Effectiveness of the enhanced psychological well-being intervention in family caregivers of schizophrenic patients

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A Dissertation Submitted in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy in Public Health
Common Course
COLLEGE OF PUBLIC HEALTH SCIENCES
Chulalongkorn University
Academic Year 2019

ประสิทธิผลของโปรแกรมเสริมสร้างสุขภาวะทางจิตในญาติผู้ป่วยโรคจิตเภท

นางญาดา ธงธรรมรัตน์

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธารณสุขศาสตรดุษฎีบัณฑิต
สาขาวิชาสาธารณสุขศาสตร์ ไม่สังกัดภาควิชา/เทียบเท่า
วิทยาลัยวิทยาศาสตร์สาธารณสุข จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2562

Thesis Title	Effectiveness of the enhanced psychological well-being intervention in family caregivers of schizophrenic patients
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Field of Study	Public Health
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Accepted by the COLLEGE OF PUBLIC HEALTH SCIENCES, Chulalongkorn University in Partial Fulfillment of the Requirement for the Doctor of Philosophy

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ญาดา ธงธรรมรัตน์ : ประสิทธิผลของโปรแกรมเสริมสร้างสุขภาวะทางจิตในญาติผู้ป่วยโรคจิตเภท . (Effectiveness of the enhanced psychological well-being intervention in family caregivers of schizophrenic patients) อ.ที่ปรึกษาหลัก : รศ. ดร.เขมิกา ยามะรัต

ชุดกิจกรรมสำหรับญาติผู้ป่วยจิตเภทส่วนใหญ่มีวัตถุประสงค์เพื่อช่วยเหลือผู้ป่วยจิตเภทมากกว่าการช่วยเหลือญาติผู้ป่วยจิตเภท ซึ่งญาติผู้ป่วยจิตเภทมีความต้องการชุดกิจกรรมที่เน้นการพัฒนาศักยภาพที่เป็นจุดแข็งของญาติผู้ป่วยจิตเภทมากกว่าการมุ่งแก้ไขปัญหาสำหรับผู้ป่วยจิตเภท การศึกษาครั้งนี้กลุ่มตัวอย่างเป็นญาติผู้ป่วยจิตเภท ในเขตอำเภอโนนสูง จังหวัดนครราชสีมา จำนวน 127 คน โดยแบ่งเป็นกลุ่มทดลอง 63 คนและกลุ่มควบคุม 64 คน กลุ่มทดลองได้รับการจัดกิจกรรมเสริมสร้างสุขภาวะทางจิต จำนวน 4 ครั้ง จัดกิจกรรมสัปดาห์เว้นสัปดาห์ กลุ่มตัวอย่างทุกคนได้รับการประเมินสุขภาวะทางจิตและภาระการดูแลก่อนการทดลอง หลังการทดลอง และการติดตามผล 3 เดือน ผลลัพธ์พบว่า หลังการจัดกิจกรรมกลุ่มทดลองมีคะแนนสุขภาวะทางจิตสูงขึ้นอย่างมีนัยสำคัญทางสถิติ แต่คะแนนภาระการดูแลลดลงอย่างไม่มีนัยสำคัญทางสถิติ การศึกษาในอนาคตควรมีการพัฒนาชุดกิจกรรมที่เฉพาะเจาะจงมากขึ้น เพื่อให้สามารถลดภาระการดูแลในกลุ่มญาติผู้ป่วยจิตเภท ทั้งนี้อาจเพิ่มกิจกรรมเพื่อการดูแลผู้ป่วยจิตเภท เช่น สุขภาพจิตศึกษา

สาขาวิชา สาธารณสุขศาสตร์ ลายมือชื่อนิสิต ....
ปีการศึกษา 2562 ลายมือชื่อ อ.ที่ปรึกษาหลัก ....

5779157053 : MAJOR PUBLIC HEALTH

KEYWORD: psychotic patients, positive psychology, continuity of care, burden of care

Yada Thongthammarat : Effectiveness of the enhanced psychological well-being intervention in family caregivers of schizophrenic patients. Advisor: Assoc. Prof. KHEMIKA YAMARAT, Ph.D.

Most of the family-based interventions focus on assisting patients more than the family caregivers. Family caregivers of schizophrenic patients require intervention which focuses more on their strengths than on solving problems for schizophrenic patients. For this study with 127 family caregivers of schizophrenic patients in Nonsung District, Nakornratchasima Province, Thailand, 63 were in the intervention group and 64 were in the control group. The 4-session intervention was held every other week. Psychological well-being and burden of care were assessed pre-intervention, post-intervention, and at 3-month follow-up. The intervention group had significant increase in psychological well-being after receiving the intervention, but did not have significant decrease in burden of care after receiving the intervention. Further research is needed to develop specific interventions to better alleviate burden of care for family caregivers, which might include skill-building and psychoeducation for schizophrenic patient care.

Field of Study:	Public Health	Student's Signature ....
Academic Year:	2019	Advisor's Signature ....

ACKNOWLEDGEMENTS

I wish to express my appreciation to my advisor, Assoc.Prof.Khemika Yamarat, who has supported and encouraged me to be a professional and do the right thing. I wish to express my gratitude to all recommendation from my committees; Prof.Surasak Taneepanichskul, Dr.Peter Xenos, Dr.Montakarn Chuemchit, and special thanks for my external examiner-Dr.Pitakpol Boonyamalik. Without the funding from Nakornratchasima Rajanakerindra Psychiatric Hospital and my big boss Dr.Suwannee Ruangdet, my study would not have been realized. I would like to acknowledge for all supports that my family and colleagues provided during my study.

Yada Thongthammarat

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CHAPTER I
INTRODUCTION

1.1 Background and Rational

A report on the global burden of diseases in 2010 [1-3] revealed the following breakdown on the lifetime impacts of diseases. From this study, it was determined that mental, neurological and substance-use disorders accounted for 10.4% of global DALYs (Disability-adjusted life years), 2.3% of global YLLs (Years Lost to premature mortality), and 28.5% of global YLDs (Years Lived with Disability). For the global DALYs total, mental health had the greatest impact (56.7%).

Schizophrenia is a chronic and severe mental illness affecting more than 23 million people worldwide. It more commonly occurs among male subjects than females. It is associated with certain disabilities and is also associated with emotional and occupational impacts. Schizophrenic patients or persons with schizophrenia (PWS) are 2 to 3 times more likely to die earlier than members of the normal population, and this outcome is often associated with a range of physical illnesses [4, 5].

In Thailand, the overall prevalence rate of mental disorders for the entire population was 12.2% [6]. The degree of prevalence as classified by the mental health illness group was as follows: 1) Substance Alcohol Use Disorders 12.4, 2) Suicidality 6.4, 3) Dementia 3.9, Mood Disorders 3.3, 4) Substance Non-alcohol Use Disorders 1.4, and 5) Psychotic Disorders 1.2 [6]. The survey prevalence of schizophrenia for members of the Thai population aged between 15 to 59 years in 2003 was 8.8 per 1,000 [5]. The health care costs associated with productivity losses per person per year for schizophrenia ranked from 86,004 to 146,526 Baht [7]. Although Nakornratchasima Rajanakarindra Psychiatric Hospital (NRPH) is a medium-sized hospital, this institution ranks second in terms of treating mental disorders. At NRPH, schizophrenia was the form of mental disorder with the highest number of admitted patients at around 6% of the hospital’s total list of patients. Therefore, almost of them reside within their own community [5, 8, 9]. However, family caregivers for Schizophrenic patients also face a significantly high burden [10].

According to the Public Health Reform act in 2012, NRPH was established to address and serve the mental health needs of the community. The following year, NRPH implemented the psychiatrist mentor project which aimed to provide mental health services at the community hospital level with the assistance of general doctors. Since 2013, Department of Mental Health has implemented the Mental Health Gap Action Program (mhGAP) in 14 districts of Public Health Region 9. In this region, 5 of the districts were in Nakornratchasima Province. The mhGAP program aimed to increase the accessibility rate of mental health services by providing proper care, psychosocial assistance and medication for local communities [11]. In this program, individuals diagnosed as schizophrenia will be able to benefit from mental health services at their community hospitals. With regard to the actual benefits of the two projects mentioned above, it will be more convenient and cost-effective than in the past for individuals identified as schizophrenia to obtain mental health services. According to the outcomes of these projects, each patient could save around 200-300 baht per one visit to the NRPH [12]. Nevertheless, these projects are more focused on the patient than the family members who serve as caregivers. However, many studies have reported that there is a significant impact upon the family’s members that act as caregivers over the course of the recovery process for individuals diagnosed as schizophrenia. Notably, individuals identified as schizophrenia who meet their relatives on fewer occasions than once a week tend to suffer a decrease in quality of life [13].

Caregiving have been defined as ‘a basic component of human nature and a primary element of close relations’ [14]. Thai family caregivers are divided into two groups, those who are willing to provide care and those who are unwilling to provide care. Both of them require some degree of background information on schizophrenia and should be willing and eager to know how to offer proper care for their family members in need. In theory, they can help schizophrenic patients by providing routine care, searching for alternative treatments, avoiding psychotic episodes, and planning for the future [15].

As schizophrenia is a severe mental disease [16], its sufferers are significantly dependent upon family caregivers. A family member's illness is an important event which can lead to increased levels of stress among all other members of the family unit [6]. A recent study revealed that family caregivers of schizophrenic patients are faced with shouldering a significant burden [17]. The burden of care placed upon the family caregiver for the recovery process of a schizophrenic patient has increased over the last two decades [18]. The burden of care can have a negative effect on the behavior of caregivers [19]. The burden of care actually has two relevant components [20]. These components are labeled as objective and subjective. The objective burden includes the amounts of time and finances that are devoted to care as can be seen in the economic constraints and financial demands that family caregivers have to bear. Subjective burden deals with how the family caregivers perceive the burden of care. It encompasses elements of emotional distress that are associated with family conflicts, a low quality of life (QoL) measurement, as well as feelings of anxiety and depression [20]. Although family caregivers of schizophrenic patients have positive experiences, they can also experience the negative side of dealing with a loved one who has been diagnosed as schizophrenia. Family caregivers tend to be the group that is most at risk of experiencing their own mental health problems because the burden of mediation is commonly associated with certain other stressors and elements of psychological distress [21]. The level of stress that results from providing care for a schizophrenic patient increases someone's own level of exposure to emotional distress and to other potential physical and mental health problems such as depression [22]. The rates of significant depressive symptoms among family caregivers of schizophrenic patients can vary across countries [22], with reported rates of 34% in the United States, 66% in India, 83% in Italy, 6% in Malaysia [23] and 19.5% in Thailand [22]. For older caregivers with lower levels of education, there can be a low level of psychological well-being, whereas the siblings of those individuals can have higher levels of well-being. Notably, there is a strong negative correlation between a caregiver's burden and their psychological well-being [24]. Even though the public health system has increased the accessibility rate of mental health care, this psychological issue still remains an important concern for family caregivers. A study conducted in health region 9 revealed that the family caregivers of those suffering from mental illnesses reported a low to moderate burden score, whereas their quality of life was also found to be very low [25]. However, their subjective burden score was higher than their objective burden score. Examples of this would be that they experienced feelings of stress and felt hopeless or unfortunate with regard to their situation. Some claimed to suffer from depression or even had ideas of suicide.

From previous studies involving family caregivers of schizophrenic patients, the high-value knowledge of experienced mental health professionals on the attitudes or skills needed for providing patient care to schizophrenic patients was presented [26, 27]. A number of studies aimed to reduce the levels of expressed emotions, feelings of stress and family burdens in order to enhance the capacity of relatives to address problems and to reduce potential relapses and subsequent hospitalizations of individuals identified as schizophrenia. Most family-based intervention regimens focused more on the results of the patients than on the family caregivers. Overall, the main objective of the family-based intervention program was to enhance the family atmosphere and to decrease incidences of relapses for schizophrenia. However, there is no evidenced-based intervention regimen that focuses on the positive aspects of being a family caregiver of schizophrenic patient. Additionally, the strategies needed to strengthen the psychological well-being of family caregivers for those identified as schizophrenia need to be developed. Therefore, family caregivers of schizophrenic patients would require an intervention program that focuses on developing their own specific strengths rather than on solving the problems for schizophrenic patients. The Enhanced Psychological Well-Being Intervention will be developed in the form of a group of workshops for family caregivers of schizophrenic patients and will be comprised of four workshops that take place every other week. Mainly, the program aims to change the negative feelings (automatic thoughts) and replace them with feelings of well-being [28]. All activities were developed based on the Transtheoretical Model (TTM) [29] and involved positive psychology (Mindset Theory [30, 31], psychological well-being theory [32, 33], positive psychology intervention [20] and the process of well-being therapy (WBT) [18, 19].

This study involved a quasi-experiment group, an intervention group and a control group for family caregivers of schizophrenic patients in Nonsung District, Nakornratchasima Province. It aimed to evaluate the effectiveness of the Enhanced Psychological Well-Being Intervention by increasing the psychological well-being, and decreasing the burden of care of family caregivers of schizophrenic patients.

1.2 Research Questions

1.2.1 Does the Enhanced Psychological Well-Being Intervention increase the family caregivers' psychological well-being?

1.2.2 Does the Enhanced Psychological Well-Being Intervention decrease the family caregivers' burden of care?

1.3 Objectives

1.3.1 General objective

To evaluate the effectiveness of the Enhanced Psychological Well-Being Intervention of family caregivers of schizophrenic patients before and after the period of intervention.

1.3.2 Specific objectives

1.3.2.1 To determine and compare the family caregivers' psychological well-being before and after the period of intervention.

1.3.2.2 To determine and compare the family caregivers' burden of care before and after the period of intervention.

1.3.2.3 To determine and compare the different scores of family caregivers' psychological well-being between the intervention and control groups.

1.3.2.4 To determine and compare the different scores of the family caregivers' burden of care between the intervention and control groups.

1.4 Hypotheses

H_O : *Psychological well-being scores* among family caregivers were not different between the intervention group and the control group after implementation of the intervention.

H_1 : *Psychological well-being scores* among family caregivers were different between the intervention group and the control group after implementation of the intervention.

$H_O : \mu_1 = \mu_2$ As μ_1 = family caregiver in the intervention group
$H_1 : \mu_1 \neq \mu_2$ μ_2 = family caregiver in the control group

H_O : *Burden of care scores* among family caregivers were not different between the intervention group and the control group after implementation of the intervention.

H_1 : *Burden of care scores* among family caregivers were different between the intervention group and the control group after implementation of the intervention.

$H_O : \mu_1 = \mu_2$ As μ_1 = family caregiver in the intervention group
$H_1 : \mu_1 \neq \mu_2$ μ_2 = family caregiver in the control group

1.5 Conceptual Framework

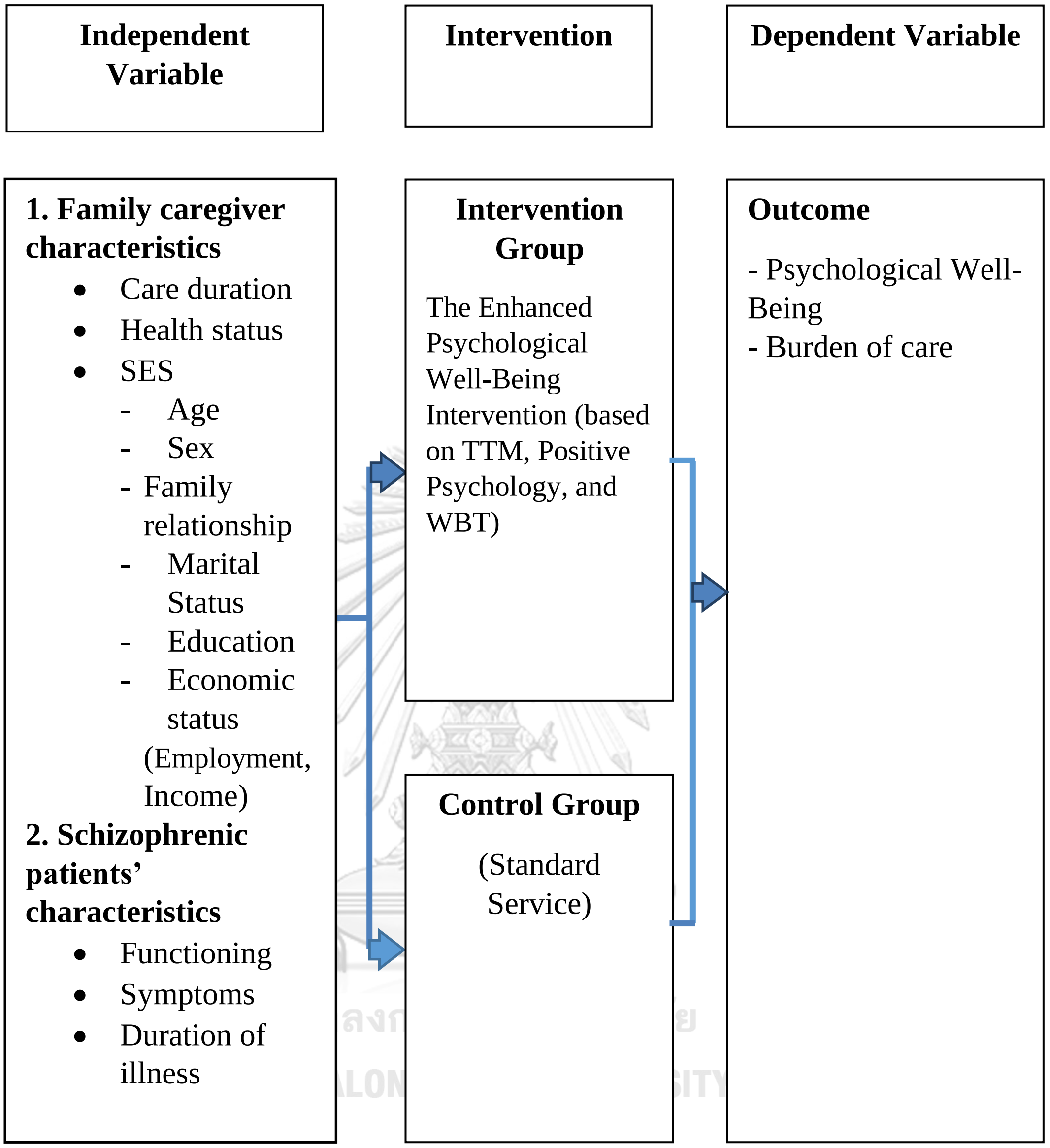


Figure 1 Conceptual Framework

1.6 Expected Outcomes

The intervention program could ease or prevent mental health problems with regard to the burden of care among family caregivers of those diagnosed as Schizophrenic patients.

1.7 Operation Definitions

Family caregiver [34, 35] defined as a family member (father/mother/sibling/husband/wife/daughter/son/ son- or daughter-in-law/brother- or sister-in-law) aged 18 years old or older who provides most of the long-term care required for a family member diagnosed with schizophrenia on a voluntarily basis.

Age [36] defined as the number of years that a family caregiver has lived. It can be rounded up to 1 year if the duration is more than 6 months.

Sex [37] defined as the biological characteristics which define a family caregiver as a man or woman.

Family relationship [38] defined as some degree of kinship – whether through blood, marriage, or adoption between family caregivers and Schizophrenic patients such as father, mother, sibling, husband/wife, daughter, son, son- or daughter-in-law, and brother- or sister-in-law.

Marital Status [39] is defined as the family caregivers' state of being single, married, widowed, divorced, or separated, whether in-law or not.

Education [21] is defined as the final education level of the family caregivers: uneducated, primary, secondary, Vocational Certificate/ Technical Certificate, High Vocational Certificate/ Diploma, Bachelor's Degree, or others.

Economic status [21] is defined as a situation of employment or of being unemployed and the amount of income per month one receives from all sources including allowance for disabilities, support from others, and so on.

Duration of Schizophrenic patients' illness [3] is defined as the number of years since the Schizophrenic patients had been diagnosed as schizophrenia until the present. It can be rounded up to 1 year if the duration is more than 6 months.

Schizophrenic patients' Symptoms [40] is defined as both positive symptoms such as delusions, hallucinations, catatonic behavior, disorganized speech, and negative symptoms such as poverty of speech, affective flattening, avolition, or other psychotic symptoms.

Schizophrenic patients' functioning [41] is defined as the Schizophrenic patients' performance in daily life activities (self-help in eating, dressing, bathing, excretion) which were recorded by the family caregiver and classified. These can be divided into four functioning groups: deficit, ineffective, questionable, and complete. *Deficit functioning* is defined as how much longer the Schizophrenic patient takes than normal and whether they need a lot of help from others. *Ineffective functioning* is determined when Schizophrenic patient is inefficient in completing basic tasks and takes longer than normal but can finish the task. *Questionable functioning* is determined when a Schizophrenic patient is inefficient in completing basic tasks but can finish on time. *Complete functioning* is determined when a Schizophrenic patient can do daily activities as normal.

The Enhanced Psychological Well-Being Intervention program is defined as a group of workshops for family caregivers of Schizophrenic patients that is comprised of four workshops taking place every other week. Mainly, this program aims to increase psychological well-being and to decrease the burden of care placed on the caregiver by employing the Transtheoretical Model, Positive Psychology (Mindset, Psychological Well-Being, Positive Psychology Intervention), and Well-Being Therapy.

Psychological well-being [33, 42-44] is defined as the balance of wellness that encompasses concepts of autonomy, environment mastery, personal growth, positive relations with others, feelings of purpose in life, and self-acceptance. It will be assessed through the use of the Psychological Well-Being Scale (PWBS).

Burden of care [18, 20, 45, 46] is defined as either the positive or negative perception and experience of being a family caregiver for Schizophrenic patients. It will be assessed through the use of the Zarit Burden Interview (ZBI).

CHAPTER II
LITERATURE REVIEW

2.1 Schizophrenia

Schizophrenia is characterized by “cognitive, behavioral and emotional abnormalities, including positive symptoms (e.g., delusions, hallucinations, catatonic behavior, disorganized speech) and negative symptoms (e.g., poverty of speech, affective flattening, avolition)” [40].

As referenced by the International Classified Listing of Diseases (ICD-10) [47], the general characteristics of schizophrenia involve a distortion of thinking and perception and other related inappropriate affects. The important symptoms of schizophrenia can be divided into nine groups:

(1) thought echo, thought insertion or withdrawal, and thought broadcasting;

(2) delusions of control, influence, or passivity, clearly referring to body or limb movements or specific thoughts, actions, or sensations; delusional perception;

(3) hallucinatory voices giving a running commentary on the patient’s behavior, or patients carrying on a conversation with themselves, or other types of hallucinatory voices coming from within;

(4) persistent delusions of other types that are culturally inappropriate and completely impossible, such as perceived religious or political identity, or superman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);

(5) persistent hallucinations in any modality, when accompanied either by fleeting or hale-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;

(6) breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;

(7) catatonic behavior, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;

(8) “negative” symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance; it must be clear that these feelings are not due to depression or to neuroleptic medication;

(9) significant and consistent change in the overall quality of some aspects of personal behavior, manifesting as a loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

In acute phases of schizophrenia, positive symptoms are easily noticed [48]. For example, the Schizophrenic patient will experience a loss in contact with reality, delusions, hallucinations, thought disorders and movement disorders. These symptoms can be severe in some cases, but some are hardly noticeable. In the chronic phase of schizophrenia, negative symptoms are dominant while positive symptoms can reoccur [48].

The risk factors for schizophrenia are either environmental or genetic [49]. For the environmental factors, these include infection, malnutrition, cannabis use, and certain social factors such as migration, childhood trauma, and socioeconomic status. The genetic factors are relevant to a subject's genes and their interactions with others, as well as certain genetic and environmental conditions, and exposure to different environments.

Schizophrenia is a worldwide pervasive neuropsychiatric disorder with a prevalence of 1% in the adult population and a mean annual incidence rate of 0.2 per 1,000 people at a range of 0.04-0.58 per 100 people [40]. However, the prevalence and incidence rates are varied due to the differing definitions of schizophrenia. In a 2003 survey of schizophrenia of the Thai population aged 15-59 years [5], the prevalence was found to be 8.8 per 1,000 people with a male to female ratio of 1.1 to 1. The modeled incidence rate was 0.3 per 1,000 and was highest for subjects aged 15-24 years for both male and female individuals. The average duration of time for schizophrenia was 30 years in men and 34 years in women. The YLD of schizophrenia per capita in Thailand (0.004) was higher than the average number across the world (0.002) and among all other Southeast Asian countries (0.001). Chronically disturbed cognition levels of subjects identified as Schizophrenic patients can affect the executive function and verbal fluency of the subjects [40]. For all individuals who have been diagnosed as living with schizophrenia for more than ten years [48], only 25% might completely recover. Another 25% of these individuals would experience some degree of improvement but would need a support network, and 15% would show no improvement and so would need to be re-hospitalized.

Furthermore, the Schizophrenic patients and family members will also have to absorb direct and indirect costs related to providing care [50]. The main cost is the cost of hospitalization, and the rest include out-patient services and medication. The range of costs per year per person of schizophrenia is approximately THB 87,000 to THB 31,000. Whereas the indirect, unemployment, absenteeism and presenteeism values of Schizophrenic patients and family members was 61% of the economic burden of schizophrenia. The indirect costs also include intangible costs (such as pain, suffering, and quality-of-life) and direct non-health care costs (such as those associated with law enforcement and the criminal justice system). The recommended treatment for schizophrenia includes generic risperidone as a first line of treatment in combination with family intervention programs, and treatment with clozapine for those who do not respond to risperidone [51]. The factors viewed as the facilitators of recovery were illness acceptance, hope, and adherence to treatment, whereas the barriers included a low level of self-responsibility and other illness-related factors [52].

A study in Thailand revealed that the overall perception of a person diagnosed with schizophrenia can be divided into four themes: perception of mental illness, perception of the cause of illness, perception of discrimination, and attempting to live with schizophrenia [48]. Individuals identified as Schizophrenic patients perceived their illness as one that is chronic with a need for regular medication and treatment, and as one with a low recovery rate. They believe that supernatural powers, bad karma from past actions, or biological factors were the causes of their illness. They were commonly discriminated against by the community and were often called “phee-bha (mad)”. Consequently, they believed that their illness was chronic and had to find a way to live with their illness.

2.2 Family caregiver and burden of care

Caregiving is defined as the activities delivered by family members who have established certain roles and relationships with the Schizophrenic patients, for example wife-husband, and child-parent. Support is given in the form of care that they are not able to provide for themselves [14, 53]. A principle caregiver is someone who provides the greatest level of care and support to a patient [35]. Informal caregiving is used to describe the relationship between the caregiver and the client, and involves offering care in the form of time, effort, et cetera with no payment being given [20]. A study in Finland reported that there are five types of caregivers for people with mental illnesses [54]. The frequency for the indicated type is as follows: coping (43.4%), resigned (20.5%), activating (20.1%), anxious (11.9%), and supervising (4.1%).

The situations of family caregivers in Thailand are divided into two groups: those that are willing and those that are unwilling [55]. The first group refers to a family caregiver who is willing, and the second refers to an individual who is unwilling to care for the Schizophrenic patients. Nevertheless, both groups would require some information and knowledge of schizophrenia with regard to the proper care for an individual diagnosed as Schizophrenic patients, and the appropriate treatment for them. Family caregivers could help the Schizophrenic patients in providing routine care, searching for alternative forms of medicine, preventing psychotic episodes, and by planning for the future. At a stable stage of illness, family members of Schizophrenic patients may have a stronger impact on their psychological status due to the presence of other stresses that are associated with family life [56].

From the 3 C strategies [57] (Client-Caregiver-Community) of caring for the Schizophrenic patients in the community, the first role of the caregiver is that they should understand and accept the Schizophrenic patients. Secondly, they should observe the warning signs associated with Schizophrenic patients, and have appropriate skills for providing care for Schizophrenic patients. Finally, they should also manage their own mental health state in order to prevent feeling excessively stressed.

Thai family caregivers engage in “tactful monitoring” in order to prevent the occurrence of a potential “psychotic event” [58]. Tactful monitoring includes unobtrusive observation and strategies for calming the subject. Unobtrusive observation is done by keeping an eye on the subject, checking medications, and questioning the subject (asking about symptoms, reminding about medications, and preventing strong beverage intake levels). One strategy of calming involves family caregivers using the phrase “getting better” (low expectations with Schizophrenic patients). The other strategies involved helping the Schizophrenic patients to get better by attending to the activities of daily life, using positive words, preparing favorite foods, and encouraging socialization.

The burden of care is a complex construct with a range of challenges and has a simple definition. It is normally characterized by being both broad and negative [35]. It is frequently defined by its impacts and the consequences it projects on caregivers. These include the emotional, psychological, physical and economic impacts that are both obvious and distressing such as shame and embarrassment, as well as feelings of guilt and self-blame. The experience of providing care can be used instead of the "burden of care" because it has both positive or negative aspects [35].

The development of the level of burden over a period of twelve months among Schizophrenic patients family caregivers is comprised of six types: 1) a constantly high level of burden, 2) an increased level of burden, 3) a reduced level of burden, 4) a shifting level of burden, 5) a preeminence of other burdens, and 6) a consistently low level of burden [59]. The types of burden can change based on the symptoms of the Schizophrenic patients. In the acute phase [59], family caregivers suffer from an increased level of burden (8%), and a preeminence of other burdens (19%). There is a concern over the degeneration of burdens associated with the care of a Schizophrenic patients, and other non-illness-related burdens such as those involved with health, financial, and other concerns. In the chronic phase [59], family caregivers had a consistently low level of burden (8%), as those classified as Schizophrenic patients had little or no impairments. They also had a reduced level of burden (14%) when they were accepting of or had knowledge of the Schizophrenic patients who was in recovery. Sometimes, their level of burden fluctuated from an increased level of burden to a reduced level of burden. This was classified as a shifting level of burden (8%). Conversely, a consistently high level of burden was observed along with the highest level (40%) of burden among family caregivers who cared for individuals identified as Schizophrenic patients with severe and permanent psychological function deficiencies.

