 1.

![Figure 1 The hypothesized model of factors influencing self-care behaviors for hypertension control](image-url)
Methods

Design: A descriptive cross-sectional design was used.

Participants and setting: Data were collected from people with hypertension who received treatment at outpatient medical clinics at three regional hospitals in the central part of Thailand. These hospitals provide specialized tertiary care for patients with complex health problems. Inclusion criteria for the sample was: aged >18 years; having been diagnosed with essential hypertension for at least one year; receiving antihypertensive medication; not being dependent on others for care, understanding the Thai language, and having normal cognitive and movement function. Participants aged ≥60 years were screened for cognitive function using the Short Portable Mental Status questionnaire because approximately 12.3% of Thai people aged ≥60 years have dementia. The cutoff point to indicate normal cognitive function was the score at least eight out of ten. Exclusion criteria were people with diabetes or severe complications of hypertension such as having suffered from a severe stroke or on dialysis.

Sample size: There are approximately 100,000 people with hypertension who receive treatment in the regional hospitals in the central part of Thailand. Based on Yamane’s formula, and for an alpha of .05, at least 398 people with hypertension were required for the study. Purposive sampling was used in this study.

Ethical considerations: The research proposal was approved by the Institutional Review Board of Mahidol University and the hospitals used as study sites. Prior to data collection, the researcher explained objectives, procedures, protection of confidentiality and the right to refuse or withdraw from the study to the potential participants. The confidentiality of the participants was protected by avoiding writing the participants’ names on the questionnaires, presenting the results as a whole. All participants who were willing to participate in the study gave informed consent.

Instruments: Data were obtained using 5 questionnaires as follows:

The Demographic and Health Information Sheet (DHIS) was developed by the researchers for collecting personal and health information such as: age, gender, marital status, education, career, income, living with family, history of hypertension in family, body weight, history of smoking and alcohol consumption, and history of any comorbidities.

The Chronic Illness Resources Survey (CIRS) was developed by Glasgow for measuring social support. The Family subscale and the Physician and Healthcare Team subscale of the CIRS were used for measuring family support and patient-provider communication, respectively. Both subscales were translated into Thai using the back translation process. The questionnaire was translated from English into Thai by the researchers’ advisors. The translated Thai version was back-translated from Thai into English by two Thai nursing instructors who were bilingual. They did not get access to the source of the questionnaires. The back–translated version and the original version were compared for any discrepancies in translation and relevancy to the Thai culture by the dissertation’s major advisor and three nursing instructors. The Family subscale of the CIRS consists of 7 items for measuring family support. The response is scored using the five-level Likert scale ranging from 1 (not at all) to 5 (a great deal). The total score ranges from 7 to 35. The higher score indicates higher support received from family members. The mean score of the variable was equally classified to three intervals which indicated “mild” (the interval of the low possible score), “moderate” (the interval of the middle possible score) and “high” (the interval of the high possible score) levels. The range of the total score from 7 to 16.3, 16.4 to 25.7, and 25.8 to 35 indicated “mild”, “moderate”, and “high” support received from family members, respectively. An example item is “Have your family exercised with you?”
The Physician and Healthcare Team subscale of the CIRS contains 6 items for measuring the perception of support which a person received from a physician and health care team in the past three months. The response is scored using a five-level Likert scale ranging from 1 (not at all) to 5 (a great deal). The total score ranges from 6 to 30. A higher score indicates a higher quality of provider communication. The range of the total score from 6 to 14, 14.1 to 22, and 22.1 to 30 indicates “mild”, “moderate”, and “high” quality of provider communication, respectively. An example item is “Has your doctor or other health advisors (nurse, dietician) clearly explained what you need to do to manage your illness?”

The Revised Illness Perceptions Questionnaire (IPQ-R) was developed by Moss–Morris et al. for measuring perceptions about hypertension. The Thai version IPQ-R was translated by Sriprasong. The IPQ-R consists of 37 items and 7 subscales, including timeline (acute/chronic), consequences, timeline (cyclical), controllability by person, controllability by treatment, understanding about illness, and emotional representation. The participants responded on the five-level Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The negative item scores were reversed before summation into the total scores. The total score ranges from 37 to 185. The higher scores indicate a cognitive view of hypertension to be threatening to personal health which is a chronic and cyclical condition, negative outcomes of illness, ability to control of illness, and understanding of a condition. The range of the total score from 37 to 86.3, 86.4 to 135.7, and 135.8 to 185 indicates “mild”, “moderate”, and “high” viewing of hypertension to be threatening to health, respectively. An example item is “Will my illness last a short time?”

