**Effectiveness of Mindfulness and Self-regulation Program on Healthcare Behaviors among Stroke Patients: A Randomized Controlled Trials**

Paweena Kanyapila MS¹, Saran Pimthong PhD², Ungsinun Intarakamhang PhD³,

Patrawut Intarakamhang MD⁴

1 Neurological Institute of Thailand, Bangkok, Thailand

2,3 Behavioral Science Research Institute, Srinakharinwirot University, Bangkok, Thailand

4 Department of Rehabilitation, Phramongkutklao Hospital, Bangkok, Thailand

**Background:** Stroke is the second cause of Thai death after cancer. Therefore, stroke patients need to change their healthcare behavior (HB) for sustainable recovery.

**Objective:** To study the effectiveness of mindfulness and self-regulation program (MSRP) on the HB and to analyze the interaction between family social support (FSS), and MSRP on HB of stroke patients

**Materials and Methods:** The randomized controlled trials (RCTs) were designed to test the program’s effectiveness. There was a total of 58 stroke patients at the Neurological Institute, calculated by using G\*Power 3.1 at power 0.85. Random assignment was used to allocate 28 participants in the experimental and 30 in the control group. The data was collected from the Likert rating scale with a Cronbach’s reliability of 0.934-0.989; the MSRP ran for 5 weeks with 5 activities from April to December 2021. T-tests and two-way ANOVA were used for data analysis.

**Results:**After participation, stroke patients had the HB (mean=5.32, SD=0.423) and were at a high level, and the MSRP was effective significantly in enhancing HB. Additionally, the experimental group had a higher HB than the control group and higher than before participating in the intervention (p<0.05). This study found an interaction between FSS and the MSRP effect on HB.

**Conclusion:** This MSR program should be used to initiate promoting the HB of stroke patients.

**Keywords:** Mindfulness, Self-regulation, Strokes, Healthcare, Health behavior, Health Program

# Correspondence to:

Intarakamhang U.

Behavioral Science Research Institute, Srinakharinwirot University, Bangkok 10110, Thailand. Phone: +66-89-1653520

Email: [ungsinun@g.swu](mailto:ungsinun@g.swu).ac.th

# Background

Stroke is a chronic non-communicable disease (NCD) that causes premature mortality and results in the loss of life on a global scale. The World Stroke Organization (1) estimated that 13.7 million new cases of stroke occur each year, 5.5 million deaths per year and 80 million people worldwide are still living after a stroke worldwide. In Thailand, stroke is an important public health problem. According to the latest statistics in 2019, it was found that stroke is the second leading cause of death in Thailand after cancer. According to the Information in 2018, there were 30,837 patients, representing a mortality rate of 47.15 per 100,000 population, and in 2019, there were 34,728 patients, representing a mortality rate of 53.0 per 100,000 population (2). A stroke is caused by a blockage or rupture of a blood vessel supplying the brain to the brain resulting in damage or destruction of brain cells, which has different effects depending on where it occurs in the brain. The patient's body, movement, speech, thoughts, and feelings are all affected (3). Stroke has a chance of recurrence. Therefore, it is essential to effectively control the risk factors by educating patients about stroke, and making the right changes in health behaviors and lifestyles to optimize disease prophylaxis and minimize recurrence (4-6).

Therefore, it is crucial for patients to pay attention to changing stroke patients' behaviors to healthcare behavior (HB) in order to control their disease and prevent a recurrence. Changing lifestyles to be appropriate and encompassing physical, mental, and social dimensions is therefore a sustainable solution. Currently, there have been studies of the healthcare behavior of patients in terms of physical, mental, and emotional lifestyle including diet, smoking cessation, unhealthy alcohol use, medication use, exercise, rehabilitation, physical activities, rest, illness prevention, and treatment, mental health and stress management, ongoing treatment and prevention of complications, spiritual development and interpersonal relationships (5-8). Thus, the HB of stroke patients in this research consisted of Diet, Exercise, Medication, and Stress management. When patients have the ability to take good care of themselves physically and mentally, they will be able to adapt to society and have good relationships with others.

Stroke patients are a group of people who need to change their self-care habits in a sustainable way because it is one of the factors that contribute to disease recurrence. Studies have shown that individuals are more likely to maintain this behavior if they are physically and mentally prepared (9). There were studies on the program implemented in the NCD group. Studies of positive psychology programs among patients with NCDs, most of the research found that mindfulness and self-regulation had a high influence on the outcomes of patients which stroke patients are also classified as NCDs (10). A review of literature and research suggests that positive psychology is applied in the care of NCDs, which has been shown to improve outcomes in psychology, and health and lower mortality rates. Patient well-being results in lower mortality in patients with chronic diseases (11,12). At present, mindfulness practice, which is a concept of positive psychology, has been applied to reduce stress and benefit the health of Stroke patients. It is found that patients have a better quality of life in all aspects. Mindfulness practice for mental and physical well-being helps patients learn to deal with diseases and manage stress, as observed with lower blood pressure levels after mindfulness practice (13,14). There is an application of mindfulness practice in conjunction with healthcare in stroke patients. Mindfulness has been found to improve early mindfulness skills, reduce physical and mental tension, and increase attention and determination. Mindfulness practice is a long-term treatment for mental fatigue after a stroke and has been shown to reduce muscle spasms in patients with chronic stroke (15-17). According to the concept of Kabat-Zinn (18), Mindfulness is awareness, which consists of two components: attention to the present and an attitude of openness and acceptance in the present moment. For the change in health behavior, mindfulness can help develop self-awareness and awareness of one's own thought processes. It facilitates openness and acceptance of ideas with calmness. Which is a process of mindfulness to the lack of self-awareness to behavior and change behavior (19,20).

