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The Prior-to-isolation Psychosocial Experiences of COVID-19 Diagnosed Patients: An Interpretive Phenomenological Analysis

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Abstract

Background: Changes that occurred during COVID-19 pandemic have caused people to have various responses when receiving a diagnosis of COVID-19; among others are stigma in society, lack of knowledge, various social media news that affect people's beliefs, and mental health during the pandemic.
Purpose: The purpose of this study was to explore the psychosocial experiences of patients before and when they were first diagnosed with COVID-19.
Methods: Using a phenomenological approach, we involved 19 COVID-19 survivors who were medically diagnosed and confirmed positive for COVID-19 in the first 6 months of the pandemic entering Indonesia, located in Madiun Regency, East Java Province, Indonesia. We conducted face-to-face semi-structured interviews with health protocols and analyzed using the 6-step of Interpretative Phenomenological Analysis (IPA) method.
Results: Three themed-findings illustrate patients' psychosocial experiences before being diagnosed: 1) cooperative behavior during the pandemic (with sub themes: recognizing symptoms and looking for medical help); 2) Navigating feelings when first received a diagnosis (with sub themes: being worried about the diagnosis, suspecting infection based on exposure history, and acknowledging the existence of COVID-19); and 3) Early psychosocial responses (with sub-themes: psychological response, cognitive response, behavioral response, family responses, and social response).
Conclusion: Exploring the experiences of patients with confirmed COVID-19 before and undergoing the isolation period can provide opportunities to improve the quality of physical and psychological services starting from prevention and assistance when receiving a diagnosis so as not to experience a worsening of the condition during treatment. Recommendations are for further study about COVID-19 survivors among children and adolescents who have been treated in the intensive care unit.

Keywords: COVID-19; first time; patient; phenomenology; psychosocial

Introduction

Corona Virus Disease-19 (COVID-19) has caused a global health crisis since 2019. Until January 2021, the spread of COVID-19 occurred in 223 countries in the world including Indonesia (WHO, 2020). Indonesia experienced an increase in COVID-19 cases, or what is known as the first wave, from January to March 2021 (Joyosemito & Nasir, 2021). This disease spreads quickly so that it has an impact on physical, psychological, economic, and social health (Hossain et al., 2020). People experience disturbances in sleep patterns,

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eating patterns, decreased immune systems, and worsening of comorbid diseases (CDC, 2020; Deng & Peng, 2020). The community's inability to cope with symptoms and changing conditions during the pandemic causes anxiety (Arora, Jha, Alat, & Das, 2020), fear, panic, paranoia (Dubey et al., 2020), stigma (Ying et al., 2020), restlessness, depression (Loades et al., 2020) and anxiety (Hyland et al., 2020). The pandemic changes social life in society such as social restrictions (Dubey et al., 2020), closure of schools or public facilities (Loades et al., 2020), social isolation and loneliness (Krishnamoorthy, Nagarajan, Saya, & Menon, 2020). People also experience negative behavior changes such as hoarding of necessities and negative stigma toward someone diagnosed with COVID-19 (Dubey et al., 2020). The opposite situation is a change in preventive behavior, and filtering information from various social media (Shiina et al., 2020). The COVID-19 pandemic has impacted various aspects of people's lives and caused behavioral changes in everyday life.

People diagnosed with COVID-19 are declared based on positive Real Time Polymerase Chain Reaction (RT-PCR) test results so that therapy will be carried out according to the protocol (Ministry of Health of the Republic of Indonesia, 2020). Treatment of COVID-19 patients is carried out in isolation according to their physical condition (Regulation of the Minister of Health of the Republic of Indonesia, 2020). Physical and psychological care for patients in isolation rooms is carried out by nurses in collaboration with other medical teams and they cannot meet with families directly (Djalante et al., 2020). The findings reported in the community are high stigma toward confirmed positive patients (Ying et al., 2020). The unequal level of public education affects the level of trust in COVID-19 and its prevention (Mohamed, Solehan, Mohd Rani, Ithnin, & Isahak, 2021). Public distrust is also affected because the news in the media is not true and filtered properly (Melki et al., 2021). Changes that occurred during this pandemic caused people to have various responses when receiving a diagnosis of COVID-19. Existing research has not discussed the meaning of psychological, social, and behavioral experiences in society when first diagnosed with COVID-19. Therefore, exploring the meaning of psychosocial becomes very important to overcome the psychosocial problems experienced by patients when they are first confirmed positive for COVID-19. The results of the study are also expected to improve nursing services ranging from prevention to the community to assisting when confirmed. Thus, the purpose of this article is to explore the psychosocial experience of patients when they were first diagnosed with COVID-19 before undergoing isolation and to conceptualize the experience using Interpretive Phenomenological Analysis.

Materials and Methods

Design

The study employed a qualitative paradigm to explore the experiences of COVID-19 patients when they first received a diagnosis before undergoing isolation. In so doing, in this study, data analysis was carried out using the approach by Smith and Shinebourne (2012) with the method of Interpretative Phenomenological Analysis. Interpretive phenomenology emphasizes giving meaning to a phenomenon that is not only described but also interpreted by the researchers (Creswell, 2012; Polit & Beck, 2014).

Participant and Setting

Participants in this study were patients with confirmed COVID-19. The sampling technique used was purposive to ensure that the participants met the predetermined criteria. The number of participants until saturation was reached is 19. All participants had undergone isolation at home and had recovered, and were not experiencing severe physical or mental illness. Patients were diagnosed with COVID-19 in the first 6 months of the pandemic entering Indonesia. Participants can communicate well and do not take psycho pharmaceuticals. Information on prospective participants was obtained from the clinic center database. Prior to collecting the data, the study was approved by the National and Political Unity Agency number 072/135/402.301/2021, Madiun District Health Office, and primary health center. This study is situated in Madiun Regency, The Province of East Java, Indonesia, within four primary health centers with the highest COVID-19 incidence. Table 1 showcases participants' demographic information.

Ethical consideration

This study has obtained ethical clearance from the research ethics committee of Universitas Brawijaya (No. 97/EC/KEPK-S2/03/2021).

Data Collection

After the participants agreed with the explained consents, in-depth interviews were then carried out. The interview aimed to get an overview of the participants' experiences before being diagnosed until they first received a diagnosis of COVID-19. The results of the depth of the interview are in accordance with the ability and experience of the researchers in developing questions for participants. Researchers used recording devices and field notes in addition to using Personal Protective Equipment (PPE) in the form of N95 masks, gloves, and gowns. All recording devices and notes were used to record all information during the interview (Creswell, 2012). PPE was used as the data collection process was carried out in a face-to-face setting.

Table 1. Participants' Demographic Data

Code	Age	Gender	Education	Work
P1	67	Man	High School	Unemployed
P2	39	Woman	High School	Entrepreneur
P3	55	Woman	Undergraduate	Teacher
P4	48	Man	High School	Village apparatus
P5	39	Woman	Diploma	Private sector employee
P6	27	Man	Diploma	Nurse
P7	32	Woman	Undergraduate	Nurse
P8	56	Man	High School	workshop
P9	70	Man	High School	Unemployed
P10	41	Man	Undergraduate	Bank employee
P11	53	Woman	Undergraduate	Civil servant
P12	35	Woman	Undergraduate	Bank employees
P13	31	Woman	Undergraduate	Nurse
P14	38	Woman	Master's	Civil servant
P15	47	Man	High School	Indonesian National Military
P16	40	Man	High School	Indonesian National Military
P17	34	Man	High School	Health center employee
P18	61	Man	Undergraduate	Unemployed
P19	46	Woman	Undergraduate	Employee

Table 2. Theme's Distribution

Themes	Sub themes
Cooperative behavior during a pandemic	Recognizing symptoms
	Looking for medical help
Navigating feelings when first received a diagnosis	Worried about the diagnosis
	Suspecting infection based on exposure history
	Acknowledging the existence of COVID-19
Early psychosocial responses	Psychological response
	Cognitive response
	Behavioral response
	Family response
	Social environment response

Data Analysis

Data analysis uses the approach by Smith and Shinebourne (Smith & Shinebourne, 2012) with the Interpretative Phenomenological Analysis method based on collecting data from verbatim transcription. The researcher read and re-read the transcript of the in-depth interview. Next, initial noting was done by looking for meaningful or interesting texts to produce comprehensive and detailed notes and comments about the data. Then, developing an emergent theme started from looking for keywords and then categorizing them into sub-themes and themes, which were written in tabular forms. Multiple readings were conducted in order to document initial coding from the data. When an emerging theme was obtained, we determined the categories for the themes. Afterward, we searched for connection in cross-emergent themes, moving to the next cases and looking for patterns across cases. In such a step, we interpreted the themes to explain the participants' psychological experiences. In this explanation, we employed narratives in order to plot structured voices shared by the participants. Trustworthiness is one way researchers can persuade that their data from qualitative research findings are accurate and worthy of attention (Forero et al., 2018; Nowell, Norris, White, & Moules, 2017). Trustworthiness of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2014). Trustworthiness in this study was obtained by adopting four criteria,

including credibility, dependability, confirmability, and transferability which were later applied in this study systematically. Credibility was carried out by researchers by visiting COVID-19 survivors in 2-3 meetings each to conduct direct interviews and validate verbatim results. Researchers cannot make observations because the process experienced by participants has passed. Dependability was carried out by researchers with prepared detailed drafts of the study protocol throughout the study and they developed a detailed track record of the data collection process. Confirmability was carried out by researchers with implemented reflexive journals and investigators' meetings to discuss about data results. We applied triangulation techniques (data source and theoretical). Transferability was carried out by researchers explaining this study used a purposive sampling technique and quantified data saturation. Researchers made the final report of this research in detail, systematic and reliable.

Results

Participants in this study were COVID-19 patients who had recovered and had undergone isolation in a referral or emergency hospital. The number of participants in this study consisted of 19 COVID-19 patients who had recovered and had undergone isolation and were willing to conduct in-depth interviews. Participants have an age range of 27 to 70 years. Nine participants were female and ten participants were male. Most of the participants had a diploma to a bachelor's degree. Three participants worked as nurses, two participants did not work and 14 other participants worked as employees in the private sector and the government. The participant demographic data are described in Table 1.

Findings from the study were detailed into three themes: 1) cooperative behavior during the pandemic; 2) navigating feelings when first received a diagnosis; and 3) psychosocial responses that appear early. Table 2 showcases the distribution of theme findings consisting of superordinate and subordinate themes. The first themes composed of sub-theme recognizing symptoms and looking for medical help. Recognizing symptoms from categories was such as identifying the appearance of one or more symptoms before being diagnosed. Looking for medical help from categories was such as looking for traditional medicine and medical service help to treat symptoms. The second theme composed of sub-themes such as being worried about the diagnosis, suspecting infection based on exposure history, and acknowledging the presence of COVID-19. Being worried about the diagnosis from categories was such as doubts about the results of the diagnosis and not believing in the symptoms felt. Suspecting infection was based on exposure history from categories such as travel history, close contact with exposed family or friends and close contact with COVID-19 patients at work. Acknowledging the presence of COVID-19 from categories was such as knowing the process of transmitting COVID-19, knowing the cause of the patient's death and believing that COVID-19 is true. The third theme composed of sub-themes such as psychological responses, cognitive responses, behavioral responses, family responses, and social environmental responses. Psychological responses were from categories such as stress, shock, confusion, worry, disbelief and depression. Cognitive responses were from categories such as positive thinking and blaming others. The sub-theme behavioral responses was from categories such as try to relax, go to the hospital, self-isolate, contact the closest people. Family responses were from categories ranging from sadness, shock, fear, and blame to use by providing support. Social environmental responses were from categories such as feared and shunned, looks weird, denies, ignores, giving a support.

Theme 1: Cooperative behavior during the pandemic

This theme the participant has a cooperative behavior during the pandemic means the participant being alert to the effect of the pandemic such as recognizing symptoms and looking for medical help.

Recognizing symptoms

Based on this theme, participants expressed cooperative behavior toward prevention before being diagnosed with COVID-19. The cooperative behavior carried out includes being alert by recognizing the symptoms that appear then being alert to seek health help before being diagnosed with COVID-19. The following are excerpts from participants that describe cooperative behavior in the form of being alert to the symptoms that appear:

"Yes, actually the symptoms are only cold, the first one doesn't want to eat and then cold sweat comes out, then after that, the body doesn't feel good" (P1)

"Then on Friday, the sense of smell went away, the head was dizzy, breathless, choking, couldn't sleep, Miss, Saturday morning, the feeling was getting worse, the taste was getting worse, I was getting dizzy" (P5)

Looking for medical help

The behavior of participants on standby to seek medical help to overcome the symptoms they feel is illustrated in the following quote:

"Ask the chaplain, you're smart, Ms we're not the original sick.., I'm feeling bad, I'm just sending it, I'm not happy with you, so it's very illness. Yes, there are those who send them because they don't like it so it hurts like that... well, it's true that this is the one who blames the poor people, the goods come to visit... yes, maybe there is a use for someone else… Yes, finally I prayed a lot, then was given prayers too" (P4)

"Even on Thursday, Mrs. P, I'm afraid that I don't want to check directly, I was told tomorrow to

go to the clinic, then the clinic was advised... Even the clinic was afraid, didn't you hold it too, didn't you... just asked, where did that come from, then On Thursday, it is recommended that the swab be referred to the hospital C, on Friday the swab, right, I asked Ms" (P2)

Theme 2: Navigating feelings when first receiving a diagnosis

This theme finding was because of the participants, when first confirmed COVID-19, feeling worried about the diagnosis, suspecting infection based on exposure history, and acknowledging the presence of COVID-19.

Worried about the diagnosis

Based on this theme, participants revealed that, after being diagnosed with COVID-19, they first experienced bargaining, namely feeling hesitant when receiving a diagnosis, then having suspicions about history of transmission to admit that COVID-19 is indeed true. Worrying about the diagnosis is illustrated in the following excerpts from participant interviews:

"Yes, if I think about it, yes, believe it or not, my pain is not COVID-19, Ms. I was sick at the beginning, it was just a little stomach, Ms. It's like that, Ms, yes, for treatment, we will recover, thank God, that's the proof" (P10)

"Hey, I can't believe it, when I was sick, I was crushed it seems the common cold, I lost my sense of smell but I kept quiet about it, I was afraid that my friends would think of it as COVID, so I don't think of it as a common cold, right sometimes if we have the flu, it's clogged, right? Never mind" (P12)

Suspects infection based on exposure history

Participants revealed that they suspected that they were confirmed positive for COVID-19 due to exposure from other people or travel from epidemic areas. Participants guessed based on the history of exposure as illustrated in the following quotes:

"But I have an indication that I have a stomach, because that's what my stomach is... it's reoccurring... that's where I met a lot of people... then I went home and I checked it right" (P3)

"Actually, since this pandemic, I have been asked by the office to pick up and pick up COVID-19 patients and send them to D and continue to pick up those who are declared cured while on the road, maybe because of that, where did I come from, I don't want to know" (P17).

Acknowledging the existence of COVID-19

Participants acknowledged that COVID-19 existed based on the information and experience they had obtained. Participants still believe that COVID-19 exists even though they still do not believe that they have been diagnosed with COVID-19. The following are excerpts from participant interviews:

"Yes, I believe in COVID-19, it's said that sometimes in schools there are lectures, they say that COVID-19 can be transmitted through the air" (P11)

"There is an original that there is COVID-19 but I believe that because of the loss of smell, it's true that if you lose your sense of smell and your body is half dead, you know, right from there, I came out asking, Mrs. Your husband died yesterday? Yes Sir. What's his complaint? When he get home, his body is half hot and then it's taken to the hospital, how come COVID-19" (P4)

Theme 3: Early psychosocial responses

The theme early psychosocial responses composed of meaningful participant answers about psychological responses, cognitive responses, behavioral responses, family responses, and social environment responses when confirmed COVID-19 positive.

Psychological responses

Based on this theme, participants revealed that, after receiving a confirmed diagnosis, they had felt changes in their psychological condition, thoughts, behavior, family and social environment even though the isolation period had not yet started. Participants said that they felt psychological changes such as stress, shock and fear during the time they tested positive for COVID-19. The following are excerpts from participant interviews:

"It so… stress, stress is really stressful, where is the stress, I don't know how, I don't know. All this time I'm also not going anywhere" (P1)

"Yes, his mind is messed up, we're going nowhere, I'll do it later, I'll think there, why, why, on social media on television, the news is like this, the direction stays that way" (P18)

Cognitive responses

Participants said that, when they tested positive for COVID-19 for the first time, they started thinking about blaming other people so they tried to realize and think positively about the conditions they were currently experiencing. This statement is illustrated in the following quotes:

"My husband is still holding my cell phone. I thought that at that time I was positive, yes, it's okay, it's okay, it's okay, I really have to be destined to accompany my father here, the important thing is that I don't have any symptoms, God willing, I'm safe" (P7)

"Stress stressful my head is dizzy… ooohhh crying loudly, blame she, he, and another one until you blame my boss why I was moved to this part why? I was given this task to go to groceries; It used to be impossible to get hit on a computer… I said so… it's a pity" (P5)

Behavioral responses

Participants said that, after being tested positive, they immediately took actions they could do for themselves and their families regarding their

current condition. This statement is illustrated in the following quotes:

"After I was positive, I immediately went home with self-isolation in my room, this is also my own initiative to keep this virus from spreading to others, because there are old people at home" (P3)

"When the environment was hit, it was certain to stay away from it, but I also didn't cover it up, so when I confirmed I told the neighbors of the head of the Neighborhood to stay at home for isolation, asking residents not to visit our house because we are in isolation at home. So yes, for the neighbors, please accept the news well" (P13).

