



**KNOWLEDGE AND ATTITUDES TOWARD MENTAL ILLNES
AND CAREGIVE-PATIENT RELATIONSHIPS : A STUDY OF
CAREGIVERS OF PSYCHIATRIC PATIENTS IN
SOUTHERN PSYCHIATRIC HOSPITAL**

PRISANA CHOEYSIRI

**With compliments
of**

บัณฑิตวิทยาลัย ม.มหิดล

**A THESIS SUBMITTED IN PARTIA FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF NURSING SCIENCE
(MENTAL HEALTH AND PSYCHIATRIC NURSING)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
1999**

ISBN974-663-503-4

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Thesis
entitled

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was submitted to the Faculty of Graduate Studies, Mahidol University for the degree
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ACKNOWLEDGEMENTS

I would like to express my sincere gratitude and deep appreciation to Associate Dr. Atirat Wattanapailin my Major-Advisor for her guidance, valuable advice, supervision and encouragement throughout. She was never lacking in kindness and support.

I would like to thank Associate Professor Dr. Tassana Boontong for her helpful guidance and support. I also would like to thank Associate Professor Wassana Chalamket for her great assistance.

I would like to thank Associate Professor Dr. Kanokrat Sukhatunga for her constructive comment, supervision and encouragement. She was always nice and friendly.

I wish to thank the staff of the Suansaranrom Hospital for their cooperation and generous assistance. In particular I would like to thank the samples were participated this study.

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

Prisana Choeyesiri

403091NSPS/M : MAJOR: MENTAL ILLNESS AND PSYCHIATRIC NURSING
KEY WORDS : KNOWLEDGE / ATTITUDE / RELATIONSHIP/ CAREGIVER /
PSYCHIATRIC PATIENT

PRISANA CHOESYIRI : KNOWLEDGE AND ATTITUDES TOWARD
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PSYCHIATRIC HOSPITAL. THESIS ADVISORS : ATIRAT WATTANAPAILIN,
Ed.D., TASSANA BOONTONG, Ed.D., WASSANA CHALAMKET, M.Ed., 99 p.
ISBN 974-663-503-4

The purpose of this descriptive research was to study the caregiver's knowledge and attitudes toward mental illness and caregiver-patient relationships in 340 caregivers who treated the psychiatric patients in Suansaranrom hospital on an inpatient basis. These psychiatric patients were diagnosed with schizophrenia, mood (affective) disorder, mental and behavioral due to substance use, and psychosis.

The instruments for data collection were questionnaires composed of 5 parts: demographic data of caregivers, demographic data of psychiatric patients, caregiver's knowledge about mental illness, caregiver's attitudes toward mental illness, and the caregiver-patient relationships. Content validity was assessed by 3 experts in psychiatric care. The reliability of the knowledge about mental illness was analyzed by Kuder – Richardson's equation (KR 20) at 0.76. Cronbach' alpha coefficient was used to analyze attitudes toward mental illness and the caregiver-patient relationships at 0.82 and 0.80 respectively. The derived data were analyzed and reported by frequency, percentage, mean and standard deviation.

The results of this study showed that most caregivers (62.1%) had good knowledge about mental illness. The caregivers had moderate attitude toward mental illness ($\bar{X}=2.89, SD=0.37$), and the caregiver-patient relationships was good ($\bar{X}=3.35, SD=0.34$). Nurses should give caregivers information about aspects of mental illness especially continuity of psychiatric drugs, and support appropriate attitudes toward mental illness.

กท4037091 NSPS / M : สาขาวิชา : สุขภาพจิตและการพยาบาลจิตเวชศาสตร์ ; พช.ม. (สุขภาพ
จิตและการพยาบาลจิตเวชศาสตร์)

คำสำคัญ : ความรู้ / เจตคติ / สัมพันธภาพ / ผู้ดูแล / ผู้ป่วยโรคจิต

ปริศนา เจริญศิริ : ความรู้ เจตคติเกี่ยวกับการเจ็บป่วยทางจิต สัมพันธภาพต่อผู้ป่วย : กรณี
ศึกษาญาติผู้ดูแลที่นำผู้ป่วยเข้ารับการรักษาในโรงพยาบาลจิตเวชในภาคใต้ (KNOWLEDGE AND
ATTITUDES TOWARD MENTAL ILLNESS AND CAREGIVER -PATIENT
RELATIONSHIPS : A STUDY OF CAREGIVERS OF PSYCHIATRIC PATIENTS IN
SOUTHERN PSYCHIATRIC HOSPITAL) คณะกรรมการควบคุมวิทยานิพนธ์ : อติรัตน์ วัฒน
ไพสิน ค.บ.,กศ.ม. (การแนะแนว), กศ.ด. (การวิจัยและพัฒนาหลักสูตร), ทศนา บุญทอง ค.บ.,
M.S.,Ed.D., วาสนา แฉล้มเขตร , กศ.ม.(การแนะแนว) 99 หน้า. ISBN 974-663-503-4

การวิจัยครั้งนี้มุ่งศึกษาความรู้ เจตคติเกี่ยวกับการเจ็บป่วยทางจิต สัมพันธภาพระหว่างผู้ดูแล
และผู้ป่วยโรคจิต ของผู้ดูแล จำนวน 340 ราย ซึ่งเป็นผู้ที่นำผู้ป่วยเข้ารับการรักษาในโรงพยาบาล
จิตเวชในโรงพยาบาลสวนสราญรมย์แบบผู้ป่วยในและผู้ป่วยได้รับการวินิจฉัยว่าเป็นผู้ป่วยโรคจิต
โรคอารมณ์แปรปรวน อาการโรคจิตที่เกิดจากสารออกฤทธิ์ต่อจิตประสาท และโรคจิต

ในการศึกษาใช้แบบสัมภาษณ์ประกอบด้วย ข้อมูลทั่วไปของผู้ดูแล ข้อมูลของผู้ป่วยโรคจิต
ความรู้เกี่ยวกับการเจ็บป่วยทางจิตของผู้ดูแล เจตคติเกี่ยวกับการเจ็บป่วยทางจิตของผู้ดูแล สัมพันธ
ภาพของผู้ดูแลกับผู้ป่วยโรคจิต ความตรงของเนื้อหาประเมินโดยผู้เชี่ยวชาญ 3 ท่าน ความเชื่อมั่น
ของแบบสัมภาษณ์ความรู้เกี่ยวกับการเจ็บป่วยทางจิตวิเคราะห์โดยสูตรของคูเดอร์- ริชาร์ดสัน (KR
- 20) ได้ 0.76 ความเชื่อมั่นของแบบสัมภาษณ์เจตคติเกี่ยวกับการเจ็บป่วยทางจิตและสัมพันธภาพ
ต่อผู้ป่วยโรคจิตได้ 0.82 และ 0.80 ตามลำดับ วิเคราะห์ข้อมูลโดยหาค่าความถี่ ค่าร้อยละ ค่าเฉลี่ย
ค่าส่วนเบี่ยงเบนมาตรฐาน

การวิจัยพบว่า ความรู้ของผู้ดูแลผู้ป่วยโรคจิตเกี่ยวกับการเจ็บป่วยทางจิตอยู่ในระดับดี (62.1%)
เจตคติของผู้ดูแลผู้ป่วยโรคจิตอยู่ในระดับปานกลาง ($\bar{X}=2.89,SD=0.37$) สัมพันธภาพของผู้ดูแล
ต่อผู้ป่วยโรคจิตอยู่ในระดับดี ($\bar{X}=3.35,SD=0.34$) พยาบาลควรให้ความรู้แก่ผู้ดูแลผู้ป่วยโรคจิต
เกี่ยวกับการเจ็บป่วยทางจิต ได้แก่ การรับประทานยารักษาโรคจิตอย่างต่อเนื่อง และพยาบาลควร
เสริมสร้างเจตคติของผู้ดูแลผู้ป่วยโรคจิต เพื่อนำไปสู่พฤติกรรมที่ดี

CONTENTS

	Page
ACKNOWLEDGEMENT	iii
ABSTRACT	iv
CONTENTS	vi
LIST OF TABLE	vii
CHAPER I INTRODUCTION	1
Background and Importance of Problems	1
Objective	6
Scope of the study	6
Expected results	6
Definition of variables	6
II LITERATURE REVIEW	8
Knowledge of caregivers about mental illness	8
Attitude of caregivers toward mental illness	19
Caregiver-patient relationships	23
III MATERIALS AND METHODS	27
Population characteristics and sampling group	27
Research Instrument	28
Validation of Research Instrument	31
Reliability	32
Collection of the data	33
Data analyses	33
IV RESULTS	35
V DISCUSSION	60
VI CONCLUSION	73
BIBLIOGRAPH	79
APPENDIX	85
BIOGRAPHY	99

LIST OF TABLES

Tables	Page
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.	36 38
2 Number and percentage of the psychiatric patients, classified according to age, gender, diagnosis ,and number of admissions to the hospital.	
3 Number and percentage of the psychiatric patients, classified according to the types of first abnormal symptoms. Abnormal symptoms were classified by Sompop Ruangtrakul, et.al.,(1999: 1-6).	39
4 Number and percentage of the psychiatric patients, classified according to time frame of onset of abnormal symptoms prior to admission.	40
5 Number and percentage of the psychiatric patients, classified according to the severity of symptoms which made caregivers decide to take the patients to a psychiatric hospital. Abnormal symptoms were classified by Sompop Ruangtrakul, et.al.,(1999: 1-6).	41
6 Number and percentage of the psychiatric patients, classified according to the time from the beginning of abnormal symptoms until the decision to take the patients to the hospital.	42
7 Number, percentage, and interpretation of caregivers, classified according to their knowledge of mental illness.	43
8 Number and percentage of caregivers who gave correct answer on the knowledge about mental illness, based on causes of mental illness.	44
9 Number and percentage of caregivers who gave correct answer on the knowledge about mental illness, based on psychiatric symptoms.	45
10 Number and percentage of caregivers who gave correct answer on the knowledge about mental illness, based on treatments.	46
11 Number and percentage of caregivers who gave correct answer on the knowledge about mental illness, based on caring for and improving the rehabilitation for psychiatric patients.	47

Tables	Page
12 Number, standard deviation, and interpretation of attitude of caregivers toward mental illness in total, and classified by category.	48
13 Number, standard deviation, and interpretation of attitude of caregivers toward mental illness, based on attitude toward mental illness and psychiatric patients.	49
14 Number, standard deviation, and interpretation of attitude of caregivers toward mental illness, based on attitude toward causes of mental illness.	50
15 Number, standard deviation, and interpretation of attitude of caregivers toward mental illness, based on attitude toward treatments.	51
16 Number, standard deviation, and interpretation of attitude of caregivers toward mental illness, based on attitude toward living with and caring for psychiatric patients.	52
17 Number, standard deviation, and interpretation of caregiver-patient relationships in total, and classified by category.	53
18 Number, standard deviation, and interpretation of caregiver-patient relationships, classified by helping and considering each other.	54
19 Number, standard deviation, and interpretation of caregiver-patient relationships, classified by sharing common family activities.	55
20 Number, standard deviation, and interpretation of caregiver-patient relationships, classified by accepting each other.	56
21 Number, standard deviation, and interpretation of caregiver-patient relationships, classified by communicating and sharing ideas and experiences with each other.	57
22 Number, standard deviation, and interpretation of caregiver-patient relationships, classified by avoiding contradicting each other.	58
23 Number, standard deviation, and interpretation of caregiver-patient relationships, classified by loving and caring for each other.	59

CHAPTER I

INTRODUCTION

Background and Importance of Problems

Illness is a natural status which is not desired by any persons, because it can bring a person loss and despair, especially mental illness. Mental illness exists in people who cannot adjust themselves to the present actual environment. Those patients will show abnormality of mood, thought, perception and behavior. The patients do not know themselves, are isolated, have misleading thoughts, are fickle, and have no rationality. They have wrong perceptions such as hallucinations and illusions. They may have inappropriate behaviors such as neglecting themselves, isolating themselves, harming themselves and others (Prugsachartkunakorn, P., 1990).

The present economic situation including unemployment, and high competition in education and occupation, causes people to be unable to accept changes. They have disappointment, are hopeless and this increases the incidence of mental illness. This can be seen through the increase in the number of people having consultation about mental illness and the number of suicide cases. In Thailand, statistical records of the Department of Mental Health, Ministry of Public Health indicate the people who receive treatments as outpatients for four types of illness: schizophrenia, mood (affective) disorders, mental and behavioral disorder due to psychoactive substance use, and psychosis. The number of psychiatric patients in the years from 1995 to 1998 are 232,997 ; 235,805 ; 378,108 and 375,201 cases respectively, which shows the number is increasing every year. In southern regions, the number of psychiatric patients with the four types of illness from 1995 to 1998 are 18,675 ; 23,169; 23,026 and 22,165 cases respectively. Again the numbers are increasing every year.

Mental illness is a chronic illness which requires long term and continuous treatments. The patients cannot take care of themselves, thus they need care from their families. Therefore, mental illness is an important problem for the country. Caregivers

must take care of the patients and at the same time, they must work in order to sustain family income. Because the psychiatric patients need to be cared for, the caregivers cannot work at full capacity. This causes the loss of human resources for both the patients and caregivers who are important resources in developing the country. This economic loss is increased, both in time and money, when the treatments are prolonged.

Psychiatric patients have important symptoms such as inappropriate mood; being unable to know the time; or places or people. They have abnormal movement behaviors which may be moving too slowly, too quickly or not moving at all. They have no attention to themselves or the environment such as paying no attention to daily activities. The psychiatric patients have abnormal emotions such as laughing for sadness or crying for fun, fickle emotions, and they cannot control their emotions. They have abnormal thoughts such as discontinued thoughts, misleading or paranoid thoughts, and unreasonable fears, perception of illusions, and hallucination (Areetup, S.,1981:71-91). Because of those above mentioned abnormalities, the psychiatric patients require care and help from their families which are the basic units in health care. Related caregivers are husbands, wives, fathers, mothers, children, brothers, sisters and close relatives. Those people are responsible for caring for and helping the psychiatric patients who are unable to help themselves in daily activities such as personal hygiene, eating, taking medicine, and visiting doctors. Unfortunately, mental illness is a chronic illness which requires a long period of time for treatment. Besides, behaviors of the psychiatric patients often bring shame and boredom to relatives. The relative caregivers often want to keep the patients in the hospital forever, and are unwilling to bring the patients home, despite an improved condition. This is an important management problem for every psychiatric hospital and has a great effect on the patients because every patient needs social interaction. If the families do not give love, hope and encouragement, then the patients will be worsen. Relative caregivers are very important to the patients in giving good care which will allow the patients to receive proper medication, treatments, and rehabilitation continuously, thus preventing the return of the illness.

In caring for psychiatric patients, the caregivers must know the details about the psychiatric illness because knowledge makes people change behaviors (Suwantat, S.,

1984:279). Correct understanding about the illness makes the caregivers have correct caring behaviors. Punnarunotai, S. (1987) found that if the patients and the caregivers understand and follow the advice correctly then they will be able to reduce the severity of the illness and reduce the occurrence of future illness. T.Skul, J. (1981) studied the factors affecting the return of psychiatric illness and found that the caregivers of relapsed patients lacked knowledge and understanding about psychiatric illness, the nature of the illness and the correct type of care. The results agree with the study of Charaensun, V. (1985) which found that the caregivers had little knowledge and understanding about psychiatric illness. In caring for psychiatric patients, the caregivers should have understanding that the changed behaviors, emotions, and thoughts of the patients can play a role in caring and in activating the patients to help themselves (Suwankote, K., 1996:101). Therefore, if the caregivers have psychiatric knowledge about the causes of mental illness, psychiatric symptoms, treatments, and about caring for and improving the rehabilitation for psychiatric patients, then the caregivers will understand and have correct methods of caring.

