Journal of Multidisciplinary Healthcare

Dovepress
Taylor & Francis Group

Open Access Full Text Article

ORIGINAL RESEARCH

# Psychoeducational Needs of Sundanese Indonesian Family Caregivers Caring for Persons with Schizophrenia During the Maintenance Phase: A Descriptive Qualitative Study

Imas Rafiyah[1,2], Suryani Suryani[1], Laili Rahayuwati[3], Wandee Suttharangsee[4], Nur Oktavia Hidayati[1]

[1]Department of Mental Health Nursing, Faculty of Nursing, Universitas Padjadjaran, Sumedang, West Java, Indonesia; [2]Doctoral Study Program, Faculty of Medicine, Universitas Padjadjaran, Sumedang, West Java, Indonesia; [3]Department of Community Health Nursing, Faculty of Nursing, Universitas Padjadjaran, Sumedang, West Java, Indonesia; [4]Education and Innovative Learning Academy, Prince of Songkla University, Hatyai, Songkhla, Thailand

Correspondence: Imas Rafiyah, Department of Mental Health Nursing, Faculty of Nursing, Universitas Padjadjaran, Jl Raya Ir. Soekarno Km 21, Jatinangor, Sumedang, West Java, 45363, Indonesia, Tel +62 81280050455, Fax +62 22 7795596, Email imas.rafiyah@unpad.ac.id

Journal of Multidisciplinary Healthcare downloaded from https://www.dovepress.com/
For personal use only.

**Introduction:** Family caregivers of persons with schizophrenia often face significant challenges, including stress and negative caregiving experiences. Psychoeducation is an effective nursing intervention to support caregivers, yet the specific needs of Sundanese family caregivers in Indonesia remain unexplored.

**Purpose:** This study aimed to explore the psychoeducational needs of Sundanese Indonesian family caregivers caring for Persons with schizophrenia during the maintenance phase.

**Patients and Methods:** A descriptive qualitative design was employed. Participants were purposively sampled from family caregivers in Soreang District, Bandung Regency, until data saturation was reached (n=20). Semi-structured interviews were conducted, and data were analyzed using inductive content analysis.

**Results:** Seven key main categories emerged: 1) the required psychoeducational content; 2) psychoeducation delivered by healthcare professionals in collaboration with community leaders; 3) the recipients of psychoeducation involve the primary decision-makers within the family; 4) psychoeducation is administered directly; 5) books as a medium for psychoeducation; 6) appropriate timing for implementing psychoeducation; and 7) accessible locations for carrying out the psychoeducation.

**Conclusion:** The findings highlight culturally tailored psychoeducational needs for Sundanese caregivers, emphasizing the importance of involving community leaders and family structures. These insights can inform mental health programs to reduce caregiver burden and improve outcomes for persons with schizophrenia.

**Keywords:** maintenance phase, psychoeducational needs, Sundanese family caregivers, schizophrenia

## Introduction

Schizophrenia is a chronic and severe mental disorder characterized by a constellation of symptoms, including positive symptoms (eg, hallucinations, delusions) and negative symptoms (eg, social withdrawal, affective flattening) that significantly impair daily functioning.[1] The disorder typically progresses through several phases, including acute, stabilization, maintenance, and relapse phases, with the maintenance phase being particularly critical for preventing symptom recurrence and promoting recovery. Globally, schizophrenia affects approximately 20 million people, representing a substantial public health burden across diverse populations. In Indonesia specifically, epidemiological data reveals a troubling increase in prevalence rates from 1.7 per 1000 population in 2013 to 6.7 per 1000 in 2018, indicating a growing mental health challenge.[2,3]

Received: 4 January 2025
Accepted: 30 November 2025
Published: 30 December 2025



© 2025 Rafiyah et al. This work is published and licensed by Dove Medical Press Limited. The full terms of this license are available at https://www.dovepress.com/terms.php and incorporate the Creative Commons Attribution – Non Commercial (unported, v4.0) License (http://creativecommons.org/licenses/by-nc/4.0/). By accessing the work you hereby accept the Terms. Non-commercial uses of the work are permitted without any further permission from Dove Medical Press Limited, provided the work is properly attributed. For permission for commercial use of this work, please see paragraphs 4.2 and 5 of our Terms (https://www.dovepress.com/terms.php).

The World Health Organization has advocated for community-based mental healthcare models since 2001, yet implementation remains particularly challenging in resource-limited settings like Indonesia due to chronic shortages of mental health professionals and treatment facilities.[4] Consequently, the majority in maintenance phase receive care in community settings, relying heavily on family support systems.[5] Family caregivers, typically untrained and unprepared, assume multifaceted roles including medication supervision, activities of daily living assistance, and crisis management, often without institutional support. This situation creates significant physical, emotional, and financial strain on caregivers, highlighting the urgent need for culturally-adapted psychoeducational interventions to support this vulnerable population.

Family caregivers of persons with schizophrenia face universal challenges, including psychological distress, financial strain, and social stigma.[6,7] Cross-cultural studies in Ghana, Indonesia, and the US consistently report caregivers' anxiety and insecurity when managing their family member's functional decline.[6–8] These issues are exacerbated by fragmented mental health services and the chronic nature of schizophrenia, requiring long-term care commitments. In low-resource settings like Indonesia, these pressures disproportionately affect caregivers due to systemic gaps in healthcare infrastructure.[9–11]

The Sundanese, Indonesia's second-largest ethnic group, prioritize family-based care influenced by Islamic values, yet face structural barriers like poverty and low education. Rafiyah's (2017) study found 43.2% of caregivers in West Java mental hospitals endured moderate burden, highlighting the clash between cultural obligation and caregiver exhaustion.[12] Alarmingly, West Java has the nation's highest schizophrenia prevalence (3.4/1000 population increase from 2013–2018), with 83% relapse rates tied to medication non-adherence (44.2%) and misconceptions about recovery (36.1%).[3] Local reports from Bandung Regency (2020) identify Soreang District as a hotspot, with 65 active cases and persistent challenges in community-based management.[13,14]

Chronic caregiver stress reduces quality of life, elevates relapse risks, and strains public health resources through repeated hospitalizations.[15] Nurses serve as frontline advocates, addressing medication adherence, stigma reduction, and culturally-adapted psychoeducation for Sundanese families. Their family-centered approach is critical to breaking the cycle of caregiver burnout and poor client outcomes. Multidisciplinary strategies are urgently needed to support caregivers while alleviating the government's financial burden from preventable relapses.[13,14]