The Knowledge about Self-Care Demands Questionnaire (KSCDQ) was developed by Rujiwatthanakorn for measuring the level of understanding of hypertension and self-care demands for hypertension control. The KSCDQ consists of 36 items. The response is “yes” (score = 1) or “no” (score = 0). The first part (13 items) is used for measuring knowledge about hypertension. Total scores range from 0 to 13. A higher score indicates a greater understanding about hypertension. The range of the total score from 0 to 4.3, 4.4 to 8.7, and 8.8 to 13 indicates “mild”, “moderate”, and “high” understanding about hypertension, respectively. The example item is “Do persons with hypertension have a risk for stroke more than persons with normal blood pressure?”

The second part was used for measuring knowledge about self-care demands for hypertension control. It consists of 23 items and 6 subscales, including medication-taking, dietary and body weight control, aerobic exercise, stress management, risk behavior avoidance, and self-monitoring. The response is “yes” (score = 1) or “no” (score = 0). The total score ranges from 0 to 23. Higher scores indicate greater understanding of self-care demands for hypertension control. The range of the total score from 0 to 7.7, 7.8 to 15.5, and 15.6 to 23 indicates “mild”, “moderate”, and “high” understanding of self-care demands for hypertension control, respectively. An example item is “Can persons with hypertension stop taking their drug when they feel normal and workable?”

The Self-Care Behavior Questionnaire (SCBQ) was modified from the Perceived Self-Care Efficacy Measurement (PSEM). The PSEM was developed by Panpakdee and colleagues for measuring personal confidence in practicing activities for hypertension control.
and risk avoidance. The total score ranges from 0 to 93. A higher score indicates more frequently practiced self-care for hypertension control. The range of the total score from 0 to 31, 31.1 to 62, and 62.1 to 93 indicates “mild”, “moderate”, and “high” frequently practiced self-care for hypertension control, respectively. An example item is “How often did you add salty condiments in your foods (cooked foods) in the past one month?”

A panel of 5 expert nursing instructors who were specialists in chronic illness validated the content of the Chronic Illness Resources Survey (CIRS) Thai version, the Revised Illness Perceptions Questionnaire (IPQ-R), the Knowledge about Self-Care Demands Questionnaire (KSCDQ) and the Self-Care Behavior Questionnaire (SCBQ). The content validity and the reliability of the instruments are shown in the table 1.

Table 1  The reliability coefficients of the questionnaires

<table>
<thead>
<tr>
<th>Instruments</th>
<th>Content validity index (CVI)</th>
<th>Reliability (Cronbach’s alpha)</th>
<th>This study</th>
<th>This study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This study</td>
<td></td>
<td>N=30</td>
<td>N=402</td>
</tr>
<tr>
<td>SCBQ</td>
<td>-</td>
<td>0.83</td>
<td>-</td>
<td>0.81</td>
</tr>
<tr>
<td>CIRS (family)</td>
<td>-</td>
<td>0.88</td>
<td>0.75</td>
<td>0.84</td>
</tr>
<tr>
<td>CIRS (healthcare provider)</td>
<td>-</td>
<td>0.94</td>
<td>0.91</td>
<td>0.79</td>
</tr>
<tr>
<td>IPQ-R</td>
<td>0.87</td>
<td>-</td>
<td></td>
<td>0.79</td>
</tr>
<tr>
<td>KSCDQ</td>
<td>0.97</td>
<td>-</td>
<td>0.84</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Note:  SCBQ = Self-Care Behavior Questionnaire, CIRS = Chronic Illness Resource Survey, IPQ-R = Revised Illness

**Procedure:** Data were collected after the protocol of the study was approved by the IRB committees of the investigator’s university and each hospital. Data were collected by the researcher and two research assistants between February and June, 2014. The researcher approached the participants and screened them according to the criteria. Objectives of the study and the right of human subjects were informed to the participants. The questionnaires were sent or read to the participants in sequential order, starting with the Self-Care Behaviors Questionnaire, the Chronic Illness Resource Surveys, the Revised Illness Perception Questionnaire, the Knowledge about Hypertension Questionnaire, the Knowledge about Self-Care Demands Questionnaire, and the Demographic and Health Information Sheet.