The caregivers must have not only correct knowledge, but also positive attitudes toward mental illness because attitudes are how persons feel about others and they result from learning experiences, beliefs and they stimulate others to show suitable behaviors. (Aizen and Fishbein,1975) Therefore, good attitudes lead to good caring as Rokeach (1970) stated that feelings, beliefs, or attitudes are related to actions or appeared behaviors. Having good attitudes toward mental illness and psychiatric patients, causes of mental illness, treatments, living together and caring for the psychiatric patients, are important because these will make the caregivers understand and take enough care of the patients, by bringing the patients to proper and correct treatments at the hospitals. Because society does not accept but hates psychiatric patients, therefore the caregivers who have bad attitudes toward mental illness and psychiatric patients will hate and feel ashamed to have psychiatric patients in their families. The caregivers have poor caring behaviors, annoying, or paying no attention to patients, thus the illness is not improved or the patients may relapse. The study agrees with that of T.Skul, J. (1981) which states that the family of the psychiatric patients whose illness has returned have bad attitudes toward psychiatric illness.

Moreover, the belief about the causes of mental illness such as belief in demons have effects on the treatment. The caregivers will bring the patients to have holy water or chase away demons which are wrong treatments and will not improve the illness. In the end, the patients are brought to the hospital for proper treatments. It can be seen that good attitudes bring out good caring behaviors.

Regarding the relationship with psychiatric patients, everybody needs love, and sympathy from close relatives, especially those who are ill need more love and care from the family. Therefore, the relationship between caregivers and the psychiatric patients is important. If the caregivers have a good relationship with patients, they will love, care and be interested in finding knowledge to take care of the patients and they will be able to notice signs and symptoms of the mental illness quickly. On the other hand, if the caregivers have a bad relationship or conflict with the patients, they will not be interested in caring for the patients, but just do it as their duty and pay no attention to finding knowledge about the mental illness. As a result, the illness may require a long stay in the hospital. Those who have a poor relationship with the patients usually neglect the patients, pay no visits, and want the patients to stay in the hospital forever because they hate and they are ashamed of the psychiatric patients. This agrees with the study of Chaigena et al., (1998) which stated that if the relationship with the patients is bad, then the caregivers prefer to let the patients stay in the hospital. It can be seen that the relationship between caregivers and the psychiatric patients is important and has effects on caring for patients.

The southern part of Thailand consists of 14 provinces: Nakornsritammarat, Surattanee, Chumporn, Ranong, Punga, Puret, Krabi, Songkla, Pattalung, Trang, Satun, Yala, Pattani and Narathiwas. The culture and beliefs of the southern people regarding mental illness are that the illness is caused by demons, being hit by black magic or it is their own fate. The treatments are then carried out according to their beliefs such as bringing the patients to the monks or shaman to chase away demons, releasing the black magic power or making merit to release bad omens. Most southerners have only a primary education so they have little knowledge about psychiatric illness. Kaewmaneerat, P. (1992) studied the role of family members in caring for psychiatric patients, in a case study at Suansaranrom Hospital, and found that the samples had

correct knowledge and understanding about psychiatric illness in 4 types: meaning, causes, symptoms and treatment of the illness at an average rate of 64.18 percent. Most southerners work in the agricultural sector. Their families are expanding and the family members are less likely to migrate because the topography is suitable for agriculture. The family relationship should be close with the patients. Kaewmaneerat, P. (1992) found that the relationship between family members and the patients was at a moderate level.

In southern Thailand, the Suansaranrom Hospital of Surattanee is the center for psychiatric illness. The hospital has 1,080 beds. It serves to promote psychiatric illness protection; gives treatments; and rehabilitates the psychiatric patients. It covers 14 southern provinces of Thailand. Statistical records of the numbers of inpatients of Suansaranrom Hospital from the years 1995 to 1998 are 3,316; 3,236; 3,170 and 2,218 cases respectively. This is a good example of a southern psychiatric hospital.

According to the reasons described above, the caregivers are important to the patients who need help, care, encouragement, and support in order that the psychiatric patients can be rehabilitated to live normally in society. In order that the caregivers can care for the psychiatric patients efficiently, the caregivers must have good knowledge and understanding about the psychiatric illness, good attitudes toward mental illness and the patients, and a good relationship with the patients. The researcher is interested in studying psychiatric knowledge, attitudes toward mental illness, relationships between psychiatric patients and caregivers who brought the patients for treatment at the psychiatric hospital in southern Thailand in order to use the findings as a guide in giving knowledge about psychiatric illness, and improving attitudes and relationships between relative caregivers and the psychiatric patients. This will result in increasing efficiency in caring for psychiatric patients in the future.

Objective

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 relationship between caregivers and psychiatric patients who are having treatments in the southern psychiatric hospital. 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 relationship between caregivers and psychiatric patients who are hospitalized in the Suansaranrom 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 relationship between caregivers and psychiatric patients in order that psychiatric patients will get effective care from caregivers who are their relatives.

Definition of Variables

Caregiver of psychiatric patient means a closed related caregiver who directly takes care of a psychiatric patient admitted to a psychiatric hospital in the southern region. The patient has been diagnosed as having a mental illness such as schizophrenia, mood (affective) disorder, mental and behavioral disorder due to psychoactive substance use, or psychosis.

Knowledge of caregivers about mental illness means the knowledge and understanding that a caregiver has in order to take care of a patient. The knowledge and understanding of caregiver about mental illness is classified into 4 types: causes

of mental illness, psychiatric symptoms, treatments, caring for and improving the rehabilitative for psychiatric patients.

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

Caregiver-patient relationships means the interactive behavior between caregivers who are responsible for taking care of psychiatric patients and psychiatric patients themselves (from Crandall, 1980, 410-411; Weiss by Kaewprom, C., 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 patients' happiness, giving information and advice and actual financial helps.

2. Sharing common family activities means sharing the daily activity among caregiver and patient.

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 caregiver and patient.

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

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

CHAPTER II

LITERATURE REVIEW

In caring for psychiatric patients, caregivers will have good or poor caring patterns depending on their knowledge about mental illness such as the causes of mental illness, symptoms, treatments, and caring for and improving the rehabilitation for psychiatric patients. Besides the knowledge, the attitudes toward mental such as attitudes toward mental illness and the psychiatric patients, causes of mental illness, treatments, living with and caring for psychiatric patients and good caregiver-patient relationships illness is also important to the caregivers. Therefore, the researcher is interested in studying knowledge and attitudes toward mental illness and caregiver-patient relationships in a case study of caregivers of psychiatric patients in the southern psychiatric hospital. The researcher reviewed previous studies and research according to the following topics;

1. Knowledge of caregivers about mental illness
2. Attitudes of caregivers toward mental illness
3. Caregiver-patient relationships

1. Knowledge of caregivers about mental illness

In the old days, people did not understand and knew nothing about mental illness. They believed that physical and mental illness were the results of external powers, such as black magic power. These mysterious powers were God's power or Satan's power because the sick persons had committed sins or did something wrong, so they were punished. Healing followed their beliefs such as using incantations, spraying holy water, sacrificing to those powers, or asking for forgiveness. Most of the healers were witches, religious leaders, monks, or God's disciples. Later, the sciences were improved, and there were explanations about abnormal conditions of minds, therefore people could understand more about psychiatric illness (Kiewkingkaew,S.,1984:325). It can then be seen that knowledge is very important. Presently, psychiatric education is well known and these are several psychiatric hospitals all over the country. According

to the study of Meesup, K. (1989) it was found that more than 60 percent of patients who came to the psychiatric hospital had received non-professional treatments previously.

1.1 Importance of knowledge

Knowledge means the truth and details pressed and collected by human beings (Good,1973:325). People can have knowledge though several means; by reading, listening, noticing or knowing from experiences.

The Webster Dictionary (1973:581) gives the meaning of knowledge that it means the truth, laws and structures built from education and research, or knowledge about places, materials and man obtained through noticing and experiences, or reports.

An important concept defining human behaviors is the knowledge, and understanding of specific problems. The more knowledge people have, the more the activation people have (Suwantis,S.,1984:279). Education makes people learn and causes a change in behaviors (Good, 1973:313). Therefore, the caregivers must know about the mental illness so that they can take care of the patients correctly according to doctors' advice. This can slow down or avoid deficiencies due to the illness (Charoensun,J.,1995:8-9) and Pannarunotai, S. (1987) found that if the patients had knowledge and understandings and followed advice correctly, it was possible to reduce the severity of the present and future illness.

In caring for patients, Suwankote, K. (1997) said that the caregivers of the patients should : 1) understand about the behaviors , emotions and thoughts of the patient that have been changed; 2) be involved in the treatments; 3) have families and other helping units in the community to stimulate the patients to help themselves and use those helping units.

Therefore in caring for psychiatric patients, the caregivers should have knowledge about mental illness such as causes, symptoms, treatments, rehabilitation, and caring for and preventing the recurrence of the illness so that caregivers can understand and give correct practices.

1.2 Knowledge about mental illness. This can be divided into: meaning, causes, treatments, rehabilitation, caring for and preventing the recurrence of the illness.

1.2.1 Meanings of mental illness

Klaskerud and Servellen (1985) stated that mental illness means the unbalancing of environments causing stresses and supporting helps in such personal environments.

Cherhirun, S. (1989:16) gave the definition of mental illness or abnormal minds, or poor mental health that the abnormalities were of persons who have social problems, are separated from groups, have in-complete responsibility, or can not cooperate, or have personal problems.

Petchrat, B. (1996:39) gave the meaning of psychiatric illness or mental illness that is the imbalance of persons, bio-psycho-social conditions and personal environments. This causes unhappiness, feeling under tensions, being paranoid until they could not control thoughts, feelings and their behaviors. They expressed a deficiency in rationalizing, making decisions, using consciousness and adjusting themselves to live with others in society.

Mental illness, therefore, means the in-abilities of persons to adapt themselves to the present actual environments. These persons will show their abnormal activities which deviate from normal in order to reduce conflict, or disappointment so that they cannot build up relationships and live with others.

1.2.2 Causes of mental illness Being giving the correct knowledge on the causes of mental illness caregivers can prevent other family members from having mental illness and help in caring according to the causes of the illness.

Otrakul, A. (1995:47-53) explained the causes of mental illness by proposing 3 theories.

1) The theory of the hereditary factors. This theory states that the abnormalities of mental health are directly due to heredity and explains that mental illness is a result of a transfer from parents of illnesses such as schizophrenia, mood disorders, obsessive- compulsive, and pathological illness such as early brain deficiency, and Alzhiemer's disease.

2) The theory of organic factors. This theory states that the malfunction of pathological conditions of the brain or metabolism, or the abnormalities of endocrine glands, one of the amine in the neural communication system such as serotonin, dopamine, or acetylcholine is because of these imbalance.

3) Theory of environmental factors. This theory suggest that environments have great effects on the human mind and behaviors. The most important environment is the family which forms a persons' behaviors and makes the ability to adjust ones self. The differences in thoughts, and adaptations are the results of being raised in different family environments since childhood. Presently, several studies have shown that youngsters from broken or unhappy families usually have behavioral problems. Besides, life changing environments have effects on human minds such as disappointments, for example, disappointments in love, work, or unavoidable dangers. These can make existing weak personalities or existing stresses increase so much that any adjustment is impossible, and then mental illness can occur.

1.2.3 Psychiatric symptoms

Caregivers should have knowledge about the symptoms of mental illness so that they can notice the symptoms and the degrees of patients' behaviors. In knowing these, caregivers can take the patients to receive treatments at an early stage.

Ruangtrakul, S. (1985:74) divided mental illness into 2 types which are 1) Acute illness. The illness is clearly noticeable and occurs suddenly.. 2) Chronic illness. The behaviors are changing slowly and it is difficult to notice the changes except for people who are very close to the patient.

Ruangtrakul, S. (1999:1-6) divided the psychiatric disorders into;

1) Disorders of motor activity. This type of disorder includes ticking muscles, auto-repeating actions or stereotypes, catalepsy, auto-obedience or waxy flexibility.

2) Disorders of content of thought. The patients have a strong faith in untrue tales. They blindly trust in those untrue tales and it is impossible to change their beliefs by plain explanation. These include delusion of persecution, delusion of reference, delusion of grandeur, and somatic delusion.

3) Disorders of form of thought. This type is the inability to organize thoughts, or make connections of the context. The expressions are incoherence, blocking, and circumstantiality.

4) Disorders of affect. This type of disorder is an inappropriate fear of something or events more than is normal. These include phobia, euphoria, apathy, and irritability.

5) Disorders of perception. This is the wrong interpretation of sensing such as seeing a rope as a snake, smelling a weird odor, or tickling.

6) Disturbance of consciousness. The patients are confused, delirium, or disorientated.

7) Disorders of memory. The patients' ability to memorize is reduced such as losing memory after the event or anterograde amnesia, or losing memory before the event (retrograde amnesia).

1.2.4 Treatments. Treatments of psychiatric patients consist of 1) physical therapy which are medical treatments and electrical treatments; 2) psychological therapy which are individual therapy, group therapy, and family therapy; 3) milieu therapy ; 4) behavioral therapy.

1.2.4.1 Physical therapy. This kind of treatment are medication and electrification;

(1) Medication consists of 5 types; (Tantiplachiva, K., 1993:852-931; Ruangtrakul,S.,1985:203-215; Sukothaitamatirat,1985:1187-1205; Shives, 1994:186-203)

(1.1) Anti-psychotic drugs or major tranquilizer results in blocking dopamine in the brain. This type of medication is used for healing illusion, delusion, aggression, isolation, apathy and irritability. The patients should be better after 5 weeks of medication, however it might take a year to control the psychiatric symptoms. Termination of medication may result in repeated disorders and restarting the appropriate medication from the beginning may be required.

The drugs are effective in treatment but have the following side effects: 1) affecting nerve systems such as dry mouths, dry throats, indistinct sight, constipation, inability to urinate, contracting or expanding iris, hypo-tension. 2) affecting control nerve systems. Most disorders are motor disorders such as arm and hand shaking, stiff body, psychomotor retardation, apathy, muscle contraction, stiff

neck, running saliva, nervousness, chewing or sucking. It also has effects on the heart, circulation system, skin, eyes, and endocrine glands.

(1.2) Tranquilizers. This medication is for reducing worry, nervousness, and resulting in the limbic system by making the patients calm, and releasing muscles. It can be used as a sedative drug if used in small amounts. The side effects are drowsiness, tiredness, headaches, excitement, vomiting, and drug addicting.

(1.3) Mood-stabilizing drugs. This medicine cheers up the patients. It results in blocking the neural communication with serotonin and nor-epinephrine. Normally, it takes 6-12 weeks for the medication to be effective, beginning with small doses and make adjustments. In continuous medication, the patients should receive the medication for 4-6 months, then it should be reduced it but not immediately terminated. The side effects include drowsiness, dry throat and constipation.

(1.4) Anti-depressants. The drug used is Lithium, a kind of nature salt, which can cure depressed, or irritated patients. This medication must have optimum blood concentration in order to have effect. The dosage used is for 1-2 years. General side effects induce nausea, vomiting, over dosage effect, dehydration, renal failure, diarrhea, convulsion, or heart failure.

