KNOWLEDGE AND ATTITUDES TOWARD MENTAL ILLNESS AND CAREGIVER – PATIENT RELATIONSHIPS : A STUDY OF CAREGIVERS OF PSYCHIATRIC PATIENTS IN CENTRAL REGION PSYCHIATRIC HOSPITAL

CHONLAPORN KONGKUM

A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF NURSING SCIENCE
(PSYCHIATRIC - MENTAL HEALTH NURSING)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2000

ISBN 974-663-742-8

Thesis
entitled

KNOWLEDGE AND ATTITUDES TOWARD MENTAL ILLNESS AND CAREGIVER - PATIENT RELATIONSHIPS : A STUDY OF CAREGIVERS OF PSYCHIATRIC PATIENTS IN CENTRAL REGION PSYCHIATRIC HOSPITAL

Chonlaporn Kongkum
.....
Miss Chonlaporn Kongkum
Candidate

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

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

Atirat Wattanapailin
.....
Mrs. Atirat Wattanapailin, Ed.D.
Co-advisor

.....
Prof. Liangchai Limlomwongse
Ph.D.
Dean
Faculty of Graduate studies

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

Thesis
entitled

KNOWLEDGE AND ATTITUDES TOWARD MENTAL ILLNESS AND CAREGIVER - PATIENT RELATIONSHIPS : A STUDY OF CAREGIVERS OF PSYCHIATRIC PATIENTS IN CENTRAL REGION PSYCHIATRIC HOSPITAL

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

March 19,2000

Chonlaporn Kongkum
Miss. Chonlaporn Kongkum
Candidate

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

Pornsri Sriussadaporn.
Assoc.Prof.Pornsri Sriussadaporn, M.Ed.
Member

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

Kanokrat Sukhatunga
Assoc.Prof.Kanokrat Sukhatunga M.Ed.,M.Sc.
Member

Atirat Wattanapailin
Mrs. Atirat Wattanapailin,Ed.D.
Member

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

Kobkul Phancharoenworakul.
Assoc.Prof.Kobkul Phancharoenworakul, Ph.D.
Dean
Faculty of Nursing
Mahidol University

Acknowledgements

I would like to express my sincere gratitude and deep appreciation to Associate Professor Dr.Tassana Boontong my Major advisor for her guidance, invaluable advice, supervision and encouragement throughout. She was never lacking in kindness and support.

I would like to thank Assistant Professor Wassana Chalamket and Dr. Atirat Wattanapailin for their helpful guidance and support with respect to the statistical analysis of data.

I would like to thank Associate Professor Dr. Kanokrat Sukhatungka and Associate Professor Pornsri Sriussadaporn for their constructive comment.

I wish to thank the staff of the outpatient and inpatient department of Somdet Chaopraya Hospital and Sritanya Hospital for their cooperation and generous assistance. In particular I would like to thank the relatives who were caregivers of psychiatric patients who participated in this study.

Finally, I am particularly thankful to my parents, and my friends for their great support and understanding throughout my study.

Chonlaporn Kongkum

4037088 NSPS/M: MAJOR: PSYCHIATRIC - MENTAL HEALTH NURSING
M.N.S. (PSYCHIATRIC - MENTAL HEALTH NURSING)
KEY WORDS : KNOWLEDGE/ ATTITUDE/ RELATIONSHIP/ CAREGIVER/ PSYCHIATRIC PATIENT

CHONLAPORN KONGKUM: KNOWLEDGE AND ATTITUDES TOWARD MENTAL ILLNESS AND CAREGIVER-PATIENT RELATIONSHIPS: A STUDY OF CAREGIVERS OF PSYCHIATRIC PATIENTS IN CENTRAL REGION PSYCHIATRIC HOSPITAL. THESIS ADVISORS: TASSANA BOONTONG Ed.D.,WASSANA CHALAMKET M.Ed.,ATIRAT WATTANAPAILIN Ed.D. 93 p. ISBN 974-663-742-8

Psychiatric patients suffers disorders of thought, decision, emotion, behavior, and self-care, all of which are chronic, so caregivers have an important role in helping the patient recuperate physically, emotionally, and socially. They can make sure that the patients receive proper medication and checkups consistently. In order to give effective care, the caregiver must have the right knowledge and attitudes toward mental illness and a good relationship with psychiatric patient.

This study is a descriptive study. Its purpose was to study the knowledge and attitudes toward mental illness, and the relationship between the caregiver and the psychiatric patient. The sample group is the caregivers of psychiatric patients who were admitted into the psychiatric hospitals in the central region of the country and were diagnosed having Schizophrenia, Mood disorder, Mental and behavioral disorders due to psychoactive substance use, and Psychosis, who numbered 390 patients. The questionnaires were developed by the researcher which consisted of demographic data about caregivers, demographic data about psychiatric patients, knowledge of caregivers about mental illness, attitudes of caregivers toward mental illness, and caregiver-patient relationships. It was tested for validity by experts and reliability limits of 0.77,0.86, and 0.82, respectively. The data were analyzed by frequency distribution, percentage, mean, and standard deviation.

It was found from the study that most caregivers of psychiatric patients have good knowledge of mental illness, about 72.3%. The caregivers have moderate attitudes toward mental illness ($\bar{X}$=2.80,SD=0.34), and have good relationships with psychiatric patients ($\bar{X}$=3.21,SD=0.35). It was found, in detail, that few caregivers know that genetics and neurotransmitters are causes of mental illness, or knew the side effects of electrical therapy. The caregivers felt that psychiatric patients have less tolerance than normal people, create problems and area burden to the families. Psychiatric nurse should play a role in giving knowledge to caregivers and the general public about mental illness, to develop good attitudes about mental illness, and to promote good relationships between the caregivers and the psychiatric patients continuously.

4037088 NSPS/M : สาขาวิชาสุขภาพจิตและการพยาบาลจิตเวชศาสตร์;พย.ม.
(สุขภาพจิตและการพยาบาลจิตเวชศาสตร์)

ชลพร กองคำ : ความรู้ เจตคติเกี่ยวกับการเจ็บป่วยทางจิต และสัมพันธภาพต่อผู้ป่วย: กรณีศึกษาญาติผู้ดูแลที่นำผู้ป่วยมารับการรักษาในโรงพยาบาลจิตเวชในภาคกลาง (KNOWLEDGE AND ATTITUDES TOWARD MENTAL ILLNESS AND CAREGIVER-PATIENT RELATIONSHIONS: A STUDY OF CAREGIVERS OF PSYCHIATRIC PATIENTS IN CENTRAL REGION PSYCHIATRIC HOSPITAL) คณะกรรมการควบคุมวิทยานิพนธ์: ทัศนา บุญทอง, Ed.D., วาสนา แฉล้มเขตร, กศ.ม. (การแนะแนว), อติรัตน์ วัฒนไพลิน, กศ.ด. (การวิจัยและพัฒนาหลักสูตร). 93 หน้า. ISBN 974-663-742-8

ผู้ป่วยจิตเวชมีความบกพร่องในด้าน ความคิด การตัดสินใจ การแสดงอารมณ์ พฤติกรรม รวมทั้งการดูแลตนเอง และมีลักษณะเรื้อรัง ผู้ดูแลจึงมีบทบาทสำคัญในการให้ความช่วยเหลือแก่ผู้ป่วยอย่างต่อเนื่อง เพื่อให้ผู้ป่วยได้รับการฟื้นฟูสภาพร่างกาย จิตใจ และสังคมอย่างเหมาะสม ได้รับยาและการตรวจตามนัดอย่างสม่ำเสมอ ผู้ดูแลจะให้การดูแลที่มีประสิทธิภาพแก่ผู้ป่วยได้นั้นจำเป็นต้องมีความรู้ เจตคติที่ดีต่อการเจ็บป่วยทางจิต และมีสัมพันธภาพที่ดีกับผู้ป่วยโรคจิต

การวิจัยครั้งนี้เป็นการวิจัยเชิงบรรยาย มีวัตถุประสงค์เพื่อศึกษาความรู้ เจตคติเกี่ยวกับการเจ็บป่วยทางจิต และสัมพันธภาพของญาติผู้ดูแลกับผู้ป่วยโรคจิต โดยมีกลุ่มตัวอย่างเป็นผู้ดูแลผู้ป่วยโรคจิตที่รับไว้รักษาเป็นผู้ป่วยในโรงพยาบาลจิตเวชในภาคกลางและได้รับการวินิจฉัยว่าเป็นโรค Schizophrenia, Mood disorder, Mental and behavioral disorder due to psychoactive substance use , and Psychosis จำนวน 390 คน ผู้วิจัยใช้แบบสอบถามที่สร้างขึ้นเอง ประกอบด้วย ข้อมูลทั่วไปของญาติผู้ดูแล, ข้อมูลทั่วไปของผู้ป่วยโรคจิต, ความรู้ของญาติผู้ดูแลเกี่ยวกับการเจ็บป่วยทางจิต, เจตคติของญาติผู้ดูแลเกี่ยวกับการเจ็บป่วยทางจิต และสัมพันธภาพของญาติผู้ดูแลต่อผู้ป่วยโรคจิต ได้รับการตรวจสอบความตรงตามเนื้อหาจากผู้ทรงคุณวุฒิและมีค่าความเชื่อมั่นเท่ากับ 0.77, 0.86 และ 0.82 ตามลำดับ วิเคราะห์ข้อมูลโดยหาความถี่ ค่าร้อยละ ค่าเฉลี่ย และส่วนเบี่ยงเบนมาตรฐาน

ผลการวิจัยพบว่า ญาติผู้ดูแลผู้ป่วยโรคจิตส่วนใหญ่มีความรู้เกี่ยวกับการเจ็บป่วยทางจิตอยู่ในระดับดีถึงร้อยละ 72.3 ญาติผู้ดูแลมีเจตคติเกี่ยวกับการเจ็บป่วยทางจิตอยู่ในระดับปานกลาง($\bar{X}$=2.80,SD=0.34) และมีสัมพันธภาพต่อผู้ป่วยอยู่ในระดับดี ($\bar{X}$=3.21, SD=0.35) แต่เมื่อพิจารณาในรายละเอียดพบว่ายังมีญาติผู้ดูแลจำนวนน้อยที่มีความรู้ว่าพันธุกรรมและสารเคมีในสมองเป็นสาเหตุของโรคจิต และผลข้างเคียงของการรักษาด้วยไฟฟ้า ผู้ดูแลรู้สึกว่าผู้ป่วยโรคจิตมีความอดทนต่ำกว่าคนทั่วไป สร้างปัญหาและเป็นภาระของครอบครัว พยาบาลจิตเวชจึงควรมีบทบาทในการให้ความรู้แก่ผู้ดูแลและประชาชนทั่วไปเกี่ยวกับการเจ็บป่วยทางจิต พัฒนาเจตคติของญาติผู้ดูแลเกี่ยวกับการเจ็บป่วยทางจิตไปในทางที่ดี และส่งเสริมสนับสนุนให้ญาติผู้ดูแลและผู้ป่วยโรคจิตมีสัมพันธภาพที่ดีต่อกันอย่างต่อเนื่อง

CONTENTS

CONTENTS (Continued)

LIST OF TABLES

LIST OF TABLES (Continued)

CHAPTER I

Introduction

Background and Importance of the Study

Mental illness is one of the most important public health problems of the country. From the statistical report of outpatients who have used the service of branches of the Department of Mental Health, Ministry of Public Health all over the country, it was found that in the years 1995 to 1998 there were 732,107; 769,072; 778,457; and 804,906 patients, respectively. When analyzed by region, it was found that, in the central region, the numbers of psychiatric patients who used the service of the Department of Mental Health branches, were 340,180; 338,613; 357,268; and 367, 081 patients, respectively (Department of Mental Health, 1998). From the statistics, it can be seen that the number of psychiatric patients is increasing every year. This is because, at present, there are rapid changes in the economy, society, and technology. The problems of materialism, addiction, and environmental pollution are also increasing and affecting the daily life of individuals in society. It causes members of families to become farther apart, less trusting, and less secure. It causes severe and chronic anxiety much more than individuals can adapt to, and finally individuals become mentally ill (Petchrat, B., 1996:13).

Mental illness is an imbalance of body, mind, society and environment. Individuals that cannot maintain the balance with reality will have a disorder so that he cannot control his own perceptions, thoughts, emotions and behaviors. Psychiatric patients will show disorders in reasoning, in decision making, in intelligence, and in living together with others in society (Petchrat, B., 1996:23). The important symptoms are movement disorders and behavioral disorders such as being unable to sit calmly, having to walk around or staying at one place for a long time, not taking care of themselves, not taking a bath, being dirty, or harming others or themselves. Other symptoms are thought disorders, having a delusion that they are someone very

important, paranoia, thinking that somebody will harm them; emotional disorders, depression, indifference, not showing any emotion, being aggressive, violent, laughing or crying despite reality; perception disorders, hearing voices or seeing images that are not real, and refusing therapy (Ruangtrakool, S. et al., 1999:1-6).

Because of the disorders mentioned, above psychiatric patients cannot take care of themselves and need to be taken care of by members of their family. Members of the family can take care of the patient's daily activities such as taking a bath, eating food, and taking medication. They should observe changes and help solve problems, give emotional support, or encouragement, promote the patient's self-worth, keep them company and communicate with the patient for checkups, and be responsible for medical expenses (Sirapongam,Y.,1996:87-88). It can be seen that the patient's family is important in ensuring that the psychiatric patient receives proper and continuous treatment and rehabilitation.

In order to take care of the psychiatric patients effectively, the family must understand facts and details of the meaning of mental illness, causes of mental illness, symptoms of the illness, treatments for mental illness, and care and rehabilitation of psychiatric patients, so that they can use this knowledge in thinking, determining, and deciding correctly on how to take care of the psychiatric patient properly. Also, the family's understanding of mental illness is important in ensuring patient's compliance with the treatment (Tagliacozzo & Ima, 1970:765). According to the study of Phunrunotai, S. (1987) it was found that if the patient's family understand and practice, they can reduce the severity and recurrence of the illness. Robinson & Yates (1994:312-319) found that educating psychiatric patient's families reduces the burden of care of the family. This was the result of the studies by T.Skul, J. (1981) and Ip, G.S.H. and Mackenzie (1998:293) which found that if the psychiatric patient's family lacked understanding of mental illness and did not give proper care, the psychiatric patient would have chronic recurrences.

