

Expressed Emotion among Family Caregivers of Persons with Schizophrenia: A Causal Model Study

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Abstract: The purpose of this cross-sectional correlational study was to test the Model of Expressed Emotion among Family Caregivers of Persons with Schizophrenia. A hypothesized casual model was developed based on Lazarus and Folkman's theory of stress and coping, and empirical evidence from a literature review. Relevant factors integrated into the Model included severity of illness, mental health status of the family caregiver, caregiving burden, family functioning, and stigma. The study participants, recruited by means of purposive sampling, consisted of 385 primary family caregivers of adults with schizophrenia who had been followed up at outpatient units of two major psychiatric hospitals in central Thailand. Data were collected using the Thai Expressed Emotion Scale, the Behavior and Symptom Perception Scale, the Thai General Health Questionnaire-28: the Caregiving Burden Scale, the Chulalongkorn Family Inventory, and the Perceived Stigma Questionnaire. Structural equation modeling was used to test the hypothesized model.

The study findings revealed that the modified model fitted the data and could explain 57% of variance of expressed emotion. In addition, severity of illness, mental health status, caregiving burden, and family functioning had a direct effect on expressed emotion. Meanwhile, stigma had an indirect effect on expressed emotion, mediated through caregiving burden and mental health status of the family caregiver. The Model can be used as a guideline for developing nursing interventions to reduce caregiving burden, as well as promote mental health status and family functioning among family caregivers of persons with schizophrenia.

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Introduction

Schizophrenia is a severe and chronic mental illness, identified by profound disturbances of thinking, perception, affect, and social behavior^{1,2} that often reduces a person's ability to function well in daily life, their occupation, and their social activity. Schizophrenia is ranked among the top ten causes of disability-adjusted

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life years (DALYs) globally³, with a prevalence rate of approximately 1.5%–3% worldwide, and affecting around 24 million people.⁴ In Thailand, the number of patients diagnosed with schizophrenia is more than twice the number of patients diagnosed with mood disorder, the second most common mental illness.⁵ Moreover, schizophrenia is a costly disease. For example, the overall direct cost of schizophrenia has been estimated at THB 87,000 (USD 2600) per person and THB 31,000 million (USD 925 million) for the entire population with schizophrenia.⁶ Unemployment of both patients and families is a major indirect cost, resulting in more than half (61%) of the total economic burden of schizophrenia.⁶ In addition, the consequences of schizophrenia interrupt almost every aspect of a person's life,^{1,2} since it is a dependent chronic condition that requires a high demand for care by family caregivers. Internationally, family caregivers continue to play a significant and expanding role in the care of persons with schizophrenia. Globally health and social services systems, including those in Thailand, tend to conform to the current trend of mental health care policy⁵ that focuses on shortening the hospitalization period and returning persons with schizophrenia and other mental illnesses to live with their families in the community as soon as possible. Therefore, family caregivers are significant persons because they supplement conventional medical treatment, give reassurance, and help reduce the recurrence of the illness. Caregivers may care for people with schizophrenia, as well as other family members. As a result, overwhelming tasks and struggles to balance their daily life and responsibilities often cause them to perceive more stress and difficulties in several areas in their life, reflecting a high level of burden.⁷ These experiences lead family caregivers to have high expressed emotion (HEE), which in turn increases the risk of relapse in schizophrenia in the person they are caring for.⁸

Expressed emotion (EE) is defined as an attitude, feeling, or behavior of the family caregiver

in response to and reaction towards the person with schizophrenia.^{9,10} It is composed of five key aspects: criticism or critical comments (CC); hostile, emotional over-involvement (EOI); and positive remarks and warmth^{9,10,11}; emotional under-involvement; and emotional regulation, the last two of which are additional aspects particularly found in the Thai culture.¹² EE is manifested in traits of low expressed emotion (LEE) or HEE. LEE family caregivers are usually characterized as tolerant, non-intrusive, and sensitive to patient needs.^{9,10,11} On the contrary, HEE is described as patterns of CC, hostility or marked EOI^{9,10,11} which manifest as rejection, irritability, ignorance, blaming, overprotection, self-sacrifice, or being over-intrusive.^{11,13} Such reactions of HEE family caregivers may create a negative emotional atmosphere,^{9,11,13} causing persons with schizophrenia to have more stress that can potentially precipitate a relapse.^{8,9,14}