Psychoeducation is an intervention modality that has demonstrated effectiveness for families affected by schizophrenia in various studies. Rezaei researched the impact of psychoeducation on the general health of family caregivers of persons with schizophrenia in Iran, while Carrasco examined the efficacy of psychoeducation on mental health and the burden experienced by family caregivers in Brazil through a randomized controlled trial (RCT) method. The findings from these two studies indicate that psychoeducation is beneficial in enhancing general health, mental health, and reducing the burden on family caregivers of persons with schizophrenia.[16,17] The study in Brazil conducted by Viviane[18] used a Randomised Control Trial (RCT) showed that psychoeducation has decreased the burden of family caregivers.[18] Bradley conducted experimental research in Australia to assess the effectiveness of the MF-PEG program with 34 Australian participants and 25 Vietnamese migrants. The findings indicate that MF-PEG significantly alleviates the burden for respondents in Australia; however, it does not produce a statistically significant reduction in burden for the Vietnamese migrants. This discrepancy may be attributed to cultural differences.[19]

Psychoeducation emerges as a lifeline, not merely transferring knowledge but restoring dignity. When Sundanese caregivers understand schizophrenia's biopsychosocial dimensions, they transform from struggling relatives into empowered healers. The application of psychoeducation across diverse cultural populations can yield varying results. Investigating psychoeducational needs is essential to ensure that interventions tailored for diverse cultural populations effectively address their specific requirements. To date, there has been limited research focusing on the psychoeducational needs of Sundanese family caregivers who support persons with schizophrenia. Therefore, this study aims to explore the psychoeducational needs of Sundanese family caregivers caring for persons with schizophrenia during the maintenance phase. The findings of this research will serve as a foundational resource for developing targeted psychoeducation programs for Sundanese caregivers of persons with schizophrenia.

# Materials and Methods

## Study Design

This study employed a descriptive qualitative research design rooted in the interpretivist philosophical paradigm, which acknowledges that reality is socially constructed and context-dependent. The research was conducted in Soreang District, Bandung Regency, West Java Province, Indonesia, an area selected due to its high prevalence of mental health disorders, substantial Sundanese population, and status as the district capital. The study took place over a period of six months from January to June 2022. We chose this location because preliminary data from the Bandung District Health Office indicated Soreang had one of the highest numbers of reported mental disorder cases in the region.

## Recruitment and Sample

Participants in this study were family caregivers caring for persons with schizophrenia. Criteria of a person being cared for were diagnosed with schizophrenia for at least six months, in maintenance phase, live under the same roof with family caregivers, family relationships could be children, spouses, siblings, relatives, or grandparents, and is not limited by age or gender.

Participants were selected using purposive sampling techniques to ensure they met specific criteria relevant to our research objectives. Eligible participants were family caregivers who: (1) were 18 years of age or older; (2) identified as ethnically Sundanese, defined as having at least three generations of Sundanese ancestry and currently living in West Java; (3) lived with and provided care for a family member diagnosed with schizophrenia for at least six months; (4) demonstrated at least mild caregiver burden as measured by the Zarit Burden Interview (ZBI), with a minimum score of 21; (5) showed at least mild general health problems as assessed by the General Health Questionnaire-12 (GHQ-12), with a minimum score of 4; and (6) were communicative in either Indonesian or Sundanese languages. We excluded caregivers who had severe physical or mental health comorbidities themselves or who had received formal mental health training.

Sample size was determined by theoretical saturation, which was reached after interviewing 20 participants.[20] Participant recruitment was conducted in collaboration with local Community Health Centers, particularly their mental health program officers, and through health volunteers in the area.

## Interview Procedure

Data were collected through semi-structured interviews using a carefully developed interview guide containing 15 main questions organized into four thematic areas: (1) experiences and challenges in managing schizophrenia symptoms, (2) knowledge gaps about the illness and its treatment, (3) preferences regarding psychoeducation formats and content, and (4) cultural and spiritual considerations in caregiving.

The interview process involved three distinct phases for each participant. During the initial visit, researchers, accompanied by local health volunteers, conducted home visits to establish rapport, explain the study's purpose, and obtain written informed consent using forms approved by the ethics committee. These forms included information about the study's purpose, procedures, risks, benefits, and the participant's right to withdraw without consequences. Participants' informed consent included the publication of anonymized responses or direct quotes. The second visit consisted of the actual interview, conducted in the participant's home (typically in the living room during midday when participants were most available), lasting 60–90 minutes with audio recording after obtaining permission. Researchers also took detailed field notes documenting nonverbal cues and environmental observations. The third visit served as a member-checking opportunity to validate preliminary findings with participants. Throughout this process, we implemented several measures to ensure research rigor and minimize bias, including researcher reflexivity through bracketing journals, peer debriefing with mental health nurses, and data triangulation through consultations with community leaders.

## Data Analysis

We analyzed the data using inductive qualitative content analysis following the framework proposed by Elo and Kyngäs (2008). The analysis process consisted of three systematic phases. Firstly preparation, preparation consists of selecting units for analysis and understanding the data as a whole. Secondly organizing, organizing includes determining open

coding, coding sheets, grouping, creating categories, and abstraction into themes. Each category is named with words that characterize the content. Sub-categories with similar events and incidents are grouped into several generic categories, and generic categories are grouped as main categories. Lastly, reporting presents data in the form of narratives and charts by focusing on processes, theories, and unique and general characteristics of li e.[21] Regular team discussions ensured consistency in interpretation, and negative cases were explicitly considered to enhance the credibility of findings.

## Ethical Clearance

This study received full ethical approval from the Padjadjaran University Research Ethics Institute (Approval No: 536/UN6.KEP/EC/2021) and was conducted in accordance with the principles of the Declaration of Helsinki. All participants provided written informed consent after receiving detailed information about the study purpose, procedures, potential risks, and benefits. The consent form explicitly stated participants' right to withdraw at any time without consequences. We ensured participant confidentiality through pseudonymization of all data and secure storage of both digital and physical research materials. Special consideration was given to the vulnerable nature of our participant population, with protocols in place to provide referrals to mental health services if participants expressed distress during interviews. These measures were designed to protect participants while maintaining the scientific integrity of the study.

# Results

The final key participants in this study were 20 participants. Characteristics of key participants are described in Table 1. Table 1 shows that most participants were female (80%), with an average age of 55.2 years and the majority in middle adulthood (41–59 years). All participants were Muslim, and most were married (65%). The majority had only completed elementary school (80%) and worked as laborers (45%). More than half were mothers of the patients (55%), and the average duration of caregiving was 12.35 years, with most having cared for more than 10 years.