Attitude is the foundation of emotions, feelings and behavioral trends (Alloport, 1935 cited by Suwan, P., 1983:80). On the positive side, it shows satisfaction, likeness, and nearness and on the negative side, it shows dislike, dissatisfaction, and repulsion (Lungsuwang, K.,1981:230-240). The attitudes of caregivers toward mental

illness, psychiatric patients, causes, treatments, living with and taking care of psychiatric patients is a factor influencing the behavior of taking care of the psychiatric patient. If the family believed that the cause of mental illness is from possession or black magic, then the family would bring the patient to be exorcised (Meesup, K.,1997:87-92). In Thai society, almost all psychiatric patients were treated by witch doctors before they came to psychiatric hospitals (Suwanlert, S., 1974 cited by Tuntiplachiva, K.,1993; Yunipun, J. in Department of Mental Health, Ed.,1997:77). At the same time, Thai society still believes that psychiatric patients are dangerous, aggressive, frightening, homeless and walk the streets, and dress and behave strangely which makes most people afraid of and repelled by psychiatric patients (Kittiratanapaiboon, P., 1997:31). Nobody wants to relate to psychiatric patients and the caregivers feel shame that there is a psychiatric patient living with them in the family (Kotmon, T. et al., 1985; Nitikul, W., 1992). To be mentally ill is shameful, and they will be repelled by the society which is a negative attitude that affects the care psychiatric patients will receive (T.Skul, J., 1981). Conversely, if the caregiver has a positive attitude, the family will be concerned with, sympathize with and want to help the psychiatric patient (Tangsaree, V.et al.,1995; Huang & Mao, 1991:90-100) and the psychiatric patients will have good care from the family.

A relationship is an interaction between individuals that happens slowly but continuously, resulting in attachment, love, concern, sympathy, acceptance, and makes individuals who interact to have good feelings toward each other (Isarankul Na Ayutthaya, K., 1995:165). The relationships between the family and psychiatric patients are another factor affecting the care-giving behavior of the family. If the caregiver has a good relationship with the psychiatric patient, and they takes care of and give attention to each other, do some common activities, communicate and share experience with each other, accept each other, do not fight with each other, show affection toward each other consistently and continuously, it will be an important factor in the physical, mental, and social recuperation of the patient. From the study of Natasiri, D., et al. (1977), it was found that families that have good relationships with psychiatric patients still love, respect, and welcome the psychiatric patients back home warmly. Conversely, if the caregiver and the psychiatric patient did not have a good

relationship, or have a conflict between them, do not help, nor communicate, then the psychiatric patients will feel isolated from the family, worthless, unwanted by the family, and not get attention or care to recuperate properly. When a patient has symptoms or changes that need help, the family does not know it, so they cannot help properly and rapidly. From the study of relationships between families and psychiatric patients at Sritanya Hospital made by Chaisanoa, S. et al. (1997:1-8) it was found that a poor relationship in the family makes the family want the psychiatric patients to stay in the hospital forever. Similar to T.Skul, J. (1981) it was found that the family did not accept the psychiatric patients and wanted the psychiatric patients to stay in the hospital until completely recovered. Poor relationship is bad for patient care.

In the public health service system of Thailand, specialized treatment for psychiatric patients who have to be admitted to hospitals is available. 55% of the hospital beds are located in Bangkok and periphery (Department of Mental Health, 1997:13). The central region of the country is a center for migration of population from all other parts of the country because they look for education and jobs, so the population in the central region, especially in Bangkok and periphery, is full of variety in culture, beliefs, economic and social status, level of education, lifestyle and relationship within the family (Supap, S., 1995:84-88).

The purpose of the study is to learn about the knowledge of caregivers of psychiatric patients, the attitudes of caregivers toward mental illness and the relationship between caregivers and the psychiatric patients in the central region of Thailand. The information obtained from the study may to provide knowledge, and change the attitude and promote good relationships in the caregivers so that the psychiatric patients will receive effective care from the families.

Objectives:

1. To study the knowledge of caregivers about mental illness;
2. To study the attitudes of caregivers toward mental illness;
3. To study caregiver-patient relationships.

Scope of the Study

This research deals with the acquisition of knowledge and attitudes toward mental illness and the relationships between caregivers and psychiatric patients who are having treatments in the psychiatric hospitals in the central region. It is a descriptive study of the knowledge and attitudes toward mental illness of caregivers who are responsible for taking care of psychiatric patients and the relationships between caregivers and psychiatric patients who are hospitalized in the Somdet Chaopraya Hospital and Sritanya Hospital as inpatients.

Expected Results

It is expected to provide a guide for planning to provide proper knowledge about mental illness for promoting and developing positive attitudes toward mental illness, and for building a relationships between caregivers and psychiatric patients in order that the psychiatric patients will gain effective care from caregivers who are their relatives.

Definition of Variables

Caregiver of psychiatric patient means a close related caregivers who directly takes care of a psychiatric patient, admitted to the psychiatric hospitals in the central region. The patient has been diagnosed as having a mental illness such as Schizophrenia, Mood disorder, Mental and behavioral disorder due to psychoactive substance use, or Psychosis.

Knowledge of caregiver about mental illness means the knowledge and understanding of caregiver about mental illness is classified in 4 types: causes of mental illness, psychiatric symptoms, treatments, caring for and improving the rehabilitation of psychiatric patients.

Attitude of caregiver toward mental illness means the feelings, thoughts and beliefs of the caregiver on the mental illness and psychiatric patient, the cause of mental illness, treatments, living with and caring for psychiatric patients.

Caregiver-patient relationships means the interactive behavior between caregivers who are responsible for taking care of psychiatric patients and psychiatric

patients themselves (Crandall, 1980, 410-411; Weiss cited by Kaewprom, Ch., 1987: 40). The relationship consists of 6 factors as follows:

1. Helping and considering for each other means the help, both material and mental given to patients, such as being interested in the patients' happiness, giving information and advice and actual financial help.

2. Sharing common family activities means sharing the daily activity among caregivers and patients.

3. Accepting each other means respecting the patient's rights and human dignity.

4. Communicating and sharing ideas and experiences with each other means constantly sharing ideas and experiences among caregivers and patients.

5. Avoiding contradicting each other means making sure that both the caregivers and patients are cooperative and agreeable.

6. Loving care for each other means showing love and being concern with each other.

CHAPTER II

Literature Review

Mental illness causes patient to be debilitated in various functions. It is a chronic illness. Since, at present, the treatment policy is to admit the patient into a hospital only when the symptoms are severe and acute and to encourage the patient to return to his home and community quickly, so the patient needs long and continuous care from the family concerning general health, administration of medication, and consistent checkups to prevent recurrence and to recuperate physically, mentally, and socially continuously and properly.

In order to give effective care, there are three important factors for the family. First, they should have correct knowledge about mental illness, its meaning, its causes, its symptoms, treatment, care and physical, mental, and social rehabilitation. Second, they should have good attitudes toward mental illness and the patient. Third, they should have a good relationship with the patient, with common activities in the family, and no conflict. They should share opinions and experience between each other, accept, and have emotional involvement. The researcher is interested in studying attitudes about mental illness, relationships of psychiatric patient, in a study of caregivers who admitted patients for treatment in psychiatric hospitals in the central region of the country. The relevant research literature is presented, as follows:

1. Knowledge of caregiver about mental illness.
2. Attitudes of caregiver toward mental illness.
3. Caregiver – patient relationships .

1. Knowledge of Caregiver about Mental Illness.

Knowledge means (Good, 1973:325) facts, various details from studies or from experiences. It is about perception, memory, understanding, evaluation, analysis, synthesis, and assessment of various informations of individuals which can be measured whether it is known or not (Kusolvisitkul, V., 1984:312-313). Sufficient and valid understanding helps individuals to decide and act properly because knowledge is the foundation of thought, consideration, and the decision whether to act or not (Phumipark, Ch., 1987:6).

In the past, society believed that mental illness was caused by what was happening to the soul. Evil beings wanted to punish humans, so the treatments were done by witch doctors, exorcising the evil spirit out from human bodies. Later the belief changed to the view that mental symptoms were caused by an imbalance of bile substance, blood, and sputum, so the patient was treated by providing proper food and drink to the patient. Still later, it was believed that mental illness was caused by emotional problems, so it was treated by changing the environment to suit the patient. Nowadays, it is found that mental illness was caused by abnormality of neurotransmitters in the brain, so it is treated by giving medication, providing therapeutical environment, electrical therapy, and psychotherapy. Hence, sufficient and valid knowledge of the caregiver about mental illness and treatment is important to the caregiver in order to provide effective care for the patient (Tagliacozzo & Ima, 1970:765). Also when the family has sufficient knowledge, it will have reduced stress in giving care to the patient (Greonberg J.S.,Greenky J.R., Brown R., 1997:23).

The correct understanding of the meaning of mental illness, causes and symptoms, will help the caregiver to understand and accept the patient as an individual. They can observe abnormal behavior and bring the patient in to receive treatment early on, which can prevent the disorder from becoming more severe, and can help the patient to be cured at the onset. At the same time, knowledge will help the family to prevent mental illness in members of other families.

Mental Illness

Chaisrisuk, V.(1990:91) stated that mental illness is the constant change in emotion and thinking so that the patient is not able to adjust. Emotions change so quickly that thoughts are not expressed rationally.

Petchrat, B.(1996:23) stated that mental illness is the disharmony between the individual's psychosocial behavior and the individual's environment, which causes unhappiness, pressure and paranoia. This cause the patient to be incapable of controlling thoughts, feelings, and behaviors, which is expressed through the irrationality in, decisions, consciousness, and adjustment to others in society.

The psychiatric patient is an individual with imbalance between himself and the environment that changes his personality. He shows abnormalities in his emotions, thoughts and behavior. He cannot control his behavior so that he would not be accepted by society.

Causes of Mental Illness

Causes of mental illness can be divided into three categories as follows: (Otrakul, A., 1995:47-53)

1. Hereditary factors. This theory states that mental illness is caused by heredity from parents such as Schizophrenia, Mood disorder, Psychosis, Senile dementia and Alzheimer's disease.

2. Organic Factors. This theory states that mental illness is caused by abnormality of the brain, abnormality of metabolism, abnormality of endocrine gland, and imbalance of various neurotransmitters such as serotonin, dopamine and acetylcholine.

3. Environmental Factors. These theory states that the disorder is caused by the environment that the patients were raised insince early childhood. Children from broken families often have behavioral problem. Apart from this, despair in life, love, and work or critical events will cause frustration, which may not be adapted to well enough, so the patient becomes mentally ill.

Psychiatric Symptoms

Psychiatric symptoms can be classified into 7 groups, as follows : (Ruangtrakool, S., 1999: 1-6)

1. Disorders of motor activity-include tics, stereotypes, catalepsy and automatic obedience, for instance.

2. Disorders of content of thought-is the misconception or belief in something that is not real. The patient is fixated on a certain idea and can not be persuaded otherwise through reasoning, which is called delusion: for example, delusion of persecution, delusion of reference, delusion of grandeur, and somatic delusion.

3. Disorders of form of thought-problems in which patients can not relate their thoughts with reason. They are unable to put in order their thoughts in the order of events, which is apparent in their speech, such as incoherence, blocking and circumstantiality, for instance.

4. Disorders of affect-include phobia, euphoria, apathy and irritability.

5. Disorders of perception-misinterpretation of things from reality, such as seeing a rope as a snake, sensing bad odors, or feeling that bugs are crawling on the body, for instance.

6. Disorders of consciousness-The patient has characteristics of confusion, delirium and disorientation.

7. Disorders of memory-ability in remembering, such as anterograde amnesia and retrograde amnesia, for instance.

Ngamtipwatthana, T. (1990) studied behavior of psychiatric patients, who were brought for treatment and found that all patients had gone through the initial stages of illness without it being given importance by caregivers. Symptoms that caused caregivers to take the patient for treatment were acute symptoms, including delusion and bizarre behavior, that acutely occurred. By not noticing symptoms initially, patients were ill from 26.2 months or 2 years and up before they are brought to doctors.

Psychiatric Treatment

The treatment for mental illness is constantly advancing. Certain methods that have been ineffective have been withdrawn. The methods that are effective have continued in usage, and have been modified according to new knowledge, adding to the various forms of therapy. However, the most favored methods of therapy today are as follows :

1. Somatic Therapy
   1.1 psychopharmacotherapy
   1.2 Electroconvulsive therapy
2. Psychotherapy
   2.1 Individual psychotherapy
   2.2 Group psychotherapy
3. Milieu therapy
4. Behavioral Therapy

The various methods are detailed as follows:

1. Therapy though somatic therapy is the treatment that involves various manipulations of the body. This method comprises of psychotropic drugs and electroconvulsive therapy, detailed as follows:

1.1 Psychopharmacotherapy: drugs that have an effect on the brain function and nervous system which alter feelings, emotions and consciousness in various way, and frequently are used therapeutically in the practice of psychiatry to treat a broad range of mental and emotional illness. Categories of psychotropic drugs include: antipsychotic drugs, antianxiety drugs, antidepressant drugs, mood stabilizers, and anticholinergic/antiparkinson drug (Tuntiplachiva, K., 1993:852-931; Ruangtrakool, S., 1999:203-215; Shives, 1994; 186-203)

The side effects of psychotropic drug found are:

- Pseudoparkinson's disease which includes shaking of the hand and

fingers, head, and tongue causing the patient to faint, and suffer dystonia .

- Autonomic nervous system effects, which causes various symptoms, such as dry mouth, blurred vision, urinary retention, constipation, and disfunction of the intestines.

- Endocrine effect, in which males will develop enlarged breast similar to women (Gynecomastia). In women , breasts will tighten and breast milk may flow out, menstruation will be irregular, sexual desire will increase, and it will cause impotence in men.

- Drowsiness, poor decision making, addiction to the drugs if taken frequently.

When patients are under psychotropic drug, caregivers should care for the patient as follows:

1. Explain to the patient about the side effects that will take effect after drug usage, in order to decrease worry.

2. Avoid alteration of dosage without discussing with the doctor, or else the patient may risk danger from an excessive intake of drug.

3. Observe side effects such as dry mouth and dry throat, and inform the doctor.

4. Prohibit the patient from alcohol or sleeping pills, as they will cause drowsiness, confusion, and dizziness. Keep the patient away from machines, and prohibit them from driving.

5. The patient should avoid driving, heights, and machinery, for they may cause accidents.

6. Closely look after the patient to prevent accidents, such as orthostatic hypotension.

1.2 Electroconvulsive Therapy : convulsive seizures are induced by the passage of electrical current though electrodes applied to both temporal areas of the head. The objective of this kind of treatment is temporary rest. Patients will fear E.C.T. because of

severe seizures which may cause intervening conditions such as broken bones, disjoints, edness tongue biting, and memory loss which is temporary (Tuntiplachiva, K., 1993:393-940).

Therefore when patients return home, what caregivers can do to help is orientate the patients memory by informing the patient of places and things they can not remember or find, give mental support and sympathy in times of worry about their loss of memory, and explain to them that the loss is temporary and will return.

2. Psychotherapy is treatment through amicable conversation of understanding between the patient and therapist to reduce the abnormality. In this treatment, the patient's ideas, feelings, and behavior recover to a normal level that is accepted by society.

Psychotherapy is classified into 2 important groups which are (Chaisrisuk,V., 1990: 194)

2.1 Individual psychotherapy is treatment of patients with mental, emotional, and behavioral problems. It is done though developing a good relationship between the patient and therapist in order to change the patient's ideas, attitudes, and behaviors. One therapist meets one client at a time.

2.2 Group psychotherapy is treatment of patients with mental, emotional, and behavioral problems. This is done with members of a group and a therapist being the leader and lead participant, in which the relationship is among the group, instead of 2 people.