High and low EE family caregivers obviously differ from each other. However, many aspects of the EE concept, especially its mechanism, are not clearly understood.^{11,14} Therefore, it is important to know why some family caregivers react differently to events associated with the illness, or why some family caregivers have HEE while the others do not. Several studies have found that the meaningful factors associated with EE are severity of illness,^{15,16,17,18} mental health status of the family caregiver,^{15,18} caregiving burden,^{14,18} family functioning,¹⁹ and stigma.²⁰ Whilst emerging studies have pointed to only those individual variables that might have the direct effect on EE, a more comprehensive, multivariate model of contributors to EE has not been tested. Therefore, this study was undertaken with the hope to better understand EE among family caregivers of persons with schizophrenia. The study aimed to test the developed Model of Expressed Emotion among Family Caregivers of Persons with Schizophrenia in an attempt to describe how multiple factors influence EE.

Conceptual Framework

The conceptual model of this study was based on Lazarus and Folkman's theory of stress and coping¹⁹ and a literature review. The cognitive appraisal process was used to describe the relationship pattern of how five selected factors—severity of illness, mental health status of the family caregiver, caregiving burden, family functioning, and stigma—worked to influence EE.

According to Lazarus and Folkman's theory of stress and coping¹⁹, there are two types of cognitive appraisal, primary and secondary. Primary appraisal is a person's consideration whether the encountered situations have meaning or influence in their life. Such evaluation can be summed up as irrelevant (this is not important), benign-positive (this is good), or stressful. Stressful appraisals can be classified into three typical forms: 1) harm/loss (damage or loss that has already happened); 2) threat (the anticipation of harm that may be imminent); and 3) challenge (potential for gain and growth inherent in an encounter). Secondary appraisal is used to evaluate personal effort or competence as well as social support available in coping or handling stress. When the caregivers primarily appraise the caregiving situation as threatening they may overestimate the situation, however in secondary appraisal their ability to cope is often underestimation. Consequently, the emerging stress will affect their adaptation in a dysfunctional fashion, or by producing unhealthy outcomes.

In this study, EE was considered as the adaptation outcome, and presented as the attitude, feeling, or behavior with which the family caregivers frequently reacted to their family members with schizophrenia. EE was influenced by the stress of caring activities through primary appraisal. The severity of illness, considered in terms of the frequency or degree of patients' schizophrenic symptoms and behavior, was evaluated by the family caregivers as worsening symptoms or disturbing behaviors including annoyance, aversion, and troublesomeness.²⁰ Meanwhile, stigma

was defined in this study as the family caregivers' consideration about the frequency of their encountering negative responses of other persons in the society about their family member who was diagnosed with schizophrenia. It was also evaluated as something that caused discomfort or difficulty for family caregivers when contacting others due to social rejection.²¹ For this reason, both severity of illness and stigma were primarily appraised as the hardship of care that tended to be problematic for caregivers and caused difficulty in their life. These factors caused family caregivers to have negative attitudes and reactions toward the person with schizophrenia that could be explained with the HEE style.^{15,16,17}

Caregiving burden in this study was conceptualized as a secondary appraisal in which overwhelming tasks exceeded family caregivers' abilities and available resources to cope.²² Caregiving burden could also cause family caregivers to have negative views of their family members with schizophrenia, threatening disruption of their lives, and, as a result, leading family caregivers to choose a negative response style that reflected their HEE.²³

The mental health status of family caregivers and family functioning was conceptualized in this study in terms of the inadequate resources that did not help them manage high demands of caregiving tasks. Internal resources such as mental health status were evaluated as the frequency of signs of psychological dysfunction, such as insufficient strength or inadequate coping capabilities. In addition, family functioning was illustrated as the external resource for the entire family about the degree of family tasks and efforts to maintain family balance and adaption, so as to continue healthy and normal of the family after a member had been diagnosed with schizophrenia. In this regard, family functioning was appraised as proper or adequate resources that enabled caregivers to deal with a high demand in caring situations.²⁰ So, in the body of inadequate resources that family caregivers had when dealing with stressful situations,²⁴ they may develop

chronic stress that results in negative responses including rejection, overprotection, or being over-intrusive, all of

which reflect their HEE.^{22,25} The conceptual framework is explained in hypothesized model in Figure 1.

