Enferm Clin. 2019;29(S2):76–80

Enfermería Clínica

www.elsevier.es/enfermeriaclinica

Managing family burden through combined family psychoeducation and care decision without pasung therapies☆

Apri Rahma Dewi[a,b], Novy Helena Catharina Daulima[a,*], Ice Yulia Wardani[a]

[a] *Faculty of Nursing, Universitas Indonesia, Depok, West Java, Indonesia*
[b] *Academy of Nursing, Panca Bhakti, Bandar Lampung, Lampung, Indonesia*

Received 13 November 2018; accepted 17 April 2019
Available online 29 July 2019

KEYWORDS
Family burden;
Family psychoeducation;
Schizophrenia

Abstract
Objective: This research aimed to measure the effects of providing family psychoeducation (FPE) therapy and care decisions without *pasung* (CDWP) to families of mentally ill patients.
Method: This research used quasi-experimental pretest–posttest design with a control group consisting of 72 families divided into two groups using the purposive sampling technique. The intervention groups were given FPE and CDWP. The measurements were conducted three times using the Zarit Burden Interview.
Result: The study demonstrated that family burden was significantly lower among those who received the combination of the two therapies compared to only family psychoeducation ($p < 0.05$). Those therapies decreased the family burden into the low category.
Conclusion: The combination of these therapies provides an effective method for overcoming the burden on families who are treating family members with mental illness.

Introduction

Schizophrenia affects 21 million people around the world.[1] The number of people who suffer from mental health problems in Indonesia is 1.7 per 1000 people.[2] Schizophrenia is a mental disorder with chronic positive and negative signs and is related to decreased social function and task decline.[3] Around 25–50% of schizophrenic patients globally live with their families, and 70% of schizophrenic individuals in Asia live and depend on their families.[4] Symptoms associated with schizophrenia often cause the patient to become violent to themselves, their family, and others.[5] The severity of the emerged symptoms and the lowered productivity of patients also increase the burden suffered by family members.[6]

Caregiver burden defined as difficulties, problems, or harmful effects that influence the life of mental health

☆ Peer-review under responsibility of the scientific committee of the Second International Nursing Scholar Congress (INSC 2018) of Faculty of Nursing, Universitas Indonesia. Full-text and the content of it is under responsibility of authors of the article.

* Corresponding author.
E-mail address: novi_hc@ui.ac.id (N.H.C. Daulima).

https://doi.org/10.1016/j.enfcli.2019.04.012
1130-8621/

patients.[7] The patients' family members suffer from psychological impacts, somatic distress, and most seriously, emotional side effects.[8] Family members of schizophrenic patients suffer from insomnia (32.4%), headache (48%), anxiety (37.9%) and depression (29.4%).[9]

The family burden probably influences the care that is given to the patient, which is often not optimum for the patient's well-being. Research on the family burden of mentally ill patients has been conducted many times; however, it is essential to carry continuous development in overcoming this problem. Schizophrenia needs long term care and family is the main source of lifetime care for these patients, so the family's burdens must be addressed.

The family members of mentally ill patients face a higher risk of stress and should also be treated. Mohr and Regan-Kubinski have stated that families need empathy and support from health professionals to resolve their stress.[10] A care plan for families may offer a way to decrease the family burden and allow for optimal care of the patient.

Family psychoeducation (FPE) therapy has been shown to decrease the family burden of patients with schizophrenia and mood disorders,[11] decrease patients' symptoms, and significantly decrease family burden after one month of intervention.[12]

Families with mentally ill patients need help making appropriate care decisions for the patients. The appropriate care decision may decrease the burden and stress on the family during the patient's course of care. Care decision without *pasung* (CDWP) therapy is a family-centered therapy that helps families make decisions for mental health patients.[13]

Making a proper care decision is expected to relieve the family's burden. The objective of this research is to explore optimum approaches for managing burdens on families with mental health patients, specifically FPE and CDWP therapies.

Method

This research utilized quantitative data with quasi-experimental pretest–posttest and control group design. The intervention groups were given FPE and CDWP therapies.

The sample included 72 families of mentally ill patients. Each group consisted of 36 people. The population in this research were all families of mental health patients in East Lampung Regency Puskesmas Sidorejo, who were selected to be the intervention group, and patients from Puskesmas Sribhawono and Pugung Raharjo, who were selected to be the control group. The target setting of this study was the East Lampung district of Lampung, Sumatra, Indonesia. This district was purposively selected because it has the highest rate of *pasung* in the Lampung Province.

