PSIKOEDUKASI MENINGKATAN PERAN KELUARGA DALAM MERAWAT KLIEN GANGGUAN JIWA

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ABSTRAK

Kesehatan jiwa masih menjadi problem kesehatan baik di dunia maupun di Indonesia.Keluarga adalah bagian penting dalam proses kesembuhan pasien jiwa. Dukungan keluarga sangat diperlukan oleh penderita gangguan jiwa dalam memotivasi mereka selama perawatan dan pengobatan.Psikoedukasi merupakan salah satu bentuk terapi perawatan kesehatan jiwa keluarga dengan cara pemberian informasi dan edukasi melalui komunikasi yang terapeutik. Tujuan penelitian ini adalah untuk mengetahui pengaruh psikoedukasi terhadap peningkatan peran keluarga dalam klien gangguan jiwa di Kabupaten Mamuju.Penelitian ini merupakan penelitian pra eksperimen dengan desain pre - post test without control group design. Populasi dalam penelitian ini adalah caregiver yang mempunyai anggota keluargagangguan jiwa di wilayah kerja PuskesmasTampapadang. Sampel diperoleh dengan purposive sampling berjumlah 23 keluarga. Data dianalisa menggunakan uji paired t-test untuk mengetahui kemampuan kognitif keluarga sebelum dan sesudah psikoedukasi.Hasil penelitian menunjukkan ada peningkatan kemampuan kognitif keluarga setelah diberikan psikoedukasi dengan nilai p=0,000. Kesimpulannya psikoedukasi pada keluarga meningkatkan peran keluarga dalam merawat klien gangguan jiwa.

Kata kunci: psikoedukasi, peran keluarga, klien gangguan jiwa

PYSCHOEDUCATION ENHANCES FAMILY ROLES IN CARING CLIENTS WITH MENTAL DISORDERS

ABSTRACT

Mental health is still a health problem both in the world and in Indonesia. Family is an important part in the healing process of mental patients. Family support is needed by people with mental disorders in motivating them during care and treatment. Psychoeducation is a form of family mental health care therapy by providing information and education through therapeutic communication. The purpose of this study was to determine the effect of psychoeducation on increasing the role of families in mental disorders clients in Mamuju Regency. This research is a pre-experimental research with pre-posttest design without control group design. The population in this study was caregivers who have family members with mental disorders in the working area of Tampapadang Community Health Center. Samples were obtained by purposive sampling totaling 23 families. Data were analyzed using paired t-test to determine the cognitive abilities of the family before and after psychoeducation. The results showed there was an increase in family cognitive abilities after being given psychoeducation with a value of p = 0,000. In conclusion, psychoeducation on the family increases the role of the family in caring for clients with mental disorders.

Keywords: psychoeducation, family roles, clients with mental disorders

PENDAHULUAN

Kesehatan jiwa jiwa masih menjadi problem kesehatan baik di dunia maupun di Indonesia.*The World Federation for Mental Health* (WFMH, 2016) menyebutkan satu dari empat orang dewasa akan mengalami masalah kesehatan jiwa pada satu waktu dalam hidupnya, bahkan setiap 40 detik di suatu

tempat di dunia ada seseorang yang meninggal karena bunuh diri. Data WHO (2017) menunjukkan, terdapat sekitar 35 juta orang terkena depresi, 60 juta orang terkena bipolar, 21 juta terkena skizofrenia, serta 47,5 juta terkena demensia. Prevalensi gangguan jiwa meningkatkan beban penduduk secara global (*global burden of disease*/GBD) secara progresif. Data Riset Kesehatan Dasar (2018) melaporkan prevalensi gangguan jiwa skizofrenia/psikosis di Indonesia sebesar 7 per mil rumah tangga. Artinya per 1.000 rumah tangga terdapat 7 rumah tangga yang ada ODGJ, sehingga jumlahnya diperkirakan sekitar 450 ribu ODGJ berat. Terjadi peningkatan proporsi gangguan jiwa yang cukup signifikan jika dibandingkan dengan hasil Riskesdas 2013 dari dari 1,7% menjadi 7%. Prevalensi gangguan jiwa skizofrenia/psikosis di Sulawesi Barat sebesar 12 per mil rumah tangga. Artinya per 1.000 rumah tangga terdapat 7 rumah tangga yang ada ODGJ. Laporan tersebut juga menjelaskan bahwa kasus pemasungan terhadap penderita gangguan jiwa sebanyak 14% di berbagai wilayah di Indonesia. Pemasungan lebih banyak ditemukan di pedesaan sebanyak 17,1% apabila dibandingkan pada masyarakat perkotaan yang sebanyak 10,7%. Studi Pendahuluan yang dilakukan menemukan beberapa kasus pemasungan di Wilayah Kerja Puskesmas Tampa Padang Kabupaten Mamuju. Pemasungan yang dilakukan tidak hanya sebatas pemasungan secara tradisional, misalnya menggunakan kayu atau rantai, tetapi berupa tindakan pengekangan yang membatasi gerak dan pengisolasian.

Keluarga merupakan bagian yang sangat penting dalam merawat penderita dengan gangguan jiwa (Cheryl dkk, 2016). Penelitian Vander (2012), meneliti tentang *A Qualitative Study of Coping with Voices Hearing of People with Schizofrenia in Hong Kong*, menjelaskan bahwa elemen penting terhadap keluarga dalam meningkatkan status kesehatan anggota keluarga yang mengalami halusinasi pendengaran di Hongkong menyatakan bahwa pasien dengan skizofrenia sangat membutuhkan perawatan oleh keluarga dengan baik untuk membantu proses penyembuhan pasien. Noviria (2014) menyatakan bentuk dukungan nyata keluarga yang harusdiberikan kepada pasien skizoprenia berupa perhatian, mengantar pasien berobatmemberikan informasi tentang pentingnya kontrol secara teratur dan memberikan pujian kepada pasien.

Pemahaman sebagian keluarga yang masih belum tepat tentang perawatan ODGJ mengakibatkan sikap yang negatif terhadap pasien. Sikap negatif keluarga terhadap pasien dapat dilihat dari anggapan bahwa penyakit yang dialami pasien adalah penyakit menetap dan tidak dapat disembuhkan sehingga keluarga cenderung membiarkan pasien asal tidak mengganggu. Hampir semua keluarga menganggap bahwa pasien hanya menjadi beban keluarga karena ketidakmampuan dalam merawat diri sendiri (Marfuah & Noviyanti, 2017).

Psikoedukasi keluarga adalah salah satu elemen program perawatan kesehatan jiwa keluarga dengan cara pemberian informasi dan edukasi melalui komunikasi. (Stuart & Laraia, 2015).Program psikoedukasi memberikan informasi baik berupa informasi penyakit spesifik seperti, misalnya gejala awal dan mengatasi gejala kekambuhan atau setiap potensi genetik implikasi dari penyakit maupun informasi umum seperti promosi gaya hidup sehat, pelatihan pemecahan masalah dan keterampilan komunikasi, identifikasi stressors di rumah tangga, dan pendidikan anggota keluarga dan fasilitas pelayanan dasar untuk mengetahui kemajuan pengobatan klien (Motlova dkk, 2017).

Psikoedukasi berpengaruh terhadap peningkatan pengetahuan keluarga dan penurunan kecemasan keluarga (Lestari, 2012).Penelitian Ridwan (2012) membuktikan bahwa psikoedukasimeningkatkankemampuan merawat klien dengan hargadiri rendah.Psikoedukasi keluarga dengan pasien gangguan depresi meningkatkan keberfungsian pasien dan kesejahteraan psikologis keluarga (Brady, 2016). Terapi psikoedukasi keluarga mudah dipelajari dan digunakan oleh *caregiver* serta tidak menimbulkan efek negatif pada klien *schizophrenia* (Kartikasari dkk, 2017). Terapipsikoedukasi yang diberikan juga dapat menurunkan beban *caregiver* dalam merawat penderitastroke dari beban berat menjadi bebansedang (Agusthia, 2018). Melalui penelitian kuantitatif ini dapat diketahui efektifitas pemberian psikoedukasi untuk meningkatkan peran keluarga dalam merawat klien gangguan jiwa.

METODE

Penelitian ini merupakan penelitian pra eksperimen dengan *desain pre - posttest without control group design*. Populasi dalam penelitian ini adalah *caregiver* yang mempunyai anggota keluarga gangguan jiwa di wilayah kerja Puskesmas Tampapadang Kabupaten Mamuju. Sampel penelitian ini adalah 23 keluarga dengan anggota keluarga gangguan jiwa. Sampel diperoleh dengan *purposivesampling* yaitu *caregiver* yang mempunyai anggota keluarga dengan gangguan jiwa. Kriteria inklusi pada penelitian ini adalah anggota keluarga yang terdekat dan terlibat merawat klien gangguan jiwa(*caregiver*), bertanggung jawab terhadap klien dantinggal bersama klien, bisa membaca dan menulis, bersedia sebagai responden dalam penelitian dan kooperatif.

Instrumen yang digunakan dalam penelitian ini adalah kuesioner kemampuan kognitif keluarga yang terdiri dari 20 item (Gusdiansyah, 2016). Psikoedukasi terdiri dari lima sesi (Gusdiansyah, 2016). Sesi I pengkajian masalah yang dihadapi keluarga dalam merawat anggota keluarga dengan gangguan jiwa. Pada sesi ini peserta mendapat kesempatan untuk menyampaikan pengalaman keluarga dalam memberikan dukungan kepada gangguan jiwa dan menyampaikan keinginan dan harapan selama mengikuti program psikoedukasi keluarga. Sesi II merawat dan memberikan dukungan psikososial kepada anggota keluarga dengan gangguan jiwa. Pada sesi ini peserta mampu menyebutkan tentang gangguan jiwa dan bagaimana memberikan dukungan psikososial kepada anggota keluarga yang menderita gangguan jiwa. Sesi III manajemen beban subyektif keluarga (stress, depresi dan ansietas). Peserta mampu berbagi pengalaman dengan anggota kelompok lain tentang ansietas yang dirasakan akibat salah satu anggota keluarga mengalami perilaku kekerasan dan mendapat informasi tentang ansietas yang dialami serta mengetahui cara mengatasinya. Sesi IV manajemen beban obyektif keluarga. Peserta mengenal tanda-tanda beban yang dialami akibat adanya anggota keluarga yang menderita penyakit perilaku kekerasan dan peserta mengetahui cara mengatasi beban yang dialami. Sesi V hambatan dan pemberdayaan komunitas. dapat melakukan komunikasi yang baik dengan petugas kesehatan terdekat dalam komunitas (Puskesmas).

Analisis data dilakukan dengan analisis univariat dengan menampilkan distribusi dan persentase dari variabel. Selanjutnya dilakukan analisis bivariat menggunakan paired t-test untuk mengetahui pengaruh psikoedukasi terhadap kemampuan keluarga dengan tingkat kepercayaan 95% (α 0,05). Data dianalisis menggunakan program *SPSS for windows version17*. Penelitian ini sudah memperoleh rekomendasi persetujuan etik pada Komisi Etik Penelitian Kesehatan Politeknik Kesehatan Makassar dengan nomor: 030/KEPK-PTKMKS/II/2018 dan rekomendasi penelitian pada Kesbangpol Kab. Mamuju dengan nomor: 070/076/IV/2018/BKBP.

HASIL

Karakteristik keluarga meliputi usia, jenis kelamin, tingkat pendidikan, pekerjaan, hubungan dengan klien. Tabel 1 menunjukkan karakteristik terbanyak pada keluarga klien yaitu berjenis kelamin perempuan sebesar 20 (86,96%), umur keluarga dewasa akhir sebanyak 8 orang (34,78%), tingkat pendidikan keluarga klien yaitu berpendidikan rendah 15 (65,22%), pekerjaan keluarga klien yaitu bekerja sebesar 13 (56,52%), hubungan dengan klien yaitu orang tua/anak sebesar 15 (65,22%). Tabel 2 menunjukkan kemampuan kognitif keluarga klien sesudah mendapatkan psikoedukasi keluarga meningkat menjadi 14,65. Kemampuan kognitif keluarga menunjukkan peningkatan yang bermakna sesudah intervensi dengan *p-value* 0,000. Efektivitas psikoedukasi terhadap kemampuan kognitif keluarga sebesar 25,03 %.

Tabel 1.
Karakteristik responden (n=23)

Karakteristik Klien	f	%
Jenis Kelamin		
Laki-laki	3	13,04
Perempuan	20	86,96
Umur		
26-35 (Dewasa Awal)	5	21,74
36-45 (Dewasa Akhir)	8	34,78
46-55 (Lansia Awal)	3	13,04
56-65 (Lansia Akhir)	7	30,44
Tingkat Pendidikan		
Rendah	15	65,22
Menengah	1	4,35
Tinggi	7	30,43
Pekerjaan		
Bekerja	13	56,52
Tidak Bekerja	10	43,48
Hubungan dengan Klien		
Orang Tua/Anak	15	65,22
Suami/Istri	2	8,69
Saudara Kandung	6	26,09

Tabel 2.
Analisis kemampuan keluarga sebelum dan sesudah psikoedukasi (n =23)

Kemampuan Keluarga	Mean	SD	SE	*p value*
Kognitif:				
Sebelum	58,52	5,32	1,11	
Sesudah	73,17	4,78	0,99	0.000
Selisih	14,65	0,54	0.12	

PEMBAHASAN

Hasil penelitian menunjukkan bahwa tingkatpengetahuan sebelum diberikan psikoedukasi, nilai rata-rata 58,52 atau kategori cukup. Setelah diberikan psikoedukasi nilai rata-rata menjadi 73,17 ataukategori tinggi. Sebelum dansesudah diberikan psikoedukasi, tingkatpengetahuan responden meningkat secarabermakna yang berarti psikoedukasidapat meningkatkan pengetahuan responden. Hasil ini sejalan dengan Wiyatidkk (2010) yang menyatakan rata-rata pengetahuan keluarga keluarga lebih rendah sebelum dilakukan psikoedukasi. Penelitian Kustiawan (2013) di Kota Tasikmalaya juga menemukan peningkatan kemampuan kognitif dan psikomotor terjadi pada kelompok intervensi psikoedukasi dibandingkan dengan kelompok kontrol.

Pada Sesi I dan II Psikoedukasi memberikan informasi tentang masalah yang dihadapi oleh keluarga dan cara merawat anggota keluarga dengan gangguan jiwa. Informasi yang diperoleh menjadi bekal bagi keluarga untuk merawat dan memberi dukungan psikososial kepada anggota keluarga dengan gangguan jiwa. Pendidikan Kesehatan pada hakekatnya adalah usaha penyampaian pesan kesehatan kepada masyarakat, kelompok atau individu dengan harapan adanya peningkatan pengetahuan sehingga meningkatkan perilaku sehat yang lebih baik (Notoatmojo, 2012). Pengetahuan keluarga yang meningkat akan meningkatkan pemahaman keluarga tentang cara merawat anggota keluarga dengan gangguan jiwa.Sulastri (2018) menyatakan pemberian stimulus dalam terapi psikoedukasi keluarga dapat meningkatkan bekal kemampuan keluarga dalam merawat pasien gangguan jiwa di Wilayah kerja Puskesmas Sragi Lampung Selatan Tahun 2017.

Terapi psikoedukasi keluarga dapat meningkatkan kemampuan kognitif karena dalam terapi mengandung unsur untuk meningkatkan pengetahuan keluarga tentang penyakit, mengajarkan teknik yang dapat

membantu keluarga untuk mengetahui gejala-gejala penyimpangan perilaku, serta peningkatan dukungan bagi anggota keluarga itu sendiri. Gbiri dkk (2015) menyatakan salah satu fokus dari psikoedukasiadalah mengembangkan keterampilanpenyelesaian masalah dan mengembangkanketerampilan *crisis intervention* dan denganditingkatkannya kemampuan *caregiver*dalam menghadapi situasi permasalahannyasehingga masalah yang dirasakan dapatberkurang dan dapat membantu *caregiver*menghadapi stressor karena klien sakit.Pemberian edukasi memberikan informasi pada keluarga tentang cara perawatan pasien gangguan jiwa. Melalui aktivitas ini terjadi proses pembelajaran yangg dilakukan oleh keluarga dengan menyerap informasi yang diberikan dan mengaplikasikan langsung pada anggota keluarganya.
Pada Sesi III dan IV Psikoedukasi, keluarga sudah mampu mengetahui beban subjektif dan beban objektif yang dirasakan akibat merawat anggota keluarga dengan gangguan jiwa. Ngadiran (2010) menyatakan keluarga dengan gangguan jiwa menghadapi stressor yang berbeda dengan keluarga dengan dengan masalah kesehatan lain. Selain berkaitan dengan biaya yang dikeluarkan untuk perawatan, ketidakmampuan klien dalam memenuhi kebutuhan sehari-hari juga pada stigma masyarakat pada klien gangguan jiwa. Stressor yang dialami oleh anggota keluarga dengan gangguan jiwa sering dikenal dengan beban keluarga (*family burden*).

Pemahaman keluarga tentang beban yang dirasakan mempengaruhi persepsi keluarga tentang beban keluarga dalam merawat klien gangguan jiwa. Gonzales,dkk (2010) menyatakan psikoedukasi keluarga efektif untuk pencegahan ekspresi emosi dan beban dalam merawat pasienepisode pertama psikosis.Hal ini sejalan dengan penelitian yang dilakukanoleh Turner (2014) padakeluarga yang merawat anak dengan gangguan mentalyang menemukan terjadinnya peningkatkan keperdulian keluarga dalammerawat penderita dan memberikan cara pandangyang positif dan fleksibel terhadap permasalahan yangkeluarga hadapi dalam merawat anak denganganggangguan mental. Individu yang memiliki carapandang yang positif dan fleksibel terhadap suatumasalah dapat menurunkan kecemasan terhadapmasa depan penderita serta berusaha lebih baik dalammenyelesaikan masalah yang sedang dihadapidibandingkan dengan menyingkirkan danmengabaikan permasalah tersebut.

Pada Sesi V, keluarga mengidentifikasi hambatan yang dialami dalam merawat klien gangguan jiwa dan dilatih untuk melakukan komunikasi yang baik dengan petugas kesehatan terdekat dalam komunitas (Puskesmas). Kemampuan keluarga dalam mengontrol perilaku yang muncul pada klien gangguan jiwa tersebut sangat memungkinkan untuk ditingkatkan lagi. Kemampuan keluarga dalam hal ini *personal ability* adalah kemampuan mengatasi masalah termasukmencari informasi, mengidentifikasi masalah, mencari alternatif dan rencana menjalankan penyelesaian masalah (Stuart & Sundeen, 2013). Salah satu bentuk penyelesaian masalah dalam perawatan klien gangguan jiwa adalah memberikan pengobatan yang tepat. Setelah melalui kelima sesi Terapi Psikoedukasi Keluarga, keluarga menjadi lebih aktif untuk membawa anggota keluarga berobat ke Puskesmas.

Peran keluarga adalah memberikan klien rasa nyaman, merasa dicintai meskipun saat mengalami suatu masalah, bantuan dalam bentuk semangat, empati, rasa percaya, perhatian sehingga klien yang menerima merasa berharga. Keluarga juga harus menyediakan informasi dengan menyarankan tempat, dokter, dan terapi yang baik bagi klien, dan menyediakan fasilitas serta dana yang mencukupi untuk proses pengobatan klien. Selanjutnya keluarga perlu memberikan dorongan dan motivasi yang diberikan keluarga kepada klien, memberikan penghargaan positif tehadap ide-ide atau perasaan pasien sehingga mampu membangun harga diri klien (Friedman, 2010). Peran keluarga berupa pengetahuan yang memadai tentang perawatan klien gangguan jiwa mempengaruhi kemampuan keluarga dalam merawat dan memenuhi kebutuhan klien gangguan jiwa termasuk kebutuhan pengobatan. Dengan demikian dapat disimpulkan bahwa psikoedukasi keluarga meningkatkan peran keluarga secara bermakna dalam merawat klien gangguan jiwa.

SIMPULAN

Kemampuan kognitif keluarga dengan anggota keluarga gangguan jiwa meningkat setelah

mengikuti Psikoedukasi. Psikoedukasi efektif meningkatkan peran keluarga dalam merawat klien gangguan jiwa.

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PENELITIAN

PENGARUH *FAMILY PSYCHOEDUCATION THERAPHY* TERHADAP KEMAMPUAN KELUARGA MERAWAT PASIEN SKIZOFRENIA DENGAN HALUSINASI DI KOTA SAMARINDA KALIMANTAN TIMUR

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Abstract

Family is one of the trigger client's mental health problem as the effect of nontherapeutic family's behaviours so unable to supporting client's care. The aim of this study is to identify the effect of family psychoeducation therapy toward famiky's ability to care schizopren's client with halusination. This is a quasi experiment study with pre and post test study without control group design, the intervention is family psychoeducation. The amount of samples on this study are 25 families (total sampling), who have schizofren with halusination. Result: there is an increase of cognitive family's ability (p=0,0001; @=0,05) and increase of pshycomotor family's ability (p=0,0001; @=0,05) to care schizofren's patient. This therapy was reccomended to increasing family's ability to care schizofren's patient with halusination.

Keywords: schizofren, family psychoeducation therapy, family's ability.

