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The effectiveness of supportive and psychoeducational family therapy: A linkage towards burden and anxiety of care for children with mental retardation

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Abstract

Background: Children with mental retardation have difficulty processing information so that which affects the development process. Behavioral disorders and dependence on family members with mental retardation lead to care and family responsibilities causing burdens and anxiety in response to stress in mentally disabled children.
Purpose: To determine the effectiveness of supportive and psychoeducational family therapy: A linkage towards burden and anxiety of care for children with mental retardation
Method: A quasi-experimental pre-post test design with a control group. The population was the family who has a child with a mental retardation member. The sample was 76 participants using a simple random sampling technique. Data analyzed using Univariate and bivariate.
Results: The family burden of mentally retarded children before intervention in the treatment group was 50.18 with a standard deviation of 18.958. The burden on families with mentally retarded children after being given intervention in the treatment group was 46.45 with a standard deviation of 17.168. There are differences in the reduction of burden and family anxiety with mentally retarded children before and after the intervention in the treatment group.
Conclusion: Psychoeduactive and Supportive Therapy can be a standard therapy in overcoming the burden and family anxiety in dealing with children with mental retardation. The schools with disabilities need to have a special room to carry out therapy and improve the quality of comprehensive nursing care by recruiting nurses who are competent in providing mental therapy specialists.

Keywords: Psychoeducation; Supportive; Burden; Anxiety; Mental retardation

INTRODUCTION

Children with mental retardation are strongly associated with intellectual impairment below average causing difficulties in processing information (Suryani, 2010). The inconsistency between parents' expectations and children's potential tends to cause problems later in the child's development process (Setyowati, 2010). As a result, parents experience anxiety, which tends to protect their children excessively. Mentally retarded children experience several limitations such as intellectual function in problem-solving, limitations in adaptive behavior in the form of skills needed to live their daily lives, and unable to communicate effectively. This causes dependence on the family. In the school-age group, the number of children with mental retardation was 62,011 people (Ministry of Health Rupublic of Indonesia, 2015). The preliminary study found that the response to stress acceptance that most often appeared in families was anxiety due to the burden felt by caring for children with mental retardation.

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The family consists of members who interact and depend on each other in a physical, psychological, and social environment (Indriyani, 2014). Families with mentally retarded children need ongoing and long-lasting care. This can place an additional burden on the family to care for. This has an impact on the roles, responsibilities and relationships of the family as a caregiver for children with mental retardation (Faizah & Dara, 2017). The increasing burden of caring for a mentally retarded child will affect family functioning (Yusuf, Fitryasari, & Nihayati, 2015), and contribute to the emergence of psychosocial problems in families. In addition, the psychological burden experienced by families is anxiety about child development (Suerni, Keliat, & CD, 2013). Families experience anxiety as a response to stress due to increased burdens when they have to deal with mentally retarded children with dependency on behavior problems to reduce the quality of life of the community, families, and mentally retarded children themselves (Yusuf, Fitryasari, & Nihayati, 2015).

Efforts to overcome family barriers in caring for children with mental retardation can be in the form of explaining, demonstrating how to identify problems and motivating families to disclose problems, providing health education, conducting socialization, conducting psychoeducation, and providing information to families about using health facilities. The ability to provide support to families can be improved by providing group therapy and psychoeducation therapy (Sadock, & Sadock, 2010). Psychoeducation therapy addresses personal problems and problems caring for family members with mental retardation, treatment methods, family stress management, family burden management and community empowerment in helping families. Meanwhile, according to (Hadidi, 2016), group therapy that is given such as supportive therapy can provide support to the group so that it is able to solve the crisis it faces by building supportive relationships between client-therapists, increasing group strength, increasing group coping skills, increasing group ability to use coping, and increasing optimal independence

Previous research stated that family psychoeducation was effective in reducing the level of anxiety and perceived family burden in caring for mentally retarded children compared to health education interventions (Rosmaharani, Wihastuti, & Supriati, 2015). Supportive group therapy greatly influences the cognitive, affective and psychomotor abilities of parents in providing self-care to children with multiple visual impairments, Psychoeducation , schizophrenia , and anxiety (Dewi, Hamid, Mustikasari, 2011; Widiastuti, Hamid, Nuraini, Daulima, & Lolita, 2010; Suerni, Keliat, & CD, 2013; Buckley, Maayan, Weiser, & Adams, 2015; Bulut, Arslantaş, & Dereboy, 2016; Yunita, 2018). Interventions to reduce stress and burden felt by families need to be known, so this study was conducted to know the effects of psychoeducation and supportive therapy towards burden and family anxiety in caring children with mental retardation.