Treatment though psychotherapy usually takes a long time, for example, psychoanalysis may take up to 2–5 years (Ruangtrakool, S., 1999: 232–233). This is a long period so the caregivers must explain to the patient and make them understand the process, give encouragement, cooperate with the doctors at times when they are involved, and help in any possible way, such as taking the patient to their doctor's appointment.

3. Milieu therapy is a therapy that focuses on positive environmental manipulation. It is done by management of an environment with materials and people that

creates an atmosphere that will promote a change in the patients ideas, attitudes and behavior (Sukothaithammatrirat, 1985 :1175 – 1210).

When patients return to their families and community, caregivers must care for and arrange activities for the patient to prevent them from feeling ill all the time by providing them with daily activities according to their capability, assign them to be responsible for some work in order for them to show their capability and be accepted as a member of the family and community.

4. Behavioral therapy: this model focus on modifying and changing specific observable disfunctional patterns of behavior by means of stimulus-and-response. Therefore old learning must be erased and correct learning should be replaced (Wongsaroj, P., in Tuntiplachiva, K.,Ed., 1993:159).

Therefore, what caregivers can do is support the patient in learning correct and appropriate behavior and complimenting or rewarding them for their correct behavior. This will help patients to learn correctly and adjust appropriately. When patients behave inappropriately, such as not taking care of personal hygiene, caregivers should act as a role model for patients to imitate.

Psychiatric Rehabilitation

When patients have been treated until their mental illness or mental health has recovered or improved so that they are able to return to their community, revival of their abilities is very important (Otrakul, A.,1995:21). Revival of physical and mental abilities of patients who have been treated and improved will enable them to proceed with their lives and with others in the community without their illness relapsing again.

Psychiatric rehabilitation means the development of the process of the body, mind, emotions, or learning, and development of the self in order to fully use one's ability to adjust to society, proceed with life, and live independently. Rehabilitation of all parts must be done simultaneously in line with the principles of rehabilitation as follows: (Thamaroj, K.and Nuttarangsee, J., 1995:29–30).

The principles of rehabilitation.

- Physical rehabilitation is rehabilitation using doctor's principles such as physical therapy and activities promoting movement of body parts, such as exercise, walking, and running.

- Mental rehabilitation is rehabilitation of patients to learn how to control their emotions and feelings though verbal and nonverbal communication. It involves the acknowledgement of feelings, deciding, ordering, and expressing emotions according to feelings.

- Social rehabilitation means rehabilitation though the use of past experience in order to adjust into a community and improve relations with others, especially members of the family.

- Occupational rehabilitation is being advised together with skills development for either an old or new job, in order for the patient to feel proud of being independent.

- Community rehabilitation is used for patients to practice skills in expressing themselves with others. It also involves practicing the control of one's emotions for acceptance, and adjusting the body and mind for proceeding with one's life and in an environment appropriate with the patients environment and lifestyle. Moreover, it practices wording and expressing while with others in society, living normally as a member of society and depending on oneself.

Caregivers can help patients after returning home as follows :

- In the part of physical rehabilitation, caregivers should have the patient take care of his/her daily needs by his/herself, exercise, and participate in activities that promote movement, as in sweeping, mopping, cooking, and watering plants.

- In the part of mental rehabilitation, the most important thing is to try to understand the patient, accept their illness, encourage them in doing activities, and compliment their behavior. Express decisions and emotions appropriately, do not express aversion, provide love and understanding, which will make patients feel like a member of the family.

- In the part of social rehabilitation, as patients return to the community, caregivers should encourage activities with others in society and should teach them about manners and skills in society. Activities that patients should take part in are social activities, going outside of the house, and visiting members of society. Neighbors should be asked not to tease the patient.

- In the part of occupational rehabilitation, in cases where the patient does not have a stable career, caregivers should have patients perform work at home or assign work that patients are able to do such as cleaning, washing clothes, caring for a pet, and gardening. When patients need to search for jobs, caregivers should advise the patient on how to choose the right job after consideration of the patient's interests and skills. Estimation of the patients abilities, tolerance, and ability to work with others must be made. While patients work, they may encounter various problems. Caregivers should help, advise, and encourage the patients.

- In the part of community rehabilitation, caregivers should encourage patients to participate in activities with the family and community, such as playing a part in society as seen to be appropriate, as father, mother, husband or wife, and bring patients to charity and traditional festivals, for instance.

It is apparent that caregivers play an important role in being responsible, and caring for, and rehabilitating the patient when they return to the community, in order to prevent frequent returns for treatment. The most important factor that caregivers must consider when caring for patients are as follows. (Sritanya Hospital, 1993 : 19 – 20, 33).

1. Patients should take medication according to the doctors orders, even though the patient condition seems to have returned to normal, in order to prevent symptoms from returning.

2. Have the patient see the doctor according to their appointments.

3. Patient should avoid drugs, alcohol or hashish and avoid working with machinery (driving cars or boats).

4. If the patient can not sleep, the patient should avoid sleeping too much during

the day. Find work for the patient to do or have them exercise or allow them to do what they want freely. However if changing of activities does not work, discuss it with the doctor.

5. If the patient is obsessed, get angry easily, has mood swings, or is depressed, the cause should be found, possibly drugs, daily activities and things that have an impact on the mind, society, environment, and caregivers should carefully monitor these signs.

6. Caregivers should not force or spoil the patient much. They should explain rationally for patients to understand, instead of deceiving them because it will result in a lack of trust which will affect further treatment.

7. Caregivers should pay attention to and notice abnormal conditions of thoughts, emotions, and behavior, and bring patients to a psychiatric hospital or clinic immediately if these conditions are noticed.

7.1 Signs and behaviors of the patient which change from the original condition. such as being overly talkative, overly depressed, refusing to talk, being isolated, having poor hygiene, causing a disturbance or being aggressive should be noted.

7.2 Hallucination and delusion, such as hearing noises, talking to no one, laughing with no one, with delusion and paranoia of being harmed should also be noticed.

This correct knowledge and understanding is of great importance because the fact these caregivers possess the knowledge and understanding about mental illness and the treatment and rehabilitation after the patient returns home will help the patient receive warm care that will enable a patient to live with the family and community happily, and will also prevent frequent returns to the hospital.

2. Attitudes of Caregivers toward Mental Illness

Definition of Attitude

Opinion or attitude has an original root from latin, aptus meaning bend, and there have been people who have defined it as :

Allport (1976 : 3) Attitude is the state that the mind is ready, which is a result of

experiences. This state of readiness is the strength that directs an individuals reaction towards a related individual, thing, or place.

Rokeach (1970 : 112) Attitude is the mixture and the organization of a person's beliefs towards something or a situation, which is the result of beliefs according to their meaning. The result of beliefs is what directs how someone will react, favorably or unfavorably.

In conclusion, attitude is the result of feeling of thought that stimulates a bias in behavior; therefore, behavior is the expression of attitude, which is a result of knowledge, thoughts, beliefs, and the background learning of an individual.

The Source of Attitude

Allport (1976: 180) concluded the source of attitudes as follows:

1. Learning about culture and traditions of society, and using the knowledge as a fundamental basis for attitude.

2. Separation of knowledge and personal experience, for example, children who have been raised up well usually will be optimistic.

3. Past experience of extremes of good or bad, for example, a person with a certain characteristic who you have hated, will cause you to hate another person with the some characteristic.

4. Imitation as in children imitating their parents when the parent have an attitude on a certain person or place, children will also have the some attitude.

Characteristics of Attitude

Lasuwong K.(1985) stated the characteristic of attitude are:

1. Attitude is a product of learning or experiences, which is not inborn.

2. Attitude is the index that directs behavior. For example, if there is a positive attitude towards something, behavior will be positive. On the other hand, if attitude is negative or against something, it will be expressed in negative behavior.

3. Attitude can be passed on from one to another, for example, parent's dislike someone usually bends the children to dislike the person also.

4. Attitude can be changed due to the fact that attitude is a result of teaching or experience. If learning and experience changes, attitude can change too.

It is apparent that attitude is the stimulant to a certain behavior, which has resulted from learning and it results in feelings of like or dislike towards something. Moreover they can be passed on from one to another, and can be changed.

Elements of Attitude

Traidis (1971:2-3); Suwan, P. (1983:1-5) stated about three elements of attitude.

1. Knowledge and understanding is about beliefs and reaction towards something, whether it be positive or negative.

2. Feeling is about the emotions and personal favors which differ in each individual, causing different positive and negative attitudes.

3. Behavior is readiness or the trend to which an individual will express his/her attitude toward something, either ready to help or not. Attitude is the state of readiness of the mind, which includes thoughts, feelings, and the trend of individuals to react towards stimulants and situations in a favorable or positive, or unfavorable or negative way (Kamolrat,1991;Patcharee,1981). Attitude is created from personal learning and experience and attitude influences thoughts and the direct behavior of reactions of individuals (Path, 1982 refered to in Napapansakul M., 1996: 37–38). Apart from these, attitude can be changed depending on knowledge and understanding. As attitude changes, it will affect behavior afterwards (Zimbardo, et al.,1977:53). Therefore, for an individual to have good behavior and perform well, he/she must possess good attitude. In caring for psychiatric patients, it is also true. If caregivers possess a good attitude towards illness and patients, it will usually result in good care for the patient.

The caregiver's attitude towards mental illness is created from a mixture of experience, beliefs, various traditions, teachings, up bringing, and other elements as a

whole, and some things that are inseparable. These elements will affect both positively and negatively an individual behavior and reaction towards mental illness, care and treatment, and the mental patient. That is, if the caregivers possess a positive attitude, the caregiver will feel that they want to care, want to get close, and have no aversion towards the patient. However, if vice versa, the caregiver will possess aversion and will be embarrassed in caring for the patient. The attitude of caregivers then, must be able to support or be able to win their desire and direct their behavior in caring.

In cases where abnormalities arise, members of the family are the first people to acknowledge and interpret the signs through beliefs and knowledge of health and illness. The community then will be influential in deciding what service to use, and which method of treatment, until the process of treatment is completed (Muangwut, K., 1994:9). From the study of anthropology about illness and hospital treatment, there are beliefs about the causes of mental health problems and insanity in the present that can be grouped into three characteristics (Meesup, K., 1989: 87–92)

The first characteristic indicates that mental health problems arise from supernatural powers. It is believed that worries resulting in insanity are derived from the activities of ghosts or just from destiny. Treatment of such illness is, if it is the result of a ghost will be performed according to beliefs, by making offerings for the ghosts to leave and asking for forgiveness. If the ghosts do not leave, usually evil ghosts, they will be driven away by witch doctors and/or other rituals.

The second characteristic suggests that mental health problems arise from preternatural (unnatural) powers. It is believed that worries until the onset of insanity come from complicated powers like sorcery difficult to explain through reason. Treatment of such illness is done though sorcery, such as visits to witch doctors to cleanse sins. As for prevention of such powers, they mostly rely on Buddhist/religious artifacts such as amulets.

The third characteristic believes that mental health problems arise from natural powers, which are not complicated and can be explained. For example, it is believed that

there is an imbalance of mind in the body. Also, it is believed that hashish can cause insanity. Moreover, worry can also be passed on through heredity, loss, parting or loss of a loved one or unexpected events that can cause the mind to be restless until insanity occurs.

These beliefs will make most caregivers search for the right treatment according to their beliefs, such as seeing witch doctors and sorcerers for care, or if the belief is in karma, there will be no treatment at all, which is a reason why some patients do not receive any correct treatment. This leads to severe symptoms, and until a doctor is seen, the disease could worsen and become chronic.

It is apparent that a change in beliefs, which have been passed on or/and learned from the past, must give correct knowledge and experience and must be appropriate for the community with the basis of learning, and that human beings tend to search for the best things in life for themselves. As knowledge is correctly organized and effective, people tend to change their beliefs and behaviors, especially regarding knowledge on changing beliefs about the causes, treatment, and correct care that caregivers can give patients.

Therefore the attitude of caregivers toward mental illness is what measures the behavior in caring by the caregiver. If a caregiver possesses a positive attitude, they will be able to care for the patient immediately in emergencies and take them to the hospital. The patient is then able to return home quickly and is able to live a normal happy life.

3. Caregiver–Patient Relationships

Relationship is an English word, where the meaning has been given as bonds and relations.

Relationship is a form of interaction between individuals. The product is not a thing, but good feelings towards each other, or it could be said that relation is the process that arises between individuals, in which this process slowly and gradually happens continuously. (Israngkul Na Ayutthaya, K., 1995: 98).

Rosenthat (1973: 201) has given the limited meaning of relationship that it is a form of interaction between 2 people with the product of feelings towards each other, rather than a thing.

Relationship means the relating process of an individual, or more getting to know each other, keeping in touch, building familiarity and intimacy. Each individual will be affected by the other.

Having a member of the family ill will have an impact on other members (Friedman,1986), especially in relationships, such as in cases of chronic disease, the patient will possess negative feelings and emotions, depression, anger, discomfort, frustration, worry, despair, and be afraid of isolation which is an obstacle in building a relationship with others, except for those who love, care, and understand the patient and are willing to face their emotions. (Suwankut, K., 1987: 151)

Therefore, the relationships between a caregiver and patient is a relation, a bond that caregivers and patients should have. It is built from love, understanding, care, respect, and exchange of ideas.

Psychiatric diseases are capable of destroying a family. They are able to affect a relationship in a negative way. When a member of the family gets ill, the family usually feels it is their fault and takes responsibility (Kittiratanapaibul P.,1997:31) by caring for the patient. Morse et al., (1990 referred in to Sucharitkul, S.,1998) stated that care is expressing the relationship between individuals. Caring is the feeling and behavior that arises when individuals are related. This kind will happen with family members or close friends.

From the study by Kotmon, T.and Paolohit, S.(1995), it was found that those who bring patients to receive treatment are mostly those closest with parents being 60 % and siblings being 24 %. The fact that parents and siblings are the most people who most usually bring patients for treatment is probably because they are closest and the illness has probably affected these members. It was found that when a member has a mental problem, other members must adjust too, due to the bond in the family society, which is

influential towards each members mind.

There are many kinds of relationship:between parent–child, husband – wife, friend–friend, treator–treatee, or nurse–patient. (Boontong, T., in Sukothaithammatrirat, Ed.,1985:949)

The relation between individuals, are grouped into 2 characteristics which are the relatives–group, husband, wife, children, and relatives, and the non–relative group: friends, neighbors, co–workers (MacElveen 1978: 327 referred to in Keawprom, Ch., 1987: 5).

Elements of Relationships

Crandall (1980: 410–411) stated that relations in the family are primary relationships which include the following elements :

1. Number of roles. Relations in the family include many roles such as parents being the people who teach, raise and help members of the family in many way, and this results in interests in favorites, beliefs, until one's real self is recovered.

2. Communication. The relation of a primary group is open communication with free discusion, and exchange of ideas and with an open mind.

3. Emotional. The relation of a primary group or family is built from various emotions between members, to create love, understanding, and a bond.

4. Transferability. This relation will certain occur. It can not be easily transferred. It is relations with an individual at a time with sincere feeling, and it is hard to change.

Keawprom, Ch. (1987: 45) has referred to this idea about good relationships in society with the following elements.