Family caregivers' burden can be divided into two types: objective and subjective burdens [20, 35, 59]. Objective burdens affect one's family life as a result of the relevant psychotic symptoms. These effects impact upon the family in terms of demands on their time. The burden places financial demands on the family. Subjective burden is identified by the extent to which an informal caregiver perceives the burden of care. In Sweden [60], informal caregivers committed 22.5 hours per week and around 14% of their income toward addressing the objective burden. For the subjective burden, mental problems were found to be the most prominent issues. Most informal caregivers perceived subjective burden as being the most troublesome. Informal caregivers stated that 54% of care providers had their own mental health problems, and 50% of them experienced relational problems as a result of providing care for a family member. The burden of family caregivers is a multi-dimensional phenomenon that encompasses issues related to mental health, physical conditions, social life, and financial status, as well as the overall functioning of the family as a whole [18].

With regard to the symptoms phase of schizophrenia [59], in the acute phase, family caregivers can feel powerless and helpless, and experience emotions of fear, annoyance, and anger. In the chronic phase, they can feel guilty over being a poor parent, or feel hopelessness, grief, loss, and may worry about the future of the Schizophrenic patients. The psychological experiences of the family caregiver of a Schizophrenic patients can fluctuate in either positive or negative ways during the process of providing care [61]. Some studies have suggested that those who experience greater negative caregiving experiences also do experience positive caregiving experiences [61]. Obviously, caring for Schizophrenic patients can involve some degree of inconvenience and can even be associated with feelings of suffering [18, 61-63]. They can feel sad, disappointed, concerned and discouraged as a result of caring for a Schizophrenic patient. The three most common forms of dysfunction experienced by family members who care for a Schizophrenic patients involved issues related to problem-solving, communication, affective responsiveness, and affective involvement [3]. Family caregivers were able to establish some degree of emotional coping by acceptance, positive self-talk, relying on religious principles or beliefs, and by comparing their suffering with others [61]. From the tactful monitoring process, even though family caregivers accepted the illness of the

Schizophrenic patients, they still felt significantly tired and sad because of their situation [58].

Schizophrenic patients family caregivers face significant burdens [17]. They tend to be a group of people who are at risk of developing their own mental health problems because the burden may be mediated by an association between stressors and psychological distress [21]. The stress that caregivers experience from providing care for Schizophrenic patients increases their level of vulnerability to emotional distress and to physical and mental health problems, such as depression [22, 64]. The rates of significant depressive symptoms among family caregivers of Schizophrenic patients can vary across countries [22], with reported rates of 34% in the United States, 66% in India, 83% in Italy, 6% in Malaysia [23] and 19.5% in Thailand [22]. Studies in Germany found that family caregivers of impaired elderly individuals with and without certain mental disorders exposed them to an increased risk of some form of mental disturbance [65]. Dutch family caregivers of mental disorders, and especially those with somatic diseases, experienced higher degrees of subjective burdens than those of family caregivers who did not have a somatic disease [66]. Family caregivers of Schizophrenic patients indicated that they had a middle to high level of subjective burden in China [67], India [14], Nigeria [21]. Additionally, family caregivers of Schizophrenic patients experienced a higher level of burden than family caregivers of Bipolar Disorder in terms of the caregivers' routine, external support and other relations [14]. In Nigeria, 91.6% of family caregivers of Schizophrenic patients defined the subjective burden in terms of 'any member becoming depressed, weepy, irritable' [21]. A study on the prevalence of burden among family caregivers of Schizophrenic patients in Malaysia reported that 14% of family caregivers of Schizophrenic patients experienced some degree of psychological distress [23], whereas chronic family caregivers in Singapore predominantly experienced feelings of embarrassment and worry [68]. A study in Thailand revealed that 65.5% of family caregivers of Schizophrenic patients perceived themselves to be in a poor physical state of health [22]. However, there were fewer studies on the correlation between the burdens and the psychological well-being of family caregivers of Schizophrenic patients. A review of current literature identified two relevant studies. Indian family caregivers of Schizophrenic patients reported that 80% of them felt a moderate level of burden among older caregivers and spouses [24].

Nevertheless, being a family caregiver can result in some positive experiences [61, 62]. The positive aspects of providing care have been measured and identified as positive caregiving experiences, caregiving satisfaction, caregiving gains and finding meaning through caregiving, all of which emerge as the positive aspects of providing care. Studies have suggested that caregivers of patients with schizophrenia and psychotic disorders experience caregiving gains (in the form of becoming more sensitive to persons with disabilities, gaining clarity about their priorities in life and having a greater sense of inner strength), experience good aspects of relationship with the patient and acknowledge a range of potentially positive experiences. They also gain a sense of understanding, and of being calm, accepted, and responsible for taking care of the Schizophrenic patients [61]. For Thai Buddhist family caregivers, caring is a Buddhist belief that is correlated with feelings of compassion, acceptance, and management [63]. Caregiving is a Buddhist belief according to the notions of Karma (merit and demerit), past lives and rebirth, and dharma. Caregiving is considered a state of compassion by providing care (metta) and support (karuna). Caregiving is distinguished by three concepts: stress, symptoms, and treatment. The perception of someone labeled as Schizophrenic patients with schizophrenia in Thailand is strongly related to certain underlying cultural practices, beliefs and attitudes that are unique to Thai society, including notions on the causation of schizophrenia as mystical powers, black magic, and bad karma stemming from past actions [48]. Due to this uniquely sensitive perception of Schizophrenic patients, the informal caregiver should be more sensitive in caring and living with these individuals.

2.3 Factors related to the subjective burden of family caregivers

Based on the stress model [69], the stress process can have four domains: the background and context of stress, stressors, the mediators of stress, and the outcomes or manifestations of stress. The burden of care is one of the consequences of stress, as is shown in Figures 2.

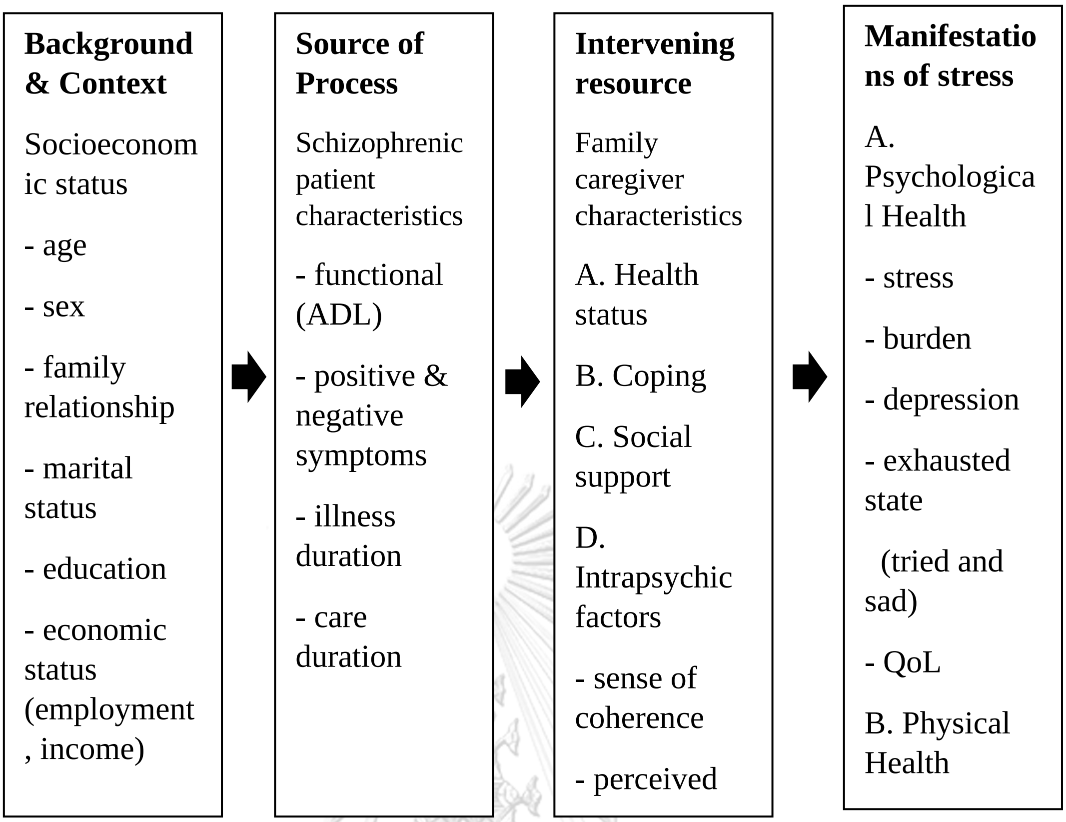


Figure 2 Conceptual Model of Caregiving Process and Caregiving Burden for those with Schizophrenia and Severe Mental Illnesses

2.3.1 Background and context

Socioeconomic situation

Age: *Age* of Schizophrenic patients and Schizophrenic patients caregivers with regard to the physical health and mental health of others [21, 70]. A study in Singapore found that age was associated with a high level of perceived burden [68]. Age was also positively correlated with the burden of care [71].

Sex: *Sex* is related to the family caregiver's level of subjective burden [18, 60] and their psychological well-being [72]. Females reported feeling greater amounts of anxiety and/or depression than male caregivers, and also were more concerned about their economic situations. In Singapore, female family caregivers for those with any chronic illness were more likely to perceive a degree of subjective burden than male caregivers [68]. With regard to Schizophrenic patients, being a female patient have a significant relationship to high levels of emotional distress among family caregivers [73]. Additionally, the relationship between gender and family caregiver burden has been mediated by resilience [74].

Family relationship: A number of studies reported on the important effects of the *family relationship* on Schizophrenic patients in countries like Thailand, Africa and Chile [2, 70]. There were a range of positive factors for the capabilities of family caregivers in caring for Schizophrenic patients [2]. For instance, the relationship of the family caregiver and the Schizophrenic patients can have an effect on the physical and mental health of all those involved [21]. Being the partner [66, 75, 76], parent [59, 75] or a child [66] of a person identified as a Schizophrenic patients can also be associated with a higher level of subjective burden.

Marital status: *Marital status* is significantly and independently associated with a high perception of burden. [68]

Education: *Education level* of family caregivers of Schizophrenic patients is related to the burden of care [21, 68, 70] and was found to be a negative predictor of burden [71]. Education was significantly and independently associated with a high degree of perceived burden [68]. Additionally, lower education levels are associated with a high level of emotional distress and increased levels of caregiver burden [73]. The best predictor of the burden of family caregivers was found to be their level of education [67]. Some studies have found that the negative predictors for the burden of care [71] included having a lower level of education with even more burden being identified in residential and rural areas [17].

Economic status (employment, income): Even though no main determinant was identified, the *socioeconomic situation* seemed more clearly linked to the family caregiver’s level of objective burden [18, 20]. Some studies in places like Africa and Chile revealed that caregiver employment was associated to the family caregivers’ degree of burden [70]. Caregiver employment and income are related to the caregiver’s burden when they have a job and receive a salary [66, 68]. Low income levels can lead to even greater levels of burden, especially when the individuals in question reside in rural areas [17]. On the other hand, patients who were unemployed have been associated with high levels of caregiver burden [73].

2.3.2 Source of process (Stressors)

Schizophrenic patients' characteristics

Function (ADL): The limited capabilities of Schizophrenic patients who were engaged in self-care can have a negative effect on the function of providing that care [19]. Caregiver burden was negatively correlated with Schizophrenic patients *functionality* [71]. Some studies argued that the functional level of the ability of the Schizophrenic patients to administer self-care did not relate to the psychological morbidity of those individuals [56].

Positive or negative symptoms: The severity of the positive or negative symptom behaviors was related to the degree of subjective burden, whereas the severity of the negative symptom behaviors was related to the objective burden [77].

Duration of Schizophrenic patients illness**:** The levels of psychopathology and disability were directly correlated with the caregivers' burden [78]. The number of hospitalizations of patients was also related to the burden of the family caregiver [71, 78]. Longer durations of providing care were also associated with caregiver burden [74].

Care duration: Stress directly relates to the caregivers' burden. Care duration has a negative effect on the caregivers' level of stress, whereas the patient's condition has a direct effect on the caregivers' level of stress [3, 56]. The amount of *daily time spent with the patient* was negatively correlated with caregiver burden [71]. More than 50 hours of providing care per each week, and providing less than three years of care for the Schizophrenic patients, were related to the objective burden of the caregivers [66]. *Living together with* Schizophrenic patients *in the same house* was related to the objective burden [66], although it was a positive predictor of that burden [71].

Health status: *Health status* was found to be one of the factors that were related to the burden of care. Caregivers with a low quality of life and those who have had an illness were related to a higher subjective burden [66]. The mental health status of family caregivers with various disorders, such as dysthymia, major depression, bipolar disorder, generalized anxiety or obsessive compulsive disorder, was associated with a high perceived burden [68]. Chronic illnesses among family caregivers were a negative factor for their capabilities in terms of providing care for Schizophrenic patients [2].

2.3.3 Mediators of stress (Intervening resource)

A study was conducted on three relevant factors (cognitive appraisal, coping strategies, and social support) and their relationship to subjective burden and wellbeing [79]. It was found that a greater number of positive and negative symptoms were related to behavior perception. Notably, problem-focused oriented coping strategies associated with negative symptoms, and problem-solving oriented coping strategies associated with positive symptoms, were both related to high levels of subjective burden. Moreover, a lower perceived frequency of positive symptom behavior and social support were found to be related to well-being.

Coping mechanisms, personal traits, and family functioning all can have an effect on the burden of care [80]. There was a significant correlation between the level of burden and the type of family caregiver (psychoticism) [81]. Coping levels were significantly correlated with extrovert personality types. This type of personality can deal better with Schizophrenic patients in the family than other types of personalities (psychoticism, and neuroticism) [81]. Good coping levels were correlated with environmental health (the fourth domain of QoL). Family caregivers of Schizophrenic patients who lived in nuclear families employed better coping strategies than those living in extended families [81]. A study on anger found a positive and weak relationship between burden and anger [82]. Bademli, Lok, and Kilic [82] found that emotional burden had a negative and strong relationship with anger control, while physical burden had a positive and strong relationship with traits of anger and the concept of anger-in. Time-dependency burden had a positive and medium relationship with traits of anger. Development burden had a negative and strong relationship with anger control, a positive and medium relationship with trait anger, and the concepts of anger-out and anger-in. Lastly, social burden had a positive and weak relationship with trait anger and the anger-in concept.

Emotionally-focused coping strategies: *A caregiver's personality* was associated with the burden of providing care. The predictors of caregiver burden included "being able to open up" to other members or friends [68], anxiety[22] and emotionally-focused coping strategies (self-control and escape-avoidance) [22].

Social support: Perceived social support had an inverse correlation with caregiver burden [78]. Seeking social support and the relevant coping strategies had a positive correlation with caregiver burden, whereas no consistent correlation was found between problem focused strategies and the burden of providing care [83].

Intrapsychic factors

Sense of coherence and the perception of a serious illness: Family caregivers who perceived Schizophrenic patients as being less responsible for their negative symptom behaviors were associated with higher levels of objective burden, whereas the perceptions for positive symptom behaviors were not related to the objective burden [77].

A number of studies were conducted in a Thai context. The factors that were related to family burden included duration of illness, mothers' employment status, family functioning, cash demands, seeking spiritual support, family appraisal of the situation, and the psychological mobility of relatives [3, 56]. The relationship between the family caregiver and the Schizophrenic patients was influenced by the duration of care, age, and social support as the positive factors for family caregivers' capabilities of providing care for the Schizophrenic patients, whereas a chronic illness in the family of the caregiver of the Schizophrenic patients was found to be a negative factor [2].

On the other hand, there are arguments claiming that these factors were not related to the family caregiver's subjective burden. Subjective burden was not associated with the caregivers' sex, caregivers' marital status, years of living together, patients' sex, patients' education level, patients' employment, government support, and total number of episodes, knowledge and the family caregivers' capabilities in caring for Schizophrenic patients [2, 70].

2.4 Measurement tools for psychological well-being and burden of care

2.4.1 There are various tools used to measure the level of psychological well-being [24, 84]. Some make direct assessments, but some assess only the issues that are deemed to be relevant to psychological well-being. Other tools are web-based resources employing quality of life and well-being related scales, as well as Satisfaction with Life Scale (SWLS), Psychological Well-being Scales, the Subjective

Happiness Scale (SHS), Authentic Happiness PANAS (Positive and Negative Affect Schedule), CES-D, Fordyce Emotions Questionnaire, Approaches to Happiness Scale, Warwick-Edinburgh Mental Well-being Scale (WEMWBS), and Psychological Well-Being Scales (PWBS).

Other scales are used to measure specific mental health issues such as GHQ-12, Patient Health Questionnaire (PHQ-9), Center for Epidemiologic Studies Depression Scale (CES-D), PANAS (Positive and Negative Affect Schedule), and Bradburn's Affect Balance scale.

2.4.2 Measurement of burden of care [24, 85-88]

There are many measurement tools that are used to assess the burden such as Zarit Burden Interview (ZBI) by Zarit et al. (1980), Social Behaviour Assessment Schedule (SBAS) by Platt et al. (1980), Family Burden Interview Schedule (FBIS) by Pai and Kapur (1981), Feetham Family Functioning Scale (FFFS) by Roberts and Feetham (1982), Caregiver Burden Inventory (CBI) by Novak and Guest (1989), Burden Assessment Scale (BAS) (Reinhard et al., 1994) [85], Experience of Caregiving Inventory (ECI) by Szmukler et al. (1996), Perceived Family Burden Scale (PFBS) by Levene et al. (1996, Involvement Evaluation Questionnaire (IEQ) by Van Wijngaarden et al. (2000), Family Burden Scale (FBS) by Madianos et al. (2004), CarerQoL Instrument (CarerQoL) by Brouwer et al. (2006), the Schizophrenia Caregiver Questionnaire (SCQ) by F. Hoffmann-La Roche, Zarit et al. (2012), and the Burden Assessment Schedule (BAS). However, only the Zarit Burden Interview (ZBI) and Burden Assessment Schedule (BAS) have been made available in Thai versions. Both tested the psychometric factors of the caregiver with regard to dementia and schizophrenia.

2.5 Intervention for family caregiver of Schizophrenic patients

As family caregivers are accepted as important resources for Schizophrenic patients, a significant amount of empirical evidence has been studied. Family intervention as psychoeducation and support groups were found to have a beneficial effect on the course of Schizophrenic patients [18]. Psychoeducation is a strategy for teaching patients and families about mental health diseases, treatment strategies, coping techniques and resources. Examples of the results of psychoeducation include a decrease in the degree of burden, and positive results were especially noticed among mothers and caregivers with lower education levels [89]. A support group was formed that focused on client-led interventions to professionally-controlled mental health interventions. An RCT study involving mutual support groups for families of Schizophrenic patients found that the duration of patient re-hospitalization and increased family functional levels increased the degree of the family burden [53].

The trend of psychosocial interventions for family members of Schizophrenic patients nowadays is believed to encourage the establishment of positive environments, while decreasing the levels of expressed emotions. From the Cochrane database of systematic reviews [26, 27], there have been 369 studies involving brief family interventions and 327 studies involving family intervention programs. Nevertheless, only 4 of the 369 studies, and 53 of 327 studies followed the randomized control trial design. Intervention programs can work by reducing levels of expressed emotion, stress, family burden, and by enhancing the capacity of relatives to solve problems whilst maintaining patient compliance with medication regimens. Additionally, family intervention programs aim to reduce any potential relapses and the subsequent need for hospitalization.

Briefly, family intervention programs for Schizophrenic patients [26] are comprised of five sessions or less and should be delivered by mental health professionals. The aims of the intervention program are to improve the capabilities of relatives in anticipating and solving problems, achieving significant changes in relatives’ behavior and belief systems, supporting relatives by setting and maintaining suitable limits and by maintaining some degree of separation as appropriate. The intervention program also aims to minimize emotions of anger and guilt felt by relatives, minimize negative family environments, build therapeutic coalitions with the caregivers of a person with schizophrenia, and to encourage an understanding of the limitations to patient performance. It was designed to educate the Schizophrenic patients and their family members about the illness, create an alliance in planning the treatment strategy and to provide mutual support to all those involved and then to generate an understanding of the disease. In family intervention programs, family members can provide insight to researchers into the signs and symptoms of the illness.

Family intervention programs for Schizophrenic patients [27] involve six sessions or more and are delivered by skilled and specifically trained mental health professionals. The intervention program is constructed through an alliance with relatives who care for the Schizophrenic patients. The aim of the program is to reduce the presence of an adverse family atmosphere (by lowering the emotional climate in the family by reducing stress and burden on relatives), to enhance the capacity of the relatives to anticipate and solve problems, to reduce any expressions of anger and guilt experienced by the family members, to maintain reasonable expectations in terms of patient performance, the encouragement of relatives to set and keep to appropriate limits whilst maintaining some degree of separation when needed, and to attain desirable change in the behavior and belief systems of relatives. The intervention program was designed to include motivated interviews and a regimen of cognitive behavioral intervention. There would be 24 hours of support made available to family therapy groups, along with a crisis-oriented family intervention plan, a relaxed training strategy, role play activities, and homework exercises.

In Thailand, helping the family members of Schizophrenic patients involves four major stages; establishing trust, strengthening connections, promoting readiness to care, and supporting the family [90]. Further studies on the keys to success for building a system of supportive care for Schizophrenic patients revealed a five-stage approach [91]. First, the approach would involve building trust between psychiatric nurses and informal caregivers. Second, there would be a procedure of engagement with the family members to assess their concerns and needs. Third, a mutually arranged preparation plan for giving care would be established. The fourth, stage would involve broader cooperation between all involved with Schizophrenic patients care. Finally, a system of monitoring outcomes would need to be employed.

In Thailand in the past, families were seen as one of the causes of schizophrenia. Over the last two decades, family caregivers in Thailand have been considered in the development of a system of treatment of Schizophrenic patients [92]. Family caregivers tend to suffer from a range of Schizophrenic patient symptoms and also experienced increases in the amounts of burden they shouldered. They also lacked knowledge with regard to the background of schizophrenia and how to provide care. Nowadays, these individuals are exposed to various intervention programs that deliver knowledge and skills on providing care, instruction on the benefits of family therapy and how family groups can be supportive. All of these focused on supporting and helping the family caregivers in providing care for Schizophrenic patients. Some examples of this in Thailand are presented in Table 1.

Table 1 Examples of family caregiver of Schizophrenic patient intervention strategies in Thailand

Intervention	Contents	Results
Holistic caring program [93]	Six sessions 1) rapport and motivate building 2) self-esteem building 3) spiritual well-being 4) knowledge of Schizophrenic patients caring 5) health caring 6) social skill developing.	Decreased caregivers' burden
Combined individual and family psychoeducation [94]	Psychoeducation at home For Schizophrenic patients 1) Orientation and knowledge of schizophrenia 2) Relapse prevention 3) Symptoms observation and important of regularly medication intake 4) Relationship and Schizophrenic patients responsibility 5) Stress management	1. Increased knowledge of both the Schizophrenic patients and the informal caregiver 2. Increased daily function abilities score among Schizophrenic patients.

Intervention	Contents	Results
Combined individual and family psychoeducation [94]	For family caregiver 1) and 2) same as Schizophrenic patients 3) Acute and rehabilitation phase treatment 4) Family role in caring 5) communication, family construction and problems 6) stress management	
Case management on medication adherence behavior of Schizophrenic patients [95]	Case management following the individual case management manual and clinical pathway for Schizophrenic patients in the community	1. Increased medication adherence behavior scores 2. Decreased the burden of care
Psychiatric Family Caregiving Program [96]	Six sessions 1) Knowledge of Schizophrenic patients care 2) Knowledge of schizophrenia and Schizophrenic patient symptoms 3) Knowledge of medication and other treatments 4) Daily functioning skill 5) Adversity behavior management 6) Medication management	Deceased the burden of care

Intervention	Contents	Results
Caregiver's empowerment program of schizophrenic patients with auditory hallucinations [97]	Three activities 1. how to learn about the effects on caregivers from caring for a schizophrenic patient with violent behavior 2. effectiveness of coping with the problem 3. how to request assistance from other support systems to manage a schizophrenic patient with violent behavior	The care behavior scores of schizophrenic patients with auditory hallucinations were higher than the control group
coping skills enhancement program compounded with seven activities [98]	Seven activities 1) relationship building 2) appraisal of caregiving related stress 3) seeking resources and enhancement of knowledge/ skills vital for schizophrenia's caregiver 4) communication skills training 5) problem-solving coping skill training 6) emotion-focused coping skill training 7) reappraisal	Increased the level of caring ability of Schizophrenic patients' caregivers

A number of other studies were conducted and found that psychological well-being could be applied to the family caregiver of Schizophrenic patient intervention program, as is shown in Table 2.

Table 2 Examples of intervention programs that focused on psychological well-being

Intervention	**Target**	**Contents**	**Results**
Worldwide			
Positive Psychology Intervention [99]	Elderly	Self-administered positive psychology intervention in an online setting 1) Gratitude visit 2) Three good things 3) Three funny things 4) Using signature strengths in a new way	1. Gratitude visits, three good things, using signature strengths in a new way increased happiness. 2. Three funny things and using signature strengths in a new way decreased depressive symptoms.
Lighten up! A community-based group intervention [100]	Elderly	Eight sessions, each 90 mins : Teach to identify and savor positive experiences across multiple domains of eudaimonic well-being 1) well-being in everyday life 2) well-being in the past 3) obstacles to savoring well-being 4) automatic thoughts and impacts on well-being 5) cognitive reconstructing 6) domains of well-being 7) strategies to improve well-being 8) well-being and health	1. Increased psychological well-being, life satisfaction, social well-being 2. Decreased levels of depression, physical symptoms, sleep complaints

Intervention	Target	Contents	Results
Thailand			
Holistic Caring Program [93]	Family Caregiver of Schizophrenic patients	Six activities 1. Rapport and motivation 2. Self-esteem development 3. Spiritual well-being 4. Schizophrenic patients care knowledge and attitude 5. Health education 6. Social skill development	1. Capabilities in caring increased. 2. Burden of care decreased.
Personal Growth Group [101]	Elderly	Twelve sessions - 3 to 5 sessions per week - 1 to 1.30 hrs. per each session Group process of personal growth group counselling - Security stage - Acceptance stage - Responsibility stage - Working stage - Closing stage	1. Psychological well-being increased 2. Key success factor 2.1 Positive interactions and warm and trusting relationships between the leader and group members 2.2 Supportive and meaningful relationships experienced by group members
Successful aging of Thai elderly [102]	Elderly	Six key factors of high psychological well-being 1. Mindfulness with life 2. Engagement in worthwhile activities 3. Pride in oneself 4. Satisfaction with life 5. Positive family relationship 6. Good health	-

Generally, family interventions tend to focus on various communication strategies that include problem solving and stress management techniques, as well as by providing a level of psychoeducation on schizophrenia and the management of it. There have only been a few studies that were specifically focused on the impacts and the easing of the burden of care placed on informal caregivers [35]. Most of the family caregiver intervention programs have been focused on the level of burden of the family caregiver, or on the negative aspects of providing that care along with the methods of coping for family members as the main outcomes. Researchers in this field have recommended that future family intervention programs should be set up as follows [18, 56, 79]. First, they should be developed based on the resiliency model in conceptualizing family life with Schizophrenic patients [56]. Second, they should employ a narrow focus but should still include the other dimensions of providing care such as quality of life (of either Schizophrenic patients or informal caregiver), feelings of being recognized and feelings of being valued as an individual [18]. Third, they should involve creative and multi-dimensional approaches in supporting both family caregivers and Schizophrenic patients [18]. Fourth, they should use problem-focused coping techniques that include the positive symptom behaviors which may decrease the level of subjective burden [79]. Fifth, programs should be focused on the links between multiple dimensions of health and the eudaimonic aspects of well-being that can provide purpose in life [100]. Sixth, Schizophrenic patients family caregivers should be given knowledge and support to cope with their burden and any feelings of anger they may experience [82]. Finally, there should be mediation of the positive effects of family psychosocial intervention on Schizophrenic patients' outcomes involving feelings of sympathy by the relatives and a lack of dominance [103].

2.6 Theory for developing intervention

There are three strategies of prevention that can be included in the guidelines for the design of any intervention program [104]. The first involves the concept of universal prevention. This strategy is designed to be provided to all population members without regard to any individual risk factors. The second strategy involves selective prevention. This strategy is designed to be provided for specific members of the at-risk population such as substance abusing adolescents. Finally, the last strategy involves the concept of indicated prevention. It is designed to be provided to individuals who show early signs of certain important risk factors such as school failure, stress, and so on. Individuals at this stage have not yet reached the point of receiving any clinical diagnosis.

In a Thai context [6], for the general public, knowledge of mental health and mental health illnesses passes the minimum criteria (60%). In contrast, their attitudes toward these issues did not pass the criteria (53%). The NRPH reported on the percentage of either clients or family caregivers with knowledge of mental illness upon being admitted to the hospital [105]. In the Acute Phase II, clients have knowledge and understanding of caring at 90%, whereas family caregivers have this type of knowledge at 86%. In the Sub-Acute Phase, clients have knowledge and understanding of caring at 90%, while family caregivers have knowledge at 87%. In accordance with the findings of a study conducted in Turkey [71], there was no correlation between burden and knowledge with regard to schizophrenia among Schizophrenic patients family caregivers. Therefore, in developing an intervention program in this study, the researcher focused on the attitudes of family caregivers of Schizophrenic patients by changing any negative thoughts and emotions, and also by strengthening their degree of psychological well-being. The theories or concepts that are being used are as follows: The Transtheoretical Model (TTM), Positive Psychology (Mindset, Psychological Well-Being, Positive Psychology Intervention), and Well-Being Therapy.

