THE ADAPTATION MODEL OF CAREGIVER IN TREATING FAMILY MEMBERS WITH SCHIZOPHRENIA IN KEDIRI EAST JAVA

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ABSTRACT

Introduction: Schizophrenia is a severe mental disorder that is characterized by impaired reality (hallucinations and delusions), inability to communicate, affect unnatural or blunt, cognitive disorders (not capable of abstract thinking) and had difficulty doing daily activities. Normally, the family is most affected by the presence of people with schizophrenia in their families. The purpose of this study was to develop an adaptation model of the caregiver in caring for family members with schizophrenia in Kediri. **Methods**: This study used cross-sectional design with nature explanatory research. Data were collected using a questionnaire on 135 respondents in nine health centers in the city of Kediri region. The sampling technique used simple random sampling. For data analysis and test, the feasibility used a test model of SEM with AMOS program 19. **Results:** The results showed self esteem caregiver (-0.25 <0.05), community resources (0.24 <0.05), self-efficacy (0.22> 0.05) , caregiver coping effort (12:17 <0.05), and the perception of caregiver about the family situation at this time (0:19 <0.05), which means that adaptation of caregiver in treating patients with schizophrenia is influenced by the characteristics of the family, namely community resources, self-efficacy, caregiver coping effort, self-esteem and perception of family caregiver to the conditions experienced at this time. Perception of caregiver about the condition of today's families is affected by stress, which appears on a caregiver stress due to stressor for caring for people with schizophrenia, especially the aggressive behavior of schizophrenics. **Discussion**: Adaptation of caregiver was highly influential in the care of people with schizophrenia because in this case becomes one of the important points to be able to sustain the process of treatment and prevent relapse of schizophrenics.

Keywords: *Schizophrenia, caregiver, adaptation*

INTRODUCTION

Mental Disorder is a condition in which the process of physiological or mental poorly functioning properly so interfere with the functioning of daily life. This disorder is often also referred to as a psychiatric disorder or mental disorders, and the general public is sometimes referred to as a nervous breakdown. Mental disorders experienced by a person can have a variety of symptoms, both obvious and only when they exist in his mind. Starting from the avoidance behavior of the environment, do not want to touch or talk to other people and would not eat until the raging with no apparent reason. Starting from the silent ones to the speaking ones is not clear. Some can talk to and others are not attentive to her surroundings. From the above condition makes the client must be hospitalized to recover her mental condition (Hawari 2009).

Most people with mental disorders have schizophrenia. Schizophrenia is a severe mental disorder that is characterized by impaired reality (hallucinations and delusions), inability to communicate, affect unnatural or blunt, cognitive disorders (not capable of abstract thinking) and had difficulty doing daily activities (Keliat 2006). Schizophrenia is a brain disease that leads to persistent and serious psychotic behavior, concrete thinking, and difficulty in information processing, interpersonal relationships, and solve the problem (Stuart 2013)). Schizophrenia is a form of psychotic disorders (severe mental illness) which is relatively frequent. The lifetime prevalence of nearly 1%, the incidence annually about 10-15 per 100,000 and schizophrenia is a syndrome with a variety of presentations and one variable, the disease course is long term, and often suffer relapses (Davies 2009).

Schizophrenia is the most severe functional psychosis, and pose the greatest personality disorganization; the patient has no reality. The incidence of schizophrenia was 0.1 per million in the world regardless of their socio-cultural status (Varcarolis 2000). 2009 based on data from 33 psychiatric hospitals in Indonesia noted that patients with severe mental disorders reached 2.5 million people (Alert Online 2010). Based on data from 2013 Riskesdas known that the average people with

severe mental disorders in all provinces in Indonesia was 1.7 per million, with the highest prevalence was in DI Yogyakarta and Aceh which is 2.7 per million and for the province of East Java 2.2 per million, and based calculation Riskesdas 2013 in the province of East Java possible economic losses arising from severe mental disorders is based on the loss of productivity of patients and their families who become caregiver is as much as 22.5 billion (Riskesdas, 2013). Kediri City Health Department in 2012 said the number of people with mental disorders in health centers increased. According to the City Health Office Kediri, the increasing rates of up to 15 percent of people with mental disorders in the clinic Kediri. As the research findings, data on the number of people who experience mental disorders has increased approximately 15 percent. The latest data from Kediri City Health Department in 2013 showed the number of people with schizophrenia in the town of Kediri reached 200 people, spread over nine health centers in the city of Kediri.