The inclusion criteria for this research were families with mentally ill patients who suffered from hallucinations and/or were at risk of violent behavior and who had not been treated with psychopharmacology or who had stopped taking medication.

Instrument

The instrument was screening for hallucinations[14] and violent behavior assessment.[15] The Zarit Burden Interview Questionnaire was used to measure family burden. This research consisted of three dimensions-namely burden, rejection, and incapability.[16] The Zarit Burden Interview, Indonesian Version, was used with valid results, and Cronbach's alpha reliability test result was equal to 0.837.[17]

Procedure

The researcher intervened four times within three weeks period. Sessions were 35–40 min and were executed during three meetings, two for FPE and one for CDWP. The control group participated only in the control group pretest and posttest. Interventions were carried out individually with one day nine families alternately.

Throughout this research, the measurements were obtained three times, first for the pretest and twice after treatment (Posttests 1 and 2). Posttest 1 was conducted two days after the family received FPE therapy and Posttest 2 after they received CDWP.

Results

In this research, the average age of the family members was 50 years old. The main caregivers were female (63.9%), and 34.7% of caregivers had not graduated from elementary school, representing the largest group. The majority of families were low-income (69.4%), and the caregivers were mostly parents (50%). The family burden was primarily rated in the moderate category (48.63), to see more complete characteristics, demography and family burden can be seen in Table 1.

The post-intervention results of the intervention and control groups can be seen in Table 2. The family burden decreased significantly, as much as 7.94%, after families were given FPE and CDWP therapies (p-value < 0.05). The control groups showed no significant differences between pretest and posttest.

Discussion

Based on the research results relating to family burden, there was a significant decline after families received FPE and CDWP, compared to only receiving FPE.

The family burdens fell in the moderate category, in line with the other research results.[11,18] Families with mentally ill patients exhibit higher burdens than those affected by other mental disorders.[19] FPE was provided to families to provide knowledge about schizophrenia, communication strategies, stress management, and coping methods.[20] FPE was effective in decreasing family burden and increasing families' self-efficacy.[21,22] The FPE, combined with other therapies, also showed a decline in the signs and symptoms of violent behavior in the patient and increased the family's ability to control violent behavior.[23] After being treated with FPE, the family burden decreased but still fell within the moderate category; this is likely due to financial burdens that still linger on the family.

The objective financial burden is the largest and primary burden of families car mental health patients.[19] Although

Table 1 The characteristics and equivalence of demography and family burden.

Variable	Intervention ($N = 36$) Mean ± SD	Control ($N = 36$) Mean ± SD	p value
Age	53.53 ± 13.47	48.14 ± 11.41	0.512**
Burden	48.89 ± 5.08	48.36 ± 5.96	0.168**

Variable	Intervention ($N = 36$) N (%)	Control ($N = 36$) N (%)	p value
Gender			
Male	10 (27.8)	16 (44.4)	0.141*
Female	26 (72.2)	20 (55.6)	
Education level			
Did not graduate elementary school	15 (36.1)	11 (30.6)	0.679*
Elementary school	9 (25.0)	11 (30.6)	
Junior high school	6 (16.7)	5 (13.9)	
High school	7 (19.4)	9 (25.0)	
Higher education	0 (0)	0 (0)	
Income			
Low	25 (69.4)	25 (69.4)	0.471*
High	11 (30.6)	11 (30.6)	
Relationship to patient			
Parent	15 (41.7)	21 (58.3)	0.412*
Husband/wife	7 (19.4)	6 (16.7)	
Children	4 (11.1)	1 (2.8)	
Sibling	5 (13.9)	4 (11.1)	
Etc.	5 (13.9)	4 (11.1)	

* Chi-squared test.
** Independent t-test.

Table 2 The ratio of the average value of family burden between intervention and control groups.

