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THE EFFECT OF SUPPORTIVE GROUP THERAPY ON STRESS AND COPING BEHAVIOR OF CAREGIVERS OF PSYCHIATRIC PATIENTS

MALINEE PANPOUNGKAEW

With compliments
of
บัณฑิตวิทยาลัย มหิดล

A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
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Thesis
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Malinee Pan.
.....
Miss. Malinee Panpoungkaew
Candidate

Tassana Boontong
.....
Assoc.Prof.Tassana Boontong, Ed.D.
Major-Advisor

Wasana Chalamket
.....
Asst.Prof.Wasana Chalamket, M.Ed.
Co-advisor

Yajai Sitthimongkol
.....
Asst.Prof.Yajai Sitthimongkol, Ph.D.
Co-advisor

.....
Prof.Liangchai Limlomwongse,Ph.D
Dean
Faculty of Graduate Studies
Mahidol University

Kobkul Phancharoenworakul
.....
Assoc.Prof. Kobkul Phancharoenworakul, Ph.D.
Chairperson
Master of Nursing Science Programme
Faculty of Nursing
Mahidol University

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Was submitted to the Faculty of Graduate Studies, Mahidol University for the degree of Master of Nursing Science (Psychiatric-Mental Health Nursing)

On

January 31,2000

Malinee Panpoungkaew
Miss. Malinee Panpoungkaew
Candidate

Tassana Boontong
Assoc.Prof.Tassana Boontong, Ed.D.
Chairperson

Kobkul Phancharoenworakul
Assoc.Prof.Kobkul Phancharoenworakul, Ph.D.
Member

Wasana Chalamket
Asst.Prof.Wasana Chalamket, M.Ed.
Member

Wajjanin Rohitsuk
Lect.Wajjanin Rohitsuk, Ph.D.
Member

Yajai Sitthimongkol
Asst.Prof.Yajai Sitthimongkol, Ph.D.
Member

Liangchai Limlomwongse
Prof.Liangchai Limlomwongse, Ph.D.
Dean
Faculty of Graduate Studies

Kobkul Phancharoenworakul
Assoc.Prof. Kobkul Phancharoenworakul, Ph.D.
Dean
Master of Nursing Science Programme
Faculty of Nursing

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Malinee Panpoungkaew

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M.N.S.(PSYCHIATRIC- MENTAL HEALTH NURSING)
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MALINEE PANPOUNGKAEW : THE EFFECT OF SUPPORTIVE GROUP THERAPY ON STRESS AND COPING BEHAVIOR OF CAREGIVERS OF PSYCHAITRIC PATIENTS. THESIS ADVIORS : TASSANA BOONTONG,Ed.D.,WASANA CHALAMKET, M.Ed., YAJAI SITTHIMONGKOL, Ph.D. ISBN 974-663-573-5

This was a quasi experimental research on the application of supportive group therapy to reduce stress and coping behavior of caregivers of psychiatric patients. The sixteen samples were psychiatric patient caregivers who took patients to receive treatment at Prasert Kangsadalya 5, Psychiatric Unit , Siriraj Hospital. The samples were selected using a purposive sampling basis. They were divided into two groups by a Simple Random Sampling – experimental and control group, each of which consisting 8 of samples. The control group received guidelines and assistance similar to other caregivers taking patients to the hospital. The experimental group participated in a supportive group therapy program organized by researchers twice a week for 4 weeks. Each meeting in the program one to one and a half hours. The information gathered was then used to provide descriptive analysis and t – test statistical analysis. The threshold of statistical significance was at 0.05.

The findings of the study showed that :

After participating in the supportive group therapy program,1) the subjects in the experimental group had lower levels of stress than they did before.2)the subjects in the experimental group had lower levels of stress than those in the control group.3)the subjects in the experimental group had a higher mean score for coping behavior than they did before.4)the subjects in the experimental group had had a higher mean score for coping behavior than those in the control group.

Recommendations

This study has shown that the supportive group therapy is a good social support, helping caregivers of psychiatric patients to cope with problem arising from tending to their patients based on information and support from one another in the group. Therefore, it's appropriate to recommend continuation of the supportive group therapy for caregivers of psychiatric patients and difference group of caregivers. Furthermore, nursing staff and the health personnel involved should be received thorough training in assessment technique, knowledges and skills.

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4037094 NSPS /M : สาขาวิชา : สุขภาพจิตและการพยาบาลจิตเวชศาสตร์ ;
พย.ม. (สุขภาพจิตและการพยาบาลจิตเวชศาสตร์)

มาลินี ปานพวงแก้ว : ผลของการใช้กลุ่มบำบัดแบบประคับประคองต่อความเครียดและพฤติกรรมการเผชิญความเครียดของผู้ดูแลผู้ป่วยจิตเวช (THE EFFECT OF SUPPORTIVE GROUP THERAPY ON STRESS AND COPING BEHAVIOR OF CAREGIVERS OF PSYCHAITRIC PATIENTS) คณะกรรมการควบคุมวิทยานิพนธ์ : ทัศนา บุญทอง, Ed.D., วาสนา แฉล้มเขตร, กศ.ม. (การแนะแนว), ยาใจ สิทธิมงคล, Ph.D., ISBN 974-663-573-5

การวิจัยเรื่อง ผลของการใช้กลุ่มบำบัดแบบประคับประคองต่อความเครียดและพฤติกรรมการเผชิญความเครียดของผู้ดูแลผู้ป่วยจิตเวช โดยทำการศึกษาในผู้ดูแลผู้ป่วยจิตเวชที่พาผู้ป่วยจิตเวชมารับการรักษาที่หอผู้ป่วยประเสริฐกังสดาลย์ 5 โรงพยาบาลศิริราช จำนวน 16 คน แบ่งเป็นกลุ่มควบคุมและกลุ่มทดลองกลุ่มละ8 คน มีการทดสอบก่อนและหลังการทดลอง กลุ่มควบคุมจะได้รับคำแนะนำและการช่วยเหลือ เช่นเดียวกับผู้ดูแลผู้ป่วยที่พาผู้ป่วยจิตเวชมารับการรักษาในโรงพยาบาลโดยทั่วไป ส่วนกลุ่มทดลองจะได้เข้าร่วมโปรแกรมกลุ่มบำบัดแบบประคับประคองที่ผู้วิจัยสร้างขึ้น สัปดาห์ละ 2 ครั้ง ครั้งละ 1 ชั่วโมง30 นาที เป็นเวลา 4 สัปดาห์ โดยผู้วิจัยเป็นผู้นำกลุ่มตามแนวทางของโรเจอรส์ วิเคราะห์ข้อมูลโดยการทดสอบความแตกต่างของค่าเฉลี่ยของคะแนนความเครียดและคะแนนพฤติกรรมการเผชิญความเครียด ด้วยวิธีการทดสอบค่าที (t-test) ค่านัยสำคัญทางสถิติกำหนดไว้ที่ระดับ 0.05

ผลการศึกษาพบว่า

ผู้ดูแลผู้ป่วยจิตเวชที่เข้าร่วมกลุ่มบำบัดแบบประคับประคองมีระดับความเครียดต่ำกว่าก่อนเข้าร่วมกลุ่มบำบัดแบบประคับประคองและมีระดับความเครียดต่ำกว่าผู้ดูแลผู้ป่วยจิตเวชที่ไม่ได้เข้าร่วมกลุ่มบำบัดแบบประคับประคอง อีกทั้งผู้ดูแลผู้ป่วยจิตเวชที่เข้าร่วมกลุ่มบำบัดแบบประคับประคองมีคะแนนพฤติกรรมการเผชิญความเครียดสูงกว่าก่อนเข้าร่วมกลุ่มบำบัดแบบประคับประคองและมีคะแนนพฤติกรรมการเผชิญความเครียด สูงกว่าผู้ดูแลผู้ป่วยจิตเวชที่ไม่ได้เข้าร่วมกลุ่มบำบัดแบบประคับประคอง

ผลการศึกษาวิจัยมีข้อเสนอแนะว่า

กลุ่มบำบัดแบบประคับประคองเป็นแหล่งสนับสนุนทางสังคมที่ดี สามารถช่วยเหลือผู้ดูแลผู้ป่วยจิตเวชในการจัดการกับปัญหาต่างๆที่เกิดจากดูแลผู้ป่วยจิตเวช โดยอาศัยข้อมูลและความช่วยเหลือของสมาชิกภายในกลุ่ม ดังนั้น จึงควรนำกลุ่มไปใช้อย่างต่อเนื่องและทดลองใช้ในผู้ดูแลผู้ป่วยกลุ่มอื่นๆ ต่อไป นอกจากนั้นพยาบาลควรได้รับการฝึกฝนในเรื่องของเทคนิคต่างๆ ความรู้และทักษะในการทำกลุ่มเป็นอย่างดี เพื่อช่วยให้สมาชิกกลุ่มได้รับประโยชน์จากกลุ่มอย่างเต็มที่

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CHAPTER I

INTRODUCTION

Background and Significance of the Study

In daily life people encounter many problems, such as social problems and economic problems., which cause them stress. Stress may be defined as an unbalanced mental condition a perceive acknowledgement or assessment of a received stimulus which they perceive resulting from interpret as a threat to their happiness(Lazarus &Folkman,1984). Although everyone is subject to get stress from stimuli, reactions differ depending on the individual characteristics of each person. In addition, while lower level stresses generally stimulate adaptive behavior, higher-level stresses often produce feelings of sadness. (Morgan, 1986).

A chronic illness suffered by any family member is usually considered 'stressor' leading to further stresses in the family. This is particularly so in cases of mental illness, because dealing with behavior cause by mental illnesses is generally more difficult than dealing with physical illnesses (Whitley and Madden,1986),due to the unpredictable effect of most mental disturbances. The psychiatric patients potentially tend to exhibit abnormal behavior such as inconsistency, anger without evident cause, acting out of reality, poor insight, disorientation, self isolation , and overly stereotyped actions. In addition to these signs of mental illness, patients often become less interested in working.(Areephak, 1981). In relation to their functional ability, psychiatric patients are not fully able to take care of themselves, and need

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assistance from other people in at least some of the physical care activities which normal people can do by themselves. For example, they often ignore basic tasks such as eating, cleaning themselves, and sleeping. They may develop abnormal sleeping patterns, sleep in the daytime and / or stay awake during the night, make loud noises, or talk to themselves. Furthermore, their sex lives are often usual, with unlawful sexual behavior and immature marriage being relatively common. However most married psychiatric patients usually ignore sexual intercourse, although a minority have over active sexlives. (Torrey, 1983). Normally, taking medication regularly is required for psychiaatric patient. Unfortunately, patient do not accept that they are mentally ill, consequently refusing to and having to be coaxed to take their medicine(Areephak, 1981). During periods of chronic mental illness and recuperation, it is very common to find that psychiatric patients feel hopeless about their lives and what they have or have not achieved. Some feel guilty and shamed of their mental problems and aberrant behavior, which often produces depression. Indeed, suicide and attempted suicide are caused by relcutirely very common amongst these patients.

In Thailand mental illness is considered as a serious and unavoidable problem. Local treatment generally aims at getting the patient into normal life as much as possible, so that treatment is only required on an outpatient basis. (Chaisanoh and et.al., 1997). Accordingly, hospitals will usually accept inpatient only in emergency cases psychosis which require immediate treatment. This means that primary caregivers assumed the very important role of taking care of non-hospitalized patients. In addition, these caregivers can usually involve patients in activities which help increase self-esteem, reduce anxiety, boost self-confidence and foster a sense of responsibility to their patient.(Waraasawapati, 1997). Taking

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psychiatric patients to see the psychiatrist for treating them or when special symptoms arise is considered to be an essential task and it is a task which caregivers are often given responsibility for. In this respect, caregivers must be alert to any changes in behavior after their patients have taken their medication. Most psychiatric patients have unstable relationships and difficulty in adapting themselves to the surrounding environment because they have abnormal confidence levels. Therefore caregivers should attempt to normalize their confidence levels by not showing any feelings of dislike and by listening to them with compassion. In addition, the caregivers should aim to improve the family environment or circumstances so as to provide patients with better treatment and alternative treatment where applicable, and also aim to minimize all factors which tend to worsen the mental condition of their patients. (Chaisanoh and et.al., 1997).

In nearly all cases the tasks which caregivers must perform in taking care of their patients are tasks that they have not previously done. Thus such tasks are usually a very heavy new responsibility; requiring a great deal of their energy, time, and effort, and of course the more serious of their patients' symptoms are, the more care is needed. Unfortunately, the result is all too often that caregivers feel they are under a lot of pressure, heavily obligated, and tense. Naturally this can and does negatively effect the preferred life-style and state of mind of caregivers. For example, it is usually the case that families have to spend lots of money for psychiatric fees for continuous treatment, and a significant reduction in the amount of money that those families are able to save is nearly always the case. In addition, caregivers personal freedom is often reduced especially where they are responsible for patients 24 hours a day.(Baker, 1989). Naturally, such restrictions can lead to feeling of bitterness, resentment, and

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oppression (Torry, 1983). Further, caregivers often have to live with the stress caused by feeling guilt about being unable to treat the illness or from feeling discouraged about disappointing progress. Patients themselves often have feelings of guilt about being a burden on their families.

A further impact is that caregivers generally have to deal with the sense of shame and non-acceptance which most societies subject them to negative impacts such as those cited above often seriously effect the married lives and the emotional conditions of other family members, including the stability of the family institution itself. For example, conflicts and disagreements about the care of patients may arise among relatives, While lack of acknowledgement or support from neighbors, government departments, and private companies can only add to the stress caregivers.(Malone, 1990)

In spite of these common problems and difficulties, psychiatric patients should be treated appropriately and compassionately as possible so that they have the change to improve as much as they can. however, if they do not receive proper treatment and their caregivers do not receive proper support, then the caregivers, risk becoming mentally ill themselves should the burden become unbearable. Heavy stress over long periods can lead to mental depression(Ball, 1990) which may become severed and significantly affect their style of living, and result in mental disorders or nervous diseases. (Lazarus, 1966).

Fortunately, there are several methods of helping psychiatric caregivers to manage their stress, one relatively new method being 'group support '. The goal of supportive group therapy is to promote mental health and help to prevent mental health problems. By harnessing group support, supportive group therapy can provide

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group members with shared feeling of warmth, compassion, and unconditional mutual acceptance. In addition, group members will have the opportunity to exchange experiences and opinions, and provide other members with alternative suggestions, strategies and guideline for improving their skills in problem solving and problem management. As part of the group, members are able to far more readily acknowledge their problems due to the atmosphere of trust, understanding, concern which is developed by the group leader and sympathy. The group leader offers encouragement, advice and a different perspective on their problems, and which helps the members to realize that their problems need not overwhelm them. Helping to build up the self-confidence of group members is an important part of this process, which, if successful, allows psychiatric patient caregivers to reduce their stress, level and to maintain or well state of mind. (Kane, 1984). Ultimately, it should be possible for patients and caregivers to live together with their families in perfect harmony.

In conclusion, the researcher believes that group supporting therapy is an effective strategy for assisting caregivers to cope with stress. Which can be used as a key element in developing mental health services to patients and their caregivers.

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Conceptual Framework of the Study

In this study, the researcher has combined the work of Lazarus & Folkman, (Lazarus & Folkman, 1984) with the group support of Rogers (Rogers, 1980) to produce a standard guideline .

Caregivers who have the responsibility of taking care of the psychiatric patients may create many stress. However they may not necessarily lose their own happiness. During In the process of caring for the psychiatric patient, caregiver has to monitor the patients' every daily activity, assess their symptoms, administer medicine, and support their patient both emotional and spiritually. Furthermore, the caregiver will often have additional responsibilities, such as doing the housework, as well as taking care of the patient, contacting persons in the mental health field, deciding on various matters, and conducting various business activities which may include responsibility for the family's finances. Clearly, all of the above responsibilities would strongly tend to increase the stress levels of the caregiver.

Usually the psychiatric patient's caregiver who is under stress, will try to find a way to handle the problem by using either of the following stress management methods : Problem-focused coping and Emotional-focused coping. The next step is reappraisal, where the caregiver examines whether the still exists and is still attacking the caregiver's state of mind. This process of reappraisal is then repeated until the caregiver is able to express his coping behavior in an appropriate manner.

The basic concept of this client – centered the supporting group therapy is to instill in group member the belief that they are good , valuable, capable persons , and that they are capable of becoming more effective. To accomplish this, the group

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leader helps the other members to achieve a better understanding of themselves and the facts of their situation so that they can use their own abilities to decide what to do about their problems. However, the effectiveness of this method also depends largely on establishing the group as the supporting factor in this process. The group leader tries to build trust within the group in order to free expression of opinions and feelings, the exchange of experiences, and the process of learning to give help to and receive help from others within the group. The group leader tries to also create in the caregivers an awareness of their own will-power which they can harness to help themselves cope with their problems .The caregiver should therefore be able to achieve higher self-esteem which in turn will improve his effectiveness in coping with stress.

