STUDY ON RECOVERY IN PEOPLE WITH SCHIZOPHRENIA (ODS) IN SAMARINDA CITY EAST KALIMANTAN

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Abstract

People with schizophrenia (ODS) withdraw from other people and reality, often entering into a fantasy life full of delusions and hallucinations. The present study is to find out the description of their recovery particularly those with residual type. This study was conducted in a mixed method using a descriptive design. Sample collection was conducted through purposive sampling, equipped with criteria of Residual Type PWS with age above 18 years old. Previously, testing of the Recovery Assessment Scale (RAS) measuring instrument was conducted to 30 PWS, who were all outpatients. The result of this study reveals that using the method, PWS outpatients has a deemed high recovery rate, yet they still have constraints in dominant symptom factors.

Keywords: *People with Schizophrenia (PWS), Recovery, Schizophrenia*

INTRODUCTION

The term schizophrenia (schizophrenia) is a combination of the Greek words for “split” (skhizein) and “mind” (phren), introduced by a Swiss psychiatrist Eugen Bleuler (1908)[1]. People with schizophrenia (ODS) withdraw from other people and reality, often entering into a fantasy life full of delusions and hallucinations[2].

Based on prevalence data from the World Health Organization (WHO), schizophrenic patients in Indonesia are one percent or an estimated 2.6 million people. However, this number could increase considering that most of those who experience schizophrenia are of productive age. Based on the results of basic health research (Riskesdas) in 2018, it was found that the prevalence of severe mental disorders (schizophrenia/psychosis) increased to 7 per mile or 7 people out of 1000 people[3]. This is an increase from the previous data of 1.2 per mil or 1-2 people out of 1000 citizens in Indonesia[4].

Misunderstanding of schizophrenia causes problems in the form of stigma and discrimination. The existence of being called “crazy people”, isolation and shackles by family or society, a growing belief in society that recovery of People With Schizophrenia (hereinafter referred to as ODS) is difficult to achieve.

In the era of demonology (150 BC), people with mental disorders were believed to be influenced by the power of evil spirits or demons. Today, some families and society still consider schizophrenia a disorder or "disease" caused by things that are irrational or

supernatural. For example, ODS are often considered as “crazy people” due to witchcraft or being swallowed up, possessed by demons, possessed by evil spirits, violated prohibitions or taboos and other types. Many ODS are not taken to doctors, but are taken to traditional healers, “smart people”, psychics and other types. Thus, ODS is not getting better but getting worse[5].

On the other hand, this view seems negative in describing the true state of schizophrenia. With ODS efforts accompanied by medical treatment or psychosocial therapy can improve the situation. Although there are other factors that prevent ODS from improving its recovery. Regarding how to respond to symptoms, experience drug side effects, relapse, psychological distress, self-acceptance, ability to interact socially, hope, meaningfulness, cognitive dissociation, stigma, problem-focusing and so on[6,7].

Recovery itself is a new perspective for mental health services, where there are 2 kinds of definitions of recovery. First, recovery is an outcome; Research suggests that many people with mental disorders have learned to overcome their disability so that they can achieve life goals related to living independently. Second, recovery is a process; introduce an important value such as hope, orientation towards empowerment and purpose in the service system. Both definitions have supporting data, this shows that the integration of the two offers the most complete and effective recovery picture. Psychosocial interventions integrated with psychopharmacological strategies have been shown to be most effective in helping individuals to recover[8].

One of the goals of the emerging recovery movement of consumers, survivors, and former patients is to re-inject hope into the lives of people diagnosed with this disorder[8]. As a result, recovery from this perspective is less concerned with outcomes in terms of whether the person achieves freedom from symptoms and disability and is more about the process. Rather than being symptom-free and without disability, recovery here has more to do with meaningfulness in life and personal comfort[8].

This research will only focus on ODS with residual type. This type is the remnant (residual) of the symptoms of schizophrenia are not so prominent. For example, feeling dull and flat and inconsistent (inappropriate), withdrawal from social interactions, eccentric behavior, illogical and irrational thoughts or loosening of thought associations even though the symptoms of schizophrenia are not active or do not show positive symptoms of schizophrenia[5].

Therefore, before arriving at the right intervention for ODS with Residual Type, the researcher wants to know how the picture of recovery in ODS with Residual type is.

MATERIAL AND METHODS

The method used in this study is a descriptive method that provides a description of the research subject based on the data and variables obtained and the group of subjects studied and not intended.