2.6.1 Transtheoretical Model (TTM)

Transtheoretical Model (TTM) [29] employs the stages of change to integrate the processes and principles of change across major theories of intervention. TTM was developed by Prochaska and colleagues from a comparative analysis of the principal theories of psychotherapy and behavior change in a determination to integrate all of the more than 300 recognized theories. The core construct of TTM involves the stages of change, processes of change, decisional balance (Pros and Cons), and self-efficacy. The model is briefly outlined in Table 3.

Table 3 Transtheoretical Model Constructs

Construct	Description
Stage of Change	
Precontemplation	No intention to take action within the next 6 months
Contemplation	Intends to take action within the next 6 months
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
Action	Changed overt behavior for less than 6 months
Maintenance	Changed overt behavior for more than 6 months
Termination	No temptation to relapse and 100% confidence
Processes of Change	
Consciousness raising	Funding and leaning new facts, ideas, and tips that support the healthy behavior change
Dramatic relief	Experiencing negative emotions (fear, anxiety, worry) that go along with unhealthy behavior risks
Self-reevaluation	Realizing that behavior change is an import part of one's identity as a person

Construct	Description
Environmental reevaluation	Realizing the negative impacts of unhealthy behavior or the positive impacts of healthy behavior on one’s proximal, social and/ or physical environment
Self-liberation	Making a firm commitment to change
Helping relationships	Seeking and using social support for healthy behavior change
Counterconditioning	Substitution of healthier alternative behaviors and cognitions for unhealthy behavior
Reinforcement management	Increasing rewards for positive behavior changes and decreasing rewards for unhealthy behavior
Stimulus control	Removing reminders or cues to engage in healthy behavior and adding cues or reminders to engage in healthy behavior
Social liberation	Realizing that the social norms are changing in the direction of supporting healthy behavior change
Decisional Balance	
Pros	Benefits of changing
Cons	Costs of changing
Self-Efficacy	
Confidence	Confidence that one can engage in healthy behavior across different challenging situations
Temptation	Temptation to engage in unhealthy behavior across different challenging situations

2.6.2 Positive Psychology Intervention

Positive psychology asserts that a perfect science and practice of psychology should regard knowledge of pain versus happiness and validated intervention methods. Positive psychologists attempt to develop intervention programs that have a well-organized perspective of human experience and can augment mainstream interventions [106]. Seligman [30] said that treatment is not just fixing an unpleasant life; it also involves creating a pleasant life. Psychology is not just about disease; it is about work, education, insight, love, growth, and play. Positive psychology interventions (PPIs) are the techniques that activate 'the plesant life, the engaged life and the meaningful life'[107]. On the other hand, Sin and Lyubomirsky [108] give a definition of positive psychology interventions that includes the treatment procedures that are developed to cultivate positive feelings, behaviors or intelligence levels.

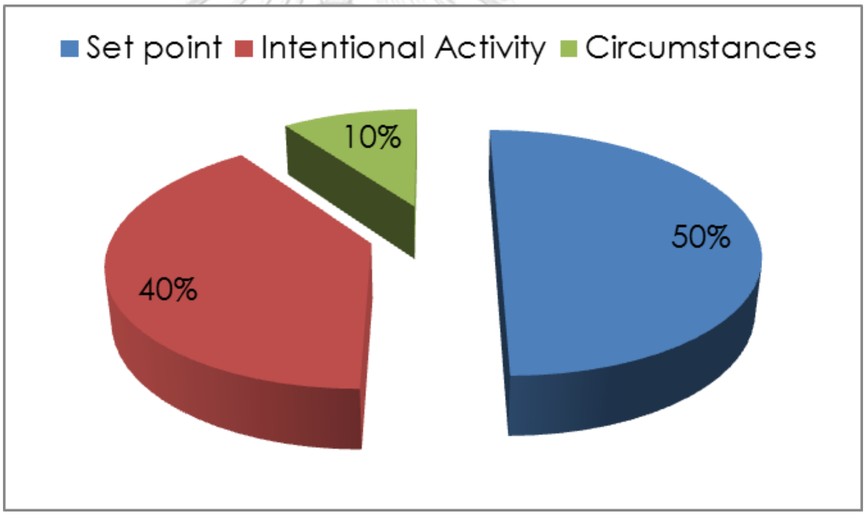


Figure 3 Pursuit of Happiness model

As can be seen in Figure 3, there are three factors that characterize the chronic happiness level; 50% of happiness set point, 10% of circumstances and 40% of intentional activities [109]. The happiness set point is controlled by genetics that need to be fixed, are certain and can be difficult to change. Circumstances, including national, geographical, cultural region, demographic factors, as well as life story and life status, are the general factors, but these are fixed by a person's actual circumstances. Intentional activities refer to the different ways people think and perform. Therefore, changing a person's intentional activities is a more effective way of increasing a person's happiness rather than by trying to change their circumstances.

2.6.3 Well-being Therapy

2.6.3.1 Structure

Well-being therapy (WBT**)** [28, 110] is based on Ryff's cognitive model of psychological well-being. WBT aims to achieve "a state of euthymia". The definition of a state of euthymia is constructed of three specific features as follows. First, there is a lack of mood disturbances that can be subsumed under diagnostic rubrics. Specifically, if one has a previous history of having a mood disorder, one should be in full remission. Also, if sadness, anxiety or an irritable mood are experienced, they tend to be short-lived and are usually related to specific situations. Ultimately, they do not significantly affect one's everyday life. Second, one feels cheerful, calm, active, interested in things and their sleep is refreshing or restorative. Finally, one displays balance and integration of psychic forces (flexibility) and has a unifying outlook on life that guides action and feelings in shaping their future accordingly. They also display a resistance to stress (resilience and anxiety or frustration tolerance).

Table 4 Definitions of theory-guided dimensions of well-being

Definitions of theory-guided dimensions of well-being	
Autonomy	
High Score	Is self-determining and independent; able to resist social pressures to think and act in certain ways; regulates behavior from within; evaluates self by personal standards.
Low Score	Is concerned about the expectations and evaluations of others; relies on the judgments of others to make important decisions; conforms to social pressures to think and act in certain ways.

Definitions of theory-guided dimensions of well-being	
Environment mastery	
High Score	Has a sense of mastery and competence in managing the environment; controls a complex array of external activities; makes effective use of surrounding opportunities; able to choose or create contexts suitable to personal needs and values.
Low Score	Has difficulty managing everyday affairs; feels unable to change or improve surrounding context; is unaware of surrounding opportunities; lacks a sense of control over external world.
Personal growth	
High Score	Has a feeling of continued development; sees self as growing and expanding; is open to new experiences; has sense of realizing his or her potential; sees improvement in self and behavior over time; is changing in ways that reflect more self-knowledge and effectiveness.
Low Score	Has a sense of personal stagnation; lacks a sense of improvement or expansion over time; feels bored and uninterested with life; feels unable to develop new attitudes or behaviors.
Positive relations with others	
High Score	Has warm satisfying, trusting relationships with others; is concerned about the welfare of others; capable of strong feelings of empathy, affection, and intimacy; understands the give and take of human relationships.

Definitions of theory-guided dimensions of well-being	
Low Score	Has few close, trusting relationships with others; finds it difficult to be warm, open, and concerned about others; is isolated and frustrated in interpersonal relationships; not willing to make compromises to sustain important ties with others.
Purpose in life	
High Score	Has goals in life and a sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living.
Low Score	Lacks a sense of meaning in life; has few goals or aims, lacks sense of direction; does not see purpose of past life; has no outlook or beliefs that give life meaning.
Self-acceptance	
High Score	Possesses a positive attitude toward the self; acknowledges and accepts multiple aspects of self, including good and bad qualities; feels positive about past life.
Low Score	Feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled over certain personal qualities; wishes to be different than what he or she is.

The therapists’ goal is to lead the clients from an impaired level to an optimal level with regard to the six dimensions of psychological well-being (details presented in Table 4). The important role of a therapist is not to encourage their clients to pursue the highest levels in all dimensions of psychological well-being, but to encourage them to gain a balanced sense of functioning. In a clinical setting, the therapist may use various techniques to overcome the impairment of psychological well-being. These include cognitive restructuring techniques (modification of automatic or irrational thoughts), the scheduling of activities (mastery, pleasure, and graded task assignments), assertiveness, and problem-solving techniques.

WBT is differentiated from standard Cognitive Behavior Therapy (CBT) in four ways. First, WBT is focused on instances of emotional well-being, whereas CBT is focused on psychological distress. Second, the goal of WBT is to promote psychological well-being based on Ryff's model, but the goal of CBT is to decrease distress thoughts and to establish automatic thought control or contrast. Third, WBT may be conceptualized as a specific strategy within the broad spectrum of self-therapies, although both can share similar techniques and therapeutic ingredients. Finally, WBT relies on a client's evaluation of their positive self-progression, while CBT can be explained by its own rational and the relevant strategies of the clients.

WBT's sessions can range from 8 to 16-20, or may be shortened to 4-6 sessions taking place every week or every other week. The duration for each session may range from 45 to 60 minutes. WBT can implement either normal or clinical populations. Originally, WBT was designed for individual therapy with residual symptoms; and it could be applied to a group therapy approach. The benefits of group therapy may increase by sharing optimal experiences and the personal understanding of psychological well-being. Nonetheless, in the clinical population, WBT may be used in sequential combination with other psychotherapeutic strategies such as CBT. WBT is specifically recommended for second or third-line treatment programs.

The development of WBT sessions involves 3 phases.

1) Initial phase: (1-2 sessions) Identifying the episodes of well-being
2) Intermediate phase: (3-5 sessions) Identifying well-being related automatic thoughts
3) Final phase: (6-8 sessions) Positive Cognitive Restructuring

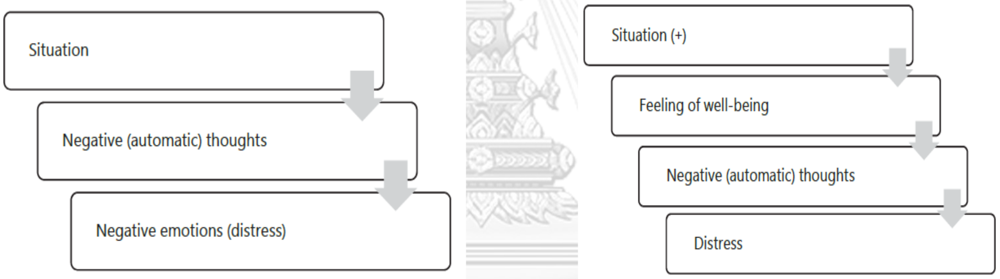
2.6.3.2 Four characteristic features of WBT

1) Monitoring of Psychological well-being

The client is persuaded to recognize episodes of well-being and to set them into a situational context. Then, they have to record their reactions in a structured diary regarding the circumstances surrounding their episodes of well-being and to rate their experiences on a scale of 0-100. The scale ranges from 0 (an absence of wellbeing) to 100 (the most intense state of well-being). This concept leads the clients to a perception of high environmental challenges and the importance of environment mastery, deep concentration, involvement, enjoyment, control of the situation, clear feedback on the course of activity and intrinsic motivation.

2) Identification of low tolerance to well-being by seeking automatic thoughts

After the monitoring of one's psychological well-being, the client is encouraged to identify thoughts and beliefs that may lead to premature interruption of well-being (automatic thoughts). Unlike CBT, as is illustrated in Figures 4, the trigger for self-observation in WBT focuses on the optimal situation and negative thoughts that lead to distress and obstruct well-being. A therapist and client can discuss the optimal activities and assignments that let the client have optimal experiences. These can develop the growth and improvement of one's self.



Cognitive Therapy (CBT) **Well-being Therapy (WBT)**

Figure 4 Basic mechanism of cognitive therapy and well-being therapy

3) Cognitive restructuring using specific psychological well-being models

Through the monitoring of a well-being episode, the therapist can understand the impairment level of the client by following the WBT conceptual framework (as illustrated in Table 5). The client will then learn how to address any well-being interruptions and pursue optimal experiences by using cognitive behavior techniques.

In reference to the cognitive model presented in Figures 4, the restructuring model in this intervention program will be as follows.

Stressors → negative thoughts → negative emotions → burden of care

4) Individualized and balanced focus

A client obtains a degree of balance functioning, which includes and contains positive characteristics such as gratitude and autonomy under the rubric of euthymia. There are no negative or positive aspects, and the impact depends on each situation and the interaction with any level of concurrent distress as well as the psychological attitudes of others.

2.6.3.3 WBT conceptual framework

As has been mentioned before, WBT is a cognitive restructuring of a strategy [110, 111] that follows Ryff's conceptual framework. However, there are some individual differences with regard to the optimal and balanced feelings of well-being due to each client's individual factors such as personality, social role, and culture.

Table 5 Modification of the six dimensions of psychological well-being according to Ryff's (1989) Model

Impaired Level	Optimal Level
Dimension 1: Environment mastery	
This dimension is the most frequent impairment in clients. The lack of sense of control leads clients to miss surrounding opportunities, with the possibility of a subsequent sense of regret washing over them.	
The subject has or feels difficulties in managing everyday affairs; feels unable to change or improve their surrounding contexts; is unaware of surrounding opportunities; lacks a sense of control over the external world.	The subject has a sense of mastery and competence in managing the environment; controls external activities; makes effective use of surrounding opportunities; is able to create or choose contexts suitable to personal needs and values.
Dimension 2: Personal Growth	
Clients often feel their goal is too far beyond reach to achieve. The impairment is the inability to recognize similarities between events and situations that were handled successfully in the past and those that are about to come about (transfer of experiences).	
The subject has a sense of personal stagnation; lacks a sense of improvement or expansion overtime; feels bored and uninterested with life; feels unable to develop new attitudes or behaviors.	The subject has a feeling of continued development; sees self as growing and expanding; is open to new experiences; has a sense of realizing own potential; sees improvement in self and behavior over time.

Impaired Level	Optimal Level
Dimension 3: Purpose in life	
Clients may perceive a lack of a sense of direction and may devalue their function in life. This would be the consequence of impairment in terms of mastery of the environment and a sense of personal goal.	
The subject lacks a sense of meaning in life; has few goals or aims, lacks a sense of direction, does not see purpose in past life; has no outlook or beliefs that offer life meaning.	The subject has goals in life and a sense of directedness; feels there is meaning to both present and past life; holds beliefs that give life purpose; has aims and objectives for living.
Dimension 4: Autonomy	
Clients may perceive the lack of self-worth leads to unassertive behavior.	
The subject is over concerned with the expectations and evaluations of others; relies on the judgment of others to make important decisions; conforms to social pressures to think or act in certain ways.	The subject is self-determining and independent; able to resist social pressures; regulates behavior from within; evaluates self by personal standards.
Dimension 5: Self-acceptance	
Clients may maintain unrealistically high standards and expectations, driven by perfectionistic attitudes (that reflect a lack of self-acceptance) and/or endorsement of external instead of personal standards (that reflect a lack of autonomy).	
The subject feels dissatisfied with self; is disappointed with what has occurred in the past life; is troubled over certain personal qualities; wishes to be different from what he or she is.	The subject has a positive attitude toward the self; accepts his or her good bad qualities; feels positive about his or her past life.

Impaired Level	Optimal Level
Dimension 6: Positive relations with others	
Positive relations with others may be damaged by the impairment in self-acceptance (with the resulting belief of being rejected and unlovable).	
The subject has few close, trusting relationships with others; finds it difficult to be open and is isolated and frustrated in interpersonal relationships; is not willing to make compromises to sustain important ties with others.	The subject has warm and trusting relationships with others; is concerned about the welfare of others; is capable of strong feelings of empathy, affection, and intimacy; understands the give and take of human relationships

2.6.3.4 Validity implementation of WBT

As mentioned, WBT is recommended as a second line of treatment in the residual phase. There are four clinical groups that are employed in order to determine the effectiveness of WBT [110]. The first group involved the residual phase of affective disorder. WBT can increase the PWB on the Personal Growth subscale. Improvement of the residual symptoms may be based on a sense of balance between the positive and negative effects. The second group involves the prevention of recurrent depression. WBT is considered a part of CBT and incorporates lifestyle modifications. The intervention group is comprised of a lowering of residual symptoms and a lower relapse rate with 2 years of follow-up assessment. The third group involves a loss in clinical effects. As a treatment strategy, WBT is combined with CBT and antidepressant drug-taking. WBT may restore and continue remission with antidepressant drugs when a response fails or is going to fail. Finally, it is considered a treatment for anxiety disorders. In this way, WBT works in conjunction with CBT. Both can reduce anxiety and increase PWB. However, the application of WBT in the acute phase of psychotic patients can be quite difficult. It can be a part of a broader approach to therapy such as CBT. There have been some studies on WBT when it has been combined with CBT in terms of treatment resistance in affective disorders, body image disturbances, health psychology, and obsessive-compulsive disorders.

CHAPTER III
METHODOLOGY

3.1 Study Design

This study followed a quasi-experimental design, along with the pretest-posttest no-treatment control group design [112]. The experiments employed in this study evaluated the effects of the Enhanced Psychological Well-Being Intervention by comparing the family caregiver's psychological wellbeing and the degree of burden that exists between the intervention group and the control group.

Both groups were assessed to establish a baseline one week before the first workshop. Due to the need to consider stages of change [29], in the preparation stage, participants were expected to take action within the subsequent 30 days and to take some behavioral steps in the appropriate direction after the intervention program was implemented. For the action stage, participants were asked to change their behaviors for less than 6 months after the intervention program had been implemented. Therefore, the first follow up would take place at the end of a final workshop and the second follow up would take place three months after the intervention was implemented. The intervention program was administered at the health promotion hospital (HPH).

3.2 Study Area

Nakhonratchasima Province, or Korat [113], is located in the northeastern part of Thailand, around 250 kilometers from Bangkok. The area covers approximately 20,000 km^2. In this province, there are 32 districts and the population is around 2.6 million.

Nonsung District of Nakornratchasima Province, with the exception of Muang District, reported the highest number of Schizophrenic patients [105]. This study was conducted in the HPHs that were located in Nonsung District of Nakorn Ratchasima Province [114]

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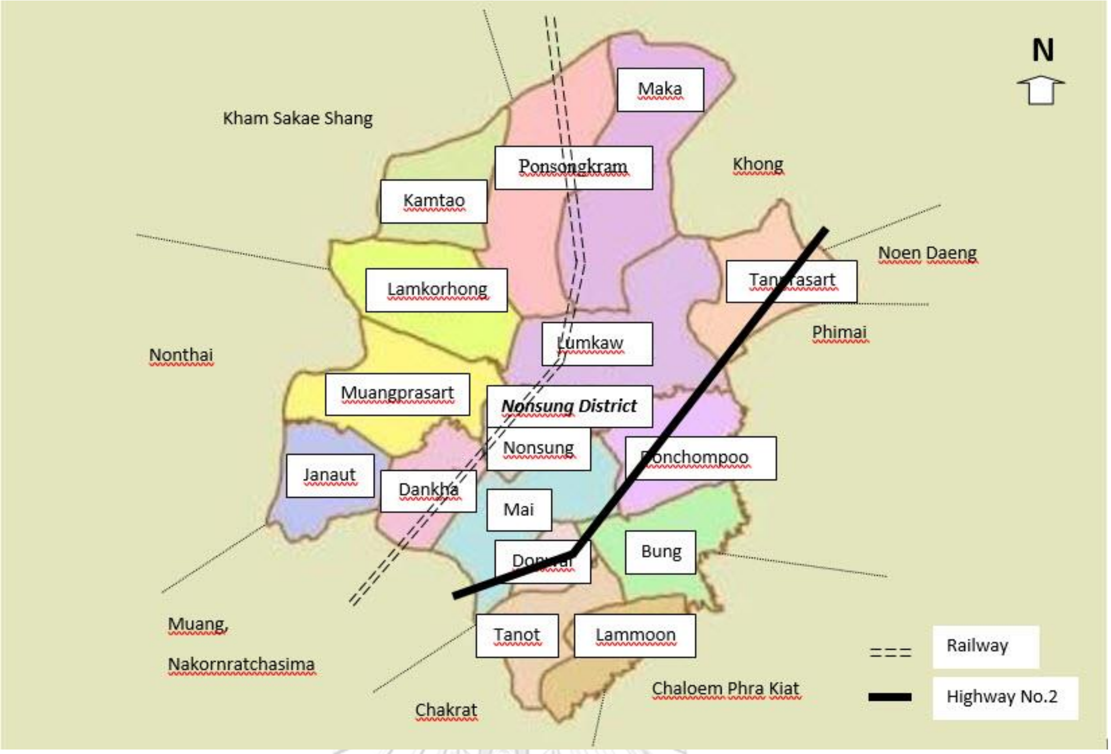

Figure 5 Adapted Nonsung District Map

3.3 Study population and sample group

3.3.1 Population: Family caregiver of Schizophrenic patients from 18 HPHs, Nonsung District, Nakornratchasima Province.

3.3.2 Sample: Family Caregivers of Schizophrenic patients from 7 HPHs considered medium or big in size [115]. A medium-sized HPH has the responsibility of caring for 3,000 to 8,000 people and has a nurse practitioner on staff. A big-sized HPH has the responsibility of caring for populations of over 8,000 people. In this study, the researcher selected the medium or big-sized hospitals because the minimum number of participants for a group intervention program should have at least 8 persons per group [116].

3.3.3 Inclusion criteria for participants

3.3.3.1 One who is a family caregiver of Schizophrenic patients (father/ mother/ sibling/ husband/ wife/ daughter/ son/ son or daughter in law/ brother or sister in law)

3.3.3.2 One who is 18 years old or older

3.3.3.3 One who can read and write in the Thai language

3.3.3.4 One who does not have any mental illness (as determined by the score from 2 Questions resulting in a Depression Screen score of zero) such as psychosis, schizophrenia, and so on.

3.3.3.5 One who does not have any physical illness such as cancer, tuberculosis, and so on, with the exception of Diabetes, Hypertension.

3.3.3.6 In the event there is more than one family member providing care in the family, the participant will be the one who devotes the highest numbers of hours per week to providing caring for the Schizophrenic patients.

3.3.3.7 The Schizophrenic patients under the care of the participant does not have any physical illnesses such as cancer, tuberculosis, and so on, with the exception of DM, HT.

3.3.3.8 One who agrees to participate in this study

3.3.4 Exclusion criteria for participants

3.3.4.1 One who has lived and cared for more than one relative with a chronic mental or physical illness

3.3.4.2 One who has cared for a Schizophrenic patient for less than 1 year

3.4 Sample size calculation

This study employed the n4study [117], which is an application developed for iPhone or Android devices to calculate a sample size by employing the following equation [118].

$$n = \frac{\left(z_{1-\beta} + z_{1-\alpha/2}\right)^2 \sigma^2}{\left(\mu_0 - \mu_1\right)^2}$$

In reference to a previous study, Martin-Carrasco et al. [119] assessed the efficacy of a psychoeducational intervention program (PIP) on the burden of Schizophrenic patients family caregivers. The burden in the intervention group was significantly decreased with a moderate effect size at 4 and 8 months (SMD = -0.35, and -0.40). An effect size of 0.40 with a statistical power of .8 and a Type I error (α) of .05 were determined. A sample size of 118 was selected for the two groups. Assuming a 10 % rate of quitting, the study required an additional 12 participants. In total, there were 130 participants for this study, 65 of which were assigned to the intervention group and 65 were assigned to the control group.

3.5 Sampling Technique

A purposive sampling technique [120-122] was employed. This is because the study was conducted within the community, which requires a certain criterion for the sample. It was also selected for reasons of cost and time-effectiveness. On the other hand, this technique has the disadvantage of employing a biased form of selection and is limited to a representative sample of the population. Before sampling, the researcher invited all 18 HPHs in Nonsung District to participate in this study. The researcher then administered the sampling procedure as follows. First, the researcher conducted the area sampling procedure by using the railway to distinguish between the west and east sides of the district in order to decrease chances of contamination. Each side was comprised of eight sub districts, that were either urban or suburban. There was a total of 18 HPHs; 9 HPHs located in the west (188 persons) and 9 HPHs in the east (171 persons). Second, the researcher administered a simple random sampling step to determine whether the east side or the west side would be designated as the intervention group or the control group. The west side was designated the control group, and the east side was designated the intervention group. Third, the researcher conducted a purposive sampling step after being granted acceptance by the directors of the HPHs to participate in this study. There were 5 HPHs that made up the control group, and 3HPHs made up the intervention group. Researchers sent a formal letter to the directors to verify the name list of family caregivers for Schizophrenic patients. There were 104 persons at 5 HPHs that agreed to participate as members of the control group, and 102 persons from 3HPHs that agreed to participate as members of the intervention group. Fourth, the researcher screened the caregivers of the families of the Schizophrenic patients through the use of the inclusive and exclusive criteria. The researcher then persuaded them to participate in this study. The researcher provided all potential participants with information on the study, informed them of their rights to protection, and asked them to complete the consent from. The application process was closed as the number of either the control or the intervention group reached 65. Finally, there were 65 eligible participants in the intervention group, and 65 in the control group. The number of participants located at each HPH group varied in relation to the number of patients that were administered at each HPH. A flowchart of recruitment is presented below.

The researcher did not match pairs according to the burden score and the severity level of the Schizophrenic patients. This is because the number of Schizophrenic patients was considered inadequate. In the event the participant refused to continue taking part in the study or could not participate in all 4 workshops, they were asked to drop out of the study. Ultimately, the researcher calculated a sample size of 10% or more to account for that dropout rate.

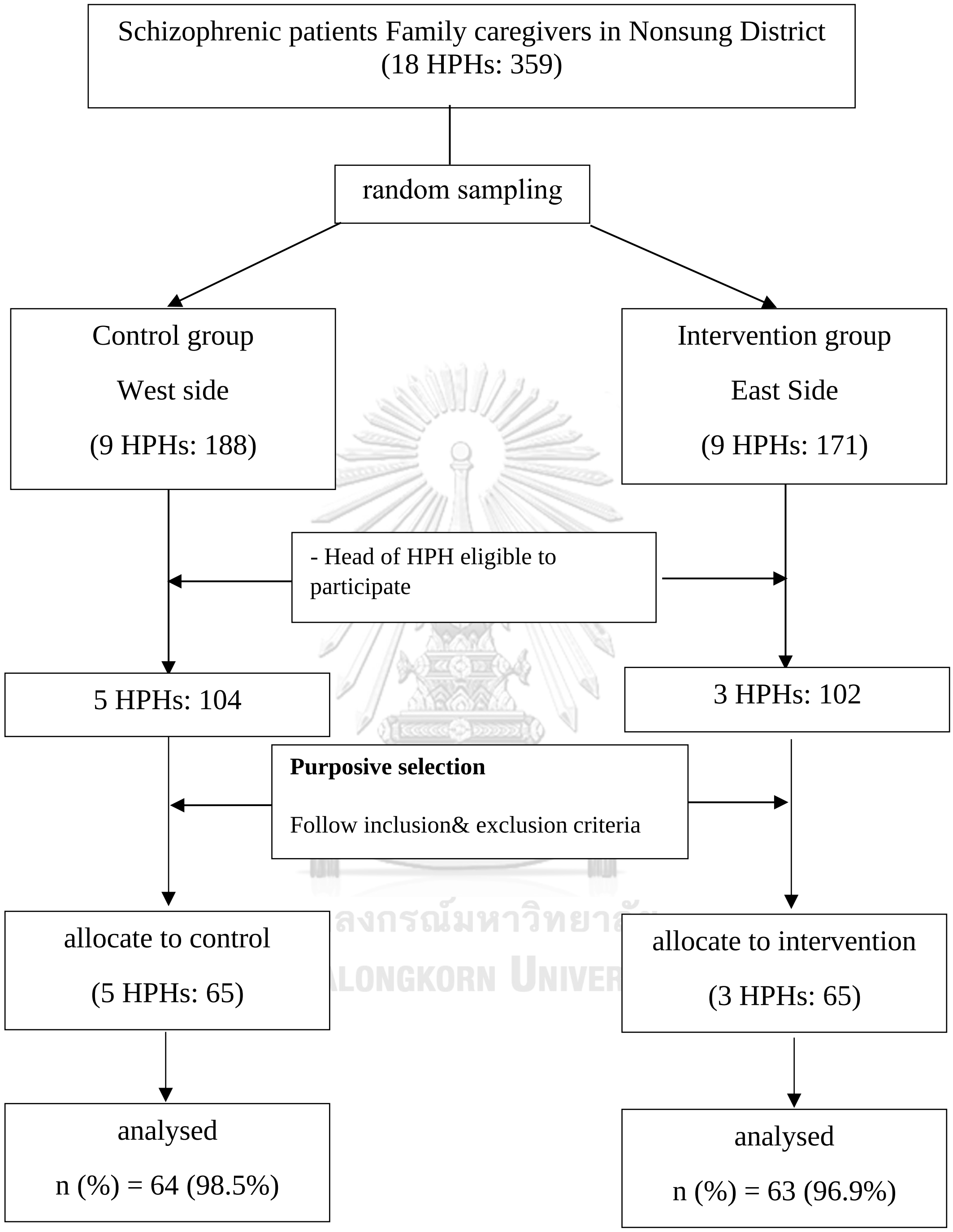

Figure 6 Flowchart of recruitment

3.6 Intervention Development

3.6.1 Process of intervention design

Researcher did the process of intervention design as follow [123-125].

