# LAPORAN AKHIR TAHUN/ TAHUN TERAKHIR*
# PENELITIAN BERBASIS KOMPETENSI
# (PBK)

## PENGEMBANGAN MODEL HOLISTIC DALAM PERAWATAN PASIEN GANGGUAN JIWA

**TAHUN KE – 3 (TIGA) DARI RENCANA 3 (TIGA) TAHUN**


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**KEMENTERIAN RISET, TEKNOLOGI, DAN PENDIDIKAN TINGGI**
**SESUAI DENGAN PERJANJIAN PENDANAAN PENELITIAN DAN PENGABDIAN KEPADA MASYARAKAT**
**NOMOR: 122/SP2H/PTNBH/DRPM/2018**

**UNIVERSITAS AIRLANGGA**
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# RINGKASAN

Gangguan jiwa merupakan sebuah sindroma perilaku, berkaitan dengan gejala penderitaan, keterbatasan, ketidakmampuan dalam menjalankan fungsi penting manusia. Riset kesehatan dasar tahun 2013 menunjukkan 1,7/1000 penduduk Indonesia mengalami gangguan jiwa berat (psikosis/skizofrenia), dengan 14,3 % pernah di pasung. Enam dari 100 orang Indonesia mengalami gangguan mental emosional, akibatnya produktifitas dan kualitas hidup terganggu. Asuhan keperawatan kesehatan jiwa merupakan sebuah proses interpersonal yang berupaya meningkatkan dan mempertahankan perilaku adaptif pasien untuk memberikan kontribusi pada fungsi integrasi.

Berbagai alternatif terapi dalam merawat pasien gangguan jiwa telah dikembangkan. Penemuan obat psikofarmaka terbaru, terapi kejang listrik, terapi kognitif dan perilaku, terapi aktifitas kelompok, terapi keluarga dan rehabilitasi psikiatri telah dikembangkan. Roadmap Indonesia bebas pasung tahun 2014 telah disosialisasikan sejak tahun 2010. Kenyataanya temuan kasus pasung terus meningkat. Data kementerian kesehatan menunjukan penemuan kasus pasung tahun 2010 sebanyak 383, tahun 2011 sebanyak 1139 kasus, Januari sampai Agustus 2012 dilaporakan sebanyak 803 kasus pasung. Tujuan penelitan ini adalah untuk mengembangkan model holistik dalam perawatan pasien gangguan jiwa, sebagai upaya penyempurnaan Buku Ajar Keperawatan Kesehatan Jiwa yang sudah ada. Data primer hasil penelitian diolah dengan analisis statistik deskriptif dan analisis inferensial PLS (*Partial Least Square)* menggunakan bantuan software Smart PLS ver 2 *for windows*.

Hasil penelitian tahun pertama menunjukkan bahwa masalah gangguan jiwa bukan hanya masalah pasien, tetapi masalah keluarga, masyarakat, tenaga kesehatan termasuk perawat. Kompetensi perawat dalam merawat pasien gangguan jiwa adalah melaksanakan asuhan keperawatan, melaksanakan standar prosedur operasional, melaksanakan terapi modalitas dalam keperawatan jiwa. Hambatan pelaksanaan kompetensi berupa dokumentasi asuhan keperawatan belum memadai, fasilitas pelayanan terbatas, kurang efektifnya pelaksanaan manajemen di ruangan, kondisi sumber daya manusia Perawat dan kondisi pasien yang dirawat. Stigma masyarakat terhadap gangguan jiwa didapatkan 23 tematik dari lima tujuan utama penelitian, yaitu: persepsi keluarga yang salah satu anggota keluarganya mengalami gangguan jiwa, cara merawat anggota keluarga gangguan jiwa, perasaan keluarga, aspek stigma, dampak yang dirasakan, dan harapan keluarga.

Penelitian tahun ke dua berhasil menyusun instrumen pengembangan model holistik berdasar telaah kritis pada tahun pertama, kuesioner diberikan kepada 120 perawat di rumah sakit jiwa Dr. Radjiman Wediodiningrat Lawang dan rumah sakit Jiwa Menur Surabaya. Hasil uji model didapatkan Model holistic dalam merawat pasien gangguan jiwa dibangun atas peran perawat dalam melaksanakan asuhan keperawatan secara integral, pengkajian spiritual, menegakkan diagnosis keperawatan sesuai standar diagnosis yang berlalku, membuat diagnosis keperawatan pada aspek biologis, psikologis, sosial dan spiritual. Asuhan keperawatan secara holistic ini dibangun oleh komponen pelaksanaan terapi modalitas dalam keperawatan, standar prosedur operasional untuk intervensi keperawatan sesuai diagnosis yang ditegakkan, sumber daya manusia keperawatan, kebijakan asuhan keperawatan yang berlaku di rumah sakit, fasilitas rumah sakit, kondisi masyarakat dan kondisi lintas sektor yang terlibat dalam pelayanan keperawatan kesehatan jiwa. Berbagai variabel signifikan pada hasil ini disusun standar operasional prosedur sebagai pedoman perawat (modul) dalam melaksanakan terapi modalitas sebagai implementasi model holistik dalam merawat pasien gangguan jiwa. Berbagai modul yang diperoleh ini akan dilakukan eksperimen pada akhir tahun ke dua dan ke tiga penelitian ini.

Hasil penelitian tahun ketiga difokuskan pada evaluasi hasil uji model, eksperimen variabel terapi modalitas, fokus group diskusi (FGD), mengikuti temu ilmiah keperawatan kesehatan jiwa, diskusi pakar, workshop tim peneliti untuk penyelesaian draft buku terapi modalitas dalam keperawatan kesehatan jiwa dan draft buku keperawatan kesehatan jiwa; pendekatan holistik dalam asuhan keperawatan.

Luaran yang telah dihasilkan pada tahun ketiga ini adalah publikasi pada jurnal nasional, jurnal nasional terakreditasi, jurnal internasional, presentasi poster pada PKB Psikiatri RSUD Dr. Soetomo Surabaya, presentasi poster pada kegiatan World of Addiction Institut of Mental Health, Addiction and Neouroscience di Jakarta, menjadi pembicara pada International Week for Teaching Assigment (incoming) Academic Year 2017 – 2018 di Lucian Blaga University of Sibiu Romania, Draft buku Terapi Modalitas Dalam Keperawatan Kesehatan Jiwa dan Draft buku Keperawatan Kesehatan Jiwa; Pendekatan Holistik dalam Asuhan Keperawatan.

# PRAKATA

Dengan memanjatkan puji syukur kehadirat Tuhan yang Maha Esa, kami dapat menyusun laporan kemajuan tahun ke tiga penelitian berbasis kompetensi dengan judul pengembangan model holistik dalam perawatan pasien gangguan jiwa tepat pada waktunya. Pada tahap ahir ini, kami telah berhasil menyelesaikan uji model holistik dalam merawat pasien gangguan jiwa, menyusun berbagai standar prosedur operasional pelaksanaan terapi modalitas yang secara signifikan menyusun model holistik ini untuk dijadikan modul pedoman intervensi keperawatan dalam bentuk buku terapi modalitas dalam keperawatan jiwa sebagai penyempurnakan buku ajar keperawatan kesehatan jiwa yang telah terbit sebelumnya dan kelengkapan dari buku keperawatan kesehatan jiwa; pendekatan holistik dalam asuhan keperawatan sebagai out put utama penelitian berbasis kompetensi ini.

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7. Seluruh tim peneliti, tim teknis yang sangat berperan dalam proses pengumpulan data, editing, penyusunan pelaporan, sehingga program ini dapat berjalan sesuai aturan yang berlaku
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Surabaya, 12 November 2018
Tim Peneliti

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# DAFTAR TABEL

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# BAB 1. PENDAHULUAN

Jiwa adalah unsur manusia yang bersifat non-materi, tetapi fungsi dan manifestasinya sangat terkait pada materi. Mahasiswa yang pertama kali mempelajari ilmu keperawatan jiwa, sering mengalami kesulitan dengan obyek yang harus di pelajari, jiwa bersifat abstrak, tidak berwujud benda. Setiap manusia memiliki jiwa, tetapi ketika ditanya mana jiwa mu? hanya sebagian kecil yang dapat menunjukkan mana jiwa nya. Jiwa memang tidak berbentuk benda, melainkan sebuah system perilaku, hasil olah pemikiran, perasaan, persepsi dan berbagai pengaruh lingkungan sosial. Semua ini merupakan manifestasi sebuah kejiwaan seseorang. Oleh karena itu, untuk mempelajari ilmu keperawatan jiwa, pelajarilah dari manifestasi jiwa terkait pada materi yang dapat diamati berupa perilaku manusia.

Gangguan jiwa adalah sebuah sindroma perilaku yang secara khas berkaitan dengan gejala penderitaan atau hendaya dalam satu atau lebih fungsi penting dari manusia, yaitu fungsi psikologik, perilaku, biologik, dan sosial. Gangguan itu tidak hanya terletak pada hubungan antar manusia, tetapi juga terkait dengan lingkungan, dunia kerja, dan masyarakat (Maslim, 2002. Maramis, 2010). Gangguan jiwa merupakan deskripsi sindrom dengan variasi penyebab, banyak yang belum diketahui dengan pasti dan perjalanan penyakit tidak selalu bersifat kronis. Umumnya ditandai penyimpangan yang fundamental dan karakteristik dari pikiran, persepsi serta adanya afek yang tidak wajar atau tumpul (Maslim, 2002).

Riset kesehatan dasar tahun 2013 menunjukkan 1,7/1000 penduduk Indonesia mengalami gangguan jiwa berat (psikosis/skizofrenia), dengan 14,3 rumah tangga dengan salah satu anggota keluarga mengalami gangguan jiwa pernah dipasung. Gangguan mental emosional dialami oleh 6% penduduk (Depkes, 2013). Banyaknya pasien gangguan jiwa ini, belum di imbangi oleh kebijakan, fasilitas pelayanan kesehatan jiwa, sumber daya manusia kesehatan dan kerjasama lintas sektoral yang memadai. Sebagai contoh, angka gangguan jiwa berat di Jawa Timur adalah sekitar 2,2/1000 (lebih tinggi dari angka nasional). Jika di hitung dengan jumlah penduduk Jawa Timur sebanyak 38 juta lebih, dan gangguan jiwa berat dialami oleh penduduk dewasa (sekitar 70%), maka angka gangguan jiwa berat di Jawa Timur adalah 2,2/1000 x (70% x 38 juta) = sekitar 58,520 orang. Rumah sakit jiwa di Jawa Timur hanya ada RSJ Lawang dengan kapasitas 600 tempat tidur dan RSJ Menur 300 tempat tidur. Ada beberapa unit psikiatri di rumah sakit umum seperti RSUD Dr. Soetomo, RSAL Dr. Ramelan, RS Bhayangkara Surabaya, dan RS Saiful Anwar Malang, dengan kapasitas tidak lebih dari 100 tempat tidur. Dengan demikian, seluruh fasilitas pelayanan kesehatan jiwa di Jawa Timur

hanya mampu menampung 1000 pasien. Selebihnya tinggal di rumah, lingkungan dan masayarakat (*hospital with out wall*), menjadi gelandangan psikotik atau di pasung.

*Roadmap* Indonesia bebas pasung pada tahun 2014 telah disosialisasikan menteri kesehatan sejak tahun 2010. Berbagai kegiatan telah dilaksanakan, Kementerian Kesehatan bekerja sama dengan Kementerian Sosial melaksanakan penanganan kasus pasung memalui pembebasan dari pasungan, pembersihan diri di panti, pananganan medis dan merujuk ke rumah sakit bagi pasien yang mempunyai penyakit lainnya atau membahayakan masyarakat, bahkan memberikan pengobatan *haloperidol* yang *long acting* untuk satu bulan sekali. Kenyataanya temuan kasus pasung terus meningkat. Data kementerian kesehatan menunjukan penemuan dan penanganan kasus pasung tahun 2010 sebanyak 383, tahun 2011 sebanyak 1139 kasus, Januari sampai Agustus 2012 dilaporakan sebanyak 803 kasus pasung.

Potensi ekonomi yang hilang akibat gangguan jiwa berat berat adalah setara dengan jumlah pasien x upah minimum regional (58.520 orang x 2,2 juta) sekitar 128.744.000.000 rupiah. Belum lagi hilangnya hari-hari produktif salah satu anggota keluarga yang harus menjadi *care giver* bagi pasien (satu orang tiap satu pasien). Dengan demikian, total estimasi potensi ekonomi yang hilang akibat gangguan jiwa di Jawa Timur adalah (Rp. 128.744.000.000,- X 2) yaitu sekitar 257 Milyar rupiah setiap bulan.

Jumlah penduduk Jawa Timur yang mengalami gangguan mental emosional adalah 6,4% (Riskesdas, 2013). Jika dihitung dengan jumlah penduduk dewasa Jawa timur, maka penderita gangguan mental emosional di Jawa Timur adalah 6,4% X (70% x 38 juta), sekitar 1.702.400 orang. Penderita gangguan mental emosional ini tidak berobat ke rumah sakit, kalaupun datang ke sarana pelayanan kesehatan, lebih karena gangguan fisik yang dirasakan seperti sakit kepala, pusing, tekanan darah meningkat, gangguan pencernaan, hormonal, dan sebagainya. Dengan demikian, penderita gangguan mental emosional menjadi tidak terdiagnosis. Diagnosis dan terapi, umumnya difokuskan pada gejala fisik yang timbul, bukan pada penyebab masalah mental emosionalnya. Masalah mental emosional tidak teratasi dengan baik, kualitas hidup terganggu, kualitas kerja dan produktifis kerja terganggu.

Keperawatan jiwa adalah suatu proses interpersonal yang berupaya meningkatkan dan mempertahankan perilaku, untuk memberikan kontribusi pada fungsi yang terintegrasi (Stuart, 2007). Dalam pelaksanaannya, pemberian asuhan keperawatan kesehatan jiwa selalu di integrasikan dengan berbagai alternatif terapi yang disarankan dalam terapi modalitas, seperti pemberian psikofarmaka, terapi kejang listrik, terapi aktifitas kelompok, terapi kognitif, terapi perilaku, terapi keluarga, dan sebagainya. Meskipun demikian, kesembuhan pasien gangguan jiwa masih belum efektif, angka kekambuhan pasien gangguan jiwa masih tetap tinggi. Pasien

yang sudah dinyatakan sembuh dan boleh pulang dari rumah sakit jiwa, dalam waktu yang singkat kembali lagi ke rumah sakit jiwa. Permasalahan utama terletak pada kesiapan keluarga dan masyarakat dalam menerima pasien gangguan jiwa di rumah (Fitryasari, 2009). Hal ini terjadi karena adanya beban obyektif dan subyektif yang dirasakan keluarga dalam merawat pasien gangguan jiwa.

*Retairement Village* adalah suatu tempat penampungan khusus dalam suatu wilayah tertentu, didalamnya terdapat pengelola, tenaga kesehatan, dan pekerja sosial, yang bertugas mengelola semua kegiatan khususnya pemberdayaan penghuni *retairement village*. Bagi pasien gangguan jiwa, kegiatan dapat direncanakan berupa terapi lingkungan, latihan kerja, dan bengkel kerja terlindung. Untuk itu, diperlukan sinkronisasi kebijakan antara Kementerian Kesehatan, Pemerintah Daerah dan Dinas sosial. Apabila hal ini dapat dilaksanakan, maka pasien gangguan jiwa dapat mengembangkan diri lebih optimal, dan dapat kembali hidup produktif di masyarakat. Oleh karena itu, pengembangan model asuhan keperawatan kesehatan jiwa yang paling tepat, sesuai dengan karakteristik masyarakat Indonesia, perlu terus di teliti dan dikembangkan, yaitu model model holistic dalam merawat pasien gangguan jiwa.