1. Closeness, which makes an individual feel warm and soft, is provided by the family member, and can be received in relationships of married couples, friends, sibling, and parents.

2. Contribution to society is expressed by being a part of other individuals and creating exchanges of ideas, news, thoughts, experiences, and admiration towards each

other. Not being a part of society will make the person hated by society. This kind of relation is usually found in groups of friends.

3. Behavior of responsibility, such as father–mother caring for their young child, and an adult child caring for his aging father–mother, and a stronger person looking after a weaker person. If individuals do not perform their duty, then discomfort, incompleteness, emptiness, and disorientation will be felt by the individual.

4. Acceptance will occur when individuals are able to act in various ways according to what is appropriate. These roles may be roles in the family or in a career. Acceptance makes the person receiving it confident, accepted, and respected. If it does not occur, confidence will decrease.

5. Helping means helping, in various ways, those who have relations with each other and will provide help.

From the elements of a relationship in a family and the factors that are the factors of good relations, it can be concluded that relations or relationships between relative caregivers and psychiatric patients must have the following elements:

1. Helping and considering for each other means the help, both material and mental given to patients, such as being interested in patients' happiness, giving information and advice and actual financial help.

2. Sharing common family activities means sharing the daily activity among caregivers and patients.

3. Accepting each other means respecting the patient's rights and human dignity.

4. Communicating and sharing ideas and experiences with each other means constantly sharing ideas and experience among caregivers and patients.

5. Avoiding contradicting each other means making sure that both the caregivers and patients are cooperative and agreeable.

6. Loving and caring for each other means showing love and being concerned with each other.

The study by Yosthammasanee, W.et al. (1995), it found that in communicating,

members of the family who communicate in a hostile tone of voice, and members who are usually silent when dissatisfied, which is considered incorrect communication, may cause the patient to return to hospital for treatment. It was also found that if members help, trust, and love each other, and parents equally love their children, patients will not need to return for treatment frequently. Moreover, in the study by Nitikul, W.(1992) about stress in relatives of psychiatric patients, it was found that relatives are distressed about the altered relationship in the family such as members feeling aversion towards the patient, and members not accepting the patient's abnormal behavior, and members feeling that caring for the patient is an intrusion in their life. T. Skul, J.(1981) found that those patients who frequently return for treatment are unable to live normally and happily with families. They feel that members do not understand and do not accept them.

It is apparent that good relations between caregivers and patients will help the patients live happily in society. If not, patients are unable to live in society outside hospitals and will tend to return to hospitals for treatment frequently.

Possessing correct knowledge and understanding, good attitude on mental illness, and treatment, and good relations between the caregivers and patients will positively affect the care for a patient. This will enable the patient to live with their family, in the community, and society with happiness without having to frequently return to psychiatric hospitals for treatment.

CHAPTER III
Materials and Methods

This research will study the knowledge and attitudes toward mental illness of relatives of psychiatric patient who are their caregiver, and also the relationship between caregiver and psychiatric patient, it is study caregiver of psychiatric patient in the central region psychiatric hospitals.

Population Characteristics and Sampling Group

Population

The population used in this study were caregivers of psychiatric patients who were fathers, mothers, spouses, children, brothers, sisters, or close relatives and were most directly taking care of the patients and had brought psychiatric patients to the Somdet Chaopraya Hospital and Sritanya Hospital. The patients were admitted and diagnosed as having Schizophrenia, Mood (affective) disorder, Mental and behavioral disorder due to psychiatric substance uses, or Psychosis.

Sampling Group

The accidental sampling method was used in this study. The sample size was estimated by using the formula developed by Yamanae (cited by Kypredarborisuthi, B. 1997:111-112).

$$n = N/(1+N(e)^2)$$

where

n = desired sample size;

N = the number of desired population members;

e = five percent error.

$$n = 12327/(1+12327\times(0.05)^2) = 387$$

The sample size used was 387. Therefore, in collecting samples, the total number of 390 persons were selected from the Somdet Chaopraya Hospital and Sritanya Hospital. The sample size of each hospital was calculated by:

Each sample size = N×number of psychiatric patients in each hospital/total number of psychiatric patients

The sample size from the Somdet Chaopraya Hospital = 390×5073/12327 = 160.

The sample size from the Sritanya Hospital = 390×7254/12327 = 230.

Research Instruments

The instruments used in collecting data consisted of:

1. Demographic data about caregivers such as age, gender, education, religion, family status, relationship with patients, family members, occupation, caregivers income, family income, residence.

2. Demographic data about psychiatric patients such as age, gender, diagnosis, number of admissions to the hospital, the type of first abnormal symptoms, the time frame of onset of abnormal symptoms prior to admission, the severity of symptoms which made caregivers decide to take the patients to the psychiatric hospitals, the time from the beginning of abnormal symptoms until the time of the decision to take the patients to the hospitals.

3. Questionnaires about knowledge of caregivers concerning mental illness. These questionnaires were developed by reviewing the literature and related research. Each questionnaire consists of 4 types of questions, 29 items in total. The first type of question is about causes of mental illness. There are 5 items of this type. The second type of question is about psychiatric symptoms. There are 7 items of this type. The third type of question is about treatments. There are 10 items of this type. The fourth type of question is about caring for and improving the rehabilitation for psychiatric patients. There are 7 items of this type.

Elements of the questionnaires consisted of 23 correct statements (No. 1–10, 12–15, 17,18, 20-23, 26-27, and 29) and 6 incorrect statements (No. 11, 16, 19, 24, 25, 28). Samples can answer questionnaires with "true", "false", or "unknown".

"true" means that caregivers agree with the statements.

"false" means that caregivers do not agree with the statements.

"unknown" means that caregivers do not know whether the statements are true or false;

In answering the questionnaires, the samples were allowed to answer freely according to their knowledge and understanding by using the following criteria.

If the answer is correct then one point was added;

If the answer is wrong then no point was added;

If the answer is unknown then no point was added.

Thus the minimum score is 0,and the maximum score is 29. The interpretation of the data of knowledge and understanding of caregiver about mental illness followed the following criteria.

Above 80 % of possible points means that the caregivers have good knowledge and understanding about mental illness;

Between 60 –80 % of possible points means that the caregivers have moderate knowledge and understanding about mental illness;

Below 60 % of possible points means that the caregivers have poor knowledge and understanding about mental illness.

4. Questionnaires about attitudes of caregivers toward mental illness. The researcher developed these questionnaires by reviewing books, articles, and related research. There are 26 items and 5 types of questions which are: attitudes toward mental illness and psychiatric patients (9 items, No.1-9); attitudes toward causes of mental illness (4 items, No.10-13); attitudes toward treatments (5 items, No.14-48); and attitudes toward living with and caring for psychiatric patients (8 items, No. 19-26). These questionnaires contain 9 items with positive meanings (No. 1, 3, 7, 8, 13, 14, 16, 19, 21) and 17 items with negative meanings (No. 2, 4-6, 9-12, 15, 17, 18, 20, 22-26). There are 4 rating scales for the questionnaires as follows:

"strongly agree" means that caregivers strongly agree with the questions;

"moderately agree" means that caregivers moderately agree with the questions;

"less agree" means that caregiver less agree with the questions;

"disagree" means that caregivers do not agree with the questions.

Samples were free to answer the questionnaires according to their feelings and beliefs. The questionnaires were weighted by assigning the following points.

For positive meaning statements:

"strongly agree" is equivalent to 4 points;

"moderately agree" is equivalent to 3 points;

"less agree" is equivalent to 2 points;

"disagree" is equivalent to 1 point.

For negative meaning statements:

"strongly agree" is equivalent to 1 point;

"moderately agree" is equivalent to 2 points;

"less agree" is equivalent to 3 points;

"disagree" is equivalent to 4 points.

The minimum score is 1, and the maximum score is 4. The interpretation of attitudes of caregivers toward mental illness was based on the following criteria:

$\overline{X}$ score 3.00-4.00 means that caregivers have good attitudes toward mental illness ;

$\overline{X}$ score 2.00-2.99 means that caregivers have moderate attitudes toward mental illness;

$\overline{X}$ score1.00-1.99 means that caregivers have poor attitudes toward mental illness.

5. Questionnaires about caregiver-patient relationships. The researcher designed these questionnaires based on the ideas concerning factors affecting family relationships (Crandall, 1980:410-411) and good relationships in societies (Weiss referred in Kaewprom, Ch.1987: 45). The questionnaires contain 25 items which are classified to 6 types:

- Helping and considering for each other contains 5 items (No. 1-5);
- Sharing common family activities contains 5 items (No. 6-10);
- Accepting each other contains 6 items (No. 11-16);
- Communicating and sharing ideas and experiences with each other contains 3 items (17-19);
- Avoiding contradicting each other contains 3 items (No. 20-22);

- Loving and care for each other contains 3 items (No. 23-25).

The questionnaires contain both positive and negative meanings. Positive meanings have 22 items (No. 1-2, 14, 15, 17-19, 21-25). Negative meanings have 3 items (No. 13, 16, 20. The answers were classified into 4 rating scales as follows:

"often" means that caregivers think or behave almost every time;
"moderately often" means that caregivers think or behave sometimes;
"rarely" means that caregivers rarely think or behave;
"never" means that caregivers never think or behave.

In answering the questions, samples were free to answer the questions according to their ideas and behaviors. The answers were weighted according to the following criteria:

For positive meanings:

"often" is equivalent to 4 points;
"moderately often" is equivalent to 3 points;
"rarely" is equivalent to 2 points;
"never" is equivalent to 1 point.

For negative meanings:

"often" is equivalent to 1 point;
"moderately often" is equivalent to 2 points;
"rarely" is equivalent to 3 points;
"never" is equivalent to 4 points;

The minimum score is 1, and the maximum score is 4 . Interpretation of the caregiver-patient relationships was based on the following criteria:

$\overline{X}$ score 3.00-4.00 means that caregivers have good relationships with psychiatric patients;
$\overline{X}$ score 2.00-2.99 means that caregivers have moderate relationships with psychiatric patients;
$\overline{X}$ score 1.00-1.99 means that caregivers have poor relationships with psychiatric patients.

Validation of Research Instrument

The research instruments were validated by two professors of psychiatric nursing and one qualified nurse in a psychiatric hospital. After being considered by the experts, the questionnaires were corrected according to their ideas and suggestions to improve the relationship between the question context and the desired information, clarify the questions, and provide more appropriate order of questions and ensure appropriate language usage.

Reliability

The questionnaires about (1) knowledge of caregivers about mental illness; (2) attitudes of caregivers toward mental illness; (3) caregiver-patient relationships were tested with 30 samples and the results were calculated for reliability. The reliability of questionnaires about knowledge of caregivers in mental illness was calculated by using Kuder-Richardson's equation (KR-20) Ruechar, Y. et al., (1997:124):

$$\text{KR-20:} \qquad r_{tt} = (n/(n-1)(1-\sum pq/s_t^2)$$

where

r_{tt} = reliability coefficient of the questionnaires;

n = the number of questions in each questionnaire;

p = the proportion of samples who gave correct answers;

q = the proportion of samples who gave wrong answers;

s_t^2 = variance of all points obtained by the samples.

The reliability of the questionnaires about attitudes of caregivers toward mental illness and about caregiver-patient relationships were calculated by using Cronbach's Alpha Coefficient which is described below (Ruechar, Y.et al., 1997:122-129)

$$\alpha = (n/(n-1)(1-\sum s_i^2/s_t^2)$$

where

α = reliability coefficient of the questionnaires;

n = the number of questions in each questionnaire;

s_i^2 = variance of all points in each question.

s_t^2 = variance of all points obtained by the samples.

Results of the reliability of the questionnaire are:

1. Knowledge of caregivers about mental illness has reliability of 0.77;
2. Attitudes of caregivers toward mental illness has reliability of 0.86;
3. Caregiver-patient relationships has reliability of 0.82.

Collecting Data

The researcher collected data in the following orders:

1. The researcher requested for an introduction letter from the Graduate School to send to the Directors of Somdet Chaopraya Hospital and Sritanya Hospital. The letter was necessary in order to receive cooperation in collecting data. The time for collecting data was set for every weekday during official hours.

2. After being approved, the researcher introduced herself to the head of the outpatient and inpatient department and described the details of collecting data. Then the researcher started collecting the data.

3. The researcher selected psychiatric patients who were diagnosed by a psychiatrist as experiencing psychiatric disorders and were admitted as inpatients of the hospitals. The selection was made by studying the patients' OPD card at inpatient and outpatient admission unit, then sampling the caregivers who had admitted the patients and who had the characters described.

4. The researcher introduced herself to the samples and developed a good relationship with them at an appropriate room or place. Then the researcher explained the purpose of this study and explained the rights of the samples about participating in this research before they made a decision.

5. After receiving the cooperation of the samples, the samples answered the questionnaires without any time limitation, and they were allowed to ask additional questions.

6. After obtaining 390 samples, the researcher graded the responses to the questionnaires according to the criteria and then analyzed the results by using statistical methods.

Data Analysis

The researcher analyzed the data obtained in the following orders:

1. Demographic data about caregivers and psychiatric patients was analyzed by frequency distribution and percentage.

2. The number and percentage of caregivers who gave correct answers on the knowledge of caregivers about mental illness was calculated and classified according to the items.

3. The mean and standard deviation of points indicating attitudes toward mental illness and caregiver-patient relationships in total was calculated and classified according to the questionnaire types and items.

CHAPTER IV

Results

The research study was a descriptive research to explore knowledge and attitudes toward mental illness and caregiver-patient relationships. It was a study of the caregivers of psychiatric patients in the central region psychiatric hospitals. The sample size of 390 was selected from caregivers who had admitted patients to Somdet Chaopraya Hospital and Sritanya Hospital as inpatients. The results were analyzed and presented with descriptions in the following order.

1. Demographic data about caregivers;
2. Demographic data about psychiatric patients;
3. Knowledge of caregivers about mental illness;
4. Attitudes of caregivers toward mental illness;
5. Caregiver-patient relationships;

1. Demographic Data about Caregivers;

Table 1. Number and percentage of caregivers classified according to age, gender education, religion, family status, relationship with patients, family numbers, occupation, caregivers income, family income, and residence.

Characteristics of caregivers	Number (n=390)	Percentage
Age (years)		
Below 21	7	2.1
21-40	113	26.1
41-60	211	57.3
Above 60	59	14.5
Gender		
Male	143	36.7
Female	247	63.3
Education		
No education	35	9
Primary level	247	50
Highschool or vocational certificate level	92	23.6
Higher than highschool level or Vocational diploma	68	17.4
Religion		
Buddhism	370	94.9
Islam	10	2.6
Christian	8	2.1
Others	2	0.5
Family status		
Family head	244	62.6
Family member	146	37.4
Relationship with patients		
Father or mother	177	45.4
Spouse	67	17.2
Brother or sister	89	22.8
Son or daughter	34	8.7
Relative	24	5.9
Family numbers (persons)		
1- 3	113	29
4 – 6	219	56.2
7 – 9	44	11.3
> 9	14	3.6

Table 1 (cont.)