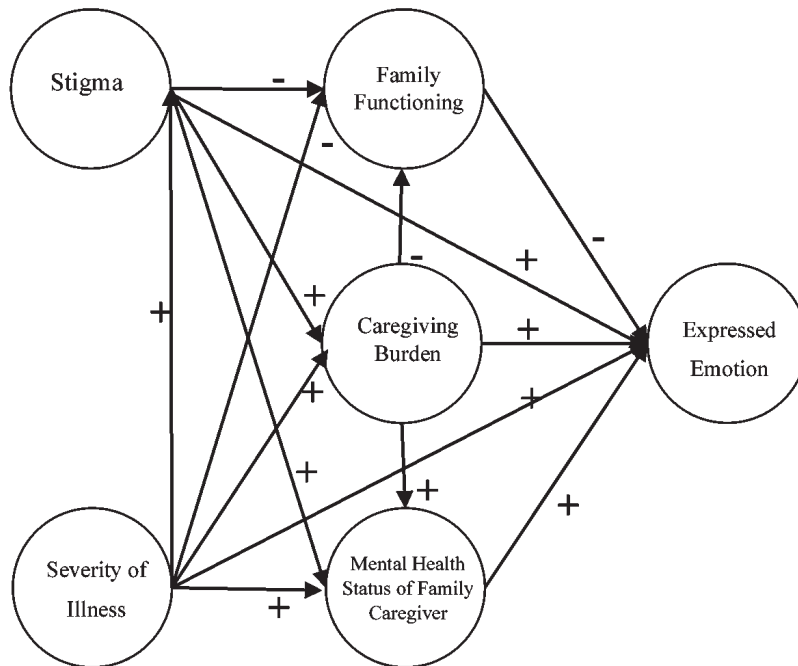


Figure 1: The hypothesized model illustrating the influence of severity of illness, mental health status of family caregivers, caregiving burden, family functioning, and stigma on EE among family caregivers of persons with schizophrenia

Method

Design: A cross-sectional, correlational research design was employed to test the developed causal model of EE among family caregivers of persons with schizophrenia.

Sample and setting: Data were obtained from 385 family caregivers of adults who had been diagnosed with schizophrenia for at least six months and who were being followed up at outpatient units of two major psychiatric hospitals in central Thailand. The caregivers were referred by nurses using purposive sampling based on the inclusion criteria as follows: (1) living with a person with schizophrenia for whom they had been primary caregivers for at least six months;

(2) able to read and verbally communicate in Thai; and (3) at least 18 old. The sample size was determined based on the rule of thumb, with the sample size-to-parameters ratio of 10:1.²⁶ The 35 estimated parameters (21 loadings and 14 between construct correlation estimates) were used to estimate the sample size, a minimum of 350 participants. However, an additional 10% or 35 participants were added into the calculated sample size,²⁷ in case of attrition, so the final number of participants was 385.

Ethical Considerations: This study was approved by the Research Ethics Committee of the Faculty of Nursing, Chiang Mai University and the hospital used as the study site. Verbal and written explanations of the study objectives, procedures, and participant rights

were clearly stated to potential participants, and written informed consent was obtained from those willing to participate in the study before data collection commenced.

Instruments: Data were obtained using the six questionnaires as follows:

The Thai Expressed Emotion Scale (TEES) was developed by Sunpaweravong²⁸ to assess EE among family caregivers of relatives with schizophrenia in the Thai context. It consists of 49 items with seven subscales including CC (seven items), Hostility (eight items), EOI (five items), Warmth (seven items), Positive Remarks (seven items), Emotion Regulation (seven items), and Emotional Under-involvement (eight items). An example of an item is "I feel ashamed of his/her behavior." The items were arranged in a 4-point rating scale ranging from 1 (strongly disagree) to 4 (strongly agree), except for the positive items under the positive subscales of Warmth, Positive Remarks, and Emotion Regulation, for which reverse scoring was used. A total score is obtained by summing the scores of all items, and possible total scores ranged from 49 to 196 points, with higher scores reflecting more negative attitudes or behaviors of family caregivers, hence a higher level of HEE, and vice versa.²⁸ In this study, regarding the reliability of the instrument, the Cronbach's alpha coefficient was 0.84.

The Behavior and Symptom Perception Scale (BSPS) was developed by Pipatananond²⁹ to measure the extent to which family caregivers' perceived the degree of each behavior and symptom caused by schizophrenia impairment. An item example is "Inadequate care of him/herself." The BSPS consists of 29 items with a 4-point Likert scale ranging from 0 (never) to 3 (always). Possible total scores range from 0 to 87 points, with higher scores indicating a greater perception of severity of the patient's illness.²⁹ As for reliability in this study, the Cronbach's alpha coefficient was 0.77.

