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LIFE EXPERIENCE OF ADAPTATION AFTER A STROKE

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ABSTRACT

A stroke is a critical life event that leaves some disabilities in adults and the elderly in the long term. It may be permanent that the patient must adapt for survival, growth, reproduction, and mastery. The purpose of this study was to describe how a person could adapt after a stroke. The sample was obtained by selected criteria and processed by a qualitative interview procedure. Eleven stroke patients who were still able to communicate participated in this study. The study revealed five themes of adaptation after a stroke: (1) fright (perceived loss of physical functions, expecting to recover, fear of death and not being able to recover, and loneliness), (2) dreams (hope, and seek miracle help), (3) realization (depression, loss of self-worth, hopelessness, and suicidal ideation), (4) acceptance (projecting, seeking for spiritual attachment, and intuition), (5) adjustment (let it be, back to family, and self-help). The findings provide an important basic knowledge for health care providers to understand the patients who have to adapt after a stroke, create strategies to support them, and approach their families in a way to support them to adapt with effective responses.

Keywords: Adaptation, stroke patient, life experience.

INTRODUCTION

A stroke is the most common life threatening neurological disease, a major cause of disability and the third cause of mortality in adults and the elderly worldwide (Khaw, 1996; Barba et al., 2002). In Asian countries, studies on stoke has been comparatively limited (Viriyavejakul, 1990). In Thailand, the Public Health Statistics, 2003 indicated that stroke is a leading cause of death after cancer and accidents similar to other developed countries' situation. In Thailand, the prevalence rate of stroke for persons over 20 years of age was about 6.9 per 1,000 persons, which is similar to the prevalence rates of other developed countries (Viriyavejakul et al., 1985) and, approximately, not less than 150,000

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new cases per year (Poungvarin, 2000). The overall expert consensus recommends that stroke patients in general should be urgently hospitalized to ensure accurate diagnosis and care. There is considerable international variation in hospital admission rates after a stroke. Around the world, approximately 80-90% of acute stroke patients are hospitalized (Bogousslavsky, 1997). Most of the deaths (17 - 34%) occurred in the first 30 days (Appelros et al., 2003; Silver et al., 1984; Kothari et al., 2006; Musico et al., 2003). Because of their sequelae, strokes are categorized as a sudden onset, constant course chronic illness (Hafsteinsdottir and Grypdonck, 1997). Although 34% to 70% of stroke survivors regain functional independence (Kothari et al., 2006; Hankey et al., 2002; Wilkinson et al., 1997; Yamamoto and Magalong, 2003), 15% to 30% are permanently disabled (Kothari et al., 2006; Hankey et al., 2002; Wilkinson et al., 1997). During hospitalization, the stroke survivor experienced stress on a variety of levels. In addition to an insult, which leaves the patient with loss of movement, the patient would be submitted to complex nursing and medical interventions (Hafsteinsdottir and Grypdonck, 1997).

The stroke patients must adapt to stroke symptoms as physical, psychosocial and spiritual changes or disability. Adaptation is the process and outcome whereby thinking and feelings maintain integrity or meet the system's goals for survival, growth, reproduction, and mastery, while ineffective responses threaten an individual's integrity or do not meet those goals and, therefore, signal a need for intervention (Roy and Andrew, 1999). In recent years, there has been an increased awareness among health care professionals that recovery after a stroke cannot be measured purely by one's functional abilities. Researchers are incorporating standard psychological and social indices with activities of daily living (ADL) measurements in an effort to capture the realistic lifestyle stroke patients actually lead (Hafsteinsdottir and Grypdonck, 1997). However, the basic knowledge to describe the patient's adaptation process from a stroke is important and needs to be explained.

With a large number of stroke survivors in the country, health care personnel must understand the post-stroke adaptation process. The understanding of the process of stroke adaptation from the patients' descriptions of their experiences will help the health care personnel to identify potential intervention to help them effectively adapt in a short time. The theory development proposed for this project is built particularly on in-depth interview data of eleven stroke patients. The purpose is to develop a descriptive or explanatory model of stroke patients' adaptation.