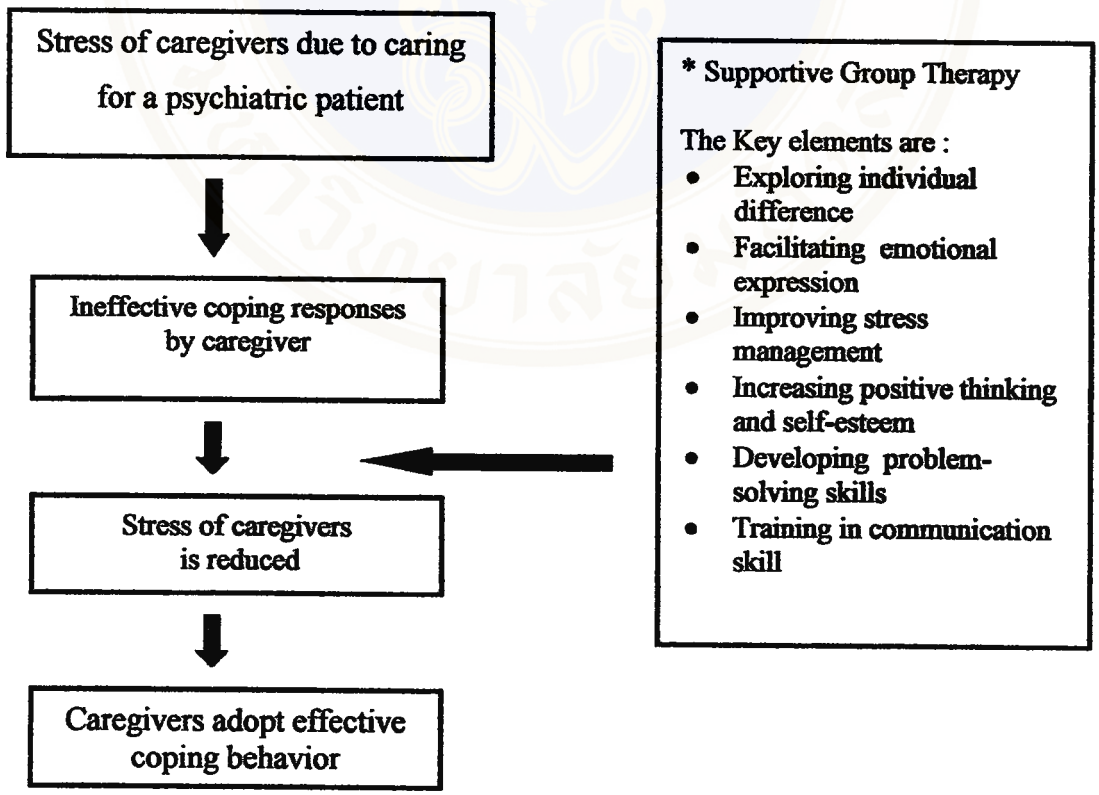

Figure 1 : Conceptual Framework of the Study

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The Purpose of the Study

To examine the nature of the various stresses on psychiatric caregivers and to compare the coping behavior of caregivers who have participated in supportive group therapy with caregivers who have not participated in support group therapy in order to evaluate the effectiveness of the support group method.

Hypotheses of the Study

1 Psychiatric patient caregivers who participate in the supportive group therapy will have stress level lower than before the therapy.

2. Psychiatric patient caregivers who participate in the supportive group therapy will have lower stress level than psychiatric patient caregivers who did not participate in the therapy.

3. Psychiatric patient caregivers who participate in the supportive group therapy will have higher score for stress coping behavior than before the therapy.

4. Psychiatric patient caregivers who participate in the supportive group therapy will have higher scores for coping behavior than caregiver who did not participate in the therapy.

Scope of the Study

This research examines the results of using supportive group therapy to combat the stress and ineffective coping behavior of psychiatric patient caregivers . Which involved studying a group of 16 psychiatric patient caregivers whose patients were receiving treatment at Siriraj Hospital.

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Benefits of the Study

1. The study is expected to show that psychiatric patient caregivers can expect to develop improved stress and to be able to apply the knowledge gained from their group participation experiences to their daily lives which will eventually result in a significant improvement in the caregiver's life as a family member..

2. The study is expected to produce guidelines for authorities involved in this area to follow in relation to the promotion, maintenance and recovery of the mental health of psychiatric patient caregivers, so that they are better able to take care of and help their patients.

The Definition of the Terms

Supportive Group Therapy means the arrangement whereby psychiatric patient caregivers who have moderate to severe stress and moderately effective to ineffective coping behavior participate in the supportive group therapy of the client-centered type initiated by Rogers(1970).In this program, the researcher acts as the group leader. The leader encourages caregivers to feel trusting, accepting, and intimate with each other, which gives them the confidence to express their feeling and opinions and to exchange their experiences. Their involvement in this process helps them to solve or better manage some of their specific problems, to increase their will power and self-belief, to decrease the stress on themselves from their personal environment and to achieve a state of emotional equilibrium and emotional control. The supportive group therapy sessions for this study were held twice for 4 weeks were of 1-1.5 hours duration each.

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Stress means to a state which is manifested by mental imbalance and feelings of mental discomfort , unhappiness, or sadness suffered by psychiatric patient caregivers which are considered threatening, harmful, or diminishing to their self-esteem or life-threatening by exceeding their individual or situational capacity to cope with. Stress levels were assessed using a stress questionnaire, developed by the model of stress appraisal and coping as detailed by Lazarus & Folkman (1984).

Coping Behavior means the problem-focused coping behavior and emotional-focused coping behavior that psychiatric patient caregivers responded within order to alleviate the stresses on them associated with taking care of their patients. This was assessed by using the coping behavior questionnaire developed for this study from a model of stress , appraisal and coping behavior as detailed by Lazarus & Folkman (1984).

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CHARPTER II

LITERATURE REVIEW

This study examined the effects of supportive group therapy program on the stress level and coping behavior of psychiatric patient caregivers . The literature review covered the following topics.

- Psychiatric patients and psychiatric patient caregivers
- Stress and coping behavior of psychiatric patient caregivers
- Group supportive therapy

Psychiatric Patients and Psychiatric Patient Caregivers

Psychosis causes suffering and distress to patients as well as persons around them and caregivers because of the patients abnormal emotional, mental, and behavioral expression. For example, patients can be hot tempered, angry, thinking out of reality, or exhibit very strange behavior unacceptable to society. Psychiatric patients are usually unable to take proper care of themselves or carry our normal daily routines, and unable to create or maintain normal relations with other persons. In addition, their capacity to study and work is usually significantly impaired. Therefore, psychiatric patients require caregivers to help them with daily activities that normal people accomplish without assistance. Tending efficiency depends greatly on caregivers' knowledge and understanding of the disease and its effects as this will help them

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determine how to best manage their patient. (Phumipak, 1980). The type of knowledge and understanding required to properly tend to psychiatric patients is described in this section.

Definition of Psychosis

Otrakul (1995): Psychosis is a serious mental disorder affecting thought processes, emotions and behavior in ways which make the patient different from normal persons. Their thoughts are often disconnected from reality, and are typified weird and mistaken notions. Hallucinations, ineffective emotional control, and warped perceptions, irrelevant are also common.

The Department of Mental Health (1998): Psychosis is a state of serious mental and emotional disorder, where thoughts and behavior are unreal and the sufferer is unable to lead a normal independent life. In addition, sufferer often refuse to accept that.

In conclusion, psychosis may be defined as a serious emotional, mental, sensory, and behavioral disorder, which causes sufferers to be unable to control their actions sufficiently to interact normally with other persons.

Psychological Symptoms

Mental illness is the manifestation of failure in self-adoption. The symptoms do not appear directly or clearly, rather they occur in the form of symbols which reflect the state of mind. Symptoms of mental illness may be categorized into 6 main groups.

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1. Disturbances of consciousness. common symptoms : disorientation , confusion , clouding of consciousness.

2. Disorders of motor activity. common symptoms: Stereotypy, negativism, psychomotor retardation , psychomotor agitation.

3. Affect disturbances . common symptoms : blunted affect, flat affect, labile affect, inappropriate affect, euphoria mood , expansive mood , panic attack, apathy.

4. Thinking disturbances. common symptoms : blocking, preservation, Loosen of association, circumstantiality, neologisms, Flight of idea , preoccupation, delusion .

5. Perceptual disturbances. common symptoms : illusion, Hallucination, delusion

6. Disturbances of memory. common symptoms : amnesia, confabulation.

Psychiatric Treatment

Psychiatric treatment is aimed at helping patients to recover as soon as possible. Patients are helped to adapt themselves and tune their personality so as to be able to get along in society. At present, there are three main forms of psychiatric treatment: somatic treatment, psychotherapy and milieu therapy. Each of these should be applied as appropriate to a proper state of patients needs. Moreover, a particular method cannot be used to treat different. For instance, somatic treatment using drugs, electric treatment or tying the patient is only suitable when patients are unable to control their physical response, where as at a different stage other drugs may be on

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help to control emotions. Caregivers should not only be knowledgeable about the effect of various drugs and their possible side-effects, they should also observe and keep records of patient behavior. Once the mental disturbance abates sufficiently, psychotherapy can be introduced patients express their worries and anxieties and find healthy ways to cope with their problems. Milieu treatment will help patients recover. In short, it's necessary for caregivers to have knowledge of different kinds of treatment for efficient caring.

Role of Caregivers of Psychiatric Patients

1. Food : Caregivers need to ensure that patients are given wholesome meals three times a day and that patients do not eat too much or too little. Caregivers should try to ensure that patients who are undergoing pharmacotherapy avoid snacks and high-energy foods so that they do not gain excessive weight.

2. Rest and sleep : Generally, patients should sleep about 6-8 hours a day. Insufficient sleep may lead to stress, anxiety, dizziness, confusion, weakness, and other problems. Therefore caregivers should try to ensure that patients have enough sleep each day in order to improve their changes of recovery.

3. Physical exercise and recreation : Psychiatric patients should take physical exercise appropriate to their level of physical fitness and symptoms. This will help the patient's emotional balance and also relieve stress and pressure. Physical exercise or movement of deficient or out-of-control bodily parts will assist physical rehabilitation and help to prevent physical deterioration. Therefore, caregivers should try to ensure that patients get to regular physical exercise and recreation.

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4. Household chores and occupational training : Because of their impaired ability to help themselves and others in task-oriented activities, psychiatric patients should be assigned household chores or occupational training only as appropriate to their capabilities. The aim should not be to force patients under take these tasks or become more indepent, but to raise their self-esteem by showing themselves that they can still make a valuable contribution to society and that they can do something constructive and useful with their time. While patients may be positively preoccupied or absorbed in such activities, over-imagination and emotional confusion may follow once the activity ceases which may bring about recurrence of negative symptoms. In addition, relatives may not understand that patients can do may harm to others or themselves during such activities. Relatives should also understand that the patient might harm themselves or damage things while attempting to carry out the assigned task. Similarly the patient may not complete the task as required or even create a larger task for some one else because of their incompetent handing of the task assigned. It is often necessary to train patients how to carry out tasks properly so that they can achieve satisfaction and higher self –esteem from performing such tasks successfully.

5. Administering drugs continuously to prevent recurrence of illness : Returning home after psychiatric treatment, patients should be well taken care of and supervised by family members in relation to both their daily activities and the drugs administered to them to prevent recurrence of illness. A recurrence of illness or relapse will make life even harder for patients family members and others. While drugs are used to control mental illness, patients usually have to take them for a long time, some for life. However, over time, patients may become fed up with taking their medication and claim that they don't need to take them any more because they are no longer ill.

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Those supervising the patient need to ensure that patients take the proper dosage of medicine, and that patients do not stop taking medicine without their doctor's permission. Caregivers should observe patient for any side-effects after taking medicine, for instance, stiff tongue or actue dystonia so that prompt assistance can be given. If side-effects are observed, relatives should keep a close eye on their patients and administer an anti-allergic drug as prescribed by their doctor. Finally, a point from individual doses, patients should not have access to supplies of their medication or any other drugs.

6. Handling with care and tenderness : Patients tend to easily lose self confidence, especially in dealing with other people. They often find it hard to change their ways of thinking – especially about being inferior. The best assistance to patients in recovering their self-confidence and self-esteem comes from care providers who can handle patients with understanding and tenderness. The way they do this is by talking to them and not showing any dislike, listening to their stories and following their expressions, giving them information and letting them make decisions by themselves, respecting their rights and not forcing them to follow their relatives' or caregivers' wishes, suggesting how they should behave, providing encouragement and rewarding them when they do something right so that they can learn how to control their emotions, thoughts and reactions, and by positive reinforcement when patients show appropriate responses.

Support of this nature will help restore patient's confidence and pride, and foster feelings that other people pay attention to them, love them and care for them. This then makes them want to improve their behavior and try to control themselves even more. This means that patients can live at home longer and more successfully

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which in turn means that the opportunity of the sickness recurring will be reduced. In addition, all family members should treat the patient in as much the same way as possible in order to prevent confusing the patient. This means that, caregivers have to clearly and simply explain to family members the nature of the disease, its symptoms, expected behavior and the treatment required. Patients should be encouraged by family members to participate in community activities such as temple fairs, or traditional ceremonies. Tasking part in such activities will help train them to adjust themselves to social and community realities, which in turn may mean that the community will more readily accept such patients..

Stress of Caregivers of Psychiatric Patients

Stress may be defined as a state of inbalance in the human system caused by internal and/or external environmental change. The human system is an open system, perceiving environmental change at all times. Making adjustments and trying to maintain this balance is an ongoing process. Because of this, stress is a natural reaction which may occur at any time. A person may react to stress positively or negatively. In its negative aspect, stress is manifested as unhappiness which people try to avoid or case to varying degrees in various ways. Too much stress may lead to physical sickness or personality problems, while serious stress may cause death (Wallace, 1978). In its positive aspect, stress presents a challenge to the individual's capability, and successfully coping with stress brings about new knowledge and self-awareness which boosts physical and spiritual development.

Rogers (1951) defines stress as mental state in which person feel threatened, worried, anxious and uncertain of their self-behavior as a result of unconformity to

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'self-structure'. In other words, mismatched perceptions of the persons self and reality cause the mind to employ self-defense mechanisms, which distort the perception of that experience in order to maintain 'self-structure', resulting in misperceptions, worries, denial of their self-behavior and feeling of being under threat.

Selye(1956) defines stress as a physical reaction to threat, causing structural and chemical change in the human being to counter the threat. The stress reaction commonly expresses itself physical symptoms such as headache, backache, and high blood pressure.

Lazarus(1971) defines stress as temporary state of imbalance caused by the perception or evaluation of the environment as a threat. This perception or evaluation is a result of joint action between the external environment (such as the work environment, social environment and everyday events) and internal human factors (such as attitude, personality traits, emotions, past experiences and desires.

Mental and emotional stress refers to intellectual evaluation of perceived threats, or danger stimuli which give rise to feelings of uncertainty. Sometimes these feelings (and therefore the stress reaction)may be under control, but at other times they may not be. When they are not, this gives rise to mental contradiction, and confused feelings and emotions which may produce anger, sadness, fear, guilt, or a variety of other feelings (Lazarus, 1982).

Lazarus & Folkman(1984) state that stress refers to an event which the person concerned evaluates as a threat to their personal welfare or well being which places a heavy burden on their ability to cope and thus erodes or destroys their peace of mind or mental equilibrium. Whether the event is deemed a stress or not depends on

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the balance of desire and resources in that person as determined through the intellectual process.

After considering the concepts and opinions advanced by noted academics in field of human stress. We can define stress rather more simply as state in which a person feels pressured, uneasy, worried, afraid, anxious and/or depressed as a result of their perception or evaluation of a personal experience as a mental threat or physical danger, which affects their physical and mental balance and drives them to react with self-defense mechanisms, and/or organic, behavioral, imaginary and emotional changes in an attempt to reduce the pressure or stress and so return to a balanced state.

Causes of Stress

Appley and Trumbull (1967) say that stress is caused by unacquainted, serious, suddenly changed, or unexpected events as well as events which a person has not enough patience to cope with. ?By contrast, they also say that, receiving no stimulus, not receiving the expected stimulus, or receiving an unwanted stimulus over a long period tiresome, which leads to misperceptions, that eventually stimulate a stress reaction.

Lazarus(1971) says there are two causes of stress :

1. Environment:

Stress is caused by external factors –the natural, social or working environments, and events in daily life, such as limitations to privacy, too much responsibility, on a working environment which does not allow a person to make good use of their abilities.

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Murray and Huelskoetter(1987) compiled a list of many of the social and cultural causes of stress : social and cultural pressure, negative aspects of relationships, social pressure combined with rapid technological change, migration, changing social customs and culture, economic anxiety, and uncertainty in relation to sexual role or identity. They concluded that if change is significant and frequent they stress will rise accordingly.

2. Human factors.

2.1 Attitudes and traits: Always hurrying and trying to do as much as possible. An over competitive attitude which makes it hard to relax and easy to be hostile to others. Trying to achieve goals without proper planning where the person dares not express such goals, or where their hopes are too high and they dare not express such hopes will feel uneasy and tense.

2.2 Emotions: Negative feeling such as unhappiness, confusion, worry, guilt, despair, strong negative emotion or great uneasiness causes stress or intensifies it.

2.3 Past experience: Negative memories of daily life, negative perception of past events, recollection of real or perceived failure. These may be perceived and evaluated as a threat, which leads to stress.