The Thai General Health Questionnaire (Thai GHQ-28) was translated from English into the Thai language and modified by Nilchaikovit, Sukying, and

Silpakit.³⁰ It has been widely used to assess common mental health problems amongst Thais. The Questionnaire contains 28 items classified into four subscales of Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction, and Severe Depression. An item example is "Have you recently lost much sleep over worry?" Each item is rated on a 4-point response scale ranging from a = not at all/better than usual, to d = much more than usual/much worse than usual. Scoring is undertaken using the bi-modal method (0-0-1-1) in which the value of the first two types of positive answers is 0, and for the two others, 1 is for the negative answers. The possible total scores ranges from 0 to 28 points. A high total scores reflects greater perception of having more mental health problems. Cronbach's alpha coefficient in this study was 0.82.

The Psychiatric Caregiver Burden Scale (PCBS) was originally developed by Oberst & Hughes (1990) and was modified by Pipatananond to assess burden of caregivers of persons with schizophrenia in the Thai culture.³¹ The Scale is composed of 18 items divided into two subscales of Demand and Difficulty. The items are arranged in a 5-point Likert scale ranging from 1 (none) to 5 (a great deal). The Demand subscale assesses the caregivers' perception of the scope of the task or activity required by persons with schizophrenia, and the Difficulty subscale evaluates caregivers' perception of the degree to which the activity is seen as difficult or troublesome. An item example is "Seeking help in crisis situations or in home care." Each subscale has a possible score ranging from 18 to 90 points. Half of the total scores in both subscales reflect a caregiver's perception of the caregiving burden they are facing, with higher scores indicating greater perception of caregiving burden and vice versa.³¹ As for reliability, in this study, the PCBS achieved a Cronbach's alpha coefficient of 0.85.

The Chulalongkorn Family Inventory (CFI) was originally developed by Trangkasombat³² in Thai to measure family functioning. It is comprised of

seven subscales. Six of the seven subscales were developed based on the McMaster model of family functioning developed by Epstein and Bishop (1973), Problem Solving (six items), Communication (five items), Roles (four items), Affective Responsiveness, (five items), Affective Involvement (five items), and Behavior Control (four items). The remaining subscale was developed specifically to assess general functioning of the family. In this study, the participants were asked to rate only 28 items of the six subscales. An item example is: "Our family is able to solve daily problems that happen within our family." The items are arranged in a 4-point rating scale ranging from 1 (strongly disagree) to 4 (strongly agree). The total scores are obtained by summing the scores of all items, including those of the nine negative items for which reverse scoring is used. Possible total scores range from 28 to 112 points, with higher scores indicating greater perception of well family functioning and vice versa. As for reliability of the instrument, in this study, Cronbach's alpha coefficient was 0.83.

The Perceived Stigma Questionnaire (PAQ) was developed by Khumhom³³ based on the questionnaire originally developed by Wahl (1999) to measure stigma experienced by family caregivers. It is composed of two components: Stigma (nine items) and Discrimination (eight items), each of which is arranged on a 6-point Likert scale ranging from 0 (never) to 5 (always), except for four items that are statements regarding positive experiences and for which reverse scoring is used. An item example is "You avoid telling anyone that you have a family member who has a psychiatric problem." Higher scores reflect a greater perception of higher stigma and vice versa.³³ As for reliability of the questionnaire, in this study, Cronbach's alpha coefficient was 0.86.

Data collection: The participants were asked to complete the seven self-administered questionnaires in a private place at the study site. Data collection lasted approximately 60–80 minutes, with a break time of 10–15 minutes.

Data analysis: Descriptive statistics were used to describe the demographic characteristics of the study participants and selected study variables. Statistical assumptions underlying structural equation modeling (SEM), including normality, linearity, homoscedasticity, and multicollinearity, were tested. Then, the hypothesized model was tested using SEM conducted with the SPSS version 16.0 and the Linear Structural Relationship Modelling (LISREL 8.52) program. The maximum likelihood method was used to estimate the strength of the relationships that existed among the study variables.