There were 450 eligible participants, and 10% (n = 45) refused to participate in answering the questionnaires because of time limitations. Finally, 402 people participated in this study. Ninety-five percent (n = 378) answered the questionnaires at an interview and 5% (n = 24) by self-administration. They each took approximately 20–30 minutes for the completion of the questionnaires.

**Data analysis:** Descriptive statistics and Pearson’s correlation were used to analyze the characteristics of the samples and variables using the Statistical Package for Social Science (SPSS) version 18. The pattern of relationships among the variables in the hypothesized model was analyzed using the Mplus program version 7.1. The assumptions for analysis using structural equation modeling were checked before data analysis. Knowledge of self-care demands did not display normal distribution. The estimation of parameters using maximum likelihood with standard errors and a mean-adjusted chi-square or MLM was selected for
increasing the robustness of the parameter estimation in the data with non-normal distribution.33

Results

Participant characteristics: Overall 402 participants with hypertension participated in the study and their age ranged from 32 to 88 years (mean = 59.87 years, SD = 9.56). The majority were female (64.4%), with a primary level education (70.4% %), married (66.9%), housekeepers (22.1%), incomes of less than 5,000 baht (38.6%), living with family (89.8%), overweight or obese (59.7%), and with a family history of hypertension (56.2%). The participants who currently smoked or drank alcohol were 4.5%, and 11.9%, respectively. Over half (56.5%) were successful in controlling their blood pressure to a level of less than 140/90 mmHg. Comorbidities with hypertension were heart diseases (6.2%), strokes (3.7%), renal diseases (1.6%), transient ischemic attacks (0.9%), and dyslipidemia (67.1%). The antihypertensive drug used was calcium channel blockers (21.4%), β-blocker (13.7%), angiotensin converting enzyme inhibitors (12.9%), and antilipidemic agents (23.6%).

Study variables’ characteristics: The participants perceived healthcare providers as having a moderate quality of communication. The duration of their hypertension ranged from 1 to 46 years (mean = 7.3, SD = 5.4) and they received moderate support from a family member. The majority had an enhanced knowledge about hypertension and self-care demands for hypertension control. They perceived hypertension as a moderate threat to them and practiced self-care behaviors for hypertension control at a moderate level. The study variables’ characteristics are shown in the table 2.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Possible range</th>
<th>Actual range</th>
<th>Mean</th>
<th>SD</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-provider communication</td>
<td>6 – 30</td>
<td>12–29</td>
<td>20.1</td>
<td>3.2</td>
<td>Moderate quality</td>
</tr>
<tr>
<td>Duration of HT (year)</td>
<td>1</td>
<td>1 – 46</td>
<td>7.3</td>
<td>5.4</td>
<td>Long duration</td>
</tr>
<tr>
<td>Family support</td>
<td>7 – 35</td>
<td>7 – 34</td>
<td>21.2</td>
<td>7.1</td>
<td>Moderate support</td>
</tr>
<tr>
<td>Knowledge about HT</td>
<td>0 – 13</td>
<td>2 – 13</td>
<td>9.8</td>
<td>2.1</td>
<td>High understanding</td>
</tr>
<tr>
<td>Knowledge about SCD</td>
<td>0 – 23</td>
<td>8 – 23</td>
<td>21.9</td>
<td>1.9</td>
<td>High understanding</td>
</tr>
<tr>
<td>Perception about HT</td>
<td>37 – 185</td>
<td>80 – 158</td>
<td>123.4</td>
<td>11.4</td>
<td>Moderate threat</td>
</tr>
<tr>
<td>Self-care behaviors</td>
<td>0 – 93</td>
<td>41–83</td>
<td>58.6</td>
<td>6.8</td>
<td>Moderate practicing</td>
</tr>
</tbody>
</table>

Note: SD = Standard deviation, HT = Hypertension, SCD = Self-care demands

Measurement model testing: All subscales of the KSCDQ and SCBQ were significant at p < 0.001 and IPQ–R were significant at p < 0.001 or p < 0.05, except for coherence (p = 0.150). Overall results of the measurement model testing were acceptable for the theoretical model analysis.

