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The Effectiveness Of Psikoeducation On Burnout Levels Skizofrenia Client Caregiver In Kersamanah Village Garut District

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ABSTRACT

The prevalence of burnout in schizophrenia caregivers is quite high compared to other chronic diseases. The aim is to determine the relationship between the effectiveness of psychoeducation and the level of burnout caregivers in schizophrenic clients. This research method is a quasi-experimental with a model of two groups pre and post-test with control design. The number of used samples is 32 people with 16 people in the control group and 16 people in the intervention group. The intervention group received 5 sessions of psychoeducation therapy, while the control group received no intervention. Hypothesis testing was used the Mann Withney test to determine the differences in caregiver burnout level scores in the control group and the intervention group after the psychoeducation intervention and repeated measures to determine the highest score at each intervention session. The results showed a significant difference in scores between pre and post-test in the intervention group with U = 24 and p-value = 0.01. In the psychoeducation session, it was found that session 3 could reduce the high level of caregiver burnout followed by session 5, session 4, session 2, and session 1. The results showed a significant difference in scores between pre and post-test in the intervention group with U = 24 and p-value = 0.01. In the psychoeducation session, it was found that session 3 could reduce high levels of caregiver burnout followed by session 5, session 4, session 2, and session 1. The results of psychoeducation were effective in reducing caregiver burnout levels so that they could be applied in dealing with psychosocial problems experienced by caregiver clients with schizophrenia. In conclusion, there is no change in the burnout level score. There is a significant difference in the level of caregiver burnout of schizophrenic clients before and after the psychoeducation intervention in the intervention group which is significant with Z = -3.145 and p-value = 0.002.

Keywords: Burnout, Caregiver, Psychoeducation, Schizophrenia

INTRODUCTION

The increasing prevalence of mental disorders occurs globally. The World Health Organization [WHO] (2009) estimates that as many as 450 million people worldwide have mental disorders. Mental disorders account for 13% of all diseases and are likely to grow to 25% in 2030. Based on Basic Health Research (Riskesdas) in 2007, the prevalence of mental disorders reached 0.46% of the total population of Indonesia or

around 1,065,000 people, Riskesdas in 2013 the prevalence of mental disorders in the population of Indonesia is 1.7 per mile or 1-2 people out of 1000 people experiencing mental disorders out of 250 million people. In West Java alone, mental disorders reach 72,000 out of 45.5 million people (Riskesdas, 2013). While the number of Garut residents who experience mental disorders is around 4,805 people from a total population of 3,003,004 souls. Likewise, the prevalence of mental disorders in Kersamanah Garut sub-district based on data at the Kersamanah health center shows that in 2012 data there were 98 schizophrenic clients and in 2012 there were 98 schizophrenic clients and in 2014 there were 125 sufferers, this village was also reported as a "crazy village" in 2012. the year 2008 in one of the national mass media.

Schizophrenia is a serious mental disorder. Schizophrenia is a type of mental disorder that ranks at the top of the existing types of psychosis (Rubbyana, 2012). Psychosis is a mental condition where personality disorganization occurs, deterioration in social functioning, and loss of contact or distortion of reality. In this condition, the client will not realize that other people have not experienced what he is experiencing and the client will feel surprised because other people do not react the same as him (Stuart, 2013). Schizophrenia is also considered a disease that is no less dangerous than other chronic diseases. Ho, Black, and Andreasen (2003) stated that schizophrenia is the most confusing and most tragic life-threatening disease and the most destructive disease.

Currently, health care is more focused on schizophrenic clients, while the caregiver as a person who is always close to clients and provides emotional care and support is still a little researched. Based on emotional support as well as little research has been done. Based on literature studies related to experiences and problems faced by caregivers in caring for schizophrenia clients and their handling in Indonesia, it is still limited. The caregiver's attention is important because the success of treatment and client care cannot be separated from the help and support provided. This is supported by research conducted by Reinhard Given, Petlick and Bemis (2008) which states that information about the fluctuation of the client's condition, signs, and symptoms, as well as the client's response to treatment, can only be obtained from the client's family who is a caregiver.