Abstrak

Keluarga merupakan salah satu faktor pencetus timbulnya masalah kesehatan mental klien sebagai akibat sikap keluarga yang tidak terapeutik sehingga tidak mampu mendukung dalam perawatan klien. Tujuan penelitian ini adalah untuk Mengetahui pengaruh *Family Psychoeducation Therapy* (FPE) terhadap kemampuan keluarga merawat klien skizofrenia dengan halusinasi. Penelitian ini adalah *quasi eksperiment* dengan rancangan *pre post test without control group design* dengan intervensi *Family Psychoeducation*. Jumlah sampel 25 keluarga (total sampling) yang memiliki pasien skizofrenia dengan halusinasi. Hasil: ditemukan peningkatan kemampuan kognitif keluarga (p=0,0001 ; α=0,05) dan peningkatan kemampuan psikomotor keluarga merawat (p=0,0001 ; α=0,05) dalam merawat pasien skizofrenia. Terapi ini direkomendasikan sebagai terapi yang bisa meningkatkan kemampuan kluarga dalam merawat pasien skizofrenia dengan halusinasi

Kata Kunci: skizofrenia ; *Family Psychoeducation Therapy* (FPE); kemampuan keluarga

Pendahuluan

Halusinasi merupakan masalah keperawatan yang dapat mengakibatkan perilaku kekerasan pada pasien yang mengalaminya. Hal ini terjadi bila pasien mengalami halusinasi yang isinya memerintah untuk melakukan sesuatu yang mengancam atau membahayakan diri atau orang lain. Rasa takut dapat mengakibatkan pasien melakukan sesuatu yang berbahaya, seperti melompat keluar melalui jendela. Oleh karena itu intervensi amat penting segera dilakukan (Stuart & Laraia, 2005). Berdasarkan studi pendahuluan tentang pelaksanan perawatan lanjutan di rumah pasien skizofrenia tahun 2012-2013 yang didapatkan datanya dari rumah sakit jiwa Atma Husada Samarinda, telah dilakukan kunjungan ke rumah keluarga (*home visite*) yang memiliki penderita skizofrenia untuk dilakukan terapi generalis dengan hasil yang baik walaupun masih ada beberapa keluarga yang masih belum paham tentang cara perawatan penderita skizofrenia terutama masalah halusinasi. Di wilayah kerja Puskesmas Juanda Samarinda, merupakan salah satu daerah yang telah dibentuk kelurahan siaga sehat jiwa dengan jumlah keluarga yang memiliki penderita skizofrenia sebanyak 36 keluarga dengan masalah halusinasi sebanyak 25 keluarga. Informasi dari perawat yang bertugas di Puskesmas Juanda telah ada pelayanan poli jiwa dengan angka kunjungan sangat rendah dikarenakan pemahaman yang rendah terhadap perawatan pasien skizofrenia dengan halusinasi dan keluarga merasa malu. Hal ini menunjukkan masih kurangnya pemahaman keluarga tentang pentingnya perawatan pada penderita skizofenia dan masih kuatnya stigma yang buruk dari lingkungan masyarakat yang membuat keluarga merasa malu karena memiliki anggota keluarga yang menderita skizofrenia dengan masalah halusinasi. Penyelesaian masalah saat merawat anggota keluarga yang mengalami skizofrenia (skizofrenia) dapat ditentukan oleh faktor-faktor yang mempengaruhi kemampuan keluarga. Menurut Notoadmojo, 2003), perilaku dipengaruhi oleh 3 faktor yaitu *predisposing factor* (faktor predisposisi yang meliputi pengetahuan, sikap, sistem nilai, tingkat pendidikan, tingkat sosial ekonomi), *enabling factor* (faktor pemungkin yang meliputi ketersediaan sarana dan prasarana, fasilitas kesehatan) dan *reinforcing factor* (faktor penguat yang meliputi sikap dan perilaku tokoh masyarakat dan petugas kesehatan, undang-undang, dan peraturan pemerintah). Berdasarkan paparan di atas,

dapat disimpulkan bahwa kemampuan keluarga dalam merawat anggota keluarga yang mengalami skizofrenia dipengaruhi oleh banyak faktor yang harus diketahui dan dimiliki oleh keluarga sehingga dapat memberikan asuhan yang berkualitas kepada pasien skizofrenia khususnya masalah halusinasi.

Family psychoeducation therapy adalah salah satu bentuk terapi perawatan kesehatan jiwa keluarga dengan cara pemberian informasi dan edukasi melalui komunikasi yang terapeutik. Program psikoedukasi merupakan pendekatan yang bersifat edukasi dan pragmatis (Stuart & Laraia, 2005). Carson (2000) menyatakan bahwa psikoedukasi merupakan suatu alat terapi yang keluarga yang makin popular sebagai suatu strategi untuk menurunkan faktor-faktor risiko yang berhubungan dengan perkembangan gejala-gejala perilaku. Tujuan umum dari *Family psychoeducation therapy* adalah menurunkan intensitas emosi dalam keluarga sampai pada tingkatan yang rendah sehingga dapat meningkatkan pencapaian pengetahuan keluarga tentang penyakit dan mengajarkan keluarga tentang upaya membantu mereka melindungi keluarganya dengan mengetahui gejala-gejala perilaku serta mendukung kekuatan keluarga (Stuart & Laraia, 2005). Terapi ini dirancang terutama untuk meningkatkan pengetahuan keluarga tentang penyakit, mengajarkan teknik yang dapat membantu keluarga untuk mengetahui gejala-gejala penyimpangan perilaku, mengurangi kekambuhan pasien dengan skizofrenia, meningkatkan fungsi pasien dan keluarga sehingga mempermudah pasien kembali ke lingkungan keluarga dan masyarakat dengan memberikan penghargaan terhadap fungsi sosial dan okupasi pasien skizofrenia, meningkatkan kemampuan keluarga dalam upaya menurunkan angka kekambuhan, mengurangi beban keluarga, melatih keluarga untuk lebih bisa mengungkapkan perasaan, bertukar pandangan antar anggota keluarga dan orang lain, serta peningkatan dukungan bagi anggota keluarga itu sendiri.

Penelitian tentang *Family psychoeducation therapy* (FPE) telah banyak dilakukan, seperti pada penelitian yang dilakukan oleh Wardaningsih, Keliat, dan Helena (2007) tentang pengaruh *family psychoeducation* terhadap beban dan kemampuan keluarga dalam merawat pasien dengan halusinasi di Kabupaten Bantul Yogyakarta. Hasil penelitian ditemukan adanya pengaruh *family psychoeducation* secara bermakna dalam menurunkan beban keluarga dan peningkatan kemampuan keluarga dalam merawat pasien dengan halusinasi.

Sari, Keliat, dan Mustikasari (2009), mengemukakan tentang Pengaruh *Family Psychoeducation Therapy* terhadap Beban dan Kemampuan Keluarga dalam Merawat Pasien Pasung di Kabupaten Bireuen Nanggroe Aceh Darussalam. Hasil penelitian ditemukan menunjukkan penurunan beban keluarga dan peningkatan kemampuan keluarga secara bermakna setelah mendapat FPE. Berdasarkan latar belakang tersebut diatas maka penulis merasa tertarik untuk melakukan penelitian tentang *Family Psychoeducation theraphy* untuk mengetahui pengaruhnya terhadap kemampuan keluarga merawat pasien Skizofrenia dengan halusinasi dengan alasan masih kurangnya pemahaman keluarga dalam memberikan perawatan pada penderita skizofrenia dengan halusinasi di Kota Samarinda dan belum adanya penelitian tentang *Family Psychoeducation theraphy* keluarga dalam merawat pasien skizofrenia dengan halusinasi di Kota Samarinda Provinsi Kalimantan Timur.

Metode

Penelitian ini menggunakan metode *quasi eksperiment* dengan rancangan *pre post test without control group design* dengan intervensi *Family Psychoeducation.* Alasan peneliti menggunakan metode ini berdasarkan pada area penelitian yang merupakan daerah untuk kelurahan siaga sehat jiwa sehingga secara perlakuan semua keluarga sudah mendapatkan terapi generalis sebagai dasar dalam pemberian terapi spesialis, selain itu juga melihat pada aspek etika penelitian yaitu azas keadilan (*justice*), di mana seluruh responden mempunyai hak yang sama untuk mendapatkan perlakuan intervensi yang diberikan oleh peneliti. Pengambilan sampel menggunakan metode *total sampling* (25 keluarga) di mana semua keluarga dengan anggota yang memenuhi kriteria inklusi akan menjadi sampel penelitian ini. Pada saat penelitian yang sudah dilakukan oleh peneliti, seluruh sampel (responden) dapat mengikuti kegiatan intervensi yang dilakukan oleh peneliti dari sesi pertama sampai dengan sesi kelima.

Hasil

Karakteristik keluarga yang merawat pasien skizofrenia terbanyak adalah perempuan (68%), berpendidikan SMP (11%), pendapatan dibawah UMR (48%), dan hubungan dengan pasien sebagai saudara (28%). rerata usia keluarga yang merawat pasien skizofrenia adalah 41,40 tahun (SD 10,874). Usia termuda keluarga yang merawat pasien skizofrenia dengan halusinasi dalam penelitian ini adalah 20 tahun dan yang

tertua adalah berusia 64 tahun. Karakteristik pasien skizofrenia berdasarkan jenis kelamin terbanyak adalah laki-laki (72%) dengan rutinitas berobat sebanyak 72%. Rerata usia pasien skizofrenia dengan halusinasi yaitu 36,68 tahun (SD 12,711). Usia termuda pasien pasien skizofrenia adalah 17 tahun dan yang tertua adalah berusia 65 tahun. Rerata lama menderita skizoprenia yaitu 8,66 tahun (SD 7,709), dengan waktu tertinggi 30 tahun dan terendah 2 tahun. Sedangkan rerata jumlah kekambuhan yang dialami pasien skizofrenia adalah 1,80 kali (SD 1,780), dengan jumlah kekambuhan terbanyak adalah 7 kali.

Ditemukan adanya peningkatan rerata kemampuan keluarga merawat pasien skizofrenia dengan halusinasi dalam aspek kognitif dari sebelum intervensi sebesar 34,72 (SD 4,026) menjadi 38,80 (SD 3,969) sesudah intervensi FPE. Peningkatan rerata kemampuan keluarga merawat pasien skizofrenia dengan halusinasi juga terlihat pada aspek psikomotor, yaitu 28,32 (SD 7,392) sebelum intervensi menjadi 32,40 (SD 6,331) sesudah intervensi FPE. Hasil penelitian menunjukkan koefisien korelasi antara usia keluarga dengan kemampuan kognitif keluarga dalam merawat pasien Skizofrenia dengan halusinasi sebesar -0,198. Koefisien korelasi negatif menunjukkan hubungan negatif antara usia dengan kemampuan kognitif keluarga dalam merawat pasien skizofrenia. Uji statistik menunjukkan bahwa usia keluarga tidak berhubungan signifikan dengan kemampuan kognitif keluarga dalam merawat pasien skizofrenia *(p value 0,05)*. Koefisien korelasi antara usia keluarga dengan kemampuan psikomotor keluarga dalam merawat pasien skizofrenia sebesar -0,136. Koefisien korelasi negatif menunjukkan hubungan negatif antara usia dengan kemampuan psikomotor keluarga dalam merawat pasien skizofrenia. Uji statistik menunjukkan bahwa usia keluarga tidak berhubungan signifikan dengan kemampuan psikomotor keluarga dalam merawat pasien skizofrenia. Hubungan negatif berarti semakin bertambah usia (semakin tua) keluarga (caregiver) semakin rendah kemampuan kognitif dan psikomotor keluarga dalam merawat pasien Skizofrenia dengan halusinasi. Rerata kemampuan kognitif keluarga yang berjenis kelamin laki-laki dalam merawat pasien skizofrenia sebesar 38,75 (SD 3,495) hampir sama dengan perempuan yaitu sebesar 38,82 (SD 4,275). Uji statistik menunjukkan tidak ada perbedaan kemampuan kognitif keluarga dalam merawat pasien

skizofrenia yang signifikan antara responden laki-laki dan perempuan. Berdasarkan hasil analisis ini maka disimpulkan bahwa jenis kelamin keluarga tidak berhubungan dengan kemampuan keluarga merawat pasien skizofrenia dalam aspek kognitif maupun psikomotor. rerata kemampuan kognitif keluarga merawat pasien skizofrenia dengan halusinasi lebih tinggi pendidikan SD dan PT dibandingkan dengan SMP dan SMA, sedangkan rerata tertinggi kemampuan psikomotor keluarga merawat pasien skizofrenia dengan halusinasi yang tertinggi adalah SD dibandingkan dengan PT, SMP, dan SMA. Hal ini menunjukkan bahwa pendidikan tidak mempengaruhi seseorang dari aspek pengetahuan dan keterampilan dalam memberikan perawatan kepada pasien dengan Skizofrenia dengan halusinasi.

Berdasarkan hasil analisis kemampuan psikomotor keluarga ini disimpulkan bahwa pendidikan keluarga berhubungan dengan kemampuan keluarga merawat klien skizofrenia khususnya dalam aspek psikomotor. Hal ini bisa disebabkan karena faktor kemauan merawat, adanya waktu yang lebih banyak dalam memberikan perawatan, dan pengalaman caregiver dalam merawat anggota keluargannya dengan skizofrenia halusinasi. Hasil Uji statisti juga menunjukkan tidak ada hubungan antara pekerjaan, pendapatan, hubungan pasien dengan kemampuan keluarga secara kognitif dan psikomotor *(p value 0,05)*. koefisien korelasi antara usia pasien, jenis kelamin, lama menderita, rutinitas berobat, jumlah kekambuhan dengan kemampuan kognitif dan psikomotor menunjukkan bahwa tidak berhubungan signifikan dengan kemampuan keluarga dalam merawat pasien skizofrenia.

Pembahasan

Karakteristik utama kemampuan keluarga adalah kemampuan untuk manajemen stres yang produktif (Fontaine, 2003). Pengetahuan atau kognitif merupakan domain yang sangat penting untuk terbentuknya tindakan keluarga yang merujuk pada pikiran rasional, mempelajari fakta, mengambil keputusan dan mengembangkan pemikiran sedangkan psikomotor atau kemampuan praktik merujuk pada pergerakan muskuler yang merupakan hasil dari koordinasi pengetahuan dan menunjukkan penguasaan terhadap suatu tugas atau keterampilan (Craven, 2000). Hasil analisis menunjukkan skor kemampuan kognitif keluarga sebelum pemberian psikoedukasi adalah 34,72. Tujuan utama *Family Psycheducation* adalah terapi yang digunakan untuk memberikan informasi terhadap keluarga yang mengalami distress, memberikan

pendidikan pada mereka untuk meningkatkan ketrampilan untuk dapat memahami dan mempunyai koping akibat gangguan jiwa yang mengakibatkan masalah pada hubungan keluarganya (Goldenberg, I & Goldengerg, H., 2004).

Marsh (2000, dalam Stuart & Sundeen, 2006), program komprehensif dengan pemberdayaan keluarga memenuhi komponen informasi tentang gangguan jiwa dan sistem kesehatan jiwa, komponen keterampilan (komunikasi, resolusi terhadap konflik, pemecahan masalah, asertif, manajemen perilaku dan stres), komponen emosional, komponen proses keluarga (fokus pada koping terhadap gangguan jiwa) dan komponen sosial (cara meningkatkan hubungan terhadap dukungan formal maupun informal). Keterlibatan keluarga dalam pengambilan keputusan perawatan pasien meningkatkan hasil dengan cara pendidikan dan dukungan keluarga untuk bekerja sama (Stuart & Laraia, 2005).

Hasil penelitian menunjukkan ada perbedaan yang bermakna tingkat kemampuan kognitif keluarga setelah mendapatkan *family psychoeducation* yaitu menjadi 38,80. Uji statistik dengan *paired t-test* menghasilkan nilai probabilitas sebesar 0,0001 (p value<0,05) yang menunjukkan adanya perbedaan rerata kemampuan kognitif keluarga dalam merawat pasien skizofrenia yang signifikan antara sebelum dan sesudah intervensi. Hasil penelitian ini sesuai dengan riset yang dilakukan oleh Chien dan Wong (2007) tentang efektifitas psikoedukasi pada 84 keluarga dengan skizofrenia di Hongkong yang diikuti selama 12 bulan. Program psikoedukasi yang diberikan meliputi materi tentang persepsi, pengetahuan (kognitif) dan keterampilan (psikomotor) tentang perawatan anggota keluarga dengan skizofrenia. Setelah dievaluasi, sebagian besar keluarga melaporkan adanya perbaikan fungsi keluarga dan fungsi pasien, manajemen beban keluarga serta penurunan jumlah dan lama hospitalisasi pasien dibandingkan dengan standar perawatan yang diterima sebelumnya. Penelitiannya mendukung bahwa *family psychoeducation therapy* dapat menjadi intervensi dasar di masyarakat yang lebih efektif pada anggota keluarga dengan Skizofrenia dengan halusinasi di Hongkong, dibandingkan dengan perawatan rutin di pelayanan kesehatan jiwa. Hasil penelitian ini dan didukung hasil-hasil riset terdahulu membuktikan bahwa *family psychoeducation* berpengaruh dalam meningkatkan kemampuan kognitif keluarga dalam merawat pasien dengan gangguan jiwa khususnya dengan

halusinasi di rumah. Peningkatan kemampuan kognitif keluarga setelah mengikuti intevensi *family psychoeducation* terlihat dari antusiasme dan partisipasi aktif sebagian besar keluarga dalam mengikuti setiap sesi. Uraian di atas disimpulkan bahwa *family psychoeducation* dapat meningkatkan kemampuan kognitif keluarga dalam merawat anggota keluarga dengan gangguan jiwa khususnya dengan halusinasi.

Hasil analisis menunjukkan skor kemampuan psikomotor keluarga sebelum pemberian psikoedukasi adalah 28,32. Untuk mengubah perilaku terlebih dahulu dilakukan strategi untuk mengubah pikiran (kognitif). Perubahan perilaku dapat dilakukan dengan 3 strategi (WHO, dalam Notoadmodjo, 2003) yaitu: menggunakan kekuatan/ kekuasaan/ dorongan, pemberian informasi, dan diskusi partisipan. Sementara Sunaryo (2004) menyatakan bahwa perubahan perilaku dipengaruhi oleh faktor kebutuhan, motivasi, sikap dan kepercayaan. Pemberdayaan keluarga secara langsung yang didukung pengetahuan yang cukup dan sikap positif maka akan meningkatkan kemampuan keluarga untuk merawat pasien (kemampuan psikomotor).

Hasil penelitian menunjukkan ada perbedaan yang bermakna kemampuan psikomotor keluarga sesudah mengikuti *family psychoeducation* menjadi 32,40. Uji statistik dengan *paired t-test* menghasilkan nilai probabilitas sebesar 0,0001 (p value<0,05). Hasil uji ini menunjukkan adanya perbedaan rerata kemampuan psikomotor keluarga dalam merawat pasien skizofrenia yang signifikan antara sebelum dan sesudah intervensi. Hal ini menunjukkan bahwa *skill* atau ketrampilan tertentu dapat dilatih melalui proses belajar sehingga mengalami peningkatan. Teori belajar sosial Bandura menjadi pijakan dalam memahami tingkah laku dan sebagai prinsip dasar untuk menganalisis fenomena psikososial di berbagai tingkat kompleksitas dari perkembangan intrapersonal sampai tingkah laku interpersonal.

Hasil penelitian ini membuktikan bahwa kemampuan psikomotor keluarga dalam merawat pasien halusinasi dapat meningkat secara bermakna setelah mengikuti FPE. Menurut peneliti, hal ini didukung proses latihan psikomotor keluarga dalam merawat pasien secara langsung dengan memberikan pengetahuan dan latihan terstruktur serta konsisten sesuai dengan modul *family psychoeducation* yang telah disusun. Keluarga dilatih untuk merawat pasien dengan dilibatkan secara langsung dalam *role play* dan latihan tentang cara merawat pasien dengan halusinasi, manajemen stres dan beban, serta memonitor kemampuan dan

kegiatan pasien sehari-hari. Pengetahuan yang memadai tentang gangguan jiwa khususnya halusinasi dan perawatannya akan mempengaruhi kesiapan keluarga untuk bertindak dan bersikap sehingga dapat meningkatkan kemampuan psikomotor merawat pasien dengan halusinasi.

Kesimpulan

Karakteristik keluarga *(caregiver)* yang mempunyai anggota keluarga yang menderita halusinasi berada pada rata-rata usia dewasa menengah, dengan jumlah perempuan lebih banyak, berpendidikan SMP, status tidak bekerja, hubungan dengan pasien adalah saudara dan penghasilan rata-rata diatas upah minimal regional/UMR. Dari karakteristik tersebut dapat disimpulkan bahwa *family psychoeducation* yang diberikan pada keluarga klien pasung yang mayoritas adalah orang tua klien dengan umur yang sudah lanjut, tingkat pendidikan yang dikategorikan rendah dan bekerja menunjukkan peningkatan hasil akhir yang bermakna.

Karakteristik pasien dengan halusinasi berada rata-rata usia dewasa menengah dengan jumlah laki-laki lebih banyak, rutin berobat. Rata-rata lama menderita skizofrenia yaitu delapan tahun dengan jumlah kekambuhan terbanyak adalah tujuh kali. Dari karakteristik tersebut dapat disimpulkan bahwa asuhan keperawatan yang diberikan pada klien halusinasi sebagian besar laki-laki pada usia produktif, menderita gangguan jiwa yang cukup lama dengan tingkat kekambuhan rata-rata tujuh kali, rutin berobat.

Kemampuan keluarga merawat pasien halusinasi secara kognitif dan psikomotor tidak berhubungan dengan karakteristik keluarga. Kemampuan keluarga merawat pasien halusinasi secara kognitif dan psikomotor tidak berhubungan dengan karakteristik pasien. *Family psychoeducation* (FPE) meningkatkan kemampuan kognitif dan psikomotor keluarga dalam merawat pasien halusinasi secara bermakna.

Saran

Aplikasi Keperawatan

Dinas Kesehatan Kota Samarinda: membuat peraturan daerah terkait program pelayanan kesehatan jiwa di Samarinda dengan meningkatkan peran serta keluarga untuk mengaktifkan pemberdayaan masyarakat.