Variable	Group	Before intervention Mean ± SD	After FPE therapy Mean ± SD	After CDWP therapy Mean ± SD	p value Within After FPE	p value Within After FPE and CDWP	p value Between After FPE	p value Between After FPE & CDWP
Burden	Intervention	48.89 ± 5.081	46.86 ± 4.580	39.89 ± 4.090	0.000*	0.000*	0.022**	0.000**
	Control	48.36 ± 5.967	48.44 ± 6.385	47.83 ± 5.135	0.791*	0.064*		

* Dependent t-test.
** Independent t-test.

some families can take care of the mental health patient and overcome this burden, without combining psychopharmacology with therapy, the financial burden cannot be addressed. Schizophrenia is a chronic illness; thus, the duration of the illness influences the family burden, as family members are typically the main caregivers.[24] The need for long-term care could increase the subjective burden to the main caregiver.[19]

During FPE therapy, the families were encouraged to utilize available support systems to enhance the family system by integrating with community systems, such as public health services.[25]

Family decisions to utilize health services are important because patients who do not seek medical therapy have exhibited a higher risk of violent behavior than patients who are routinely treated.[26] FPE was not sufficient to reduce family burden; after receiving FPE, the family burden decreased to the low category, but three months after, the family burden increased.[11] Combined therapies are needed to overcome and maintain the decreased burden.

After receiving the combination of FPE and CDWP therapies, family burden entered the low category. The CDWP therapy aimed to provide alternative choices to the family when they are deciding the best care to give the mentally ill patient as well as to inform the family of the advantages of utilizing health services. Family decisions led to treatment of the patient through health services and the utilization of psychopharmacology therapy, which is the optimum care. Patients treated in this manner are more cooperative in completing their daily activities.[13]

Patients who can conduct their daily activities independently could decrease stressors and burdens on their families, both objectively and subjectively. CDWP therapy also reduces the stress levels on the family.[13] The combination of FPE and CDWP therapies was more effective on overcoming the burden on families who care for mentally ill patients.

Community Mental Health Nursing is important in maintaining the family burden in the low category. Workshops and monitoring are provided by nurse specialists to primary care nurses to allow them to be able to detect, treat, and observe the mentally ill patient and decrease the burden on the family while the patient is in treatment.[27]

FPE and CDWP should become the proper therapies to address stress in family caregivers of mental health patients. This combination therapy can be used as a family-based intervention and could help relatives to provide optimum care to the patient. The combination therapy could be optimum for maintaining or decreasing family burdens with the support of community mental health services.

Future research should examine this combination therapy with the addition of individual therapy for the patient; thus, the burden to families could be optimally overcome.

Conflict of interests

The authors declare no conflict of interest.

Acknowledgment

This work was supported by Hibah PITTA 2018 funded by DRPM Universitas Indonesia No. 1850/UN2.R3.1/HKP.05.00/2018.

