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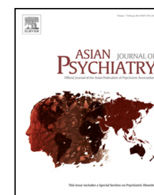

Effects of the family schizophrenia psychoeducation program for individuals with recent onset schizophrenia in Viet Nam

T.N. Ngoc[a,*], B. Weiss[b], L.T. Trung[a]

[a] Da Nang Psychiatric Hospital, 193 Nguyen Luong Bang Street, Da Nang, Viet Nam
[b] Clinical Sciences Program, Vanderbilt University, 230 Appleton Place, Nashville, TN, 37203, USA

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ABSTRACT

Objective: Although psychoeducation has been found effective for improving the life functioning of patients with schizophrenia in high income countries, there have been relatively few studies of schizophrenia psychoeducation adapted for low and middle-income countries (LMIC), particularly in Southeast Asia. The present study assessed effects of the *Family Schizophrenia Psychoeducation Program* (FSPP) among Vietnamese patients and their families on the patients' (1) quality of life and (2) medication non-compliance, and the family and patients' (3) stigma towards schizophrenia, and (4) consumer satisfaction.

Method: This intervention study involved 59 patients, and their families, from the Da Nang Psychiatric Hospital, randomly assigned to treatment (n = 30) or control (n = 29) conditions. Control subjects received services as usual (antipsychotic medication); treatment group subjects received the FSPP as well. Blind-rater assessments were conducted at T1 immediately after project enrollment (prior to participating in the FSPP) and at T2 six months later.

Results: There were significant treatment effects on: (1) quality of life, (2) stigma, (3) medication compliance, and (4) consumer satisfaction, with all effects favoring the treatment group. Effect sizes were moderate to large.

Conclusions: This psychoeducation program appears to reduce stigma, improve quality of life and medication compliance, and increase consumer satisfaction of Vietnamese patients with schizophrenia and their families, beyond the effects of antipsychotic medication. It involves relatively little cost, and it may be useful for it or equivalent programs to be implemented in other hospitals in Viet Nam, and potentially other low-income Asian countries to improve the lives of patients with schizophrenia.

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1. Introduction

Schizophrenia is a chronic disorder with a prevalence of a little less than 1% of the general population across the world (Jablensky, 2000). In addition to its core symptoms of delusions, etc., the disorder is associated with life functioning impairment in a variety of domains (e.g., occupational functioning; social functioning) as well as social stigma (Galuppi et al., 2012). Many of these negative secondary effects, however, often are the result of misunderstandings by patients and their families about schizophrenia as a medical disorder, rather than inherent to the disorder. For instance, families with a member with schizophrenia sometimes believe that it is best for the patient to rest at home, rather than having a job, developing social relationships outside the family, etc. As a consequence, the patient's life becomes restricted and their life functioning and quality of life are diminished. However, the reality is that if the patient is successfully treated, he or she can have a relatively fulfilling life with a career, their own family, etc. (Gaebel, 2011).

In high income Western countries, psychoeducation is used to help patients with schizophrenia achieve such better outcomes. Psychoeducation provides patients and families with accurate information about schizophrenia, about the potential for patients with schizophrenia to lead productive lives when successfully treated, and reduces stigma (Kulhara et al., 2009); psychoeducation also has been found to increase medication compliance among patients with schizophrenia (Rummel-Kluge et al., 2008). Unfortunately, use of psychoeducation is not widespread in Asia, in particular in Southeast Asian countries like Viet Nam. In fact, to the best of our knowledge, at the time of the present study there were no schizophrenia psychoeducation programs being provided in Viet Nam. Therefore, the purposes of the present study were to (a)

* Corresponding author.
E-mail address: TranNgoc.DPH@gmail.com (T.N. Ngoc).

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develop a schizophrenia psychoeducation program adapted for Viet Nam, and (b) to conduct an initial randomized evaluation of the program to determine if a full scale evaluation would be justified. Outcomes included patient and family reports for (1) stigma towards schizophrenia, and the patients' (2) quality of life, (3) medication compliance, and (4) consumer satisfaction with the program. The research study was conducted at the Da Nang (Viet Nam) Psychiatric Hospital from March, 2014 to July, 2015 and was sponsored by the U.S. National Institutes of Health. The trial was registered with ClinicalTrials.gov (DPH20140818).