(1.5) Anti-cholinergic drugs. This medicine is for curing motor disorders such as; stiff muscles, hand shaking, upward face, running saliva, or stiff walking. This medicine adds dopamine to the brain to reduce the muscle stiffness and hand vibration. This medicine is usually used along with psychiatric medicines.

The caregivers should care for patients in taking medication as follows:

1) prevent the patients from drinking alcohol and using sedative drugs because it makes them drowsy and that is a risk for accidents. The patients should not drive and not work with machinery.

2) avoid direct exposure to the sunlight because the drugs make the skin dry and allergic to the sun.

3) not change the dose or terminate the medication without consulting doctors. If the patients are not getting well in 3 weeks, the caregivers should notice side effects and then report to the doctors.

4) If the patient has a chronic illness, the caregivers must report to the doctors because taking these drugs with others such as antacid drugs, it can make psychiatric drugs not work efficiently;

5) avoid taking anti-allergic drugs, because it can increase the effect and it is dangerous and not drink caffeine substances such as coffee because it may act against the medicine and keep the patient alert;

6) avoid continuous use of tranquilizer drugs because the patients may become drug addicted and not terminate the medication suddenly because it may make the patients have insomnia and bad dreams;

7) before receiving other medication, the doctors must be notified about the present medicine for sluggishness;

8) drinking water at least 3 liters/day, and drinking enough water for those who receive diuretic drugs;

9) eating salted food with balanced the salt will help discharge the drug effect through urination.

(2) Electric-convulsive therapy (ECT). The treatment is done by applying 70-130 volts to the brain cortex for 1-5 seconds to make the patients convulse. The patients can ease the effects of ECT by: 1) modified ECT; 2) unmodified ECT. The unmodified ECT is not used very often because it causes severe jerks which cause other side effects such as breaking bones, moving joints, or temporary loss of memory. In caring for patients who received the ECT, the caregivers should help the patients recall memories such as telling them about places, or materials. The caregivers should not threaten the patients with ECT for their inappropriate behaviors because it will scare the patients.

1.2.4.2 Psychotherapy. This can be conducted as individual therapy, group therapy, or family therapy.

(1) Individual therapy is the treatment of those who have mental disorders, emotional disorders and behavior disorders by making the patients change their thoughts, attitudes and behaviors by using the relationships between the patients and the therapist.

(2) Group psychotherapy is uses relationships between group members and the patients to change thoughts, behaviors and the lifestyle of the patients. The group makes the patients feel that there is someone who are worse than themselves. This can make the patients feel better and have social skills.

(3) Family therapy aims to solve emotional conflicts and improve the minds of the patients and family members. This improves communication.

The caregivers should give care to the patients during individual, group, and family therapy as follows:

- 1) encourage the patients to receive therapy in full because these therapies require rather along time, and the patients may be discouraged;
- 2) bring the patients to the doctors every appointment;
- 3) cooperate with the doctors such as in family therapy, bring the family and the patients to see the doctors.

1.2.4.3 Milieu therapy. Improving the environment so that each patient can interact among each other and the staff can effectively use techniques in the treatment systematically (including medication therapy, group therapy, individual therapy, and family therapy) in order to control the patients' behavioral expressions and let patients learn proper psycho-social skills.

The principles of arranging environment are (Shives, 1994: 102-103):

- 1) making the environment safe and similar to home;
- 2) the arranged environment must promote learning and express proper behaviors of the patients;
- 3) the patients have the rights according to the law and have equal rights with others;
- 4) allow the patients to take part and communicate with others;
- 5) accept the patients as human beings and support them to use their potential to solve the problems and;
- 6) conduct a routine evaluation to follow up the progress of the therapy.

The caregivers have roles in arranging the environments as follow: 1) arranging activities for the patients so that they may not feel the illness, such as housework, or hobbies according to their abilities; 2) assigning responsibilities to the patients to express their abilities, and ideas; and 3) accept the patients as family members.

1.2.4.4 Behavioral therapy. This therapy emphasizes controlling and changing appropriate behaviors. In the treatments, the need and objectives must be clearly identified to see how much change in the patients is required. This can be evaluated. The relatives have roles in caring for the patients as follows: 1) encouraging, talking and being interested in the improved behaviors ; 2) cooperating with the treatment team; and 3) always following and noticing the changed behaviors.

1.2.5 Psychiatric rehabilitation

Rehabilitation is very important. When the patients receive treatments until the symptoms are improved or have disappeared and return to their families or communities, rehabilitation will help the patients continue their lives in the communities without having psychiatric illness again. Psychiatric rehabilitation means the processes of developing bodies, minds, emotions, or leaning the psychiatric patients' developments by using their abilities to adapt themselves to the communities, live in a daily routine and work appropriately (Thamarode,K. and Nuttarungsi,J.,1995: 29-30).

Rehabilitation should be implemented all together at the same time with the following principles:

1) Rehabilitation of the body is the rehabilitation by using medical principles to let the patients do activities facilitating the motor activity such as walking, jogging, working out, and having recreation.

2) Mental rehabilitation is the rehabilitation by telling the patients to learn to control themselves. Verbal or nonverbal communication, perceiving feelings and thoughts, making decisions, giving commands and emotional expressions in accordance with the feelings are the methods.

3) Social status rehabilitation is the rehabilitation using life experiences so that the patients can adjust themselves with others, and develop relationship building with others.

4) Occupation rehabilitation is introducing and training the patients capabilities for a previous or new occupation so that they may feel proud and rely on themselves without being other people's burdens.

5) Community rehabilitation is to manage the patients to train their skills, express ideas, control their emotions so that they may be accepted and it leased to the adjustment of minds to live properly in accordance with the environment. They should also have training in talking, acting in front of others, and have a role in family members and community members. They should try to rely on themselves as much as they can.

Role of caregivers in helping psychiatric patient rehabilitation.

-In the rehabilitation of the physical body, the relatives should let the patients do their daily routines such as taking a bath, dressing, cleaning, planting and working out.

-The mental rehabilitation. The caregivers must try to understand the patients, accept them, encourage them in activities and admire them when they express appropriate behaviors, emotions, or make decisions. The relative should not show hatred but give love and understanding which makes the patients feel that they are part of the family.

-Social rehabilitation. The caregivers should support the patients to attend activities with others. The patients should be taught about manners and skills in the social aspect. The activities are such as visiting family members, and neighbors, and attending parties.

-Occupation rehabilitation. The caregivers should allow the patients to do housework such as cleaning houses, and washing according to their skill and abilities. If the patients want to work outside, the caregivers should help, give advice, and encourage the patients in the case of work problems.

-Community rehabilitation. The caregivers should promote attending community activities and undertaking appropriate community duties.

It can be seen that the caregivers are important persons responsible for caring for and rehabilitating the patients when they are back in the community. **The caregivers must take care of the psychiatric patients as follows:** (Sritunya Hospital, 1994:19-20):

- 1) The patients must regularly take the prescribed drugs even though the patients seem to be normal because it can control or prevent any abnormalities of the patients. Moreover, the caregivers must check for the following abnormalities: stiff body, stiff tongue, running saliva, walking without moving arms, hanging eyes. If these are found, the patients are allergic to the drug. If after solving the problem the patients do not improve, the doctors should be seen to adjust the treatments.
- 2) Follow up the treatments and bring the patients to the doctors as appointed.
- 3) Avoiding addictive substances, alcoholic substances, and avoiding working with machines
- 4) If the patients do not sleep during the day, have the patients do light work, exercise, or go out. After adjusting these activities, if the patients still do not sleep, then see the doctors.
- 5) If the patients have stress, are angry, or sad easily, the caregivers should help them find the causes such as lack of psychiatric drugs, and what impacts the patients such as psycho-social and environmental factors. The caregivers must give close care.
- 6) The caregivers should not force or free the patients too much. The caregivers should explain with reason and should not trick the patients because if the patients lose trust, it is not good for the treatment.
- 7) In sending the patients to receive treatments, the caregivers should observe the abnormalities in thoughts, emotions, and behaviors. The caregivers should bring the patients to the hospitals if the following symptoms occur:
 - 7.1) Changed behaviors such as talking more than usual, silence, isolation, carelessness, fury, or confusion;

7.2) Having hallucinations, and delusions such as hearing someone talking to them, talking or cursing alone, laughing alone, paranoia, or delusions of persecution.

All the above mentioned are the knowledge that the caregivers should have. Kane (1984) found that one difficulty in caring for the patients is the lack of knowledge and skill, especially about the medication. The caregivers cannot force the patients to take drugs. The study agrees with that of T. Skul, J. (1981) who found that the caregivers do not have knowledge and understandings about psychiatric illness, the progression of the illness, and the correct methods for caring for patients. Therefore, the caregivers should have knowledge about psychiatric illness in order to provide proper care and rehabilitate the patients when returning home. This makes the patients live with happiness in the communities and prevents the return of the illness.

2. Attitudes of caregivers toward mental illness

The caregivers are important to the psychiatric patients who cannot care for themselves. According to the previous studies, the expressed behaviors are the results of attitudes which directly occur from experiences in the response of a person to the stimulus and events (Cohen, 1963:138). This is the same as the study of Schwartz (1975:30) who stated that attitudes are the moderator which causes the following actions. Therefore, in caring for psychiatric patients, the caregivers who have positive attitudes toward the mental illness and the psychiatric patients, will have good behaviors. In contrast, the caregivers who have negative attitudes will have poor caring.

2.1. Meaning of attitudes

The word attitudes has its root from the Latin a 'Aptus' which means a tendency. A number of definitions are:

Baron et. al., (1988:86) gave the definition that is something by which we can evaluate our experiences by responding positively or negatively to people and things. Attitudes are built from knowledge, beliefs, experiences, likeness or unlikeness which results in defining behaviors to those things or people.

Ajizen and Fishbein (1975) stated that attitude is a representative to express a person's evaluation which reflects feelings, and emotions. Attitudes can be learned, therefore they can be changed and stay for a period of time. Attitudes stimulate a person's behaviors. What a person acts, part of it is the result of attitudes and that behavior will be in accordance with the attitude.

Rokeach (1972:53) said that attitude is the mixing and arranging of beliefs of a person to a thing or an event which is the combination of beliefs by his meaning and is a component of the person who may not realize those beliefs. These can be shown by talking, and acting. No matter what the beliefs would be, they will define the tendency of the person to act.

Kovasin, C. (1977) defined attitude as a feeling of a person to things. The feeling is the results of learning, experiences, and they stimulate the person to express his behaviors or the tendency to response to that stimulus, either against it or to support it.

In summary, attitudes are the results of thoughts, and feelings which will stimulate a behavior in one direction, either for or against. Therefore, behavior is the expression of attitudes which are the previous results of knowledge, thoughts, beliefs, and learning of the person.

2.2. Components of attitude

Rosenburg and Horland (1960) talked about the components of attitude that consist of 3 parts.

1) Cognitive component. It is about beliefs, and perceptions of a person to a positive or negative point.

2) Affective component. It is about emotions, feelings, and values of a person which are different to others. These result in either liking or disliking something, place, or event.

3) Behavioral component. This is the readiness or tendency to act or response to something such as ready to be against or support something.

From the components of attitude, it can be concluded the attitude of caregivers toward the mental illness are the readiness of the mind which includes thoughts, feelings, and the tendency to respond to the psychiatric illness. Attitudes occur from

previous experiences, beliefs, customs, raising methods and learning. These caregivers have either positive or negative responses to the psychiatric illness and the psychiatric patients. If the caregivers have positive attitudes, they will not hate them and are ready to care for the patients but if they have negative attitudes, they will feel shame and will not want to take care of the patients. The caregivers, therefore, can support or be against the willingness and defend the direction of behaviors.

In the case when the beliefs are part of an attitude, Sangingkaew, P. (referred to in Dechatiwong Na Ayuthaya, S. et al., 1977) stated that in the past people believed that the psychiatric illness was the punishment of a mysterious power, or supernatural power such as angels. Those who believed in the tree would worship the tree. Those who believed in the water well, would use the water to heal their illness. Moreover, they used quack medicines to heal the illness. Sometimes, black magic was used in the healing. If the illness persisted, the patients would be chained. The study agreed with that of Mesup, K. (1989:87-93) who classified the beliefs into 3 types: 1) Those caused by supernatural powers, i.e. demons made abnormal behaviors; 2) Those caused by doing wrong to the supernatural powers such as being cursed, breaking promises to angels, insulting holiness, old fate, or demon oil; 3) Those caused by natural powers such as imbalance of the body elements, the results of marijuana usage, heredity, or losing a loved one. The results of these beliefs made the relative bring the patient to quack treatments according to their beliefs. For example with, demon possession they brought the patients to have holy water poured onto them or went to voodoo doctors etc. Yupa et al., (1980) studied 273 patients of Sritanya Hospital and found that 48 percent of male patients and 52 percent of female patients have had quack medicine. This agreed with the study of Mesup, K. (1989:86) who had interviewed staff in the psychiatric sections of the Nakorn Ratchsima Hospital, Khonkaen Hospital and Suansaranrom Hospital and found that 60 percent of the psychiatric patients had visited voodoo doctors before. Baker (1976:349) said that how a person believes in health, so he would behave to his health. Therefore the belief in illness is related to how that person acts. The result of his belief leads to little prevention of psychiatric illness because he believes that it is caused by supernatural power, and man cannot do anything. Moreover, the treatment may not be continued because if no improvement

occurs he will then switch to other treatments, or have both voodoo doctors and psychiatrist specialists at the same time. This is the result of lacking correct knowledge.

The opinion of society to psychiatric patients affects the attitudes of caregivers. The stronger the effect of psychiatric patients on the minds and emotions of family members, the more society reacts to the changed behaviors. Goffman stated that those who had been in psychiatric hospitals were hated by society, therefore the relatives did not want to bring their patients to the psychiatric hospital. The study agreed with that of Paorohit, S. (1985) who found that the relatives were very ashamed to have a psychiatric patient in their home. Dechawong Na Ayuthaya, S. (1977) said that the attitudes of the relatives toward the psychiatric illness were usually in the form of shame, and they did not want other people to know that there was a psychiatric patient in their family. Nithikul, W. (1994) found that the caregivers did not accept the psychiatric illness and were ashamed when the patients behaved strangely. Therefore, the relative caregivers who had good attitudes toward mental illness would accept and, gave help to the patients. This reduced the return of the illness. The study agreed with that of T.Skul, J. (1981) who found that the family which had relapsed patients would have poor attitudes toward psychiatric illness. Therefore, having good attitudes toward the psychiatric patient and the illness is very important for hospitals to create such attitudes in the caregivers because if the relatives had bad attitudes, they would hate and would not want to care for patients or would not make good care, thus the patients might have repeated illness and require a long stay in the hospital. This is against the policy of the psychiatric hospitals that try to send the patients back to the communities as soon as possible.

Therefore, it can be seen that the attitudes of the caregivers toward the psychiatric illness can indicate or measure the caring behaviors and show if they are positive or negative . If the caregivers have good attitudes, they will be able to give help immediately and bring the patients to the hospital quickly. The patients will then be returned to the communities sooner and have normal lives.

