Effectiveness of Family Therapy Based on the Satir Model in Family of Patients with Schizophrenia

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Objective: *To compare the effectiveness of family therapy based on the Satir model vs. family psychoeducation on family function, self-esteem, and depressive symptoms in family members (including the patient), and the social functioning and severity of symptoms in patients with schizophrenia.*

Material and Method: *A randomized control trial was conducted. The authors recruited 13 families to a family therapy group and 11 to psychoeducation group. Each group received six sessions of intervention. The effectiveness of the interventions was assessed using the Chulalongkorn Family Inventory, the Clinical Global Impression Severity Scale (CGI-S), the Personal and Social Performance Scale-Thai version, the Self-esteem visual analog scale (SVAS), the Rosenberg Self Esteem Scale-Thai version (RSES-T), and the KKU-Depression Inventory. The effectiveness of each intervention was measured four times: a) baseline, b) one month after the fourth session (the third month), c) one month after the last session (the fifth month), and d) one year after the last session (the sixteenth month).*

Results: *Both interventions helped to improve the perception of family functioning, self-esteem, and depressive symptoms among family members, and decreased the severity of symptoms and improved social functioning in patients with schizophrenia. The family therapy group had more significant results on the improvements of the SVAS, the RSES-T, and the CGI-S score.*

Conclusion: *Both interventions produced positive results in almost all of the follow-up measurements, but the family therapy group had more significant results, particularly with respect to self-esteem scores.*

Keywords: *Satir, Family therapy, Family function, Depression, Schizophrenia, Self-esteem*

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Schizophrenia is a major psychiatric problem in Thailand[1,2]. Patient behavior and the emotional impact on caregivers impinge family relationships, social life, and the personal life of both patients and the family members[3]. Both patients and family experience negative feelings, perceptions, and have many unmet expectations and yearnings. Family relationships are disturbed, due to conflict, distancing, and/or enmeshment[4]. Family functioning is worse than the average, especially general functioning, affective involvement, and affective responsiveness[5,6]. Caregivers report constraints in social activities, negative effects on family life, the feeling of loss, and high subjective burden[7].

Most family interventions in control trials are behavioral, cognitive, psychoeducational, or supportive. Compared with standard care, the family intervention may help to decrease the relapse, reduce hospital admission, encourage compliance with medication, and seems to improve general social impairment and the levels of expressed emotion within the family[8-10]. In 60% of the trials reviewed by Lobban et al, the relatives of patients with psychosis also benefitted from family interventions in at least one outcome category (i.e., emotional response and family functioning)[10]. A few trials employing the other schools of family therapy showed good outcomes on pharmacological compliance and outcomes of symptoms and social improvements of the patients[11,12].

The Satir model operates on the assumption that changes are possible, at least internally, and the focus is mainly on changes to personal experience that people can change their coping, feelings, perceptions, and expectations, fulfilling their yearnings and connecting with their life energy[13]. In Thailand, research has been done using counseling based on the Satir model in five families of patients with schizophrenia. Most of the family members perceived an improvement in self-esteem and family functioning[4,6]. The present study was a randomized controlled trial and aimed to measure the effectiveness of the Satir

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model family therapy on patient family functioning and other key aspects compared with families in a psychoeducation group.

Material and Method

The research proposal was approved by the Khon Kaen University Ethics Committee for Human Research (HE501128). The samples included families of patients with schizophrenia being treated at Srinagarind Hospital, Khon Kaen University, between June 2008 and July 2010, whose symptoms were not active and lived with first degree relative at the time of recruitment, and agreed to participate in the therapy. The authors planned to include 15 families to be treated with family therapy (based on the Satir model) and 15 to be the control group treated with group psychoeducation. The study including intervention was conducted between June 2008 and November 2011. The samples were randomized into the family therapy and psychoeducation control groups. In the family therapy group, the families underwent six sessions of family therapy based on the Satir model while in the psychoeducation group, the families received six sessions of group psychoeducation at the first, third, fifth, ninth, thirteenth, and seventeenth week.