METHODOLOGY

The aim was to explore how stroke patient's experiences adapt with their stroke. A qualitative research was designed to uncover the thoughts, perceptions and feelings experienced by the stroke patients in the process of adaptation or facing stroke and its sequel. Qualitative methods concerned with understanding human behavior from the perspective of the participants and are helpful for discovering complex interactional human processes (Sack and Nelson, 2007). This study design included concurrent data collection, constant examination of conceptual interactions, linkages, and the conditions under which they occurred. A semi-structured schedule question was developed to ensure that the research questions were being addressed. The Khon Kaen University Ethics Committee for Research on Human Subjects approved the study.

Participants were recruited through a rehabilitation nurse in the rehabilitation unit of university hospital and primary care unit nurse of the university hospital located in Khon Kaen Province, Thailand. The criteria for inclusion were that the participants were: diagnosed as stroke patients, age not younger than 20 years old, cognitively intact, being able to verbally communicate, having no psychiatric problems, willing to participate and cooperate in the data collection procedures in the study. The patients with difficulties in language expressions or comprehension, experiences of any

type of aphasia or inability to fully participate in all data collection process, any premorbid psychiatric history or a previous history of mental illness, antidepressant medications, and a post-stroke dementia were excluded. Eleven stroke patients who met the selection criteria were selected by theoretical sampling to cover different age groups, the duration and side of stroke, and the socioeconomic status. They were explained the general nature of the study, and were asked for their willingness and consent to participate in giving information for this study.

Data collection was carried out using a semi-structured schedule through individual, audio-taped interviews with each research participant. One researcher participated in data collection, which took place in four months. The interviews took place at the rehabilitation unit and their home. The interviews lasted 1-3 hours and were audio-taped and transcribed by permission of the participants. To create a comfortable atmosphere, the interviews started with the participants being asked to tell their stroke story, from the first occurrence in their life up to now. Subsequently, the respondents were asked about particular events or realities faced in life with the stroke; how they had managed and adapted to these events or realities. In order to validate and enrich the stroke patients' descriptions of their adaptation with stroke experiences, all audio-taped interviews were transcribed verbatim, and audited. The researcher completed field notes during and after the interviews. Data collection was terminated at the point of data saturation, indicated when data became redundant or patterns became repetitive in the interview and data was thematically saturated in content analysis. To promote rigor of the study, six participants confirmed and clarified the transcripts and validated or clarified preliminary understandings.

Content analysis was used to analyze the interview data in this study. Analysis was conducted by first reading each transcript and field notes in its entirety to get a general overview of the interview. This was a systematic procedure whereby verbatim or unstructured data was systematically categorized and constantly compared by content area. Data analysis using the technique of coding was done immediately after each interview had been transcribed. Themes that consistently emerged were coded. Interpretation of data goes beyond retelling a story or reporting common themes, and shows the meaning of the phenomenon or a new way of looking at a common event.

RESULTS

Eleven patients were selected as participants in this study, three of them were admitted at the rehabilitation units of a university hospital and seven were living in communities. These participants consisted of five females and six males. They ranged in age from 32 to 74 years (mean = 56; median = 60 years) at time of interview. Only one patient had the first stroke onset when he was older than 60 years old. All were married; however, two of them were divorced after the stroke. They were mostly from different backgrounds of pre-stroke occupation. The duration of the stroke ranged from one month to 10 years, six of them had after effects on the left side and five on the right. All of them were unemployed after the stroke. The major caregiver was spouse and daughter of the stroke patient. The demographic and clinical characteristics data of the stroke patients in this study are summarized in Table 1.

Table 1. The demographic and clinical characteristics profile of the stroke patients in this study.

Participant	Sex	Age	Marital status	Duration of stroke	Pre-stroke occupation	Major career
1	Male	68	Married	3 years	Police	Spouse
2	Male	74	Married	5 years	Worker	Spouse
3	Male	61	Divorced	10 years	Worker	Daughter
4	Female	63	Widowed	4 years	Business woman	Daughter
5	Male	58	Married	6 months	Public health officer	Spouse
6	Female	55	Divorced	2 years	Business woman	Daughter
7	Male	35	Married	1 year	Soldier	Spouse
8	Male	60	Married	8 months	Business man	Spouse
9	Female	45	Married	3 months	Trader	Spouse
10	Female	32	Married	1 month	Trader	Spouse
11	Female	66	Married	10 months	Teacher	Daughter