Findings

The 385 participants ranged in age from 22 to 70 years (mean = 45.35, SD = 11.73). Almost three quarters were female (70.9%, n = 273), and almost half were married (41.5%, n = 160). Most participants were Buddhists (86.2 %, n = 332), more than one-third completed elementary education (39.5%, n = 152), and almost one-third worked as wage earners (32.2%, n = 124). Furthermore, the largest group of participants were parents of adults with schizophrenia (34.8%, n = 134), and they lived in an extended family (69.1%, n = 266). Nearly half of participants perceived they had sufficient family income for living but not for saving (44.7%, n = 172), with their average income ranging from THB 8,700 (USD 247.19) to THB 50,000 (USD 1,420.66) per month (mean = THB 21,887.35 or USD 621.89, SD = 9,703.24).

Findings regarding the study variables are shown in Table 1. Regarding EE scores, the mean score of EE was higher than half of the possible range. Likewise, more than half of the participants, or 53.77% (n = 207), rated that they had a higher score than the mean. This indicates that the majority of the participants experienced an infrequent HEE. In terms of severity of illness, the mean score of severity of illness was slightly higher than 75% of the possible

range. Moreover, the mean score of mental health status based on the Thai-GHQ28 was 6.50 (SD = 1.13) with the prevalence elevated risk of mental health problem of 81.04% (n = 312), owing to their

total scores being higher than 23 points. Finally, other variables such caregiving burden, family functioning, and stigma had the mean score higher than half of the possible range.

Table 1 Descriptive Statistics of Study Variables (N = 385)

Variables	Possible Score	Actual Score	Mean	SD
Expressed Emotion	49–196	104–159	130.94	7.29
Severity of Illness	0–87	54–73	65.56	3.31
Mental Health Status	0–28	4–9	6.50	1.13
Caregiving Burden	18–90	38.50–65.50	54.71	4.89
Family Functioning	28–112	44–82	63.39	5.91
Stigma	0–85	25–69	50.44	6.02

During model testing, it was found that the hypothesized model did not fit the actual data. Therefore, modification of the model was performed based on both reasonability of statistical findings until it fitted the data well ($\chi^2 = 245.26$, $p = 0.10$, $df = 199$, $GFI = 0.95$, $AGFI = 0.93$, $CFI = 0.95$, $RMSEA = 0.02$, $SRMR = 0.05$). The final model could explain 57% of variance in EE among family caregivers of persons with schizophrenia. Stigma had an indirect effect on EE and was mediated through caregiving burden and mental health status of the family caregivers. In

addition, severity of illness had a direct effect on EE and also indirect effects through caregiving burden and mental health of the family caregiver. Caregiving burden had the strongest significant positive direct effect on EE and a significant indirect effect through mental health status and family functioning. Moreover, mental health of the family caregivers had a direct effect on EE, and family functioning had the strongest significant negative direct effect on EE. The results of hypothesized model testing are presented in Figure 2 and Table 3 that follow.

Table 2 Direct, Indirect, and Total Effect of Study Variables in the Final Model

Causal Variables	Affected Variables											
	Caregiving Burden			Mental Health Status			Family Functioning			Expressed Emotion		
	TE	IE	DE	TE	IE	DE	TE	IE	DE	TE	IE	DE
Severity of Illness	0.12**	0.01	0.11**	0.23*	0.02	0.21*	-0.06	-0.03	-0.03	0.31*	0.13*	0.18*
Stigma	0.24*	-	0.24*	0.27**	0.03	0.24**	-0.09	-0.05	-0.04	0.29*	0.21*	0.08
Caregiving Burden	-	-	-	0.11*	-	0.11*	-0.22**	-	-0.22**	0.58*	0.11*	0.47*
Mental Health Status	-	-	-	-	-	-	-	-	-	0.23*	-	0.23*
Family Functioning	-	-	-	-	-	-	-	-	-	-0.40*	-	-0.40*
Structural Equation	$R^2 = 0.18$			$R^2 = 0.36$			$R^2 = 0.23$			$R^2 = 0.57$		