Self-regulation is a process in that persons make a plan and direct their own behaviors with the purpose to change their behaviors to target behaviors. It is a process that requires practicing and development to achieve behavioral change. Self-regulation consists of 3 processes self-observation through goal setting and self-monitoring, self-judgments, and self-reaction (21). According to the study on the effectiveness of telephone follow-up to set a goal of HB among stroke patients, the program used in the experimental group was a goal-setting program, a procedure for self-regulation. The study results showed that the telephone follow-up had effectiveness to increase consistency in medicine taking among stroke patients (7). Besides, there was a study through systematic review about the use of self-management among stroke patients. Most of the programs used emphasized the most common components, such as information giving, goal setting, planning, and problem-solving. All of the programs gave importance to the psychosocial aspect in addition to physical factors. The study results found that after receiving the self-management program, patients gained more knowledge and self-efficacy including self-management behaviors, HB adjustment about physical rehabilitation and daily life activities, social activities, quality of life, and perceived emotions of participants, with the reduction of undesirable outcomes like dependence and death (22,23).

Social support is one of the factors influencing health behaviors. Family support is an environmental factor that plays an important role in the recovery from illness. When patients receive support from family members in various ways, it gives them encouragement. Understand the problem and fight it. It also affects the good quality of life. From the literature review, family involvement is the action taken by family members to gain comfort by taking care of family members during hospital admission. Families are involved in care in many ways, such as helping with meals and brushing teeth. Other activities for comfort and assist in patient posture or joint movement or exercise (24). The study found that to improve the patient's quality of life, health personnel and family members, in addition to providing physical assistance, should also provide emotional support. Social support is important for social activity participation, rest, and return to work in stroke patients (25,26).

Consequently, the researcher was interested in studying the effect of mindfulness and self-regulation programs (MSRP) affecting HB among stroke patients since only one concept cannot be used to change self-care behaviors, which are complicated, in every aspect. It is believed that when patients have mindfulness, awareness, acceptance, and attention to the present, they shall be able to express those behaviors through self-regulation, leading to the HB adjustment in terms of physical, mental, and social aspects in a sustainable manner.

# Materials and Methods

## Setting and subjects

This study was the randomized controlled trials (RCTs) conducted to study the effectiveness of MSRP on HB of stroke patients at the Neurological Institute of Thailand. The study, including evaluation and intervention, was conducted at a physiotherapy unit. Participants were in-patients who were referred for rehabilitation counseling at the rehabilitation department in the hospital where the study was conducted were recruited.

The inclusion criteria were patients diagnosed with a stroke 20-80 years of age, was communicable by stroke severity scores (The National Institutes of Health Stroke Scale) for item 1a (level of consciousness), item 1b (questions) and item 1c (commands) were 0, Barthel Activities of Daily Living Index Score greater than or equal to 9/20 which is moderately dependent and never received a training program. Exclusion criteria included patients on the nasogastric tube and inability to eat food by mouth, communication problems, dementia, impaired cognition, can’t read and write, and Thai mental state examination test scores equal to or less than 23.

There were 50 stroke patients by the G\*Power program with a prescribed α level of .05 and the researcher set the power of the test at 0.85 and the effect size was obtained based on a previous study (27) was calculated to be 0.77, plus 20% of the sample size as considering the likelihood of drop-out (28), the total of sample size was 60 persons. The stroke patients have been divided into two groups using assignment random sampling. There were 58 out of 60 stroke patients who participated in all activities 28 in the experimental group, and 30 subjects in the controlled group. Stroke patients in each group were assessed pre-and post-intervention (Figure 1).

Post-intervention assessment of HB (n=28)

Post-intervention assessment of HB (n=30)

Dropped out due to early discharge (n=2)

Standardized rehabilitation therapy including physical and occupational therapy, received an average of 3 hours of rehabilitation per day, 5 days per week +MSRP (5 activities) including self-directed towards goals, mindfulness practice for health, adjusting to change behavior, being aware of changing behaviors, and controlling health through mindfulness

Standardized rehabilitation therapy including physical and occupational therapy, received an average of 3 hours of rehabilitation per day, 5 days per week.

Pre-intervention assessment of HB and FSS in experiment group (n=30)

Pre-intervention assessment of HB and FSS in control group (n=30)

Allocation (n=60)

Enrollment

Screened for eligibility stroke patients who were sent to consult at the Department of Rehabilitation, Neurological Institute of Thailand (n=145)

Figure 1. Flow chart of the study. MSRP indicates mindfulness and self-regulation programs.

## Ethical approval and consent to participate

The research has received ethical approval from the Srinakharinwirot University board of ethics committee with a certificate numbered SWUEC/E/G-117/2564 and the Neurological Institute of Thailand board of ethics committee with a certificate number 64027. Every participant has received a consent form and been given a thorough explanation of the program before participating in the trial.

## Instruments and procedure

The instruments used in the present study consisted of MSRP refers to the activities that promote the patient's awareness and acceptance of what is happening in the present moment, recognize their own mental and physical symptoms according to the actual situation without judgment, and be able to self-direct to carry out purposeful activities to achieve their own health behavioral goals. The intervention program, developed by the researcher based on a review of the literature, is mindfulness training based on the concept of Jon Kabat-Zinn (18), each activity is contextualized for stroke patients based on previous research (29) and Bandura's concept of self-regulation (21) consists of 3 processes: Self-observation, Self-judgments, and Self-reaction. By allowing patients to practice self-regulation by setting goals and recording health behavior data. In addition, participate in the activities with the technique of group activities once a week, consisting of 5 activities, namely, 1) Self-direction towards goals 2) Mindfulness practice for health 3) Adjust to change behavior 4) Be aware of changing behaviors and 5) Control health through mindfulness as shown in Table 1.