3. Caregiver-patient relationships

When a family members is sick, the family will assign a person to replace the patients' responsibilities and this helps the sick improve continuously. These caregivers are the family members such as spouse, father, mother, children, including relatives, friends, and neighbors. These caregivers do an important job which is caring for patients for both body and mind in doing daily routines. They also follow the doctor's advice such as bringing the patients to the hospital and giving medicine etc. Morse et al., (1990 referred to in Sucharitkul, S., 1997) stated that caring is the expression of relationships among people. Caring is the feeling and behaviors that occur when people have relationships. This type of caring will occur in families or among close persons. If the caregivers have good relationships with the patients, this will result in good caring such as being interested in caring. In contrast, if the caregivers had bad relationships, the caring behaviors will not be good or they pay no attention to caring or will not follow doctors' advice.

3.1. Meaning of relationship

Relationship means concern, relating to Boontong, T. (1985:949) who gave the meaning of a relationship as a process bringing two or more people to know each other, building familiar relations, and closeness. The related people will receive an impact from each other such as the relationship between parents and children, spouses, teacher and students.

Chiewkingaew, S. (1984:66) said that a relationship is the process between two people making them familiar and dealing with each other for a period of time depending on the type of relationship between the two people.

Gay (1981:441) stated that a relationship is the processes occurring between two people, little by little and combining to be familiar.

Rosenthal (1973:201) stated that a relationship is a pattern of having interaction between two people and the results are not material but good feelings to each other.

Bowlby (1981:114) said that a relationship is love, and concern that a person has to another person permanently.

The summary of relationship is the relation of two people acting to each other with good feelings. Therefore the relationship of the caregiver to the patient is the relationship that the caregivers and the patients act to each other, and the love and concern they have together.

3.2. Components of relationship

Crandall (1980:410-411) talked about the components of the primary relationship as follows:

1) Number of role. The family relationship plays many roles such as father and mother are teachers, caregivers and helpers to the rest of the family members. They are creative in many ways, interesting, know values, and trust the actual personalities of each person.

2) Communication. The primary relationship is open communication. This is talking, and sharing ideas freely and broadly.

3) Emotion. The primary relationship of a family is built from emotions among members causing love understanding, loving care, concern, conflict and angry.

4) Transferability. The primary relationship is built in a certain person and is difficult to transfer to an other person. It is the specific interaction between individuals and is difficult to change.

It can be seen that the relationship between caregivers and patients is the primary one which consists of a number of role for each other; open communication, emotions such as love or anger, cooperation or conflict and individual feeling.

3.3 Characters of good relationship

Kaewprom, C. (1987:45) discussed the idea of Weiss that a good relationship consist of:

1) Closeness. This makes people feel warm and safe which the family members give to each other.

2) Involvement in society. This expresses the involvement between a person and others, resulting in sharing experiences, information, and admitting each other's faults.

3) Responsibility behaviors. For example, parents take care of the children, grownups take care of the elderly parents, and the stronger take care of the weaker.

4) Accepting. This occurs when a person has the ability to work appropriately. This may be the family role or occupational role. Accepting makes a person feel confident.

5) Helping. This is sharing help between related people.

From the components of the primary relationship and factors of good relationship in the society, it may be concluded that the good relationship between the caregivers and the patients must consist of:

1. Helping and considering for each other. This make the caregivers and the patients become close. The caregiver can notice the changes quickly, know the needs of and give help quickly and appropriately and also increase understanding.

2. Sharing common family activities. This makes the patients and the caregivers become close. The patient feels valuable and is part of the family.

3. Accepting each other. This makes the caregivers and the patients feel important and have feelings for each other.

4. Communicating and sharing ideas and experiences with each other. The patient and the caregivers understand and know each other more.

5. Avoiding contradicting each other. Conflicts make the caregivers become senseless and careless which causes poor caring behaviors.

6. Loving and caring for each other. Love makes concern between the caregivers and the patient to help each other.

Therefore, if the caregiver-patient relationships follow the above described factors, it means that they will have good relationship. If one person is sick, the other person will be interested in and willing to give care, help and feel sympathy in the case of a prolonged or severe illness. Mental illness is a prolonged illness and requires a lot of caring and commitment. In contrast, if the relationship is poor, the caregiver will feel that it is a heavy burden and will not be willing to care, pay no attention, thus the patient will not improve or may have repeated illness.

From the study of Chaisamoa, S., et.al., (1997:1-8) it was found that families with poor relationships wanted to keep the psychiatric patient in the hospital forever. The study agreed with that of Alanen et. al., (1986) which found that caregivers felt that they were enemies of the patients. This finally led to abandoning the patient. The study of Nithikul, W. (1994) found that psychiatric patients had perception disorders, thought disorders, the patient usually pleased himself and did not respond to the caregivers' need. This made the caregivers lose hope, feel despair, confused and angry with the patient and again might lead to abandoning the patient, or paying no attention to the sick. The study is in contradiction with that of Huang and Mao (1991) who found that the caregivers felt worried that if they had passed away who would take care of the patients. The study agreed with that of Charoensun, V. (1985) who found that the caregivers gave a warm welcome home to the patients.

It can be seen that the caregiver-patient relationships, no matter if good or poor, has effects on caring behaviors. In other words, if the relationships are good, the caregivers will be interested and willing to care, help, and feel sympathy, but if the relationships are poor, the caregivers will be bored and not willing to give care, feeling that it is a burden and thus it will result in poor caring.

CHAPTER 3

MATERIALS AND METHODS

This research will study the knowledge and attitudes toward mental illness, of relatives of psychiatric patients who are their caregiver, and also the relationship between caregiver and psychiatric patient. It is a case study of the caregivers of psychiatric patients in the southern psychiatric hospital.

Population characteristics and Sampling group

Population

The population used in this study were caregivers of psychiatric patient 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 Suansaranrom 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 (cite by Kypredaborisuthi, 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.

$$n = 2,128/(1+2,128 \times 0.05^2) = 336.7$$

The sample size used was 337. Therefore, in collecting the samples, the total number of 340 persons were selected from the Suansaranrom Hospital.

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 numbers, occupation, caregivers income, family income, residence.

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

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 caregiver agree with the statements.

“false” means that caregiver do not agree with the statements.

“unknown” means that caregiver 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 zero and the maximum score is twenty-nine. The interpretation of the data of knowledge and understanding of caregiver about mental illness was based on 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. 14-18); and attitudes toward living with and caring for psychiatric patients (9 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 caregivers 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 points;
 “moderately agree” is equivalent to 2 points;
 “less agree” is equivalent to 3 points;
 “disagree” is equivalent to 4 points.

The minimum score is one and the maximum score is four. The interpretation of attitude toward mental illness of caregivers followed the following criteria:

X scores 3.00 - 4.00 means that caregivers have good attitude toward mental illness ;

X scores 2.00-2.99 means that caregivers have moderate attitude toward mental illness ;

X scores 1.00 - 1.99 means that caregivers have poor attitude 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, C. 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 3items(No. 20-22);
- Loving and caring 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 caregiver think or behave almost every time;
“moderately often”	means that caregiver think or behave sometimes;
“rarely”	means that caregiver rarely think or behave;
“never”	means that caregiver 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 one and the maximum score is four. Interpretation of the caregiver-patient relationships was based on the following criteria:

X score 3.00 - 4.00	means that caregivers have good relationship with psychiatric patients;
X score 2.00 - 2.99	means that caregivers have moderate relationship with psychiatric patients;
X score 1.00-1.99	means that caregivers have poor relationship with psychiatric patients.

Validation of Research Instruments

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, clarity 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 questionnaires about knowledge of caregivers in mental illness was calculated by using Kuder-Richardson's equation (KR-20) (Ruechar, Y., et al., 1997:124):

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

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 attitude of caregivers toward mental illness and caregiver-patient relationships was calculated by using Cronbach's Alpha Coefficient which is described below (Ruecha, 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 question.

Results of the reliability of the questionnaire are:

1. Knowledge of caregivers about mental illness has reliability of 0.76;
2. Attitudes of caregivers toward mental illness has reliability of 0.82;
3. Caregiver-patient relationships has reliability of 0.80.

**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 Director of Suansaranrom 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 departments 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 inpatient of the hospital. The selection was made by studying the patients' records, 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. 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 340 samples, the researcher graded the responses to the questionnaires according to the criteria and then analyzed the results by using statistical methods.

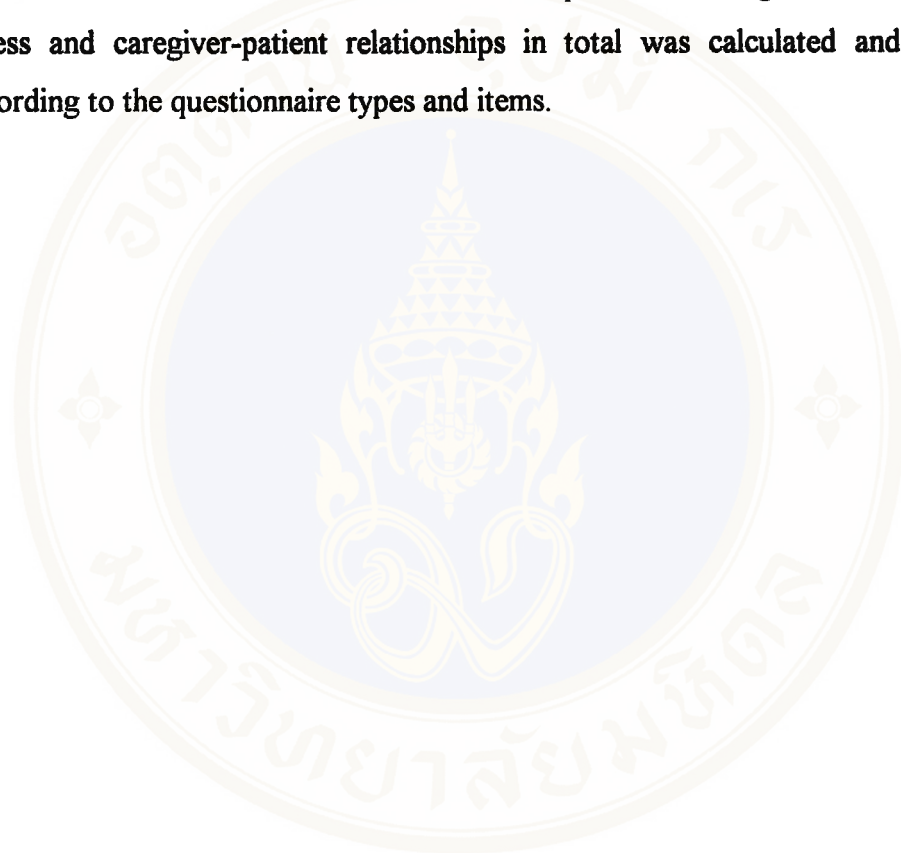
Data analysis

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 attitude 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 is a descriptive research to explore knowledge and attitudes toward mental illness and caregiver-patient relationships. It was a study of caregivers of psychiatric patients in southern psychiatric hospital. The sample size of 340 were selected from caregivers who had admitted patients to Suansaranrom 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 caregiver

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=340)	Percentage
Age (years)		
below 21	11	3.2
21-40	90	26.5
41-60	161	47.4
above 60	78	22.9
Gender		
male	121	35.6
female	219	64.4
Education		
no education	20	5.9
primary level	217	63.8
high school or vocational certificate level	69	20.3
higher than high school level or vocational diploma	34	10.0
Religion		
Buddhism	314	92.4
Islam	24	7.1
Christian	5	1.3
Family status		
family head	174	51.2
family members	166	48.8
Relationship with patients		
father or mother	169	49.7
spouse	50	14.7
brother or sister	76	22.4
son or daughter	23	6.8
Family numbers (persons)		
1- 3	95	27.9
4 - 6	198	58.2
7 - 9	45	13.2
more than 9	2	0.6

Table1. (cont.)

Characteristics of caregivers	Number (n = 340)	Percentage
Occupation		
house keeper	15	4.4
vendor	49	14.4
government employee	34	10.0
unemployed	45	13.2
employee	67	19.7
student	2	0.6
farmer	128	37.6
Caregivers' income (baht/month)		
≤ 5,000	233	68.5
5,001-10,000	62	18.2
10,001-15,000	14	4.1
15,001-20,000	18	5.3
> 20,000	13	3.5
Family income (baht/month)		
≤ 5,000	186	54.7
5,001-10,000	73	21.5
10,001-15,000	31	6.8
15,001-20,000	4	6.5
> 20,000	108	10.6
Residence		
central	6	1.8
northern	3	0.9
northeastern	2	0.6
southern	329	96.8

From Table 1, it is found that the largest number of caregivers were aged between 41-60 years old (47.4 %). Most of them are female (64.4 %), and their education is at the primary school level (63.8 %). Most of the samples are Buddhist (92.4 %). The largest number are family head (51.2 %), and they are fathers and mothers of the psychiatric patients (49.7 %). The largest number of the samples have their family numbers between 4 and 6 persons (58.2 %). The largest number of them are farmers (37.6 %). Most caregivers have their income is equal or less than 5,000 baht/month (68.5 %). Family income is equal or less than 5,000 baht/month (54.7%). Most of the samples have their residences in the southern (96.8 %).

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=340)	Percentage
Age (years)		
below 21	29	8.5
21-40	217	63.8
41-60	78	22.9
above 60	16	4.7
Gender		
male	222	65.3
female	118	34.2
Diagnosis		
Schizophrenia	270	79.2
Mood (affective) disorder	27	7.9
Substance induced psychosis	31	9.1
Psychosis	12	3.5
Number of admissions to the hospital		
first	109	32.1
second	75	22.1
third or more	156	45.1

From Table 2, it is found that most of the psychiatric patients are aged between 21-40 years (63.8 %), and male (65.3 %). They are diagnosed as being schizophrenic (70.3 %), and the largest number of them it is their third or more admissions in the hospital (45.1%).

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

Abnormal symptoms	Number (n = 184)	Percentage
The types of first abnormal symptoms.(Each patient has one or two symptoms)		
disorders of motor activity	89	48.4
disorders of form of thought	79	42.9
disorders of affect	42	22.8
disturbance of consciousness	30	16.3
disorders of content of thought	25	13.6
disorders of perception	24	13.0
others	1	0.5

From Table 3, it is found that caregivers has notices abnormal symptoms that appeared for the first time. It was also the first time that they brought the patients to the hospital as inpatients. After interviewing 184 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 disorder of motor activity (48.4 %) such as walking around continually, escaping from home, insomnia, sleeping, and mutism. The second most common was disorder of form of thought (42.9%) such as talking to themselves, uncontrolled talking, meaningless talking, and neologism. Next most common was disorder of affect (22.8 %) such as laughing or crying without reason, aggressive destroying materials, harming themselves and others. This was followed by disturbance of consciousness (16.3%) such as confusion and clouding of consciousness. Then come disorder of content of thought (13.6%) such as delusion of persecution, delusion of grandeur, delusion of jealousy, delusion of reference, and delusion of being controlled. Next to it was disorder of perception (13%) such as auditory hallucination and visual hallucination. Finally other disorder (0.5%) was regression.

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

Duration	Number (n =184)	Percentage
Time frame of onset of abnormal symptoms prior to admission		
1 week	23	12.5
2 weeks	8	4.3
3 weeks	1	0.5
1 month	14	7.6
2 - 6 month	17	9.3
7-12 month	17	9.3
>1 year	10	55.4

From Table 4, it is found that the largest number of psychiatric patients (55.4%) acquired abnormal symptoms one year or more before they were first admitted to hospital.

