The Lived Experience of Community-Dwelling Older Adults With Chronic Obstructive Pulmonary Disease (COPD) in a Rural Community in Northern Thailand

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Abstract

The purpose of this study was to describe the experience of community-dwelling older adults living with chronic obstructive pulmonary disease (COPD) in a rural community in Northern Thailand. The study was grounded in Parker and Barry's model of community nursing practice model based on the concepts and values of respect, persons in their wholeness, and caring in nursing. Data were generated and analyzed using Giorgi's phenomenological approach. Four themes were revealed: *confronting a life-threatening illness, caring for self, keeping meaningful relationships, and living guided by spiritual beliefs.* The meaning of the experience was synthesized as finding balance between living with a threatening illness and living meaningful lives.

Keywords: older adults, COPD, community nursing, Giorgi's phenomenological approach

Introduction

Chronic obstructive pulmonary disease (COPD) is a condition characterized by airflow limitation, which is not fully reversible, gradually progressive in nature, and often caused by cigarette smoking (Global Initiative for Chronic Obstructive Lung Disease [GOLD] Committee, 2011). COPD is a critical public health problem of a global magnitude. It is expected to be the fourth leading cause of death worldwide by 2030 (World Health Organization, 2008). It was estimated that from 2004 to 2030 there will be 8.3 million deaths attributable to smoking, which represents almost 10% of all global deaths (WHO, 2008). This burdensome trend of COPD will continue because of the cumulative exposure of risk factors and the increasing aging of the world's population (GOLD Committee, 2011; WHO, 2008).

In 2009 in Thailand, COPD ranked second out of the top 10 Disability Adjusted Life Years (DALYs) lost among older men and the tenth for women. Loss of older people, reported as DALYs, is higher in men, 148 per 1,000 men (9%), than in women, which was 48 per 1,000 women (2.5%) (International Health Policy Program Thailand, 2012). In 2006, in Thailand, the total direct out-of-pocket expenditure for COPD treatment was US$242,350 million per year, with an average direct out-of-pocket treatment cost of US$387.69 per person per year (Leartsakulpanitch, Nganthavee, & Salole, 2007). These data reveal that COPD in older adults is a critical health concern in Thailand.

Literature Review

A review of the literature provided a summary of research studies that focused on the experience of living with COPD. There is a lack of published literature about the experiences of older adults living with COPD in rural Thailand communities, where the healthcare system, customs, and lifestyles can affect their experiences differently, and few articles addressed the role of community health nurses in caring for community dwelling older adults. The findings from this study expand the understanding of the experience of older adults living with COPD in rural communities.

COPD impacts the activities of daily living because of breathlessness at rest and on exertion. Several qualitative studies described the experiences of patients living with COPD and focused on functional performance, daily activities, and impact on the daily life of participants (Fraser, Kee, & Minick, 2006; Jeng, Tsao, Ho, & Chang, 2002; Leidy & Haase, 1999). Barnett (2005) conducted a phenomenological study to describe the subjective phenomena of patients living with COPD. The findings revealed the detrimental effects of this disease on the daily lives of participants through the following four themes: perception of severity of symptoms, functional disabilities, emotional trauma of coping with COPD, and social loss.

Elofsson and Öhlén (2004) explored the meaning of the lived experiences of older persons who were severely ill with COPD and in need of everyday care. The findings illustrated dialectic experiences of resignation-contentedness, loneliness-connectedness, and being homeless yet being at home. The interpreted whole indicated that life, suffering, and comfort are interlaced in the participants' lives.

Ek and Ternestedt (2008) identified that daily life for people with COPD during the palliative phase of disease was affected in several ways. Emotional feelings vacillated between viewing life as meaningful and meaningless every day. The findings suggested nursing care should include support and facilitation, so that patients can live rather than exist to the end of their lives.

Theoretical Consideration

The community nursing practice model (CNPM) (Parker & Barry, 2010) was used to explore the meaning of the experience of older persons living with chronic obstructive pulmonary disease in a rural community in Northern Thailand. The CNPM is grounded in the values of respect, persons in their wholeness, and caring in nursing. This theoretical model guided the approach to explain the participants' openness to learn and grow from their experiences. Understanding the experience of older adults living with COPD from their own points of view was derived from the interview data, which were inspiring nursing care practices while supporting and nurturing the wholeness of persons and their environment through caring. The purpose of this study was to describe the meaning of the experience of older adults living with COPD in a rural community in Northern Thailand.