Adaptation after a stroke begins once the patients have been attacked with the first initial stroke and throughout their life. It included the thinking and feelings of the stroke persons (Roy and Andrews, 1999). The stroke patients have to adapt with the internal and external environments all the time and sometimes they do not know or are not aware of their adaptation, but the major or critical adaptation is an important situation which disturbs their normal life or an object or an event present in their consciousness (Roy and Andrew, 1999). Individual adaptations are complex and highly specific to each stroke patient. The path of an interesting developing adaptation reported by the stroke patients' is like a life-cycle that most stroke patients have to pass. That is they can live after a stroke with their life's satisfactory. This process of adaptation appears to incorporate with the background experience of each individual. The purpose of this study is to develop a theory of stroke adaptation, which includes five themes- fright, dreams, realization, acceptance, and adjustment including its corresponding sub-themes.

Fright

Since the stroke attacked, the patients would have to immediately adapt themselves. First, they would have to realize that the symptoms of a stroke had occurred at the point of time especially of physical effects or losses of physical activity or mobility such as loss of control to some part of their leg, arm, and speaking. The most common physical effects of a stroke are unilateral weakness, sensory and visuoperceptual disturbance, incontinence, aphasia, dysphasia and facial palsy. In this study, all stroke patients did not know about the warning signs or the signs and symptoms of strokes before.

When they were attacked by a stroke, four stroke patients with mild to moderate progressive stroke perceived that they had common illness for a

while; they had physical weakness and expected that it would be over completely after a rest. Therefore, one of them decided immediately to go for a traditional massage. The worst of the signs and symptoms of the illness later made them frightened (awake and alert) and perceived that it was not common as they thought. Thus, they decided to go to hospital. Nonetheless, four stroke patients decided immediately to go to hospital immediately after they had had the first signs and symptoms of a stroke.

All stroke patients went to hospital (in different duration of time after the first stroke attacked). Inevitably they were admitted to hospital with the duration ranging from three days to two months. At that time the patients did not know what a stroke was; they only knew that it was an obstruction or stenosis or hemorrhage of the cerebral vascular after they were told by the physician.

None of these patients' family member had had a stroke before. Two of them had some friends or acquaintances that had had a stroke but they thought they would be different. All of them thought that their stroke could be cured and completely recovered soon. On the contrary, some of their physical loss made them frightened. They were afraid of dying, not being able to fully recover, or having permanent loss of physical functions.

As a sequence, perceived loss of physical functions, expectation to recover, fear of death and not being able to recover, and loneliness were arranged as sub-themes of this theme.

Perceived loss of physical functions

First of all, stroke patients must face some neurological deficits or physical function impairments such as weakness or numbness of one side of the body, sensory loss of one side of the face, dysphasia, and incontinence, etc. All the stroke patients experienced a physical loss but expressed in different ways depending on the pathological condition of the brain and their context. The same expression was found in all of the stroke patients in both sexes of different ages. They described the perceived loss of physical functions as the loss of physical activity or mobility, including lack of control over their bodies, loss of energy to function as:

"..I went numb on the side of my body. I cannot grasp anything, and cannot move my body anymore. I cannot speak and my mouth is distorted."

"I cannot move my leg and arm; it has no power or energy."

"One of my legs does not have strength; it is paralyzed."

"My thigh is fatigued, the leg is weak, and so it cannot be lifted. It started in one leg and then slowly moved to an arm, and then my hand is weak and cannot do anything anymore."

"After the first attack, I have a mouth distortion and the saliva leaks out from the corner of my mouth."

"My leg and arm are very heavy".

"When I want to use the toilet, I cannot wait."

The loss of physical functions is the most important aspect that stimulates the persons to be concerned and influenced by the psychosocial and spiritual status of the person. It does not occur only in the early days of their stroke but it also continues long after the stroke and is related to other themes. The loss of control appeared to be related to fear or uncertainty about the immediate situation, future and during the recovery; it appeared to be related to feelings of being dependent on others.