Carrying out the role of a caregiver is faced with the demands and duties of caring for clients or duties as an individual. These demands can be a source of conflict that can lead to tension and pressure resulting in feelings of anxiety, stress, frustration, psychological fatigue, and even depression for caregivers (Yusuf, Nuhu & Akinbiyi, 2009). Family

tension and despair last not only temporarily (Freadman, Bowden & Jones, 2003). These conditions place the caregiver under the burden. Each caregiver's response to facing the burden is different. This difference is influenced by the psychological characteristics contained in the caregiver. Research results (Schultz, 2000; Teasell et al., 2011; Brown, Brown & Penner, 2012). Explain the differences in caregiver perceptions of the meaning and understanding of schizophrenia, which is the coping ability and acceptance or perception of the treatment itself (Maldonado, Urizar & Kavanagh, 2005). Meanwhile, the stress level is a person's coping and acceptance ability which is influenced by that person's personality. If a caregiver has a low ability to control emotions, which is one of the personality characteristics, it will add to the problems that have an impact on the client and the caregiver himself. Maslach and Leiter (1988) stated that a person when serving clients generally experiences negative emotions such as anger, irritation, fear, anxiety, and worry. If these emotions cannot be controlled, they will become impulsive and overuse self-defense mechanisms or become involved in client problems. This condition will trigger burnout in the caregiver.

The caregiver's burnout process cannot be felt by the caregiver itself. Etzion (1984) suggests that the process of burnout runs slowly and without realizing it so that individuals suddenly feel tired. Pines and Maslach (1982) argue that physical, mental, and emotional exhaustion is caused by individual involvement in situations that are emotionally demanding and last a long time. If the caregiver's burnout condition is not handled, it will have an impact that is not only felt by the client but also on the caregiver himself. The impact received by caregivers can be in the form of a decrease in the quality of life so that it will affect mental health conditions and even experience mental disorders (Takai et al., 2011) so that the number of mental disorders increases. While the impact that will be received by the client is that the care is not optimally provided by the caregiver, even if the caregiver does not care about meeting the client's needs and the client's recovery, it will increase the recurrence rate and return to care (relapse & readmission). A psychiatric nurse is one of the professions that is responsible for handling psychological problems experienced by the caregiver so that in the future this does not become a cause of mental disorders. The role that mental nurses can play in the problems faced by the caregiver can be in the form of modality therapy. Therapeutic modalities that have been developed in mental nursing are in the form of individual, family, and group therapy. The caregiver is a family of schizophrenic clients. The

psychotherapy that has been developed for families includes family psychoeducation and triangle therapy (Keliat & Walter, 2011).

According to Cartwright (2007) psychoeducation is a modality therapy carried out by professionals, which integrates and synergizes psychotherapy and educational interventions. The psychoeducation program is an educational and pragmatic approach (Strut & Laraia, 2005). According to Cartwright (2007), psychoeducation intervention can reduce symptoms of mental health problems, in particular reducing anxiety and depression.is providing information about mental health. Caregiver psychoeducation programs provide opportunities to share feelings and strategies to share feelings that are felt. Based on the data and background above, the researcher intends to conduct research on the effectiveness of psychoeducation interventions on the level of caregiver burnout of schizophrenia clients in Kersamanah Village, Garut Regency. Through this research, it is expected that the caregiver's burnout rate can decrease so that it can improve their quality of life and they are ready to care for schizophrenic clients with all the problems.

MATERIAL AND METHODS

The design used in this study is a quasi-experimental model with two groups pre-post test with control design. Experimental research is a study that is conducted with one group by giving an intervention throughout the research (Creswell J. W., 2009). The intervention given in this study was psychoeducation to caregivers with schizophrenia. Before being given the intervention group and the control group, a pre-test was carried out in the form of measuring the level of burnout experienced by the caregiver. Furthermore, the intervention group was given 5 sessions of psychoeducation intervention and each intervention session was completed with a post-test to measure the level of caregiver burnout. In the control group, a post-test was carried out at each session after the intervention in the intervention group.