**Table 1** Percentage of Participants Characteristics (n=20)

| Characteristics | | Frequency (f) | Percentage (%) | Mean |
|---|---|---|---|---|
| Age | 18–40 (early adulthood) | 1 | 5% | 55.20 |
| | 41–59 (middle adulthood) | 11 | 55% | |
| | ≥ 60 (late adulthood) | 8 | 40% | |
| Gender | Female | 16 | 80% | |
| | Male | 4 | 20% | |
| Religion | Islam | 20 | 100% | |
| Marital status | Married | 13 | 65% | |
| | Widow/widower | 7 | 35% | |
| Educational level | Elementary | 16 | 80% | |
| | Junior high school | 3 | 15% | |
| | Senior high school | 1 | 5% | |
| Occupation | Laborer | 9 | 45% | |
| | Self-employed | 4 | 20% | |
| | Household | 7 | 35% | |
| Relationship | Mother | 11 | 55% | |
| | Father | 4 | 20% | |
| | Wife | 1 | 5% | |
| | Grandmother | 1 | 5% | |
| | Sister | 2 | 10% | |
| | Relative | 1 | 5% | |
| Duration of providing care | 6 months–<5 years | 4 | 20% | 12.35 |
| | ≥ 5–<10 years | 5 | 25% | |
| | ≥10 years | 11 | 55% | |

Based on the results of the data interview, the main categories were obtained: 1) the required psychoeducational content; 2) psychoeducation delivered by healthcare professionals in collaboration with community leaders; 3) the recipients of psychoeducation involve the primary decision-makers within the family; 4) psychoeducation is administered directly; 5) books as a medium for psychoeducation; 6) appropriate timing for implementing psychoeducation; and 7) accessible locations for carrying out the psychoeducational.

## The Required Psychoeducational Content

### Information About the Diseases and Treatment

Several participants stated that they rarely received information from health workers, so they were confused about the client's condition and did not know the cause.

> …at the hospital, the doctor asked the symptoms, when it happened, just like that…. (P6)

> Whether his condition is healthy or not… whether he is sick or not… yes, that's how it is… in thoughts and feelings… it has been three years just like that. (P2)

> I don't know why, the child suddenly did that, doesn't know its origin, just suddenly. (P3)

Some participants were afraid of the side effects of medication, wanted effective medication, and wanted to recover without medication.

> Just stop because if the child continues to be given medication, the child may not be able to talk, and the child may become more disabled… so just stop). (P1)

> If a child is violent, I wish they were given effective medicine, so far, this is the only medicine…

> I want the child to stop controlling… I don't know if I have to continue controlling…. (P12)

### Information About Relapse Management and Recovery

Family caregivers struggled significantly with recognizing and responding to schizophrenia relapse. Most participants reported receiving no formal education about early warning signs or crisis intervention strategies. This knowledge gap often led to delayed treatment, as families only sought medical help when symptoms became severe. Additionally, many caregivers held unrealistic expectations about complete recovery, creating emotional distress when these expectations clashed with the chronic nature of the illness.

> We never know when his illness is coming back - he just suddenly changes and we panic every time. (P7)

> After hospital discharge, we're left alone with no instructions about what to do next. (P3)

> I'm confused about treating it if it recurs… what should I do…. (P14)

> I want my child to be healthy again… I want him to work and have a wife… if he has good fortune…. (P13)

### Need for Psychoeducation on Healthcare System Navigation

Family caregivers expressed significant difficulties in accessing and utilizing mental health services, highlighting an urgent need for psychoeducation about healthcare system navigation. Many reported challenges with hospital procedures, medication availability, and insurance processes that directly impacted treatment adherence. These systemic barriers often exacerbate caregivers' stress while managing their family member's condition in the maintenance phase.

> I avoided hospitals for years after being mocked by staff. Now I don't know how to properly manage his medications. (P8)

> The online registration system confuses me - I keep missing appointments when the quota fills. (P12)

> Nobody explained how to maintain our insurance. When it lapsed, we had to pay full price for medications. (P14)

Previously, I was afraid of going to the hospital… that's why I had unclear treatment. At first, I went to the hospital. I was ridiculed… I was afraid…. (P8)

The Problem in Soreang is that the medicine is not complete, sometimes the mental medicine is available, sometimes it's not, it says so… it's a bit of a hassle for me to buy the one that's missing. (P17)

Insurance was created but not continued, confused; I have to pay once a month…. (P14)

If possible, in the future, I would like to apply for free insurance. (P17)

He gets emotional easily… so we have to be patient…. (P12)

### Information on How to Improve Personal Skills

The analysis revealed that caregivers face significant challenges in managing the psychological and practical demands of long-term schizophrenia care, highlighting a crucial need for culturally-adapted skill-building interventions. Participants described experiencing chronic exhaustion, financial strain, and social constraints that limit their ability to implement effective care strategies. These challenges are compounded by traditional gender roles and family hierarchies that discourage open discussion of caregiver stress.

When the stress becomes too much, I practice ngabrangbrangkeun - sitting quietly by the river to calm my thoughts. But I wonder if there are better ways. (P14)

After violent episodes, I shake for hours. No one has taught us how to handle this fear. (P8)

Between medicine costs and taking days off work, we've sold our rice fields piece by piece. How do other families survive this? (P20)

I skip meals to afford his medications, but then I'm too weak to care for him. (P3)

My uncle insists on traditional healing instead of medicine. If I disagree, I'm disrespecting our ancestors. (P17)

I just kept quiet… never did anything. (P14)

I'm running out of money… I'm tired…" (Tired, looking for money… yes, feeding…) (P20)

If I do this or that… I'm afraid of being called a know-it-all. (P14)

Tired, I am already looking for money, and providing eating dinner…. (P20)

## Psychoeducation is Delivered by Healthcare Professionals in Collaboration with Community Leaders

Family caregivers emphasized the importance of receiving psychoeducation from trusted authority figures, combining medical expertise with community leadership. Participants specifically requested that mental health professionals deliver clinical information while local leaders provide cultural context, creating a dual-source approach. This preference reflects the Sundanese cultural values of respecting hierarchical knowledge structures while maintaining community-based support systems.

When the nurse and religious leader explain together, I believe the information more. (P11)

The community health worker knows our family situation best - they should be involved in these education sessions. (P7)

I want to get information from a doctor or nurse directly because they understand better. (P3)

Psychoeducation should involve community leaders. (P15)

## The Recipients of Psychoeducation Involve the Primary Decision-Makers within the Family

Family caregivers identified key decision-makers as crucial recipients of psychoeducation within the household structure. Participants emphasized that effective schizophrenia management requires educating both primary caregivers and family authorities who control resources and treatment decisions. This need stems from traditional Sundanese family hierarchies where elders or male members often oversee healthcare choices and financial allocations.

> All treatment decisions must go through my husband first - if he doesn't understand the illness, nothing changes. (P9)
>
> My father-in-law controls the money for medications. Without convincing him, we can't continue treatment. (P4)
>
> They should educate my brothers too, because when I'm away, they're the ones who handle his care. (P15)
>
> Treatment efforts depend on his father. (P14)
>
> Psychoeducation was delivered to me, or his father is okay. (P1)

## Psychoeducation is Administered Directly

Participants strongly advocated for in-person, culturally-adapted psychoeducation sessions conducted in their native Sundanese language. Caregivers emphasized the importance of interactive, dialogue-based learning that respects local communication norms and allows for immediate clarification of concerns. This preference reflects both practical literacy limitations and cultural values emphasizing oral tradition and respectful, personalized knowledge transmission.

