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Empowerment Program on Empowerment Perception and Caring Activities in Caregiver of Psychiatric patients

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ABSTRACT: This study was quasi-experimental research employing a two-group pretest-posttest design with a one-month follow-up. The objective was to examine the effects of an empowerment enhancement program on perceived empowerment and care giving practices among caregivers of psychiatric patients. The sample consisted of 44 caregivers of psychiatric patients, selected through purposive sampling based on specific inclusion criteria. The intervention tools included an empowerment enhancement program composed of two parts: (1) an empowerment enhancement plan for caregivers of psychiatric patients and (2) a caregiver home care manual. Data collection instruments included a perceived empowerment interview form and a psychiatric patient care practices interview form, both of which were validated for content validity and tested for reliability. The instruments demonstrated a high level of internal consistency, with a Cronbach's Alpha coefficient of 0.9. The results revealed that caregivers in the experimental group had significantly higher mean scores of perceived empowerments immediately after the intervention (95.20%) and at the one-month follow-up (96.00%) compared to those in the control group (70.20%) and to their own pre-intervention scores, with statistical significance at the .05 level. Moreover, there was no significant difference between the mean perceived empowerment scores after the intervention and at the follow-up within the experimental group. Additionally, the caregivers in the experimental group showed significantly higher mean scores in care giving practices than those in the control group and compared to their own pre-intervention scores, with statistical significance at the .05 level. There was no significant difference in care giving practice scores Pre-Experimental, Post-experimental and follow-up in the experimental group.

1. INTRODUCTION

Psychiatric patients are individuals with impairments in emotion and cognition, leading to limitations in fulfilling responsibilities and difficulties in daily life adaptation. These patients often struggle to find value or meaning in life, living in a purposeless manner, escaping from reality, and responding to others in an unpredictable way[1]. Patients frequently experience episodic relapses alternating with periods of remission. After each relapse, the patient's functional abilities may not return to their original state. As a result, the responsibility for care often falls upon the caregivers, who must assume the role of continuing care from mental health professionals[2]. This situation significantly impacts caregivers, who often feel fearful of the patient's unpredictable and severe psychiatric symptoms[3]. Most caregivers are family members who must not only manage their own daily routines and those of their families but also take care of the patient with schizophrenia. Consequently, caregivers often report feelings of pressure, distress, and hardship, all stemming from the burden of caregiving[4]. The caregiving burden can be categorized into two types: Objective burden – perceived changes in five aspects of daily life, including reduced personal time, decreased independence, reduced social participation, changes in work responsibilities, and health-related problems. Subjective burden – emotional responses to these changes, which cause distress and a sense of heavy responsibility, affecting caregivers' physical, psychological, emotional, social, and economic well-being[5].

These impacts may lead to a decline in caregivers' self-care and caregiving abilities. Since the care provided by family members directly influences the course of illness in schizophrenic patients, inadequate caregiver knowledge and skills can result in inappropriate or inconsistent treatment, increasing the likelihood of relapse and re-hospitalization. Empowerment, as conceptualized by Gibson[6], is a dynamic process involving reception, exchange, and interaction. It emphasizes setting shared goals, fostering learning and awareness, and strengthening individuals through problem-solving. Key components for successful empowerment, particularly in the elderly, include health education, the process of problem recognition, participation in decision-making, and social support. As a result, empowerment leads to improved knowledge, attitudes, self-efficacy, and health behaviors among the elderly.

2. METHODS

2.1 Design

This research was designed as a two - groups repeated measure experimental research and aimed to examine the effects of empowerment program on power perception and caregiving practice among family caregivers in psychiatric patients.

2.1.1 Participants and sampling

Participants: The participants consisted of 120 caregivers of psychiatric patients who were closely related to the patients receiving inpatient treatment at Ban Kra Sang Sub-district Health Promoting Hospital.

Sample: The sample comprised 44 caregivers of psychiatric patients who were closely related to the patients receiving outpatient treatment at Ban Kra Sang Sub-district Health Promoting Hospital. The participants were purposively selected based on specific inclusion criteria, and then randomly assigned into two groups: 22 in the experimental group and 22 in the control group.

2.1.2 Instrument

1) The intervention tool was the Empowerment Enhancement Program,

developed by applying the Empowerment Concept (5), and implemented in a structured manner. The program consisted of two components: (1) an Empowerment Enhancement Plan for caregivers of schizophrenia patients, and (2) a Home Care Manual for caregivers of schizophrenia patients, as detailed below.