RESULTS

Table. 1 Distribution of respondent characteristics in the intervention group and control group in Kersamanah Village

Characteristics	Intervention Group	Percentage (%)	Control Group	Percentage (%)
Age				
20-30 th	4	25	3	18,75
31-40 th	1	6,25	1	6,25
41-50 th	7	43,75	7	43,75
51-60 th	3	18,75	4	25
> 60 th	1	6,25	1	6,25
Gender				
Male	1	6,25	1	6,25
Female	15	93,75	15	93,75
Level Of Education				
No School	0	0	0	0
Basic	11	68,75	8	50
Middle	4	25	7	43,75
High	1	6,25	1	6,25
Bachelor	0	0	0	0
Profession				
Work	2	12,5	1	6,25
Does not work	14	87,5	15	93,75
Income				
< Rp. 1,000,000	16	100	15	93,75
1,000.000- 2.000.000	0	**0**	1	**6,25**
> 2,000,000	0	**0**	0	**0**
Marital status				
Merried	14	87,5	15	93,75
Un Merried	2	12,5	1	6,25
Relationship with Client				
parents	7	43,75	5	31,25
other	4	25	8	50
children	2	12,5	1	6,25
the wife / husband	3	18,75	2	12,5
Others	0	0	0	0
Amount	**16**	**100,0**	**16**	**100,0**

The results of the study based on table 1. indicate that most of the caregiver ages in the control and intervention groups (43.75 %%) were in the age range 41-50 years with a mean age of 43 years in the intervention group and 45 years in the control group. Almost all of the caregiver gender in the control and intervention groups were women (93.75%). Caregiver education in the intervention group mostly graduated from elementary school (68.75%) and in the control group half of the caregivers graduated from elementary school (50%), the occupational data shows that almost all caregivers did not work well

in the intervention group (87.5%) and the control (93.75%), and income data shows that all respondents in the intervention group earn less than one million (100%) and in the control group almost all caregivers earn less than one million. The marital status of caregivers in the intervention and control groups showed that almost all of them were married (87.5% and 93.75%). Meanwhile, the relationship with the client shows that almost half of the caregivers are the client's parents (43.75%) in the intervention group, and in the control group the caregiver is the client's child.

Table 2. Differences in the level of burnout of schizophrenia caregiver clients in the control group and the intervention group before the intervention

	Mean	Std. Deviation	Minimum	Maximum	P Value	U
Control group before intervention	1.3750	.50000	1.00	2.00	1,000	128
Intervention Group Before intervention	1.3750	.50000	1.00	2.00		

From table 2. It can be seen that the caregiver burnout rate in the control and intervention groups before the intervention showed the same score (both 1.375) or showed no difference. Based on the results of the Mann Whitney test, it was found that U = 128 with p-value = 1 (because the previous scores for the intervention in the intervention and control groups were the same so that there must be no difference), Ho is accepted, in other words, there is no difference in the level of caregiver burnout in the intervention group and control group before the intervention.

Table 3. Differences in the level of burnout of the schizophrenia caregiver clients in the control group and the intervention group after the intervention

	Mean	Std. Deviation	Minimum	Maximum	P Value	U
Control group after intervention	1.3750	.50000	1.00	2.00	0.001	24
Intervention Group After Intervention	2.5000	.51640	2.00	3.00		

The results of the above research can be seen that the caregiver burnout level in the intervention group (score greater than 2.5) compared to the control group (score 1.375), this indicates that the intervention group experienced an increase in score or a decrease in burnout level. This decrease is a significant decrease according to the Mann Whiteney

test U = 24 with p-value = 0.001, so Ho is rejected, in other words there is a difference in the level of caregiver burnout in the intervention group and the control group after the intervention.

DISCUSSION

The results of the analysis of caregiver burnout levels before intervention in the control group and the intervention group showed that most caregiver burnout rates were high, with a rate of 62.5%. This shows that the schizophrenic client caregiver has a high burnout rate. Supporting research is research conducted by Onwumere, et al (2015) that the burnout rate of mental disorders caregivers is 78% experiencing high levels of burnout with 7% fulfilling the full criteria for high burnout in all burnout dimensions.
The high score of caregiver burnout was due to the caregiver as a respondent in this study who had cared for the client for at least six months. This condition can lead to increased emotional stress and caregiver's economy. This is consistent with research which shows that caregiver stress levels increase due to family financial problems (Caqueo-Uriza et al, 2014). Fontaine (2009) states that the caregiver burden is the level of caregiver distress experienced as an effect of the condition of his family members. Another study conducted by Yusuf et al. (2009) found that caregivers have a large burden in caring for schizophrenic clients when it is associated with financial factors, stigma, and negative client behavior. The burden on the caregiver has negative consequences on the physical state, emotional state, and economic condition. The level of stress associated with the caregiver's burden in caring for schizophrenic clients can make the caregiver vulnerable to burnout (Truzzi, et al, 2012).