Family responses

Participants when confirmed positive for the first time received different responses from their families, ranging from sadness, shock, fear, and blame to use by providing support. This statement is illustrated in the following quotes:

"But if my family panics and cries, especially my brother and the children, that makes me even more worried" (P19)

"Your family is blaming me…. I mean, how come because of you, how come you can't go out in the end, you own this business, so you can't sell it, you can't do it" (P12)

Social environment responses

Participants said they received various different responses such as being feared and shunned from society when they were first diagnosed with COVID-19. This statement is illustrated in the following quotes:

"If you know, it's okay, madam, if you don't know, you're confused, confused like this, someone said how come the situation here seems to be worrying about this... so neighbors already know, right, so they just walk away on their own, basically no one comes close" (P17)

"This environment, yes, ma'am, the name is ordinary people, yes, it's so excited that it's okay, until it's shared in the village and then everyone knows… I'm okay, I'm not really okay, it's true, sickness, it's okay, it's not a disgrace, isn't it?" (P9)

Discussion

Individual awareness in recognizing early symptoms when sick is one focus of behavior seeking health help (Saah, Amu, Seidu, & Bain, 2021). The behavior of seeking medical help in a developing country like Indonesia varies from doing nothing, self-medicating, seeking treatment from traditional services and seeking treatment from professional services (Siswanto, 2018). This is influenced by various factors, one of which is knowledge in understanding the disease and the signs and symptoms that appear. Result of the study found 11 participants had undergraduate education and other high school, thus this correlated with their behavior on standby to seek medical help to overcome the symptoms. Someone who has a level of knowledge and understanding regarding COVID-19 will be more alert to changes in their physical condition during a pandemic (Saah et al., 2021). This knowledge affects how patients behave in seeking health behavior (Saah et al., 2021). Other factors which influenced the participants' health-seeking behaviors are health status changes, financial or socioeconomic, a desire to live, socio-cultural, structural environment and health system (Musinguzi et al., 2018; Ogunkorode et al., 2021). There were medical teams participating in this study who had more knowledge and understanding regarding the disease and its management so that the attitudes and behavior when confirmed would be different from the general public. So, when someone knows the concept of disease and knows what signs and symptoms might appear, they will be more alert when there is a change in their health condition.

Most people have the severity of the disease ranging from asymptomatic, mild, moderate and severe symptoms (Esakandari et al., 2020). COVID-19 not only affects the respiratory tract resulting in pneumonia, but can also affect the gastrointestinal, neurological, or cardiovascular systems (Tali et al., 2021). The better a person's perception and level of knowledge in recognizing the symptoms of COVID-19 can speed up the medical treatment process and prevent wider transmission. Society gets information about COVID-19 but has a different perception or does not believe. Based on the study some participants had not believed, so they searched for information in the non-medical service. Thus, this condition causes changes in compliance behavior so that an increase in cases occurs. The increase in cases can be suppressed if the society has the knowledge to be able to prevent, has the right attitude and follows the procedures for handling COVID-19 when symptoms appear (Bhagavathula, Aldhaleei, Rahmani, Mahabadi, & Bandari, 2020; Tali et al., 2021). Collaboration between the community, health workers, and the government is needed to increase knowledge, change beliefs and behavior in recognizing symptoms to follow COVID-19 management procedures.

The behavior of seeking health help increases during the pandemic, people are more active in seeking information and carrying out activities to maintain health. A person who already has a risk of frequent visits to health services increases alertness by conducting regular check-ups (Abdulkareem, Augustijn, Filatova, Musial, & Mustafa, 2020). On the contrary, people choose traditional medicine to prevent COVID-19 because it is believed to be a natural treatment and easy to do independently (Subagyo & Irwansyah, 2021). Based on the result this study, participants choose health seeking behavior in the religious leaders and non-medical service. Participants also use herbal remedies to reduce symptoms and help the healing process from COVID-19. In another study, people use traditional medicine, reflecting various cultural beliefs in

the community and believe that natural herbal materials are less harmful and more effective than conventional medicine (Hasan, Stanmore, & Todd, 2021). Some people who believe in COVID-19 and recognize the signs and symptoms choose to seek medical help from relatives, medical personnel in the community or pharmacies instead of going to a hospital or laboratory (Saah et al., 2021). The community tries to stay healthy by conducting examinations to seek clarity about their condition, hoping for appropriate treatment and care. People who work as a medical team will be more responsive and looking for professional health services. This is different from the general public who choose to try to self-medicate, use traditional medicine and go to professional health services after the condition does not recover.

Results of this study show participants do not believe and doubt COVID-19, because in the beginning stomach illness is the same with common cold. In another research, patients feel doubtful about the diagnosis results based on RT-PCR test, resulting in feelings of rejection and fear (Sun et al., 2021). Initial rejection in COVID-19 patients is the same as in Ebola patients (James, Wardle, Steel, & Adams, 2019). Based on the result of this study, participants are stressful, mind is messed up, blame others, are worried and self-isolate. Self-isolation is because neighbors stay away from and stigmatize COVID-19 patients. The initial attitude of the patient after being diagnosed with COVID-19 is fear, denial and strong stigma from the community (Sun et al., 2021). Feelings of doubt that arise in patients because they do not get an explanation are related to the examination. Some of the participants when experiencing symptoms did a rapid test with a negative result and when it was validated with a swab, it became positive. This makes the patient doubtful about the diagnosis received. The high social stigma and danger of this disease can cause death, making feelings of denial appear as an initial response when receiving a diagnosis.

Individuals who have a history of exposure from epidemic areas express fear when showing clinical symptoms such as cough with fever (Asmundson & Taylor, 2020). Living with family members carrying SARS-CoV-2 in the home environment and interacting together for a long time causes a higher risk of exposure to COVID-19 infection (Chen, Wang, Zhu, & Hu, 2020). History of exposure to COVID-19 can also occur in health workers who have a high risk; until now many health workers have been exposed to death (Iswanti, Ilmi, & Syafwani, 2021). Individuals who have vigilance, are able to recognize symptoms, and have good knowledge so they can guess the origin of a history of exposure to COVID-19. Another thing that can happen is when individuals do not know the history of exposure because they feel they have complied with health protocols but have a lot of activities outside the home.

The level of trust and knowledge of COVID-19 is related to the response and the impact felt by the patient (Sembiring & Meo, 2020). Patients with a good level of knowledge are more ready to accept a diagnosis, while patients who have low confidence have a negative psychological impact (Alkhamees, Alrashed, Alzunaydi, Almohimeed, & Aljohani, 2020). People need to have proper knowledge about this disease so as to be able to have attitudes and follow the right practices to prevent transmission (Nwagbara et al., 2021). Knowledge, belief, attitude and behavior are interrelated. This is because knowledge forms one's beliefs and then becomes the basis for determining behavior and making decisions, including belief in COVID-19.

Someone who gets a stressor can manifest an assessment mechanism for the stressor, which includes cognitive, affective, physiological, behavioral and social (Stuart, Keliat, & Pasaribu, 2016). The pandemic impacts the mental health of the global population and causes negative psychosocial effects, which can lead to a psychological crisis (Wu, Chen, & Chan, 2020). Psychological responses that appear when a patient receives a confirmed diagnosis of COVID-19 for the first time are feelings of anxiety, panic, paranoia, depression, fear of death, frustration (Brooks et al., 2020), stress, anxiety, and sleep disturbances (Liu et al., 2020; Wei et al., 2020), aggressive and delusional behavior (Xie et al., 2020), guilt, fear of transmission (Ibáñez-Vizoso, Alberdi-Páramo, & Díaz-Marsá, 2020) as well as anger (Sun et al., 2021).

At first receiving the diagnosis, the patient will feel a psychological burden that becomes a burden during isolation. These feelings can encourage the patient to take both positive and negative actions. Psychological and behavioral responses by patients are influenced by social responses, namely from family and society. The response of family, work friends, and community environment affects the patient's coping ability to deal with the burden felt after being diagnosed. The amount of support can reduce the patient's burden and increase readiness to undergo a period of isolation. The opposite happens when the patient does not have a good source of coping when he gets a stressor, which can cause psychological disorders. Therefore, psychological assistance is needed starting from the initial diagnosis until the patient returns to the community.

Limitations

Although our study has shared findings from a phenomenological interpretation, some limitations may exist. First, the study did not exclude patients who have jobs as medical personnel as they may have different views and readiness from the community when facing receiving a diagnosis. Second, the study did not cover all patients throughout the first or second wave of the pandemic. Lastly, since the study recruited a small number of participants, its results cannot be generalized to wider people in the region.

Conclusion

This study reveals that the participants encountered multiple psychosocial responses and conditions when they were first diagnosed with COVID-19. The focal participants in the study have tried to implement a pattern of behavior that is in accordance with what the government has conveyed during the pandemic. Efforts are being made in the forms of being alert to the symptoms that appear and trying to seek health help when experiencing changes in conditions that lead to signs of COVID-19 symptoms. This shows the need to improve preventive behavior and adherence to the application of health protocols in new normal conditions. Participants also experienced bargaining or felt doubts when receiving a diagnosis. Participants were worried when they were confirmed for COVID-19 for the first time and had suspicions about a history of transmission. Transmission can come from traveling from a pandemic area or close contact with a confirmed patient. COVID-19, which is caused by a virus that cannot be seen directly by the eyes, with rapid transmission and can cause death, makes people feel rejected when they experience it. Participants feel confident in the existence of COVID-19 but do not believe if they are confirmed positive until repeated diagnostic examinations and information from medical personnel can convince the patient. Feelings and thoughts of not accepting this condition can worsen the patient's psychological condition, which can hinder the physical healing process during isolation. Thus, the importance of psychosocial health interventions ranging from prevention to assistance before undergoing isolation.

Declaration of conflict of interest

The authors declare that there is no conflict of interest.

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”Protect Me”: An Intervention to Overcome and Prevent Domestic Violence in Adolescent Pregnancy

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Abstract

Background: Some pregnant adolescents experience violence that has a negative impact for the pregnant adolescent itself and also their babies. It is necessary to make a health promotion intervention as an effort to prevent and control violence against pregnant adolescents.
Purpose: This research aimed to analyse the influence of the health education about domestic violence named “Protect Me” on knowledge, self-efficacy, and help-seeking behavior again violence among adolescent with pregnancy.
Methods: There were 37 participants of pregnant adolescents involved in violence screening. Based on the screening results, 30 participants experienced violence and agreed to involve in this research. Research with pre-experimental study design using a total sampling of 30 pregnant adolescents experiencing domestic violence from April to June 2020.
Results: The results showed that 6.7% of pregnant adolescents experienced psychological, physical and economic violence and 13.3% pregnant adolescents experienced sexual violence. There was a significant difference between the level of knowledge ($p < 0.001$) and help-seeking behavior ($p = 0.002$) of pregnant adolescents after being given “Protect Me” intervention and Self-efficacy has no relation with Protect Me intervention ($p = 0.186$)
Conclusion: The results of the research concluded that the domestic violence prevention and management efforts could be carried out by applying education based intervention “Protect Me”, to improve the knowledge and help-seeking behavior of pregnant adolescents.

Keywords: adolescents; help seeking behavior; knowledge; self-efficacy; violence

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Introduction

Maternal mortality that occurs in pregnant adolescent population is 40% (Koroma, 2013). Adolescents aged 10-19 years have more risk of having preeclampsia, cervix inflammation, and systemic infections compared to those aged 20-24 years (Kiani, Ghazanfarpour, & Saeidi, 2019; Koroma, 2013). Globally, complications of pregnancy and childbirth are the main cause of teenage girl mortality aged 15 to 19 years (World Health Organization, 2019). Psychological problems could lead to maternal mortality in pregnant adolescents, while stress due to role transition into motherhood, not being ready for pregnancy, lack of support from closest people, and violence, lead to depression and suicidal behavior in pregnant adolescents (Palladino, Singh, Campbell, Flynn, & Gold, 2011; Wilson-Mitchell, Bennett, & Stennett, 2014).

Violence is one of the causes of mental disorders in pregnant women which can lead to suicidal behavior and is one of the causes of maternal mortality (Quintanilla, Pollock, McDonald, & Taft, 2018; Storm et al., 2014; Véronique, Doris, Carine, Wendy, & Lale 2016; World Health Organization, 2019). Campo (2015) said that young women aged 18–24 years were more at risk of experiencing violence by a partner during pregnancy, and it became worse if violence had occurred before, compared to other adult women. Domestic

violence against pregnant adolescents includes physical, sexual, emotional, and verbal violence perpetrated by their partner. Research reported that 4% of pregnant adolescents experienced coercion in sexual intercourse, 5% experienced emotional and psychological violence in the form of threats, and 48% of pregnant adolescents experienced a blow to their abdomen during pregnancy by the father of the fetus (Santiago, Iñiguez, Solorzano, Burgos, & Monreal, 2014).

Violence suffered by pregnant adolescents has a negative impact on adolescents themselves and their babies. Therefore, it is necessary to do intervention to pregnant adolescents, including health promotion regarding violence, types of violence, perpetrators of violence, impact, control, and methods of prevention. This intervention aims to increase knowledge, self-efficacy about violence against women and help-seeking behavior in pregnant adolescents. High knowledge about violence and help-seeking behavior will increase individual self-efficacy so those who are at risk, have, or are currently experiencing violence are able to do help-seeking behavior. According to (Donatus, Sama, Tsoka-Gwegweni, & Cumber, 2018), this effort is important because pregnant adolescents have less knowledge about physical and sexual violence.

Materials and Methods

Design

The research used the quantitative research with pre-experimental design: one group pre-test-post-test.

Sample and setting

The research was carried out at all Health and Medical Centers in Depok District, West Java Province, Indonesia. Sampling in this research was the total sampling as of April to June 2020. The inclusion criteria of participants were defined as follows: (1) Pregnant adolescent aged < 20 years who have experienced or are experiencing violence; (2) Pregnant adolescents who can communicate, read and write; (3) Willing to be a participant; (4) Having telephone access. The exclusion criteria include: (1) Participant refuses to be involved in the research; (2) Participant who cannot be contacted by phone call; (3) Participant who has mental health problems. There were 37 participants involved in violence screening. Based on the screening results, 33 participants experienced violence and four people did not experience violence. There were three participants who experienced violence who withdrew from this research. So, a total 30 participants were involved in this research since the pre- and post-test.

Instruments

Pregnant adolescents were given a violence screening questionnaire as screening to become research participants. Violence screening uses a modified Abuse Assessment Screen (AAS) questionnaire by McFarlan, Parker, Soeken, and Bullock (2012) and the Center for Research & Education on Violence Against Women & Children (2020) consisting of 16 questions about violence of A physical, sexual, psychological or economic nature. The questionnaire has been tested for validity and reliability with a value of r count> 0.44.

The demographics questionnaire includes participants' age and gestational age using a numeric scale. Education background, occupation, marital status and family income used a nominal scale. Self-efficacy questionnaire used the modified general self-efficacy by Schwarzer and Jerusalem (1995) and Fitriana, Suryawati, and Zubaidah (2018). It consists of 10 questions which score of each question starting from 1 (disagree) to 4 (strongly agree) on positive questions and 1 (strongly agree) to 4 (disagree) on negative questions. The questionnaire has been tested for validity and reliability with a value of r count> 0.44.

Help-seeking behavior questionnaire was modified from (Center for research & education on violence against women & children, 2022) and consists of nine Yes or No questions. Categorization of help-seeking behavior is high and low with cutoff point pre- and post-test. The questionnaire has been tested for validity and reliability with a value of r count> 0.44.

Intervention

Participants involved completed a violence screening questionnaire. Subsequently, the pregnant adolescents in the violence screening were asked for consent to research involvement and the, completed the demographic data and pre-test questionnaires. The participants were then each given the "Protect Me" intervention for three telephone sessions by the research team with 20-30-minute duration for each meeting.

The first phone call consisted of four sessions, namely introduction, violence experience sharing, explanations by the research team with respect to violence including the definition, perpetrators, types, forms, impacts, and violence handling by using booklets as the media, teaching the participants to use monitoring sheets while at home, and continued with questions and answers at the end of the session. The second phone call was a review about the first phone call, sharing about their experiences at home, and self-monitoring evaluation. In the third phone call/online meeting, which was the last intervention, the participants carrying out self-monitoring evaluation were given a post-test questionnaire. This research was conducted for a total of 12 weeks.

Data collection and variable

In the preparation step, data collection procedure was started after obtaining ethical approval for the study and the research permit letter from the Faculty of Nursing, University of Indonesia. Then,

Table 1. Distribution of Violence Screening (n=37), Demographic Frequency Distribution and Frequency of Violence Type at District Health and Medical Centers in Depok in 2020 (n=30)

	Variables	n	%
Distribution of Violence Screening	Experiencing	33	89.2
	Not Experiencing	4	10.8
Age	16 years	2	6.7
	17 years	6	20
	18 years	5	16.7
	19 years	17	56.7
Gestational Age	1-13 week	5	16.6
	14-27 week	16	53.4
	28-40 week	9	30
Education	Elementary School	3	10
	Junior High School	12	40
	Senior High School	15	50
Occupation	Employed	1	3.3
	Unemployed	29	96.7
Marital Status	Married	30	100
Income	Low	21	70
	High	9	30
Psychological Violence	Experiencing	30	100
Physical Violence	Experiencing	2	6.7
	Not experiencing	28	93.3
Sexual Violence	Experiencing	4	13.3
	Not experiencing	26	86.7
Economic Violence	Experiencing	2	6.7
	Not experiencing	28	93.3

the researcher submitted the research permit letter to the Unity of Nations and Politics of Depok District, Health Department of Depok District and then to the Public Health Center (Pusat Kesehatan Masyarakat/ Puskesmas). After obtaining permission from the Public Health Center, the research team collected data of pregnant adolescents in the medical records in the Public Health Center. Then, the research team, assisted by officers of the Public Health Center, contacted pregnant adolescents for the introduction and approach process. The research team contacted pregnant teenagers to ask about the current condition of their pregnancy.

On the next day, the researcher contacted the pregnant teenagers to ask for permission to fill out the violence screening through an online questionnaire on their mobile phone. Researchers processed and analyzed the violence screening information that filled in by the pregnant adolescents. Pregnant adolescents who experienced violence were contacted again through phone call by researchers assisted by Public Health Center officers to ask permission to conduct research through a phone call. Then, the research team started to do intervention activities through phone calls to the pregnant adolescents who agreed to be research participants.

In the implementation step, data collection was carried out after participants agreed to be involved in the research. The involved participants filling out demographic data questionnaires and pre-test questionnaires; the research team then gave "Protect Me" intervention to participants in three phone call sessions with duration of 20-30 minutes for each session and the interval of each session was two days.

The first phone call session consisted of four sessions, namely introductions, sharing experiences about violence, explanations from the research team about violence, then followed by a discussion session at the end of the phone call session. In the second phone call session, the research team gave a review about the first session, sharing participants' experiences while at home, and self-monitoring evaluation. The third phone call session was the end of the intervention. Participants were evaluated for self-monitoring and then given a post-test questionnaire.

Data analysis

Bivariate analysis was conducted to determine the correlation between the independent variables and

Table 2. The Correlation between "Protect Me" Intervention and Knowledge, Self-Efficacy, and Help-seeking Behavior

Dependent Variables	Intervention				P Value
	Before		After		
	n	%	n	%	
Knowledge					
Low	15	50	7	23.3	< 0.001
Good	15	50	23	76.7	
Self-Efficacy					
Low	14	46.7	12	40	0.186
High	16	53.3	18	60	
Help-seeking behaviour					
Low	13	43.3	3	10	0.002
High	17	56.7	27	90	

dependent, as well as analyzing. In the bivariate analysis of the pre- and post-test dependent variables Wilcoxon statistical tests were used.