Puskesmas: menetapkan program pelayanan kesehatan jiwa masyarakat sebagai program utama dalam program pokok pelayanan Puskesmas. Perawat CMHN meningkatkan peran dan fungsinya dalam merawat pasien gangguan jiwa khususnya dengan halusinasi.

Komunitas: meningkatkan pelayanan Kelurahan Siaga Sehat Jiwa serta mempercepat

terbentuknya Kelurahan Siaga Sehat Jiwa di seluruh kota Samarinda.

Keluarga pasien dengan halusinasi: berperan lebih aktif dalam merawat dan mencari sumber pendukung untuk meningkatkan kemampuan dalam merawat pasien halusinasi.

Metodologi

Penelitian lebih lanjut hendaknya mampu menjawab hasil penelitian dengan memperbanyak sampel serta memperluas populasi khususnya untuk melihat faktor yang paling dominan berhubungan dengan kemampuan keluarga.Perlu direncanakan prosedur pengambilan data dan metode pelaksanaan intervensi yang sesuai dengan kondisi di lapangan untuk mengantisipasi jika sewaktu-waktu terjadi perubahan sesuai dengan kondisi di area penelitian. Perlu peningkatan dalam proses pelaksanaan FPE dalam menentukan frekuensi dan lama waktu untuk setiap sesi sesuai dengan situasi dan kondisi keluarga untuk mencapai hasil yang optimal. Untuk penelitian selanjutnya, hendaknya lebih difokuskan pada Kelurahan Siaga Sehat Jiwa (KSSJ) untuk mengetahui peran aktif perawat CMHN dan Kader Kesehatan Jiwa (KKJ) serta dukungan instansi terkait dan pemerintah daerah dalam peningkatan program CMHN yang telah dicanangkan.

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PENGARUH PSIKOEDUKASI KELUARGA TERHADAP KEMAMPUAN KELUARGA DALAM MERAWAT PENDERITA SKIZOFRENIA

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ABSTRACT

The presence of stigma and discrimination against with mental disorders encourage some parties either form government or non goverment organization develops several methods to improve healing in people with mental disorders. The act of them is mentoring the family with mental disorders. The nursing intervension that can be given to the family is psychoeducation. The purpose of this study is to detemine the influence of family psychoeducation on the ability of families in caring for schizophrenia patients. The kind of research used is that of quasi-experiment by pre- and post-test controll group design. Data were collected of research subjects consisted of 24 divided into control group and treatment group. Psychoeducation performed for 5 weeks with a frequency of 5 times with the duration of each time 45-60 minutes. Based on test results with Mann Whitney obtained p value <0.05 which means that comparison between the control group and treatment group showed significant improvement ability. The conclusion in this study is that psychoeducation has been proven to be effective in improving ability of family in treating people with schizophrenia. The nursing implications in this study are expected that psychoeducation becomes one part of promotive health efforts

Keywords: Psikoedukasi, family, skizofrenia

PENDAHULUAN

Hak atas kesehatan merupakan kebutuhan yang penting bagi kehidupan manusia, karena dengan jiwa yang sehat, maka akan dapat berpikir secara sehat. Pentingnya hak atas kesehatan tersebut secara tegas dijamin di dalam Pasal 12 Kovenan Internasional Hak Ekonomi, Sosial dan Budaya yang telah diratifikasi melalui Undang-Undang Nomor 11 Tahun 2005, yang intinya mengakui hak setiap orang untuk menikmati standar tertinggi yang dapat dicapai dalam hal kesehatan fisik dan mental (Depkes, 2013).

Mengacu pada UU No. 23 Tahun 1992 tentang Kesehatan secara garis besar masalah kesehatan jiwa digolongkan menjadi: masalah perkembangan manusia yang harmonis danpeningkatan kualitas hidup, masalah gangguan jiwa, serta masalah psikososial(Depkes, 2013). Menurut *A Statement On Psyciatric Mental Health Clinical Nursing Practice And Standart Of Psyciatric Mental Health Nursing Practice, ANA 1994* didapatkan masalah kesehatan mental atau psikiatrik diantaranya hambatan atau keterbatasan fungsi perawatan diri yang berhubungan dengan distres mental dan

emosional, perubahan konsep diri dan kesulitan dalam berhubungan dengan orang lain (Sarka, 2007)**.**

Skizofrenia merupakan salah satu penyakit yang dalam perawatannya berdampak terhadap keluarga khususnya orang yang secara langsung merawat (Kebede, Negash, Fekadu, & Jacobsson, 2003)**.** Ketidak mampuan penderita dengan gangguan jiwa untuk berinteraksi dengan orang lain menjadikannya sering dikucilkan dari komunitas sosialnya atau bahkan sering dianggap menjadi salah satu aib bagi kelurganya sendiriitambah lagi juga kurang nya peran dari pemerintah. Menurut Rosa(2009) Disebutkan bahwa penderita gangguan jiwa masih dipandang sebelah mata oleh pemerintah, Sehingga salah satu bentuknya adalah penderita sering melarikan diri dari tempat tinggalnya atau bahkan mereka sengaja dibuang oleh keluarganya dan mereka terlantar atau menjadi gelandangan.

Dari hasil penelitian yang dilakukan oleh puspitasari (2009) dinyatakan bahwa penderita gangguan jiwa sering mendapat stigma yang negatif dari masyarakat atau lingkungan sosial yang ada disekitarnya dan juga sering diperlakukan secara tidak manusiawi seperti halnya di olok – olok, perilaku kekerasan atau bahkan diapssung untuk diasingkan. Bentuk perilaku yang seperti inilah yang sering menimbulkan kekambuhan bagi penderita dengan gangguan jiwa yang sudah sembuh. Diakitkan dengan masalh tersebut sudah tentunya keluarga memiliki peran yang sangat penting untuk mendukung proses peningkatan kualitas kembali dari penderita jiwa baik yang sudah sembuh atau masih dalam tahap pemulihan. Keluarga adalah sistem pendukung yang utama untuk mencegah seorang anggota keluarga jatuh pada keadaan maladaptif. Selain itu keluarga merupakan bagian yang sangat pendting dalam merawat penderita dengan gangguan jiwa (Cheryl, Irene, Mao, Bo, & Cecilia, 2016)

Banyak sekali perilaku-perilaku menyimpang yang dilakukan oleh keluarga yang berdampak salah satu anggota keluarganya jatuh pada keadaan maladaptif, hal ini disebabkan karena keluarga adalah wadah utama yang sangat penting dalam melakukan pencegahan primer,sekunder, ataupun tersier. Keluarga pada dasarnya berkontribusi terhadap cepat lambatnya kesembuhan penderita gangguan jiwa selama proses rehabilitasi dan pengobatan, baik yang bersifat medis maupun psikologis. Namun dengan derajat kesadaran dan pengetahuan berbeda-beda yang dimiliki setiap keluarga, menjadikan proses tersebut apakah benar-benar menolong atau tidak. Karena masalah gangguan jiwa menyangkut persoalan yang bersifat holistik dalam kontek kesehatan fisik, psikis, sosial dan spiritual individu. Sehingga dibutuhkan konsep dan pemahaman yang jelas dalam memahami dan mengarahkannya ke dalam posisi yang benar-benar normal atau sehat(Shalahuddin, 2010)**.**

Berdasarkan hasil penelitian Tolin dan Frost (2008) dalam chasson (2014) mengemukakan bahwa pemberdayaan keluarga mampu meningkatkan keakraban dalam keluarga. Hal ini berarti bahwa dukungan dari keluarga akan memberikan kemungkinan akan keberhasilan pengobatan yang sedang dijalani oleh penderita skizofrenia. Salah satu intervensi keperawatan yang bisa diberikan pada keluarga adalah psikoedukasi.

Psikoedukasi keluarga merupakan pemberian informasi atau pengetahuan pada keluarga tentang penyakit yang diderita oleh anggota keluarga dengan tujuan untuk mengurangi kecenderungan klien untuk kambuh dan mengurangi pengaruh penyakitnya pada anggota keluarga yang lain Townsend, 2009). Dalam aplikasinya psikoedukasi banyak diberikan pada pasien dengan gangguan psikiatri termasuk anggota keluarga dan orang yang berkepentingan untuk merawat pasien tersebut (Lukens & Mcfarlane, 2004).

Berdasarkan hasil penelitian yang dilakukan oleh lestari (2011) didapatkan bahwa psikoedukasi ini berpengaruh terhadap peningkatan pengetahuan keluarga dan penurunan kecemasan keluarga dengan TB. Penelitian lain yang dilakukan oleh Goldenberg (2004) didapatkan bahwa angka kekambuhan pada klien tanpa diberikan terapi keluarga yaitu sebesar 25-50% sedangkan angka kekambuhan pada klien yang diberikan terapi keluarga yaitu sebesar 5-1 0% (Wiyati, 2010).

Berdasarkan latar belakang diatas maka peneliti ingin meneliti tentang Pengaruh Psikoedukasi Keluarga Terhadap Kemampuan keluarga dalam merawat penderita Skizofrenia.

METODE

Penelitian ini merupakan jenis penelitian kuantitatif dengan *Desain Quasy Eksperimental Pre Post Test With Control Group*. Jumlah populasi dalam penelitian ini adalah 56 orang. Teknik *sampling* yang digunakan adalah *purposive sampling* dengan jumlah sampel sebanyak 24 orang yang kemudian dibagi menjadi dua kelompok (kelompok kontrol dan kelompok perlakuan). Instrumen yang digunakan dalam penelitian untuk mengkur kemampuan keluarga mengacu pada perawatan penderita skizofrenia oleh Keliat yang kemudian dilakukan modifikasi oleh peneliti. Intrumen tersebut telah dilakukan uji validitas dan reliabiltas. Analisis pada penelitian ini terdiri dari analisis *univat*dan *bivariate* dengan menggunakan wilcoxon dan *Mann Whitney*.

Pelaksanaan penelitian total membutuhkan waktu 5 minggu. Kelompok kontrol membutuhkan frekuensi 1 kali selama penelitian dengan durasi waktu 45-60 menit.Sedangkan pada kelompok perlakuan membutuhkan frekuensi 4 kali pertemuan dengan jeda setiap pertemuan 5-7 hari dengan durasi pertemuan 45-60 menit.

HASIL PENELITIAN

Subyek penelitian dalam penelitian ini 24 orang. Karakteristik responden bisa dilihat pada tabel

Tabel 1 Karakteristik responden

NO	Karakteritik	Kelompok Kontrol	%	Kelompok Perlakuan	%
1	Jenis Kelamin				
	Laki-laki	0	0%	0	0%
	Perempuan	12	100%	12	100%
2	Pekerjaan				
	Petani	6	50%	8	66.7%
	Pegawai Negeri/swata	4	33.3%	1	8.33%
	Wiraswasta	2	16.7%	3	25.0%

3	Pendidikan				
	SD	2	16.7%	0	0%
	SMP	8	66.7%	8	66.7%
	SMA	2	16.7%	4	33.7%
	Diploma/Srata I dan II	0	0%	0	0%

Tabel 2: Analisis Perbedaan kemampuan keluarga dalam merawat penderita Skizofrenia sebelum dan sesudah (penyuluhan ditambah dengan psikoedukasi)

Variabel	N	Median (Minimum-maksimum)	Pv
Kemampuan kognitif	24	1 ((-1)-2)	0.034
Kemampuan Afektif		1 (0-2)	0.024
Kemampuan Psikomotor		1 (0-1)	0.038

PEMBAHASAN

Analisis perbedaan pengaruh psikoedukasi keluarga terhadap kemampuan keluarga dalam merawat penderita Skizofrenia antara kelompok kontrol dan kelompok perlakuan

Berdasarkan hasil penelitian Tujuan utama dari psikoedukasi keluarga adalah untuk bias berbagi informasi kepada keluarga tentang cara merawat penderita gangguan jiwa dengan lebih menitik beratkan pada perubahan perilaku kearah yang lebih baik, dengan anggapan bahwa perilaku adaptif dapat dipelajari (Varcolis, 2006). Kemampuan kognitif merupakan hal yang penting dalam mewujudkan tindakan yang dilakukan oleh keluarga menuju kearah yang lebih baik. Begitu juga dengan kemampuan afektif yang juga memiliki pengaruh terhadap tindakan yang dilakukan oleh sesorang dimana sikap ini sangat erat kaitannya dengan pengetahuan yang dimiliki. Kemampuan psikomotor merujuk pada gerakan muskuler yang merupakan hasil dari koordinasi pengetahuan, sikap terhadap sebuah tugas atau tanggung jawab yang dilaksanankan (craven, 2000).

Adanya perbedaan kemampuan responden dalam merawat penderita skizofrenia antara kleompok kontrol dan perlakuan disebabkan karena pada kelompok perlakuan mendapatkan informasi yang lebih sering dibandingkan dengan kelompok kontrol. Psikoedukasi keluarga merupakan pertemuan dengan keluarga yang membahas tentang masalah yang telah disepakti sesuai dengan kebutuhan keluarga. Psikoedukasi keluarga mampu meningkatkan kemampuan kognitif karena dalam psikoedukasi mengandung unsur peningkatan pengetahuan keluarga tentang penyakit serta kemampuan keluarga dalam merawat penderita (stuart & Laraia, 2005). Komponen yang ada dalam psikoedukasi menurut marsh (2000) dalam (stuart & Laraia, 2005) menyebutkan bahwa psikoedukasi dapat meningkatkan kemampuan unsur didaktik atau mendidik. Sebagian besar pembelajaran kemungkinan besar melibatkan perubahan perubahan di neuron dan sinapsis. Banyak beberapa

penelliti menyakini bahwa landasan fisiologis pembelajaran dan perkembangan kognitif terletak pada perubahan perubahan yang terjadi dalam hubungannya dengan neuron. (Gould, Beylin, Tanapat, Reeves & Shors, 1999; C. A. Nelson, Thomas, & de Haan, 2006; R. A. Thompson & Nelson, 2001) dalam ormrod (2008) menyebutkan bahwa pembentukan neuron-neuron terjadi sepanjang hidup manusia dimana pembentukan neuron baru tersebut dapat distimulasi oleh pengalaman sebelumnya atau pengelaman belajar yang masih baruPada kegiatan psikoedukasi responden mendapatkan pemberian informasi tentang cara merawat penderita. Hgoldengerg (2004) mengemukakan bahwa Psikoedukasi merupakan pemberikan informasi pada keluarga guna meningkatkan kemampuan keluarga dalam merawat anggota keluarga dengan harapan mereka mempunyai koping yang positif. Penelitian ini didukung oleh penelitian gumus (2017) yang menyatakan bahwa psikoeduaksi keluarga mampu meningkatkan kualitas hidup dan fungsi kehidupan. Selain itu keaktifan dari Hal ini menuntut peran pelayanan kesehatan pada upaya promotif (Am J Public Health. 2010). Berdasarkan hasil penelitian dengan metode kohort studi menyatakan bahwa kemampuan keluarga dalam merawat penderita dengan skizofrenia berpengaruh terhadap kesembuuhan penderita (Ran, 2016). Penelitian ini didukung oleh hasil penelitian yang dilakukan oleh (Taylor-rodgers & Batterham, 2014) pada remaja. Psikoedukasi dilakukan selama 3 minggu menyebutkan bahwa psikoedukasi terbukti meningkatkan kemampuan untuk mencari atau mendapatkan akses pelayanan yang lebih baik. Dixon *et all* (2000) menyebutkan bahwa psikoedukasi keluarga menawarkan kombinasi antara informasi tentang gangguan jiwa, praktek dan dukungan emosional, pengembangan kterampilan keluarga dalam *problem solving* dan manejeman krisis keluarga. Penelitian ini juga didukung oleh jaccobson (2002) yang menyatakan bahwa pelayanan kesehatan yang diberikan pada penderita dengan skizofrenia. Selain itu penelitian ini juga didukung oleh penelitian gumus (2017) yang menyatakan bahwa psikoedukasi mampu meningkatkan kualitas penderita bipolar. Sehingga perlu adanya deteksi dini tentang gangguan jiwa (Aalsma, Brown, Holloway, & Ott, 2014). Sehingga pemberian intervensi pada keluarga dengan skizofrenia manjadi salah satu alternatif yang bisa diberikan pada keluarga untuk mampu meingkatkan peran nya dalam melakukan fungsi keluarga (Yu et al., 2017)

KESIMPULAN

Psikoedukasi keluarga terbukti mampu meningkatkan kemampuan keluarga dalam merawat penderita TB

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The impact of a psychoeducational intervention on family members' views about schizophrenia: Results from the OASIS Italian multi-centre study

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Abstract

Background: The opinions of relatives of patients with schizophrenia about this disorder can influence its course and outcome.

Aims: In 2003, the Italian Psychiatric Association promoted a study on family psychoeducational intervention to explore its effectiveness in improving relatives' opinions and beliefs about schizophrenia.

Methods: In each of the 10 Italian mental health centres, 30 patients with schizophrenia and 30 key relatives were randomly recruited to receive the experimental intervention or the standard care. The experimental intervention consisted of 12 manual-based informative sessions on schizophrenia. Each relative filled in the self-reported questionnaire on family opinions about schizophrenia.

Results: The treated sample included 107 patients and 112 relatives; the control group consisted of 105 patients and 118 relatives. In both groups, stress, traumas, heredity and family difficulties were most frequently mentioned as causing the disorder. Relatives' opinions about patients' civil rights and social competence, in particular the right to get married, to have children and to vote, improved and the belief that patients with schizophrenia are unpredictable decreased at the end of the intervention.

Conclusions: These results confirm that relatives of patients with schizophrenia should receive psychoeducational interventions, particularly in Italy where family involvement in schizophrenia care is particularly frequent.

Keywords

schizophrenia, psychoeducational interventions, family opinions

Introduction

The opinions and views of patients' family members on the causes, treatments and psychosocial consequences of major mental disorders can influence patient course and outcome. In fact, it has been shown that relatives' beliefs about mental disorders may improve patients' adherence to treatments as well as reduce their feelings of stigma and of loneliness through an improvement of coping strategies and a reduction of family burden (Hall et al., 1994; Stuart and Arboleda-Florez, 2001). Several studies have been carried out on relatives' burden and expressed emotions and on the influence of family psychoeducational intervention on patients' outcome and well-being (Magliano and Fiorillo, 2006). However, the impact of psychoeducational interventions on relatives' opinions about mental illness has been explored only rarely and in contexts in which families do not represent the main care provider (Berkowitz et al., 1984; Quinn et al., 2003).

Moreover, despite the fact that Italy is one of the countries with the longest experience in community-orientated mental healthcare (De Girolamo and Cozza, 2000), very few studies on the impact of psychoeducational intervention on families of patients with severe mental disorders have been conducted in this country (Magliano et al., 2001).

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This is an unfortunate phenomenon, given that most patients with mental disorders in Italy live in close contact with their family members, who also frequently represent the main source of patient support (Magliano et al., 2002).

Yet, the attention of professionals to the relatives' need for information has occurred so far only in a limited percentage of cases and often with unsatisfactory results. A national survey conducted in 709 patients with schizophrenia and their family members in 30 Italian mental health centres showed that 80% of the families were in regular contact with their local mental health centres, but only a small percentage (8%) had received any form of psychoeducational intervention (Magliano et al., 2002). This particular study surveyed relatives' opinions about patients' social competence and civil and affective rights, but these opinions were difficult to disentangle. For instance, many family members agreed that patients should have the right to vote, but were also conservative regarding affective rights, such as the right to marry or to have children, which may also be due to the high levels of perceived burden. It was argued that family psychoeducational intervention providing information on patients' mental disorder, its treatments and outcome, as well as on patients' civil and affective rights, may positively influence family opinions about schizophrenia (Magliano et al., 2004a).

In 2003, the Italian Psychiatric Association promoted the study OASIS (the Italian acronym for Guidance, Help, Support and Information on Schizophrenia) on the dissemination of a family psychoeducational intervention aimed at exploring: (i) the effects of a psychoeducational intervention model based on the Italian cultural and social context; (ii) the possibility to implement this type of intervention in routine settings; (iii) the effectiveness of this intervention on patients' clinical status and psychosocial functioning; and (iv) its effectiveness in improving relatives' opinions and beliefs about mental disorders (Bassi et al., 2007; Fiorillo, 2003).

The present paper describes the surveyed beliefs about the causes, treatment and psychosocial consequences of schizophrenia in a sample of 112 family members of patients with schizophrenia, who were assessed before and after participating in a psychoeducational programme for patients and their relatives. It was expected that relatives' participation in this intervention would have a positive impact on their opinions and beliefs about mental illness. Specifically, it was hypothesized that, at the end of the intervention, treated relatives would show more tolerant opinions about the disorder than family members who did not receive the intervention. Data on other parts of the study will be reported elsewhere.

Methods

The study was conducted in 10 Italian mental health centres. In each centre, 30 patients with schizophrenia and 30 family members were randomly recruited and randomized to receive either psychoeducational intervention plus standard clinical management or standard clinical management only.

Patients were eligible for the study if they: (i) were between 18 and 45 years of age; (ii) had a DSM-IV diagnosis of schizophrenia; (iii) had had at least two contacts with their mental health centre over the previous 12 months; (iv) had been under the mental health centre for at least two years; (v) had not received any form of hospitalization nor suffered any relapse over the previous month; (vi) were living with at least one family member in the same household; (vii) had provided informed consent to take part in the study.

For each selected patient, the single family member determined to spend most time in daily contact with the user was then asked to take part in the study. Criteria for participating family members were: (i) age between 18 and 70 years; (ii) no history of psychosis or other major mental disorder; (iii) no cohabitation with other persons suffering from chronic physical or psychiatric illness apart from the patient. Because in Italy most patients with schizophrenia live with their families of origin, a relatives' upper age limit of 70 was defined in order to include a more naturalistic sample of these families, rather than a research one.

