An Educational Intervention to Reduce the Burden on Family Caregivers of Patients with Schizophrenia

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Abstract

Background: Schizophrenia is a chronic psychosis and experiences a high burden level of the family caregiver and consequent impairment in their health condition. Aim: This study aimed to explore the effectiveness of an educational intervention program for decreasing the family caregivers’ burden of patients with schizophrenia. The study design: A quasi-experimental design was employed. The study was applied at the Psychiatric Outpatients Unit, in Beni-Suef University Hospital. Forty-four family caregivers participated, 22 allocated to the experimental group and 22 in the control group. Tool of the study: Demographic data and the Zarit Caregiver Burden Scale. The program was conducted once a week for four-months in the experimental group. Results: the burden level diminished significantly in an experimental group; the mean scores of caregiver burden reduced from 84.05 pre-program into 53.24 post-program (P < 0.001). However, the mean scores in the control group were slightly changed. The program was effective for family caregivers with low educational level. Conclusion: The majority of the studied family caregivers’ burden was reduced after implementation of an educational program, with a highly positive significant statistical difference between parents and family caregivers with lower educational levels between before and after educational sessions. Recommendations: Apply the components of this program in future studies which emphasis to decline burden level of family caregivers of patients with schizophrenia and mentally ill.

Keywords - Burden, Caregivers, Education, Family, Intervention, Schizophrenia.

1. INTRODUCTION

Schizophrenia is a chronic psychosis in which the patient loses contact with reality. It is distressing illness, often affecting in a loss of social performance in affected persons [1]. Schizophrenia is a severe mental disorder, which is traumatic for the patients as well for their family caregiver [2], [3]. Between 50% - 80% of patients live with or have regular contact with family members, and depend on their families [4]. The family members remain the major source of care for the patient with schizophrenia and have a powerful effect on managing their illness. Schizophrenia in a family also affects the responsibilities and interactions within the family. They have lots of burden including care burden, fear, and humiliation around illness signs and symptoms, uncertainty about the course of the disorder, lack of social reinforcement, and stigma. The caregiver burden refers to the negative impact of the individual’s mental disorders on the entire family [5]-[8].

The educational program attempt to create the following principles: the disorder is a brain disease; the pharmacological treatment is essential, the involvement of the family as the main rehabilitation agent, ensure a satisfactory emotional warmth in the family, caring for reducing the level of demands on the patient by allowing free expression and facilitating the reintegration into the social environment. However, these families’ caregiver states great levels of burden related to care for a member with schizophrenia [9]. The caregiver burden is a multidimensional concept reflecting emotional, social, physical and financial concerns increasing from caring for an impaired family member. Several descriptions of the concept of caregiver burden have been attempted. The burden is escalating as a significance of being in close contact with a severely ill psychiatric family member [10], [11].

A. The Significance of the Study

In Egypt, the primary care provider is usually the main source of support for the sick person and is commonly a family member [12]. Therefore, family caregivers who deliver care for family members with schizophrenia are at potential risk for burden and consequent decline in health status [13]. There are multiple consequences of the caregiver burden, such as psychiatric-health problems (e.g., depression anxiety, stress, and burnout disorder), physical health decline (e.g., diabetes and hypertension), and other negative things (e.g., social isolation, family dysfunction, excessive use of health facilities, and economic problems) [14].
The essential nursing intervention is prevention which focuses on reducing the stress and the stress response from having a harmful effect on the caregivers. Chronic schizophrenic patients with the leading professional care, nurses working at each stage; however, the family caregivers must have guidance from the nurses on dealing with this difficult situation and provide support for them. An understanding of the burden between family caregivers of people with schizophrenia may help identify areas of priorities that can be incorporated into an educational program, based on their specific needs, and how to diminish the burden level.

B. The Aim of the Study
This study aimed to explore the effectiveness of an educational program to reduce the care burden on family caregivers of patients with schizophrenia.

