

EXPLORING JEMBER COMMUNITY VIEW IN THE TREATMENT OF MENTAL HEALTH DISORDERS WITH THE PERSPECTIVE OF A TRANSCULTURAL NURSING

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ABSTRACT

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The problems of people with mental health disorders (PWMHD) include physical problems, psychological problems, and social problems. Jember Regency in 2018 had 514 new cases, and Panti village was ranked first with 114 clients (22.1%) of the total cases in the Jember Regency. Community views accompanied by cultural background often prevent families with PWMHD from coming to the health center to seek care and management of health services. Negative public views on PWMHD will reduce PWMHD visits to seek treatment so that cases of drug withdrawal will increase. Nurses have an essential role in providing nursing care to clients with mental disorders. Without knowledge of the cultural viewpoints of the community, nurses will find it difficult to find strategies to reduce the occurrence of stigma and discrimination in PWMHD. This study was used an ethnography study, qualitative approach, and descriptive design to explore and to understand about the Jember community view in the treatment of mental disorders with a perspective of transcultural nursing. The technique of collecting data was used in-depth interviews with a semi-structured interview guide involving seven participants, and the data were analyzed using interpretive phenomenology analysis. This research has passed the ethical test with ethical approval No.595 / UN25.8 / KEPK / DL / 2019. This research conducted five themes. First is the family efforts to seek healing; the second theme is received trials from God; the third theme is community stigma to people with mental disorders; the fourth theme is community expectations for people with mental disorders, and the fifth theme is community acceptance of people with mental disorders. Considering the impact that will arise from this condition if it does not get proper treatment, it is needed the role of health workers in providing services to the family to be able to increase visits to health services in order to improve the recovery of people with mental disorders.

BACKGROUND

Mental disorder is a disease that has an increasing number of cases each year. Management of mental disorders is a national instruction that can be accessed in primary health services or health centers, but the problem occurs when the number of cases of low number of visits is because families are still reluctant to conduct examinations and management related to routine mental problems to health services (Schoonover et al., 2012). Cases of mental disorders have increased in Indonesia. Riskesdas (2018) ex-

plains that the number of family members with mental disorders in Indonesia is 7%. In East Java, the number of family members with mental disorders amounts to 6%. Increasing cases of mental disorders every year makes people with mental disorders (PWMHD) interactions with the community more frequent. Jember is one of the cities that has quite a several mental disorders in East Java is 514 cases in 2018, whereas many as 22.1% or 114 cases are found in the Panti sub-district.

Community views that tend to be negative for PWMHD often hamper clients with PWMHD

from coming to health services for treatment. Poor social support makes families with PWMHD feel experiencing unpleasant experiences, whether it is a shame or feelings of isolation from the social environment. Based on the results of observations and interviews conducted with families with PWMHD in July 2019 it is known that one of the reasons the family is still not intense in conducting the process of treatment and mental therapy is the presence of negative stigma from the surrounding community (Tse et al., 2012). Nurses have an important role in providing mental nursing care to PWMHD. Holistic nursing actions are given to all aspects, namely biopsychosocial and cultural. An approach to the family is also needed so that families can increase visits related to the treatment of family members who have mental disorders quickly to the health service (Porter & Fitzpatrick, 2014).

METHODS

This study uses an ethnography study, qualitative approach, and descriptive design to explore and understand the Jember community view in the treatment of mental disorders with a perspective of transcultural nursing.

A purposive sampling strategy was used to recruit participants from the community. Formal letters were sent to PHNs in Panti district In Jember, East Java, Indonesia, requesting them to inform those affected by mental health disorder and the community besides patient with a mental disorder

Participants in this study are family or caregiver people with mental disorders who have or are currently taking care of family members who have mental disorders, religious leaders, community leaders, community patients affected by mental disorders, health workers at the Panti District Health Center. The number of participants involved in this study was ten people. The method of selecting participants is done by purposive sampling or purposive sampling; that is, the sample chosen is oriented towards the research objectives. Deliberately, Individuals are selected or chosen because they have experience by caring for people with mental disorders (Sugiyono, 2012).

At the recruitment stage, the researchers used the inclusion criteria, so those prospective participants matched the research objectives. The inclusion criteria include: 1) families who live in the same house as PWMHD, 2) Family members who are the decision-makers in conducting PWMHD care, 3) are willing to participate as a participant by signing a let-

ter of willingness to become a participant, 4) can tell his experience well / cooperatively.

Participants were interviewed using a semi-structured approach that allowed them to elaborate on their personal experiences. After an initial introductory period during which the participant gained familiarity and trust, the interviewer asked an open-ended question relative to their current experience of flood disaster in general.

The researcher who collected the data was trained in conducting qualitative interviews. Predictive techniques such as probing, reflection, and paraphrasing were used to indicate an understanding of the participants' experiences, which were often of a sensitive and emotional character. Follow up questions were asked only if essential for clarification. Interviews were terminated when participants indicated that they had exhausted their descriptions. All interviews were audio-recorded and transcribed. The interviews lasted between 45 to 90 minutes and were conducted over a three-month period. Following all interviews, the researcher conversed with the participants related to neutral topics to reduce any emotional activation that may have occurred that was associated with the discussion of disaster's experience topics.