Research Method

Giorgi's phenomenological method was used based on Husserl's descriptive theory of intentionality. Husserl (Giorgi, 1997) described consciousness as always conscious of something beyond itself. It is important to understand the whole experience of persons in their actual situation. In this study, the descriptive phenomenological method of Giorgi guided the process of determining the meaning of the lived experience of older adults with COPD as it was lived by them.

Selection and Description of Participants

A purposive sampling of 18 participants was obtained from a list of patients with COPD cared for at a health promotion hospital in Northern Thailand. The inclusion criteria were individuals whose ages were between 60 years and 88 years; had a confirmed diagnosis of COPD for at least one year; had the ability to describe their experience in Thai language; and were willing to participate in the study. See Table 1.

Of the 18 participants, 16 were men and 2 were women. The ages of the participants ranged from 63 to 88 years, with a mean of 73.2 years. Thirteen of the participants were married, one participant was single, and four were widows. The highest level of educational attainment included 10 of the participants completing the fourth year of primary school; five of the participants finished the sixth year of high school; and one participant graduated with a bachelor degree. Two of the participants did not attend school at all. The duration of illness of the participants ranged from 18 months to 40 years, with a mean of 9.4 years. All of the participants received medical treatments at a hospital.

Table 1
Characteristics of Participants (N = 18)

Characteristics	Number
Gender	
Male	16
Female	2
Age (Range: 63-88, *M* = 73.2 years)	
60-69	4
70-79	12
80-89	2
Marital status	
Single	1
Married	13
Widow	4
Highest education at attainment	
Not attending school	2
Primary school	10
High school	5
Bachelor degree	1
Duration of illness (Range: 18 months-40 years, *M* = 9.4 years)	
1-5	11
6-10	3
11-15	1
16-20	1
>20	2
Currently smoking	
Rarely smoked	2
None smoked	16

Ethical Considerations

The study was approved by the Human Ethics Committee of Naresuan University in Thailand. An informed consent was obtained from each participant prior to the interview. Participants could refuse to answer questions or withdraw from the study at any time without penalty. If untoward signs and symptoms were experienced during the interview such as difficulty of breathing, the interview would be stopped immediately and treatment sought at the nearest hospital. Participants' confidentiality was assured with coding procedures, such as using pseudonyms and reporting data as an aggregate.

Data Collection

Data were collected at the participants' homes in a space that was quiet, private, and comfortable. Interviews lasted up to 60 min and were recorded using an audiotape recorder. The semistructured interviews were conducted using open-ended questions. These interviews began with broad questions: "Please tell me about your experience of living with COPD." "How did you recognize that your breathlessness was beginning?" Probing questions such as "Please tell me more about that" or "Please give me an example" helped clarify responses. The interviews ended with the following questions: "Is there anything else you would like to tell me about your experience of living with COPD? And how can nurses be helpful to you?" The interviews were conducted until no new information was provided.

Data Analysis

Interviews were transcribed in Thai language and translated into English language. Data, in English, were analyzed using Giorgi's phenomenological approach (Giorgi, 1985) in order to identify themes and the contextual meaning of the participants' experience. Observations and field notes were recorded by the researcher to increase the richness of the findings. Five steps for data analysis included: (a) reading the entire description of the experience to get a sense of the whole; (b) reading the description again more slowly, identifying transitions or themes in the experience; (c) eliminating redundancies in the themes, clarifying or elaborating the meaning of the remaining themes by relating themes to each other and the whole; (d) reflecting on the given themes, still identified in the concrete language of the subject; and (e) involving integration and synthesizing the themes into a descriptive structure of the meaning of that experience.

Methodological Rigor

Trustworthiness was established guided by Lincoln and Guba's criteria (1985). Credibility was achieved by recruiting participants who had experienced the medical phenomenon of COPD and who met the inclusion criteria. The data, in Thai language, were transcribed verbatim. The transcripts were then translated into English by a Thai researcher who was fluent in both Thai and English languages. The coauthors also reviewed the transcripts and verified the specific contents of the raw data. Transferability and dependability were demonstrated by the rich descriptions established by an inquiry audit, in which the findings were examined for contradictions. Confirmability was achieved by providing audit trails that illustrated how the themes were revealed. These included the researchers' reflected feelings, thoughts, questions, and field notes derived from the data collection to enhance the understanding of the participants' experiences.