Hypothesized model testing: The hypothesized model did not fit the empirical data with the values of Chi-square = 612.301, df = 219, p < 0.0001, CFI = 0.650, TLI = 0.595, RNI = 0.650, RMSEA = 0.067, and SRMR = 0.082, therefore the hypothesized model was modified. Finally, the modified hypothesized model fitted with the empirical data with the values of Chi-square = 232.672, df = 154, p < 0.0001, CFI = 0.923, TLI = 0.895, RNI = 0.923, RMSEA = 0.036, and SRMR = 0.053. The results show that the model explains 49% of the variance of self-care behaviors for hypertension control. Patient–provider communication had a positive direct effect on self-care behaviors for hypertension control (γ = 0.52, p < 0.001) and a
positive indirect effect on self-care behaviors for hypertension control through knowledge about hypertension ($\gamma = 0.13, p < 0.05$), knowledge about self-care demands ($\gamma = 0.18, p < 0.05$), and perception about hypertension ($\beta = 0.42, p < 0.001$). The results of the hypothesized model testing are presented in Figure 2 and Table 3.
Discussion

The hypothesized model testing results supported the validity of the SCDNT regarding the influence of basic conditioning factors on self-care agency. Patient–provider communication had a strong effect both directly and indirectly on self-care behavior through knowledge about hypertension, knowledge about self-care demands, and perception about hypertension. The findings support the proposition of Orem’s SCDNT in that “Self-care is learned within the context of social groups by human interaction and communication”. Orem also emphasized that nurses must exercise nursing agency to increase the self-care agency of the clients through patient interaction.

Patient–provider communication had a strong positive direct effect on self-care behaviors for hypertension control. The results can be explained by the fact that patient–provider communication increases understanding and awareness about hypertension control and helps to solve problems and addresses health concerns. This finding is consistent with Tian et al who found that patient–provider communication was effective in the increase of self-care behaviors of people with chronic illness. Patient–provider communication is positively associated with antihypertensive medication adherence and information provided by healthcare providers is important for adherence to antihypertensive treatments.

Patient–provider communication also had a positive indirect effect on self-care behaviors for hypertension control through knowledge about hypertension, knowledge about self-care demands, and perceptions about hypertension. This result can be explained by knowledge about hypertension and knowledge about self-care demands changing perceptions about hypertension being consistent with scientific knowledge. Perception about hypertension are used for investigation about an unchangeable condition (the condition of having hypertension) and what self-care activities are required for the control of changeable factors (e.g., eating, exercising, and taking medication) in the estimative operation. Perceptions about hypertension are used for making the decision to begin and to maintain self-care actions for hypertension control. If people have clear and correct perceptions about hypertension, they are more likely to make appropriate decisions about self-care in the transitional operation process. Finally, people with hypertension create their own course of action and evaluate the performance, results, and subsequent actions in the productive operation process. Therefore, these findings confirm Orem’s statement that scientific knowledge and commonsense knowledge (perception) are used along with states of deliberate action and are essential in the estimative operation. The findings also supported the illness perception concept in that the perceptions about illness influences personal behaviors in response to a health threat such as following treatment regimens. In addition, the results supported that perception about hypertension was associated with self-care behaviors for hypertension control and adherence to antihypertensive treatments.

The duration of hypertension did not affect self-care agency and self-care behaviors for hypertension control. The findings of previous research were inconsistent in demonstrating the relationship between the duration of hypertension and self-care behaviors for hypertension control. A long duration of hypertension had positive, negative, and no associations with self-care behaviors for hypertension control. In the present study, a half of the participants could not control their blood pressure, but they had a low level of comorbidities and complications of hypertension thus they might perceive that they are healthy, and they might accept practicing self-care behaviors as usual was enough for their health. This reason could be supported by Panpakdee et al who found that Thais with hypertension were not practicing self-care when were recovering from a crisis or symptom of hypertension.

Family support did not affect self-care agency and self-care behaviors for hypertension control. It
could be explained that people with hypertension could care for themselves, which lead to the perception of being healthy. Social support is a factor for reducing stress that affects health. In a situation without stress, social support might not be perceived as a necessity. In contrast to some studies, family support was associated with self-care behaviors for hypertension control. People who have both hypertension and diabetes mellitus were not included in this study. The participants may not be stressed due to the perception of having a less severe disease such as hypertension. Therefore, family support is not perceived as a necessity for helping them to control hypertension. This reason could be supported by Anthony et al. who found that people with hypertension and diabetes perceived their hypertension as a chronic disease with more of an impact on their daily life than those without diabetes.