RESEARCH METHOD

The study was a quasi-experimental study design and was conducted from May to September 2020. The study was taken place in Jambi Province, Indonesia. The population in this study were 96 participants who had children with mental retardation in Jambi City. The total sample was 76 people consisting of 38 people in the intervention group and 38 people in the control group. Samples were obtained through a simple random sampling technique. The inclusion criteria were as follows: 1) parents of mentally retarded children; 2) parents who care directly and live in the same house with mentally retarded children; 3) parents can write and read; 4) willing to participate fully.

Parental demographic instruments consist of age, gender, education, family type, income, child's age, gender, and level of mental retardation. This study used The Zarit Caregiver Burden Interview (ZBI) instrument which consists of 22 items to measure the burden while caring for a sick family member. This instrument covers health, social and personal life, financial situation, emotional health

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and interpersonal relationships. ZBI uses a Likert scale (0-4). The total score is 88. The score 0-20 is light load or no load; scores 21-40 are light to moderate loads, scores 41-60 are moderate to heavy loads, while scores 61-88 are heavy loads. The results of testing the instrument found reliability with Cronbach Alpha 0.947. Anxiety was measured by the Hamilton Anxiety Rating Scale (HARS). The instrument consists of 14 statements with each group given a weighted score of 0 - 4, namely: a score of 0, if 0% the number of symptoms that appear in each symptom group. Then a score of 1, if 1% - 25% of the number of symptoms that appear in each symptom group. Score 2, if 26% - 50% of symptoms occur in each symptom group. Score 3, if 51% - 75% of symptoms occur in each symptom group. Score 4, if 76% - 100% of symptoms that occur in each symptom group. Furthermore, each number value in the symptom group is added up to determine the degree of anxiety. HARS category, namely: ≤ 20 is mild anxiety, 21-27 is moderate anxiety, and 28 - 41 is severe anxiety (Arti, Kanca, & Suwiwa, 2018).

The research stage consisted of the pretest stage, with participants filling out a questionnaire to determine the conditions of burden and anxiety experienced by the family. In the intervention group (psychoeducation and supportive therapy). Researchers provide psychoeducation therapy followed by supportive therapy. Therapy activities are carried out every day. In the intervention group, the psychoeducation therapy consisted of five sessions where each session was carried out once, while the supportive group consisted of four sessions which were carried out in six meetings (each session was carried out once except for sessions two and three on supportive therapy). The duration of the activity will be 30 minutes. Furthermore, the control group received psychoeducation and supportive therapy in this group, the procedure carried out would be the same as the intervention group (each session was carried out one meeting unless supportive therapy was carried out once in two sessions). In the posttest stage, the questionnaire was re-administered to evaluate the differences in the provision of psycho-educational and supportive therapy.

The analysis was performed using a Paired t-test and the Independent t-test with a signicancy level of $p<0.05$. This research has passed the ethics test from the Health Research Ethics Committee of the Health Poltekkes Jambi Ministry of Health with number LB.02.06 / 2/122/2020 on July 28, 2020.

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RESULTS

Table 1. Demographic Characteristics (N=76)

Variabel	Result
Family/caregiver Characteristics	
Age (Mean±SD)(Range)(Year)	(41.68±9.017)(25-61)
Gender (n/%)	
Male	57/75
Female	19/25
Education Levels (n/%)	
Primary school-Junior high school	57/75
Senior High School-University	19/25
Economic Status of Family (n/%)	
Income equal to expenses	33/43.4
Income greater than expenses	22/28.9
Income less than expenses	21/27.7
The children with mental retardation	
Age (Mean±SD)(Range)(Year)	(11.11±2.324)(5-15)
Gender (n/%)	
Male	43/56.6
Female	33/43.4
Dependency level (n/%)	
Slight	57/75
Total	19/25