In qualitative research. Data coding plays an important role in the process of data analysis and determines the quality of data abstraction of research results. Data coding in this study was carried out by giving code to the types of participants, namely, code 1 = family; code 2 = religious figure; code 3 = community figure; code 4 = community around PWMHD environment; code 5 = health workers at the Panti District Health Center.

The audiotapes were reviewed several times and transcribed verbatim. Researchers examined transcripts line-by-line, highlighting critical statements describing participants' experiences and coding them for content. Content codes were defined, categorized, and formulated into thematic clusters. To explore the hidden meanings, the data were 'interrogated': For example: What was said?; how was it said?; What do you mean by this sentence? (Spradley, 1979).

Two levels of phenomenological reduction to reduce study bias was incorporated to ensure scientific rigor, and to maintain the assumptions of the phenomenological approach. The first assurance was via bracketing to reduce investigator bias. The second level of rigor included continuous study during the interviews; allotting adequate time and building trust in the relationship between the interviewer and interviewee; review and revision of the content and

translation by senior investigators; and finally, participants' view of notes and descriptions. Data analysis and validation were done as a research team to increase the study's credibility. These categories were initially derived individually by members of the study team and then compared as a group until theme consensus was attained.

RESULTS

Total content units about the family experience were extracted from the data for analysis. From the existing sub-themes, we get five main themes: (a) Family efforts to seek healing; (b) Receive trials from God; (c) Community stigma to people with mental disorders; (d) Community expectations for people with mental disorders; (e) Community acceptance of people with mental disorders. The following is a detailed description of the themes related to each sub-theme. We used pseudonyms to protect participant anonymity.

Family Efforts to Seek Healing

The participants stated the sub-theme of family efforts to seek healing because many among families with mental disorders patients said that they sought to heal for patients by seeking treatment to religious leaders and the nearest health care center. Two examples are given:

"..... Taken to religious leaders, taken to Jember, taken to a mental hospital for treatment" (participant 1)

"..... Some are taken directly to the nearest health service center, some are taken to religious leaders or ruqyah" (participant 5)

Receive Trials from God

The family's attitude and response in treating patients with mental disorders are that they accept sincerely and steadfastly in the face of trials given by God. as expressed by several participants:

"..... I fight patiently. This is God's destiny with sincerity, other than trying, praying, that's all" (participant 1)

"..... Yes how not to accept, it's fate from God" (participant 1)

Community Stigma to People with Mental Disorders

Some of the social stigmas that exist in society towards people with mental disorders today, based on interviews that have been conducted:

"..... Poor, just afraid of anger, when you are alone, you will be seen, then you will be hassled, so stay silent" (participant 4)

"..... afraid ... not the person who was doused, sprayed with water in front of him. They say crazy people are afraid of water, they said" (participant 4)

"..... if I stay away, yes ... but it means that I stay away for fear of being thrown, afraid of what, afraid of the anger and others even if he doesn't. Sometimes it just smells, sometimes I'm not strong enough to smell urine ... I see. Yes, then I entered. Yes, if feelings of pity are always there because of our fellow humans" (participant 4)

Community Expectations for People with Mental Disorders

Nearby health workers expect the formation of an integrated service post-program for people with mental disorders if human resources are sufficient to implement the program. Stated as follows:

"..... I once wanted to do an integrated service post for people with mental disorders" (participant 5)

"..... I want to form a spirit integrated service post" (participant 5)

"..... Except adequate human resources. If there is already a need for awareness (spirit integrated service post) it's okay" (participant 5)

Community Acceptance of People with Mental Disorders

Community acceptance can be seen from their attitude in treating people with mental disorders as treated the same as healthy people, embracing, invited to do positive activities, as stated by the participant as follows:

"..... hugged, just like normal people, generalized" (participant 2)

"..... sometimes the person has a mental disorder, sometimes relapsing, sometimes not, joining the santri day yesterday" (participant 5)

Table 1. Main Themese And Categories Of The Exploring Jember Community View In The Treatment Of Mental Disorders With The Perspective Of A Transcultural Nursing

No	Themes	Categories
1	Family efforts to seek healing	<ol style="list-style-type: none"> 1. Ruqyah by religion leader 2. Inject at a midwife every month 3. Taken to the community health centers 4. Stocks 5. Fear of PWMHD patients
2	Receive temptation from God	<ol style="list-style-type: none"> 1. The family keeps caring 2. Accept the existing circumstances 3. Pray for each other to heal
3	Community stigma again People with mental health disorder	<ol style="list-style-type: none"> 1. Devil possessed 2. Amuk (angry and aggressive) 3. People whose minds are disturbed 4. Cleanliness is very poor 5. Excommunicated from the community
4	Community expectation for people with mental health disorder	<ol style="list-style-type: none"> 1. The patient can be recover 2. Can be sociable
5	Community acceptance of people with mental health disorders	<ol style="list-style-type: none"> 1. Does not matter 2. Ordinary 3. Received and included in social activities

"..... In my opinion yes, treated the same as us, must be respected" (participant 5)

"..... So many people already know that if a person with a mental illness cannot be locked up and should not be ostracized, the point should be generalized as being considered the same as a healthy person" (participant 5)

DISCUSSION

From the fifth themes discussed in the research results, it shows the relationship with each other as in the first theme about the family effort to seek healing. Families with family members who have the same mental problems have many problems when caring for people with mental disorders.