The authors tried to get all of the members in the family to participate but it was not always possible. The family sessions were conducted by a therapist (psychiatrist) trained in the Satir model. The psychoeducation sessions were conducted by a psychiatric nurse. The authors assessed the perception of family members and patients regarding to their family functioning using a self-rating scale (i.e., the Chulalongkorn Family Inventory [CFI]). The perception of family members and patients vis-à-vis depression and self-esteem were assessed using self-rating scales: viz., the Khon Kaen University Depression Inventory (KKU-DI), the Rosenberg Self-Esteem Scale-Thai version (RSES-T), and the Self-Esteem Visual Analog Scale (SVAS). The severity of symptoms of patients was assessed by a psychiatrist using the Clinical Global Impression Severity scale (CGI-S). The social functioning and performance of patients were assessed by a psychiatric nurse using the Personal and Social Performance Scale, Thai version (PSP-T).

The CFI is a 36-item questionnaire adapted from the Family Assessment Device with a Cronbach's Alpha between each item of 0.88[14]. The PSP-T has an interclass correlation for the total score of 0.75[15]. The Cronbach's Alpha for the RSES-T is 0.849 and the Pearson's correlation between it and the SVAS is 0.618[16]. The authors used two measurements of self-self-esteem to measure self-esteem in general by visual analog scale and itemized dimension of self-esteem by RSES-T. The effectiveness of interventions has been measured using questionnaires at: a) baseline, b) the third month (one month after the fourth session), c) the fifth month (one month after the last session), and d) the sixteenth month (one year after the last session).

The family therapy group received six sessions of family therapy based on the Satir Model. The intervention included working with internal experiences and the interactive parts from each member, using the personal iceberg metaphor. The authors thereby: a) explored the impact of the illness on individuals, b) drew a family map, c) sculpted impacts, d) resolved unmet expectations and unfinished business, e) connected individuals to their internal resources in order to fulfill their yearnings, and f) de-enmeshed relationships and enhanced congruent communications. The therapist used herself to make the sessions: a) experiential, b) systemic, c) change focused, and d) positive directional. The psychoeducation group received six such sessions; including getting information about: a) the goals of the treatment, b) symptomology, c) compliance and adherence to treatment, d) side-effects of medications, e) self-care, f) daily life management, g) stress and crises management, and h) relapse prevention.

Statistical analysis

The sample sized were calculated by

$$n = [(Z_{1-\alpha/2} + Z_{1-\beta})^2 (\sigma^2)] / (\mu_1 - \mu_2)^2$$

(where $\alpha = 0.05$, $\beta = 0.9$, σ = standard deviation of CFI scores of patients with schizophrenia (13.87)[5], $\mu_1 - \mu_2$ = desired mean (17), n = 7 in each group). The results were analyzed by SPSS version 16.0. Continuous data were analyzed using means and standard deviations (SD). Comparisons between two groups were performed using longitudinal data analysis with generalized estimating equation module.

Results

The authors included 24 families in our study, but one family dropped out of the family therapy group due to physical illness of one family member. There were 15 male and 9 female patients. Most of the patients were single with average age of 25±6.35 years old. The level of education ranged from primary school to Master degree. There were 13 patients in the family therapy group and 11 in the psychoeducation group. Most of the relatives were married with average age

of 53.65±6.35 years old. There were 22 mothers, nine fathers, one sister, and two other relatives of the patients. The religious affiliation of all participants was Thai Buddhism. Most participants had a primary school education and were married. Table 1 presents demographic information, including age, education, marital status, occupation, income, and average number of admissions. There were no statistical differences in demographic data between groups except in gender and income of the patients. The baseline scores were shown in Table 2. Two families dropped out of the family therapy group after the first and second session (respectively) because the fathers did not want to continue the therapy. Data were missing in the family therapy group: a) on the last two measurements for two families, and b) on the last measurement for one family. One patient in each group had an admission during the therapy but there were no admissions during the follow-up in either groups.