RESULTS

Based on the results of the study, there were 30 participants with various demographic characteristics. Respondents in this study were 83% of adults and 17% of early adults. These respondents consisted of 80% men and 20% women. The education level of respondents is generally 39% high school and 25% undergraduate and the rest are various. Based on employment status, respondents who do not have a job are 44% and those who have a job are 56%. For the diagnosis owned by the respondents ranged from Paranoid Schizophrenia (36%), Residual Schizophrenia (27%), Schizophrenia (25%), the rest varied between schizoaffective, hebephrenic schizophrenia, and YTT schizophrenia. The results of descriptive statistical tests to see the demographic distribution of ODS in the outpatient phase can be seen in table 1.

Table 1. Frequency and percentage of the profile of the respondents

Characteristics	Frequency (n)	Percentage (%)
Age (years)		
Young Adult (18-25)	9	30
Adult (25-65)	21	70
Gender		
Male	24	80
Female	6	20
Level of Education		
Elementary School	4	13
Junior High School	7	23
Senior High School	5	17
Vocational Education	5	17
Bachelor Education	9	30
Job		
Have a Job	23	77
Don’t have a job	7	23
Diagnosis		
Skizofrenia	11	39
Skizofrenia Paranoid	8	27
Skizofrenia Residual	5	17
Skizofrenia Hebefrenik	2	7
Skizofrenia YTT	3	10

The description of the data allows researchers to categorize by referring to the criteria of 3 groups by Azwar (2012), namely low, medium, and high. The purpose of this categorization is to place subjects into groups whose positions are tiered according to an existing categorical norm and so that the data will be easier to understand[9].

Table 2. ODS Recovery Categorization Outpatient Phase

Category	Range	Frequency (n)
Low	0-36	0
Medium	37-73	6
High	74-110	24

Based on the results of table 2 data, the recovery variable from 30 respondents has an average value of 86.36 and is in the High category. The minimum score (45) is in the medium category, and the maximum value (110) is in the high category.

Based on the results of the study, there are recovery characteristics from ODS which are classified into 5 factors according to Corrigan (2004)[8]. The results showed that the category of ODS recovery in the outpatient phase was in the high (95%) and moderate (5%). Can be seen in table 3.

Table 3. Frequency and percentage of the profile of the respondents

Characteristics	Frequency (n)	Percentage (%)
Self-confidence and personal expectations		
Low	1	3
Medium	6	20
High	23	77
Goals and success orientation		
Low	1	3
Medium	1	3
High	28	94
Positive dependence on others		
Low	0	0
Medium	12	40
High	18	60
Willingness to ask for help		
Low	1	3
Medium	6	20
High	23	77
Not dominated by symptoms		
Low	1	3
Medium	13	43
High	16	54
Recovery		
Low	0	0
Medium	3	10
High	27	90

After analyzing the descriptions of the 30 participants, then 2 participants who were diagnosed with residual schizophrenia were willing to be interviewed qualitatively. The following is a description of the identity of the residual type of ODS, which was interviewed with reference to recovery factors.

Table 4. ODS Residual Type Outpatient Phase

Characteristic	P1 (BD)	P2 (FS)
Age (years)	40	37
Gender	Male	Male
Ethnic group	Banjar	Bugis
Religion	Islam	Islam
Level of education	Senior high school	Vocational Education
Job	Salesman	Private
Status	Marriage	Single
Sibling	1st child of 3	3rd child of 4
Live with	Wife and children	Mother and sibling
Diagnosis	SR	SR
Onset (years)	± 20	± 16
Family history	Grandmother	Sibling

Based on table 4 above, there are similarities and differences that characterize each participant. The similarities found from the two participants are that all participants are residual type ODS who are male, aged between 37-40 years, with a minimum educational background of high school, ethnicity Banjar and Bugis, Muslim, domiciled in Samarinda, and status lower middle economy. The differences between the participants were differences in marital status, age of onset, occupation, composition of the ninth child and family history of illness.

The 2 participants had recovery scores that were in the high range, following table 5 which describes the recovery results of the 2 participants.

Table 5. ODS Recovery Type Residual

Participant	Recovery	
	Score	Category
P1	98	High
P2	103	High

Participant 1

P1 is the eldest of 3 siblings. He lives with his wife and 1 child. In terms of appearance P1 looks quite simple in wearing clothes, he often wears a hat when traveling. Regarding physical condition, P1 has difficulty walking because in the past (in his 20s) he had an accident that caused his leg to fracture, so that in walking and other movements that require leg support, P1 seemed to have difficulty. Regarding psychological conditions, P1 often looks at things with a blank stare (dreamingly). Due to these daydreams, P1 feels that he often hears voices in his mind in the form of unclear chatter.