Results

The findings revealed four themes of the experience of community-dwelling older adults living with COPD in Northern Thailand. These are: *confronting a life-threatening illness, caring for self, keeping meaningful relationships,* and *being guided by spiritual beliefs.* See Table 2.

Confronting a Life-Threatening Illness

Confronting a life-threatening illness was described by all participants as they encountered difficulty in breathing, tightness in the chest, weariness, and fearfulness. The situation of illness was unstable and unpredictable, and they expressed that their lives were threatened by feelings between being dead and being alive. Three thematic categories describe the theme of confronting a life-threatening illness.

Seeking help. All participants sought help to be "alive" when they experienced shortness of breath. They were unable to rely on themselves, and they felt dependent on others to take care of them and to save their lives. One participant explained: "Sometimes when I was talking, I suddenly felt short of breath like I was going to die. I need help from a doctor and I was alive. In the evening it happened again, I was at the hospital again." Another participant exclaimed: "I accepted that my breath had been shortened, and I could not fully breathe. I found that breathing out through my mouth slowly was helpful and I am alive."

Understanding illness. All participants knew that they had to pace themselves and limit physical activities. When breathlessness occurred, it interrupted the activities of daily living and affected emotional and social health. One participant explained: "At that time I cannot even walk from here to the bicycle park (8 steps). I was too tired. I had to stay close to the toilet and could hardly bathe myself and could not take care of myself." Another participant declared that, "I knew I had to limit my activities. It's uncomfortable during that time… I could not do anything or go anywhere: I just stayed with doing nothing at home. Otherwise I knew I would be worse."

Following the health plan. All participants received medical treatment including oral medicine, inhalator, and follow-up care with the physician. One participant stated: "I don't use any other medicines; I trust my doctor; I don't add any other drugs. I had expectorants, mouth spray medicine, and bronchodilator. I see the doctor for examination every three months at the hospital." This statement was supported by another participant who exclaimed that, "I have symptomatic treatment, so whatever happens, I see the doctor and take medicines on time as told by the doctor."

Table 2
List of Themes Extracted

Theme: Confronting a Life-Threatening Illness

"I did nothing. Suddenly short of breath, hearing wheezing sound, being exhausted. When it happened, it scared me like I was going to die."

Thematic categories

Seeking help.

"When I cannot breathe well, I need help from a doctor to safe my life."

Understanding illness.

"I knew when it happened; I cannot do anything myself or go anywhere. I have to stop any activities. If I did not do hard work, I was fine."

Following the health plan.

"Having a bad health, I must use mouth spray to help my breathing and follow up my health on doctor's appointment."

Theme: Caring for Self

"My life was changed after I had COPD. I concerned about my health and cared for self to preserve my capacity."

Thematic categories

Avoiding triggers.

"I avoided burning smokes and dust from the trucks passing. Smoke provokes my condition. When there was smoked outside, I walked away to the North of wind."

"I quitted smoking after I had COPD and not exposed to smoke outdoor."

Staying active.

"Previous time I went to cycling with friends outside that far. Currently, I still do cycling but I do at home instead. My health is better."

"I regularly exercise with arms rising and Thai tradition dance with friends at home."

Finding balance.

"I talked to people outside to release my tension. If I was bored, I rode a bicycle to see and talk with my friends."

Theme: Keeping Meaningful Relationships

"My younger sister and I have never been in quarrel. We nurtured and help each other."

"When I got sick, she took care of me well. I help her prepare food in the morning. In the evening when she came home back, she would cook. We alternated."

Thematic categories

Meaningful relationships with family.

"My wife took care of me. She was with me when I was sick and need help. I could talk with her at any time. I was not alone."

"I have spent more than 60 years of life and it's worthy. I gained more experiences and reflected all that are good and bad and taught my offspring not to involve with liquor and cigarette as they are bad.

Meaningful relationships with friends and neighbors.

"My friends and I often go to the temple to do good deed. I hardly stayed at home and I felt happy to do it."

"My neighbors are friendly. They are all relatives and sibling. They visit me and care for me. I was so proud and happy with them."

Meaningful relationships with nurses and physicians.