# BAB 2. TINJAUAN PUSTAKA

## 2.1 Konsep Holistik dalam Keperawatan

Konsep holistik dalam keperawatan merupakan sarana petugas kesehatan dalam membantu proses penyembuhan pasien secara keseluruhan. Pelayanan holistik yang dimaksud adalah, dalam memberikan pelayanan kesehatan semua petugas harus memperhatikan pasien dari semua komponen seperti biologis, psikologis, sosial, kultural bahkan spiritual (Dossey, 2005). Keperawatan holistik merupakan tujuan dari semua bentuk pelayanan kesehatan dan atau keperawatan yang diberikan oleh petugas kesehatan.

Seseorang yang mengalami sakit, apalagi sampai dirawat di rumah sakit, respon mereka tidak hanya terkait dengan biologis (organ yang sakit saja), tetapi akan berpengaruh terhadap psikologisnya, seperti menjadi pendiam, malu, mudah marah, merasa tidak berdaya. Respon psikologis ini juga dipengaruhi oleh kondisi sosial dan spiritual seseorang. Oleh karena itu, setiap petugas kesehatan dalam membantu mengatasi permasalahan pasien akibat penyakitnya, diharapkan dapat melakukan asuhan keperawatan secara holistik.

Dua tantangan utama dalam keperawatan pada abad 21 adalah mengintegrasikan berbagai konsep teknologi terkini, *mind* (pikiran) dan *spirit* dalam praktik keperawatan. Tantangan kedua adalah mengembangkan dan mengintegrasikan beberapa teori model keperawatan untuk memberikan arahan (*guide*) dalam proses penyembuhan. Beberapa teori model keperawatan yang diintegrasikan antara lain teori lingkungan, adaptasi, sistem, transpersonal, dan lainnya.

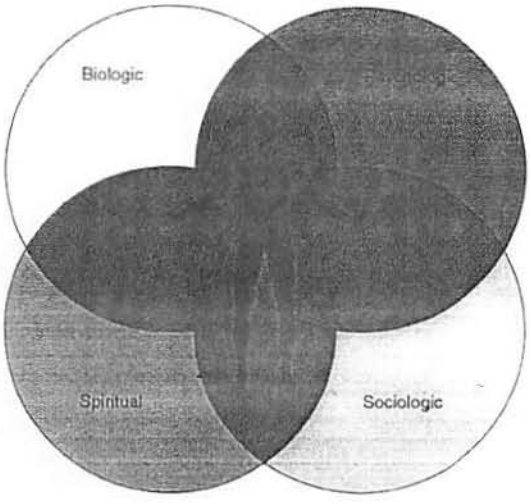
### 2.1.1 Model Bio-psiko-sosial-spiritual dalam Keperawatan Holistik

Model yang komprehensif dalam memandang berbagai respons sehat sakit adalah model bio-psiko-sosial dan spiritual (Dossey, 2005). Dalam model holistik, semua penyakit mengandung komponen psikosomatik, biologis, psikologis, sosial dan spiritual. Penyakit dapat disebabkan faktor bio-psiko-sosial-spiritual, demikian juga respons akibat penyakit.

Dimensi biologis terkait dengan semua komponen organ tubuh yang mengalami sakit. Dimensi psikologis terkait dengan semua perilaku dan faktor yang mempengaruhi perilaku yang ditampilkan akibat penyakit. Dimensi sosial terkait dengan dampak penyakit terhadap pola komunikasi pasien dengan masyarakat sekitar dengan berbagai tata nilai dan budayanya. Dimensi spiritual dalam model ini meliputi konsep tentang nilai, makna, dan persiapan untuk

hidup. Semua ini direfleksikan dalam semua sifat pembawaan manusia dalam mencari keperawatan, cinta, ketulusan hati, kejujuran, kebebasan, dan imajinasi.

Berikut adalah model bio-psiko-sosial-spiritual yang diintegrasikan dalam keperawatan holistik.

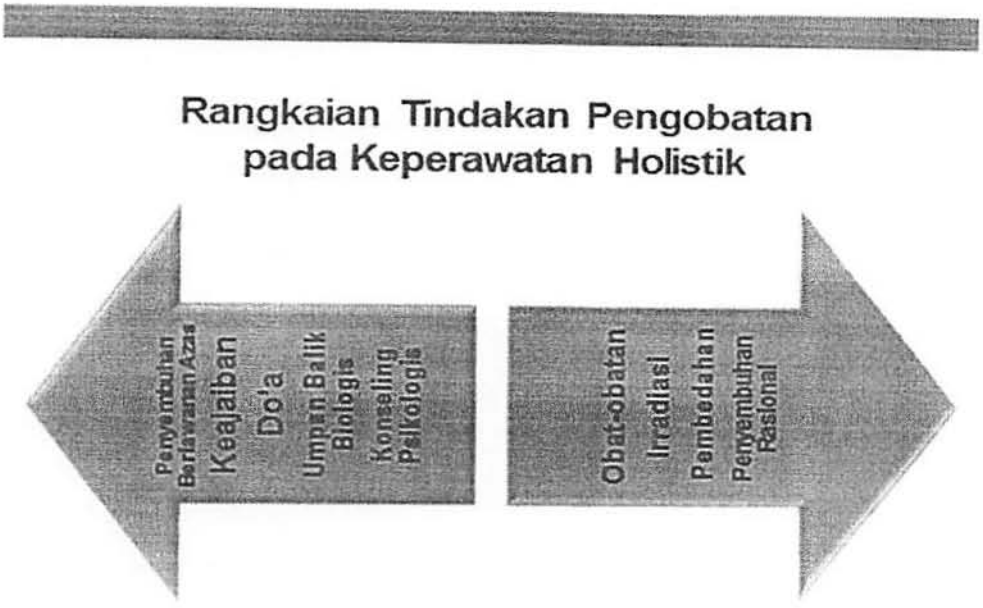



Gambar 2.1. Model bio-psiko-sosio-spiritual dalam keperawatan holistik (Dossey, 2005).

### 2.1.2 Proses Penyembuhan dalam Keperawatan Holistik

Semua aktivitas dan pengalaman untuk memperoleh proses penyembuhan diakomodir dalam keperawatan holistik. Era pertama diawali dengan pendekatan mekanis, material dan penyembuhan secara medis. Era kedua yang memfokuskan proses penyembuhan melalui penyembuhan badan-fikiran (*mind-body*), era ketiga yang memfokuskan pada proses penyembuhan transpersonal.

Dari semua aktivitas dan pengalaman untuk memperoleh proses penyembuhan tersebut dapat diklasifikasikan dalam dua kelompok besar yang tergabung dalam kelompok rasional dan kelompok paradoksikal (berlawanan arah). Kelompok proses penyembuhan rasional diawali dari konseling psikologis, penggunaan obat, radiasi sampai pembedahan. Kelompok paradoksikal menekankan pada komponen spiritual doa dan keajaiban dalam proses penyembuhan.




Gambar. 2.2. Kontinuum dari Rasional vs Paradoksikal *healing* (Dossey, 2005).

Dari beberapa pengalaman untuk memperoleh proses penyembuhan, baik yang rasional, paradoksikal, maupun karena "keajaiban" (*miracles cures*), pada kenyataannya kesemuanya dapat menunjukkan hasil dari proses penyembuhan. Oleh karena itu, dalam keperawatan holistik dikenal istilah terapi komplementer dan alternatif (*complementary and alternative therapy*, CAM).

### 2.1.3 Terapi Alternatif dan Komplementer dalam Keperawatan Holistik

Klasifikasi terapi alternatif dan komplementer didasarkan pada fokus pemberian terapi yang digunakan, seperti berdasarkan tanda dan gejala medis yang muncul, kerusakan bilogis yang terjadi, manipulasi badan dan pikiran yang digunakan.

Tabel 2.1. Terapi Komplementer dan Alternatif (Dossey, 2005).

| Complementary and Alternative Therapies | |
|---|---|
| ■ Alternative Medical Systems<br>✓ Acupuncture<br>✓ Anthroposophic medicine<br>✓ Ayurveda<br>✓ Environmental medicine<br>✓ Homeopathic medicine<br>✓ Latin American rural practices<br>✓ Native American practices<br>✓ Natural products<br>✓ Naturopathic medicine<br>✓ Past life therapy | ■ Biologically Based Therapies<br>✓ Antioxidizing agents<br>✓ Cell treatment<br>✓ Chelation therapy<br>✓ Metabolic therapy<br>✓ Oxidizing agents (ozone, hydrogen peroxide)<br>✓ Gerson therapy<br>✓ Macrobiotics and other therapeutic diet programs<br>✓ Megavitamins |

| | |
|---|---|
| ✓ Shamanism<br>✓ Tibetan medicine<br>✓ Traditional Chinese medicine | ✓ Nutritional supplements<br>✓ Botanical medicines |
| ■ Manipulative and Body-Based Methods<br>✓ Acupressure<br>✓ Alexander technique<br>✓ Biofield therapeutics<br>✓ Chiropractic medicine<br>✓ Feldenkrais method<br>✓ Massage therapy<br>✓ Osteopathic manipulation<br>✓ Reflexology<br>✓ Trager method<br>✓ Zone therapy | ■ Energy Therapies<br>✓ Electroacupuncture<br>✓ Electromagnetic fields<br>✓ Electrostimulation and neuromagnetic stimulation devices<br>✓ Magnetoresonance spectroscopy<br>✓ Magnets/magnetic fields<br>✓ Qi gong<br>✓ Reiki<br>✓ Therapeutic touch<br>✓ Healing Touch |
| ■ Mind-Body Interventions<br>✓ Art therapy<br>✓ Biofeedback<br>✓ Counseling<br>✓ Dance therapy<br>✓ Guided imagery<br>✓ Humor therapy<br>✓ Hypnotherapy<br>✓ Meditation<br>✓ Music therapy<br>✓ Prayer<br>✓ Psychotherapy<br>✓ Relaxation techniques<br>✓ Support groups<br>✓ Tai chi<br>✓ Yoga | ■ Additional Interventions Frequently Used by Holistic Nurses<br>✓ Aromatherapy<br>✓ Autogenics<br>✓ Breathing exercises<br>✓ Cognitive therapy<br>✓ Community-based health care practices<br>✓ Exercise and movement<br>✓ Goal setting and contracting<br>✓ Healing presence<br>✓ Healing touch modalities<br>✓ Holistic self-assessments<br>✓ Journaling<br>✓ Nutrition counseling<br>✓ Play therapy<br>✓ Self-care interventions<br>✓ Self-reflection<br>✓ Smoking cessation<br>✓ Weight management |

Pemberian terapi alternatif dan komplementer (seperti pada tabel 2.1 di atas) dapat dikategorikan berdasarkan pendekatan metodologis yang digunakan, seperti pendekatan medis, biologis, manipulasi terhadap tubuh, terapi energi, intervensi terhadap badan dan pikiran.

## 2.2 Gangguan Jiwa

### 2.2.1 Pengertian Gangguan Jiwa

Gangguan jiwa menurut PPDGJ III adalah sindrom pola perilaku seseorang yang secara khas berkaitan dengan suatu gejala penderitaan (distress) atau hendaya di dalam satu atau lebih fungsi yang penting dari manusia, yaitu fungsi psikologik, perilaku, biologik, dan gangguan itu tidak hanya terletak di dalam hubungan antara orang itu tetapi juga dengan masyarakat (Maslim, 1998).

Gangguan jiwa merupakan deskripsi sindrom dengan variasi penyebab, banyak yang belum diketahui dengan pasti dan perjalanan penyakit tidak selalu bersifat kronis. Pada umumnya ditandai oleh adanya penyimpangan yang fundamental dan karakteristik dari pikiran dan persepsi serta oleh adanya afek yang tidak wajar atau tumpul (Maslim, 1998).

### 2.1.2 Sumber Penyebab Gangguan Jiwa

Manusia bereaksi secara keseluruhan, somato-psiko-sosial. Dalam mencari penyebab gangguan jiwa, unsur ini harus diperhatikan, walaupun gejala gangguan jiwa yang menonjol adalah unsur psikisnya namun yang sakit dan menderita tetap sebagai manusia seutuhnya.

1. Faktor Somatik (Somatognik), akibat gangguan pada neuroanatomi, neurofisiologi, dan neurokimiami, termasuk tingkat kematangan dan perkembangan organik, serta faktor pre dan perinatal
2. Faktor Psikologik (psikogenik), terkait dengan interaksi ibu dan anak, peranan ayah, persaingan antar saudara kandung, hubungan dalam keluarga, pekerjaan, permintaan masyarakat. Selain itu faktor intelegensi, tingkat perkembangan emosi, konsep diri dan pola adaptasi juga akan mempengaruhi kemampuan untuk menghadapi masalah. Apabila keadaan ini kurang baik dapat mengakibatkan kecemasan, depresi, rasa malu dan rasa bersalah yang berlebihan.
3. Faktor Sosial Budaya, meliputi berbagai faktor kestabilan keluarga, pola mengasuh anak, tingkat ekonomi, perumahan, masalah kelompok minoritas yang meliputi prasangka dan fasilitas kesehatan dan kesejahteraan yang tidak memadai, juga pengaruh rasial dan keagamaan (Maramis, 1998)

### 2.2.3 Klasifikasi Gangguan Jiwa

Klasifikasi gangguan jiwa telah mengalami berbagai penyempurnaan mulai PPDGJ 1 sampai PPDGJ III, sebagian menganut klasifikasi ICD (*International Classification of Desease*), DSM (*Data Statistic of Mental Disorder*), ataupun NIC-NOC (*Nursing Intervention*

*Classification and Nursing Outcoma Creteria*). Untuk Indonesia menggunakan PPDGJ, pengelompokan diagnosis menggunakan pendekatan ateoritik dan deskriptif (Maslim, 2002).

PPDGJ III mengelompokkan diagnosis gangguan jiwa ke dalam 100 kategori diagnosis, mulai dari FOO sampai dengan F98. F99 untuk kelompok gangguan jiwa yang tak tergolongkan (YTT), yaitu kelompok gangguan jiwa yang tidak khas. Menurut hasil riset kesehatan dasar tahun 2007 (Keliat, 2009) secara umum gangguan jiwa dibagi menjadi dua bagian, yaitu (1) gangguan jiwa berat / kelompok psikosa, dan (2) ganguan jiwa ringan meliputi semua gangguan mental emosional yang berupa kecemasan, panik, gangguan alam perasaan dan sebagainya. Untuk skizofrenia masuk dalam kelompok gangguan jiwa berat.

### 2.2.4 Skizofrenia

Skizofrenia adalah suatu deskripsi sindrom dengan variasi penyebab (banyak belum diketahui) dan perjalanan penyakit (tidak selalu bersifat kronis atau *deteriorating*) yang luas, serta sejumlah akibat yang tergantung pada perimbangan pengaruh genetik, fisik, dan sosial budaya (Maslim, 2002).

Skizofrenia pada umumnya ditandai oleh penyimpangan yang fundamental dan karakteristik dari pikiran dan persepsi, serta oleh afek yang tidak wajar atau tumpul. Kesadaran yang jernih dan kemampuan intelektual biasanya tetap terpelihara, walaupun kemunduran kognitif tertentu dapat berkembang kemudian (Maslim, 2002).

Beberapa klasifikasi Skizofrenia antara lain paranoid, hebefrenik, katatonik, skizofrenia tak terinci, depresi pasca skizofrenia, skizofrenia residual, simplek, skizofrenia lainnya dan skizofrenia yang tak tergolongkan.

### 2.2.5 Penanganan Gangguan Jiwa

Penanganan gangguan jiwa dilakukan secara *holistic* tidak hanya mengandalkan psikofarmaka tetapi antara lain juga psikoterapi, terapi kognitif, terapi perilaku, terapi aktivitas kelompok, terapi keluarga, manipulasi lingkungan, terapi kerja, dan rehabilitasi. Beberapa tindakan untuk mengatasi gangguan jiwa antara lain;

1. Suasana terapi, yaitu suasana yang tercipta antara tim medis dengan pasiennya, terapi ini memegang peranan penting dalam mendukung adaptasi pasien karena bagaimanapun pasien merupakan manusia yang holistik dan hidup berperasaan sebagaimana manusia yang lain.
2. Somatoterapi, meliputi pengobatan psikotropik, yaitu berbagai obat yang mempunyai efek terapeutik langsung pada proses mental pasien karena efeknya pada otak dan terapi elektrokonvulsi, yaitu suatu alat yang mengeluarkan aliran listrik sinusoid dan meniadakan

satu fase dari aliran tersebut sehingga penderita akan menerima aliran listrik yang terputus-putus dan pasien menjadi tidak sadar seketika, selanjutnya pasien tidak akan mengingat kembali kejadian yang dilewatinya.