Randomization of patients and relatives was performed using SPSS statistical package. All eligible patients and relatives were posed on a randomization list, which was managed centrally by an independent site. Eligible cases varied from 30 to more than 100, depending on the catchment area.

The psychoeducational intervention programme was conducted by skilled mental health professionals who had taken part in a three-day intensive training course. In each mental health centre three professionals (one of them being a psychiatrist) with previous experience in behavioural family interventions were involved in the study.

The intervention programme consisted of 12 manual-based informative sessions which dealt with the following aspects: (i) signs and symptoms of schizophrenia; (ii) diagnosis; (iii) causes of schizophrenia; (iv) pharmacological interventions and their side effects; (v) early warning signs; (vi) treatment in emergency situations; (vii) role of evidence-based psychosocial interventions, such as social skills training, problem-solving therapy, cognitive remediation and cognitive therapy, in the management of schizophrenia; (viii) role of family members; (ix) alcohol and drug abuse; (x) and social, affective and sexual relationships. Two additional introductory and conclusive sessions were also provided.

Sessions were held separately for patients and relatives, according to the McFarlane multiple-group format (McFarlane et al., 2003); professionals were invited to conduct three monthly sessions lasting 60–90 minutes each, including the presentation of a short video to introduce the topic of the session. The mean number of participants per session was 12. Professionals provided the participants with leaflets and written materials prepared by the research team on the basis of Italian socio-cultural context and mental healthcare. The whole intervention lasted four months, with two additional booster sessions performed at months 5 and 6.

Assessment procedures

Information about the patients' clinical status and the patients' and family members' socio-demographic characteristics were collected with ad-hoc schedules. Each family member was asked to fill in the Relatives' Questionnaire on the Opinions About Mental Illness (QO) (Magliano et al., 1999). The QO has been developed on the basis of a review of the literature and referring to the Opinion on Mental Illness Questionnaire (OMI; Struening and Cohen, 1963) and the Community Attitudes toward Mental Illness (CAMI, Taylor and Dear, 1981). The QO is a self-report instrument exploring beliefs about: (i) the causes of schizophrenia; (ii) the effectiveness of treatment; (iii) patients' rights to be informed; (iv) the political, social and affective rights of patients with schizophrenia; and (v) patients' ability to perform social and occupational roles. The 28 items of the questionnaire are grouped into four subscales (social isolation, social distance, utility of treatments, biopsychosocial causes of schizophrenia), whose intra-rater reliability ranges from 0.36 to 0.84. Cronbach's α coefficient, which tests the content validity of the subscales, ranges from 0.56 to 0.66. Factor analysis led to the identification of two factors (opinions on social consequences and utility of treatments, and beliefs on the causes of schizophrenia), accounting for 73% of the total variance (Magliano et al., 1999).

For the purposes of this paper, the beliefs on the causes of schizophrenia have been divided into two groups: biological causes, which include heredity, physical illness in pregnancy or childhood, inappropriate therapy, presence of physical illness; and social causes, which include stress, family conflicts, psychological traumas, disillusionment in love and frequenting bad company.

Responses to QO items were listed in three tables and were grouped into two response options ('completely true' or 'partially true'; 'not true'); replies such as 'don't know' were not included and account for the missing residual percentages in each column.

Statistical analysis

All analyses were performed using the SPSS for Windows (2000) statistical analysis package.

Descriptive analyses were run on both samples; differences between the two samples were tested by χ^2 and analysis of variance, as appropriate.

A MANOVA test adjusted for repeated measures was used to show pre/post changes in the two experimental groups, using 'treatment' (type of intervention) as categorical predictor, 'time' (before and after intervention) as 'within-group' factor and the individual QO scores as dependent variables. In the case of a significant *F* test, post hoc Tukey tests were performed in order to examine changes in the various factor scores of the QO.

For all tests the statistical significance level was set at 0.05.

Results

Each participating mental health centre was expected to recruit 30 patients with schizophrenia and 30 family members. Hence, the expected overall sample was to be made up of 300 patients and relatives. However, the intervention programme had been delayed for several months to obtain ethical committee approval for each centre, and some patients and relatives later refused to be involved despite their earlier agreement. Therefore, the sample randomized to the intervention comprised 216 patients and 236 relatives. Very few participants dropped out of the study during the intervention programme and the final sample was therefore made up of 212 patients and 230 relatives. The treated sample included 107 patients and 112 relatives; the control group was made up of 105 patients and 118 relatives. The main socio-demographic characteristics of both patients and relatives are listed (Table 1).

There was a significant difference in the opinions of the patients' relatives about mental illness between the two

Table 1. Patients' and family members' sociodemographic characteristics

Items	Experimental group		Control group	
	Patients (*n* = 107)	Relatives (*n* = 112)	Patients (*n* = 105)	Relatives (*n* = 118)
Gender, male, %	61	33	76	37
Age, mean (*SD*)	35 (7)	59 (10)	36 (8)	58 (12)
Marital status, %				
Single	88	7	85	6
Married	8	63	12	65
Divorced	3	13	3	11
Widowed	1	17	–	18
Employment, yes, %	27	30	19	28
Educational level, %				
Up to secondary school degree	53	66	65	82
High school degree	41	24	32	13
University degree	6	10	3	5

groups ($F_{40,189}$ = 5.4, $p < 0.000001$), with a marked 'pre/post' effect ($F_{40,189}$ = 77.2, $p < 0.0001$) and a significant interaction between the factors 'treatment' and 'time' ($F_{40,189}$ = 3.2, $p < 0.05$).

Opinions on the concept and causes of schizophrenia

At the end of the intervention, 84.2% of family members from the experimental group vs. 62.0% of the control group stated that they were aware that their ill relative had a mental disorder and that they were receiving the intervention for this reason. At the beginning of the study, these percentages were 75.2% and 63.6%, respectively.

In both groups, family members most frequently mentioned stress, trauma, heredity and family difficulties as determinants of the disorder. In the experimental group, the most evident pre/post variations in opinions and beliefs concerned the role of heredity (18.9 % vs. 28.9%), family stress (48.9% vs. 57.8%) and family conflicts (34.4% vs. 26.7%) as causes of schizophrenia.

The two broad groupings of biological and social determinants showed no significant pre/post-intervention changes (Table 2): at the end of the intervention, 97% of relatives

Table 2. Opinions about the determinants, outcome, and possibility of treating schizophrenia, and about patients' and family members' rights to be informed in both samples, at baseline and follow-up

Items	Experimental group (% of respondents)			Control group (% of respondents)		
	Baseline	Follow-up	$p <$	Baseline	Follow-up	$p <$
Biological determinants	37.8	37.8	ns	37.9	35.6	ns
Social determinants	92.2	97.6	ns	86.2	82.8	ns
Patients can recover from this disorder *						
Completely true	17.3	20.0	ns	16.7	16.7	ns
Partially true	41.8	38.2		52.5	40.0	
Not true	26.4	21.8		20.0	14.2	
Drugs are useful in the treatment of this disorder						
Completely true	49.1	53.6	ns	38.3	34.2	ns
Partially true	39.1	32.7		45.8	36.6	
Not true	6.4	1.8		4.2	5.8	
Other non-pharmacological interventions are useful in the treatment of this disorder						
Completely true	56.4	59.1	ns	21.7	15.8	ns
Partially true	29.1	30.0		25.8	29.2	
Not true	3.6	2.7		6.7	5.8	
Mental disorders are not different from other physical illnesses	18.2	32.7	0.01	15.0	20.0	ns
	20.9	20.0		23.3	20.0	
Completely true	52.7	37.3		46.7	40.0	
Partially true						
Not true						
Patients with this disorder should be informed by psychiatrists about their own disorder [a]						
Completely true	58.2	70.0	0.05	64.2	58.3	ns
Partially true	23.6	14.5		26.7	15.8	
Not true	6.4	4.5		1.7	3.3	
Patients with this disorder should be informed by psychiatrists about drugs and their side effects						
Completely true	72.7	73.6	ns	71.7	64.2	ns
Partially true	20.9	15.4		15.8	10.0	
Not true	3.6	7.3		2.5	4.2	
Relatives should be informed by psychiatrists about the mental disorder of their family member						
Completely true	87.3	90.0	ns	88.3	76.7	ns
Partially true	10.0	4.5		6.7	3.3	
Not true	1.8	0.9		0.8	1.7	
There is little to be done for these patients, apart from helping them to live in a peaceful environment						
Completely true	34.5	41.8	ns	42.5	28.3	ns
Partially true	30.9	22.7		26.7	27.5	
Not true	30.0	28.2		22.5	21.7	

a = differences at T0 between treated and control groups = $p < 0.05$; * = differences at T6 between experimental and control groups = $p < 0.05$

from the experimental group and 83% from the control group believed that schizophrenia was mainly due to psychological determinants.

Opinions on outcomes, right to be informed and treatment of schizophrenia

The relatives' opinions about outcome, treatment and information required by patients with schizophrenia and their families were compared (Table 2). There were no differences in either group at follow-up vs. baseline assessments for likely outcome of the disorder but, at the end of the intervention, 22% of treated relatives vs. 14% of the control group stated that they did not expect their family member to ever recover from schizophrenia ($p < 0.05$). Most respondents considered medication very helpful and a striking majority of respondents underscored the need to receive comprehensive information about the disorder and medication side effects, for both themselves and the ill family member. Specifically, at the end of the intervention, treated relatives were more convinced than at baseline that patients with schizophrenia should be informed by mental health professionals about their disorder ($p < 0.05$). At baseline, 52.7% of treated relatives stated that they considered mental disorders as being different from other physical diseases; this percentage decreased to 37.3% at follow-up ($p < 0.01$).

Opinions on the social competence and civil rights of patients with schizophrenia

An important significant variation in opinions about the social competence of patients with schizophrenia concerned social distance: while 74.5% of respondents at baseline completely or partially admitted that people keep aloof from patients with schizophrenia, this percentage decreased at 65.5% after the intervention ($p < 0.05$) (Table 3).

A very similar percentage of family members in the experimental group completely or partially believed at both

Table 3. Opinions on the social competence of patients with schizophrenia in both samples, at baseline and follow-up

Items	Experimental group (% of respondents)			Control group (% of respondents)		
	Baseline	Follow-up	$p <$	Baseline	Follow-up	$p <$
Patients with this disorder are unpredictable						
Completely true	27.3	30.9	ns	25.0	21.7	ns
Partially true	32.7	35.4		47.5	36.7	
Not true	33.6	29.1		22.5	20.0	
People keep aloof from patients with this disorder						
Completely true	33.6	27.3	0.05	29.2	29.2	ns
Partially true	40.9	38.2		39.2	30.0	
Not true	22.7	30.9		27.5	30.0	
Psychiatric hospitals are more similar to prisons than to hospitals						
Completely true	68.2	68.2	ns	65.0	54.2	ns
Partially true	17.3	13.6		15.8	15.0	
Not true	3.6	3.6		1.7	2.5	
A person who previously suffered from this disorder and is recovered may work as a babysitter						
Completely true	16.4	22.7	ns	11.7	13.3	ns
Partially true	44.5	43.6		43.3	32.5	
Not true	22.7	19.1		27.5	23.3	
It is easy to recognize that these patients have had this disorder						
Completely true	31.8	32.7	ns	26.7	18.3	ns
Partially true	37.3	37.3		38.3	40.0	
Not true	26.4	20.9		26.7	17.5	
Patients with this disorder are as able to work as any other people						
Completely true	12.7	25.4	ns	15.8	10.8	ns
Partially true	48.2	41.8		55.0	41.7	
Not true	33.6	26.4		25.0	25.8	
Patients with this disorder should be admitted to an asylum						
Completely true	3.6	2.7	ns	2.5	2.5	ns
Partially true	22.7	15.8		25.0	15.8	
Not true	66.4	60.8		65.8	60.8	

baseline and follow-up that patients with schizophrenia are unpredictable (60.0% and 66.3%, respectively).

Finally, the percentage of family members stating that patients with this disorder should be treated in mental hospitals was very low for both groups, both at baseline and at follow-up.

Approximately 15% of the respondents at baseline vs. 6.4% of respondents at follow-up were convinced that patients with schizophrenia should not be granted the right to vote ($p < 0.05$) (Table 4). Moreover, a positive intervention effect was observed for the variable of exploring relatives' opinions on family burden. In fact, although 91% of the respondents completely or partially agreed at baseline that the patients' situation impinged only on their own families, this percentage decreased to 72% at follow-up ($p < 0.05$).

Discussion

The present study represents the first known effort to explore the impact of a family psychoeducational intervention on the opinions and beliefs of relatives of patients with schizophrenia about their disorder in Italy.

One of the most striking findings is that the control group showed no significant change over time in any of the 22 items tested, whereas the experimental group showed significant changes in five of the 22 items. In particular, the intervention seems to be particularly useful in reducing relatives' levels of stigma. In fact, at follow-up a lower percentage of treated relatives thought that people kept themselves aloof from patients with schizophrenia and a higher proportion of them reported that mental disorders are not different from physical illnesses. The reduction of family stigma and social distance may be particularly useful in improving the process of integration of these patients in the community (Crisp et al., 2000).

The need of patients to be informed is highly acknowledged by the sample after intervention, as shown by the high percentage of relatives who believed that patients should be informed by doctors about their disorder (70.0% vs. 58.2%), suggesting that the way information was communicated to relatives (through informative videos and leaflets) has been highly appreciated by participants.

On the other hand, it must be reported that the OASIS intervention had a limited impact in changing family members' opinions and beliefs about the outcome of schizophrenia and patients' social competence. This phenomenon may be explained by the time-consolidated community-orientated mental healthcare available in Italy, which may have led to a full integration of patients with schizophrenia

Table 4. Opinions on the civil rights of patients with schizophrenia in both samples, at baseline and follow-up

Items	Experimental group (% of respondents)			Control group (% of respondents)		
	Baseline	Follow-up	$p <$	Baseline	Follow-up	$p <$
Patients with this disorder should not get married						
Completely true	22.7	31.8	ns	23.3	14.2	ns
Partially true	40.9	29.1		38.3	31.7	
Not true	16.6	22.7		17.5	23.3	
The law should allow anybody to divorce sooner if the spouse suffers from schizophrenia [a*]						
Completely true	22.7	29.1	ns	30.8	23.3	ns
Partially true	33.6	30.0		33.3	29.2	
Not true	21.8	15.8		15.8	19.2	
Patients with this disorder should not have children [b*]						
Completely true	30.9	38.2	ns	40.8	31.7	ns
Partially true	25.4	26.4		28.3	20.0	
Not true	19.1	14.5		16.7	17.5	
The patient's situation poses a burden to his/her family only						
Completely true	59.1	50.0	0.05	66.7	62.7	ns
Partially true	31.8	21.7		20.0	29.1	
Not true	7.3	10.0		9.2	4.5	
Patients with this disorder should not be granted the right to vote [a*]						
Completely true	8.3	4.2	0.05	14.9	11.7	ns
Partially true	18.8	10.4		10.6	8.5	
Not true	65.6	481.3		59.6	63.8	

a = differences at T0 between treated and control groups = $p < 0.05$; b = differences at T0 between treated and control groups = $p < 0.01$;
* = differences at T1 between treated and control groups = $p < 0.05$

in their own social and family environments over the past 25 years (De Girolamo and Cozza, 2000). In fact, results from recent comparative studies point to a significant change in opinions about mental illness in the Italian general population compared to those expressed in 1988 – 10 years after the promulgation of the reform law (Magliano et al., 2004b). In particular, Italians tend to express more positive attitudes towards patients' social competence, civil and affective rights, and potential for recovering from schizophrenia than in 1988 (Kemali et al., 1989). The long-term experience in community mental healthcare in Italy may also explain the less negative opinions about schizophrenia reported by the family members examined in the present sample than those reported in the literature.

However, at the end of the intervention, participants expressed more negative views about the likelihood of patients' recovery. This is probably due first to the fact that in the OASIS informative packages no one session specifically addressed the likelihood of recovery from schizophrenia and, second, to a 'ceiling effect', given that relatives of patients with schizophrenia living in Italy express very low levels of pessimistic opinion. It is unlikely that any informative programme could make much of a contribution to changing the extremely low percentage of relatives reporting pessimistic opinions about the outcome and social competence of people with the disorder. A replication of the present study is recommended to be conducted in sociocultural contexts where even a partial integration of the mentally ill has not yet been achieved.

The very low drop-out rate observed for both patients and relatives is probably one of the most significant positive outcomes of the intervention, as it is much lower than that reported in the literature on the dissemination of family psychoeducational interventions (McFarlane et al., 2001). This is probably due to the involvement of three professionals in each mental health centre, one of them being a psychiatrist. This methodological choice may have facilitated the identification of eligible cases, the integration of psychoeducational intervention with other professional workloads and responsibilities, and the time set aside for the programme by each mental health centre – all key difficulties reported by professionals in implementing these interventions in routine care (Magliano et al., 2006). Moreover, the fact that the programme called for separate sessions for patients and family members and the use of informative videos and leaflets, may also have had a significant role in this very low drop-out rate.

Probably one of the main positive outcomes of the OASIS programme was the general satisfaction of participants and of mental health professionals, as witnessed by the high proportion of centres that continued to run the intervention once the study had concluded. However, the design of the study does not allow this outcome to be analytically measured; this analysis should be included in future studies on the dissemination of family psychoeducational interventions.

The fact that the programme included informative sessions on schizophrenia only, without considering communication and problem-solving strategies, nor examining individual goals – as typically occurs with most psychoeducational intervention programmes (Anderson et al., 1986; Falloon, 1985; Mueser and Gingerich, 2006) – may represent one of the main limitations of the study. At the same time, however, difficulties in implementing such a structured type of intervention in routine clinical work have been shown to be a major impediment to the dissemination of psychoeducational intervention programmes on a large scale (Fadden, 1997; McFarlane et al., 2001; Magliano et al., 2006).

The results of this study confirm that family psychoeducational interventions are of benefit in the management of schizophrenia, particularly if they are provided in a multi-family setting. The fact that the intervention protocol reduced family burden, as witnessed by the lower percentage of relatives who think that the patient's situation poses a burden to his/her family only, shows that multi-family psychoeducational interventions can help patients' relatives to overcome feelings of isolation and loneliness which can, in turn, promote the development of mild psychiatric disturbances (such as minor depression, anxiety and insomnia) in relatives of patients with severe mental illness.

Further studies should be conducted in randomly selected mental health centres and in settings with different types of mental healthcare organizations. Family psychoeducational interventions should be tailored to the cultural and social background of each target population in order to guarantee their implementation and to improve patients' care and family support.

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BMC Psychiatry

RESEARCH ARTICLE Open Access

Effect of a psycho-educational intervention for family members on caregiver burdens and psychiatric symptoms in patients with schizophrenia in Shiraz, Iran

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Abstract

Background: This study explored the effectiveness of family psycho-education in reducing patients' symptoms and on family caregiver burden.

Methods: Seventy Iranian outpatients with a diagnosis of schizophrenia disorder and their caregivers were randomly allocated to the experimental (n = 35) or control groups (n = 35). Patients in the experimental group received antipsychotic drug treatment and a psycho-educational program was arranged for their caregivers. The psycho-educational program consisted of ten 90-min sessions held during five weeks (two session in each week). Each caregiver attended 10 sessions (in five weeks) At baseline, immediately after intervention, and one month later. Validated tools were used to assess patients' clinical status and caregiver burden.

Results: Compared with the control group, the case group showed significantly reduced symptom severity and caregiver burden both immediately after intervention and one month later.

Conclusions: These results suggest that even need based short-term psycho-educational intervention for family members of Iranian patients with schizophrenic disorder may improve the outcomes of patients and their families.

Trial registration: IRCT Number:138809122812 N1`

Background

Schizophrenia is a severe mental illness, which is stressful not only for the patients but also for their family members. Between 50% and 80% of patients with schizophrenia live with or have regular contact with family members [1], and rely on relatives for housing, and emotional and financial support. Therefore, the quality of their relationships greatly influences the patients' outcomes [2]. However, these families report high levels of burden related to caring for a member with schizophrenia [3,4]. As a result, studies have attempted to find a link between patients' symptoms and family burden [5,6]. Patient stressors such as negative and disruptive symptoms have been linked to increased burden in caregivers of patients with schizophrenia. Winefield and Harvey (1993) found a significant positive correlation between the level of behavioral disturbance in the patient and caregivers' distress [5]. However, one study found no link between these patient stressors and family burden [7].

There are different types of family interventions for reducing the patient/caregiver burden such as behavioral family management, psychoeducational family intervention, family therapy, etc. In a recent study that compared different models of family interventions, the researchers concluded that psychoeducation was more useful in decreasing the burden in the mothers caring for their child suffering from schizophrenia [8]. Recent changes in the treatment of schizophrenia disorder make use of both traditional and psycho-educational interventions to treat the symptoms [9-14]. Several other studies have also demonstrated the efficacy of family psycho-educational

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interventions in reducing of relapses, re-hospitalization [15-17] and family burden [18-20]. The psycho-educational intervention is a set of systematic intervention based on supportive and cognitive behavior therapy approach with emphasis on patients and family needs. The intervention is focused on increasing patient and family knowledge about disease, better adjustment to illness, communication and facilitating problem solving skills [21]. Despite the current emphasis on community-based care and family psycho-education for these patients [2,22,23], these approaches have not been attempted in Iran yet. In a study by Mottaghipour and her colleagues, Sutherland Mental Health Service in New South Wales was used to show that organizational changes are needed to implement a "family friendly service" [24]. In an Iranian study, Malakouti and his colleagues conducted a comparative study of the clinical outcomes of mental health workers and consumers' family members as case managers with 12 months of home-visit services for 129 patients with Schizophrenia. Burden, knowledge, quality of life and the general health condition of the care-givers, as well as positive/negative symptoms and social skills of the consumers were evaluated. Most clinical variables were improved without significant differences between groups. The hospitalization rate was reduced by 67% [25].