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From the preliminary study, researchers found that the city of Kediri has nine health centers covering three districts. Of the nine health centers in Kediri have no mental health program in Integrated Health Post (Posyandu). Mental health programs that exist now only to the rehabilitation process in the form of regular checks for the treatment of patients with schizophrenia, but there is no special program for families in their participation in the care of people with schizophrenia after the return from the mental hospital. Results of interviews with 9 Public Health Centers (puskesmas) officers who are responsible for the reporting of mental health in health centers Kediri city, all stated that they had been doing duty in checking the administration of antipsychotic drugs in patients with schizophrenia in the city of Kediri, while for families attendant health centers only provide health education about schizophrenia and drugs must be taken by the patient. Public Health Centers - Puskesmas officers had never been taught to families how to prevent the family could have done relapse of schizophrenic patients using behavior therapy and the implementation strategy in patients with schizophrenia as the primary caregiver of schizophrenics. The result of research interviews with seven families of schizophrenics in the town of Kediri, all stated that they frequently experience anxiety and confusion in caring for a family member who has schizophrenia, especially if the schizophrenic patients had a relapse. In addition to a recurrence of the problem for the family, the financial condition of the family also becomes impaired because of family financial income also decreased due to caregiver who cares for family members of schizophrenics confusion devote time to work for a living by caring for their family members who suffer from schizophrenia. Another problem that arises from the family is confusion families how to care for and how to adapt to families with a schizophrenic who had been suffering from schizophrenia especially the decades and repeatedly experienced a relapse.

People With Schizophrenia handling process (ODS) in length, ranging from hospitalization, administration of drugs, to social support, families, and communities, became a multi-factor for ODS recovery process. Suppose a patient is already getting the drug properly, the process of recovery in the hospital running good, but if the house is not supported by the family and the environment, it could be the patient will relapse. Not given the role at home, then the negative stigma of society will make the ODS recur; therefore the recovery process of this disease takes many years. As a result of the healing process is long, it takes perseverance and patience of families. During this time, many families go into the pit of despair, which ultimately makes ODS stocks. Government data, in Indonesia there are approximately 18 thousand ODS stocks. Many families that include members of the family who ODS to a mental hospital, clinic, foundation treatment of

mental illness, brought to the shaman, a special boarding school madman, or poorhouse (Taufik, 2014).

One with mental disorder schizophrenia causes suffering not only for the individual sufferer but also for people who are closest. Normally the family is most affected by the presence of people with schizophrenia in their families. In addition to the high cost of care, patients also require more attention and support from the community, especially families, in the treatment of mental disorder schizophrenia one of which requires a relatively long time, when patients discontinued treatment will have a relapse (Arif 2008). Once clients go home, the client should perform follow-up care at Public Health Centers - pukesmas in its territory who have mental health programs, and the role of the family is needed in the healing process in the client's home (Yosep 2009).

METHODS

This study uses survey research methods, the research implemented by taking a sample from a population and using questionnaires as the main data collection instrument. The design of this study uses cross-sectional design with the nature of the research studies explanation (explanatory research), based on the perception of respondents, which explains the causal relationships between variables based on the answers of respondents through hypothesis testing. Independent variables consist of family characteristics, stressors, and Community Resources. Intervening variables consist of caregiver perceptions of family members who suffer from schizophrenia, stress on the caregiver, self-efficacy, adversity quotient, caregiver coping effort and caregiver about perception of their current family situation. The dependent variable is the adaptation caregiver in caring for family members with schizophrenia.