Difference between the family therapy and psycho-education groups

No statistical differences were identified between two groups in the baseline scores of: a) family functioning, b) severity of symptoms and psychosocial performance of patients, and c) self-esteem and depressive symptoms of family members (Table 2). No statistical differences in both groups regarding change of mean scores of: a) family functioning, b) depressive symptoms of family members, and c) social performance of the patients in the third, fifth, and sixteenth month (i.e., a respective one month after the fourth session, one month after last session, and one year after the last session). The severity of

Table 1. Demographic data of patients with schizophrenia and family members

Group	Patients			Family members		
	Family therapy (n = 13)	Psychoeducation (n = 11)	*p*-value	Family therapy (n = 19)	Psychoeducation (n = 15)	*p*-value
Sex			0.07[a]			0.53[a]
Male	6 (46.15%)	9 (81.82%)		7 (36.84%)	4 (26.67%)	
Female	7 (53.85%)	2 (18.18%)		12 (63.16%)	11 (73.33%)	
Marital status			0.27[a]			0.38[a]
Single	13 (100%)	10 (90.91%)		0	0	
Married	0	0		16 (84.21%)	10 (66.67%)	
Widow	0	0		2 (10.53%)	2 (13.33%)	
Divorced	0	1 (9.09%)		1 (5.26%)	3 (20.00%)	
Occupation			0.32[a]			0.51[a]
Unemployeded	9 (69.23%)	5 (45.45%)		0	0	
Agriculture	1 (7.69%)	2 (18.18%)		7 (36.84%)	6 (40.00%)	
Merchant	0	2 (18.18%)		3 (15.79%)	4 (26.67%)	
Worker	3 (23.08%)	2 (18.18%)		1 (5.26%)	2 (13.33%)	
Housewife	0	0		4 (21.05%)	3 (20.00%)	
Civil service	0	0		4 (21.05%)	0	
Years of education, median (range)	12 (6 to 18)	12 (6 to 14)		6 (6 to 16)	6 (6 to 16)	
Average admission, median (range)	1 (0 to 4)	1 (0 to 4)		-	-	
Average income (Bath/month), median (range)	0 (0 to 2,000)	0 (0 to 7,000)		4,500 (0 to 28,000)	3,000 (300 to 15,000)	

[a] Pearson Chi-square

Table 2. Baseline scores of patients with schizophrenia and family members in family therapy and psychoeducation groups

	Mean of baseline scores* (mean ± SD)		*p*-value
	Family therapy	Psychoeducation	
Chulalongkorn Family Inventory	105.13±10.48	109.20±14.31	0.23
Rosenberg Self Esteem Scale-Thai version	19.27±3.57	19.12±3.62	0.88
Self-Esteem Visual Analog Scale	7.90±3.48	8.74±2.61	0.32
Khon Kaen University Depression Inventory	21.72±15.89	22.04±16.14	0.94
Clinical Global Impression Severity scale	3.15±1.07	2.82±1.17	0.47
Personal and Social Performance Scale, Thai version	64.62±8.46	64.82±7.56	0.95

symptoms scores of the patients (CGI) in the family therapy group were significantly decreased over the control group at the sixteenth month (p-value = 0.031). In the third month, self-esteem of the family therapy group (as measured by SVAS scores) were significantly increased over the control group (p-value = 0.02). There was no statistically significant difference in the scores of other follow-up measurements in either group (Table 3).

Effects on family functioning

All family members, the patients and the relatives in the family therapy group perceived an improvement in family functioning, as measured by CFI, in all follow-up measurements, albeit the improvements were not statistically significant (Table 4, 5).

Effects on symptoms and social performance of patients

The severity of symptoms among patients in the family therapy group, as measured by CGI-S scores, were decreased, albeit not statistically significant, at the third month. There was a significant decrease, however, at the fifth (p-value = 0.04) and the sixteenth (p-value = 0.049) month while the severity of symptoms in the psychoeducation group were increasing, albeit albeit not statistically significant, compared to baseline. The respective personal and social performance of patients, as measured by PSP-T in both groups, was better in all follow-up measurements. The improvements reached statistical significance in the sixteenth month (p-value = 0.02) in the family therapy group and in the fifth month (p-value = 0.02) in psychoeducation group (Table 5).