C. The Study Hypotheses
The family participants of patients with schizophrenia who attain the educational program will reduce their burden level.

II. METHODS
A. Research Design
The study adopted a randomized control trial (quasi-experimental) to examine the perceived burden level of the family caregivers of the patient with schizophrenia.

B. Setting
The study was applied at the Psychiatric Outpatients Department, in Beni-Suef University Hospital, which affiliated to the Ministry of Higher Education, Egypt. The mental health services in this unit provide free services for rural and urban, all age groups and all types of mental illness. Care is provided by a multidisciplinary team, psychiatrists, psychiatric nurses, social workers, and psychologists.

C. Subjects
The family members who care for patients with schizophrenia; attending to the outpatient mental health department at Beni-Suef University Hospital and agree to participate in this study. Forty-four caregivers contributed in this research: 22 family caregivers allocated to experimental group and 22 family caregivers assigned to a control group.

D. Inclusion and Exclusion Criteria

1- Inclusion criteria for patient
a. Patients who have schizophrenia, according to the Diagnostic and Statistical Manual of Mental Disorders “DSM-IV” edition and according to patients’ sheet.
b. The patient has been diagnosed for a period not less than one year.

2- Inclusion criteria for family Caregiver
a. Caregivers taking care of a relative who is providing management for a patient with schizophrenia, and who attended to the outpatient clinic.
b. The caregiver is a first-degree relative and living with the patient all time.

3- Exclusion criteria for family caregiver
The caregiver will be ineligible for this study if he/she is:
a. Taking care of more than one chronically ill person within the family.
b. Caring for a patient with co-morbidity.
c. Unwilling to participate in the study.

E. Tools for Data Collection:
Part I: Demographic Data Sheet: This was designed by researchers to collect general information about patients’ caregivers. The information from caregivers will include gender, age, income, level of education, and average time spent in caring for the patient per day.

Part II: Zarit Caregiver Burden Scale (ZCBS): Developed by Zarit, Reever and Bach-Peterson [15]. It was used to assess caregivers of patients’ with schizophrenia burden by Ribé et al., [16]. It is a self-administered scale comprising 22 items that explore the negative effects of the burden on caregivers in different areas of their life (mental, social, physical and economic). It contains three subscales: 1) Burden, which indications to the subjective influence of caring in the caregiver’s life; 2) Rejection, which contains items related to feelings of rejection/hostility towards the patient; 3) Competence, which is associated with caregivers’ self-assessment about their ability to preserve the relationship of care.

Each item is assessed on a 5-point Likert scale ranging from “Never” (0) to “Almost always” (4). Entire scores range from 0 to 88 (0 to 21 “No burden”; 22 to 40 “Moderate burden”; 41 - 60 “Moderate burden”, and 61 to 88 “Intense burden”). The study tools were translated to Arabic language and translate back to English and to Arabic by a foreign person and submitted to a jury of five experts in the psychiatric nursing and medical fields to test content validity. Internal consistency was proven to be high (alpha 0.89), as is test-retest reliability (0.86).

F. Procedures
Official permissions to carry out the study and collect data were obtained from the dean of the Faculty of Nursing, Beni-Suef University and form the director of the identified study setting. Researchers explained the purpose of the study to participants. After giving oral consent, family caregivers were assessed individually. The participants were randomly assigned to the control or the experimental groups. The control group a family of patients who received the usual intervention, involving periodical meetings with psychiatry staff in order to prescribe the drug for their patients.
The experimental group was distributed into four groups which received the family intervention program. Both control and experimental, the patients sustained to take an antipsychotic drug. The program was conducted through the period from the beginning of September to the end of December 2018 from the selected setting.

G. An Educational Family Program

Involved four phases

1. Assessment Phase: The program was designed after reviewing the literature. The researchers were attention to socio-cultural of Beni-Suef Governorate and the educational level of the caregivers to design the program to suitable for them. The program was conducted once a week for four months in psychiatric outpatient clinics of the Mental Hospitals in Beni-Suef Governorate.