Ethical consideration

This research has obtained the approval of ethical study under number: SK-118/UN2.F12.D1.2.1/ETIK 2020 from Research Ethics Committee of Faculty of Nursing Science, Universitas Indonesia, Indonesia.

Results

Based on Table 1, violence screening showed that 33 respondents experienced violence (89.2%). We obtained a description that 100% of respondents experienced psychological violence, 6.7% experienced physical and economic violence and 13.3% experienced sexual violence.

Based on Table 2, there is a significant difference in knowledge of "Protect Me" to the knowledge of pregnant adolescents ($p < 0.001$). In the self-efficacy variable, it can be concluded that there is no significant difference in self-efficacy between before and after the intervention. The "Protect Me" intervention had no effect on the self-efficacy of pregnant adolescents ($p = 0.186$). In the help-seeking behavior variable, it can be concluded that there was a significant difference in help-seeking behavior between before and after the "Protect Me" intervention, where the "Protect Me" intervention has an effect on help-seeking behavior ($p = 0.002$).

Discussion

The results of this research indicated that "Protect Me" intervention affected the respondents' knowledge on violence. This was in line with research conducted by Taghdisi et al. (2014) stating that health education on violence was able to increase women's knowledge and awareness. The form of health education carried out in this study was by following-up the phone calls consisting of explanation, sharing, and question and answer sessions. The media used to provide health education interventions in this study was soft file booklets sent by an online message application. This was similar to the research conducted by Divakar et al. (2019) stating that digital health education such as smartphones, email, messages and applications had the potential to be effective learning tools in preventing violence. In addition, the research carried out by Djuwitaningsih and Setyowati (2017) which used application-based interactive educational media also showed that pregnant adolescents had a great interest in such applications; consequently, we could use such applications in the course of improving adolescents' knowledge.

Interventions and interactive media in the health education process affected the respondents' interest in reading. This is evidenced by the results of the pre-test and post-test research through knowledge questionnaires. Based on the results of the research, the average score of knowledge was higher after the intervention was given compared to the average score before the "Protect Me" intervention was given. They showed that the "Protect Me" intervention was effective in improving the knowledge of pregnant adolescents.

The results of this research indicated that "Protect Me" intervention did not affect the pregnant respondents' self-efficacy. This is contrary to the research conducted by Fitriana, Suryawati, and Zubaidah (2018) which showed that health education affected self-efficacy in preventing sexual violence. The research conducted by Setiawati, Setyowati, and Budiati (2017) which used "BE LOYAL" health education to increase self-efficacy in adolescent mothers also indicated that health education was effective in increasing the self-efficacy of adolescent mothers.

The result indicating that "Protect Me" intervention had no effect on self-efficacy of pregnant adolescents in this study was also contrary to the research conducted by Djuwitaningsih and Setyowati (2017) using application-based interactive educational media for adolescents. The results indicated that pregnant adolescents had a

great interest in these applications and that, as a consequence, using these applications, we could improve their knowledge and self-efficacy.

There was no change in self-efficacy in this research since the form of intervention was carried out only by phone. The telephone medium used was less attractive since it only involved voice and did not involve video or online applications. Therefore, the effort of nurses to increase pregnant adolescents' self-efficacy by verbal persuasion and physiologic arousal sources did not significantly affect the self-efficacy of pregnant adolescents, as shown by the results of this research. In fact, with respect to verbal persuasion and physiologic arousal points, nurses played an important role in increasing the self-efficacy of pregnant adolescents. This showed that interactive and attractive media were very supportive and affected the interventions given.

The results showed that the health education in the form of "Protect Me" intervention had an influence on the help-seeking behavior of pregnant adolescents. This was in line with the research conducted by (Pope & Tilghman, 2017) using the "CARE" educational intervention, which discussed information about violence and its prevention to improve women's help-seeking behavior.

The help-seeking behavior was successful when the individuals were aware that they were experiencing problems, namely they were able to ask other people or parties for help, and were able to express the problems they were facing (Bilican, 2013; Cornally & Mccarthy, 2011; O'Mahony & Hegarty, 2009). It could be achieved through promotional actions carried out by nurses by providing explanations or education about the concept of violence and how to handle it, just like what was carried out in this research. Consequently, by applying them the awareness of pregnant adolescents about violence, their confidence about their capacity to be free from violence, and their help-seeking behavior could be improved in accordance with the results of this research.

Conclusion

The "Protect Me" intervention is an education-based nursing intervention provided to pregnant adolescents to prevent violence. The results of this study indicated that the "Protect Me" intervention affected the knowledge about violence and help-seeking behavior of pregnant adolescents. Good knowledge and help-seeking behavior was able to improve the awareness and help-seeking behavior of pregnant adolescents experiencing violence.

Declaration of Interest

No potential conflict of interest was reported by the authors.

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The Indonesian survivors' perspective about recovery from schizophrenia: An exploratory study

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Abstract

Background: Recovering from schizophrenia is a unique process and is influenced by the cultural background of survivors.
Purpose: The purpose of this study is to describe the important aspects of the recovery process of Indonesian people living with schizophrenia.
Methods: This study used qualitative exploratory descriptive and data were collected through focus group discussion with seven participants at a Residents office on July 2018. Data were analysed using the theory of Braun and Clarke to identify key themes.
Results: Five themes arose from this study including becoming an agent of recovery, accepting yourself as you are, keeping a smile in all situations, seeking God's help as a way to get well, and ignoring by the government.
Conclusions: It was concluded that, in the process of recovery, survivors became agents of recovery, so patient-centred care becomes very important in providing nursing care to the survivors. The result of this research can be considered for community nurses in caring for schizophrenia survivors.

Keywords: qualitative; important aspects; recovery; survivor experience; schizophrenia

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Introduction

Recovery from mental illnesses, especially schizophrenia, is not only a process of returning to premorbid level of functioning and asymptomatic phase of the person's life (Jacob, 2015), rather, it is a long journey that is full of twists and turns and back and forth, sometimes healed, sometimes relapsing (Jacob, 2015; S Suryani, 2013). During the recovery process, individuals will face various challenges and obstacles due to their limitations as a result of the disease.

Recovery is a non-linear process and goes through different stages for each individual (Hancock, Smith-Merry, Jessup, Wayland, & Kokany, 2018). Through the recovery process, the individual will regain the ability to control his/her life, the ability to function socially, and feel more welcome in the family and in the community. Recovery is felt complete when they no longer need drugs and symptoms of the disease are minimal (Jose et al., 2015).

A qualitative study conducted by Wood, Price, Morrison, and Haddock (2010) on the concept of recovery in the perspective of patients found that the key to the success of the recovery process is the alleviation of symptoms and or negative emotions. Other important aspects are motivation, independence, individual coping and dangerous behaviour changes. Another study by Subandi (2015) found three steps of the recovery process according to his participants, including gaining insight; struggling to achieve recovery; and harmonious integration with family and community integration. In many Western countries such as England, Australia and the USA, the concept of recovery in people diagnosed with schizophrenia has been developed and implemented. As a result, many people with schizophrenia have recovered and played a role in the community. They are even becoming an expert by experience, such as the members of the Hearing Voices Network, an international organisation

of people with hearing voices. Recently, in Australia (at the Central Queensland University), there has been an innovation in implementing the concept of recovery, where psychiatric nurses played a key role to make it a reality (Happell et al., 2014). Recovery as a discipline of life experience has been developed to support the application of the recovery concept into services (Byrne, Happell, & Reid-Searl, 2015). In Asia, the concept of recovery has also been developed in several countries such as China, Singapore, the Philippines, Malaysia, Thailand and Indonesia. However, in Indonesia, the recovery concept is still not well-implemented due to a lack of support from the government and community.

The recovery process does not always run smoothly. There are several factors that can support and inhibit it. In general, it can be categorised into two factors, namely personal and environmental factors. Personal factors that support recovery in both Western and Eastern countries are self-acceptance (Hancock et al., 2018; Kaewprom, Curtis, & Deane, 2011) coping (Roosenschoon, Kamperman, Deen, Weeghel, & Mulder, 2019; Woods, Hart, & Spandler, 2022), and adherence to the treatment (Kaewprom et al., 2011). What's different is that in Eastern countries religious beliefs also support recovery (Dein, 2017; Subandi, 2015; Suryani Suryani, Welch, & Cox, 2013), while there are some personal inhibiting factors in both Western and Eastern countries, including severity symptoms (Kaewprom et al., 2011; Van Eck, Burger, Vellinga, Schirmbeck, & de Haan, 2018) and negative symptoms (Ventura et al., 2015).

Supporting factors from environmental aspects in both Western and Eastern countries are family and community, which provide for personal growth and developing resilience to stress (Jacob, 2015; Kaewprom et al., 2011; Naheed, Akter, Tabassum, Mawla, & Rahman, 1970),while the main supporting factors in Western countries are the quality of mental health services (Data, n.d.; Perkins & Slade, 2012). In contrast, the most common inhibiting factors in both Western and Eastern countries is stigma about mental illness (Andika, Syahputra, & Marniati, 2017; ANGERMEYER & SCHOMERUS, 2012; Avdibegović, E., & Hasanović, 2017; Vass et al., 2015). However, there is another factor that inhibits recovery in Eastern countries, that is the inadequacy of the available services caused by lack of political will and resources (Rathod et al., 2017).

Regarding the application of the concept of recovery in mental health nursing services, since 2013, we have conducted several studies such as life experiences of patients with schizophrenia, factors related to relapse of patients with schizophrenia, family experiences in caring for an individual with schizophrenia, family perceptions of schizophrenia and perceptions of clients, families, policymakers and community health staff about recovery. From these studies, we conclude that there are many factors associated with the recovery of schizophrenic patients, namely the individuals themselves, family, environment or community, policymakers and mental health services. So a comprehensive study is needed to find a recovery model in schizophrenia patients in Indonesia.

Our recent research "recovery model for Indonesian people with schizophrenia" aims to develop recovery models for individuals who experience schizophrenia in Indonesia. With regard to the recovery model development, several activities such as approaches to community health centres, community leaders and cadres have been carried out. Peer and family support groups have been formed. Counselling has been done several times to the community where this research was conducted. Workshops for family support groups have been carried out, and training for cadres has also been conducted. Furthermore, the person in charge of mental health programmes in community health centres and mental health cadres as well as the role of policymakers and community in supporting the recovery process of individuals with schizophrenia were evaluated through qualitative research. Evaluation of recovery processes experienced by survivors with schizophrenia has also been done.

Individuals who experienced schizophrenia have the opportunity to recover from their illness. Many survivors in several countries proved that they can recover from schizophrenia, although many also do not recover and often relapse. Therefore, understanding about what makes the survivor recover from schizophrenia and live more productively is needed. This study aims to describe the Indonesian survivors' perspective about recovery from schizophrenia. The findings of the study will add new knowledge about aspects related to the recovery process.

Methods

Design

This study used a qualitative exploratory descriptive to answer questions about experience of recovery from schizophrenia (Hammarberg, Kirkman, & de Lacey, 2016). The qualitative exploratory descriptive is considered appropriate as it allowed the researchers to gain a deep understanding of the experiences of survivors in the process of recovery.

Participants and Setting

A focus group discussion (FGD) was conducted to obtain information from participants, who were selected using a non-probability sampling technique with a purposive sampling method (Clarke, V., & Braun, 2013). Seven survivors who participated in the FGD were selected using purposive sampling technique. The inclusion criteria were as follows: survivors diagnosed with schizophrenia but have been declared stable by a mental specialist from the West Java Psychiatric Hospital, had no impaired cognitive function (measured using mental status assessments), have good insight (measured using the standard mental status examination), and can

communicate well and cooperatively. Participants were contacted in person by the lead researcher through the outpatient unit of the Melong Community Health Centre, South Cimahi, West Java, Indonesia. At the time, the participants were informed that they needed to be assessed by the attending psychiatrist to ensure that they met the inclusion and exclusion criteria for involvement in this study.

Ethical consideration

Ethical clearance was obtained from the Ethics Committee, Faculty of Medicine, Padjadjaran University, with number 627 / UN6. KEP / EC / 2018. Before starting the FGD, the researchers explained the study to all participants, and then they were asked to sign the consent form manually.

Data collection

Information was gathered through an FGD on 17 July 2018. Some people might find it difficult to express their feeling or opinions. Sometimes, it takes listening to the opinions of others in a small and safe group setting before they form thoughts and opinions. Focus Group Discussion as data collection methods and techniques in social research and as part of a participatory approach to identify the circumstances, needs, problems and potential development opportunities into the community and social capital in development, can reveal a wealth of detailed information and deep insight (Wilkinson, 2011). When well-executed, a focus group creates an accepting environment that puts participants at ease, allowing participants to thoughtfully answer questions in their own words and add meaning to their answers. The FGD was conducted for 1.5 hour, and all participants were able to express their experiences and opinions well. However, some needed a reiteration of the questions from the moderator. At the beginning of the FGD, the participants were no longer shy and hesitant after the facilitator encouraged them. In the last session of the FGD, the moderator summarised the results of the discussion for the participants to validate.

Data analysis

Data were analysed using the theory of Clarke and Braun (2013) to identify key themes. The first step was to familiarise the data. This was accomplished by transcribing the conversation, reading and re-reading the data, and then underlining the main point. This process gave the researcher a general sense of the participants' experiences. Then, the researcher commenced the process of identifying significant statements which captured the core elements of the participants' experiences. The next step was sharing the initial code. The researcher looked for common categories or themes across the entries for each question. We asked several people to participate in this process, including all researchers and some participants. After that, the researchers reviewed the theme to check whether it works in relation to extracting the code (stage one) and the entire data set (stage two) and then produced thematic maps of the analysis. Finally, the researchers defined and named the theme; in this stage, the researchers analysed each theme continuously for improvement and then made a report (Clarke, V., & Braun, 2013).

To maintain strictness in data analysis, bracketing was employed in the analysis process to understand the experiences of the participants as they truly were. The researchers reviewed each of the participants' significant statements and assigned meaning to each. This required the consideration of both the explicit and implicit meanings inherent in each statement. This involved two fundamental processes: intuiting (eidetic comprehension or accurate interpretation) and reflexivity (moving backwards and forward between the participants' statements to the initially formulated meanings

Figure 1. Five Themes in This Study

developed) until the researchers were satisfied that the formulated meanings were an accurate reflection of the intended meanings of the participants.

Results

The number of participants in this study was seven survivors diagnosed with schizophrenia: four men and three women. The level of education of survivors varied from primary, junior and senior high school. Four of the participants were not married and do not have a job. They lived with their parents. While three of them were married and have a part time jobs. The survivors' age ranges from 22 years old to 47 years old, and the average length of illness is between 10-15 years.

Becoming an Agent of Recovery

This theme means that the survivor is the person who plays the most important role in the recovery process. The survivor is the central point in his or her recovery instead of the therapist. This theme is confirmed by all participants in this study. All participants agreed that, to be able to recover from schizophrenia, they must be the one who takes the responsibility to recover. One of the participants stated, *'…my own responsibility, yes… I have to work and earn money. I have to help myself*'. Another participant stated, '*I have to recover from this illness… I have to be an agent recovery of myself'.* This theme is also supported by the statement of another participant, saying '*every survivor has a different experience in overcoming the pain and stress. They have their own way to recover… and… they have to be responsible for their own health'*.

Keep Smiling in All Situations

This theme was proposed by one participant who revealed that healing can be achieved by making yourself and others happy by smiling. Although not all participants (four participants) expressed this feeling, the researchers considered this theme as a very significant aspect in supporting the recovery process. A smile is the distinctive characteristic of the Indonesian culture, especially of the Sundanese people who always prioritise the importance of compassion by always smiling to everyone in every situation.

During the recovery process, the survivor felt that a smile possessed an extraordinary power. Smiles can make someone see the world more beautifully, and a sincere smile can melt a frozen relationship, encourage people who are desperate and create a bright atmosphere in an interpersonal relationship. Smiling can become a spirit of energy that makes survivors feel accepted by others around them. One participant said that healing can be obtained by making yourself and others happy with a smile, stating '*…your smile heals, if you see people smile, it feels pleasing, if you receive smiles from other people and we also have to smile'*.

Accepting Yourself as You Are

Almost all participants (six participants) in the FGD confirmed that 'accepting yourself as you are' is an important aspect in their recovery. A participant said that is how she was able to accept her condition. She said that having a strong commitment to not think about the past is a way of accepting your present condition. She stated, we '*…must accept ourselves as we are, with a strong commitment to recover. Do not think about the past'*.

Another participant also had the same way of accepting herself by not remembering the past and focusing on thinking about the future, saying *'… don't think about what you used to be… you have to see the future'*. Another participant added, '*… always introspect yourself… so you can understand about yourself and can rebuild yourself*'. Another participant said the same thing, stating *'…don't despair… be thankful for your life'*. Other participants found various ways of accepting themselves by thinking positively and having the spirit to recover.

Seeking God's Help as a Way to Get Well

This theme was approved by almost all participants (six participants) at the FGD. The survivors have almost the same way of recovering by seeking God's help. A participant shared how to be healed by always remembering God, stating *'… remember God continuously… pray to him'*. Another participant agreed and said that his healing was achieved by seeking the help of Allah and by always loving Allah, stating '*…love for Allah… so he will love you'*. Other participants have the same way of recovering, i.e., by participating in Islamic studies, along with the statement, '*…join the recitation… and… studying religion'*. From the statement of the participants above, it can be seen that the survivors' spiritual responses are shown by their effort of seeking God's help to heal in a variety of ways and prioritising God in every healing process.

Ignoring by the Government

This theme was approved by five participants. In this theme, the participants proposed various responses on how the government should support the recovery process. A participant stated, *'…we want support and attention from the government'.* The participant's opinion was supported by another participant who reminded the government not to underestimate people with mental illness, saying *'…the government should not look at us with one eye'*. Another participant also agreed to his friend's statement and stated that the government should not ignore people who have mental disorders, saying *'…the government should not ignore us'.* Another participant also had the same hope for the government, suggesting that there should be many recovery-based programmes for mental illnesses, saying '*…there must be many programmes from the government for us*'. From the statements above, it can be seen that survivors have great hopes for the government to provide recovery-based community

mental health services to support the healing process.

