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Dear readers:

We are thrilled to publish this Focus on Thailand issue. When we began planning the issue, we knew that the 11th World Congress SCDNT would occur in Thailand, 2010. However, we did not anticipate the awesome plans that became a reality and are announced in this issue. It is an honor for the IOS to be among the sponsors of this international event.

Our Focus on Thailand issue features a Historical Perspective article by the esteemed Somchit Hanucharurnkul, PhD, Professor, Ramathibodi School of Nursing Mahidol University, Bangkok, Thailand. She gave the SCDNT life in Thailand. We thank Dr. Donna Hartweg for her expert assistance to Somchit in editing her manuscript.

With this Focus on Thailand, it is fitting to recognize a recent Thai PhD graduate, Dr. Vineekarn Kongsuwan, as recipient of the IOS New Scholar Award. We also want to recognize her mentors: Drs. Wandee Suttharangsee, Sang-arun Isaramalai, and Susan Kools.

It is our privilege to highlight events in Vietnam where the first (and only) MSN Program in that country graduated its first class in September. Dr. Berbiglia is encouraged by the two SCDNT-framed theses. You will be interested in their Abstracts we include in this issue.

In closing, I know that some of you can recall the 6th International SCDNT Conference, Bangkok, Thailand, 2000. Dr. Marjorie Isenberg was our president. Dr. Susan Taylor gave the welcome address. For me, the highlight of the conference was the Reception/Dinner in the Emerald Hotel. The Thai sponsors went all out! There were fruit and vegetable carvers on display, fresh flower bracelets for everyone, and Thai dancing lessons from the Mahidol Nursing faculty!

We look forward to seeing you at The International Conference for Prevention and Management of Chronic Conditions & the 11th World Congress of SCDNT, Bangkok, Thailand, 2010.

Violeta Berbiglia and Virginia Keatley
Co-Editors, Self-Care, Dependent-Care & Nursing

From the President

On behalf of the IOS I would like to thank the faculty of the Schools of Nursing of Mahidol University and Prince Songkha University for the invitation to hold the Self-Care Deficit Nursing Theory Congress in Thailand for a second time. This time we have the opportunity of joining with the 2nd International Conference on Prevention and Management of Chronic Conditions to share on-going research, experiences and ideas concerning self-care and self-management of health states. It is a privilege for the IOS to share sponsorship of this conference with the two Thailand schools of nursing, the Schools of Nursing of the University of North Carolina at Chapel Hill, Yale University, and the World Health Organization.

The IOS is truly an international organization. In addition to congresses held in Canada and the United States, SCDNT congresses have been held in Belgium, Germany, and South Africa. At previous congresses, in addition to the host countries, there have been presentations and attendees over the years from, I believe something like 26 countries including among others Armenia, Australia, Iran, Japan, Mexico, Turkey. How fortunate we are to be able to meet together and share our common love of nursing as a profession and our nursing knowledge.

A major challenge for nursing continues to be the development and explication of theories related to nursing and the organization of nursing knowledge within those theoretical perspectives. In her writings, Orem proposed that there are stages in the development of nursing science (Orem, Nursing: Concepts of Practice 5th ed. p. 179). In a communication to the Orem study group (1995) she proposed that the following be undertaken:

Describe nursing science questions investigated (or under investigation) in which concepts and theoretical elements of self-care deficit nursing theory provided structure for the investigation.

- How was each nursing science question formulated and expressed?
- What knowledge in terms of structure or patterns of events was the result of each investigation?
- What articulations with other disciplines of knowledge specific to basic conditioning factors were developed, formalized and expressed within each investigation?
• Where does this investigation fit and what is the contribution to a particular stage of development of nursing science?

• What, if any, rules of nursing practice (tentative or firm) can be inferred from this investigation?

Is it time to begin such an investigation and organization? Perhaps answers to the above questions could be included in articles published in this journal and in papers presented at the upcoming congress.

Kathie Renpenning
The 2nd International Conference on Prevention and Management of Chronic Conditions and the 11th World Congress Self-Care Deficit Nursing Theory


Invited Speaker:
- Dr. Sanlee Phianbangchang WHO Regional Director for South-East Asia
- Dr. Kathy Respenning President of International Orem Society for Nursing Science and Scholarship
- Dr. Jean Yan Chief Scientist Nursing and Midwifery, WHO, Geneva.
- Dr. Margaret Grey Yale University, USA.
- Dr. Gwen Sherwood University of North Carolina at Chapel Hill, USA.
- Dr. Merle Mishel University of North Carolina at Chapel Hill, USA.
- Dr. Katherine Kuflle University of North Carolina at Chapel Hill, USA.
- Dr. Somchit Hanucharnkun Mahidol University, Thailand.
- Dr. Orasa Panpudke Mahidol University, Thailand.

Goal:
- To advance self-care science in practice and research.
- To improve prevention and management of chronic conditions/illnesses through sharing evidence/research based.
- To share health policy, health and nursing system to improve prevention and management of chronic conditions/illnesses globally.
- To build network in research, practice, and education related to prevention and management of chronic conditions/illnesses.

Preliminary Program
November 5, 2010
Theme: Self care in the prevention & management of chronic conditions/illnesses, health care system for chronic conditions/illnesses
- Global Health and Revalorisation of Self-care: Epidemiology of chronic conditions/illnesses
- The role of SCIENT in health care system during the world crisis
- Prevention of major health threats and chronic conditions/illnesses
  - Metabolic syndrome
  - Cancer
  - HIV/AIDS
  - COPD

November 6, 2010
Theme: Management of chronic conditions/illnesses
- Meeting the challenges of chronic conditions/illnesses: Nurses contributions
- The role of family and community in management of chronic conditions/illnesses

November 7, 2010
Theme: Health care system for chronic conditions/illnesses
- Health care system for chronic conditions/illnesses
- Health care system for elderly across the world
- Concurrent session

Congress secretariat:
Dr. Serm Sri Santati, RN, PhD.
Ramathibodi School of Nursing, Faculty of Medicine Ramathibodi Hospital, Mahidol University, Bangkok 10400, THAILAND.
info@iscc2010.com

Registration fee:

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Call for Abstracts

The Call for Abstracts can be found on the conference official website:

Enhancing Supportive-Educative Nursing Systems to Reduce Risk of Post-Breast Cancer Lymphedema

Jane M. Armer, PhD, RN, FAAN, Robin P. Shook, MS, Melanie K Schneider, MPH, Constance W. Brooks, PhD, APRN, BC, Julie Peterson, RN, BSN, Bob R Stewart, EdD

Acknowledgement

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Abstract

This study describes the use of data regarding self-care agency to enhance a supportive-educative nursing system for breast cancer survivors to reduce the risk of developing lymphedema post surgery. Impetus for this study came from the analysis of participant feedback from a parent study (Lance Armstrong Foundation pilot study) that sought to plan an educational program for nurses that will improve their supportive-educative nursing system when working with breast cancer survivors. The goal is to enable these women to reduce the risk of lymphedema post surgery. The parent study examined a bundled behavioral-educative intervention, which included standard lymphedema education coupled with Modified Manual Lymph Drainage (MMLD) to reduce the risk of developing lymphedema in newly-diagnosed breast cancer survivors. Based upon the feedback received from the parent study, the research team recognized that many of the participants were not fully following the recommendations of the intervention protocol. In order for nurses to help patients develop self-care agency (SCA) (Orem, 2001) to engage in actions that addressed the self-care requisites associated with post-breast cancer surgery, these nurses needed to refine their intervention skills. Prior to the development of a program for the nurses, the research team conducted a study to explore the state of power related to SCA of the study participants. The information obtained from this was then used in the development of an educational program for bundled intervention. Both motivational interviewing (Miller & Rollnick, 2002) and solution-focused therapy (Berg & DeJong, 1996) were incorporated into the educational program for the research nurse team to strengthen and improve supportive-educative nursing systems. Supportive-educative systems of care that integrate self-care deficit nursing theory, motivational interviewing, and solution-focused therapy can assist patients to develop and sustain self-care agency.

MeSH Keywords: Breast neoplasms, lymphedema, self-care, Orem Self-Care Model

Introduction

Lymphedema (LE) is the accumulation of lymph in the interstitial spaces caused by the failure of the lymph-conducting system to accept and/or conduct lymph back to the blood circulation system (Browse, Bernard, & Mortimer, 2003). Breast cancer-related LE results from treatment such as axillary node dissection and radiation therapy, and manifests itself as chronic and distressing upper limb swelling due to accumulation of protein-rich interstitial fluid. Although typically less than half of breast cancer survivors develop LE, even using conservative estimates, the number of survivors affected or potentially affected by breast cancer-related LE is staggering, comprising potentially 1 to 5 million people worldwide (ACS, 2006; Armer & Stewart, 2005).

