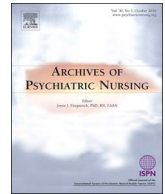




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# The Effect of a Brief Cognitive Behavioural Stress Management Programme on Mental Status, Coping with Stress Attitude and Caregiver Burden While Caring for Schizophrenic Patients

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## ABSTRACT

This experimental study was carried out using a pre-test/post-test control group model to evaluate the effect of a "Brief Cognitive Behavioural Stress Management Programme" (BCBSMP) on mental status, coping with stress attitude, and caregiver burden while caring for patients with schizophrenia. A total of 61 caregivers who provided care for schizophrenia patients at a community mental health centre were included in the study. Caregivers were matched according to gender and scale scores and were assigned to either the study or the control group. Before and after the programme, caregivers in both groups were given the "Demographic Data Form", "Zarit Caregiver Burden Scale", "Coping Attitude Evaluation Scale", "Stress Indicators Scale", and the "General Health Survey-28". Caregivers in the study group were taken to a BCBSMP one session per week (each session lasted 120 min) for seven weeks. We determined that the stress indicators, the risk of developing a psychological disorder, and caregiver burden decreased and skills related to both the problem-oriented and emotion-oriented aspects of stress increased in the study group after the programme.

## INTRODUCTION

Schizophrenia is a clinical syndrome that is mostly accompanied by distinctive hallucinations and delirium, through cognitive, emotional, behavioural and other functional disorders and progresses in time mostly with relapses. Schizophrenia is a severe and chronic mental illness that affects emotion, thought and behavior domains, which are the most important functions of the brain (Öztürk & Uluşahin, 2011). Due to various symptoms of this disorder, the patient experiences situations such as change of identity, social isolation, occupational insufficiency, cognitive disorders, and deterioration of health (Carlborg, Winnerbäck, Jönsson, Jokinen, & Nordström, 2010). If the symptoms do not improve with study, the disease becomes chronic, and most of the patients cannot fulfil their social roles (Arslantaş & Adana, 2011; Carlborg et al., 2010; Çetinkaya Duman & Bademli, 2013; Rafiyah & Sutharangsee, 2011). When disease symptoms increase over time and relapses are frequently experienced, most patients have to be hospitalised. After the completion of the treatment in the hospital, the patients return to their families or relatives who provide care for them (Arslantaş & Adana, 2011; Çetinkaya Duman & Bademli, 2013; Weimand, Hedelin, Sällström, & Hall-Lord, 2010).

When patients return to their family following treatment, families become responsible for the patient's care. Families help the patients' with medical treatments, support them emotionally and defend their rights (Mizuno, Iwasaki, Sakai, & Kamizawa, 2012). In this way, families act as caregivers, helping the patient to achieve a better state of health and welfare. The families also aid the patients in daily activities, such as bathing, dressing, eating, taking medications, and going to toilette (Caqueo-Urizar & Gutiérrez-Maldonado, 2006; Grandon, Jenaro, & Lemos, 2008). To fulfil these requirements, most families have to live with the patient 24 h a day every day of the year to support them (Jones, 2006).

On the other hand, continuously living with an individual who suffers from schizophrenia and giving them care might have an adverse effect on family dynamics and cause the caregiver to lose his or her job, to be unable to work outside the home, and to limit social relationships with friends (Grandon et al., 2008; Rafiyah & Sutharangsee, 2011). Consequently, the disease effects the family as much as the patient him or herself (Aggarwal, Avasthi, Kumar, & Grover, 2011). When caregivers embrace all of the responsibilities of the patient, they may develop feelings such as anger, displeasure, loss, stigma, fear, insignificance, shame, guilt, despair, uncertainty, anxiety about the future,

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stress and depression (Chang and Harrocks, 2006; Magana, Garcia, Hernandez, & Cortez, 2007; McCann, Lubman, & Clark, 2011).

In addition to these negative situations, when patients depend on family members to help them fulfil their daily activities (such as drinking, eating, clothing, bathing, walking, excretion, etc.), the caregiver begins to feel burdened (Çetin, Demiralp, Oflaz, & Özşahin, 2013). Throughout the course of the illness, symptoms and the loss of patients' skills cause the family to live under financial and spiritual burden (Arslantaş & Adana, 2011; Durmaz & Okanlı, 2014). In most of the studies, there is a relationship between coping strategies of caregivers and the level of burden (Huang, Hung, Sun, Lin, & Chen, 2009; McCann et al., 2011; Nitsche, Koch, & Kallert, 2010). They also state that they use coping methods such as crying, denial, fury, withdrawal from social life, aggressive behaviors, positive thinking, getting information, getting support from family and neighbors, and seeking social support (Huang, Sun, Yen, & Fu, 2008). In addition to this, families also need to learn how to cope with difficulties, collaborating with health personnel and actively participating in the treatment (Çetinkaya Duman & Bademli, 2013). In the studies, it is stated that coping strategies used by families of individuals who have mental disorders to sustain functionality of the family are insufficient, and caregivers require professional support to develop their coping ability (Ganguly, Chadda, & Singh, 2010; Liu, Clinton & Lambert, 2007; Bademli & Çetinkaya Duman, 2011). Hence, the family should be included in the treatment plan and helped if he or she uses non-functional methods for coping with the illness (Kung, Tseng, Wang, Hsu, & Chen, 2012).