In addition, there are only limited studies focusing on Iranian populations with focus on patients and family need assessment, and it is unclear whether family psycho-education, which has been recognized as effective in European and American populations, can be applied successfully in Iranian family. Therefore, it is important to test the efficacy of psycho-education in enhancing family knowledge about the illness and the ability to cope with care giving role in Iranian families with a member who has schizophrenia.

Iranian families are characterized by their intimate interpersonal relationships and many interactions among family members. Therefore, illnesses in one family member results in a substantial burden for the whole family. In addition, Iranian families report a low level of formal support services as compared with their Western peers [26].

Currently, there are no community mental health centers specifically for following up patients with schizophrenia in Iran. The patients mainly refer to psychiatrists or Psychiatric centers or primary healthcare centers that do not clearly address the specific needs of each family. Moreover, since mental illness is considered as a taboo in our cultural settings and many families are not aware of the needs and illness of their patients, they experience a great amount of burden. Also, the patients nor their families do not receive routine non-pharmaceutical treatment such as family interventions. Moreover, we do not have trained professionals in this regard to perform such interventions.

Considering the lack of routine long term psychoeducational programs for patients with schizophrenia and their families based on their specific needs, we aimed to investigate the efficacy of family psycho-education in reducing patients' symptoms and its efficacy of family psycho-education in reducing family caregiver burden.

Methods

Design

This randomized controlled trial was conducted in Shiraz, a city of about 2.5 million inhabitants in southern Iran. Seventy caregivers patients with schizophrenia whose records were available at three psychiatric centers in Shiraz were randomized blindly to two groups considering the inclusion criteria and consulting with their psychiatrists. We developed our intervention based on the families' needs and the modified existing literature in this regard [27,28]. The psycho-educational program consisted of ten 90-min sessions held during five weeks (two sessions each week). Each caregiver attended 10 sessions (in five week) on the afternoon of their choice from the point of suitability of time. Four psycho-educational groups of eight or nine caregivers each were arranged with the same contents, and the program was conducted by a psychiatric nurse or psychiatrist.

The goals and contents of each of the ten sessions are summarized in Table 1. The beginning of the first session was practically a needs assessment session in which we asked the caregivers about the types of issues and problems they have with their patients and what they would like to know about their patient's condition in order to better organize the interventions. After doing subjects' need assessment,each psycho-educational session included a variety of educational techniques designed to enhance the participant's learning and maintain their attention (for example; visual aids such as charts, film presentation and Microsoft PowerPoint slideshows). The first part of each session consisted of a lecture given by a psychiatrist or psychiatric nurse and the last part of each session (30 min) consisted of a question-and-answer and group discussion period. During this period, the caregivers described situations and incidents related to their patients and discussed alternative ways of coping with and resolving their difficulties with care giving. At the second session, the guest speaker was a patient with a DSM-IV diagnosis of schizophrenia who had a clinically stable status. He related his experiences with his illness and offered insights to the caregivers. At the end of the sessions, an educational booklet was given to all family members.

Approval for the study was obtained from the Ethics Committee of Shiraz University of Medical Sciences. Written consent was obtained from the patients and

Table 1 Content of psycho educational program

Session	Goals	Content
1	To orient caregivers to the program and to create a trusting relationship between caregivers and instructors	. Assessment of family needs. . Overview of the program and introduction of instructors and members to each other. . Discussion of the importance of orientation to patient behaviors and symptoms . Completion of Brief Psychiatric Rating Scale and Family Burden scale by participants.
2	To understand schizophrenia, its symptoms and treatments, and its effects on patients and families	. Presentation of a patient with a DSM-IV diagnosis of schizophrenia with clinically stable status. The patient describes his experiences and offer insights. The instructor offers explanations of the symptoms and behaviors, and of their effects on the family. . Discussion of the etiology and treatments . Question-answer and group discussion.
3	To recognize the effect of medications and compliance.	. A review of the previous session. . Discussion of positive and negative effects of antipsychotic drugs and problems related to side effects. . Emphasis on the importance of drug compliance and maintenance. . Question-answer and group discussion.
4	To orient caregivers to the warning signs of relapse and relapse prevention	. A review of the previous session. . Discussion about warning signs of relapse. . Explanation of the family role in relapse prevention. . Exploration of family intervention when the relapse has occurred. . Question-answer and group discussion.
5-6	To improve communication skills in the family	. A review of the previous session. . Discussion of the importance of effective communication skills in the family and the role of environmental stress as a risk factor for schizophrenia relapse. . Discussion of skills for effective communication between family members. . Question-answer and group discussions.
7	To manage the patient's symptom and skills in coping with them	. A review of the previous session. . Discussion of effective communication skills with patients when they have symptoms. . Discussion of token economy and negative reinforcement for managing patients' symptoms. . Explanation of skills for coping with some of the patients' symptoms.

Table 1 Content of psycho educational program *(Continued)*

		. Question-answer and group discussion.
8	To understand effective way to express emotion	. A review of the previous session. . Exploring intense emotions towards the patient. . Discussion of expressing emotion and emotional environment in the family. . Discussion of how to cope with the patient's negative emotions. . Question-answer and group discussion.
9	To orient caregivers to stress management in the family	. A review of the previous session. . Introduction of the importance of stress management in the family. . Discussion of ways to reduce stress. . Question-answer and group discussion.
10	To orient caregivers to relaxation methods	. A review and summary of the contents of past sessions. . Practicing relaxation methods during sessions. . Conclusion.

their families. All participants were informed about the purpose of the study and about their right to withdraw at any time, and were assured that all personal information would remain confidential.

Participants

The reviewed the records of all patients with schizophrenia which were available at the Psychiatric centers. We called those patients who met our inclusion criteria and told their family about their study and invited the patient and one of their family members who is the main caregiver to participate in our trial. The patients had lived with their families for at least two years. Therefore, seventy caregivers of outpatients with a diagnosis of schizophrenia disorder who were members of their immediate family were randomly allocated to the experimental (n = 35) or control group (n = 35). In the control group, only the patients received routine care (antipsychotic drug treatment) whereas in the experimental group, the caregivers participated in a psycho-educational program while the patients received antipsychotic drug treatment. The intervention was conducted by the same psychiatrist and psychiatric nurse. The co-researcher (assessor) was blind to study treatment and condition and completed the scales. We included caregivers whose patients had the following criteria: i) a diagnosis within the preceding 5 years of schizophrenia disorder according to DSM-IV criteria, and ii) no other Axis 1 disorder during recruitment. All caregivers who were invited to participate identified themselves as the primary caregiver with the greatest responsibility for providing care within the family, and they themselves had no known mental illness. It is necessary to mention that after the intervention a certificate of attendance was given to participant and thanked them accordingly.

The exclusion criteria for the study were: i) caregivers who had participated in another psycho educational program during the preceding year, ii) caring for more than one family member with mental illness, and iii) substance abuse problem in the patient.

Instruments

Data were collected with a personal information sheet, the Iranian version of the Brief Psychiatric Rating Scale (BPRS) [29] which was completed for every patient by caregiver, and the Family Burden questionnaire [25]. The concept of family burden consists of two aspects, objective burden related to the performance of daily assistance activities, financial impact, behavior supervision and disruption of family routine, and subjective burden

concerning worries about the patients and feelings of being disturbed by care giving activities.(26). A specially designed questionnaire was used to collect data on the participants' age, sex, education, marital status, type of medication, the degree of patient compliance to taking medication, employment status, economic status, and relationship between the caregiver and the patient.

Before, immediately after and one month after the intervention, psychiatric symptoms were assessed with the BPRS. The BPRS is a widely applied instrument consisting of 16 symptom constructs for evaluating the psychiatric status of a patient and it is in four subscales: positive symptoms, negative symptoms, mania-hostility symptoms and depressive-anxiety symptoms. Each item is rated from 1 (absent) to 7 (very severe) (16 symptom constructs) [30]. This scale has been translated in persian and utilized in Fallahi's (2007, 2011) studies. The coefficient for reliability of the tool was determined by chronbach's alpha to be $r = 0.8$ in some studies [29,31,32]. Also Khodabakhshi Koolaee [2007] indicated satisfactory content validity and internal consistency with Cornbach's alpha to be 0.72 [33].

The caregiver burden was estimated with the validated Persian version of the family Burden questionnaire. This instrument contains ten closed questions. It has been used in Iran and its reliability and validity has been proved by several studies. The reliability of the questionnaire was assessed by the Spearman-Brown correlation coefficient and reported to be 0.80 [26,33,34]. Also Schene reported the Cronbach's alpha coefficient for reliability of the tool is based on internal consistency of 0.85 [35].

Statistical analysis

SPSS v. 15 was used for the statistical analysis. At baseline, sociodemographic characteristics in the two groups were compared with the chi-squared test. Between-group comparisons of the variables were done with Student's *t*-test and repeated measurement analyses of variance were used to determine whether the improvements in these variables were changed over time.

Results

A total of 65 families completed the study. Five participants (two from the experimental group and three from the control group) dropped out before completion of the study for different reasons unrelated to the study. The two groups of patients and their families did not differ significantly in any of the sociodemographic characteristics. Mean age of the patients in the experimental group was 32.5 years and that of their caregivers in the same group was 50.5 years. Mean age of the patients in the control group was 30 years and that of their caregiver in the same group was 52.5. Women made up 63% of the patients in the experimental group and 43% in the control group. Most of the patients in both groups were single and unemployed. The majority of caregivers in both groups were mothers of patients, most of whom had primary education and belonged to the middle class. All of the patients were on antipsychotic medication. No patient in either group was hospitalized during the study period. There were no significant differences regarding demographic data between the groups.

The patients'BPRS Means profile in experimental & control Group is shown in Figure 1 and FBS mean profiles in experimental & control Group is shown in Figure 2.

The patients' clinical status and family caregiver burden time 0 (baseline), time 1 (immediately after the intervention), and time 2 (one month post-intervention) is shown in Table 2.

Comparisons of the baseline scores of the variables (positive symptoms, negative symptoms, mania-hostility symptoms, depressive-anxiety symptoms, global BPRS score and family burden) detected no significant differences between the two groups.

The findings after completion of the psycho educational program indicated statistically significant differences between the two groups for negative symptoms (especially uncooperativeness) and depressive-anxiety symptoms, an improvement in the global BPRS score, and a reduction in the family burden score, with respect to the baseline (Table 2). One month post-intervention, there were statistically significant differences between the two groups in negative symptoms (especially uncooperativeness), depressive-anxiety symptoms and positive symptoms. In addition, we found major improvements in the global BPRS score as well as a greater reduction in family burden score with respect to the baseline. The mean scores at time 0 (baseline) and time 2 (one month post-intervention) indicated that the experimental group had improved steadily in the global BPRS score ($P < 0.037$) and family burden ($P < 0.0001$).

Discussion

The family psychoeducation in this study demonstrated positive effects in reduction of family burden and patients symptoms immediately and one month after the intervention. Most previous family psychoeducational studies have focused on European and American populations [35], whereas some studies have been carried out in Asian populations including the Iranian population. Nevertheless, Iranian families are characterized by their intimate interpersonal relationships and many interactions among family members. Therefore, illnesses in one family member results in a substantial burden for the whole family. In addition, some Western studies reported formal support services for their patients [26,36]. The present study

focused on the impact of psycho educational intervention in Iranian families in which one member has schizophrenia. The results of our psycho educational intervention were encouraging and the caregivers in the experimental group indicated a significant decrease in family burden. Also, there was an improvement in most aspects of the BPRS in the patients they took care of. Improvement in the patient's clinical status and decreases in family burden may be related to the family's awareness of strategies for dealing with daily problematic situations [37]. In addition, our results may be related to family orientation to the patient's symptoms and behavior, and to their skills of coping with them, consistent with other studies [38]. As a result of our intervention, family members may have learned to understand effective ways of expressing emotions in the family context. Also Xiong and her colleagues in their study about family-based intervention for schizophrenic patients in china mentioned that improvements in patients' symptoms may have been related to enhanced treatment compliance because families were better able to

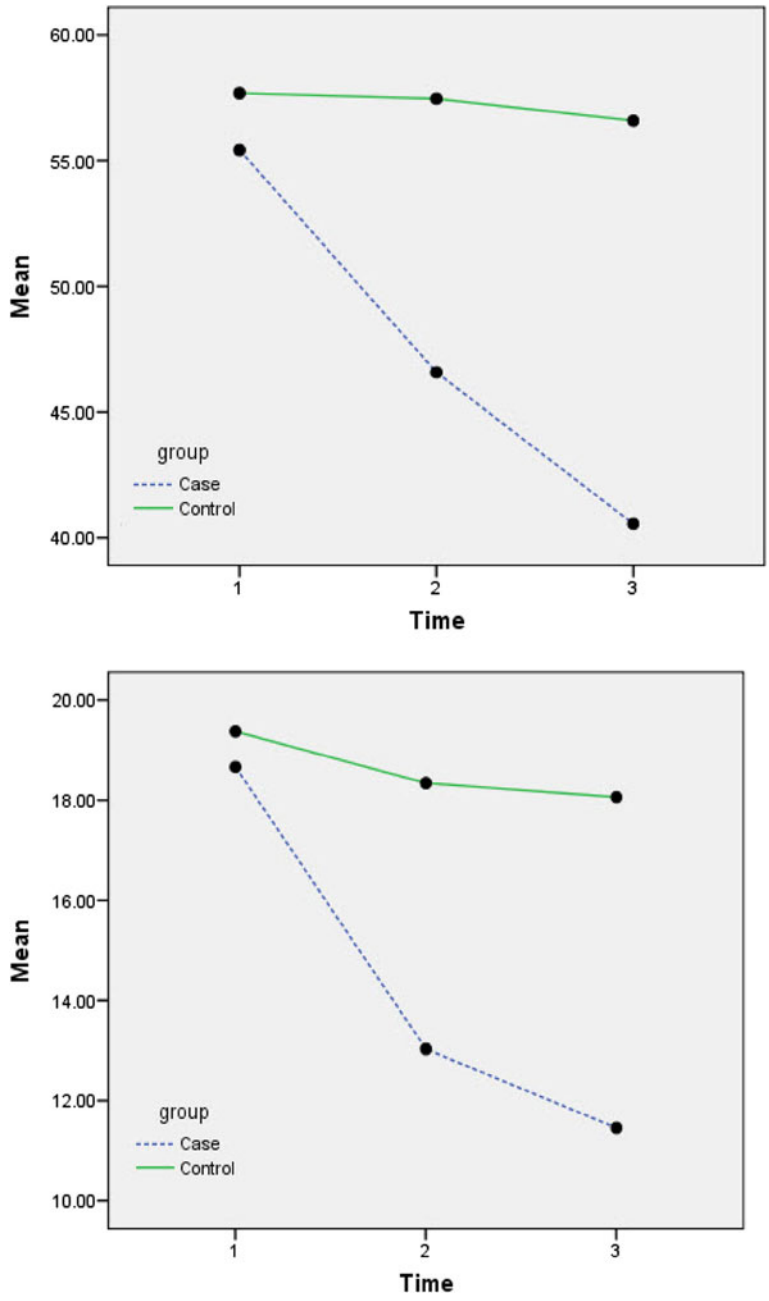

Figure 1 BPRS Means profile in experimental & control Group.

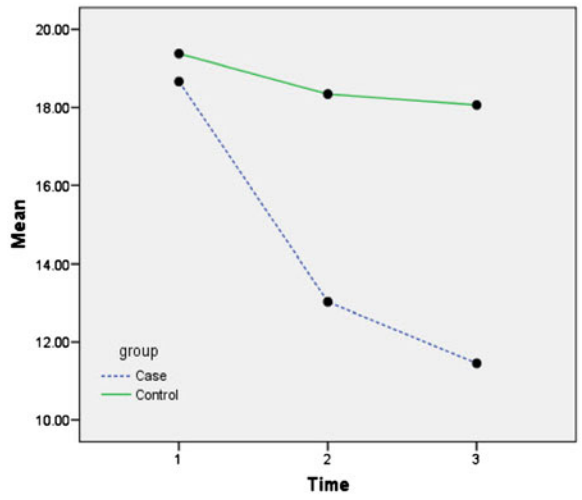

Figure 2 FBS Means profile in experimental & control Group.

supervise the patient's use of antipsychotic drugs [36]. Also Niksalehi and colleagues (2011) reported that nursing home care services were more effective than telephone follow-ups for schizophrenic mental conditions [32].

The findings of this study are consistent with those of earlier research in other countries suggesting that participation in an educational and supportive group for caregivers of patients with schizophrenia results in better acceptance of the illness, and enhanced adaptability to their care giving role [38]. Medvene and Krauss found that mutual aid groups for caregivers of the mentally ill resulted in increased comfort in talking with other caregivers about their problems in care giving situations [39]. In addition, several studies have reported that the interactions between caregivers in groups may give rise to emotional support and practical help, which is extended to the post-intervention period [40]. Family psycho educational intervention may have a positive effect on family burden by reducing many patient risk factors of burden. This is consistent with the positive

Table 2 Patients' clinical status and family caregiver time 0 (baseline), time 1 (immediately after the intervention), and time 2 (one month post-intervention)

Variable	Experimental group (N=33)Mean	Control group (N=32) Mean	F	P <
BPRS global score				
Time 0	55.42 ± 16.63	57.68 ± 20.36		
Time 1	46.57 ± 17.78	57.46 ± 20.90		
Time 2	40.54 ± 16.57	56.59 ± 20.19		
Effect of time			45.09	< 0.001
Interaction of time and treatment			34.08	< 0.001
Treatment			4.55	0.037
BPRS positive				
Time 0	2.96 ± 1.60	3.25 ± 1.73		
Time 1	2.64 ± 1.47	3.23 ± 1.77		
Time 2	2.17 ± 1.12	3.17 ± 1.72		
Effect of time			15.11	< 0.001
Interaction of time and treatment			10.09	< 0.001
Treatment			2.65	0.108
BPRS negative				
Time 0	3.81 ± 1.52	4.13 ± 1.64		
Time 1	3.15 ± 1.59	4.18 ± 1.60		
Time 2	2.87 ± 1.55	4.20 ± 1.62		
Effect of time			18.13	< 0.001
Interaction of time and treatment			24.76	< 0.001
Treatment			5.38	0.024
BPRS manic/hostility				
Time 0	2.72 ± 1.55	2.87 ± 2.00		
Time 1	2.54 ± 1.49	2.87 ± 2.05		
Time 2	2.17 ± 1.33	2.82 ± 2.03		

Table 2 Patients' clinical status and family caregiver time 0 (baseline), time 1 (immediately after the intervention), and time 2 (one month post-intervention) *(Continued)*

Effect of time			14.31	< 0.001
Interaction of time and treatment			9.56	< 0.001
Treatment			0.755	0.388
BPRS depression/anxiety				
Time 0	4.78 ± 1.69	4.96 ± 1.66		
Time 1	3.68 ± 1.69	4.89 ± 1.68		
Time 2	3.13 ± 1.75	4.78 ± 1.59		
Effect of time			38.46	< 0.001
Interaction of time and treatment			24.28	< 0.001
Treatment			6.38	0.014
Family Burden				
Time 0	18.66 ± 6.59	19.37 ± 6.22		
Time 1	13.03 ± 5.74	18.34 ± 6.5		
Time 2	11.45 ± 5.52	18.06 ± 6.68		
Effect of time			94.24	< 0.001
Interaction of time and treatment			45.08	< 0.001
Treatment			7.88	0.007

therapeutic effects of psycho education on family burden reported by other authors [41,42]. Also Reza and colleagues (2004) in their study indicated that psycheducational programs can facilitate social adjustment of Iranian psychiatric patients [43].

Our control group, which received routine care, showed little improvement in the patient's clinical status and family burden. These results may reflect the fact that routine services for schizophrenia patients and their families in Iran do not meet the patients' and families' needs.

Our study had some limitations. The sample size was relatively small, so larger studies are needed to confirm these results. The improvements in the patients' symptoms and family burden were confirmed for a relatively short follow-up period of one month. Therefore, further studies are needed to confirm the long-term effects of this family psycho-educational intervention. Also more studies are recommended to perform and apply different models of psychoeducation, family to family intervention, etc.

Conclusions

The present findings show the efficacy of a family psycho-educational intervention both in improving the patient's clinical status and in reducing the family caregiver burden in an Iranian sample. These results suggest that even a short-term psycho-educational intervention for family members of patients with schizophrenia can improve the outcomes for patients and their families. In addition, our results showed a correlation between symptoms of schizophrenia and family burden. Further research on this approach is needed for family caregivers from culturally different backgrounds in the Iranian population as well as the populations of other countries. One of the differences of this study compared with other studies in Iran is that we have performed needs assessment before intervention. Longer follow-up periods are recommended to determine the long-term effects of family psycho educational intervention on outcomes for patients and their families.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

FS, the main investigator, coordinated the research and wrote the first draft of the manuscript. MSH was responsible for data collection and contributed to the data analysis. AM assisted in the study design and liaised with the patients for the intervention. All the authors read and approved the final manuscript.

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The Effects of Group Psychoeducational Programme on Attitude toward Mental Illness in Families of Patients with Schizophrenia, 2014

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ABSTRACT

Introduction: Family members often play a vital role as caregivers in the lives of individuals with schizophrenia. Results of the studies showed that family invironment is the most important determinint of patients outcomes like as quality of life, relapse, adherence. This study aimed to determine the effect of group psychoeducational programme on attitude towards mental illness in families of patients with schizophrenia.

Methods: In this quasi-experimental study, 74 families who have schizophrenic patients hospitalized in psychiatric wards during sampling were selected by convenience sampling method. Then the sample was randomly assigned to experimental and control groups. The families of experimental group received 8 continuous 90-minute 3 times a week psychoeducational sessions. Family attitude towards mental illness was measured using the questionnaire of Opinion about Mental Illnesses (OMI) before and after intervention. Data analysis was conducted using ¡ ^{2} test, independent t-test, and paired t-test on SPSS software version 13.