Worldwide, 10 million breast cancer survivors are at life-time risk of developing lymphedema (LE) (American Cancer Society (ACS), 2007; Ferlay, Bray, Pisani, & Parkin, 2004). Once manifested in breast cancer survivors, lymphedema is considered to be a chronic and life-long condition. However, there are self-care activities that may reduce the risk of developing LE, such as avoiding body weight gain and obesity, avoiding limb infections on the affected side, and reducing high levels of hand use (Soran et al., 2006). The simple act of providing lymphedema education information to breast cancer survivors has been shown to increase the practice of risk-reduction behaviors, thus preventing LE in many survivors. (Fu, Axelrod, & Haber, 2008).

Once an individual develops lymphedema, the standard of care focus is on improving lymph function through various manual techniques administered both by a trained therapist in a clinic setting and by the individual at home (Mayrovitz, 2009). Manual lymph drainage, designed to move lymph fluid out of affected areas to healthy regions, is one component of this treatment. This process is initiated by a therapist and continued by the individual. However, these treatments usually occur after lymphedema has developed, and have rarely been reported to be used to reduce the risk of developing LE.

A Lance Armstrong Foundation-funded pilot study (referred hereto after as the parent study) examined a bundled intervention combining standard lymphedema education plus Modified...
Manual Lymph Drainage (MMLD; referred hereto after as the bundled intervention) designed to reduce the risk of developing lymphedema in newly-diagnosed post-surgery breast cancer survivors. The intervention of MMLD is a behavioral-educative self-care action consisting of deep breathing, abdominal massage, axillary clearance, and gentle lymphatic manipulation of the limb, coupled with standard LE education. The education component included information about the appropriate use of compression garments, skin care and avoiding injury to the skin, lifestyle modification, and caution about limb constriction. Increasing self-care agency through motivational interviewing and solution-focused therapy via the supportive-educative nursing system may help patients engage in self-care actions to reduce the risk of developing LE.

**Power and Self-Care Agency (SCA)**

Self-care agency, which is the power to engage in self-care, develops through the spontaneous process of learning. Its development is aided by intellectual curiosity, instruction, and supervision of others and by experience in performing self-care measures (Orem, 2001). The Nursing Development Conference Group (NDCG) (1979) identified 10 power components or specific enabling capabilities essential for performing estimative, transitional, and productive operations of SCA (Table 1). The NDCG (p. 205) also identified themes for the degrees of development of SCA as underdeveloped, developing; developed but not stabilized; developed and stabilized; and developed but declining. If nurses are to be effective in helping patients to develop self-care agency, they need to understand the elements and principles of self-care, particularly patient capabilities and limitations.

At various time points during the parent study, data from field notes on return visits and telephone contacts indicated patients were not routinely performing self-care measures as instructed in the bundled nursing intervention. The research team recognized the need to refine the bundled intervention to assist patients in developing self-care agency to engage in self-care actions that addressed the self-care requisites associated with post-breast cancer surgery.

Helping patients develop self-care agency requires a supportive-educative (developmental type) nursing system. In order to enhance self-care agency, the team developed an educational program (referred hereto after as supportive-educative nursing system) incorporating motivational interviewing and solution-focused therapy to be taught to and piloted by the research nurse team working with the study participants.

**Motivational interviewing**

Motivational interviewing has been used successfully with patients experiencing health

---

Table 1: Power Components of Self-Care Agency

- Ability to maintain attention and exercise requisite vigilance with respect to self as self-care agent and internal and external conditions and factors significant for self-care
- Controlled use of available physical energy that is sufficient for the initiation of the movements required to initiation and completion of self-care operations
- Ability to control the position of the body and its parts in the execution of the movements required for the initiation and completion of self-care operations.
- Ability to reason within a self-care frame of reference
- Motivation (i.e. goal orientations for self-care that are in accord with its characteristics and its meaning for life, health, and well-being)
- Ability to make decisions about care of self and to operationalize these decisions
- Ability to acquire technical knowledge about self-care from authoritative sources, to retain it, and to operationalize it
- A repertoire of cognitive, perceptual, manipulative, communication, and interpersonal skills adapted to the performance of self-care operations
- Ability to order discrete self-care actions or action systems into relationship with prior and subsequent actions toward the final achievement of regulatory goals of self-care
- Ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living.

care deviations who require self-care behavior change such as smoking cessation, lifestyle changes in hypertension, and dietary changes (Burke et al., 2003). Motivational interviewing is a specific approach directed toward helping patients. Miller (1983) devised a model that includes five general principles: 1) express empathy, 2) develop discrepancies, 3) avoid arguments, 4) roll with resistance, and 5) support self-efficacy. In addition, motivational interviewing can be adapted using a three-step framework that includes: 1) build rapport with the patient, 2) perform the usual assessment, and 3) summarize and reconnect with patient to develop awareness of discrepancies, explore pros and cons of self-care actions, and set self-care goals (Martino et al., 2006).

Effective motivational interviewing requires a change in perspective from the nurse being the expert in charge and responsible for patient compliance to a focus on giving the patient charge of daily self-care management. This method stresses collaboration between nurse and patient (Moyers, Miller, & Hendrickson, 2005). The role of the nurse is to provide information, expertise, and on-going support to empower the patient. This change in perspective also requires that nurses discontinue the use of words such as adherence, compliance, and non-compliance and replace them with words such as impact, self-care choices, self-management, quality of life, and consequences of care.

Solution-focused therapy

Solution-focused therapy is an approach which guides the interviewer/interventionist to focus on what clients want to achieve rather than on the problem(s) that brought them to seek health care. This method, developed by Berg and de Shazer and at the Family Therapy Center in Milwaukee, WI (Berg & De Jong, 1996) invites patients to envision a preferred future and the small or large changes that they might make to achieve this future vision. This method assumes that change is constant and by helping people to identify the things they wish to change and also to attend to what is currently happening in their life, patients can move toward the preferred future.

Methods

Study Design

Twenty-seven newly-diagnosed breast cancer survivors scheduled for surgery were recruited in the parent study where limb volume measurements and symptoms were assessed prior to and following surgery at periodic intervals (pre-op, post-op, and every six months through 18 months after surgery). The bundled intervention of individual education on lymphedema risk-reduction and MMLD was provided by the nurse researchers at the post-op visit and reinforced as appropriate thereafter.

As the parent study progressed, data from field notes on return visits and telephone contacts indicated patients were not routinely performing self-care measures as instructed in the nursing intervention. These findings were elicited from conversations with and observations of patients in the study by the research nurses. Participants reported low energy, fatigue, and lack of motivation as some of the reasons for not performing self-care measures. Many patients were not keeping diaries or not bringing them with them to return visits.

Based on these findings, the research team recognized the need to refine the bundled intervention to assist patients in developing self-care agency to engage in self-care actions that addressed the self-care requisites associated with post-breast cancer surgery. The research team engaged a doctorally prepared nurse with expertise teaching motivational interviewing. This expert had previously worked to enhance the skills of nurses and registered dieticians working with patients experiencing diabetes. These patients reported barriers to self-care management similar to those experienced by the participants in the parent study (Brooks C., personal communication, November 20, 2007).

A questionnaire was developed through consensus by the investigators based on Orem’s power components (2001). This guide consisted of 19 open-ended interview questions to explore the essential capabilities of study participants to engage in self-care actions related to health care deviation requisites specific to risk-reduction of lymphedema. These questions were designed to elicit inferences to patient power/capabilities to perform self-care. Examples of open-ended questions included: How would you describe the level of energy you have to perform self-care activities on a continuous basis to reduce risk for or decrease lymphedema? How do you fit the self-care practices of specialized lymphatic massage, deep breathing, and other self-care measures into your daily routine of your over-all self-care?

The questionnaires were mailed to the 27 participants currently enrolled in or who had recently completed the 18-month parent study. Mail-back envelopes were enclosed with the survey, and telephone interviews were conducted by the study research nurse or a trained graduate student for those who did not return the survey by
A total of 14 participants returned the surveys by mail or participated in a telephone interview. Respondent age ranged from 35 to 81 years with a mean of 60 years. The average participant was 13 months beyond breast cancer surgery at the point of the completion of the survey.

Data Analysis

Survey data were recorded from phone interviews and hand-written return surveys. Data were analyzed and categorized using Crabtree and Miller’s (1999) template guidelines for qualitative data analysis and categorized as related to the power components described by Orem (1979, p.205; 2001, p. 265) in Table 1. Each participant statement was compared to Orem’s description of the power components. The themes, initially identified by the third author and confirmed by the research team, emerged from comparison of these statements to the power component definitions. For example: Comparing the power component of “the ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family and community living” to the statement “family helps me make time to do it” indicates that self-care capability is present and consistent with the support of others. The focus of this analysis was to explore the state of power related to self-care agency in this population. Since the goal was to elicit general information for developing the educational program to enhance the supportive educative nursing intervention, data were not analyzed specific to each participant but in the aggregate.