Characteristics of caregivers	Number (n=390)	Percentage
Occupation		
House keeper	25	6.4
Vendor	82	21.0
Government employee	48	12.3
Unemployed	80	20.5
Employee	123	31.5
Student	3	0.8
Farmer	29	7.4
Caregivers' income (baht)		
≤ 5,000	217	55.6
5,001-10,000	94	24.6
10,001-15,000	26	6.7
15,001-20,000	8	2.1
> 20,000	45	11.5
Family income (baht)		
≤ 5,000	128	32.8
5,001-10,000	119	30.5
10,001-15,000	31	7.9
15,001-20,000	4	1.0
> 20,000	108	27.7
Residence		
Central	306	78.5
Northern	34	8.7
Northeastern	36	9.2
Southern	14	3.6

From Table 1, it is found that the largest number of caregivers were aged between 41-60 years old (57.3%). Most of them are female (63.3%) and their education is in the primary school level (50%). The largest number are Buddhist (94.9%). Most of the caregivers are family heads (62.6%), and they are fathers or mothers of the psychiatric patients (45.4%). Most of the caregivers have their family number between 4-6 persons (56.2%). Most caregivers are employees (31.5%). Most caregivers have an income equal to or less than 5,000 baht/month (55.6%). Family income is equal to or less than 5,000 baht/month (32.8%). The largest number of the caregivers have their residences in the central regions (78.5%).

2. Demographic Data about Psychiatric Patients;

Table 2 Number and percentage of the psychiatric patients classified according to age, gender, diagnosis and number of admissions to the hospital.

Characteristics of psychiatric patients	Number (n=390)	Percentage
Age (years)		
Below 21	11	13.1
21-40	109	55.4
41-60	211	24.4
Above 60	59	7.2
Gender		
Male	222	56.9
Female	168	43.1
Diagnosis		
Schizophrenia	274	70.3
Mood (affective) disorder	50	12.8
Substance induced psychosis	32	8.2
Psychosis	34	8.7
Number of admissions to the hospital		
First	130	33.3
Second	72	18.5
Third or more	188	48.2

From Table 2, it is found that most of the psychiatric patients are aged between 21-40 years (55.4%), and male (56.9%). 70.3% of psychiatric patients are diagnosed as being schizophrenic, and for most psychiatric patients it is their third or more admission in the hospital (48.2%).

Table 3 Number and percentage of the psychiatric patients, classified according to the type of first abnormal symptoms. Abnormal symptoms were classified by Ruangtrakool, S. et al., (1999:1-6).

Abnormal symptoms	Number (n=202)	Percentage
The type of first abnormal symptoms. (Each patient has one or two symptoms)		
-Disorders of motor activity	99	49.01
-Disorders of affect	93	46.04
-Disorders of form of thought	65	32.18
-Disorders of content of thought	60	29.70
-Disturbance of consciousness	56	27.72
-Disorders of perception	19	9.41
-Disorders of memory	10	4.95

From Table 3, it is found that caregivers had noticed abnormal symptoms that appeared for the first time. It was also the first time that they brought the patients to the hospitals as inpatients. After interviewing 202 caregivers, it was found that they could identify one or two abnormal symptoms that happened for the first time for each patient. The largest number of abnormal symptoms was disorders of motor activity, at 49.01% , such as insomnia, walking around continually, mutism, refusing to wash the body and eat food, in selecting appropriate clothing to wear, escaping from home, and cleaning or sleeping whole day. The second most common was disorders of affect at 46.04%, such as laughing or crying without reason, social isolation, aggressively, destroying materials, harming themselves, headache. The third most common was disorders of form of thought at 32.18%, such as talking to themselves, uncontrolled talking, meaningless talking, and neologism. The fourth most common was disorders of content of thought at 29.70%, such as delusion of persecution, delusion of jealousy, delusion of grandeur, delusion of reference, and delusion of being controlled. The fifth most common was disturbance of consciousness at 27.72%, such as confusion and clouding of consciousness. The sixth most common was disorders of perception at 9.41%, such as auditory hallucination

and visual hallucination. Finally, disorders of memory was at 4.95%, such as psychogenic amnesia and confusion of memory.

Table 4 Number and percentage of the psychiatric patients, classified according to the time frame of onset of abnormal symptoms prior to admission.

Duration	Number (n=202)	Percentage
Time frame of onset of abnormal symptoms Prior to admission.		
1 week	69	34.16
2 weeks	-	-
3 weeks	-	-
1 month	-	-
2 - 6 months	62	30.7
7-12 months	46	22.79
>1 year	25	12.38

From Table 4, it is found that the largest number of psychiatric patients (34.16%) acquired abnormal symptoms 1 week before they were first admitted to hospital.

Table 5 Number and percentage of the psychiatric patients, classified according to severity of symptoms which made caregivers decide to take the patients to the psychiatric hospitals. Abnormal symptoms were classified by Ruangtrakool, S. et al., (1999:1-6).

Abnormal symptoms	Number (n=390)	Percentage
The severity of symptoms which made caregivers decide to take the patients to the psychiatric hospitals. (Each patient has one or two symptoms)		
-Disorders of affect	279	71.54
-Disorders of motor activity	213	54.62
-Disorders of content of thought	97	24.87
-Disorders of form of thought	75	19.23
-Disturbance of consciousness	49	12.56
-Disorders of perception	40	10.26
-Disorders of memory	12	3.08
-Others	8	2.05

From Table 5, it is found that caregivers had noticed the severity of symptoms for each patient and that had make them decide to take the patient to the hospitals. This data was obtained by interviewing 390 caregivers, and it was found that they could identity one or two symptoms. The largest number of patients at 71.54% showed disorders of affect, such as harming others, destroying materials, being aggressive, harming themselves, isolating themselves, laughing or crying without reason, inappropriate affect, and euphoria. The second most common was disorders of motor activity at 54.62%, such as insomnia, escaping from home, mutism, refusing to wash the body and eating food the whole day. The third most common was disorders of content of thought at 24.87%, such as delusion of persecution, delusion of grandeur, delusion of jealousy, and delusion of reference. The fourth most common was disorders of form of thought at 19.23%, such as talking to themselves, uncontrolled talking, meaningless talking, and neologism. The fifth most common was disturbance of consciousness at 12.56%, such as confusion and

clouding of consciousness. The sixth most common was disorders of perception at 10.26%, such as auditory hallucination and visual hallucination. The seventh most common was disorders of memory at 3.08%, such as psychogenic amnesia. Finally, other disorders were at 2.05%, such as zoophilia and regression.

Table 6 Number and percentage of the psychiatric patients, classified according to the time from the beginning of abnormal symptoms until the time of the decision to take the patients to the hospitals.

Duration	Number (n=390)	Percentage
The time from the beginning of abnormal symptoms until the time of the decision to take the patients to the hospitals.		
1 week	252	64.6
2 weeks	32	8.2
3 weeks	17	4.4
1 month	40	10.3
2-6 months	31	7.9
7 -12 months	18	4.9

From Table 6, it is found that most psychiatric patients (64.6%) were taken to hospital 1 week after the commencement of abnormal symptoms.

3. Knowledge of Caregivers about Mental Illness;

Table 7 Number, percentage and interpretation of knowledge of the caregivers about mental illness.

Knowledge of caregivers	Number (n=390)	Percentage	Interpretation
Above 80% of possible points (23-29 score)	282	72.3	good
Between 60-80%of possible points (18-22score)	94	24.1	moderate
Below 60% of possible points (0-17 score)	14	3.6	poor

From Table 7 , it can be seen that most caregivers (72.3%) have good knowledge about mental illness and scored more than 80% of possible points. 24.1% of caregivers have moderate knowledge about mental illness. The numbers of caregivers who gave correct answers of less than 60 % was only 3.6%.

Table 8 Number and percentage of caregivers who gave correct answers on the knowledge about mental illness, based on causes of mental illness.

Knowledge of caregivers	Correct answers (n=390)	Percentage
Causes of mental illness		
-Disappointment from education, occupation, or love can cause mental illness.	359	92.1
-Addictive substances such as amphetamines, marijuana, heroin, whisky, or other addictive substances can cause mental illness.	340	87.2
-Poverty; prolonged social problems can cause mental illness.	335	85.9
-Mental illness occurs due to abnormality of chemical substances in the brain .	202	58.1
-Mental illness is due to heredity.	192	42.9

Table 8, shows most caregivers (92.1%) have correct answers on the knowledge about the causes of mental illness regarding disappointment from education; occupation, or love can cause the mental illness. Caregivers (42.9%, and 58.1%) have correct answers on the knowledge regarding (1) mental illness is due to heredity, and (2) mental illness occurs due to abnormality of chemical substances in the brain, respectively.

Table 9 Number and percentage of the caregivers who gave correct answers on the knowledge about mental illness, based on psychiatric symptoms.

Knowledge of caregivers	Correct answers (n=390)	Percentage
Psychiatric symptoms		
-Psychiatric patients usually are out of reality and unable to control themselves.	378	96.9
-Psychiatric patients have weird, abnormal behavior such as sitting at the same location for a long time or walking for a whole day.	378	96.9
-Psychiatric patients have hallucinations such as seeing what others cannot; seeing what does not exist and hearing strange noises.	374	95.9
-Psychiatric patients often talk to themselves; discontinuous talking; indirect or improper words not understood by others.	367	94.1
-Psychiatric patients have delusion thoughts such as being hurt by others; thinking of being important and powerful persons.	366	93.8
-Psychiatric patients have abnormal affects. They laugh or cry without reasons.	363	93.1
-Psychiatric patients are less interested in the surrounding environment.	183	46.9

Table 9, shows caregivers (96.9%) have correct answers on the knowledge about psychiatric symptoms regarding (1) psychiatric patients usually are out of reality and unable to control themselves, and (2) psychiatric patients have weird, abnormal behavior such as sitting at the same location for a long time or walking for a whole day, respectively. Only 46.9% of caregivers gave correct answers on the knowledge about psychiatric patients having less interest in the surrounding environment.

Table 10 Number and percentage of the caregivers who gave correct answers on the knowledge about mental illness, based on treatments.

Knowledge of caregivers	Correct answers (n=390)	Percentage
Treatments		
-Treatments for psychiatric patients does not take a long time nor involve continuity of treatment.	384	98.5
-Rewarding and encouraging the patients for their proper behaviors will make them repeat those behaviors.	373	95.6
-While having medication, psychiatric patients should not drink alcohol.	372	95.4
-Drugs for mental illness can cause drowsiness.	369	94.6
-Allowing psychiatric patients to be responsible for daily activities by themselves and sharing family activities can help them feel more valuable.	361	92.6
-Treatment by psychotherpy can make psychiatric patients understand themselves and change behaviors.	353	90.5
-Psychiatric patients should not stop the medication if they feel better.	327	83.8
-Drugs for mental illness may cause side effects such as stiff tongue; stiff body; or staring eyes.	313	80.3
-Treatment by using electricity can reduce psychiatric symptoms.	228	58.5
-Treatment by electricity does not cause permanent loss of memories.	118	30.3

Table 10, shows caregivers (98.5%, and 95.6%) have correct answers on the knowledge about treatments regarding (1) treatments for psychiatric patients does not take a long time nor involve continuity of treatments, and (2) rewarding and encouraging the patients for their proper behaviors will make them repeat those behaviors, respectively. Caregivers (30.3%, and 58.5%) have correct answers regarding (1) treatment by electricity dose not cause permanent loss of memories, and (2) treatment by using electricity can reduce psychiatric symptoms, respectively.

Table 11 Number and percentage of the caregivers who gave correct answers on the knowledge about mental illness, based on caring for and improving the rehabilitation for psychiatric patients.

Knowledge of caregivers	Correct answers (n=390)	Percentage
Caring for and improving the rehabilitation for Psychiatric patients		
-Although the patients become normal, they should be checked at every appointment.	381	97.7
-Patients must be trained to do daily activities by themselves.	376	96.4
-Psychiatric patients should have opportunities to think, be rational; and decide matters with family members.	371	95.1
-Allowing the patients to take part in activities such as charity activities and seasonal celebrations helps them adapt themselves to others.	358	91.8
-Psychiatric patients should not stay home and do nothing.	319	81.8
-Psychiatric patients can have any career.	212	54.4
-Psychiatric patients should not be pleased in every matter to prevent stress.	195	50.5

Table 11, shows caregivers (97.7%, and 96.4%) have correct answers on the knowledge about caring for and improving the rehabilitation for psychiatric patients regarding (1) although the patients become normal, they should be checked at every appointment, and (2) patients must be trained to do daily activities by themselves, respectively. Caregivers (50.5% and 54.4%) have correct answers on the knowledge regarding (1) psychiatric patients should not be pleased in every matter to prevent stress, and (2) psychiatric patients can have any career, respectively.

4. Attitudes of Caregivers toward Mental Illness;

Table 12 Mean, standard deviation and interpretation of attitudes of caregivers toward mental illness in total, and classified by category. (n=390)

Attitudes of caregivers	$\bar{X}$	SD	Interpretation
Attitudes toward mental illness in categories			
-Attitudes toward mental illness and psychiatric patients	2.42	0.39	moderate
-Attitudes toward causes of mental illness	2.94	0.68	moderate
-Attitudes toward treatments	3.18	0.44	good
-Attitudes toward living with and caring for psychiatric patients	2.92	0.55	moderate
Attitudes toward mental illness in total	2.80	0.34	moderate

From Table 12, it can be seen that caregivers have moderate attitudes toward mental illness in total aspects ($\bar{X}$=2.80). In consideration of the categories, caregivers have moderate attitudes toward mental illness. These categories are (1)attitudes toward mental illness and psychiatric patients, (2) attitudes toward causes of mental illness, (3) attitudes toward living with and caring for psychiatric patients. There is only one good attitude which is attitude toward treatments.

Table 13 Mean, standard deviation, and interpretation of caregiver's attitudes toward mental illness, based on attitudes toward mental illness and psychiatric patients. (n=390)

Attitudes of caregivers	$\bar{X}$	SD	Interpretation
Attitudes toward mental illness and psychiatric patients			
- Psychiatric patients require a lot of mental support.	3.85	0.41	good
- Mental illness is a kind of illness which can occur to any person at any age.	3.39	0.67	good
- Psychiatric patients are still useful and productive.	2.93	0.83	moderate
- Psychiatric patients are responsible for house work.	2.80	0.92	moderate
- Psychiatric patients are not usually dangerously angry with others.	2.20	1.06	moderate
- Psychiatric patients are not lazy.	2.13	1.09	moderate
- Psychiatric patients have tolerance to problems as much as normal people.	1.60	0.82	poor
- Psychiatric patients are not furious and aggressive.	1.50	0.73	poor
- Psychiatric patients usually do not act according to their desires.	1.35	0.60	poor

From table 13, it can be seen that caregivers have good attitudes toward mental illness and psychiatric patients regarding (1) psychiatric patients require a lot of mental support, and (2) mental illness is a kind of illness which can occur to any person at any age, respectively. There are three items that caregivers have poor attitudes regarding (1) psychiatric patients usually do not act according to their desires, (2) psychiatric patients are not furious and aggressive, and (3) psychiatric patients have tolerance to problems as much as normal people, respectively.