Table 3. Differences in scores at each measurement compared with baseline between family therapy and psychoeducation groups

	t-test for equality of means*								
	At 3rd month			At 5th month			At 16th month		
	Mean difference	SE difference	p-value	Mean difference	SE difference	p-value	Mean difference	SE difference	p-value
CFI	3.98	3.38	0.24	1.21	3.65	0.74	-4.27	4.30	0.32
CGI	-0.18	0.40	0.66	-0.97	0.59	0.12	1.43	0.61	0.03
PSP	-2.71	6.69	0.69	-5.52	5.10	0.37	-8.75	7.50	0.26
RSES-T	1.53	1.07	0.15	-0.31	1.41	0.83	-0.47	1.24	0.71
SVAS	1.51	0.62	0.02	1.00	0.85	0.25	-0.38	0.77	0.62
KKU-DI	-1.44	4.20	0.73	0.04	4.22	0.99	1.02	4.34	0.82

CFI = Chulalongkorn Family Inventory; CGI = Clinical Global Impression Severity scale; PSP = Personal and Social Performance Scale, Thai version; RSES-T = Rosenberg Self Esteem Scale-Thai version; SVAS = Self-Esteem Visual Analog Scale; KKU-DI = Khon Kaen University Depression Inventory at the 3rd, 5th, and 16th month

* Independent sample t-test

Table 4. Changes in scores from the baseline at each measurements of all family members compared within group

	Group	Difference from baseline*								
		At 3rd month			At 5th month			At 16th month		
		Mean	SD	p-value	Mean	SD	p-value	Mean	SD	p-value
CFI	Family therapy	-2.74	12.25	0.30	-3.47	11.51	0.23	-2.39	15.81	0.53
	Psychoeducation	1.24	11.13	0.58	-2.26	11.32	0.35	-1.88	12.37	0.46
RSES-T	Family therapy	-1.91	3.83	0.03	-1.35	3.74	0.16	-0.78	4.01	0.42
	Psychoeducation	-0.38	3.63	0.59	-1.67	4.86	0.11	-0.31	4.07	0.70
SVAS	Family therapy	-1.93	2.31	0.00	-1.37	2.15	0.02	-1.10	2.57	0.09
	Psychoeducation	-0.42	2.06	0.31	-0.37	3.02	0.55	-0.72	2.42	0.15
KKU-DI	Family therapy	5.09	16.65	0.17	4.82	11.15	0.09	2.82	11.43	0.32
	Psychoeducation	3.65	12.39	0.15	4.86	14.75	0.11	1.81	15.30	0.55

CFI = Chulalongkorn Family Inventory; RSES-T = Rosenberg Self Esteem Scale-Thai version; SVAS = Self-Esteem Visual Analog Scale; KKU-DI = Khon Kaen University Depression Inventory

* Independent sample t-test

Effects on self-esteem

The authors found that self-esteem in the family therapy group, as measured by SVAS, had significantly increased at the third and fifth months but was not statistically significant at the sixteenth month (p-value = 0.001, 0.02, and 0.09, respectively), and the self-esteem, as as measured by RSES-T, was significantly increased at the third month (p-value = 0.03) and increased without statistical significance at the fifth and sixteenth months. By comparison, self-esteem in the psychoeducation group was increased without statistical significance (Table 4). Self-esteem among schizophrenia patients in the family therapy group, as measured by SVAS, in all follow-up measurements was significantly increased, but the RSES-T scores were increased without statistical significance (Table 5). In the psychoeducation group, the SVAS scores of the patients changed inconsistently, while the RSES-T scores increased in each follow-up measurement, albeit without statistical significance (Table 5). Self-esteem among relatives in the family therapy group, as measured by SVAS, increased in each follow-up measurement, albeit without statistical significance, while the RSES-T scores increased in each follow-up measurement and reached statistical significance at the third month, although self-esteem among relatives in the psychoeducation group had increased without statistical significance (Table 5).

Effects on depression

The depressive symptoms measured by KKU-DI were non-significantly decreased in every follow-up measurement in both groups, except in the patients in the psychoeducation group, for which the score for the last measurement was higher than the baseline (Table 4, 5).