Discussion

Theme 1: Becoming an Agent of Recovery

In this study, almost all participants revealed that healing is the responsibility of the individuals themselves. A survivor is an agent of recovery, which means that the survivor should become the central point and should participate majorly in the recovery process. Recovery puts the individual as the agent of his/her own story, rather than as the recipient of clinical care (Woods et al., 2022). In this study, all participants confirmed that recovering from an illness is an individual's responsibility. This means that every survivor is responsible for his or her own recovery.

Through a long experience (10–15 years) participants finally found that he/she was responsible for his/her recovery. Even though they have a mental disorder they must be responsible for themselves. In Indonesian culture, a child will feel ashamed if he continues to depend on his/her parents. A child should take care of his parents when his parents are getting older, rather than burdening them. These findings supported those of Hancock et al. (2018) that, in the recovery process, which sometimes goes up and sometimes down, it is the survivors who are responsible for the process so that the sustainability of the recovery can be maintained.

Unfortunately, mental health services in Indonesia today are still medically-oriented, which places doctors as determinants of patient treatment (Suryani Suryani et al., 2013). Patients must adhere to whatever the doctor says, and other professionals also have little influence in treating patients. Everything is determined by the doctor. This situation will certainly affect the recovery process of survivors. Doctor-centred health services result in patients becoming dependent and, of course, never being able to fully recover.

Based on the description above, it is crucial to change the concept of providing services in Indonesia, from a medical-centred to person-centred orientation. Survivors should become the centre of their recovery. They are the origin of power or strength from within that drives, evokes, moves and controls them to achieve their recovery, which enables them to live productively.

Theme 2: Keeping a Smile in All Situations

Matsumoto and Juang (2016) proposed that emotion refers to a typical feeling and state of mind that prepare an individual to do something. New evidence suggests that positive emotions, particularly gratitude, may also play a role in motivating individuals to engage in positive behaviours leading to self-improvement. We propose and offer supportive evidence that expressing gratitude leads people to muster effort to improve themselves via increases in connectedness, elevation, humility, gratitude, happiness, positive emotions, self-improvement, and wellbeing. According to Armenta, Fritz, and Lyubomirsky (2017), positive emotions can encourage someone to behave positively so that they can improve their physical, mental and social health.

In this theme, the positive emotion that emerges is a smile that can provide happiness and healing. This statement was expressed by one participant who revealed that healing can be obtained happily by yourself and others with a smile. She stated, '…A smile can heal illnesses. You feel happy when you see someone smile to you, and we should be able to smile in every situation, be happy'.

Although not all participants expressed this feeling, the researchers considered this theme as important, as it is a new insight into this research because there were no previous studies that found and reported it. Moreover, keeping a smile is one of the characteristics of Indonesian people, especially the Sundanese people, who always promote 'welas asih' (compassion for others). The 'welas asih' has been the spirit of the Sundanese people's everyday lives.

Smiling when dealing with various conditions that occur in life is a part of the religious teachings in Indonesia. Facing problems with a smile indicates that individuals are patient and sincere in dealing with them. This is in line with the results of Fauziah, Suryani, and Hernawaty (2019) in which one of the themes found that families are patient and sincere in dealing with the stigma of mental disorders in the community against sufferers.

Theme 3: Accepting Yourself as You Are

In this theme, almost all participants revealed that 'accepting yourself as you are' is very important in the recovery process. Self-acceptance is very influential on how a person goes through life. If people can accept themselves, then they will not be afraid to see themselves honestly, because they cannot run away from themselves, no matter what they do. According to Bernard, Vernon, Terjesen, and Kurasaki (2013), self-acceptance as a positive character has been proposed in positive psychology as a strong character that is related to happiness and wellbeing.

Accepting yourself as you are is an important element of the recovery process as expressed by participants in this study and is the attitude taught by parents to their children since childhood. This attitude comes from Indonesian culture, which is rooted in Islamic teachings, stating that humans must be able to accept whatever happens in their lives as God's destiny (provision). This concept was also found in a previous study conducted by Rahmawati, Suryani, and Rafiyah (2017) in West Java, Indonesia, where one of the themes suggested the importance of self-acceptance in order to be motivated to recover. Similarly, Subandi (2015) in Central Java, also found the importance of self-acceptance to "Bangkit" (an Indonesian word meaning motivational force that

can exert a transformative effect on individuals faced with illness and seeking to recover) as an important theme in his study. Participants can "bangkit" from their condition or illness if they are able to accept themselves

Theme 4: Seeking God's Help as a Way to Get Well

In this study, all participants revealed that they sought help from God to overcome the pain. This theme was important for participants to raise, and it gives new insights for health professionals. In this study, one of the participants revealed that '… Tahajjud prayers and reading Quran can help my healing process'.

They seek help from God because they believe that God is the most powerful and merciful, and only by seeking help from him can people be protected from evil spirits. At times of seeking help from God, participants turned to Tahajjud prayers and reciting the Quran as a means of invoking Allah's help. Tahajjud prayer is a special Islamic prayer, which is recommended (but not compulsory) for all Muslims. The Tahajjud is prayed after Isha (the obligatory nightly prayer) and before Fajr (the obligatory morning prayer).

This finding is supported by a previous research conducted by Suryani (2013b) concerning the 'Experience of Indonesian Muslim with Chronic Mental Illness'. The study emphasised that spiritual approaches, such as prayers and dhikr, can help individuals with mental illnesses prevent the emergence of voices. Participants in both studies revealed that only God can help them. Therefore, they are very eager to seek God's help, through ritual activities of worship and prayer. This is the characteristic of Indonesian religious people who believe in the power of God above all else

In Eastern countries, religious beliefs have been proven to support recovery (Dein, 2017; Subandi, 2015; S Suryani, 2013). However, according to Okasha et al. (2012), religious and spiritual beliefs are powerful forces and may impart both harmful and beneficial effects; therefore, a tactful consideration of patients' religious beliefs and spirituality should be considered as an essential component of psychiatric history. An understanding of religion and spirituality and their relationship to the diagnosis, aetiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.

Mental health nurses and other mental health professionals are expected to respect and be sensitive to the spiritual/religious beliefs and practices of their patients and the families and carers of their patients (Ho et al., 2016). Whatever their personal beliefs are, mental health professionals should be willing to work with leaders or members of faith communities, in support of the wellbeing of their patients (Ho et al., 2016), and should encourage all colleagues in mental health work to do likewise. Mental health nurses should, whenever appropriate, work to better understand colleagues and patients of different religions and cultures, bearing in mind that social harmony contributes to mental health and wellbeing.

Theme 5: Ignoring by the Government

Almost all participants in this study perceived that the government ignored them. The results of this study are consistent with what we found during community mental health programmes in the working area of the Melong Health Centre where this study was conducted. We found that there were still many people with mental illnesses who did not receive treatment and visits from the community health centre. Mental health services are only oriented inside the building. Home visits, counselling and health education do not work effectively. In addition, there are no governmental programmes that deal with the stigma in the community, and no mental health programmes are related to recovery.

Unlike mental health services in Indonesia, recovery services oriented for people with mental illnesses in developed countries, such as America, England, Australia and New Zealand, were developed many years ago (Boardman & Shepherd, 2012), for example, the Centre for Psychiatric Rehabilitation in Boston University, USA. This centre promotes wellness, resilience and recovery services that are supported by the government, community and University. In England, the recovery-oriented programme for mental health has been established since 2011 by the Department of Health through The Implementing Recovery – Organisational Change (ImROC) project that was funded by government. In Australia, not only has this recovery programme been developed, even a national framework has been created by the Queensland Mental Health Commission. The purpose of the framework is to support the development and expansion of lived experience roles across Queensland (Byrne et al., 2015).

Unfortunately, the situation of people with mental illnesses in Indonesia is still far from satisfactory. They do not receive the appropriate treatments necessary for recovery. Some of them even have no access to treatment as services for mental illnesses are not available in some areas in Indonesia. Primary health services do not have mental health as a priority, and the skills of primary health clinicians are not sufficient to ensure detection and appropriate treatment of mental disorders. Some people with mental illnesses are confined and restrained in the community, and custodial treatments dominate in psychiatric hospitals. As in many developing countries, the standards of care of mental health services in Indonesia are still poor.

The finding of this theme can become basic information for the Indonesian government to pay more attention to mental health problems and develop programmes that can support the recovery process of people with schizophrenia. The

Indonesian government should put mental health programmes as a priority in community health centres. The government needs to make mental health an important programme at the puskesmas, as with the six other main programmes, and increase funding for its implementation.

Conclusion

During the process of recovery, the Indonesian survivors confirmed that they have become agents of their recovery. They developed their way to recover by accepting themselves, keeping a smile in all situations and seeking God's help to get well. In the process of recovery, schizophrenia survivors need support from the family, environment and policymakers. Moreover, the survivors are the centre of the recovery process, so patient-centred care is implemented when providing nursing care.

Declaration of Interest

The authors declare no conflict of interest

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Determinant of Effective Family Communication among First-Grade High School Adolescents Aged 15 – 16 Years: A Multi-Centre Cross-sectional Study

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Abstract

Background: Family communication can become a support system for adolescents. Ineffective communication in the family causes emotional problems and poor psychological well-being in adolescents.
Purpose: This study aimed to analyze the determinant factor of effective family communication in adolescents.
Methods: This was a cross-sectional multi-centre design with 357 participants aged 15-16 from five high schools in Indonesia. We used the convenience sampling method to select participants. Communication in the family questionnaire, Rosenberg Self Esteem Instrument, Depression Anxiety Stress Scale (DASS-21), and the Scale for Suicide Ideation (SSI) questionnaires were used to measure communication within the family, self-esteem, stress, anxiety, depression, and suicide ideation, respectively. Data were analyzed using Chi-square and binary logistics regression.
Results: Most of the adolescents were male (52.1%), had harmonious families (96.6%), had economic status above the minimum wage (65.5%), had high self-esteem (88.5%), and had high social support (67.8%). However, in terms of mental health problems, as many as 47.3%, 74.2%, 72%, and 30.5% of adolescents experienced stress, anxiety, depression, and suicidal ideation, respectively. The multivariate analysis concluded that gender (AOR: 0.499; 95% CI: 0.294-0.847) and socioeconomic status (AOR: 0.2.162; 95% CI: 1.296–3.608) were significantly correlated with family communication.
Conclusion: Males adolescents are more likely to have ineffective family communication than female adolescents. Also, adolescents with a family socioeconomic status below the minimum wage have a greater risk of ineffective family communication. Therefore, it is essential to improve family communication through assertive communication training in adolescents and families in the educational and community setting.

Keywords: adolescents; communication barriers; family; socioeconomic factors

Introduction

Adolescents are vulnerable groups to exposure to risk factors that result in mental health problems. Mental health disorders in children and youth are the leading cause of disability and predict impaired health outcomes and

mental health wellbeing in adulthood, with a global prevalence of 6.7% (Erskine et al., 2017, 2015; Otto et al., 2021). Adolescents' mental health problems include anxiety, depression, frustration, anger, eating disorders (anorexia, bulimia), drug abuse, low self-esteem, and suicide (Moksnes & Reidunsdatter, 2019; WHO, 2019). Unpleasant events in childhood lead to low self-concept and maladaptive coping and depression (Hayward, Vartanian, Kwok, & Newby, 2020; Wong, Dirghangi, & Hart, 2019). Adolescents tend to experience anxiety because of the stage of self-identity development and are influenced by hormones (Gill, Watson, Williams, & Chan, 2018; Sun, Niu, You, Zhou, & Tang, 2017). Stressors that make adolescents feel stressed often arise from the family, home environment, conflicts between peers, and preparation for graduation exams (W. J. Liu et al., 2019; Zheng, Rijsdijk, Pingault, McMahon, & Unger, 2016). These problems can be caused by cognitive factors, relationships in the family, including communication, interaction with peers, and academic burden (Chi et al., 2020).

About 1 in 7 adolescents aged 10–19 years in the world experience mental health problems, most of which are still untreated (WHO, 2021). From 2009 to 2019, there was an increase of 40% of high school students who had experienced persistent feelings of sadness or hopelessness (CDC, 2019). Indonesia is one of the most populous countries globally, and about 6.1% of the population aged 15 and older reports symptoms of anxiety or depression (Riskesdas, 2018). Only 9% of people with depression are taking medication/or undergoing medical treatment (Riskesdas, 2018). Depression occurs in adolescents in Indonesia, 32% in women and more than in adults (Brooks et al., 2019). Research from Wiguna et al. (2020) showed that 10.6%, 14.2%, 15%, 28.3%, and 38.1% of Indonesian adolescents in the study were at risk of emotional problems, experienced total difficulties problems, at-risk of conduct behaviour, at risk of pro-social behaviour problems, and was at risk of peer-relationship problems, respectively. The incidence of depression, anxiety and stress in adolescents is often associated with problems with communication patterns in the family (Novak, Parr, Ferić, Mihić, & Kranželić, 2021).

Family function and communication affect adolescents' psychological wellbeing (Kavehfarsani, Kelishadi, & Beshlideh, 2020). The poor communication skills of adolescents and their families cause adolescents to feel blamed and lonely (Shi, Wang, & Zou, 2017; Wang, Rost, Qiao, & Monk, 2020). Ineffective communication in the family causes emotional problems such as anxiety, stress and depression in adolescents (Rocha, Rhodes, Vasilopoulou, & Hutton, 2018). Families are expected to provide positive feedback and openness in communication to become a support system for adolescents (Adam, Demissie, & Gelagay, 2020). The current situation is that problems in the family, such as the economy, become a priority so that forms of communication, interaction and attention to children are reduced (Guo, Tian, & Scott Huebner, 2018; Leavey et al., 2020). This causes adolescents to feel rejection quickly, disappointment, conflict, difficulty adapting, and socialising with the environment (Anyan et al., 2018; Liu et al., 2020).

Apart from school, teens spend most of their time at home. Around 87.9% of adolescents live with their nuclear family, while single parents raise 2.4%. Around 35.8% of students get pressure from their parents to excel academically (Sakthivel, Kannappan, & Panicker, 2021). Internal and external factors can influence mental health in adolescents. External factors such as the system in the family and environmental influences such as peers and society are at risk. Internal factors include biological, cognitive, religious, positive beliefs and self-ability, including the ability to communicate with family. These factors can be maximised as protective factors that minimize risk factors for mental health problems when adolescents receive stressors. Knowing the relationship between communication makes it possible to determine sustainable promotive, preventive, rehabilitative and curative efforts to address adolescent mental health problems in the community. Therefore, this study aimed to analyse the determinant factor of effective family communication in adolescents.

Materials and Methods

Study Design and participant

A cross-sectional study was conducted in September and October 2021 to measure determinant variables and communication in the family by using a questionnaire. We used the convenience sampling method to select participants in this study. The population in this study comprised adolescents from multi-centre high schools in Indonesia. The minimum sample size in this study was calculated with the Slovin formula, which required the minimum sample to be 280 participants. The inclusion criteria in this study were 1) high school first-grade adolescents aged 15–16 years, 2) willing to take part in the study, and 3) completing the questionnaire. Survey questionnaires were disseminated to participants via a WhatsApp platform. We sent the questionnaire to the five senior high schools in Indonesia. As many as 386 participants who met the inclusion criteria completed the questionnaire; 29 participants did not complete the questionnaire. Finally, the total sample in this study was 357 adolescents.

Instruments

Communication in the family was measured using a self-developed questionnaire based on five adequate interpersonal communication quality domains: openness, empathy, support, positive attitude and similarity (Devito, 2014). This questionnaire consists of seven questions using a Likert scale of yes (2) and no (1) for positive questions, and vice versa for

Table 1. Characteristics of Respondents (n = 357)

Characteristics	n	%
Gender		
Female	171	47.9
Male	186	52.1
Family Harmonious		
Harmonious	333	93.3
Not harmonious	24	6.7
Family Social Economic Status		
Above minimum wage	234	65.5
Below minimum wage	123	34.5
Social Support		
High	242	67.8
Low	115	32.2
Self Esteem		
High	316	88.5
Low	41	11.5
Stress Symptoms		
Normal	188	52.7
Mild	37	10.4
Moderate	58	16.2
Severe	41	11.5
Extremely Severe	33	9.2
Anxiety Symptoms		
Normal	92	25.8
Mild	42	11.8
Moderate	40	11.2
Severe	42	11.8
Extremely Severe	141	39.5
Depression Symptoms		
Normal	100	28.0
Mild	45	12.6
Moderate	79	22.1
Severe	44	12.3
Extremely Severe	89	24.9
Suicide Ideation		
None	248	69.5
Have Suicide Ideation	109	30.5
Family Communication		
Effective	259	72.5
Ineffective	98	27.5

negative questions. As a result, communication was categorised into adequate family communication (Score > 7) and inadequate family communication (Score 7). Before data collection, the researcher conducted validity and reliability tests on the Senior High Schools in Malang, East Java. The communication in the family passed the validity (Correlation Pearson Product-moment between 0.432 – 0.704 > r table (0.396) and reliability test (Cronbach's alpha 0.827 > 0.7).

The independent variables in this study were gender, family harmony, family socioeconomic

Table 2. Bivariate and Multivariate Analysis (n = 357)

Characteristics	Family Communication				X2	AOR	95%CI	
	Effective		Ineffective				Lower	Upper
	n	%	n	%				
Gender								
Female	138	38.7	33	9.2	0.445**	*Ref.*		
Male	121	33.9	65	18.2		0.499**	0.294	0.847
Family Harmonious								
Harmonious	241	67.5	92	25.8	0.873	*Ref.*		
Not Harmonious	18	5.0	6	1.7		0.834	0.306	2.274
Family Social Economic Status								
Above minimum wage	186	52.1	48	13.4	2.654***	*Ref.*		
Below minimum wage	73	20.4	50	14		2.162**	1.296	3.608
Social Support								
High	173	48.5	69	19.3	0.845	*Ref.*		
Low	86	24.1	29	8.1		0.986	0.575	1.691
Self Esteem								
High	223	62.5	93	26.1	0.333**	*Ref.*		
Low	36	10.1	5	1.4		0.384*	0.142	1.039
Stress Symptom								
No	136	38.1	52	14.6	0.978	*Ref.*		
Yes	123	34.5	46	12.9		1.053	0.568	1.952
Anxiety Symptoms								
No	66	18.5	26	7.3	0.947	*Ref.*		
Yes	193	54.1	72	20.2		0.98	0.429	2.241
Depression Symptoms								
No	73	20.4	27	7.6	1.032	*Ref.*		
Yes	186	52.1	71	19.9		1.374	0.568	3.222
Suicide Ideation								
None	189	52.9	59	16.5	1.785**	*Ref.*		
Have suicide ideation	70	19.6	39	10.9		1.654*	0.984	2.781

**p<0.1, **p<0.05, ***p<0.001, AOR: Adjusted Odd Ratio, CI: Confident Interval, X2: Chi-square*

status, social support, self-esteem, stress, anxiety, depression, and suicide ideation in adolescents. The first part of the instrument related to demographic data covering initials, gender (male or female), harmony in the family (harmonious/disharmonious), family economic status (below the minimum wage/ above the minimum wage), and social support (high/ low).