The research was conducted on a sample of location research that month from February to June 2015 in the area of Kediri (includes 9 Public Health Centers Puskesmas Kediri). The population in this study is all the families who have family members with schizophrenia post treatment of the Hospital or Psychiatric Hospital in Kediri. The sample in this study is a caregiver who are family members of patients Schizophrenia Kediri to have the inclusion criteria for the Care Giver include: Caregiver lived one house with patients Schizophrenia, a "Care Giver" major, willing to become respondents, domiciled in the City of Kediri, while the family inclusion criteria include: the condition of the family structure is still intact, in one family only one who suffers from schizophrenia. For patients, inclusion criteria include: the schizophrenic ever been treated/be a mental patient / post-discharge.

The samples are taken by the formula Rule Of Thumb. The parameters used in this study amounted to 27 parameters, so the formula Rule Of Thumb obtained sample number: 27 x 5 = 135 respondents. Sampling was simple random. Analytic analysis done using SEM test is by AMOS program 19.

RESULTS

The results showed the majority of patients aged between 26-45 years, with 79 respondents (58.5%). Most of the patients were male, i.e. 88 respondents (65.2). Almost half of the patient's status was a child, namely 47 respondents (34.3%). For the caregiver, the results showed that most of the caregivers aged between 46-65 years are 65 respondents (48.1%). Most of the caregivers are female, i.e. 92 respondents (68.1%). Almost half of the care giver's status is the patient's mother, 49 respondents (36.3%) and educated past high school level, i.e. 58 respondents (43.0%).

Almost all the caregiver has knowledge of the treatment of schizophrenia in the poor category, ie 109 respondents (80.7%). For most of the economic status of the caregiver is the category High (> UMK), i.e. 83 respondents (61.5%). Caregiver portion has some family members of more than four people, namely 69 respondents (51.1%). Caregiver most have high self-esteem, that is 83 respondents (61.5%). Caregiver most have family members who have schizophrenia for more than ten years, namely 58 respondents (43.0%). For the stigma, some caregiver gets a stigma from the society in negative categories, namely 79 respondents (58.5%). The average score of aggressive behavior (48.04) is higher than the score of behavioral withdraw (43.98), it can be concluded that the behavior of patients with

schizophrenia in this study tended to behave in extreme aggression. The partial caregiver has a perception in the negative categories, namely 78 respondents (57.8%). The negative perception here is the interpretation caregiver includes feelings and images in caring for family members who have schizophrenia. Fraction caregiver has a lower stress level category, namely 52 respondents (38.5%). Low stress or light means the state experienced caregiver as a result of environmental changes that threaten, challenge when caring for family members with schizophrenia in conditions of low or mild. The most caregiver gets enough social support categories, namely 77 respondents (57.0%).

The most caregiver has a Collective Efficacy in positive categories, namely 72 respondents (53.3%). Collective Efficacy positive means that the ability of perception of family members and the public on the effectiveness of the relationship between tasks, skills, and role in caring for family members with schizophrenia to produce change towards a positive showing for the caregiver or schizophrenic. Most of the caregiver has a social network in enough categories, namely, 86 respondents (63.7%). Social network means enough communication and cooperation obtained caregiver and family while caring for a family member suffering from schizophrenia enough. It is obtained from the local community as well as from health workers in health centers. Almost all the caregivers have access to new contact and information in enough categories, namely 125 respondents (92.6%).

For most self-efficacy caregiver has a negative self-efficacy, which is 72 respondents (53.3%) and almost all the caregiver has adversity quotient in the category campers, i.e., 124 respondents (91.9%). Adversity Quotient campers' category means the caregiver feel quite satisfied or feel safe with what was achieved at this time in the care of family members who have schizophrenia. No effort or progress further to find other ways of caring for family members who have schizophrenia. The partial caregiver has a perception in the negative category, which is 69 respondents (51.1%).