> Face-to-face explanations work best - we can ask questions right away when we don't understand. (P6)
>
> Group discussions with neighbours help more than reading pamphlets - we learn from others' experiences too. (P10)
>
> Psychoeducation is given directly so we can ask questions and answers. (P3)
>
> If he accepts it, you have to do it slowly…little by little is the key. speak is not loudly…speak little by little… speaking Sundanese. (P2)

## Books as a Medium for Psychoeducation

While emphasizing the preference for direct, verbal psychoeducation, caregivers also recognized the value of simple written materials as ongoing reference tools. Participants specifically requested illustrated booklets in Sundanese language that could reinforce key concepts from face-to-face sessions and be shared with other family members. This need reflects both the practical challenges of recalling verbal information and the desire to educate extended family networks.

> A picture book would help us remember - my husband can read it when he comes home from work. (P5)
>
> Simple drawings with short Sundanese explanations are best - we can check them anytime. (P13)
>
> My children can read the book to me when I forget what the nurse taught us. (P9)
>
> Books and media are better… you can read them again…. (P2)

## Appropriate Timing for Implementing Psychoeducation

Participants identified specific temporal considerations crucial for effective psychoeducation delivery in their agricultural community. Caregivers emphasized the need to schedule sessions around harvest cycles, family responsibilities, and cultural events to ensure maximum participation. The findings reveal how caregiving duties intersect with socioeconomic realities in rural Sundanese households.

Thursday afternoons work best - after weekly market closes and before Friday prayers. (P8, Mother, 52)

Not during planting season - from dawn to dusk we're in rice fields. (P3)

Evening sessions help most - after children are fed but before night prayers. (P11)

Psychoeducation can be carried out on any day as long as there are no conflicts. (P3)

### Accessible Locations to Carry Out Psychoeducation

Participants emphasized the importance of holding psychoeducation sessions in familiar, community-based settings that minimize transportation burdens and cultural barriers. Three distinct location preferences emerged from the data, reflecting the socioeconomic realities of rural Sundanese caregivers:

The community hall works best - everyone knows it and we feel comfortable there. (P5)

The mosque meeting room would be good - we're there every Friday anyway. (P12)

For bedridden patients, teachers should come to our houses - we can't leave them alone. (P9)

Psychoeducation can be carried out on any day as long as there are no conflicts). (P3)

If costs are a problem, it's better to conduct psychoeducation at home or in the village…. (P4)

## Discussion

Data were collected from twenty Sundanese family caregivers who provide care for persons with schizophrenia in the maintenance phase through semi-structured interviews. The study revealed seven main categories regarding the psychoeducational needs of Sundanese family caregivers of persons with schizophrenia in the maintenance phase.

The result of the study found that Sundanese family caregivers of persons with schizophrenia in the maintenance phase expressed a need for clear and continuous information regarding the illness and its treatment, including its causes, symptoms, and treatment process. This finding aligns with previous studies, which reported that insufficient illness-related knowledge among caregivers contributes to anxiety, caregiving burden, and increased risk of relapse.[22,23] However, unlike earlier research that predominantly focused on caregivers during the acute phase of schizophrenia, the present study emphasizes that caregivers in the maintenance phase seek not only basic information but also sustained, practical guidance to support daily care and prevent recurrence. Within the Sundanese cultural context, shaped by values such as *silih asah, silih asih, silih asuh* (mutual learning, caring, and nurturing), caregiving is considered a moral and collective responsibility.[24] Consequently, the lack of adequate information leads to uncertainty, dependence on health professionals or traditional beliefs, and fear of making mistakes in treatment. These findings highlight the importance of culturally sensitive and ongoing psychoeducation programs that address the long-term informational needs of family caregivers in the maintenance phase of schizophrenia.[25] A good understanding of chronic mental disorders, such as schizophrenia, is very important for building an attitude of acceptance and active involvement of the family in the treatment process.[26] In Sundanese culture, which upholds the value of harmony and tends to avoid conflict, this ignorance increases the risk of families responding to patients incorrectly, such as considering strange behavior as a result of the supernatural or lack of worship.[27] Without structured and continuous educational intervention, families will not have a basis for making appropriate treatment decisions.

The results revealed that Sundanese family caregivers expressed a strong need for information related to relapse management and the recovery process during the maintenance phase of schizophrenia. This finding is consistent with previous research, which highlights that family knowledge about early warning signs, medication adherence, stress management, and strategies to prevent relapse significantly contributes to reduced rehospitalization rates and improved patient outcomes.[28] However, the present study offers a culturally specific perspective by showing that caregivers often rely on experiential knowledge and traditional beliefs, which sometimes leads to delays in recognizing relapse symptoms or reluctance to seek professional help. In Sundanese culture, values such as *sabar* (patience), *ikhlas* (acceptance), and

reliance on spiritual coping may help caregivers remain resilient, but can also result in underestimating early signs of relapse. Some families still have the hope that the patient will be "completely cured".[29] Without an understanding of the relapsing and chronic nature of schizophrenia, this hope becomes unrealistic and actually risks causing frustration, rejection, or even emotional abuse.[30] In local cultures, the concept of recovery is still understood as "going back to the way it was", not as a long-term adaptation process. This shows the need for a redefinition of recovery in a cultural context.[31] Therefore, relapse-related psychoeducation should not only focus on clinical knowledge but also integrate culturally appropriate explanations, practical guidance, and spiritual considerations to support families in making timely and informed decisions. These findings underscore the need for culturally tailored relapse management education to strengthen family readiness and sustain long-term recovery in persons with schizophrenia.

This study indicated that Sundanese family caregivers caring for persons with schizophrenia in the maintenance phase experience difficulties navigating the healthcare system and expressed a strong need for psychoeducation related to accessing mental health services, referral procedures, insurance procedures, medication procurement, and coordination with healthcare providers. These findings are consistent with previous research reporting that caregivers often feel confused or unsupported when attempting to access appropriate mental health services due to complex administrative systems, limited information, and fragmented care pathways.[11,32] Barriers such as online queuing systems, unstable drug availability, and confusion in BPJS management are factors that often lead to discontinuation of therapy.[33] However, while earlier studies have primarily focused on general service accessibility or barriers during acute episodes, the present study highlights that, in the maintenance phase, caregivers require structured and continuous information related specifically to routine follow-ups, medication continuity, insurance procedures, and crisis management within the healthcare system. In the Sundanese cultural context, where families are deeply involved in caregiving decisions and often assume primary responsibility for treatment adherence, the lack of knowledge about how to effectively navigate healthcare services leads to feelings of helplessness, delays in seeking care, and increased caregiving burden. Cultural values such as *guyub* (togetherness) and *tanggung jawab keluarga* (family responsibility) encourage caregivers to persist in their roles, yet without adequate guidance, they are unsure how to optimize available healthcare resources. Therefore, these findings emphasize the need for culturally tailored psychoeducation programs that focus not only on illness understanding and medication but also on practical guidance in navigating the healthcare system, including referral mechanisms, insurance, mental health service networks, and communication with healthcare professionals. Education about the health system and support in administrative management must be part of comprehensive psychoeducation, not just focusing on the clinical aspects of the disease.[29]