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

Abnormal symptoms	Number (n =340)	Percentage
The severity of symptoms which made caregivers decide to take the patients to a psychiatric hospital. (Each patient has one or two symptoms)		
disorders of affect	309	90.9
disorders of motor activity	145	42.6
disturbance of consciousness	78	22.9
disorders of form of thought	58	17.0
disorders of content of thought	42	12.4
disorders of perception	24	7.0
others	1	0.3

From Table 5, it was found that most of caregivers had noticed the severity of symptoms for each patient and that had made them decide to take the patients to psychiatric hospital. The data was obtained by interviewing 340 samples. The largest number of patients were disorders of affect (90.9%) such being aggression, harming others, destroying materials, harming themselves, social isolation, inappropriate affect, laughing or crying without reason. The second most common was disorders of motor activity (42.6%) such as walking around continually, escaping from home, insomnia, mutism, sleeping whole day, and rigidity. Next most common was disturbance of consciousness (22.9%) such as confusion and clouding of consciousness. This was followed by disorders of form of thought (17.0%) such as talking along, uncontrolled talking, meaningless talking, and neologism. Then come disorders of content of thought (12.4%) such as delusion of persecution, delusion of grandeur, delusion of jealousy, delusion of reference, and delusion of being controlled. Next to it was disorder of perception (7.0%) such as auditory hallucination and visual hallucination. Finally other disorder (0.3%) was 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 hospital.

Duration	Number (n=340)	Percentage
The time from the beginning of abnormal symptoms until the time of the decision to take the patients to the hospital.		
1 week	232	68.2
2 weeks	49	14.4
3 weeks	3	0.9
1 month	40	11.8
2-6 months	13	3.8
7 -12 months	3	0.9

From Table 6, shows that most patients (64.6%) were taken to hospital one week after the commencement of abnormal symptoms.

3. Knowledge of caregivers about mental illness

Table 7 Number, percentage, and interpretation of the caregivers, classified according to their knowledge of mental illness.

Knowledge of caregivers		Number	Percentage	Interpretation
		(n=340)		
Above	80% of possible points (23-29 score)	211	62.1	good
Between	60-80 % of possible points (17-22 score)	111	32.6	moderate
Below	60% of possible points (0-16 score)	18	5.3	poor

From Table 7 , it can be seen that most caregivers (62.1%) have good knowledge about mental illness. They gave correct answers and scored more than 80% of possible points. 32.6% of caregivers have moderate knowledge about mental illness. Only 5.3% of caregivers have poor knowledge about mental illness.

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

Knowledge of caregivers	Correct answer (n=340)	Percentage
Causes of mental illness		
- Poverty, prolonged social problems can cause mental illness.	313	92.1
- Disappointment from education, occupation, or love can cause mental illness.	309	90.0
- Addictive substances such as amphetamines, marijuana, heroin, whisky, or other addictive substances can cause mental illness.	299	87.9
- Mental illness occurs due to abnormality of chemical substances in the brain.	207	60.9
- Mental illness can be due to heredity.	191	56.2

From Table 8, most caregivers (92.1%) have correct answers on the knowledge about causes of mental illness regarding poverty, prolonged social problems can cause mental illness. The less caregivers (56.2%) have correct answers on the knowledge about causes of mental illness regarding mental illness can be due to heredity.

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

Knowledge of caregivers	Correct answer (n=340)	Percentage
Psychiatric symptoms		
- Psychiatric patients usually are out of reality and unable to control themselves.	329	96.8
- Psychiatric patients have weird, abnormal behavior such as sitting at the same location for a long time or walking for a whole day.	327	96.2
- Psychiatric patients have hallucinations such as seeing what others cannot; seeing what does not exist and hearing strange noises.	324	95.3
- Psychiatric patients often talk alone; talk discontinuously; or use indirect or improper words not understood by others.	317	93.2
- Psychiatric patients have delusion thoughts such as being hurt by others; thinking of being important and powerful persons.	313	92.1
- Psychiatric patients have abnormal effects. They laugh or cry without reasons.	302	88.8
- Psychiatric patients have less interested in the surrounding environment.	136	40.0

Table 9, shows most caregivers (96.8%,96.2%) 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, relatively. The less caregivers (40%) have correct answers on the knowledge about psychiatric symptoms regarding psychiatric patients have less interested in the surrounding environment.

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

Knowledge of caregivers	Correct answer (n=340)	Percentage
Treatments		
-Treatments for psychiatric patients does not take a long time nor involve continuity treatment.	336	98.2
-While having medication, psychiatric patients should not drink alcohol.	332	97.6
-Drugs for mental illness can cause drowsiness.	323	95.0
-Allowing psychiatric patients to be responsible for daily activities by themselves and sharing family activities can help them feel more valuable.	305	89.7
-Rewarding and encouraging the patients for their proper behaviors will make them repeat those behaviors.	305	89.7
-Treatment by psychotherapy can make psychiatric patients understand themselves and change behaviors.	291	85.6
-Drugs for mental illness may cause side effects such as stiff tongue, stiff body, or staring eyes.	263	77.4
-Treatment by using electricity can reduce psychiatric symptoms.	197	57.9
-Psychiatric patients should not stop the medication if they feel better.	196	57.6
-Treatment by electricity does not cause permanent loss of memory.	84	24.9

Table 10, shows most caregivers (98.2%,97.6%) have correct answers on the knowledge about psychiatric treatment regarding 1)treatments for psychiatric patients does not take a long time nor involve continuity treatment, and 2)while having medication, psychiatric patients should not drink alcohol, relatively. The less caregivers (24.9%,57.6%,57.9%) have correct answers on the knowledge about psychiatric treatment regarding 1)treatment by electricity does not cause permanent loss of memory; 2)psychiatric patients should not stop the medication if they feel better, and 3) treatment by using electricity can reduce psychiatric disorders, relatively.

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

Knowledge of caregivers	Correct answer (n=340)	Percentage
Caring for and improving the rehabilitation for psychiatric patients		
-Although the patients become normal, they should be checked at every appointment.	334	98.2
- Patients must be trained to do daily activities by themselves.	313	92.1
-Psychiatric patients should have opportunities to think, be rational, and decide matters with family members.	308	90.6
-Allowing the patients to take part in activities such as charity activities and seasonal celebrations helps them adapt themselves to others.	302	88.8
- Psychiatric patients should not stay home and do nothing.	233	68.5
- Psychiatric patients can have any career.	142	41.8
- Psychiatric patients should not be pleased in every matter to prevent stresses.	132	38.8

Table 11, shows most caregivers (98.2%, 92.1%) 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 followed up every appointment, and 2) patients must be trained to do daily activities by themselves, relatively. The less caregivers (38.8%, 41.8%) have correct answers on the knowledge about caring for and improving the rehabilitation for psychiatric patients regarding 1) psychiatric patients should not be pleased in every matter to prevent stresses, and 2) psychiatric patients can have any career, relatively.

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=340)

Attitudes of caregivers	\bar{X}	SD	Interpretation
Attitudes toward mental illness in categories			
Attitudes toward mental illness and Psychiatric patients	2.48	0.40	moderate
Attitudes toward causes of mental illness	2.95	0.69	moderate
Attitudes toward treatments	3.26	0.42	good
Attitudes toward living with and caring of psychiatric patients	2.86	0.62	moderate
Attitudes toward mental illness in total	2.89	0.37	moderate

From Table 12, it can be seen that caregivers have moderate attitudes toward mental illness in total aspect ($\bar{X}=2.89$). By consideration of the categories, caregivers have moderately attitudes toward mental illness. These categories are attitudes toward causes of mental illness, attitudes toward caring psychiatric patients, and attitudes toward mental illness and psychiatric patients. There is only one good attitude which is attitudes toward treatments.

Table 13 Mean, standard deviation, and interpretation of attitudes of caregivers toward mental illness, based on attitude toward mental illness and psychiatric patients. (n=340)

Attitudes of caregivers	\bar{X}	SD	Interpretation
Attitudes toward psychiatric illness and patients			
- Psychiatric patients require a lot of mental support.	3.82	0.50	good
- Mental illness is a kind of illness which can occur to any person at any age.	3.41	0.78	good
- Psychiatric patients are still useful and productive.	2.92	0.83	moderate
- Psychiatric patients are responsible for housework.	2.62	0.96	moderate
- Psychiatric patients are not lazy.	2.36	1.18	moderate
- Psychiatric patients are not usually dangerously angry with others.	2.35	1.20	moderate
- Psychiatric patients have tolerance to problems as much as normal people.	1.77	0.92	poor
- Psychiatric patients are not furious and aggressive.	1.54	0.87	poor
- Psychiatric patients usually do not act according to their desires.	1.42	0.73	poor

From Table 13, it is be seen that caregivers have good attitude toward mental illness and psychiatric patients which are 1) psychiatric patients require a lot of mental support, 2)mental illness is a kind of illness which can occur to any person at any age, relatively. The caregivers have poor attitude toward mental illness and psychiatric patients which are 1)psychiatric patients usually do not act according to their desires; 2) psychiatric patients are not furious and aggressive; and 3)psychiatric patients have tolerant to problems as much as normal people, relatively.

Table 14 Mean, standard deviation, and interpretation of attitudes of caregivers toward mental illness, based on attitude toward causes of mental illness. (n=340)

Attitudes of caregivers	\bar{X}	SD	Interpretation
Attitudes toward causes of mental illness			
- Mental illness is not caused by magic power from other persons.	3.23	1.04	good
- Mental illness does not occurs because patients have done wrong to places or spirits.	3.18	1.07	good
- Mental illness is caused by varied and imbalance body materials.	2.93	1.03	moderate
- Mental illness is not caused by bad fate.	2.46	1.23	moderate

From Table 14, it is 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. The caregivers have moderate attitudes toward causes of mental illness regarding 1) mental illness is not caused by bad fate, 2) mental illness is caused by varied and imbalance body materials.

Table 15 Mean, standard deviation, and interpretation of attitudes of caregivers toward mental illness, based on attitudes toward treatments. (n=340)

Attitudes of caregivers	\bar{X}	SD	Interpretation
Attitudes toward treatments			
- Bringing patients to have treatments in psychiatric hospitals can be able to make patients well again.	3.83	0.24	good
- Monks or witches cannot chase away demons to cure the patients.	3.68	0.75	good
- Magic activities such as chasing away demons or releasing omens cannot cure the mental illness.	3.49	0.82	good
- Mental illness can be totally cured.	3.19	1.03	good
- Religious activities or making merit cannot reduce the severity of mental illness.	2.11	1.07	moderate

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

Table 16 Mean, standard deviation, and interpretation of attitude of caregivers toward mental illness, based on attitudes toward living with and caring for psychiatric patients. (n=340)

Attitudes of caregivers	\bar{X}	SD	Interpretation
Attitudes toward living with and caring for psychiatric patients.			
- Psychiatric patients should have care from relatives regularly.	3.85	0.47	good
- Psychiatric patients should not be separated from society.	3.36	1.02	good
- Psychiatric patients should not be in the hospital for the rest of their lives.	3.24	1.09	good
- Psychiatric patients can participate in society with normal people.	3.15	0.87	good
- Having psychiatric patients in the house is not shameful for relatives.	2.99	1.27	moderate
- Caregiver will not be cautious when you are near psychiatric patients.	2.17	1.17	moderate
- Psychiatric patients do not create problems for family members.	2.14	1.09	moderate
- Having psychiatric patients in the house is not a burden for family members.	2.00	1.11	moderate

From Table 16, it can be seen that caregivers have good attitudes toward treatments regarding 1) psychiatric patients should have care from relatives regularly, 2) psychiatric patients should not be separated from society, relatively. The caregivers have moderate attitudes toward treatments regarding 1) having psychiatric patients in the house is not a burden for family members, 2) psychiatric patients do not create problems for family members, relatively.

5. Caregiver-patient relationships.

Table 17 Mean , standard deviation, and interpretation of the caregiver-patient relationships in total, and classified by category. (n=340)

Caregiver-patient relationships	\bar{X}	SD	Interpretation
Caregiver-patient relationships in categories			
-Helping and considering for each other	3.56	0.45	good
-Sharing common family activities	2.27	0.76	moderate
-Accepting each other	3.11	0.48	good
-Communicating and sharing ideas and experiences with each other	3.47	0.56	good
-Avoiding contradicting each other	3.40	0.27	good
- Loving and caring for each other	3.82	0.34	good
Caregiver-patient relationships in total	3.35	0.34	good

From Table 17, it can be seen that the caregiver-patient relationships in total are good. In consideration of the categories, the caregiver-patient relationships are good which are 1)helping and considering for each other; 2)accepting each other; 3) communicating and sharing ideas and experiences with each other; 4)avoiding contradicting among each other, and 5)loving and caring for each other. There is one moderate relationship which is sharing common family activities.

Table 18 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by helping and considering each other. (n=340)

Caregiver-patient relationships	\bar{X}	SD	Interpretation
Helping and considering for each other			
-Caregiver will know whenever the patient is unhappy or abnormal.	3.89	0.38	good
- Caregiver investigates on a daily basis the happiness of the patient such as asking about food: being on time; daily activities.	3.62	0.65	good
-Caregiver helps the patient financially.	3.56	0.83	good
-Caregiver gives advise and help in solving problems.	3.48	0.77	good
-Caregiver takes care of the patient in many activities such as eating; cleaning clothes and his/her matter.	3.25	0.97	good

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

Table 19 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by sharing common family activities. (n=340)

Caregiver-patient relationships	X	SD	Interpretation
Sharing common family activities			
-Caregiver and the patient eat together.	3.37	0.89	good
- Caregiver and the patient do housework together such as cleaning clothes, and shopping.	3.33	0.93	good
-Caregiver and the patient watch TV together.	3.24	1.10	good
-Caregiver and the patient have leisure time together, such as watching movies; and listening to music.	2.62	1.13	moderate
-Caregiver and the patient join social events together such as making merit; weddings and attending funerals.	1.99	1.44	poor

From Table 19, it can be seen that caregivers have good relationship in sharing common family activities regarding 1)they and the patient eat together,2) they and the patient do housework together such as cleaning clothes, and shopping, relatively. The caregivers have poor relationship regarding they and the patient join social events together such as making merit; weddings and attending funerals.

Table 20 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by accepting each other. (n=340)

Caregiver-patient relationships	\bar{X}	SD	Interpretation
Accepting each other			
-Caregiver listens to and understand the ideas of the patient.	3.85	0.41	good
-Caregiver accepts the ideas of the patients.	3.78	0.48	good
-Caregiver trusts the work done by the patient.	3.25	0.97	good
-Caregiver and the patient talk and share daily activities together.	3.08	1.00	good
-Caregiver make the patient feel important.	2.43	1.33	moderate
-The patient shares responsibilities in housework according to his/her ability.	2.23	1.89	moderate

From Table 20, it can be seen that the caregivers have good relationship of accepting each other regarding 1) they listen to and understand the ideas of the patient, 2)they accept the ideas of the patients, relatively. The caregivers have moderate relationship of accepting each other regarding 1) the patient shares responsibilities in housework according to his/her ability, 2) they make the patient feel important.