Maslach (1982) explains that burnout is a response to an emotionally demanding situation with the demands of receiving care that requires assistance, assistance, and attention from the giver of care. The same thing was stated by Baron, et al. (1994) stated that burnout is a condition of physical and psychological fatigue due to chronic stress due to involvement with other people who need it. In the DSM-V (Diagnostic and Statistic Manual of Mental Disorder) burnout is also defined as a mental adjustment disorder characterized by the development of clinically significant emotional or behavioral symptoms in response to psychosocial stressors or stress. Burnout is not an immediate reaction to a stressor, but a result of chronic stress that lasts somewhat slowly and does not resolve after six months. The results of the analysis of differences in caregiver burnout levels before intervention in the control and intervention groups using the Mann

Whitney test obtained p-value = 1, so there is no difference in caregiver burnout level scores or other words both have high burnout rates. Factors that can cause this similarity can be seen from the similarity of respondent characteristics such as the age of each group who are in adulthood, gender who are mostly women, most of the respondents are people who do not work, educational history is the most elementary school. Most of the caregivers are parents of clients and subsequently spouses, and ha, for all respondents have an income of less than one million per month.

The gender of the respondents in this study were mostly women. To find out whether women and men have different levels of caregiver burnout, Truzzi, et al. (2012) conducted a study on gender differences in caregiver burnout rates in dementia clients, where dementia is classified as cognitive impairment as well as schizophrenia. The results showed that female caregivers had higher burnout. This difference may be due to gender role stereotypes, in which men appear less likely to express negative feelings to female caregivers. This is supported by the research of Hubble and Hubble (2002) which states that male caregivers think more positively than women in caring for clients with Alzheimer's.

The next characteristic that can affect the level of caregiver burnout is the level of education. The higher the level of education, the more knowledge level is so that it can have an impact on their positive attitudes and behavior (Wawan & Dewi, 2010). So that the higher the level of caregiver education, the higher the positive behavior that is generated in caring for schizophrenic clients.

The caregiver who experiences burnout is closely related to the disruption of his psychological condition, which can cause the caregiver to experience psychosocial problems. The mental nurse is one of the professions that is responsible for handling psychological problems experienced by caregivers so that in the future this does not become a cause of mental disorders. Early treatment can be done to anticipate mental disorders related to the caregiver role played by the family in caring for schizophrenic clients.

A research conducted by Jusuf (2006) entitled Assessment of Schizophrenia Caregiver Needs, it was found that schizophrenic caregivers need to master coping skills to overcome the burdens experienced in carrying out their roles. Among the various aspects that play a role in achieving effective coping, knowledge and information play an important role because they are needed in the problem-solving process and determine

the emotional reactions that arise. Therefore, the schizophrenia client caregiver needs to have sufficient information about the schizophrenia disorder itself and the burdens borne by the sufferer's family and how to deal with it. One of the treatments that can be done is with psychoeducation therapy, this is in accordance with what was stated by Dizon, et al. (2001) stated that psychoeducation is an evidence-base practice for dealing with the burden experienced by mental care caregivers. The results of the analysis of the effectiveness of the psychoeducation intervention on the caregiver's burnout level showed that the caregiver who experienced burnout in the intervention group experienced an increase in score or in other words, the burnout level score decreased with p-value = 0.002, while the control group did not experience a change in the caregiver burnout level score. Although similar research has never been carried out either in or outside the country, Sharief, et al. (2012) suggested that psychoeducation carried out on schizophrenic client caregivers had a positive impact in reducing the care burden and symptoms of clients after one month of intervention.