2) Empowerment Enhancement Plan for Caregivers of psychiatric

patients: The researcher adapted this plan from an empowerment enhancement plan originally developed for caregivers of patients with chronic illnesses (6). The plan includes detailed components such as goals, objectives, activities based on the empowerment process, and theoretical rationale. It also specifies the implementation setting, duration, supporting materials and equipment, as well as the evaluation methods. The total duration of program implementation was four weeks.

3) Home Care Manual for Caregivers of psychiatric patients: This

manual was developed by the researcher through a review of relevant textbooks, academic documents, and related research studies. It includes detailed content on the definition of psychiatric patients., severity levels, symptoms and manifestations, treatment approaches, and guidelines for managing abnormal behaviors.

2.2 Data Collection Instruments

2.2.1 Interview Form on Perceived Empowerment of Caregivers of

psychiatric patients: This instrument was adapted by the researcher from the perceived empowerment scale (6), based on the Empowerment Concept (5). It consists of 40 closed-ended questions assessing the caregiver's confidence in their ability to manage patient care and self-care across physical, psychological, emotional, and social dimensions. The form employs a rating scale to assess the level of perceived empowerment, with five response levels: 5 = Very High, 4 = High, 3 = Moderate, 2 = Low, and 1 = Very Low.

2.2.2 Interview Form on Caregiving Practices for psychiatric

patients: This instrument was developed by the researcher based on a review of relevant research. It covers essential aspects of caregiving for psychiatric patients in physical, psychological, social, and spiritual dimensions. The assessment was conducted through interviews with caregivers regarding the activities they performed for the patients. The instrument consists of 40 closed-ended questions and utilizes a Likert scale to rate each caregiving activity. The scale includes four levels: 3 = Regularly, 2 = Often, 1 = Occasionally, and 0 = Never.

2.3 Instrument Quality Validation

2.3.1 Content validity was assessed by three experts: one nursing professor with experience in psychiatric nursing and two nurses with experience in caring for schizophrenia patients. They evaluated the accuracy of the content, its comprehensiveness, alignment with the objectives, the appropriateness and correctness of the language, the format, the suitability of the activities, as well as the logical sequence of content and activities, and the appropriateness of the time allocated for each activity. Based on their feedback, the researcher made revisions and improvements and subsequently re-validated the accuracy of the content

2.3.2 A try-out was conducted with 30 caregivers of psychiatric patients who had similar characteristics to the target sample. The Cronbach's Alpha coefficient was then calculated, yielding a value of 0.9.

2.4 Data analysis

2.4.1 Personal Data of Caregivers and psychiatric patients. The personal data of caregivers and psychiatric patients were analyzed using frequency distribution and percentages.

2.4.2 Perceived Empowerment and Caregiving Practices Scores. The scores for perceived empowerment and caregiving practices before the intervention, immediately after the intervention, and one month after the intervention in both the experimental and control groups were calculated using mean and standard deviation.

2.4.3 Comparison of Mean Scores for Perceived Empowerment and Caregiving Practices.

The mean scores for perceived empowerment and caregiving practices before the intervention, immediately after the intervention, and one month after the intervention were compared between the experimental and control groups. This comparison was conducted using a two-way analysis of variance with repeated measures (Two-way ANOVA with Repeated Measures), with one between-subjects variable and one within-subjects variable.

2.4.4 Testing using Multiple Comparisons. Pairwise testing was performed using multiple comparisons, employing the Newman-Kaul's method.

3. RESULTS

In the experimental group, consisting of 22 caregivers, the majority were female (59.0%). Most caregivers were aged between 60-65 years (54.5%) and had a marital status of being married (63.6%). The highest level of education was at the high school level (45.4%), and the average family income per month ranged from 15,001 to 20,000 Baht (31.8%). Over half of the caregivers reported that their income was insufficient to cover their expenses (54.5%). The majority of caregivers had been providing care for less than 1 year (54.5%) and spent the entire day (24 hours) caring for the patient. Most caregivers (86.3%) had no pre-experience in caregivers of psychiatric patients. The majority had a spouse (77.2%) as their relationship with the patient. None of the caregivers had any assistance in patient care. Regarding health status, 68.1% of caregivers had chronic illnesses, while 90.9% had sources of support.