References

1. World Health Organization. Schizophrenia; 2017. Available from: https://www.who.int/news-room/fact-sheets/detail/schizophrenia [updated 09.04.18] [internet].
2. National Institute of Health Research and Development. Riset Kesehatan Dasar. Jakarta: Ministry of Health, Republic of Indonesia; 2013.
3. Meyer N, Maccabe HH. Schizophrenia. Medicine (Baltimore). 2016;44:649–53, http://dx.doi.org/10.1016/j.mpmed.2016.08.003.
4. Chan SW. Global perspective of burden of family caregivers for persons with schizophrenia. Arch Psychiatr Nursing. 2011;25:339–49, http://dx.doi.org/10.1016/j.apnu.2011.03.008.
5. Ghoreishi A, Kabootvand S, Zangani E, Ahmadi A, Khazaie H. Prevalence and attributes of criminality in patients with schizophrenia. J Injury Violence Res. 2015 01;7:7–12, http://dx.doi.org/10.5249/jivr.v7i1.635.
6. Hjärthag F, Helldin L, Karilampi U, Norlander T. Illness-related components for the family burden of relatives to patients with psychotic illness. Soc Psychiatry Epidemiol. 2010;45:275–83, http://dx.doi.org/10.1007/s00127-009-0065-x.
7. Oshodi YO, Adeyemi JD, Aina OF, Suleiman TF, Erinfolami AR, Umeh C. Burden and psychological effects: caregiver experiences in a psychiatric outpatient unit in Lagos, Nigeria. Afr J Psychiatry. 2012;15:99–105, http://dx.doi.org/10.4314/ajpsy.v15i2.13.
8. Wittenberg E, Saada A, Prosser LA. How illness affects family members: a qualitative interview survey. Patient. 2013;6:257–68, http://dx.doi.org/10.1007/s40271-013-0030-3.
9. Gupta S, Isherwood G, Jones K, Van Impe K. Assessing health status in informal schizophrenia caregivers compared with health status in non-caregivers and caregivers of other conditions. BMC Psychiatry. 2015;15:162, http://dx.doi.org/10.1186/s12888-015-0547-1.
10. Fontaine KL. Mental health nursing. New Jersey: Pearson Prentice; 2009.
11. Navidian A, Kermansaravi F, Rigi SN. The effectiveness of a group psycho-educational program on family caregiver burden of patients with mental disorders. BMC Res Notes. 2012;5:1, http://dx.doi.org/10.1186/1756-0500-5-399.
12. Sharif F, Shaygan M, Mani A. Effect of a psycho-educational intervention for family members on caregiver burdens and psychiatric symptoms in patients with schizophrenia in shiraz, Iran. BMC Psychiatry. 2012;12:48, http://dx.doi.org/10.1186/1471-244X-12-48.
13. Daulima NHC [unpublished thesis] Proses pengambilan keputusan tindakan pasung oleh keluarga terhadap klien gangguan jiwa. Depok: Universitas Indonesia; 2014. Available from: http://lib.ui.ac.id/detail?id=20426709&lokasi=lokal#parentHorizontalTab
14. Wahyuningsih D [unpublished thesis] Pengaruh assertiveness training (AT) terhadap perilaku kekerasan pada klien skizoprenia di RSUD Banyumas. Depok: Universitas Indonesia; 2009.
15. Sudiatmika IK, Keliat BA, Wardani IY. Efektivitas cognitive behaviour therapy dan rational emotive behaviour therapy terhadap gejala dan kemampuan mengontrol emosi pada klien perilaku kekerasan. Jurnal Keperawatan Jiwa. 2013;1:1–10.
16. Gutiérrez-Maldonado J, Caqueo-Urízar A. Effectiveness of a psycho-educational intervention for reducing burden in Latin American families of patients with schizophrenia. Qual Life Res. 2007;16:739–47, http://dx.doi.org/10.1007/s11136-007-9173-9.
17. Suryaningrum S, Wardani IY. Hubungan Antara Beban Keluarga Dengan Kemampuan Keluarga Merawat Pasien Perilaku Kekerasan di Poliklinik Rumah Sakit Marzoeki Mahdi Bogor. Jurnal Keperawatan Jiwa. 2013;1:148–55.
18. Yu Y, Liu Z, Tang B, Zhao M, Liu X, Xiao S. Reported family burden of schizophrenia patients in rural China. PLOS ONE. 2017;12:e0179425, http://dx.doi.org/10.1371/journal.pone.0179425.
19. Koujalgi SR, Patil SR. Family burden in patient with schizophrenia and depressive disorder: a comparative study. Indian J Psychol Med. 2013;35:251, http://dx.doi.org/10.4103/0253-7176.119475.
20. Withnell N, Murphy N. Family interventions in mental health. UK: Open University Press; 2012.
21. Yildirim A, Buzlu S, Hacihasanoglu Asilar R, Camcioglu TH, Erdiman S, Ekinci M. The effect of family-to-family support programs provided for families of schizophrenic patients on information about illness, family burden

and self-efficacy. Turkish J Psychiatry. 2014;25:31–7, http://dx.doi.org/10.5080/u7194.
22. Herminsih AR, Barlianto W, Kapti RE. Pengaruh terapi family psychoeducation (FPE) terhadap kecemasan dan beban keluarga dalam merawat anggota keluarga dengan skizofrenia di kecamatan bola kabupaten sika, nusa tenggara timur. J K Mesencephalon. 2017;3:80–90.
23. Komala EPE, Keliat BA, Wardani IY. Acceptance and commitment therapy and family psychoeducation for clients with schizophrenia. Enfermería Clínica. 2018;28S:88–9, http://dx.doi.org/10.1016/S1130-8621(18)30044-5.
24. Lasebikan V, Ayinde O. Family burden in caregivers of schizophrenia patients: prevalence and socio-demographic correlates. Indian J Psychol Med. 2013;35:60, http://dx.doi.org/10.4103/0253-7176.112205.
25. Varcarolis ME. Essentials of psychiatric mental health nursing. 2nd ed. Singapore: Elsevier; 2013.
26. Hodgins S. Among untreated violent offenders with schizophrenia, persecutory delusions are associated with violent recidivism. Evid Based Ment Health. 2014;17:75, http://dx.doi.org/10.1136/eb-2014-101859.
27. Kakuma R, Minas H, van Ginneken N, Dal Poz MR, Desiraju K, Morris JE, et al. Global mental health 5: human resources for mental health care: current situation and strategies for action. The Lancet. 2013;378:1654–63, http://dx.doi.org/10.1016/S0140-6736(11)61270-1.