"Nurses visited me at home. I never thought she will come and she talked to me like her relatives. She taught me to do pursed-lip breathing and medicine usage. I followed her teaching and my health gradually recover."

Theme: Being Guided by Spiritual Beliefs

"I liked to listen to sermon at a local temple. My mind was peaceful and I felt happy."

Thematic categories

Making merit.

"I do merit on the Buddhist holy day, such as I went to the temple to offer foods to monks, gave money for donation, and dedicated the merit to the departed. It made me happy."

Applying Dharma through life.

"I applied Dharma in living life to better understand nature of life such as birth, aging, illness, and death. Nobody can avoid it; thus whatever will be, will be, I accept it."

Preparing for peaceful death.

"I told my children that I want to live with them and be happy together at home until the last day came. If I pass away, I need to die peacefully."

Caring for Self

All participants stated that their illness changed them. They were more concerned about their health in the present and in the long term and cared for themselves through some small and substantive changes. Three thematic categories describe the theme of caring for self.

Avoiding triggers. Avoiding triggers was identified by all participants. Some participants described the importance of positioning, taking a rest, and pursed-lip breathing, which helped control shortness of breath. Some participants avoided dust and outdoor smoke, which affected their breathing. One participant described: "I knew that my breath had been shortened, not a full breath. I had to breathe through my mouth, pursed-lip breathing. If I only breathed through my nose, I surely would not survive." Another participant described the experience in the following: "I had to be careful of burning smoke that drifted along with the wind and dust from passing trucks. When there was smoke outside, I walked away to the north of the wind, to avoid it."

Most of the participants recognized that tobacco use including cigarette smoking was the main cause of their illness and was harmful to their health. Additionally, seeing an example of a patient with COPD, who was suffering in the hospital, heightened their awareness of the dangers of smoking; this ultimately led them to understand the necessity of quitting smoking. One participant stated: "The doctor showed me a smoker with a tracheotomy tube that had oxygen pumping. He is dying, he smoked just as you did… I could not sleep thinking about that man, then I made up my mind to quit."

Staying active. The majority of the participants spent free time doing activities that they liked including planting flowers, growing vegetables, cutting grass, or other pleasurable hobbies such as basketry… Several participants exercised regularly, listened to their body, and observed their health. As participants expressed: "I go out cycling with a group. We went far to the Indo-China Intersection (a major road intersection). I like to do exercise; I don't know if it is related, but my symptoms get gradually relieved." Another participant exclaimed, "Raising arms, swinging arms back and forth slowly, jogging 10 to 20 meters, and sometimes cycling. I had exercise 10 to 15 min until I sweated. I exercised so I have immunity. I felt better when I exercise."

Folk dance or Thai tradition dance was another activity and made the participant feel happy. One participant stated: "We had a folk dance class 'Lam-Wong' every day at home. I joined the dance with my friends. I hadn't been tired or having shortness of breath. I was happy to do it."

Finding balance. Most of the participants sought balance in everyday life. When the participants felt stressed and dispirited, they might go outside to relax or find somebody to talk to. One participant indicated: "I talked to people outside to pour out my feeling, but I cannot talk at home because nobody listens… If I was bored, I talked with people in the neighborhood, or crossing over there to chat with friends." One participant claimed: "I felt worried when my health was unstable. However, I thought every problem has a solution. If I get stressed, I cannot sleep. My life is not happy. I have to relax myself and live peacefully."

Keeping Meaningful Relationships

Keeping meaningful relationships included family, friends or neighbors, and nurses and physicians. The following three thematic categories describe the theme of keeping meaningful relationships.

Meaningful relationships with family. The participants indicated that family members must care and love each other to be happy. Their children and grandchildren cared for, loved, and respected them as perceived by the participants, thus they were happy and proud of it. One participant stated: "We cook food together at home. We have a party… My two grandchildren called me daddy not grandpa. I nurture them and they love me as their father. When they went somewhere, they bought some food to me."

The participants had consideration of their children feelings, thus they did not complain to them and strived to nurture meaningful relationships. One participant explained: "My daughter cooked. I usually don't complain. Whatever she cooked, I could eat it regardless if it's salty, sour, hard, or soft. If I could eat it, I did. When she was gone, I didn't eat but only a bit."