3. Psikoterapi yaitu suatu cara pengobatan terhadap masalah emosional yang dilakukan dengan mengoreksi prilaku yang terganggu dan mengembangkan kepribadian yang positif. Terdiri atas psikoterapi suportif (mengembangkan mekanisme *coping* dan adaptasi pasien), reduktif (membangkitkan potensi kreatif yang ada), dan konstruktif (pengembangan potensi penyesuaian diri yang baru).
4. Manipulasi Lingkungan, yang diprioritaskan pada lingkungan sosial terutama yang mempengaruhi pasien, baik lingkungan rumah maupun lingkungan dimana pasien dirawat (RSJ) dengan fasilitas dan peraturan yang dibuat untuk mempercepat kesembuhan pasien (Maramis, 1998).

Tetapi apabila gangguan jiwa tersebut disebabkan suatu masalah psikologik ataupun sosial, maka tidak ada obat yang dapat menyembuhkan kecuali pasien itu sendiri sedang tim medis hanya membantunya ke arah penyelesaian masalah atau penyesuaian diri yang lebih baik (Maramis, 1998).

### 2.2.6 Teknik Komunikasi Terapeutik

Beberapa pendekatan yang telah digunakan para terapis dalam menangani pasien gangguan jiwa adalah (Maramis, 1998; Stuart, 1995):

1. Teknik terapi psikoanalisis, bahwa dalam tiap individu terdapat kekuatan yang saling berlawanan, menyebabkan konflik internal tidak terhindarkan. Konflik yang tidak disadari itu memiliki pengaruh kuat pada perkembangan kepribadian individu, sehingga menimbulkan stres dalam kehidupan. Teknik ini menekankan fungsi pemecahan masalah dari *ego* yang berlawanan dengan impuls dari *id.* Model ini banyak dikembangkan oleh Sigmund Freud. Menurut Freud, paling tidak terdapat lima macam teknik penyembuhan penyakit mental, antara lain; mempelajari otobiografi, hipnotis, catharsis, asosiasi bebas, dan analisis mimpi. Teknik terapi Psikoanalisis Freud pada perkembangan selanjutnya disempurnakan oleh Jung dengan teknik terapi Psikodinamik.
2. Teknik terapi perilaku, menggunakan prinsip belajar untuk memodifikasi perilaku individu. Teknik ini meliputi desensitisasi sistematik, *flooding*, penguatan sistematis, pemodelan, pengulangan perilaku yang pantas, dan teknik regulasi diri perilaku.
3. Teknik terapi kognitif perilaku, merupakan teknik memodifikasi perilaku dan mengubah keyakinan maladaptif. Ahli terapi membantu individu mengganti interpretasi yang

irasional terhadap suatu peristiwa dengan interpretasi lebih realistik. Membantu pengendalian reaksi emosional yang terganggu, seperti kecemasan, depresi dengan mengajarkan cara yang lebih efektif untuk menginterpretasikan pengalaman mereka.

4. Teknik terapi humanistik, adalah teknik dengan pendekatan fenomenologi kepribadian, membantu individu menyadari diri sesungguhnya dan memecahkan masalah mereka dengan intervensi dari ahli terapi yang minimal. Gangguan psikologis diduga timbul jika proses pertumbuhan potensi dan aktualisasi diri terhalang oleh situasi atau oleh orang lain. Carl Rogers, mengembangkan psikoterapi berpusat pada pasien *(client-centered-therapy)*, bahwa karakteristik ahli terapi penting untuk kemajuan dan eksplorasi-diri pasien adalah empati, kehangatan, dan ketulusan.
5. Teknik terapi eklektik atau integratif, yaitu memilih berbagai teknik terapi yang paling tepat untuk pasien tertentu, daripada mengikuti dengan kaku satu teknik tunggal. Ahli terapi mengkhususkan diri dalam masalah spesifik, seperti alkoholisme, disfungsi seksual, dan depresi.
6. Teknik terapi kelompok dan keluarga. Teknik ini memberikan kesempatan bagi individu untuk menggali sikap dan perilakunya dalam interaksi dengan orang lain yang memiliki masalah serupa. Terapi keluarga merupakan bentuk terapi kelompok khusus yang membantu hubungan orang tua dan anak, untuk mempelajari cara yang lebih efektif, dalam berhubungan satu sama lain untuk menangani berbagai masalahnya.

## 2.3 Keperawatan Jiwa

### 2.3.1 Pengertian

Stuart & Sundeen memberikan batasan tentang keperawatan jiwa adalah suatu proses interpersonal yang berupaya untuk meningkatkan dan mempertahankan perilaku, yang mengkontribusi pada fungsi yang terintegrasi. Sedangkan ANA *(American Nurses Association)* mendefinisikan keperawatan kesehatan jiwa adalah suatu bidang spesialisasi praktik keperawatan yang menerapkan teori perilaku manusia seabagai ilmunya dan penggunan diri secara terapeutik sebagai kiatnya. (Stuart; 1995). Berdasarkan dua pengertian diatas, maka setiap perawat jiwa dituntut mampu menguasai bidangnya dengan menggunakan ilmu perilaku sebagai landasan berfikirnya dan berupaya sedemikian rupa sehingga dirinya dapat menjadi alat yang efektif dalam merawat klien (Depkes RI, 2000).

2.3.2 Falsafah Keperawatan Jiwa

Beberapa keyakinan mendasar yang digunakan dalam keperawatan jiwa antara lain (Depkes RI. 2000):

1) Individu memiliki harkat dan martabat, masing-masing individu perlu dihargai.
2) Tujuan individu meliputi tumbuh, sehat, otonomi dan aktualisasi diri
3) Masing-masing individu mempunyai potensi untuk berubah
4) Manusia adalah mahluk *holistic* yang berinteraksi dan bereaksi dengan lingkungan sebagai manusia yang utuh
5) Masing-masing orang memiliki kebutuhan dasar yang sama
6) Semua perilaku individu adalah bermakna
7) Perilaku individu meliputi persepsi, pikiran, perasaan, dan tindakan
8) Individu memiliki kapasitas koping yang bervariasi, dipengaruhi oleh kondisi genetic, lingkungan, kondisi stress, dan sumber yang tersedia
9) Sakit dapat menumbuhkan dan mengembangkan psikologis bagi individu
10) Setiap orang mempunyai hak mendapatkan pelayanan kesehatan yang sama
11) Kesehatan mental adalah komponen kritikal dan penting dari pelayanan kesehatan yang komprehensif
12) Individu mempunyai hak untuk berpartisipasi dalam pembuatan keputusan untuk kesehatan fisik dan mentalnya
13) Tujuan keperawatan adalah meningkatkan kesejahteraan, memaksimalkan fungsi (meminimalkan kecacatan / ketidak mampuan) dan meningkatkan aktialisasi diri
14) Hubungan interpersonal dapat menghasilkan perubahan dan pertumbuhan pada individu

2.3.3 Peran dan Fungsi Perawat Jiwa

Peran dan fungsi perawat jiwa saat ini telah berkembang secara kompleks dari elemen historis aslinya (Stuart, 1998). Peran perawat jiwa sekarang mencakup parameter kompetensi klinik, advokasi klien, tanggung jawab fiskal (keuangan), kolaborasi professional, akuntabilitas (tanggung gugat) sosial, kewajiban etik dan legal. Dengan demikian, dalam memberikan asuhan keperawatan jiwa perawat dituntut melakukan aktivitas pada tiga area utama yaitu;

1) aktivitas asuhan langsung,
2) aktivitas Komunikasi, dan
3) aktivitas pengelolaan / penatalaksanaan manajemen keperawatan

(seperti pada tabel; 2.1).

Meskipun tidak semua perawat berperan serta dalam semua aktivitas, namun mereka tetap mencerminkan sifat dan lingkup terbaru dari asuhan yang kompeten dari perawat jiwa. Selain itu perawat jiwa harus mampu melakukan hal-hal sebagai berikut:

1) Membuat pengkajian kesehatan biopsikososial yang peka terhadap budaya
2) Merancang dan mengimplementasikan rencana tindakan untuk klien dan keluarga dengan masalah kesehatan yang kompleks dan kondisi yang dapat menimbulkan sakit
3) Berperan serta dalam aktivitas pengelolaan kasus, seperti mengorganisasi, mengkaji, negosiasi, koordinasi, dan mengintegrasikan pelayanan serta perbaikan bagi individu maupun keluarga.

Tabel: 2.1.

**AKTIVITAS KEPERAWATAN JIWA**

| AKTIVITAS ASUHAN LANGSUNG | AKTIVITAS KOMUNIKASI | AKTIVITAS PENATALAKSANAAN |
|---|---|---|
| Advokasi | Konferensi kasus klinik | Alokasi sumber & anggaran |
| Tindak lanjut setelah keperawatan | Mengembangkan rencana penanggulangan | Penyelia klinik |
| Penanggulangan perilaku | Dokumentasi asuhan | Kolaborasi |
| Konsultasi kasus | Kesaksian forensik | Peran serta komite |
| Pengelolaan kasus | Hubungan antar agen | Tindakan komunitas |
| Penanggulangan kognitif | Umpan balik sejawat | Hubungan konsultasi |
| Penyuluhan komunitas | Menyiapkan laporan | Negosiasi kontrak |
| Konseling kepatuhan | Jaringan kerja perawat profesional | Koordinasi pelayanan |
| Intervensi krisis | Pertemuan staf | Delegasi penugasan |
| Perencanaan pulang | Penulisan order | Penulisan jaminan |
| Intervensi keluarga | Pertemuan tim | Pemasaran dan humas |
| Kerja kelompok | Laporan verbal tentang asuhan | Mediasi & resolusi konflik |
| Peningkatan kesehatan | | Pengkajian dan perkiraan kebutuhan |
| Penyuluhan kesehatan | | Penguasaan organisasi |
| Pengkajian risiko tinggi | | Penatalaksanaan hasil |
| Kunjungan rumah | | Evaluasi kinerja |
| Konseling individu | | Pengembangan kebijakan dan prosedur |
| Skrining dan evaluasi masukan | | Presentasi profesional |
| Pemberian pengobatan | | Evaluasi program |
| Penatalaksanaan pengobatan | | Perencanaan program |
| Peningkatan kesh mental | | Publikasi |
| Pernik-pernik terapi | | Aktivitas peningkatan kualitas |
| Konseling nutrisi | | Aktivitas rekruitmen dan retensi |
| Informed consent | | Aktivitas badan legislasi |
| Penyuluhan orang tua | | Penatalaksanaan risiko |
| Triase pasien | | Pengembangan perangkat lunak |
| Pengkajian fisik | | Penjadwalan staf |
| Penanganan psikologis | | Penyuluhan staf dan peserta didik |
| Terapi bermain | | |
| Obat-obatan yang diresepkan | | |
| Memberikan keamanan lingkungan | | |
| Pengkajian psikososial | | |
| Psikoterapi | | |
| Pencegahan kekambuhan | | |

| | | |
|---|---|---|
| Implementasi penelitian<br>Aktivitas perawatan diri<br>Pelatihan ketrampilan Sosial<br>Penanganan somatik<br>Penatalaksanaan stress | | Perencanaan strategik<br>Penguasaan unit<br>Umpan balik<br>pendayagunaan |

Sumber: Stuart & Sundeen. 1998

4) Memberikan pedoman pelayanan kesehatan kepada individu, keluarga dan kelompok untuk menggunakan sumber yang tersedia di komunitas kesehatan mental termasuk pemberi pelayanan terkait, teknologi, dan sistem sosial yang paling tepat.
5) Meningkatkan, memelihara kesehatan mental serta mengatasi pengaruh penyakit mental melalui Penyuluhan dan Konseling
6) Memberikan asuhan kepada mereka yang mengalami penyakit fisik dengan masalah psikologik dan penyakit jiwa dengan masalah fisik.
7) Mengelola dan mengkoordinasi sistem pelayanan yang mengintegrasikan kebutuhan klien, keluarga, staf dan pembuat kebijakan.

Dalam menjalankan peran fungsinya, perawat jiwa harus mampu mengidentifikasi, menguraikan, dan mengukur hasil asuhan yang mereka berikan pada klien, keluarga, dan komunitas. Hasil adalah semua hal yang terjadi pada klien dan keluarga ketika mereka berada dalam sistem pelayanan kesehatan, dapat meliputi: status kesehatan, status fungsional, kualitas kehidupan, ada atau tidaknya penyakit, jenis respon koping, kepuasan terhadap tindak penanggulangan.

Evaluasi hasil dapat berfokus pada; kondisi klinik, intervensi, proses pemberian asuhan. Berbagai hasil dapat dievaluasi mencakup indikator-indikator; klinik, fungsional, finansial, dan perseptual. kepuasan klien dan keluarga (seperti tampak pada tabel 2.2).

Tabel 2.2. Indikator Hasil Tindakan Keperawatan Jiwa

| KATAGORI TENTANG INDIKATOR HASIL |
|---|
| INDIKATOR HASIL KLINIK<br>❖ Perilaku risiko tinggi<br>❖ Simptomatologi<br>❖ Respons adaptasi<br>❖ Kekambuhan<br>❖ Kejadian berulang<br>❖ Masuk kembali di rumah sakit<br>❖ Jumlah episode penanggulangan<br>❖ Komplikasi medik<br>❖ Laporan insidens |

| |
|---|
| ❖ Mortalitas |
| INDIKATOR HASIL FUNGSIONAL<br>❖ Status fungsional<br>❖ Interaksi sosial<br>❖ Aktivitas hidup sehari-hari<br>❖ Kemampuan okupasional<br>❖ Kualitas hidup<br>❖ Hubungan keluarga<br>❖ Penataan rumah |
| INDIKATOR HASIL PERSEPTUAL, KEPUASAN PASIEN & KELUARGA<br>❖ Hasil<br>❖ Pemberi pelayanan<br>❖ Sistem pelayanan<br>❖ Pelayanan yang diterima<br>❖ Organisasi |
| INDIKATOR HASIL FINANSIAL<br>❖ Biaya perepisode penanggulangan<br>❖ Pajak tiap episode penanggulangan<br>❖ Lama masa rawat inap<br>❖ Penggunaan sumber pelayanan kesehatan<br>❖ Biaya yang berhubungan dengan kecacatan |

Sumber: Stuart & Sundeen. 1998.

### 2.3.4 Peran Perawat dalam Pelayanan Kesehatan

Peran perawat jiwa dalam masing-masing tingkat pelayanan kesehatan adalah sebagai berikut (Depkes RI. 2000):

1) Peran Perawat dalam Prevensi Primer
   a. memberi penyuluhan tentang prinsip-prinsip sehat jiwa
   b. mengefektifkan perubahan dalam kondisi kehidupan, tingkat kemiskinan, dan pendidikan
   c. memberikan pendidikan dalam kondisi normal, pertumbuhan dan perkembangan, serta pendidikan seks
   d. melakukan rujukan yang sesuai sebelum gangguan jiwa terjadi, berdasarkan pada stressor dan perubahan kehidupan yang potensial
   e. membantu klien di RSU untuk menghindari masalah psikiatri di masa mendatang
   f. bersama-sama keluarga memberi dukungan pada angota keluarga dan meningkatkan fungsi kelompok
   g. aktif dalam kegiatan masyarakat dan politik yang berkaitan dengan kesehatan jiwa
2) Peran Perawat dalam Prevensi Sekunder
   a. melakukan skrining dan pelayanan evaluasi kesehatan jiwa

b. melaksanakan kunjungan rumah atau pelayanan penanganan di rumah
c. memberikan pelayanan kedaruratan psikiatri di RSU
d. menciptakan lingkungan terapeutik
e. melakukan supervisi klien yang mendapatkan pengobatan
f. memberikan pelayanan pencegahan bunuh diri
g. memberikan konsultasi
h. melaksanakan intervensi krisis
i. memberikan psikoterapi individu, keluarga, dan kelompok pada berbagai tingkat usia
j. memberikan intervensi pada komunitas dan organisasi yang telah teridentifikasi masalah yang dialaminya

3) Peran Perawat dalam Prevensi Tersier
a. melaksanakan latihan vokasional dan rehabilitasi
b. mengorganisasi "setelah perawatan" untuk klien yang telah pulang dari fasilitas pelayanan kesehatan jiwa untuk memudahkan transisi dari rumah sakit ke komunitas
c. memberikan pilihan "*partial hospitalization*" (perawatan rawat siang) pada klien.