3.6.1.1 Review of literature (previous studies and theories)

3.6.1.2 Design of the intervention program

3.6.1.3 Approval of and content validity conducted by three experts; one psychiatrist, one clinical psychologist, and one psychiatric nurse

3.6.1.3 Correction of the intervention program according to the experts’ recommendations

3.6.1.4 Pilot study to test the intervention program

3.6.1.5 Improvement and correction of the intervention program

3.6.1.6 Implementation of the intervention program in this study with the use of a sample

3.6.1.7 Editing of the final version of the intervention manual

3.6.2 Intervention Design

According to the previous study, it was recommended that the intervention program should be identified by the type or burden (objective versus subject), and then by the selection or design of the intervention program [20]. From a review of relevant literature, the informal caregiver experienced more problems in terms of the subjective burden than with the objective burden. Thus, the objective burden could be addressed by the recommended policy, whereas the subjective burden may be solved through the implementation of the intervention program. The researchers of this study, therefore, designed the intervention program for only the subjective burden.

The intervention design was based on the theory of the Transtheoretical Model (TTM), Positive Psychology (Mindset, Psychological Well-Being, Positive Psychology Intervention), and Well-Being Therapy. It aimed to increase the psychological well-being and to decrease the burden of care. Facilitators collaborated with a group leader and two co-group leaders. The researcher was one of the group leaders. The primary group leader was a licensed clinical psychologist and had more than ten years of experience in administering group psychotherapy. There were two co-group leaders. One of the co-group leaders was a registered psychiatric nurse who had more than ten years of experience in administering group psychology and serving the mental health community. The other co-group leader was a licensed clinical psychologist working in the community hospital who had more than five years of service working in the mental health community. They also helped the group leader to oversee the ice-breaking activities, run the small groups and encouraged group members to participate. They were trained (via a one-day workshop) to facilitate the activities of this intervention program by the researcher. Facilitators oversaw the activities with a relaxing atmosphere. The overall process for each workshop began with a mindfulness activity, followed by the workshop content and ended with a period of reflection. Afterwards, a group discussion was held and the participants took part in role play activities.

The intervention program was divided into 3 phases.

1. Initial phase: (workshop 1) Identifying the episodes of well-being
2. Intermediate phase: (workshop 2) Identifying well-being relative to automatic thoughts
3. Final phase: (workshop 3-4) Positive Cognitive Restructuring

Each workshop was held for 180 minutes with a 15-minute break. Assessments were made of the cooperation of participants of each workshop. Participants were assessed with the use of the Psychological Well-Being and Burden of Care model one week before the beginning of workshop 1, again at the start of workshop 4, and 3 months after the completion of the intervention program.

The conceptual framework for the Enhanced Psychological Well-Being Intervention is shown in Figure 7 with more details for each workshop presented in Appendix D.

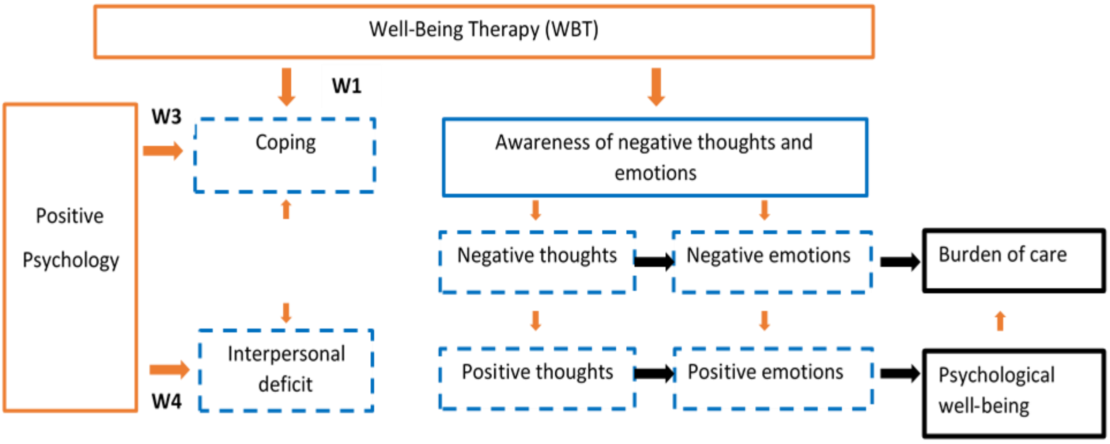

Figure 7 Conceptual framework for the Enhanced Psychological Well-Being Intervention

Based on the cognitive model presented in Figure 7, the burden of care emerges from stressors, negative thoughts and emotions. In contrast, psychological well-being emerges from positive thoughts and emotions, and mediated burden of care. There are two strategies employed to increase psychological well-being and decrease the burden of care. One strategy is to manage the situation with stressors. This intervention program was focused specifically on coping and the interpersonal deficits of family caregivers of Schizophrenic patients. The other strategy is to reconstruct any negative thoughts and emotions. Workshop one (W1) aimed to help participants cope with the stressors through the use of positive feeling regulation, exploring the situation and through an assessment of the intensity of well-being. Workshop two (W2) aimed to help participants become aware of any negative thoughts and emotions. They would then be able to understand the relationship between situations, automatic thoughts, and negative emotions. They were also informed on how to practice distress monitoring. Workshop three (W3) aimed to reconstruct the perception of stressors (coping) by understanding the fixed and growth mindsets that were related to the psychological well-being of each participant. It also aimed to enhance their understanding of environment mastery, personal growth, purpose in life and autonomy. Workshop four (W4) aimed to enhance self-acceptance and establish positive relationships with others. Participants would then be able to understand and practice self-compassion, and establish positive relationships with others.

This intervention program was developed through current research and had never before been administered in Thailand. Therefore, it required approval in terms of its content validity by three experts as follows:

1. Dr. Dutsadee Jungsirakulwit
    - child and adolescent psychiatrist; expert level
    - Director of Rajanakarindra Institute of Child Development
2. Mr. Wee Mekwilai
    - clinical psychologist; professional level
    - Division of Mental Health Technology, Department of Mental Health
3. Miss Praneat Chumputsa
    - psychiatric nurse
    - Head of Mental Health Community Division
    - Nakornratchasima Rajanakarindra Psychiatric Hospital

All experts agreed with the prescribed activities (IOC = 1) and offered detailed recommendations to the program. For example, it was suggested that the well-being diary activity may not be suitable in a Thai context and participants should be encouraged to engage in group discussions instead. Consequently, a researcher amended the intervention program according to the experts' recommendations. A pilot study was then conducted involving family caregivers of Schizophrenic patients from the out-patient department of NRPH.

3.7 Measurement Tools

The questionnaire in this study was comprised of three sections:

Section I: General information, 10 items

Section II: The Psychological Well-Being Scale (PWBS), 42 items

Section III: Zarit Burden Interview (ZBI), 22 items

3.7.1 Psychological Well-Being Scale (PWBS)

PWBS was used to assess the following six dimensions [33]: 1) *autonomy* - whether respondents viewed themselves to be living in accordance with their own personal convictions; 2) *environment mastery* - how well they were managing their life situations; 3) *personal growth* - the extent to which they were making use of their personal talents and potential; 4) *positive relationships* – the depth of connection they had in their ties with significant others; 5) *purpose in life* - the extent to which respondents felt their lives had meaning, purpose, and direction, and 6) *self-acceptance* – the knowledge and acceptance they had of themselves, including awareness of personal limitations. PWBS has been associated with high test–retest reliability in a range from 0.81 to 0.88, and the six dimensions of the questionnaire were determined to have high internal reliability with alpha coefficients for each dimension ranging from 0.86 to 0.93 [44, 126]. PWBS was comprised of four versions [126]; 1) 84 items, 2) 54 items 3) 18 items, and a special version with 42 items was used in the National Survey of Midlife Development in the United States (MIDUS II) during the period of 2004 to 2006. The psychometrics for each dimension were as follows: anatomy (α=.71), environment mastery (α=.78), personal growth (α=.75), positive relationships with others (α=.78), purpose in life (α=.70), and self-acceptance (α=-84) [127].

PWBS is classified as an instrument of self-report. The items identified from six dimensions were mixed. Participants can respond using a seven-point format [127]: strongly agree (1), somewhat agree (2), a little agree (3), neither agree nor disagree (4), a little disagree (5), somewhat disagree (6) and strongly disagree (7). PWBS results were ultimately constructed by calculating the sum scores. Responses to negatively scored items (R) were reversed in the final scoring procedures so that high scores would indicate high self-ratings on the dimension being assessed. There were no specific scores or cut-points for defining high or low levels of well-being. Those distinctions were best derived from distributional information obtained from the collected data. For example, high well-being values (for short or long versions of the scales) could be defined as scores that were in the top 25% (quartile) of the distribution, whereas low well-being values could be defined as scores that were in the bottom 25% (quartile) of the distribution. Another alternative would be to define high well-being values as scores that were 1.5 standard deviations above the mean, whereas low well-being values were scores that were 1.5 standard deviations below the mean [126].

A Thai version of PWBS was developed by Rohitarabutra [101]. It was comprised of 48 items and was given a total reliability score 0.88. The number of items and the reliability of each dimension are as follows: autonomy (5 items, $\alpha=.60$), environment mastery (13 items, $\alpha=.60$), personal growth (7 items, $\alpha=.58$), positive relationships with others (9 items, $\alpha=.76$), purpose in life (6 items, $\alpha=.61$), and self-acceptance (8 items, $\alpha=.62$).

The intervention program was developed based on the psychological well-being theory of Ryff [33]. The PWBS Thai version [101] was also developed based on the psychological well-being of Ryff. There were 48 items in the Thai version, but the items in each domain were not equal. For example, there were 13 items in the environment mastery dimension, whereas there were 6 items in the purpose in life dimension. Thus, it may useful to assess the overall degree of psychological well-being. On the other hand, the items in each dimension in any version of the original PWBS were equal. Therefore, the original version of the PWBS was more suitable when used to measure and observe the changes for each dimension of psychological well-being. In this study, the version comprised of 42 items was used because it was associated with a high internal reliability score and a proper number of items.

3.7.2 Zarit Burden Interview (ZBI)

ZBI [128] is classified as a self-administrated instrument that can be used to assess the level of burden experienced by the principle caregivers of older persons with senile dementia, along with disabled persons. It has been wildly administered among principle caregivers of Nervous System Diseases and Mental Disorders, and especially to caregivers of those diagnosed with Dementia. It was developed by Zarit et al. in 1980 and is comprised of 29 items. It was then reduced down to a 22-item version. There are also short form versions that are comprised of 18 items, 12 items, and screening 4 items.

There are English versions of this instrument in the USA, Australia, Canada, and the UK. It has been wildly used and translated in many languages such as the

French, German, and Thai languages. There are both paper-based and e-versions. The scaling and scoring of the ZBI are as follows [129]. It is comprised of five domains: burden in the relationship (item 1, 8, 11, 14, 18,20), emotional well-being (item 2, 4, 5, 9, 10, 21, 22), social and family life (3, 6, 12, 13), finances (item 15), and loss of control over one's life (item 7, 16, 17, 19). A higher score means a greater level of caregiver distress or burden. Each item employed the Likert scale with five possible responses from "never" (0) to "nearly always" (4) for item 1 to 21, and from "not at all" (0) to "extremely (4) for item 22. Total scores ranged from 0 to 88. The scoring and interpretation were done if 75% of the items were completed. Internal consistency was found to be high (alpha 0.91), and the test-retest reliability was 0.86. Convergent validity with GHQ was found to be 0.63 [89].

In this study, the ZBI instrument with 22 items was used because it measures the subjective burden and is associated with high internal reliability. The Thai version of the ZBI [130] was validated by the caregivers of the patients with chronic illnesses: schizophrenia, dementia, and epilepsy. Convergent validity testing with the Hospital Anxiety Depression Scale (HAD) revealed a score of 0.92. Additionally, there is a shorter version of the ZBI that is comprised of 12 items. The Cronbach's alpha coefficient score of the short version was 0.88.

3.7.3 Development of Thai version of Psychological Well-Being Scale (PWBS)

PWBS was developed by using a back-translated process [130-135]. First, the initial translator blindly translated the PWBS instrument into Thai. Second, a reviewer checked the Thai language version for language accuracy. Third, a second translator blindly produced a back-translated version into English. Fourth, a content validity check was done using face validity. The two versions of the PWBS (original language version and back-translated version) were compared for concept equivalence by both translators and a reviewer until all agreed that the two versions of the PWBS were identical in content and had no errors in meaning. Fifth, the researcher administered a cognitive test to 5 family caregivers of Schizophrenic patients from the out-patient department of NRPH. Finally, the degree of internal reliability [131] was tested by conducting a pilot study involving 30 family caregivers of mental health illness from the out-patient department of NRPH. The Cronbachs' alpha coefficient was recorded at .88.

PWBS is an instrument of self-report. The items involving six dimensions were mixed. Participants responded using a seven-point format [127]: strongly agree (1), somewhat agree (2), a little agree (3), neither agree nor disagree (4), a little disagree (5), somewhat disagree (6) and strongly disagree (7). The PWBS was constructed by calculating the sum scores. Responses to negatively scored items (R) were reversed in the final scoring procedure so that high scores indicated high self-ratings on the dimension being assessed. There were no specific scores or cut-points for defining high or low well-being values. Those distinctions were best derived from distributional information obtained from the data collected. For example, a high well-being value (for short or long versions of the scales) could be defined as scores that were in the top 25% (quartile) of the distribution, whereas low well-being values could be defined as scores that were in the bottom 25% (quartile) of the distribution. Another alternative would be to define high well-being values as scores that were 1.5 standard deviations above the mean value, whereas low well-being values included scores that were 1.5 standard deviations below the mean value [126].

The qualifications of the translators and a reviewer are described as follows. The first translator was a researcher who graduated with a Master's degree from the UK. The second translator was a freelance translator who graduated with a Bachelor's degree in the English Language. The reviewer was a senior psychiatrist who graduated with a Master's degree from the UK. She also earned her Master's degree in Translation. Because the language preference of the first translator and the reviewer was Thai, they were involved in the translation from English to Thai. The second translator was able to communicate fluently in both Thai and English languages and had a firm understanding of both cultures. Therefore, she was involved in the back-translation of the materials from Thai to English. Overall, all individuals engaged in the procedure of face validity.

3.8 Data Collection

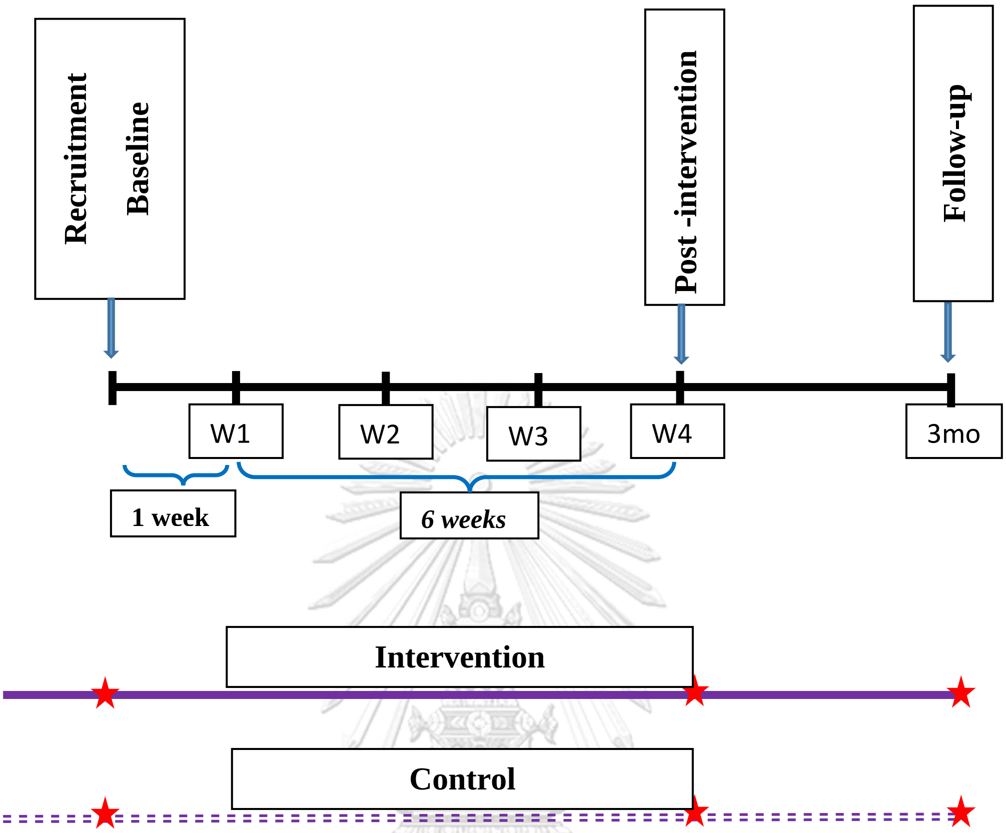

Figure 8 Timeline of Data Collection

As can be seen in Figure 8, all participants were assessed in terms of psychological well-being and burden of care one week before workshop one (W1), after finishing workshop four (W4), and in a follow-up session three months after the intervention program. The members of the intervention group were asked to attend an appointment every other week (for 6 weeks of the intervention program).

3.9 Data Analysis

For the purposes of comparison with regard to the parameters of the study group, Fisher's exact test for categorical variables and general linear regression (GLM) for continuous variables were employed.

At baseline, there was a significantly different between the intervention group and the control group in sex, relationship, marital status, income, and schizophrenic patients' symptom. These variables much be controlled for and ANCOVA allows for the inclusion of these variables in the equations as controls. Intervention effects were tested by using the repeated measurement ANCOVA [136-138], because ANCOVA used to determine whether there are any significant differences between two of more independent (unrelated) groups on a dependent variable while statistically control the confounding variables as sex, relationship, marital status, income, and schizophrenic patients' symptom.

The results reported with the estimated marginal means [140] because it gives the adjusted means (controlling for sex, relationship, marital status, income and schizophrenic patients' symptom). The effect of sex, relationship, marital status, income and schizophrenic patients' symptom has been statistically removed, and 95% confidence intervals (CIs) were determined.

3.10 Ethical Considerations

This study was approved of by the Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University (COA no. 048/2561). The intervention group received a program of enhanced psychological well-being intervention, whereas the control group received standard service and was then given the intervention program after a follow-up session was completed for the intervention group.

CHAPTER IV
RESULT

This study was a quasi-experiment study. It aimed to test the effectiveness of the enhanced psychological well-being intervention on psychological well-being and burden of care in family caregivers of schizophrenic patients. This chapter shows the results in two sections. The first section presents the general characteristics of participants at baseline. The second section presents hypothesis testing composed of the effectiveness of the enhanced psychological well-being intervention on increasing psychological well-being and decreasing burden of care in family caregivers of schizophrenic patients.

4.1 General characteristics of participants at baseline

Of the 130 participants who enrolled at baseline, 127 (97.69%) were available at 3 months follow up. During the intervention 3 participants dropped out: 2 participants from the intervention group, and 1 participant from the control group. Baseline characteristics comparison of the family caregivers of schizophrenic patients in Table 6 shown no statistically significant differences between the intervention and the control group in age, education, job, length of care, schizophrenic patients' symptom, schizophrenic patients' function (p-value < 0.05). However, there were statistically significant differences between the intervention and the control group in sex, relationship, marital status, income, and schizophrenic patients' symptom (p-value < 0.05).

Table 6 Comparison of Socio-demographic characteristics between the intervention group and the control group at baseline (p-value < 0.05)

Characteristics	Intervention = 63 (%)	Control = 64 (%)	*p*-value
Sex			0.002*
Male	10 (15.9)	27 (42.2)	
Female	53 (84.1)	37 (57.8)	
Age: year			0.249
≤ 40	2 (3.2)	7 (10.9)	
41 – 60	32 (50.8)	32 (50.0)	
≥ 61	29 (46.0)	25 (39.1)	
Mean (SD, min-max)	58.7 (12.30, 22-80)	57.0 (13.07, 29-82)	
Relationship			0.003*
Father	5 (7.9)	8 (12.5)	
Mother	21 (33.3)	16 (25.0)	
Sibling	17 (27.0)	11 (17.2)	
Husband/ Wife	3 (4.8)	17 (26.6)	
Daughter/ Son	8 (12.7)	10 (15.6)	
Others	9 (14.3)	2 (3.1)	
Education			0.942
Primary	48 (76.2)	50 (78.1)	
High School	12 (19.1)	12 (18.8)	
Diploma/ Bachler Degree	3 (4.8)	2 (3.1)	
Marital Status			0.042*
Married	42 (66.7)	53 (82.8)	
Others	21 (33.3)	11 (17.2)	
Job			1.000
Unemployed	24 (38.1)	24 (37.5)	
Farmer	23 (36.5)	24 (37.5)	
Employed	16 (25.4)	16 (25.0)	
Income: Bath			0.008*
< 5,000	50 (79.4)	36 (56.3)	
≥ 5,000	13 (20.6)	28 (43.8)	
Length of Care: year			1.000
≤ 5	22 (34.9)	22 (34.4)	
> 5	41 (65.1)	42 (65.6)	

Table 6 Comparison of Socio-demographic characteristics between the intervention group and the control group at baseline (p-value < 0.05) (continue)

Characteristics	Intervention = 63 (%)	Control = 64 (%)	p-value
Schizophrenic patients' Symptom			0.006*
Negative symptoms	32 (50.8)	51 (79.7)	
Positive psychosis symptoms	10 (15.9)	3 (4.7)	
Positive disorganization symptoms	8 (12.7)	5 (7.8)	
Remission	13 (20.6)	5 (7.8)	
Schizophrenic patients' Function			0.526
Deficit	7 (11.1)	4 (6.3)	
Ineffective	6 (9.5)	3 (4.7)	
Questionable	11 (17.5)	11 (17.2)	
Complete	39 (61.9)	46 (71.9)	

From table 6, sex, relationship, marital status, income, and schizophrenic patients' symptom could be the confounding factors. Therefore, researcher did the covariance analysis to compare the baseline psychological well-being score and burden of care score of family caregivers of schizophrenic patients. The result shown in table 7. Overall, at p value < .05 there was no significantly different in psychological well-being score (*p* value .542), and burden of care score (*p* value .062) between the intervention and control group. For the sub domain of psychological well-being score at p value < .05, there was no significantly different between the intervention and control group in environment mastery, personal growth, positive relationship, purpose in life and self acceptance, but there was significantly different in autonomy. For the sub domain of burden of care score at p value < .05, there was no significantly different between the intervention and control group in relationship, social and family life, and finance, but there was significantly different in emotional well-being and loss of control over one's life.

Table 7 Comparison of psychological well-being score and burden of care score between the intervention group and the control group at baseline (p-value < 0.05)

Variables		Intervention = 63 Mean (SD)	Control = 64 Mean (SD)	*p*-value
Psychological well-being score		202.3 (23.9)	203.8 (26.3)	.542
	Domain 1 Autonomy	35.4 (5.5)	32.9 (5.0)	.009*
	Domain 2 Environment mastery	33.2 (6.0)	32.9 (5.4)	.506
	Domain 3 Personal Growth	9.1 (6.3)	7.2 (4.7)	.132
	Domain 4 Positive relation with other	35.0 (7.7)	35.7 (5.9)	.941
	Domain 5 Purpose in life	29.4 (6.9)	32.0 (5.5)	.128
	Domain 6 Self-acceptance	34.7 (5.9)	35.9 (6.9)	.869
Burden of care Score		25.0 (15.8)	18.3 (13.8)	.062
	Domain 1 the relationship	7.2 (5.2)	6.1 (4.4)	.592
	Domain 2 emotional well-being	8.0 (5.3)	5.5 (4.9)	.047*
	Domain 3 social and family life	2.6 (2.5)	1.9 (2.9)	.419
	Domain 4 finance	2.0 (1.5)	1.6 (1.2)	.332
	Domain 5 loss of control over one’s life	5.3 (4.6)	3.1 (2.7)	.002*

4.2 The effectiveness of the Enhanced Psychological Well-being Intervention on psychological well-being and burden of care

The analysis of the enhanced psychological well-being intervention effectiveness on psychological well-being and burden of care, researcher controlled for the confounding factors as sex, relationship, marital status, income and schizophrenic patients' symptom.

From table 8, the family caregivers' psychological well-being in the intervention group increased after received the enhanced psychological well-being intervention whereas in the control group decreased.

Table 8 Estimated Marginal Means for psychological well-being score at baseline, post intervention, and 3 months follow up controlling for sex, relationship, marital status, income, and schizophrenic patients' symptoms

Group	Time	Mean	Std. Error	95% Confidence Interval ^{a}	
				Lower	Upper
Intervention (n=63)	Baseline	204.6 ^{a}	3.2	198.190	210.932
	Post intervention	216.1 ^{a}	3.6	208.880	223.296
	3 months follow up	205.2 ^{a}	3.4	198.554	211.837
Control (n=64)	Baseline	201.6 ^{a}	3.2	195.305	207.934
	Post intervention	199.9 ^{a}	3.6	192.722	207.010
	3 months follow up	193.5 ^{a}	3.3	186.928	200.093

a. Covariates appearing in the model are evaluated at the following values: Sex = 1.71, RelaGroup = 3.20, MariGroup = 1.25, IncomeGroup = 1.32, SympGroup = 1.73.

From table 9, the family caregivers’ psychological well-being in the intervention group had a significantly increased after received the enhanced psychological well-being intervention at post intervention, but had not sustained at 3 months follow up. In the control group, the family caregivers’ psychological well-being had no significantly decreased at post intervention, but had a significantly decreased at 3 months follow up.

Table 9 Pairwise comparisons of the different measurement of psychological well-being scores for the intervention (*n*=*63*) *and the control group* (*n*=*64*)

Group	Time (I)	Time (J)	Mean difference (I-J)	*p-value* [a]	95% Confidence Interval [a]	
					Lower	Upper
Intervention (n=63)	Baseline	Post intervention	-13.413*	.003	-22.960	-3.865
	Baseline	3 months follow up	-4.032	.645	-11.965	3.901
	Post intervention	3 months follow up	9.381*	.051	-.027	18.789
Control (n=64)	Baseline	Post intervention	3.609	1.000	-5.723	12.942
	Baseline	3 months follow up	11.453*	.012	2.080	20.826
	Post intervention	3 months follow up	7.844	.303	-3.764	19.452

Based on estimated marginal means
*The mean difference is significant at the 0.05 level.
a. Adjustment for multiple comparisons: Bonferroni

From table 10, the family caregivers’ burden of care in the intervention group gradually decreased after received the enhanced psychological well-being intervention. In the control group the family caregivers’ burden of care was fluctuating. It decreased at post intervention and decreased than baseline at 3 months follow up.

Table 10 Estimated Marginal Means for Burden of care score at baseline, post intervention, and 3 months follow up controlling for sex, relationship, marital status, income, and schizophrenic patients’ symptoms

Group	Time	Mean	Std. Error	95% Confidence Interval [a]	
				Lower	Upper
Intervention (n=63)	Baseline	24.4 [a]	1.9	15.094	22.731
	Post intervention	23.8 [a]	2.0	17.172	24.865
	3 months follow up	19.3 [a]	2.1	14.074	22.329
Control (n=64)	Baseline	18.9 [a]	1.9	20.553	28.259
	Post intervention	21.0 [a]	1.9	19.942	27.703
	3 months follow up	18.2 [a]	2.1	15.123	23.452

a. Covariates appearing in the model are evaluated at the following values: Sex = 1.71, RelaGroup = 3.20, MariGroup = 1.25, IncomeGroup = 1.32, SympGroup = 1.73.

From table 11, the family caregivers' burden of care in the intervention group had no significantly decreased after received the enhanced psychological well-being intervention at post intervention, but had significantly decreased at 3 months follow up. In the control group, the family caregivers' psychological well-being had no significantly decreased at post intervention, and at 3 months follow up

Table 11 Pairwise comparisons of the different measurement of burden of care scores between the intervention (n=63) and the control group (n=64) controlling for sex, relationship, marital status, income, and schizophrenic patients' symptoms

Group	Time (I)	Time (J)	Mean difference (I-J)	*p-value* [a]	95% Confidence Interval [a]	
					Lower	Upper
Intervention (n=63)	Baseline	Post intervention	.873	1.000	-3.663	5.409
	Baseline	3 months follow up	5.746*	.010	1.102	10.390
	Post intervention	3 months follow up	4.873*	.031	.333	9.413
Control (n=64)	Baseline	Post intervention	-2.391	.400	-6.263	1.482
	Baseline	3 months follow up	.094	1.000	-5.343	5.531
	Post intervention	3 months follow up	2.484	.719	-2.671	7.640

Based on estimated marginal means

*The mean difference is significant at the 0.05 level.

a. Adjustment for multiple comparisons: Bonferroni

A repeated measure ANCOVA was conducted to compare the effectiveness of the enhanced psychological well-being on psychological well-being and burden of care whilst controlling for sex, relationship, marital status, income, and schizophrenic patients' symptom. Levene's test and normality checks were carried out and the assumptions met.

From table 12 and figure 9, across three times, there was a significant difference in psychological well-being [*F* (1, 120) = 8.436, *p* = .004] between the intervention and control groups whilst adjusting for sex, relationship, marital status, income, and schizophrenic patients' symptoms. The partial Eta Squared value indicates the effect size was 0.01 = small, 0.06 = medium and 0.14 = large [146]. It can be seen that the effect size of the enhanced psychological well-being intervention on psychological well-being is medium (0.066).

Apart from between-subjects effect, Table 12 demonstrates the within-subject effect and further indicates that there was no difference across three time periods over psychological well-being (*F*(2, 240)=1.396, *p*=.250) and the null effect across time periods was held for both groups as indicated in insignificant difference of the interaction effect between Intervention and Time (*F*(2, 240)=2.252, *p*=.107).