Meaningful relationships with friends and neighbors. Several participants have social contact with friends, and they have done meaningful things in life. They spent time with friends to nurture friendship and good relationships. One participant stated: "I made marble boundary balls. My friends often picked me up to take me to see boundary balls. I went to many temples to observe the foundation made with these balls. I had hardly stayed home."

Most neighbors were sisters, brothers, and siblings who lived next to the participants' homes. Though the participants were older adults, they were able to walk outside the home and to talk with close friends who lived next to their homes. The participants were proud and happy when their friends thought about them.

Meaningful relationships with nurses and physicians. The participants indicated that nurses from the Health Promotion Hospital sometimes came to visit them especially when their condition was more active… Nurses advised medicine usage, inhalator and cleaning, avoiding triggers, exercise, sleeping, food, and breathing methods. One participant stated: "Nurses came to see me at home. They advised me to do exercise, eat properly, avoid hard work, and do pursed-lip breathing."

Nurses and the Local Authority Organization supported the participants in the community. One participant said: "Some nurses from the health station came to ask me how I felt and how often I was tired. When I had a bad condition or emergency, she coordinated to Local Authority Organization and took me to the hospital."

Being Guided by Spiritual Beliefs

The participants perceived that their life was guided by spiritual beliefs in order to live a happy, peaceful life. The participants were concerned about spiritual practices in everyday life. Three thematic categories describe the theme of being guided by spiritual beliefs: making merit, applying Dharma through life, and preparing for a peaceful death.

Making merit. All of the participants believed in virtues and making merit. Most of them always made merit on Buddhist observance day at the temple resulting in a peaceful mind and happy life. One participant explained: "I went to the temple every observance day. I always ask my daughter when it's the observance day. I pay homage to monks, making merit made me happy. For those who have never made merit, they don't know that." Another participant stated: "In early morning, I regularly cooked rice and put food offering in the Buddhist monk's alms bowl… Then I poured water onto the ground slowly to dedicate the merit to the departed. I felt peace."

Applying Dharma through life. Dharma refers to the teaching and methods of the Buddha (Payutto, 2007). Dharma raised consciousness and led the participants to understand the truth of life, that is, birth, aging, sickness, and death. Some participants applied Dharma in living life because it was practical and important as they aged. As participants exclaimed: "I apply Dharma in living my life, using free time listening to radio programs on Dharma, or watching TV programs of Buddhist sermons. I gained knowledge. I thought this way–I'm old so I need to turn to Dharma." This response was supported by one participant's claim that, "Buddha's teaching is real. In real life we are born, aged, sick, and dead, that's the way they are. I accepted my health problem and spent the rest of my life with my family as much as I could."

Preparing for peaceful death. All the participants accepted death and did not worry about it. Participants were familiar with their love homes, homes they lived in since birth. They felt safe and warm when they lived, thus if they pass away, they wanted to die at home. One participant stated: "I am afraid of staying in the hospital. If I have to die, then just die at home. I'm not afraid of it. But if I am in hospital, it troubles others to take care of my cremation."

Participants explained how they did not want to suffer but wanted a good and peaceful death. One participant described: "If I die, I need to die peacefully. I am not afraid about it anymore."

Offering the dead body to the hospital was prepared in advance by one participant. In addition, he arranged the cremation and budget. One participant described: "I've already prepared for the end. I have health insurance for 200,000 baht at minimum. I told my children that only three nights of praying service are enough and then cremation, nothing much, I don't want to trouble them."

Discussion

The descriptive meaning of the experience was revealed as *finding balance between living with a threatening illness and living a meaningful life*, which provides a lens through which to view the meaning of the experience of older adults living with COPD in a rural community in northern Thailand. The theme confronting a life-threatening illness is described as a feeling between being dead and being alive. After they sought treatment, the illness of the participants was less demanding so that they were able to breathe fully and go on with their lives. Elofsson and Öhlén (2004) found that living with COPD in old age was considered as a sense of contentedness shifted between a passive contentedness and an active attempt to handle the illness's situation. Nicholls (2003) described that chronic respiratory illness has a profound effect on the ability of person to function in the community.