### 2.3.5 Terapi Modalitas dalam Keperawatan Jiwa

Terapi modalitas dalam keperawatan jiwa adalah berbagai macam alternatif terapi yang mungkin dapat diberikan pada pasien yang mengalami gangguan jiwa (Stuart, 1995). Terapi modalitas ini terdairi dari berbagai alternatif terapi dan setting pengobatan, seperti pada tabel 2.3.

Tabel 2.3

**Terapi Modalitas dalam Keperawatan Jiwa**

| | TREATMENT MODALITIES | TREATMENT SETTINGS |
|---|---|---|
| 1. | Psychopharmacology;<br>• Role of the nurse<br>• Pharmacokinetics<br>• Antianxiety<br>• Antidepresant<br>• Mood-stabilizing drugs<br>• Antipsychotic | 1. Hospital-Based Psychiatric Nursing Care;<br>➢ The psychiatric hospital in transition<br>- inpatient programs<br>- partial hospital programs<br>➢ managing the therapeutic milieu<br>➢ implementing care-giving activities<br>➢ integrating care delivery<br>➢ evaluating out-comee |
| 2. | Somatic Terapies;<br>• ECT<br>• Phothoterapy<br>• Sleep deprivation therapy | |
| 3. | Preventing and Managing Aggressive Behavior;<br>• Theories on aggression<br>• Nursing interventions | |

| | | |
|---|---|---|
| | • Crisis management techniques | |
| 4. | Cognitive Behavioral Therapy;<br>• Classical conditioning<br>• Operant conditioning<br>• Treatment strategies<br>• Role of the nurse | 2. Community Psychiatric Nursing Care;<br>➢ Public health model<br>➢ Biological-medical model<br>➢ System model<br>➢ Patient-centered model<br>➢ Nursing role |
| 5. | Therapeutic Groups;<br>• Component of small group<br>• Group development<br>• Nurse as group leaders | |
| 6. | Family Interventions;<br>• Family functions<br>• Non clinical interventions<br>• Clinical interventions<br>• Family systems therapy<br>• Structural family therapy<br>• Strategic family therapy | 3. Home Psychiatric Nursing Care |

(Sumber; Stuart, 1998)

# BAB 3. TUJUAN DAN MANFAAT PENELITIAN



## Tujuan

### Tujuan Umum

Mengembangkan model holistic dalam perawatan pasien gangguan jiwa.

### Tujuan Khusus

Tujuan khusus pada tahun kedua ini adalah;

1. Menyusun kuesioner pengembangan model holistik sesuai hasil eksplorasi variabel tahun pertama
2. Melakukan uji model pendekatan holistik dalam merawat pasien gangguan jiwa
3. Menyusun standar operasional prosedur berbagai terapi modalitas dalam keperawatan jiwa sesuai hasil uji model
4. Menganalisis pengaruh terapi modalitas dengan pendekatan holistik dalam keperawatan kesehatan jiwa
5. Melakukan sosialisasi hasil riset melalui publikasi dan berpartisipasi pada pertemuan Nasional dan Internasional.
6. Menyusun Draft SOP lengkap pelaksanaan terapi modalitas keperawatan dengan pendekatan holistik
7. Menyusun Draft Buku Holistik dalam merawat pasien gangguan jiwa sebagai penyempurnaan buku ajar keperawatan yang telah ada sebelumya.

## Manfaat Penelitian

Hasil penelitian dan pengembangan model ini digunakan sebagai bahan *evident based practice in nursing*, dalam merumuskan model holistic dalam perawatan pasien gangguan jiwa. Menyempurnakan buku ajar keperawatan kesehatan jiwa yang telah disusun oleh tim peneliti. Diintegrasikan dalam kurikulum pembelajaran, untuk menghasilkan lulusan yang kompeten dalam pemberian asuhan keperawatan kesehatan jiwa. Pada bagian akhir akan dikembangkan buku model holistic dalam perawatan pasien gangguan jiwa.

# BAB 4. METODE PENELITIAN

Metode penelitian dalam penelitian ini terdiri dari dua tahap. Tahap pertama dengan pendekatan kualitatif untuk mengetahui berbagai variabel yang berhubungan dengan perawatan pasien gangguan jiwa. Pada tahap awal dilakukan indepth interview pada perawat dan keluarga pasien, serta FGD (focus group discussion) pada perawat di Rumah Sakit Jiwa Menur dan Rumah Sakit Jiwa Dr. Radjiman Wediodiningrat Lawang Malang, menyusun draft kuesioner berdasarkan analisis tematik hasil penelitian tahun pertama.

Penelitian pada tahap kedua dilakukan secara kuantitatif untuk menguji hasil pengembangan model holistik dalam merawat pasien gangguan jiwa. Hasil penelitian diolah dengan analisis statistik deskriptif dan analisis inferensial PLS (*Partial Least Square)* karena PLS lebih bersifat *predictive model*. Pengujian model struktural dalam PLS dilakukan dengan bantuan software Smart PLS ver 2 *for windows*.

Hasil penelitian ini akan ditelaah lebih lanjut melaui *focus group discussion* (FGD) antara tim peneliti dan stake holder untuk menyusun standar operasional prosedur sebagai pedoman pelaksanaan terapi modalitas dalam merawat pasien gangguan jiwa secara holistik, sebagai bahan penyempurnaan buku ajar keperawatan kesehatan jiwa dan materi dasar penyusunan draft buku holistik dalam merawat pasien gangguan jiwa..

## Organisasi Tim

Pengorganisasian dan pelaksanaan penelitian ini direncanakan oleh ketua pengusul, dilaksanakan bersama dengan tim yang dibentuk dari seluruh anggota tim, praktisi dari Rumah Sakit Jiwa Menur, unit Psikiatri RSUD Dr. Soetomo Surabaya, Rumah Sakit Jiwa Dr. Radjiman Wediodiningrat Lawang. Setiap sub penelitian dilaksanakan oleh tim yang dibentuk sesuai keahlian anggota tim.

# BAB 5. HASIL DAN LUARAN YANG DICAPAI

Bab ini membahas hasil penelitian yang didapatkan dari data primer dan diolah dengan analisis statistik deskriptif dan analisis inferensial PLS (*Partial Least Square)* karena PLS lebih bersifat *predictive model*. Pengujian model struktural dalam PLS dilakukan dengan bantuan software Smart PLS ver 2 *for windows*.

Hasil analisis deskriptif meliputi karakteristik responden dan variabel indikator dari model pendekatan holistik dalam merawat pasien gangguan jiwa. Langkah selanjutnya dilakukan analisis inferensial untuk mengetahui hubungan pengaruh diantara variabel eksogen terhadap endogen. Berdasarkan hasil analisis inferensial diketahui hubungan pengaruh yang signifikan diantara konstrak dan juga diketahui model pendekatan holistik dalam merawat pasien gangguan jiwa yang tepat dalam hal ini model fit.

Penelitian ini menggunakan data primer yang didapatkan melalui pengumpulan data langsung ke responden perawat di RS Jiwa Dr. Radjiman Wediodiningrat Lawang dan RS Jiwa Menur Surabaya, total 120 responden.

## 1. Gambaran Umum Tempat Penelitian

Penelitian ini dilaksanakan di Rumah Sakit Jiwa Dr. Wediodiningrat Lawang Malang dan Rumah Sakit Jiwa Menur Surabaya Provinsi Jawa Timur. Toal sampel sebanyak 120 responden. Berikut adalah gambaran umum tempat penelitian.

### RS Jiwa Dr. Radjiman Wediodiningrat Lawang

Rumah Sakit Jiwa Dr Radjiman Wediodiningrat Lawang berada di Jalan A. Yani, Kecamatan Lawang, Kabupaten Malang. RSJ Dr Radjiman Wediodiningrat Lawang merupakan RSJ pusat tipe A dengan fasilitas pelayanan terdiri dari rawat jalan dan rawat inap. Rawat jalan terdiri dari IGD, poliklinik Napza, poliklinik anak dan remaja, poliklinik geriatri, poliklinik umum, poliklinik KIA, poliklinik kulit, poliklinik tumbuh kembang anak, poliklinik fisioterapi, dan poliklinik foto aura.

Rawat Inap terdiri dari IPCU (Anyelir, Camar, Perkutut), ruang rawat inap pria (Bangau, Bekisar, Cendrawasih, Cucakrowo, Garuda, Kakak Tua, Kasuari, Kenari, Kutilang, dan Parkit), ruang rawat inap wanita (Cempaka, Flamboyan, Mawar, Melati, Nusa Indah, Sedap Malam, dan Seruni), ruang geriatri (Betet, Bismo dan Kenanga), ruang sakit

(Kemuning), ruang pelayanan umum (Metro), Ruang Napza, dan Ruang anak dan remaja (Wijaya Kusuma).

Kapasitas total rawat inap RSJ Dr Radjiman Wediodiningrat Lawang adalah 700 tempat tidur. Jumlah ketenagaan secara keseluruhan adalah 831 orang. Jumlah tenaga keperawatan adalah sebanyak 371 perawat. Tenaga medis terdiri dari 16 dokter umum, 12 dokter spesialis jiwa dan 24 dokter spesialis lainnya.

**RS Jiwa Menur Surabaya**

Rumah Sakit Jiwa Menur adalah Badan Layanan Umum Daerah yang terletak di Jalan Raya Menur No. 120 Kelurahan Kertajaya, Kecamatan Gubeng, Kota Surabaya. Jumlah TT (Tempat Tidur) yang tersedia sebanyak 250 TT dari kapasitas total 300 TT. Visi dari Rumah Sakit Jiwa Menur adalah menjadi rumah sakit jiwa kelas A pendidikan dengan pelayanan holistik dan komprehensif yang berakhlak untuk kesejahteraan bersama (LAKIP RSJ Menur, 2014).

Rumah Sakit Jiwa Menur Surabaya merupakan instasi milik pemerintah Provinsi Jawa Timur dan menjadi satu-satunya rumah sakit di Surabaya yang khusus untuk rehabilitasi mental, psikologi dan penyembuhan kejiwaan, selain itu juga menjadi pusat rujukan kesehatan jiwa yang peripurna. Fasilitas pelayanan yang tersedia di RSJ Menur Surabaya meliputi: Pelayanan jiwa diantaranya rawat jalan, rawat inap, dan gawat darurat, pelayanan umum dan spesialis diantaranya: poliklinik umum, gigi dan mulut, spesialis NAPZA, spesialis jantung, paru, syaraf, psikiatri, THT, kulit dan kelamin, poliklinik Psikologi, poliklinik tumbuh kembang, poliklinik VCT, UGD, pelayanan Askeskin, pelayanan rehabilitasi, serta pelayanan penunjang lainnya. Rumah sakit ini memiliki beberapa ruang rawat inap seperti Ruang Puri Anggrek, Ruang Wijaya Kusuma, Ruang Flamboyan, Ruang Kenari, Ruang Gelatik, dan Ruang Puri Mitra.

Rumah Sakit Jiwa Menur Provinsi Jawa Timur merupakan Rumah Sakit Khusus dengan Klasifikasi Kelas A yang menjadi rujukan se-Jawa Timur.

## 2. Hasil Penelitian

### 2.1 Karakteristik Responden

Karakteristik responden berdasarkan hasil deskripsi yang disajikan dalam bentuk tabel berupa nilai persentase frekuensi mulai dari nilai terbesar sampai terkecil. Hasil selengkapnya disampaikan dalam tabel berikut ini.

**Tabel 5.1** Karakteristik Responden

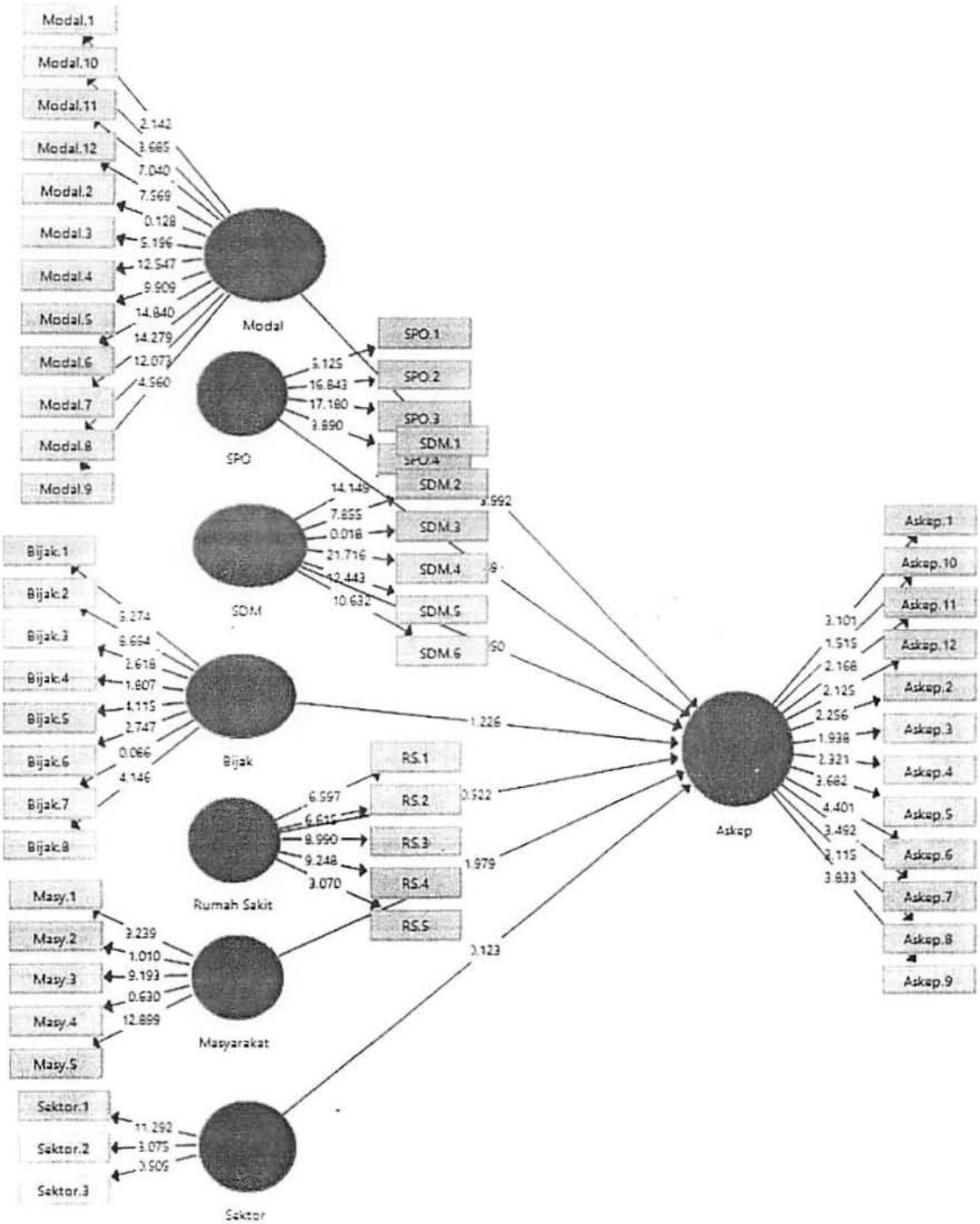
| Karakteristik | Kategori | Frekuensi | Persentase |
|---|---|---|---|
| Jenis Kelamin | Perempuan | 58 | 48,3 |
| | Laki-laki | 62 | 51,7 |
| Umur | 21 – 25 | 5 | 4,1 |
| | 26 – 30 | 19 | 15,8 |
| | 31 – 35 | 18 | 15,0 |
| | 36 – 40 | 24 | 20,0 |
| | 41 – 45 | 16 | 13,3 |
| | 46 – 50 | 23 | 19,1 |
| | 51 – 55 | 14 | 11,6 |
| | 56 – 60 | 1 | 0,8 |
| Masa Kerja | 1 – 5 | 14 | 11,7 |
| | 6 – 10 | 22 | 18,3 |
| | 11 – 15 | 25 | 20,8 |
| | 16 – 20 | 15 | 12,5 |
| | 21 – 25 | 13 | 10,8 |
| | 26 – 30 | 19 | 15,9 |
| | 31 – 35 | 8 | 6,7 |
| | 36 – 40 | 1 | 0,8 |
| | Missing | 3 | 2,5 |
| Tempat Kerja | Rawat Inap | 89 | 74,2 |
| | Rawat Jalan | 31 | 25,8 |
| Pendidikan | D3 Keperawatan | 55 | 45,8 |
| | D4 Keperawatan | 15 | 12,5 |
| | Ners | 49 | 40,9 |
| | S2 Kesehatan | 1 | 0,8 |

Mayoritas responden usia 36 – 40 tahun, masa kerja 11 – 15 tahun, bekerja di ruang rawat inap dan pendidikan Diploma 3 Keperawatan.