Expectations to recover

This stage occurs before medical diagnosis. All stroke patients did not know what they had, but they thought that it might be a general illness and expected that they could get well or be completely healed. Even though, two of them had some friends or acquaintances that had had a stroke and was left with physical disability, but they thought they were different.

As a result, six stroke patients went home to rest and one went for a massage because they thought if they rested for a while they would be better or completely recover, four of them who were with a serious condition went to hospital immediately. This sub-theme, the stroke patients said:

"When I had a stroke, I could not move, my mouth distorted, my right side of the body was paralyzed and I thought if I rested for a while I would get better"

"I went out to jog in the morning. When I came back and drank coffee I started to feel numb. I did not know what happened, but I thought a rest would help so I went back to bed."

"I got dizzy suddenly, and then a headache; I felt that my head was heavy and I got numb. So, I went to bed. I thought that I would be better after a rest."

One stroke patient expected that if he went for a traditional message, he would get better:

"On the first day, my thigh began to get fatigue and I could not lift my foot. The day after, I had the same sign. Then I went for a massage because I thought it would make me better."

Expectations to recover occurred in the early stage of a stroke since they were not aware of or have enough knowledge about it before.

Fear of dying and not being able to recover

The fear of dying and not being able to recover were found in all of the stroke patients especially at the early stage after the stroke and when they found out that the physical loss would not be recovered as they had expected. Some stroke patients got the feeling of fear after they had waited for the recovery, but it was not coming and the doctor confirmed that the physical loss might be better but it would not be recovered completely. The fear of not being able to recover occurred in all stroke patients; it was followed by the fear of dying. Four stroke patients felt that their condition was worse. However, the fear of dying disappeared when stroke condition was stable or was not worse or better than the initial stage. After they accepted that the chance of full recovery was little, some of them had the fear of worse physical function loss or worse condition of the disease or recurrent stroke. This fear was hiding along the fear of dying and the fear of not being able to recover in some stroke patients. They described this sub-theme as follows:

"Initially, I thought a lot until I was under stress and afraid of not being able to recover."

"At the beginning, I feared not being able to recover, feared death, then I cried; I questioned why I was like that. I cried for a month."

"At the early stage, I thought so much; I thought that I would die."

Loneliness

Loneliness occurred after the patients were discharged from the hospital to return home. At their home, most of them were left to stay alone during the day because their family members had to go to work and the children had to go to school. Only one case hired someone to care for him for a short period. Some said they felt that the time went by very slowly after they had a stroke. The stroke patients described this sub-theme as follows:

"I feel lonely because of my illness. I cannot go anywhere."

"I have many children but it seems that I do not have any at all. None of them are concerned with me. When I had a stroke, they did not come to look after me. They only called me."

"I stay alone in the house because my wife goes to work and my child goes to school."

"During the day, I stay alone and I feel lonely. If my wife is retired, I will not be alone."

"I often cry; I stay alone, so I am more sensitive; it makes me sad."

Dreams

After the stroke patients knew from the doctor that their physical function loss would be better, but it would not be fully recovered. It was hopeless to be cured by modern medicine. But there are several ways of treatment for it. Most of them had heard before they had a stroke that the person who had a stroke could be cured from alternative therapy. This hope motivated them to seek another treatment.

Hope

Hope is an important feeling, which gives patients vital life energy to survive. All the stroke patients hoped or wished to gain complete recovery or to be better, even though they had gotten the information about recovery outcomes from the physician. Most of them thought that if they received good medicine or good therapy-like massages in the right way, they might recover fully. The hope in some of them was related to God or something supernatural. Hope seemed to be emerging in all the strokes' lives. They described this sub-theme as the following:

"I think, I will recover some day if I have a good traditional massage therapist."

"I hope that I will recover as before."

"I hope I will recover even though it is only a dream."

"I feel that I will recover but it takes time. Some recover after 12 years, some after ten, and some after eight. However, someone had a stroke for ten years and is still in a wheel chair, but I can walk while several patients cannot even in the same duration of a stroke."

"I think I will recover. I pray to god to help me recover. Every day I put the food in a bowl for the monk and I pray for my recovery."

"I hope that I will recover if I get some good medicine, I am sure I will recover."