Discussion

Based upon the present study, both Satir model family therapy and family psychoeducation

Table 5. Changes in scores from the baseline at each measurements of patients and family members compared within group

	Group	Difference from baseline*								
		At 3rd month			At 5th month			At 16th month		
		Mean	SD	*p*-value	Mean	SD	*p*-value	Mean	SD	*p*-value
Patients										
CFI	Family therapy	-1.91	14.86	0.68	-5.89	12.91	0.21	-3.38	15.44	0.56
	Psychoeducation	1.27	10.87	0.71	-0.36	12.25	0.92	5.36	9.31	0.09
CGI	Family therapy	0.09	1.30	0.82	0.88	0.99	0.04	1.25	1.49	0.05
	Psychoeducation	-0.09	0.30	0.34	-0.09	1.45	0.84	-0.18	1.17	0.62
PSP	Family therapy	-2.20	19.15	0.73	-2.67	17.15	0.65	-17.75	17.49	0.02
	Psychoeducation	-4.91	10.71	0.16	-8.18	9.23	0.02	-9.00	15.13	0.08
RSES-T	Family therapy	-1.73	4.54	0.24	-1.56	3.94	0.27	-1.13	3.98	0.45
	Psychoeducation	-0.82	4.88	0.59	-2.45	6.25	0.22	-0.55	5.79	0.76
SVAS	Family therapy	-3.36	2.35	0.00	-2.09	2.49	0.04	-2.45	2.47	0.03
	Psychoeducation	-0.86	3.15	0.38	0.27	3.33	0.79	-0.93	2.98	0.35
KKU-DI	Family therapy	5.82	21.19	0.38	6.22	13.55	0.21	4.50	14.15	0.40
	Psychoeducation	2.36	13.62	0.58	6.55	16.35	0.21	-1.82	20.59	0.78
Family members										
CFI	Family therapy	-3.50	9.91	0.25	-0.75	9.81	0.84	-1.60	16.89	0.77
	Psychoeducation	1.21	11.74	0.71	-4.00	10.63	0.22	-0.86	14.05	0.82
RSES-T	Family therapy	-2.08	3.23	0.04	-1.13	3.76	0.43	-0.50	4.22	0.72
	Psychoeducation	-0.07	2.52	0.92	-1.00	3.42	0.31	-0.13	2.36	0.83
SVAS	Family therapy	-0.61	1.31	0.14	-0.56	1.45	0.31	-0.02	2.19	0.98
	Psychoeducation	-0.09	0.49	0.51	-0.87	2.78	0.26	-0.57	2.08	0.30
KKU-DI	Family therapy	4.36	11.50	0.24	-0.57	2.08	0.30	1.33	8.99	0.67
	Psychoeducation	4.60	11.81	0.15	3.54	13.85	0.36	4.47	9.88	0.10

CFI = Chulalongkorn Family Inventory; RSES-T = Rosenberg Self Esteem Scale-Thai version; SVAS = Self-Esteem Visual Analog Scale; KKU-DI: Khon Kaen University Depression Inventory; CGI = Clinical Global Impression Severity scale; PSP = Personal and Social Performance Scale, Thai version

* Independent sample t-test

interventions help to a) improve family functioning and self-esteem, b) reduce depressive symptoms of family members and patients with schizophrenia, and c) improve the clinical symptoms and social performance in patients with schizophrenia. There was almost no statistically significant difference between groups, perhaps because psychoeducation is the standard treatment of schizophrenia[8,9]. Notwithstanding, when compared within groups, the authors found that the family therapy group had better overall results. The authors observed a positive, more sustained effect of family therapy using the Satir model on family functioning than psychoeducation. This agrees with Kongsook et al who found that family members who underwent family counseling based on the Satir model perceived that their family functioning was better after the intervention[4,6].

The severity of symptoms of patients in the family therapy group decreased while the severity of symptoms in the psychoeducation group increased. This might be associated with the better self-esteem, reduced depressive symptoms, and improved family functioning in the family therapy group. Although most of the family interventions for schizophrenia are educational or cognitive-behavioral based, and there is no comparative study using the Satir model family therapy, Bressi et al found that systemic family therapy for schizophrenia could improve the clinical course and resulted in better pharmacological compliance[11]. Similarly, De Giacomo et al found that paradoxical family therapy helped patients to have better outcome of symptoms and social improvements compare with routine treatment; although no significant differences in re-admission rates at the one-year follow-up between both groups[12]. Bressi et al also found that there were no differences regarded to relapse and pharmacological compliance at 12 months follow-up after the end of the therapy between systemic family therapy and routine psychiatric treatment[11].