This study found that Sundanese family caregivers of persons with schizophrenia in the maintenance phase expressed a need for information on how to improve their personal caregiving skills, including stress management, coping skills, problem-solving, crisis management, and communication techniques with the patient. This finding is consistent with previous research, which shows that caregivers often feel unprepared and lack practical skills in managing daily care, contributing to an emotional burden, ineffective caregiving, and increased relapse rates.[34] However, while earlier studies primarily focused on general caregiving burden or emotional stress, the present study emphasizes that caregivers actively seek structured, skill-based education to enhance their competency and confidence in caregiving, particularly in the long-term maintenance phase. Within the Sundanese cultural context, caregiving is influenced by values such as *silih asah, silih asih, silih asuh* (mutual learning, caring, and nurturing), which reinforce family responsibility and emotional closeness.[35] Despite this strong commitment, many caregivers reported feeling unsure about how to effectively respond to patients' behavioral changes, manage medication adherence, or handle crises due to a lack of formal training. In Sundanese culture, which emphasizes devotion and fortitude, caregivers tend to hold inner stress without space to express it.[36] This cultural expectation to provide care, combined with limited knowledge and skills, often leads to stress, vulnerability, exhaustion, self-doubt, and dependence on healthcare professionals.[37] Family psychoeducation not only focuses on the patient but also trains caregivers in emotional regulation and psychosocial support.[38] Therefore, these findings highlight the need for psychoeducation programs that are culturally sensitive and focused on practical skill-building, including communication skills, behavioral management, self-care strategies, and problem-solving techniques, to empower caregivers in their roles and support long-term recovery outcomes. Culturally responsive interventions should include locally based coping skills training, such as spiritual counseling or community approaches.[39]

This study showed that Sundanese family caregivers perceive psychoeducation as most effective when it is delivered not only by healthcare professionals but also with the involvement of community and religious leaders. According to the World Health Organization (WHO), in most countries, nurses are the largest group of professionals providing mental health care in both primary and specialist health services. Nurses can contribute to the promotion of mental health and the prevention and treatment of mental disorders.[5] Family caregivers reported that information coming from psychiatrists, nurses, or psychologists is considered credible and clinically useful, yet they also emphasized that the participation of local leaders increases acceptance, trust, and adherence to caregiving practices within the family and broader community. This finding aligns with previous studies showing that family psychoeducation delivered by professionals improves knowledge, treatment adherence, and reduces relapse rates.[40] However, unlike many earlier studies that focused solely on hospital-based or professional-led psychoeducation, the current study highlights the added value of incorporating culturally respected community figures to enhance engagement and reduce stigma, particularly in collectivist cultures. In the Sundanese cultural context, community leaders and religious figures hold significant authority in influencing health beliefs and daily practices. In Sundanese society, the involvement of religious leaders and village cadres is essential to instill values and reduce stigma.[41] The involvement of cultural or religious leaders can bridge the gap between medical recommendations and traditional beliefs, making psychoeducation more culturally acceptable This is in line with cultural congruence theory, which suggests that interventions be delivered by figures who have both scientific and cultural legitimacy.[39] Caregivers in this study expressed that when information about medication, relapse prevention, and caregiving techniques is reinforced by community leaders, families feel more confident and less isolated in caregiving decisions. Therefore, these findings suggest that psychoeducation for schizophrenia in the maintenance phase should be developed using a collaborative, culturally sensitive model that integrates mental health professionals with community or faith-based leaders to enhance sustainability, reduce stigma, and strengthen community support. With this approach, medical information is not only accepted rationally, but also emotionally and socially.

This study found that in Sundanese families, psychoeducation is not only delivered to the primary family caregiver but also to parents and family decision-makers. In Sundanese families, there is usually not only one person who cares for schizophrenic clients, because they have the value of togetherness and taking care of each other. Parents also feel they have a responsibility to care for persons with schizophrenia.[42] This finding aligns with previous studies indicating that in collectivist Asian cultures, healthcare decisions are often made by parents or heads of households, making their inclusion in psychoeducation a crucial factor for treatment adherence and family support.[43] However, the present study offers a novel contribution by emphasizing that, in the Sundanese cultural context, providing psychoeducation to decision-makers functions not only to improve knowledge but also to obtain social legitimacy before caregivers make major treatment decisions, such as medication adjustments or hospital referrals. Psychoeducation that only targets the primary caregiver without involving family authority is at risk of not having an impact on real change.[44] Decision-makers in the Sundanese family, such as husbands or fathers, need to be involved in psychoeducation.[42] Based on family systems theory, each family member plays a role in an interdependent system, and the success of the intervention is largely determined by the involvement of parties who have control over resources and decision legitimacy.[29] This phenomenon is strongly influenced by cultural values such as respect and obedience toward the head of the family or those holding higher positions within the family, such as father or husband, and hierarchical family structures that position them as a moral and decision-making authority. These findings suggest that healthcare professionals should design family-based psychoeducation that involves parents or heads of families to enhance social support, ensure treatment adherence, and prevent relapse among persons with schizophrenia. Psychoeducation that only targets the primary caregiver without involving family authority is less effective.[45]

This study revealed that Sundanese family caregivers prefer psychoeducation to be delivered directly through face-to-face interactions rather than via digital platforms. This preference is consistent with previous studies showing that direct communication allows caregivers to gain a clearer understanding, ask questions immediately, and build trusting relationships with healthcare professionals.[46] However, the present findings add a new cultural dimension by showing that in Sundanese communities, direct psychoeducation is also valued because it aligns with cultural norms of face-to-face communication, *someah hade ka semah* (respectful hospitality), and the belief that verbal explanations are more trustworthy when delivered personally by health professionals. Families are more receptive to information through direct

delivery in a friendly and slow Sundanese language. This shows the importance of interpersonal communication in the context of a high-context culture.[33] Direct communication allows for clarification and builds emotional closeness between health workers and families. Successful psychoeducation programs in Asian communities tend to use oral communication that is contextual, personal, and involves examples from everyday life.[38] Family caregivers reported that direct sessions help reduce uncertainty, enhance confidence in managing symptoms during the maintenance phase, and prevent misinterpretation of information. These findings underscore the importance of culturally sensitive psychoeducation models that prioritize interpersonal interaction and verbal dialogue, particularly in collectivist societies where relational harmony and trust are essential in the caregiving process.

