THE RELATIONSHIP BETWEEN FAMILY SUPPORT AND QUALITY OF LIFE OF STROKE PATIENTS IN THE OUTPATIENT INSTALLATION OF THE ROYAL PROGRESS HOSPITAL NORTH JAKARTA.

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Abstract

Stroke is the second leading cause of death and the third leading cause of disability worldwide. Sudden changes in life for stroke patients impact their psychological conditions, with physical limitations that can interfere with the quality of life of post-stroke patients. Family support is crucial in helping post-stroke patients achieve an optimal life. The purpose of this study was to determine the relationship between family support and the quality of life of post-stroke patients. This study is a quantitative analytical correlational study with a cross-sectional approach involving 73 respondents selected through a purposive sampling technique. Bivariate analysis was conducted using the Chi-Square test. The results of the univariate analysis showed that the quality of life of post-stroke patients was good in 53.7% of cases, and family support was good in 56.2% of cases. Bivariate analysis obtained a p-value of 0.000, indicating a relationship between family support and the quality of life of post-stroke patients. It is hoped that nurses can prepare the families of post-stroke patients with discharge planning before they return home and conduct home visits so that families can care for patients well, prevent stroke recurrence, and improve the quality of life, especially in the physical and psychological domains post-stroke.

Keywords: Family Support, Quality of Life, Post Stroke Patients

INTRODUCTION

Stroke is a significant health problem with a major role as the second leading cause of death and the third leading cause of disability worldwide. Each year, it is recorded that approximately 5.7 million deaths occur due to stroke, and 15 million people who suffer from a stroke experience physical impairments and disabilities. The World Health Organization (WHO) projects an increase in the number of stroke patients in several European countries from 1.1 million per year in 2000 to 1.5 million per year in 2025, with an estimated rise in disability due to stroke from 38 million in 1990 to 61 million in 2020. Globally, 87% of deaths due to stroke occur in low- and middle-income countries, with an increase of more than 100% over the last four decades (Owolabi et al., 2018). Indonesia, one

of the middle-income countries, had a stroke prevalence of 8.3 per thousand in 2007, which increased to 10.9 per thousand (Riset Kesehatan Dasar:2018, 2018).

According to Hamjah et al., (2019), out of 51 post-stroke patients, almost all experienced high levels of death anxiety (76.5%), while a small portion experienced low levels of anxiety (23.5%). Risk factors for stroke can be divided into two, namely non-modifiable and modifiable. Non-modifiable risk factors are age, gender, ethnicity/race, and congenital diseases. Modifiable risk factors are hypertension, diabetes mellitus, heart disease, smoking, dyslipidemia, obesity, metabolic syndrome, use of oral contraceptives, and others (Riset Kesehatan Dasar:2018, 2018). Stroke has an impact on death if early management is late for both hemorrhagic stroke (bleeding) and ischemic stroke (not bleeding). Other impacts are paralysis, coma, financial due to high medical costs and requiring a long time, and psychological impacts. (Intercollegiate Working Party for Stroke, 2012) states that the psychological impacts that arise after a stroke are depression, anxiety, unstable emotions, fatigue, inadequate coping, apathy, anger, disturbed social relationships. In addition, the impact of stroke is an increase in the economic burden on the health care system, increasing poverty rates, decreasing quality of life for sufferers and families, thwarting economic development, and can weaken or even reduce life expectancy.

If a stroke befalls a family member, then a few days or even weeks after the stroke can cause stress for the family because a stroke usually occurs suddenly and most families will experience anxiety about the prognosis, and uncertainty of the progress of treatment and rehabilitation of the family member. Couples who experience a stroke are at risk of depression and emotional distress in the weeks and months after the stroke. Healthy stroke couples are more depressed and generally less happy with their lives (Greenwood et al 2009). Stroke and its consequences are important issues for patients, families, and the health care system. Measuring health-related Quality of Life (HRQoL) in post-stroke patients is very important to evaluate their health status conventionally. The main factors that influence the decline in HRQoL in post-stroke patients are depression, physical and mental disabilities, chronic pain, cognitive deficits, disturbances in emotions, self-identity, and social isolation. Rehabilitation directed at increasing the independence of post-stroke patients, reducing

isolation, treating depression, and strengthening social support is considered to contribute to improving HRQoL. (Kawecka-Jaszcz et al., 2014).