P1 does not clearly remember what his initial history was that caused him to develop schizophrenic disorder. Since his teens, P1 felt himself to be a closed person and often daydreaming. When he was in his 20s, P1 who had not found a job felt stressed, so that it made him often angry and daydreaming incoherently, even hearing voices. He was then treated at the hospital and improved. Despite having a mental illness, P1 is happy that a woman is willing to marry him. After getting married, P1 also experienced stress again due to

getting laid off from the Telkom company, he used to work in the management department. Due to unemployment, the behavior that is often daydreaming arises, and hears the voices of other people talking. At that time P1 felt depressed because his roles as father and husband could not work well. He could not provide for his wife and children. Due to the reappearance of voice hallucinations and tantrums, P1 was taken to the Atma Husada Samarinda mental hospital and is currently receiving outpatient treatment at Karang Asam Samarinda Health Center.

Table 6. ODS Recovery Factors Residual Type

Factors	Recovery	Category
Participant 1 (P1)		
Self-confidence and personal expectations	34	T
Goals and success orientation	22	T
Positive dependence on others	20	T
Willingness to ask for help	12	T
Not dominated by symptoms	10	T
Participant 2 (P2)		
Self-confidence and personal expectations	36	T
Goals and success orientation	25	T
Positive dependence on others	18	T
Willingness to ask for help	15	T
Not dominated by symptoms	9	T

Currently, P1 feels his condition is getting better than before. The support of his wife, children, and even neighbors who used to help him when he was sick made him feel confident that his condition could recover. Although the situation is starting to improve, the emotions are more controlled, and the voices that used to judge P1 are getting less and less, and the voices are more incoherent. In the past he heard every day and could for a long time. By now he would hear incoherent voices 4 times a week, more often if he daydreams, and within 10 minutes. Due to taking psychotic drugs, P1 feels that he has side effects in the form of hands or feet that often shake, his weight has increased (because his activities are only eating and sleeping), and he feels less energetic and prefers to rest often (sleep).

Regarding recovery factors in terms of self-confidence and personal expectations, P1 feels that he still has hope of being able to recover 100%, being able to work, and not taking antipsychotic drugs anymore. That is also the goal at this time. In daily life, P1 has positive dependence on other people, such as nuclear family and neighbors. He felt that the negative stigma did not come from his nuclear family and neighbors, but from the wider community who did not know him well. When in need, P1 also has the willingness to ask for help from his family in particular. Regarding the dominance of symptoms, as previously explained, it is still quite dominated by positive symptoms in the form of voice hallucinations. So overall P1 feels

that he is still not recovering, even feels that he is in the range of 60-65 regarding his current situation.

Participant 2

P2 is the 5th child of 5 siblings. He lives with his mother and sister. P2's daily activities are taking care of the boarding houses in his house. In terms of appearance, the P2 looks neat and clean. His gait seemed slow, and his speech seemed staggered (from childhood). Regarding his physical condition, P2 said that he has GERD which causes his throat to feel dry and uncomfortable to swallow food. Regarding his psychic condition, P2 feels afraid and insecure when interacting with other people. Regarding the history of his disorder, P2 understands that his disorder is a form of depression due to the bullying behavior that he got since he was a teenager. P2 also said that there was a brother who was hospitalized due to excessive stress which P2 did not understand the cause. P2 felt that there was a change in him when he was in high school at the age of 16. He felt that he had a feeling of insecurity due to his small and thin body. Due to this, he also received verbal bullying from his friends. P2 often locks himself in his room, and even feels like someone is following him wherever P2 goes. This made P2 choose not to go to school because he was worried that someone would follow him continuously. P2 then went to RSHS for treatment. When entering college, P2 found it increasingly difficult to establish relationships with the same sex or the opposite sex. When he entered college, the problem of establishing relationships again occurred, P2 also felt that the course he took was not suitable for him. This is what makes P2 decide to leave his university and move to another university with a D3 path.

Currently, P2 feels his situation is getting better. Even though he's scared a lot, he's getting better and better. P2, who used to be afraid to travel alone, is now able to even though there are some places he fears and avoids (chooses a detour), P2 who used to be afraid to take an angkot (often his head shakes continuously and he is difficult to avoid).