## 2.2 Hasil Analisis Inferensial (Pengujian Outer Model/Model Struktural)

Berdasarkan model pengukuran sebelumnya diketahui semua indikator valid mengukur konstrak, selanjutnya dilakukan pengujian model struktural dari pendekatan holistik dalam merawat pasien gangguan jiwa. Evaluasi pengukuran model awal bersifat reflektif, yaitu convergent validity dan discriminant validity. Convergent validity dimulai dengan melihat item reliability (indikator validitas) yang ditunjukkan dengan nilai loading factor (outer loading). Indikator dikatakan memenuhi convergent validity jika memiliki outer loading > 0,5.

Berikut ini tampilan model struktural awal dari model holistik dalam merawat pasien gangguan jiwa antara variabel eksogen terhadap variabel endogen.




Gambar 5.1 Model Struktural Awal
Pendekatan Holistik dalam Merawat Pasien Gangguan Jiwa

Tabel 5.2 Keterangan Indikator Variabel Penelitian

| | | |
|---|---|---|
| Modalitas (X1) | X1.1 | Psikofarmaka |
| | X1.2 | Electro convulsive therapi ECT |

| | | |
|---|---|---|
| Pelaksanaan terapi modalitas dalam perawatan kesehatan jiwa | X1.3 | Terapi individu |
| | X1.4 | Terapi kognitif |
| | X1.5 | Terapi psikologis |
| | X1.6 | Terapi perilaku |
| | X1.7 | Terapi spiritual |
| | X1.8 | Terapi aktivitas kelompok |
| | X1.9 | Terapi keluarga |
| | X1.10 | Terapi berbasis kelompok khusus |
| | X1.11 | Terapi berbasis masyarakat |
| | X1.12 | Melakukan discharge planning |
| SPO (X2)<br>Standar prosedur operasional (SPO) tindakan keperawatan | X2.1 | Sudah ada untuk semua jenis terapi |
| | X2.2 | SPO sudah sesuai fasilitas RS |
| | X2.3 | SPO dapat dilaksanakan dengan baik |
| | X2.4 | Mengembangkan SPO sendiri |
| SDM (X3)<br>Sumber daya manusia keperawatan | X3.1 | Kualifikasi perawat terpenuhi |
| | X3.2 | MAKP dilaksanakan dg baik |
| | X3.3 | Rasio perawat : pasien |
| | X3.4 | Jenjang karier perawat |
| | X3.5 | Komunikasi antar perawat |
| | X3.6 | Komunikasi antar profesional lain |
| Kebijakan (X4)<br>Kebijakan yang berlaku di Rumah Sakit | X4.1 | Job deskripsi jelas |
| | X4.2 | Wewenang |
| | X4.3 | Over lap dengan profesi lain |
| | X4.4 | Supervisi Karu |
| | X4.5 | Remunersi |
| | X4.6 | Tugas administratif tambahan |
| | X4.7 | Punishment |
| | X4.8 | Reward |
| Rumah Sakit (X5)<br>Fasilitas yang tersedia di Rumah Sakit | X5.1 | Secara unum sesuai harapan |
| | X5.2 | Terapi modalitas keperawatan |
| | X5.3 | Pelaksanaan ADL pasien |
| | X5.4 | Fasilitas rehabilitasi |
| | X5.5 | Intervensi berbasis keluarga/masyarakat |
| Masyarakat (X6)<br>Kondisi masyarakat | X6.1 | Kooperatif dg fasyankes |
| | X6.2 | Stigma |
| | X6.3 | Memperlakukan pasien dengan baik |
| | X6.4 | Ada pasung di masyarakat |
| | X6.5 | Siap menerima pasien pasca pasung |
| Sektor (X7)<br>Kondisi lintas sektor | X7.1 | Lintas sektor berjalan baik |
| | X7.2 | RS sebagai leading sektor |
| | X7.3 | Pemda sebangai leading sektor |
| Asuhan keperawatan (Y1)<br>Pelaksanaan model holistik dalam merawat pasien gangguan jiwa | Y1.1 | Integrasi asuhan keperawatan |
| | Y1.2 | Pengkajian fisik |
| | Y1.3 | Pengkajian psikologis |
| | Y1.4 | Pengkajian sosial / budaya |
| | Y1.5 | Pengkajian spiritual |
| | Y1.6 | Diagnosis sesuai 10 masalah utama |
| | Y1.7 | Diagnosis bio-psiko-sosial-spiritual |
| | Y1.8 | Diagnosis mandiri |
| | Y1.9 | Intervensi sesuai SPO |
| | Y1.10 | Intervensi dirancang sendiri |
| | Y1.11 | Evaluasi asuhan keperawatan |
| | Y1.12 | Dokumentasi asuhan keperawatan |

Hasil Outer Weight khususnya kolom T Statistics (|O/STDEV|) menunjukkan angka merah adalah sub-variabel yang tidak signifikan. Angka yang tidak signifikan akan di keluarkan dari analisis data sehingga semua Variabel secara secara signifikan valid menyusun konstruk model holistik dalam merawat pasien gangguan jiwa (seperti tampak pada model akhir).

Tabel 5.3 Hasil Outer Weight Model Struktural Awal
(Signifikan Indikator Variabel Laten)

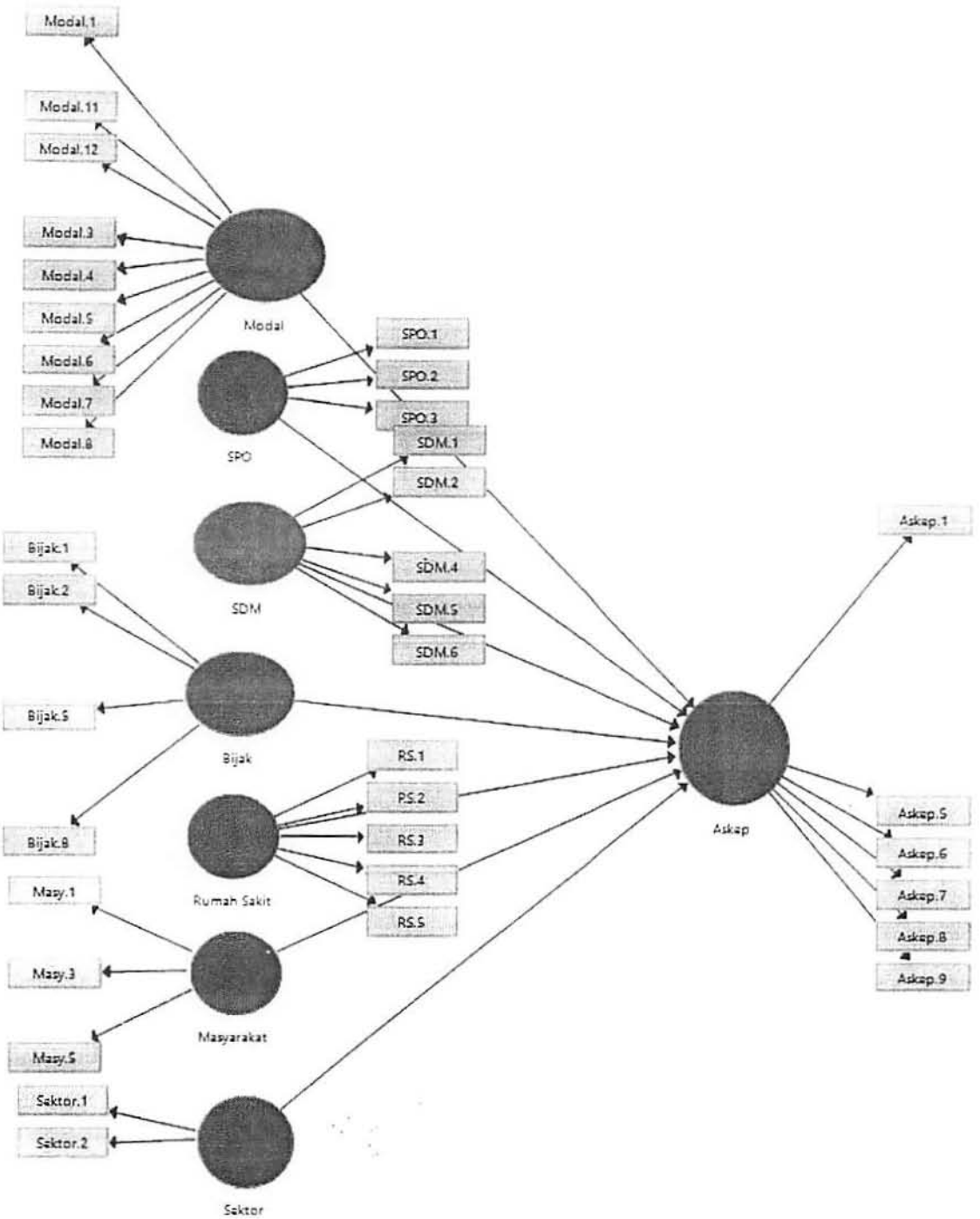
| | T Statistics (\|O/STDEV\|) | P Values |
|---|---|---|
| Askep.1 <- Askep | 3.534 | 0.000 |
| Askep.10 <- Askep | 2.090 | 0.037 |
| Askep.11 <- Askep | 1.476 | 0.141 |
| Askep.12 <- Askep | 1.547 | 0.123 |
| Askep.2 <- Askep | 1.621 | 0.106 |
| Askep.3 <- Askep | 2.030 | 0.043 |
| Askep.4 <- Askep | 1.422 | 0.156 |
| Askep.5 <- Askep | 2.838 | 0.005 |
| Askep.6 <- Askep | 3.373 | 0.001 |
| Askep.7 <- Askep | 3.232 | 0.001 |
| Askep.8 <- Askep | 2.727 | 0.007 |
| Askep.9 <- Askep | 3.300 | 0.001 |
| Bijak.1 <- Bijak | 3.196 | 0.001 |
| Bijak.2 <- Bijak | 5.049 | 0.000 |
| Bijak.3 <- Bijak | 0.723 | 0.470 |
| Bijak.4 <- Bijak | 0.610 | 0.542 |
| Bijak.5 <- Bijak | 2.086 | 0.037 |
| Bijak.6 <- Bijak | 1.867 | 0.062 |
| Bijak.7 <- Bijak | 0.538 | 0.591 |
| Bijak.8 <- Bijak | 2.365 | 0.018 |
| Masy.1 <- Masyarakat | 4.854 | 0.000 |
| Masy.2 <- Masyarakat | 0.998 | 0.319 |
| Masy.3 <- Masyarakat | 3.236 | 0.001 |
| Masy.4 <- Masyarakat | 0.138 | 0.891 |
| Masy.5 <- Masyarakat | 6.709 | 0.000 |
| Modal.1 <- Modal | 2.234 | 0.026 |
| Modal.10 <- Modal | 1.720 | 0.086 |
| Modal.11 <- Modal | 2.847 | 0.005 |
| Modal.12 <- Modal | 3.717 | 0.000 |
| Modal.2 <- Modal | 0.497 | 0.619 |
| Modal.3 <- Modal | 3.323 | 0.001 |
| Modal.4 <- Modal | 2.661 | 0.008 |
| Modal.5 <- Modal | 4.431 | 0.000 |
| Modal.6 <- Modal | 5.637 | 0.000 |
| Modal.7 <- Modal | 2.923 | 0.004 |
| Modal.8 <- Modal | 2.676 | 0.008 |

| | | |
|---|---|---|
| Modal.9 <- Modal | 2.724 | 0.007 |
| RS.1 <- Rumah Sakit | 3.448 | 0.001 |
| RS.2 <- Rumah Sakit | 2.030 | 0.043 |
| RS.3 <- Rumah Sakit | 3.387 | 0.001 |
| RS.4 <- Rumah Sakit | 3.927 | 0.000 |
| RS.5 <- Rumah Sakit | 1.241 | 0.215 |
| SDM.1 <- SDM | 7.055 | 0.000 |
| SDM.2 <- SDM | 2.604 | 0.009 |
| SDM.3 <- SDM | 0.700 | 0.484 |
| SDM.4 <- SDM | 7.375 | 0.000 |
| SDM.5 <- SDM | 3.226 | 0.001 |
| SDM.6 <- SDM | 2.651 | 0.008 |
| SPO.1 <- SPO | 3.639 | 0.000 |
| SPO.2 <- SPO | 4.639 | 0.000 |
| SPO.3 <- SPO | 5.615 | 0.000 |
| SPO.4 <- SPO | 1.636 | 0.102 |
| Sektor.1 <- Sektor | 5.776 | 0.000 |
| Sektor.2 <- Sektor | 5.301 | 0.000 |
| Sektor.3 <- Sektor | 0.935 | 0.350 |

Penjelasan:

Pada huruf yang diberikan warna merah bahwa nilai T statistik yaitu kurang dari 1,96 sehingga menggambarkan tidak signifikan sebagai indikator untuk variabel laten → dihilangkan, sampai diperoleh hasil akhir sebagai berikut;

Berdasar hasil uji model struktural akhir diketahui model holistic dalam merawat pasien gangguan jiwa dibangun atas peran perawat dalam melaksanakan asuhan keperawatan secara integral, pengkajian spiritual, menegakkan diagnosis keperawatan sesuai standar diagnosis yang berlalku, membuat diagnosis keperawatan pada aspek bioologis, psikologis, sosial dan spiritual. Asuhan kepeawatan secara holistic ini dibangun oleh komponen pelaksanaan terapi modalitas dalam keperawatan, standar prosedur operasional untuk intervensi keperawatan sesuai diagnosis yang ditegakkan, sumber daya manusia keperawatan, kebijakan asuhan keperawatan yang berlalku di rumah sakit, fasilitas rumah sakit, kondisi masyarakat dan kondisi lintas sektor yang terlibat dalam pelayanan keperawatan kesehatan jiwa.




Gambar 5.2 Model Struktural Akhir
Pendekatan Holistik dalam Merawat Pasien Gangguan Jiwa

Berdasarkan uji model struktural akhir diatas, dapat diketahui signifikansi indikator variabel laten adalah sebagai berikut.