2. Preparation Phase: According to the results accomplished from patients’ records, interviewing, and observation, as well, review of the literature, a training instruction was established by the researchers. It was applied immediately after the pretest. The contents of the program: handouts were designed to meet the caregivers’ needs and to fit into their interest and levels of understanding. Methods of teaching: all the experimental groups have given the same training program content, and utilized the same instruction methods, these were: lectures/discussions, demonstration, and re-demonstration. Media of teaching: included handouts, pictures, videos, and the slide showed on the researchers’ computer.

3. Implementation Phase: The researchers visited the psychiatric outpatient clinics of the Beni-Suef University Hospital, once a week for 4 months from 9.00 a.m. to 2.00 p.m. immediately after completion of the assessment and the preparation phases, the training program was implemented. The sample of 44 patients was classified into two equal groups (control & experimental). The program was applied to the experimental group that was divided into four subgroups who took the program in a parallel manner. Each session continued 1.30 hours inside 10 minutes, break.

The Researchers Divided the Implementation Phase of the Program into Two Parts:

Theoretical Part:- It includes 6 educational sessions. It included information about the introduction of program and disorder such as display of the members into the group, introduction to the program and outline of the benefits from it. Exploring what relatives know about schizophrenia and modification of erroneous beliefs. Expressing of feelings, experiences, and behaviors toward schizophrenia were notifying. It was giving information about disease, causes and symptoms and subtypes of schizophrenia. Explanation of medical treatment, types of drugs, and adverse effects.

Practical Part:- It includes 10 sessions for applying the program, through demonstration and redemonstration by the family caregiver under observation of researchers. It included the skills and activities structured by the researchers for the family associations social implications of the disease. Applying the strategies to reduce the patient’s distressing behaviors, and discuss the objectives to reach with the patient, concepts of listening and empathy, significance of self-care, and accepting the need for help. Improving the skills in the family to deal with the patient and understanding the need to reduce excessive stimulation. Applying of problem-solving approaches, and develops self-esteem. Training about deep breathing for relaxation and elimination of body tensions were applying.

4. Evaluation Phase:

Evaluation of the program was accomplished promptly after the eventual application of the program functionality a post-test survey, which was the same as the pre-test to evaluate the effect of the program.

H. Ethical Considerations

A verbal agreement from each caregiver who accepted to participate in the study was confirmed. The researchers explained the purpose of the study to the patients. The researchers assured privacy for participants, data that will be used for research purposes only. The caregivers were also informed that participation is voluntary, and they had the right to withdraw from the research work at any time without giving any reason.

I. Pilot Study

In demand to determine that the tools of the study are feasible, clear, and applicable, a pilot study was done on 5 patients. No modifications were made; consequently, they were involved in the study sample.

J. Statistical Analysis:

The statistical analysis of the data in the questionnaires was conducted through using the Statistical Package for Social Sciences (SPSS) software, version 22. Descriptive data were described as a percentage or frequency, and significance was determined using the Pearson’s (r) test. Differences with P-values < 0.05 were considered significant and P-values < 0.01 highly significant. To assess the effectiveness of the program, the measures of ANOVA was used to compare between the burden scores before and after the program in the experimental and control groups.

III. RESULTS

Table1 shows the socio-demographic characteristics of caregivers in both groups. The studied sample comprised 44 family caregivers (31
women and 13 men). The mean age was 51.67 years (SD = 19.76) among the experimental group and 55.48 years (SD = 10.36) in the control group. There were 21 mothers, 6 fathers, 4 sisters, 5 daughters, 5 wives, and 3 other relatives. As regard residence areas, twenty-nine family caregivers were from rural. Twenty-two family caregivers had not completed secondary school, and 14 were unemployed. As well, marital statuses of family caregiver were 11 single, 18 married, 8divorced and 7 widows. There were no statistically significant differences between the experimental and control groups; this means that there was homogeneity between the studied groups.