Results: The results showed that majority of the families had negative attitude towards mental illness (88.90%). In addition, the results showed that there was significant difference between different dimensions of attitude towards mental illness before and after psychoeducation in the experimental group. The mean score of families' post-test in the experimental group increased compared to control group 108.86 (14.9), vs. 88.86 (7.5).

Conclusion: The results of this study indicate that psychoeducation improves family attitude towards mental illness. Training methods like group psych education for the families of mental patients can be effective on their attitudes towards mental illness.

Introduction

Severe psychiatric disorders have significant impact on patients and families quality of life.

In comparison with other psychiatric disorders, schizophrenia has the highest rate of hospitalization.[1] Emotional, social, and financial consequences of mental illness cause significant effects on their families. The outcomes of living with a psychiatric patient can include: family burden, fear of mental illness signs and symptoms, uncertainty about causes of the disease, lack of social support, and stigma.[2] Results of researches acknowledged that attitude towards mental illness is one of the most important determinant factors in the recovery process in the mental ill patients. Positive family environment predicts improvement in symptoms and social functioning among

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psychiatric patients.[3-5] Being diagnosed with a serious mental illness can be a shock- both for the person diagnosed and for his or her family and friends. On the other hand, finally obtaining a diagnosis and treatment plan can sometimes help relieve stress in the family and start moving recovery forward. Family members can be an invaluable resource for individuals dealing with serious mental illnesses. By learning more about the illness, they can support their loved one through diagnosis and beyond.[6] An important way of changing the attitude toward a phenomenon is giving information about it.[7] On the other hand, the attitude toward mental disorders plays an important role in the stigmatization of psychiatric patients. Stigma causes the following effects on patient's life: (a) the patient feels inability to achieve social ideals due to the symptoms and the negative outcomes of the disease, feeling shame and hopeless; (b) the patient tries to hide his disease for self-protection by isolation and withdrawal himself from society; and c) the patient losses individual and social rights.[8]

Results of a survey on patients referred to mental health services showed that patients with mental disorders reported the most discrimination from their friends, family and coworkers (52%, 56% and 47% respectively).[9]

Thorneycroft believes that psychiatric patients are more vulnerable than others. They also have little close relationships, less likely to marry, lose custody and guardianship of their children, more likely to be abuses by friends and neighbors and there are few recreational facilities for them and their life span is usually low.[10] Another negative consequence of stigma is low patient adherence medication that increases the rate of relapse and readmission.[11] The results of some studies showed that people's attitude toward psychiatric disorders are very discriminatory.[12-15]

Over the last decade, focus on the family environment has been increased. It is believed that the family environment plays an important role in the progression and prognosis of the illness. So, it led to development of psychosocial interventions broadly, with focus on the family unit.[12]

These interventions can be helpful for families to better understand the nature, treatment plan and prognosis of the psychiatric disorders.[13] The results of a study conducted by Griffiths and coworkers on consequences of stigma toward a patient with mental illness showed that the majority of public people did not accept to hospitalize their patients due to the fear of stigmatization.[16] Results of Angermayer and Matshinger study also showed that labeling as mental illness had a negative impact on public attitudes towards people with schizophrenia and made strong negative effect on the people's reaction to someone with schizophrenia and increased their preference for social distance.[15] In the study was investigated by Mosses, adolescents with mental disorder reported that they have been treated by inappropriate behavior such as distrust, humiliation, ridicule, being neglected in family decision-making and unfairly blamed by their families.[17] Kavanagh conducted a meta-analysis in which the effect of six family interventions on recovery of patients with schizophrenia were assessed. The results showed that the rate of relapse was very low in the experimental group.[18]

Miklowitz et al. conducted a randomized study of family-focused psycho-education and pharmacotherapy in the outpatient management of bipolar disorder. The results showed that the patients in the experimental group significantly showed more improvement and lower relapse in comparison with the patients of the control group.[19]It can be concluded that the family environment should not be ignored in the disease process. Because in that case, the family resists against the treatment plans by the denial, prejudices and sense of shame of his patient.[19,20] Therefore, the treatment plan should be focused on the patient and family environment.

The reaction of a family to his patient with mental disorder is significantly important. It should be considered for some reasons include: a) family plays main role in the relapse of the disorder, b) the family is in crisis when his patient is hospitalized c) how family copes with this situation is very important and d) due to reduced patient length of hospitalization, the family is responsible for patient care.[20]

The review of the literature showed that family attitude toward mental illnesses is the key factor to determine the quality of caring of mental patients. It is concluded the family plays the main role in the patient's treatment process. Since no similar study was found in Iran in the search of the databases, this study aimed to examine the effect of group psychoeducational programme on attitudes toward mental illness in families of patients with schizophrenia.We hope that the results can be helpful to introduce the best way to improve attitude toward mental patients in the family.

Materials and methods

This study was a quasi-experimental study with a control group. The study population includes the families of the patients with schizophrenia disorder that their patients were admitted to the psychiatric wards of Razi hospital in the time of sampling. The study sample size was calculated using the results of the study conducted by Shahveysi et al.[21]

Accordingly, with a type I error probability of 0.05 and a power of 0.80, the sample size was determined to be 68 families.

Due to the possibility of sample loss in clinical studies, the number of participants in each group increased to 37 and finally, a total of 74 families were recruited for sample size.

Following approval by the ethics committee of the research deputy of Tabriz University of Medical Sciences, convenience sampling was performed for recruiting the families in the study. The families were selected based on the inclusion criteria that were: (a) willingness to participate in the study by signing a written informed consent; (b); literacy; (c) main caregiver(a person who have main responsible for patient care like as a parent, spouse, or child); and (d)having no psychiatric problems. The inclusion criteria for patients were: (a) being diagnosed as a schizophrenia disorder based on diagnostic interview and SCID-I/CV test results (b) having no comorbidity disorders and (c) having no mental retardation. For the random allocation, each participant assigned to experimental or control group randomly. This means that an identifier was given to each participant and then participants were assigned to experimental or control group randomly. The allocation sequence was prepared by a person not involved in the study. Therefore, the data collector was unaware of the type of groups (experimental or control).

In addition, the below activities were done for ethical considerations: (a) describing the objectives, (b) obtaining informed consent and (c) ensuring confidentiality of information. Furthermore, the participants of the control group were informed that if they were interested, the researcher would hold training sessions for them after conducting post-test for both groups.

Data were collected through a two parts questionnaire; first part was about personal-social information (age, sex, marital status, education, job and type of relationship with the patient) and second part included Opinions about mental illness scale (OMI) that was developed by Cohen and Struening.[22] OMI is a five-point Likert scale (1 = strongly agree to 5 = strongly disagree).This scale measures beliefs and attitudes towards the etiology, treatment, and prognosis of mental illness. It is a self-report scale and based on six dimensions comprising 34 items.

The dimensions include: a) separation (10 items), b) stereotyping (4 items), c) restrictiveness (4 items), (d) benevolence (8 items), e) pessimistic prediction (4 items) and (f) stigmatization (4 items). OMI ranges from

34 to 170. Acquiring the score higher than the average (more than102) is considered as a positive attitude. Opinions about mental illness scale was selected for this study because of the satisfactory psychometric properties of the scale and broad using in many studies.[22-26] For face and content validity, the instrument was presented to 10 faculty members of Nursing and Midwifery Department at Tabriz University of Medical Sciences. The final questionnaire was developed after collecting comments and making the required corrections. The reliability of the scale was determined by Cronbach's alpha coefficient (α= 0.71) after pilot study. Reliability of OMI scale in the other studies was approved.[27-29]

The pre-test was done for all participants, then the group psychoeducational programme was conducted in eight continuous 90-minute three times a week sessions in the afternoon for experimental group. Lecture, group discussion and question and answer methods were used to manage sessions. All participants of the experimental group were taught in a class together. At the beginning of each session, the researcher explained the topic selected for that session for 15 minutes.

Then participants were asked to discuss about their experience in 20 minutes. The researcher taught the families about the selected topic in 40 minutes. In the remaining 15 minutes, a conclusion form the discussion was made by the participants. The topics specified for each session included: a) the nature of the mental illness, b) prognosis, c) progression of disease, d) treatment modalities, e) how to manage patients' inappropriate behaviors, f) how to manage anger, g) how to de-stigmatization of patients with mental disorders and h) how to empower patients to improve their performance. During the study, two participants in the control group and two participants in the experimental group were unwilling to continue; therefore, final analysis was based on 70 participants (Figure 1).

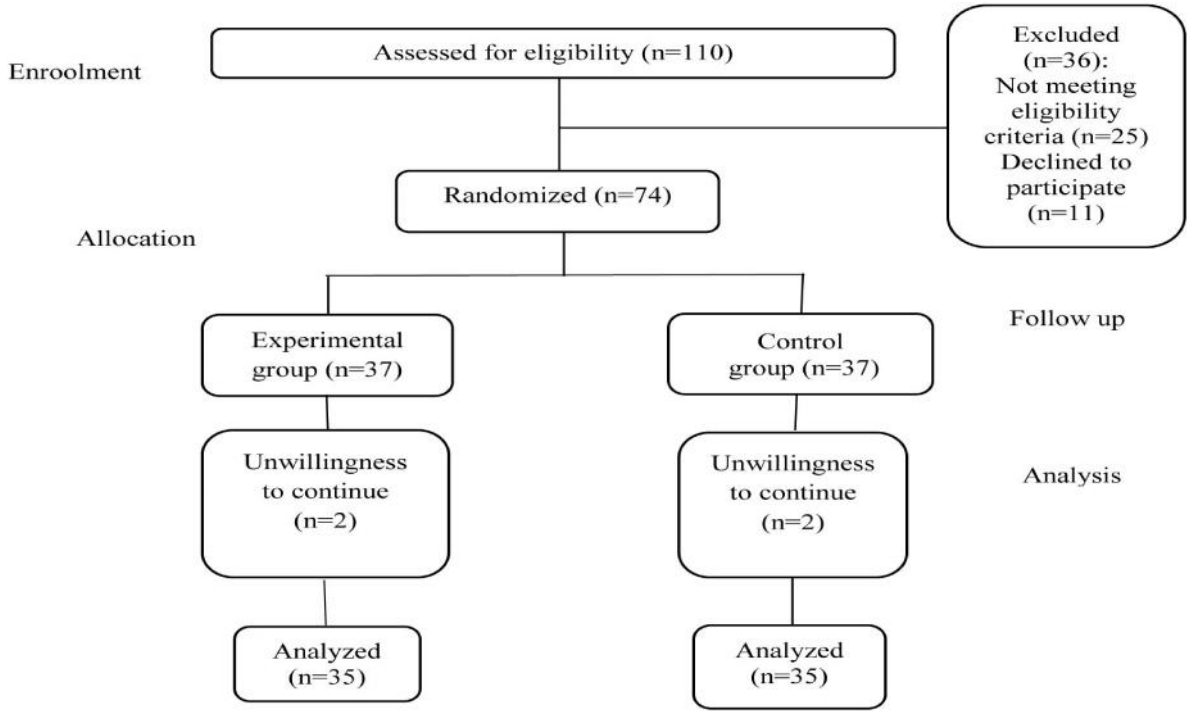

Figure 1. Consort flow chart of participants

Data was analyzed by using SPSS statistical software ver. 13. The normality of data was confirmed by using Kolmogorov-Smirnov statistical test. The distributions of all demographic variables, total OMI score and all its dimensions were normal. Chi square test was used for qualitative variables.

Independent-samples t-test was used for comparison of the scores of normal variables between two groups before and after the intervention. In addition, paired- samples t-test was used for comparison of total OMI score and all its dimensions before and after the intervention within each group.

Results

The mean age (SD) of all families in the experimental group and the control group was 35.56 (9.04) years and 34.27 (9.52) years respectively. The age of all participants ranged from 29 to 55 years. Most of the participants (30.64%) were male. The majority of them (60.48 %) were employed, their highest level of education (70.35%) were diploma and type of relationship with patient was parent (37.54%).There were no statistical differences between two groups before intervention in age, education and job variables (P> 0.05).

As seen in table 1, most of families in experimental group and control group had negative attitude toward mental illness before intervention (71.43% and 74.30, respectively). But in comparison with control group, most of families in experimental group had positive attitude toward mental illness after intervention (80.00% and 28.57%, respectively).

The mean score of pre-test for all participants was 88.90 (8.34) in both groups. The score of OMI scale ranged from 75.90 and 107.09 in pre-test.

As shown in table 2, there was no significant difference among the groups' OMI score before intervention 90.08 (9.69) vs. 87.72 (8.90), P > 0.05 and no statistical differences between two groups in subscales of OMI before intervention (P> 0.05). But, in comparison with the control group, total mean score of post-test was significantly higher in experimental group 88.86 (7.50), vs. 108.86 (14.19), P<0.05. Changes of OMI subscales mean score between the two groups also statistically significant.

Discussion

This study aimed to investigate the effect of the group psychoeducation on the attitude toward mental illness in families of the patients with schizophrenia. The results of this research showed that the most families had negative attitude towards mental illness.

This result is consistent with other results of the researches conducted by Shahveysi et al. Namdar et al. Shibreh et al. and Ostman et al. [21, 30-32] They claimed that families of the psychiatric patients feel ashamed of their psychiatric patient.

Table 1. Frequency distribution of attitude toward mental illness in the experimental and control groups (n= 70)

	Experimental group N (%)	Control group N (%)	Statistical indicators*
Pre-test			
Negative attitude	25 (71.43)	26 (74.30)	P>0.05
Positive attitude	10 (28.57)	9 (25.72)	P>0.05
Post-test			
Negative attitude	7 (20.00)	25 (71.42)	P<0.05
Positive attitude	28 (80.00)	10 (28.57)	P<0.05

*Chi square

Table 2. Comparing mean scores OMI dimensions before and after intervention in experimental and control groups (n= 70)

Openions about mental disorders scale dimensions scores	Experimental group (n = 35) Mean (SD)	Control group (n = 35) Mean (SD)	Mean changes (95% CI)	Statistical Indicators*
Separation (10-50)				
Pre	24.64 (2.92)	24.16 (4.49)	0.48 (-2.28,1.32)	P>0.05
post	28.86 (3.45)	24.96 (2.71)	3.90 (2.90, 5.40)	P<0.05
dependent t-test result	P<0.05 ,df=34, t=3.02	P>0.05, df=34, t=0.73		
Stereotyping (4-16)				
pre	8.93 (1.21)	)1.09 (8.87	0.06 (-1.09, 1.47)	P>0.05
post	11.45 (2.91)	8.95 (1.64)	2.50 (1.47, 3.12)	P<0.05
dependent t-test result	P<0.05 ,df=34, t=3.64	P>0.05, df=34, t=0.63		
Restrictiveness (4-16)				
pre	8.84 (2.33)	8.87 (2.09)	0.02 (-1.03, 1.08)	P>0.05
post	10.79 (2.41)	9.02 (2.16)	1.77 (0.67, 2.87)	P<0.05
dependent t-test results	P<0.05 ,df=34, t=3.65	P>0.05, df=34, t=0.65		
Benovalence (8-32)				
Pre	20.92 (3.78)	19.23 (2.88)	1.69 (-0.08, 2.29)	P>0.05
post	24.49 (3.54)	19.62 (3.05)	4.87 (3.28, 5.44)	P<0.05
dependent t-test results	P<0.05, df=34, t=3.11	P>0.05, df=34, t=0.53		
Pessimistic prediction (4-16)				
pre	8.58 (2.38)	8.67 (2.14)	0.09 (-1.03, 1.17)	P>0.05
post	10.63 (2.16)	8.77 (2.20)	1.86 (1.02, 2.10)	P<0.05
dependent t-test result	P<0.05, df=34, t=3.91	P>0.05, df=34, t=0.21		
Stigmatization (4-16)				
pre	8.23 (2.31)	9.19 (2.59)	-0.95 (-1.21, 1.73)	P>0.05
post	11.62 (3.23)	7.10 (1.99)	4.51 (3.23, 5.79)	P<0.05
dependent t-test result	P<0.05, df=34, t=3.30	P>0.05, df=34, t=0.77		
Total score (34-170)				
pre	90.08 (9.69)	87.72 (8.90)	2.35 (-6.32, 1.61)	P>0.05
post	108.86 (14.19)	88.86 (7.50)	17.46 (15.48, 20.49)	P<0.05
dependent t-test result	P<0.05, df=34, t=2.65	P>0.05, df=34, t=1.17		

* Independent t- test

Fontaine believes that caring of patients with schizophrenia in home imposed on families a lot of stress. The families often have little knowledge about the nature of mental illness and receive little information from mental health professionals about how manage their patient's behavior. Mental illness also has negative impact on families' physical and mental health. Therefore, the family and caregivers should be informed about mental illness and receive more support from medical staff to cope with their situation.[33]

The results also showed that the mean scores of the separation, stereotyping and restrictiveness dimensions were lower in the pre-test of both groups. It can be concluded that, the families tended to neglect their patients and apply limited measures against

them. These results are consistent with the results of Shahveysi et al., and Millasa et al., studies.[21,34] Furthermore, the results showed that the mean score of OMI in post-test have been increased. This means that family psychoeducational intervention has been effective on improving family attitude toward mental illness. These results are consistent with the results of some studies.[35,36] The results of these studies showed that psychoeducational family programs designed to improve attitude toward mental illness have been successful. Furthermore, these programs had effectiveness on medication compliance, positive coping with stressors and reducing the risk of relapse in the first year following hospital discharge. Desousa et al. in their study concluded that family psychoeducation is an integral part of schizophrenia treatment programs. Recent shifts to briefer hospitalization and a focus on community care have emphasized the significance of relative education in this phase of treatment.[37]

A review conducted by Barbato and coworkers to update evidence from studies on family intervention in schizophrenia looking carefully at methodological issues. They concluded that the efficacy of a variety of different family intervention models was supported by a large body of research.[12]

Limitations of this study included: (a) one type of the mental disorders was studied, (b) No follow-up was done after completion intervention and (c) low follow rate due to excluding four participants from the study.

Future work needs to address improving delivery of existing psychosocial interventions and identifying the amount of treatment (e.g., number of sessions) needed before treatment response is expected. In addition, we suggest that further studies investigate the effects of family psychoeducational program on the other outcomes like as relapse rate, patient functioning and medication adherence after hospital discharge.

Conclusion

Family psychoeducation is an effective psychosocial treatment for schizophrenia. As the results of this study showed that attitude toward mental illness improved with the use of family psychoeducation intervention. Thus, family psychoeducation is an important part of comprehensive care for patients with schizophrenia and is applicable in clinical settings. The application of group psychoeducation is recommended as a supportive intervention for improving families' attitude toward mental illness.

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Ethical issues

None to be declared.

Conflict of interest

The authors declare no conflict of interest in this study.

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The effects of group psychoeducational programme on family burden in caregivers of Iranian patients with schizophrenia

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Accessible summary

- This randomized-controlled trial investigated the effect of group psychoeducation therapy on family burden in caregivers of Iranian patients with schizophrenia.
- Results of this study on 71 caregivers of patients with schizophrenia showed that a 4-week group psychoeducational programme was significantly effective in reducing family burden by more than one third.
- Findings showed that group psychoeducational programme for caregiver and family of patients with schizophrenia is beneficial for reducing family burden.

Abstract

This study was aimed at assessing the impact of group psychoeducation therapy on family burden in caregivers of Iranian patients with schizophrenia during the acute phase of the disease. Using a randomized-controlled trial design, 71 caregivers of patients with schizophrenia were randomly assigned to either a 4-week group psychoeducational programme ($n = 36$) or the control group ($n = 35$). Family burden was assessed by Family Burden Index Schedule (FBIS) at the beginning, and after a month of psychoeducation therapy as a follow-up. FBIS assesses family burden in six different dimensions with score ranging from 0 to 48, higher scores indicating higher burdens. At baseline mean, FBIS score was not significantly different between the cases and the controls. After the intervention, the mean total FBIS score was significantly lower in the case group compared with the control group ($P < 0.001$). In the intervention group, FBIS score change was significant through the study in all dimensions as well as the total score ($P < 0.001$). A significant reduction in family burden has been achieved by implementing group psychoeducational programmes for inpatients with acute phase schizophrenia in Iranian population.

Introduction

Schizophrenia is a chronic psychotic disorder that impairs mental health and social functions (Lewis & Lieberman 2000). It has been associated with lack of insight and poor compliance with treatment. In developing countries such as Iran, families have traditionally been partners in the care of patients, and despite of the difficulties imposed on the families for the care of patients with schizophrenia (Lauber *et al*. 2005, Awad & Voruganti 2008, Hou *et al*. 2008, Moller-Leimkuhler & Obermeier 2008, Kalra *et al*. 2009, Hjarthag *et al*. 2010, Lloyd *et al*. 2010), they prefer to take care of their patient at home rather than using long-term care facilities (Malakouti *et al*. 2002).

Each disease, especially chronic diseases, has been associated with different family burden like economic and care

burden. Chronic psychiatric disorders such as schizophrenia have been associated with more family burden because of lack of full recovery, repeated hospitalizations, and school failure; unemployment due to job loss; and the cost of drugs and etc.

Psychoeducation (in general) is a systematic and structured psychotherapeutic intervention for informing the patients and their family members about the disorder and its treatment. Psychoeducation integrates emotional aspects and enables patients as well as family members and caregivers to cope with the illness (Wiedemann *et al.* 2003, Bauml *et al.* 2006, Rummel-Kluge & Kissling 2008a).