Tabel 5.4 Hasil Outer Weight Model Struktural Akhir

| | T Statistics (\|O/STDEV\|) | P Values |
|---|---|---|
| Askep.1 <- Askep | 6.947 | 0.000 |
| Askep.5 <- Askep | 3.117 | 0.002 |
| Askep.6 <- Askep | 5.433 | 0.000 |
| Askep.7 <- Askep | 7.143 | 0.000 |
| Askep.8 <- Askep | 2.930 | 0.004 |
| Askep.9 <- Askep | 2.914 | 0.004 |
| Bijak.1 <- Bijak | 6.522 | 0.000 |
| Bijak.2 <- Bijak | 10.020 | 0.000 |
| Bijak.5 <- Bijak | 7.718 | 0.000 |
| Bijak.8 <- Bijak | 4.669 | 0.000 |
| Masy.1 <- Masyarakat | 9.490 | 0.000 |
| Masy.3 <- Masyarakat | 3.222 | 0.001 |
| Masy.5 <- Masyarakat | 9.672 | 0.000 |
| Modal.1 <- Modal | 2.221 | 0.027 |
| Modal.11 <- Modal | 2.236 | 0.026 |
| Modal.12 <- Modal | 3.257 | 0.001 |
| Modal.3 <- Modal | 3.027 | 0.003 |
| Modal.5 <- Modal | 3.303 | 0.001 |
| Modal.6 <- Modal | 5.539 | 0.000 |
| Modal.7 <- Modal | 3.836 | 0.000 |
| Modal.8 <- Modal | 2.200 | 0.028 |
| RS.1 <- Rumah Sakit | 5.671 | 0.000 |
| RS.2 <- Rumah Sakit | 6.557 | 0.000 |
| RS.3 <- Rumah Sakit | 4.051 | 0.000 |
| RS.4 <- Rumah Sakit | 6.164 | 0.000 |
| RS.5 <- Rumah Sakit | 2.749 | 0.006 |
| SDM.1 <- SDM | 8.325 | 0.000 |
| SDM.2 <- SDM | 3.377 | 0.001 |
| SDM.4 <- SDM | 8.418 | 0.000 |
| SDM.5 <- SDM | 4.116 | 0.000 |
| SDM.6 <- SDM | 4.824 | 0.000 |
| SPO.1 <- SPO | 4.006 | 0.000 |
| SPO.2 <- SPO | 5.727 | 0.000 |
| SPO.3 <- SPO | 5.502 | 0.000 |
| Sektor.1 <- Sektor | 8.617 | 0.000 |
| Sektor.2 <- Sektor | 9.678 | 0.000 |

Ternyata seluruh indikator yang ada telah signifikan karena nilai T lebih dari 1,96 dengan demikian dapat digunakan sebagai indikator variabel laten yang menyusun suatu model pendekatan holistik dalam merawat pasien gangguan jiwa.

Hasil uji validitas rho_A dan uji composite reliability pada original sampel (O) didapatkan bahwa seluruh indikator bekerja secara simultan dan terintegrasi membentuk variabel laten model holistic dalam merawat pasien gangguan jiwa.

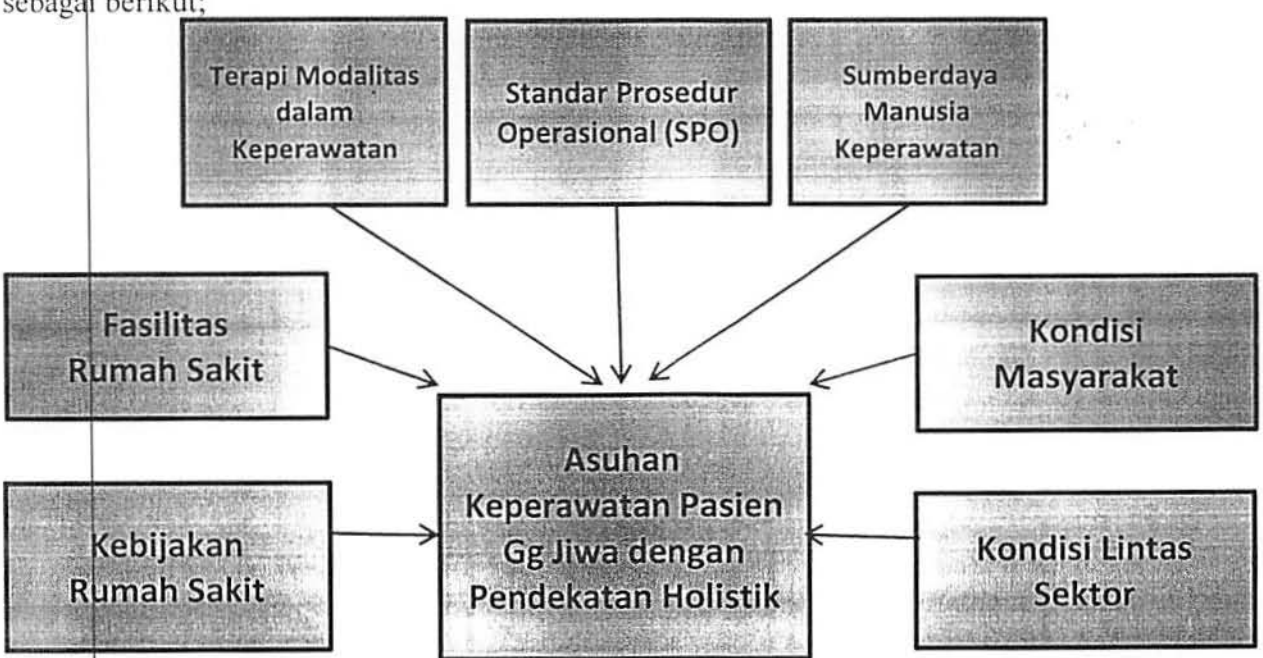
Tabel 5.5 Hasil Uji rho_A

| | Original Sample (O) | Sample Mean (M) | Standard Deviation (STDEV) | T Statistics (\|O/STDEV\|) | P Values |
|---|---|---|---|---|---|
| Askep | 0.621 | 0.629 | 0.053 | 11.754 | 0.000 |
| Bijak | 0.567 | 0.574 | 0.053 | 10.736 | 0.000 |
| Masyarakat | 0.797 | 0.799 | 0.056 | 14.252 | 0.000 |
| Modal | 0.824 | 0.818 | 0.074 | 11.169 | 0.000 |
| Rumah Sakit | 0.861 | 0.874 | 0.037 | 23.028 | 0.000 |
| SDM | 0.838 | 0.843 | 0.028 | 30.341 | 0.000 |
| SPO | 0.749 | 0.792 | 0.182 | 4.107 | 0.000 |
| Sektor | 0.756 | 0.781 | 0.067 | 11.326 | 0.000 |

Tabel 5.6 Hasil Uji Composite Reliability

| | Original Sample (O) | Sample Mean (M) | Standard Deviation (STDEV) | T Statistics (\|O/STDEV\|) | P Values |
|---|---|---|---|---|---|
| Askep | 0.749 | 0.742 | 0.031 | 24.087 | 0.000 |
| Bijak | 0.730 | 0.727 | 0.022 | 32.485 | 0.000 |
| Masyarakat | 0.841 | 0.838 | 0.022 | 37.569 | 0.000 |
| Modal | 0.849 | 0.841 | 0.018 | 48.066 | 0.000 |
| Rumah Sakit | 0.869 | 0.866 | 0.018 | 48.694 | 0.000 |
| SDM | 0.853 | 0.852 | 0.015 | 56.701 | 0.000 |
| SPO | 0.829 | 0.825 | 0.023 | 36.759 | 0.000 |
| Sektor | 0.886 | 0.884 | 0.018 | 48.153 | 0.000 |

Model akhir keperawatan kesehatan jiwa dengan pendekatan holistik yang terbentuk adalah sebagai berikut;



Model holistik dalam merawat pasien gangguan jiwa dalam penelitian ini dibentuk secara signifikan oleh pelaksanaan terapi modalitas keperawatan jiwa, kebijakan rumah sakit dan situasi di masyarakat. Hasil ini didukung oleh beberapa penelitian terkait pendekatan holistik keperawatan yang menyatakan bahwa pendekatan holistik terdiri dari dua aspek, yaitu pasien dan multidimensi yang menjadi rumit akibat situasi sakit pasien (Berg & Sarvimaki, 2003; Dossey, 2008; Kubsch, Hankerson, & Ghoorahoo, 2005; Papathanasiou, Sklavou, & Kourkouta, 2013). Model holistik dalam merawat pasien gangguan jiwa berfokus bukan hanya kepada kondisi kesehatan pasien gangguan jiwa yang diwujudkan dalam pelaksanaan terapi modalitas keperawatan, tetapi juga melakukan upaya kepada aspek diluar sistem pasien, yaitu rumah sakit dan masyarakat.

Keberadaan pasien gangguan jiwa menuntut adanya pelayanan kesehatan khusus di rumah sakit khusus seperti rumah sakit jiwa. Rumah sakit perlu memiliki kebijakan yang mendukung terhadap pelaksanaan terapi modalitas bagi pasien gangguan jiwa. Selain itu, model holistik juga memperhatikan respon masyarakat terhadap keberadaan pasien gangguan jiwa dan mengembangkan intervensi berbasis masyarakat dengan tetap berporos pada rumah sakit. Kesinambungan antara terapi modalitas keperawatan untuk memperbaiki kondisi kesehatan pasien gangguan jiwa dan dengan adanya dukungan kebijakan rumah sakit serta intervensi untuk menyiapkan masyarakat merupakan inti dari penerapan pengembangan model holistik keperawatan jiwa.

Model holistik dalam merawat pasien gangguan jiwa yang dikembangkan dalam penelitian ini menggunakan pendekatan asuhan keperawatan. Hasil penelitian menunjukkan bahwa model holistik keperawatan jiwa diterapkan dengan melakukan asuhan keperawatan terintegrasi dimulai dari kegiatan pengkajian terutama dalam aspek spiritual, melakukan diagnosis berdasarkan 10 masalah keperawatan utama, masalah bio-psiko-sosio-spiritual dan masalah keperawatan mandiri, dan melaksanakan intervensi berdasarkan SOP. Model ini sejalan dengan Mariano (2007) yang menyebutkan bahwa perawat holistik akan memberikan perawatan kepada seorang pasien secara menyeluruh meliputi proses pengkajian, penentuan diganosis, merumuskan tujuan dan rencana perawatan, melakukan intervensi dan evaluasi. (Papathanasiou et al., 2013) dalam penelitiannya juga menyampaikan bahwa pendekatan keperawatan holistik menimbulkan tuntutan bagi perawat untuk bisa berinteraksi dengan pasien secara baik sehingga mampu menentukan status kesehatan pasien dan menentukan tindakan yang tepat untuk meningkatkan kesehatan. Sehingga pendekatan asuhan keperawatan merupakan metode yang tepat dalam menyusun sebuah pengembangan model holistik dalam keperawatan pasien gangguan jiwa.

Berdasarkan hasil penelitian, pengkajian yang penting untuk dilakukan perawat dalam menerapkan model holistik adalah pengkajian spiritual pada pasien gangguan jiwa. Pengkajian spritual difokuskan pada sejauh mana keyakinan spiritual pasien mampu mempengaruhi kehidupan terkait penyakit yang dialami, bentuk dukungan spiritual yang diharapkan diperoleh dari tenaga kesehatan, cara memenuhi kebutuhan spiritual selama sakit, kebutuhan pasien akan konsultan spiritual/rohaniawan dan harapan pasien terhadap penyakitnya (Yusuf, Nihayati, Iswari, & Okviansanti, 2016). Perawat harus memperhatikan kebutuhan spiritual yang tidak

terpenuhi pada setiap pasien, termasuk pasien dengan gangguan jiwa. Namun demikian perawat juga harus menilai sejauh mana kemampuan pasien dalam memberikan penilaian terhadap aspek spiritual yang dimiliki, mengingat bahwa proses penyakit gangguan jiwa memiliki dampak yang mempengaruhi cara dan proses berpikir pasien. Saat ini asuhan keperawatan yang diberikan kepada pasien masih berfokus pada aspek biologis, psikologis dan sosial, sehingga penambahan pada aspek spiritual akan melengkapi pendekatan asuhan keperawatan dalam model holistik keperawatan.

Terapi modalitas merupakan sebagai salah komponen penerapan model holistik dalam merawat pasien gangguan jiwa karena terapi modalitas memberikan intervensi secara langsung kepada pasien gangguan jiwa. Terapi modalitas merupakan pendekatan klien gangguan jiwa yang bervariasi dan bertujuan untuk mengubah perilaku maladaptif menjadi lebih adaptif. Terapi modalitas merupakan pilihan berbagai terapi yang dapat diberikan kepada pasien gangguan jiwa, meliputi terapi somatik, terapi psikologis, terapi lingkungan, terapi komunitas dan terapi aktivitas (Srevani, 2009). Definisi tersebut mendukung hasil dalam penelitian ini, bahwa rangkaian terapi modalitas adalah intervensi yang sangat bervariasi, meliputi pemberian psikofarmaka, terapi indvidu, kognitif, perilaku, psikososial, spiritual dan TAK (kelompok). Terapi modalitas juga melibatkan sistem yang lebih luas, yaitu sistem keluarga melalui pemberian discharge planning dan sistem komunitas melalui intervensi berbasis masyarakat. Perawat dalam memberikan terapi modalitas harus memperhatikan karakteristik pasien dan kondisi penyakit, sehingga pasien bersedia dan dapat mengikuti proses terapi.

Model holistik mengintegrasikan aspek biologi, psikologis, sosial dan spiritual dalam terapi modalitas pada pasien gangguan jiwa. Aspek biologi diwujudkan dalam pemberian psikofarmaka yang akan membantu pasien gangguan jiwa mencapai peningkatan fungsi mental yang lebih baik (Srevani, 2009). Psikofarmaka bekerja untuk menyeimbangkan unsur biologis dan kimiawi otak dan berdampak pada pengaturan cara pikir, perilaku dan emosi di otak. Pemberian intervensi pada aspek biologis harus diikuti dengan intervensi pada aspek psikologis. Terapi psikologis berfokus pada penggunaan komunikasi baik verbal maupun non verbal, melakukan perbaikan pada pola pikir pasien dan membantu pasien memhami penyebab gangguan jiwa yang dialami (Bentall et al., 2009; Harris, Nagy, & Vardaxis, 2010). Penerapan terapi psikologis sering beriringan dengan terapi sosial, yaitu proses dinamis yang melibatkan dimensi fisik, kognitif, afektif, perilaku dan sosial seseorang melalui interaksi dengan orang lain dan lingkungan (World Health Organisation, 2005). Model holistik dalam merawat pasien gangguan jiwa mengimplementasikan terapi indvidu, terapi kognitif, terapi perilaku, terapi psikososial dan TAK untuk melatih pasien secara mandiri merubah pikiran negatif menjadi lebih positif, merubah perilaku yang kurang baik menjadi lebih baik, belajar berinteraksi secara bertahap dan berinetraksi dalam kelompok kecil. Selama proses terapi perawat memperhatikan respon verbal dan non-verbal pasien, memberikan batasan yang jelas tentang perilaku yang boleh dan tidak boleh dilakukan dan didukung dengan pemberian sistem reward yang telah disepakati. Model holistik keperawatan menambahkan terapi spiritual sebagai bagian penting dalam penerapan terapi modalitas. Bentuk pemberian terapi spiritual adalah dengan mambantu pasien untuk mengenali kemampuan diri dalam menghadapi sakit yang dialami, khususnya terkait motivasi, sikap positif dan optimisme (Yusuf et al., 2016). Perawat bisa melakukan

pendampingan terhadap pasien gangguan jiwa agar tetap melaksanakan kegiatan ritual keagamaan, membantu berdoa dan menumbuhkan sikap positif bahwa setiap permasalah dalam hidup akan diberikan jalan keluar, termasuk menumbuhkan adanya keyakinan dan harapan akan diberikan kesembuhan dan kehidupan yang lebih baik.

Kunci dari serangkaian pemberian terapi modalitas tersebut adalah hubungan terapeutik yang baik antara pasien dan perawat (Fisher, 2011). Hubungan akan terjalin dengan baik melalui proses pengkajian yang teliti dan mendalam terkait kondisi pasien, sehingga pemilihan jenis terapi modalitas dapat membantu pasien untuk mencapai kondisi yang lebih baik. Penerapan terapi modalitas merupakan upaya untuk mengoptimalkan kembali fungsi biologis, psikologis, sosial dan spirtual pasien yang mengalami perubahan akibat proses gangguan jiwa yang dialami.