Results/Findings

The survey data revealed that study participants were experiencing the most difficulty in four selected power components. These power components included: 1) ability to maintain attention and exercise requisite vigilance with respect to self as self-care agent, internal and external conditions, and factors significant for self-care; 2) ability to reason within a self-care frame of reference; 3) motivation; and 4) ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living. Table 2 presents the results of the analysis, with data categorized by power component and theme.

Discussion of findings

The following discussion relates the themes from the selected power components to Orem’s degrees of development of SCA (1979, p. 205). The themes emerging from the data (Table 2) reflect a range of self-care capabilities from undeveloped to developed and stabilized self-care agency (Orem, 1979).

Un-developed self-care agency

Undeveloped power is noted in the theme of absence of power. This is reflected in the statement “I lack focus.” This statement may also indicate undeveloped power in the second and fourth power components.

Developing self-care agency

The statements in the three themes of power component two, ability to reason within a self-care frame of reference, (Table 2) reflect developing or possibly developed SCA. Statement one indicates the patient is aware of the risk of lymphedema. Statement two reflects partial development as this patient is performing the deep breathing exercises, but does not see the importance of engaging in the other self-care measures such as MMLD. Statement three indicates the patient recognizes risk, believes self-care is important, and notices the impact of completing self-care measures. The statement in the third power component theme, motivated with desire but no specific goal, also reflects developing SCA.

Developed but not stabilized

Developed but not stabilized SCA is observed in the theme of intermittent power and is reflected in the statement “Easier to pay attention when not distracted with life events. The statements in the fourth power component theme, power consistent with support of others, is an example reflecting SCA that is developed but sustained with the support of significant others. Self-care actions for this patient are developed. However the operability of self-care (Orem, 1976), is dependent upon the support of others.

Developed and stabilized self-care agency

The statement “Nothing gets in the way” in power component one, theme fully developed, is an example reflecting developed and stabilized power in maintaining attention and exercising
Table 2: Themes of Selected Power Components

| First Power Component: ability to maintain attention and exercise requisite vigilance with respect to self as self-care agent, internal and external conditions, and factors significant for self-care |
|:---:|---:|
| Theme: | Example: |
| Fully developed power | “Nothing gets in the way.” |
| Intermittent power | “Get bored with same routine.” |
| | “Easier to pay attention when not distracted with life events.” |
| Absence of power | “I lack focus.” |

| Second Power Component: ability to reason within a self-care frame of reference |
|:---:|---:|
| Theme: | Example: |
| Recognizing the risk of lymphedema | “I believe I am at risk for lymphedema based on information.” |
| Expressing values and beliefs about self-care related to lymphedema | “I believe self care can prevent or reduce lymphedema;” |
| | “I don’t do any of self-care measures except deep breathing outside, [there is a] heavy smoker in the house and [I] think [it is] better to breathe fresh air.” |
| Recognizing the importance of self-care in risk | “I think it [self-care] is important, I can tell the difference in flexibility in daily activities and [self-care] reduces stress.” |

| Third Power Component: motivation |
|:---:|---:|
| Theme: | Example: |
| Motivated with specific goals | “[My]goals are to lose weight, massage, exercise daily, meditation, and take known precautions (e.g. wearing [compression] sleeves on arms when flying, wearing gloves for chores, taking blood pressure in leg rather than affected arms).” |
| Motivated with broad goals | “Already doing everything to prevent it.” |
| | “Keep [lymphedema] at minimum, try to avoid excessive swelling.” |
| Motivated with a desire but no specific goal | “I have desire to prevent it [lymphedema]” |
| | “Desire to do what it takes.” |
| | “I’d like to prevent it [lymphedema].” |
| Not motivated with no goals established | “Nothing, they never told me to do anything, I haven’t done anything.” |

| Fourth Power Component: ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living |
|:---:|---:|
| Theme: | Example: |
| Consistent power | “Take care of self, others, yard, drive car and boat, and keep my appointments.” |
| | “Do MMLD every morning when I get up.” |
| Struggling with consistency of power | “Still trying to get into a routine.” |
| | “Some days I can.” |
| | “Ability now, if things get worse would need assistance.” |
| Power consistent with support of others | “I don’t see any family much.” |
| | “Good emotional support, talk on phone a lot.” |
| | “Encourages me to exercise.” |
| | “Family helps me make time to do it.” |
| | “Family members remind me.” |
| Inconsistent power | Competing commitments of: |
| | “Just daily living, my husband and pets. I think you take care of everyone else first.” |
| | “Between the office and keeping up with house work I don’t seem to have enough time.” |
requisite vigilance with respect to self as self-care agent, internal and external conditions, and factors significant for self-care. This statement may also be an indication of developed and stabilized power in motivation for self-care (power component three) and ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family and community living (power component four).

These findings demonstrate that post-breast cancer surgery patients experience a range of self-care capabilities in performing the bundled intervention actions to reduce the risk of lymphedema.

This reinforces the need for individualized supportive-educative systems of care.

These findings also suggest persons strong in one area of power may also be strong in other areas For example: One participant stated that (MMLD) fits with my schedule, convenience, practical and not complicated to perform, time efficient”. This statement indicates developed and sustained power in the component of ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living. This same participant considered her physical capabilities in performing MMLD as excellent. Strengthening one area may leverage capacity in another. The findings in this study also indicate that statements made by patients may overlap in describing the strengths and limitations of patients in performing self-care actions related to multiple power components. This information is helpful in designing supportive-educative systems of care. For example, helping a patient who perceives lack of focus as the problem in performing self-care to regain that focus may increase the patient's SCA in several power component areas. These areas could include ability to reason within a self-care frame of reference and consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living. These areas could also include the power component of ability to maintain attention and exercise requisite vigilance with respect to self as self-care agent, internal and external conditions, and factors significant for self-care.

Implementation
Development of the Educational Program to Enhance Supportive/Educative Nursing System

Nurses help patients to develop and sustain SCA in undeveloped and underdeveloped areas through supportive-educative nursing systems. Motivational interviewing integrated with solution-focused therapy is one method to help nurses provide more effective supportive-educative interventions. This supportive-educative system approach is patient focused and individualized; key factors in self-management programs (Coster & Norman, 2009).

The supportive-educative nursing system was developed by the second author, an advanced practice nurse in adult psychiatric nursing who is expert in motivational interviewing, to enhance nurse agency in the supportive-educative role system. The educational model consisted of five components (see Table 3).

The questionnaire provided data subsequently used to teach the research nurses involved with the bundled intervention motivational interviewing and counseling skills to help patients develop their self-care agency. This supportive-educative nursing system furthers the development of nursing methods of guiding or supporting to help patients enhance their self-care agency in performing the bundled intervention including MMLD (including deep breathing, abdominal massage, axillary clearance, and gentle lymphatic manipulation of the affected limb) and self-care practices of skin care (avoidance of constriction, burns, and muscle strain; care of cuts, scratches, or burns).

Operating in the supportive-educative nursing system in order to enhance self-care actions is a basic premise of Orem's (2001) self-care deficit nursing theory. Using motivational interviewing (Miller & Rollnick, 2002) and the solution-focused

Table 3: Educational Model to Enhance Supportive-educative Nursing Systems

| 1. Overview of Orem (2001) concepts |
| 2. Introduction to motivational interviewing (Emmons & Rollnick, 2001; Miller & Rollnick, 2002: Resnicow, Dilorio, Soet, Borreli, Hecht, & Ernst, 2002) and solution-focused therapy (Berg & De Jong 1996) concepts and their application to nursing |
| 3. Review of a video on motivational interviewing techniques (Miller, 2000) and discussion of the application to the interpersonal role of nursing |
| 4. Integration of components of solution-focused therapy with motivational interviewing techniques |
| 5. Review of a case study developed by the second author specific to the study population and example questions based on limitations of self-care agency as identified in the survey assessment of SCA power components |
therapy developed by Berg and de Shazer (Berg & De Jong, 1996) as methods to enhance the supportive-educative nursing system are considered promising interventions for helping patients to develop new self-care abilities related to health care deviation requisites and to change ineffective health care behaviors (Burke, Arkowitz, & Menchola, 2003; Keller & White, 1997; Shinitzky & Kub, 2001).

Motivational interviewing can be adapted using a three-step framework that includes: 1) build rapport with the patient, 2) perform the usual assessment (review patient diary, take arm measurements), and 3) summarize and reconnect with patient to develop awareness of discrepancies, explore pros and cons of self-care actions, and set self-care goals (for performing MMLD and other self-care practices related to post-breast cancer surgery) (Martino et al., 2006).