Table 2 presents that, the patient characteristics of the studied sample among the experimental and control groups. The studied sample of 44 patients, 29 was men. The mean age was 34.72 years (SD = 6.24) among the experimental group and 32.09 years (SD = 9.74) in the control group. All patients had a diagnosis of schizophrenia and were receiving antipsychotic medication. Twenty-one patients had not completed secondary school. Thirty-seven patients were unemployed, but only 16 were receiving financial assistance from the Government. On average, patients had been hospitalized 3-4 times in the previous 3 years (SD = 1.2). Marital statuses of the studied patients were 20 single, 7 married, and 12 divorced and 5 widows. There were no statistically significant differences between an experimental and control groups; this means that there is homogeneity between two main groups of the study sample.

Table 3 shows that the mean scores of family caregiver burden in the experimental and control groups, before and after the program. There was significant statistical change in the caregiver burden in an experimental group between before and after the intervention (t=16.5 (P < 0.001). As burden levels diminish from pre-program (Mean = 84.05, SD= 12.98) to post-program (Mean = 53.24, SD= 12.18) in the experimental group, this means that the educational program was having an important effect. There was no statistical significant change in the control group with a traditional treatment between before and after conducting the program.

Table 4 states that the comparison of the mean scores of caregiver burden, rejection, and incompetence before and after application of the program in the experimental group. There was a significant statistical relation between the time of measurement (pre/post-intervention) and caregiver education program which caregiver burden (F = 211.61; P < 0.001); caregiver rejection (F= 81.63; P < 0.001), caregiver incompetence (F = 43.04; P < 0.001). This means that family caregiver has benefited from the nursing program and reduces the level of burden.

Table 5 demonstrates that the comparison between burden level in relation to caregivers' characteristics, before and after application of the program in the experimental and control groups. There was a significant statistical relationship between caregiver burden and educational level and Kinship. The reduction of the burden being significantly higher in parents (t = 15.32; P < 0.001), than other caregivers (t = 7.86; P < 0.001). The reduction of the caregiver burden being significantly higher in low educational level (t = 12.98; P < 0.001) than among high educational level (t = 12.25; P < 0.001). This is a good indicator of the validity of the intervention program to reduce the family caregiver burden and accept them the ability to care for their relatives who have schizophrenia. There was no statistically significant change in the control group with the usual treatment between before and after conducting the program.
The families’ caregivers of patients with schizophrenia experience very high levels of burden, which has a negative effect on all areas of their lives. The family caregiver intervention program described here had a significant influence in reducing the general burden.

The contact between outpatients’ unit staff and caregivers were more common in the experimental group than in controls, the greater reduction in burden observed in the experimental group may have been due in part to other non-specific effects deriving from increased contact with the hospital. Also, families’ members and patients with schizophrenia need to be taught effective coping strategies, more, to enhance the quality of life of family caregivers.

Therefore, the present study aimed to investigate the effect of the family intervention on caregivers’ burden.

Concerning caregivers’ gender, the majority of the caregivers were females. In relation to the degree of relative to patients, mothers’ of the patients were the foremost caregivers. This is expected because females are accountable about caring for all family members especially the sick persons. In addition, the majority of the patients live in rural regions where the extended families are common. Mothers as caregiver denote nearly half of the studied samples; this may be related to the nature of the extended families, more than one-third of the patients were married, which means that mothers are responsible for their caring and this reflects the future of the females in Egyptian culture. These results are going in line with the previous studies by [19], [20] clarified that more than half of the caregivers were females, were married. In contrast, the studies done in Portugal by [21], [22] displayed that the greatest of the caregivers were males.