Kebijakan rumah sakit merupakan komponen kedua dari model holistik keperawatan yang sangat dibutuhkan untuk menjamin pasien mendapatkan pelayanan secara holistik. Hasil penelitian menunjukkan bahwa kebijakan rumah sakit terkait dengan job deskripsi, kewenangan, remunerasi dan reward sangat diperlukan untuk dapat terselenggaranya model holistik keparawatan jiwa. Job deskripsi merupakan informasi yang menjelaskan tentang standar pekerjaan dan daftar tugas yang harus dikerjakan berkaitan dengan kedudukan seseorang dalam suatu pekerjaan tertentu (Dessler, 1997). Job deskripsi berkaitan dengan kewenangan seseorang untuk melakukan suatu tindakan. Perawat yang bekerja dalam institusi kesehatan menurut UU RI NO 36 tahun 2009 tentang Kesehatan, diharuskan memiliki kemampuan dan kewenangan melakukan tindakkan keperawatan berdasarkan ilmu yang dimilikinya, yang diperoleh melalui pendidikan keperawatan. Kewenangan perawat adalah hak dan otonomi untuk melaksanakan asuhan keperawatan berdasarkan kemampuan, tingkat pendidikan, dan posisi yang dimiliki. Lingkup kewenangan perawat meliputi kondisi sehat dan sakit, sepanjang daur kehidupan. Perawat dalam menerapkan model holistik memiliki sejumlah job deskripsi dan kewenangan dalam melakukan asuhan keperawatan dan terapi modalitas seluruh aspek pasien, baik biologis, psikologis, sosial dan spiritual yang telah ditetapkan oleh rumah sakit. Kendala yang sering ditemui adalah masih banyaknya tugas dokumentasi rumah sakit dan keterbatasan jumlah perawat sehingga perawat harus menjadi perawat sekaligus menduduki jabatan struktural rumah sakit. Situasi tersebut menyebabkan seorang perawat memiliki tugas ekstra, merasakan ketidakjelasan tugas yang harus dikerjakan dan pada akhirnya yang membatasi waktu perawat untuk sepenuhnya melaksanakan tugas utama yaitu melaksanakan perawatan pada pasien. Temuan penelitian ini sejalan dengan pendapat Fisher (2011) bahwa rasio pasien dan perawat yang tinggi dan sejumlah dokumen rumah sakit yang harus dikerjakan menjadi penyebab perawat belum dapat melaksanakan tindakan psikososial terhadap pasien jiwa secara intensif, sehingga perawat akan lebih berfokus pada pengobatan pasien yang bersifat biologis. Kondisi tersebut juga berkaitan juga dengan sistem reward yang diterima oleh perawat yang dirasakan masih belum sesuai (Fisher, 2011). Hasil penelitian menunjukkan bahwa sistem remunerasi dan reward merupakan aspek penting dalam kebijakan rumah sakit yang perlu diperhatikan ketika model holistik akan diterapkan. Model holistik menuntut perawat memperhatikan pasien secara menyeluruh, sehingga diperlukan strategi

khusus bagi rumah sakit melalui kebijaknnya untuk menetapkan job deskripsi dan kewenangan secara jelas dan diikuti dengan sistem remunerasi dan reward yang sesuai.

Penerapan model holistik keperawatn jiwa tidak lepas dari dukungan situasi masyarakat dalam pelaksanaan kegiatan keperawatan bagi pasien gangguan jiwa. Masyarakat secara kooperatif mau memanfaatkan fasilitas pelayanan kesehatan yang ada dan kesediaan untuk memperlakukan pasien dengan baik dan mengungkapkan penerimaan pasien pasca pasung. Hasil penelitian tersebut menunjukkan adanya unsur pemberdayaan masyarakat dalam model holistik keperawtan jiwa. Pasien gangguan jiwa setelah dirawat di rumah sakit akan kembali ke keluarga dan masyarakat, sehingga membutuhkan situasi dan kondisi yang mendukung agar tidak terjadi proses kekambuhan. Namun demikian sangat disadari bahwa masih tingginya stigma masyarakat terhadap keberadaan pasien Skizofrenia, sehingga diperlukan pendekatan secara intensif agar masyarakat mulai menerima dan mendukung keberadan pasien di keluarga dan masyarakat. Stigma yang berkembang dimasyarakat disebebkan oleh ketidakpahaman terkait gangguan jiwa, dampak dan cara pengobatannya (Arianandа, 2015). Penerapan model holistik memerlukan startegi khusus untuk mengelola stigma yang ada dimasyarakat. Sehingga model holistik keperawatan yang sudah diterapkan sejak pasien dirawat di rumah sakit dapat dilanjutkan dengan penerimaan masyarakat yang baik, bahkan masyarakat ikut mendukung penggunaan fasilitas pelayanan kesehatan, akan dapat menurunkan angka kekambuhan.

## 3. Luaran yang Telah Dicapai

1. **Publikasi pada Jurnal Nasional;**

1.1 Fenomena Pasung dan Dukungan Keluarga terhadap Pasien Gangguan Jiwa Pasca Pasung, Jurnal Keperawatan (JKP) Unpad, Vol 5 Nomor 3, Desember 2017, http://scholar.google.co.id/scholar_url?url=http://jkp.fkep.unpad.ac.id/index.php/jkp/article/download/653/177&hl=id&sa=X&scisig=AAGBfm2iVST0QDPea0Kp219DHOC5gWEgIA&nossl=1&oi=scholaralrt

1.2 Gambaran Spiritualitas Remaja yang Tinggal di Sekitar Eks Lokalisasi, Jurnal Ilmiah Kesehatan, Vol 13. No 1. Februari 2018, http://journal.unusa.ac.id/index.php/jhs/article/view/563

1.3 Penggunaan Mindfulness Meditation Dalam Manajemen Stres: Sebuah Systematic Review, http://forikes-ejournal.com/index.php/SF/article/view/224

1.4 Intervensi Non Farmakologik untuk Menurunkan Kecemasan pada Pasien Pre-Operasi; Literatur Rivew, Jurnal Penelitian Kesehatan Suara Forikes, Vol 9 nomor 2, April 2018, http://forikes-ejournal.com/index.php/SF/article/view/226

1.5 Predictors Of Family Stress In Taking Care Of Patients With Schizophrenia, Jurnal Ners, vol 3, nomor 1, April 2018, https://e-journal.unair.ac.id/JNERS/article/view/7762/pdf

1.6 Pengaruh *Millieu Therapy* Metode Kreasi Seni membuat Gelang terhadap Penurunan Kesepian (*Loneliness*) Lansia, MKK: Volume 1 No 1 Mei 2018 http://jurnal.unpad.ac.id/mkk/article/view/16980

2. **Publikasi pada Jurnal Internasional;**

2.1 Perceived Barriers On Mental Health Services: Mental Illness Patients' Family Perspectives, International Journal of Nursing Sciences, International Journal of Nursing Sciences, vol 5, issue 1, January 2018. https://doi.org/10.1016/j.ijnss.2017.12.003

2.2 Family members' perspective Of family Resilience's Risk factors in taking care of schizophrenia patients, International Journal of Nursing Sciences, International Journal of Nursing Sciences, vol 5, 2018 https://reader.elsevier.com/reader/sd/F73722C31A02AF6FC134032D99775FD942813ACB8A05D3A12D2D103806765EE98FB670FCDEC5D2C1EE3E40C35AE8C6CF

2.3 Intention to stay model of nurse staff in hospital, Indian Journal of Public Health Research & Development Year : 2018, Volume : 9, Issue : 8 First page : ( **351**) Last page : **(355)** Print ISSN : 0976-0245. Online ISSN : 0976-5506. Article DOI : 10.5958/0976-5506.2018.00745.3

http://www.indianjournals.com/ijor.aspx?target=ijor:ijphrd&volume=9&issue=8&article=063

http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=704

2.4 Return Migration of Nurses; a Concept Analisys, Indian Journal of Public Health Research & Development Year : 2018, Volume : 9, Issue : 9,

http://www.indianjournals.com/ijor.aspx?target=ijor:ijphrd&volume=9&issue=9&article=037
Article DOI : 10.5958/0976-5506.2018.00994.4
http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=710

2.5 Development of Holistic Nursing Care Model for Mental Disorder Patients Care in Indonesia, Indian Journal of Public Health Research & Development, Accepted No, 1416/IJPHRD/2018

2.6 Influence of Picture and Picture Methode Against Moral Development of Children, Indian Journal of Public Health Research & Development, Vol 9 No. 10, October 2018 (318-323).

http://www.indianjournals.com/ijor.aspx?target=ijor:ijphrd&volume=9&issue=10&article=062

http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=703

2.7 Assessment Potential of Familes Increasing Ability to Care for Schizophrenia Post Restrain at East Java Indonesia, Indian Journal of Public Health Research & Development, Vol 9 No. 10, October 2018 (369-3374).

http://www.indianjournals.com/ijor.aspx?target=ijor:ijphrd&volume=9&issue=10&article=071

http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=699

2.8 Factors Associated to Infant Vaccination in Madurese, Indonesia, Indian Journal of Public Health Research & Development, Vol 9 No. 10, October 2018 (364-368).

http://www.indianjournals.com/ijor.aspx?target=ijor:ijphrd&volume=9&issue=10&article=070

http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=700

2.9 Developing Community Resilience as a Supporting System in the Care of People with Mental Health Problem in Indonesia, Indian Journal of Public Health Research & Development, Accepted No, 2575/IJPHRD/2018

3. Presentasi sebagai Pembicara "Mental Health Problem in Indonesia" pada Kegiatan International Weeks for Teaching Assigment (incoming) Academic Year 2017 – 2018 di Lucian Blaga University of Sibiu Romania, tanggal 14 – 22 Juni 2018
http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=706
4. Presentasi poster "Koping Keluarga dalam Merawat Pasien Gangguan Jiwa (ODGJ) Pasca Pasung, pada PKB (Pendidikan Kedokteran Berkelanjutan) Psikiatri RSUD Dr. Soetomo Surabaya, tanggal 3 – 4 Februari 2018
http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=714
5. Presentasi poster " The Factors Related to Family Health Seeking Behavior on Clients Mental Disorder based on Plan Behavior Theory", pada kegiatan World of Addiction Institut of Mental Health, Addiction and Neouroscience di Jakarta, tanggal 16 – 17 Maret 2018
http://eprints.ners.unair.ac.id/cgi/users/home?screen=EPrint%3A%3AView&eprintid=713
6. Draft Buku; Kesehatan Jiwa; Pendekatan Holistik dalam Asuhan Keperawatan
7. Draft Buku; Terapi Modalitas dalam Keperawatan Kesehatan Jiwa

# BAB 6
# RENCANA TAHAPAN BERIKUTNYA

Rencana tahapan berikutnya mengacu pada skema usulan penelitian sebagai berikut:
Warna biru merupakan kegiatan yang telah dilakukan tahun pertama, warna kuning merupakan kegiatan yang dilakukan tahun ke dua, warna hijau kegiatan yang akan dilakukan pada pada tahun ke tiga. Pada laporan kemajuan di tahun terahir ini, semua proses tahapan penelitian telah dilaksanakan, saat ini tinggal finishing Draf Buku Terapi Modalitas dalam Keperawatan jiwa dan Draft Buku Keperawatan Kesehatan Jiwa; Pendekatan Holistik dalam Asuhan Keperawatan. Bulan November ini, Draft buku Kesehatan Jiwa: Pendekatan Holistik dalam Keperawatan sudah dapat masuk ke Penerbit sehingga ahir Desember atau awal Januari Buku sudah dapat terbit secara umum.

<table>
<tr><th colspan="2">TAHUN I</th><th colspan="2">TAHUN II</th><th colspan="2">TAHUN III</th></tr>
<tr><th>Kegiatan Yang Dilakukan</th><th>Hasil Yang Diharapkan</th><th>Kegiatan Yang Dilakukan</th><th>Hasil Yang Diharapkan</th><th>Kegiatan Yang Dilakukan</th><th>Hasil Yang Diharapkan</th></tr>
<tr><td>Penelitian tanda dan gejala gangguan jiwa</td><td>Instrumen Pengkajian Keperawatan Kesehatan Jiwa</td><td>Terapi Kelompok:<br>- Sosialisasi<br>- Orientasi realitas<br>- Stimulasi Persepsi<br>- Stimulasi Sensori</td><td>Modul Terapi Aktifitas Kelompok</td><td rowspan="2">- Evident base practice<br>- Critical analysis<br>- FGD<br>- Diskusi pakar<br>- Eksperimen SPO Terapi Modalitas</td><td rowspan="2">Penyelesaian Buku Terapi Modalitas dalam Keperawatan Kesehatan Jiwa</td></tr>
<tr><td>Penelitian Upaya Masyarakan dalam Mencari Pengobatan</td><td>Variabel Pendukung dalam Keperawatan Jiwa</td><td>Terapi Keluarga:<br>- Psiko edukasi<br>- Triangle<br>- Spiritual<br>- Supportiv</td><td>Modul Terapi Keluarga</td></tr>
<tr><td>Terapi Fisik<br>- Psiko farmaka<br>- ECT<br>- Fiksasi</td><td>Standar Operasional Prosedur / Protap dan alat yang digunakan</td><td>Terapi Lingkungan</td><td>Standar Operasional Prosedur Pelaksaan Terapi Lingkungan</td><td rowspan="3">- Evident base practice<br>- Critical analysis<br>- Literatur riview<br>- FGD<br>- Diskusi pakar<br>- Eksperimen SPO Terapi Modalitas<br>- Analisis kebijakan lintas sektor</td><td rowspan="3">Penyelesaian Buku Model Holistic dalam Perawatan Pasien Gangguan Jiwa</td></tr>
<tr><td>Terapi Psikologis<br>- Kognitif<br>- Perilaku<br>- Asertif</td><td>Modul Terapi Psikologis</td><td>Rehabilitasi Psikiatri</td><td>- Modul<br>- Sarana Terapi<br>- Standar Prosedur<br>- Shelter Workshop</td></tr>
<tr><td colspan="4">UJI MODEL<br>Penemuan variabel komprehensif dalam perawatan pasien gangguan jiwa dengan pendekatan holistik</td></tr>
<tr><td colspan="2">PUBLIKASI<br>Nasional | Internasional</td><td colspan="2">PUBLIKASI<br>Nasional | Internasional</td><td colspan="2">PUBLIKASI<br>Nasional | Internasional</td></tr>
<tr><td colspan="4">HAKI - Penyempurnaan Buku Ajar Keperawatan Kesehatan Jiwa<br>(Draft Buku Terapi Modalitas dalam Keperawatan Kesehatan Jiwa)</td><td colspan="2">Buku: Model Holistic dalam Perawatan Pasian Gangguan Jiwa</td></tr>
</table>

# BAB 7. KESIMPULAN DAN SARAN



## Kesimpulan

Model holistik dalam merawat pasien gangguan jiwa menggunakan pendekatan asuhan keperawatan jiwa yang dalam pelaksanaannya memperhatikan pasien dari aspek biologis, psikologis, sosial dan spiritual. Model holistik di laksanakan dengan mengaplikasikan terapi modalitas keperawatan jiwa yang didukung oleh kebijakan, fasilitas rumah sakit, standar prosedur operasional, sumber daya manusia keperawatan yang kompeten dan situasi keluarga serta masyarakat yang kondusif.

## Saran

Perlu disusun standar operasional prosedur secara lengkap sebagai paduan pelaksanaan terapi modalitas dalam keperawatan kesehatan jiwa, sehingga dapat digunakan sebagai indikator pemberian asuhan keperawatan secara holistik.