Table 14 Mean, standard deviation, and interpretation of caregiver's attitudes toward mental illness, based on attitudes toward causes of mental illness.(n=390)

Attitudes of caregivers	$\bar{X}$	SD	Interpretation
Attitudes toward causes of mental illness			
- Mental illness is not caused by magic power from other persons.	3.26	1.01	good
- Mental illness does not occurs because patients have done wrong to places or spirits.	3.03	1.10	good
- Mental illness is caused by varied and imbalanced body substances.	2.98	0.95	moderate
- Mental illness is not caused by bad fate.	2.49	1.17	moderate

From table 14, it can be seen that caregivers have good attitudes toward causes of mental illness regarding (1) mental illness is not caused by magic power from other persons, and (2) mental illness does not occurs because patients have done wrong to places or spirits, respectively. There are two items that caregivers have moderate attitudes regarding (1) mental illness is not caused by bad fate, and (2) mental illness is caused by varied and imbalanced body substances, respectively.

Table 15 Mean, standard deviation, and interpretation of caregiver's attitudes toward mental illness, based on attitudes toward treatments.(n=390)

Attitudes of caregivers	$\bar{X}$	SD	Interpretation
Attitudes toward treatments			
- Bringing patients to have treatments in psychiatric hospitals can make patients well again.	3.71	0.53	good
- Monks or witches cannot chase away demons to cure the patients.	3.61	0.78	good
- Magic activities such as chasing away demons, or releasing omens cannot cure mental illness.	3.26	0.96	good
- Mental illness can be totally cured.	3.14	0.91	good
- Religious activities or making merit cannot reduce the severity of mental illness.	2.19	1.03	moderate

From table 15, it is seen that caregivers have good attitudes toward treatments regarding (1) bringing patients to have treatments in psychiatric hospitals can make patients well again, and (2) monks or witches cannot chase away demons to cure the patients, respectively. The caregivers have moderate attitudes regarding religious activities or making merit cannot reduce the severity of mental illness.

Table 16 Mean, standard deviation, and interpretation of caregiver's attitudes toward mental illness, based on attitudes toward living with and caring for psychiatric patients.(n=390)

Attitudes of caregivers	$\bar{X}$	SD	Interpretation
Attitudes toward living with and caring for psychiatric patients.			
- Psychiatric patients should have care from relatives regularly.	3.82	0.46	good
- Psychiatric patients should not be separated from society.	3.51	0.88	good
- Psychiatric patients can participate in society with normal people.	3.43	0.74	good
- Psychiatric patients should not be in the hospital for the rest of their lives.	3.43	0.96	good
- Having psychiatric patients in the house is not shameful for relatives.	2.95	1.14	moderate
-Caregivers will not be cautious when they are near psychiatric patients.	2.35	1.08	moderate
- Psychiatric patients do not create problems for family members.	1.96	0.95	poor
- Having psychiatric patients in the house is not a burden for family members.	1.94	1.04	poor

From table 16, it can be seen that caregivers have good attitudes toward living with and caring for psychiatric patients regarding (1) psychiatric patients should have care from relatives regularly, and (2) psychiatric patients should not be separated from society, respectively. The caregivers have poor attitudes regarding (1) having psychiatric patients in the house is not a burden for family members, and (2) psychiatric patients do not create problems for family members, respectively.

5. Caregiver-Patient Relationships

Table 17 Mean, standard deviation, and interpretation caregiver-patient relationships in total, and classified by category. (n=390)

Caregiver-patient relationships	$\bar{X}$	SD	Interpretation
Caregiver-patients relationships in Categories			
-Helping and considering for each other	3.55	0.43	good
-Sharing common family activities	2.75	0.72	moderate
-Accepting each other	2.87	0.52	moderate
-Communicating and sharing ideas and experiences with each other	3.43	0.63	good
-Avoiding contradicting each other	3.22	0.61	good
-Loving and caring for each other	3.81	0.36	good
Caregiver-patient relationships in total	**3.21**	**0.35**	**good**

From Table 17, it can be seen that the caregiver-patient relationships in total are good ($\bar{X}$=3.21). In consideration of the categories, the caregiver-patient relationships are good regarding (1) loving and caring for each other, (2) helping and considering for each other, (3) communicating and sharing ideas and experiences, and (4) avoiding contradicting each other, respectively. There are two categories in which caregiver-patient relationships are moderate regarding (1) sharing common family activities, and (2) accepting each other, respectively.

Table 18 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by helping and considering for each other. (n=390)

Caregiver-patient relationships	$\bar{X}$	SD	Interpretation
Helping and considering for each other			
-Caregiver will know whenever the patient is unhappy or abnormal.	3.78	0.51	good
-Caregiver investigates on a daily basis the happiness of the patient such as asking about food: being on time; daily activities.	3.67	0.60	good
-Caregiver helps the patient financially.	3.49	0.80	good
-Caregiver gives advise and help in solving problems.	3.44	0.75	good
-Caregiver takes care of the patient in many activities such as eating; cleaning clothes and his/her mattress.	3.37	0.83	good

From Table 18, it can be seen that the caregiver-patient relationships in helping and considering for each other is good.

Table 19 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by sharing common family activities.(n=390)

Caregiver-patient relationships	$\bar{X}$	SD	Interpretation
Sharing common family activities			
-Caregiver and the patient eat together.	3.24	0.94	good
-Caregiver and the patient watch TV together.	3.24	0.96	good
-Caregiver and the patient do house work together such as cleaning, washing clothes, and shopping.	2.74	1.10	moderate
-Caregiver and the patient have leisure time together, such as watching the movies and listening to music.	2.32	1.06	moderate
-Caregiver and the patient join social events together such as making merit; attending weddings and funerals.	2.23	1.00	moderate

From Table 19, it can be seen that caregivers have good relationships in sharing common family activities regarding (1).they and the patient eat together, and (2) they and the patient watch TV together, respectively. The caregivers have moderate relationships regarding (1) they and the patient join social events together such as making merit, attending weddings and funerals, and (2) they and the patient have leisure time together, such as watching the movies and listening to music, respectively.

Table 20 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by accepting each. (n=390)

Caregiver-patient relationships	$\bar{X}$	SD	Interpretation
Accepting each other			
-Caregiver makes the patient feel important.	3.71	0.81	good
-Caregiver listens to and understand the ideas of the patient.	3.55	0.64	good
-Caregiver and the patient talk and share daily activities together.	3.03	0.93	good
-The patient shares responsibilities in house work according to his/her ability.	2.72	1.09	moderate
-Caregiver trusts in the work done by the patient.	2.17	1.10	moderate
-Caregiver accepts the ideas of the patient.	2.07	1.09	moderate

From Table 20, it can be seen that the caregivers have a good relationship in accepting each other regarding (1) they make the patient feel important, (2) they listen to and understand the ideas of the patient, respectively. The caregivers have a moderate relationship regarding (1) they accept the ideas of the patient, (2) they trust in the work done by the patient, respectively.

Table 21 Mean , standard deviation, and interpretation of caregiver-patient relationships, classified by communicating and sharing ideas and experiences with each other.(n=390)

Caregiver-patient relationships	$\bar{X}$	SD	Interpretation
Communicating and sharing ideas and experiences with each other			
-Caregiver and the patient have no secret.	3.47	0.75	good
-Caregiver and the patient have events to share.	3.21	0.94	good
-Caregiver always has an opportunity to talk with the patient.	3.06	0.74	good

From Table 21, it can be seen that the caregiver-patient relationships in communicating and sharing ideas and experiences with each other is good.

Table 22 Mean , standard deviation, and interpretation of caregiver-patient relationships, classified by avoiding contradicting each other.(n=390)

Caregiver-patient relationships	$\overline{X}$	SD	Interpretation
Avoiding contradicting each other			
-When caregiver and the patient have a conflict, each can make an agreement.	3.56	0.73	good
-Caregiver and the patient try to get along with each other.	3.56	0.70	good
-Caregiver has no conflict with the patient.	2.54	1.05	moderate

From Table 22, it can be seen that the caregivers have a good relationship regarding (1) when they and the patient have a conflict, each can make an agreement, and (2) they and the patient try to get along with each other, relatively. But caregivers have a moderate relationship regarding they have no conflict with the patient.

Table 23 Mean , standard deviation, and interpretation of caregiver- patient relationships, classified by loving and caring for each other.(n=390)

Caregiver-patient relationships	$\bar{X}$	SD	Interpretation
Loving and caring for each other			
-Caregiver will feel distress when the patient suffers.	3.85	0.41	good
-When caregiver is away, he/she is worried about the patient.	3.80	0.45	good
-Caregiver tries to protect the patient and tries to make others feel sympathy for the patient.	3.79	0.50	good

From Table 23, it can be seen that caregiver-patient relationships in loving and caring for each other is good.

CHAPTER V

Discussion

From the study of knowledge of, and attitudes toward mental illness, relationships of caregivers and psychiatric patients in the study where the caregivers bring the patients to the psychiatric hospitals in the central region, it was found that:

1. Demographic Data about Caregivers and Psychiatric Patients

Most caregivers are female (63.3%), aged between 41-60 years old (57.3%). Most were heads of families (62.6%), are fathers or mothers of the psychiatric patients (45.4%), have education up to primary school (50%), and are employed with a salary of not more than 5,000 baht (55.6%).

Most psychiatric patients are aged between 21-40 years old (55.4%), were diagnosed to be schizophrenic (70.3 %), were nearly equal in number between male and female (56.9% and 43.1%), and had been admitted into the psychiatric hospitals three times or more (48.2%).

It can be seen that even though society has changed, mothers and females still have an important role in maintaining a family (Wongtes, P.,1992:191). When a number of the family got sick, the responsibility of giving care fell on the mother of the patient which agrees with the study by Doornbos (1997:23) which found that the majority of caregivers of psychiatric patients (89%) were the father or mother of the patient.

At the same time these caregivers have only primary school education, were employed, and have only 5,000 baht income per month. Most psychiatric patients fell ill with schizophrenia which is chronic, and needs continuous care to recuperate physically, emotionally, and socially. The patients have to get their medication and come to have checkups regularly. These caregivers may feel the psychiatric patient is

a burden and make it stressful to give care, and think that to bring the patient in to see the doctor and get medication continuously is a waste of working time and expensive, so they give more importance to making a living than to bringing in the psychiatric patient for a check up. Thus, the psychiatric patients may not get their medication and the illness may relapse, and cause more disorder of personality which ratifies the patients' information which showed that 48.2% of the psychiatric patients were admitted to hospitals three times and more.

The nurse should help caregivers in assessing stress from giving care to the patients and promote creative changes, understand and make the caregivers see the importance of bringing in the patients for checkups and getting medication to prevent relapse. Also they should help to fine social benefices which can help to pay for the medication cost for the patients. From the study of Kempe, A.R. (1994), it was found that knowledge exchange, time given, and involvement between nurses and caregivers were important factors which make families cooperate with the therapy.

The family found that most psychiatric patients (49.01%) have disorders of movement as the first symptom, such as sleeplessness, continuously walking, not speaking, not eating, not taking a bath, dressing inappropriately, continuously cleaning the house, or sleeping all day. The family decided to take the patient to a psychiatric hospital for the first time within 2-6 months (30.7%), 7-12 months (22.7%), and more than a year (12.38%), respectively. The symptoms of disorder that made the family decide to bring the patient to the psychiatric hospital at later times were mood disorder (71.54%) such as harming others, destroying things, being aggressive, harming himself, be coming separate from society, laughing or crying with no reasons, or showing emotions that did not match reality, and the length of time it took to decide to bring the patient into a psychiatric hospital was about one week (64.6%).

At the first time, the family took a longer time to bring in the patient than at later times. This supports the study of Jeon & Madjar (1998:698) which found that families were very confused and took several months to several years because the psychiatric patients slowly changed until they were diagnosed with mental illness.

The caregivers would try to consider what happened to the patient, find causes, and solve problems on their own. The family would not understand what had happened to the patient and postponed bringing in the patient to be treated in a psychiatric hospital. The fact that, at later times, the family took only one week to decide to bring in the patient to the psychiatric hospitals can be explained because the family then had direct experience from giving care to the psychiatric patient and got knowledge and suggestions from the health team about mental illness and its symptoms, so they can release the disorder of the psychiatric patient quicker.

2. Knowledge of Caregivers about Mental Illness

Most caregivers (72.3%) have good knowledge about mental illness and most were caregivers of patients who had been admitted in psychiatric hospitals at least two times (66.7%). Every time they came to the hospital, they would learn about mental illness, symptoms, and treatment from members of health teams through various forms such as knowledge boards, videotapes, brochures, individual training, group consultants, group health education about methods of care and rehabilitation. This caused the family to have more knowledge, so that the result was different from the study of Leavitt (1975, cited in Rose, 1996:70) which found that the family felt that they learned nothing about mental illness while the psychiatric patient was admitted in a hospital. It is also different from the study of T.Skul,J. (1981) and Ip,G.S.H. & Makenzie. (1998:293) which found that the family still lacked an understanding about mental illness and methods of care for psychiatric patients. When analyzed by knowledge type, it was found that:

2.1 Cause of mental illness (Table 8)

Only 42.9% of caregivers knew that mental illness may be due to heredity causes which are the cause of worry because the family will not see the importance of contraception for the patient. If we allow the psychiatric patients to have children freely, the children of these patients will have a higher chance to have mental illness from heredity than that from normal people (Fox JC. & Kane CF.,1996:232;1998:290).

Few caregivers have the correct knowledge of mental illness that it occurs due to chemical substance in the brain (58.1%). The knowledge that psychiatric patients have a disorder of neurotransmitters was new and was taught only by health teams. For this reason, the family did not understand that psychiatric medication changes the balance of biochemical in the brain, so the patient must receive medication continuously to maintain the balance and to prevent relapse. If the family understand this matter, it will help the psychiatric patient to receive medication regularly.

2.2 Psychiatric symptoms (Table 9)

Few caregivers know that psychiatric patients still recognize the environment surrounding them. Only 46.9% of caregivers answered correctly. The reason the caregiver thought that the psychiatric patient was indifferent to the environment was because the psychiatric patients in this study are mostly schizophrenic patients (70.3%) who have symptoms of separating themselves, being less aware of the environment, decreasing in various functions. Because most caregivers thought that the psychiatric patients were indifferent to the environment, the families may give less importance to stimulate the interest of the psychiatric patients about social activities around the psychiatric patients. If left like that, it will make the psychiatric patient more self-obsessed and he may deteriorate.

2.3 Treatments (Table 10)

Few caregivers know that electrical therapy may cause permanent memory loss (30.3%), but 58.5% of caregivers know that electrical therapy calms the psychiatric patients down. It can be explained that before electrical treatment for every psychiatric patient, the health team will explain about the treatment to the family, but while being treated, the psychiatric patients must be in the hospitals, so the caregivers did not see the psychiatric patients while being treated, so the caregiver did not know about electrical therapy in this part.