In first-grade high school adolescents, self-esteem was measured using the Rosenberg Self Esteem Instrument (Maroqi, 2018). The questionnaire consisted of 10 questions and four categories of answers (strongly agree (3); agree (2); disagree (1), and strongly disagree (0)) for the positive statement, and vice versa for negative statements. Adolescent self-esteem was classified into high self-esteem (score ≥15) and low self-esteem (score<15) (Maroqi, 2018). The validity and reliability test from the previous study was 0.463 – 0.660 (Correlation Pearson Product Moment r-table (0.396) and Cronbach's alpha 0.762 (Windarwati et al., 2021).

To measure stress, anxiety and depression, we used the Depression Anxiety Stress Scale (DASS-21) questionnaire, translated into Indonesian; the reliability test from previous study was >0.7 (Windarwati et al., 2022). This instrument consists of 21 questions with a Likert scale with four ranges, never (0) – always (3). The final DASS-21 score was multiplied by two with the cut-off category for depression being 0-9 (normal), 10-13 (mild), 14-20 (medium), 21-27 (severe) and > 28 very severe. The cut-off point for anxiety was 0-7 (normal), 8-9 (light), 10-14 (medium), 15-19 (severe) and > 20 very severe. The limit point for stress was 0-14 (normal), 15-18 (mild), 19-25 (medium), 26-33 (severe) and >34 very severe (Muttaqin & Ripa, 2021). In this study, the depressive symptoms were defined

to follow the depression subscale ≥10, anxiety symptoms≥8, and stress symptoms≥15.

Suicide ideation was measured using the Scale for Suicide Ideation (SSI) instrument, with reliability test from previous study being>0.7 (Windarwati et al., 2022). The SSI instrument is an ideal tool in the psychological and clinical investigation of suicidal ideation and differentiates individuals based on their level of suicidal ideation (Kesuma, Atmodiwirjo, & Idulfilastri, 2021). The cut-off points for suicide ideation were 0 (did not have suicide ideation) and ≥1 (have suicide ideation). All of the questionnaires in this study were originally written in English, and then the questionnaires were translated into Indonesian with the help of an independent translator. The questionnaire in this study was designed using a Google Form in a structure that was easy to follow and kept the questionnaire as simple as possible. The questionnaire used precise wording and instruction.

Data analysis

Descriptive analysis was used to summarise the demographic data of the participant's characteristics and each variable. Data analysis was carried out using the SPSS version 22 program. Chi-Square and binary logistics regression were performed to analyse the correlation between determinant factors with family communication in adolescent families because the variables are categorical, and the dependent variable was not measured on an interval or ratio scale. We used an adjusted odds ratio (AOR) with a 95% Confidence Interval (CI), and the level of significance was set at a p-value < 0.05.

Ethical consideration

This research has obtained permission from the Health Research Ethics Commission of the Faculty of Medicine Universitas Brawijaya Malang before the data collection with a Certificate of Ethical Approval ("Ethical Approval") No. 241/EC//KEPK/08/2021. Before participating in the study, participants have explained the objectives, benefits, and disadvantages that might be experienced in the research process. Participants who were willing to participate in the study signed informed consent. The informed consent was given and approved by their parents. Respondents' participation in this study was voluntary.

Results

Of 386 participants who filled out the questionnaire, 357 completed it (response rate of 92.49%). The results showed that, among 357 participants in this study, some of the adolescents were male (52.1%). Almost all adolescents had harmonious families (93.3%) and high self-esteem (88.5%). More than 60% of adolescents had a family economic status above the minimum wage (65.5%) and high social support (67.8%). The adolescents' mental health status characteristics indicated that most adolescents had stress levels within normal levels (52.7%). Meanwhile, on anxiety and depression, it was shown that some adolescents had normal and extremely severe levels of anxiety and depression at 25.8% and 39.5% (anxiety) and 28% and 24.9% (depression), respectively. In terms of suicide ideation, as many as 30.5% of adolescents had the intention of suicidal ideation. Based on the characteristics of family communication, most adolescents had adequate family communication (72.5%) (Table 1).

Table 2 presents the bivariate and multivariate analyses. On the basis of the bivariate analysis, we found that gender, socioeconomic status, self-esteem, and suicide ideation have a significant correlation with effective family communication in first-grade high school adolescents. We then conducted the multivariate analysis. Male respondents were 0.449 times more likely to have ineffective family communication (AOR: 0.499; 95% CI: 0.294-0.847) than females. In addition, when assessing the socioeconomic status, the adolescents with a status above minimum wage were found to be 2.162 times less likely to have an ineffective family communication (AOR: 0.2.162; 95% CI: 1.296–3.608) compared to the family with below minimum wage.

Discussion

In this study, effective communication in the family was significantly influenced by gender, socioeconomic status, self-esteem and suicide ideation. However, only gender and socioeconomic status were significantly related to family communication in adolescents during multivariate analysis.

The research finding showed that adolescents with a socioeconomic status above minimum wage were 2.162 times less likely to have ineffective family communication. In line with the findings of this study, families with low socioeconomic status have a high communication gap (Indrawati, 2015). Families with high socioeconomic status tend to improve parent-child communication and parental time with children, while low socioeconomic families tend to have a strict discipline (Li, Yang, Wang, & Jia, 2020). This is because low social status tends to focus more on working to meet needs and low levels of education (Manstead, 2018). In contrast, the ability to communicate is also influenced by the level of education (Mousena & Raptis, 2021). As a result, families with low socioeconomic status will differ in applying communication patterns and interactions between family members (Pramono, 2020). Intense communication is vital in interpersonal relationships in the family (Pantoja & Martins, 2020). Adolescents who have good relationships with family, environment and friends will be better able to use adaptive coping strategies and stress management when receiving stressors (Pei, Wang, Wu, Shockley McCarthy, & Wu, 2020). In addition, interpersonal communication

skills in the family can help adolescents develop their identity (Ramadhana, Karsidi, Utari, & Kartono, 2019).

Each family member also has a different way of expressing his opinion according to his personality, education and interaction patterns. In this study, male adolescents had a 0.449 times greater risk of having ineffective communication in the family than females. Males are more introverted, so they have different personalities from females, who easily express feelings and communicate (Eunson, 2015). Females adolescents perceived more positive and open nature communication between parents and children (Bireda & Pillay, 2018). More than half of teenage males have a low conversation orientation. Conversation orientation refers to openness, warmth and supportive communication. Conversation orientation also shows attention from one to another and the frequency of communication between parents and children (Pramono, Lubis, Puspitawati, & Susanto, 2017). Parents and child communications were significantly associated with adolescents' wellbeing (Bireda & Pillay, 2018).

The results showed that family communication was not related to adolescents' stress, anxiety and depression. This is possibly because adolescent mental health problems such as stress, anxiety, and depression can be caused by the social environment and do not necessarily come from within the family. Adequate communication can act as a source of protection for adolescents and be used to intervene in their mental health problems (Garcia-Carrion, Villarejo, & Villardón-Gallego, 2019). Furthermore, family communication quality predicts adolescent life satisfaction through the mediating effects of autonomy and future orientation (Bi & Wang, 2021). A family is a central unit for family members, communication among family members, sharing, and mutual discussions tend to considerably influence a child's social and emotional functioning (Saleem, Mahmood, & Daud, 2017). Therefore, effective family communication is essential to adolescent functional life and gives adolescents the potential to have psychological wellbeing.

The study's limitations were that it was conducted in first-grade high school adolescents, so the results may not reflect the adolescent population in general. However, this study can also add to the literature on the determinant factor of effective communication in families in Indonesia, which is still very limited.

Conclusion

Communication in the family can become a risk factor or protective factor for adolescents' mental health. This study concluded that adolescent communication in the family was significantly related to socioeconomic status and gender. Inadequate family communication is often found in teenage boys than girls. Moreover, adolescents with a family socioeconomic status below the minimum wage also had a potential risk of ineffective communication in the family. Therefore, it is essential to improve effective communication in the family, especially male adolescents and adolescents with a family socioeconomic status below the minimum wage. Assertive communication training in adolescents and families in the educational and community setting can increase communication skills and facilitate good relationships between adolescent and their families. Also, there is a need to further research about factors that impact effective family communication in high school adolescents.

Declaration of interest

There is no conflict of interest

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Data Availability

The datasets generated during and analyzed during the current study are available from the corresponding author on reasonable request.

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International Migration of Nurses from South to North amidst the COVID-19 pandemic and beyond: A gain or a drain

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Abstract

The complexity of health, social and economic problems caused by the COVID-19 pandemic demands rapid, adequate and effective responses. This includes the urgent response from the existing health system to provide high quality of care for infected persons. Unfortunately, the performance of health system in low-resource settings has been weakened prior to the COVID-19 pandemic. The current pandemic has posed more pressure to the health system including the health workforce security and availability with the isolation periods and lock-down scenarios for many low- and middle-income countries. Nursing has been recognized as a profession with high global mobility. Nurses from the South (developing countries) would often migrate to the North (developed countries) due to security, better pay, and professional development, including working conditions. Nevertheless, aggressive recruitment of nurses from South amid the COVID-19 pandemic is considered unethical. Nurses as part of the essential health workforce are critically needed in their home countries. This editorial argues the benefits and disadvantages of nurses' migration from South to North. Several key sources from both scientific and grey literature were used in this editorial.

Keywords: developed countries; developing countries; international migration; nurses; south-north

Main Text

The COVID-19 pandemic creates significant challenges to the health system globally. The effort of delivering and enhancing routine healthcare services is also challenged by the urgent need of responding to the rapid increase in COVID-19 cases. As one of the essential components of health service delivery, healthcare workers, such as nurses, need to be strengthened in responding to the high demand of healthcare services during and beyond the COVID-19 pandemic (WHO, 2020). The demand to meet the needs of sufficient and qualified nurses is even more crucial for all countries. It has been argued that, prior to the COVID-19 pandemic, developed countries have been actively recruiting nurses from the developing countries for tackling the nurses shortage in their countries (Stievano, Hamilton, & Bakhshi, 2021).

Despite the benefits of international migration of nurses from developing countries, which also known as the South to the North (developed countries), the criticism against the negative impacts of nurses' migration remains. Recruiting nurses from the South during the COVID-19 pandemic and beyond has to be ethically reconsidered as this may weaken the health system in many low- and middle-income countries (LMICs) which have been identified as having a fragile health system (International Council of Nurses, 2019). This editorial argues the disadvantages of international migration, such as the weakening of LMICs' health systems, causing a brain drain phenomenon. Brain drain could be simply defined as the migration of health staff for various purposes, such as better working conditions, career development and quality of life, to other countries.

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The World Health Organization (WHO) has reported that there has been an increasing number of foreign doctors and nurses in Organization for Economic Co-operation and Development (OECD) countries since 2004 and most of them are migrating from developing countries such as the Philippines, India and Africa (World Health Organization, 2010). It is reported that the number of doctors and nurses from the South to the North continues to rise significantly even during the COVID-19 pandemic as a quick solution to their health crisis (Stievano et al., 2021). To overcome the health crisis caused by COVID-19, the developed countries such as the UK, Canada and USA aggressively attracted health care workers from the South to work in their countries by easing the immigration procedures (Stievano et al., 2021). As a result, significant numbers of nurses and doctors from LMICs have migrated to the North. Better remuneration package, better working and living conditions are considered as pull factors that have attracted nurses and doctors to work overseas, particularly for developed countries (Aluttis, Bishaw, & Frank, 2014). On the other hand, low remuneration, poor working conditions, lack of professional development, lack of recognition from the government and inadequate appreciation from the professional association are the push factors that motivate nurses and doctors to leave their country of origin (Aluttis et al., 2014).

Migrating to industrialized countries has been recognized as a fundamental human right option for seeking better working and living conditions (Shaffer, Bakhshi, Cook, & Álvarez, 2022). Furthermore, international placement of nurses provides economic benefits for the country of origin. Remittance incomes from the migrated nurses boost the stabilization of their household income and the home country's economic dynamics. Furthermore, this remittance can be used for improving countries' health systems. It has been accepted that international migration contributes to the reduction of poverty as well as improves the economic growth of the sending countries. According to a study by the World Bank, a 10% increase in citizens leaving developing countries to work in developed countries is associated with a 1.6% of poverty reduction (World Bank, cited in WHO, 2010). In contrast, a study of nine sub-Saharan African countries conducted by Mills et al. (2011) found that the total investment loss on training for doctors who migrate reached $2.17 billion and Kenya loses investment worth the US $300,000 for every emigrating nurse. Moreover, Mills et al. (2011) (Mills et al., 2011) calculated that the United Kingdom and the United States of America as receiving countries can reduce their training investment for doctors and nurses and save about $2.7billion and $846 million, respectively. Accordingly, it can be said that there is a shift in investment to the destination countries, which has benefited the high-income countries.

In addition, for the source countries, which are commonly LMICs, the negative impacts of nurses' migration outweigh its benefits. The first negative impact of losing nurses to the North is the weakening of the health system. It has been well-documented that the health system in many LMICs is fragile. The COVID-19 crisis has exacerbated weaknesses of many LMICs health systems. As indicated by the WHO, healthcare workers such as nurses are one of the health system's key building blocks. Health workforce should be equally well-managed as an important aspect of health systems, besides access to medication, health information systems and access to healthcare. If a country fails to have adequate number of health workers, the health outcomes cannot be reached effectively. Health problems in the developing countries, such as HIV/AIDS, tuberculosis and maternal deaths, remain high when compared to the developed nations (Batata, 2005), and this is exacerbated by the COVID-19 crisis (Stievano et al., 2021). For example, in the Philippines, a country with a high number of migrant nurses abroad (Shaffer et al., 2022), the migration of nurses creates a gap in the supply of health workers, which has affected the quality of care delivered, especially in rural areas (Castro-Palaganas et al., 2017).

The second drawback of sending nurses out of the home country is the "brain drain" phenomenon where talented people go to other countries to improve their economic status, the standard of living and better access to more advanced technology (Dodani & LaPorte, 2005). Industrialized countries tend to recruit excellent performing nurses from developing countries. Hence, developing countries will likely to experience a lack of competent nurses. Consequently, health services in the developing countries will be provided by the less motivated and less skilled nurses compared to those who migrate with excellent skills and experience. This situation will impact the overall quality of healthcare services (Ahmad, 2005).

It is argued that migrant nurses working in the North can gain more skills and competence, especially for advanced technology in health. The benefit of this is that, when these nurses return to their country of origin, they can transfer their knowledge and skills to other nurses. This phenomenon is called "brain gain" (Dodani & LaPorte, 2005). It has been argued that interventions that are implemented to enhance brain gain will minimize the brain drain. However, since most developing countries have poor human resource management systems, particularly in the healthcare sector, there are insufficient records on the database for nurses who have migrated to other countries and who have already returned to their home countries. As a result, the circular migration strategy which should be implemented by the government will be ineffective and the phenomenon of brain drain will continue to exist.

The migration of nurses from the South to the North would also lead to another disadvantage known as "brain waste." This phenomenon happens when nurses cannot perform their nursing duties for

a certain period due to destination countries having different standards that allow someone to work as a nurse in the healthcare settings such as hospitals. This leads to the nurses losing all their nursing competencies. For example, Indonesian nurses who work in Japan, cannot work in hospitals before they pass the Japanese nursing licensure exam, they can only work as caregivers. In addition, if they cannot pass the Japan licensure test over a 3-year period, they have to come back to Indonesia (Efendi, Chen, Nursalam, Indarwati, & Ulfiana, 2016). In this case, when they return to Indonesia, they will also experience losing their nursing competencies. Therefore, the Indonesian government will not be able to reach its goal of gaining benefits from these returnees.

The WHO (2010b) (WHO, n.d.) has suggested there are three methods of international recruitment of health professionals. The first is the Government-to-Government collaboration (G-to-G). This scheme is a formal method in which a memorandum of understanding is made by both sending and receiving countries. The second method is the Government-to-Private (G-to-P). In this less formal scheme, the sending country initiates to make a memorandum of understanding with the private recruitment agency in the host country. Finally, the least formal scheme is Private-to-Private (P-to-P). This scheme is run through business-oriented recruiter agencies both in sending country and receiving country. It has been argued that Indonesia has been experiencing a surplus of nurses, and, in combination with the increase of nurses globally in response to the COVID-19 pandemic, an increasing number of nurses to be placed abroad has been claimed as an Indonesian government' strategy to reduce unemployed nurses in the country. Nevertheless, formal cooperation between Indonesia and the receiver countries is still lacking.

The Global Code of International Recruitment regulates international recruitment practices and is aimed to protect the sending countries from the negative effects of international migration. Moreover, this global code strongly recommends that the international recruitment of healthcare workers should be conducted through the scheme of Government-to-Government agreement in order to protect the migrant health workers as well as facilitate full potential benefits for both the sending and receiving countries (World Health Organization, 2010). International migration could also create psychological and social tensions due to feelings of fear of a new situation, as well as feeling lonely and overwhelmed by the cultural differences. Moreover, this stressful situation is exacerbated by the inability to speak the language of the host country. Furthermore, the migrant workers will not be able to communicate appropriately, which could cause a stressful situation in the workplace. These issues are even more crucial in the COVID-19 pandemic where migrant nurses with their limitations are vulnerable to be infected with COVID-19 in their workplace. Therefore, migrant healthcare workers such as nurses need to have formal protection from both the destination country and their home country. The government of the source country should collaborate with the destination country especially in maintaining a database and registry of migrant healthcare workers, comprehensively recording and including essential data, such as the hiring institutions, address of the employer and date that their contract starts and ends. In addition, the communication between migrant healthcare workers should also be maintained both by both the country of origin and the destination country. However, this situation will be unlikely to occur in the case of the recruitment process through Private-to-Private. The WHO has reported that the G-to-G scheme is fewer than other schemes such as the Government-to-Private (G-to-P) scheme or the Private-to-Private (P-P) scheme. The nature of the Private-to-Private scheme is purely business. Therefore, the private recruitment agencies will pay less attention to the security and protection of nurses. Consequently, as an obligation to protect its citizen, home countries must make extra effort to tackle the issue and protect their migrant healthcare workers abroad. This measure can be costly for the source countries and will furthermore create greater burden on the source countries. Again, rather than gaining more economic benefits from sending nurses or healthcare workers to work abroad, the developing countries must struggle to overcome the problems caused by the migration of qualified nurses. It can be argued here that the paradoxical situation occurs where developed countries which are supposed to help to strengthen the health system in developing countries, but instead it is the developing countries who actually support the health system of the developed countries.