Limitations

This cross sectional study did not meet the assumptions of structural equation modeling in the aspect of temporality (the requirement in measuring a variable in a model at a different time point). The use of purposive sampling limited the generalization only to people with hypertension who had the same characteristics as the participants of this study.

Conclusions and recommendations

Patient–provider communication is a powerful factor, which has a large positive direct effect on the self-care behaviors for hypertension control as well as an indirect effect on self-care behaviors through knowledge about hypertension and self-care demands, and perceptions about hypertension. Thus, the implications for nursing practice is for the development of a nursing intervention program and the health service system to promote patient–provider communication for helping individuals with hypertension to increase their self-care behaviors, for the control of hypertension. Future studies should also be designed to test the effectiveness of various types of patient–provider communication such as computer-based approach.

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References


อิทธิพลของปัจจัยพื้นฐานและความสามารถในการดูแลตนเองต่อพฤติกรรมการดูแลตนเองในคนไทยที่เป็นความดันโลหิตสูง

ลัดดา สะลีมา  อรสา พันธ์ภักดี มณี อาภานันทิกุล ธีรเดช ฉายอรุณ

บทคัดย่อ: ผู้ที่เป็นความดันโลหิตสูงและไม่สามารถควบคุมโรคได้มีความเสี่ยงต่อการเกิดโรคหัวใจ โรคหลอดเลือดสมอง และโรคอื่นๆ พฤติกรรมการดูแลตนเองมีความสำคัญในการควบคุมความดันโลหิตสูง การศึกษาครั้งนี้เป็นการทดสอบทฤษฎีการประพฤติในการดูแลตนเอง เพื่อศึกษาแบบจำลองความสัมพันธ์ของปัจจัยพื้นฐานและความสามารถในการดูแลตนเองที่มีอิทธิพลต่อพฤติกรรมการดูแลตนเองเพื่อควบคุมความดันโลหิตสูง กลุ่มตัวอย่างเป็นผู้ที่ได้รับการวินิจฉัยเป็นความดันโลหิตสูงจำนวน 402 ราย ที่ได้รับการวิจัยที่แผนกผู้ป่วยนอกโรงพยาบาลสุข 3 แห่ง ในการวิจัยของประเทศไทย การเก็บข้อมูลแบบสำรวจโดยใช้แบบสอบถามข้อมูลส่วนบุคคล แบบสำรวจแหล่งสนับสนุนของผู้ป่วย เริ่มแบบสอบถามการรับรู้ความต้องการของการเข้าป้องกับบริการ แบบสอบถามการรับรู้ความต้องการ การดูแลตนเอง และแบบสอบถามพฤติกรรมการดูแลตนเอง วิเคราะห์แบบจำลองความสัมพันธ์ โดยใช้แบบจำลองการเรียงโครงร่าง

ผลการวิจัยพบว่าพฤติกรรมการดูแลตนเองเพื่อควบคุมความดันโลหิตสูงที่ได้รับการปรับปรุงมีความสอดคล้องกับข้อมูลเชิงประจักษ์ โดยผลการวิจัยที่สามารถวางแผนการควบคุมพฤติกรรมการดูแลตนเองได้ ร้อยละ 49 การวิเคราะห์ผลการวิจัยที่มีอิทธิพลต่อพฤติกรรมการดูแลตนเอง โดยความรู้เกี่ยวกับโรคความดันโลหิตสูง ความรู้เกี่ยวกับความต้องการการดูแลตนเอง และการวิจัยเกี่ยวกับพฤติกรรมการดูแลตนเอง ผลการศึกษาครั้งนี้สนับสนุนทฤษฎีความพร่องในการดูแลตนเองของโอเร็มเกี่ยวกับปัจจัยพื้นฐาน ที่มีอิทธิพลต่อความสามารถในการดูแลตนเอง ผลการศึกษาเป็นหลักฐานในการพัฒนาโปรแกรมการส่งเสริมการสื่อสารระหว่างบุคลากรทีมสุขภาพกับผู้ป่วย เพื่อช่วยให้ผู้ป่วยเป็นความดันโลหิตสูงพฤติกรรมการดูแลตนเองเพื่อควบคุมความดันโลหิตสูง

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คำสำคัญ: ความดันโลหิตสูง ความรู้ การติดต่อสื่อสารระหว่างผู้ให้บริการและผู้ป่วย การติดต่อสื่อสารระหว่างผู้ให้บริการและผู้ป่วย การดูแลตนเองเพื่อควบคุมความดันโลหิตสูง

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