Psychoeducational interventions in patients with schizophrenia increase patients' knowledge and insight into the illness and its treatment, and enable the patient to cope with the illness more effectively and improves prognosis (Xia *et al.* 2011). In patients with schizophrenia, psychoeducational intervention reduces relapse rate and readmission, increases patient compliance with treatment and decreases the length of hospital stay in hospitalized cases (Xia *et al.* 2011).

Previous studies have shown that providing non-pharmacologic interventions [such as cognitive behaviour therapy (CBT), cognitive rehabilitation, psychoeducation] for family members and caregivers also can decrease the family burden and help them to cope with the task of caring for a patient with schizophrenia (Magliano *et al.* 2005, Hanzawa *et al.* 2008, Giron *et al.* 2010). Moreover, this strategy may also influence the quality of life of both patients and caregivers and have an impact on the patient outcomes like number of relapses and hospitalizations (Lincoln *et al.* 2007, Rummel-Kluge & Kissling 2008a, Rummel-Kluge & Kissling 2008b, Giron *et al.* 2010).

Beneficial effects of short- and long-term psychoeducational interventions in reducing family burden have been shown in patients with different psychiatric disorders such as bipolar disorder, mood disorder and post-traumatic stress disorder (PTSD; Canive *et al.* 1996, Lubin *et al.* 1998, McDonell *et al.*, 2003, Fristad *et al.* 2004, Glanville & Dixon 2005, Rouget & Aubry 2007, Nasr & Kausar 2009).

In spite of proven efficacy of psychoeducational intervention for patient, yet there is limited information about the effects of family psychoeducational interventions on family burden.

This intervention is not commonly applied in clinical practice in Iran. Yet there is information gap in different aspects of this intervention such as minimum effective dose of psychoeducation, quality-of-life issue and so on, and previous studies have urged future research.

There is no information about the family burden of schizophrenia in Iran as well as the effect of family psychoeducational interventions in schizophrenia, and its various aspects need to be clarified.

Considering different ethnicities and cultural attitudes and beliefs in Iran and Islamic and traditional nature of families which makes it different from other countries, there is the need to assess the effects as well as implications of psychoeducational programmes on family burden of Iranian patients with schizophrenia in acute phase of disease.

This study's aim was to assess the impact of group psychoeducational intervention on family burden in caregivers of Iranian patients with schizophrenia.

Method and materials

Design

A randomized-controlled trial was conducted on caregivers of Iranian patients with schizophrenia.

Patients

From November 2007 to March 2008, 71 caregivers of patients with schizophrenia, hospitalized in Razi Psychiatric Center in Tehran, were included in this trial. Razi Psychiatric Center is a psychiatric hospital with specialists and subspecialists in the field of Psychology, affiliated to the University of Social Welfare and Rehabilitation Sciences (USWR) located in Tehran, capital city of Iran, with a total of 1200 beds (400 beds for acute inpatient admissions and 800 beds for patients with chronic psychiatric disorders).

Patients and their family were selected during a 3-month period (December 2007 to February 2008), intervention was done during this period and they were followed-up and evaluated 1 month after the end of intervention programme.

Among 10 wards (each as one study cluster) of the centre dedicated to the patients with acute disorders, six wards were selected (cluster sampling). Then, eligible patients who fulfilled inclusion criteria were selected from these six wards. In the next step, among the family members of these selected patients, eligible caregivers were selected (multistage sampling). Family members were divided into foursome blocks randomly, and then blocks were randomly allocated into intervention or control groups (block randomization). These caregivers were participants of our study.

To determine the required sample size, a pilot study was carried out on 10 families. Sample size was calculated by using formula for predicting mean difference between groups considering 0.3 effect size and estimation of a difference as 1.3 points. For obtaining 80% power ($\beta = 0.20$) with 95% confidence level ($\alpha = 0.05$), a minimum of 35 subjects in each group was required. The reliability of the

instrument in these subjects was assessed by test–retest method in 10 subjects of the control group at baseline and 1 month after the baseline assessment. The results indicated a good reliability (Cronbach's alpha = 0.91).

A total of 200 patients and their caregivers were screened for enrolment in the study. Among them, 110 pairs did not meet the inclusion criteria. Ninety patients were identified to have an eligible caregiver for participation. Among 90 eligible pairs, 71 of patients and their caregivers were selected by simple random sampling (required sample size for the study).

Patients aged between 18 and 35 years were included, and their eligible caregiver was selected among their family members considering study inclusion criteria. We considered the patients aged 18–35 years because these ages are the most useful and reproductive ages in the life, and also this age group was considered to remove the problems related to the early adulthood and elderly and to have a homogenous patient population with almost similar problems in the family (job and responsibility). Inclusion criteria for member of patient's family were: to be a legal guardian or caregiver of an admitted patient with a confirmed diagnosis of schizophrenia in the acute phase according to *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* criteria (American Psychiatric Association 2000), their patient aged 18–35 years, to have direct responsibility of patient's care and to be able to participate in the educational sessions. Caregivers who had previously attended in a family psychoeducational programme, or had any cognitive impairment, substance abuse or other intellectual disability were excluded.

Participants, who met the inclusion criteria described above, were randomly assigned (with the use of permuted blocks of four on a 1:1 basis) into the intervention (psychoeducational) or routine care groups (controls). Allocation was performed by opaque, sealed envelopes. During the follow-ups, five participants in the intervention group left the study and did not complete the sessions for which no outcome measures were available for post-intervention assessments.

The study protocol was approved by the ethics committee at USWR. All participants were provided by detailed description of the study, and written informed consents were obtained from the caregivers. None of the participants were under pressure to take part in the study, and routine care was available for all patients regardless of the participation of their caregivers.

Intervention

The group psychoeducational programme consisted of four 2-h sessions that were held once weekly in the Razi Psychiatric Center. The programme content was organized based on educational programme of psychiatric nursing and psychiatric textbooks (Campbell 2009) and was converted to the understandable text for patients and families.

Caregivers were also provided with written educational handouts containing information regarding schizophrenia management and care. The group instructor was a psychiatric nurse who had been trained for the psychoeducational programme. The sessions' contents were as follows; 1st session: orientation, description of psychosis, aetiology, schizophrenia diagnostic symptoms; 2nd session: discussing living with hallucinations and delusions; 3rd session: introduction to correct use of medications and non-organic interventions; 4th session: recurrence of the disease, role of the treatment on recurrence prevention, strategies for coping with schizophrenia, review of available social supports and services and conclusion.

Outcomes and measures

At baseline, demographic characteristics of patients and caregivers were recorded. Clinical data were extracted from patients' hospital records. The primary outcome measure was the family burden assessed by the Persian version of Family Burden Interview Schedule (FBIS) (Pai & Kapur 1981) at baseline, at the end of the 4-week psychoeducational programme and 1 month after the last session of psychoeducational programme.

FBIS is a 24-item instrument assessing six dimensions of family burden including: financial burden during recent 12 months (six items); effect on daily activities during last month (five items); effect on family entertainments and welfare (four items); effect on family relationships (five items); effect on physical health of the family members (two items); and effect on mental health of the caregiver and family members (two items). Answers to each item are designed in Likert scale, with 0 (no burden), 1 (moderate burden) and 2 (severe burden). Total FBIS score is calculated by adding up the scores of all 24 items and ranges from 0 to 48 with higher scores indicating more family burden. Based on the method previously described (Malakouti *et al*. 2002), family burden was categorized into three groups of severity consisting of mild (0–16 points in FBIS), moderate (17–32 points) and severe (33–48). The validity and reliability of the Persian version of FBIS has been verified in a previous study (Malakouti *et al*. 2002).

Caregivers were recalled and invited by the staff of Razi Center, and interviews were conducted in the centre by a trained interviewer. To remove any bias that might interfere, all interviews were performed by one interviewer blind to the group assignment of each caregiver.

Table 1
Demographic characteristics of 71 patients with schizophrenia

Patient demographics	Psychoeducation group (n = 36)	Control group (n = 35)	Total (n = 71)	P-value
Sex				0.705
Male, *n* (%)	31 (86.1)	29 (82.9)	60 (84.5)	
Female, *n* (%)	5 (13.9)	6 (17.1)	11 (15.5)	
Age (mean ± SD), years	28.36 ± 6.69	30.94 ± 7.07	29.63 ± 6.88	0.119
Current work status				0.731
Homemaker	4 (11.1)	4 (11.4)	8 (11.3)	
Retired	0	1 (2.9)	1 (1.4)	
Qualified job	1 (2.8)	0	1 (1.4)	
Worker	13 (36.1)	12 (34.3)	25 (35.2)	
Unemployed	18 (50.4)	18 (51.4)	36 (50.7)	
Educational background, *n* (%)				0.112
Illiterate	3 (8.3)	2 (5.7)	5 (7)	
Primary school	3 (8.3)	11 (31.4)	14 (19.7)	
Secondary school	30 (83.3)	22 (62.8)	52 (73.3)	
Higher education	0	0	0	
Marital status, *n* (%)				0.757
Single	24 (66.7)	26 (74.3)	50 (70.4)	
Married	6 (16.7)	5 (14.3)	11 (15.5)	
Divorced	6 (16.7)	4 (11.4)	10 (14.3)	
Number of family members, *n* (%)				
1–3	11 (30.6)	13 (37.1)	24 (33.8)	
4–6	18 (50)	9 (25.7)	27 (38)	
>6	7 (19.4)	13 (37.1)	20 (28.2)	

SD, standard deviation.

Statistical analysis

All statistical analyses were performed using the Statistical Package for Social Sciences, version 13 for Windows (SPSS® Inc., Chicago, IL, USA). Continuous variables were summarized as mean ± standard deviation for numerical variables and number (percent) for categorical variables. Paired *t*-test and pooled *t*-test were used for comparison of the means between the groups. For data without normal distribution, Mann–Whitney *U*-test was used for comparing means. Friedman test was used for between-subject comparisons of FBIS scores across the measurements. Comparisons of categorical variables were performed by chi-square test. All tests of significance were two-tailed and considered to be significant at *P*-value less than 0.05.

Results

Baseline characteristics of patients and caregivers

The majority of patients with schizophrenia were men (84.5%) with the mean age of 29.63 ± 6.88 years. Paranoid type (73.2%) was the most frequent type of the schizophrenia among the patients. Mean duration of disease was 6.72 ± 4.99 years with the mean of 2.70 ± 1.54 times of previous hospitalizations. In the intervention group, five participants did not complete the study, and finally, 31 caregivers completed the study. Demographic and clinical characteristics of the study patients are presented in Tables 1 and 2.

Almost all (93%) of the caregivers were female with mean age of 54.01 ± 13.53 years. The most of them (78.9%) were parents of the patients, and most were married (78.9%) and were housewives (85.9%). The mean time spent for the care of the patients was 7.28 ± 3.64 h daily. Fourteen (19.7%) had a history of a physical illness, while only two caregivers (2.8%) had a history of a psychiatric illness. Almost two third of caregivers reported a severe decline in their social relations as a result of the responsibilities of caregiving (Table 3).

One third (36.6%) of the patients were not provided with any kind of social or welfare support, and all the treatment expenses (almost $US 180 monthly) was provided by the family members.

Family burden

At baseline, the mean FBIS score was 40.64 ± 2.88 for caregivers in psychoeducation group and 40.51 ± 3.17 for those in control group, respectively (maximum possible FBIS score = 48). No significant difference was found between the two groups at baseline (P = 0.986). By categorizing the FBIS score into three levels, it was revealed that all caregivers fell into the severe category of family burden (Fig. 1).

Table 2
Clinical characteristics of 71 patients with schizophrenia

Clinical characteristic	Psychoeducation group (n = 36)	Control group (n = 35)	Total (n = 71)	P-value
Disease type, n (%)				0.435
Paranoid	27 (75)	25 (71.4)	52 (73.2)	
Catatonic	1 (2.8)	3 (8.6)	4 (5.6)	
Disorganized	2 (5.6)	4 (11.4)	6 (8.5)	
Undifferentiated/residual	6 (16.6)	3 (8.6)	9 (12.7)	
Disease duration, years, (mean ± SD)	6 ± 5.41	7.46 ± 4.53	6.72 ± 4.99	0.224
Number of hospitalizations, (mean ± SD)	2.33 ± 1.35	3.09 ± 1.72	2.70 ± 1.54	0.052
Caregivers' perceived disease severity, n (%)				0.38
Severe	23 (55.6)	16 (45.7)	36 (50.7)	
Moderate	11 (41.7)	19 (54.3)	34 (47.9)	
Mild	1 (2.8)	0	1 (1.4)	

SD, standard deviation.

Table 3
Demographic characteristics of 71 caregivers of patients with schizophrenia

Caregiver demographics	Psychoeducation group (n = 36)	Control group (n = 35)	Total (n = 71)	P-value
Sex				0.62
Male, n (%)	2 (5.6)	3 (8.6)	5 (7)	
Female, n (%)	34 (94.4)	32 (91.4)	66 (93)	
Age (Mean ± SD), years	54.6 ± 12.3	53.4 ± 14.7	54.01 ± 13.53	0.70
Relationship with patient, n (%)				0.81
Spouse	4 (11.1)	3 (8.6)	7 (9.9)	
Parents	30 (83.4)	26 (74.3)	56 (78.9)	
Siblings	1 (2.8)	5 (14.3)	6 (8.4)	
Children	1 (2.8)	1 (2.9)	2 (2.8)	
Duration of living with patient, years, (mean ± SD)	20.31 ± 9.03	24.2 ± 10.75	22.23 ± 10.04	0.06
Daily time spending with patient, hours, (mean ± SD)	13.6 ± 4.2	15.09 ± 6.14	14.73 ± 5.25	0.47
Daily time spending for patient care, hours, (mean ± SD)	6.69 ± 1.78	7.89 ± 4.86	7.28 ± 3.64	0.70
History of physical illness, n (%)				0.98
Yes	7 (19.4)	7 (20)	14 (19.7)	
No	29 (80.6)	28 (80)	57 (80.3)	
Social relations change due to patient care, n (%)				0.91
Severe decline	22 (61)	23 (65.7)	45 (63.4)	
Moderate decline	12 (33.3)	10 (28.6)	22 (31)	
No change	2 (5.6)	2 (5.7)	4 (5.6)	
Increase	0	0	0	
Available social services, n (%)				0.20
State Welfare Organization	2 (5.6)	8 (22.9)	10 (14.1)	
Imam Khomeini relief committee	6 (16.7)	6 (17.1)	12 (16.9)	
Insurance	13 (36.1)	10 (28.6)	23 (32.4)	
None	15 (47.1)	11 (31.4)	26 (36.6)	
Monthly cost of patient care USD, (mean ± SD)	178750 ± 62328	178285 ± 77402	178520.8 ± 70161.68	0.97

SD, standard deviation; USD, US dollar.

The total FBIS score changes during the study are summarized in Table 4. Changes in the total score in all measurements were significant between groups. Before the study, in all aspects of FBIS, both groups had a similar burden score.

After the intervention, the total FBIS score showed a significantly lower mean score in the intervention group (27.87 ± 2.9 vs. 37.82 ± 2.78; $P < 0.001$). The difference between the two study groups was observed in all aspects of the FBIS, and in all of them, the intervention group had lower scores compared with the controls (Table 5).

Out of 31 caregivers who completed the psychoeducational programme, only one (3.2%) indicated a severe burden, and all remainders (96.8%) were labelled to moderate burden. In the control group, one caregiver (2.9%) had moderate burden (Fig. 1).

In follow-up assessments 1 month after the last session of group psychoeducation, all caregivers in the intervention group indicated a moderate burden, while in the control group, 33 (94.3%) still had a severe burden. However, none of the caregivers in any group showed a mild burden at any stage of assessment. Caregivers, who underwent the

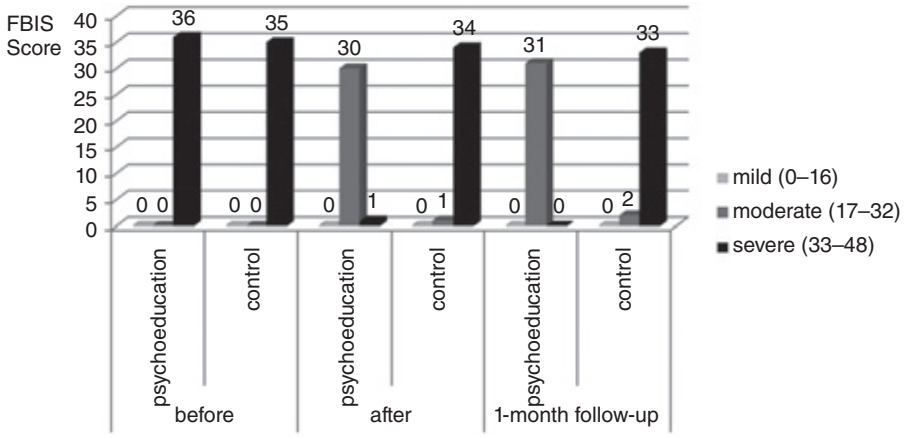

Figure 1
Family burden before, after and 1 month after the intervention assessed by Family Burden Index Schedule (FBIS; Pai & Kapur 1981)

Table 4
Change in total FBIS score through the study according to the treatment received

	FBIS score (before study)	FBIS score (after study)	FBIS score (1-month follow-up)	*P*-value (before vs. after)	*P*-value (before vs. 1-month follow-up)	*P*-value (after vs. 1-month follow-up)
Psychoeducation group	40.64 ± 2.88	27.87 ± 2.9	21.3 ± 2.46	<0.001	<0.001	<0.001
Control group	40.51 ± 3.17	37.82 ± 2.78	37.3 ± 2.81	<0.001	<0.001	0.002
P-value between groups	N/S	<0.001	<0.001			

FBIS, Family Burden Index Schedule.

psychoeducation intervention, had scored lower in all aspects of FBIS in comparison with the control group (Table 5).

FBIS score changes were significant through the study in all aspects as well as the total score in the intervention group ($P < 0.001$). These changes were present in control group as well, except in the aspect of effect on mental health of caregiver and family members, in which the difference was not significant through the course of our study (P = N/S).

Discussion

This study aimed to assess the effect of a group psychoeducation intervention on family burden in caregivers of Iranian patients with schizophrenia, admitted in acute phase of the disease. The results showed that the family burden in Iranian families with a patient with schizophrenia is considerably high (over 40 in a scale of up to 48), and almost all families face a severe burden. A 1-month group psychoeducational programme caused a significant reduction in family burden of the intervention group compared with the control group (27.87 vs. 37.82; $P < 0.001$). In all six elements of the FBIS and total family burden, the intervention group showed lower scores compared with the controls.

Care for patients with schizophrenia constitutes a considerable burden on family members (Awad & Voruganti 2008, Hou *et al*. 2008). Decreased quality of life is frequently observed in caregivers as a consequence of physical, emotional and economic distress that they face (Moller-Leimkuhler & Obermeier 2008). We found out that all caregivers of these patients indicated a severe burden on their families, and the severity of this burden was considerably higher than previous reports in other populations (Canive *et al*. 1996, Zhang *et al*. 1998, Yamaguchi *et al*. 2006, Chien & Wong 2007, Nasr & Kausar 2009).

A study on Chinese patients in Hong Kong (Chien & Wong 2007) reported a baseline mean family burden of 29.3 ± 5.0 assessed by FBIS (maximum score = 50), which is significantly lower than our findings. Our report shows that the severity of burden in the case of our population is even higher than a previous report from Iran. In that study (Malakouti & Posht Mashahadi 2006) which aimed to assess the efficacy of clozapine in comparison with other antipsychotic medications, a baseline mean burden severity of 21.05 ± 9.70 in 48 FBIS score was reported. The high level of burden of participants may partially be related to the characteristics of the population studied. All enrolled patients were admitted in a public psychiatric centre within their acute phase of the disease. It has been demonstrated previously that the severity of the disease manifestations have an influence on the level of burden that the family may experience (Grandon *et al*. 2008, Hjarthag *et al*. 2010).

Table 5
Change in FBIS score dimensions through the study according to the treatment received

Family burden dimensions and measures		Treatment groups: Psychoeducation group Mean ± SD	Treatment groups: Control group Mean ± SD	*P*-value
Element 1	Before	9.11 ± 1.6	9.69 ± 1.79	ns
financial burden	After	7.16 ± 1.5	9.17 ± 1.6	<0.001
	1-month follow-up	6.06 ± 1.4	8.71 ± 1.6	<0.001
	P value	<0.001	<0.001	
Element 2	Before	9.19 ± 1.14	9.03 ± 1.04	ns
daily activities	After	6.45 ± 1.23	8.11 ± 1.10	<0.001
	1-month follow-up	4.39 ± 1.17	7.4 ± 1.31	<0.001
	P value	<0.001	<0.001	
Element 3	Before	7.75 ± 0.44	7.4 ± 0.88	ns
entertainments and	After	5 ± 0.58	7.03 ± 0.75	<0.001
welfare	1-month follow-up	3.9 ± 0.54	7.31 ± 0.76	<0.001
	P value	<0.001	0.005	
Element 4	Before	9.28 ± 1.11	8.86 ± 1.19	ns
family relationships	After	6.16 ± 0.90	8.6 ± 1.14	<0.001
	1-month follow-up	5.06 ± 0.77	9.06 ± 0.99	<0.001
	P value	<0.001	0.007	
Element 5	Before	3 ± 0.68	3.03 ± 0.75	ns
physical health	After	1.87 ± 0.62	2.37 ± 0.69	0.004
	1-month follow-up	0.87 ± 0.34	2.26 ± 0.66	<0.001
	P value	<0.001	<0.001	
Element 6	Before	2.22 ± 0.54	2.37 ± 0.69	ns
psychological health	After	1.29 ± 0.59	2.37 ± 0.69	<0.001
	1-month follow-up	1.06 ± 0.25	2.29 ± 0.57	<0.001
	P value	<0.001	ns	
Total family burden	Before	40.64 ± 2.88	40.51 ± 3.17	ns
	After	27.87 ± 2.9	37.82 ± 2.78	<0.001
	1-month follow-up	21.3 ± 2.46	37.03 ± 2.81	<0.001
	P value	<0.001	<0.001	

ns, not significant; SD, standard deviation.