In conclusion, developed countries need more nurses to strengthen their health services with the increasing number of older population and health crisis due to the COVID-19 pandemic. To fulfill this need, developed countries rely on the nurses from the developing countries which, to some extent, are already lacking relating to nurses' availability. Nurses in the South are, for several reasons, interested in working abroad. The reasons can come from destination countries, namely pull factors, or push factors which originate from the home countries.

The international movement of nurses has both positive and negative impacts. The disadvantage of sending nurses abroad is brain drain. This phenomenon occurs when highly talented and motivated health professionals leave their home country to work in other countries for a better salary and working conditions. The phenomenon can weaken the existing health system in the developing countries as the source countries. On the other hand, international migration can increase a country's remittance. However, the sending countries' loss of investment in nurses' training and education outweighs the benefit of having remittance from the

international migration. Therefore, the governments of developing countries should improve the nurses' working and living conditions as well as recognition of their essential contribution to the healthcare system. Also, the international placement of nurses should be managed strategically and efficiently to gain full potential benefit for nurses as individuals, as well as for the improvement of health systems in the developing or source countries.

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Life Experiences of Borderline Personality Disorder Survivors in the Recovery Process: A Phenomenology Study

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Abstract

Background: Borderline Personality Disorder (BPD) is a personality disorder with the main symptoms of emotional instability, impulsive behavior, negative self-concept, and impaired interpersonal function. Recovery in BPD is directed at the existence of satisfaction and meaning in life even with limited conditions due to symptoms of the disorder that still exists.
Purpose: The aim of this study is to explore the life experiences of BPD survivors in their recovery process.
Methods: This research is a qualitative research with a phenomenological approach. In-depth interviews were conducted with 10 BPD survivors from the Indonesian BPD Community. The research was conducted from August to November 2021 and interviews were conducted using Zoom Meeting. Interview transcripts were analyzed using the Colaizzi method.
Results: Six themes were extracted in this study, namely, the recovery process is not found alone, difficult to understand and love oneself, difficult to build stable relationships with others, journey to peace with oneself, the most painful experience that comes from the closest people and the experience of mental health services in Indonesia.
Conclusion: The process of self-identification is the first step in the recovery process in an individual's journey with BPD. The available support system helps BPD survivors to be able to adapt to the experience resulting from BPD symptoms. It is necessary to increase the knowledge of nurses about BPD in order to be able to provide good nursing care.

Keywords: borderline personality disorder, life experience, recover

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Introduction

Borderline Personality Disorder (BPD) is a personality disorder whose main symptoms include significant emotional changes, impulsive behavior, and impaired interpersonal and/or work functioning, which is characterized by a weak self-image and suicidal thoughts (Grenyer, Ng, Townsend, & Rao, 2017). BPD often makes an individual experience a lifelong struggle with the consequences of the destructive actions associated with the disorder (Helleman, Goossens, Kaasenbrood, & van Achterberg, 2014).

The prevalence of BPD is different in each country. Surveys in North America estimated the prevalence of BPD to be 1.6% in the general population and 20% of the psychiatric inpatient population (Ellison, Rosenstein, Morgan, & Zimmerman, 2018). According to Tomko et al. (2014) approximately 2% to 3% of patients presenting to primary care in the United States experience BPD, and the prevalence of BPD in the United States reaches 5.9%. In the Netherlands, from the survey data, it was found that 3.8% of the population experienced three to four symptoms of BPD and 1.1% experienced more than five symptoms of BPD. Meanwhile in Spain, the prevalence of BPD sufferers from the population reached 1.4-5.9% (Aragonès, Salvador-Carulla, López-Muntaner, Ferrer, & Pinol, 2013). It is estimated that between 1% and 4% of the total Australian population live with BPD, and the rate is three times higher in women than men (Acres, Loughhead, & Procter,

2019). In Indonesia, the number of people with BPD is not certain, but it can be estimated that it will increase every year (Raharja & Jusup, 2021) along with the increasing prevalence of emotional mental disorders at the age of more than 15 years, to 9.8 % based on the results of the 2018 Basic Health Research (Kementerian Kesehatan RI, 2018). Along with the unknown prevalence and incidence in Indonesia, research related to BPD in Indonesia is still very limited (Wulandari, 2020). Several studies found in Indonesia related to BPD show an overview of the causes of BPD (Hendrawan, Suryanto, & Aldrin, 2020; Raharja & Jusup, 2021) , therapy for people with BPD (Oey, Sanjaya, & Wibhowo, 2021; Valentina, Marchira, Afiatin, & Hadjam, 2021; Wardani & Suromo, 2021), and a description of the behavior of patients with BPD (Claudya, 2019; Kusumawardhani, 2007).

The government's efforts in handling BPD are more focused on optimizing the National Health Insurance (JKN). Presidential Regulation Number 82 of 2018 concerning Health Insurance states that the health insurance benefits obtained by individuals include promotive, preventive, curative and rehabilitative services. So that all National Health Insurance participants can benefit from the program according to medical indications (Nurmansyah & Kilic, 2017). BPD survivors who become National Health Insurance participants can get access to mental health services that help them in the recovery process.

BPD can have a negative impact on personal relationships (Bhome & Fridrich, 2015), quality of life (IsHak et al., 2013), and workplace settings (Juurlink et al., 2018). Individuals with BPD are often associated with high drug and alcohol use, low quality of life, and severe disturbances in interpersonal and social relationships (Barrachina et al., 2011). Individuals with BPD are often neglected and marginalized at the levels of policy, planning, staff training, and service delivery, also experiencing problems of social oppression (Kealy & Ogrodniczuk, 2010). Bonnington and Rose (2014) added that individuals with BPD also experience stigma and discrimination from friends, family, environment, education, and civil society.

Recovery is a description of a very personal and unique life journey in living a satisfying life, having the ability to participate in society, being actively involved in planning and evaluating health services, regardless of the symptoms and limitations caused by mental illness (Larivière et al., 2015). Recovery in individuals with BPD is mostly seen in the context of symptom improvement and no longer meets diagnostic criteria (Donald, Duff, Broadbear, Rao, & Lawrence, 2017). However, recovery is not seen as a decrease in symptoms only but leads to personal recovery, which is understood as survivors feeling they are living a meaningful and satisfying life even though some symptoms are still experienced (Anthony, 1993; Donald, Lawrence, Broadbear, & Rao, 2019). Qualitative studies conducted by Gillard et al (2015) and Shepherd et al. (2017) describe recovery from the perspective of individuals with BPD that involves improvements in relationships with oneself that are fostered through interpersonal relationships and integration in the community.

Katsakou et al. (2012) add that people living with BPD appear to have a unique and complex recovery experience. This arises as a result of drastic mood swings in individuals with BPD (Corradi, 2013) and frequent attempts to self-harm (Dickens, Hallett, & Lamont, 2016) as their defense mechanism. So that recovery in BPD is not included in the concept of "complete recovery," because individuals with BPD survive the difficulties caused by symptoms due to BPD for a long time (Shepherd et al., 2017).

A big challenge for healthcare providers, including nurses, in providing health services for individuals with BPD is the condition of their changing attitudes, which can be very dramatic and passionate, but sometimes their life situations seem chaotic and depressing (Stang et al., 2011). Individuals with BPD have a high sensitivity to their environment (Gunderson & Lyons-Ruth, 2008) which makes them afraid of abandonment or rejection, whether it has happened or not.

The splitting phenomenon experienced by individuals with BPD is also a challenge for health service providers in providing treatment. They often classify the people around them in extreme terms as good people or bad people (Kring & Johnson, 2018). However, this grouping can easily change, namely, people who are considered good, can suddenly be considered as bad people, or vice versa (Bateman & Fonagy, 2013). In addition to the splitting phenomenon, parasuicide phenomena also often appear in individuals with BPD where they use suicide attempts to force other people (family, lovers, friends or therapists) to pay attention and not ignore them (Paris, 2019).

The role of nurses is very supportive in health services for individuals with BPD (McCarrick, Irving, & Lakeman, 2022). Nurses are people who help them learn to deal with the demands of everyday life and meet their basic needs (O'Connell & Dowling, 2013). According to Ntshingila et al. (2016), mental health nurses can help clients find what is best for them by learning to recognize signs of distress, stressors, and how to deal with them. Psychiatric nurses also navigate clients with BPD to be able to take responsibility for their own lives by helping clients learn how to name the feelings they are experiencing, learn to reduce symptoms and self-control through the use of mindfulness skills, and how to take responsibility for their actions.

Many studies have been carried out on exploring the experiences of people with BPD in their recovery process (Donald, Duff, Broadbear, Rao, & Lawrence, 2017; Katsakou et al., 2012) and several systematic reviews related to the experience of the recovery process in individuals with BPD have also been published (Barnicot et al., 2012; Lamont & Dickens, 2019).The results of a literature study conducted

by researchers found that the majority of studies related to exploring individual experiences with BPD were mostly carried out in developed countries such as the United Kingdom, Canada, Australia, the Netherlands, and Norway. Researchers only found one article related to the exploration of patient experiences with BPD conducted in a developing country, namely South Africa (Ntshingila et al., 2016).

Based on the description above, researchers have a desire to get a more meaningful picture and get the essence of the experiences of BPD survivors in their recovery process against the background of conditions that exist in Indonesia. The purpose of this study was to explore the life experiences of BPD survivors in their recovery process.

Research Methods

Design

This study uses a qualitative method with a descriptive phenomenological approach.

Participants and Setting

The sampling technique used was purposive sampling with inclusion and exclusion criteria. The inclusion criteria used in this study were BPD survivors aged 18 years and over, undergoing therapy such as pharmacotherapy and/or psychotherapy and had recovered for more than one year with the results of the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD) questionnaire less than 7, able to communicate well and willing to participate in research. Meanwhile, the exclusion criteria were survivors who still had five symptoms out of nine BPD characteristics based on DSM-V. The data reached saturation after conducting interviews with 10 participants at different times.

Data Collection

The research was conducted in August – November 2021 at the Indonesian Borderline Personality Community. Participants in this study were BPD survivors. In-depth interviews were used as a data collection technique after all participants completed the informed consent. The research instrument in this study was the researcher himself using Zoom Meeting and WhatsApp as a medium for interviews.

Data Analysis

Data analysis was carried out using the Collaizi method, which, according to Sanders (2003 in (Suryani, Welch, & Cox, 2016) consists of seven steps, such as transcribing and translation of interviews, extracting significant statements, formulating meanings from significant statement, organizing the aggregate formalized meanings into theme clusters, writing an exhaustive description of the phenomenon, identifying the fundamental structure, and validating the exhaustive description with each participant.

Trustworthiness

Rigor and trustworthiness in this study are guided by four criteria according to Guba and Lincoln (1985 as cited in De Chesnay, 2014), namely: the value of truth (credibility), application (transferability), consistency (dependability), and neutrality (conformability). The three strategies used by researchers to increase credibility are Prolonged Engagement, Persistent Observation and Peer Debriefing. The strategy taken by researchers to meet the transferability criteria is to make detailed, clear, systematic, and reliable research reports so that the readers of the research results can correctly understand them. Dependability is obtained by researchers by conducting audit trail investigations. Confirmability is obtained by confirming findings to participants and presenting research results at conferences to obtain input and improve research results.

Ethical Consideration

This research was conducted after obtaining

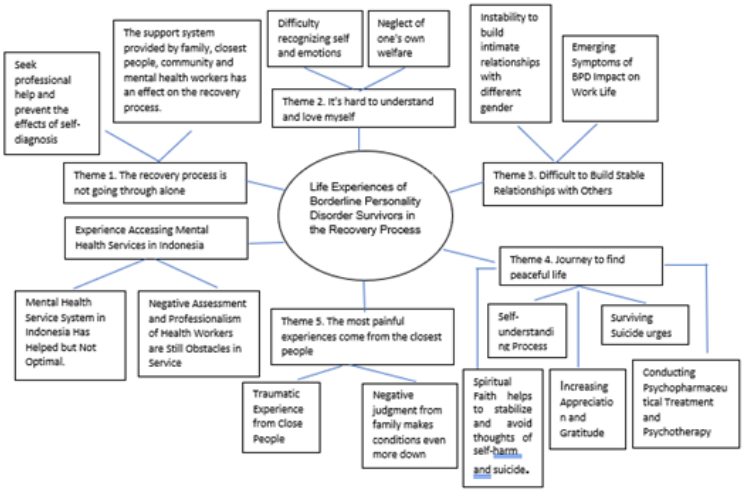

Figure 1. Themes and Subthemes

research permission from the ethics committee of Padjadjaran University with the number 607/UN6. KEP/EC/2021.

Results

The number of participants in this study was 10 people, consisting of three men and seven women. The average age of the participants was 29.5 years. The youngest participant was 18 years old and the oldest was 43 years old. The education level of the majority of the participants was S1 and the other three were high school graduates. Currently three participants are not working, three are entrepreneurs, two are private employees and two are students. Several participants who took part in this study had comorbidities, including three participants having comorbid bipolar disorder, one participant having comorbid major depression, one having comorbid schizophrenia, two having comorbid eating disorder and three other participants having no comorbidities.

The results of this study provide an overview of the life experiences of borderline personality disorder or BPD survivors in the recovery process, which are then broken down into six essential themes.

The recovery process is not passed alone

All participants in this study showed a need for the presence of others in the recovery process they went through. The presence of these other people can be in the form of support from family, friends, partners, communities or health workers. The presence of other people can also be a condition that facilitates the participant's need to understand his condition and facilitates their self-actualization. This theme consists of two sub-themes that describe the need for the presence of others that is felt by the participants.

Sub-theme 1: Seek professional help and prevent the effects of self-diagnosis

Seeking professional help became a step taken by participants to get explanations and actions related to their uncomfortable conditions.

"I cannot handle this with myself, that's it. I need help from a professional." (P4)

In the early days of symptoms, self-diagnosis is often done before seeking professional help. And this often has a negative impact on participants. Participant 7 said that it was difficult for him to accept the fact that he had BPD. So far, based on his self-diagnosis, P7 believes that he is suffering from depression. However, after consulting with a health professional, he was diagnosed with BPD.

"What is certain is that I don't accept it (with the diagnosis of BPD). First time, eeehm, first time hearing. And the second one was not accepted, because eeeehm the self-diagnosis effect is possible, huh. So it's like, "Oh there's depression too" like that. So it's like, I, I feel like I'm depressed." (P7)

Sub-theme 2: Support system from family, close people, community and mental health workers influential in the recovery process

The majority of participants said that the support they received from the environment greatly influenced them in undergoing the recovery process. Significant support for participants was obtained from family, close friends, spouses, community and health professionals.

"Yes, I follow, sometimes, there is a kopdar that I follow. But because of this corona, I couldn't meet… Yes, because many motivate people to give that spirit. (coughs). Sorry sorry…"(P1)

"But still, I have to tell some close friends. Because, I'm the type of person who can't, can't hold his own. But if you keep it to yourself, it's like, you can't do it, I'll tell you, I'll tell you. So, I'm like telling stories only to friends." (P2)

"The biggest support from my wife. My wife provides motivation and helps to rise from adversity. This support is very helpful in BPD recovery." (P3)

"So what's more, for example, the nurse knows, oh, this needs to be calmed down like that. The thing is, once, there was also the feeling, the nurse just wanted to hurry up like that. Or there is also a nurse who, sits, relaxes like that and really... eeehhhmm... helps to cool down." (P7)

It's hard to understand and love myself

Based on the data analysis conducted by the researcher, the majority of the participants admitted that they had difficulty in understanding themselves. Participants also described difficulties in loving themselves. The difficulties described by the participants also varied, ranging from the inability to recognize the feelings that arise, difficulty expressing emotions, inability to see positive things about oneself, defense mechanisms by self-harm, self-blame, or even a strong urge to commit suicide.

Sub-theme 1: Difficulty in recognizing self and emotions

The majority of participants described their strenuous journey through their day as a result of difficulty recognizing themselves and their emotions. This creates discomfort that results in self-loathing, confused about themselves, feelings of guilt, feelings of emptiness and confusion of expressing emotions.

"… ah I feel that my self is different, I'm like, I'm confused with myself, who am I? what am i? I'm confused about my identity. Especially when I found out I was BPD, it was mental problem, right? Wow, so I'm not like normal people." (P2)

"I'm having a hard time, um, I can't recognizing the emotions. Because most of what I felt is empty. Empty, sometimes his emotions go up and down…". (P6)

Sub-theme 2: Neglect of one's own welfare

Five out of 10 Participants described that when they face problems or stressors that arise, it often makes them ignore self-compassion and use destructive self-defense mechanisms.

"If I hurt myself, how do I feel, it's possible, I can get out like that. What I endure, because I do not dare. That's a shame." (P4)

"So from there (remembering the past), from there until S had thoughts of committing suicide like that. Until, you want to harm yourself, want, want, just want to destroy yourself like that." (P7)

Difficult to build stable relationships with others

Data analysis conducted by the researcher found that the difficulties experienced by the participants to understand themselves were also a difficulty experienced by the people around them to understand and be understood by them. This condition makes the participants find it difficult to build stable relationships with other people, especially with their partners, or with people in their world of work.

Sub-theme 1: Inability to build intimate relationships with different gender

Five out of 10 participants in the study said they had difficulty establishing stable relationships with the opposite sex. This condition is motivated by many factors, whether the partner is the trigger for the participant, the abusive attitude of the participant, the fear of being left behind and the result of a significant change in feelings.

"Then, those related to dating, that's it. Frequently changing partners. Which means, you know, umm... at first I was really happy. Very happy. You know, huh.. you know it's gone, don't know ah. I don't want it anymore, already." (P6)

"Well dominate (in relationships). You have to do what I want. Then, I just want it like this, I don't need attention, I don't need anything. But I'm, um, scared, I have a fear of being left behind." (P8)

Sub-theme 2: Emerging symptoms of BPD impact on work life

For the participants, BPD affected their work life. P4 said that he often gets angry when he finds things that don't suit him. He also said that when he didn't like the job he was doing now, he would dare to leave the job without a second thought. Until finally he was often called a "jumping flea" because he often changed jobs. This was conveyed by P4 in his statement below:

"If I'm honest at work, yes, I often get angry like that, that's the type. And if, for example, I don't like it, I can just do that, just dare to leave, even though I don't have a new job yet, that's what it is. So actually from my work experience, I was said to be a jumping bug, so often…" (P4)

Theme 4: A journey to find a peaceful life.