Levels of Stress

Jenis(1952) divides stress into three levels.

1. Mind stress: A state of low stress found in normal daily life, such as waiting for a bus or missing an appointment. This kind of stress will disappear in a few minutes or a few hours.

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2. Moderate stress: A level of stress in which body and mind are set in conflict by organic, behavioral, emotional and imaginary change. Tackling the cause of stress until the situation returns to normal will also bring stress back to a normal level.

3. Severe stress: A state of severe stress may linger for months or years, serious bodily and mental problems which have a strong negative effect on daily life.

Stress-inducing Factors on Psychiatric Patient Caregivers

Normally, when a family member gets physically sick, it's an unpleasant experience which may lead to stress for other family members (Nithikul, 1992). Mental sickness is even worse and other family members may become even more tense in this case since mental sickness is generally more severe than physical sickness.

Stress in each person is independent and differs. Birchwood & Smith, 1987, have compiled the following list of the effects of psychiatric patient's behavior on their relatives and family members.

1. Coping with troublesome behavior : A patient's troublesome behavior is often expressed in unpredictable ways, and this is most stressful to the patient's relatives (Torrey, 1983). The patients emotions are disturbed and unpredictable. A bad mood leading to a show of aggressive behavior, is an experience that most relatives have experienced. Some of the most frequently encountered behavior of this type include withdrawal, low energy, silence, lack of motivation, poor relationships with others, acting out fantasies, hostility, paranoid, and delusion-based actions and communications. (Torrey, 1983 quoted in Chaisanoh, 1997). For example, The patient

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may try to communicate a delusional belief that relatives are planning to kill them, which often becomes a most worrying matter for the relatives concerned.

Patient's action may s disturb relatives' sleep. A sudden worsening of symptoms may cause patients to despair and want to commit suicide, which in turn may require great deal of attention and care from their relatives to prevent When patients show troublesome behavior, caregivers often employ the following methods to cope. (Birchwood & Smith, 1987)

1. Coercion: Punishing the patient by verbal or physical aggression.

2. Avoidance: Keeping away from the patient or not helping them with a job they find hard to do.

3. Indifferent reaction: Acceptance or belief that the behavior is part of the patient's personality sickness and caregivers abandon efforts to suppress it.

4. Collusion: An inclination to accept the patient's delusional belief in order to avoid a quarrel or to let the patient have their wish fulfilled, or to and forgive them for various transgressions, or to never try to tell them the truth.

5. Reassurance: Non-threating gestures and affectionate body contact such as gentle hugging and patting and explaining the pros and cons of the available options without being swayed by emotional displays.

6. Disorganization : Various methods of coping with the patient's behavior are tried with little or no interest shown in the consequences nor the relative merits of methods employed. This is regarded as an unstable reaction to the patient's behavior, Which is confusing to both the patient and relatives.

7. Construction: Caregivers observe the effectiveness of various coping methods and try to employ the most promising ones for different situations.

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2. Emotional change in caregivers : Psychiatric patient caregivers have varying emotional reactions –shyness, fear, worry, guilt. In general, when a person gets sick physically, it looks acceptably ordinary and the patient is willing to tell anyone that they are sick. By contrast, mental illness is not accepted by society. Mental illness is considered to entail a loss of dignity and honor and it has to be kept secret. Thus relatives often try to keep it hidden. (Inim, 1988).

The patient's close relatives often feel guilty about the psychosis, especially the father who may blame himself for not staying at home when the child was still small and the mother who may blame herself for showing her anger to her child too often or overprotecting it. In some cases, parents blame themselves and each other (Torrey, 1983, quoted in Nithikul, 1992). The patient's father and mother often feel guilty about their ignorance of the first stages of the mental disorder and their consequence failure to offer early assistance. They wonder and worry whether the child would have become so sick if they as parents had been more knowledgeable or shown more responsibility.

Caregivers may become so tense that at times they are unable to cope with the tasks involved properly due to physical fitness and emotional problems, uneasy feeling, worried about the future, fear of making plans or of being harmed by patients and repeated disappointment about patient recovery. They may come to feel that tending the patients is an insupportable burden.

Often family members are not only victims of stress of living with a mentally disordered person, but because of this they also find it hard to correct and improve the patient's behavior despite wanting to do so. (Birchwood & Smith, 1987).

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A study of the worries of psychiatric patient's relatives' by Buranangjura (1995)shows that relatives generally do care and are concerned about the patient's mental sickness, but that they often find it hard to take care of the patient, worry about the patient's future, and let the patient's get their own way too often. These finding correspond closely with those of Borichan and et.al.(1991) who also reported that relatives generally care about and are concern about the sickness and take the trouble to help the patient in every possible way.

3. Economic factors : The family's economic status is a significant factor affecting the patient's care. A wealthy family has for less difficultly in providing equipment and social support for patients than a poor family.

The economic impact of mental illness on patients who used to financially support their family or on their relatives who can not continue in their job or career because they have become a caregiver is obvious. Psychiatric patients cannot manage their own finances. They spend money lavishly or lose it, causing stress to their family. Morever, family which has a psychiatric patient generally has on going extra expenses, reduced family savings and often has looming financial difficulties.

A study on relatives worries and behavior in coping with stress by Borichan and et.al.(1991) shows that when taking a patient to see a doctor, the patient's relative usually had to take leave from work for a day and spend more money on expenses than normal. In other words, there was a significant financial cost both in terms of lost earnings and higher expenditure.

By contrast, an in-depth interview with a psychiatric patient's relatives, who were mostly low income earners by Guanaccia & Parra(1996) found that they did not see such financial costs as a burden, most likely due to the financial assistance they

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received from public charities or foundations. Indeed most relatives have access to extra income from a social welfare scheme of some kind which helps them to afford to tend the patients. Nevertheless, many other relatives are still uneasy about the financial limitations they are faced with, such as their inability to use the treatment method of their choice. In summaries, while the economic burden does negatively effect the ability to tend for the patient a low income does not necessarily indicate a commemorate decrease in the standard of care that the patient receives

4. Social and private life : Living with psychiatric patients has a number of negative effects on the family particularly on the social and private lives of family members (Torrey, 1983). Research conducted on psychiatric patient's relatives shows that living with a psychiatric patient restrictive effect on their social activities and hobbies (Brown, et al, 1966). Patients often exhibit strange behavior which is unacceptable in normal in society. While some patients do not want to have social contacts, others do however they don't have the social skill required to do so successfully. One of the major negative effects is that patients often require 24 hour a day supervision(Baker, 1989). Often this means that relatives cannot leave the home for long because patients cannot be left unattended for only short periods (Creer and Wing, 1974). Thus the social activities and private lives of caregivers are limited and as a result. They often become dissatisfied and angry. However direct expression of these negative feelings is sometimes suppressed instead it later appears as a sad and withdrawn attitude. (Torrey, 1983).

5. Family relationship : Family relationship here in refers to the relationship between the patient and other family members as well as the relationship amongst other family members. In general, the family relationship is characterized by

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helping and caring for one another. However the mental illness of a family member nearly always has a negative effect on the family which often leads to conflict and stress within it . Relatives who stay by the side of a patient and help the patient for years can become disturbed by the patient's indifferent reaction to their care especially if the patient is withdrawn and finds it difficult to live with others (Chen ,1985). Though a patient may have lived with other family members for years, the sudden onset of a mental disorder may cause unsettle the family's balance as family members turn their attention to the patient and ignore other members' needs (Leffey, 1987: Torrey, 1983 quoted in Chaisanoh and et.al.1997) thus giving rise to feelings of neglect and discontent.

6. Contact with officers and mental health services : Contacts with officers disappoints and disturbs relatives. For example, when they are denied the opportunity to participate in the treatment process, when mental health services try to push psychiatric patients out of the hospital and into home care when they are not ready, or when the family feels they admitted as an in-patient but the hospital tries to treat them as an outpatient. Thus disappointments and unsatisfactory dealings such as the above only increase the burden on relatives. (Chaisanoh, 1997).

Other Factors Influencing Caregiver Stress.

1. Age : Personal development and maturity differs according to age and experience. In relation to decision making, Newman (1997) says that the caregivers' age is a joint stimulus which influences the caregivers' adjustment. For example mature and experienced caregivers are most likely more prudent and careful. Similarly aged caregivers are usually more patient and thus more resistant to stress (Ryff, 1982)

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and have less emotional effects and mental problems than junior caregivers (Carey et al, 1991)and a study by Kaewraya (1997) shows that older the relatives and caregivers are, the better they adjust themselves. However, aged caregivers may alsohave their own health problems and find it more difficult to meet patient's need. Therefore a correlation between the caregivers' age and their capability in patient care cannot be assumed.

2. Sex : In general, males becomes ill more easily than females because they are less attentive to their health. However, research on sex and stress coping ability is in conclusion. For example, Moos&Schaefer concluded that sex is related to stress coping sex is and is not related to stress coping (Moos & Schaefer, 1984). A study of stress coping among heart disease patients shows no difference in stress coping ability between males & females(Nagrat,1990). A similar study conducted on patients who had undergone heart surgery to replace a valve concluded that sex had no relationship to self-adjustment (Laohaviriyakamol, 1988).

3. Educational level : Education brings about physical, emotional and intellectual development as well as introducing many of the basic principles needed to cope with modern life. Educated persons show more intelligence and one for better able to keep up with other educated people and current affairs (Rungvisai, 1980). Education is the foundation on which people can develop their intellectual capabilities and prepare themselves face life's opportunities and misfortunes (Supab, 1986). Because Intellectual and educated persons are better able to evaluate events on a realistic basis they suffer less stress than the uneducated (Lazarus and others, quoted in Somjit Nucharoenkul, 1991). Similarly, educational level has been found to be a significant positive factor inrelation to the ability cope with problems and identify

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related factors (Jalowiec & Power, 1981). Because less educated persons are less able to understand and properly evaluate most circumstances they generally cope with situations less effectively. A study of the relationship between social support and stress coping of patients of chronic diseases shows that university graduates are better able to cope with stress than primary school educated persons or uneducated persons Phuvaraputpanich (1994) because educated caregivers have better reasoning and problem solving abilities and they are better at finding assistance.

4. Family support : As mental illness is often a chronic and complex disease, tending and meeting psychiatric patient's needs, will be done with better feeling if caregivers receive assistance from other persons, because naturally people who face with problems or unhappiness want a helping hand from others usually a family member or a person close to them (Panthusena, 1993). In this situation, the caregivers spouse is usually the source of support and assistance because marital relationships are normally intimate, understanding and mutually dependent (Phupaibul, 1994). Thus when a problem arises in a family, such couples naturally tend to help each other. By contrast unmarried people often lack a person to share their burden with or someone to counsel and encourage them, which leads to stress and a negative effect on their ability to cope with stress (Mishel, 1988).

The family is also usually the most significant source of social support to caregivers because the family can yields cooperation, provide assistance in terms of materials and labor needed to tend patients and thus help to share the burden. This is very important because it makes caregivers feel that they're recognized for their role. And encourages them to continue tending the patient. A study by Guanacia & Parra (1996) who conducted in-depth interviews with home caregivers of psychiatric

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patients, shows that most caregivers thought that the family of was the best source of mental and social support(such as preparing food, doing their laundry, shopping, administering the patient's medicine, taking the patient to hospital and managing their financial affairs) with most caregivers being of the opinion that the social support they receive from health service teams is the least valuable help they get.

A study of the relationship between personal factors, available social support and the stress coping capability of a family with an adult psychiatric patient by Tapseripathai (1991) shows that social support has a positive relationship with the stress coping capability of families with an adult psychiatric patient, thus concurring with a study by Cohen and Will (1987) which concluded that social support helps to reduce such crises because social support acts like a format an armor to block and reduce some stresses thus allowing other stresses to be dealt with more effectively.

lastly, A study by Keith(1995) shows that families with two or more daughters tend to be better managed than others. The same study also found that family traits such as character and unity can have a significant influence on caregivers' adjustment capability.

5. Period of exposure : The amount of time that caregivers are exposed to psychiatric illness has a significant impact on caregivers' perceptions of the sickness. Mishel (1990) says that once the illness is regarded as long-term or incurable, the caregivers perception of the situation will either remains unchanged or attain a new balance according to time and threshold factors which are different for each person. Similarly, Lazarus and Folkman (1984) conclude that being stimulated with stress for a long time, the person will learn how to cope with the stress, for example re-evaluating the situation or learning to cope more effectively with the stress through

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meditation. Panthusena (1993), says that the self-adjustment needed to cope with stress and to recover the balance usually takes about 4-6 weeks and in a serious case not more than 2 years. A study by Nithikul (1992) on stress in psychiatric patient's relatives, found that relatives of patients who have been sick for 1-5 years had higher stress levels than relatives of patients who have been sick for more than 10 years. Worry and uncertainly over the cause of the disease and the decision to take the patient to hospital, says Kiewkingkaew (1984), produces long-lasting stress on relatives which stimulates an emotional reaction involving both body and mind learning such persons feeling very tense. Thus, the perceived duration of the illness clearly has a significant influence on stress and stress-coping behavior.

Finally, the major impact on caregivers comes from deep, gradual, long-lasting behavioral change in patients which impacts on caregivers and their families and creates tension . The level of stress created depends on the nature and level of patient's behavioral severity. The more severe it is, the stronger the impact on caregivers will be.

Coping Behavior of Caregivers of Psychiatric Patients

Stress-coping responses are employed to combat mental disturbances and inbalances such responses act to eliminate or reduce the problem by controlling either or both the perception of events and the emotions they generate so that they becomes more appropriate to the circumstances (Pearlin and Schooler, 1978). Often they form part of the behavioral plan which a person or family employs to cope with the threat to health that stress presents. (Jensen and Bobak, cited in Friendman, 1981).

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Similarly, Garland and Bush (1982) say that stress-coping responses are a process in which a person tries to relieve or eliminate stress, while Miller (1983) says that coping with stress is a process of learning to cope with what a person perceives as a threat or challenge where by the unpleasant feelings associated with stress are corrected.

Coping can also be said to be constantly changing cognitive and behavioral efforts to manage specific external / internal demands that are appraised as taxing or exceeding the resources of the person concerned (Lazarus and Folkman, 1984).

Therefore, stress coping may be defined as a process during which the person concerned tries to cope with a situation threatening to his welfare through their reactions or feeling which are continually changing according to the situation and experience of that person

Coping Process

Stress coping, according to Lazarus, is a cognitive process or cognitive appraisal which occurs when there is a change in the balance between a persons and their environment which has an impact on that person.

Lazarus and Folkman (1984) analyzed three major or aspects of people's stress coping ability in daily life in three major aspects as outlined below.

1. Eventer stress

2. Appraisal : the cognitive determinant of emotion, usually a rapid and conscious process , based largely on past experience.

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2.1.1 Irrelevant : The person has no investment in possible outcomes; they inpinge on no value, need, or commitment; nothing is to be lost or gained in the transaction.

2.1.2 Benign Positive : This type of appraisal is likely to occur if the outcome of the encounter is construed as positive, that is if it preserves or enhances well-being or promises to do so.

2.1.3 Stress appraisals are examined below under three headings :

2.1.3.1 harm / loss : some damage to the person has already been sustained, such as an incapacitating injury or illness, recognition of some damage to self- or social esteem, or loss of a loved or valued person.

2.1.3.2 Threat : harm or loss has not yet taken place but are anticipated. Even after a harm/loss has occurred, it is always fused with threat because every loss is also pregnant with negative implication for the future.

2.1.3.3 Challenge : By contrast he main difference is that challenge appraisals focuses on the potential for gain or growth inherent in an encounter. characterized by pleasurable emotions such as eagerness, excitement, and exhilaration.

2.2 Secondary appraisal : is a judgment concerning what might and can be done. It includes evaluation of whether a given coping option will accomplish what it is supposed to, whether a particular strategy or set of strategies can be applied effectively, and an evaluation of the consequences of using a particular strategy in the context of other internal and/ or external demands and constraints.

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2.3 Reappraisal : refers to a change of appraisal based on new information from the environment and/ or the person concerned . A reappraisal differs from an appraisal only in that it follows an earlier appraisal. Sometimes reappraisals are the result of cognitive coping efforts. These are called defensive reappraisals and are often difficult to distinguish from reappraisals based on new information.

3. Coping behavior

3.1 Problem-focused Coping: This process attempts to solve the problem by defining its scope, considering various solving methods, choosing an appropriate one, and going to the root cause of the problem. The solution is concentrated on the person concerned and their environment. It involves changing the environment, finding a source of interest, learning how to behave acceptably, and discovering new information and additional knowledge.

3.2 Emotional-focused Coping: Stress is reduced but not eliminated. Coping consists of stress avoidance by looking at it as a minor matter, keeping away from stressful situations, paying particular attention to one aspect of the problem, exercising, meditating, or involvement in similar stress-reducing activities.

Coping resources

Lararus and Folkman (1994) indentified major categories of resources. Their purpose was not be exhaustive, but to illstrate the multidimensionality of coping resources and the various levels of abstraction at which several of these dimensions can be considered.

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1. Health and energy : A person who is frail, sick, or other wise debilitated has less energy to expend on coping than a healthy.