In this study, we thought that participating in a short-term stress management programme (Brief Cognitive Behavioural Stress Management Programme – BCBSMP) would be beneficial for caregivers to cope with the challenges of caring a schizophrenia patient. BCBSMP has advantages such as being individual-oriented, having a short application period, and using cognitive techniques that can be applied in every environment needed. Additionally, the therapy can be sustained through homework at participants' houses, limiting the time they spend away from home and the patient. Also, the programme improves the coping skills of the participants. Moreover, in the literature, it is stated that use of cognitive behavioural techniques would reduce negative thoughts of individuals, help him or her cope with stress, and decrease various psychiatric problems ranging from daily stress to anxiety and depression (Basco, Glickman, Weatherford, & Ryser, 2000; Hamamci, 2006; Hiçdurmaz & Öz, 2011). It is thought that with the application of the programme, caregivers would develop more effective coping behaviors, and in parallel, the care burden, stress, and mental illness risk would decrease, and family functioning would become healthier. Furthermore, it can be said that BCBSMP can be easily used by nurses to support families. When the number of nurses working at the community mental health centre is considered, we found that with this particular type of programme, the constant attendance by the nurses can be reduced since the program is short and much of it consists of homework completed by the caregiver. With this caregiver-centred set-up, nurses can use their time more effectively, and sessions can be planned according to the needs of the caregiver. This study was carried out to evaluate the effect of the BCBSMP on mental status, coping with stress attitude, and caregiver burden in the caregivers of the patient with schizophrenia.

## METHOD

### STUDY PATTERN AND PARTICIPANTS

This experimental study was carried out using a pre-test/post-test control group model to evaluate the effect of the BCBSMP on mental status, coping with stress attitude, and feelings of burden experienced by caregivers of patients with schizophrenia.

The hypotheses of the study were as follows:

**H1.** BCBSMP will improve the stress coping behaviors of caregivers positively than those of caregivers who do not have BCBSMP.

**H2.** BCBSMP will decrease stress levels of caregivers than those of caregivers who do not have BCBSMP.

**H3.** BCBSMP will decrease burden levels of caregivers than those of caregivers who do not have BCBSMP.

**H4.** BCBSMP will decrease psychiatric symptoms of caregivers than those of caregivers who do not have BCBSMP.

It was carried out at a Community Mental Health Centre (CMHC) in a city in Central Anatolia, Turkey. 100 patients diagnosed with schizophrenia were followed by the CMHC between the 1 January 2012–1 January 2013. Sample size was calculated with the PASS (Power Analysis and Sample Size) 11 Statistical Software (NCSS LLC, Kaysville, Utah, USA). The sample size was calculated using the following values: margin of error = %5, confidence level = %95 and response distribution = %50, and based on the calculations, 40 individuals were assigned to each group (total 80). The inclusion criteria were as follows:

For relatives of patients:

- Being older than 18 years
- Living in the city centre (because CMHC is in the city centre)
- Being open to communication and cooperation
- Having no disorder that would prevent participation in the study, such as psychotic illness, substance addiction and mental retardation
- Giving care to the patient at least for last three months
- Being directly responsible for the care of the patient.
- Not giving care to any another person who is in need of care
- Agreeing to take part in the study
- Giving care to the patient with schizophrenia registered in the community mental health centre.

Caregivers of 71 schizophrenia patients, who were under followed-up due to schizophrenia diagnosis according to DSM-IV-TR diagnosis criteria and met the inclusion criteria for the study, were included in the study. Caregivers were grouped according to gender and scale scores and were assigned to either the study ( $n = 36$ ) or the control group ( $n = 35$ ). The program was completed with 28 people because 8 of the caregivers taken for the study group could not attend the sessions regularly for several reasons during the study. In the control group, we could not reach 2 caregivers from the address and phone number. The programme was completed with 28 people in the study group and 33 individuals in the control group.

### DATA COLLECTION TOOLS

#### DEMOGRAPHIC DATA FORM

The researcher developed the Demographic Data Form according to the literature to determine initial characteristics of caregivers and their patients such as age, gender, marital status, the number of children, educational status, the period of giving care, the period of illness, and the number of hospitalisations (Arslantaş & Adana, 2011; Bademli & Çetinkaya Duman, 2011; Durmaz & Okanlı, 2014). It is comprised of 27 questions (eight open-ended and 19 closed-ended).

#### ZARIT CAREGIVER BURDEN SCALE (ZCBS)

Zarit, Reeve and Bach-Peterson developed the Zarit Caregiver Burden Scale in 1980 (Zarit & Zarit, 1990) and İnci and Erdem adapted it into Turkish in 2008 (İnci & Erdem, 2008). The scale was developed to evaluate difficulties experienced by caregivers. The scale, which can either be completed by the caregiver or through an interview with the researcher, is comprised of 22 statements that determine the effect of caregiving on the life of the individual. The scale uses a Likert-type assessment, ranging from 0 to 4. The lowest total score obtained from

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