Table 12 Repeated measure ANCOVA of psychological well-being scores between the intervention and the control (n=127)

Source of variation	SS	df	MS	F	*p*-value	*Effect size*
Between subjects						
Group	7758.926	1	7758.926	8.436	.004	0.066
Error (between group error)	110371.409	120	919.762			
Within subjects						
Time	1381.138	2	690.569	1.396	.250	
Group x time	2229.182	2	1114.591	2.252	.107	
Error (Time Error)	118762.328	240	494.843			0.018

Significant at p-value < 0.05

SS: Sum of squares, df: Degree of freedom, MS: Mean Square

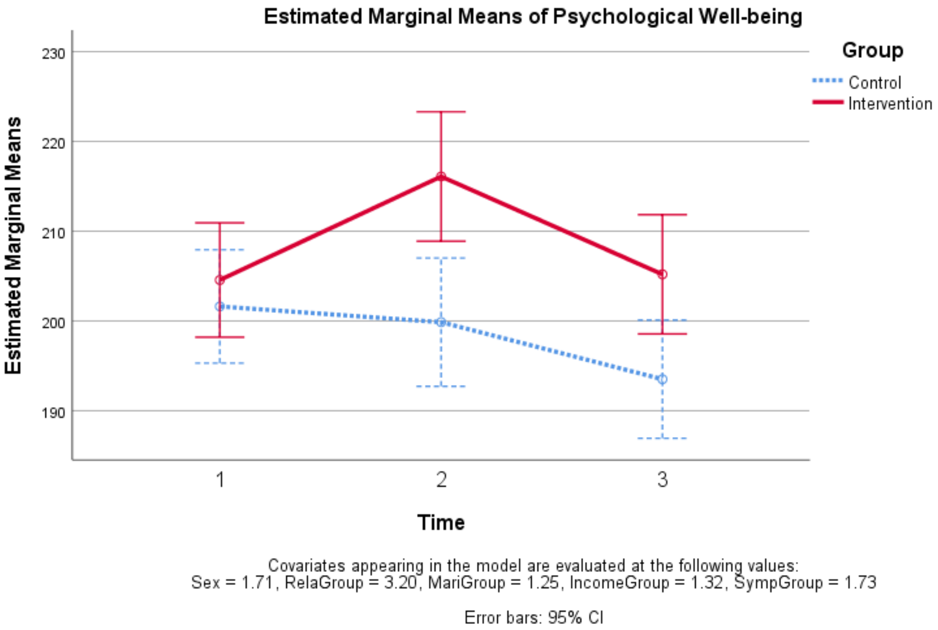

Figure 9 Change over times on psychological well-being scores between the intervention and control group

Researcher also analyzed in subdomains of psychological well-being. Across three times, it found that there was a significant difference between the intervention and control group in domain 1 - autonomy [F (1, 120) = 18.020, *p* =

.000] and domain 3 – personal growth [F (1, 120) = 22.008, *p* = .000]. Nevertheless, there was no significant difference between the intervention and control group in domain 2 - environment [F (1, 120) = 3.534, *p* = .063], domain 4 – positive relationship [F (1, 120) = .960, *p* = .329], domain 5 – purpose in life [F (1, 120) = 1.042, *p* = .309], and domain 6 – self acceptance [F (1, 120) = 2.850, *p* = .094].

From table 13 and figure 10, across three times, there was no significant difference in burden of care [F (1, 120) =1.695, p=.195] between the intervention and control group whilst adjusting for sex, relationship, marital status, income, and schizophrenic patients' symptom. It can be seen that the effect size of the enhanced psychological well-being intervention on burden of care is small (0.014).

In addition to between-subjects effect, Table 16 shows that there was no difference across three time periods over burden of care (*F*(2, 240)= 1.314, *p*=.271) and the null effect across time periods was also found for both groups as indicated in no difference of the interaction effect between Intervention and Time (*F*(2, 240)= 1.020, *p*=.362).

Table 13 Repeated measure ANCOVA of burden of care scores between the intervention and the control (n=127)

Source of variation	SS	df	MS	F	*p-value*	*Effect size*
Between subjects						
Group	718.062	1	718.062	1.695	.195	0.014
Error (between group error)	50829.430	120	423.579			
Within subjects						
Time	310.791	2	155.395	1.314	.271	
Group x time	241.430	2	120.715	1.020	.362	0.008
Error (Time error)	28392.835	240	118.303			

Significant at p-value < 0.05

SS: Sum of squares, df: Degree of freedom, MS: Mean Square

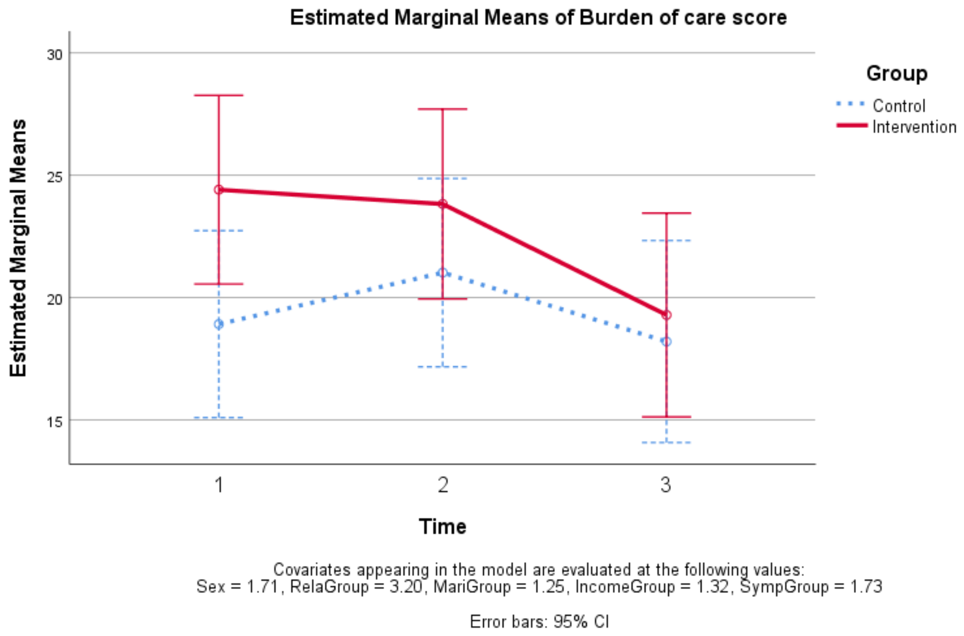

Figure 10 Change over times on burden of care scores between the intervention and control group

Researcher also analyzed in subdomain of burden of care. Across three times, it found that there was no significant difference between the intervention and control group in domain 1-relationship [F (1, 120) =.552, p=.459], domain 2 – emotional well-being [F (1, 120) =3.389, p=.068], domain 3 – social and family life [F (1, 120) =.029, p=.866], domain 4 – finance [F (1, 120) =.324, p=.570], and domain 5- loss of control over one’s life [F (1, 120) =2.214, p=.139].

CHAPTER V

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter provides an important discussion and establishes the significance of the conclusions of this study with regard to the effectiveness of an enhanced psychological well-being intervention program on the psychological well-being and burden of care of family caregivers who look after schizophrenic patients. The findings of this study have been supported by comparing and contrasting them with the results of previous studies. In addition, the conclusion, the limitations of the study and future research will be discussed in this chapter.

5.1 Discussion

This study examined the effectiveness of an enhanced psychological well-being intervention program on the psychological well-being and burden of care among family caregivers of schizophrenic patients.

The results revealed that the degree of psychological well-being of those in the intervention group significantly increased after implementation of the intervention program, but no significant increases were observed at the 3-month point during the follow-up period. The intervention group also reported a significant increase in psychological well-being when compared to the control group. With regard to the six sub-domains of psychological well-being, the intervention group also revealed significant increases in the categories of autonomy and personal growth, but reported no significant increases in the categories of environmental mastery, positive relations with others, purpose in life, and self-acceptance when compared with the control group.

In this sense, the findings relate well with the pursuit of happiness model [109]. This model proposes that a sense of well-being is governed by genetic factors (50%), circumstantial factors (10%), as well as by certain relevant activities and practices (40%). It can be assumed that our degree of happiness can change. Our findings are also supported by the social psychological theory in that psychological well-being is based on how experiences are interpreted [32]. The mindset theory similarly acknowledges an association between one’s perception of their abilities and their qualities [30, 31].

Due to the degree of enhanced psychological well-being that was obtained based on the positive psychology theory and WBT, family caregivers were trained to monitor their levels of well-being and distress through the use of a well-being diary. They seemed to acquire a greater understanding of the relationships between a given situation, a sense of well-being, negative emotions, and negative thoughts. They also learned to evaluate and reconstruct their negative thoughts and emotions. WBT may help to maintain flexibility and a sense of balance in terms of the psychological dimension that motivates optimal human functioning [139]. As a result, WBT, in the long-term, could increase the degree of psychological well-being within the personal growth domain [28].

The intervention program included mindfulness activities as part of the mindfulness movement, along with relevant breathing exercises that enabled participants to apply and practice stress management techniques and embrace the concept of here-and-now. Evidence of improvements in the level of psychological well-being through mindfulness activities has been supported by numerous studies. Notably, mindfulness practice had a medium effect on the physical and mental health of participants [140, 141]. It also decreased their levels of psychological distress, while increasing their positive emotions [142-144]. Stress management was found to also decrease the participants’ feelings of anxiety, while elevating their degrees of resilience, gratitude, happiness, life satisfaction, and a general sense of quality of life [145, 146]. Participants who reported less stress in terms of social relationships also experienced a greater sense of purpose [147], while making the realization that they had acquired techniques to positively interact with others [145].

In this study, writing strategies were employed involving well-being diaries along with activities that were designed to acknowledge the best possible sense of self. The systematic literature review and meta-analysis 34 RCT revealed small overall effects on feelings of positivity and optimism, and indicated no sustainable follow-up effects [148]. Other studies found that the activities employed to achieve the best possible sense of self could increase feelings of positivity, self-determination, situational motivation, optimism, and elevate the participants' perceptions of positive future expectations and academic commitments [149-151]. The intervention program also decreased the number of incidences of illness [152] , negative moods [153] and psychiatric symptoms [154]. In terms of personal growth, the success of effective learning relies on self-reinforcement, meaning, engagement, and positive emotions. One who is happy and comfortable with oneself is more likely to learn more effectively and faster than someone who is not particularly comfortable [155].

However, the strongest effects on positive emotional outcomes were identified through the assessments that were done immediately after implementation of the intervention program [148]. These outcomes involved longer-term benefits to well-being and cognitive processes, while feelings of self-regulation appeared to have been limited [151]. Some participants found that talking about their own life goals was more difficult than writing about them [153].

The degree of the burden of care among members of the intervention group was not found to have significantly decreased after implementation of the intervention program. At the 3-month follow-up point, the burden of care was found to have gradually decrease among members in the intervention group but fluctuated among participants in the control group. The intervention group also reported no significantly different decreases in the level of burden of care when compared with members of the control group. With regard to the four sub-domains of the burden of care category, the intervention group also reported no significantly different decreases in terms of relationships, emotional well-being, social and family life, finances, and loss of control over one's life when compared with the control group.

Evidence indicates that family caregivers of those with severe and permanent psychological function deficiencies typically experience a high level of burden [59]. According to the burden of care of the family caregiver during the chronic phase, the level of burden can actually fluctuate between a reduced level to an increased level [59, 61]. It is likely that the family burden would be able to stabilize after thirteen years of caregiving [156]. In this study, the average length of care was found to be twelve years when the Schizophrenic patient symptoms were chronic. These social factors are assumed to be the cause of a small change in terms of the family burden. The symptoms of Schizophrenic patients in this study were in remission at a level of

14.2%, while 65.4% had negative symptoms and 20.4% reported positive symptoms. Other studies have suggested that a small clinical change in chronically ill Schizophrenic patients would be insufficient to affect long term experiences of burden [157]. Notably, burden decreased to the extent that family caregivers were able to perceive positive and/or negative symptoms. A high level of burden of care was related to a greater number of Schizophrenic patients who were able to perceive their own positive and/or negative symptoms [79]. Among members of the intervention group, their burden gradually decreased even if it was not significantly different from the baseline. It is assumed that they were trained to redirect their own negative perceptions toward more positive perceptions, whereas members of the control group were not.

In contrast, some intervention measures could effectively decrease the burden of care, such as those employed in the case management on medication adherence behaviors of Schizophrenic patients, Holistic Caring Program, and so on [93, 95, 158, 159]. Those also focused on important aspects of knowledge, attitude, and practice in taking care of Schizophrenic patients.

5.2 Conclusion

Our findings suggest that the Enhanced Psychological Well-Being Intervention is an effective intervention program for enhancing family caregivers' psychological well-being, especially in terms of autonomy and personal growth, although it did slightly reduce the burden of care. Nevertheless, the perception of difficult circumstances can be highly influential [32]. This could possibly be explained by the extent to which there is a perception of the family caregiver of the symptoms of the Schizophrenic patients, along with the other struggles they may be facing in their lives. Greater perceptions of positive and negative symptoms could increase the burden of care, but fewer perceptions of the positive symptoms could increase the degree of psychological well-being [79]. It seems that anyone can live with happiness even if they feel that have a lot of problems.

5.3 Limitations of this study and Future research

There were several limitations to this study. First, participants were selected by purposive sampling which did result in a disadvantage in the form of bias selection. This was because the participants in the intervention group were selected from a specified group, were voluntary and who were then required to join the workshop continuum. Therefore, the intervention group had more female members than the control group. Second, the number of participants in this study may not be able to be effectively generalized for all family caregivers of Schizophrenic patients in Thailand. Third, all measurements were obtained by self-report questionnaires. Consequently, the data may have been impacted by socially desirable factors and recall bias. Finally, the study did not account for the symptoms of the Schizophrenic patients and their degree of medication adherence, which may have affected the Schizophrenic patients' symptoms during the course of this study [160].

Despite these limitations, this study had strengths that were related to well-known clinical measurements and intervention measures that were based on the positive psychology theory. This theory was focused on strengths rather than weaknesses. Furthermore, this study excluded the depressive symptoms of the sample. Further research needs to be done to develop specified interventions that would better alleviate the burden of care on family caregivers. Future intervention programs should consider including certain specific skills for the caring of schizophrenic patients such as those related to psychoeducation. It would be beneficial to conduct future research studies that involve developing support systems in the community which could help prevent incidences of Schizophrenic patient relapses. In terms of the unsustainable effects observed at the 3-month point of the follow up procedure, the researcher may need to include a booster session.

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Appendix

Appendix A: Questionnaire on Socio Demographic Characteristics of care giver and Schizophrenic patients’ Characteristics

Appendix B: Psychological Well-being Scale (PWBS)

Appendix C: The Zarit Caregiver Burden Scale (ZCBS)

Appendix D: The Enhanced Psychological Well-Being Intervention

Appendix E: Inclusion and Exclusion criteria

Appendix F: Professional Name List

Appendix G: Abbreviation List

Appendix A: Questionnaire on Socio Demographic Characteristics of care giver and Schizophrenic patients' Characteristics

Section I: Questionnaire on Socio Demographic Characteristics of care giver and Schizophrenic patients' Characteristics

1. Sex ☐ male ☐ female 2. Age………. years

3. Relationship with Schizophrenic patients
☐ father ☐ mother ☐ sibling ☐ husband ☐ wife ☐ daughter ☐ son

☐ son in law ☐ daughter in law ☐ brother in law ☐ sister in law

4. Marital Status

☐ single ☐ married ☐ widowed ☐ divorced ☐ separated

5. Education

☐ Primary ☐ Secondary ☐ Vocational Certificate/ Technical Certificate

☐ High Vocational Certificate/ Diploma ☐ Bachler Degree ☐ Others………

6. Employment

☐ unemployed ☐ farmer ☐ self-employed

☐ employee ☐ government officer ☐ Others…………………

7. Income per month (from all sources)
☐ no income ☐ less than 5,000 Bath ☐ 5,000-10,000 Bath

☐ 10,001-15,000 Bath ☐ 15,001- 20,000 Bath ☐ 20,000-30,000 Bath

☐ more than 30,000 Bath

8. Duration of Schizophrenic patients illness
☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years ☐ ….. years

9. Symptoms
☐ affective flattening ☐ poverty of speech ☐ avolition ☐ delusions

☐ hallucinations ☐ catatonic behavior ☐ disorganized speech/ thinking

☐ Others (specific)…………………

10. Schizophrenic patients functioning in daily life (self-help in eating, dressing, bath, excretion)

☐ Deficit: a Schizophrenic patient take long time than normal, and need a lot of help from others.

☐ Ineffective: a Schizophrenic patient is inefficient, take long time than normal, but can finish.

☐ Questionable: a Schizophrenic patient is inefficient, but can finish on time.

☐ Complete: a Schizophrenic patient can do daily activities as normal.

ส่วนที่ 1 ข้อมูลทั่วไปของญาติผู้ป่วยโรคจิตเภทและข้อมูลทั่วไปของผู้ป่วยจิตเภท

1. เพศ ☐ ชาย ☐ หญิง 2. อายุ .... ปี

3. ความสัมพันธ์กับผู้ป่วย

☐ พ่อ ☐ แม่ ☐ พี่ชาย/ น้องชาย/ พี่สาว/ น้องสาว ☐ สามี ☐ ภรรยา

☐ ลูกสาว ☐ ลูกชาย ☐ ลูกเขย /ลูกสะใภ้ ☐ พี่เขย/ น้องเขย/ พี่สะใภ้/ น้องสะใภ้

4. สถานภาพสมรส
☐ โสด ☐ สมรส ☐ หม้าย ☐ หย่า ☐ แยกกันอยู่

5. การศึกษา

☐ ประถมศึกษา ☐ มัธยมศึกษา ☐ ปวช/ ปวส

☐ ปวท./ อนุปริญญา ☐ ปริญญาตรี ☐ อื่น ๆ (ระบุ)..................

6. การทำงาน

☐ ไม่ได้ทำงาน ☐ เกษตรกรรม ☐ ทำงานส่วนตัว ☐ ลูกจ้าง ☐ ข้าราชการ

☐ อื่น ๆ (ระบุ)..

7. รายได้ต่อเดือน (รวมทั้งหมดจากทุกแหล่งรายได้ เช่น เบี้ยคนพิการ เบี้ยยังชีพคนชรา ลูกหลานส่งเสีย ฯลฯ)

☐ ไม่มีรายได้ ☐ น้อยกว่า 5,000 บาท ☐ 5,000-10,000 บาท

☐ 10,001-15,000 บาท ☐ 15,001- 20,000 บาท ☐ 20,000-30,000 บาท

☐ มากกว่า 30,000 บาท

8. ระยะเวลาการเจ็บป่วยของผู้ป่วยจิตเภทที่ดูแลอยู่

☐ 1 ปี ☐ 2 ปี ☐ 3 ปี ☐ 4 ปี ☐ 5 ปี ☐ ..... ปี

9. อาการของผู้ป่วยจิตเภทที่พบในปัจจุบัน

☐ อารมณ์เรียบเฉย ☐ พูดโต้ตอบช้า/ ติดขัด/ ไม่ตอบ ☐ ไม่สนใจสิ่งรอบข้าง/ คนอื่น ☐ มีภาพหลอน

☐ มีหูแว่ว ☐ กล้ามเนื้อที่อเหมือนหุ่นยนต์ ☐ การพูด/ การคิด ดูสับสน ☐ อื่นๆ (ระบุ)...................................

10. ความสามารถของผู้ป่วยจิตเภท ในการช่วยเหลือตนเองด้านการทำกิจวัตรประจำวัน

☐ บกพร่องมาก: ผู้ป่วยใช้เวลานานมากกว่าคนทั่วไปในการทำกิจวัตรประจำวัน และต้องช่วยเหลืออย่างมาก

☐ ทำได้ดีปานกลาง: ผู้ป่วยใช้เวลานานมากกว่าคนทั่วไปในการทำกิจวัตรประจำวัน แต่สามารถทำให้เสร็จเรียบร้อยได้ด้วยตนเอง

☐ ทำได้ดีพอใช้: ผู้ป่วยสามารถทำกิจวัตรประจำวันให้เสร็จตามเวลาได้ แต่ทำได้ไม่ดีเท่าที่ควร เช่น อาบน้ำเสร็จแต่ไม่ค่อยสะอาดนัก

☐ ทำได้ดี: ผู้ป่วยสามารถทำกิจวัตรประจำวันได้เองตามปกติ

Appendix B: Psychological Well-Being Scale

Section II: Psychological Well-Being Scale [33, 127]

Instruction: Circle the number that best describes your present agreement or disagreement with each statement.

Items	**strongly agree (1)**	**somewhat agree (2)**	**a little agree (3)**	**neither agree nor disagree (4)**	**a little disagree (5)**	**somewhat disagree (6)**	**strongly disagree (7)**
1. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people. ***(R)***							
2. My decisions are not usually influenced by what everyone else is doing. ***(R)***							
3. I tend to be influenced by people with strong opinions.							
4. I have confidence in my opinions, even if they are contrary to the general consensus. ***(R)***							
5. It's difficult for me to voice my own opinions on controversial matters.							
6. I tend to worry about what other people think of me.							
7. I judge myself by what I think is important, not by the values of what others think is important. ***(R)***							
8. In general, I feel I am in charge of the situation in which I live. ***(R)***							
9. The demands of everyday life often get me down							
10. I do not fit very well with the people and the community around me.							
11. I am quite good at managing the many responsibilities of my daily life. ***(R)***							
12. I often feel overwhelmed by my responsibilities.							

Items	**strongly agree (1)**	**somewhat agree (2)**	**a little agree (3)**	**neither agree nor disagree (4)**	**a little disagree (5)**	**somewhat disagree (6)**	**strongly disagree (7)**
13. I have difficulty arranging my life in a way that is satisfying to me.							
14. I have been able to build a living environment and a lifestyle for myself that is much to my liking. ***(R)***							
15. I am not interested in activities that will expand my horizons.							
16. I think it is important to have new experiences that challenge how you think about yourself and the world. ***(R)***							
17. When I think about it, I haven't really improved much as a person over the years.							
18. I have the sense that I have developed a lot as a person over time. ***(R)***							
19. For me, life has been a continuous process of learning, changing, and growth. ***(R)***							
20. I gave up trying to make big improvements or changes in my life a long time ago.							
21. I do not enjoy being in new situations that require me to charge my old familiar ways of doing things.							
22. Most people see me as loving and affectionate. ***(R)***							
23. Maintaining close relationships has been difficult and frustrating for me.							
24. I often feel lonely because I have few close friends with whom to share my concerns.							
25. I enjoy personal and mutual conversations with family members or friends. ***(R)***							
26. People would describe me as a giving person, willing to share my time with others. ***(R)***							

Items	strongly agree (1)	somewhat agree (2)	a little agree (3)	neither agree nor disagree (4)	a little disagree (5)	somewhat disagree (6)	strongly disagree (7)
27. I have not experienced many warm and trusting relationships with others.							
28. I know that I can trust my friends, and they know they can trust me. ***(R)***							
29. I live life one day at a time and don't really think about the future.							
30. I have a sense of direction and purpose in life. ***(R)***							
31. I don't have a good sense of what it is I'm trying to accomplish in life.							
32. My daily activities often seem trivial and unimportant to me.							
33. I enjoy making plans for the future and working to make them a reality. ***(R)***							
34. Some people wander aimlessly through life, but I am not one of them. ***(R)***							
35. I sometimes feel as if I've done all there is to do in life.							
36. When I look at the story of my life, I am pleased with how things have turned out. ***(R)***							
37. In general, I feel confident and positive about myself. ***(R)***							
38. I feel like many of the people I know have gotten more out of life than I have.							
39. I like most parts of my personality. ***(R)***							
40. In many ways, I feel disappointed about my achievements in life.							

Items	strongly agree (1)	somewhat agree (2)	a little agree (3)	neither agree nor disagree (4)	a little disagree (5)	somewhat disagree (6)	strongly disagree (7)
41. My attitude about myself is probably not as positive as most people feel about themselves.							
42. When I compare myself to friends and acquaintances, it makes me feel good about who I am. ***(R)***							

ส่วนที่ 2 แบบวัดสุขภาวะทางจิต

คำแนะนำ วงกลมรอบตัวเลขที่ตรงกับความคิดเห็นของท่าน

ข้อคำถาม	ไม่เห็นด้วยอย่างมาก	ค่อนข้างไม่เห็นด้วย	ไม่เห็นด้วยเล็กน้อย	เฉยๆ	เห็นด้วยเล็กน้อย	ค่อนข้างเห็นด้วย	เห็นด้วยอย่างมาก
1. ฉันกล้าออกความเห็นที่ต่างจากคนส่วนใหญ่*	1	2	3	4	5	6	7
2. การกระทำของคนอื่นไม่ค่อยมีผลต่อการตัดสินใจของฉัน*	1	2	3	4	5	6	7
3. ฉันชอบคล้อยตามคนที่ยึดความเห็นตัวเองเป็นหลัก	1	2	3	4	5	6	7
4. ฉันมั่นใจในความเห็นของตนเองแม้จะเห็นต่างจากคนส่วนใหญ่*	1	2	3	4	5	6	7
5. ฉันคิดว่ายากที่จะออกความเห็นในเรื่องที่สังคมยังไม่ได้ข้อสรุป	1	2	3	4	5	6	7
6. ฉันกังวลว่าคนอื่นคิดอย่างไรกับฉัน	1	2	3	4	5	6	7
7. ฉันตัดสินตัวเองจากสิ่งสำคัญในมุมมองของฉัน ไม่ใช่ของคนอื่น ๆ*	1	2	3	4	5	6	7
8. ส่วนใหญ่แล้วฉันรับผิดชอบกับสถานการณ์ในชีวิตตัวเอง*	1	2	3	4	5	6	7
9. เรื่องต่าง ๆ ที่ต้องทำในชีวิตประจำวันทำให้ฉันรู้สึกแย่บ่อย ๆ	1	2	3	4	5	6	7
10. ฉันเข้ากับคนและชุมชนรอบตัวไม่ค่อยได้	1	2	3	4	5	6	7
11. ฉันจัดการหน้าที่ต่าง ๆ ในชีวิตประจำวันได้ค่อนข้างดี*	1	2	3	4	5	6	7
12. ฉันมักรู้สึกท่วมท้นจากภาระต่าง ๆ	1	2	3	4	5	6	7
13. การทำให้ชีวิตฉันเองเป็นไปอย่างที่ฉันพอใจ เป็นเรื่องยาก	1	2	3	4	5	6	7
14. ฉันทำให้บรรยากาศรอบตัวและวิถีชีวิตใกล้เคียงกับที่ฉันชอบได้*	1	2	3	4	5	6	7
15. ฉันไม่สนใจกิจกรรมเปิดหูเปิดตา	1	2	3	4	5	6	7

ข้อคำถาม	ไม่เห็นด้วยอย่างมาก	ค่อนข้างไม่เห็นด้วย	ไม่เห็นด้วยเล็กน้อย	เฉยๆ	เห็นด้วยเล็กน้อย	ค่อนข้างเห็นด้วย	เห็นด้วยอย่างมาก
16. ฉันให้ความสำคัญกับประสบการณ์ใหม่ๆที่อาจเปลี่ยนมุมมองต่อตนเองหรือผู้อื่น*	1	2	3	4	5	6	7
17. เมื่อมองย้อนกลับไป หลายปีมานี้ฉันไม่ค่อยได้พัฒนาตัวเองนัก	1	2	3	4	5	6	7
18. ฉันคิดว่าตัวเองค่อยๆพัฒนาขึ้นมามากในช่วงที่ผ่านมา*	1	2	3	4	5	6	7
19. ชีวิตคือการเรียนรู้ เปลี่ยนแปลงและเติบโตอย่างต่อเนื่อง*	1	2	3	4	5	6	7
20. ฉันเลิกพยายามจะพัฒนาหรือเปลี่ยนแปลงชีวิตตัวเองไปตั้งนานแล้ว	1	2	3	4	5	6	7
21. ฉันไม่ชอบเหตุการณ์ที่ฉันต้องทำอะไรแปลกไปจากที่เคยทำ	1	2	3	4	5	6	7
22. คนส่วนใหญ่มองว่าฉันเป็นคนที่รักและใส่ใจต่อผู้อื่น*	1	2	3	4	5	6	7
23. การคบหาคนอื่นอย่างสนิทสนมเป็นสิ่งที่ยากและน่าอึดอัดสำหรับฉัน	1	2	3	4	5	6	7
24. ฉันเหงาบ่อย ๆ เพราะมีเพื่อนสนิทให้ปรับทุกข์ได้ไม่กี่คน	1	2	3	4	5	6	7
25. ฉันชอบคุยกับครอบครัวและเพื่อนทั้งเรื่องส่วนตัวและเรื่องที่มีประสบการณ์ร่วมกัน*	1	2	3	4	5	6	7
26. คนอื่นมองว่าฉันเป็นผู้ให้ และเต็มใจสละเวลาเพื่อผู้อื่น*	1	2	3	4	5	6	7
27. ที่ผ่านมาความสัมพันธ์ระหว่างฉันกับคนอื่น ๆ มีไม่มากนักที่จะอบอุ่นและไว้ใจกันได้	1	2	3	4	5	6	7
28. ฉันรู้ว่าไว้ใจเพื่อนๆได้ และเพื่อนๆก็รู้ว่าไว้ใจฉันได้เช่นกัน*	1	2	3	4	5	6	7
29. ฉันมีชีวิตอยู่กับปัจจุบัน และไม่ค่อยได้นึกถึงอนาคต	1	2	3	4	5	6	7
30. ฉันมีเป้าหมายในชีวิตและรู้ว่าจะดำเนินชีวิตไปทางไหน*	1	2	3	4	5	6	7

ข้อคำถาม	ไม่เห็นด้วยอย่างมาก	ค่อนข้างไม่เห็นด้วย	ไม่เห็นด้วยเล็กน้อย	เฉยๆ	เห็นด้วยเล็กน้อย	ค่อนข้างเห็นด้วย	เห็นด้วยอย่างมาก
31. ฉันไม่แน่ใจว่าต้องพยายามทำอะไร เพื่อให้ประสบความสำเร็จในชีวิต	1	2	3	4	5	6	7
32. กิจกรรมในชีวิตประจำวันมักจะดูธรรมดาและไม่สำคัญต่อฉัน	1	2	3	4	5	6	7
33. ฉันชอบวางแผนอนาคตและทำให้มันเป็นจริง*	1	2	3	4	5	6	7
34. หลายคนใช้ชีวิตไปเรื่อยเปื่อยไร้จุดหมาย แต่ฉันไม่ใช่คนแบบนั้น*	1	2	3	4	5	6	7
35. บางครั้งฉันรู้สึกว่าได้ทำทุกเรื่องที่สมควรทำในชีวิตเรียบร้อยแล้ว	1	2	3	4	5	6	7
36. เมื่อย้อนมองเรื่องราวในชีวิต ฉันยินดีกับสิ่งที่เกิดขึ้น*	1	2	3	4	5	6	7
37. โดยทั่วไป ฉันรู้สึกมั่นใจและรู้สึกดีต่อตนเอง*	1	2	3	4	5	6	7
38. คนที่ฉันรู้จักหลายคนใช้ชีวิตได้เป็นประโยชน์มากกว่าฉัน	1	2	3	4	5	6	7
39. ฉันพอใจบุคลิกตัวเองเป็นส่วนใหญ่*	1	2	3	4	5	6	7
40. ในหลายครั้ง ฉันรู้สึกผิดหวังต่อความสำเร็จในชีวิต	1	2	3	4	5	6	7
41. ฉันคงมองตัวเองแย่กว่าที่คนส่วนใหญ่เขารู้สึกต่อตัวเขาเอง	1	2	3	4	5	6	7
42. ฉันรู้สึกดีในสิ่งที่ฉันเป็น เมื่อเปรียบเทียบตัวเองกับเพื่อนหรือคนรู้จัก*	1	2	3	4	5	6	7

Appendix C: Zarit Burden Interview (ZBI)

Section III: Zarit Burden Interview (ZBI) [129]

Instruction: The following is a list of statements, which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way; never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers.