2. Positive beliefs : Oneself positively can also be regared as a very important psychological resource for coping. Positive beliefs include in two category, general and specific beliefs that serve as a basis for hope and that sustain coping efforts in the face of the most adverse conditions.

3. Problem-solving : Problem-solving skills include the ability to search for information, analyze situations for the purpose of indentifying the problem in order to generate alternative courses of action, weigh alternative course of action, weigh alternatives with respect to desired or anticipated outcomes, and select and implement an appropriate plan of action. They are also important resources for coping.

4. Social skills : Social skills refer to the ability to communicate and behave with others in ways that are socially appropriate and effective. Social skills facilitate problem-soving in conjunction with other people, increase the likelihood of being able to enlist their cooperation or support, and in general give the individual greater control over social interactions.

5. Social support : The individual gains sustenance and support from social relationships has been know intuitively for a long time, and should be, in a sense, obvious. Schaefer (1982 cite in Lazarus & Folkman , 1984) distinguished three types of functions of social support.

5.1 Emotional support includes attachment, reassurance, being able to rely on and confide in a person, which contributes to the feeling that one is loved or cared about.

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5.2 Tangible support involves direct aid such as loans or gifts, and services such as taking care of someone who is ill, doing a job or chore.

5.3 Information support providing information or advice, and giving feedback about how a person is doing.

5.4 Material Resources refers to money and the goods and services that money can buy. This obvious resource is rarely mentioned in discussions of coping, although its importance is implied in discussions of the strong relationships that are found among sconomic status,stress, and adaptation.

Adaptation Outcome

Adaptive outcome requires cognitive appraisal and coping behavior. This involves the following three areas.

1. Social function ways in which the individual fulfills theor various roles and interpersonal relationship.

2. Morale : this is concerned with how people feel about themselves. This type of evaluation is based on affects or emotion such as satisfaction / dissatisfaction, happiness / unhappiness, or hope / fear.

3. Somatic health : stress and coping are causal factors in illness. During a stressful period, any or all of these areas may be compromised. Successful coping results in an improvement in social functioning, psychological well-being, and health.

Lazarus divided stress coping into 5 models:

1. Information seeking: An attempt to learn more about and understand the problem in order to solve it.

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2. Direct action: Coping reactions to cope with a situation evaluated or determined as stressful.

3. Inhibition of action: Action is inhibited or suspended because such action is deemed dangerous.

4. Seeking assistance and support from surrounding people.

5. Intrapsychic processes: Sensations considered threatening to body and mind care counteracted by activities such as self defense training, relaxation techniques or biological reaction techniques.

Factors Influencing Stress-Coping Behavior

When a person comes under stress, they usually attempt to cope with it in some way in order to keep their physical and mental balance. Whether they are successful in coping with this stress depends on various factors.

Alquilera & Messick, quoted in Phasuk, 1985, refer to threefactors influencing stress coping capability.

1. Perception of events: If an event or problem is perceived correctly, it can be successfully tackled and the stress reduced accordingly. However, if misperceived, problems will not be solved and the stress will remain.

2. Social support and assistance: People in society need to be able to rely on one another since solitude and loneliness will usually only intensify stress.

3. Adjustment mechanism: Daily routines, learning how to cope more effectively with stress and reduce stress are slowly developed while further experience is gathered.

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Ziemer(1982) listed the following for says factors which influence how well a person copes with stress.

1. their coping ability or planning
2. the assistance and support they receive
3. their emotion profile
4. their perception of events or situations

The Concept of Supportive Group Therapy

The Meaning of Supportive Group Therapy

Supportive group therapy is a relatively resent development in therapeutic treatment that involves the formation of group compromising 6-12 members with similar problems. A therapist or the group leader facilitates the exchange of experiences and ideas among group members while interfering as little as possible. Members are encouraged to talk about their personal problems with each other so that will be encouraged to do the same.(Wolberg , 1967)

The process of group therapy brings together two or more users of health services to freely discuss their disappointments, doubts and anxieties by establishing an environment which they can develop personal relationships with each other. This can then lead on to the users helping each other with their problems. However, if their opportunities to express themselves freely are disrupted or cut off this may result in problematic understanding and strengthening members' mental defense mechanism. (Rockland,1989)

Consequently, supporting group therapy is considered as a contemporary treatment (here and now) . Encouraging group participants to express themselves

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fosters their sense of self confidence and provides them with gives mental support which can help them in various ways (Bloch,1996):

1. Relieving their symptoms or helping to solve some specific problems.
2. Recovering their emotional equilibrium
3. Replenishing their exhausted mental powers.
4. Helping them to manage their problems by dealing with them on a conscious level.
5. Helping to decrease the pressure on them from their surroundings
6. Suggesting more effective ways of improving their emotional control

Aims of Treatment. (Holmes , 1991)

1. For the patient acknowledge and face up to the real losses and deprivation that they have experienced, but not to allow them to use these to prevent themselves from making progress in life.
2. To prevent further breakdowns by monitoring the patient's current mental state
3. To act as the temporary auxiliary ego of the patient in an attempt to strengthen the patient's own ego through identification
4. To encourage the patient to develop new and more satisfactory behavior and ways of coping with life.
5. To provide a source of comfort to which the patient can return for as long as they need it.

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Components of Supportive Therapy (Bloch , 1996)

1. Reassurance : The therapist tries to reassures patients in at least two way : 1)by removing doubts and misconceptions and 2)by pointing to their assets. Patients commonly harbour thoughts or sentiments about themselves which are ill-founded and lead to considerable distress. The therapist therefore aims to create a climate of hope and positive expectation, but without deceit and disingenuousness.

2. Explanation : The goal of this strategy is to promote insight. However, explanation of such phenomena as transference, resistance, defense, and unconscious determinants of behavior, is inappropriate and best avoided. Instead, explanation focuses practical on day-to-day matters, on the current and external reality with which the patient contends. The goal is not to promote self- understanding of a psychodynamic kind, but to enhance the ability to cope by clarifying the nature of the problems and challenges the patient faces and how he can best deal with them.

3. Guidance : Supportive therapy usually entails providing guidance to patient in a range of situations, mainly through direct advice. As with explanation, the stress is on practical issues, including the most fundamental such as budgeting, personal hygiene, nutrition, and sleep. Advice may be necessary with regard to of work ; family ; or leisure. The therapist's goal here is not merely to assist the patient to deal with a particular problem, but also to teach him requisite skills for coping with similar problem.

4. Suggestion : This strategy is similar to guidance although the patient is offered less choice in considering whether to comply. The therapist aims to induce change by influencing the patient him implicitly or explicitly.

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5. Encouragement : Group members attending supportive therapy sessions often feel totally unacceptable, not only to other people but also themselves. However, if they are sure of the therapist's non-judgemental understanding, or at least of the therapist's best attempts at understanding them, they are likely to feel some measure of acceptance. This in turn leads to their feeling more acceptable to themselves, and to a raising of their self-esteem.

6. Effecting changes in the patient's environment : Typically, group members are markedly influenced by social forces(both human and institutional) that impinge on them. In supportive therapy a cardinal consideration with regard to the patient is their social context; the goals of removing or altering beneficial ones. There are two dimensions to this strategy: 1) working directly with the patient by helping him,2) working with people who are important to the patient, particularly relatives.

7. Permission for catharsis : The relative security typifying the therapeutic relationship permits the patient to share with a sense of relief their pent-up feelings such as fear, grief, sorrow, concern, frustration, and envy. Indeed, the clinic is often the sole place where the patient feels sufficiently safe to do so. The therapist, by showing that they are a sympathetic, active listener who accepts the patient unconditionally, grants them permission to share whatever 'secrets' they have no matter how painful or embarrassing they may be. Although sharing of emotionally charged material is not necessarily effective in itself , the process often leads to a sense of relief and serves as a vehicle for other strategies.

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Supportive Group Therapy Base on Client – Centered Therapy

The process of Supportive Group therapy that follows from Roger's ideas requires researchers to have a thorough understanding of human nature. This means that they must be able to comprehend the causes and results of stress, and be able to deal with stress successfully themselves . It also requires understanding about the characteristic of a person. The researchers therefore will have move understanding in psychiatric patient's caregiver, and seek out the alternative of supportive group program arrangement.

In Rogers(1977) the authors states his personal belief that basically all human beings have reasons, just need to be taught how. Similarly they usually aim to achieve success and progress, and are not afraid to face most truths. Rogers went on to describe five aspects of human character:

1. Humans have self worth, high intelligence, and decision-making. Therefore, everyone should have freedom to express his or her opinions and actions providing they do not in which they never interfere with other persons.

2. Humans have a tendency to self-improvement. Accordingly, the group leader should arrange situations which provide opportunities for patients to excel in.

3. Humans are decent and trust worthy.

4. Humans have the ability to acknowledge themselves and the surrounding environment. Rogers strongly emphasized that an individual's actions and adoptions should agree with his environment experiences and self examination. Therefore, correct personal understanding is an acknowledgement their nature.

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5. Humans need love, care and acceptance from others. Therefore the group leader should have a positive attitude, and accept members unconditionally

Aspects of Group Relations

The development of interpersonal relationship depends greatly on the following six factors which are the foundation on which group relations can progress smoothly (Trotzer , 1977 : 11-13).

1. Trust : The feeling of being secure and having a stable state of mind in which a person can open up to others without fear, rejection, or revenge. Mutual, trust and credibility allow group members make to be certain that their life stories and problems will remain confidential.

2. Acceptance : this is the characterized by the ability to freely express thoughts and feelings to others despite the problems which the group member is experiencing in their life.

3. Respect : This is the condition in which group members can relate to each other as self-reliant individual.

4. Warmth : This may be defined as a feeling of acceptance without conditions. It requires caring, non-possessive love, prizing, and liking. Warmth cannot be measured in terms of numerical values or scores.

5. Communication : This is the one of the most important and meaningful factors in any interpersonal relationship. Valid communication that all members can express their desires, have the ability to start a conversation, and can respond to others though the process of communication.

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6. Empathy: This is the ability to share the same vision with other members. Rogers (1952) described it as an ability to listen with understanding as a way to destroy barriers to communication. These barriers or walls according to Roger's theory, develop because humans like to assess, to compile, and to interpret information that other people communicate to them instead of using their own judgement to properly understand the real messages and feelings that is trying to be expressed or communicated.

Process and Pattern

Rogers(1970) explanin the group process as following a pattern of 15 steps, in which any step can occur in any order. These 15 possible steps are described below.

1. Milling around : As the leader or facilitator makes clear at the outset that this is a group with unusual freedom and not one for which he will take directional responsibility, there tends to develop a period of initial confusion, awkward silence, polite surface interaction, 'cocktail-party talk,' frustration, and continuity is lacking.

2. Resistance to personal expression or exploration : During the milling around period, some individuals are likely to reveal rather personal attitudes. This tends to provoke very ambivalent reactions from other members of the group. Although it is only the public self that members tend to show each other initially, and only gradually, fearfully, and ambivalently they take steps to reveal something of their private self.

3. Description of past feelings: In spite of ambivalence about the trustworthiness of the group and the consequent fear exposing themselves, expression of feelings begins to assume a larger proportion of the discussion.

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4. Expression of negative feelings : This is when , the first expressions of genuinely significant 'here and now' feelings are put forward. These usually take the form negative attitudes toward other group members or the group leader.

5. Expression and exploration of personally meaningful material : Following such negative experiences as the initial confusion, resistance to personal expression, focus on outside events, and the voicing of critical or angry feelings, the event most likely to occur next is for some individual to reveal port of their true self to the group in a significant way.

6. The expression of immediate interpersonal feelings in the Group: Entering into the process, sometimes earlier- sometimes later, is the explicit bringing into the open of feelings experienced in the immediate moment by one member towards another. These are sometimes positive and sometimes negative. Such feelings or attitudes can they be explored more fully in the increasing climate of trust which usually develops.

7. Development of healing capacity in the Group : In this step a number of group members begin to show a natural and spontaneous capacity for dealing in a helpful, facilitating, and therapeutic fashion with the pain and suffering of others. Feelings of care, compassion and support towards members are gradually made known.

8. Self-acceptance and the beginning of change : Rather than feeling that self-acceptance stands in the way of change, members begin to see their group experiences as therapeutic and the beginning of change.

9. The cracking of facades : As the sessions continue, so many things tend to occur together that it is hard to know which to describe first. It should again be

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stressed there is no definite order in which steps must occur, and indeed that these different threads and stages tend to always interweave and overlap. However, one development which usually stands out is the groups increasing impatience with defenses i.e. as time goes by the group become increasing by unable to tolerate members who continue to try and live behind a mask or front.

10. Individual receives feedback : In this process of freely expressive interaction, the individual rapidly acquires a great deal of data as to how he appears to others. The hail-fellow-well- met extrovert may find that others resent his exaggerated friendliness. The executive who weighs his words carefully and speaks with heavy precision may discover for the first time that others regard him as stuffy.

11. Confrontation : There are times when the term feedback is far too mild to describe some of the interactions when individual directly confronts another, or 'level' with them. Although such confrontations can be positive, frequently they produce decidedly negative outcomes.

12. The helping relationship outside the group session : Some problems can becomes topics for discussion outside of the group meetings just as some forms of group support are not confined to such sessions. In this step members begin to relate to each other outside as well as inside group meeting.

13. The basic encounter : A member feels the closeness and accepted of being in a group. They also develop an ability to communicate with others with understanding and sincerity. Thus, the group relationship allows him to express his feeling truthfully.

14. The expression of positive feeling and closeness : Once members are able to express their feelings and have them received positively by other members of

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the group relations among them become warmer and trusting until they become an essential part of the group. In other words, shared feelings, understanding, and the growing relationship among group members produce the type of closeness that is usually associated with belonging to the same family.

15. Behavioral change in the group: Members have tendency to change their gestures, tone of voice, their level of assertiveness and their degree of independence. Moreover, such tendencies are marked by feelings of concern, good relations, trust, and determination to help others.

Characteristics of Group Leader

Rogers (1980: 115) states the belief that each person possesses the power and ability to achieve self-understanding, to correct their self-concept and basic point of view, and to control their self-directed behavior.

Accordingly, all human abilities are sought to be used in the group relationship. The following three properties are especially useful

1. Realness means being a direct, straightforward, sincere, and independent types of person. The real person must be aware of his own ideas and feelings and they must also be able to reveal their experiences, and point of view.

2. Unconditional positive regard means trust in a person. That they too values, feelings, opinions, the ability to make decisions, and to improve themselves regardless of any assessment or judgement. This type of acceptance, therefore, can be expressed through facial expressions, speech, gestures, and tone of voice.

3. Accurate empathy means the ability of the group leader to relate to conceive members ideas, feelings, beliefs, and the true meaning of their experiences.

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In other words, it is the group leader's specific understanding without assessment and judgement transferred to group members that allows them to realize and clarify their own feelings. This type of understanding requires particularly attentive and careful listening.

Establishing relationship with group members on the basis of the above properties will allow the leader to help members achieve positive change and optimism through being accepted and valued. This also helps members to play closer attention to themselves and to comprehend their circumstance better, including better understanding their own point of view and their own feelings.

Responsibility of Group Leader

The group leader is responsible for maintaining the members progress and for helping members to participate in group activities. These responsibilities are further desuribed under the following nine heading

1. Climate-setting function : One of many responsibilities of thr group leader is to create a group-like atmosphere, which helps members to feel comfortable and secure. One common way this done is for the leader to ask all members to tell something of their life story. The leader must also do their best to accommodate members' requests so that a feelings of positive mutual expectation will be encouraged.

2. Acceptance of the individual : The group leader must show tolerance and acceptance towards group members by playing the part of a normal member to some extent at times. The leader should also respond more to members' present feelings than their past experiences.

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3. Empathic understanding : The group leader must try to find meaningful interpretations of a members expressions. This may require the leader to seek clarification or justification of member's expressions before they can give a meaningful explanation back to the member concerned.

4. Operation in terms of feeling is the type of expressions : The group leader should aim to maintain a good relationship with participants and encourage them to freely express their feelings. The leader must be essentially sensitive to the members' feeling so that he is able to respond to any situation immediately. One caution nevertheless for a group leader: never try to answer any question regarding social manners, instead, try to provide members the answers that point out some meanings and implications.

5. Confrontation and Feedback : These techniques used by the a group leader to involve members in reflecting on what has happened in the session so they are presented with a clear picture of their situation. Letting members make suggestions to one another, although some painful experiences may unavoidably occur when they are faced with reality or truth, can from an important part of the confrontation and feedback process. However, the group leader must act quickly to feelings which the leader considers undesirable or counter productive .

6. Expression of the leaders own problem : The group leader's fear of expressing or identifying their own fears can have negative effect on the group's process if it leads to a decline in members' ability to receive and process messages and information. Moreover, noticing some peculiarity and discomfort in the leader, members may mistakenly blame themselves for letting the leader down. Therefore, the leader must be prepared for any when the feelings of awkwardness or worry of

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their own to arise. Such preparation will help to prevent a rise in stress and pressure, improve group response, and allow members to continue to share their experiences openly.

7. Avoidance of planning and exercise : If any planning by the group leader and members is necessary, then it should be allowed to arise and be dealt with naturally according to the way in which the session unfolds. Rogers believes that in this way acting natural can be very effective providing such activities or exercises are conducted within the constraints of the groups overall objectives.

