



Effects of a Family-to-Family Support Program on the Mental Health and Coping Strategies of Caregivers of Adults With Mental Illness: A Randomized Controlled Study



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ABSTRACT

This randomized, controlled intervention study was carried out to investigate the effects of a Family-to-Family Support (FFS) program on the coping strategies and mental health status of caregivers of schizophrenia patients. Data were collected via a General Health Questionnaire (GHQ) and the Ways of Coping with Stress Scale (WCSS). During the first phase of the study, the FFS program was developed, followed by a second phase in which the participants of the study were identified and trained. In the third phase, trained caregivers trained other caregivers. The study sample consisted of 46 caregivers. We determined statistically significant differences in the mean GHQ scores of the FFS group over four measurements. In the WCSS subscales, the self-confident approach, optimistic approach and seeking social support approach scores of caregivers participating in the FFS program were high, while their helpless approach score was low. The FFS program had a positive impact on the coping strategies and mental health status of caregivers of schizophrenia patients.

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Chronic mental illnesses adversely affect the emotions, thoughts, perceptions and behavior of an individual. Being unable to fulfill their expected roles within the family and society, patients with schizophrenia encounter difficulties and need the constant care and support of their families. Most patients with schizophrenia live with their families who often undertake the responsibility of care giving without any external support (Pickett-Schenk, Lippincott, Bennett, & Steigman, 2008). Chronic mental illnesses negatively impact the lives of not only the patients, but also their families and cause them to experience stress (Addington, McCleery, & Addington, 2005; Chien, 2008). As a result of the stress they experience, caregivers of patients with chronic mental illnesses are found to have a high prevalence of depressive symptoms and anxiety (Magana, Garcia, Hernandez, & Cortez, 2007; Perlick et al., 2007). Families are reported to resort to mechanisms such as crying, denial, anger, withdrawal from social life, aggressive behavior, positive thinking, knowledge acquisition, support from friends and neighbors and social support for coping with stress. In a study by Li, Lambert, & Lambert (2007), it was shown that in families of patients with chronic mental illnesses, coping strategies used for dealing with problems while providing care are often insufficient. It was further indicated that effective nursing interventions are needed to improve the mental health status of family caregivers.

It has been reported that if patients, families and healthcare workers work in close collaboration during the treatment of schizophrenia, treatment effectiveness is increased while the rate of relapse and re-hospitalization is reduced (Doğan, 2002; Maldonado & Urizar, 2007). A meta-analysis conducted by Pilling et al. (2002), showed that psychosocial interventions reduce the risk of relapses and re-hospitalization among the caregivers of patients with schizophrenia while increasing patient compliance with drug therapy. Sin and Norman (2013) evaluated the efficiency of psychosocial education programs among families of patients with schizophrenia in a systematical review and found that the education programs were highly effective on the knowledge levels and coping strategies of caregivers while they were less useful in psychological morbidities of caregivers such as emotional burden or expressed emotion. They also added that group works were comparatively much more efficient in which caregivers could easily share their emotions (Sin & Norman, 2013). In a meta-analysis of studies on the families of patients with schizophrenia by Pitschel-Walz, Leucht, Bauml, Kissling, and Engel (2001), it was reported that family interventions reduce the rates of relapse by 20%. However, family interventions are applied only when families participate in research and some families can only receive services after the patient is hospitalized (Fung & Fry, 1999; Lincoln, Wilhelm, & Nestoriuc, 2007). The fact that family interventions are not a part of the practices carried out by healthcare workers has led to the emergence of Family-to-Family Support (FFS) programs (Dixon et al., 2001).

FFS programs are community support programs that provide families with information about mental illnesses while creating a forum for sharing thoughts and feelings. In these programs, healthcare workers

Interest in families of schizophrenia patients.

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train volunteers among family members who in turn train other family members (Burland, 1998). Experts are included in the program only when they are essentially needed. The goals of the program are to equip the caregivers with self-help skills, to provide emotional support, and to ameliorate the traumatic impact of chronic mental illnesses on caregivers. The program additionally aims to help caregivers to receive education from other caregivers with similar experiences and to share their experiences in a group (Baxter, 2001). In this program, families can interact with other families with similar stories, share their experiences, and develop a new perspective towards their own lives (Chien, Thompson, & Norman, 2008).

Results of studies with FFS program interventions showed that caregivers gained more knowledge about the causes and treatment of mental illnesses (Chien, 2008; Dixon et al., 2004; Pickett-Schenk et al., 2008), coped more easily with the difficulties they encountered (Chien, 2008), felt stronger (Pickett-Schenk et al., 2008), had less negative emotions (Dixon et al., 2004), received more social support and were less anxious about the mentally ill individuals (Reay-Young, 2001).