2.4 Caring for and improving the rehabilitation for psychiatric patients (Table 11)

Few caregivers know that the caregivers should not indulge the patient in everything (50.5%). It may be because most caregivers are female (63.3%), in late

adulthood, (41-60 years old) and most psychiatric patients are male (56.9%), in early adulthood (21-40 years old), so the caregivers did not want to face the behavior of the psychiatric patients when the psychiatric patients did not get their own way, so it could be safe for themselves. But in fact, the psychiatric patients should not be having their own way in every case. The caregivers should train the psychiatric patients to know how to wait or how to be refused in some cases when the caregivers could not indulge them.

Only 54.4% of the caregivers believes that psychiatric patients can have any career. The psychiatric patients should be encouraged to work in an appropriate profession which will give the psychiatric patients something to do, interact with other people, having a chance to develop his profession, rely on himself, have financial security, and instigate self pride and uniqueness (Scheid & Anderson, 1995:164-176).

3. Attitudes of Caregivers toward Mental Illness

Caregivers have moderate attitudes toward mental illness (Table 12) which does not agree with the result of study of T.Skul,J. (1981) which found that the family felt mental illness caused shame, and the study of Hoontrakul,S. and Jampong, M. (1989) which found that the family was repelled by the psychiatric patients. It shows that there is a change in a positive way of attitudes toward psychiatric patients in society which accepts, understands, and sympathizes more with the psychiatric patients. When considered in detail, it was found that:

3.1 Attitudes toward mental illness and psychiatric patients.

The caregivers have a moderate attitude ($\overline{X}$=2.42) toward mental illness and psychiatric patients (Table 12 and 13). The caregivers have a poor attitude toward psychiatric patients by believing that, psychiatric patients are often angry and aggressive ($\overline{X}$=1.35), and that psychiatric patients do as they want ($\overline{X}$=1.35). This may be because the caregivers have direct experience due to staying with the psychiatric patient almost all the time which makes them feel bad when affected by the inappropriate behavior of the psychiatric patient. This result agrees with this study about caregiving knowledge of rehabilitation for psychiatric patient which found that

only 50.5% of the caregivers know that they should not always let the psychiatric patients have their own ways.

3.2 Attitudes toward causes of mental illness.

The caregivers have a moderate attitude ($\overline{X}$=2.94) toward the causes of mental illness (Table 12 and 14). It was found that caregivers have a good attitude toward the causes of mental illness by not believing that mental illness is caused by others using black magic on the patient ($\overline{X}$=3.26). This may be because the central region of Thailand is the center of every aspect of the development of the country which reduces the belief in black magic and spirits. More people believe in scientific reasoning, coupled with various media that distribute knowledge of mental health such as television, radio, and books, the caregiver receive new knowledge and improves attitude toward causes of mental illness (Langsuwong, K.,1985).

3.3 Attitudes toward treatments.

The caregivers have good attitudes toward treatments of mental illness ($\overline{X}$=3.18) (Table 12 and 15). It was found that the caregivers believed that taking in the psychiatric patient to be treated by a doctor in a hospital will cure the patient ($\overline{X}$=3.71) a monk or a witch doctor cannot cure the psychiatric patient ($\overline{X}$=3.61), mental illness can be cured completely ($\overline{X}$=3.14), and religious ceremonies and donations would not heal the psychiatric patient ($\overline{X}$=2.19). It shows that the caregivers believed in the public health service that they get from the government psychiatric hospitals that it would help cure the psychiatric patient and did not take the psychiatric patient to a witch doctor which agrees with the result of this study in the part of knowledge of caregivers about treatment which was found to have correct knowledge of treatment.

3.4 Attitudes toward living with and caring for psychiatric patients.

The caregivers have a moderate attitude ($\overline{X}$=1.92) toward living with and caring for the psychiatric patients (Table 12 and 16). When considered in detail, it was found that the caregivers have a good attitude which means the psychiatric patient should be taken care of by the family ($\overline{X}$=3.84), the psychiatric patient can live with normal people in society ($\overline{X}$=3.43), and the psychiatric patient should not stay in the

hospital his whole life ($\bar{X}$=3.43). It shows that, even though mental illness is chronic needing continuous care, the caregivers still payed attention to giving care to the patient, was glad to stay with the patient, and did not push the burden of care to the hospital or society. This agrees with study of families of patients in the Khon Kaen Psychiatric Hospital by Tangsaree,V.et al., (1995) who found that the family sympathizes with the patient, feels that if kept separated the illness may deteriorate, and when cured until he gets better, would like him to come to live at home, but it disagrees with the study of Chaisanoa,S. et al., (1997) which found that the family wants the hospital to take care of the patient for ever.

At the same time, the caregivers have a poor attitude toward staying together with and taking care of the patient. The caregiver believes that psychiatric patients creates problems for the family ($\bar{X}$=1.96), having the patient at home creates a burden for the family ($\bar{X}$=1.94). Most caregivers are heads of the family (62.6%) and the family's income is less than 5,000 baht. When the patient is out of medication and the symptoms are aggravated, the caregiver must stop working to take care of the patient, earns no income, and has to pay for the treatment, so the caregiver believes that psychiatric patients create problems and are a burden for the family (Sirapongam,Y.,1996:84).

4. Caregiver - Patient Relationships

The caregivers have a good relationship with the psychiatric patients ($\bar{X}$=3.21) (Table 17) i.e. helping and considering for each other, communicating and sharing ideas and experiences with each other, avoiding contradicting each other, and loving and caring for each other because the caregiver is the father or mother (45.4%). This result supports the study of Jeon & Madjar (1998:701) which found that the caregiver who is the father or mother of the patient will give unconditional love. Even though the patient has mood disorder and is not wanted by others, the caregiver still wants to take care of the psychiatric patient. It also supports the study of Rose (1998:368) which found that the caregiver still takes care of the patient continuously because no one knows the patient better than the caregiver, and she wants to help the patient

manage his illness. In general, Thai families have personal one-to-one relationships, have sympathy for each other, understanding, open communication and is full of love, and attention (Kompayak,J., 1986:351). So, when the caregiver has a good relationship with the patient, the caregiver would want to take care of the patient which is good. Rose (1998:368) and Warnar (1985:257) found that schizophrenic patients will be happy in a stimulating but not stressful atmosphere, and a warm, but not imposing environment.

When considered in detail, it was found that the caregiver and the psychiatric patient do house work together, have leisure time together, and join social events together. The caregiver gives a chance for the psychiatric patient to be responsible for suitable housework, entrusts work to the psychiatric patient, accepts the ideas of the patient, and has conflict with the psychiatric patient in moderate level. The psychiatric patient is slow and sleepy because of the illness and the side effects of the medication (Scheid & Anderson, 1995:170), so the psychiatric patient may be sleepy all the time, and may participate in domestic and social activities with the caregiver to a lesser extent. If the psychiatric patient runs out of medication, there may be symptoms of disorder of emotion, thought, and behavior in intervals, so the caregiver accepts and trusts in the psychiatric patient's work only at a moderate level, but if we look at the whole picture, the caregiver does have a good relationship with the psychiatric patient.

The result of the study can be summarized that most caregivers (72.3%) have correct knowledge of mental illness, especially the causes, symptoms, treatments, care, and rehabilitation of psychiatric patients. The caregivers will use their knowledge as a basis to think before acting toward the patient which will have an effect on the feeling and thought of the caregiver. The caregivers have a moderate level in attitude toward mental illness, a good relationship with psychiatric patient, and no conflict, love and attach emotionally to the psychiatric patient when living together with the psychiatric patient. Because the caregiver has correct knowledge, good attitude toward mental illness, and a good relationship with the psychiatric patient, the psychiatric patient will have correct and rapid treatment, no recurrence, so

this will lessen the burden of the family and psychiatric hospitals which complies with the National Plan for Economic and Social Development, 8th edition (1997-2001) (Department of Mental Health, 1997:21). This will make psychiatric patients adapt themselves and go back to the community quicker.

This study is a study of knowledge of, and attitude toward mental illness, and the relationship between caregivers and psychiatric patients who were admitted to psychiatric hospitals. These caregivers have good knowledge about mental illness and good relationships with psychiatric patients so that they brought the patients to psychiatric hospitals to receive treatment. There should be a comparative study of knowledge of, and attitude toward mental illness, and caregiver-patient relationships between caregivers in a sample group, and of the caregivers who left the psychiatric patients in a hospital or in a half-way house.

CHAPTER VI

Conclusion

Conclusion

This study is a descriptive study of knowledge, attitudes toward mental illness, and relationships with the patient: a study of caregivers who brought the patients to psychiatric hospitals in the central region of the country to receive treatment.

The sample group in this study is caregivers who brought the patient to receive treatment at Somdet Chaopraya Hospital and Sritanya Hospital, numbering 390 persons. The instrument used was a questionnaire which is designed by this researcher and consisted of a questionnaire for demographic data about caregivers, questionnaire for demographic data about psychiatric patients, questionnaire for knowledge of caregivers about mental illness, questionnaire for attitudes of caregivers toward mental illness, and questionnaire for caregiver-patient relationships. It was checked for validity by 3 experts and was improved to be more suitable.

The researcher collected the data by herself through interviews and the questionnaire between February 15- to April 28, 1999. The data was analyzed by the frequency, percentage, mean and standard deviation. The result can be summarized as follows:

1. Demographic Data about Caregiver

From the study, it was found that most caregivers are about 41-60 years old (57.3%), are female (63.3%), have primary school education (50%), are the patient's parents (45.4%), have 4-6 members in the family (56.2%), are employed (31.5%), have a monthly income of 5,000 baht or less (32.8%), and live in the central region of the country (78.5%).

2. Demographic Data about Psychiatric Patients

There were 390 psychiatric patients, most between 21-40 years old (55.4 %), most are male (56.9%), have diagnosed to be schizophrenic (70.3%), and were admitted in the hospital 3 times and more (48.2%).

The caregiver noticed symptoms of disorder of movement (49.01%) which is the first symptom before the patient was admitted into a psychiatric hospital for the first time, and had the symptom for 2-6 months (30.7%), 7-12 months (22.79%), and more than a year (12.38%), respectively. The symptom that made the caregiver decide to bring the patient into the hospital this time is mood disorder (71.54%) and the patient had the symptom for about one week before being brought in to the hospital.

3. Knowledge of Caregivers about Mental Illness

Most caregivers (72.3%) know about mental illness well and can answer more than 80% of all questions.

When considered in detail, it was found that 42.9% of the caregivers know that mental illness can caused by heredity, 58.1% of the caregivers know that the cause is from disorder of chemical substance in the brain, 46.9% of the caregivers know that psychiatric patients were less interested in the surrounding environment, 58.5% of the caregivers know that electrical therapy can calm the psychiatric patients down, 30.3% of the caregivers know that electrical therapy can cause temporary memory loss, 54.4% of the caregivers know that psychiatric patients can perform work professionally, and 50.5% of the caregivers know that they should let the patients have their ways so as not to stress them.

4. Attitudes of Caregivers toward Mental Illness

Overall, the attitudes of caregivers toward mental illness is at a moderate level ($\overline{X}$=2.80,SD=0.34). When considered in detail, it was found that the caregiver has a poor attitudes toward mental illness in the following ways: psychiatric patients had less tolerance to problems than normal people; psychiatric patients were furious and

aggressive; psychiatric patients usually act according to their desires; psychiatric patients create problems for family members; having psychiatric patients in the house is a burden for family members.

5. Caregiver-Patient Relationships

Overall, the caregivers have a good relationships with the psychiatric patients. ($\overline{X}$=3.21,SD=0.35) except in some cases when it is at a moderate level as follows: caregiver and the patient do house work together, such as cleaning clothes and shopping; caregiver and the patient have leisure time together, such as watching the movies and listening to music; caregiver and the patient join social events together such as making merit, attending weddings and funerals; the patients share responsibilities in house work according to their ability; the caregivers trust in the work done by the patients, and the caregivers accept the ideas of the patients; caregivers have conflict with the patients.

Suggestions

Suggestion for Implication

1. Knowledge. Psychiatric health teams should give knowledge about mental illness in various forms to the caregiver, such as causes of illness from heredity and disorder of chemical substances in the brain, as well as related of symptom of psychiatric illness. These knowledges will enable the caregivers to giver care properly to the patient and lowering the level of stress of the caregivers themselves.

2. Attitudes. Psychiatric health teams should help develop good attitudes of caregivers about mental illness by promoting programs for self-help groups for caregivers, study groups of caregivers that take care of the patient, into develop good attitudes in families and in groups.

3. Relationships. Psychiatric health teams should arrange programs to form a group that promotes skill in forming relationships in the family of the psychiatric patients and the caregivers.

Suggestions for Further Study

1. A comparative study of methods of teaching about mental health in various forms should be made.

2. A comparative study of caregiver's attitudes who join the program of knowledge about mental illness divided in to a sample group and control group should be made.

3. A comparative study of relationships between caregivers and psychiatric patients for caregivers that join the program promoting relationships between caregivers and psychiatric patients divided into a sample group and control group should be undertaken.

4. A comparative study of knowledge of, and attitudes toward mental illness, and caregiver-patient relationships between caregivers in a sample group, and the caregivers who left the psychiatric patients in a hospital or in a half-way house.

BIBLIOGRAPHY

Allport,G.W.(1976). Attitude in Attitude Theory and Measurement. New York: Wiley and Son,Inc.

Chaisanoa, S., Wirekarut, J. and Pratepajit, C.(1997). Situations of Family Caring of Psychiatric Patients. Journal of Mental Health of Thailand, 4(1),1-8.

Chaisrisuk, V.(1990). Mental Health. Bangkok:Sang.

Crandall,R,C.(1980). Gerontology: A Behavioral Science Approach. Reading,Massachuat: addisor-wesley publishing Company.

Department of Mental Health, Ministry of public Health. (1998). A Report on the Patient Statistics of 1998. Nothaburi ; Department of Mental Health.

_____.(1997). National Plan for Economic and Social Development, 8th edition (1997-2001). Bangkok: Saiminsert.

_____ .(1994).Rehabilitation of Psychiatric Patients in Community (Book 1-3). Bangkok: Thammasat press.

_____(1997). The Conference on Mental Health 1997: Development of Psychiatric Services to Overcome the Economic Crisis, 7-9 September 1998 at Prince Palace Hotel Bangkok. Nontaburi: Department of Mental Health.

Doornbos, M.M.(1997). The Problems and Coping Methods of Caregivers of Adults with Mental Illness. Journal of Psychosocial Nursing,35(9),23.

Fox, JC. & Kane, CF. (1998). "Schizophrenia". Annual Review of Nursing Research,16:287-332.

Fox, JC. & Kane, CF.(1996). Psychiatric Mental Health Nursing: Integrating the Behavioral and Biological Sciences. Philadelphia: WB Saundess.

Good, Carter V. (1973). Dictionary of Education. New York: Mc Graw-Hill Company.

Greonberg JS., Greenley JR., Brown R. (1997). Do Mental Health Services Reduce Distress in Families of People with Serious Mental Illness. Psychiatric Rehabilitation Journal,21(1),20-49.

Huang, PL. and Mao China-Ling. (1991). An Investigation of the Home Caregiving Experience of Schizophrenia Patients' Relatives & Stress Perception and Coping Behavior. Proceeding of the Second International Family Nursing Conference, Portand, Oregon, 99-100.