**Table 1:** Activities of MSRP for the experimental group.

| **MSRP** | **Activities** |
| --- | --- |
|
| Self-direction towards goals | - To give knowledge about stroke and healthcare for preventing the recurrence of the disease.  - Learning the process of self-regulation and practicing self-regulation skills: self-monitoring and goal setting. |
| Mindfulness practice for health | - Activities related to healthcare skills in food, exercise, medicine, and stress management including continuous mindfulness practice (Body Scan) and mindfulness homework on one’s own (Mindful Walking Meditation).  - Practice self-regulation skills for self-judgments by practicing how to create a self-care plan. |
| Adjust to change behavior | - Practicing self-regulation skills for self-reaction.  - Continuous mindfulness practice and mindfulness homework on one’s own (Yoga/Mindful movement sequent). |
| Be aware of changing behaviors | - Follow up on the results of the self-regulation.  - Continuous mindfulness practice and mindfulness homework on one’s own (Seated Mindfulness Meditations/ Loving Kindness, imagery‐based guided meditations). |
| Control health through mindfulness | - Review all activities for healthy behavior modification.  - Review mindfulness practices for healthcare.  - Activities reflect what has been gained from participating. |

The questionnaires used in the experimental stage included 1) a General demographic information questionnaire with 12 items, 2) an HB questionnaire that has been developed by the researcher that refers to the operational definition which means the actions of stroke patients in diet, exercise taking medicine, and stress management. That is a continuous practice, intentionally and objectively, by using their abilities and potential to maintain a good quality of life and live in a normal society. The researchers created a measure based on the operational definition. The measure consisted of 31 items. It was a 6-level estimation scale that "most practice" was given 6 points and "never practice” was given 1 point, namely 10 items focusing on dietary, 9 items focusing on exercise, 8 items focusing on medicine, and 4 items focusing on stress management with the reliability of 0.939, and 3) FSS has been developed by the researcher that referring to the operational definition that refers to the perception of stroke patients that they are supported by their families in various fields, including emotional, informational, instrumental, and appraisal. The researchers created a measure based on the operational definition. The measure consisted of 19 items. It was a 6-level estimation scale in which "most true" was given 6 points and "not true” was given 1 point. namely 7 items focusing on emotional support, 5 items focusing on informational, 5 items focusing on instrumental, and 2 items focusing on the appraisal with a reliability of 0.988.

For the experimental stage from April to December 2021, the control group received standardized rehabilitation therapy, meaning received an average of 3 hours of rehabilitation at the hospital as an inpatient per day, 5 days per week, or at least 15 hours per week. Rehabilitation therapy is determined according to the disability and loss of function of each patient including physical and occupational therapy. And the progress of symptoms will be monitored by a multidisciplinary team. The experimental group received standardized rehabilitation therapy and participated from the first to the fifth activities of MSRP which the intervention based on the concept of Jon Kabat-Zinn (18) and Bandura's self-regulation concept (21). The MSRP is contextually adjusted to suit a stroke patient with 5 activities in 5 weeks. Content validation: Three experts accepted the MSRP for all activities with the Index of Congruence ranging from 0.67 to 1.00. The program was also revised according to the recommendations of those experts and piloted by some of the stroke patients to determine if this program fitted.

## Statistical analysis

First of all, to accurately measure the data collected, a descriptive statistic was employed to determine the mean, standard deviation (S.D.) values, and percentage (%) to study the demographic information of the participants. For the test of normality, the Shapiro-Wilk Test was used. The baseline of demographic characteristics used the Chi-square for the comparison of categorical variables. Secondly, the independent-sample t-test was used to compare the mean level of HB between the experimental group and the control group. Thirdly, the paired sample t-test was used to compare the mean level of HB in both groups before and after participating in the program. Finally, Two-way ANOVA was used to compare the mean of healthcare behavior between groups and FSS by SPSS version 22. In addition, a two-tailed p-value of < 0.05 was considered statistically significant.

# Results

## Demographic data

Based on the findings, 60 participants were included in this study; two participants in the experimental group dropped out of the study due to early discharge. Therefore, the data of 28 participants in the experimental group and 30 participants in the control group were entered for analysis. The basic characteristics of the two groups are shown in Table 2, most of the participants were males aged 31-60 years and more than 60 years. The participants were married and had graduated at a level of bachelor’s degree. Mostly used rights to healthcare schemes and were found to be employed, with a mean monthly income of 20,001-30,000 baht, and live with their spouse. Most of the participants have underlying diseases, a duration of illness of fewer than 3 months, and weakness on one non-dominant side of the body. No significant differences in the demographic between the two groups.