Note: * = $p < 0.05$, ** = $p < 0.01$, *** = $p < 0.001$

TE = total effect, IE = indirect effect, DE = direct effect

Expressed Emotion among Family Caregivers

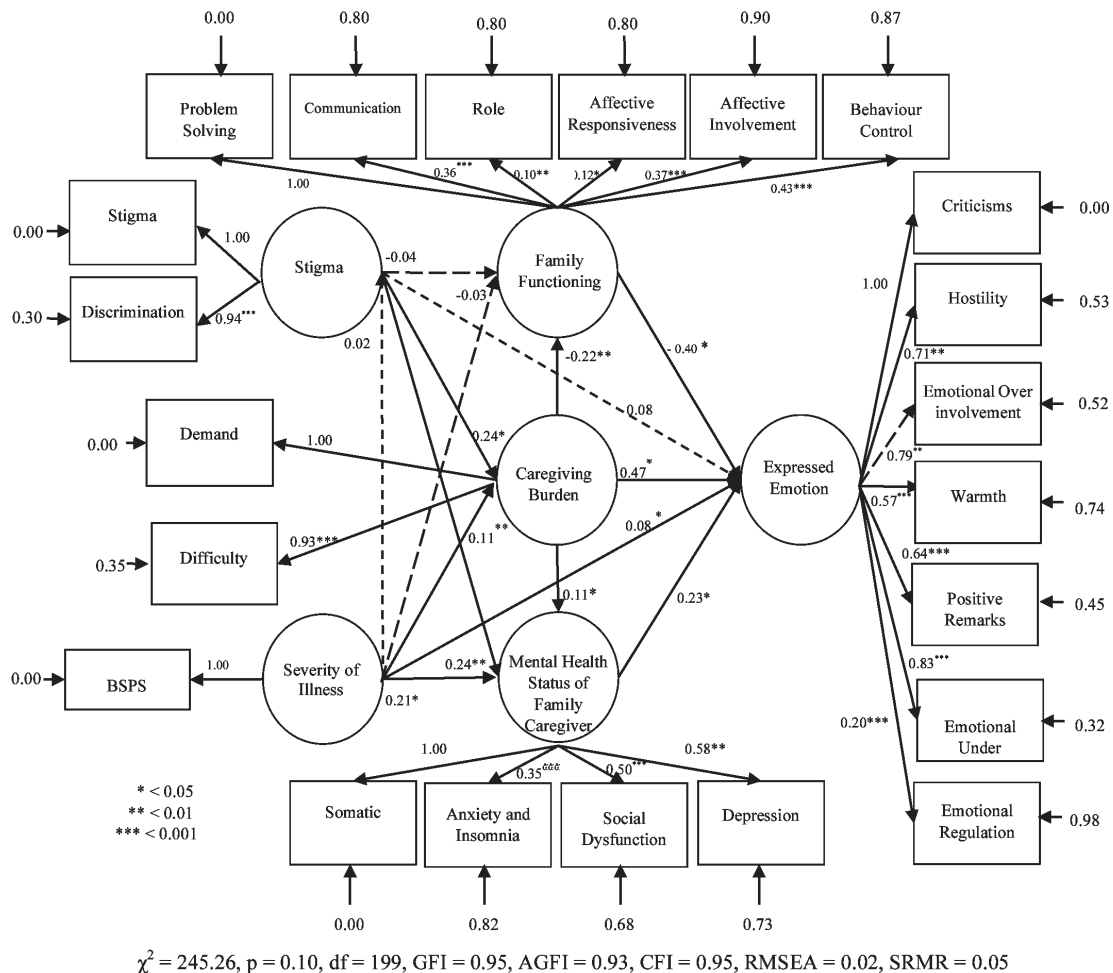


Figure 2: The modified model of EE among family caregivers of persons with schizophrenia

Discussion

This study has produced a model of factors that leads to better understanding of EE among family caregivers of persons with schizophrenia. The findings indicate that the final modified model fitted the data well and could explain 57% of the variance in EE. Overall, the findings support Lazarus and Folkman's stress and coping theory that emphasizes the important role of cognitive appraisal when encountering a difficult situation and mediating between that situation and the outcomes.¹⁹

It is worth noting that the findings of the present study were not always consistent with previous studies. For instance, it was found in this study that stigma had an indirect effect on EE. Phillip et al. found there was a small predictive power of stigma on EE even though it should have had greater power to explain EE when it had the mediated effect.²¹ Likewise, this study found that stigma could explain EE through the mediating effect of caregiving burden and mental health status of family caregivers. However, although the links among the four variables – EE, stigma, caregiving burden, and mental health status