Table 21 Mean, standard deviation, and interpretation of caregiver-patient relationships, classified by communicating and sharing ideas and experiences with each other. (n=340)

Caregiver-patient relationships	\bar{X}	SD	Interpretation
Communicating and sharing ideas and experiences with each other			
-Caregiver always has an opportunity to talk with the patient.	3.79	0.53	good
- Caregiver and the patient have events to share.	3.34	0.85	good
-Caregiver and the patient have no secrets.	3.27	0.99	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=340)

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

From Table 22, it can be seen that the caregivers have good relationship regarding 1) they and the patient try to get along with each other, and 2) When they and the patient have a conflict, each can make an agreement. There is only one 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=340)

Caregiver-patient relationships	\bar{X}	SD	Interpretation
Loving and caring for each other			
- When caregiver is away, he/she worried about the patient.	3.86	0.44	good
-Caregiver will feel distress when the patient suffers.	3.86	0.40	good
-Caregiver try to protect the patient and try to make others feel sympathy for the patient.	3.74	0.61	good

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

CHAPTER V

DISCUSSION

This investigation studied knowledge and attitudes toward mental illness and caregiver-patient relationships of the caregivers of psychiatric patients in southern psychiatric hospital. The samples were caregivers who had taken the patients to receive treatment at Suansaranrom Hospital. The discussion will be decided into the following sections:

Demographic data of caregivers and psychiatric patients

Objective 1. To study knowledge of caregivers about mental illness

Objective 2. To study attitudes of caregivers toward illness

Objective 3. To study caregiver-patient relationships.

Demographic data of caregivers and psychiatric patients

This study showed that the largest number of caregivers were aged between 41-60 years old (47.4%), female (64.4%), fathers and mothers (49.7%) and that psychiatric patients were aged between 21-40 years old (63.8%). This might be because Thai society expects women to have responsibilities in caring for family members who were ill. Mothers or fathers had the duty to take care of their children. They were unable to neglect the patients even though the patients were adult or grown up persons because normally mothers and fathers always loved their children.

The largest number of caregivers were the family head (51.2%), the families number had between 4-6 persons (58.2%), caregivers' income was less than 5,000 baht/month (68.5%), and families income was less than 5,000 baht/month (54.7%). This showed that caregivers must work for their own income and their family income because they were head of the family, so it could be that they had less time to take care of the patients. The patients might be responsible in taking care of themselves, and sometimes they did not take the medicine which caused relapse. This agreed with

Chaeronsun, C.(1995) who showed that the psychiatric patients who repeatedly received treatments did not take medicine regularly.

The largest number of caregivers were educated at primary level (63.8%), their occupations were farmers (37.6%), their residences were in the south (96.8%), and their religion was Buddhism (92.4%). This agreed with Kaewmaneerat, P. (1992) who studied the role of family members in caring for psychiatric patient in a case study at Suansaranrom Hospital and found that most of the samples were educated at primary level (61.3%), their occupations were farmers (40.7%), and their religion was Buddhism (92%).

The largest number of psychiatric patient were male (65.3%), and their most common diagnosis was schizophrenia (65.3%). They had been admitted to the psychiatric hospital three or more times (45.1%). Schizophrenia was commonly found in the ages from late teenage to young adulthood, and males and females had an equal chance to be schizophrenic (Ruangtrakool, S.,1999:191). Schizophrenia is a chronic illness so the patients and the caregivers have to usually pay for treatments. Also the caregivers could receive experience such as symptoms, and treatments in caring for and gaining knowledge about mental illness from psychiatric patients.

Interviewing 184 from 340 caregivers who took the patients to the psychiatric hospital for the first time, it was found that the types of first abnormal symptoms were disorders of motor activity (48.4%) such as walking around continually ,escaping from home, insomnia, sleeping the whole day, and mutism. The time of onset of abnormal symptoms prior to admission was more than 1 year (55.4%). This result showed that caregivers could not detect abnormal symptoms of mental illness early, so they took the psychiatric patients to psychiatric hospital at a later time.

Interviewing 340 caregivers, it was found that the severity of symptoms which made caregivers decide to take the patients to a psychiatric hospital were disorders of affect (47%) such as being aggressive, harming others, destroying materials, harming themselves, social isolation, inappropriate affect, or laughing or crying without reason. The time from the beginning of abnormal symptoms until the time of the decision to take the patients to the hospital was 1 week (68.2%). This result showed that the violent behavior of psychiatric patients caused the caregivers troublesom and being

disturbed, so they could notice the symptoms and they took the psychiatric patients to the psychiatric hospital quickly.

Objective 1. To study knowledge of caregivers about mental illness

This study showed that caregivers had correct knowledge about mental illness (62.1%). This can be explained that most of the psychiatric patients were admitted to the psychiatric hospital for the second or more times (67.2%). The caregivers had got their experience from caring for the patients for a long time and they had more opportunities to gain knowledge about mental illness from psychiatric nurses. Because of those reasons, the caregivers had correct knowledge about mental illness. The study agreed with that of Kaewmaneerat, P. (1982) entitled "The role of family members in caring for psychiatric patients: a case study of Suansaranrom Hospital, studying the sample of caregivers who were family members and who took the patients to the Suansaranrom Hospital more than twice." The results showed that the family members in the patients' families had correct knowledge about understanding psychiatric illness in 4 categories: meaning (67.8 %), causes (50.4 %), symptoms (59.5 %), and treatments (18.9 %). The study differed from that of T.Skul, J.(1981) about forcing the psychiatric patients to return to receive treatment in the hospital. The results show that most caregivers did not have knowledge and understanding about mental illness, the progression of the illness, and correct caring methods.

When considering the knowledge of caregivers by categories and items, it was found that:

1.1 Causes of mental illness (Table 8). Most caregivers had correct knowledge in that: 1)a stressful society resulted in psychiatric illness (92.1%); 2) disappointments from education, work, and love could cause psychiatric illness (90.9%); 3)addictive substances could cause psychiatric illness (89.9%). This was because the caregivers had direct experiences from the patients or from other mass media such as TV, newspapers.

Sixty point nine percent of caregivers had correct knowledge that mental illness was caused by abnormal brain chemical substances . It can be explained that



these are specific causes that could only be known through medical staff, or by reading books about mental illness. Therefore, most people and patients did not know about this knowledge.

Only 56.2% of caregivers had correct knowledge that the cause of psychiatric illness can be heredity. It could be explained that those who could answer correctly had direct experiences from their family members who were psychiatric patients. The caregivers who gave wrong answers might have experiences in caring for mental illness caused by other causes such as addictive material; etc.

1.2 Psychiatric symptoms (Table 9). Most caregivers had correct knowledge that: 1)most psychiatric patients did not know themselves and had difficulty in controlling themselves (96.8%); 2)they had movements such as walking up and down (96.2%); 3)they had illusions (95.3%); 4)they were talking alone, they discontinued talking, or spoke weirdly (93.2%); 5)they had delusions such as delusion of persecution (92.1%); and 6)they were apathetic, or laughed irrelevantly and cried (88.8%). According to this investigation the types of first abnormal symptoms, most commonly found were disorders of activity (48.4%). And the severity of symptoms which made caregivers decide to take the patients to the psychiatric hospital this time was usually disorders of affect (47%). The caregivers had direct experiences in caring for the patients, so they had good knowledge about psychiatric symptoms and they could make decisions when the patients were violent and they took the patients to the hospital immediately. According to this investigation, most patients had showed their disorders for 1 week before the caregivers decided to take them to the hospital.

Only 40% of caregivers had correct knowledge that the patients were interested in the surrounding environment. It could be explained that this symptom did not bother the caregivers. Most of the caregivers could not notice this symptom except for the patients who isolated themselves from the community.

1.3 Treatments (table 10). Most of the caregivers had correct knowledge that: 1)treatments for the patients did not take a long time nor involve continued treatment (98.2%); 2)while having medicine, the patients should not drink alcohol (97.6%); 3) psychiatric drugs can cause drowsiness (95%); 4)allowing the patient to be responsible for daily activity by themselves could help them feel more valuable (89.7%);

and 5) psychotherapy made the patient understand themselves (85.6%). It could be explained that the caregivers had direct experiences in noticing that the patients were drowsy after taking the drugs, and they also got advice from the hospital staff about home care for the patients.

Seventy-seven point four percent of caregivers had correct knowledge that psychiatric drugs could cause side effects such as a stiff tongue and stiff body. The explanation could be that the caregivers could notice these side effects because these side effects usually occur when the patients took a large dosage. When the patients were in the hospital, the caregivers did not have these experiences.

Fewer caregivers had correct knowledge that: 1) treatments by electricity did not cause permanent loss of memory (24.7%); 2) the patients should not stop medication (57.6%); and 3) treatment by electricity could reduce psychiatric symptoms (57.9%). The explanation could be that the electric treatments were used less than the medication and the electric treatment was used to treat severe cases who were inpatients, so few caregivers knew about the electricity treatments and their side effects. The caregivers stopped the medication without consulting the doctors because they lacked knowledge about psychiatric drugs. This agreed with the study of Hutpanom, W. et al., entitled "Factors causing the return of psychiatric patients to Khonkaen Hospital". This study of the relatives of the patients found that because the relatives lacked knowledge about psychiatric medicine, therefore the patients did not receive the medicine continuously while they lived at home. The perceived reason was that the patients were normal, and did not need the medication.

1.4 Caring for and improving the rehabilitation for psychiatric patients (Table 11). Most caregivers had correct knowledge that: 1) although the patients became normal, they should be followed up at every appointment (98.2%); 2) patients must be trained to do daily activity by themselves (92.1%); 3) patients should have opportunities to think with family members (90.6%); and 4) allowing the patients to take part in activities such as charity activities helped the patients to adapt themselves to others (88.8%). It could be explained that the caregivers received advice from the hospital staff that the psychiatric patients should be able to help themselves, share in

family social activities, and be taken to the doctor for every appointment. These caused the caregivers to have correct knowledge.

Fewer caregivers had correct knowledge that: 1)the psychiatric patients should not be pleased in every matter to prevent stresses (38.8%); and 2)psychiatric patients can have any career (41.8%). It could be explained that the caregivers had long experience in caring for the patients and had found that the patients were aggressive, and violent when they did not get what they wanted. Besides, most caregivers were women (64.4%) where as most patients were men (65.5%) and were aged between 21-40 years (63.8%) which were the productive ages and they were strong. When the patients were furious they might hurt the caregivers, so the caregivers pleased the patients to avoid violent from the patients.

Objective 2. To study attitudes of caregivers toward mental illness

According to this study, it was found that the caregivers had a moderate attitudes toward mental illness in total.(Table12) It might be because the knowledge about promotion of mental health and prevention of mental illness have not been widely publicized. Only well educated people that possess knowledge regarding mental illness. As the majority of the caregivers have little education, the knowledge about mental illness was also at moderate or poor level. Baron et al.,(1985:81) stated that attitudes were developed from knowledge, beliefs, experiences, which led to define behaviors.

When considered by categories and items, it was found that:

2.1 Attitudes toward mental illness and psychiatric patients (Table13).

This category the caregivers had a moderate attitudes. This means that the caregivers had some good and some poor attitudes, which was similar to the study of Tuntraporn, S. (1981) who studied the attitude of relatives to psychiatric ward patients and found that most relative had sympathy and accepted the patients. The study of T. Skul, J. (1981) studying factors forcing the return of schizophrenic patients for treatment in the hospital found that psychiatric illness was unaccepted by society.

The caregivers had a good attitudes toward mental illness and psychiatric patients in the following items: psychiatric patients require a lot of encouragement; and mental illness is a kind of illness which can occur to any person at any age. It could be

explained that most of the caregivers were fathers and mothers (49.7%) and loved their children so much. And this study found that caregivers had good relationship with the patients. So the caregivers had good attitudes toward the psychiatric patients and the mental illness.

The caregivers had a moderate attitudes toward mental illness and psychiatric patients in the following items: the psychiatric patients were still useful and productive; responsible for housework; not lazy; and not dangerously angry with others. It could be explained that the largest number of caregivers were fathers and mothers (49.7 %) and the caregivers had a good relationship with the patients. They loved the patients, therefore they accepted and recognized the values of the patients. They had direct experiences in caring for the patients and found that sometimes the patients could be productive, but sometimes could not. Therefore, they had a moderate attitude about mental illness. The caregivers did not know about the side effect which could cause drowsiness. They did not know that the patients who had repeated illness would become less productive for society. They thought that the patients were lazy.

The caregivers had poor attitudes toward mental illness and psychiatric patients in the following items: the patients usually did not act according to their desires; they were not furious and aggressive; and they had less tolerance. The explanation could be that the caregivers had long experiences in caring for the patients and found that if the patients were furious or did not receive medicine, they could not sleep. The caregivers experienced that the patients were furious and acting out to please themselves.

2.2 Attitudes toward causes of mental illness (Table 14). This category the caregivers had a moderate attitudes. This means that the caregivers had a good attitude because they thought that mental illness was caused by an imbalance of body substances. But those who had a poor attitudes because they thought that mental illness was caused by demon possession, or being hit by magic powers. This was similar to the study of Mesup, K. (1989) who interviewed social workers about the pattern of belief about psychiatric illness and self-care in Thai communities and found that more than 60% of the patients received treatment from voodoo or quacks before treatment in psychiatric hospitals.

The caregivers had a good attitudes toward causes of mental illness in the following items: mental illness was not caused by magic power from other persons; and it did not occur because patient had done wrong to places or spirits. It could be explained that presently, there has been more education about mental illness, and the new generations believed in science rather than black magic. These causes the caregivers to know that mental illness was caused by abnormalities in body, mind and society, not by supernatural powers. Besides, the patients had received the quack treatments and realized that they did not improve, therefore they did not believe in those black magic powers or supernatural powers.

The caregivers had a moderate attitude toward causes of mental illness in the following items: mental illness was caused by varied and unbalanced body materials; and not caused by bad fate. The explanation could be that most caregivers were Buddhist (92.4 %); they believed that the patients had bad fate in the past therefore they presently received those results (Thamapidok,1983:25-26); It was the perception of caregivers to accept the condition more easily and that reduced the burden of thoughts. The results of this study showed that most caregivers had moderate knowledge that mental illness occurred due to abnormality of chemical substances in the brain (Table 8).

2.3 Attitudes toward treatments (Table15). This category the caregivers had a good attitudes because most caregivers had experiences in taking the patients to receive quack treatments but the patients did not get better, but when the caregivers took them to receive treatment in a psychiatric hospital the patients got better. So the caregivers did not believe in black magic powers or quack treatments and realized that mental illness have to be treated by psychiatrists.

The caregivers had a good attitudes toward treatments in the following items: bringing patients to have treatments in psychiatric hospital could make patients well again; the caregiver did not believe that monks or wizards could chase away demons to cure the patients; they did not believe that the black magic activities such as releasing omens could cure mental illness; and mental illness could be totally cured.

The caregivers had a moderate attitudes toward treatments in item that they did not believe that religious activities or making merit could reduce the severity of

symptoms or illness. This meant that some caregivers had good attitudes but some had bad attitudes. It could be explained that most caregivers were Buddhist (92.4%) and believed that doing good deeds could reduce the results of bad fate and the caregivers would feel better when they did good religious deeds.

2.4 Attitudes toward living with and caring for psychiatric patients (Table 16). This category the caregivers had a moderate attitudes. T. Skul, J. (1981) found that most relatives were interested, paid attention and respected the patients, but they thought the patients were their burden and it was not easy to care for the patients. Forty-two point seven percent of the relatives wanted to keep the patients in the hospital forever. This is similar to the study of Wansanit, P. (1983), who stated that "Some social problems made the patients unable to stay home and the relative must take them to psychiatric hospital again". This study also found that the patients were burdens of the relatives in caring for them. This made relatives take them to the psychiatric hospital again. It could be seen that the relatives who had poor attitude toward living with and caring for psychiatric patients would give poor care and that caused repeated illness.