Solution-focused therapy can be applied through scaling questions to motivate clients to change behavior. For example, the nurse might ask, “On a scale of 1-10, how motivated are you to do MMLD on the days you work?” If the patient says, “My motivation is about 5,” then the nurse’s next question might be, “What could you do that might move you from a 5 to an 8 on that scale?” This patient might then move forward in planning and making changes in her self-care behaviors to manage her risk for lymphedema. This series of questions helps the patient to consider how she might incorporate MMLD into her self-care. Exception-seeking questions are also used such as, “On a day that you were able to complete the MMLD, what was going on for you that made that possible?” Another format of questions used in this method are coping questions such as, “I am intrigued that you are able to work each day and care for your grandchild several evenings a week. How do you do that?” This type of question helps patients to recognize their own coping skills. Another key component of solution-focused therapy is helping clients identify self-care capabilities, external resources, and external support (e.g. family support). For example, the nurse might ask the patient “Can you identify the people who might support you in making a change to incorporate MMLD into your self-care strategies?”

Example scenarios and questions for nurses to use with patients were extrapolated from the data of this study, and one case is provided in Box 1.

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**Box 1: Motivational Interview Using Data from Power Component Assessment Survey**

**Scenario:**

Mrs. X comes to see the nurse for her first follow-up clinic appointment. Mrs. X was previously seen at an initial clinic visit to enroll in a pilot study behavioral education program to reduce the risk of lymphedema. On her initial visit, Mrs. X was taught self-care management that included performing MMLD (including deep breathing, abdominal massage, axillary clearance, and gentle lymphatic massage of the affected limb) and self-care practices of skin care (avoidance of constriction, burns, and muscle strain; care of cuts, scratches, or burns). Mrs. X’s follow-up visit to the clinic is to receive arm measurements as part of the lymphedema study and to assess her self-care status related to the behavioral-educational intervention.

**The nurse begins by building rapport**

Nurse: “Welcome to the clinic. Glad you could come in all this rain” (an affirmation statement lets the patient know the nurse values her).

Patient: “I’m glad I can be part of the study. I just hope I can learn all this.”

Nurse: “Sounds like you are a little concerned about what you want to learn. You might find the information a little overwhelming at first” (lets the patient know the nurse has empathy).

**The nurse then performs the usual assessment**

Nurse: “Let’s take a look at where you are now. Would that be Ok with you?” (asking permission affirms the decision-making skills of the patient).

Patient: “Sure.”
The nurse performs the usual assessment including arm measurements, review of diary, open-ended questions to determine the patient’s perspective of current health status and self-care management status.

Nurse: “So now that we have your arm measured, tell me how things are going for you in your self-care management activities.”

Patient: “I’m still trying to get into a routine. I don’t do any of the self-care measures except deep breathing outside because there is a heavy smoker in the house. I think it is better to breathe fresh air.”

Nurse: “Good, you’re doing deep breathing outside in the fresh air. You’re not doing other self-care measures. I wonder what you’re thinking about these other self-care activities.”

Patient: “I have the desire to prevent it [lymphedema].”

Nurse: “It seems important for you to keep lymphedema from happening. What other self-care measures are you considering or taking to reach that goal?”

Patient: “My family encourages me to exercise and some days I can.”

Nurse: “It sounds like your family supports you and there are times you can do exercise. What concerns do you have about the other self-care management activities?”

Patient: “Well, I tried the MMLD things you showed me, but I didn’t keep doing them. I’m not sure if I can do them right and I don’t have access to a physical therapist to help me.”

**Summarize, Awareness of Discrepancies, Pros and Cons, Goals**

Nurse: “Let’s summarize where you are right now. It sounds like you are doing some of the self-care measures such as deep breathing, some exercise, and skin care. It also seems like performing the lymph massage is a real challenge for you. If you would like to work on that, there are several things we can do that might help. Would you like me go over those with you?” (use of “we” demonstrates nurse-partnership; leaves option open for patient to make a choice about learning MMLD).

Patient: “Yes, I would like to work on that. I just don’t know how to do it right.”

Nurse: “Ok, let’s look at some options. I can give you a DVD that demonstrates the procedure. We can go over your handout again. I can demonstrate the procedure. You could perform the procedure and I can coach you in doing it correctly. What do you think might work best for you?” (providing choices affirms patient decision-making).

Patient: “Well, I think it would help if I do it and you coach me and then give me the DVD to review at home if I get stuck.”

Nurse: “That sounds fine.”

The nurse coaches the patient in performing MMLD.

Patient: “I think I can do this now. I feel better about doing it if I know I can do it right.”

Nurse: “Good, you did this very well. Remember, you can call me if you have questions or get stuck between now and your next clinic visit.”

The nurse reassures patient, affirms her self-care skills, and offers on-going support as needed, using the word stuck as the patient used in an earlier statement. The use of the patient’s language demonstrates empathy and understanding by the nurse. As in standard motivational counseling, the nurse is guided to close the patient encounter with an affirmation. This can be a comment on any area in which the patient has made progress, even if it is only in keeping the appointment.
The nurse research team has incorporated the supportive-educative nursing system into the parent study. The next steps under consideration by the research team include further coaching and education through case conferencing of patient situations, discussion of articles on self-care and motivational interviewing, coaching of nurses involved with the parent study on motivational interviewing techniques, and further exploration of health care deviation requisites of post-breast cancer surgery patients. The development of future study components to evaluate the use of these supportive educative nursing interventions is the logical next step.

Implications/Recommendations

Recommendations for the future include a more extensive review of how power components are measured and the development of questions that are more specific to measuring the constructs of the power components. The development of more specific tools that measure self-care agency related to specific health care requisites is needed. Further exploration to determine how increasing self-care capabilities in one area impacts on other areas is warranted.

Upon reflecting about insights gained from this preliminary work, some of these findings may have broader application. For example, it is important to provide support throughout the educational program. Orem (2001) describes supportive-educative systems as consisting of helping actions that include combinations of support, guidance, provision of developmental environment and teaching. Much of the current literature indicates a focus on education to help persons develop self-management abilities. (Coster & Norman, 2009) Unfortunately, education can overshadow support; it is important to remember that education alone may be insufficient. Support may be the essential component in developing self-care agency.

Nurses are the largest group in the health care workforce with the knowledge and skills to assist persons with self-care management (Astin & Closs, 2007). They have the opportunity to change the face of health care by helping patients to develop self-care agency both to meet self-care requisites related to post-breast cancer surgery and other health conditions and to develop self-care abilities to prevent injury and disease. Supportive-educative systems of care that integrate self-care deficit nursing theory, motivational interviewing, and solution-focused therapy can assist patients to develop and sustain self-care agency. Caring for patients with chronic disease is an increasing burden on health care delivery services worldwide (Coster & Norman, 2009). It is imperative for nurses to strengthen the supportive-educative system of care as they work with this growing population.

References


The purpose of this paper is to describe the integration of self-care deficit nursing theory in research and practice in graduate nursing education in Thailand. Emphasis is placed on advancement of self-care science using both quantitative and qualitative studies by graduate faculty and students. The relevance of these initiatives to promotion of self care within the context of primary care in South East Asia will also be described.

National health care system and self-care

Changes within Thailand’s national health care system provide a foundation for the use of self-care theory. Recently, the nation adopted a universal or near universal coverage system to achieve the nation’s dual objectives of equity and efficiency for the people’s health (Nitayarumphong & Mills, 2005). To accomplish this change required a shifting of health paradigms. The first was the shift from a biomedical model to holistic model. The holistic paradigm views health as the presence of well being including physical, psychological, social and spiritual health. Spiritual health influences the other three dimensions and is necessary for happiness to occur. This conceptualization relates health to almost everything in people’s lives. The second paradigm shift was the move from emphasis on the acute care hospital setting to the primary care and community setting. Basic within this view is the notion that primary care quality is key to success in a universal health care system. Thus the primary care unit must be located closest to where people live to ensure access to the service when in need for help.

Primary care in Thailand is defined as the basic health care provided for all people. It includes health promotion, disease and illness prevention, treatment for common health problems, and rehabilitative and palliative care. As holistic care, it also provides for continuity of care in healthy and high risk people in their homes. This includes services for common health problems, chronic illness and end of life care. Networking with various levels of care from primary, secondary, to tertiary care is essential for quality of care.

Primary care goals seek to help people be agents of self-care and self-reliance; to make judgments related to factors that impact the individual, family and community health; and to seek health care from professionals when appropriate. Thus, self-care is one key to success in the universal national health care system. This combination of the paradigm shifts to a holistic model and to primary care, with emphasis on self-care is consistent with Orem’s self-care deficit nursing theory. Also self-care deficit nursing theory provides a distinct focus especially for nurses to help people care for themselves and to intervene only when people encounter self-care deficits.