of the family caregivers – were not explored in the previous study, they could still be explained within the framework of the cognitive appraisal process of Lazarus and Folkman's theory and the related literature review. For example, similar findings can be found in the study of Phillip et al. which revealed the relationships among stigma, caregiving burden, and EE.²¹ Generally, stigma often has direct effect towards the person with schizophrenia in the form of rejection, and this makes them uncomfortable in contacting someone outside their family. As a result, they may isolate themselves from non-family members and thus depend more on family caregivers. In such cases, family caregivers need to evaluate how their life has been disrupted by stigma. Thus, the adverse effect of negative emotions can lead to caregiving burden, which, in turn, increases HEE.²³ It is noteworthy that the mediator effect of the mental health status of family caregivers between stigma and EE has not been thoroughly explored in existing literature. However, the findings of the present study are consistent with another study result that stigma is associated with the mental health status of family caregivers.³⁴ In this study, perceived stigma was evaluated as a difficult and painful experience for family caregivers as it eventually induced negative responses such as distress, depression, and anxiety^{35,36} This is reflected in a mental health status leading to the development of more pronounced EE attitudes.^{37,38}

In addition, severity of illness had a direct influence on EE, in that family caregivers who perceived more severity of the schizophrenia had a higher level of EE. This finding is also consistent with previous studies^{15,17,39} in that family caregivers and their family members with schizophrenia are not in control of the severity of illness. Thus, sufferers of schizophrenia may not be able to carry out daily activities by themselves and turn back to depend more on their caregivers. As a consequence, family caregivers are likely to evaluate their life as being interrupted.¹⁸ This belief of the family caregivers about their own inability to manage

severe symptoms might make them encounter repetitious long-term stress, causing them to have the reactions or behaviours found in the HEE style.^{22,25}

In addition, our findings demonstrated that the severity of illness had indirect effects on EE through caregiving burden and mental health of the family caregivers. This is congruent with a previous study indicating that family caregivers who perceived a patient's illness as being more severe, had greater caregiving burden and a poorer mental health status, and thus a higher level of HEE.³⁴ According to the cognitive appraisal process in Lazarus and Folkman's theory, severity of illness is often overestimated as hardships requiring more caregiving demand and which generate the caregiving burden.^{7,38} The negative effects of caregiving burden have been described as the suffering of body pains, a decrease in vitality, development of depressive and anxiety disorders, and restrictions in physical role and social function.^{37,38}

The deviated mental health status due to severity of illness and caregiving burden was appraised as the inadequate resource for the family caregivers in managing the stress from the caring situation. This could cause the family caregivers to react to their family members with schizophrenia in a negative way, hence HEE. Moreover, the finding that caregiving burden had a direct effect on EE is consistent with a previous study which indicated that family caregivers with caregiving burden had HEE.³⁹ Their caregiving tasks were secondarily appraised by caregivers as being more than their ability to control. This belief about their inability to control caregiving burden could cause long-term stress among family caregivers. Consequently, they may develop a negative response style reflecting HEE.

Our findings also revealed that caregiving burden had an indirect effect on EE through the mental health of the family caregivers and family functioning. Related literature supports the mediator effect of mental health of the family caregivers between caregiving burden and EE in that family

caregivers who have burden and poor mental health status have HEE.³⁴ In general, burden of care for persons with schizophrenia generates negative effects including depression, anxiety, grief, and somatic complaints. These reflect the poor mental health status of family caregivers, and in turn lead to the development of high EE attitudes.^{37,38} Caregiving burden is also identified as the disruption of family functioning because of the inability to overcome the demand of care. Consequently, family caregivers cannot fulfill the expectations of the family members with schizophrenia, and also other family members.^{40,41} This contributes to dissatisfaction and excessive stress for both the person with schizophrenia and the family, and might generate negative emotions that are associated with impaired family functioning.^{40, 41}

Our finding that mental health status of caregivers and family functioning had direct effects on EE in this study is similar to that described by Boger et al.⁴¹ Together these were appraised as inadequate resources preventing caregivers from performing behaviors to fulfill the instrumental and affective needs of the family members that made them less able to solve caregiving task problems. Thus, family caregivers might respond negatively to persons with schizophrenia such as commenting on their behavior, rejecting them, having exaggerated emotional responses, being overprotective, doing self-sacrificing, or being over-intrusive, all of which reflect their HEE.

Limitations

This study may have limited generalizability given that the participants and their caregivers were referred from only two major psychiatric hospitals in central Thailand. Next, as the research design was cross-sectional, the interpretation of causal relationships must be done with caution. Preferably a longitudinal study should be undertaken to verify the credibility of the study findings. Additional studies are also needed to explore the stability of the Model with other

populations of family caregivers of persons with schizophrenia. Ultimately, a nursing intervention to promote a reappraisal process for balancing the estimation between perceived threatening situations and the caregivers' coping ability should be developed and tested.