Psychoeducation therapy research conducted on caregiver clients with schizophrenia is still limited to its effect on the burden of care, emotions, and client care management. Psychoeducation interventions for caregiver clients with schizophrenia from various studies that have been conducted have a positive impact on caregiver problems in caring for clients. Research conducted by Magliano, et al. (2000), Church (2005), Sharief, et al. (2012), Tanriverdi & Ekinci (2012), Ozkan et al., (2013) and Fallahi, et al., (2014) state that psychoeducation is effective in increasing the family's ability to care for clients so that it reduces the recurrence rate and is treated, reduces the burden on caregivers. , reduce emotions and depression in caregivers. This supports the results of the study that psychoeducation was effective in reducing the level of caregiver burnout of schizophrenic clients significantly with p-value = 0.001.

The focus of psychoeducation according to Griffiths (2006) is to educate participants about challenges in life, help participants develop sources of support and social support in facing life's challenges, develop coping skills for the participants 'sense of stigma, change participants' attitudes and beliefs towards a disorder. (disorder), identifies and explores feelings on an issue, develops problem-solving skills, and develops crisis-intervention skills. Psychoeducation is concerned with teaching someone about a problem so that they can reduce the stress associated with that problem and prevent the problem from recurring. Psychoeducation is also advised on the strengths of participants

and focuses more on the present and the future than on the difficulties of the past. Psychoeducation intervention in the intervention group carried out on schizophrenic caregivers on caregiver burnout levels with five sessions with session 1 discussing problems faced by caregivers in caring for schizophrenic clients, session 2 on how to care for schizophrenic clients, session 3 stress management, session 4 on load management and burnout and session 5 on family empowerment. The results showed that in session 3 the highest score increased, in other words, experienced lower burnout levels, followed by session 5, session 4, session 2, and session 1. In session 3 the caregiver was given information about stress, stress management, and practicing stress management, deep breaths, and progressive relaxation. Munandar (2001) explains that stress management is trying to prevent the onset of stress, increase the stress threshold of the individual, and accommodate the physical consequences of stress. Stress management carried out in this study is progressive relaxation, which is based on the theory presented by Mulyono (2005) which explains some of the benefits obtained from relaxation exercises, including making a person more able to avoid overreaction due to stress.

The stress experienced by the caregiver is situational stress, namely stress caused by a problem that the caregiver has not previously experienced. This is in accordance with the theory of Luthans (1992) that situational stress is caused by changes in the family, economic and financial conditions, relationships with other people or social and community conditions, or places of residence. This is according to the research of Caqueo-Uriza et al. (2014) that the level of caregiver stress increases due to problems in caring for clients and when getting a way to deal with stress and doing it at home, stress experienced by the caregiver can be reduced, this is in line with the results of research that with psychoeducation intervention, the level of stress experienced by the caregiver decreases after doing stress management. This is supported by research conducted by Nurbani (2009) that psychoeducation therapy can reduce the level of anxiety, stress, and family burdens in caring for stroke clients where the stroke is a chronic disease similar to schizophrenia. The next session that shows an increase in score is the fifth session, which is a session where other families are empowered to care for clients. In this session, an increase can be caused because empowering other families can reduce the burden on caregivers. This is supported by research conducted by Deni (2011) which states that the increasing family supports the less the family burden in caring for clients with

hallucinations, where appropriate family support makes the burden to be borne by the family.

Research conducted by Suryani (2015) shows that schizophrenia caregivers need support from professionals and families. Other research related to family support conducted by Sahar (2002) shows that caregivers need support from various parties such as community health centers which can develop family empowerment programs through training to prevent problems faced by caregivers. This shows that family support as family members and support from health professionals are needed by the caregiver to reduce the burden experienced in caring for schizophrenic clients.

CONCLUSION

There was no difference in the level of caregiver burnout of schizophrenic clients before and after the psychoeducation intervention in the control group with Z = 0.001 (Wilcoxon test) and p-value = 1.00, but each session experienced a change in score although not significant. There was no difference in the level of burnout caregiver for schizophrenic clients between the intervention group and the control group before the psychoeducation intervention was carried out with the Mann Whitney test (U = 128.00) and p-value = 1.00, or in other words, the scores before the intervention in the intervention and control groups were the same. There is a difference in the level of caregiver burnout of schizophrenic clients between the intervention group and the control group after psychoeducation intervention with the Mann Whitney test (U = 24.00) and p-value = 0.01, these results indicate that there is a significant difference between caregiver burnout in the intervention group and the control group.

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