Self care deficit nursing theory in Thailand

In 1988, nursing theory and its importance to the development of nursing science were introduced to the graduate faculty and students at Ramathibodi School of Nursing, Mahidol University in Bangkok. Orem’s self-care model was introduced as one of the grand theories and became a popular model for use especially by a number of graduate faculties who were clinical experts. These individuals became very active in application of Orem’s theory to practice and guided masters’ nursing students in application to both practice and research. These faculty and students became the advocates of Orem’s work and were the primary reasons for advancement of Orem’s theory.

Self care deficit nursing theory was then expanded to many schools of nursing and especially in master programs in nursing in Thailand. Various conferences on self-care theory were organized for nurses, nursing educators and administrators. A book related to self-care theory and its application to clinical practice and research was published in the Thai language (Hanucharurnkul, 1991). Expertise was further developed in faculty through continuing education programs. In 1994 Dr. Susan Taylor presented...
an Orem-based curricular theory workshop at Khonkhen University. This was followed in 2000, when Ramathibodi School of Nursing, Mahidol University and the International Orem Society hosted an International Self Care Deficit Theory Conference in Bangkok on “self care and self management in health and illness”. The conference was very successful with attendance of over 500 nurses and 200 presentations on self care deficit nursing theory applied to nursing practice and research.

**Nursing Practice**

As new interest emerged in self-care theory or concepts by health care personnel and health policy makers, the first strategy to introduce Orem’s self-care deficit nursing theory was to present the significance of self-care from many perspectives. This was followed by an explanation of Orem’s General Theory of nursing distinctiveness from these other perspectives. This approach assisted nurses and policy makers to understand how self-care deficit theory is unique to nursing. Although many were interested in self-care in general, Orem’s perspective helped clarify the nurses’ role, when a patient’s self-care agency or abilities cannot meet the demands. A nurse can then exercise his/her nurse agency (or abilities) to help clients meet those demands through increasing clients’ self-care agency.

Orem’s theory not only guides the patient and the nurse in the individual situation, but also with the family and the community. This is especially evident with the increased aging population and chronic conditions. Family and community provide care to individuals during sickness, or chronic illness through home and community based care. This care extends from the hospital or health facility to homes through family participation and community involvement as a collaborative effort. Home care and community based care are important to help people living with chronic illness learn self care skills and positive living approaches. Family members and other caregivers learn new skills to provide care and cope with caring responsibilities more effectively. Also patients participate in other family and community activities while receiving care in the more familiar home and community environment. In addition, community health workers and volunteers link patients with other chronically ill people and family members to other services that are not within the family’s reach. The result is a less stressed health system, with resources to care for all in need. Furthermore, there is substantial evidence from more than 400 published articles that interventions designed to promote patients’ role in self care or self management of chronic illness/conditions are associated with improved outcomes. Self-care on a daily basis (e.g., adherence to medication regimens, exercise, eating properly, sleeping regularly, interacting with health care organizations and ceasing tobacco use) influence their health for more than medical interventions alone (WHO, 2002).

**Nursing Research**

Use of theory to guide research is required for all master’s theses in Thailand. Orem’s general theory of nursing was selected for the majority of master’s programs and then expanded to doctoral education. All three major research traditions in philosophy of science are used to guide research. These include the following: a) empirical/post-positivist, which hypothesizes that reality exists independently; b) interpretative (constructivist), which theorizes the reality is constructed; and b) critical theory and emancipatory, and action research, which combines aspects of post-positivist and humanistic approaches to address the influence of sociopolitical and cultural factors (Jacox, Supppe, Campbell, & Stashinko, 1999). The following examples of advancement of self-care science illustrate the contribution of research within three different philosophical traditions.

**Empirical/post-positivist approach**

An integrative review and meta-analysis of research based on Orem’s self-care research in Thailand from 1986-1999 revealed 123 quantitative studies conducted from the empirical, post-positivist philosophy. The designs of these were descriptive/correlational and experimental. The major sources were from master theses and doctoral dissertations. In quantitative descriptive studies, the relationship between basic conditioning factors and self-care agency were usually examined. Results from meta-analysis revealed that various basic conditioning factors influence self-care agency as proposed in self-care deficit nursing theory. Health state had the largest effect size; knowledge, education and social support had a moderate effect size and other factors had a small effect size on self-care agency/behaviors (Hanucharurnkul et al., 2001).

Experimental studies have been used to test the effectiveness of various strategies in self-care promotion programs. From this same meta-analysis by Hanucharurnkul (2001), it can be concluded that self-care promotion interventions are effective to increase self-care agency in persons with diabetes (Phonploy, 1995; Tantayotai, 1997; Hanucharurnkul, Keratiyutawong, &
Diabetes is the leading health problem in many developing countries including Thailand. With its prominence, many studies relate to promotion of self-care among people of Thailand. A meta-analysis by Likitcharoen (2000) on 57 educative-supportive intervention research studies on diabetics in Thailand found that most used Orem’s self-care deficit nursing theory. Results of the meta-analysis supported the effectiveness of concepts related to supportive-educative programs. The greatest weighted mean effect sizes were on self-care ability (ES = 1.65), knowledge (ES = 1.52), and belief and attitude (ES = 1.41), with a moderate effect size on metabolic control (HbA1c and blood sugar) (ES = 0.60).

Interpretative, humanistic or naturalistic approach.

A number of qualitative studies from the interpretative, humanistic, or naturalistic tradition use grounded theory to develop self-care theory. These approach research from the perspective of persons with chronic illness such as diabetes and hypertension. Sritanyarat (1997) identified self-care management as a central phenomenon of self-care process among persons with diabetes mellitus. This self-care process was comprised of three phases: pre-diagnostic and diagnostic, managing diabetes, and managing and living with diabetes. Four phases of self-care process were identified within the three phases of self-care management. The first phase was learning about diabetes, which was found during the pre-diagnostic and diagnostic phase. The second phase, trial and error, was found in managing diabetes. Through trial and error, participants sought cure from modern traditional and alternative therapies that were available in the Thai culture. The third phase, sacrifice, was also found in the phase of managing diabetes. Participants choose to give up their normal life-styles and develop new ones, which often included developing new roles. The fourth, going on with, was found in the phase of managing and living with diabetes. Participants described themes such as keeping routines, comprising self-regulation and preparing for uncertainty. In persons with hypertension, critical theory or emancipatory approach. Critical theory or emancipatory philosophy provides foundation for both quantitative and qualitative research designs. These are influenced by the principle of non-hierarchical partnership, with gender, ethnicity, and culture as central issues (Jacox, Suppe, Campbell & Stashing, 1999). One method employed in this philosophical approach is action research characterized by collaboration between researchers and practitioners/patients. The focus is on solution of practical problems, changes in practice, and development of practice theory. A study using this methodology is research on a self-care promotion program for diabetes (Hanucharurnkul & Keerayuthiwong, 1997). In this study, critical theory provided sensitivity to the domination of health care providers over the patients in the health care system. Orem’s self-care deficit nursing theory provided the counterbalance between the perspective of human capabilities and the patients’ need to participate in self-care. The assumption was that people can develop self-care abilities if there is support from health care providers. This action research is appropriate for
those whose self-care agency can be developed such as those with chronic illness.

The purpose of action research is to empower the patients and families to care for themselves. The outcome of data analysis was the model of promotion of self-care, the method of helping; factors that influenced self-care, and the effectiveness of the model. The model elucidated how the patients and nurses worked together. Patients use effort, time, and resources to perform self-care and find out self-care strategies appropriate for them. The nurses used nine methods of helping: 1) creating therapeutic relationships to build trusting relationships which is the foundation to other methods, 2) providing diabetic information and knowledge continuously; 3) promoting a learning environment for self-care; 4) ensuring self-care actions initiated by the patients, 5) encouraging and supporting to sustain self-care effort; 6) setting goals with the patients to adjust their self-care behaviors; 7) teaching patients to monitor their signs and symptoms; 8) promoting families’ involvement; and 9) being a liaison between the patient and the physician. The model is illustrated in Figure 1.

Qualitative research emerging from this philosophical tradition also supports Orem’s concepts. For example, Orem’s posits that basic conditioning factors influence self-care agency. Research supports specific internal factors such as patterns of living style, perceptions of disease, length of diagnosis, health status, and personal habits. External factors include family system, sociocultural orientation and health care system. In the mixed method study, quantitative findings revealed the effectiveness of the program, as self-care agency of many patients moved from underdeveloped and developing to the developed but not stabilized and the developed and stabilized stage. In addition, number of patients whose HbA1C was under control was increased.