8. Avoidance of interpretation : Interpretation should be avoided by the group leader as it tends to cause the group to break down into subgroups, which may give rise to conflicts between such groups.

9. Physical movement : The group leader should make their own physical movements naturally so that stress and pressure on members is reduced or at least not exacerbated.

The roles of the group leader, therefore, is ultimately to facilitate members self-understanding and their understanding of reality. Carkhuff (1983) describes this process in the steps below.

1. Involvement : Group members are motivated to improve their behavior.

2. Understanding : Group members achieve the ability to perform self-examination and are able to reveal their personal experiences and problems. As the result, they can set goals and develop solutions for their problem.

3. Realization : Group members understanding of the problems that they can find their own solutions.

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4. Action : Group members are able directly participate in problem solving activities .

Group Members

The question of who qualifies to be a group members largely depends upon the suitability of the treatment being offered. For example, a group may contain members of varying age and maturity and point of view providing they are capable of sharing the same topics of discussion and ideas. Preferably the group should be comprised of roughly equal numbers of females and males in order to stimulate maximum improvement in their emotional and intellectual development. In another words, each member is able to make gains in their problem solving ability by exchanging his ideas and experiences with others.

Group Size

Many psychologists agree that there should be only 4-8 persons in each group if the optimum improvement is to be obtained. However, actual group size also depends group structure and purpose. (Rogers, 1970)

Duration

Ideally, sessions should be held at least 8 times, be of 1-2 hours duration, and be conducted at least once or twice per week and every week.

Earlier studies have brought attention to thread to support not just the treatment of mental patients, but their attendants who suffer indirectly from the patient's illness. Moreover, during the studies researchers discovered that treatments were only targeting patients physically, but not emotionally and mentally. In order to

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overcome this short coming group supporting therapy was developed as an effective complementary or alternative treatment. Furthermore, many other studies have revealed that relatives or attendants who live closely with psychotic patients for large amounts of time develop severe stress. This leads to great amounts of energy being wasted (and often permanent mental scars) the group supporting therapy can reduce stress substantially , and can improve by improving stress management skills then these relatives will be able to manage their own lives much more effectively and constructively.

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CHAPTER III

METHODOLOGY

This chapter presents the research design, population and samples , research instruments, procedures, and data analysis of this study.

Research Design

The design of this study was quasi-experimental. It have control group that consist of pre- test and post-test. The research design is shown in Figure 2 below.

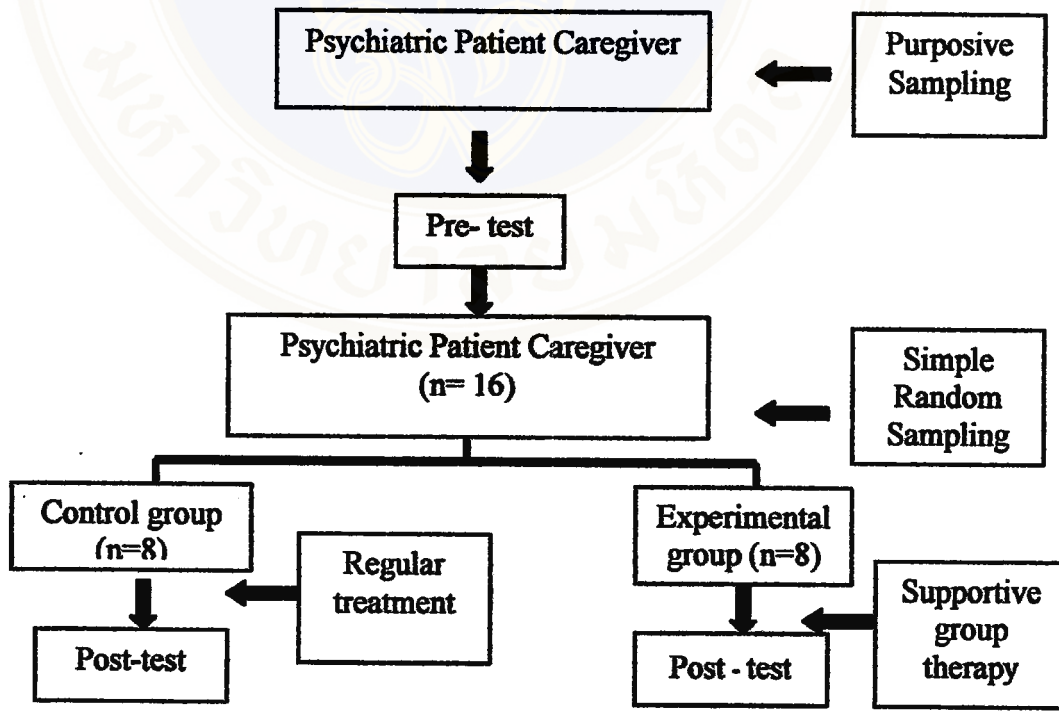

Figure 2 : Research Design

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Population and Sample

In this study, the population was psychiatric patients caregivers. The sample was taken from caregivers of psychiatric patient at Prasert Kangsadal 5, Psychiatric Unit of Siriraj Hospital, Bangkok The criterion for caregivers was characterized as follows:

1. Primary caregiver
2. More than six months experience as a caregiver
3. Caregiver of Schizophrenia Patient
4. Never previously attended a group supportive therapy
5. Ready and able to voluntarily cooperate with the study.

Twenty caregivers were selected according to these criteria. The researcher then asked these caregivers to supply demographic data about themselves, and to complete the stress questionnaire and the coping behavior questionnaire. These 20 caregivers were then subjected to two further criteria :

1. a moderate to severee stress score
2. a moderately effective or ineffective coping behavior.

Sixteen subjects were found to meet both sets of criteria. These sixteen subject were then randomly divided into two groups, an experimental and group a control group, as follows:

1. Eight persons from the experimental group were assigned to participate in the supportive group therapy session for a four week period.
2. . Eight persons from the control group were asked to make use of the normal services available at Siriraj Hospital .

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Instruments

1. Research Instruments :

Supportive Group Program : The supportive group program developed for this study was largely based on the Stress-Coping model of Lazarus and Folkman (1984) and the client-centered therapy and the Encounter Groups of Rogers(1970). The goal of the program was to achieve reduced stress in the caregivers by making their coping behavior more effective. During the program caregivers were given the opportunity to share knowledge about the patients they were caring for, express their emotions, learn new ways of managing their stress, undergo training in positive thinking, and problem-solving techniques, and practice new communication skills.

Once the program was developed, four experts in group therapy were asked to validate the program content. The program was then tried out on group of student nurses at Baromratchonnanee Nursing College, Bangkok. To further confirm the integrity of the process.

Subjects in the experimental group participated in a four- week program of closed group sessions which were held twice a week Each group session was of 60-90 minutes duration and started at 4.30 pm. The sessions began with a 20- minute warm up before working through the major themes of the session for the remaining 40-70 minutes. Individual sessions had the following objectives and activities.

Session 1 : Orientation and relationship building : The objectives of the first session were to 1) inform the participants of the program's and the session's objectives, the roles of the participants, the leader and the co-leader, the length of time they would be participating in the supportive group therapy program, and 2) begin to establish relationships between the participants. The leader used the 'buddy' game as

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a ways of achieving the second objective. Before the end of the first session, the leader asked all participants to share their feelings about it and to raise any doubts or questions about the information that the leader had provided.

Session 2 : Understanding of individual differences : The objectives of the second session were 1) to help the participants to understand their individual differences, and 2) to encourage the participants to perceive themselves realistically. The participants were asked to play the game 'my preferred picture' which involves participants in choosing a picture and then reflecting on their feelings about it. This provided participants with the opportunity to share their thoughts about their family members who were in psychiatric care. The object of this exercise was to make participants realize that no two people are exactly alike.

Session 3 : Emotions and the way of emotional express : The objectives of the third session was for participants to learn about and understand the nature and the expression of emotions. The leader brought along an 'emotion doll' for participants to analyze the emotional expression of and then encouraged the participants to share their own experiences of emotional expression with the group .

Session 4 : Stress and stress management : The objectives of fourth session were 1) to provide participants with information about the nature of stress and 2) to train them in relaxation techniques. Role-play situation involvoing stressful episodes were used to facilitate the sharing of stressful experience and there by reduce the stress of participants. The leader then provided the participants with the opportunity to reflect on their previous experiences with stress and relaxation methods followed by the introduction of muscle relaxation techniques for participants to practice in order to reduce their stress levels. Finally, the leader provided the participants with an

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opportunity to reflect on their thoughts and feeling about muscle relaxation as a stress management technique.

Session 5: Positive thinking training : The objectives of the fifth session were 1) to learn about positive thinking, and 2) to increase the self-esteem of the participants. The leader brought 'my gift' (a piece of cloth with holes in it) which was used as a prop to stimulate idea about its usefulness and of course to demonstrate the benefits of positive thinking while involving the participants. In this activity participants were encouraged to search for the strengths of themselves, each other and their families.

Session 6 : Problem-solving activities : The objective of the sixth session was to develop the problem-solving skills of participants. The leader motivated participants to reveal what was worrying them about their present situation and what help they wanted. They were then asked to decide on one of the or worries or problems after they had shared their understanding of the and its causes and effects and they had received suggestions about how to tackle problem from others participants. Finally, the leader encouraged them to summarize the concept of problem-solving.

Session 7 : Communication training : The objective of the seventh session was to train participants in request-communication as a means of stress reduction . The leader used the role-play to involve the participants in asking one another to help them. Participants then shared their impressions of this experience. Next, the leader provided the participants with on opportunity to voice any personal doubts they had about themselves and to express the thoughts and feelings associated with these

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doubts. The leader then informed participants that the next session would be the last in the supportive group therapy program.

Session 8 : Summary and evaluation : The last session are participants the opportunity to reflection the sessions they had participated in and to evaluate what they got out of them. The leader then asked them to complete self evaluated questionnaire about their thoughts and feelings regarding their participation. The leader they encouraged participants to apply the knowledge and skills they had gained to making positive changes in their daily liver. Finally, the leader thanked everyone for their participation.

2. Data Collection Instruments:

2.1 Demographic Data

2.1.1 Demographic data was sought about caregivers in relation to their sex, age, education, marital status, occupation, salary, duration of caregiver , and their experience of taking care of patients.

2.1.2 Demographic data was sought about psychiatric patients in relation to their sex, age, family role, salary, duration of sickness, and their ability to care for themselves.

2.2 Stress Questionnaire

The researcher developed this instrument. It was based on a theoretical model of stress and coping behavior by Lazarus and Folkman(1984) and literature review and research on caregivers who had a mentally retarded child. Eventually a set of 42 questions was developed. These may be categorized as follows:

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2.2.1 Personal factor influencing stress : question 1-8

2.2.2 Expectations about the caregiver's role, and the patient's ability : question 9-19

2.2.3 The Environmental Factors

2.2.3.1 Behavior Problem of psychiatric patients questions 20-28

2.2.3.2 Social support : questions 29-42

In answering each question, an assessment was required about the level of stress involved according to the four levels of stress indicated below :

No stress	you do not have feelings of discontent or dissatisfaction
Mild stress	you have the feeling of mild discontent
Moderate stress	you have the feeling of strong discontent
Severe stress	you have feeling of extremely strong discontent.

Scores were then given as follows:

Not stress	:	zero
Mild stress	:	1
Moderate stress	:	2
Severe stress	:	3

Average scores were then calculated to provide some interpretation of these scores.

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0.00	indicated does not have stress.
0.01 – 1.00	indicated has mild stress.
1.01 – 2.00	indicated has moderate stress.
2.01 - 3.00	indicated has severe stress

Once the instrument was constructed and readied for content review, four experts were asked to examine it for the content validity. Responses from thirty caregivers attending in Somdetjoapraya Hospital were used in this included in evaluation of reliability. Cronbach's alpha reliability was 0.75 indicating.

2.3 Coping Behavior Questionnaire

The coping behavior scale developed for this study was based on a theoretical model of stress and coping behavior developed by Lazarus and Folkman(1984), which was then modified to take into account the author's literature review and specific research concerning caregivers of psychiatric patients. Eventually a set of 24 questions was developed. These may be categorized as follows :

2.3.1 Problem-focused coping behavior: questions 1 – 12

2.3.2 Emotional-focused coping behavior,question 13– 24.

In answering these questions respondents were asked to chose the most appropriate answer from a frequency of coping behavior which was constructed :

'Never'	no experience in dealing with stress
'Seldom'	some experience in dealing with stress
'Usually'	usually dealing with stress
"Always"	continually dealing with stress

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Scores were then given for appropriate behavior (question 1-12,14,18-20) as follows:

Frequency	Score
Never	0
Seldom	1
Usually	2
Always	3

Next sores for **inappropriate** behavior (questions 13,15-17,21-24) were given as follows :

Frequency	Score
Never	3
Seldom	2
Usually	1
Always	0

Average scores were then calculated and interpreted.

Average Score	Interpretation
0.01 – 1.00	caregiver employ use ineffective coping behavior.
1.01 – 2.00	caregivers employ somewhat ineffective coping behavior.
2.01 – 3.00	caregiver employ effecting coping behaviors.

Once the instrument was constructed and readied for content review, four experts were asked to examine it for the content validity. Responses from thirty caregivers attending in Somdetjoapraya Hospital were used in this included in evaluation of reliability. Cronbach's alpha reliability was 0.85 indicating.

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Content Validity and Reliability

Content Validity

The content validity of the stress questionnaire and the coping behavior questionnaire has been revised many times. This was achieved by having both questionnaires evaluated by four experts from the field of psychiatric medicine as listed below.

Two nursing instructors from the Nursing School of Mental Health

One nurse who specialized in- supportive group therapy

One nursing instructor with specific academic qualifications in the qualified of stress and coping behaviors

The feedback thus obtained was then applied by researchers to their specific area of study.

Reliability

Thirty caregivers meeting the same criteria as the caregivers in the study sample assess the reliability of the stress questionnaire and coping behavior questionnaire. In fact these caregivers all had a psychiatric patient who used the services of Somdetjoapraya Hospital. The reliability of both questionnaires was then tested by calculating Cronbach's Alpha coefficient, with the reliability of the stress questionnaire and the coping behavior questionnaire found to be 0.75 and 0.85 respectively.

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Procedures of the Study

Preparations of The Researcher and The Assistant Researcher

The researcher and the assistant research had already gained some practice in supportive group therapy procedures by acting as group leader and assistant group leader respectively, in addition to formal classroom lessons. The experiment consisted of 16 sessions held , from 18 September to 27 November 1998 at the Adolescent Psychiatric Unit and the Rossukon Psychiatric Unit of Somdetjoapraya Hospital. Bhipat Kantayanuwong, M.D., chief of the Adolescent Psychiatric Unit and and Mrs. Amphan Jarutassanangkoon, a staff nurse nurse in the Rossukon Psychiatric Unit, supervise the sessions .

Data Collection

The data collection procedure was conducted in the following sequence :

1.Permission to collect data was sought by submitting documents from the Graduate Studies Program of Mahidol University to the dean of the Faculty of Medicine, Siriraj Hospital Mahidol University requesting permission for conducting this research there.

2. The researcher then approached psychiatric patient's caregivers who took their patients to receive treatment at the Prasertkangsadan 5, Psychiatic Unit of Siriraj Hospital . They were informed about the purpose of study and were asked to confirm their willingness to participate in it by signing a consent form.

3. Purposive sampling was then conducted according to inclusion criteria which were used to identify various characteristics of psychiatric patient caregivers.

4.These 16 caregivers were then asked to complete the stress questionnaire and coping behavior questionnaire. The 16 subjects then scored both questionnaires.

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5. Then 16 samples were then divided into an experimental group and a control group with 8 subjects each group as determined by simple random sampling.

6. Appointments were then made with the subjects as follows.

6.1 Subjects in the control group were asked to answer both questionnaires again 4 weeks later.

6.2 Subjects in the experiment group were asked to participate in the supportive group therapy program for caregivers of psychiatric patients at Siriraj Hospital

7. The researcher acted as the group leader throughout the supportive group therapy program for caregivers of psychiatric patients.

8. Following the eight and final session of supportive group therapy, subjects in the experimental group were asked to complete both questionnaires a second time in order to reveal any changes during the 4 weeks period.

9. In addition, subjects in the control group were also asked to complete both questionnaires again. They were also given information about caring for caregivers of psychiatric patients.

10.The data then collected and processed the data ready for analysis

Data Analysis

The data collected from these 16 subjects was then analyzed by using the Statistical Package for the Social Sciences for Windows(SPSS/FW) as follow :

1. Descriptive statistics of frequency and percentage were derived in order to describe to demographic characteristic of the sample.

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2. Descriptive statistics of mean and standard stress deviation level and coping behavior were derived from the same sample data.

3. A T-test was conducted in order to determine stress level and coping behavior score differences in the experimental group before and after the experiment.

4. A T-test was conducted in order to determine stress level and coping behavior score differences in the control group before and after the experiment.

5. A T-test was conducted in order to determine stress level and coping behavior score differences between the experimental group and the control group following the experiment.