This study revealed that Sundanese family caregivers expressed the need for books or printed modules as a medium for psychoeducation to support their long-term caregiving tasks. This finding aligns with prior research indicating that written psychoeducational materials with examples and illustrations, such as manuals and family guides, can enhance caregivers' knowledge retention, allow repeated review, and provide structured information about symptom management, medication adherence, and relapse prevention.[47] However, the present study adds cultural specificity by highlighting that books are valued not merely as information sources but also as trusted and respectful forms of learning that align with Sundanese cultural habits of gradual, calm, and reflective understanding (*ngadengekeun bari mikir heula*). Additionally, caregivers reported that having a tangible book enables them to share knowledge with other family members, including parents and decision-makers, without the need for confrontation or verbal discussion, which is often avoided to maintain family harmony. Although verbal communication is dominant, caregivers want a Sundanese language guidebook that contains important information with simple illustrations. This media not only functions as a reminder, but can also expand the reach of education to other family members.[48] The use of visual media as a complement to oral education, especially in populations with low literacy. This desire shows that psychoeducation must be multimodal and inclusive, not just focused on lecture methods.[49,50] These findings suggest that developing culturally adapted psychoeducational books, written in clear language and enriched with local values, may serve as a sustainable and acceptable medium to enhance caregiver competence during the maintenance phase of schizophrenia.

This study showed that Sundanese family caregivers emphasized the importance of delivering psychoeducation at an appropriate time, specifically when the patient has achieved clinical stability during the maintenance phase. This finding is consistent with previous studies indicating that psychoeducation is most effective when implemented after acute symptoms have been controlled, as families are more emotionally prepared and cognitively receptive to receiving information on long-term care, relapse prevention, and medication adherence.[51] However, the current study adds a culturally specific perspective by showing that Sundanese caregivers believe that providing psychoeducation too early, such as during episodes of acute psychosis, may increase family anxiety, cause rejection of information, or be viewed as culturally inappropriate because it violates the principle of *ulah kagok* (not forcing someone in distress). Caregivers also reported that timing should consider spiritual and emotional readiness, family consensus, and gradual acceptance of the illness. These insights highlight that, beyond clinical stability, culturally appropriate timing also requires sensitivity to familial decision-making norms and emotional adaptation. The participants had no problem with the time as long as it did not clash. They usually have holidays on Saturday or Sunday. Culturally, Sundanese family caregivers have the freedom in their time to meet people. They are not used to making contracts before meeting. Psychoeducation needs to be designed by considering the rhythm of life of local communities that are agricultural and religious. The availability of time is greatly influenced by the planting season, market activities, and worship times. Without time adjustments, the level of participation will be low.[52] The importance of community timing alignment in village-based programs. Therefore, a flexible and community-based approach needs to be integrated into educational intervention planning.[33] Psychoeducation programs should be designed to align with both clinical milestones and cultural readiness to optimize engagement and long-term caregiving outcomes.

This study found that Sundanese family caregivers preferred psychoeducation to be conducted in places that are affordable, easily accessible, and do not impose financial or logistical burdens on the family. For Sundanese people, meeting anywhere is not a problem as long as it is accessible. They usually come together to the event venue.[42] This finding aligns with previous research showing that the accessibility and cost of psychoeducational services greatly influence caregiver participation, particularly in low- and middle-income settings.[9] Community health centers, local

clinics, and village halls have been identified in earlier studies as effective and low-cost venues for delivering family-based psychoeducation.[11] However, the present study contributes a new cultural perspective by revealing that Sundanese caregivers often prefer local community or religious spaces because these locations are not only affordable but also socially acceptable, familiar, and reduce feelings of shame or stigma when seeking mental health support. Caregivers expressed that conducting psychoeducation in hospitals may be perceived as costly, intimidating, or associated with severe illness, while community-based settings feel more welcoming and less formal. The concept of deinstitutionalization in mental health services also emphasizes the importance of moving interventions from formal institutions that are often considered intimidating or foreign, to friendly and socially acceptable community spaces, such as village halls, mosques, or residents' homes.[26,53] These locations not only reduce logistical barriers but also symbolically cement the connection between mental health education and people's daily lives.[29,54] This approach is in line with the principle of community-based mental health, which places the family and social environment as an integral part of the patient's support system.[41] Psychoeducation can be delivered in a more inclusive, participatory, and contextual manner, thereby strengthening social cohesion and reducing the distance between professional services and residents.[55] The selection of familiar and accessible psychoeducation locations plays a strategic role in the success of interventions, especially in rural communities with limited access and high sensitivity to stigma. These findings highlight the importance of designing psychoeducation programs that are not only clinically appropriate but also economically feasible and culturally comfortable for families, thereby enhancing participation, continuity, and effectiveness of care during the maintenance phase of schizophrenia.[30]

## Limitation

This study faced several limitations. First, the number of participants who met the inclusion criteria was limited, and their geographic distribution across various regions made coordination and data collection more challenging. Additionally, cultural stigma surrounding discussions of death and dying posed difficulties in recruiting participants willing to openly share their experiences. These challenges were further compounded by the constraints of the COVID-19 pandemic, which restricted face-to-face interactions and limited access to potential participants. To address these obstacles, researchers engaged with relevant stakeholders and community contacts to facilitate participant recruitment and maintain ethical and respectful communication throughout the process.

## Conclusion

This qualitative study explored the psychoeducational needs of Sundanese family caregivers of persons with schizophrenia, highlighting the complex and multidimensional nature of caregiving within a specific cultural context. The findings indicate that caregivers require not only accurate and comprehensible information about the illness, its treatment, and relapse prevention strategies, but also support in navigating mental health services, understanding available insurance schemes, and enhancing their caregiving competencies. Moreover, the study underscores the importance of delivering psychoeducation through trusted sources, such as health professionals and community or religious leaders, and in formats that are both accessible and culturally acceptable, including face-to-face sessions, printed materials, and affordable venues. Future research involving larger and more diverse populations is recommended to validate these findings and to support the design of comprehensive, accessible, and sustainable psychoeducational programs tailored to caregivers' unique needs. The results of this research can provide new knowledge for mental health nurses in community health centers in the Bandung Regency area as a basis for developing alternative interventions in treating schizophrenic family caregiver clients.

## Data Sharing Statement

The data are not available due to privacy and ethical restrictions.

## Acknowledgments

The authors acknowledge the contribution of the following health professionals who were involved in this research project. The authors would also like to thank the participants in this project, particularly family caregivers caring for persons with schizophrenia.

## Funding

This project was funded by Universitas Padjadjaran, Bandung, West Java Province, Indonesia.

## Disclosure

The authors report no conflicts of interest in this work.