2. Methods

2.1. Study site, participants, and sampling

Study participants were recruited from the Danang Psychiatric Hospital, the primary mental health facility in central Viet Nam and the third largest psychiatric hospital in the country. Study inclusion criteria were: (a) an ICD-10 diagnosis of schizophrenia (F20.x); (b) no more than 3 prior psychiatric hospitalizations including the current one; (c) a duration of less than three years for their schizophrenia; (d) age between 18 and 30 years; (e) the family living within 50 kilometers of the hospital (in order that follow-up interviews which took place in the patient's home be feasible). Exclusion criteria were suicidal ideation. Study consent was obtained from both the patient and the patient's family. Families were informed about the study and recruited after the intake session at the hospital; patients were informed about the study and recruited after their psychosis was controlled with medication, typically about two weeks after entering the hospital. A total of 65 patients met the inclusion criteria, 2 met the exclusion criteria (see Fig. 1); 63 families and patients were informed about the study, and 59 were interested in participating, consented to the study, and were randomized to condition (intervention group n = 30 patients and their families; control group n = 29). Table 1 reports demographic and baseline characteristics of the sample. All patients randomized to condition completed the baseline assessment. The study was approved by the hospital's US FWA IRB (#00011251).

2.2. Control and intervention conditions

The control group received services as usual, which consisted of psychotropic medication selected and monitored by the patient's hospital physician. The intervention group received the *Family Schizophrenia Psychoeducation Program* (FSPP), as well as medication. The FSPP was developed based on review and adaptation of similar programs used in other countries (e.g., Kung et al., 2012) followed by several months of pilot testing and modification in the hospital. One of the primary cultural modifications involves the program, throughout its course, strongly emphasizing the potential capabilities of the family member with schizophrenia, and the dangers of "spoiling" the family member. In Viet Nam, out of their concern and desire to be supportive, families often reduce the responsibilities and expectations for a family member with a disability, including schizophrenia. The consequence is, of course, that the family member does not develop their capabilities, their life becomes restricted, and their quality of life actually diminishes.

The program consists of three sessions of approximately 1.5 h duration that take place in the hospital. Sessions include both the family members staying with the patient as well as the patient. (In Viet Nam, a family member(s) typically stays with in-patients receiving acute care at or near the hospital during the patient's stay.) Sessions are interactive, with the hospital staff providing information but also facilitating discussion with the family and patient. Because of the complexity of scheduling multiple families, the program is provided to individual families rather than in a group. Sessions were conducted by a hospital psychiatrist, two psychologists and two nurses. Sessions typically are provided over a period of a week and a half.

Session 1: The first session discusses schizophrenia as a medical condition, what it is and what its symptoms are, what is known about the medical/biological causes of schizophrenia, and what treatments for schizophrenia are, and the prognosis including the potential for the patient to have a full life with their own family, etc. if successfully treated. Because stigma reduction may be one way to increase patient quality of life (Sibitz et al., 2011), this session also discusses stigma, its causes, and how stigma is inaccurate and harmful.

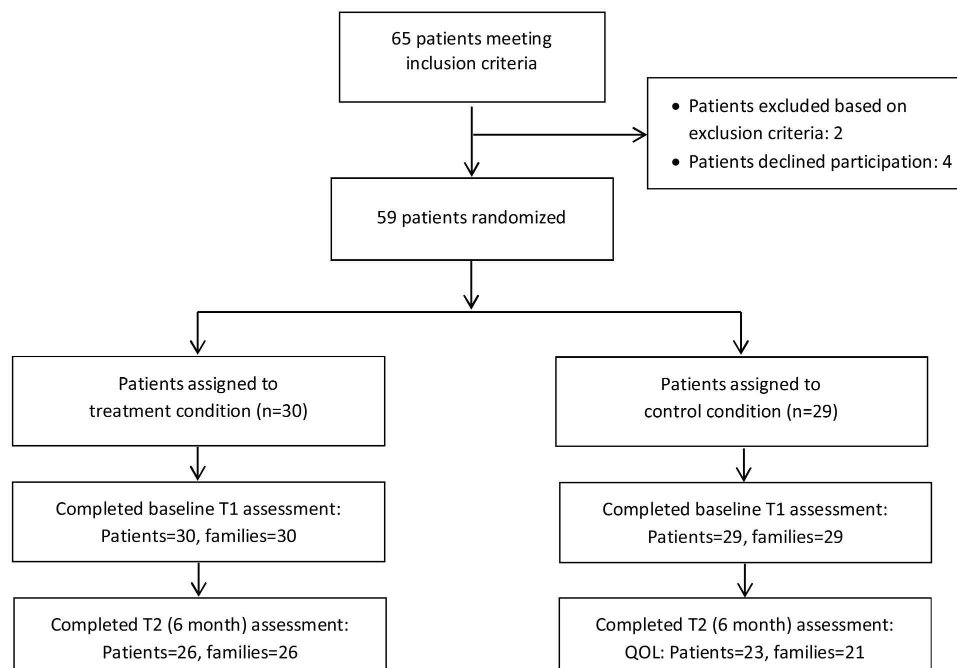

Fig. 1. Patient recruitment, enrollment, and retention.

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