The 1-month group psychoeducation intervention added to the routine care for caregivers of patients with schizophrenia reduced family burden significantly, and the effect was constant even 1 month after the end of programme. Decrease in family burden, following psychoeducation interventions, has been reported to be effective psychologically (Magliano *et al*. 2005) and clinically (Rummel-Kluge & Kissling 2008b, Giron *et al*. 2010). These interventions have also been found to be cost-effective (Gutierrez-Recacha *et al*. 2006). Although the efficacy of these interventions has been confirmed, these strategies are not applied in clinical practice in Iranian patients with psychotic disorders including schizophrenia.

A relative relieve in burden perceived by caregivers of the control group was observed during the study period. It can be due to the decrease in symptoms of patients during the time as a result of routine care they received.

A previous study has shown positive effects of multi-family group therapy on improvement in patient medication adherence and outcome (Kopelowicz *et al*. 2012). A recent study showed that patients with early-stage schizophrenia receiving combination of medication and psychosocial intervention have a better treatment adherence, a lower relapse rate, and improved insight, quality of life and social functioning compared with those receiving medication only without psychosocial intervention (Guo *et al*. 2010).

All aspects of burden were measured in our study at high level including financial aspects, daily activities, entertainments, family relationships as well as physical and mental health. Financial burden has been reported to be a great contributor to family burden (Tsang *et al*. 2003, Grover *et al*. 2005). The high level of financial burden is a consequence of job loss by both the patients and their caregivers. Relatively high monthly expenditures on medication and care costs would be an addition to this financial crisis.

It is important to note that there are some limitations in this study. First of all, almost 40% of the caregivers were illiterate, and we did not consider it as exclusion criteria. This factor could impair and confound the perception of the issues discussed in the psychoeducational programme. However, as this situation may be common among caregivers of the patients, especially in low socioeconomic states, it may impair the generalizability of the results. Secondly, the information regarding family burden is gathered by

only one member of the family who is more involved in the care of the patient. As a result, the level of burden reported by the primary caregiver may be higher than the burden perceived by the whole family. Thirdly, the relatively short follow-up duration may limit our results regarding the long-term effects of such programme. We believe that this kind of education may help with the coping capacity of the caregivers by actively involving them and helping them to better understand the nature of schizophrenia and the required care. Thus, the programme would have a long-life effect in families taking care of a patient with schizophrenia.

The exact mechanism by which group psychoeducation reduces the level of family burden is not yet fully understood. Improving knowledge regarding the disease and changes in attitudes and subsequent changes in behaviours of the caregivers, all may cause this reduction (Nasr & Kausar 2009). Assessing these changes may provide deeper insight into the mechanism of burden reduction. This can direct psychoeducational programmes to focus more on the better targeted and designed interventions. We suggest facilitating access to such programmes in psychiatric centres and clinics and to merge this intervention into the routine treatment strategies for patients with schizophrenia. The topics discussed in four sessions of this trial can be discussed more deeply if the time and number of sessions increase.

Our study is somewhat different from previous studies in this area. We used FBIS to evaluate the family burden and its improvement after psychoeducational intervention that has not been used in most of similar previous studies. Also, most of previous studies about family psychoeducation have evaluated the effect of family psychoeducation on patient outcome (symptom, relapse and so on) but not on the family burden (caregiver and other family members) by itself including financial aspects, daily activities, entertainments, family relationships as well as physical and mental health. Our results highlight the positive effects of family psychoeducation on improvement of family burden of patients with schizophrenia to better cope with the illness and retain family relationships, and perform daily activities and entertainments.

Future studies are warranted to assess long-term effects of group psychoeducational intervention on clinical and health-related outcomes in patients and their caregivers and cost-effectiveness of such interventions in Iranian centres.

Conclusion

Our findings highlight the fact that a 1-month group psychoeducational programme is beneficial for reducing the family burden by more than one third. Almost all caregivers receiving psychoeducational intervention did not suffer from a severe family burden any more. Because enhanced non-organic interventions such as group psychoeducational programmes can be beneficial for patients and caregivers, providing facilities to integrate such programmes in clinical practice can be a good strategy for reducing the stress of families with a patient with schizophrenia.

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Lampiran 1 : Lembar *Critical Appraisal*

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : Masnaeni Ahmad*, Zulhaini Sartika A. Pulungan, Hardiyati
Year : 2019

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☑	☐	☐	☐
2. Were the participants included in any comparisons similar?	☑	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☑	☐	☐	☐
4. Was there a control group?	☑	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☑	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☑	☐	☐	☐
8. Were outcomes measured in a reliable way?	☑	☐	☐	☐
9. Was appropriate statistical analysis used?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : Gajali, Badar
Year : 2016

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☑	☐	☐	☐
2. Were the participants included in any comparisons similar?	☑	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☑	☐	☐	☐
4. Was there a control group?	☑	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☑	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☑	☐	☐	☐
8. Were outcomes measured in a reliable way?	☑	☐	☐	☐
9. Was appropriate statistical analysis used?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : Tri Nuhudo Sasono, Faizatur Rohmi
Year : 2017

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☑	☐	☐	☐
2. Were the participants included in any comparisons similar?	☑	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☑	☐	☐	☐
4. Was there a control group?	☑	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☑	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☑	☐	☐	☐
8. Were outcomes measured in a reliable way?	☑	☐	☐	☐
9. Was appropriate statistical analysis used?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : Andrea Friolllio,dkk
Year : 2015

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☑	☐	☐	☐
2. Were the participants included in any comparisons similar?	☑	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☑	☐	☐	☐
4. Was there a control group?	☑	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☑	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☑	☐	☐	☐
8. Were outcomes measured in a reliable way?	☑	☐	☐	☐
9. Was appropriate statistical analysis used?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

JBI Critical Appraisal Checklist
for Randomized Controlled Trials

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : Farkhondeh Sharif,dkk
Year : 2012

	Yes	No	Unclear	NA
1. Was true randomization used for assignment of participants to treatment groups?	☑	☐	☐	☐
2. Was allocation to treatment groups concealed?	☑	☐	☐	☐
3. Were treatment groups similar at the baseline?	☑	☐	☐	☐
4. Were participants blind to treatment assignment?	☑	☐	☐	☐
5. Were those delivering treatment blind to treatment assignment?	☑	☐	☐	☐
6. Were outcomes assessors blind to treatment assignment?	☑	☐	☐	☐
7. Were treatment groups treated identically other than the intervention of interest?	☑	☐	☐	☐
8. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
9. Were participants analyzed in the groups to which they were randomized?	☑	☐	☐	☐
10. Were outcomes measured in the same way for treatment groups?	☑	☐	☐	☐
11. Were outcomes measured in a reliable way?	☑	☐	☐	☐
12. Was appropriate statistical analysis used?	☑	☐	☐	☐
13. Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in theconduct and analysis of the trial?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : Farnaz Rahmani,dkk
Year : 2015

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☑	☐	☐	☐
2. Were the participants included in any comparisons similar?	☑	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☑	☐	☐	☐
4. Was there a control group?	☑	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☑	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☑	☐	☐	☐
8. Were outcomes measured in a reliable way?	☑	☐	☐	☐
9. Was appropriate statistical analysis used?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

JBI Critical Appraisal Checklist for Quasi-Experimental Studies (non-randomized experimental studies)

Reviewer : Sri Rahmaani N
Date : 28 Juli 2020
Author : M.Fallahi,dkk
Year : 2013

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☑	☐	☐	☐
2. Were the participants included in any comparisons similar?	☑	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☑	☐	☐	☐
4. Was there a control group?	☑	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☑	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☑	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☑	☐	☐	☐
8. Were outcomes measured in a reliable way?	☑	☐	☐	☐
9. Was appropriate statistical analysis used?	☑	☐	☐	☐

Overall appraisal: Include ☑ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

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Lampiran 2 : Lembar Konsultasi Bimbingan

CATATAN BIMBINGAN SKRIPSI PEMBIMBING UTAMA

Nama Mahasiswa : Sri Rahmaani NurHakiim
NIM : AK116146
Judul Skripsi : Pengaruh Terapi Psikoedukasi terhadap kemampuan keluarga dalam merawat pasien dengan gangguan jiwa: *Literature Review*
Pembimbing Utama : R.Siti Jundiah,S.Kp.,M.Kep
Pembimbing Pendamping : Rizki Muliani,S.Kep.,Ners.,MM

No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
1.	Senin, 9 Maret 2020	Lakukan Studi Pendahuluan ke Poskeswa	
2.	Jumat,20 Maret 2020	1. Metode Penelitian gunakan Literature riview 2. Mengumpulkan bab 1 via email	
3.	Jumat,20 April 2020	Bab 1 : 1. Penjelasan terapinya, sejauh mana keluarga membutuhkan terapi 2. Ada paragraph yang tidak ada sumbernya	
4.	Minggu, 19 April 2020	Bab 1 1. Ada beberapa paragraph yang masih tidak ada sumbernya 2. Stupen di Riung Bandung hilangkan 3. Sampaikan mengapa terapi psikoedukasi yang dipilih 4. Buat Bab 3	

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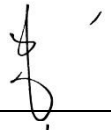
No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
5	Senin, 27 April 2020	1. Bab 1 ACC 2. Bab 3 apakah sudah dicari jurnal nya?	
6	Sabtu, 2 Mei 2020	ACC Sidang Up (12 Mei 2020)	
7.	Rabu, 13 Mei 2020	Mengirimkan Revisi Hasil sidang Up	
8.	Kamis, 16 Juli 2020	Bab 4 dan 5 : pembahsannya hasus berdasarkan jurnal yang hasil telusur bukan dari jurnal yg lain. sumber yang dikutip di pembahasan banyak yg bukan dr jurnal pd tabel. kemudian tidak dikutip beserta tahunnya. jelaskan mengapa jurnal tsb mempunyai kesimpulan demikina bagaimana prosesnya atau dalam penyakit patofisiologinya kemudain didikung tidak atau ada kesamaan dengan urnal lainnya yg sdh ditelusur	
9	Senin, 3 Agustus 2020	Bab 4 dan 5 : Apakah memang sedikit yang bias dibahas dari hasil penelitian gambaran keluarga dan terapi menurut 7 jurnal?	

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No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
10	Kamis, 6 Agustus 2020	Bab 3 nya belum diperbaiki: Sampel masih 10 jurnal di bab 4hanya 7 jurnal JBI menggunakan yang quasy eks. Tapi dijurnal ada yang RCT Pembahasan : Psikoedukasinya sama? Jika berbeda bahas. Sampelnya sama? Jika berbeda bahas.. Ada perbedaan yang mencolok tidak? Yang menyebabkan perbedaan hasil misalnya..	
10.	Rabu, 12 Agustus 2020	Dibahas perbedaannya,setelah itu siapkan draft lengkap.	
11.	Jumat, 14 Agustus 2020	Pernyataan pakai materai ttd,setelah itu daftar sidang	

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CATATAN BIMBINGAN SKRIPSI PEMBIMBING PENDAMPING

Nama Mahasiswa : Sri Rahmaani NurHakiim
NIM : AK116146
Judul Skripsi : Pengaruh Terapi Psikoedukasi terhadap kemampuan keluarga dalam merawat pasien dengan gangguan jiwa: *Literature Review*
Pembimbing Utama : R.Siti Jundiah,S.Kp.,M.Kep
Pembimbing Pendamping : Rizki Muliani,S.Kep.,Ners.,MM

No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
1.	Rabu, 22 April 2020	**Bab 1 :** 1. Variabel ke dua nya apa? 2. Terapi apa saja yang bisa diberikan kepada keluarga? 3. Mengapa psikoedukasi yang dipilih? 4. Sumbernya cari yang terbaru 5. Buat kalimat paragraph penutup **Bab 2 :** 1. Urutannya Konsep gangguan Jiwa, Konsep Keluarga, Konsep Variabel ke-2, Konsep Psikoedukasi, jurnal-jurnal yang terkait, Kerangka Konsep **Bab 3 :** 1. Jurnalnya apakah bisa ditambah menjadi 15? 2. Tahapan literature riview, tulisannya	

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No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
		diperbaiki	
2.	Selasa, 28 April 2020	**Bab 1 :** 1. Tambahkan data kekambuhan gangguan jiwa 2. Tambahkan data tentang dukungan keluarga terhadap pasien dengan gangguan jiwa **Bab 2 :** 1. Cari sumber terbaru diatas 2010 2. Tambahkan sub judul terapi dalam meningkatkan kemampuan keluarga merawat pasien gangguan jiwa 3. Penulisan pakai nomor, Bahasa asing dicetak miring 4. Tambahkan sub judul teori keperawatan yang mendukung **Bab 3 :** 1. Penelitian menggunakan pendekatan SLR 2. Tambahkan jurnal menjadi 15 jurnal (rentang tahun 10 tahun ke belakang) 3. Jelaskan bagaimana menggunakan Boolean operator, langkah teknik citation 4. Jelaskan berapa item pertanyaan di instrument JBI, bagaimana cara menilainya.	

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No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
		5. Tambahkan 3.4.4. ekstraksi data 6. Jelaskan seperti apa etik dalam litrev ini	
3.	Kamis, 30 April 2020	**Bab 1 :** 1. Tambahkan manfat bagi peneliti selanjutnya **Bab 2 :** 1. Kerangka konsep buat no dan sub judul bagan 2. Kerangka konsep membahas bagan gangguan jiwa butuh dukungan keluarga perlu kemampuan keluarga dalam merawat pasien pendekatan terapi keluarga psikoedukasi jelaskan bagaimana terapi psikoedukasi dapat meningkatkan kemampuan keluarga dalam merawat **Bab 3 :** 1. Revisi penggunaan AND untuk apa OR untuk keywoard apa, jelaskan satu-satu	
4	Jumat, 1 Mei 2020	ACC	
5.	Rabu,	Mengirimkan revisi hasil sidang UP	

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No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
	13 Mei 2020		
6.	Senin, 20 Juli 2020	**Bab 1-3** Bab 3 harus sudah Bahasa aplikatif ketika melakukan pencarian jurnal bukan Bahasa proposal lagi 1. Beri penjelasan dulu ttg skizofrenia yg dipilih… knp ini yg dipilih.Baru buat dulu kalimat penghubung jika gang jiwa itu perlu ditangani dan jika tdk ditangani dpt menyebabkan kekambuhan… jelaskan secara teori 2. Jelaskan juga dampak fisik dan finansial krn merawat anggota klg yg sakit 3. LR tdk ada kerangka konsep 4. Krn sdh pencarian literature maka hrs ada jlh populasi dr jlh pencarian jurnalnya 5. Rubah kalimat menjadi kalimat aplikatif utk pencarian jurnal **Bab 4-5** 1. Cek lagi jurnal yg diambil hrs sesuai dgn kriteria dan tujuan penelitiannya biar homogen…Cek lagi isi jurnalnya jika ada kaitan dgn pengaruh terhadap kemampuan klg dlm merawat pasien dgn gangguan jiwa bias diambil walaupun judulnya tdk	

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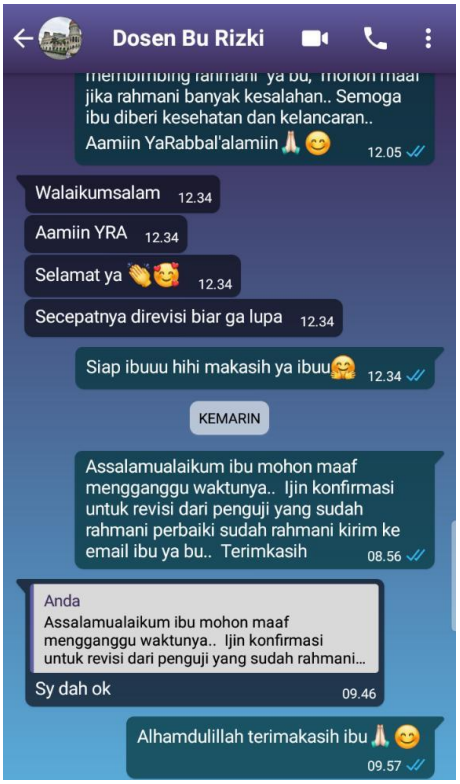
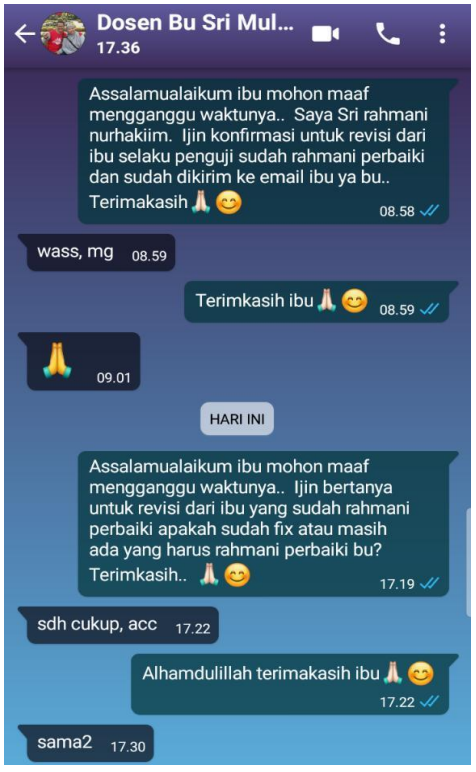
No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
		spesifik ke kemamp klg 2. Tambahkan judul dan penjelasan : Desain, Instrumen, Analisis 3. Yg dijelaskan proses intervensi psikoedukasi dan cara pengumpu;an datanya 4. Di pembahasan itu harus bisa mengcompare, mensistesis, membedakan dr semua jurnal yg ditelaah.Jd dalam 1 paragraf itu hrs sdh bias menggabung hasil dr bbrp sumber jurnal, bukan satu2 lg .Di pembahasan hrs terbahas : - Kemampuan klg dlm merawat pasien ggn jiwa.Identifikasi apa saja yg dibuthkan klg dlm merawat pasien ggn jiwa - Terapi psikoedukasi klg.Hrs bisa merumuskan terapi psikoedukasi klg yg paling efektif dr semua jurnal yg ditelaah itu yg mana… langkah2nya spt apa… bg,n tahapannya… brp lama dan brp kali diberikan - Pengaruh terapi psikoedukasi terhdp kemamp klg dlm merawat pasien dgn ggn jiwa - Bahas bgmn psikoedukasi klg itu	

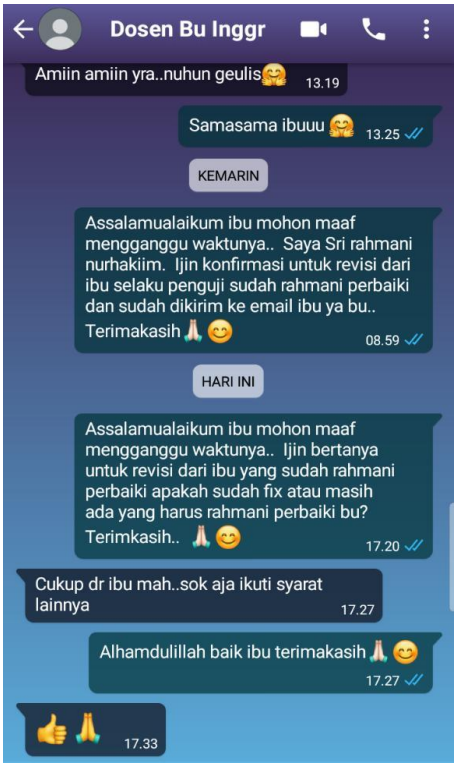
Jl. Soekarno Hatta No 754 Bandung
022 7830 760, 022 7830 768
bku.ac.id contact@bku.ac.id

No	Hari/Tanggal	Catatan Pembimbing	Paraf Pembimbing
		bisa merubah kemamp klg dlm merawat pasien dgn ggn jiwa… bahas hasil2 penelitiannya. - Biar lebih rinci di pembahasan buat sub judul ini utk jd pembahasan - Subjudul ini masukkan ke dlm tujuan khusus di BAB I yg sebelumnya blm ada 5. Simpulkan sesuai 3 point yg dibahas tadi	
7.	Sabtu, 25 Juli 2020	Perbaiki Revisi Banyak yang belum direvisi sesuai comment Bab IV dan V belum ada perbaikan Gabung Bab I-V dalam 1 file	
7.	Minggu, 9 Agustus 2020	Perbaikan final Lanjut abstrak dan lengkapi draft komplit	
8.	Rabu, 12 Agustus 2020	Perbaikan Final	
9.	Kamis, 13 Agustus 2020	ACC Sidang Akhir Kasih no dan judul table di bab III yang uji kelayakan	

Lampiran 3 : Persetujuan Pembimbing dan Penguji







FKep.Sri Rahmaani Nurhakiim AK116146.

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Lampiran 4 : Riwayat Hidup

RIWAYAT HIDUP

Nama	: Sri Rahmaani NurHakiim
NIM	: AK116146
Tempat Tanggal Lahir	: Bandung, 28 Juni 1998
Alamat	: Jl.Ciremay dalam No.3A 002/008 Kel.Lingkar Selatan Kec.Lengkong Kota.Bandung
No.Telp	: 081320011620
Email	: srirahmaaninurhakiim98@gmail.com

Pendidikan :

1. TK ALfitroh : Tahun 2003-2004
2. SDN Gumuruh X : Tahun 2004-2010
3. SMPN 20 Bandung : Tahun 2010-2013
4. SMK Bhakti Kencana Bandung : Tahun 2013-2016
5. Universitas Bhakti Kencana (S1 Keperawatan) : Tahun 2016-2020