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Table 2. Evaluation of Intervention Measures (N=76)

	Intervention (n=38)	Control (n=38)	p-value
Burden (Mean±SD) (Range)			
Before	(50.18±18,859)(6-84)	(53.55±7.894)(33-67	0.000
After	(46.45±17.168)(6-72)	(46.45±17.168)(6-72)	
Anxiety level (Before) (n/%) Before)			
Mild	0/0	0/0	0.000
Moderate	38/100	38/100	
Anxiety level (After) (n/%)			
Mild	26/68.4	0/0	
Moderate	12/31.6	38/100	

Based on the table above, the average maternal age frequency is 41.68, the standard deviation is 9.017, the range is 25-61 years, the frequency of low education is 57 (75%) participants, the frequency of income is > UMP 54 (71.1%) participants, the frequency of the type of extended family is 55 (72.4). %) participants, the frequency of children's average age is 11.11, the standard deviation is 2,324, the range is 5-15 years, the frequency is male 43 (56.6%), the frequency of mild and moderate mental retardation is 38 (50%), the frequency of family burden on the treatment group before the intervention averaged 50.18, standard deviation 18.859, range 6-84, frequency of family burden in the control group before intervention averaged 53.55, standard deviation 7894, ranged 33-67 (p-value 0.000), frequency of family burden on The treatment group after the intervention averaged 46.45, the standard deviation was 17.168, the range was 6-72, the frequency of family burden in the control group after the intervention was an average of 52.76, the standard deviation was 7.875, the range was 33-66 (p-value 0.000), the frequency of anxiety analysis was to family in the treatment group before the intervention (moderate) 38 (100%) participants, the frequency of analysis of family anxiety in the control group after the intervention (moderate) 38 (100%) participants (p-value 0.000), the frequency of analysis of family anxiety in the treatment group after the intervention no anxiety 26 (68.4%) participants, the frequency of analysis of family anxiety in the control group after the intervention was 38 (100%) participants (p-value 0.002).

DISCUSSION

The increasing burden of caring for a mentally retarded child will affect family functioning (Yusuf, Fitryasari, & Nihayati, 2015), and contribute to the emergence of psychosocial problems in families. One of the psychosocial problems of families with mentally retarded children is anxiety. One of the psychosocial problems of families with mentally retarded children is anxiety. Previous research explained that in Pakistan, as many as 77% of families experience anxiety when caring for mentally retarded children (Azeem, Dogar, Shah, Cheema, Asmat, Akbar, & Haider, 2013). Previous research stated that anxiety can arise as a result of a person's failure to interpret and control emotions when facing a problem (Hosseinkhanzadeh, Yeganeh, Rashidi, Zareimanesh, & Fayeghi, 2013). Previous studies have stated the relationship between caregiver burden and coping strategies, social support, psychological morbidity, and quality

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of life in schizophrenic caregivers. (Kate, Grover, Kulhara, & Nehra, 2013).

The community has a big influence in the rehabilitation and recovery of children with mental retardation. Health care providers, including nurses, should play a leading role in assessing the adequacy and effectiveness of community resources and in recommending changes to improve access and quality of mental health services. The condition of the family as a whole has a very big influence on each family member's health. The family burden statement shows that the lack of the family's ability to care for mentally retarded children.

Based on the explanation above, parents assess that the limitations that exist in children are difficult to overcome so that parents do not bring their children for therapy. Meanwhile, children's socialization is prohibited because parents feel that their lack of children can become material for peer ridicule. Parents can improve their ability to care for mentally retarded children by increasing knowledge about caring for mentally retarded children through mass media and children's schools.

The results showed that all participants had the same level of anxiety in the intervention group and the control group, namely moderate anxiety. This is because both groups must meet the inclusion criteria for the study, namely moderate anxiety levels. Anxiety is defined as a response to a stressful situation. Stressful situations can occur because the family goes through a crisis period while caring for a mentally retarded child. This crisis period consists of three stages, namely: rejection or denial, grief or sadness, and the acceptance stage (Yusuf, Fitryasari, & Nihayati, 2015). These three stages appear as a manifestation of the stressor which is interpreted as a form of burden due to having a mentally retarded child. The anxiety felt by families with mentally retarded children is caused by reactions from stress due to high economic and care burdens, family psychological burdens, decreased quality of life for children and families, reduced social support, and unclear children's future.