The present study reported that more than one-third of the studied sample was receiving financial assistance from the Government. But, the Arab culture all people give emotional support for each other, this reflects the importance of the role of families and friends in supporting patients according to the Islamic teachings. In line with the foregoing, [23], [24] which highlighted that the significance of family and friends in supporting people mentally ill. The results of the present study corroborate those reported by the World Federation of Mental Health [25] clarified that the problem of lower socioeconomic status is further compounded by the fact that greatest countries do not offer financial support for the care services that family provide for their mentally ill relative. The poor financial status in the family may further increase the risk or vulnerability for perceiving burden and the resulting distress and negative consequences such as mental health problems [26].

### Table (3): Mean Scores of Family Caregiver Burden in the Experimental and Control Groups, Before and After the Program.

<table>
<thead>
<tr>
<th>Intervention Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>22</td>
<td>84.05</td>
<td>13.98</td>
<td>16.8</td>
<td>0.001</td>
</tr>
<tr>
<td>Post</td>
<td>22</td>
<td>53.24</td>
<td>12.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>22</td>
<td>86.75</td>
<td>12.31</td>
<td>0.64</td>
<td>0.42</td>
</tr>
<tr>
<td>Post</td>
<td>22</td>
<td>86.22</td>
<td>13.99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant at p<0.05 ** highly significant at p <0.01

### Table (4): Comparison between Mean Score of Caregiver Burden, Rejection, and Incompetence, Before and After Application of the Program in the Experimental Group. (n=22)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-program Mean (SD)</th>
<th>Post-program Mean (SD)</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burden</td>
<td>47.22 (7.89)</td>
<td>25.5 (0)</td>
<td>5.79</td>
<td>0.001 **</td>
</tr>
<tr>
<td>Rejection</td>
<td>17.84 (3.45)</td>
<td>9.51 (2.9)</td>
<td>2.99</td>
<td>0.001 **</td>
</tr>
<tr>
<td>Incompetence</td>
<td>20.21 (3.45)</td>
<td>15.2 (3.2)</td>
<td>4.30</td>
<td>0.001 **</td>
</tr>
</tbody>
</table>

* Significant at p<0.05 ** highly significant at p <0.01

### IV. DISCUSSION

Previous studies reported that caregivers commonly don’t have enough knowledge and skills for providing care to a patient with mental illness; therefore, family intervention has been established to intervene and teach effective coping strategies for the families with mentally ill members [17], [18].

The families’ caregivers of patients with schizophrenia experience very high levels of burden, which has a negative effect on all areas of their lives. The family caregiver intervention program described here had a significant influence in reducing the general burden.

The contact between outpatients’ unit staff and caregivers were more common in the experimental group than in controls, the greater reduction in burden observed in the experimental group may have been due in part to other non-specific effects deriving from increased contact with the hospital. Also, families’ members and patients with schizophrenia need to be taught effective coping strategies, moreover, to enhance the quality of life of family caregivers.

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The present study reported that more than one-third of the studied sample was receiving financial assistance from the Government. But, the Arab culture all people give emotional support for each other, this reflects the importance of the role of families and friends in supporting patients according to the Islamic teachings. In line with the foregoing, [23], [24] which highlighted that the significance of family and friends in supporting people mentally ill. The results of the present study corroborate those reported by the World Federation of Mental Health [25] clarified that the problem of lower socioeconomic status is further compounded by the fact that greatest countries do not offer financial support for the care services that family provide for their mentally ill relative. The poor financial status in the family may further increase the risk or vulnerability for perceiving burden and the resulting distress and negative consequences such as mental health problems [26].

### Table (5): The Comparison between Burden Level in Relation to Caregivers’ Characteristics, Before and After Application of the Program in the Experimental and Control Groups.