Hoontrakul, S., and Jampong, M. (1989). The Effective of the Family on the Readmission of Schizophrenia Patient: A Case Study at Somdetchaopraya Hospital. Journal of Nursing,8(1),47-56.

Ip,G.S.H. and Mackenzie, A.E.(1998). Caring for Relative with Serious Mental Illness at Home The Experiences of Family Cares in Hong Kong. Archives of Psychiatric Nursing, 12(5),288-249.

Isarangkul Na Ayutthaya, K. (1995). A Relation Between Images and Relationships of Spouses and Women Having Menopause. Master degree in Public health (Family health), Faculty of Graduate studies, Mahidol University.

Jeon,Y. and Madjar,I. (1998). Caring for a Family Member with Chronic Mental Illness. Qualitative Health Research, 8(5),694-706.

Kaewprom, Ch. (1987). Relationships between Social Structurs and Social Support, and Elder's Mental Health in the Bangkok Elderly Assembly. Master Thesis in Nursing Mamagent, Chulalongkon University.

Kempe,AR.(1994). Forming Alliances: toward a Grounded Theory of the Nurse Caring for the Family Caregiver of a Schizophrenic Member. Way State University.

Kittiratanapaibul, P. (1997). Stigma and Mental Illness. Journal Suanprung Hospital , 13(1),29-36.

Kompayak, J.(1986). Family: Unit of Health and Caring. Journal of Nursing,4(4),351-364.

Kotamon,T. and Paolohit,S. (1995). A Study of Social Problem of Schizophrenia Patient of the Khon Kaen Psychiatric Hospital. A research report, Khon Kaen Hospital.

Kumrat, S. et al., (1971). Attitudes of Isarn People toward Psychiatric Patients. Journal of the Psychiatric Association of Thailand, 16(3),201.

Kypredarborisuthi, B. (1997). Handbook: Research and Thesis Writing. Faccult. of Social Science and Humanities, Mahidol University.

Langsuwong, K.(1985). Psychology. Bankok:Mahamongkul Rathawittayalai.

Meesup, K. (1997). A Pattern of Belief in Mental of Health and Madness and Self Caring in Thai Societies. Journal of Clinical psychology,2(1),83-101.

Natasiri,D. et al.,(1977). Possibilities of Families and Neighbors in Helping Psychiatric Patients. A Report on the 31th Conference in Mental Health. Somdetchaopraya Hospital, 13-18 Febury 1978.

Ngamthipwatthana, T. (1992).Initial Recognition by Relatives of Behavior in Schizophrenic Patients. Journal of the Psychiatric Association Thailand,31(2), 126-127.

Nitikul, W. (1992). A Study on the Stress of Psychiatric Patients' Relatives. A Master Thesis in Art, Department of Psychology, Chulalongkorn University.

Otrakul, A. (1995). Mental Health. Bangkok: Numugsorn Press.

Petchrat,Y. (1996). Nursing of Mental and Psychiatric Illness (Book 1). Songka: Textbook Producing Project, Facult of Nursing. Songklanakarin University.

Phumipak, Ch. (1987).Learning and Treaching Psychology. Bangkok : Thaiwattanapanich.

Phupaiboon, R. (1994). Family Nursing : Khon Kaen : Khon kaen press.

Piyamanotham,V. (1996). Development in Family. Bangkok : Umarin Printing and publishing company.

Ponganutri, C. (1988). Helping the Relatives of Schizophrenia Patients. Journal Psychiatric Association of Thailand, 33(3),100.

Phunrunotai, S. (1987). How Much the Patients Can Understand their Continued Illness. Journal of Medicine. Area 6,1(May-August),17-24.

Rattanakorn, N. (1993). Structure and Economic of Families' Readiness in Home-Caring of Psychiatric Patients, Nonthaburi Province. Master Thesis, Department of Medical Protection and Society, Chulalongkorn University.

Robinson,K. and Yates,K. (1994). Effects of Two Caregiver-Training Programs on Burden and Attitude toward Help. Archives of Psychiatric Nursing,5:312-319.

Rokeach,M. (1970). Belief, Attitude and Value: A Theory of Organization and Chang Sanfrancisco. Jossey Press Inc.

Rose,L.E. (1996).Families of Psychiatric Patients: A Critical Review and Future Research Directions. Archives of Psychiatric Nursing, 2,67-76.

Rose,L. (1998). Gaining Control: Family Members Relate to Persons with Severe Mental Illness. Research in Nursing and Health, 21,363-373.

Rokeach, M.(1970). Belief, Attitude and Value: A theory of Organization and Change Sanfrancisco. Jossey Press Inc.

Rosenthal, M.K. (1973). Attachment and Mother – Infant Interaction. Journal Child Psychology, 14 (September), 201-207.

Ruangtrakool, S.(Ed). (1999). Textbook of Psychiatry. (6th ed) Bangkok: Parppim Press.

Ruechar, Y.,et al.,(1997). Research nursing (6th ed). Bangkok:Siamsilp Press.

Scheid,L and Anderson,C. (1995). Clinical Care Update Living with Chronic Mental Illness: Understanding the Role of Work. Human Sciences Press, Inc.

Shives, L. R.(1994). 1st ed. Basic Concepts of Psychiatric Mental Health Nursing. (3nd ed). Pennsylvania: J.B. Lippicott Company.

Sitthimongkol,Y.(1995). Family Burden in Caring Psychiatric Relatives: An Analysis a Research Report. Journal of Nursing,1(Janury-March),19-26.

Sirapongam, Y. (1996). Family Caregivers:Concept and Problems in Reseach. Rama Nursing Journal, 2(1),84-92.

Sritanya Hospital.(1994). Handbook of Rehabilitation of Psychiatric Patientts in Communities, Book 1-3. Bangkok: Thammasat University.

Sukothaithammatrirat University. (1985). A Lecture Note on Selection of Caring Method for Mothers, Babies and Psychiatric Patients ,No.10-15. Bangkok: Numkung Press.

Supap, S.(1996). Social Problems. Bongkok: Thaiwattanapanit.

Suwanlert, S. and Kunsong, L. (1977). Roles of Relatives by Mental Health. A Report of Conference on Mental Health 1977 : 14-19 February 1977. Chiang Mai : Saun Prung.

Suwan, P. (1983). Attitudes: Measuring the Changes and Health Caring Behaviors (2nd ed). Bangkok: Wangburapa.

Suwankote, K. (1996). A Not on Selection of Nurses for Rehabilitation no. 6-10. (2nd ed). Bangkok: Chuanpion Press.

T.Skul, J. (1981). Factors Forcing the Return of Schizophrenia Patients for Treatment. A Master Thesis, Faculty of Social Sciences, Thammasat University.

Thamroj, K., and Nuttarangsee, J. (1995). Psychiatric Rehabilitation . Journal of Psychiatric Nursing and Mental Health,9(2),27-35.

Tagliacozzo, D.M. & Ima,K.(1970). Knowledge of illness as a Predictor of Behaviors. Journal of Chronic Disease,22(November),765-775.

Tangsaree, V. et al., (1995). The Comparison between the First and Rehospitalized Attitude in Schizophrenia Patients' Relative at Khon Kaen Psychiatric Hospital. A Research Report, Khon Kaen Psychiatric Hospital.

Triandis, H.C.(1971). Attitude and Attitude Change. New York: Wiley and Sons.

Tuntiplachiva, K.(Ed). (1993). Textbook of Psychiatry.Bangkok: Thammasat.

Visuttikosol, Y. et al., (1980). Traditional Treatment by Psychiatric Patients. Journal of the Psychiatric Association of Thailand, 24 (March), 25-33.

Warnar, R.(1995).Recovery From Schizophrenia: Psychiatry and Political Economy. Lodon: Routledge and Kegan Paul.

Wongtes, P.(1992). Gender and Culture. Nakonpatom :Sinpakon.

Zimbardo, P.G. et al., (1977). Influencing Attitude and Changing Behavior. London: Addsion – Wesley publishing company.

APPENDIX

Appendix A

List of Experts

Expert clinician names are validators the instruments.

1. Associate Prof. Dr. Ubon Niwatchai

   Department of Mental Health and Psychiatric Nursing.

   Faculty of Nursing. Chiang Mai University.

2. Assistant Prof. Yajai Sitthimongkol

   Department of Mental Health and Psychiatric Nursing.

   Faculty of Nursing. Mahidol University.

3. Mrs. Duangta Kulrattanayan

   Division of Psychiatric Nursing.

   Somdetchaopraya Hospital.

Appendix B

Consent Form

To whom it may concern.

I am Chonlaporn Kongkum, a graduate nursing student in mental health and psychiatric nursing, Faculty of Nursing, Mahidol University. I am presently working on a thesis entitled "Knowledge and Attitudes toward Mental Illness and Caregiver-Patient Relationships : A Study of Caregivers of Psychiatric Patients in Central Region Psychiatric Hospitals". I am in the process of collecting data and information for this study. The results of this study would serve as a guide to give psychiatric knowledge to caregivers who are in charge of caring for psychiatric patients at home.

Therefore, I would ask your cooperation to answer every question according to your feeling as much as you can. Your answers will be kept secret and it will not affect you and other related persons but it will be beneficial to the public.

You have the right to refuse to answer these questions and it will not have any effects on you. You are free to ask anything that you do not understand or you want explained at any time.

Thank you for your cooperation.

K. Chonlaporn

Appendix C

Research Instruments

- Demographic data about caregivers
- Demographic data about psychiatric patients
- Knowledge of caregivers about mental illness
- Attitudes of caregivers toward mental illness
- Caregiver – patient relationships

Research Instruments

Date.....

Questionnaire no. .....

Name of the hospital.....

Diagnosed result.....

A Thesis Questionnaire

Knowledge and Attitudes toward Mental Illness and Caregiver- Patient Relationships:
A Study of Caregivers of the Psychiatric Patients in
Central Region Psychiatric Hospital.

This questionnaires contains 5 parts;

part 1. Demographic data about caregivers contains 11 items

part 2. Demographic data about psychiatric patients contains 5 items

part 3. Knowledge of caregivers about mental illness contains 29 items

part 4. Attitudes of caregivers toward mental illness contains 26 items

part 5. Caregiver-patient relationships contains 25 items

PART 1

Demographic Data about Caregivers

Instruction: Fill up correct information about yourself in the spaces provided.

1. Age .....years
2. Gender ( ) Male ( ) Female
3. Education
   - ( ) No education
   - ( ) Primary level
   - ( ) High school or vocational certificate level
   - ( ) Higher than high school level or vocational diploma
4. Religion
   - ( ) Buddhism
   - ( ) Islam
   - ( ) Christian
   - ( ) Others

.
.
.

10. Relationship with patient
    - ( ) Father or Mother
    - ( ) Spouse
    - ( ) Brother or Sister
    - ( ) Son or Daughter
    - ( ) Relative
11. Residence
    - ( ) Central
    - ( ) Northern
    - ( ) Northeastern
    - ( ) Southern

PART 2

Demographic Data about Psychiatric Patients

Instruction: Fill up correct information about psychiatric patients in the spaces provided.

1. Ages.....years

2. Gender
   ( ) Male
   ( ) Female

*3. The first abnormal symptom appearance was the first symptom of the patient
.....
The time onset abnormal symptom until first admission.....

4. The severity symptoms which made the caregiver to decide bring the patient to the hospital.....
the time from the beginning of abnormal symptoms until the time of the decision to take the patient to the hospital.....

5. Number of admission in the hospital.....

* Skip this question if the number of admission is 3 or more times.

PART 3

Knowledge of Caregivers about Mental Illness

Instruction: This questionnaire is designed to gain information about the knowledge and understanding of caregivers about mental illness in 4 types: causes of mental illness, psychiatric symptoms, treatments, caring for and improving the rehabilitation for psychiatric patients. The persons answering reviewed and understood all statements in the questionnaire before using it.

The persons answering make (/) in the blocks according to the answers in accordance with the following criteria.

"true" means that caregiver agree with the statement
"false" means that caregiver do not agree with the statement
"unknown"' means that caregiver do not know that the statement is correct or not

knowledge of caregivers	True	False	Unknown
1. Mental illness is due to heredity. 2. Mental illness occur due to abnormality of chemical substances in the brain . 3. Addictive substances such as amphetamines, marijuana, heroin, whisky, or other addictive substances can cause mental illness. 4. Poverty; prolonged social problems can cause mental illness. . . . 28. Psychiatric patients should be pleased in every matter to prevent stresses. 29. Although the patients become normal, they should be checked at every appointment.			

PART 4

Attitudes of Caregivers toward Mental Illness

Instruction: This questionnaire is designed to gain information about feelings, thoughts and beliefs of caregivers about mental illness and psychiatric patients, about causes of mental illness, about treatments, and about living with and caring for psychiatric patients. The persons answering reviewed and understood all statements in the questionnaire before using it.

The persons answering make (/) in the blocks according to the answers in accordance with the following criteria.

"strongly agree" means that caregiver strongly agree with the question
"moderately agree" means that caregiver moderately agree with the question
"less agree" means that caregiver less agree with the question
"disagree" means that caregiver do not agree with the question

Attitudes of caregiver	strongly agree	moderately agree	less agree	disagree
1. Mental illness is a kind of illness which can occur to any person at any age. 2. Psychiatric patients have less tolerance to problems than normal people. 3. Psychiatric patients are still useful and productive. 4. Psychiatric patients are furious and aggressive. . . . 25. Having psychiatric patients in the house is a burden for family members. 26. Having psychiatric patients in the house is shameful for relatives.				

Part 5

Caregiver-Patient Relationships

Instruction: This questionnaire is designed to get information about the general relationship in the daily lives of the caregivers. Questions about the relationships consist of 6 categories: helping and considering for each other, sharing common family activities, accepting each other, communicating and sharing ideas and experiences with each other, avoiding contradicting each other, and loving and caring for each other. The persons answering reviewed and understood all statements in the questionnaire before using it.

The persons answering make (/) in the blocks according to the answers in accordance with the following criteria.

"often"	means that caregiver think or behave almost every time;
"moderately often"	means that caregiver think or behave almost sometimes;
"rarely"	means that caregiver rarely think or behave;
"never"	means that caregiver never think or behave.

Caregiver- patient relationships	Often	moderately often	rarely	never
1. You investigate on a daily basis the happiness of the patient such as asking about food: being on time; daily activities. 2. You give advice and help in solving problems. 3. You will know whenever the patient is unhappy or abnormal. . . . 24. You will feel distress when the patient suffers. 25. You try to protect the patient and try to make others feel sympathy for the patient.				

BIOGRAPHY

NAME	Miss. Chonlaporn Kongkum
DATE OF BIRTH	25 Janury 1965
PLACE OF BIRTH	Saraburi, Thailand
INSTITUTIONS ATTENDED	Boromarajonani College of Nursing Nakornrajsima 1984-1988 : Diploma in Nursing Science Mahidol University, 1997-2000: Master of Nursing Science (Psychiatric - Mental Health Nursing)
POSITION & OFFICE	1988-1990 Division of Nursing, The National Cancer Institute 1990- Present, Division of Nursing, Somdet Chaopraya Hospital