Self-esteem in the family therapy group was increased more significantly than in the psychoeducation group. The tendency to increase in self-esteem in the family therapy group might be explained by the mechanism of therapy that works through internal experience and transforms the experience in a more positive direction than education alone. Our results agreed with Kongsook et al[6] who did a study in families with schizophrenic patients and found that 14 of 15 family members had better self-esteem after the course of family counseling using the Satir model. Another possibility is that self-esteem is one of the meta-goals, which is the main focus of Satir Model therapy[17]; however, statistical significance was clear only when measured using SVAS, implying that our sample and/or instrument might not be sufficiently large and/or sensitive.

Depressive symptoms were non-significantly decreased in every follow-up measurement in both groups; except for the patients in the psychoeducation group, for which the scores in the last measurement were higher than the baseline. This implies that family therapy in the Satir model could lessen depressive symptoms in patients and family members whereas the psychoeducation helps mainly in the family members group. The trend of the effect of the interventions on depressive symptoms in both groups was less in the second and third measurement; perhaps because the positive and negative symptoms of the patient might continuously impact the mood state of family members, so long-term supportive intervention might be necessary to restore the mood of both patients and family members.

The authors observed that the scores at the last measurement, one year after the termination of the therapy, trended to be worse than in the second and third measurement in both groups. Bressi et al also found the better effect of Systemic Family Therapy (than routine psychiatric treatment) on the rate of relapse and pharmacological compliance at the end of therapy, but no difference at the 12-month follow-up after the end of the therapy[11]. The chronic nature of schizophrenic symptoms is a stressor that continuously impacts the family. The families are at once in a state of uncertainty regarding relapse and affected by the impairment of function of the patient. Consequently, longer course of therapy to help the family through the course of the disease, combined with adequate biological intervention, are needed to maintain self-esteem, family functioning, mood equanimity as well as social performance of the patients. However, confounding factors such as compliance, living condition, physical and mental illness of family members that did not analyzed in the present study might impact the scores in the last measurement.

Limitation

The present study has limitations. There might be other confounding factors that did not include in this study, such as the medication, duration of illness, and the illness of family members. Family members who participated in the present study were mostly in their adult life but still depended on their parents. Their

siblings lived independently and did not want to join the therapy. The symptoms of the patients were mostly mild to moderate and some families had already adapted to the illness and did not want to participate in the study. The researchers found that most of the family members who participated in the sessions were mothers who were also the primary caregivers of the patients. Fathers rarely accompanied the patients to hospital. Many fathers had left the marriage or did not take the role of caregiver. If present, the fathers might be stressors to the patients, by having high emotional expression toward the patient. Other family members refused to come to the therapy sessions because they did not want to miss their job or classes nor did they want the stigmatization of coming to the psychiatric unit. With reference to family therapy, in African culture there is also a barrier to relatives coming to participate in family interventions due to transportation, work commitment, and/or competing demands on energy and time. They may also feel stigmatized by the illness or being identified as a regular attendee at a psychiatric facility[18]. Koolaee and Etemadi[19] reported that in Iranian families, it is mothers who show most interest in patient care, whether married or divorced. Interestingly, intervention for mothers of patients with schizophrenia clearly benefitted both the mothers and the patients[19]. The structure of therapy, thus must be adapted to fit the culture and try to include those absent as they are likely to benefit based on other studies.

Future steps

The current study a) included a small sample size that might not represent the real population, b) had a selection bias for unemployed participants, farmers and housewives in a lower socioeconomic strata, and c) not all of members of each patient's nuclear family came to the sessions. The structure of the therapy sessions depends on the context of the family; the transformational changes are difficult in families in which the patients still have active symptoms. In follow-on research, the authors recommend a larger sample size and more heterogeneous groups of families. The current study did not use the Positive and Negative Syndrome Scale, which has greater sensitivity for measuring the severity of psychotic symptoms of patients, so, the authors cannot conclude whether the results of the therapy are associated with the severity of the symptoms.