Systematic, planned and continuous intervention programs have not yet been implemented in Turkey to improve the ability of caregivers of patients with schizophrenia to cope with difficulties encountered during the caring process. Studies show that intervention programs for caregivers of patients with schizophrenia are unavailable mainly due to short hospital stays, a lack of programs designed for families in routine clinical practices, an insufficient number of professionals trained in family intervention, lack of time and insufficient clinical experience (Rose, Mallinson, & Walton, 2004; Rummel, Hansen, Helbig, Pitschel-Walz, & Kissling, 2005). Because structured and continuous programs designed for families are not part of routine practice, caregivers are not able to receive the information and support they need. Consequently, they have difficulty in coping with the stress they experience while providing care for patients and therefore are at increased risk of mental health deterioration. The purpose of the development and implementation of the FFS program is to create environments where caregivers can interact with and receive emotional support from each other, increase their knowledge about the causes and treatment of mental illnesses, better cope with their difficulties and protect their own mental health. In addition, the development and widespread use of the FFS program aims to facilitate the involvement of families in the treatment and rehabilitation of chronic psychiatric patients, which is one of the priorities listed in the Turkish National Mental Health Policy. The current study was conducted on the development and assessment of the effectiveness of the FFS program because there have not been any prior FFS support programs or relevant published studies in Turkey. The aim of this study was to assess the effects of the FFS program developed in the study on mental health status and the coping skills of caregivers of patients with schizophrenia.

STUDY HYPOTHESES

Hypothesis 1. There will be statistically significant differences in the mean mental health scores at, first post-intervention follow-up, second follow-up at month 3 and third follow-up at month 6 between FFS and control group caregivers.

Hypothesis 2a. The mean “optimistic” subscale scores of the Ways of Coping with Stress Scale (WCSS) will be higher in the FFS group than in the control group at, first follow-up, second follow-up and third follow-up.

Hypothesis 2b. The mean “self-confidence” subscale scores of the WCSS will be higher in the FFS group than in the control group at first follow-up, second follow-up and third follow-up.

Hypothesis 2c. The mean “helpless” subscale scores of the WCSS will be lower in the FFS group than in the control group at first follow-up, second follow-up and third follow-up.

Hypothesis 2d. The mean “submissive” subscale scores of the WCSS will be lower in the FFS group than in the control group at first follow-up, second follow-up and third follow-up.

Hypothesis 2e. The mean “social support” subscale scores of the WCSS will be higher in the FFS group than in the control group at first follow-up, second follow-up and third follow-up.

MATERIAL AND METHODS

Design

This research was conducted as a randomized controlled intervention design to determine the effectiveness of FFS program. The study was conducted between September 2010 and July 2011 at the İzmir Schizophrenia Solidarity Association in Turkey. The Schizophrenia Solidarity Association was founded in 1997 in İzmir in order to support patients with schizophrenia and their relatives. Approximately 550 family members are registered with the association. The association offers various scientific activities and ergo therapy programs for patients and their families. These programs and activities are developed in collaboration with experts in the field.

Sample

The study sample consisted of registered family members of the association, and caregivers in the control group continued to participate in activities offered by the association. The sample was calculated via PASS statistical software. Total sample size for the study was 68, with 34 subjects each in the FFS and the control groups. While calculating the sample size, effect size was 0.61 (Cohen *d*), power was 0.80 and margin of error type 1 was taken as 0.05 and, consequently, the sample size was found to be 68.

All registered family members who visited the İzmir Schizophrenia Solidarity Association were notified about the FFS program by the president of the association and presented with an information pamphlet. Family members who did not visit the premises were informed about the program on the phone, and they were invited to participate. Brochures announcing the location and the starting date were placed at psychiatric and outpatient clinics in İzmir to promote the program. Following the announcements, a meeting was held with the families who wished to participate in the FFS program at the Conference Hall of the Karabağlar Municipality of İzmir. The objectives, content and method of the program were explained in this meeting.

Inclusion criteria of the study were that participants must consent to participate in the study, be literate and above 18 years of age, and be the primary caregiver responsible for a period of over 3 months for the care and treatment of a patient who was diagnosed with schizophrenia at least 1 year before the study. Exclusion criteria were to attend less than three sessions out of eight sessions in total and their relative suffered no co-morbidity of other mental illness during recruitment to the study.

Randomization was conducted in the first meeting of the families wishing to participate. Caregivers who agreed to participate in the trial were randomly selected for the FFS and control groups. The participants were randomly handed out labels, marked with A and B, and they were told that those who were holding forms marked with A would be in the study group and B in the control group. Care givers were seated in the hall without any prior planning. Survey forms marked with A and B were randomly delivered. Twenty-seven caregivers who received the questionnaires marked “A” were identified as the FFS group while the remaining 27 caregivers who received the questionnaires marked “B”

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