<table>
<thead>
<tr>
<th>Experimental group</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>High educational level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low educational level</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Regarding the level of caregiver burden was high, which pre-program (Mean = 84.05, SD= 13.98). This is might indicate that the high level of caregiver burden in family with patient with schizophrenia. These results go in line with a study in China by Chine, Chan and Morrissey revealed that the burden of caregivers of individuals with schizophrenia is high [27]. The caregivers of patients with mental disorders in Zimbabwe are suffering from significant burden from care [28], while this is moderate to severe in Iran [29]. The study in Jamaican Africans, Alexander et al., presented that the burden of family caregiving is moderate in caring for persons with schizophrenia [30]. The burden of caregivers causes devastating effects not only for themselves but also for patients, other family members, and the health care system [31].

The current study showed that decreased burden level at the post-program in the experimental group which (Mean =53.24, SD= 12.18).There was significant statistical relation in family caregiver burden in an experimental group between before and after the intervention (t=16.5; P < 0.001). This means that the intervention program was having a significant effect to reduce family caregiver burden, they need some skills to deal with patients’ behavior and reach their ability to give care for the patient with schizophrenia. These results were similar to the results revealed by Tanriverdi and Ekinci [32] Huis et al., [33] stated that caregivers who established the educational intervention estimated a decline of caregivers’ burden. In line with the foregoing, Yildirim et al., showed that the programs are effective in reducing the burdens on the family [34].

The result of the present study revealed that there was a significant statistical relation between the pre/post-intervention and caregiver educational program which caregiver burden (F = 211.61; P < 0.001); caregiver rejection (F = 81.63; P < 0.001), caregiver incompetence (F = 43.04; P < 0.001). This means that family caregiver has benefited from the nursing program and reduces the level of burden. These findings were supported by Stam and Cuijpers [35] presented that the components of the burden total score in which the program is greater effectiveness. The result recommended that the program is effective for the family caregivers to provide good care for the patient and in reducing their feelings of contradiction, irritation or rejection.

The present study demonstrated that there was a significant statistical relationship between caregiver burden and educational level and kinship. The reduction of the burden being significantly higher in parents (t = 15.32; P < 0.001), than other caregivers (t = 7.86; P < 0.001). This might be due to the parents are the ones who take care of their children from young to adult, especially the patient one and those with mental illness in the Egyptian culture. This result is in agreement with [36], [37] which stated that the greatest of the caregivers were the parents of the patients with schizophrenia. This goes in line with [38] explained that the mothers had greater tension, upsetting, and complete burden; and fathers had higher distressing. In line with the studies carried out by [39]-[41] revealed that mothers were most of the caregivers. Mothers may perceive a greater care burden than fathers because mothers may be in closer contact with their child, feel more responsible for the main part of the patient’s care, or are more affected by their child’s deteriorations.

The findings of the current study revealed that the reduction of the caregiver burden being significantly higher in low educational level (t = 12.98; P < 0.001) than among high educational level (t = 12.25; P < 0.001). This is a good indicator of the validity of the intervention program to reduce the family caregiver burden and accept them the ability to care for their relatives who have schizophrenia. According to the survey performed by [42] stated that the educational program demonstrated the greatest effect among family caregivers of low educational level. The results of the present study stated that the better effectiveness of the program in caregivers with low educational level may be due to their higher burden level before the educational program.

The findings of current educational intervention were supportive and the caregivers in the experimental group directed a significant decrease in family burden. These results might be recognized to the strong desire of the participants to receive the needed information about their relatives’ disorder, also the lack of caregiver skills to handle patient problems, allowing more interaction between each other’s and sharing experiences, in addition to giving chances to express their held feeling related to caregiving duties and burdens.

| Level of educational | Control group | Kinship | | |
|----------------------|---------------|---------| | |
|                      | Parents       | t = 12.25; P < 0.001 | 75.09 (10.0) | 97.47 (9.3) |
|                      | Other caregivers | t = 12.98; P < 0.001 | 45.71(12.2) | 63.23 (3.8) |
|                      | Parents       | t = 15.32; P < 0.001 | 89.47 (12.6) | 67.20 (4.1) |
|                      | Other caregivers | t = 7.86; P = 0.001 | 43.72 (14.4) | 52.67 (11.5) |
|                      | Parents       | t = 1.38; P = 0.18 | 91.00 (11.8) | 75.50 (8.3) |
|                      | Other caregivers | t = 1.38; P = 0.18 | 90.47 (12.4) | 72.75 (11.0) |