Seeking for miracles to heal

All of the stroke patients had some fear and hope of recovery at the same time. This made them seek for alternative treatment. In this sub-theme, seven stroke patients used herbs; some went for traditional medicine at another village and had herbs for the cure; some got herbs from a seller who walked around the village and told about the properties or the effects of the herbs; and some were given herbs by their son or spouse. Three stroke patients went to a fortuneteller to ask about their life. If it was bad, they hoped that the fortuneteller would suggest how to change it. Two stroke patients believed that they got a stroke because of a spirit or devil, and tried to find a way to drive the devil out of them. Two of them paid all the money they had. One sold everything that they had, i.e., the house to get the money to pay for alternative care. Seeking for help is going on as long as they have hope. The stroke patients described this sub-theme as quoted here:

"After the doctor said I had a stroke, I called my son to boil some herbs to drink with the medicine that the doctor ordered. I could not speak and lay in bed for a month, and then I called my son to boil the herbs again. After that I could speak but not so well, like a child."

"When I had a stroke, I went for treatment everywhere: the temple or the place that people recommended. My wife drove me to seek the treatment for five years, but it was in vain.

"Someone told me that a ghost from the big tree which was cut down three years ago made me ill. I invited a voodoo doctor to drive out the ghost from me."

Realization

After the stroke, the doctor told patients that they would get better but would not completely recover. Later they found that the alternative therapy could not make them better either the acceptance or acknowledgement of the problems resulting from the stroke had to be pursued. Once the stroke patients realize the stroke condition, the responses are depression, anger, loss of self-worth, hopelessness, and suicidal tendencies. These are the sub-themes of realization. The stroke patients described this theme as follows:

Depression

Depression is the feeling of sadness or sensitivity, which the patient feels. Easton (1999) defines characteristics or sub-themes of realization of post-stroke adaptation as depression. It was found that most patients felt depressed immediately after the realization that they had lost part of themselves

forever. In this study, all the stroke patients experienced the feeling of sadness or sensitivity about the limitation of the physical function especially in the first phase of stroke. This feeling goes all their life. But in the later phase, three of them felt depressed with their fate.

"I feel depressed that I cannot do anything."

"I am depressed and sensitive why I am like this now. What a fate I have!"

"My mind feels shrunken in spirit and depressed."

"I feel sad. Some people invite me out but I cannot go anywhere. I feel that I cannot do anything."

Anger

Anger is a feeling that the stroke patients describe as unsatisfied, frustrated, and irritable. All had this feeling in the first phase of the stroke, and some continued having this feeling all their life, especially two of them who had aphasia in the early phase of stroke. Feelings of anger and exhaustion were expressed repeatedly and seemed to be particularly acute for aphasics who had lost the ability to communicate. The lack of communication was the most frustrating aspect of stroke. This is how they described these sub-themes:

"I could not put my shoes on. I felt anger then, so I used my hand to hit my leg."

"Sometimes, I feel angry that I cannot do anything as I want." "Since I was ill, I have felt angry most about my hand and foot, for I cannot move them."

"During the first phase of sickness, I had a row with my family. I felt that I could easily get angry, irritated, and nervous."

"The most irritating thing is that I cannot help myself. I easily get angry, irritated and emotional labile. I often cry, and feel irritated and angry with other people.

Loss of self-worth

The feeling of self-worth loss occurred in the informants who perceived that they could not do anything. Even though only one side of the body was impaired. This feeling occurred in two males, a soldier and a policeman. It occurred in the first phase of the stroke. The stroke patients described these sub-themes as follows:

"I feel I am not worthy anymore."

"I feel empty; I cannot do anything; it is like I am wasting my breath and waiting to die."

Hopelessness

Hopelessness occurred after they had a stroke, and they knew that they would never return to normal life as before. Their wishes, dreams, and plans for their future now are impossible for them. These include their hope to recover and return to normal life. They said:

"I do not hope to recover, and let it be. I am sure I cannot recover."

"I plan to open a restaurant with my wife after my retirement, but after the stroke I quit this plan because it is impossible now."

"If I did not have a stroke, I thought I could work and get a lot of money. I will use my capacity to do honest work to get money to help my child. If I have a lot of money, my family will be happy."