1. Do you feel that your relative asks for more help than he/ she need?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

3. Do you feel stress between caring your relative and trying to meet other responsibilities for your family or work?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

4. Do you feel embarrassed over your relative's behavior?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

5. Do you feel angry when you are around your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

6. Do you feel that your relative currently affects your relationships with other family members or friends in a negative way?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

7. Are you afraid what the future holds for your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

8. Do you feel your relative is dependent on you?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

9. Do you feel strained when you are around your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

10. Do you feel your health has suffered because of your involvement with your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

11. Do you feel that have as much privacy as you would like because of your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

12. Do you feel that your social life has suffered because you are caring for your relatives?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

13. Do you feel uncomfortable about having friends over because of your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

14. Do you feel that your relative seems to expect you to take care of him/ her as of you were the one he/ she could depend on?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

15. Do you feel that you don’t have enough money to take care of your relative in addition to the rest of your expense?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

16. Do you feel that you will be unable to take care of your relative much longer?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

17. Do you feel you have lost control of your life since your relative’s illness?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

18. Do you wish you could leave the care of your relative to someone else?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

19. Do you feel uncertain about what to do about your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

20. Do you feel you should be doing more for your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

21. Do you feel you could do a better job in caring for your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

22. Overall. How burdened do you feel in caring for your relative?

0. Never 1. Rarely 2. Sometimes 3. Quite frequently 4. Nearly always

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ส่วนที่ 3 แบบประเมินภาระการดูแล [130]

คำแนะนำ ต่อไปนี้เป็นข้อความเกี่ยวกับความรู้สึกที่อาจเกิดขึ้นกับบุคคลที่ทำหน้าที่ดูแลบุคคลอื่น ตอนท้ายของแต่ละข้อกรุณาระบุว่าคุณรู้สึกแบบนั้นบ่อยเพียงใด; ไม่เคยเลย นานๆ ครั้ง เป็นบางครั้ง ค่อนข้างบ่อย หรือเกือบจะเป็นประจำ คำตอบไม่มีผิดหรือถูก

1. คุณรู้สึกว่าญาติของคุณขอความช่วยเหลือมากกว่าที่จำเป็นหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

2. คุณรู้สึกว่าไม่มีเวลาสำหรับตัวคุณเองเลย เพราะต้องใช้เวลาดูแลญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

3. คุณรู้สึกเครียดเพราะต้องดูแลญาติของคุณ ในขณะที่ยังต้องรับผิดชอบครอบครัวและงานด้วยหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

4. คุณรู้สึกอับอายกับพฤติกรรมของญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

5. คุณรู้สึกโกรธเมื่ออยู่กับญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

6. คุณรู้สึกว่าญาติของคุณทำให้ความสัมพันธ์ระหว่างคุณกับสมาชิกคนอื่นๆ ในครอบครัวและเพื่อนๆ ขณะนี้เป็นไปในทางลบหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

7. คุณกลัวสิ่งที่จะเกิดขึ้นในอนาคตกับญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

8. คุณรู้สึกว่าญาติของคุณพึ่งพิงคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

9. คุณรู้สึกเหนื่อยล้าเมื่อต้องอยู่ใกล้กับญาติของคุณหรือไม่

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

10. คุณรู้สึกเป็นทุกข์กับสุขภาพเพราะการดูแลญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

11. คุณรู้สึกว่าคุณไม่มีความเป็นส่วนตัวอย่างที่คุณอยากได้เพราะญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

12. คุณรู้สึกว่าการดูแลญาติทำให้ชีวิตทางสังคมมีปัญหา ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

13. คุณรู้สึกอึดอัดที่จะให้เพื่อนของคุณมาเยี่ยมเนื่องจากญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

14. คุณรู้สึกว่าญาติของคุณดูเหมือนจะคาดหวังให้คุณดูแลเขาราวกับว่าคุณเป็นเพียงคนเดียวที่เขาจะพึ่งพาได้หรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

15. คุณรู้สึกว่าคุณมีเงินไม่เพียงพอสำหรับการดูแลญาติของคุณ รวมทั้งค่าใช้จ่ายอื่นๆ ด้วยใช่หรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

16. คุณรู้สึกว่าคุณไม่สามารถดูแลญาติของคุณได้อีกไม่นานใช่หรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

17. คุณรู้สึกว่าคุณสูญเสียการควบคุมชีวิตของคุณเองตั้งแต่ญาติของคุณป่วยหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

18. คุณอยากทิ้งภาระการดูแลญาติของคุณให้คนอื่นดูแลแทนหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

19. คุณรู้สึกไม่แน่ใจว่าจะทำอย่างไรกับผู้ป่วยหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

20. คุณรู้สึกว่าคุณควรจะทำอะไรมากยิ่งขึ้นเพื่อญาติของคุณหรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

21. คุณรู้สึกว่าคุณควรทำหน้าที่ดูแลญาติของคุณได้ดีกว่านี้หรือไม่ ?

0. ไม่เคยเลย 1. นาน ๆ ครั้ง 2. เป็นบางครั้ง 3. ค่อนข้างบ่อย 4. เกือบจะเป็นประจำ

22. โดยรวมแล้ว คุณรู้สึกเป็นภาระเพียงใดในการดูแลญาติของคุณ ?

0. ไม่เลย 1. เล็กน้อย 2. ปานกลาง 3. ค่อนข้างมาก 4. มากที่สุด

Appendix D: The Enhanced Psychological Well-Being Intervention

Workshop 1 My well-being

Theme

1. Making rapport and building the relationship between the group member
2. The situation and intensity of well-being

Objectives

1. To do the icebreaking among the group member, leader, and co-leaders
2. To regulate the positive feeling by a savoring practicing
3. To explore the situation and the intensity of well-being

Evaluation

1. The content and understanding of exploring the situation and intensity of well-being
2. Participant’s cooperation

Time	Activities	Materials
30 mins	1. Ice breaking activity 1.1 Clap your hand - clap your hand following the group leader such as 1/ 3/ 5 - clap your hand plus 1 such as leader say 1, all have to clap 2 - clap your hand minus 1 such as leader say 2, all have to clap 1 1.2 Song “Wan nee yin dee” - all stand in two circles; in and out - group leader sing a song “wann nee yin dee, yin dee tee rao pob kan wann nee yin dee, yin dee tee rao pob kan, yin dee, yin dee, yin dee, ter gub chan pob kan sawaddee, sawaddee krab, sawaddee ka” - as leader sing a song, all move to the right side and do “sawaddee” with the others - game to divide all into 3 small groups, 7-8 persons in each group, divided by the three seasons.	- percussions - flip chart

Time	Activities	Materials
15 mins	1.3 Chit-chat (work in pair) 1) what make you happy in this week 2) the best event of you in today 3) what do you expect from this intervention 1.4 discuss the all answer with all	
15 mins	Break	- Snack
5 mins	2. Mindfulness activity	- Flower Bloom VDO file (Sathina-Dhammasathan Song)
25 mins	3. Savoring Practicing [161] and discuss in pair	- Information sheet no. 1
45 mins	4. My well-being [162] - work in pair, talk about the situation which you feel good (10 mins each) - describe/ write the situation when feel good - describe/ write what he/she experienced - rating on a scale of 0-100. The scale ranges from 0 (being absence of PWB) to 100 (the most intense PWB) - share the story to all	- Flip chart or activity sheet no.1
30 mins	5. Discussion for the reflection form all activities	- Flip chart
15 mins	6. Mindfulness movement	- Body movement VDO (Thai Health Promotion Organization)

Information sheet

No. 1 Savoring Practicing [161]

Savoring practicing processes through which people regulate their positive feelings by attending to: (a) memories of *past* positive experiences (through reminiscence); (b) ongoing positive experiences in the *present* (by savoring the moment); or (c) *future* positive experiences (through anticipation). Savoring is a mindful process of attending to pleasurable feelings and either amplifying or dampening them, prolonging or curtailing them. Savoring requires focused attention on or "meta-awareness" of pleasurable feelings. There are four critical conceptual components: savoring experiences, savoring processes, savoring strategies, and savoring beliefs.

1) *Savoring experience* consists of "the totality of a person's sensations, perceptions, thoughts, behaviors, and emotions when mindfully attending to and appreciating a positive stimulus, outcome, or event, along with the accompanying environmental or situational features of that encounter". Examples include soaking in a warm bubble bath, reading a novel, or spending the day with your best friend.

2) *Savoring process* is "a sequence of mental or physical operations that unfolds over time and transforms a positive stimulus into positive feelings to which a person attends". Examples include thanksgiving (regulating gratitude in response to good fortune), marveling (regulating awe in response to perceived grandeur), basking (regulating pride in response to personal accomplishment), and luxuriating (regulating pleasure in response to positive sensations).

3) *Savoring strategy* or response is a specific concrete thought or behavior that amplifies or dampens the intensity, or prolongs or shortens the duration, of positive feelings. Examples include carefully taking a "mental photograph" of a spectacular vista for later recall, mentally congratulating oneself in response to a personal achievement, and closing one's eyes to focus attention while tasting a delicious wine.

4) *Savoring beliefs* reflect people's perceived ability to enjoy positive experiences, as distinct from their ability to obtain positive outcomes. Savoring beliefs encompass three times frames: the ability to reminisce about past positive experiences, the ability to savor positive experiences in the present, and the ability to anticipate positive experiences that may happen in the future.

Activity sheet

No.1 The Well-being Diary 1 [162]

Situation	Feeling of well-being	Intensity (0-100)
0 indicates the complete absence of well-being, while 100 indicates the most intense well-being the you could actually experience.		

Workshop 2 My thought and psychological well-being

Theme

1. Mechanism of Cognitive Therapy (CBT) and Well-being therapy (WBT)
2. The episodes of psychological well-being (PWB)

Objectives

1. To understand the relationship between situation, automatic thoughts, and negative emotions
2. To practice the distress monitoring
3. To continue the well-being diary

Evaluation

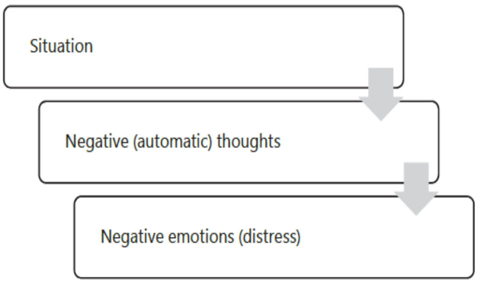
1. The content from the activity sheet no.2
2. Participant’s cooperation

Time	Activities	Materials
5 mins	1. Mindfulness activity	- Flower Bloom VDO file
10 mins	2. Ice breaking activity - all stand in a circle - leader dance and all follow - co-leader dance and all follow - ask volunteer to lead any dance and all follow (easy or funny style)	- Flock danced song VDO such as ‘kor jai lak bur to’
15 mins	3. Review the experienced of well-being (group activity) - the situation - well-being - intensity	- Flip chart
30 mins	4. Mechanism of Cognitive Therapy (CBT) [28]	- Information sheet no.2
15 mins	Break	- Snack
30 mins	5. Mechanism of Well-being Therapy (WBT) [28]	- Information sheet no.2
15 mins	6. Practicing the advance well-being diary [162] - explain about interrupting thoughts and observer’s interpretation - group activity and discussion on the advance well-being diary	- Flip chart - Activity sheet no.2

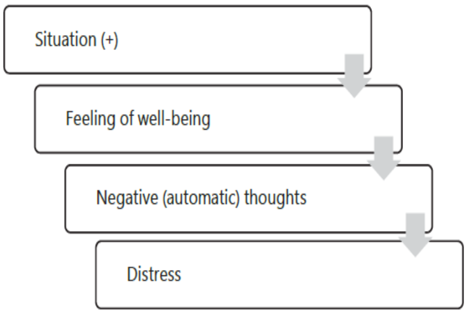
Time	Activities	Materials
15 mins	7. The dimensions of psychological well-being (PWB) [33, 163]	- Information sheet no.3 and 4
30 mins	8. Discussion for the reflection form all activities	- Flip chart
15 mins	9. Mindfulness movement	- Body movement VDO

Information sheet

No. 2 Basic mechanism of Cognitive therapy and Well-being therapy [28]



Cognitive Therapy (CBT)



Well-being Therapy (WBT)

Cognitive Therapy (CBT)

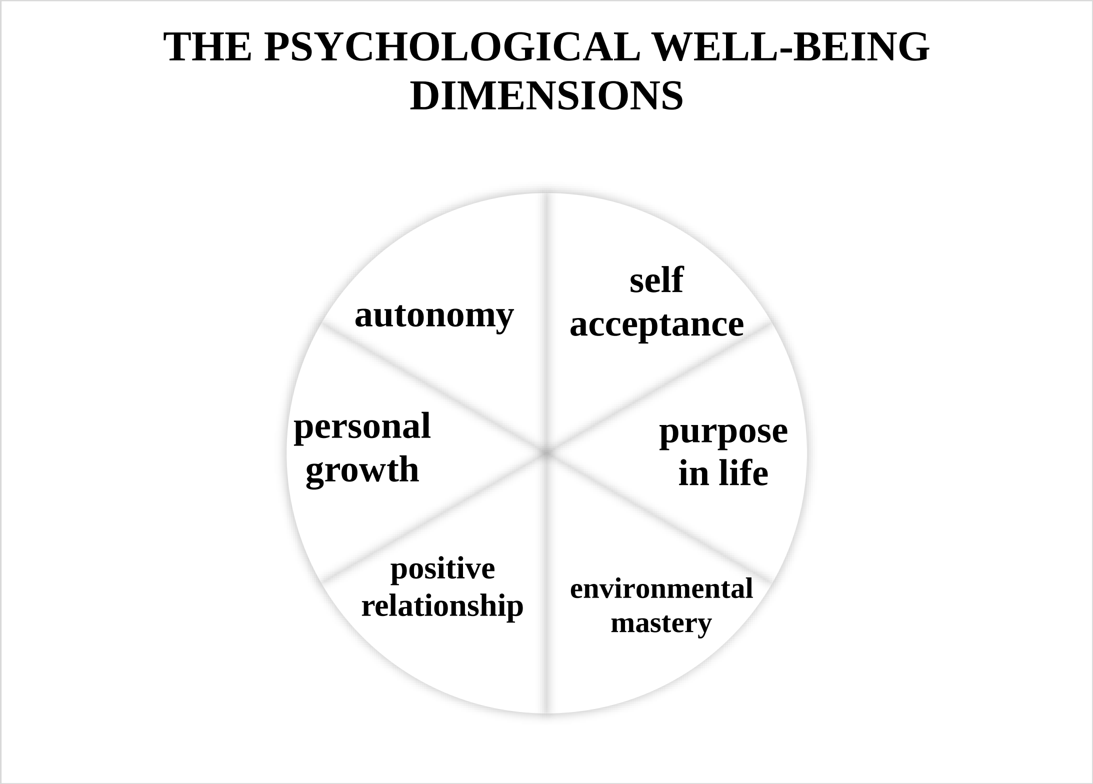
One has to identify the situation and the negative thought (automatic thought) which lead to distress.

Well-being Therapy (WBT)

One has to identify the situation, negative thoughts and beliefs which lead to premature interruption of well-being (automatic thoughts), and finally lead to distress.

Information sheet

No.3 The Psychological Well-Being Dimensions [33, 163]



Information Sheet

N0.4 Modification of the six dimensions of psychological well-being [110, 162]

Dimension	Impaired Level	Balanced Level	Excessive Level
Environment mastery	The person feels difficulties in managing everyday affairs, feel unable to change or improve things around, is unaware of surrounding opportunities, lack sense of control, and is over the external world.	The person has a sense of mastery and competence on managing the environment, controls external activities, makes effective use of surrounding opportunities, and is able to choose what is more suitable to personal needs and values	The person is looking for difficult situations to be handled, is unable to savor positive emotions and leisure time, and is too engaged in work or family activities
Personal Growth	The person has a sense of being stuck, lacks a sense of improvement overtime, feels bored and uninterested with life, and feels unable to develop new attitudes or behaviors	The person has a feeling of continued development, sees self as growing and expanding, is open to new experiences	The person is unable to elaborate past negative experiences, cultivates illusions that clash with reality, and sets unrealistic standards and goals
Purpose in life	The person lacks a sense of meaning in life, has few goals or aims, lacks a sense of direction, does not see purpose in past life, and has no outlooks or beliefs that give life meaning.	The person has goal in life and a sense of directedness, feels there is meaning to present and past life, holds beliefs that give life purpose, and has aims and objectives for living.	The person has unrealistic expectations and hopes, is constantly dissatisfied with performance and is unable to recognize failures

Information Sheet

N0.4 Modification of the six dimensions of psychological well-being [110, 162]

Dimension	Impaired Level	Balanced Level	Excessive Level
Autonomy	The person is over concerned with the expectations and evaluation of others, relies on judgment of others to make important decisions, and conforms to social pressures to think or act in certain ways.	The person is self-determining and independent, able to resist social pressures, regulates behavior from within, and evaluates self by personal standards.	The person is unable to get along with others, to work in a team, to learn from others, and is unable to ask for advice or help.
Self-acceptance	The person feels dissatisfied with self, is disappointed with what has occurred in past life, is troubled about certain personal qualities, and wished to be different from what he or she is.	The person has a positive attitude toward the self, accepts his or her good bad qualities, and feels positive about his or her past life.	The person has difficulties in admitting own mistake, he/ she attributes all problems to others' faults.
Positive relations with others	The person has few close, trusting relationships with others, finds it difficult to be open and is isolated and frustrated in interpersonal relationships, and is not willing to make compromises to sustain important ties with others	The person has worm and trusting relationships with others, and understands the give and tale of human relationships	The person sacrifices his/ her need and well-being for those of others, low self-esteem and sense of worthlessness induce excessive readiness to forgive

Activity sheet

No.2 A Well-being diary 2 [162]

Situation	Feeling of well-being	Interrupting thoughts	Observer's interpretation

* *Interrupting thought or automatic thought* can be a thought or visual image that person may not be aware of unless specific attention is focused on it. It can precede episode of distress (in CBT), but can also lead to interruption well-being, which may or may not be followed by emergence of distress.

***** *An observer's interpretation* is pretending to think what another person may think in that situation.

Workshop 3 My growth

Theme

1. Mindset
2. Environment mastery and personal growth
3. Purpose in life and autonomy

Objectives

1. To understand the fixed and the growth mindset which related to psychological well-being
2. To enhance environment mastery, personal growth, purpose in life and autonomy
3. To continue the well-being diary

Evaluation

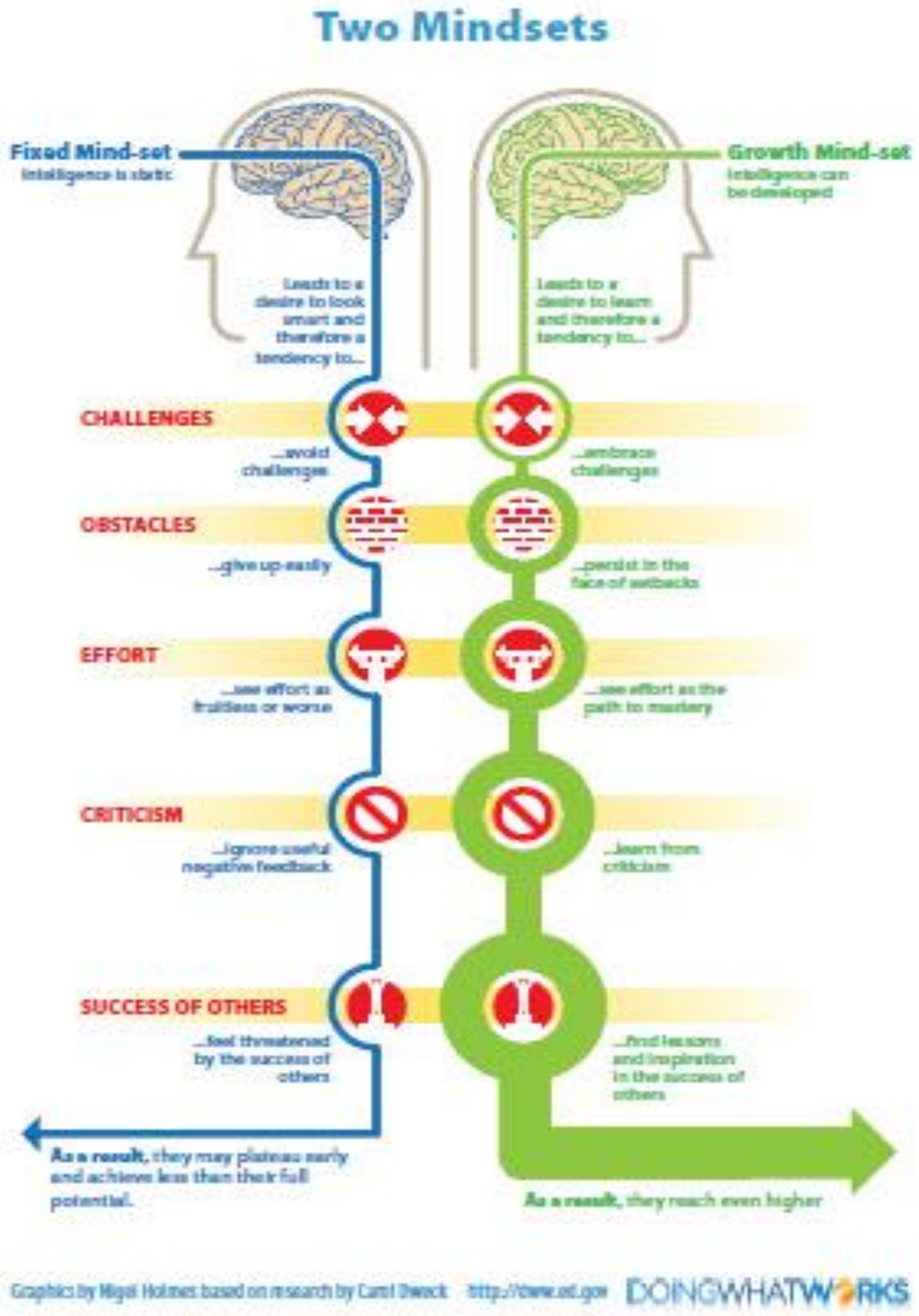
1. The content from meaning and purpose in life flip chart, and activity sheet no.3
2. Participant’s cooperation

Time	Activities	Materials
5 mins	1. Mindfulness activity	- Flower Bloom VDO file
10 mins	2. Review the experienced of well-being diary	- Flip chart
30 mins	3. Mindset [30, 31] A card game - assign each group build the tower from cards as high as they can - discuss the feeling and thinking about yourself and toward others either success or failure - summarize the card game and link to the concept of mindset	- Cards (3 sets) - Information sheet no.5
15 mins	Break	- Snack
30 mins	4. Meaning and purpose in life [164] - reflect on the past life since they’ve started to be a family caregiver of Schizophrenic patients, and identify two areas in which growth has occurred - tell a short story which represent future growth	- Flip chart

Time	Activities	Materials
30 mins	5. Best possible self-activity [30, 165] - draw your current state on the left side, and your desired new reality on the right side of paper - do the visual goal setting - one representative from each group present to all	- Information sheet no.6 - Activity sheet no.3 (blank A3 size) - pencils & pencil colors/ pastel colors
15 mins	6. Discussion for the reflection form activities	
15 mins	7. Mindfulness movement	- Body movement VDO

Information Sheet

No.5 Mindset [31, 166]



Information sheet

No.6 Best Possible Self [30, 165, 167]

To draw your dream into reality, need three steps

1. see it 2. believe it 3. act it

To reach your goals with visual goal setting need seven steps.

Step 1: Your Name: Draw your name at the top of the paper. Have fun with this, maybe try bubble letters, swirls, or whatever feels right at the moment.

Step 2: Current State: On the left side of your paper, draw your current state using words and images that come to mind. You may want to choose a single color or a darker color for this section. Don't worry if it's not perfect, just do your best. In her book, Patti provides some great sample images to draw from. Reflect on what you see and how you feel.

Step 3: Desired Reality: Before you start on this section, take a break and allow yourself to change your focus. Go for a walk, play loud music, or drink a glass of water. Once you feel like your mind is clear, get your pens and pencils ready. On the ride side of your paper, draw your desired future reality using words and images that express the feeling you'd like to achieve. Where do you want to see yourself in one year? If your inner critic shows up, banish it from the room. Allow yourself to dream. Reflect on what you see and how you feel.

Step 4: Bold Steps: Now, look at both sides of the paper, where you are now and where you want to be a year from now. On a separate piece of paper, brainstorm a list of steps you could take right now to achieve your goals. Get as many ideas as you can, and when you're finished, narrow the list down to your top three. Write down your three Bold Steps in the center of your document.

Step 5: Action Steps: Under each bold step, make a list of 8-10 smaller actions you can take to achieve each bold step. For example, on mine, one of my bold steps is to List Our Current House. Some smaller action steps include: Prepare the house for sale, Clean and declutter each room, make any necessary repairs, and Paint the stairs. Do this for each of your 3 Bold Steps.

Step 6: Success Measures: Set success measures for each of your Bold Steps. When you complete the Bold Step, what will success look like to you? For my Bold Step of Listing Our Current House, my success measures include: Having our house ready to present to potential buyers, completing all necessary repairs, and Having freshly painted stairs. Complete this for each of your 3 Bold Steps.

Step 7: Revisit and Reinvigorate: Staying motivated and inspired to achieve your goals is essential. By revisiting your map each week and feeling what success would feel like, you can maintain your enthusiasm. According to Patti, it's also important to celebrate each success. When you accomplish a task, no matter how small, say, "I drink this ________ in celebration of my continued success with ________."

Workshop 4 Me and the others

Theme

1. Self-acceptance and positive relations with others
2. Planning to maintain the PWB

Objectives

1. To understand and to practice the self-compassion
2. To understand and to practice the positive relationship with others
3. To continue the well-being diary

Evaluation

1. The content of group discussion and reflection
2. Participant's cooperation

Time	Activities	Materials
5 mins	1. Mindfulness activity	- Flower Bloom VDO file
15 mins	2. Review the experienced of well-being diary and the random acts of kindness	- Flip chart
30 mins	2. Self-compassion activity [168, 169] (in pair) 2.1 Self-compassion break - think about your life situation right now that is difficult for you (but not too difficult) such as concerning, relationship problem, or stress. - get in touch with the situation: What's going on? What's happen or might happen? Who's said what? - focus on the three phases: 1) This is the moment of suffering. It is in present. Find some language that speak to you such 'this is really hard right now'. 2) Suffering is a part of life. Find some language that speak to you such 'it's not a normal to feel this way'. 3) May I be kind to myself at this moment? Bringing kindness to yourself. Find any language that support any kindness as you talk with a good friend in your same situation, such 'I'm here for you'. You will be well, and relief from suffering. - observe your body, and allow it as you are. 2.2 practice the self-compassion/ loving kindness meditation	- Information sheet no.7 - Self-compassion audio file [169]

Time	Activities	Materials
15 mins	Break	- Snack
40 mins	3. Dry leaf game [170] (in pair) - one will be a dry leaf and fold yourself as tight as you can, and other will try to unfold a dry leaf. - repeat, and this time one try to unfold a dry leaf with the kindness, to comfy a dry leaf - discuss the experienced as a dry leaf and an unfold person. - discuss the feeling as an unfold person 1) what do you think about its' feeling? 2) what do you want to do with them? 3) what is your feeling as you unfold it, 1st and 2nd time? 4) who is a dry leaf in your life? - group discuss and leader link to the awareness of positive interpersonal relationship and positive communication	- Information sheet no.8 - Flip chart
30 mins	4. Discussion for the reflection form all activities 5. Reflection all workshops in term of implementation.	- Flip chart - Information sheet no.9
15 mins	6. Mindfulness movement	- Body movement VDO
30 mins	Follow up	- PWB Scale - Zarit Burden Interview (ZBI)

Information Sheet

No.7 Self-compassion [168, 169]

Having compassion for oneself is really no different than having compassion for others. Think about what the experience of compassion feels like.