Table 1. Demographic Characteristics of Participants (N=44)

Personal Information	**Experimental (*n* = 22)**		**Control (*n* = 22)**	
	N	**%**	**N**	**%**
Gender				
Male	9	40.9	9	40.9

Female	13	59	13	59
Age (years)				
20 – 59	10	45.4	11	50
60 - 65	12	54.5	11	50
Marital Status				
Single	3	13.6	2	13.6
Married	14	63.6	14	63.6
Widowed	3	13.6	3	13.6
Divorce	2	9.1	3	13.6
Education Leve				
Non-Education	2	9	2	9
Primary school	4	18.1	7	31.8
Secondary school	10	45.4	11	50
Diploma	5	22.7	2	9
Bachelor's Degree	1	4.5	0	0
Length of patient care				
< 1 year	12	54.5	12	54.5
1-3 year	5	22.7	5	22.7
4-6 year	3	13.6	3	13.6
6 year >	2	6.1	2	6.1
Length of patient care				
12 hr./day	0	0	0	0
24 hr./day	22	100	22	100
Caregiving Experience				
Non	19	86.3	19	86.36
yes	3	13.6	3	13.6
Relationship with the Patient				
Spouse	17	77.2	17	77.2
Child	4	18.1	5	22.7
Other Relatives	1	4.5	0	0

The mean scores for perceived empowerment among caregivers of psychiatric patients in the experimental group were 94.0 (sd = 7.3) in the pre-experimental phase, 135.2 (sd = 6.4) during the intervention, and 134.2 (sd = 6.5) in the post-experimental phase. In comparison, the control group reported mean scores of 95.5 (sd = 7.8), 94.0 (sd = 6.4), and 91.8 (sd = 4.3) during the same respective phases. These findings suggest a marked improvement in perceived empowerment following the intervention in the experimental group, while the control group showed a slight decline over time. (table 2).

Table 2. Comparison of Baseline Characteristics of Caregivers in the Experimental and Control Groups

group	Phase	$\bar{x}$	*SD*
experimental	Pre exp.	94.0	7.3
(n = 22)	Post exp.	135.2	6.4
	Follow up	134.2	6.5
Control	Pre exp.	95.5	7.8
(n = 22)	Post exp.	94.0	6.4
	Follow up	91.8	4.3

In the experimental group, the mean score for caregiving practices after the intervention was significantly higher than the pre-experimental score at the 0.05 level. Similarly, the mean score during the follow-up period was also significantly higher than the pre-experimental score at the 0.05 level. However, there was no significant difference between the mean scores obtained after the intervention and during the follow-up phase (Table 3).

Table 3. Comparison of Mean Scores for Caregiving Practices in the Experimental Group at Pre-Intervention, Immediately Post-Intervention, and Follow-Up Phases Using the Neuman-Keuls Multiple Comparison Test (Neuman-Kuels)

Mean	**Pre test** **73.0**	**Post test** **96.0**	**Follow up** **95.2**
73	-	23.0*	23.2*
96		-	0.2*
95.2			-
r		2	3
q.94(r,12)		3.0	3.7
SQR(MSerror/n) q.94(r,12)		3.2	3.9

*p<0.05

In the control group, the mean score for caregiving practices post-experimental was significantly lower than the pre-experimental score at the 0.05 level. Similarly, the mean score for caregiving practices during the follow-up period was significantly lower than the pre-experimental score at the 0.05 level. However, there was no significant difference between the mean scores post-experimental and the follow-up phase (Table 4).

Table 4. Comparison of Mean Scores on Caregiving Practices in the Control Group: Pretest, Posttest, and Follow-up Using Newman–Keuls

Mean	**Pre test** **74.1**	**Post test** **70.2**	**Follow up** **71.8**
74.1	-	3.8*	2.2*
70.2		-	1.5*
71.8			-
r		2	3
q.94 (r,12)		3.0	3.7
SQR (MSerror/n) q.94 (r,12)		2.4	2.9