All of the participants talked about how their journey made peace with themselves. This journey was described in various ways by the participants. Starting from being aware of the conditions that result from BPD symptoms, taking negative actions to find comfortable feelings, realizing and surviving negative impulses, seeking appropriate treatment, how spirituality affects their condition and so on.

Sub-theme 1: Self-understanding process of knowing

Four out of 10 participants told how they had to deal with changes in their unstable mood and tried to identify things that made them uncomfortable and find ways to deal with them.

"So what are we like, there are, well, there are differences of opinion. Maybe for other people it's normal. But at that time I was again, again not taking medication. So I'm really hooked. And I'm angry again, want to be angry again. But I managed to control myself. I went upstairs, I took the medicine, "no, later... I want to take medicine, I want to take medicine". I said." (P6)

Sub-theme 2: Surviving suicide urges

Three out of 10 participants said that surviving suicidal urges was a condition that often appeared on their journey.

"My birthday, July 7th. That's actually, a really bad condition. But like, still manageable (the urge to commit suicide). And can still be arrested. From like, day by day, I feel like it's getting worse and worse." (P5)

Sub-theme 3: Conducting psychopharmaceutical treatment and psychotherapy.

In dealing with the symptoms caused by BPD such as emotional instability and the urge to self-harm, the majority of participants sought professional help to obtain actions that could help them to be able to control themselves and become more stable. Treatment in the form of psychopharmaceuticals and psychotherapy is often the action given to them.

"At first I was hesitant, madam, I didn't want to take medicine. But after not wanting to take the drug, I felt my condition was getting worse. Then after taking this medicine there are no symptoms, anger, or anything else." (P1)

"If it's to hold back self-harm, that's mindfulness. Eee, like huuhm, more like, to focus on what is around, what is heard. Eeee, breath, breath relaxation too." (P7)

Sub-theme 4: Spiritual faith helps to stabilize and avoid thoughts of self-harm and suicide.

Five out of 10 participants said that, in the recovery process, their spiritual beliefs helped them to remain stable and not do things that were detrimental to themselves.

"To kill myself, I don't. God willing, no. Because in Islam it's not allowed, that's how it is to commit suicide. Suicide is, yes, fades all our charities, that's how it is. In the end, we are not grateful for ourselves. And that's the point we are least grateful

for. By the grace of Allah. That's the first. The point is, religion and Allah, Allah is it." (P2)

"That, I actually avoided the incident of wanting to commit suicide, for example, wanting to hurt, wanting to be angry. That can be resolved with regular worship, going to the mosque, praying dhuha, remembrance, and so on. That's the solution, if we get sick with BPD, we just let it go, yes, in the end, we end up hurting ourselves and committing suicide." (P3)

Sub-theme 5: Increasing appreciation and gratitude

Seven out of 10 participants described that, in the process of making peace with themselves, they built many feelings. Such as being grateful, appreciating every opportunity, being someone you can rely on, building self-confidence, increasing motivation and so on.

"Me, through this, yes, through this online motorcycle taxi driver. I have a feeling, happily this way, that I am with that driver. I help some of what my wife and children need (e.g. shuttle)." (P3)

"…. I planted it in my mind. that I have to fend for myself. With that good thought I am now trying to cultivate a sense of self-respect. so that people outside cannot judge my life.… life will go well if we believe in ourselves." (P8)

The most painful experiences come from the closest people

Data analysis conducted by researchers found that half of the participants experienced unpleasant conditions from those closest to them.

Sub-theme 1: Traumatic experience from close people

Some participants described the traumatic experiences they had from those closest to them. These traumatic experiences were obtained by the participants from parental neglect, divorce, bullying and parents who experienced mental health problems.

"Because I just changed schools, I happened to change places of residence, so I changed schools. It was bullied, as a new kid. It's said..... When I talk to Mama, Mama just laughs like that. It's like thinking, oh, what the heck, that's the thing, it's a trivial thing." (P4)

"So at first, it came from family, well from family. When I was young, I was separated from my sister and separated from my mother too. So I, S, live with my grandmother. Not the same mother, not the same father. Even though it's black on white, it's the same as father." (P7)

"My dad also trigger because he is a bipolar." (P10)

Sub-theme 2: Negative judgment from family makes conditions even more down

Participant 4 and Participant 8 revealed that they received a negative assessment from their families regarding their condition with BPD. Participant 4 said that, apart from his mother, his other family always considered that his BPD condition was excessive behavior or a sign of lack of faith.

"For the other (family) it's like they think I'm too lazy, like I lack faith and so on." (P4)

The experience experienced by P4 is also in line with that experienced by P8. P8 said the condition of symptoms caused by BPD was often considered weak, weak in faith and ungrateful by his family.

"……. So someone in my family said that I was weak. I'm like this because I'm weak, right? And that makes me really down." (P8)

Experience in accessing mental health services in Indonesia

Several participants described that the programs organized by the government related to health insurance had helped a lot but the implementation was not optimal. In addition to the program, several participants also shared their experiences with the mental health service system or mental health professionals.

Sub-theme 1: Mental health service system in Indonesia has helped but is not optimal.

Six out of 10 participants described statements related to the mental health service system they received. Participant 1 said that the existence of the National Health Insurance helped him access mental health services, but Participant 2 and Participant 3 said that the services financed by the National Health Insurance were not comprehensive. In addition, the inadequate information system caused discomfort for the participants because they had to repeat the story about their condition.

"And Alhamdulillah, I also use BPJS (assisted cost). I'm still in college, and I've never worked. Now, that's also my reason, why I don't take psychotherapy and only pharmacology (Psychologist and Psychotherapy are paid)." (P2)

"Because it's true, the barriers are very far away. So the conversation has to be a bit louder (during the consultation). Then it's like that, the top is open. So everyone can hear it, so it's not very comfortable." (P9)

"There is the system, like every time it is controlled. That's a different doctor. So it's like, in my opinion, okay, control, but every time you tell a story, it's like you have to, if you go there, you have to keep telling stories. It's like being repeated again and again." (P5)

Sub-theme 2: Negative assessment and professionalism of health workers are still obstacles in service.

Four out of 10 participants described that there was a negative perception of health workers who provided services to them. This is based on negative assessments conveyed by health workers and the lack of professionalism of health service providers.

"Is that so, like, what do you think is different

about you, like that. I even, oh well. I sometimes talk about it, how come I don't believe it (mental health professionals) like that (laughs)." (P2)

"Only the first time I tried going to the mental health clinic at the Health Center, the doctor was a bit lacking, it wasn't fun, right, he judged me. It shouldn't be like that. Being judged, just because of lack of faith, because of that. That, I was traumatized, scared, traumatized for about 2 years or more, don't dare to do that." (P4)

"It's self-searching (related to drug information). The doctor, or the nurse, never care, sis." (P5)

Discussion

The recovery process is not about going through it alone

In the recovery process, support from family, peers, neighbors, community, health workers and the government affects the recovery process (Jacob, 2015). Results of qualitative research conducted by Donald et al. (2017) showed the most significant relationships supporting recovery were relationships with family, friends, partners and with doctors or colleagues in therapy. Larivière et al. (2015) revealed in their research that nine out of 12 participants confirmed that the support they received from their social environment helped them through their experiences with BPD. Katsakou and Pistrang (2018) say that mental health service providers who are open, accepting, honest, willing to listen, and genuinely care about the difficulties of BPD survivors, really help survivors in understanding and accepting themselves as BPD survivors. Failure to seek professional help leads to misdiagnosis which leads to other problems such as bipolar disorder, anxiety and depression (Porr, 2017). According to Porr (2017), the impact of delay or misdiagnosis has an effect on individual acceptance of the diagnosis of BPD.

Difficult to understand and love yourself

Lovell and Hardy (2014) stated that seven out of eight participants in their research expressed confusion in explaining and understanding experiences and communicating their experiences, thoughts and emotions. The confusion that arises can also be caused because individuals with BPD have different levels of identity coherence and different abilities to connect with themselves and others (Agnew, Shannon, Ryan, Storey, & McDonnell, 2016). Identity disorder is a hallmark that appears in BPD (Gold & Kyratsous, 2017). A negative self-concept makes individuals with BPD tend to judge themselves as bad and worthy of punishment and they also experience a deep sense of shame (Beeney, Hallquist, Ellison, & Levy, 2016; Donald et al., 2019; Vater, Schröder-Abé, Weißgerber, Roepke, & Schütz, 2015). Nishimoto and Hohashi (2016) say that, the manifestations of the impulsive behavior of individuals with BPD that are often found are wrist slashing, overdose, excessive spending and sexual deviations.

It's hard to build stable relationships with other people

BPD has an effect on decreasing quality of life in the bio-psycho-socio domain, including decreased physiological function, emotional control, relationships with partners or family and decreased sexual function caused by emotional dysregulation experienced by individuals with BPD negatively impacting interpersonal relationships, by triggering more negative communication and interpersonal feelings (Miano, Grosselli, Roepke, & Dziobek, 2017). Pergjini et al. (2020) stated that individuals with BPD often idealize someone (idealization), but this will significantly turn into hatred because individuals with BPD assume that the person does not care about them (devaluation).

Hill et al. (2011) state that there are several BPD criteria that are significantly associated with romantic dysfunction in individuals with BPD, namely interpersonal disorders, fear of abandonment, impulsive behavior and self-injurious behavior.

Meanwhile, in the world of work, research from Sio et al. (2011) found poor job outcomes in individuals with BPD due to impulsive symptoms that appeared after 12 months of work. Catthoor et al. (2015) and Juurlink et al., (2018) add that individuals with BPD have difficulties in carrying out their functions in work settings, experience high levels of stress and are stigmatized.

A journey of peace with yourself

Kverme et al. (2019) stated that research participants experienced a learning process from the therapy they went through and they also gathered knowledge related to their emotions, thoughts and behavior which was used as a way to find keys to unlock various possible changes in themselves. Research conducted by Holm and Severinsson (2011) illustrates that the urge to suicide is experienced by the majority of women who are participants in their research. This urge appears as a form of getting peace and escaping from the world. Holm and Severinsson (2011) also describe the struggles of participants who want to heal and use their own ways to find strength in surviving the urge to commit suicide.

Rogers and Acton (2012) stated that some of the participants in their study, expressed psychopharmaceutical treatment as an important part of their recovery process and they appreciated its benefits. Evidence-based use of psychopharmaceuticals in individuals with BPD is still very scarce and psychopharmaceutical agents that are beneficial in reducing global symptoms of BPD have also not been found (Antai-Otong, 2016; Bozzatello, Garbarini, Rocca, & Bellino, 2021; Bridler et al., 2015; Stoffers□Winterling et al., 2018; Stoffers et al., 2012; Zanarini, Frankenburg, Bradford Reich, Harned, & Fitzmaurice, 2015).

Psychotherapy is a process that encourages

mindfulness processes that can help people understand and accept themselves, their emotions and behavior (Barnicot et al., 2012). Oud et al. (2018) say that psychotherapy remains the most effective treatment for BPD to date. A factor that adds to the list of journeys to make peace with yourself is spirituality. (Bonelli & Koenig, 2013) explain that there is a relationship between essential spirituality and better mental health (hopelessness and self-esteem) experienced by patients with BPD. Huguelet et al. (2016) added that BPD patients who have good spirituality show an increase in their self-esteem and a decrease in hopelessness even though they tend not to feel a good quality of life.

In addition, actualization is a factor that is added to the list of making peace with oneself. In a study by Larivière et al. (2015), eight participants revealed that the most important thing in their recovery period is being able to fulfill roles related to their families. Individuals with BPD feel meaningful when they are able to take care of themselves, engage in meaningful roles and activities, own and maintain jobs and carry out projects that take on responsibility. The most painful experiences come from the closest people

The closest person or "family" includes family, partners, friends and other supporters who are often a group that occupies an ambiguous space that can be interpreted as supporting recovery or triggering relapse in healthcare research and practice (Bland & Foster, 2012; Wyder & Bland, 2014). In their research, Ntshingila et al. (2016) stated that participants reported experiences related to unstable family dynamics such as separation and divorce, which also caused a lot of instability for the participants. Apart from the condition of unhealthy family dynamics, parents with mental problems can also be one of the factors that provide unpleasant experiences for individuals with BPD in childhood. De la Serna et al. (2021) stated that mood disorders are more common in the offspring of parents with bipolar disorder.

Negative judgments from family often appear as obstacles in the recovery process. Bonnington and Rose (2014) mention that individuals with BPD often experience stigma and discrimination from friends, family, environment, education and civil society.

Experience accessing mental health services in Indonesia

Based on Presidential Regulation No. 12 of 2013, the first level BPJS services include: Service administration; Promotive and preventive services; Examination, treatment and medical consultation; Non-specialist medical measures, both operative and non-operative; Services for drugs and medical consumables; and First-level laboratory diagnostic support examination ("PERATURAN PRESIDEN REPUBLIK INDONESIA NOMOR 12 TAHUN 2013 TENTANG JAMINAN KESEHATAN," 2013). Idaiani and Riyadi (2018), studying the mental health system in Indonesia, show that health resources and mental health expenditures in Indonesia are still very low compared to countries around ASEAN. In addition, the health information system that runs in Indonesia is still inadequate.

Rogers and Acton (2012) mention that the lack of information from service providers causes them to look for other resources, for example from the Internet. Which can have a negative impact on individuals with BPD. One of the negative impacts on people with BPD is that they lack access to mental health services and self-identification regarding their condition. In addition, many studies have reported on the negative attitudes and stigma that arise from mental health service providers toward individuals with BPD (Agustina, S, & Widianti, 2019; McGrath & Dowling, 2012; Natalia, Suryani, & Rafiyah, 2019; Westwood & Baker, 2010).

The main limitation of this research is the process of interaction and interviews between participants and researchers conducted through online media. Government policy to implement health protocols in every field, including research, requires researchers to follow research procedures that minimize face-to-face meetings as a form of preventing the spread of COVID-19. The process of interaction and interview with online media raises various obstacles, including: poor network, difficulty in assessing the non-verbal language of participants, adjustment of the time of interview activities between participants and researchers, and a decrease in focus.

However, there are several scientific updates that were also found in this research. The first is the discovery of other factors that affect the recovery process for BPD survivors. Self-diagnosis that appears at the beginning of the BPD survivor's journey can hinder the recovery process, while spirituality can support the BPD survivor's recovery process. The next scientific update is the perspective of using mental health services in Indonesia, which is taken from the perspective of BPD survivors.

Conclusion

In this study, the results obtained have several similarities with the results of previous studies that discuss the life experiences of BPD survivors. Such as the need for a support system, which helps survivors to adapt to the experiences they experience as a result of the symptoms that arise from BPD. The existence of a picture of an unstable relationship with oneself and others is also shown in the results of this study. Meanwhile, the process of self-recognition is the first step in the journey of individuals with BPD to come to terms with themselves and make peace with past traumas. In addition, the results of this study also revealed that the therapy the survivors went through, be it psychopharmaceuticals or psychotherapy, supported their recovery. And finally, an overview of the mental health service system is presented in this study. The emergence of negative attitudes and assessments of health services can be used

as special attention to develop activities that can anticipate this condition. It is necessary to increase the knowledge of nurses about BPD in order to be able to provide good nursing care.

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Global Shortage of Nurses Continues

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Abstract

Nurses play an important role in providing healthcare to individuals, families, and communities. One of the major challenges that global health systems face is a nursing workforce shortage. Various factors such as job dissatisfaction, intention to leave, and burnout are some of the predictors of nurse turnover. Another significant concern is whether the profession will be able to attract enough nurses to care for populations in the future. To ensure a healthy population, governments and health policymakers around the world must invest in nursing and healthcare and pay attention to the needs of health systems. To avoid a shortage among nurses, the government and relevant policymakers should pay highly on this issue as it may impact our future healthcare systems.

Keywords: challenge, global, needs, nurses, nursing shortage

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Main Text

Nursing is a noble profession that necessitates a great deal of effort and self-dedication to provide the best nursing care possible to the community. Nurses play an important role in healthcare, accounting for the majority of the health profession. The global nursing and midwifery workforce for both genders is estimated to be around 27 million, accounting for nearly half of the global health workforce (World Health Organization (WHO), 2022). Furthermore, the WHO reported that there is a global shortage of health workers, particularly nurses and midwives, who account for more than half of the current shortage, with South East Asia and Africa experiencing the greatest needs-based shortages of nurses and midwives. The shortage of nurses is multidimensional, with varying degrees of severity in different countries. The consequences of a nursing shortage affect not only the community, but also other registered nurses. It has an impact on their performance, such as stress or moral distress caused by work overload and long shifts, which affects the nurses' physical, psychological, social, and family relationships, as well as a lack of leadership support. New research suggests that less-than-ideal hospital work environments may jeopardize efficient and effective nursing care delivery, as well as contribute to job dissatisfaction and a high turnover rate among nurses who are already in short supply (Nantsupawat et al., 2017). Furthermore, due to the rapid advancement of technology, nurses' roles are no longer limited to working in hospitals or health clinics; rather, the scope of their practice should be expanded to include tele-care for patients who are unable to receive treatment in the current facilities (Che Hasan, Nurumal, Firdaus, & Jamaludin, 2021).This is also in high demand due to the current pandemic COVID-19, which limits face-to-face interactions between healthcare professionals and patients.

Nursing shortages are primarily caused by an aging population, a retiring workforce, limited school capacity, increasing patient acuity, an explosion of knowledge and technology, and the ever-expanding role of nurses (Liu, Lam, Fong, & Yuan, 2013; Maurits, De Veer, Van Der Hoek, & Francke, 2015; Tamata, Mohammadnezhad, & Tamani, 2021). This pace should also be consistent with the rapid advancement of technology, the global increase in the number of older people, chronic disease, and the

current challenges and opportunities for providing the best possible care (Firdaus, Komariah, & Che Hasan, 2022; Sawyer et al., 2019). In addition to COVID-19 factors, there are numerous reports of global staff shortages such as the absence of appropriate staff within their specialties.