For coping mechanisms, some caregiver has a coping effort in the category of problem-focused coping, i.e. 76 respondents (56.3%) and partial caregiver own adaptation in the negative categories, namely 70 respondents (51.9%). Adaptability caregiver (caregiver coping effort) negative means caregiver

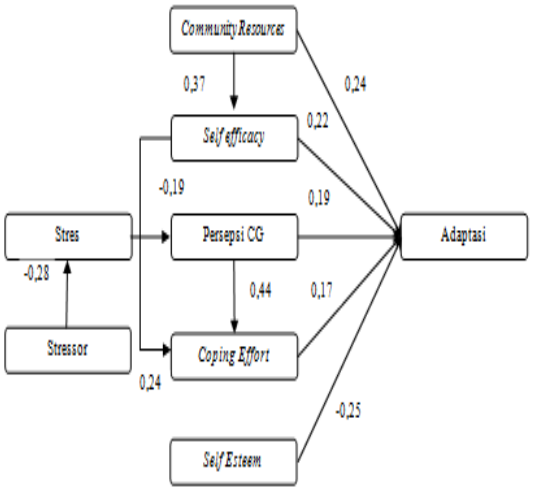

Figure 1. Adaptation Model of caregiver in treating schizophrenic Kediri

cannot adjust themselves well in business and shape their behavior to overcome barriers or problems that arise when caring for family members with schizophrenia.

DISCUSSION

Families of people with schizophrenia feel the stigma and discrimination surrounding environment. Conditions of their schizophrenic in the family will cause various problems, not only the patients themselves but also family particularly caregiver who treats the schizophrenic. One problem that arises is self-esteem disorder in caregiver. Impaired self-esteem or self-worth are disturbed, e.g., low self-esteem. This condition appears one reason is the emergence of stigma on people who think that schizophrenia is a disgrace in the family. It raises the shame of the caregiver, which could eventually create the perception of schizophrenia caregiver becomes less good. Awards and public acceptance of large families affect self-esteem, one caregiver that is part of the family because the family is the first place to interact in someone's life.

One of the signs of disorder such example is the self-esteem of the care giver's unwillingness to interact with others. (Warner R 2007) states that the family's reaction arising

from mental disorder suffered by their family members is to not talk to anyone about the mental disorder for years, sometimes even on their close friends. Ironically, the family is open and discusses the matter is getting abuse from the public. Family responds to these abuses by withdrawing socially, avoiding friends or even moving to a new residence. Although there is a tendency of family members to reject stigma, concealment and withdrawal are based on shame will bring them into social isolation.

The healing process in patients with mental disorders should be done holistically and involve family members. Without it, as well as common illnesses, mental disorders can recur. Family coping very important to participate in the healing process for the family is a major supporter in treating patients. Therefore, nursing care that focuses on the family not only restore the patient but aims to develop and enhance the ability of families to cope with mental health problems in the family (Syaifullah, 2005). The family is the unit closest to the patient and is the "primary caregivers" for patients. Families must have an adaptive coping in overcoming or dealing with people with schizophrenia to determine how or the necessary care of patients at home. The success of the nurses at the hospital will be useless if it is not passed in the house which then lead to patients should be treated back (relapse). The role of the family since the beginning of hospital care will increase the ability of families caring for patients at home so that the possibility of recurrence can be prevented.

The quality of Life a caregiver associated with the female gender is lower than in men (Awadilla, 2005). Data from this study showed that most sex of patients was male and caregivers were mostly women. The condition also can be a stressor itself for caregiver, especially woman as caregiver will usually involve feelings or emotions when the action or make a decision. There is a reciprocal relationship between the behavior of people with schizophrenia are disruptive to the emergence of a negative response to family members caring. The behavior of the sufferer can cause high emotion in the family, and then this condition will lead to negative behavior and lead to psychological stress both for patients and for the family, and psychological stress which appears in the patient can trigger or trigger a relapse. Comments and criticism from family members with high emotional expressions cause the emergence of more thoughts and unusual behavior of the patient and the thoughts and unusual behavior that will trigger an increase in comments and criticisms of the family. In addition it is depression, anxiety; self-confidence is low and less than optimal adaptability accompanied by a lack of adequate information about schizophrenia to be associated with high expression of emotions in the family.Expression of high emotion of the family is one of the significant stressors for people with schizophrenia. Stress that elicits emotional expressions of caregiver will affect the way caregiver in providing care for people with schizophrenia. The more stress caregiver can make the treatment process can not be the maximum, because the caregiver stress can also lead to physical and emotional complaints to the caregiver for example illness, so the ability to provide care to decrease.