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CHAPTER IV

RESULTS

The research on the application of supportive group therapy to reduce stress and the effect of supportive group therapy on coping behavior of psychiatric patient caregivers by studying 16 psychiatric patient caregivers taking patients to receive medical treatment at Prasert Kangsadalaya 5, Psychiatric Unit, Siriraj Hospital. The 16 are divided into two 8 caregiver group – control group and experiment group. The control group has received guidelines and assistance similar to other caregivers taking patients to the hospital but the experiment group has participated in a supportive group therapy program organized by researchers twice a week for 4 weeks. Each time takes about one to one and a half hours. Findings are shown in the tables and description as follows:

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Table1 : Number and Percentage of Psychiatric Patient Caregivers, Classified by Personal Data of the Samples.

Classified samples	experimental group		control group	
	number	percentage	number	percentage
age(years)				
31-40	2	25.0	3	37.5
41-50	2	25.0	2	25.0
51-60	3	37.5	3	37.5
more than 60	1	12.5	-	-
status				
single	1	12.5	1	12.5
married	6	75.0	6	75.0
widowed	-	-	1	12.5
divorce	1	12.5	-	-
education				
primary school	3	37.5	1	12.5
secondary school	2	25.0	4	50.0
diploma	2	25.0	2	25.0
bachelor / higher than	1	12.5	1	12.5
occupational				
government official	2	25.0	1	12.5
employment	2	25.0	4	50.0
trade	3	37.5	1	12.5
housewife	-	-	1	12.5
state enterprise	1	12.5	-	-
farmer	-	-	-	-
incomes of family (Bt/month)				
less than 8000	5	62.5	6	75.0
8000-16000	3	37.5	-	-
16001-24000	-	-	1	12.5
more than 24000	-	-	1	12.5
psychiatric patients in care				
1	8	100	8	100
duration in care(years)				
6 month- 1 year	2	25.0	2	25.0
1-3	5	62.5	5	62.5
4-6	-	-	-	
7-10	1	12.5	-	-
more than 10	-	-	1	12.5

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Findings from Table 1: Age range of the caregiver were between 51-60 years constituting 37.5 percent is the highest in the experiment group while the age range of 31-40 years and 51-60 years constituting 37.5 percent is the highest in the control group. In terms of marital status, 75.0 percent of samples both in the control and experiment groups are married. Educational background of the largest number of caregivers in the experiment group or 37.5 percent is at the primary school level while half of the control group or 50.0 percent is at the secondary school level. Most of the experiment group or 37.5 percent have a career of trading while half of the control group or 50.0 percent are employees. Average income of most families in both the experiment and control groups is less than Bt8,000 a month, constituting 62.5 percent and 75.0 percent respectively. Each of all samples or 100 percent in both groups has one psychiatric patient under his/her care. Largest number of both samples or 62.5 percent have to take care of patients for 1-3 years.

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Table 2: Number and Percentage of Psychiatric Patient Caregivers, Classified by Psychiatric Patient's Personal Data

Classified psychiatric patients	experimental group		control group	
	number	percentage	number	percentage
Sex				
male	2	25.0	3	37.5
female	6	75.0	5	62.5
Age (years)				
less than 20	2	25.0	1	12.5
21 – 30	4	50.0	4	50.0
31 – 40	2	25.0	2	25.0
41 – 50	-	-	1	12.5
family role				
leader	1	12.5	-	-
wife	3	37.5	2	25.0
child	3	37.5	4	50.0
other	1	12.5	2	25.0
duration of illness (years)				
6 months – 1 year	2	25.0	2	25.0
1 – 3	5	62.5	5	62.5
4 – 6	-	-	-	-
7 – 10	1	12.5	-	-
more than 10	-	-	1	12.5
Level of functional ability				
eating				
by himself	2	25.0	1	
12.5				
support	4	50.0	6	75.0
non	2	25.0	1	12.5
hygiene				
by himself	3	37.5	1	12.5
support	4	50.0	6	75.0
non	1	12.5	1	-
12.5				
take medicine				
by himself	1	12.5	-	-
support	4	50.0	6	75.0
non	3	37.5	3	37.5

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Findings from Table 2: In the two sample groups, more patients under their care are female or 75 percent and 62.5 percent respectively and halft of the patients or 50.0 percent have an age range of 21-30 years. In terms of family role, in the experiment group, largest number of patients or 37.5 percent are wives and 50.0 percent of patients in the control group are children. In the term of duration of illness, 62.5 percent of samples both in the control and experiment have 1-3 years illness. In terms of patients' ability to take care of their own daily activities, caregivers in the experiment and control groups, or 50.0 percent and 75.0 percent respectively, have to support patients to eat food. Caregivers in the experiment and control groups, or 50.0 percent and 75.0 percent respectively, have to support patients to wash their bodies. And caregivers in the experiment and control groups, or 50.0 percent and 62.5 percent respectively, have to support patients to take medicine.

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Table 3: Comparing the difference in mean stress score for the experimental group before and after intervention using the t-test.(n = 8)

Experiment group	stress score		t
	X	S.D.	
Pre-test	2.172	0.120	- 12.675 *
Post-test	0.951	0.306	

* $p < 0.05$

Table 3 shows that after participating in the supportive group therapy, the level of stress of the subjects in the experiment group recorded a significant decrease, as indicated by a statistical significance of $p < 0.05$.

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Table 4: Comparing the difference in mean stress score of the control group before and after the intervention using the t-test (n = 8)

control group	stress score		t
	X	S.D.	
Pre-test	1.773	0.219	-.447 ns
Post-test	1.785	0.141	

ns = non significant

Table 4 shows that after participating in the supportive group therapy program, the level of stress of the subjects in the control group showed no significant change, as indicated by a statistical significance of $p>0.05$.

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Table 5: Comparing the difference in mean stress score of the experiment and control group after the intervention using the t-test (n=16)

Sampling	stress score		t
	X	S.D.	
Experiment group	0.951	0.306	-7.001 *
Control group	1.785	0.141	

* $p < 0.05$

Table 5 shows that after participating in the supportive group therapy program, the level of stress of the subjects in the experiment group was significantly lower than those in the control group, as indicated by a statistical significance of $p < 0.05$.

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Table 6: Comparing the difference in mean coping behavior score for the experimental group before and after intervention using the t-test.(n = 8)

Experiment group	coping behavior score		t
	X	S.D.	
Pre-test	0.306	0.207	-10.040 *
Post-test	2.230	0.505	

*p < 0.05

Table 6 shows that after participating in the supportive group therapy program, the mean of coping behavior score of the subjects in the experiment group recorded a significant increase, as indicated by a statistical significance of p <0.05 .

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Table 7: Comparing the difference in mean coping behavior score of the control group before and after the intervention using the t-test (n = 8)

Control group	coping behavior score		t
	X	S.D.	
Pre-test	0.870	0.154	-0.056 ^{ns}
Post-test	0.962	0.072	

ns = non significant

Table 7 shows that after participating in the supportive group therapy program, the mean score of coping behavior of the subjects in the control group showed no significant change, as indicated by a statistical significance of $p>0.05$.

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Table 8: Comparing the difference in coping behavior score of the experiment and control group after the intervention using the t-test (n=16)

sampling	coping behavior score		t
	X	S.D.	
Experimental group	2.230	0.505	7.075 *
Control group	0.962	0.072	

* $p < 0.05$

Table 8 shows that after participating in the supportive group therapy program, the mean score of coping behavior of the subjects in the experiment group was significantly higher than those in the control group , as indicated by a statistical significance of $p < 0.05$.

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CHAPTER V

DISCUSSION

The objective of this research was to study the application of supportive group therapy to reduce the stress and improve the coping behavior of psychiatric patient's caregivers. The research samples used consisted of a group of 8 psychiatric patient caregivers participating in the experiment and a control group of another 8 persons. Members of the experimental group had previously attended supportive group therapy while member of the control group had previously attended ordinary treatment programs.

Research findings can be explained by the following four hypotheses.

Hypothesis 1: After the experiment, psychiatric patient caregivers who have attended supportive group therapy sessions have lower levels of stress than before the therapy.

Research Findings: Psychiatric patient's caregivers who attended supportive group therapy sessions have significantly lower levels of stress than before attending supportive group therapy sessions, as indicated by a statistical significance of 0.05 (Table 3), thus supporting the first hypothesis. The most likely explanation for this is that most caregivers who attended the supportive group therapy sessions had high stress levels : they felt uneasy, worried, defensive and avoided discussion about

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themselves in early sessions because they did not trust one another, which itself is a very common response. The group leader encouraged group members to speak out about their negative feelings and listened attentitively to the opinions and feelings, they subsequently expressed without making judgments or criticisms so as to encourage group members to reveal their feelings toward past events and about any other matters not directly concerned with themselves as individuals. Group members then began to accept one another and to feel that in the group they could safely express negative and positive feelings. They dared to reveal their true selves and concurrently to explore their own minds. Consequently the psychiatric patient caregivers who attended these therapy sessions realized that the problems they were facing were not specific to them, but that others in their group had similar problems, and because of this they were able to make friends of others in the group.

At the same time, psychiatric patient caregivers who had attended the supportive group therapy sessions express their feelings about caring their psychiatric patients as well as gain a better understanding of themselves and others, learn to accept individual differences, to become aware of their own emotions and learn how to express their emotion properly, to learn about stress and its causes and how to cope with it , how to think positively, and to learn how to communicate effectively with their families. Each member built up trust in the group, which then allowed for self-disclosure. They came to care for one another and what happened in the group, and they tried to help one another as much as they could. Finally, they were able to perceive, accept and apply what they learned in the group sessions to their real lives, thus reducing their stress levels significantly.

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One factor that clearly had a positive influence on the stress levels of psychiatric patient caregivers was their voluntary participation in the supportive group therapy. The age range of most caregivers who attended the therapy sessions was is 51-60 years old and indeed age was found to be a positive influence on caregivers' self-adjustment. The most likely explanation for this is that as maturity and experience generally bring about greater prudence, older caregivers are generally more patient and there time less prone to stress than younger ones. This is corresponds with a study by Kaewraya (1997) which concluded that 1) older caregivers were able to adjust better than younger ones and the more the patients are able to help themselves, the less stress caregivers would have.

Therefore, it can be concluded that the supportive group therapy can reduce the levels of stress in psychiatric patient caregivers, thus corresponding with the idea proposed by Jitapankul (1992) that group therapy sessions can be beneficial to persons suffering from stress. Similarrly,a study by Mass and O'Daniell(1968) indicated that group counseling of psychiatric patient's relatives helped to reduce worries and dissatisfaction among family members and family tensions. These findings are backed up by Kahan and Brummel Smith (1985) who conducted group psychiatric treatment with relatives of encephalitis patients and concluded that group therapy helped to reduce the sadness and stress suffered by patient's relatives, as well as Rogers(1970) who concluded that group therapy could significantly reduce personal stress.

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Hypothesis 2: After the experiment, psychiatric patient caregivers who have attended the supportive group therapy will have lower stress level than psychiatric patient caregivers who did not participate in the supportive group therapy.

Research Findings: After attending supportive group therapy, psychiatric patient caregivers had significantly lower levels of stress than those caregivers who didn't attend the supportive group therapy, as indicated by a statistical significance at 0.05 (Table 5),thus supporting the second hypothesis. The most likely explanation for this finding is that most psychiatric patient caregivers in the experiment and control groups had high stress levels before the experiment and that these subsequently fell closer to more normal levels due to receiving supportive group therapy which helped group members to understand themselves and stress better and which gave them the opportunity to discuss, their worries and concerns openly. Participation in the group helped members to understand that others caregivers suffered similar problems. Group members were helped to understand the nature of psychiatric disorders, patient symptoms and how to manage.

This process was assisted by the direct experience of some group members. Group members were also able to see the progress and patient tending behavior of other group members which provided a source of inspiration for some. Group members encouraged one another, and as they got to know themselves better they became less focused on themselves and their problems. They became better able to accept the status, background, limitation or stimulus factors responsible for theirs present situation, and by learning how to cope more effectively with the situation, became more acceptable in society. Importantly, it exposed group members to

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effective behavior models which they could choose to imitate. Corly(1985)says that relationships as friends and acceptance among group members helps to reduce their stress and improve both their attitude and their problem-solving ability thus corresponding with Ohlsen(1970) who says that group treatment helps members to accept their problems and to try to solve them before they intensify by learning how to apply what they received in the group treatment to their daily lives.

However, procedures, techniques, features of particular therapies, group size, leader and group atmosphere are all factors which can reduce the stress of group members, which is in line with the findings of Shertzer and Stone(1968)Rogers(1970) found that group sessions helped members develop better understanding and acceptance of their problems and apply this to solving problems in their daily lives, and that this depended largely on factors such as group leader behavior, group members, procedures, techniques and group atmosphere, which are all correlated.

Another likely, psychiatric patient caregivers who attended supportive group therapy had lower levels of stress is that they voluntarily attended the therapy and were self-motivated to reduce their stress. Group size of not more than 8 persons also facilitated learning and understanding of their problems by making participants relatively comfortable about expressing their opinions openly, in line with Wilk and Caplan (1977) who concluded that a group size of 8 persons is proper because it allows members to present their problems or opinions by group members extensively. Similarly, Bualert (1993) found that relatives of psychiatric patients who attend psychological counseling according to Roger's guidelines subsequently had lower stress levels.

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This research reveals that the stress levels of psychiatric patient caregivers who have not attended supportive group therapy showed no significant change. On the contrary, their stress levels seem to increase (Table 4). The most likely explanation for this is that psychiatric patient caregivers tending patients for a long time with insufficient support feel increasingly burdened, especially if the patient's condition deteriorates.

Hypothesis 3: After the experiment, psychiatric patient's caregivers who have attended the supportive group therapy will have higher scores for coping behavior than before attending the supportive group therapy.

Research Findings: After attending supportive group therapy, the average score for the coping behavior of psychiatric patient caregivers was significantly higher than before attending the supportive group therapy, as indicated by a statistical significance of 0.05 (Table 6) thus supporting the third hypothesis. The most likely explanation for this is that their scores for stress-coping behavior before attending the therapy were significantly lower than the average normal person. Voluntary attendance is a positive factor, as is the feeling they develop that they are not only the people who are in such a situation. After discussion and learning more about their situation and the other participants they become more acquainted, warmer and trusting with one another. As a result they have more confidence in expressing their feelings and ideas, thus reducing their emotional stress and worries.

During the therapy, psychiatric patient's caregivers exchange opinions, support and encourage one another. They become more their own selves. Feeling free

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to give and receive feedback they are able to learn more, to understand themselves more, to better accept and understand individual differences, are more aware of their emotions, how to deal with and express their emotions properly and their thinking becomes clearer. By developing acceptance trust, and concern for one another, they can better understand and accept their problems and help one another to choose the best option for solving or managing their problems and achieving their goals. The group leader plays an important role in this process of stimulating behavioral change. Learning from other group members helps participants to correctly assess situations they face now and in the future, thereby improving their ability to control such situations. As one member said:

"After electric treatment, She feel better. She used to sing alone, eat and talk little, and feel dazed. Now my symptom are slowly disappearing. Everyone seems to have the same experiences. My daughter is no exception and now she is much better."

In addition, attending supportive group therapy increases problem-solving skills. Discussion and idea exchanges among group members helps them to develop better ways of behavior. The following are testimonials to some of the benefits of supporting group therapy :

"Once I was so angry with my wife and hit a glass which hurt my hand. I finally understood that the one who is hurt is myself. I thought my wife was pretending because she wanted to attract my attention but actually she was sick."

"When I'm unhappy or sad and I can speak to someone, I feel that half the sadness is gone. It's so nice."

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"You're happy while mocking or being ironical but now I can admit that afterwards you become sadder than before."

"I think if we worry about things that may not happen it is damaging to us . What will be will be. Trying to do the best we can in any given moment is good enough."

Thus it can be concluded that supportive group therapy is useful in enabling psychiatric patient's caregivers to better cope with a variety of problems. If it is successful, participants will have learned better ways of expressing themselves, better ways of solving their problems, how to share with and value others more, and how to help others develop more effective problem-solving behavior.

The researcher also found that the education level of psychiatric patient caregivers who have attended a supportive group therapy is related to their stress-coping behavior. Education can help people assess situations more accurately and to discover the correct factors in problem solving. This is in line with a study by Phuvaravudhipanich (1994) which concluded that says educated caregivers are more reasonable, choose better ways of solving their problems, and know how to seek assistance better than lower educated caregivers. Similarly, psychiatric patient caregivers who have no personal economic problems have a better change of being able to attend other activities and take care of their health than those with personal economic problems, and good family support helps to less in the burden in tending patients by reducing their stress and enabling them to face stress more effectively. This corresponds with a study by Thapseriphathai (1991) which says that social support has a positive relationship with the stress coping ability of family members.

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Hypothesis 4: After the experiment, psychiatric patient's caregivers who have attended the supportive group therapy will have higher scores for coping behavior than those who haven't attended the supportive group therapy.