*p<0.05

4. DISCUSSION

The comparison of empowerment perception and caregiving practices pre and post the intervention program revealed that the experimental group had significantly higher mean scores post-experimental and at follow-up compared to the control group, and also significantly higher than their own pre-experimental scores ($p < 0.05$). These findings are consistent with the study by Sirirat Khumsin [7,8,9]), which found that caregivers exhibited improved empowerment perception and quality of life after participating in an empowerment program compared to the control group and their pre-experimental phase. Female caregivers are generally considered more suitable due to their gentle nature and attentiveness, making them well-suited for the caregiving role[10]. In contrast, male caregivers tend to assume supportive roles, primarily focusing on tasks related to management and logistics, such as accompanying patients to medical appointments, providing financial support, or arranging necessary supplies and facilities, rather than direct caregiving activities like household chores or personal hygiene assistance (e.g., bathing and dressing)[11],[12]. According to prior research, the two primary caregivers are often the spouse and the children, respectively [13] The caregiving period was 24 hours per day, accounting for 100 percent, indicating that the patients were in a state of high dependency. This high level of dependency resulted from physical and psychological changes, pain, suffering from treatment, and the constantly progressing pathology of the illness. Consequently, patients experienced a decline in their ability to carry out daily activities independently and increasingly required assistance from their caregivers [14].A comparison of empowerment perception and caregiving activities between the experimental group, who received the program, and the control group, who received standard nursing care, revealed that the experimental group had a significantly higher mean score of empowerment perception than the control group at the .05 significance level, based on the concept of Gibson[5] that empowerment is primarily an individual process of self-development by using knowledge, skills, and confidence. Building a trusting and empathetic relationship is a fundamental element for successful mental health treatment, as it promotes open communication, collaborative problem-solving, and self-reflection. These processes contribute to improving the quality of life and enhancing the self-esteem of individuals with schizophrenia. Moreover, they foster a sense of pride and responsibility among family caregivers, enabling them to develop more effective approaches to caring for relatives with mental illness[15]. The process of empowering caregivers begins with discussing the challenges of providing long-term care for patients with unstable symptoms. Together, they consider the problems and seek solutions collaboratively, weighing the advantages and disadvantages. The caregiver then makes the decision, which fosters a genuine sense of responsibility for the chosen course of action and leads to actual implementation **(**Sense of Personal Control**)[16].** This approach is adapted to the context of each family. For example, if the patient is reluctant to take medication, the caregiver may use negotiation strategies, such as promising a treat if the medication is taken. In some families, caregivers may give the patient desired items, such as accessories, clothing, or lipstick **(**Self-Determination)[17]. After addressing the problems, discussions with the research team are conducted regarding the issues. Positive reinforcement is provided to the caregivers periodically, enabling them to recognize their own abilities to effectively manage various problems[18]. At the end of the experiment, a meeting was held for the caregivers in the experimental group to share experiences and encourage one another. This served as a form of empowerment to help sustain effective actions[19]. This also includes self-care to maintain balance, such as daily living activities, strengthening the body, and relaxing the mind. Some caregivers reported assigning tasks to the patients with mental illness, such as sweeping the house, hanging clothes to dry, washing dishes, and folding clothes. In addition, they engaged in conversations with neighbors to exchange information about social and community matters[20]. Comprehensive care covers all dimensions of health in a holistic manner, allowing caregivers to develop skills, understand problems, and be able to appropriately plan for managing issues[21.] Monitoring and providing counseling, guidance, and information, as well as being a supporter in certain activities that require knowledge and caregiving skills, are conducted alongside the caregiver manual for schizophrenia patients[22]. Allowing caregivers to participate in the process of analyzing and finding solutions at every step, and empowering them to make decisions about the appropriate caregiving methods, results in caregivers perceiving a sense of empowerment when they perform the activities they have chosen, leading to increased effectiveness[23,24] Stimulating the maintenance of problem-solving behaviors by providing positive reinforcement through praise and encouragement helps caregivers feel more confident in their abilities to manage and control various situations. This leads to an increase in their sense of empowerment after the intervention and the persistence of this sense of empowerment during the follow-up phase[25].

5. CONCLUSION

Empowerment and perception of power and the performance of care activities by caregiver's terminal Psychiatric patients It is a process that helps strengthen the abilities and develop the potential of caregivers of Psychiatric patients.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

ETHICS STATEMENT

This research was approved by the Human Research Ethics Committee of the Buriram Provincial Public Health Office, approval number MTH 2025-48. The researcher explained to the participants that their participation in this study was voluntary, and they could choose to participate or not. Declining participation would not affect the treatment they had previously received. The research results will be presented in aggregate form and used solely for academic and research purposes.

DATA AVAILABILITY STATEMENT

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Data supporting the findings of this study are available from the corresponding author upon reasonable request.

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