Several studies have shown that a cohesive group relationship will have a positive effect on research results (Buckley, Maayan, Weiser, Adams, 2015). So, it is hoped that the use of psychoeducation and supportive therapy will be effective in measuring changes in anxiety levels in clients with moderate anxiety levels, because clients with this level are still able to process information, learn, and solve problems (Hadidi, 2016). Mild anxiety level was not chosen as the inclusion criterion, because someone with this level is still in the normal anxiety level range. Moderate anxiety is a level of anxiety where the family focuses on what is important and puts aside other things. Research by (Dewi, Hamid, Mustikasari, 2011), There were differences in family anxiety level before the implementation of supportive group therapy, between the intervention group and the control group. Based on the explanation of the research results above, the anxiety experienced by the family dramatically affects the family in caring for children with mental retardation, and families need psychoeducation and supportive therapy to reduce anxiety or anxiety that has been felt by the family.

Similar studies also prove that supportive group therapy is quite effective in reducing anxiety levels in pregnant women (Sari, 2010). Meanwhile, other studies have found that supportive group therapy can reduce the anxiety level of a group of adolescents who experience learning disorders in building social relationships and friendships with other people. After giving therapy for 15 weeks, several participants in the study stated that they had benefited from giving therapy, because they had the opportunity to express feelings and share unpleasant experiences with other participants in one group (Kyrios, Mouding, & Nedelkovic, 2011).

The results showed that the reduction in the burden on families with mentally retarded children before and after intervention in the treatment group experienced a significant effect. The increasing burden of caring for a mentally retarded child will affect family functioning (Yusuf, Fitryasari, & Nihayati, 2015), and contribute to the emergence

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of psychosocial problems in families. The results showed that the provision of psychoeducation and supportive therapy was able to cause differences in anxiety levels in treating children with mental retardation between the intervention group receiving supportive psychoeducation therapy and the control group.

This shows that the provision of nursing therapy, both generalist and specialist therapy, is able to prevent participants from experiencing higher anxiety. The intervention group in this study received generalist therapy (deep breath relaxation and five finger hypnosis) and specialist therapy: psychoeducation and supportive therapy. Meanwhile, the control group also received generalist therapy (deep breath relaxation and five finger hypnosis). However, if you look at the final results of the study, generalist therapy alone is not sufficient to increase the proportion of participants to experience a decrease in anxiety levels. A specialist therapy is needed to strengthen the family's ability to manage anxiety, so that by providing supportive group therapy as specialist therapy, it has been able to reduce the anxiety level of participants, as evidenced by the proportion of participants with mild anxiety levels is more common in families who receive supportive group therapy. Previous research stated that there were differences in the level of family anxiety after the application of supportive group therapy, between the intervention group and the control group (Dewi, Hamid, & Mustikasari, 2011).

Several patients in the study claimed to have benefited from providing supportive therapy by providing support and advice to minimize stress and decrease their anxiety. Other research also strengthens the concept that supportive group therapy is quite effective in reducing the anxiety level of a group of adolescents with learning disorders in building social relationships and friendships with others (Shechtman & Katz, 2007). After giving therapy for 15 weeks, several participants stated the benefits of giving therapy, because they could express feelings and share unpleasant experiences with other participants in one group. Some of the studies described above use sick individuals as participants or objects of therapy. The study results indicated that some parents in the intervention group reported reduced levels of stress and anxiety, felt more confident about their role as parents, and reported that their children had better behaviors.

CONCLUSION

The provision of psychoeducation and supportive therapy significantly reduces the family's burden and anxiety in caring for children with mental retardation. It is suggested that schools with disabilities in Jambi City should have a special room to carry out psychoeducation and supportive therapy and improve the quality of comprehensive nursing care by recruiting nurses who are competent in providing mental therapy specialists.

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