* Significant at p<0.05** highly significant at p <0.01

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This result is in agreement with [43] suggested that there was an improvement in the greatest aspects of the behaviors of families’ caregivers in the patients whom they took care of. Enhancement in the patient’s clinical status and decreases in family burden may be related to the family’s consciousness of strategies for dealing with daily challenging situations. In this respect [44], [45] who emphasized that the family caregivers should be involved as active members of the health care staff giving care for the patients with schizophrenia.

The family caregiver program was designed to develop skills to progress communication and self-management; thus, an enhancement in these aspects as a result of the intervention could also have contributed to reduce the burden. The effect of the presence in group therapy, as well as the better knowledge learned during the program and the increase of interactions between family caregivers and the psychiatric staff are part of the therapeutic effect. The reduction in burden may be determined by factors such as recognition of the disorder, access to information about schizophrenia that may counteract the negative symptoms of incapacity and danger, learning about the use of problem-solving strategies, increased social support and community networks, and a greater appreciation of their own needs. This explanation was supported by [46].

The findings of our control group, there was no statistical significance change from before to after the program. Which the patients were received usually care in an outpatient unit. These results were presented with a slight improvement in the patient’s clinical status and family burden. It may reflect the fact that predictable services for clients with schizophrenia and their families’ caregivers in Egypt do not meet their needs. These results go in line with a study in Iran by Sharif et al., stated that the control group, which established usual care, displayed little improvement in the patient’s clinical conditions and family caregiver burden. These results may reflect the fact that usual management in the outpatient clinic for patients with schizophrenia and their families, in do not meet the patients” and families” needs [4].

VI. IMPLICATION FOR NURSING PRACTICE

This study reveals the need to initiate nursing interventions that will ameliorate the burden of caregivers however providing the nursing care to patients with schizophrenia. Nurses being in direct contact with the patients and their caregivers need to constantly give education, advice, information, counseling, and motivation to the caregivers. This will help prevent real danger to the physical and mental health of the caregivers.

The Nurse should provide caregivers with information on how to balance the important care role with their own health and well-being. Nurses should also advocate for implementation of community mental health to bridge the gap between inpatient and outpatient services and to bring services closer to the people and ensure adequate supervision to prevent recurrence and relapse. Nursing interventions that will be mindful of the role of the caregiver and the impact of illness on their wellbeing should be ensured, thus providing a comprehensive service that addresses caregivers’ concerns as well as linking them to services that will improve their own health and lead to better health outcomes for the caregivers.

VII. CONCLUSION

Based on the findings of the present study it can be concluded that the effectiveness of the family caregivers program aimed to reduce the burden on the caregiver of patients with schizophrenia, and reduced their burden in all three parts: burden, rejection, and incompetence. The program was effective in reducing the burden in parents and in caregivers with a low educational level in the experimental group and slight changes in the control group.

VIII. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made in order to improve the burden experienced by relatives of patients with schizophrenia and mental illness.
- The psychiatric/mental health nurses should provide family focus programs can intervene to prevent the sufferings of the patients with schizophrenia and their relatives and improve their daily life and well-being.
- Establishment and thorough supervision of mental health agencies, providers, policymakers, and educators to provide service, monitoring, supervision, and support for the mentally ill individuals and their caregivers.
- There is a need for the development of community mental health services under the primary health care which will aim at focusing not only on the management of the patients but also to meet the needs of the caregivers.
- Locally based family support groups should be created for assisting caregivers and advocating for the promotion of their well-being in society.

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DECLARATION OF CONFLICTING INTERESTS

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