Research Findings: After attending the supportive group therapy, the average scores for coping behavior of psychiatric patient caregivers were significantly higher than those who didn't attend as indicated by a statistical significance of 0.05 (Table 8), thus supporting the fourth hypothesis. This result can be explained as follows: The group therapy provides an opportunity for psychiatric patient caregivers meet, discuss, and exchange ideas with one another. They learn to trust and accept one another in the group. Group members can express their feelings, learn and exchange their ideas, all of which help reduce stress. They also receive information from other group members in a two-way communication. Group members also receive the direct and indirect information relevant to their situation since the information comes from other participants who also have direct experience in tending psychiatric patients and the group leader is also able to provide useful information to the group members. As a result, psychiatric patient caregivers can better assess their stress and get it under control. Group therapy also increases their problem-solving skills. In other words, their responses to idea exchanges in group therapy helps members to learn about other issues and problems apart from their own. Other members may also provide them with behavioral models to imitate. Group members then have options to solve problems, to apply such options themselves, or to recommend that others apply them. Learning becomes more systematic, thereby increasing their problem-solving skills.

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Members become better givers and takers. All these new or improved problem-solving skills help group members to better cope with stress, Lazarus & Folkman, 1984.

In terms of assisting and supporting one another, idea exchanges among group members provides an opportunity for psychiatric patient caregivers to express their feelings, thus reducing their stress. The more friendly the group atmosphere is, the more acquainted with one another the group members become as they develop more confidence in expressing themselves, their feelings and their problems. If they have different problems, other members can still listen attentively and try to help solve them. Attending the group therapy also make them feel that other people understand them, and being accepted in a group makes them feel valuable as part of the group, thus the more they learn to help others, the more valuable they feel.

Attending the supportive group therapy helps psychiatric patient caregivers receive information relevant to their situation to learn how to assess situations better to learn how to cope with stress better and to increase their problem-solving skills. In addition, the group process provides social support which their feeling of self-worthiness. All of these factors help psychiatric patient caregivers to choose appropriate options to cope with their situations, improve or maintain their health and to feel satisfied with their options. Clearly, psychiatric patient caregivers who have attended group therapy thus have better stress-coping behavior than those who haven't, corresponding with a study by Kredkungvanklai (1997) which found that the average score for stress-coping behavior of womb cancer patients who have attended a self-assistance group was higher than for those who haven't.

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By contrast, Psychiatric patient caregivers who haven't attended supportive group therapy often receive general information which may not correspond with their particular needs, despite the fact that this information often comes from medicinal personnel or nurses, because outside therapy sessions caregivers have little chance to express their feelings and problems. Similarly, assistance from follow caregivers is usually of little real value and often unfocused. Research undertaken for this study found that the average score for the stress-coping behavior of the control group before and after the experiment were not significantly different. (Table 7)

Limitations of the Study

The sample group for this research consisted of the caregivers of psychiatric patients who took their Schizophrenia patient to receive treatment at the Prasert Kangsadalaya 5, Psychiatric Unit of Siriraj Hospital, Bangkok. Participants in the program were selected by purposive sampling They were divided into two groups by simple random sampling into an experiment group and a control group, 8 members on samples, which is a suitable member of participants for group therapy. Nevertheless, this research and analysis constitutes only a preliminary or pilot study because a simple of 8 can only have limited relevance in scientific terms. Accordingly, further studies should be conducted on other groups of caregivers who are receiving health care services at a different organization.

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CHAPTER VI

CONCLUSION

This study used quasi-experimental research to determine the effects of supportive group therapy on stress and coping behavior of psychiatric patient caregivers. Conceptual frameworks developed from the Stress–Coping Model of Lazarus & Folkman (1984) and the Client-Centered Theory of Rogers (1970). The sample used in the study consisted of 16 psychiatric patient caregivers who were taking their patients to receive treatment at the Prasert Kangsadalaya 5, Psychiatric Unit of Siriraj Hospital, Bangkok. Samples were selected on a purposive sampling basis and divided into two groups by simple random sampling into an experimental and a control group, each of consisting of 8 samples.

The instruments of this study included 1)research instruments are a supportive group therapy program.2)research collection instrument are demographic data for personal data, stress questionnaires , coping behavior questionnaires.

The research proceeded according to the following steps.

1. The researcher picked psychiatric patient caregivers according to the selection criteria and asked them to answer both the stress questionnaire and the coping behavior questionnaire.

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2. Those who recorded high scores for stress and ineffective coping behavior were selected to participate in the supportive group therapy sessions and divided into 2 groups -- the experimental and the control group, by a process of random sampling.

3. Those in the experimental group were asked to attended the supportive group therapy continuously twice a week, for 8 time, with each session taking about one or one and a half hours. These therapy sessions featured discussion, the exchange of ideas, the expression of emotions, the development of positive thinking, information about mental disease and how to take care of psychiatric patients, and how to improve stress management. At the end of the supportive group therapy program, the researcher repeated the checked on stress levels and stress-coping behavior of participants and asked them to complete the stress questionnaire , the coping behavior questionnaire, and also to provide their opinions about the supportive group therapy on the same day that the program finished.

4. As usual the control group received information and recommendations from nurses and medical staff about mental diseases and their treatment. After 4 week the supportive group therapy program involving the experimental group finished, the researcher asked caregivers in the control group to fill in the same stress questionnaire , and coping behavior questionnaire that the experimental group had been given.

The personal data and opinions obtained were then analyzed using the T-testing to determine percentages, average scores, and standard deviations. In addition, T-tests were performed to determine the difference between the average of stress score between the experimental and the control group both before and after the

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treatment program, and the difference between the average coping behavior score between the experimental and the control group both before and after the treatment

Research Findings can be Summarized in the Following Four Statements:

1. Psychiatric patient caregivers who attended the supportive group therapy had significantly lower levels of stress than before they attended the supportive group therapy. ($p < 0.05$)

2. Psychiatric patient caregivers who attended the supportive group therapy had significantly lower levels of stress than those who had not attended the supportive group therapy. ($p < 0.05$)

3. Psychiatric patient caregivers who attended the supportive group therapy had significantly higher scores for coping behavior than before they had attended the supportive group therapy. ($p < 0.05$)

4. Psychiatric patient's caregivers who attended the supportive group therapy had significantly higher scores for coping behavior than those who had not attended the supportive group therapy. ($p < 0.05$)

Recommendations

Application of Research Findings

This study has shown that the supportive group therapy is a good social support, helping psychiatric patient caregivers to cope with problems arising from tending to their patients based on information and support from one another in the group. Therefore, it's appropriate to recommend continuation of the supportive group

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therapy for psychiatric patient caregivers. However, proper implementation of the supportive group therapy requires the following factors to be taken into consideration:

1. Cooperation from organizations concerned and coordination with the medical treatment team are essential for psychiatric patient caregivers to attend the group activities happily. Grouping, venue, and flexibility in patient visiting hours should first be discussed with and approved by the medical personnel concerned such as doctors, nurses in order to gain their full cooperation.

2. Only caregivers of psychiatric patient caregivers with similar mental diseases should be selected because they will have similar problems and matters to discuss, and so that they are more likely to relate to and sympathize with one another and help one another with their problems.

3. The time for group meetings should be arranged according to the groups requirements so as to maximize data exchange and mutual support and assistance.

From participation in the group therapy sessions, the researcher found that the state of their personal finance, their works and other tasks had a strong influence on both the stress and coping behavior of caregivers. Therefore, psychiatric nursing staff should coordinate the involvement of concerned health personal such as social workers in order to provide effective preliminary assistance as required.

The researcher also found that compilation of data and inquiries regarding patient's background conducted by the nursing staff and the health personnel involved was often duplicated by these two groups, which caused stress to caregivers and gave them negative impression of the organization providing the services. Therefore the nursing staff and health personnel involved must be given clear-cut procedures to

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follow in compiling data. This requires that staff receive thorough training in assessment technique as necessary.

Application for Future Research

1. There should be periodical follow-up assessments of the supportive group members, for instance, every 2 months or 6 months in order to monitor their success in making behavioral adjustments, and other effects of the supportive group experience and to offer immediate assistance in case old problems reappear or new problems arise.

2. The supportive group therapy program should be tried with other sample groups such as tenders of hospitalized chronic disease sufferers, patients waiting to return home, or other persons suffering from ongoing stress in order to test the effectiveness of the program more extensively.

3. A comparison of the effects of the supportive group therapy and other kinds of coping group programs should be conducted in order to establish proper what the most effective activities are for psychiatric patient caregivers.

4. Other influential factors, such as personality, should be studied in order to broaden the body of available research in this field.

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APPENDIX

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APPENDIX A
LIST OF EXPERTS

The are four experts who have validated the Program of Supportive Group Therapy and Questionnaire of Stress level and Questionnaire of Coping Behavior level.They are :

1. Vipavee Poukuntaratron

   Professional Nurse at Day Hospital (Psychiatric Hospital)

2. Payoa Pooncharean, M.Ed.

   Assistant Professor

   Department of Nursing, Faculty of Medicine , Ramathibodi Hospital, Mahidol University

3. Pongsri Srimoragot, Ph.D.

   Assistant Professor

   Department of Surgical Nursing,Faculty of Nursing, Mahidol University

4. Atirat Wattanapairin, M.Ed.

   Department of Mental Health and Psychiatric Nursing, Faculty of Nursing, Mahidol University

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APPENDIX B

Consent Forms

The Experimental Group

I'm Malinee Panpoungkaew . I'm studying in master degree at Faculty of Nursing, Mahidol University. I'm conducting a research on stress and coping behavior of psychiatric patient caregivers after you have attended a supportive group therapy. I wish to take some time to explain the details of the research if you don't mind.

This research is to find a result of the application of a supportive group therapy to reduce stree and coping behavior of psychiatric patient caregivers. The group is composed of 8-10 psychiatric patient caregivers who will receive counseling, exchange ideas and information among group members. Are you interested in participating in the group therapy ? If yes, I wish to ask you to fill in the questionnaires for your personal data and patient's data, questionnaires to assess stress level and coping behavior which will take about 20 minutes. After that we'll make an appointment with you to attend therapy activities for 8 times, twice a week. Each time takes about one to one and a half hours. Then, I wish you to fill the same set of questionnaires once again and to express your opinions on group activities. Your data will be very useful to improve the hospital service capability. Data from you will be kept strictly confidential. You're free to participate in or refuse to attend the supportive group therapy. During the research process, should you have any question, you can ask me any time. You can reach me at Tel : (01)3181591. Are you interested in attending the research?

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For Psychiatric Patient Caregivers.

I've read and heard explanations aforementioned. I understand them and wish to join in this research.

signature.....

(.....)

...../...../.....

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The Control Group

I'm Malinee Panpoungkaew . I'm studying in master degree at Faculty of Nursing, Mahidol University. I'm conducting a research on stress and coping behavior of psychiatric patient's caregiver after you have attended a supportive group therapy. I wish to take some time to explain the details of the research if you don't mind.

This research is to find a result of the application to reduce stress and coping behavior of psychiatric patient's caregivers. Are you interested in this research? If yes, I wish to ask you to fill in the questionnaires for your personal data and patient's data, questionnaires to stress level and coping behavior which will take about 20 minutes. Then four week I wish you to fill the same Questionnaires once again . Your data will be very useful to improve the hospital service capability. Data from you will be kept strictly confidential. You're free to participate in or refuse to attend the supportive group therapy.

During the research process, should you have any question, you can ask me any time. You can reach me at Tel : (01)3181591. Are you interested in attending the research?

For Psychiatric Patient Caregivers.

I've read and heard explanations aforementioned. I understand them and wish to join in this research.

signature.....

(.....)

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...../...../.....

APPENDIX C

DATA COLLECTION INSTRUMENTS

Questionnair No....
HN.....
Date.....

DEMOGRAPHIC DATA

Demographic data of Psychiatric Patient Caregivers

1.Age.....Sex.....Address.....

2.Status

O single

O married

O windowed

O divorce

3. Education level

O primary school

O secondary school

O diploma

O bachelor / higher than

4. Occupational

O government official

O employment

O trade

O housewife

O state enterprise

O farmer

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5. Incomes of family (Bt /month)……..

6. Psychiatric patient in care……..

7. Duration in care……

Patients' data

1. **Age……Sex……**
2. **Role in family……..**
3. **Duration of illness……**
4. **Level of functional ability……..**

Eating	O by himself	O support	O none
Hygiene	O by himself	O support	O none
Take medicine	O by himself	O support	O none

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STRESS QUESTIONNAIRE

This questionnaire is find your opinions when you meet with incidents while you care your patients. Please mark (/)in the block below the most accurate description of your stress level. Choose only one answer to each situation. The characteristics of answer are the scales of four level of stress assessment.

No stress means you do not have the feeling of discontent or dissatisfaction

Mild stress means you mildly have the feeling of discontent

Moderate stress means you have highly the feeling of discontent

Severe stress means you have extremely high in the feeling of discontent.

Example

Situation	What are you feeling ?			
	Not	Mild	Moderate	Severe
When you tell about patient to your relatives				/

Explanation : When you tell about patient to your relatives you have extremely high in the feeling of discontent

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Situation	What are you feeling ?			
	Not	Mild	Moderate	Severe
1. When you come to know your relative is suffering from psychiatric ? 2. you don't understand the cause of the illness 3. you don't have knowledge of how to care patients 4. you don't understand what the purpose of electric treatment are 5. you don't know how to care and promote the patient to take care of himself 42				

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COPING BEHAVIOR QUESTIONNAIRE

This research is to find how often you think or act to cope with stress while caring your patients. Please mark(/) in the box below the most accurate response. Choose only one answer to each question. The scale of four levels can be constructed through the frequency of coping behavior.

"Never" means a thought of encountering stress never comes into mind

"Seldom" means ever have some minimal experience in dealing with stress

"Usually" means almost every time that stress encountering occur

"Always" means all the time that stress encountering occur.

Example

Situation	never	seldom	usually	always
you set goals to solve problem				/

Explanation : you set goals to solve problem all the time

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Situation	never	seldom	usually	always
1. you acquire knowledge how to take care of patients by reading 2. you ask doctors, nurses or officers involved in patient tending 3. you talk to other fellow patient caregivers who face similar problems 4.you plan to adapt your way of life to your responsibility for patient caring 5. you accept the illness of patients .... 24.....				

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APPENDIX D

RESEARCH INSTRUMENT

The Supportive Group Therapy Program

Session I ; Orientation and relationship building

Objectives

1. To establish the relationship between the group leader and the group members and between the group members themselves toward group therapy program.

2. To inform about the group, such as its character, objectives, agreement, and the role of its members.

Resources : None

Activities: these proceeded by the following steps.

1. The group leader introduced herself to the group members, then showed the appreciation for their participating in the group therapy program.

2. The group leader informed the group members about their right as members in the group activities and asked their permission for tape recording during each session.

3. Each member introduced herself to the group.

4. The group leader informed about the group as follows

4.1 The objectives of the group therapy program were:

4.1.1 To provide an opportunity for the group members to exchange their opinions, feelings, and experiences with each other.

4.1.2 To improve the self-awareness, self-understanding and self-acceptance of the group members.

4.1.3 To increase self-esteem of the group members.

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4.1.4 To increase the willpower and feel competence in managing problems of the group members.

4.1.5 To encourage the group members to apply the acquired knowledge and experiences into their daily living.

4.2 The supportive group therapy sessions met for 60-90 minutes each week for eight consecutive weeks.

4.3 Role of the group leader

4.3.1 To assist the group members in achieving the goal of the group therapy program.

4.3.2 To clarify issues and give information to the group members.

4.4 Role of the co-leader

To assist the group leader in facilitation group activities during the process of the group therapy program.

4.5 Role of the group members

4.5.1 To be an active listener.

4.5.2 To ask the question when you suspect.

4.5.3 To exchange experiences and opinions.

4.5.4 To share comments and suggestions.

4.5.5 To keep confidential.

5. The group leader asked for questions or suggestions from the group members.

6. The group leader then started with "Buddy Game" for forming the good relationship among the group members as follows:

6.1 Each member made a pair voluntarily.

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6.2 Each pair was asked to interchange their personal information such as age, occupation, address, favorite things, etc.

6.3 After knowing each other, each member introduced her partner to the group.

6.4 The group leader provided the group members with the opportunity to ask about personal data of each member.

6.5 The group leader summarized the characteristic of each member.

7. The group leader provided the group members with an opportunity to express their feelings about the initial session.

8. The group leader summarized the session and informed the topic that would be discussed in the next session. The group members were encouraged to share their opinions and comments about what they learned from this session.

9. The group leader allowed the group members to ask any questions related to the session.

10. The group leader thanked the group members for their cooperation and confirmed the date and the time for next session.

Session II ; Understanding of individual differences

Objectives

1. To understand self and other in the realistic way.

2. To accept the concept of individual differences.

Resources

Ten pictures (including pictures of animals, sea, park, skyline buildings, working people, etc.)

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Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader explained the activities for this session.

3. The group leader asked each member to look at ten pictures and chosen one that they liked the most.

4. Then the group members were asked to talk about the pictures and their feelings towards the pictures one by one.

5. The group leader showed each picture to the group and then asked them that "Who chose this picture?" The group leader gave that picture to those who chose that picture. (If more than one member chose the same picture, the group leader asked them to sit side by side.)