Conclusion

Family therapy based on the Satir model and group psychoeducation helps to improve self-esteem, depressive symptoms and family functioning of family members of patients with schizophrenia, and improve the clinical symptoms and psychosocial performance in the patients. The improvement seemed to be better and longer lasting in the family therapy group than the psychoeducation group, although the difference was not statistically significant between groups.

What is already known on this topic?

Family intervention can a) decrease the frequency of relapse, b) reduce hospitalization, c) encourage medication compliance, and d) improve general social impairment and the levels of expressed emotion within the family[8,9].

What this study adds?

The Satir model family therapy, over against group psychoeducation, can help to a) lessen the severity of symptoms, b) improve social functioning of the patients, and c) increase self-esteem of family members.

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Potential conflicts of interest

None.

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ประสิทธิภาพของการทำครอบครัวบำบัดตามแนวซาเทียร์ สำหรับครอบครัวของผู้ป่วยโรคจิตเภท

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วัตถุประสงค์: *เปรียบเทียบประสิทธิภาพระหว่างการทำครอบครัวบำบัดตามแนวซาเทียร์กับกลุ่มสุขภาพจิตศึกษาต่อการทำหน้าที่ของครอบครัว ความภาคภูมิใจในตนเอง อารมณ์เศร้าของสมาชิกในครอบครัว และการทำหน้าที่ทางด้านจิตสังคมและความรุนแรงของอาการของผู้ป่วยโรคจิตเภท*

วัสดุและวิธีการ: *เป็นการศึกษาเชิงทดลองแบบสุ่ม แบ่งครอบครัวเป็น 2 กลุ่ม กลุ่มทดลอง 13 ครอบครัว ได้รับครอบครัวบำบัดตามแนวซาเทียร์ กลุ่มควบคุม 11 ครอบครัว ได้เข้ากลุ่มสุขภาพจิตศึกษา ทั้งสองกลุ่มได้รับการบำบัด 6 ครั้ง ประเมินประสิทธิภาพของการบำบัดโดยเปรียบเทียบการเปลี่ยนแปลงของค่าคะแนนของแบบทดสอบ Chulalonkorn Family Inventory, Self-esteem visual analog scale (SVAS), Rosenberg Self Esteem Scale-Thai version (RSES-T), KKU-Depression Inventory, Thai Social and Performance Scale และ Clinical Global Impressionat (CGI) ในทั้ง 2 กลุ่ม โดยวัดก่อนการทดลองและในเดือนที่ 3 (หนึ่งเดือนหลังการบำบัดครั้งที่ 4) เดือนที่ 5 และ 16 (หนึ่งเดือนและหนึ่งปีหลังจบการบำบัด ตามลำดับ)*

ผลการศึกษา: *การแทรกแซงทั้งสองชนิดช่วยให้การทำหน้าที่ของครอบครัว ความภูมิใจในตนเอง อารมณ์เศร้าของสมาชิกในครอบครัว และช่วยให้การทำหน้าที่ทางสังคมและอาการของผู้ป่วยดีขึ้น โดยกลุ่มครอบครัวบำบัดมีผลที่มีนัยสำคัญทางสถิติมากกว่ากลุ่มควบคุม โดยในเดือนที่ 3 ความภูมิใจในตนเองในกลุ่มทดลองวัดโดย SVAS เพิ่มขึ้นมากกว่ากลุ่มควบคุม และความรุนแรงของอาการของผู้ป่วยวัดโดย CGIในกลุ่มทดลองในเดือนที่ 16 ลดลงมากกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติ สมาชิกในครอบครัวที่ได้รับครอบครัวบำบัด มีความภูมิใจในตนเองวัดโดย RSES-T เพิ่มขึ้นในเดือนที่ 3 และวัดโดย SVAS ในเดือนที่ 3 และ 5 เพิ่มขึ้นอย่างมีนัยสำคัญทางสถิติ*

สรุป: *การแทรกแซงทั้งสองมีผลดีต่อครอบครัวโดยกลุ่มครอบครัวบำบัดให้ผลที่มีนัยสำคัญทางสถิติมากกว่า โดยเฉพาะอย่างยิ่งผลในด้านความภูมิใจในตนเองของสมาชิกในครอบครัว*