Role of self care in the future health care system

In January, 2009, the World Health Organization (WHO) at the South East Asia Region Office (SEARO) provided regional consultation on “Self care in the Context of Primary Health Care” in Bangkok, Thailand. WHO/SEARO envision that in order to achieve national and international health goals, sustained self care promotion should be an essential component of revitalization of primary health care. Many believe that effective self care is important not only to reduce health care costs but also as an instrument to improve health equity. Within this primary health care context, self care is defined as “the ability of individuals, families, and communities for promotion, prevention, maintenance of health, to cope with illness and disability with or without support of a health care provider” (WHO/SEARO, 2009, p.2). Thus, WHO/SEARO requested the member states to respond to the following: a) Give serious consideration to strengthening self care as a program in their efforts to revitalize primary health care; b) Re-examine national health policies and strategies to strengthen support structures, legislation and financing for self care; c) Document existing local self care best-practices and conduct operational research to develop evidence-based effective self care practices; and d) Establish a network of individuals and institutions for self care promotion. WHO/SEARO will do the following for member states: a) advocate for strengthening self care in the context of revitalizing primary health care; b) provide technical support to promote effective self care; c) provide support with documentation, assessment and evaluation and research on self care practices; and d) develop common tools and guidelines (WHO/SEARO, 2009).

Ferguson (1992) pointed out that, as we are living in the information age, individuals, families and health care professionals will be much better informed and knowledgeable about health care issues. In this new era, people begin by using their own resources to manage health problems. If the problem cannot be solved, they will turn to resources in this order; family and friends, self-help groups, and networks, health professionals as facilitators, health professionals as partners and health professionals as authorities. Thus, this information age has established the legitimacy and importance of self-care.

Conclusion:

Self-care from various perspectives including Orem’s self care deficit nursing theory will continue to be used in practice, education and research. Understanding the phenomena of self-care will

Figure 1: Model of self care promotion among person with diabetes mellitus
help nurses facilitate patients’ participation in their own care and find strategies to empower the patients, families and communities to care for themselves and to control the environment to promote healing and health. In Thailand many best practices have been documented to reflect human capabilities in finding innovative strategies to care for themselves and others through support groups. These self care practices are documented and can be tested for the effectiveness in various groups. Self care is an essential component of health care. In order to achieve maximum health and quality of life, self care must be integrated at all levels of care from individual, family and community.

Acknowledgements

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References


The IOS is pleased to announce the presentation of the New Scholar Award to Dr. Vineekarn Kongsuwan, a 2009 graduate of the Nursing International Program, Prince of Songkla University, Thailand. We became acquainted with this outstanding scholar when she presented for the 10th World Congress SCDNT. That paper appears in this section of original manuscripts.

Vineekarn has an appointment to the Faculty of Nursing, Prince of Songkla University. She has been the recipient of grants and scholarships:

- 2006 The Dissertation Grant, the Faculty of Graduate School, Prince of Songkla University, Thailand.
- 2005 Royal Thai Government, the Higher Education Commission Scholarship, Ministry of Education, Thailand (Doctoral degree)
- 2004 Research Scholarship: Praboromarajchanok Institute Health Workforce Development under the jurisdiction of the Ministry of Public Health, Thailand
- 1995 Research Scholarship: Faculty of Psychology, Chulalongkorn University, Thailand
- 1994 Teacher Assistant Scholarship: Faculty of Psychology, Chulalongkorn University, Thailand

Dr. Kongsuwan’s publications and presentations include:

**Publications**


**Presentations**

30-31 March 2006, at the Convention Center, Chulabhorn Research Institute, Bangkok, Thailand.


Perspectives of Adolescents, Parents, and Teachers on Youth Violence

Vineekarn Kongsuwan, Wandee Suttharangsee, Sang-arun Isaramalai, and Susan Kools

Abstract

Background: Youth violence has become a worldwide concern and there is great need for culturally appropriate prevention programs. There is a need for understanding the nature of adolescent violent behavior across cultures, as well as to learn more about adolescent, parent, and teacher perceptions of adolescent violence in school settings.

Aim: The purpose of this study was to explore the perceptions, needs, concerns, and issues surrounding youth violence.

Methods and Participants: Focus group methods and qualitative individual interviews were conducted with 23 participants involving 15 adolescent students, 4 teachers, and 4 parents to assess their perceptions, needs and concerns. Thematic analysis was conducted to code transcribed interview data and identify violence themes.

Results: Three major themes were discovered: the nature of youth violence, including its relation to self-care deficits; factors relating to youth violence, which is the basic conditioning factors concerning violence prevention; and violence prevention, which are youths' self-care operations for preventing aggressive responses to social and environmental hazards or precipitants.

Conclusions: Violent behaviors may be conceptualized as adolescent responses to self-care deficits. Violence prevention efforts should be directed at teaching adolescents potential alternatives to cope with stressful situations, promoting social support at home and school, and collaborating with teachers and parents to reduce environmental conditions that promote violence.

Keywords: adolescent violence, self-care, school health promotion, violence prevention program

Background and Significance

Violence has increasingly become recognized globally as a critical social problem that requires vital attention. Youth violence is prevalent and continues to be a significant public health problem (UNICEF, 2000; Centers for Disease Control and Prevention [CDC], 2004; WHO, 2006; Fields & McNamara, 2003). The World Health Organization has ranked the problem of violence as critical and cautioned the entire world to be on the alert for this problem (WHO, 2005). Youth violence in Thailand is an especially serious local public health problem, evidenced by a recent surge of aggressive outbreaks in schools, homes, and the community (Department of Disease Control, 2007; Unit of National Police, 2005; Ministry of Social Development and Human Security, 2005; Ministry of Public Health, 2006; Department of Juvenile Observation and Protection, 2006). Furthermore, community violence is of special concern in rural Thailand. For example, recent violent episodes indicate that violence in adolescence is a social and cultural problem (National Mental Health Information Center, 2007; Ministry of Social Development and Human Security, 2005; Kongsuwan, 2004; Charoenwong, Kongsuwan, & Thokani, 2007).

Unfortunately, although efforts exist to discourage violence in communities, especially in schools, in Thailand, violence among Thai adolescents is still a problem in Thai society and in the communities involved. Violence prevention needs to be more effective than the current existing policies of Health Promotion in schools of Thailand (Department of Health, 2006). Violence prevention programs are developed and implemented without regard to other activities operating within the local community and without the support of key stakeholders in the community, such as parents or school and community leaders (Chinlumphrasert, 2003; Ministry of Social Development and Human Security, 2005). Thus, communities require that violence prevention efforts be both culturally appropriate and locally relevant. Examining the communities' perceptions and cultural dimensions of any approach to violence prevention is a core component of effective program interventions (Dahlberg, 1998; Dahlberg & Potter, 2001; International Clinical Epidemiology Network, 2005).

Presently, very little is known about the contextual qualities of community violence, and there have been few research studies on the management of violence. Furthermore, few preventive interventions have been based on existing data regarding what violence means to the targeted community and what local people,
including adolescents themselves, value as appropriate strategies for health and safety in school life in rural Thailand. Violence prevention for diverse adolescents must be empirically derived and culturally adapted to the values and beliefs of the people (Thornton et al., 2000; UNICEF, 2000; WHO, 2004). School violence prevention programs can incorporate socio-cultural backgrounds and self-care practices of adolescents (McCaleb & Cull, 2000). Therefore, school health promotion programs are one of the most promising means of improving adolescent health (Ruangkanchanasetr, 2005; Mental Health Department, 2001). No information is currently available about more specific violent behavior among school adolescents in Thai high school settings. Thus, the experiences and views of students, teachers, and parents are largely unknown.

Theoretical Framework

Orem’s Self-Care Deficit Nursing Theory (SCDNT) provided the theoretical basis of the study. According to Orem (2001), adolescents require care from others because they are in the early stages of development physically, psychologically, and psychosocially. Adolescent needs generate developmental self-care requisites for safety and the prevention from hazards (Cull, 1996). Violent behavior in the adolescent is a phenomenon that is an important stage of the adolescent’s life. It is difficult for the adolescent to regulate self with rational agency (Taylor, 2008). Adolescents have unique needs and ways of thinking and behave according to their social and cultural environments as influenced by peers, teachers, and parents (Orem, 2001). Signs of violence may indicate the need to obtain help as soon as possible. A variety of signs of violence may point to mental health disorders or serious emotional disturbances as well as aggressive behavior disorders in adolescents (National Mental Health Information Center, 2007).

Self-care is an action system (Taylor, 2001 cited in Alligood & Tomey, 2002). Self-care must be learned and performed deliberately and continuously in time and in conformity with the regulatory requirements of individuals (Orem, 2001). Self-care agency is understood as developed capabilities of individuals to engage in the named self-care operations in order to know self-care requisites and the means of fulfilling them within time and place frames of references. Underlying Orem’s Self-Care Deficit Nursing Theory is the operational basis to guide the study: nurses and others will assist adolescents to meet developmental self-care requisites. This study sought to identify the perceptions, needs, concerns, and issues surrounding violence as related to the behaviors, attitudes, and management of violence among high school aged adolescents and among relevant adult stakeholders, including teachers and parents.