Inadequate time management that occurs in families due to family members still has to work to meet the needs of life in the morning, with the average income of the community or families with family members who experience mental disorders are still included in the category of lower to middle society. This statement is as expressed by (Purnama, Yani, & Sutini, 2016), where the Indonesian people have a pattern of working as much as 8 hours. This statement will undoubtedly have an impact on the existence of family members who need care. Crowe (2015) also explained that people with mental disorders

need a special companion to be able to take care of mental health problems. Of course, the time required is not small and intensive. Hayes et al. (2015) explained that caregivers or families who are responsible for caring for family members who suffer from psychiatric disorders would experience the burden of life because of the complex responsibilities of caregivers on funding, patient health care, and freedom and caregiver activity itself. The research of (Mehrotra, Nautiyal, & Raguram, 2018) in line with the first theme, namely the management of family coping mechanisms with mental family members explaining that the term 'mental health literacy' which is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Mental health literacy consists of several components, including (a) the ability to recognize specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. Tan (2013) explain that the burden of caring is the impact and consequences received by caregivers, which include emotional aspects, physical aspects, psychology, and economic impacts (Shamsaei, Cheraghi, & Bashirian, 2015) define bur-

dens in objective and subjective categories where objective burdens are events or activities related to the adverse experience caregiver. In contrast, the subjective load is the feeling experienced by the caregiver while caring.

Based on the second theme, they are receiving trials from God, which is marked by a sincere attitude knowing to have a family with a mental disorder even though at first felt embarrassed to neighbors or people around. This research is in line with the results of research conducted by (Hayes et al., 2015) that families feel an increase in emotions, disturbances, boredom, and shame. Besides, the results of research conducted by Hayes et al. (2015), which states that caregivers who treat schizophrenic patients in Taiwan experience anxiety, shame, and sinful and disturbed while treating patients. Anxious emotions that appear as the most dominant emotion in supporting research are also in line with the emergence of angry emotions as the most dominant emotion felt by families in caring for post-pasung patients, which is also a further response to anxiety. Schulz (2007) characterization the relationship between religion and mental health in caregivers of patients with dementia. Four main findings emerge. First, religion is essential for most caregivers. Second, divine presence, prayer, and beliefs are associated with reducing depression in active caregivers. Third, the frequency of attendance of religious services increases in the grieving sample, most likely due to the death of the caregiver being allowed to re-engage in social activities. Moreover, fourthly, increased attendance is also associated with sadness, which is not too complicated apart from changes in satisfaction with social support and social integration.

Then based on a third theme is community stigma to people with mental disorders such as stating that people with mental disorders have bad causes before they are affected by mental disorders. This is in line with the results of the study (Grover et al., 2017) states that stigma among patients with severe mental disorders is associated with demographic variables such as being female, single, outside the materialized education, unemployment, nuclear family formation, rural locality, and middle socioeconomic status or on.

Furthermore, based on theme 4 is community expectations for people with mental disorders who get good care or treatment for the healing of sufferers. The results of this study are in line with previous research by Purnama (2016) that the reason people are worried about accessing health services is the lack of facilities and infrastructure as well as the dis-

tance between residents' homes and health care centers. Difficulties in accessing health services are also an obstacle for the community or families with family members who experience health problems. This problem will no doubt be one factor that can reduce the interest and willingness of families who have family members with mental problems to be able to go to the health care center regularly. So it is expected to improve health facilities for patients with mental disorders.

Furthermore, the last is the fifth theme about community acceptance of mental disorders that can be seen about the attitudes of the closest people from mental disorders patients. The results of this study are in line with previous studies (Menear et al., 2019) collaborative mental health care has emerged as the dominant model of team-based care for general mental protection for primary care. Patient and family issues must be considered as a core component of this model that contributes to centralized patient and family care. Indeed, for collaborative care to be truly patient-centered, patients must consider as an agreeing and autonomous partner in care and receive timely access to information that is useful, supportive, and encouraging to be an active participant in care planning, decision making, and independence care. Collaborative care must also be family-centered, recognizing families can be important allies in the care of their loved ones and, together with patients, important members of the collaborative care team.

These findings underscore the fact that efforts to improve mental health can facilitate a number of supporting factors such as family, the environment, community leaders and health workers

Limitations

The study is limited by its small sample size and a homogenous sample. The limitation on taking participants is that the researcher only looks at the family perspective, the researcher does not see his family type, the researcher does not look at the family's economic background in detail, and the researcher does not see the stage of his family's development.

CONCLUSION

This research produced fifth themes, there is: (a) Family efforts to seek healing; (b) Receive trials from God; (c) Community stigma to people with mental disorders; (d) Community expectations for people with mental disorders; (e) Community acceptance of people with mental disorders.

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