Based on Ayuningputri's research (2013), stroke has a physical impact where most stroke patients will experience very varied symptoms, such as impaired mobility or motoric disorders, visual disturbances, speech disorders, emotional changes, and other symptoms according to the location of the brain that experiences infarction or blockage. These symptoms can affect their physical, psychological, and social aspects which will have an impact on decreasing productivity and quality of life both permanently and temporarily. Physical impacts can also appear such as partial paralysis, communication disorders, and cognitive disorders. The most common deficit experienced by stroke patients involves motoric actions. This physical paralysis can occur directly and usually, patients realize that they cannot move their arms and legs on one side of the body.

Early treatment of stroke patients and comprehensively from within the family to the hospital and back to the family is very important and determines success both in maintaining optimal quality of life and improving the quality of life of patients. Treatment of stroke patients requires large costs and a long time. The role of nurses in the treatment of stroke patients includes developing treatment plan goals, determining functional assessment tools, designing activities to prevent complications, maximizing patient abilities, increasing maximum physical function and minimizing risk factors that will be implemented by the family or caregiver while the patient is at home, where the longest time of the patient's rehabilitation process.

Based on data on patients who visited Bhakti Husada Hospital, there were 157 patients. On average, patients who visit are accompanied by a Caregiver and accompanied by family or accompanied only by a Caregiver.

RESEARCH METHODS

This type of research is quantitative analytical correlational with a cross-sectional study approach to determine the relationship between family relationships and the quality of life of post-stroke patients. The sampling technique was purposive sampling with a total of 73 respondents. Data collection in this study was a questionnaire. This study was conducted at Bhakti Husada Hospital.

RESULTS AND DISCUSSION

Results

Univariate Analysis

a. Frequency Distribution of Family Support for Post-Stroke Patients

Family Support	Frekuensi	Persentase (%)
Less Good	32	43.8%
Good	41	56.2%
Total	73	100.0%

Based on the results of the univariate analysis, it was found that more than half received good family support, as many as 41 people (56.2%).

b. Frequency Distribution of Quality of Life for Post-Stroke Patients

Quality of Life	Frekuensi	Percentage (%)
Less Good	21	28.8%
Good	32	43.8 %
Very Good	20	27.4%
Total	73	100.0%

Based on the results of the univariate analysis, it was found that the quality of life of 32 patients (43.8%) was good

Bivariate Analysis

The Relationship between Family Support and Quality of Life in Post-Stroke Patients

Family Support	*Quality Of Life*						Total		P
	Less Good		Good		Very Good				
	f	%	f	%	f	%	F	%	
Less Good	17	53.1%	10	31.3%	5	15.6%	32	43.8%	0,000
Good	4	9.8%	22	53.7%	15	36.6%	41	56.2%	
Total	21	28.8%	32	43.8%	20	27.4%	73	100,0%	

Based on the bivariate analysis, it was found that good family support with good quality of life of patients was 22 people (53.7%). The p-value is 0.000 where this value is smaller

than alpha ($\alpha = 0.05$), so there is a correlation between the family support variable and the quality of life of post-stroke patients at Bhakti Husada Hospital.

Discussion

The results of this study indicate that the majority of respondents provide good family support, totaling 41 respondents (56.2%). Similar results were found Rawung et al., (2023) in their study on the relationship between family support and quality of life in stroke patients. Their research showed that the majority of respondents (66.7%) received high levels of family support.

According to Yahya (2021), family support is a form of interpersonal relationship that consists of attitudes, actions, and acceptance toward family members, allowing sick family members to feel cared for. This family support includes financial support, informational support, assistance with daily routine activities, support in treatment and care, and psychological support. Furthermore, family support can have a positive impact on improving quality of life. Health maintenance is one of the five functions of a family, aimed at maintaining the health status of family members so that they can remain highly productive. Therefore, good family support for post-stroke patients indicates that the family is fulfilling its function by being involved in the efforts for the patient's recovery and rehabilitation, enabling the patient to live optimally.

Factors influencing family support can include internal factors such as developmental stage, education or knowledge level, and emotional factors that affect beliefs about the presence of support and how it is provided. The spiritual aspect can be seen in how someone lives their life, including the values and beliefs they practice, relationships with family or friends, and the ability to find hope and meaning in life. External factors include how the family provides support, social and psychosocial factors that can increase the risk of disease and influence how a person defines and reacts to their illness, economic level, marital stability, lifestyle, work environment, and cultural background that affect beliefs, values, and individual habits in providing support, including personal health practices (Friedman, 2010).