The condition of self-efficacy caregiver when treating people with schizophrenia may also be influenced by community resources. The community itself can be divided resources form the two are psychologically in the form of collective efficacy, social and psychological support and none namely social contact and access to new contacts and information. Social caregiver support received in the form of support from the social community for example, from the neighbors, social contact with people, another family as well as with health care. Besides access to search information about schizophrenia and collective efficacy of the public and health workers around are also influential. Patients with schizophrenia and families need information about social situations that support recovery, the resources they can use to improve the quality of life and information about the management of the crisis. Patients with schizophrenia and families also need social support from the wider community (WFMH, 2009; Temes 2011).

The results showed 65 respondents have a negative self-efficacy and the adversity quotient on stage campers. Self-efficacy caregiver formed as a process of adaptation and learning that are in the situation they face when caring for family members who suffer from schizophrenia. The longer caregiver care

for family members who suffer from schizophrenia, the higher self-efficacy owned caregiver in carrying out their duties, but did not rule out the possibility that self-efficacy which is owned by the caregiver actually tends to decrease or remain as it has entered the stage of stagnant or in conditions of adversity quotient on stage campers, where the caregiver was already satisfied with what was achieved or was resigned to her condition during this time. It could be a family experiencing saturation in schizophrenia their care at home, should always control all activities of sufferers, have to face difficulties in the costs of care and treatment of patients in a long time.

The research found empirically that the adaptation caregiver the ability caregiver to adjust in treating patients with schizophrenia is influenced by community resources, self-efficacy, perceptions of caregiver about the condition of the family in caring for people with schizophrenia, coping effort (coping mechanism) and self-esteem or price self. Community resources in this regard include collective efficacy is the belief of society and the family in the care of people with schizophrenia, social support, namely the support obtained by the family of the surrounding community, a social network that is communication and cooperation that can be obtained and carried out by the family as they care for family members schizophrenic and access to new contact that is the ability of families in an effort to find resources to learn about schizophrenia and treatment processes families suffering from schizophrenia. Care giver's perception about the state of today's families is affected by stress, which appears on a caregiver stress due to stressor for caring for people with schizophrenia, especially the aggressive behavior of people with schizophrenia.

Theories about the adaptation of the family in the care of people with schizophrenia did not exist before. The theory that there had existed only said about the adaptation of the family in general in the face of problems or difficulties in the family, one of them when there are family members who experience pain conditions. Previous theories, in general, is the theory ABCX Hills (Rice, 2000) which states that an event (A) interact with family members, will create a crisis (B) and bring up interpretation of the family about the incident (C). What distinguishes the theory of the results of the development of the model here is the adaptation of the family in caring for people with schizophrenia are not only influenced by stress and perceptions of the family but is also influenced by the self-esteem of the caregiver, community resources, caregiver coping effort (coping mechanism) and the perception of caregiver of family conditions experienced at this time.

CONCLUSION

Adaptation of caregiver is the ability to provide welfare care in people with schizophrenia. This is influenced by community resources, self-efficacy, caregiver perception about the family condition in caring for schizophrenia, coping mechanism, and self-esteem or self-esteem. Community resources are the beliefs of people and families in the care of people with schizophrenia, a social support obtained by families from the surrounding communities, social networks of communication and cooperation that can be obtained and carried out by families, and access for families to find resources that support the care of patients with schizophrenia.

The care giver's perception of family circumstances is currently influenced by stress, which is apparent in the stress of caregiver because of the stressors to treat people with schizophrenia, mainly due to the aggressive behavior of schizophrenics.

The model required criteria and parameters of mental health and rehabilitation of standardized, measurable and easy-to-implement mental rehabilitation of schizophrenic patients upon return from hospitalization, enabling maximum families to assist schizophrenic healer recovery, and preventing recurrence, one of which is the establishment of Integrated Health Services. In addition to providing training for Public Health Centers about rehabilitation therapy for people with schizophrenia especially the holder of the mental health program at puskesmas.

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