**Table 2** The biosocial characteristics of participants in the experimental and the control group.

| **Biosocial characteristics** | **Experimental group** | | | | **Control group** | | | | ***p*** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Number (person)** | | | **Percentage (%)** | **Number (person)** | | | **Percentage**  **(%)** |  | |
| **Gender** |  | | |  |  | | |  | 0.800 | |
| Male | 14 | | | 50 | 16 | | | 53.3 |  | |
| Female | 14 | | | 50 | 14 | | | 46.7 |  | |
| **Age** |  | | |  |  | | |  | 0.455 | |
| Age less than/equal to 30 years | 2 | | | 7.1 | 1 | | | 3.3 |  | |
| Age 31 – 60 years | 18 | | | 64.3 | 16 | | | 53.4 |  | |
| Age more than 60 years | 8 | | | 28.6 | 13 | | | 43.3 |  | |
| **Marital status** |  | | |  |  | | |  | 0.754 | |
| Single | 9 | | | 32.1 | 8 | | | 26.6 |  | |
| Married | 13 | | | 46.5 | 18 | | | 60.0 |  | |
| Divorced / Separated | | 3 | 10.7 | | | 2 | 6.7 | |  |
| Widow / Widowed | | 3 | 10.7 | | | 2 | 6.7 | |  |
| **Education level** | |  |  | | |  |  | | 0.067 |
| Primary school | | 5 | 17.9 | | | 8 | 26.7 | |  |
| Secondary school/equivalent | | 6 | 21.4 | | | 8 | 26.7 | |  |
| Bachelor's degree | | 16 | 57.1 | | | 8 | 26.7 | |  |
| Higher Bachelor's degree | | 1 | 3.6 | | | 6 | 19.9 | |  |
| **Rights to healthcare scheme** | |  |  | | |  |  | | 0.066 |
| Use rights to healthcare scheme | | 25 | 89.3 | | | 30 | 100.0 | |  |
| Pay medical expenses on one’s own | | 3 | 10.7 | | | 0 | 0.0 | |  |
| **Duration of illness** | |  |  | | |  |  | | 0.929 |
| Less than 3 months | | 25 | 89.3 | | | 27 | 90.0 | |  |
| 3 – 6 months | | 3 | 10.7 | | | 3 | 10.0 | |  |
| **Characteristics of living** | |  |  | | |  |  | | 0.713 |
| Live with their spouse | | 13 | 46.4 | | | 14 | 46.7 | |  |
| Live with their children /relatives | | 13 | 46.4 | | | 12 | 40.0 | |  |
| Live alone | | 2 | 7.2 | | | 4 | 13.3 | |  |
| **Career** | |  |  | | |  |  | | 0.421 |
| Unemployed | | 5 | 17.9 | | | 8 | 26.7 | |  |
| Employed | | 23 | 82.1 | | | 22 | 73.33 | |  |
| **Patients’ history of underlying diseases** | |  |  | | |  |  | | 0.849 |
| Have underlying diseases | | 18 | 64.3 | | | 20 | 66.7 | |  |
| Do not have underlying diseases | | 10 | 35.7 | | | 10 | 33.3 | |  |
| **Income** | |  |  | | |  |  | | 0.184 |
| Less than 10,000 baht | | 2 | 7.1 | | | 0 | 0.0 | |  |
| 10,001-20,000 baht | | 4 | 14.3 | | | 9 | 30.0 | |  |
| 20,001-30,000 baht | | 11 | 39.3 | | | 6 | 20.0 | |  |
| 30,001-40,000 baht | | 4 | 14.3 | | | 7 | 23.3 | |  |
| More than 40,000 baht | | 7 | 25.0 | | | 8 | 26.7 | |  |
| **The side of the body that is affected** | |  |  | | |  |  | | 0.259 |
| Dominant side | | 9 | 32.1 | | | 14 | 46.7 | |  |
| Non-dominant side | | 19 | 67.9 | | | 16 | 53.3 | |  |

The independent samples t-test was performed to compare the means of the two groups on the levels of HB after participating in the program. In addition, Levene's Test for Equality of Variances was analyzed, and the assumption of homogeneity of variances was met (P >0.05). Thus, the equal variances assumed part was shown in the result after running the independent samples t-test. Before participation, found that no statistically significant difference between the means of the two groups on the level of HB (p>0.05). After the participation, the experimental and the control group had different HB with a statistical significance level of 0.05(t=-9.406, p = 0.0005). It was found that the experimental group had higher scores of HB than the control group, as shown in Table 3

**Table 3:** Comparison of differences of the average scores of HB among stroke patients in the pretest and posttest between the experimental group and the control group

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Healthcare behavior** | **Experimental Group**  **(n=28)** | | **Control Group**  **(n=30)** | | ***p*** |
|  | **S.D.** |  | **S.D.** |  |
| Pre-Experiment | 4.05 | 0.774 | 3.99 | 0.591 | 0.379 |
| Post-Experiment | 5.32 | 0.423 | 4.05 | 0.592 | 0.0005 |

\* p < 0.05

Paired t-test was used to compare differences in the average scores before and after participating in the program between the experimental group and the control group. The Shapiro-Wilk Test for normality was achieved prior to running the t-test (P > 0.05). It was found that the experimental group had a higher average score of HB in the posttest than in the pretest (t = -15.344, p = 0.0005). Stroke patients in the control group had a lower average score of HB in the pretest than in the posttest. According to the statistical test to compare the average scores of HB, the average score of HB in the posttest was higher than in the pretest without a statistical significance level of 0.05 (t=-1.403, p = 0.086), as shown in Table 4.

**Table 4**: Test results of the average scores of HB among stroke patients in the pretest and posttest, compared within the group

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Healthcare behavior** | **Experimental Group**  **(n=28)** | | | **Control Group**  **(n=30)** | | | |
|  | **S.D.** | ***p*** |  | **S.D.** | ***p*** |
| Pre-Experiment | 4.05 | 0.774 | 0.0005 | 3.99 | 0.591 | 0.086 |
| Post-Experiment | 5.32 | 0.423 | 4.05 | 0.592 |

\* p < 0.05

Two-way ANOVA was used to compare HB among patients who participated /not participated in the program, with different FSS. The Shapiro-Wilk Test for the normality of two variables was achieved prior to running the t-test (P > 0.05). Test results of interaction between patients who participated /not participated in the program and FSS, significance value was 0.046 which was lower than the significance level set at 0.05. It means that the interaction between participated /not participated in the program and FSS had an effect on scores of HB among stroke patients. It was found that stroke patients who participated in the MSRP and received a high level of FSS had a higher average score of HB (mean = 5.585) than stroke patients who did not participate in the MSRP and received a low level of FSS (mean = 3.587).