The caregivers had a good attitudes toward living with and caring for psychiatric patients in the following items: psychiatric patients should have care from relatives regularly; should not be separated from society; should not be in the hospital for the rest of their lives; and could live with normal people. The explanation could be that most caregivers were fathers and mothers (49.7 %) who loved and had concern for and felt sympathy with the patients. Despite the mental illness, they still loved and needed them. According to Thai customs, fathers and mothers were expected to take care of their children, and if they did not they would be condemned by society.

The caregivers had a moderate attitudes toward living with and caring for psychiatric patients in the following items: psychiatric patients were not shameful for relatives; they did not cause problems for family members; the caregivers would not be cautious when they were near the patients; and having psychiatric patients in the house was not a burden for their family. The explanation could be that most caregivers had direct experiences in caring for the patients for a long time, so they found the bad behaviors of the patients such as: stripping; stealing made the caregivers feel that the

patients were trouble makers, and made them feel ashamed. This was similar to the study by Paorohit, S. (1979) and Dechatiwang Na Ayuthaya, S. (1977) that the relatives were ashamed to have their patients live in the families because of neighbors. The study was similar to that of Nithikul, V. (1992) in that the relatives were ashamed when the patients expressed weird behaviors. In this study, it was found that the severity of symptoms which made caregivers decide to take the patients to the hospital mostly were disorders of affect (47%). Most of the symptoms that had been found were hurting other persons and themselves. The caregivers were afraid of being hurt, thus when the patients were furious the caregivers would be more cautious of being near the patients. Most caregivers were the heads of family (51.2%) and had personal and family incomes of less than 5,000 baht/month. The caregivers must work for their income, therefore, they had less time to care for the patients. Some caregivers have to stop working in order to care for the patients and thus they lost income but at the same time they must pay for the treatments. The caregivers believed that having the patient live in the family would increase burdens. In contrast, the results of this study showed that caregivers had a good relationship with the patients, and therefore they accepted the burdens of caring and did not think that the patients were trouble makers or brought shame to the family.

Objective 3. To study caregiver-patient relationships

It was found that caregivers had good relationships with the patients in total (Table 17). This could be explained because most of them were fathers and mothers (49.7 %). Fathers and mothers had to take care of the children when they were sick, and they loved and had concern for their family members. The average number of family members was 4-6 persons (58.2 %). Each family consisted of father, mother, children, or husband, wife, brother and sister which was a small number of family members, so the relationship between family member was close. Therefore, when a family member had mental illness, or changed their emotions and behaviors all family members would be worried, pay attention and share the burdens. This was similar to the study of Pupaiboon, R. (1991:6-7) in that every family member had the duty to please the patients for physical and emotional needs by giving them close love and care.

These would make the patients have a strong mind and recognize their own values. Good relationships were important to the patients. However, the results of this study differed from that of Kaewmaneerut, P. (1992) in that the close family members had duties to take care of the patients and had moderate relationships with the patients.

When considered by categories and items, the explanation could be as follows:

3.1 Helping and considering for each other (Table 18). This category the caregiver-patient relationships was good. The caregiver-patient relationships was good in the following items: the caregivers would know whenever the patient was unhappy or abnormal; they investigated on a daily basis the happiness of the patient; they helped the patients financially; they gave advice and helped solve problems; and they took care of the patient in many activities. Most caregivers were female (64.4%) who were gentle and vigilant, therefore they recognized any symptoms quickly. Most caregivers were fathers and mothers of the patients (49.7%). Therefore, they were interested in helping with many things such as eating, personal hygiene, and financial aids. Most caregivers were farmers (37.6%), and therefore usually worked at home, so they had ample time to take care of the psychiatric patients.

3.2 Sharing common family activities (Table 19). This category the caregiver-patient relationships was at moderate level. The caregiver-patient relationships was good in the following items: the caregivers and the patients ate, watched TV and did housework together. The explanation could be that eating together, watching TV together, sharing housework, and shopping together were family activities and the caregivers could take control of these activities.

The caregiver-patient relationships in sharing common family activities was poor in item that caregiver and the patients joined social events together such as making merit. And caregiver-patient relationship was a moderate level in item that caregiver and the patients had leisure times together such as watching movies. The explanation could be that the patients did not do outdoor activities which require communication and interaction with other people well because most psychiatric patients had problems about perceptions, behaviors, thoughts, communication, and building relationships (Petcharat, B., 1996:23). The caregivers were worried that the patients might increase their problems and if the patients were out of control, they would be

ashamed other. Some caregivers thought that the patients were still not ready to go out of the houses.

3.3 Accepting each other (Table20). This category caregiver-patient relationships was good. The caregiver-patient relationships was good in the following items: the caregivers listened to and understood the ideas of the patients; accepted the ideas of the patients; and trusted the work done by the patient. They and the patients took and shared daily activities together. The explanation could be that most caregivers were parents (49.7%) who always loved and accepted the patients. Therefore they listened and tried to understand and trust in the patients' ideas and talked together. The caregivers assigned work to the patients such as washing dishes, cleaning the house, etc., thus, this made the patients feel valuable so they were willing to participate in family activities. This was similar to the study of Cohen and Will, (1985:356-357) which found that good family relationships made people have a firm emotion, work better, reduce stresses and brought good health.

3.4 Communicating and sharing ideas and experiences with each others (Table21). This category caregiver-patient relationships was good. The caregiver-patient relationships was good in the following items: caregivers always had an opportunity to talk with the patients; and had events to share; they and the patients had no secrets. This could be explained that most families have 4-6 family members (58.2%) which were small families, therefore caregivers could take care of the patients closely. The largest number of caregivers were farmers (37.6%), so they had ample time to meet, and talk with the patients.

3.5 Avoiding contradicting each other (Table22). This category caregiver-patient relationships was good. The caregiver-patient relationships was good in the following items: when caregivers and the patients had a conflict, each could make an agreement; they and the patients tried to get along with each other. This could be explained because the caregivers and the patients loved each other. It might be because the largest number of caregivers were aged between 41-60 years (47.4 %) which are mature and had enough experiences, reasons, maturity in emotions and they knew how to solve problems and make good decisions (Chanaim, S.,1993:171).

3.6 Loving and caring for each other (Table 23). This category caregiver-patient relationships was good. The caregiver-patient relationships was good in the following items: when caregivers were away, they were worried about the patients; they would feel distress when the patients suffers; they tried to protect the patients and tried to make other feel sympathy for the patients. These could be explained that most caregivers were fathers and mothers (49.7%), therefore they loved and had much concern for the patients. They despaired when their children were sick, especially with mental illness because they expressed shameful behaviors such as stealing, and shouting. The caregivers tried to protect the patients and convinced others to understand the patients.

In summary, this research shows that caregivers in the south of Thailand gave reasonable care for the psychiatric patients in giving medicine, bringing the patients to the hospitals as appointed, and rehabilitating the patients. If the caregivers gave suitable care to the patients, then the patients would not be violent, not repeat the illness, and thus reduce the expenditure for treating the psychiatric patients. Therefore making the caregivers know about mental illness correctly was important in caring for the patients. It was an important factors and supported the policy of the Ministry of Public Health in reducing the number of days of hospital stay and it could also reduce the burdens of caring for psychiatric patients.

CHAPTER VI CONCLUSION

This investigation was a descriptive research to study knowledge and attitudes toward mental illness and caregiver-patient relationships. It was a study of caregivers of psychiatric patients in southern psychiatric hospital.

The samples a total 340 cases were caregivers who were relatives and who were most directly taking care of the psychiatric patients and they had taken the patients to receive treatment at the Saansaranrom hospital as inpatients from February 1999 to April 1999.

The research instrument consisted of questionnaires about demographic data of the caregivers, demographic data of the psychiatric patients, knowledge of caregivers about mental illness, attitude of caregivers toward mental illness, and caregiver-patient relationships.

The data obtained were analyzed as follows:

1. Demographic data of caregivers and psychiatric patients was analyzing by frequency distribution and percentage.
2. Number and percentage of caregivers who gave correct answers on the knowledge about mental illness, classified according to the categories and items were calculated.
3. Mean and standard deviation of points indicating attitude toward mental illness and caregiver-patient relationships in total were calculated. They were classified according to the categories and items.

Results

Demographic data of caregivers. The largest number of caregivers were aged between 41-60 years old (47.4%), female (64.4%), had completed primary school (63.8%), were Buddhist (92.4%), and family head (51.2%). Fifty eight point two percent had between 4-6 family members. Thirty seven point six percent were farmers.

The majority of caregivers had income of less than 5,000 baht/month (68.5%) and total family income of less than 5,000 baht/month (54.7%). Concerning the relationships with the patients, they were fathers and mothers of the patients (49.7%), and lived in the southern region of Thailand (96.8%)

Demographic data of psychiatric patients. The largest number of psychiatric patient were aged between 21-40 years (63.8%) and were male (65.3%). The most common diagnosis of the psychiatric patients was Schizophrenia (79.2%) and the most common number of admissions to the hospital was three or more (45.1%). Interviewing 184 from 340 caregivers who took the patients to the hospital as inpatients for the first time. It was found that the types of abnormal symptoms were mostly disorders of motor activity (48.4%) and the time frame of onset of abnormal symptoms prior to admission was more than 3 years (30.2%).

Regarding severity of symptoms which made caregivers decide to take the patients to the psychiatric hospital this time, it was found that the largest number of symptoms were the disorders of affect (37.7%) and the time from the beginning of abnormal symptoms until the time of the decision to take the patients to the hospital was one week. (68.2 %).

Knowledge of caregivers about mental illness

Most caregivers (62.1%) had good knowledge about mental illness. They gave correct answers and scored more than 80% of possible points. After consideration by categories and items follows:

Cause of mental illness. More than 80% of caregivers had correct knowledge that: poverty and prolonged social problems; disappointment from education, occupation, or love; and addictive substances such as amphetamines, marijuana, heroin, whisky, or other addictive substances can cause mental illness. Less than 61% of caregivers had correct knowledge regarding mental illness occurs due to abnormality of chemical substances in the brain; and can be due to heredity.

Psychiatric symptoms. More than 80% of caregivers had correct knowledge that: psychiatric patients usually are out of reality and unable to control themselves; have weird, abnormal behavior such as sitting at the same location for a long time or walking for a whole day; have hallucinations such as seeing what others

cannot; seeing what does not exist and hearing strange noises; often talk alone; talk discontinuously; or use indirect or improper words not understood by others; have delusive thoughts such as being hurt by others; thinking of being important and powerful persons; have abnormal effects; and laugh or cry without reasons. Less than 60% of caregivers had correct knowledge that psychiatric patients had less interest in the surrounding environment.

Treatments. More than 80% of caregivers had correct knowledge that: treatments for psychiatric patients does not take a long time nor involve continued treatment; while having medication, psychiatric patients should not drink alcohol; drugs for mental illness can cause drowsiness; allowing psychiatric patients to be responsible for daily activities by themselves and sharing family activities can help them feel more valuable; rewarding and encouraging the patients for their proper behaviors will make them repeat those behaviors; treatment by psychotherapy can make psychiatric patients understand themselves and change behaviors. Less than 60% of caregivers had correct knowledge regarding treatment by electricity can reduce psychiatric disorders; and may cause permanent loss of memory; psychiatric patients can stop the medication if they feel better.

Caring for and improving the rehabilitation for psychiatric patients. More than 80% of caregivers had correct knowledge that: although the patients become normal, they should be checked at every appointment; psychiatric patients must be trained to do daily activities by themselves; should have opportunities to think, be rational, and decide matters with family members; allowing the patients to take part in activities such as charity activities and seasonal celebrations helps them adapt themselves to others. Less than 60% of caregivers had correct knowledge regarding psychiatric patients must be trained to do daily activities by themselves; and allowing the patients to take part in activities such as charity activities and seasonal celebrations helps them adapt themselves to others.

Attitudes of caregivers toward mental illness

The caregivers had a moderate attitudes toward mental illness in total. They had a good attitudes toward treatments; a moderate attitudes toward causes of mental

illness; living together and caring psychiatric patients; mental illness and psychiatric patients. After consideration by categories and items follows:

Attitudes toward mental illness and psychiatric patients. The caregivers had a good attitudes that: psychiatric patients require a lot of encouragement; and mental illness is a kind of illness which can occur to any person at any age. The caregivers had a poor attitude that: psychiatric patients usually do not act according to their desire; are not furious and aggressive; are less tolerant against problems than normal people.

Attitudes toward causes of mental illness. The caregivers had good attitudes that: mental illness is not caused by magic power from other persons; nor occur because patients have done wrong to places or spirits.

Attitudes toward treatments. The caregivers had a good attitudes that: bringing patients to have treatments in psychiatric hospitals can make patients well again; monks or witches cannot chase away demons to cure the patients; magic activities such as chasing away demons or releasing omens cannot cure the mental illness; and mental illness can be totally cured.

Attitudes toward living with and caring for psychiatric patients. The caregivers had good attitudes that: psychiatric patients should have care from relatives regularly; should not be separated from society; nor in the hospital for the rest of their lives; and could participate in society with normal people.

Caregiver-patient relationships

The caregivers had good caregiver- patient relationships in total. They had good relationship with the patients in the following categories: loving and caring for each other; helping and caring for each other; communicating and sharing ideas and experiences with each other; avoiding contradicting each other; accepting each other. The caregivers had moderate relationship with the patients in sharing common family activities. After consideration by categories and items follows:

Helping and considering for each other. The caregiver-patient relationships was good in that: caregivers will know whenever the patient is unhappy or abnormal; investigate on a daily basis the happiness of the patient such as asking about food, and daily activities; help the patient financially; give advice and help in

solving problems; and take care of the patients in many activities such as eating; cleaning clothes and mattresses.

Sharing common family activities. The caregiver-patient relationships was good in that: caregivers and the patients eat together; do housework together such as cleaning clothes, and shopping; and watch TV together. The caregiver-patient relationships was poor in that caregivers and the patient join social events together such as making merit; going to weddings; attending funerals.

Accepting each other. The caregiver-patient relationships was good in that: caregivers listen to and understand the ideas of the patient; accept the ideas of the patients; trust the work done by the patient; and they and the patient talk and share daily activities together.

Communicating and sharing ideas and experiences with each other. The caregiver-patient relationships was good in that: caregivers always have an opportunity to talk with the patient; they and the patient have events to share; and have no secrets.

Avoiding contradicting each other. The caregiver-patient relationships was good in that: caregivers and the patient try to get along with each other; and when they and the patient have a conflict, each can make an agreement.

Loving and caring for each other. The caregiver-patient relationships was good in that: when caregivers are away, they are worried about the patient; they will feel distress when the patient suffers; and try to protect the patient and try to make others feel sympathy for the patient.

Suggestion

For nursing

1. The results of this study indicated that not many caregivers know that mental illness is the result of heredity and imbalance of brain chemical substances. The caregivers did not realize that the psychiatric patients were not interested in the surrounding environment. They understood the patients could stop the medication if their symptoms improved. Most caregivers did not know about the electricity treatment.

Nurses should educate the public and especially the caregivers about the causes of mental illness, psychiatric symptoms, treatments, and care for and improve the rehabilitation for psychiatric patients by using leaflets, group education, or educating the caregiver when they visited the patients, or educating them when the patients were discharged from the hospital. As a result that the caregivers could have correct knowledge about mental illness and they would have correct caring behavior.

The psychiatric hospitals and Department of Mental Health, Ministry of Public Health should publicize more knowledge about promoting mental health to general public by using the mass media ie. television, radio, newspapers, and leaflets for the prevention of mental illness as well as Internet.