Purpose of the Study

This paper describes an exploratory study of the perceptions, needs, concerns, and issues surrounding violence as related to the behaviors, attitudes, and management of violence among high school aged adolescents, and among relevant adult stakeholders, including teachers and parents.

A specific aim of the study was to understand adolescent violence and to gain information to help determine appropriate local and cultural responses to solving the problem of adolescent violence among high school students.

Methods

Focus group methods and qualitative individual interviews were used for data collection. Focus groups (Morgan, 1998; Krueger & Casey, 2000) are useful because they can cooperate with key stakeholders within the community (Taylor, 2003; Ross, 2003). The major aim of conducting a qualitative study is to develop an understanding that is grounded in the data. That is, qualitative research attempts “to make sense of, or to interpret, phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 2000). Thematic analysis was conducted in three phases to code transcribed interview data and to identify violence themes. This study was undertaken with approval from the Committee for Human Research at the Faculty of Nursing, Prince of Songkla University and with school permission.

Participants

There were 23 participants including 15 adolescent students enrolled in grade 7 (13-year-olds) at High School, including 4 teachers, and 4 parents. Adolescent students were recruited from a large high school in Songkhla province in the southern part of Thailand to talk about their perceptions and experiences with violence. The inclusion criteria were: students with experience with violence, had known peers who were violent, and who were non-violent. All of the adolescents were willing to participate. They were randomly divided into two interview groups. The eight adult participants included four parents and four
Focus group and qualitative individual interviews procedures

Focus groups were conducted in order to learn more about perceptions of adolescent violence in Thai high schools. The focus group discussion guide was flexible, in that it provided topics and subject areas of inquiry. Moderators had the freedom to explore, probe, and ask relevant follow-up questions in order to clarify participants’ perspectives. Adolescent student group interviews were conducted during class time. The researcher served as a moderator for all of the groups to ensure consistency in the conduct of the sessions.

Individual interviewing was used with parents and teachers. The interviewer met parents in their homes in the community. The researcher conducted the interview. All individual meetings were audiotaped and transcribed into word documents by independently hired transcribers.

Data Analysis

Data analysis was performed to identify salient themes regarding the perceptions of adolescents, teachers, and parents. A thematic analysis of the qualitative data was accomplished through multiple close readings of the transcripts of the focus group and individual interviews (DeSantis & Ugarriza, 2000; Wolcott, 1994). Research team members individually developed a list of thematic categories and subcategories. These categories were then further developed and ordered by the first author and reviewed and edited by the others. The team members then met in a consensus conference to discuss both the deductively and inductively derived categories, resolve questions, and refine the thematic categories. Final higher order categories were developed that represented the most salient themes expressed by the participants.

Findings

The findings can be described as follows:

Nature of adolescent violence

The nature of adolescent violence can be organized into 2 patterns: physical and psychological violence. Physical violence is the action of inflicting fear, pain, or injury to another person, object or property such as fighting, insubordination, harassment, and bullying. Psychological violence includes verbal violence referring to speech which causes oneself or another person suffering, shame, sadness, dissatisfaction or anger, for examples: spreading rumors, reputation-damaging gossip, insults, and making false accusations.

The risk factors of adolescent violence

There were five sub-themes which place an adolescent's life at risk for violence: school's environment, responsibility of parents and teachers, receiving acceptance from peers, imitation of media, and students themselves. The sub-themes are presented in Table 1.

Violence Prevention

Study results characterized violence prevention into 2 sub-themes: (1) effective strategies in school and (2) school service system. The themes are shown in Table 2.

Table 1: Sub-themes which place an adolescent’s life at risk for violence

<table>
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<tr>
<th>School Environment</th>
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<tr>
<td>• Ineffective restrictions and punishment</td>
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<td>• Inconsistent application of rules</td>
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<tr>
<td>• Failure to encourage responsibility</td>
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<td>• Neglect of moral and spiritual needs</td>
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<tr>
<th>Responsibility of Parents and Teachers</th>
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<tbody>
<tr>
<td>• Inadequate assumption of roles</td>
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<td>• Poor interpersonal relationship</td>
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<td>• Ineffective problem solving</td>
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<th>Receiving Acceptance from Peers</th>
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<tbody>
<tr>
<td>• Need to be with peers who have the same attitude</td>
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<tr>
<td>• Desire to be a hero and feel self-acceptance</td>
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<th>Imitation of Media</th>
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<tr>
<td>• Growing anger</td>
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<td>• Inappropriate judgments</td>
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<td>• Lack of self-awareness</td>
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<th>Students Themselves</th>
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<td>• Suppression of pressure for a long time</td>
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<td>• Personality</td>
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<td>• Failure in problem solving</td>
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Discussion

Violence is a complex issue that is caused by multiple factors. It has been conceptualized from various perspectives (Brookmeyer, Henrich & Schwab-Stone, 2005) and by investigating the contributions of individual traits, family context, school environment, community characteristics, and culture in explaining how adolescent students may be targets or aggressors. In this study, teachers identified the need for integrating violence prevention into the curriculum and for incorporating adolescents' self-care values. Teachers were stimulated to formulate a new school mission and vision statement with family members. This approach can guide continued development of instruction by teachers for eventual implementation in the school curriculum.

The school needs to collaborate with parents in order to provide assistance. In addition, comprehensive school health services are needed to help adolescents deal with tough issues. Adolescents need training in self-care practices and help with keeping guarded secrets about family violence and dealing with silent behavior that is commanded by adults (Slusher, 1999; Moore, 1995). School health services should provide adolescents' access to trustworthy adults and provide psychosocial support to resolve any self-blame for parental conflicts. This strategy implies that adolescents' developmental self-care requisites are concerned with both physical and psychological suffering. In other words, teaching self-care to violent adolescents should be a key activity for school health services that have not been available to young children at risk for violence in a school environment (McCaleb & Cull, 2000). A school policy for a violence prevention team is essential to schools for providing violence prevention (USDHHS, 2001; Carmona, 2004; Leff, Power & Manz, 2001). The team investigates complaints and recommends solutions as well as develops guidelines for teachers' interventions (Ross, 2003). There are limited public and social services available to residents, and that there are limited recreation and development programs for youths as well as fewer public and voluntary associations (National Center for Injury Prevention and Control, 1993; Chinlumprasert, 2003). It is difficult for individuals to establish common values and norms and to develop informal ties and support networks (Elliott, Hagan, & McCord, 1998; Sampson, Morenoff, & Gannon-Rowley, 2002). An adolescent violence prevention program would afford the opportunity to endorse school health policy to make violence prevention a community affair. Schools need to send a strong message to all members of the community that violence is not acceptable (Lutzker, 2006; National Center for Injury Prevention and Control, 1993). The research team recommends the formation of a community association to prevent violence in the school district. Stakeholders are needed to champion the health of youngsters and to prevent violence in neighborhoods and the community.

Conclusions

The findings from these focus group and qualitative study support efforts to reduce violence in rural Thailand. Encouraging self-care is increasingly important among adolescents to prevent hazards. Orem's SCDNT concepts can be useful for those adolescents who behave violently to assist them to estimate their self-care ability for controlling violence and to improve their self-care practices. SCDNT concepts can guide the promotion of both adolescent autonomy, ongoing follow-up, and reduction of recidivism in adolescents who are at risk for violence. SCDNT can guide the nurse and other care providers in, using specialized knowledge and skill, and creating a supportive-developmental system.

Acknowledgments

This work was partially supported by a grant from the Higher Education Commission, Ministry of Education Thailand. We also thank the adolescents, parents, and teachers of the Navamindarajjudis Thaksin Songkl High School for their participation.

References


Table 2 Sub-themes of Violence Prevention

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<tr>
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<td>• Positive approach</td>
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<tr>
<td>• Creation of effective school activities</td>
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<tr>
<td>• Promotion of self-care ability</td>
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<tr>
<td>• Encouragement of social responsibility</td>
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<td>• Supportive-educative violence prevention</td>
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<td>• Effective coordination with parents and other external resources</td>
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**Table 2 Sub-themes of Violence Prevention**

**Effective Strategies in Schools**

- Student-teacher relationship
- Positive approach
- Creation of effective school activities
- Promotion of self-care ability
- Encouragement of social responsibility
- Supportive-educative violence prevention

**School Service System**

- Leadership by a key person
- Counseling center
- Administration center
- Effective coordination with parents and other external resources


An Analysis of Self Care Knowledge of Hepatitis B Patients

Luu Thi Thuy, MSN

Introduction: Hepatitis B is one of the most important diseases affecting the Asian population. Many people have insufficient knowledge about Hepatitis B. Its treatment has many limitations. Self-care of patients plays an important role in improving their health and preventing the spreading of HBV to others. The aim of this study was to determine the levels of self-care knowledge in patients with hepatitis B and to identify background characteristics that affected their self-care knowledge.