At a high level and low level of FSS, it was found that the average scores of HB of stroke patients who received/did not participate in the program were different with a statistical significance level of 0.05. Patients who participated in the program had a higher average score of HB than patients who did not participate in the program. The average scores of HB of stroke patients with different levels of FSS were different with a statistical significance level of 0.05. Patients with a high level of FSS had a higher average score of HB than patients with a low level of FSS, as shown in Table 5.

**Table 5:** Comparison results of the average scores of HB among those participating in the program (the experimental group) and not participating in the program (the control group) and FSS at different levels.

| **Level** |  | **S.D.** | ***p*** |
| --- | --- | --- | --- |
| **High level of FSS** | | | |
| participated in the program | 5.585 | 0.087 | 0.000\* |
| not participated in the program | 4.523 | 0.087 |
| **Low level of FSS** | | | |
| participated in the program | 5.012 | 0.094 | 0.000\* |
| not participated in the program | 3.587 | 0.087 |
| **Participated in MSRP** | | | |
| High level of FSS | 5.585 | 0.087 | 0.000\* |
| Low level of FSS | 5.012 | 0.094 |
| **Not participated in the MSRP** | | | |
| High level of FSS | 4.523 | 0.087 | 0.000\* |
| Low level of FSS | 3.587 | 0.087 |

\* p < 0.05

# Discussion

The results of this study found that HB average scores of the experimental and control groups were found to be different, and the experimental group higher than before participating in the intervention with statistical significance, possibly because “MSRP is the process of a group activity designed to be consistent with the context of patients with stroke”, aimed to strengthen HB among patients with stroke. This is in harmony with a study on a mindfulness program to promote recovery from stroke, increase the ability to live a life among patients with chronic stroke, and help reduce stress levels (29). The program was adjusted to meet the group of stroke patients, and a study found that social cognitive theory using self-regulation as the conceptual framework can be adapted to be a guideline for developing a program for patients with chronic diseases (30). The result was consistent with the previous study indicating that mindfulness, self-efficacy, and self-regulation-based psychology program was most applied in the study on health outcomes of patients with chronic non-communicable diseases (10,14).

In this research, the program was designed to meet the context of stroke patients through a series of activities that last for 5 weeks. Self-regulation was applied to the 5 series of activities with the following 3 procedures (21): 1) self-observation about self-care behavior, analyzing behaviors that affect their health. Besides, goal setting was carried out in terms of behaviors that need to be changed or improved, and self-monitoring by recording self-care behaviors in a personal health record book. Data obtained from the observation shall lead to another procedure, namely, 2) self-judgments by making a plan to adjust behaviors as intended. Next, a comparison is made between results and the goal setting, and 3) self-reaction – it was found that when self-care met the goal, participants in the experimental group were satisfied with themselves. In this study, a reward was used as external reinforcement for the experimental group. Self-rewarding was recommended to create internal motivation for self-care. Therefore, internal motivation and external motivation are significant since motivation shall promote the durability of behaviors if it constantly helps people be satisfied with outcomes from expressing new behaviors (9). According to the self-regulation process, changes occurred among participants in the experimental group as they were aware of and see the importance of adjusting their self-care behaviors to prevent the recurrence of the disease. They could control their own actions and practiced health behaviors as they set the goal to change things better, making their average healthcare score increase. This is consistent with the self-regulation concept of Bandura who believed that behaviors have not resulted from external reinforcement only but from some actions to control one’s thoughts, feeling, and actions. It is a procedure that requires practice and development to lead to behavioral adjustment. Self-regulation uses mental resources and shall decrease when it is used in the self-regulation process caused by stress, tiredness, including emotional factors. Therefore, coping with stress and emotional management shall help promote the self-regulation process to be durable (31,32). Consequently, the experimental group was given mindfulness practice to be aware of and accept what happen to them at present according to the concept of Kabat Zinn(18) to enhance activity participants to mental and physical preparedness, having an effect on modification of self-care behaviors, both physical and mental aspects, through group activities by being aware of each in-breath and out-breath as the main activity of mindfulness practice and the continuous practice of mindfulness by oneself, based on mindfulness practice activities for oneself. According to the previous study (29), each activity adjusted its context to meet patients with stroke. It was found that the mindfulness program had the effectiveness to change HB after practicing activities of the program, which can be seen from the increased average scores of HB. Mindfulness practice increasingly promotes behavioral changes since it can help support and promote behavioral changes through the interaction of 3 components affecting better self-regulation, i.e. 1) increased attention control that supports emphasis on goals continuously, 2) better emotional control that helps increase positive emotions and self-reinforcement and 3) change in self-awareness by becoming less attached to something and increased perceived self-efficacy, improved self-observation, and keep calm and maintain monitoring(19,33-34). This is consistent with a study finding that mindfulness practice can help reduce stress, depression, and anxiety, and helps boost brain function responsible for attention control and positive emotions including caring and other social emotions which promote behavioral changes (34-37). It is consistent with a systematic review, indicating that mindfulness training could help reduce blood pressure in patients with chronic non-communicable diseases (10,14). This is consistent with a study on the effect of short-term mindfulness training in stroke patients to improve basic mindfulness skills and enhance the ability to restore physical function and movement (16). It was found that mindfulness practice for 2 weeks was able to increase the level of mindfulness. In addition, according to a study on the effectiveness of telephone follow-up to determine the goals in health behaviors of stroke patients, it was found that goal setting is a process of self-regulation through telephone follow-up that was efficient to increase consistency in taking medicines among patients with stroke (7).