Conclusion and Implications for Nursing Practices

The findings of this study have provided more understanding of the role of cognitive appraisal and the adaptation outcomes among family caregivers of persons with schizophrenia. Such findings can be used as a guideline for screening vulnerable family caregivers who have more influential factors of EE, especially caregiving burden, mental health status, as well as family functioning. It is hoped that the Model will ultimately assist nurses to develop and conduct nursing interventions to promote the capability of family caregivers to reappraise their situations and experiences, so that they can more effectively manage the stress of caregiving situations of their family members with schizophrenia. Finally, it is anticipated that the findings of the present study would eventually be utilized to bring about a reduction in a negative atmosphere in families where there is person with schizophrenia, such as EE.

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การแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัวผู้ที่เป็นโรคจิตเภท: แบบจำลองเชิงสาเหตุ

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บทคัดย่อ: การศึกษาครั้งนี้ เป็นการวิจัยแบบภาคตัดขวาง เพื่อทดสอบแบบจำลองเชิงสาเหตุของการแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัวผู้ที่เป็นโรคจิตเภท ซึ่งพัฒนาโดยใช้กรอบทฤษฎีความเครียดและการเผชิญกับปัญหาของลาซารัสและฟอล์คแมนร่วมกับการประมวลความรู้จากหลักฐานเชิงประจักษ์ที่บ่งบอกถึงความสัมพันธ์ระหว่างปัจจัย ได้แก่ การรับรู้ความรุนแรงของโรค ภาวะสุขภาพจิต การรับรู้ภาระในการดูแล การทำหน้าที่ของครอบครัว และการรับรู้ตราบาป กับ การแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัวผู้ที่เป็นโรคจิตเภท กลุ่มตัวอย่างจำนวน 385 คน คือ ผู้ดูแลในครอบครัวของผู้ใหญ่ที่ได้รับการวินิจฉัยว่าเป็นโรคจิตเภท ที่รับการรักษาในแผนกผู้ป่วยนอกของโรงพยาบาลจิตเวช ในเขตภาคกลาง ประเทศไทย เก็บข้อมูลโดยใช้แบบสอบถามจำนวน 6 ฉบับ ได้แก่ แบบวัดการแสดงออกทางอารมณ์ในญาติผู้ดูแล แบบวัดการรับรู้ความรุนแรงของโรค พฤติกรรมและอาการทางจิต แบบประเมินสุขภาพจิต แบบวัดภาระของผู้ดูแล แบบประเมินการทำหน้าที่ของครอบครัว และแบบสอบถามการรับรู้ตราบาปของผู้ดูแล วิเคราะห์ผลการวิจัยโดยใช้สถิติทดสอบแบบจำลองสมการเชิงโครงสร้าง

ผลการศึกษา พบว่า โมเดลสมมติฐานการวิจัยมีความสอดคล้องกับข้อมูลเชิงประจักษ์และสามารถ อธิบายความแปรปรวนของการแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัวผู้ที่เป็นโรคจิตเภท ได้ร้อยละ 57 โดยพบว่า การรับรู้ความรุนแรงของโรค ภาวะสุขภาพจิต การรับรู้ภาระในการดูแล และการทำหน้าที่ของครอบครัว มีอิทธิพลทางตรงกับการแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัว ส่วนการรับรู้ตราบาปมีอิทธิพลทางอ้อมต่อการแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัว โดยส่งผ่านทาง การรับรู้ภาระในการดูแล และสภาวะทางสุขภาพจิต ซึ่งผลการวิจัยนี้ สามารถนำไปพัฒนากิจกรรมการพยาบาลที่จะช่วยส่งเสริมศักยภาพของผู้ดูแลในครอบครัวให้สามารถลดการรับรู้ภาระในการดูแล ลดปัญหาสุขภาพจิต เพื่อลดระดับของการแสดงออกทางอารมณ์ของผู้ดูแลในครอบครัวต่อไป

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คำสำคัญ: การแสดงออกทางอารมณ์ แบบจำลองเชิงสาเหตุ ผู้ดูแลในครอบครัว ภาระในการดูแลจิตเภท

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