## References

1. Stuaart GW, Laraia MT, Sundeen SJ, editors. *Stuart & Sundeen's Principles and Practice of Psychiatric Nursing*. 10th ed. Mosby, Inc; 2012.
2. National Institute for Health Research & Development. Riset kesehatan dasar (national health survey). *Minist Health Repub Indones*. 2013;(1):1–303. doi:10.1007/s13398-014-0173-7.2
3. Ministry of Health, Republic of Indonesia. Indonesia basic health research (riskesdas) report 2018. *Ris Kesehat Dasar 2018*. 2018:182–183.
4. Herzog EA, Varcarolis EM. Schizophrenia. In: Varcarolis EM, Halter MJ, editors. *Foundation of Psychiatric Mental Health Nursing: A Clinical Approcah*. 6th ed. 2010:306–343.
5. World Health Organization. Mental health policies and action plans. 2007. Available from: https://www.who.int/mental_health/policy/services/1_MHPolicyPlan_Infosheet.pdf?ua=1. Accessed December 13, 2025.
6. Gloria O, Osafo J, Goldmann E, Parikh NS, Nonvignon J, Kretchy IMA. The experiences of providing caregiving for patients with schizophrenia in the Ghanaian context. *Arch Psychiatr Nurs*. 2018;32(6):815–822. doi:10.1016/j.apnu.2018.06.005
7. Katz J, Medoff D, Fang LJ, Dixon LB. The relationship between the perceived risk of harm by a family member with mental illness and the family experience. *Community Ment Health J*. 2015;51(7):790–799. doi:10.1007/s10597-014-9799-3
8. Suryani S. Caring for a family member with schizophrenia: the experience of family carers in Indonesia. *Malaysia J Psychiatry*. 2015;24:1.
9. Opoku-Boateng YN, Kretchy IA, Aryeetey GC, et al. Economic cost and quality of life of family caregivers of schizophrenic patients attending psychiatric hospitals in Ghana. *BMC Health Serv Res*. 2017;17(Suppl 2). doi:10.1186/s12913-017-2642-0
10. Koschorke M, Padmavati R, Kumar S, et al. Experiences of stigma and discrimination of people with schizophrenia in India. *Soc Sci Med*. 2014;123:149–159. doi:10.1016/j.socscimed.2014.10.035
11. Irazabal M, Pastor C, Molina MC. Family impact of care and respite service: life experiences of mothers of adult Children with intellectual disability and mental disorders. *Revista de Cercetare Si Interventie Sociala*. 2016;55:7–18.
12. Rafiyah I, Kp S, Prof A, Sutharangsee W. Review: burden on family caregivers caring for patients with schizophrenia and its related factors. *Nurse Media J Nurs*. 2011;1(1):29–41. doi:10.14710/nmjn.v1i1.745
13. District Health Office, Bandung. *Annual report*. 2016.
14. Bandung Regency Health Office. *Annual report*. 2020.
15. Kusumawardani W, Yusuf A, Fitryasari R, Ni'mah L, Tristiana RD. Family burden effect on the ability in taking care of schizophrenia patient. *Indian J Public Health Res Dev*. 2019;10(8):2654–2659. doi:10.5958/0976-5506.2019.02269.1
16. Rezaei O, Bayani A, Mokhayeri Y, et al. Applying psychoeducational program on general health and communication skills in caregivers of patients with schizophrenia: a randomized controlled trial. *Eur J Psychiatry*. 2018;32(4):174–181. doi:10.1016/j.ejpsy.2018.04.001
17. Martín-Carrasco M, Fernández-Catalina P, Domínguez-Panchón AI, et al. A randomized trial to assess the efficacy of a psychoeducational intervention on caregiver burden in schizophrenia. *Eur Psychiatry*. 2016;33:9–17. doi:10.1016/j.eurpsy.2016.01.003
18. Tabeleão V, Tomasi E, de Avila Quevedo L. A Randomized controlled trial of the effectiveness of a psychoeducational intervention on family caregivers of patients with mental disorders. *Community Ment Health J*. 2018;54(2):211–217. doi:10.1007/s10597-017-0126-7
19. Bradley GM, Couchman GM, Perlesz A, Nguyen AT, Singh B, Riess C. Multiple-family group treatment for English- and Vietnamese-Speaking families living with schizophrenia. *Psychiatr Serv*. 2006;57(4):521–530. doi:10.1176/appi.ps.57.4.521
20. Polit D, Hungler B. *Nursing Research: Principles and Methods*. 6th ed. Lipincott Williams & Wilkins; 1999.
21. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008;62(1):107–115. doi:10.1111/j.1365-2648.2007.04569.x
22. Mitsonis C, Voussoura E, Dimopoulos N, et al. Factors associated with caregiver psychological distress in chronic schizophrenia. *Soc Psychiatry Psychiatr Epidemiol*. 2012;47(2):331–337. doi:10.1007/s00127-010-0325-9
23. Annisa F, Hengudomsub P, Deoisres W. Predicting factors of burden among family caregivers of patients with schizophrenia in Surabaya, Indonesia. *Thai Pharm Health Sci J*. 2015;10(3):87–97.
24. Ninin RH. The self of sundanese ethnic: interdependent construal and religious self. *Asian Soc Sci*. 2015;11(16):1–8. doi:10.5539/ass.v11n16p1
25. Matsuda M, Kohno A. Effects of the nursing psychoeducation program on the acceptance of medication and condition-specific knowledge of patients with schizophrenia. *Arch Psychiatr Nurs*. 2016;30(5):581–586. doi:10.1016/j.apnu.2016.03.008
26. Cleary M, West S, Hunt GE, McLean L, Kornhaber R. A qualitative systematic review of caregivers' experiences of caring for family diagnosed with schizophrenia. *Issues Ment Health Nurs*. 2020;41:667–683. doi:10.1080/01612840.2019.1710012
27. Alfan M, Muhyiddin A, Thohir A. Cosmology of native Indonesian religions in facing contemporary times: a study of Sundanese Javanese religion. *Hanifiya J Stud Agama-Agama*. 2024;7(1):1–14. doi:10.15575/hanifiya.v7i1.31362
28. Gumley A, Bradstreet S, Ainsworth J, et al. Early signs monitoring to prevent relapse in psychosis and promote well-being, engagement, and recovery: protocol for a feasibility cluster randomized controlled trial harnessing mobile phone technology blended with peer support. *JMIR Res Protoc*. 2020;9(1):e15058. doi:10.2196/15058
29. Bora ST, Buldukoğlu K, Bailey DE. Effectiveness of an uncertainty management psychoeducation program for schizophrenia caregivers: a Randomized controlled trial. *J Am Psychiatr Nurses Assoc*. 2022;30(3):590–602. doi:10.1177/10783903221141890
30. Rafiyah I, Suryani S, Rahayuwati L, Suttharangsee W. Culturally Adapted Psychoeducation among family caregivers of schizophrenic clients: a scoping review. *Open Access Maced J Med Sci*. 2021;9(T6 SE–Psychiatry):143–152. doi:10.3889/oamjms.2021.7315
31. Alizioti A, Lyrakos G. Measuring the effectiveness of psychoeducation on adherence, depression, anxiety and stress among patients with diagnosis of schizophrenia. a control trial. *Curr Psychol*. 2021;40(8):3639–3650. doi:10.1007/s12144-019-00255-4