In addition, the results of this study revealed that HB of stroke patients who participated in the MSRP and received a high level of FSS had a higher average score than patients who did not participate in the program and received a low level of FSS, possibly because based on the concept of social support of House (38), social support plays a vital role since it is able to reduce illness, death, and confrontation with stress or hazardous conditions to health including preventing the effects of stress on health. Furthermore, social support from families and surrounding people are positively associated with a higher level of self-esteem among patients and have an effect on the health of stroke patients. Stoke patients who live alone, not accompanied by friends or families, are at risk for loneliness, have a low level of self-esteem, poor livelihood, including bad health (39). This is consistent with the study finding that low-level social support was associated with a higher risk of death caused by stroke, 1.6 times in men, compared to the group of patients receiving a high level of social support (40). A previous study found a high level of social support had a positive effect on participation in social activities and rest, including the ability to return to work after a stroke (25). It is in line with a study that revealed that a high level of FSS, friends, or health workers had an effect on the better quality of life of stroke patients in every aspect. Therefore, it is essential that in addition to the physical rehabilitation of patients in a hospital, FSS should be provided to develop stroke patients’ quality of life in conjunction with an efficient rehabilitation program (26).

Limitation of the study: The duration for data collection among the sample in the control group and experimental group was quite similar; as a consequence, there might be sample contamination. Therefore, group activities for patients in the experimental group were organized at a time and in a place where the sample from both groups had no chance to meet each other.

# Conclusion

MSRP is able to organize samples with different biosocial characteristics. In addition, the MSRP affecting HB of stroke patients is efficient for further application and additional study.

# What is already known in this topic?

It is widely known that HB is necessary for stroke patients. According to the findings HB outcomes of stroke patients are used to design the MSRP consisting of behavioral changes. The study results showed that the HB of stroke patients is at a high level**,** leading to a guideline for relevant agencies or hospitals caring for stroke patients to bring the program to strengthen HB accordingly.

# What does this study add?

Besides, the study results found the questionnaire about HB and FSSs has quality. It can be used to screen and evaluate a training program given to inpatients. Furthermore,the MSRP with 5 activities for 5 weeks is practical and can improve the HB of stroke patients. Relevant agencies or hospitals caring for patients with stroke can apply the study results to serve other benefits; for example, organizing learning activities that allow family members to participate in caring for stroke patients, organizing activities to practice self-care skills to patients, allowing patients to set a goal and make a plan by themselves while undergoing treatments, and organizing daily mindfulness practice in which the context is appropriately adjusted to meet stroke patients, etc.

# Acknowledgments

The author would like to thank the Neurological Institute of Thailand and all stroke patients who participated in the research.The research activity is funded by the National Research Council of Thailand (NRCT)

# Funding disclosure

The research was funded by the graduate research study plan, National Research Council of Thailand 2022, and Behavioral Science Research Institute Srinakharinwirot University.

# Conflicts of interest

The authors declare no potential conflicts of interest.

# References

1. World Stroke Organization. Annual Report 2019 2019 [cited 2020 20 October]. Available from: <https://www.world-stroke.org/assets/downloads/WSO_2019_Annual_Report_online.pdf>.

2. Mental Health Strategy and Planning Division, Office of the Permanent Secretary Ministry of Public Health. Public Health Statistics. 2019. N.P.2020.

3. World Stroke Organization. Learn about stroke 2020 [Available from: https://bit.ly/3KMO6Yn.]

4. Koenig KL, Whyte EM, Munin MC, O’Donnell L, Skidmore ER, Penrod LE, et al. Stroke-Related Knowledge and Health Behaviors Among Poststroke Patients in Inpatient Rehabilitation. Archives of Physical Medicine and Rehabilitation. 2007;88(9):1214-6.

5. Yuni T, Kudo M. Factors Related to Continuation of Health Behaviors among Stroke Survivors. Journal of the Japanese Physical Therapy Association. 2011;14(1):1-11.

6. Parappilly BP, Field TS, Mortenson WB, Sakakibara BM, Eng JJ. Determinants Influencing the Prestroke Health Behaviors and Cardiovascular Disease Risk of Stroke Patients: A Cross-Sectional Study. Journal of Stroke and Cerebrovascular Diseases. 2019;28(6):1509-18.

7. Wan L-H, Zhang X-P, Mo M-M, Xiong X-N, Ou C-L, Zhang M. Effectiveness of Goal-Setting Telephone Follow-Up on Health Behaviors of Patients with Ischemic Stroke: A Randomized Controlled Trial. Journal of Stroke and Cerebrovascular Diseases. 2016;25(9):2259-70.

8. Adiyasa RP, Cruz BGM. The Correlation Between Self-Care Behavior and The Self-Efficacy of Hypertensive Adults. Indonesian Nursing Journal of Education and Clinic. 2020;5(1):44-50.

9. Kwasnicka D, Dombrowski SU, White M, Sniehotta F. Theoretical explanations for maintenance of behavior change: A systematic review of behavior theories. Health Psychology Review. 2016;10(3):277-96.

10. Intarakamhang U, Macaskill A, Prasittichok P. Mindfulness interventions reduce blood pressure in patients with non-communicable diseases: A systematic review and meta-analysis. Heliyon. 2020;6(4).

11. Huffman JC, Mastromauro CA, Boehm JK, Seabrook R, Fricchione LG, Denninger JW, et al. Development of a Positive Psychology Intervention for Patients with Acute Cardiovascular Disease. Heart International. 2011;6:e14:47-54.

12. Macaskill A. Review of Positive Psychology Applications in Clinical Medical Populations. Healthcare. 2016;4(3).

13. Grossman P, Niemann L, Schmidt S, Walach S. Mindfulness-based stress reduction and health benefits. Journal of Psychosomatic Research. 2004;57(1):35-43.