Regarding recovery factors, P2 felt that he had low self-confidence, especially in terms of communication. For that he hopes to be able to communicate well in order to increase his confidence. P2 has goals and future orientation to get married. He also has a positive dependence on other people, especially on his mother and brother, in fact, often this dependence is so excessive that P2 often makes decisions based on the advice of his mother or sister. This makes him more willing to ask for help, especially with regard to daily tasks. Regarding the dominant symptoms, apart from avoiding certain social situations (worrying too much about other people talking about them), P2 also still has hallucinations of hearing people talking about them. This is only P2 overcome by keeping it quiet, taking medicine and sleeping. Overall, P2 felt that he had recovered in the form of improving his condition by being able to go alone to several places. However, P2 still doesn't feel fully recovered, because there is still

a fear of being talked about by people and hearing hallucinations. Then the percentage of recovery according to P2 is 70%.

DISCUSSION

The findings of this study were 1) out of the 30 outpatient ODS had RAS scores with a high categorization of 95%, this means that the participants gave an assessment that their recovery was in the high range. 2) after taking samples for the residual type of ODS as many as 4 participants, it was found that there were similarities in age range, religion, ethnicity, socioeconomic status. The four participants had high categorization on the 5 RAS factors. This shows that the four participants feel they have experienced recovery in terms of personal confidence and expectations, goals and success orientation, willingness to ask for help, positive dependence on others, and are not dominated by symptoms. related to recovery. Where all participants feel they have not recovered. This may be related to the items that are favorable which make participants answer in a stereotyped manner. (4) P2 has the worst positive symptom, but the RAS results show the lowest score in P1. This provides additional data on how participants view their recovery. Social support also seems to be important for ODS recovery, especially for P1 who even get social support from the surrounding environment. 5) With the condition of ODS getting better in terms of positive symptoms (even though they still have them) it seems that ODS have barriers in the social environment so that a form of therapy is needed that is able to target overall recovery in residual type ODS, so that they are more able to live fully and independently.

CONCLUSION

Based on descriptive analysis, quantitatively and qualitatively, it can be concluded that: The results of quantitative descriptive analysis for recovery in the high category are 95% of 30 ODS. This gives a positive picture that most of the ODS who are in the outpatient phase are able to achieve recovery.

The 2 ODS residual types also have a high recovery category. However, this does not appear to be supported by qualitative data from interviews which show that recovery is still low, especially for certain factors. There are still obstacles in ODS, especially on the factors of self-confidence and personal expectations, life goals and future orientation, and are not dominated by symptoms.

For the 2 residual types of ODS, the factor is not dominated by symptoms that have a high categorization, but it still seems to be a big obstacle because they still have positive and negative symptoms, accompanied by a lack of alternative solutions to overcome the disorder (silence, sleep, and taking medication).

Based on the categorization obtained from each factor of the 30 ODS. What appears to be an important focus for the outpatient phase of ODS is related to the dominance of symptoms. The moderate category (46%) and the low category (2%) indicate that the outpatient phase of ODS continues to focus on how to deal with the symptoms that arise. So it seems that interventions or programs are needed that are able to train ODS to be able to overcome the dominance of schizophrenia symptoms.

Based on demographic data from the 30 ODS, it was found that more adult males were diagnosed with schizophrenia and were in the outpatient phase. In addition, the percentage between working and not working status seems almost comparable to that of respondents (outpatient ODS). This can also be a related picture that at a productive age it appears that ODS has work problems (getting a job). This seems to need to be re-examined.

Future research is expected to provide a form of therapy or program that focuses on the recovery of ODS, especially with regard to treating the symptoms of the disorder in order to further improve the functioning of his life.

REFERENCE

1. Durand V, Barlow D. Psikologi Abnormal. 4th ed. Jakarta: Pustaka Pelajar; 2007.
2. Davison G, Neale J, Kring A. Psikologi Abnormal. 9th ed. Depok: Raja Grafindo Persada; 2012.
3. Riskesdas K. Hasil Utama Riset Kesehata Dasar (RISKESDAS). J Phys A Math Theor. 2018;44(8):1–200.
4. Badan Penelitian dan Pengembangan Kesehatan. Riset Kesehatan Dasar (RISKESDAS) 2013. Lap Nas 2013. 2013;1–384.
5. Hawari D. Skizofrenia: Pendekatan Holistik (BPSS) Bio-Psiko-Sosial-Spiritual. Jakarta: FKUI; 2014.
6. Chadwick P. Mindfulness for psychosis. Br J Psychiatry. 2014;204(5):333–4.
7. Dewi E. Remisi dan Rekoveri Penderita Skizofrenia. Surabaya: FIK UNAIR/RSUD. Dr. Soetomo; 2015.
8. Corrigan PW. Recovery from schizophrenia and the role of evidence-based psychosocial interventions. Expert Rev Neurother. 2006 Jul;6(7):993–1004.
9. Azwar S. Metode Penelitian. Yogyakarta: Pustaka Pelajar; 2012.