- First, to have compassion for others you must notice that they are suffering. If you ignore that homeless person on the street, you can’t feel compassion for how difficult his or her experience is.
- Second, compassion involves feeling moved by others’ suffering so that your heart responds to their pain (the word compassion literally means to “suffer with”). When this occurs, you feel warmth, caring, and the desire to help the suffering person in some way. Having compassion also means that you offer understanding and kindness to others when they fail or make mistakes, rather than judging them harshly.
- Finally, when you feel compassion for another (rather than mere pity), it means that you realize that suffering, failure, and imperfection is part of the shared human experience. “There but for fortune go I.”

Self-compassion involves acting the same way towards yourself when you are having a difficult time, fail, or notice something you don’t like about yourself. Instead of just ignoring your pain with a “stiff upper lip” mentality, you stop to tell yourself “this is really difficult right now,” how can I comfort and care for myself in this moment?

Instead of mercilessly judging and criticizing yourself for various inadequacies or shortcomings, self-compassion means you are kind and understanding when confronted with personal failings – after all, who ever said you were supposed to be perfect?

You may try to change in ways that allow you to be healthier and happier, but this is done because you care about yourself, not because you are worthless or unacceptable as you are. Perhaps most importantly, having compassion for yourself means that you honor and accept your humanness. Things will not always go the way you want them to. You will encounter frustrations, losses will occur, you will make mistakes, bump up against your limitations, fall short of your ideals. This is the human condition, a reality shared by all of us. The more you open your heart to this reality instead of constantly fighting against it, the more you will be able to feel compassion for yourself and all your fellow humans in the experience of life.

Information Sheet

No.8 Positive interpersonal relationship and positive communication [170]

Positive interpersonal relationship

Every day we have to communicate and make a relationship with others both in and out our family. Good relationship can balance our psychological well-being, and lead to happiness. Almost the cause of problem in any relationship is because the misunderstanding. People always need attention from others more than pay attention to others. The problem can emerge by the need without regarding the others.

A dry leaf game is the metaphor pattern of someone who have some frustration or suffering and can crack easily. Tightly self-folding seems like the way to protect themselves, don't need anyone to contact them. To unfold a dry leaf is the same as positive interpersonal relationship. You need to be aware, be gentle, and pay more attention with them. This activity emphasizes you to understand and be empathy with others. Love and compassion to the others are the secure bridge for friendship and relationship building

Positive communication is the communication with awareness, positive feeling and happiness. Positive communication can lead to agreement, resolve the conflict, build the good relationship. It should have two components: deep listening and loving speech.

1. Deep listening: listen the others story with highly attention, no critic, no bias.
2. Loving speech: creative and positive speech which create confidence, hope, and positive feeling.

Information Sheet

No.9 Seven positive practice [171]

7 POSITIVE PRACTICES

1. **Positive emotion**
   Generating positive emotions helps broaden and build our resources and moves us toward greater wellbeing.
2. **Mindset**
   Adopting a positive attitude and Growth Mindset enhances learning and opens our mind to new ways to raise happiness levels.
3. **Mindfulness**
   Mindfulness is the opposite of mindlessness. Learning to be mindful allows us to stay present in the moment.
4. **Resilience**
   Resilience is the capacity to withstand and adapt to the challenges life throws us. There are many ways to build resilience.
5. **Optimism**
   Optimism is a tendency to expect the best possible outcomes. We can learn strategies to be more optimistic.
6. **Gratitude**
   Practicing gratitude makes us aware of the good things that happen and connects us to a sense of life's wonder.
7. **Strengths**
   When we use our strengths, we enjoy what we are doing, do it better, and feel we are working toward our potential.

โปรแกรมเสริมสร้างสุขภาวะทางจิต

ครั้งที่ 1 สุขภาวะ หรือ ความอยู่ดีมีสุข

สาระสำคัญ

1. สร้างสัมพันธภาพระหว่างสมาชิกกลุ่ม
2. สถานการณ์และระดับของสุขภาวะ หรือความอยู่ดีมีสุข (well-being)

วัตถุประสงค์

1. เพื่อทำกิจกรรมละลายพฤติกรรมระหว่างผู้นำกลุ่ม ผู้ช่วยผู้นำกลุ่มและสมาชิกในกลุ่ม
2. เพื่อฝึกการรับความรู้สึกที่ดีผ่านกิจกรรมการฝึกสัมผัสความรู้สึกทางบวก
3. ฝึกสังเกตสถานการณ์และระดับของสุขภาวะ หรือความอยู่ดีมีสุขของตนเอง

การประเมินผล

1. เนื้อหาและความเข้าใจการฝึกสังเกตสถานการณ์ ระดับสุขภาวะ หรือความอยู่ดีมีสุขของตน
2. ความร่วมมือของสมาชิกกลุ่ม

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
30 นาที	1. กิจกรรมละลายพฤติกรรม 1.1 กิจกรรมปรบมือ - ปรบมือตามผู้นำกลุ่มบอก เช่น 1 ครั้ง 3 ครั้ง 5 ครั้ง - ปรบมือเพิ่ม 1 ครั้ง ตามจำนวนผู้นำกลุ่มบอก เช่น ปรบมือ 1 ครั้ง ให้สมาชิกปรบ 2 ครั้ง เป็นต้น - ปรบมือลดลง 1 ครั้ง ตามจำนวนผู้นำกลุ่มบอก เช่น ปรบมือ 2 ครั้ง ให้สมาชิกปรบ 1 ครั้ง เป็นต้น 1.2 กิจกรรมวันนี้ยินดี - สมาชิกยืนเป็นวงกลม 2 วง วงนอกและวงใน - ผู้นำกลุ่มร้องเพลง “วันนี้ยินดี ยินดีที่เราพบกัน วันนี้ยินดี ยินดีที่เราพบกัน ยินดี ยินดี ยินดี เธอกับฉันพบกันสวัสดี สวัสดีครับ สวัสดีค่ะ” -ขณะที่ผู้นำกลุ่มร้องเพลง ให้สมาชิกขยับไปทางด้านขวา และเมื่อถึงวรรค สวัสดีครับ สวัสดีค่ะ ให้สมาชิกยกมือไหว้สวัสดีกัน - แบ่งกลุ่มย่อย ออกเป็น 3 กลุ่ม กลุ่มละ 7-10 คน (แยกตามฤดูที่เกิด สามฤดู)	- เครื่องเคาะจังหวะ - กระดานแผ่นพลิก (Flip chart)

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
15 นาที	1.3 ในกลุ่มย่อย ให้สมาชิกกลุ่มจับคู่คุยกัน 1) อะไรที่ทำให้มีความสุขในช่วงสัปดาห์นี้ 2) เรื่องที่ดีที่สุดที่พบในวันนี้ และ 3) คาดหวังอะไรจากการมาร่วมกิจกรรมในครั้งนี้ 1.4 แลกเปลี่ยนสิ่งที่ได้พูดคุยกันในกลุ่มใหญ่	
15 นาที	พักทานอาหารว่าง	- อาหารว่าง
5 นาที	2. กิจกรรมการฝึกสติ	- วีดีโอเพลงดอกไม้บาน ของ เสถียรธรรมสถาน
25 นาที	3. การฝึกสัมผัสความรู้สึกทางบวก[161] จับคู่แลกเปลี่ยนความคิดเห็นกัน	- ใบความรู้ที่ 1กิจกรรมฝึกสัมผัสความรู้สึกทางบวก
45 นาที	4. สุขภาวะ หรือความอยู่ดีมีสุขของฉัน [162] - ในกลุ่มย่อย ให้สมาชิกจับคู่ คุยกันเกี่ยวกับสถานการณ์ที่ทำให้รู้สึกดี (คนละ 10 นาที) - อธิบาย หรือ เขียนสถานการณ์ที่ทำให้รู้สึกดี - อธิบายว่ารู้สึก หรือได้สัมผัสกับประสบการณ์อะไรบ้าง - ให้คะแนนความรู้สึกที่ดี จาก 0 คะแนน (ไม่รู้สึกดี) ไปจนถึง 100 คะแนน (รู้สึกดีมาก) - แลกเปลี่ยนประสบการณ์กันในกลุ่มใหญ่	- กระดานแผ่นพลิก หรือ - ใบงานที่ 1 แบบบันทึกสุขภาวะหรือความอยู่ดีมีสุข
30 นาที	5. อภิปรายสิ่งที่ได้เรียนรู้จากกิจกรรมครั้งนี้	- กระดานแผ่นพลิก
15 นาที	6. การเคลื่อนไหวอย่างมีสติt	- วีดีโอการเคลื่อนไหวอย่างมีสติ 10 ท่า ของ สสส.

ใบความรู้ที่ 1

การฝึกสัมผัสความรู้สึกทางบวก [161]

การฝึกสัมผัสความรู้สึกทางบวก คือ การฝึกควบคุมความรู้สึกทางบวกของตนเองโดยผ่านทาง

(ก) ความทรงจำที่ดีเกี่ยวกับอดีต โดยการนึกย้อนอดีต

(ข) ประสบการณ์ที่ดีในปัจจุบัน โดยการพิจารณาปัจจุบัน

(ค) ประสบการณ์ที่ดีในอนาคต โดยการคาดการณ์ในเรื่องทางบวก

การสัมผัสความรู้สึกทางบวกแตกต่างจากความรู้สึกยินดี หรือสนุก เนื่องจากเป็นการสัมผัสโดยใช้สติเพื่อให้สามารถรับรู้ถึงความรู้สึกยินดี หรือแม้แต่การตรึง หรือลดทอนความรู้สึกนั้น การฝึกสัมผัสความรู้สึกต้องการความจดจ่อกับความรู้สึกยินดี โดยมีกระบวนการ 4 ขั้นตอนดังนี้

1) สัมผัสประสบการณ์ เป็นการรวมการรับรู้ผ่านประสาทสัมผัสทั้งหมดที่เข้ามาสู่ร่างกายเรา ร่วมกับบรรยากาศที่เกิดประสบการณ์นั้น ได้แก่ การรับรู้ การคิด พฤติกรรมและอารมณ์ เช่น การแช่ตัวในอ่างน้ำอุ่นๆ การอ่านนิยายเล่มโปรด หรือการออกไปเที่ยวกับเพื่อน

2) กระบวนการสัมผัส เป็นลำดับของจิตใจหรือร่างกายในการรับรู้ประสบการณ์ทางบวกที่เข้ามาแล้วเปลี่ยนเป็นความรู้สึกทางบวก เช่น ฝึกคิดถึงอนาคตในแนวทางที่ดี ฝึกชื่นชมยินดีต่อความสำเร็จ ฝึกความยินดีต่อประสบการณ์ที่เข้ามาในชีวิต

3) วิธีการในการสัมผัส ซึ่งค่อนข้างจะเป็นความคิดหรือพฤติกรรมที่เป็นรูปธรรม ซึ่งจะส่งผลต่อระดับความรู้สึก หรือระยะเวลาของความรู้สึกทางบวกนั้น เช่น การนึกย้อนเป็นภาพเกี่ยวกับอดีต ยินดีในความสำเร็จของตนเอง หรืออาจจะใช้วิธีปิดตาแล้วสัมผัสความรู้สึกทางบวกในขณะที่ชิมไวน์รสเลิศ

4) ความเชื่อของการสัมผัส เป็นการรับรู้ของบุคคลที่สามารถมีความสุข สนุกกับประสบการณ์ที่ดีรวมถึงความสามารถในการค้นหาสิ่งที่ดีให้กับตนเอง ความเชื่อของการสัมผัสเป็นตัวกำหนด 3 ประการในด้าน ความสามารถในการนึกย้อนเกี่ยวกับเรื่องที่ดีในอดีต ความสามารถในการสัมผัสความรู้สึกทางบวกต่อเหตุการณ์ในปัจจุบัน และความสามารถในการคิดบวกเกี่ยวกับอนาคต

ใบงานที่ 1

แบบบันทึกสุขภาวะ หรือความอยู่ดีมีสุข 1 [162]

เหตุการณ์	สุขภาวะ หรือ ความรู้สึกอยู่ดีมีสุข	ระดับคะแนน (0-100)
0 บ่งชี้ว่าไม่รู้สึกดี 100 บ่งชี้ว่ารู้สึกดีมาก		

ครั้งที่ 2 ความคิดและสุขภาวะทางจิตของฉัน

สาระสำคัญ

1. กลไกของการบำบัดทางความคิด (Cognitive Therapy: CBT) และการบำบัดทางสุขภาวะ (Well-being therapy : WBT)
2. สถานการณ์สุขภาวะทางจิต

วัตถุประสงค์

1. เพื่อทำความเข้าใจความสัมพันธ์ระหว่างเหตุการณ์ ความคิดอัติโนมัติ และอารมณ์ทางลบ
2. เพื่อฝึกหัดการสังเกตความคิดทางลบ
3. เพื่อฝึกสังเกตสถานการณ์และระดับของสุขภาวะ หรือความอยู่ดีมีสุขของตนเองต่อเนื่อง

การประเมินผล

1. เนื้อหาจากกระดานแผ่นพลิกหรือใบงานที่ 2
2. ความร่วมมือของสมาชิกกลุ่ม

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
5 นาที	1. กิจกรรมการฝึกสติ	- วีดีโอเพลงดอกไม้บาน ของ เสถียรธรรมสถาน
10 นาที	2. กิจกรรมละลายพฤติกรรม - สมาชิกยืนเป็นวงกลม - ผู้นำกลุ่มไปยืนกลางวงทำท่าเต้นนำ และสมาชิกทำตาม - ผู้ช่วยผู้นำกลุ่มไปยืนกลางวงทำท่าเต้นนำ และสมาชิกทำตาม - ขออาสาสมัครมาทำท่าเต้นนำ และค่อยๆ เปลี่ยนกันมาเต้นนำ (อาจเป็นท่าที่ง่ายๆ หรือ สนุกสนาน)	- คลิปเสียงเพลงลูกทุ่ง “ขอใจแลกเบอร์โทร”
15 นาที	3. ทบทวนประสบการณ์สุขภาวะ หรือความอยู่ดีมีสุข (กิจกรรมกลุ่มย่อย) - เหตุการณ์ - สุขภาวะ หรือความอยู่ดีมีสุข - ระดับคะแนน	- กระดานแผ่นพลิก

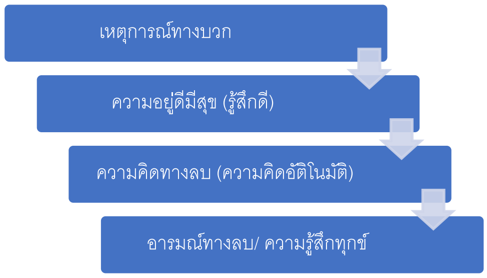
ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
30 นาที	4. กลไกการบำบัดทางความคิด (CBT) [28]	- ใบความรู้ที่ 2
15 นาที	พักรับประทานอาหารว่าง	- ของว่าง
30 นาที	5. กลไกการบำบัดทางสุขภาวะ (WBT) [28]	- ใบความรู้ที่ 2
15 นาที	6. ฝึกหัดการบันทึก/ สังเกตสุขภาวะหรือความอยู่ดีมีสุขขั้นสูง [162] - กิจกรรมกลุ่มย่อย ให้สมาชิกอธิบายเกี่ยวกับความคิดที่มารบกวนความรู้สึกเป็นสุข และการตีความหมายของความคิดที่เข้ามา - อภิปรายร่วมกันในกลุ่มใหญ่	- กระดานแผ่นพลิก หรือใบงานที่ 2
15 นาที	7. องค์ประกอบของสุขภาวะทางจิต [33, 163]	- ใบความรู้ที่ 3 และ 4
30 นาที	8. อภิปรายสิ่งที่ได้เรียนรู้จากกิจกรรมครั้งนี้	- กระดานแผ่นพลิก
15 นาที	9. การเคลื่อนไหวอย่างมีสติt	- วีดีโอการเคลื่อนไหวอย่างมีสติ 10 ท่า ของ สสส.

ใบความรู้ที่ 2

การบำบัดทางความคิด และการบำบัดทางสุขภาวะ [28]

การบำบัดทางความคิด

(Cognitive Therapy)



การบำบัดทางสุขภาวะ

(Well-being Therapy)

การบำบัดทางความคิด (Cognitive Therapy : CBT)

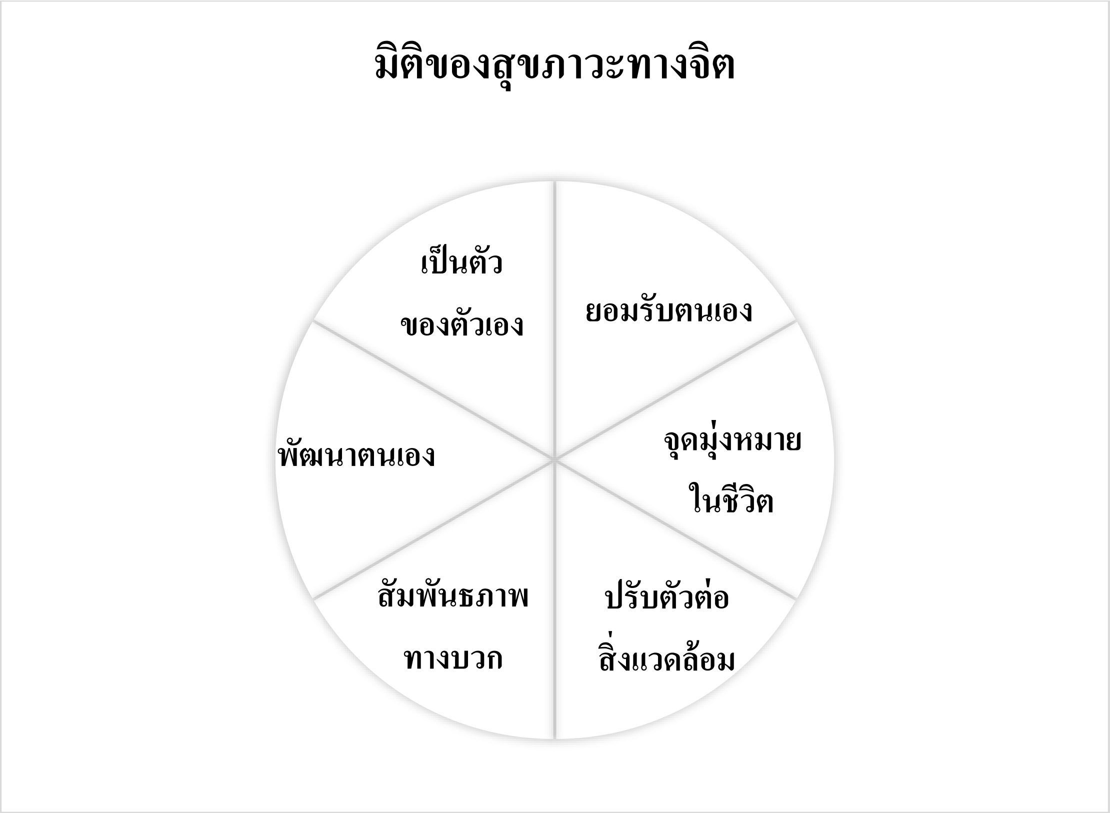
ผู้รับการบำบัด จำแนกสถานการณ์และความคิดทางลบ (ความคิดอัตโนมัติ) ที่ก่อให้เกิดความรู้สึกทุกข์ (ภาระการดูแล)

การบำบัดทางสุขภาวะ (Well-being Therapy : WBT)

ผู้รับการบำบัด จำแนกสถานการณ์ทางบวก และความคิดทางลบ(ความคิดอัตโนมัติ) ที่มารบกวนความอยู่ดีมีสุข และนำไปสู่ความรู้สึกทุกข์

ใบความรู้ที่ 3 มิติของสุขภาวะทางจิต

[33, 163]



ใบความรู้ที่ 4

องค์ประกอบของสุขภาวะทางจิต [110, 162]

องค์ประกอบ	ระดับน้อย	ระดับปกติ	ระดับสูง
ปรับตัวต่อสิ่งแวดล้อม	รู้สึกยุ่งยากในการจัดการชีวิตประจำวัน ไม่สามารถเปลี่ยนหรือพัฒนาสิ่งที่อยู่รอบตัว ไม่ค่อยไวต่อการเปลี่ยนแปลงของสิ่งรอบตัว ขาดทักษะในการจัดการและรู้สึกเหนื่อยล้ากับโลกภายนอก	มีทักษะและความสามารถในการจัดการสิ่งแวดล้อมรอบตัว จัดการกับกิจกรรมภายนอกที่เข้ามา และสร้างให้เกิดประโยชน์สูงสุด สามารถเลือกสิ่งที่ตรงกับความต้องการและค่านิยมของตนเอง	พยายามจัดการกับสถานการณ์ที่ยุ่งยาก ไม่ค่อยสัมผัสความรู้สึกทางบวก ไม่มีเวลาพักผ่อน มักให้เวลากับงาน หรือครอบครัวมากเกินไป
พัฒนาตนเอง	รู้สึกตัวเองมีข้อจำกัด ไม่ค่อยอยากพัฒนาตนเอง รู้สึกเบื่อขาดความสนใจและเบื่อหน่ายต่อชีวิต รู้สึกว่าไม่สามารถสร้างทัศนคติ หรือพฤติกรรมใหม่ๆ ได้	รู้สึกต้องการพัฒนาตนเองอย่างต่อเนื่อง มองเห็นชีวิตคือการพัฒนาและเติบโต ไปสู่ประสบการณ์ใหม่	ไม่สามารถจัดการกับอดีตที่แย่ของตนเอง หรือจัดการกับความคิดที่มารบกวนสิ่งที่เป็นจริงในปัจจุบัน สร้างมาตรฐานและเป้าหมายที่เกินจริงสำหรับตนเอง
จุดมุ่งหมายในชีวิต	ขาดความรู้สึกถึงความหมายของชีวิต มีเป้าหมายบ้างเล็กน้อย แต่ขาดทักษะในการมุ่งไปสู่เป้าหมาย ไม่ค่อยเห็นคุณค่าของสิ่งที่เกิดขึ้นในอดีต ไม่มีภาพของชีวิตที่มีจุดมุ่งหมายอยู่ในใจ.	มีเป้าหมาย และทิศทางในการดำเนินชีวิต รู้สึกชีวิตในอดีตและปัจจุบันมีคุณค่า มีความเชื่อที่สามารถทำให้ดำรงชีวิตอย่างมีเป้าหมายและมีจุดมุ่งหมาย	มีความคาดหวังความหวังที่ไม่ตรงกับความเป็นจริง ไม่ค่อยพอใจกับการกระทำของตนเอง และไม่ตระหนักถึงข้อผิดพลาดที่เกิดขึ้น

ใบความรู้ที่ 4

องค์ประกอบของสุขภาวะทางจิต [110, 162]

องค์ประกอบ	ระดับน้อย	ระดับปกติ	ระดับสูง
เป็นตัวของตัวเอง	กังวลสูงกับความคาดหวังและการตัดสินจากผู้อื่น ตัดสินใจเรื่องสำคัญของตนเองจากความเห็นของผู้อื่น ความคิดหรือการกระทำจะมากระแสสังคม	มีความมุ่งมั่น และมีอิสระทางความคิด สามารถยืนหยัดต่อแรงกดดันทางสังคม ควบคุมพฤติกรรมจากภายใน และประเมินตนเองจากมาตรฐานของตนเอง	เข้ากับคนอื่นได้ยาก ไม่ว่าจะเป็นการทำงานเป็นทีม หรือการเรียนรู้จากผู้อื่น ไม่สามารถขอความต้องการหรือคำแนะนำจากผู้อื่น
ยอมรับตนเอง	ไม่พอใจในตนเอง ผิดหวังกับสิ่งที่เกิดขึ้นในอดีต ไม่รู้คุณค่าตนเอง และอยากแตกต่างเป็นในสิ่งที่ไม่ใช่ตัวเอง	มีทัศนคติที่ดีต่อตนเอง ยอมรับข้อดีข้อด้อยของตนเอง และรู้สึกดีกับชีวิตของตนเองในอดีต	มีความยุ่งยากในการยอมรับสิ่งที่ทำผิดพลาด มักโยนปัญหาให้เป็นความผิดของผู้อื่น
สัมพันธภาพทางบวก	มีเพื่อนที่สนิท หรือสัมพันธภาพที่แน่นแฟ้นกับผู้อื่นน้อย รู้สึกยากที่จะเปิดตัวเอง โดดเดี่ยวและหงุดหงิดในความสัมพันธ์ระหว่างบุคคล ไม่เต็มใจที่จะประนีประนอมเพื่อรักษาความสัมพันธ์ที่ดีกับผู้อื่น สนใจที่จะผูกสัมพันธ์ที่ยั่งยืนกับใคร	มีความอบอุ่น และเชื่อมั่นในสัมพันธภาพกับผู้อื่น เข้าใจในเรื่องการให้และการรับเพื่อสร้างสัมพันธภาพระหว่างกันของมนุษย์	เสียสละความต้องการและความเป็นอยู่ที่ดีของตนเองให้กับผู้อื่น ความภาคภูมิใจในตนเองต่ำ ความรู้สึกไร้ค่าทำให้อภัยต่อผู้อื่นง่ายเกินไป

ใบงานที่ 2

แบบบันทึกความอยู่ดีมีสุข 2 [162]

เหตุการณ์	**ความรู้สึกอยู่ดีมีสุข**	**ความคิดที่เข้ามารบกวน**	**การแปลความหมาย**

* **ความคิดที่เข้ามารบกวน** หรือ ความคิดอัตโนมัติ อาจเป็นได้ทั้งความคิดหรือภาพที่เข้ามาโดยที่บุคคลนั้นไม่ทันสังเกต ซึ่งสามารถก่อให้เกิดความรู้สึกทุกข์ (ในการบำบัดทางความคิด) หรือขัดขวางความรู้สึกสุข (ในการบำบัดทางสุขภาวะ)และนำไปสู่ความรู้สึกทุกข์ในที่สุด

***การแปลความหมาย** คือ แนวโน้มการคิดต่อเหตุการณ์ของบุคคลนั้น ๆ

ครั้งที่ 3 การพัฒนาตนเอง

สาระสำคัญ

1. กรอบการคิด (Mindset)
2. การปรับตัวต่อสิ่งแวดล้อม และการพัฒนาตนเอง
3. จุดมุ่งหมายในชีวิต และความเป็นตัวของตนเอง

วัตถุประสงค์

1. เพื่อสร้างความเข้าใจกรอบการคิดแบบติดยึด กับแบบพัฒนา ซึ่งเกี่ยวข้องกับสุขภาวะทางจิต
2. เพื่อพัฒนาการปรับตัวต่อสิ่งแวดล้อม การพัฒนาตนเอง จุดมุ่งหมายในชีวิต และความเป็นตัวของตนเอง
3. เพื่อการฝึกบันทึกหรือสังเกตความอยู่ดีมีสุขต่อเนื่อง

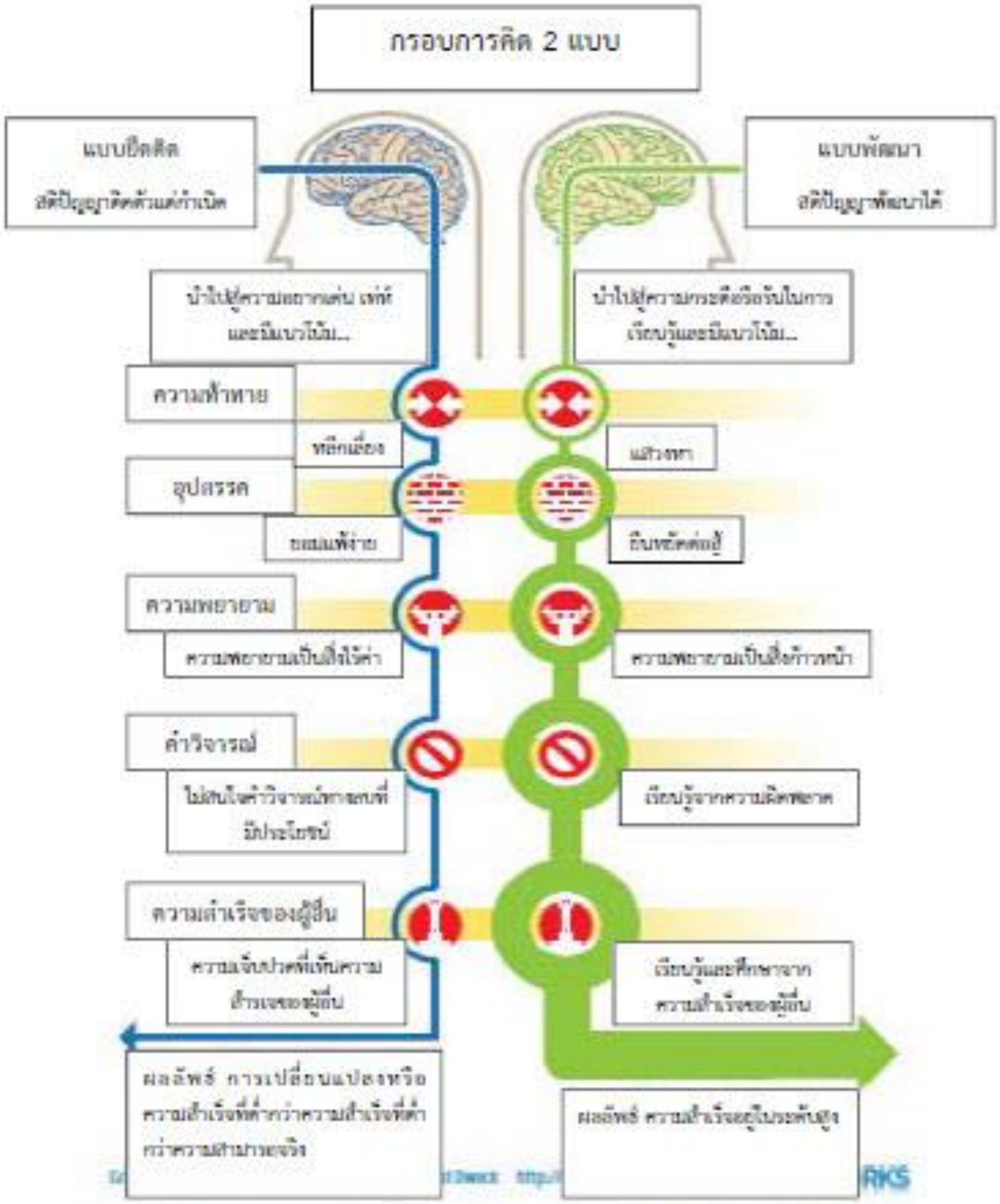
การประเมินผล

1. เนื้อหาเกี่ยวกับจุดมุ่งหมายในชีวิตจากแผ่นพลิก หรือใบงานที่ 3
2. ความร่วมมือของสมาชิกกลุ่ม