Based on the data on family characteristics, it was found that more than half of the respondents, 45 people (61.6%), had a higher education background. The higher a person's level of education, the more capable they are of providing good support, whether

informational, instrumental, emotional, or appreciative support to a family member who has had a stroke. According to Moons et al. (2004), education level is one of the factors that can influence subjective quality of life. The higher the level of education, the more positive the impact on the quality of life for oneself and others.

Family support for post-stroke patients comes in four forms: appreciative support, instrumental support, informational support, and emotional support. In this study, the highest form of family support was informational support. The availability of adequate information regarding efforts to maintain and optimize the lives of post-stroke patients greatly assists patients in utilizing healthcare facilities and other supporting resources.

In this study, appreciative support was the lowest form of support. Considering that the average age of post-stroke patients is 51–70 years, which is no longer considered a productive age and tends to have comorbidities, family support in the form of appreciative support is given merely as a gesture of respect towards the patient in their remaining life. Therefore, the support provided by the family is less or not optimal for the recovery of post-stroke patients.

In this study, patients with a good quality of life totaled 22 people (53.7%) out of all respondents. This is in line with the study conducted by Raudhotun Nisak et al. (2023) on the relationship between family support and the quality of life in stroke patients, which found that patients with a good quality of life had a high quality of life (68.3%).

Previous studies have confirmed the importance of cardiac rehabilitation as a part of secondary prevention strategies and demonstrated a reduction in cardiovascular disease mortality and better quality of life (Zuriati et al., 2023)

Quality of life is a conceptual or operational measure often used in chronic disease situations as a way to assess the impact of therapy on patients. This conceptual measurement includes well-being, quality of survival, and a person's ability to independently perform daily activities. Expressing quality of life is understood as an individual's perception of their functioning in various life domains (Zuriati et al., 2022). In this study, the relationship between Family Support and Quality of Life in Post-Stroke Patients is 0.000 (less than Alpha ($\alpha = 0.05$)), and it is concluded that there is a relationship between Family Support and Quality of Life in Post-Stroke Patients.

The study by Ludiana and Supardi (2020) at Puskesmas Banjarsari Metro found a p-value of 0.000 < 0.05, and concluded that there is a relationship between family support and the quality of life in post-stroke patients

According Rawung et al., (2023) The impact of stroke includes an inability to perform activities independently. Stroke patients become dependent on others around them. Good family support impacts the quality of life of post-stroke patients positively (88%).

Quality of life is a common term used to describe health status, though it also has a specific meaning that allows for ranking populations according to both objective and subjective aspects of health status. Health-related Quality of Life (HRQoL) includes physical and mental functional limitations and the positive expression of physical, mental, and spiritual well-being. HRQoL can be used as an integrative measure that combines mortality and morbidity, and it serves as an index of various factors including death, morbidity, functional limitations, and overall well-being (Michael J. Gibney, 2009).

The lowest form of support provided by the family is appreciative support. This occurs because the family perceives the stroke-affected member as an additional burden. At an advanced age with comorbidities, post-stroke patients become less productive and may even be considered terminally ill. In this study, more than half of the families with higher education levels have quality jobs, leading to good family support for more than half of the respondents (56.2%). This, in turn, impacts the quality of life of post-stroke patients, with 53.7% rated as good and 36.6% rated as very good. Thus, the higher the support provided by the family to post-stroke patients, the better and more excellent the quality of life of the patients will be.

Family support is crucial for improving quality of life, such as involving patients in recreational activities, providing clarity on financial sources for the patients, and ensuring the availability of facilities and infrastructure in the living environment, such as safety and comfort in the living area to prevent injuries. Given the various limitations of post-stroke patients, family support helps the patients feel that the family is facilitating their care, allowing them to remain optimal according to their health condition.

CONCLUSION

There is a relationship between family support and the improvement of quality of life in post-stroke patients. Hospitals can facilitate family members, especially caregivers, in

maximizing family support, whether it is appreciative, instrumental, informational, or emotional support, relevant to the post-stroke patient's family. This can be achieved by providing education on family support based on the four dimensions of support and involving the family throughout the patient's care, including preparation for discharge and follow-up visits for post-care control.

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