Suicidal ideas

The suicidal ideas occurred in the stage of realization. Two stroke patients thought of committing suicide and one of them did. All of them are males. The one who committed suicide sold all his properties for treatment in the first phase of stroke. However, it did not help and he was separated from his wife five years after the stroke. Another case is a soldier who is only 35 years old, the youngest among the male patients. He had a suicidal idea. These sub-themes were described as follows:

"I want to die because it cannot be cured. I want to die--I cannot do anything, I want to commit suicide. I stayed at home alone. I tried to find a poison but I could not find any because before my

wife went out to work, she kept it out of my sight."

"I had thought of suicide at that time. I cried every night because I was concerned about my children who were studying then, and my wife had to work hard. I thought a lot. I thought of committing suicide sometimes by taking a poison, sometimes by knife, but when I thought of my child's and my wife's faces, I calmed down."

Acceptance

The patients tried to prove their concepts of cures with their hope and realization through the defense such as depression, anger, loss of self-worth, hopelessness, and trying to commit suicide before beginning to learn to cope with the permanent loss from the stroke. In this process, several stroke patients described the cause of stroke as karma. Then they try to cheer up by approaching religion, listening to or reading religious teachings and put them into practice to strengthen their spirit. After that several stroke patients had insight into the truth or nature of life and accepted their condition. However, not all of them met this phase. This study found only five stroke patients who were with older people and deeply religious could achieve intuition. This theme includes projecting, seeking for spiritual attachment and intuition as sub-themes which were described by the patients as follows:

Projecting

After the stroke patients passed the stage of realizations. Four participants who had experienced a stroke more than one year projected the stroke, which unexpectedly occurred in their life as their karma. They thought it might be because of a bad thing they had done in their previous life. They believed since they had always done only good things in this life, the stroke that had hit them must have been because of something bad they had done in the previous life. One informant projected it as a ghost. The stroke patients described these sub-themes as follows:

"I thought I had sinned. It was the sin that makes me like this. I had killed chickens and fried them to sell."

"I think I am a good man, but I am like this now because it is the karma that I did before birth. I might have done a bad thing, and it followed me."

"I think it is karma. It is real. I had hit an incapacitated person because he agitated me. I hit and made one of his arms paralyzed."

"I suspected that I got a stroke because a devil made me and it was confirmed by a person who communicated with the spirit."

Seeking for spiritual attachment or help

Once the stroke patients perceived that, their hope was rarely possible. They returned to look for spiritual attachment. Five of them approached religion, practiced, read Dhamma, and listened to the monks' sermons. They described these sub-themes as the following:

"The mind attachment is God. I cannot go to the temple because it is difficult to walk. I wake up in the morning and put the food in a bowl for the monk every day."

"My hobby is to read on the monk's teachings books which my child brought to me. I feel that I approach Dhamma more. It has not been in my interests before. "

"I think of the God everyday."

"I pray and worship God and monks. I wear a necklace with a Buddha image every day."

Insight or intuition

Four of the stroke patients got insight from the lives of other people around them. Then they thought and analyzed or compared them with their own. One got insight from a book on a monk's teachings. All of stroke patients had approached religion before. They described these sub-themes as follows:

"I think something must happen; it must happen. My friends at the same age had cancer and many of them died. I went to their cremations. But I am still alive."

"Before I had a stroke, I had seen other stroke patients. I did not have any feelings. Now, I pity them. Once I went to hospital, I saw a young man with a brain tumor, he could not speak, and he just sat in a wheelchair all the time. He looked pitiful. I also found some patients complaining about their trouble and said that I was lucky because I had money."

"Initially I feared death but now I do not. Other people die younger."

"Now, I feel self-worth because I can do many things while other people cannot."

"Now I do not think much any more. Death is death. Living is living. My concept has changed, I am not sensitive or sad but it takes several years for this to happen."

"Before this, I could not accept my condition. It takes me a long time to accept it. Now I can because of a book on the monks' teachings."