According to the WHO, the world will require an additional 9 million nurses and midwives by 2030. The following measures for increasing a national supply of nurses may benefit the global community: increased government and organizational grants for nursing schools to increase student numbers; improved benefits for nurses; creation of healthy work environments; and opportunities for personal development. Some countries have also taken consideration importing the nursing workforce from other countries to cater for their own workforce needs. This is a short-term plan with many challenges reported including high linguistic diversity, making healthcare language barriers more prevalent due to this global migration of nurses (Gerchow, Burka, Miner, & Squires, 2021). The success and limitations of each of these methods, however, vary by country or region. As a result, strategies to address nursing shortages should be tailored to each country's specific circumstances. In Iran, for example, the most important strategies for overcoming nursing shortages are centered on improving nursing workforce retention (Shamsi & Peyravi, 2020). Other strategies highlighted in Macao include improving nurses' benefits and professional status, increasing nursing school enrolments, training clinical specialists, providing a transition program for new nursing graduates, and reducing workload by training nursing assistants (Liu et al., 2013). In Malaysia, the nursing program is reported to have high demand among school leavers, though it is not as popular as other programs in the healthcare system (Che Hasan, Jusoh, Abdul Hamid, & Nurumal, 2020). It should be emphasized that, when it comes to building a career, nurses should be treated on par with other professions who work in the same setting.

On the other hand, changes in the field of education should be brought to the attention of the global community so that the paradigm shift in the career, as well as the role of nurses, can be seen in a broader context. Furthermore, the need for interprofessional learning among other related professions may promote self-efficacy attributes between nursing and other healthcare professionals programs (Nurumal, Diyono, & Che Hasan, 2020). This is consistent with the teamwork, increased critical thinking, and value addition observed throughout the studies. Achieving health for all will require a sufficient number of well-trained and educated, regulated and supported nurses and midwives who are paid and recognized in proportion to the services and quality of care they provide.

According to WHO recommendations, the entry level for nursing should be standardized around the world, with a Bachelor's degree as the minimum qualification (WHO, 2021). The authors believe that it should be standardized to all healthcare professions, who are working together in the same setting. Therefore, they may be on the same wavelength when it comes to decision of care and thus promote better teamwork. Furthermore, in order to meet the requirements for professional manpower in the healthcare sector, the nation should give merit to the career of general nurses in addition to specialization and the nursing profession. Nurses with specialization provide an optimize health and safety environment for patients and frontline healthcare workers (Minissian et al., 2021). This could mold the future nurses to be a well-being nurse, having specific qualities such as strengths, interests, and expertise. Nursing strategies and directions must be developed in accordance with WHO recommendations to be prepared for a developed country and future challenges.

The strategies highlighted can assist policymakers at the decision-making level in resolving the nursing workforce shortage and its future consequences by refining and developing relevant policies that will address and strengthen the nursing workforce to meet demand and improve the delivery of quality health services to all individuals. Achieving health for all will require a sufficient number of well-trained and educated, regulated and supported nurses and midwives who are paid and recognized in proportion to the services and quality of care they provide. Increasing pay and promoting personal development could boost nurses' morale and intentions to stay in nursing. Furthermore, providing transitional program s for new graduates to reduce stress and facilitate their adaptations to nursing practice is an effective way to retain them in the nursing profession.

Declaration of Interest

The authors declare that there is no conflict of interest.

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Data Availability

The data are readily available.

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The Comparing of Problem-Based Learning and Lecture-Based Learning on Students' Learning Outcomes and Satisfaction for a Family Health Nursing Course

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Abstract

Background: Problem - Based Learning (PBL) is a method of student-centered learning. In PBL, students become centered to the learning process, whereas the teacher is the center of learning in lecture-based learning (LBL).
Purpose: This study aimed to compare the effects of PBL and LBL on students' learning outcomes and satisfaction on an undergraduate nursing course.
Methods: Quasi-experimental study. Participants included 161 students from two different classes of the course; in 2013, as a control group (n = 88) and in 2014 as an intervention group (n = 73). Both groups received LBL, which is practice in the lab and clinic, but the intervention group also received PBL. Secondary data analysis of students' learning outcomes was measured using students' learning progress in tests from lecture (theory, paper, laboratory, and clinical), while students' satisfaction was measured using teaching method evaluation from students.
Results: Students' learning outcomes (theory, laboratory, and clinical) in the PBL group were significantly more than in the control group ($p<0.001$), whereas paper lesson outcomes were higher in control group compared to the intervention group ($t=6.43$; $p<0.001$; 95% CI=1.46-2.76). There was more satisfaction with the PBL method. There was no relationship between students' satisfaction and learning outcomes ($p>0.05$). However, students considered greater satisfaction in PBL compared to LBL.
Conclusion: In problem-based learning, students contributed a lot to solving the problem and getting the skills and knowledge they needed. Students are also expected to be motivated.

Keywords: lecture-based learning, problem-based learning, family nursing

Introduction

Educators must realize that active learning is associated with three types of memory, namely working memory (place of thinking), sensory memory (perception of the world through the senses), and long-term memory (unlimited memory storage) (Wilson, Blake, Taylor, & Hannings, 2013). Therefore, it is necessary to choose the right learning strategy in learning design; consequently, it can help students absorb new information more deeply and connect it with new ideas or new experiences (Xu, 2016). Many variations of teaching and learning strategies can be chosen by educators to facilitate students. This emphasizes the importance of selecting teaching and learning strategies in nursing education, thereby making nursing learning

and teaching more exciting and compelling.

Some methods are used for teaching and learning in nursing to increase the student's capabilities. However, the lecture method of learning is highly dependent on the knowledge base and skills of the teacher, requiring well-organized content preparation and good communication skill from the teacher (Aruna & Thenmozhi, 2014). Lecture-based learning (LBL) is traditionally teaching and learning in nursing which improves critical thinking skills among nursing students (Kaddoura, 2011). The lecture is the most common method of education at all levels in medical groups (Khalili et al., 2016). This method is teacher-centered and the description and explanation of phenomena plays an essential part in it; its primary purpose is to transfer knowledge (Khodaveisi, Qaderian, & Oshvandi, 2017). Among the advantages of the lecture, the following can be referred to: being economical; flexibility; strengthening the power of the lecture; and strengthening students' listening skills (Mareno, Bremner, & Emerson, 2010).

On the other hand, problem-based learning (PBL) has been identified as an approach that improves the training of nurses by teaching them how to apply theory to clinical practice and by developing their problem-solving skills, which could be used to overcome environmental constraints within clinical practice (Shin & Kim, 2013). The PBL approach is more inductive; students learn content as they try to solve the problems. The PBL approach, therefore, facilitates the development of disciplinary knowledge bases, skills, and problem-solving strategies by placing the students in the active role of problem-solvers for issues that are aligned with real-life situations (Amakali, 2013).

Empirically, the family health nursing (FHN) course affects the health status of family members as a client system in nursing care. However, until now, FHN has not been widely developed as an object of systematic study in the field of nursing. This is related to learning systems that have not been effective, such as learning in a class, laboratory, or track practice. Therefore, using the right method for teaching and learning in the FHN course improves practice based on knowledge and skills among nursing students. Thus, the aim of this study is to compare the effects of PBL and LBL on students' learning outcomes and satisfaction in undergraduate nursing students for the FHN course.

Materials and Methods

Design

This study utilized a quasi-experimental study designed to evaluate students' learning outcomes and satisfaction in undergraduate nursing students for an FHN course in the Faculty of Nursing, University of Jember, Indonesia.

Sample and setting

Undergraduate nursing students in third-year from the School of Nursing, J-University - participated, taken from two different classes of years of the course, 2013 as the control group (n=88) and 2014 as intervention (n=73). Both groups received LBL practice in the laboratory and clinic, while the intervention group had the addition of PBL.

Data collection

Family health nursing, a 4-credit course, was selected for this purpose. Secondary data analysis of students' learning outcomes was measured using students' learning progress test from the lecture (theory, paper, laboratory, and clinical). In contrast, students' satisfaction was measured using teaching method evaluation from students. We performed LBL and PBL intervention for 14 weeks in one semester to complete the FHN subject. To evaluate students' learning outcomes, we evaluated using the paper lessons, laboratory practices, and a clinical home visit.

The paper lesson, a test in LBL groups, was conducted using a test of the material of teaching that was taught after 10 sessions (10 weeks) in class with 50 minutes per session, including eight chapters, such as introduction of family, family theory model and conceptual, family structure, family function, family environment, family stress and coping, family environment, and family nursing process (Friedman, Bowden, & Jones, 2003). Meanwhile, a paper test in PBL groups was performed using a test of the material taught that was learned after ten sessions in class with 50 minutes per session to solve five cases. Each case was solved in two sessions. At each session, students were divided into small groups (10-12 students per group) that were facilitated by one teacher per group. The score of the paper lessons was ranged from 0 – 100. Then, after the completed paper test, both the LBL and PBL groups were studied in laboratory practice (two sessions in two weeks) and clinical home visits (two sessions in two weeks).

A laboratory test was performed after two sessions with 100 minutes per session to practice how to do an assessment of the family, nursing diagnosis, make a family intervention, conduct family implementation, and evaluate the family. Furthermore, a clinical home visit was performed in two sessions in which three students visited one family to care for them twice (at least three hours each time for visiting the family) to practice the nursing process. The clinical nurses from a local public health center supervised the students to evaluate their practices. The scores of laboratory practice and clinical home visits ranged from 0 – 100. Finally, the outcomes of the FHN course were determined by the formula of count, including (3 X

Table 1. Characteristic of Participants

Variable		LBL (n= 88)	PBL (n= 73)	t/X2	p-value
		n (%)	n (%)		
Age					
	M±SD	20.00±0.79	19.83 0.69	-1.46	0.145
Gender					
	Male	31 (35.2)	18 (24.7)	1.64	0.201
	Female	57 (64.8)	55 (75.3)		

M stands for the middle number; SD stands for the standard deviation; LBL stands for lecture-based learning; PBL stands for problem-based learning; t stands for an independent student t-test; X2 stands for a chi-square test.

Table 2. Comparison Student Score of Theory, Paper Lesson, Laboratory, and Clinical Between Lecture Based Learning (LBL) and Problem Based Learning (PBL)

Indicator student score learning major of FHN	n	M	SD	t	P-value	95% CI	
						Lower	Upper
Theory							
LBL	88	61.02	7.33	-10.81	< 0.001	-12.91	-8.92
PBL	73	71.93	5.46				
Paper lesson							
LBL	88	83.72	2.09	6.43	< 0.001	1.46	2.76
PBL	73	81.61	2.06				
Laboratory							
LBL	88	81.31	2.94	-3.43	0.001	-1.83	-0.49
PBL	73	82.47	1.07				
Clinical for home visit							
LBL	88	82.82	3.11	-12.35	< 0.001	-5.46	-3.95
PBL	73	87.53	1.61				
Total score							
LBL	88	308.87	8.37	-11.18	< 0.001	-17.25	-12.8
PBL	73	323.53	8.19				
Outcome[a]							
LBL	88	76.29	2.28	-12.85	< 0.001	-5.18	-3.80
PBL	73	80.78	2.12				

Note: M= Median; SD= Standard deviation; CI= Confidence interval; FHN= Family health nursing; LBL= Lecture based learning; PBL= Problem based learning.
t= determined using Independent student t-test.
[a]Outcome determined (3x(theory+lesson paper+laboratory) + 1x(clinical for home visit) divided 4).

(theory + lesson paper + laboratory) + 1X (clinical for the home visit) divided by 4).

In the last session, in both the LBL and PBL groups, we measured student satisfaction. We used a questionnaire of student satisfaction with teaching and learning in the nursing course, which was developed by the center of learning of J-University. This questionnaire measured student perception of the teaching and learning process of the FHN subject course performed by teachers. This questionnaire consists of 11 of questions (Likert scale from 1 – 7), including how the teachers prepare teaching for the topic in class, getting feedback of evaluation results, clearly for communication, responsiveness for the student, readiness for education, opening and closing class on time, effectiveness of teaching class, comprehensive capability topic in class (theory and practice), assignment for students, systematically for teaching quality, and depth and illustration of the topic up to date.

Table 3. Comparison Student Satisfaction Between Lecture Based Learning (LBL) and Problem Based Learning (PBL)

Indicators of student satisfaction	n	M	SD	t	p-value	95% CI	
						Lower	Upper
Preparing teaching for topic in class							
LBL	88	4.07	0.84	-6.14	< 0.001	-0.94	-0.48
PBL	73	4.78	0.63				
Getting feedback of evaluation results							
LBL	88	3.73	0.84	-6.02	< 0.001	-0.96	-0.48
PBL	73	4.45	0.69				
Clearly for communication							
LBL	88	4.04	0.94	-4.00	< 0.001	-0.77	-0.26
PBL	73	4.56	0.69				
Responsiveness for student							
LBL	88	3.84	0.81	-6.09	< 0.001	-0.95	-0.49
PBL	73	4.56	0.69				
Readiness for teaching							
LBL	88	4.04	0.83	-5.30	< 0.001	-0.86	-0.39
PBL	73	4.67	0.67				
Opening and closing class on time							
LBL	88	3.84	0.93	-6.56	< 0.001	-1.08	-0.58
PBL	73	4.67	0.68				
Effectiveness teaching class							
LBL	88	3.86	0.70	-5.39	< 0.001	-0.92	-0.42
PBL	73	4.53	0.85				
Capability comprehensive topic in class (theory and practice)							
LBL	88	3.75	0.97	-3.39	0.001	-0.87	-0.23
PBL	73	4.3	1.09				
Assignment for students							
LBL	88	3.85	0.82	-5.15	< 0.001	-0.94	-0.42
PBL	73	4.53	0.85				
Systematically for teaching class							
LBL	88	3.56	0.64	-12.19	< 0.001	-1.42	-1.02
PBL	73	4.78	0.63				
Deeping and illustration of topic by up to date							
LBL	88	3.85	0.94	-5.41	< 0.001	-0.95	-0.44
PBL	73	4.55	0.69				
Total score of student satisfaction							
LBL	88	42.44	5.42	-8.26	< 0.001	-9.86	-6.05
PBL	73	50.40	6.58				

Note: M= Median; SD= Standard deviation; CI= Confidence interval; LBL= Lecture based learning; PBL= Problem based learning.
t= determined using Independent student t-test

Data analysis

SPSS was used to analyze the data. This study employed descriptive and comparative data analyses. Descriptive statistics, including frequencies and percentages, were used to summarize categorical measures; median and percentile-25 and -75 were

Table 4. Correlation Between Teaching Method and Student Satisfaction

Method	Student satisfaction (r)		p-value
	LBL	PBL	
Theory	0.058	0.021	0.305
Lesson paper	-0.011	-0.092	0.073
Laboratory	0.040	-0.078	0.452
Clinical	-0.070	-0.068	0.631
Total	0.036	-0.033	0.057
Outcome	0.039	-0.024	0.082

LBL= Lecture based learning; PBL= Problem based learning. r= determined using Pearson product moment test

used to summarize continuous measures. We used the independent t-test to compare students' learning outcomes and satisfaction between the LBL and PBL method groups. Meanwhile, we performed a Pearson product-moment test to analyze the student satisfaction between the LBL and PBL method. All significance levels are set at p< 0.05.

Ethical consideration

Ethics approval for this study was granted by the relevant University Human Research Ethics Committee No. 315/UN25.7/PIU-IDB/2018. The completion of the survey was considered implied consent.

Results

There were 88 and 73 students who used the LBL and PBL methods, respectively. The majority of students were female (64.8% for LBL and 75.3% for PBL), as illustrated in Table 1.

Table 2 shows that there were significantly different students' learning outcomes in PBL compared to the control group, in particularly theory (t= -10.81; p< 0.001; 95% CI= -12.91 – (-) 8.92); laboratory (t= -3.43; p 0.001; 95% CI= -1.83 – (-) 0.49), and clinical (t= -12.35; p< 0.001; 95% CI= -5.46 – (-) 3.95). However, paper lesson outcome was higher in control group compared ton intervention group (t= 6.43; p< 0.001; 95% CI= 1.46-2.76).

Table 3 shows that there was significantly different student satisfaction in the LBL and PBL method in each indicator (p <0.001). There was more satisfaction among students who attended the PBL method compared to LBL (t= -8.26; p< 0.001; 95% CI= -9.86 – (-) 6.05).

Table 4 showed that there was no relationship between students' satisfaction and learning outcome (p>0.05). However, students considered more satisfaction in PBL compared to LBL.

Discussion

In this study, we found that students' learning outcomes (theory, laboratory, and clinical) in the PBL group were significantly increased compared to the control group. In contrast, paper lesson outcomes were higher in the control group compared to the intervention group. We also identified that there was more satisfaction with the PBL method. However, there was no relationship between students' satisfaction and learning outcome. Contrastingly, students considered more satisfaction in PBL compared to LBL. This finding was consistent with previous studies that found PBL is useful for improving quality teaching and learning in nursing education (Amakali, 2013; Anh Phuong Nguyen et al., 2016; Hamdan, Kwan, Khan, Ghafar, & Sihes, 2014) and improving student satisfaction (González Hernando, Carbonero Martín, Lara Ortega, & Martín Villamor, 2014).

Our results found that the PBL method increased students' learning outcomes. This may be explained that through learning to solve family nursing cases with PBL, students learn independently by linking theory and the results of previous research in providing solutions to the problems of arguments raised in learning. This finding agrees with a previous study that said PBL might help students do better in their first-year medical classes (Sayyah, Shirbandi, Saki-Malehi, & Rahim, 2017), and the students learned critical thinking through PBL (Kaddoura, 2011). Therefore, PBL could be implemented for studying the FHN course that stimulated students' critical thinking to solve a nursing problem in teaching and learning.

The results identified that students are more satisfied with learning in the FHN course using the PBL method. This finding is related to previous study that found PBL improved student satisfaction along with teaching and learning in nursing (González Hernando et al., 2014). This situation explains that students learn by themselves to know more about the phenomena which they have discussed with their lecturer in their group. Therefore, PBL could be used to stimulate the student to learn more about FHN courses.

The author can explain the implications of this research based on the research results

Conclusion

Students in PBL contributed a great deal in their learning process to solve the problem and to help students acquire the necessary knowledge and skills, Also, students are expected be motivated. Students in PBL contributed a great deal in their learning process to solve the problem and to help students to acquire the necessary knowledge and skills. Therefore, PBL could be applied to undergraduate nursing students.

Declaration of Interest

There is no conflict of interest in this study.

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Data Availability

The abstract of this study was presented as oral presentation for book abstract at the 23rd East Asian Forum of Nursing Scholars (EAFONS): Advancing Nursing Scholars in the Era of Global Transformation and Disruptive Innovation for 10-11 January 2020, Chiang Mai, Thailand (https://eafons2020.com).

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