"Persons with chronic breathlessness have a constant tension between the need to maintain control over one's life and the desire to be free from the illness" (Nicholls, 2003, p. 134). In addition, the threat of breathlessness interrupted daily living of participants. They might depend on other persons, and they had to limit physical activities to move on when their condition became life threatening. The theme *caring for self* was illuminated as a result of how participants had learned to live with their illness. It represented the capacity of participants to control their health. Activities such as cycling, arm swinging, and folk dancing with friends left the participants feeling good and had fewer experiences of breathlessness. Similar to the findings of Jeng, Tsao, Ho, and Chang (2002) that some activities such as Shiang Kung and Tai Chi, the consistent soft, slow, and simple movements increased circulation, breathing capacity, and overall physical strength of older adults.

The theme *keeping meaningful relationships* emerged from the data. Participants identified keeping meaningful relationships with family, friends or neighbors, and nurses and physicians as a source of support available in the community. All participants' families cared for the participants at home and supported them as needed. This finding is similar to the findings of Jeng, Tsao, Ho, & Chang (2002) that suggested families and friends can encourage older adults with COPD to participate in daily activities with friends and family to support their feelings of well being.

The theme *being guided by spiritual beliefs* provided insight into the spiritual life of the participants. All of the participants honored Buddha, believed in virtues, and the value of making merit. Some participants specifically described how the teachings and methods of Buddha, called Dharma, were applied in their lives. Spiritual beliefs offered solace and a sense of affinity, community, and acceptance (Nicholls, 2003).

Implications

The findings of the study provide ways to understand the meaning of the experience of older adults who were living with COPD in a rural community. The community nursing practice model (CNPM) (Parker & Barry, 2010) inspired a respectful stance for the researcher to listen to the voices of the participants and bring this experience to light for community nursing practice, education, research, and advocacy. The following implications were realized.

Implications for Nursing Practice

Nurses in community settings are encouraged to understand the struggles their patients have in finding balance between living with a life threatening disease and living a meaningful life. Guided by the CNPM, the nurse views each person/patient as unique and each experience of living with COPD as unique. Respectfully being with, and listening to the client/patient, the nurse discovers what is essential and meaningful for a happy life for the client/patient. Developing a care plan with the client/patient provides an individual approach to caring with a focus on the medical plan such as avoiding particular triggers and taking the prescribed medications, as well as engaging in other meaningful activities such as dancing, biking, and keeping relationships and spiritual beliefs alive. The findings can be used to develop community nursing care plans focused on health education, improved access to care, and policy change in order to decrease the prevalence of COPD in community.

Implications for Teaching-Learning in Nursing

The findings could be integrated in the nursing curriculum at both undergraduate and graduate levels to help students understand the wholeness of older adults living with COPD. Education program for nursing students could provide strategies in management of breathlessness such as breathing control, positioning, relaxation, and exercise and energy conservation (Barnett, 2009) for older adults with COPD. An education course for community nurse practitioners might include the content of peaceful death, palliative care, and spirituality concepts. Campaigns for smoking prevention and smoking cessation must be encouraged effectively in school settings and public areas, and smoking control policies should be implemented, particularly given the well-researched public health consequences of smoking, which indicated smoking as a major contributing factor to COPD.

Implications for Nursing Policy

Nurses also play an important role in advocating for patients. Recognizing the environmental factors in the community that increase breathlessness, such as burning practices, calls attention to finding a better way to manage trash and garbage removal. Nurses could join the national campaign for smoking prevention and smoking cessation by promoting smoking control policies that limit smoking in public places and prohibit the sale of tobacco products to children. Effective anti-smoking messages that reach children in school and encourage efforts that prevent children and young adults from starting to smoke could be developed and evaluated by nurses. The CNP model inspires the nurse to reach out to other local, national, or international experts and to bring that expertise into creating effective health promotion and caring practices into nursing situations with older adults living with COPD.

Implications for Nursing Research

Future research could focus on the lived experience of older adults with COPD in the urban communities to compare the findings. Is the experience different for older adults living with COPD in cities? Is there community health support for care in the cities? Exploring the perspectives of nurses in community settings who care for patients with COPD. How do they care for and create specific intervention for patients? Does theory guide their practice? What is the role in advocating for policy change? The findings illuminate ways to nurture the wholeness of persons and environment through caring for older adults living with COPD in rural communities. The findings also inform nurse educators on the preparation of nurses for expert community practice as care givers, health promoters, advocators, policy makers, and researchers.

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The study was funded by the Naresuan University, Phitsanuloke, Thailand.

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