6. Each member was encouraged to show her picture individually to the group and express her opinions with regard to the following questions:

6.1 What did you see on that picture?

6.2 Why did you choose that picture?

6.3 How did you feel about that picture?

6.4 Why did you feel like that?

7. The rest of group members were encouraged to express their opinions about that picture being shown with regard to the following questions:

7.1 What did you see on that picture?

7.2 How did you feel about that picture?

7.3 Why did you feel like that?

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8. The group leader then repeated the steps number 6-7 for other pictures.

9. The group leader summarized that: "For this session, we had learned that each individual could have different thoughts or feeling about the same picture. Each person had his own perception toward the situation which related to his own leaning by using five senses (sight, hearing, smell, touch, taste), age, sex, attitudes, experiences, and emotion. You always found the individual difference in daily life which each person would have their own perspective point of view. For example, when you had a new dress that you thought it was good for you, but someone said that it did not fit for you or someone said that you looked smart when you dressed your new dress. If we could understand and accepted to individual differences such as these, we could live happily with others"

10. The group leader allowed the group members to ask any questions about the session.

11. The group leader thanked the group members and confirmed the date and the time for next session.

Session III ; Emotion and emotional expression

Objectives

1. To understand her own emotions.
2. To discuss about the emotional and how is affect on her.
3. To be aware of individual differences of emotional expression.
4. To learn more appropriate ways how to express their emotions.

Resources

Ten cards of cartoon-pictures demonstrating various feelings.

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Activities: these proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader explained the activities for this session: "Each member will be given one card. Then we would talk about the cards."

3. The group leader gave each member an envelope containing a card of different emotional doll.

4. Each member was encouraged to show her card to the group and expressed her opinions by the following questions:

4.1 How did the doll feel?

4.2 Why did you think that?

5. The other members were encouraged to express their opinions about that card being shown by following step 4.1 and 4.2 above.

6. The group members take turned talking by following steps number 4-5.

7. The group leader provided a correct answer of the emotion displayed by each doll.

8. The group leader provided the following summary: "An emotion was an experience that was felt with some intensity as happening to the self, was generated in part by a cognitive appraisal of a situation, and was accompanied by both learned and reflexive response. There were two basic types of emotion: one was a positive state such as happiness, joy, satisfaction, on being pleased; the other one was a negative state such as anger, fear, sadness, guilt/shame, or disgust. Individual responses and expressions depended on individual differences as persons, which were a product of individual learning, experience, reasoning, and understanding. Emotional expression

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could be verbal and nonverbal. Verbal expression was a way of clearly communication to other people how one felt so that one could understand his/her feeling. On the other hand, sometimes people misunderstood nonverbal ways of expressing emotions because of individual differences in their perception of being expressed."

9. The group leader collected the cards and shuffled them and gave each member a new card.

10. The group members were allowed to consider their new cards for three minutes.

11. The group leader asked the group members to close their eyes and think about their experience, which related to the emotions expressed on their new cards.

12. Each member was encouraged to show her new card individually to the group and express her opinions by the following questions:

12.1 Had you have any experiences which made you feel like the doll in your new card? Could you tell us about them?

12.2 How that emotion effected you both physical and mental?

13. The other members were encouraged to express their opinions about that card being shown by step 12.1 and 12.2.

14. The group members repeated steps number 12-13.

15. The group leader summarized that emotion that would effect a person both physical and mental as follow:

15.1 Emotional responses commonly stimulated physical changes such as alteration of blood pressure, heart rate, pulse, respiratory rate, muscle contraction, circulatory systems, and intestinal movement.

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15.2 Emotional responses commonly stimulated psychological changes such as anger, aggression, anxiety, despair, impaired judgement, problem-solving ability and creative thinking, and alteration of sleep and eating patterns.

16. The group leader introduced new activities to the group members as follow "The positive and negative state emotions were a part of our life. We would have many problems when we expressed our negative state emotional. So that, we would discuss about this issue."

17. The group members chose one negative state of emotion which they would like to discuss with the group.

18. The group members were encouraged to express their opinions by the following questions:

18.1 How would you express your emotions related to that situation?

18.2 How other persons expressed their emotion related to the same situation?

18.3 How did you feel when others people expressed their emotion to you?

19. The group leader summarized that "Emotion was a part of our life. It was good for us to accept the emotions that we had had. However, it was very important for us to be aware that. How did I feel right now? How did I express an appropriate way which would not give a negative impact to myself and others?"

20. The group leader allowed the group members to ask any questions about the session that they might have.

21. The group leader thanked the group members and confirmed the date and the time for next session.

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Session IV ; Stress and stress management

Objectives

1. To learn about the nature of stress.
2. To learn how to use the various relaxation techniques.

Resources

1. Two role-plays involving stress situations
2. Stress management pamphlets
3. Whiteboard
4. Whiteboard marker

Activities: These proceeded by the following steps.

1. The group leader greeted the group member and reviewed the main idea of the previous session.

2. The group leader explained the activity for this session: "I would like you play the role in a situation that I would give you. Each group could create their own scenario and did the role-play, after that we would discuss about it."

3. Each member was divided into two groups.

4. The group leader gave each group an envelope containing the information of a different role-play card.

5. Each group prepared themselves for the scenario.

6. Members of each group played the role they have been assigned.

7. The group members were encouraged to express their opinions, by toward each role play situation the following questions:

7.1 "How did you feel about your role?"

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7.2 "How did you think others feel about the role-play situation which you were involved?"

7.3 "Had you ever been faced that kind of situation in your daily life? How did you feel about it?"

8. The group leader summarized the role play activity as follows:

8.1 Stress could provide a mental warning that the demands of your present situation exceed your available resources that you appraised as for coping with it by making you felt unhappy or sad. If you did not find ways to relax, this stress would eventually cause you problems in doing your job or in your life.

8.2 Causes of stress were divided into the following three categories:

8.2.1 Mental factors-such as fear, disappointment, or anxiety.

8.2.2 Life-event changes-such as starting a new job, the loss of a favorite thing, the onset of a major change in life.

8.2.3 Physical illness-from mild to severe in degree.

9. The group leader encouraged the group members to share their responses to the following questions: "What physical and mental changed to you when you had stress?"

10. The group leader summed up stress-responses as follows:

10.1 Short-term stresses caused headaches, sleep disturbances, fatigue, constipation, diarrhea, over-excitement, anxiety, bad dreams, menoschesis, reduced sexual satisfaction, and other irritations.

10.2 Chronic stresses caused hypertension, heart disease, peptic ulcer, or mental illness.

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11. The group leader encouraged the group members to share their opinions on the following question: "What did you react when you felt stress?" The group leader then wrote the group members' answers on the whiteboard.

12. The group leader provided a summary of the following of stress management methods:

12.1 Health improvement

12.2 Environmental improvement (i.e. house, office, or workplace)

12.3 Positive thinking (better humor or more forgiving attitude0

12.4 Relaxation training (i.e. muscle relaxation, controlled breathing, meditation training, or listening to music

The group leader concluded that anyone could suffer from unhealthy levels of stress, but the most important thing was to be aware when it occured on you so you could manage them effectively.

13. The group leader demonstrated the following muscle relaxation technique.

13.1 Finding a comfortable seating position.

13.2 Contraction of the following muscle for about ten seconds and then relaxing it for a few seconds before repeating the activities ten times.

13.3 Clenching the hands and tensing the arms.

13.4 Raising the eyebrows.

13.5 Narrowing the eyes and puckering the nose.

13.6 Clamping the jaws closed, compressing the lips, and pushing up with the tongue on the roof of the mouth.

13.7 Raising the chin from the neck to the highest point and then holding that position.

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13.8 Deep breathing and lifting of the shoulders.

13.9 Contracting the abdomen and the anus during and after exhalation from the lungs.

13.10 Bending the toes, straightening the ankles and tensing the leg muscles.

14. The group leader asked the group members to demonstrate these muscle relaxation techniques themselves.

15. The group leader then provided the group members with the opportunity to share their thoughts and feelings about the muscle relaxation techniques demonstrated.

16. The group leader allowed the group members to ask any questions about the session that they might have.

17. The group leader thanked the group members and confirmed the date and the time for next session.

Session V ; Positive thinking training

Objectives

1. To learn about positive thinking.
2. To increase the group members' self-esteem.

Resource

1. Ten gifts, each contained a piece of cloth with holes.
2. Ten papers
3. Ten pens

Activities: These proceeded by the following steps.

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1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader introduced the concept of positive thinking by using the activity "The gift that I received".

3. The group leader explained the activity as follows: "Each member would receive a gift, then we would discuss about the gift that you received."

4. The group leader asked each member to select a gift and open it.

5. The group leader encouraged the group members to discuss on the following topics question :

5.1 How did you feel when you received a gift?

5.2 Why did you choose?

5.3 How did you feel when you knew what your gift were?

6. The group leader asked each member to find three positive things from the gifts, then wrote them down on the paper.

7. The group leader asked each member to write three useful things from the gift.

8. The group leader asked the group members to express their opinion on steps number 6 and 7.

9. The group leader explained the group members as follows: "In our life, we had to faces the various situations, some of which you could not be denial. Usually, we want all the good things would be happen to us and we always chosen the best choices for ourselves. Unfortunately, very often it would not meet our expectation, which created the feeling of disappointment and misery. Since there was inevitable,

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so we should unhappy find the way to live with them. By looked for the positive point from that situation."

10. The group leader encouraged members to learn how to appreciate themselves by asking them to close their eyes and listen to the group leader's voice: "During the past three weeks that we spent time together, you must have notice and recognized the good qualities to each others. You could let them know."

11. The group leader gave nine pieces of papers to each member, and asked them to write down the good qualities of each member by using a separate sheet of paper.

12. Each member had an opportunity to talk to that person and tell them what were the good points of other members, and then handed it to those members.

13. The group leader gave member the opportunity to express their responses and what they had learned from the group.

14. The group leader sum up the session as follows: " You had learned from the other that how they were appreciate on you. Some quaity, you new knew that will exist have on you. So, you learn the new thing and feel better about yourself and made you feel more confident. To help you to do this, you should look for good things around you or found ways to express the goodness within yourselves in order to boost your self-esteem, which would give you the confidence to succeed.

15. The group leader asked the group members for questions or commented about this session.

16. The group leader thanked the group members and confirmed the date and the time for next session.

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Session VI ; Problem-solving training

Objectives

1. To provide an opportunity to express feeling of unhappy situation.
2. To improve the problem-solving skills.

Resources

1. Fifty pieces of paper.
2. Ten pens.

Activities: these proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader explained the activity for this session "I would like you to close your eyes and think about any situations during the last two weeks which made you feel worried, upset or unhappy. You need someone to help you. Then I want you to write it down on separate pieces of paper. After that we would discuss these experiences that you had. Then we would help each other to find the alternative solutions."

3. The group leader asked the group members to close their eyes and think about their situations.

4. Each member wrote it down on separate pieces of paper.

5. Each member selected one of her own situations and shared to the group.

6. The group leader posted them on the whiteboard.

7. Repeat steps number 5-6 until every member shared all of their experience.

8. The group leader asked all members to group the topic into categories.

9. The group members selected one of these categories.

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10. The group members were encouraged to express their opinion by the following questions:

10.1 What was your experiences of unhappy situation?

10.2 How did you feel? What was the effect on you?

10.3 How did you act to those situations? What was the effect on you?

11. The group leader summarized and suggested the alternative procedure to deal with problem by using the 6-steps of problem-solving skills as following:

11.1 Analyzing the situation, clarifying and presenting them in hierarchy order.

11.2 Gathering the necessary information from family members, friends, or the others which related to the situation.

11.3 Setting short-term goals and long-term goals.

11.4 Thinking about all of possibility strategies to deal with the problem.

11.5 Choosing the one which appropriated to that situation.

11.6 Evaluating the results. If the problem was still alive, repeating steps 11.1-11.5 if necessary.

12. The group leader allowed the group members to ask any questions about the session that they might have.

13. The group leader thanked the group members and confirmed the date and the time for next session.

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Session VII ; Communication training

Objectives

1. To increase the effectively communication, how to ask for help, and how to express their feelings and needs.

2. To develop self-confidence in communicating with other.

Resource

1. Two role-play situations

2. The pamphlets about "asking for help"

Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader explained the activity as follows: "I would like you to play the role in a situation that I would give to you. Each group could create their own scenario. After both role play we would discuss about it."

3. The group members were divided into two groups.

4. The group leader gave each group an envelope containing the role-play situation-card.

5. Each group was given five minutes to prepare for the scenario.

6. The first group played their assigned roles.

7. The group members were encouraged to express their opinions on the following questions:

7.1 "How did you feel when you were in this role?"

7.2 "How the other felt when they were in the other role?"

7.3 "Have you ever had the same experience in your daily life? How did you feel about it?"

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7.4 "How did you react or deal with this situation?"

8. The second group played their assigned roles.

9. Follow procedure in steps number 7.

10. The group leader summarized that: "Sometimes, you could not solve all the problems that you had by yourself, so it was possible to seek help from the others. However in order to ask for help, you must realize that you need help, then you must be able to express your need to the others. This procedure asking for help presented as following:

10.1 You must accept that sometimes you could not solve your problem alone.

10.2 You must find somebody who could help you.

10.3 You must evaluate his/her willingness to help you. Then you must try appropriate to talk to him/her.

10.4 You must be able to express your feelings, your expectations and your needs to him/her.

10.5 In asking for help, it was necessary to communicate, which involved the following processes:

10.5.1 Communication was a process of transmitting information, thoughts, beliefs, feelings and attitudes between at least two persons.

10.5.2 Two types of communication

10.5.2.1 Verbal communication referred to written and spoken messages exchanged in the form of words the elements of language.

10.5.2.2 Nonverbal communication referred to messages that were conveyed by facial expressions, body movement, touch or eyes movement etc.

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10.5.3 There were different way of asking for help.

10.5.3.1 Expressing your feelings by using "I message", e.g.: "I am concerned about our child and would like you to consult the doctor with me."

10.5.3.2 Using criticism, e.g.: "You are the causes of the problem and you never help me take care you child , So you must see the doctor with me.

10.5.3.3 Expressing your feeling by using "Citing a third person", e.g.: "The doctor would like you and I to see him tomorrow about our child."

11. The group leader asked each group member to choose a partner and practice the procedure how to asking for help.

12. The group members provided the members an opportunity to express their feelings and ask for help from others while acting out the situation they thought of.

13. The group leader encouraged the group members to use these ways of communicating with others effectively in their daily lives.

14. The group leader allowed the group members to ask any questions about the session that they might have.

15. The group leader informed all group members that the next session would be the last, and would review all the concepts that we had learned.

16. The group leader thanked the group members and confirmed the date and the time for next session.

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Session VIII ; Summary and evaluation

Objectives

1. To review the acquired experiences in the supportive group therapy program.
2. To do self-evaluation and evaluate the supportive group therapy program.
3. To extend help outside after the program.

Resource : None

Activities: These proceeded by the following steps.

1. The group leader greeted the group members and reviewed the main idea of the previous session.

2. The group leader asked the group members to review the important content in the previous sessions. Each member was written down his or her opinion that was received during the program. By answered all the following questions:

2.1 What were the topics of each session?

2.2 What the new ideas you had gained from the group?

2.3 Which problems had you tried to tackle? How it affected on you?

2.4 Did you have changed? How? How did you feel about it?

2.5 What were you impressions from your participating in this group therapy program?

2.6 If the next group therapy were organized, what topic would you like to have?

2.7 Did you have any other suggestions or comments?

3. The group leader gave the group members an opportunity to take turn talking during the group therapy session.

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4. The group leader summarized the content of eight session as follow: "During the past eight weeks, you had learned that people had differences in their thoughts, feelings or emotional responses which result in their behavior and the way to react differently. By awareness and understanding of these individual differences, you can accept the differences among yourselves and others. Besides, you had also learned that stress produced feelings of unhappiness, which could happen to anyone. Then, you should deal with stress in appropriately ways. Sometime you met unexpected situation, you should learned how to cope with it by adjust the way of thinking. Bring all the positive things around us, it would make you feel better about yourselves and others which improved good relationship among the family member and skills in dealing with your problems. By following the six steps you had learned about asking others for help, which would allow you to find the best way to minimize or solve the problem."

5. The group leader thanked all the group members for their cooperation, understanding and consideration to each other in solving their problems and dealing with unpleasant circumstances.

6. The group leader concluded the final session with the following remarks: "During the past eight weeks, you had shared your feelings, opinions and experiences. Each group member should have benefited from group therapy program. I hoped that you would be able to apply this to your daily life and in dealing your problems. Although the supportive group therapy was now in the last session, please try to keep in touch with other members so that you could help one another in the future."

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BIOGRAPHY

NAME Miss Malinee Panpoungkaew

DATE OF BIRTH 5 October 1971

PLACE OF BIRTH Petchaburi, Thailand

INSTITUTIONS ATTENDED Prapokkloa Nursing College, 1989-1993
Diploma in Nursing Science
Equivalent to Bachelor of Science in Nursing
Mahidol University , 1997-2000
Master of Nursing Science
(Psychiatric-Mental Health Nursing)

POSITION & OFFICE 1993 – Present, Dept of Mental Health and Psychiatric Nursing , Prachomkloa Nursing college , Petchaburi Thailand.
Position : Professional Nurse 5

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