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
5 นาที	1. กิจกรรมการฝึกสติ	- วีดีโอเพลงดอกไม้บาน ของ เสถียรธรรมสถาน
10 นาที	2. ทบทวนประสบการณ์การฝึกบันทึก หรือ การสังเกตความอยู่ดีมีสุข	- กระดาษแผ่นพลิก
30 นาที	3. กรอบการคิด [30, 31] - ให้สมาชิกแต่ละกลุ่มย่อย ช่วยกันสร้างตึกให้สูงที่สุดเท่าที่จะสร้างได้จากไพ่ - แลกเปลี่ยนความรู้สึกและความคิดเกี่ยวกับตนเอง คนอื่น ทั้งการสร้างที่สำเร็จและไม่สำเร็จ - ผู้นำกลุ่มสรุปการเรียนรู้จากการสร้างตึกจากไพ่ และโยงเข้าสู่หัวข้อกรอบการคิด	- ไพ่ 3 สำรับ - ใบความรู้ที่ 5
15 นาที	พักรับประทานอาหารว่าง	- ของว่าง

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
30 นาที	4. จุดมุ่งหมายในชีวิต [164] - กิจกรรมกลุ่มย่อย: ให้สมาชิกนึกย้อนถึงชีวิตในอดีตที่เริ่มเป็นผู้ดูแลผู้ป่วยจิตเภท และนึกถึงด้านที่เราได้พัฒนาตนเองจากการเป็นผู้ดูแลผู้ป่วยจิตเภทมา 2 ด้าน - จากนั้นให้เล่าเรื่องต่อเนื่องไปจนถึงอนาคตว่าสามารถพัฒนาตนเองจากการเป็นผู้ดูแลผู้ป่วยจิตเภทได้อย่างไรอีกบ้าง (อาจจะเหมือนเดิมแต่พัฒนาต่อเนื่อง หรือมีประเด็นการพัฒนาตนเองใหม่ที่มองเห็นว่าจะเกิดขึ้น)	- กระดานแผ่นพลิก
30 นาที	5. กิจกรรมภาพฝันที่ดีที่สุดของฉัน [30, 165] - แบ่งกระดาษออกเป็น 3 ส่วน ทางด้านซ้ายให้เขียนสถานการณ์ในชีวิตปัจจุบัน ทางด้านขวาให้เขียนสิ่งที่เป็นไปได้ที่อยากให้เกิดขึ้นในอนาคต - ให้เขียนหรือวาดเป้าหมาย/วิธีการในส่วนกลางหน้ากระดาษ - นำเสนอภาพฝันของตนเองในกลุ่มย่อย - คัดเลือกตัวแทนกลุ่มละ 1-2 คน มานำเสนอกลุ่มใหญ่	- ใบความรู้ที่ 6 - ใบงานที่ 3 (กระดาษเปล่าขนาด A3) - ดินสอ ดินสอสี สีเทียน สีเมจิก
15 mins	6. อภิปรายสิ่งที่ได้เรียนรู้จากกิจกรรมครั้งนี้ 7. มอบหมายให้ทำกิจกรรมดี หรือสร้างสรรค์	- ใบงานที่ 4
15 นาที	6. การเคลื่อนไหวอย่างมีสติt	- วีดีโอการเคลื่อนไหวอย่างมีสติ 10 ท่า ของ สสส.

ใบความรู้ที่ 5 กรอบการคิด [31, 166]



ใบความรู้ที่ 6 [30, 165, 167]

การสร้างภาพฝันที่อยู่ในโลกของความเป็นจริง ประกอบด้วยสามขั้นตอน

2. มองเห็นภาพฝัน
3. เชื่อว่าภาพฝันเป็นไปได้
4. ทำให้ภาพฝันเป็นจริง

การไปถึงเป้าหมายด้วยการตั้งภาพฝัน สามารถทำได้เจ็ดขั้นตอน ดังนี้.

ขั้นตอนที่ 1 เขียนชื่อ

- ♥ เขียนชื่อไว้ด้านบนสุด อย่าไปเครียดกับการเขียนชื่อ ตกแต่งตามใจชอบ เช่น อาจจะเขียนเป็นลูกโป่ง หรืออะไรก็ได้ที่ชอบใจ

ขั้นตอนที่ 2 สถานการณ์ปัจจุบัน

- ♥ เขียนสถานการณ์ปัจจุบันลงบนด้านซ้ายของกระดาษ เขียนคำหรือวาดภาพที่นึกออกในขณะนั้น ให้เลือกใช้ปากกาสีเดียว หรือใช้ปากกาสีเข้มในการเขียนส่วนนี้ ทำให้ดีที่สุดเท่าที่จะทำได้ ไม่ต้องกังวลเรื่องความสวยงาม

ขั้นตอนที่ 3 ความต้องการที่อยู่ในความเป็นจริง

- ♥ ก่อนจะเริ่มขั้นตอนนี้ ให้หยุดพักสักครู่เพื่อเปลี่ยนความสนใจ อาจจะไปเดินเล่น ฟังเพลง หรือดื่มน้ำ เมื่อรู้สึกว่าความคิดโล่ง ก็เตรียมปากกา ดินสอให้พร้อม
- ♥ เขียนความต้องการในอนาคตที่อยู่ในความเป็นจริง โดยเขียนคำหรือวาดภาพที่ตรงกับความรู้สึกของความอยากที่จะเป็นเช่นนั้น
- ♥ อยากเห็นตัวเองเป็นอย่างไรในอีก 1 ปี ถ้าหากมีความคิดผุดแย้งขึ้นมาโต้แย้ง ให้สลัดมันทิ้งไป ปล่อยใจให้ฝันเขียนหรือวาดภาพฝันที่เราเห็นหรือรู้สึก

ขั้นตอนที่ 4 ย้ำเป้าหมายให้ชัดเจน

- ♥ มองไปทั้งสองด้านของหน้ากระดาษ จะเห็นสิ่งที่เป็นอยู่ในปัจจุบันและสิ่งที่เราอยากจะเป็นในอีก 1 ปีต่อจากนี้
- ♥ ในส่วนกลางของหน้ากระดาษ ให้เขียนรายการสิ่งที่ต้องทำเพื่อให้ไปถึงเป้าหมาย หรือภาพฝันที่วางไว้ให้ได้มากที่สุด จากนั้นให้จัดอันดับ 1-3 เขียนด้วยสีเข้มๆ ตรงกึ่งกลางหน้ากระดาษ

ขั้นตอนที่ 5 ปฏิบัติ

- ในแต่ละหัวข้อที่ทำสีเข้มไว้ ให้เขียนรายการย่อยที่จะไปถึงเป้าหมายใหญ่ (สีเข้ม) จำนวน 8-10 รายการ
- ตัวอย่างเช่น หัวข้อเข้มเขียนว่า “บ้านในปัจจุบัน” หัวข้อย่อยจึงเขียนว่า “เตรียมขายบ้าน ทำความสะอาดและเก็บกวาดให้สะอาด ซ่อมแซมส่วนที่ต้องซ่อม ทาสีบันได เป็นต้น

ขั้นตอนที่ 6 ติดตามผลความสำเร็จ

- ติดตามความสำเร็จในเป้าหมายที่ตั้งไว้ ความสำเร็จที่เกิดขึ้นเป็นอย่างไรบ้าง เช่น เป้าหมายบ้านในปัจจุบัน เมื่อทำตามรายการข้อย่อยสำเร็จแล้วพบว่า บ้านพร้อมที่จะบอกขายแก่คนซื้อ ซ่อมแซมเรียบร้อย สีบันไดใหม่เอี่ยม
- ติดตามทั้ง 3 หัวข้อที่เราตั้งไว้

ขั้นตอนที่ 7 ทำซ้ำและตั้งเป้าหมายใหม่

- พยายามสร้างแรงจูงใจและแรงบันดาลใจให้ตนเองไปถึงเป้าหมาย โดยการทบทวนกิจกรรมนี้ซ้ำทุก ๆ สัปดาห์ ชื่นชมความสำเร็จ ซึ่งจะทำให้มีแรงกระตุ้น

ใบงานที่ 4

กิจกรรมดีหรือสร้างสรรค์

ทำกิจกรรมดีหรือสร้างสรรค์ วันละ 1-3 กิจกรรม สังเกตผลตอบรับจากการทำกิจกรรม

วันที่	กิจกรรมดีหรือสร้างสรรค์	ผลตอบรับ
	1. 2. 3.	
	1. 2. 3.	
	1. 2. 3.	
	1. 2. 3.	
	1. 2. 3.	
	1. 2. 3.	
	1. 2. 3.	

ครั้งที่ 4 ตัวฉันและคนอื่น

สาระสำคัญ

1. การยอมรับตนเองและสัมพันธภาพทางบวก
2. การวางแผนเพื่อรักษาสุขภาวะทางจิต

วัตถุประสงค์

1. เพื่อทำความเข้าใจและฝึกหัดการเมตตาตนเอง
2. เพื่อทำความเข้าใจและฝึกหัดการสร้างสัมพันธภาพทางบวกกับผู้อื่น
3. เพื่อการฝึกบันทึกหรือสังเกตความอยู่ดีมีสุขต่อเนื่อง

การประเมินผล

1. เนื้อหาการอภิปรายแต่ละกิจกรรมย่อยจากแผ่นพลิก
2. ความร่วมมือของสมาชิกกลุ่ม

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
5 นาที	1. กิจกรรมการฝึกสติ	- วีดีโอเพลงดอกไม้บาน ของ เสถียรธรรมสถาน
15 นาที	2. ทบทวนการบันทึก/ สังเกตสุขภาวะ หรือความรู้สึกอยู่ดีมีสุข รวมถึงการทำกิจกรรมดี/ สร้างสรรค์	- กระดาษแผ่นพลิก
30 นาที	2. กิจกรรมเมตตาตนเอง [168, 169] 2.1 เมตตาตนเอง -นึกถึงเหตุการณ์ที่ยุ่งยากใจในปัจจุบัน เช่น ปัญหาสัมพันธภาพ เครียด ฯลฯ - ปล่อยใจให้สัมผัสกับเหตุการณ์นั้น เหตุการณ์เป็นอย่างไร เกิดอะไรขึ้นหรือจะเกิดอะไรขึ้น ใครพูดอะไรบ้างในเหตุการณ์นั้น - ให้จดจ่อกับสามประเด็นดังนี้ 1) นี่เป็นเหตุการณ์ที่เป็นทุกข์ มันคือเรื่องปัจจุบัน ให้คิดคำพูดกับตนเอง เช่น มันเป็นเวลาที่ทุกข์จริง ๆ 2) ความทุกข์เป็นส่วนหนึ่งของชีวิต ให้คิดคำพูดกับตนเอง เช่น คิดแบบนี้ไปก็ไม่ปกติ	- ใบความรู้ที่ 7 - คลิปเสียงเมตตาตนเอง [169]

ระยะเวลา	กิจกรรม	อุปกรณ์/ สื่อ
	2. กิจกรรมเมตตาตนเอง (ต่อ) 3) ฉันจะดีกับตัวเองได้ไหมในตอนนี้ นำความรู้สึกที่ดีสู่ตัวเอง หาคำพูดดีดีมาปลอบโยนตนเอง เหมือนคำพูดที่เราอยากจะใช้ปลอบใจเพื่อนรักของเรา เช่น ฉันอยู่กับเธอตรงนี้นะ เธอจะดีขึ้นและคลายทุกข์ได้ 2.2 ฝึกปฏิบัติการเมตตาตนเอง	- ใบความรู้ที่ 7 - คลิปเสียงเมตตาตนเอง [169]
15 นาที	พักรับประทานอาหารว่าง	- ของว่าง
40 นาที	3. กิจกรรมใบไม้แห้ง [170] - กิจกรรมกลุ่มย่อย ให้สมาชิกจับคู่กัน โดยคนแรกเป็นใบไม้แห้ง ให้ห่อตัวให้แน่นที่สุดเท่าที่จะทำได้ และให้คู่ของตนเองพยายามคลี่ใบไม้ - ทำซ้ำอีกครั้ง โดยที่คนคลี่ใบไม้ต้องทำอย่างนุ่มนวลและใส่ใจต่อเพื่อนที่เป็นใบไม้แห้ง - แลกเปลี่ยนประสบการณ์ในการเป็นใบไม้และเป็นคนคลี่ใบไม้ ดังนี้ คิดว่าคนที่เป็นใบไม้รู้สึกอย่างไร คิดว่าจะทำอย่างไรกับใบไม้แห้งนั้น รู้สึกอย่างไรเมื่อถูกคลี่ในรอบแรก และรอบที่สอง ในชีวิตของเรา มีใครเป็นใบไม้แห้งบ้าง - ผู้นำกลุ่มพูดนำเข้าสู่การมีสติในเรื่องสัมพันธภาพและการสื่อสารที่ดีกับผู้อื่น	- ใบความรู้ที่ 8 - กระดาษแผ่นพลิก
30 นาที	4. อภิปรายสิ่งที่ได้เรียนรู้จากกิจกรรมครั้งนี้ 5. แลกเปลี่ยนความคิดเห็นในการนำกิจกรรมที่ได้เรียนรู้ตั้งแต่ครั้งที่ 1-4 ไปใช้ในชีวิตประจำวัน	- กระดาษแผ่นพลิก - ใบความรู้ที่ 9
15 นาที	6. การเคลื่อนไหวอย่างมีสติt	- วีดีโอการเคลื่อนไหวอย่างมีสติ 10 ท่า ของ สสส.
30 นาที	ติดตามผล	- แบบวัดสุขภาวะทางจิต - แบบวัดภาระการดูแลของ Zarit

ใบความรู้ที่ 7

เมตตาตนเอง [168, 169]

การเมตตาตนเองนั้น ไม่มีความแตกต่างกับการเมตตาผู้อื่น ทบทวนประสบการณ์และความรู้สึกของการเมตตา

- การเมตตาผู้อื่น เราต้องตระหนักว่าเขาอยู่ในความทุกข์ ถ้าเราไม่ใส่ใจคนเร่ร่อนบนถนน เราจะไม่รับรู้การเมตตาว่าแตกต่างกับสิ่งที่เขารู้สึกอย่างไร
- การเมตตาผู้อื่น เปรียบเสมือนการเข้าไปนั่งในความทุกข์ร่วมกับเขา รู้สึกร่วมกับเขา เมื่อเรารู้สึกเช่นนี้ เราจะเกิดความอบอุ่นในใจ ใส่ใจและอยากจะช่วยให้เขาพ้นทุกข์ การเมตตาหมายรวมถึงการที่เราเข้าใจและดีต่อผู้อื่นเมื่อเขาล้มเหลวหรือทำผิด มากกว่าที่จะไปตัดสินว่าเขานั้นร้ายกาจ
- เมื่อเรารู้สึกเมตตาผู้อื่น (ซึ่งไม่ใช่ความสงสาร) นั่นก็หมายความว่าเราได้ตระหนักถึงความทุกข์ ความล้มเหลว และความไม่สมบูรณ์แบบ ว่าเป็นส่วนหนึ่งของมนุษย์ที่ได้สัมผัสพบเจอร่วมกัน “ไม่ว่าอะไรจะเกิด ฉันก็จะอยู่ตรงนั้น”

เมตตาตนเอง Self-compassion ก็เหมือนการเมตตาผู้อื่น แต่เปลี่ยนเป้าหมายมาที่ตัวเราเมื่อเรามีช่วงเวลาที่ยากลำบาก ล้มเหลว หรือไม่สมหวังกับชีวิต แทนที่เราจะเพิกเฉยต่อความรู้สึกที่เกิดขึ้น แต่เราควรหยุดเพื่อบอกตัวเองว่า “ตอนนี้เรากำลังอยู่ในช่วงเวลาที่ยากลำบากใจ ฉันจะดูแลและทำให้ตัวเองดีขึ้นได้อย่างไร”

แทนที่จะมานั่งตำหนิตัวเอง การเมตตาตนเองเป็นวิธีการที่เราดีต่อตนเองและเข้าใจตนเองเมื่อพบเจอกับปัญหา และต่อจากนั้น เราก็สามารถพูดได้ว่า “ใครกันที่บอกว่าฉันสมบูรณ์แบบ”

เรากำลังเปลี่ยนวิธีการที่ทำให้เรามีความสุขและสบายกาย เพราะเราใส่ใจต่อตัวเรา ไม่ใช่ว่าเรามองว่าตัวเราไร้ค่าหรือไม่ยอมรับในตัวเราเอง การเมตตาตนเอง สิ่งสำคัญที่สุดคือการที่เราให้เกียรติและยอมรับตัวเราในฐานะที่เป็นมนุษย์คนหนึ่ง ทุกสิ่งในโลกนี้ไม่สามารถเป็นอย่างที่เราหวังไว้ ซึ่งนั่นทำให้เรารู้สึกผิดหวัง สูญเสีย ทำให้เราทำอะไรผิดพลาด และเป็นสิ่งขัดขวางความสำเร็จ คิดอะไรไม่ออก ความทุกข์เป็นเรื่องธรรมดาของมนุษย์ ทุกคนต้องเจอ ยิ่งเราเปิดใจรับความจริงแทนที่จะปฏิเสธ เราก็จะสามารถรู้สึกเมตตาต่อตัวเองและเพื่อนมนุษย์ทุกคนที่เกิดมาร่วมโลกเดียวกัน

ใบความรู้ที่ 8

สัมพันธภาพและการสื่อสารกับผู้อื่นทางบวก [170]

สัมพันธภาพทางบวก

ในทุกวัน เราสื่อสารและสร้างสัมพันธภาพกับทั้งสมาชิกในครอบครัวและผู้อื่น สัมพันธภาพที่ดีสามารถทำให้เรามีสุขภาวะทางจิตที่ดีและมีความสุข โดยส่วนใหญ่ ความเข้าใจผิดเป็นต้นตอของปัญหาการสื่อสาร ปัญหามักเกิดจากความไม่ใส่ใจต่อคนที่เราสื่อสารด้วย เพราะส่วนมากเราต้องการให้คนอื่นสนใจเรา มากกว่าที่เราจะให้ความสนใจคนอื่น

กิจกรรมใบไม้แห้ง เป็นการเปรียบเทียบให้เห็นถึงการที่คนบางคนที่มีความรู้สึกแย่ หรือมีความทุกข์ในใจและมีความเปราะบาง การห่อตัวเองให้แน่น เปรียบเหมือนการปกป้องตัวเอง ไม่อยากให้ใครเข้ามายุ่งเกี่ยว การคลี่ใบไม้ เปรียบเสมือน สัมพันธภาพทางบวก ซึ่ง เราต้องมีสติ อ่อนโยน และใส่ใจต่อผู้อื่น ความรักและความเมตตาต่อผู้อื่น เป็นดุจสะพานเชื่อมเพื่อก่อให้เกิดมิตรภาพ และสัมพันธภาพที่ดีต่อกัน

การสื่อสารทางบวก

คือ การสื่อสารด้วยสติ มีความรู้สึกในด้านดี และมีความสุข การสื่อสารทางบวก ก่อให้เกิดสันติ การแก้ปัญหา และลดความขัดแย้ง สร้างสัมพันธภาพทางบวก การสื่อสารทางบวก ประกอบด้วย 2 ส่วน คือ การฟังอย่างตั้งใจ และการใช้ถ้อยคำที่ดีต่อกัน

3. การฟังอย่างตั้งใจ คือ การฟังเรื่องของผู้อื่นด้วยความตั้งใจ ไม่วิจารณ์ ไม่อคติ
4. การใช้ถ้อยคำที่ดีต่อกัน คือ การใช้คำพูดที่เป็นทางบวก สร้างสรรค์ ซึ่งจะสร้างความรู้สึกมั่นใจ มีความหวังและความรู้สึกที่ดีต่อกัน

ใบความรู้ที่ 9

การฝึกแนวคิดทางบวก 7 ประการ [171]

1. **อารมณ์ดี** ช่วยให้เรามีความคิดที่กว้างไกล นำไปสู่สุขภาวะทางจิตที่ดี
2. **วิธีคิดต่อโลก** การพัฒนาวิธีคิดต่อโลก ในแนวทางที่มีความเจริญงอกงาม จะช่วยให้เราเรียนรู้สิ่งใหม่ๆ และพบแนวทางใหม่ๆ ที่ช่วยสร้างความสุขแก่ชีวิต
3. **สติ** การมีสติทำให้เราใช้ชีวิตอยู่กับปัจจุบัน
4. **ความยืดหยุ่นทางใจ** คือ ความสามารถในการสู้และปรับตัวกับสิ่งที่เข้ามาในชีวิตเราได้
5. **คิดบวก** ช่วยให้เราสามารถมองหาทางที่ดีที่สุดที่เป็นไปได้
6. **ความรู้สึกขอบคุณ** เป็นการระลึกถึงเรื่องดี ๆ ที่เข้ามาในชีวิต และทำให้เรารู้สึกถึงคุณค่าของชีวิต
7. **รู้จุดเด่นของตัวเอง** การที่ทำสิ่งใดด้วยความสามารถที่เป็นจุดเด่นของเรา เราจะมีความสุขที่ได้ทำ ทำสิ่งนั้นได้ดียิ่งขึ้น และรู้สึกว่าสิ่งที่ทำนั้นเป็นการพัฒนาคุณค่าในตัวของเรา

Appendix E: Inclusion and Exclusion Criteria

Inclusion and Exclusion Criteria

Inclusion

………. 1. family caregiver (who has the highest hours per week of caring for Schizophrenic patients)

☐ father ☐ mother ☐ brother/ sister ☐ husband ☐ wife
☐ daughter ☐ son ☐ son or daughter in law ☐ brother or sister in law

………. 2. age 18 years old or older

………. 3. can read and write in the Thai language

………. 4. who does not have any mental illness (as determined by the score from 2 Questions resulting in a Depression Screen score of zero) such as psychosis, schizophrenia, and so on.

☐ felling down, depressed or hopeless

☐ little interests or pleasure in doing things

……….. 5. who does not have any physical illness such as cancer, tuberculosis, and so on, with the exception of DM, HT.

………. 6 In the event there is more than one family member providing care in the family, the participant will be the one who devote the highest numbers of hours per week providing caring for the Schizophrenic patients.

………. 7 The Schizophrenic patients, under the care of the participant does not have any physical illnesses such as cancer, tuberculosis, and so on, with the exception of DM, HT.

………. 8. who agrees to participate in this study.

Exclusion

………. 1. has lived and care for more than one relative with a chronic mental or physical illness

………. 2. has cared for a Schizophrenic patient for less than 1 years

เกณฑ์คัดเข้าและเกณฑ์คัดออก

เกณฑ์คัดเข้า

.... 1. เป็นญาติที่ดูแลผู้ป่วยจิตเภท (มีจำนวนชั่วโมงที่ดูแลผู้ป่วยต่อสัปดาห์โดยประมาณมากที่สุด)

☐ พ่อ ☐ แม่ ☐ พี่ชาย/ น้องชาย/ พี่สาว/ น้องสาว ☐ สามี ☐ ภรรยา

☐ ลูกสาว ☐ ลูกชาย ☐ ลูกเขย /ลูกสะใภ้ ☐ พี่เขย/ น้องเขย/ พี่สะใภ้/ น้องสะใภ้

.... 2. อายุ 18 ปี ขึ้นไป

.... 3. อ่านและเขียนภาษาไทยได้

.... 4. ไม่เป็นโรคทางจิตเวช (ได้คะแนน 2 คำถามต่อไปนี้ เป็นศูนย์คะแนน) ได้แก่ โรคจิตเภท โรคจิต หรืออื่น ๆ

1) ในสองสัปดาห์ที่ผ่านมารวมวันนี้ ท่านรู้สึกหดหู่ เศร้า หรือท้อแท้ สิ้นหวัง หรือไม่ ☐ ใช่ = 1 ☐ ไม่ใช่ = 0

2) ในสองสัปดาห์ที่ผ่านมารวมวันนี้ ท่านรู้สึกเบื่อ ทำอะไรก็ไม่เพลิดเพลินหรือไม่ ☐ ใช่ = 1 ☐ ไม่ใช่ = 0

.... 5. ไม่มีโรคทางกาย ได้แก่ มะเร็ง วัณโรค หรืออื่น ๆ ยกเว้น เบาหวานและความดัน

.... 6. ในกรณีที่มีผู้ดูแลผู้ป่วยจิตเภทมากกว่า 1 คนในครอบครัว ผู้มีส่วนร่วมในการวิจัย คือ ผู้ที่มีจำนวนชั่วโมงการดูแลต่อสัปดาห์สูงสุดในครอบครัว

.... 7. ผู้ป่วยจิตเภทในความดูแลของผู้มีส่วนร่วมในการวิจัย ไม่มีโรคทางกาย ได้แก่ มะเร็ง วัณโรค หรืออื่น ๆ ยกเว้น เบาหวานและความดันาพร่างกายแข็งแรง หรือไม่มีโรคประจำตัวที่รบกวนการดำเนินชีวิตประจำวัน

.... 8. ยินยอมเข้าร่วมการวิจัย

เกณฑ์คัดออก

.... 1. ดูแลและอาศัยร่วมกับญาติที่ป่วยทางจิตหรือป่วยทางกายเรื้อรังมากกว่า 1 คน

.... 2. ระยะเวลาในการดูแลผู้ป่วยจิตเภทน้อยกว่า 1 ปี

Appendix F: Professional Name List

Professional Name List

Translators and reviewer for the face validity of Psychological Well-being Scale

1. Assoc. Prof. Dr. Pornjira Pariwatcharakul
    - Psychiatrist, and Lecture at Department of Psychiatry, Faculty of Medicine Siriraj Hospital, Mahidol University
    - MSc in Clinical Neuroscience (Distinction), Institute of Psychiatry, King's College London, UK
    - Research Fellowship in Neuropsychiatry, South London and Maudsley NHS Foundation Trust, UK
    - Clinical Observership, Movement Disorders Clinic, King's College Hospital, London, UK
2. Miss Prapatsorn Leerat
    - Freelance Translator
    - Bachelors' Degree majoring in English Language, minoring Psychology with Second Class Honours, Thammasat University Faculty of Liberal Arts

Doing a content validity of the Enhanced Psychological Well-Being Intervention

1. Dr.Dutsadee Jungsirakulwit
    - Child and Adolescent Psychiatrist; Expert Level, and being a Director of Rajanakarindra Institute of Child Development.
    - MSc in Global Mental Health (Distinction), Institute of Psychiatry, King's College London, UK
2. Mr.Wee Mekwilai
    - Clinical Psychologist; Professional Level, Division of Mental Health Technology, Department of Mental Health.
    - BA. Psychology, Thammasart University
    - MSc. Applied Positive Psychology
3. Miss Praneat Chumputsa
    - Psychiatric Nurse, Head of Mental Health Community Division, Nakornratchasima Rajanakarindra Psychiatric Hospital
    - BSc. Nurse, Nakornratchasima Nurse College
    - MSc. Psychiatric Nurse, Kornkan University

Appendix G: Abbreviation List

Abbreviation List

BAS = Burden Assessment Scale

CarerQoL = Carer Quality of Life Instrument

CBI = Caregiver Burden Inventory

CBT = Cognitive Behavior Therapy

CES-D = Center for Epidemiologic Studies Depression Scale

DALYs = Disability-adjusted life years

ECI = Experience of Caregiving Inventory

FBIS = Family Burden Interview Schedule

FBS = Family Burden Scale

FFFS = Feetham Family Functioning Scale

GHQ-12 = General Health Questionnaire

HAD = The Hospital Anxiety Depression Scale

HPH = The health promotion hospital

ICD-10 = The International Classified Listing of Diseases

IEQ = Involvement Evaluation Questionnaire

mhGAP = The Mental Health Gap Action Program

NRPH = Nakornratchasima Rajanakarindra Psychiatric Hospital

PANAS = Positive and Negative Affect Schedule

PFBS = Perceived Family Burden Scale

PHQ-9 = Patient Health Questionnaire

PIP = Psychoeducational Intervention Program

PWS = Persons With Schizophrenia

PWBS = Psychological Well-Being Scale

QoL = Quality of Life

SBAS = Social Behavior Assessment Schedule

SCQ = The Schizophrenia Caregiver Questionnaire

SHS = The Subjective Happiness Scale

SWLS = Satisfaction with Life Scale (),

TTM = The Transtheoretical Model

WBT = Well-Being Therapy

WEMWBS = Warwick-Edinburgh Mental Well-being Scale

YLD = Years Lived with Disability

YLLs = Years Lost to premature mortality

ZBI = Zarit Burden Interview

VITA

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