2. The results of this study indicated that the caregivers had poor attitudes toward psychiatric patients in that: the patients usually act according to their desire. They get easily furious and aggressive, and have less tolerance to problems than normal people.

Giving correct knowledge about mental illness will change negative attitudes of caregivers toward psychiatric patient especially not taking continuity psychotic drugs to be better. Nurses should educate the caregivers and psychiatric patients to take continuity psychotic drugs by giving leaflets, by group education and by giving advice to the caregivers individually, and by paying home-visits for serious cases and after discharge.

3. The results of this study showed that the caregiver-patient relationship was at a moderate level in sharing common family activities, such as social activity.

The nurses should promote the relationship by encouraging the caregivers to bring their improved patients to attend social activities such as giving social skills training to psychiatric patients and caregivers, and distributing leaflets about promoting the caregiver-patient relationship. There should be continual education programs and promotion programs for the rehabilitation of the patients.

For further research

1. There should be a study program to develop knowledge, attitudes, caregiver-patient relationships and caring behaviors to caregivers.

2. A comparative study of attitudes and caring behaviors of caregivers, before and after educating caregivers about mental illness.

BIBLIOGRAPHY

Aizen, I. And Fishbein, M.E. (1980). Understanding attitudes predicting social behavior.

New Jersey: Prentic-Hall, Inc.

Allport, G.W. (1976). Attitude in attitude theory and measurement. New York: Wiley and Son, Inc.

Alanen, Y.O. et al. (1986). Toward need-specific treatments of schizophere psychosis: A study of the development and results of a globe psychotherapeutic approach to psychosis of the schizophrenia group in Tur, Finland. Berlin Heidelberg: Springer-Varagy.

Bailey, D.S. & Bailey, D.R. (1993). Therapeutic approaches to the care of the mentally ill. (3rd ed.) Philadelphia: F.A. Davis Company.

Barry, P.D. (1994). Mental health and mental illness. (5th ed.) Philadelphia: Lippincott Company.

Charoensun, J. (1995). Factors affecting the return of psychiatric patients to the Suansaranrom Hospital. A research report, the Suansaranrom Hospital.

Chaisamoa, S., Wirekarut, J. & Pratepajit, C. (1997). Situations of family caring of psychiatric patients. Department of mental health journal, 4(1), 1-8.

Crandall, R.C. (1980). Gerontology : A behavioral science approach. Readings, Massachuau: Addison-Wesley Pubishing Company.

Cohen, Arthur R. (1963). Attitude change and social influence. New York: Basic book Inc.

Creer, L. & Wing J.K. (1974). Schizophrenia at home. Institute of Psychiatry.

Department of Mental Health, Ministry of Health. (1997). A report on the patient statistics of 1997. Planning Division, Department of Mental Health.

.....(1997). Caring of the patients having psychiatric problem and mental health for vulunteers. (2nd ed.). Nonthaburi, Department of mental health.

- Department of Mental Health, Ministry of Health(1998). The conference on mental health 1998: Development of psychiatric services to overcome the economic crisis,7-9 September 1998 at Prince Palace Hotel Bangkok.
- Gay, J. (1981). A Conceptual framework of bonding. JONG nursing, (November-December), 440-444.
- Good, C. V.(1973). Dictionary of education. New York. Mc Graw-Hill Company.
- Haber,J., & Giuffra, M.J. (1992). Comprehensive psychiatric nursing. St. Louis: Mosby year Book.
- Horwitz, A. , & Reinhard, S. (1995). Caregiver burden: Differentiating the content and consequences of family care giving. Journal of marriage and the family, 57 (August); 741-750.
- Huang, PL. and Mao China-Ling. (1991). An investigation of the home caregiving experience of schizophrenia patients' relatives & tree perception and coping behavior. Proceeding of the Second International Family Nursing Conference, Portland, Oregon, 99-100.
- Ip, G.S.H., & Mackenzie, A.E.(1998). Caring for relatives with serious mental illness at home the experiences of family carers in Hong Kong. Archives of psychiatric nursing, 12(5),288-294.
- Jungsakul, R. (1997). Factor affecting the readiness of families in caring psychiatric patients at home. Department of mental health journal, 4 (1),21-35.
- Kaewmaneerat, P. (1991). A study on the role of family members in caring psychiatric patients: A case study of the Suansaranrom Hospital. A Master Thesis in Social Science, Faculty and Social Sciences, Thammasart University.
- Kaewprom, C. (1987). Relationships between social structures and social support, and elder's mental health in the Bangkok Elderly Assembly. Master Thesis in Nursing Mamagent, Chulalongkon University.
- Kamrut, S.,Jarenmuang, P., Pattanapitpaisarn, A., & Peande, S. (1971). Attitudes of Isarn people toward psychiatric patients. Journal of psychiatrist society of Thailand, 16(3),201.
- Kane,C.(1984). "The out-patient come home: The family's response to Deinstitutionalization". Journal of psychosocial nursing,22(November),19-25.

- Kiewkingkaew, S. (1984). Basic concepts of psychiatric nursing. (2nd ed.). Chiangmai: Pong Press.
- Kittiratanapaiboon, P. (1997). Stigma and mental illness. Suanprung Hospital Journal, 13(1),29-36.
- Kompayak, J. (1986). Families: Basis of health and caring. Journal of nursing,4(4), 351-364.
- Kotamon, T.and Paolohit, S. (1995). A study of social problems of psychiatric in-patient of the Konkaen Mental Hospital. A research report, Konkaen Mental Hospital.
- Lotakul, M., & Sooknit, P. (1996). Psychiatric sciences Ramatibadee. Bangkok: Chuanpim Press.
- Lungsuwang, K. (1981). Psychology. Bangkok: Mahamongkul Rathawittayalai.
- MacDermott, C. M. (1994). Psychopharmacology in essentials of psychiatric. 14th ed. Pennsylvania: J.B. Lippicott Company.
- Meesup, K. (1997). A pattern of belief in mental of health and madness and self caring in Thai societies. Clinical psychology, 2(1), 83-101.
- Mengarm, B. (1987). Attitudes of relatives toward psychiatric patients. A Master Thesis Education, Chulalongkorn University.
- Mental Health Institute, Ministry & Health. (1994). A handbook for rehabilitation of psychiatric patients in communities (Improved Edtion) Book 1-3. Bangkok: Thammasart University Press.
- Minkhoff K. (1978). A map of chronic mental patients. In Talbott, J.A., ed. The chronic mental patient. Washington, DC.: American Psychiatric Association: 11- 37.
- Natasiri, D.et al.,(1977). Possibilities of families and neighbors in helping psychiatric patients. A report on the 31 th conference in mental health. Somdetchaopraya Hospital, 13-18 Febuary 1978.
- Ngamthipwatthana, T. (1992). Behaviors of patients that make the relatives bring them to the hospitals. Journal of psychiatrist society of Thailand,31(2),126-127.
- Nitikul, W. (1994). A study on the stress of psychiatric patients' relatives. A Master Thesis in Art, Department of psychology, Chulalongkorn University.

- Otrakol, A. (1995). Mental health. Bangkok: Numugsorn Press.
- Petchrut, B. (1996). Nursing of mental and psychiatric illness (book 1). Songkla: Textbook producing project, Faculty of Nursing, Songklanakarin University.
- Ponganutri, C. (1988). Helping relatives of psychiatric patients. Thai Journal of Psychiatrist, 33(3),100.
- Priemmongkol, P. (1994). Psychiatric Nursing. Bangkok: Surakarnpim Press.
- Pumipark, C. (1988). Learning and teaching psychology. Bangkok: Thai Wattanapanich.
- Punnarunotai, S. (1987). How much the patients can understand their continued illness. Journal of Medicine. Area 6,1(May-August),17-24.
- Putmin, I., and Inochanon, A. (1994). Family communication. Department of mental Health Journal,2(2),9-17.
- Ratchbunditsatarn. (1982). Dictionary, Ratchbunditsatarn Edition 1982. Bangkok: Ugsornchareontus.
- Ratanatiknon, C., Assanangkornchai, S. & Tanchaiswad, W. (1997). Pattern of help-seeking by relatives of psychotic patients. J. Psychiatr Assoc Thailand,42(4), 226-232.
- Rattanakorn, N. (1993). Structure and economic of families' readiness in home-caring of psychiatric patients, Nontaburi Province. Master Thesis , Department of medical Protection and society, Chulalongkorn University.
- Robinson, K. & 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 change sanfrancisco. Jossey Press Inc.
- Rosenthal, M.K. (1973). Attachment and mother-infant interaction. Journal child psychology, 14 (September), 201-207.
- Ruechar, Y.at al., (1997). Research in nursing (6th ed). Bangkok: Siamsilp Press.
- Ruangtrakul, S.(ed).(1985). Handbook of medical science. (1st Ed) Bangkok: Parppim Press.
- Saengsingkaew, F. (1956). Family Loving Concern. Journal of Psychiatrist Society of Thailand, 12(2-3): 94.

- Samarhpun, S. (1987). Decision processes of relatives to bring psychiatric patients to receive psychiatric treatments. A Master Thesis in Humanity and a Sociology Thammasat University.
- Shives, L. R.(1994). 1st ed. Basic concepts of psychiatric mental health nursing. (3rd ed.) Pennsylvania: J.B. Lippicott Company.
- Sipongam, Y. (1996). Home relative caregivers: Ideas and problems in research. Journal of nursing, 2(1),84-92.
- Sitthimongkol, Y. (1995). Family burdens in caring psychiatric relatives: An analysis. A research report. Journal of nursing, 1(Janury- March),19-26.
- Sritanya Hospital. (1994). Handbook of rehabilitation of psychiatric patients in communities, Book 1-3. Bangkok: Thammasat University Press.
- Sukothaitammatrirat University. (1985). A lecture note on selection of caring method for mothers, babies and psychiatric patients No.10-15. Bangkok. Numkung Press.
- Sutusnee, S. (1998). Human relation. (4 ed.). Bangkok: Chulalongkorn University Press.
- Suwan, P. (1983). Attitudes: Measuring the changes and health caring behaviors. (2nd ed.). Bangkok: Wangburapa.
- Suwankote, K. (1996). A note on selection of nurses for rehabilitation no. 6-10. (2nd ed.). Bangkok: Chuanpion Press.
- Suwanlert, S., Inseepong, W., and Meesup, W. (1979). Psychiatric patients and prevention. Clinical psychology journal, 1(3),25-30.
- Suwanship, S.(1994). Factors of mental society and health. Mental Health Institute Journal, 2(1): 1-6.
- Tagliacozzo, D.M.and Ima,K.(1970). Knowledge of illness as a Predictor of Behavior. J. of Chornic Disease, 22(November),765-775.
- Tangboonngam, S. (1984). A study on social conditions affecting caring of psychiatric patients: A case study of Songklanakar Hospital, Hatyai District, Songkla. A Master Thesis in Social Sciences, Faculty of Social Sciences, Thammasart University.
- Tornsend C. Mary. (1993). Psychiatric mental health nursing: Concept of care. (1st ed.) Philadelphia: F.A. David.

- Tornsend C. Mary. (1996). Psychiatric mental health nursing : Concept of care. (2nd ed) Philadelphia: F.A. David.
- Torry, E.F. (1983). Surviving schizophrenia: Family manual. New York : Harper Colophon Books.
- T.Skul, J. (1981). Factor forcing the return of psychiatric patients. A master Thesis, Faculty of Social Sciences, Thammasat University.
- Triandis, H.C.(1971). Attitude and attitude change. New York: Wiley and Sons.
- Trungkasobat, U. (1997). Psychiatric treatment and family counselling . (1st ed). Bangkok: Fuangfa.
- Tumroj, K., & Nutrungsi, J. (1995). Rehabilitation of psychiatric patients. Journal Psychiatric nursing and mental health, 9(2),27-35.
- Tuniplachiva, K. (ed). (1993). Text Book of Psychiatry. (1st). Bangkok: Thammasat University.
- Wisitkosol, Y., et al.,(1980). Psychiatric patients and quack treatments. Journal of psychiatric association of Thailand, 24 (March), 25-33.
- Zimbardo, P.G. Ebbesen, F.B. & Maslach, C. (1977). In fluencing attitude and changing behavior. London: Addison-Wesley Publishing Company.

APPENDIX



APPENDIX A

The expert name



Expert clinician names are validated the instruments.

1. Associate Prof. Dr. Uboon Niwatchai

Department of Mental Health and Psychiatric Nursing.

Faculty of Nursing, Cheangmai 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

Informed consent note

The questionnaire



Consent form

To whom it may concern.

I am Prisana Choeyesiri, 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 Southern Psychiatric Hospital". 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 as a 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.

P. Choeyesiri

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 Psychiatric Patients in Southern 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. Ageyears

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

.
. .
.

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 disorders, treatments, caring for and improving the rehabilitation for psychiatric patients. Interviewers reviewed and understood all statements in the questionnaire before using it by reading out the questions to others and asking them their feelings and opinions. Then the persons answering were allowed to answer questions at this time. If persons the answering did not understand any questions, interviewers must clearly explain so that the persons answering would understand and answer correctly.

The interviewers 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 strongly agree with the statement

"unknown" means that caregiver do not know that the statement is correct or not

knowledge of caregivers	true	false	unknown
<p>1. Mental illness is due to heredity.</p> <p>2. Mental illness occur due to abnormality of chemical substances in the brain .</p> <p>3. Addictive substances such as amphetamines, marijuana, heroin, whisky, or other addictive substances can cause mental illness.</p> <p>.</p> <p>.</p> <p>.</p> <p>28. Psychiatric patients should be pleased in every matter to prevent stresses.</p> <p>29. Although the patients become normal, they should be checked at every appointment.</p>			

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, and treatments, and about living with and caring for psychiatric patients. Interviewers reviewed and understood all statements in the questionnaire before using it by reading out the questions to others and asking then their feelings and of opinions. Then the persons answering were allowed to answer questions at the time. If the persons answering did not understand any questions, interviewers must clearly explain so that the persons answering would understand and answer correctly.

The interviewers 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 caregivers	strongly agree	moderately agree	less agree	disagree
<p>1. Mental illness is a kind of illness which can occur to any person at any age.</p> <p>2. Psychiatric patients have less tolerance to problems than normal people.</p> <p>3. Psychiatric patients are still useful and productive.</p> <p>•</p> <p>•</p> <p>•</p> <p>25. Having psychiatric patients in the house is a burden for family members.</p> <p>26. Having psychiatric patients in the house is shameful for relatives.</p>				

Part 5**Caregiver- patient relationships**

Instruction: This questionnaire is designed to get information about the general relationships 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 showing loving care with each other.

Interviewers reviewed and understood all statements in the questionnaire before using it by reading out the questions to others and asking then their feelings and opinions. Then the persons answering answered my questions at the time. If the persons answering did not understand any questions, interviewers must clearly explain so that the answering persons would understand and answer correctly.

The interviewers 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
<p>1. You investigate on a daily basis the happiness of the patient such as asking about food: being on time; daily activities.</p> <p>2. You give advice and help in solving problems.</p> <p>3. You will know whenever the patient is unhappy or abnormal.</p> <p>.</p> <p>.</p> <p>.</p> <p>24. You will feel distress when the patient suffers.</p> <p>25. You try to protect the patient and try to make others feel sympathy for the patient.</p>				

BIOGRAPHY



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INSTITUTIONS ATTENDED Kaukarun Nursing College, 1983-1987:
Bachelor Nursing
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