Methods: A descriptive comparative research was designed to survey self-care knowledge of hepatitis B patients. Two hundred and thirty patients with hepatitis B at two large hospitals in the south of Vietnam participated. Patients were interviewed through a questionnaire. Data were analyzed by Stata 10.0 program with descriptive statistics, chi-square and Fisher.

Results: Only 51.9 per cent of the interviewed patients had good self-care knowledge. The rest had moderate or minimal self-care knowledge. Among these, the proportions of patients who had good knowledge about diet, personal hygiene, and management and monitoring of hepatitis B was low. By contrast, there were high proportions of patients who had good knowledge about exercise and rest and prevention of the spreading of HBV to others. Self-care knowledge of hepatitis B patients was affected by educational level, occupation and previous education.

Conclusion: Education should be increased to improve self-care knowledge of patients with hepatitis B. Emphasis should be placed on increasing knowledge about diet, personal hygiene, and management and monitoring of hepatitis B. Hepatitis B patients who are farmers, housewives, and retired people with low education levels and without previous education should be given priority. Further studies are necessary to learn about the relationship between self care-knowledge and practices of hepatitis B patients.

Defining and Measuring Self-Care Knowledge Deficits in Hypertensive Patients

Tran Thi Hong Diem, MSN

The purpose of this study was to define and measure the self-care knowledge deficits in hypertensive patients regarding weight control, nutrition, and exercise. We conducted a descriptive correlational/comparative research with 97 patients (57 inpatients and 40 outpatients) at People’s Hospital 115 from March 2009 to April 2009. The research instrument was a questionnaire with 40 questions that was used to interview face to face. Data were processed using statistical software Stata10.0 including percentage, mean, standard deviation, Pearson product moment correlation, T-test, and Analysis of Variance. Research results revealed the mean (SD) for knowledge about nutrition was 8.07 (1.36); for knowledge about exercise, it was 6.72 (2.04); for weight control, it was 7.18 (1.55); and for general knowledge, it was 7.56 (1.06). There were statistically significant differences between the average score of the kinds of knowledge and characteristics of study subjects such as race, family history, hospitalization status, educational levels, and occupation. There were also statistically significant opposite correlations between average score of kinds of knowledge and patients’ ages. A remarkable finding of this study was the existence of gaps in patients’ knowledge. The result of the study indicated that patients did not have a wide knowledge of active activities and good weight control.

We suggest that nurses in the People’s Hospital 115 design and implement an educational program for patients with hypertension. The education content should address the gaps in knowledge found in this study. Subsequent studies should evaluate the effectiveness of the education program.
As we spotlight the use of SCDNT in Vietnam, let me introduce you to the Friendship Bridge Nurses Group. I have been a volunteer faculty for the Friendship Bridge since 2000. I have had the pleasure of seeing nursing education mature in Vietnam. And I have had the privilege of introducing many Vietnamese nursing students to the SCDNT.

The goals of the Friendship Bridge Nurses Group are:

- Update content and knowledge in Vietnamese nursing education and practice.
- Increase the knowledge base of Vietnamese nurses to facilitate successful completion of graduate education.
- Increase the number of Vietnamese nurses teaching in nursing education programs.
- Provide curriculum consultation and support for the implementation of a nursing masters program in Vietnam.
- Increase the number of nurses with advanced credentials to promote nursing participation in curriculum and policy development.
- Seek scholarship funding for Vietnamese nurses to attend graduate education programs.
The most recent FB project brought the FB Nurses and Vietnamese colleagues from the University of Medicine and Pharmacy in Ho Chi Minh City to develop and implement the first MSN program in Vietnam. This project will have a significant impact on the improvement of nursing education and health care outcomes in Vietnam.

The graduate nursing curriculum created for this program will be a model for graduate nursing education for Vietnam.

Significance of Project: This project supports the progression of Vietnamese graduate nursing education toward an advanced level that is sustainable within Vietnam.

This is a key outcome if long-term change is to occur!

The collaborative nature of the project with Vietnamese colleagues and the fact that it is being coordinated and taught by volunteer PhD nurse educators affiliated with the Friendship Bridge Nurses Group, demonstrates the international nature of nursing practice and the shared goals that dedicated nurses world-wide hold in support of improvement of nursing education and health care.

It represents nursing at its best!

The official Friendship Bridge Nurses Group website is: http://www.friendshipbridgenurses-group.com/mission.html

The Future of SCDNT in Vietnam

Congratulations to Luu Thi Thuy and Tran Thi Hong Diem (left to right), recent MSN graduates of Ho Chi Minh City University of Medicine and Pharmacy. Their theses used the SCDNT as a framework. They were in the first cohort of the first ever MSN Program in the Vietnam. Dr. Berbiglia introduced them to Orem's theory in the theory course she taught in 2007.

Ms Diem’s research studied: Defining and Measuring Self-Care Knowledge Deficits in Hypertensive Patient. Ms Thuy’s: research studied: An Analysis of Self Care Knowledge of Hepatitis B Patients.

The IOS is fortunate to have Ms Thuy and Ms Diem using the SCDNT to frame their research in Vietnam. We wish them a bright future. They invite you to read their abstracts published in our Abstract section.

Welcome to our new Vietnamese members!!!

Winners of the SCDNT – Tell Me About It game, played in the course, Nursing Theory/Theoretical Frameworks taught by Drs Berbiglia and Avant.

MSN students Ho Chi Minh City University of Medicine and Pharmacy, Class of 2010

Left to right: Phuong Van Hoang, Dinh Thi Hang Nga, Ngo Thi Dung, Nguyen Trinh Cuong, Ngo Kim Phung

The IOS welcomes these students into our membership, their prize for winning the SCDNT game.
Guidelines for Authors

Self-Care, Dependent-Care, & Nursing (SCDCN) is the official journal of the International Orem Society for Nursing Science and Scholarship. The editor welcomes manuscripts that address the mission of the Journal.

Mission:
To disseminate information related to the development of nursing science and its articulation with the science of self-care.

Vision:
To be the venue of choice for interdisciplinary scholarship regarding self-care.

Values:
We value scholarly debate, the exchange of ideas, knowledge utilization, and development of health policy that supports self-care and dependent-care.

AUTHOR GUIDELINES

MANUSCRIPT PREPARATION
Use Standard English. The cover page must include the author’s full name, title, mailing address, telephone number, and eMail address. So that we may use masked peer review, no identifying information is to be found on subsequent pages. Include a brief abstract (purpose, methods, results, discussion) followed by MeSH key words to facilitate indexing. The use of metric and International Units is encouraged. Titles should be descriptive but short. Full-length articles should not exceed 15 double-spaced pages. Use of the Publication Manual of the American Psychological Association (5th ed.) is strongly encouraged but not mandatory. When required by national legal or ethical regulations, research-based manuscripts should contain a statement regarding protection of human subjects.

REVIEW PROCESS
Manuscripts are reviewed anonymously. One author must be clearly identified as the lead, or contact author, who must have eMail access. The lead author will be notified by eMail of the editor’s decision regarding publication.

INTELLECTUAL PROPERTY
Authors submit manuscripts for consideration solely by SCDCN. Accepted manuscripts become the property of SCDCN, which retains exclusive rights to articles, their reproduction, and sale. It is the intention of the editor to facilitate the flow of information and ideas. Authors are responsible for checking the accuracy of the final draft.

SUBMISSION
Manuscripts are to be submitted in MS Word format as an eMail attachment to the editor, Dr. Violeta Berbiglia at violetaberbiglia@hotmail.com. Submissions will be immediately acknowledged. It is assumed that a manuscript is sent for consideration solely by SCDCN until the editor sends a decision to the lead author.
Call for New Scholar Papers

The purpose of the New Scholar Papers feature is to foster the advancement of nursing science and scholarship in the area of Orem’s Self-Care Deficit Nursing Theory through the recognition of developing scholars.

NEW SCHOLAR QUALIFICATIONS
• Member of the International Orem Society (Contact Dr. Anna Biggs at biggsaj@slu.edu to become a member)
• Enrollment in nursing graduate studies
• Scholarly productivity related to the advancement of nursing science and scholarship in the area of Orem’s Self-Care Deficit Nursing Theory

RECOGNITION OF NEW SCHOLARS
• Each New Scholar will be featured in an issue of the SCDCN. The IOS will award the scholar a complimentary membership.

SUBMISSION OF PAPERS
Papers will be submitted using the Guidelines for Authors.