14. Intarakamhang U, Macaskill A. Effectiveness of a health literacy intervention based on transformative learning and incorporating positive psychology on health behavior and well-being of Thai families at NCDs risk. J Public health Res 2022;11:1935.

15. Johansson B, Bjuhr H, Rönnbäck L. Mindfulness-based stress reduction (MBSR) improves long-term mental fatigue after stroke or traumatic brain injury. Brain Injury. 2012;26(13-14):1621-8.

16. Wang M, Liao W, Chen X. Effects of a Short-term Mindfulness-Based Intervention on Comfort of Stroke Survivors Undergoing Inpatient Rehabilitation. Rehabilitation Nursing. 2019;44(2):78-86.

17. Wathugala M, Saldana D, Juliano JM, Chan J, Liew S-L. Mindfulness Meditation Effects on Poststroke Spasticity: A Feasibility Study. Journal of Evidence-Based Integrative Medicine. 2019;24:1-7.

18. Kabat-Zinn J. Full catastrophe living: Using the wisdom of your body and mind. New York, NY: DELTA; 1990.

19. Tang Y-Y, Holzel BK, Posner MI. The neuroscience of mindfulness meditation. Nat Rev Neurosci. 2015;16(4):213-25.

20. Tang Y-Y, Posner MI, Rothbart MK, Volkow ND. Circuitry of self-control and its role in reducing addiction. Trends in Cognitive Sciences. 2015;19(8):439–44.

21. Bandura A. Social foundations of thought and action: A social cognitive theory. NJ: Prentice-Hall: Englewood Cliffs; 1986.

22. Lennon S, McKenna S, Jones F. Self-management programmes for people post stroke: A systematic review. Clinical Rehabilitation. 2013;27(10):867-78.

23. Parke HL, Epiphaniou E, Pearce G, Taylor SJC, Sheikh A, Griffiths CJ, et al. Self-Management Support Interventions for Stroke Survivors: A Systematic Meta-Review. Plos One. 2015;10(7).

24. Kaakinen JR, Coehlo DP, Steele R, Tabacco A, H. HSM. Family health care nursing: Theory, practice, and research. Philadelphia: F.A. Davis Company; 2015.

25. Elloker T, Rhoda AJ. The relationship between social support and participation in stroke: A systematic review. Afr J Disabil. 2018; 7:357.

26. Butsing N, Tipayamongkholgul M, Ratanakorn D, Suwannapong N, Bundhamcharoen K. Social support, functional outcome and quality of life among stroke survivors in an urban area. Journal of Pacific Rim Psychology. 2019;13.

27. Daranee Anantasaran. Effects of health care promoting program on self-care behavior and blood pressure level among older adults with uncontrolled hypertension in Langsuan Municipality, Chumporn province. Medical Journal. 2016;30(4):299-311.

28. Grove SK, Burns N, Gray JR. The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence. ed. t, editor. St. Louis, MO: Elsevier; 2013.

29. Gray LA. Living the Full Catastrophe: A Mindfulness-Based Program to Support Recovery from Stroke. Healthcare. 2020;8(4).

30. Tougas ME, Hayden JA, McGrath PJ, Huguet A, Rozario S. A Systematic Review Exploring the Social Cognitive Theory of Self-Regulation as a Framework for Chronic Health Condition Interventions. Plos One. 2015;10(8).

31. Baumeister RF. Ego Depletion and Self-Regulation Failure: A Resource Model of Self-Control. Alcoholism: Clinical & Experimental Research. 2003;27(2):281-4.

32. Hendershot CS, Witkiewitz K, George WH, Marlatt GA. Relapse prevention for addictive behaviors. Substance Abuse Treatment, Prevention, and Policy. 2011;6(1).

33. Holzel BK, Lazar SW, Gard T, Schuman-Olivier Z, Vago DR, Ott U. How Does Mindfulness Meditation Work? Proposing Mechanisms of Action From a Conceptual and Neural Perspective. Perspect Psychol Sci. 2011;6(6):537-59.

34. Tang YY. Mindfulness Meditation and Behavior Change. The Neuroscience of Mindfulness Meditation2017. p. 35-44.

35. Davison RJ, Kabat-Zinn J, Schumacher J, Rosenkranz M, Muller D, Santorelli SF, et al. Alterations in Brain and Immune Function Produced by Mindfulness Meditation. Psychosomatic Medicine. 2003;65(4):564-70.

36. Grossman P, Niemann L, Schmidt S, Walach H. Mindfulness-based stress reduction and health benefits: A meta-analysis. Focus on Alternative and Complementary Therapies. 2010;8(4):500.

37. Hofmann SG, Sawyer AT, Witt AA, Oh D. The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. Journal of Consulting and Clinical Psychology. 2010;78(2):169-83.

38. House JS, Umberson D, Landis KR. Structures and Processes of Social Support. Annual Review of Sociology. 1988; 14:293-318.

39. Lamont RA, Calitri R, Mounce LTA, Hollands L, Dean SG, Code C, et al. Shared social identity and perceived social support among stroke groups during the COVID-19 pandemic: Relationship with psychosocial health. Appl Psychol Health Well Being. 2022.

40. Ikeda A, Iso H, Kawachi I, Yamagishi K, Inoue M, Tsugane S, et al. Social support and stroke and coronary heart disease: the JPHC study cohorts II. Stroke. 2008;39(3):768-75.