Adjusting

Once the stroke patients accepted their residual effects. Several of them returned to their family, because they love and have concern for them. They make the stroke patients return to insight, understanding and have concern for their family. Three stroke patients tried to maintain and promote the physical function by doing exercise such as walking. This adjusting phase occurred after the accepting phase which each individual accepts his or her residual effects. They reviewed their life, integrated it with the information from another person's life and the religious teachings through the process of acceptance. Then they made a new concept of their life to the direction of further life. Several stroke patients felt that the family support and the teachings of the monks encouraged them to cope with the permanent residual effects of a stroke. A significant person whom the stroke patients pointed out is the spouse and children. They felt better when the spouse and children said they were willing to take care of them and expressed respect and concern for them. This theme includes let it be, back to family and self-help sub-themes. Only four stroke patients who had a stroke more than three years ago could achieve the sub-themes of let it be and self-help.

Let it be

Most of older participants who used adaptive response as leave it be or let it up to fate. Most of them gave the meaning of let it be in the same as leave it up to fate that they accepted everything which might occur in their life including death. They did not want to be frantic anymore but would do their best at everything. One informant said he had had enough. These sub-themes were described as follows:

"The hope ended; now leave it up to fate. I am too old."

"Now, I quit thinking and let it be."

"I do not hope to recover. Let it be. I cannot recover, and I let it be every day. I always took good care of myself but I still had a stroke."

Back to family

After the phase of acceptance, most stroke patients tried to live with the residual stroke effects by creating a new life concept as let it be and then back to his or her life remainders both internal and external sources, such as family, physical and mental remainders. Most of them looked for good things that they could still have to make them live with residual stroke effects. The most important of all are family members who are close to them and have supported them all the time. All the stroke patients perceived love, respect, values, and things that their family gave to them. They said:

"Most important in my life is my wife; she takes care of everything for me. Friends are not important. A true friend is difficult to find, but a fair-weather friend is easy to find."

"My wife and children are concerned and take good care of my feelings. I am proud of them. They did not desert me. Some families took the older to the elderly home. "

"My family support and understand me. They help me with everything. It gives me will power to live."

Self-help

This last phase of post-stroke adaptation is found to be what most of participants tried to do. They tried to find a way to care for their health by themselves. They would not value the existing formal services. The new way that one found might be different from the others but it is suitable for him or her. Generally, each individual gained a sense of normality but never returned to the feelings of being exactly like before. They have power or energy to do or to create optimal or maximal useful things for themselves and others under their physical limitation. But most of them still have a dream that after waking up the next morning, they may have the physical ability as before they had a stroke. They described these sub-themes as follows:

"I do every thing I can. I plant trees, fix the house, and do other little work."

"I exercise every day. I walk for an hour to sweat out and feel stronger because I need to recover."

"After the stroke, I paid attention to this disease. I searched for more knowledge to take care of myself. When I saw this disease on television, I would watch until it ended."

DISCUSSION

A stroke is a very critical life event, which most people have never expected or prepared to accept this condition before. At the beginning, most stroke patients do not know that they have a stroke, so they wait to be better. It makes the stroke patients lose the golden period to treat and prevent another progression of the disease. Almost all of the stroke patients take a long time to the phase of effective adaptive response. In the US, Pancioli et al. (1998) revealed that only 57% of general populations were able to name at least one stroke warning sign, and only 68% were able to name at least one stroke risk factor. Among the patients admitted from the emergency department with a possible stroke, it was found that 39% of them did not know a single sign or a symptom of stroke (Kothari et al., 1997).

Patients with a stroke described the experience with the first stroke attack as frightening. One study described shock as a sub-theme in this phase (Easton, 1999). In this study, the stroke patients explained that this feeling was not a shock. Shock is too strong or a severe feeling. Loss is a major feeling perceived or being aware in the first stroke attack and expressed by all stroke patients, especially in the sense of loss of the physical function, mobility and control as reported by many studies (Mumma, 2000; Doolittle, 1991; Easton, 1999). All patients expect that they will be better and completely recover soon after physicians treat them. This expectation is related to the thought that it is a common illness and it is not severe or threatening, but stroke patients who have had severe or multiple physical losses are not sure if their expectation is right. Fear occurs in all stroke patients with different expressions such as not being able to recover, death, and worse condition, which are similar to those in the study reported by Easton and may be a stage of uncertainty as some studies reported (Burton, 2000). Doolittle (1991) reported that the survivors experienced a paralyzed self-secondary to bodily immobility, the shock of the stroke onset and fear of not knowing what might happen next. Burton (2000) found all stroke patients in her qualitative study felled they were isolated or stuck in a cage or felled waiting for family as we found most of participants feel loneliness as we found in this study.