32. Young L, Murata L, McPherson C, Jacob JD, Vandyk AD. Exploring the experiences of parent caregivers of adult children with schizophrenia: a systematic review. *Arch Psychiatr Nurs*. 2019;33(1):93–103. doi:10.1016/j.apnu.2018.08.005
33. Budiono W, Kantono K, Kristianto FC, Avanti C, Herawati F. Psychoeducation improved illness perception and expressed emotion of family caregivers of patients with schizophrenia. *Int J Environ Res Public Health*. 2021;18:7522. doi:10.3390/ijerph18147522
34. Caqueo-Urízar A, Rus-Calafell M, Urzúa A, Escudero J, Gutiérrez-Maldonado J. The role of family therapy in the management of schizophrenia: challenges and solutions. *Neuropsychiatr Dis Treat*. 2015;11:145–151. doi:10.2147/NDT.S51331
35. Rafiyah I. Sundanese Caregivers burden caring for persons with schizophrenia. *iCDMIC*. 2017;1(1):1–7.
36. Renwick L, Susanti H, Brooks H, Keliat B-A, Bradshaw T, Bee P. Culturally adapted family intervention for people with schizophrenia in Indonesia (FUSION): a development and feasibility study protocol. *Pilot Feasibility Stud*. 2023;9. doi:10.1186/s40814-023-01280-8
37. Rafiyah I, Suttharangsee W, Sangchan H. Coping and burden of Indonesian family caregivers caring for persons with schizophrenia. *Songklanagarind Med J*. 2012;30(3):135–142.
38. Mueser KT, Achtyes ED, Gogate J, Mancevski B, Kim E, Starr HL. Telehealth-based psychoeducation for caregivers: the family intervention in recent-onset schizophrenia treatment study. *JMIR Ment Heal*. 2022;9:e32492. doi:10.2196/32492
39. Suharsono S, Faidah N, Hanafi M. The effectiveness of nursing psychoeducation toward family burden and quality life on caregiver of people with schizophrenia in the community. *Healthc Low-Resource Settings*. 2023;11(s1 SE–Original Articles). doi:10.4081/hls.2023.11215
40. Lucksted A, Mcfarlane W, Downing D, Dixon L. Recent developments in family psychoeducation as an evidence-based practice. *J Marital Fam Ther*. 2012;38(1):101–121. doi:10.1111/j.1752-0606.2011.00256.x
41. Susanti H, Brooks H, Keliat B, et al. Stakeholder perspectives of family interventions for schizophrenia in Indonesia: a qualitative study. *BMC Psychiatry*. 2024;24(1):59. doi:10.1186/s12888-024-05504-w
42. Rosidi A. *Mencari Sosok Manusia Sunda (Searching for the Figure of a Sundanese Person)*. 1st ed. Dunia Pustaka Jaya; 2010.
43. Horikoshi-Roe H. Mental illness as a cultural phenomenon: public tolerance and therapeutic process among the Moslem Sundanese in West Java. *Indonesia*. 1979;28(28):121–138. doi:10.2307/3350898
44. Verma PK, Walia TS, Chaudhury S, Srivastava S. Family psychoeducation with caregivers of schizophrenia patients: impact on perceived quality of life. *Ind Psychiatry J*. 2019;28:19–23. doi:10.4103/ipj.ipj_2_19
45. Al-Shashani A, Abu Sabra MA, Al-Gamal E. The impact of using digital health interventions and psychoeducation on medication adherence among patients with schizophrenia: a scoping review. *Issues Ment Health Nurs*. 2025;1–11. doi:10.1080/01612840.2025.2492694
46. Siregar I, Rahmadiyah F, Siregar AFQ. Therapeutic communication strategies in nursing process of angry, anxious, and fearful schizophrenic patients. *Br J Nurs Stud*. 2021;1(1):13–19. doi:10.32996/bjns.2021.1.1.3
47. Pooe JM, Sokudela B, Roos JL, Motlana LM, Dlamini N, Snyman M. Testing the effectiveness of existing psycho-educational material (The Alliance Programme) for patients suffering from schizophrenia in the South African context. *Afr J Psychiatry*. 2010;13(4):302–308. doi:10.4314/ajpsy.v13i4.61881
48. Yasuma N, Sato S, Yamaguchi S, et al. Effects of brief family psychoeducation on family caregiver burden of people with schizophrenia provided by psychiatric visiting nurses: a cluster randomised controlled trial. *BMC Psychiatry*. 2024;24(1):445. doi:10.1186/s12888-024-05884-z
49. Lestari R, Yusuf A, Hargono R, Setyawan FEB, Hidayah R, Ahsan A. Adapting to people with Schizophrenia: a phenomenological study on a Rural Society in Indonesia. *Indian J Psychol Med*. 2021;43:31–37. doi:10.1177/0253717620926847
50. Bachtiar A, Windarwati HD, Keliat BA, Ismail RI, Ati NAL, Sulaksono AD. The fight against stigma: multilevel stigma interventions in schizophrenia. *J Public Heal Res*. 2020;9:jphr–2020. doi:10.4081/jphr.2020.1883
51. Falloon RH, Velentza O, Fradelos E, Papathanasiou I. The positive effects of family therapy in state psychosis: the Ian. 2014.
52. Harvey C. Family psychoeducation for people living with schizophrenia and their families. *Bjpsych Adv*. 2018;24:9–19. doi:10.1192/bja.2017.4
53. James R, Tungol J. Aggravating factors and adverse impacts of subjective burden of family caregivers of schizophrenia patients. *Indian J Health Well Being*. 2021;12:413–416.
54. Suryani S, Hidayah N, Sutini T, Al-Kofahy L. The Indonesian survivors' perspective about recovery from schizophrenia: an exploratory study. *J Keperawatan Padjadjaran*. 2022;10(2 SE–Original):99–106. doi:10.24198/jkp.v10i2.1990
55. Glecia A, Li H. Mental health and wellbeing in family caregivers of patients with schizophrenia disorder: a literature review. *Curr Psychol*. 2024;43(12):10914–10941. doi:10.1007/s12144-023-05220-w



**Journal of Multidisciplinary Healthcare**

**Dovepress**
Taylor & Francis Group

**Publish your work in this journal**

The Journal of Multidisciplinary Healthcare is an international, peer-reviewed open-access journal that aims to represent and publish research in healthcare areas delivered by practitioners of different disciplines. This includes studies and reviews conducted by multidisciplinary teams as well as research which evaluates the results or conduct of such teams or healthcare processes in general. The journal covers a very wide range of areas and welcomes submissions from practitioners at all levels, from all over the world. The manuscript management system is completely online and includes a very quick and fair peer-review system. Visit http://www.dovepress.com/testimonials.php to read real quotes from published authors.

**Submit your manuscript here:** https://www.dovepress.com/journal-of-multidisciplinary-healthcare-journal