**ผลของโปรแกรมการฝึกสติร่วมกับการกำกับตนเองที่มีต่อพฤติกรรมการดูแลสุขภาพของผู้ป่วยโรคหลอดเลือดสมอง: การทดลองแบบสุ่มมีกลุ่มควบคุม**

ปวีณา กัญญะพิลา MS1, ศรัณย์ พิมพ์ทอง PhD2,

อังศินันท์ อินทรกำแหง PhD2, ภัทราวุธ อินทรกำแหง MD4

1 สถาบันประสาทวิทยา กรุงเทพฯ ประเทศไทย

2,3สถาบันวิจัยพฤติกรรมศาสตร์ มหาวิทยาลัยศรีนครินทรวิโรฒ กรุงเทพฯ ประเทศไทย

4 กองเวชศาสตร์ฟื้นฟู โรงพยาบาลพระมงกุฎเกล้า กรุงเทพฯ ประเทศไทย

**Correspondence to: Intarakamhang U.**

สถาบันวิจัยพฤติกรรมศาสตร์ มหาวิทยาลัยศรีนครินทรวิโรฒ กรุงเทพฯ 10110, ประเทศไทย

**โทร. +66-89-1653520 Email:** [**ungsinun@g.swu.ac.th**](mailto:ungsinun@g.swu.ac.th)

**บทคัดย่อ**

**ภูมิหลัง**: โรคหลอดเลือดสมองเป็นสาเหตุการตายอันดับสองรองจากมะเร็ง ดังนั้น ผู้ป่วย จำเป็นอย่างยิ่งที่ต้องมีการปรับเปลี่ยนพฤติกรรมการดูแลสุขภาพเพื่อการฟื้นตัวอย่างยั่งยืน

**วัตถุประสงค์** : เพื่อศึกษาประสิทธิผลของโปรแกรมการฝึกสติร่วมกับการกำกับตนเองที่มีต่อพฤติกรรมการดูแลสุขภาพ และวิเคราะห์ปฏิสัมพันธ์ร่วมระหว่างการสนับสนุนทางสังคมจากครอบครัวกับโปรแกรมการฝึกสติร่วมกับการกำกับตนเองที่มีต่อพฤติกรรมการดูแลสุขภาพของผู้ป่วยโรคหลอดเลือดสมอง

**Conclusion:** This MSR program should be used to initiate the policies in promoting the HB of stroke patients.

**วัสดุและวิธีการ:** แบบแผนการวิจัยรูปแบบทดลองแบบสุ่มมีกลุ่มควบคุม เพื่อการออกแบบการทดสอบประสิทธิผลของโปรแกรม จำนวนตัวอย่าง 58 ค น มาจากการคำนวนขนาดตัวอย่างด้วยโปรแกรมสำเร็จรูป G\*Power 3.1

โดยกำหนดระดับนัยสำคัญทางสถิติ .05 ค่าพาวเวอร์เท่ากับ 0.85 และค่าอิทธิพลได้จากการคำนวผลการวิจัยที่ทำการศึกษาตัวแปรคล้ายคลึงกันได้เท่ากับ 0.77 จากนั้นกลุ่มตัวอย่างถูกสุ่มจำแนกเข้ากลุ่ม กลุ่มทดลอง 28 คน และกลุ่มควบคุม 30 คน เก็บข้อมูลด้วยแบบสอบถามประมาณค่าตามมาตรวัดของลิเคิร์ทที่มีค่าความเชื่อมั่นของครอนบาคอยู่ระหว่าง .934-.989

ซึ่งโปรแกรมการฝึกสติร่วมกับการกำกับตนเองมีทั้งหมด 5 กิจกรรมระยะเวลา 5 สัปดาห์ โดยดำเนินกิจกรรมตั้งแต่เดือนเมษายนถึงธันวาคม 2564 และวิเคราะห์ข้อมูลด้วยสถิติเชิงพรรณนา สถิติทดสอบค่าที สถิติวิเคราะห์ความแปรปรวนทางเดียว และวิเคราะห์ความแปรปรวนร่วมแบบสองทาง

**ผลการศึกษา**: พบว่าภายหลังการทดลองผู้ป่วยโรคหลอดเลือดสมองมีพฤติกรรมการดูแลสุขภาพ (ค่าเฉลี่ย = 5.32, SD=.423) และอยู่ในระดับสูง และโปรแกรมการฝึกสติร่วมกับการกำกับตนเองมีประสิทธิผลในการส่งเสริมพฤติกรรมการดูแลสุขภาพอย่างมีนัยสำคัญโดยกลุ่มทดลองมีพฤติกรรมการดูแลสุขภาพที่สูงกว่ากลุ่มควบคุมและสูงกว่าก่อนเข้าร่วมโปรแกรมฯที่ระดับนัยสำคัญที่ .05 ในการศึกษานี้พบปฏิสัมพันธ์ร่วมระหว่างการสนับสนุนทางสังคมจากครอบครัวกับโปรแกรมการฝึกสติร่วมกับการกำกับตนเอง พบว่าผู้ป่วยโรคหลอดเลือดสมองที่เข้าร่วมโปรแกรมฯและการสนับสนุนทางสังคมจากครอบครัวในระดับสูง และ มีพฤติกรรมการดูแลสุขภาพที่สูงกว่าผู้ป่วยโรคหลอดเลือดสมองที่ไม่ได้เข้าร่วมโปรแกรมฯและการสนับสนุนทางสังคมจากครอบครัวในระดับต่ำ

**สรุป:** ผลการศึกษาครั้งนี้สามารถใช้เป็นแนวทางในการส่งเสริมพฤติกรรมการดูแลสุขภาพของผู้ป่วยโรคหลอดเลือดสมอง

**คำสำคัญ:** สติ, กำกับตนเอง, หลอดเลือดสมอง, พฤติกรรมการดูแลสุขภาพ