The theme of dreaming is an ideal that stroke patients imagine about themselves and their illness. Hope is a vital energy for patients to survive after the stroke and motivates them to seek for miracle healing. Hope has been found to be an important feeling in many studies, and it is necessary for them to ensure their progress or going through difficult situations (Easton, 1999; Hafsteinsdottir and Grypdonck, 1997; Holtslandre, 2008). Not having hope threatens emotional, physical and spiritual

health and may be a predictor of suicide (Holtslandre, 2008). The seeking for miracle healing in stroke patient was found in this study, whereas in another study this situation did not appear; it may be depended on the context of culture and belief in each society.

The theme of realization is the situation stroke patients have to face. Depression is a major expression in this theme as many qualitative and quantitative studies have found (Easton, 1999; House et al., 1991; Hafsteinsdottir and Grypdonck, 1997). The prevalence of depression varies with the time since the stroke. The peak prevalence appears to be around three to six months after the stroke; however, the prevalence of depression remains high even one to three years after the incident stroke (Whyte and Mulsant, 2002). Post-stroke depression may occur from various sources. It may emerge from a reaction to functional impairment (Hafsteinsdottir and Grypdonck, 1997). Anger, loss of self-worth, and hopelessness are found in this theme; these reflect not having hope which present as the negative of self that the stroke patients described themselves. Ellis-Hill and Horn (2000) proposed that stroke patients described themselves in more negative terms than prior to their stroke that they saw themselves as less interested, capable and independent, and less in control, satisfied and active. A suicidal idea has been found in two participants and one even has committed a suicide attempt. Stenager et al. (1998) have found that stroke patients have a significantly increasing risk of suicide and 7.2% of them committed suicide, especially in women, but in our study we found only in men. Depressive stroke patient was reported to be a significant association with suicide, with the incidence of suicide as 56% (Placido and Sposito, 2007).

The theme of acceptance is a coping process. Patients usually have to spend more than one year to reach this process. Spirituality is related to this theme. Patients who are close to God or religious practice can take shorter time to reach it.

The last theme is adjusting. Stroke patients have to adapt to adjust themselves to stroke effects based on each individual context to and look after themselves and their family to care for them. The internal and external resources of each stroke patient will be drawn to use to make the patients feel more satisfied to live.

The acceptance is usually concurrent with the adjusting and might be correlated with spiritual and hope which may be a different pattern from the first phase of stroke adaptation. McKevitt et al. (2004) reported that stroke survivors have also been found to develop their own strategies to combat disabilities using strategies to foster hope during the process of adjusting to life after stroke, and drawing on spiritual beliefs and practices, including the interaction with family (Popovich et al., 2007). The support from family members is of great importance for the stroke patient outcome in all phases, even though in some phase stroke patient did not see or aware of. Castellucci (2004) stated that when stroke patients felt happiest or saddest, these were related to their families. In our study, we observed that interrelationship between stroke patients and their family takes an important role of their negative feeling as loneliness, depression, anger and loss of self-worth, and positive feeling or behavior as hope and seeking for help, while spiritual role takes advantage on insight of truth of life and leading to acceptance of their condition and adjusting their life well-being with a stroke. Let it be is a common phrase of stroke patients whose insight used most derived from religious teaching and a key phrase which can make their life better.

CONCLUSION

Knowledge about warning signs of a stroke and its potential risk factors is important. This can warrant health care providers to educate the risk groups and general population to prevent and seek for early treatment for it, which can help them achieve maximal outcomes. The adaptation process of stroke patients is important for health care providers to understand and plan to develop both service systems and care to help them. Spirituality

such as religious practice or the Lord Buddha's or monks' teachings and family are essential for patients to rapidly adapt after a stroke. The alternative or complementary therapy should be selected to provide for service in health care system as a choice of patients who have limited treatment to select at least to reduce psychological distress or improve quality of life. This suggests further studies in detail to develop advanced knowledge of strokes and implementation.

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