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# Fenomena Pasung dan Dukungan Keluarga terhadap Pasien Gangguan Jiwa Pasca Pasung

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**Abstrak**

Indonesia bebas pasung bagi pasien gangguan jiwa merupakan program prioritas yang harus dicapai pemerintah pada tahun 2019. Saat ini upaya bebas pasung telah dilaksanakan dengan baik, permasalahan baru muncul setelah masa pengobatan selesai dan harus kembali kepada keluarga dan masyarakat. Keluarga tidak menghendaki pasien kembali kepada keluarga, diabaikan, kembali kambuh atau menjadi gelandangan psikotik. Penelitian ini bertujuan untuk memperoleh gambaran dukungan keluarga terhadap pasien gangguan jiwa *pasca* pasung. Penelitian ini menggunakan desain kualitatif fenomenologi, jumlah partisipan sebesar 9 orang dipilih dengan *purposive sampling*, pengumpulan data dilakukan dengan wawancara mendalam, data dianalisis secara tematik. Hasil penelitian menunjukkan dukungan keluarga terhadap pasien gangguan jiwa pasca pasung diperoleh 2 (dua) tema besar yaitu; fenomena pasung terhadap pasien gangguan jiwa dan dukungan keluarga. Fenomena pasung meliputi; alasan, keputusan, metode, pembebasan dan dampak pemasungan. Dukungan keluarga meliputi; dukungan penilaian, instrumental, informasional dan dukungan emosional. Dukungan keluarga dibutuhkan pasien untuk dapat mencapai penyembuhan dan mencegah kekambuhan. Pengetahuan yang kurang terhadap cara perawatan pasien gangguan jiwa *pasca* pasung menyebabkan dukungan keluarga yang diberikan terhadap pasien tidak optimal. Pandangan keluarga dan masyarakat yang keliru terhadap pasien gangguan jiwa mempengaruhi penanganan yang tepat terhadap pasien gangguan jiwa.

**Kata kunci:** Dukungan keluarga, gangguan jiwa, pasung.

**Abstract**

Indonesian free of pasung for mental disorders is a priority program to be achieved by the government in 2019. Currently the effort of free of pasung for mental illness has been well implemented. A new problems arise after the treatment period is over and patients must return to family and community. Families do not want patients to return to then, ignored, relapse or become psychotic homeless. This study aims to obtain a description of pasung phenomenon and family support for patients after having pasung. This research used qualitative phenomenology design, the number of participants for 9 people was chosen by purposive sampling, data collection was done by indepth interview, the data were analyzed by thematic analysis. The result of the research showed two big themes that are; pasung phenomenon and family supports after the patient having pasung. The pasung phenomenon includes; reasons, decisions, methods, exemptions and the effects of deprivation. Family support includes: support assessment, instrumental, informational and emotional support. Family support is needed for patients to achieve healing and prevent recurrence. The lack of knowledge about the way patients care for post pasung mental disorders cause the family support provided to patients is not optimal. Misrepresentation of family and community opinions on psychiatric patients affects the proper treatment of psychiatric patients.

**Keywords:** Family support, mental disorder, pasung.

## Pendahuluan

Pasung merupakan tindakan pengekangan, pembatasan aktivitas secara fisik, menggunakan berbagai jenis alat seperti rantai, belenggu, tali, balok kayu, kurungan, diasingkan, atau dirantai pada ruangan terasing. Tindakan pasung dilakukan oleh 14,3 % Keluarga di Indonesia yang salah satu anggota keluarga mengalami gangguan jiwa berat (Kemenkes, 2013). Tindakan pasung dilakukan pada pasien gangguan jiwa kronik, disertai perilaku agresif, kekerasan, amuk, halusinasi yang berisiko menciderai diri sendiri, orang lain atau lingkungan (Daulima, 2014; Wahyuningsih, 2014). Upaya bebas pasung merupakan program prioritas yang harus dicapai pemerintah pada tahun 2019. Saat ini upaya bebas pasung telah dilaksanakan dengan baik, permasalahan baru muncul setelah masa pengobatan selesai dan harus kembali kepada keluarga dan masyarakat. Keluarga tidak menghendaki pasien kembali kepada keluarga, diabaikan, kembali kambuh atau menjadi gelandangan psikotik.

Dukungan keluarga adalah sikap, tindakan dan penerimaan keluarga terhadap penderita yang sakit,anggota keluarga memandang bahwa orang yang bersifat mendukung selalu siap memberikan pertolongan dan bantuan jika diperlukan (Friedman, 1998 dalam Kristiyaningsih, 2011), dengan demikian tindakan pemasungan merupakan kegagalan keluarga dalam memberikan dukungan keluarga untuk membawa pasien ke tempat pelayanan kesehatan, tindakan pemasungan hanya memperparah kondisi penderita gangguan jiwa tersebut (Kartono, 2009; Aji, 2016).

Pemasungan menyebabkan terbatasnya pemenuhan kebutuhan dasar hidup yang layak, termasuk kesehatan, pendidikan, dan pekerjaan ODGJ yang dipasung (Halida, Dewi, & Rasni, 2016). Pasien yang dipasung dalam waktu lama akan mengalami atropi otot, tidak bisa lagi berjalan, mengalami cedera hingga pasien harus di terapi jika pasien tersebut dilepaskan dari pasung (Puteh, 2011; Malfasari, Keliat, & Helena (2016). Dampak lain pemasungan yaitu penderita mengalami trauma, dendam kepada keluarga, merasa dibuang, rendahdiri, dan putus asa,lama-lama muncul depresi dan gejala niat bunuh diri (Lestari, Choiriyyah, & Mathafi, 2014).

Pasca pasung adalah ODGJ yang sudah terbebas dari pemasungan. Meskipun ODGJ telah diperbolehkan pulang dari rumah sakit, namun beban keluarga masih belum berakhir. Biaya yang harus ditanggung pasien selain harga obat dan jasa konsultasi (apabila tidak ditanggung asuransi seperti BPJS Kesehatan), adalah biaya transportasi ke rumah sakit dan biaya akomodasi lainnya (Djatmiko, 2007; Daulima, 2014).

Setelah dibebaskan dari pasung, dirawat di rumah sakit dan kembali ke rumah, menurut Lestari & Wardhani (2014) ODGJ tidak mendapatkan penanganan khusus yang berkelanjutan. Pengobatan penderita gangguan jiwa merupakan sebuah *journey of challenge* atau perjalanan yang penuh tantangan yang harus berkelanjutan, yaitu penderita gangguan jiwa sulit untuk langsung sembuh dalam satu kali perawatan, namun membutuhkan proses yang panjang dalam penyembuhan (Lestari & Wardhani, 2014). Ketika di rumah, dukungan keluarga sangat dibutuhkan agar penderita bisa menjalani proses penyembuhannya. Goldstein dan Shemansky (2000); Wahyuningsih, (2014) menyatakan bahwa terapi medikasi teratur pada pasien gangguan jiwa kronis dapat menurunkan angka relaps 30-40%. Relaps terjadi satu tahun pertama sekitar 60%-70% dan dengan kombinasi antipsikotik dan dukungan kelompok edukasi dapat menurunkan relaps sampai 15,7% (Olfson, 2000, dalam Wahyuningsih, 2014). Hal ini didukung dengan penelitian Saputra (2012) bahwa terdapat hubungan dukungan keluarga dengan kepatuhan mengkonsumsi obat antipsikotik pada pasien yang mengalami gangguan jiwa. Dukungan keluarga dibutuhkan agar pasien dapat mengakses pelayanan kesehatan untuk mendapatkan medikasi dengan teratur dan memastikan pasien meminum obat yang sudah didapatkan sesuai dengan ketentuan. Selain medikasi, Ambari (2010) menjelaskan bahwa semakin tinggi dukungan keluarga, maka semakin tinggi pula keberfungsian sosial pasien pasca perawatan di rumah sakit, demikian pula sebaliknya. Penelitian ini bertujuan untuk memperoleh gambaran tentang fenomena pasung yang terjadi di Indonesia dan

bagimana dukungan keluarga terhadap pasien gangguan jiwa setelah mendapatkan pasung.

## Metode Penelitian

Penelitian ini menggunakan metode kualitatif dengan pendekatan fenomenologi. Partisipan berjumlah sembilan orang, dipilih secara purposif sampling dengan kriteria inklusi; *care giver*, tinggal serumah dengan pasien, memiliki anggota keluarga dengan gangguan jiwa, pernah dipasung dan saat ini sudah lepas pasung, tinggal di wilayah Kabupan Banyumas Proponsi Jawa Tengah.

Pengumpulan data dilakukan dengan wawancara mendalam, dengan alat bantu; pedoman wawancara, catatan lapangan, dan recorder berupa *voice recorder*. Dalam penelitian ini Peneliti memberi kesempatan dan kebebasan kepada partisipan sebagai keluarga yang merawat klien gangguan jiwa pascapasung untuk menentukan apakah bersedia atau tidak untuk menjadi partisipan dalam penelitian ini (*Respect*), Setelah diberikan penjelasan tentang tujuan, manfaat dan risiko yang mungkin terjadi pada pelaksanaan penelitian, maka partisipan diberikan kebebasan untuk menentukan apakah bersedia atau tidak bersedia mengikuti penelitian ini secara sukarela (*autonomy)*, Kerahasiaan identitas partisipan (*Anonymity* dan *confidentiality*), peneliti mengusahakan agar partisipan bebas dari rasa tidak nyaman, baik secara fisik maupun psikologis *Nonmaleficence*, dan Semua partisipan yang terpilih mendapat perlakuan yang sama selama proses penelitian (*Justice*).

Selama proses wawancara peneliti berupaya menyisihkan semua asumsi umum, prasangka, teori, filsafat, agama peneliti mengenai pasung untuk mendapatkan data yang obyektif dari partisipan. Proses analisis data dilakukan bersamaan dengan pengambilan data pada partisipan. Analisis data dilakukan dengan metode Collaizi. Proses analisis data ini dilakukan dengan cara 1) Membaca berkali-kali data yang diperoleh sambil mengurangi informasi tumpang tindih atau berulang-ulang. 2) Kedua melihat signifikansi atau pentingnya data yang diperoleh;Pertanyaan pendukung adalah: apakah yang penting dari informasi yang disampaikan;3)Mengklasifikasi atau mengkoding data yang memiliki kemiripan atau kecocokandengandata lain. Hasil klasifikasi data ini kemudian dibuat label (labeling). 4) Mencari pola atau tema yang mengikat pikiran yang satu dengan lainnya.5) Mengkonstruksikan *framework* untuk mendapatkan essensi dari apa yang hendak disampaikan oleh data tersebut. Saturasi data terjadi pada partisipan ke sembilan saat peneliti tidak mendapatkan tema, sub tema maupun kategori baru dalam proses analisis data.

Untuk menjada validitas data penelitian, peneliti melakukan triangulasi yaitu triangulasi metode dengan wawancara dan observasi serta triangulasi antar aggota peneliti untuk menghindari subyektifitas peneliti. Selain itu, peneliti melakukan *member checking* yaitu dengan validasi data hasil wawancara dengan partisipan

Penelitian ini telah mendapat persetujuan dari Komisi Etik Penelitian Kesehatan Fakultas Keperawatan Universitas Airlangga dengan nomor sertifikat laik etik 251-KEPK tanggal 20 Desember 2016.

## Hasil Penelitian

Partisipan adalah *care giver* yaitu pemberi perawatan ODGJ yang merupakan salah satu anggota keluarga ODGJ, terdiri atas ayah, ibu, kakak atau adik responden, paling muda berusia 27 tahun, paling tua 66 tahun, mayoritas berpendidikan SD, tersebar di 7 Kecamatan; Lumbir, Sokaraja, Banyumas, Ajibarang, Cilongok, Pekuncen dan Kecamatan Purwojati, Kabupaten Banyumas Provinsi Jawa Tengah. Data partisipan secara lengkap, seperti pada tabel berikut;

Jumlah pasien gangguan jiwa pasca pasung adalah 9 setelah terjadi saturasi data. Pasien ini terdiri atas 8 laki-laki dan 1 perempuan. Lama pasien dipasung bervariasi dari 7 hari – 24 tahun. Delapan pasien dipasung dengan cara dikurung dan 1 pasien dipasung dengan cara dirantai. Adanya akibat pemasungan terhadap fisik yaitu kecacatan yang terjadi pada pasien yang dipasung dengan cara dikurung dalam kandang, menentukan dukungan keluarga terhadap pasien gangguan jiwa. Dengan kondisi kecacatan, pemenuhan kebutuhan

**Tabel 1 Karakteristik Partisipan**

| Partisipan | Inisial | Usia | Jenis Kelamin | Pendidikan Terakhir | Agama | Pekerjaan | Hubungan dengan pasien |
|---|---|---|---|---|---|---|---|
| 1 | P1 | 42 tahun | Laki-laki | SD | Islam | Tani | Kakak kandung |
| 2 | P2 | 60 tahun | Perempuan | SD | Islam | Buruh tani | Istri |
| 3 | P3 | 66 tahun | Perempuan | SD | Islam | Ibu rumah tangga | Ibu kandung |
| 4 | P4 | 60 tahun | Perempuan | SD | Islam | Ibu rumah tangga | Istri |
| 5 | P5 | 38 tahun | Laki-laki | SD | Islam | Wiraswasta | Kakak kandung |
| 6 | P6 | 54 tahun | Laki-laki | SD | Islam | Buruh tani | Adik ipar |
| 7 | P7 | 27 tahun | Laki-laki | SD | Islam | Dagang | Adik kandung |
| 8 | P8 | 60 tahun | Perempuan | SD | Islam | Tani | Ibu kandung |
| 9 | P9 | 48 tahun | Laki-laki | SMP | Islam | Buruh tani | Ayah kandung |

**Tabel 2 Data Demografi Pasien Gangguan Jiwa Pasca Pasung**

| Pasien Gangguan Jiwa Anggota Keluarga dari Partisipan | Jenis Kelamin | Lama Dipasung | Metode Pemasungan |
|---|---|---|---|
| P1 | Perempuan | 5 tahun | Dikurung dalam kandang |
| P2 | Laki-laki | 20 tahun | Dikurung dalam kamar |
| P3 | Laki-laki | 10 tahun | Dikurung dalam kamar |
| P4 | Laki-laki | 1 tahun | Diikat dengan rantai |
| P5 | Laki-laki | 14 tahun | Dikurung dalam kandang |
| P6 | Laki-laki | 24 tahun | Dikurung dalam kandang |
| P7 | Laki-laki | 7 hari | Dikurung dalam kandang |
| P8 | Laki-laki | 2 tahun | Dikurung dalam kandang |
| P9 | Laki-laki | 1 tahun | Dikurung dalam kandang |

sehari-hari pasien sangat tergantung pada dukungan keluarga untuk memenuhinya.

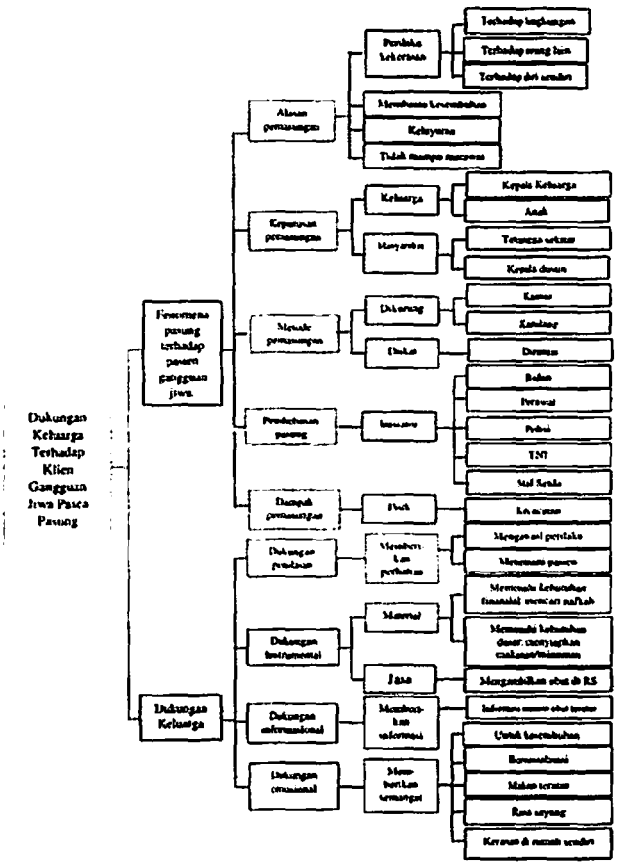
Peneliti memilih analisis tematik agar dapat mengidentifikasi ide atau data secara implisit dan eksplisit, selain itu peneliti juga dapat menemukan "pola" pada penterjemahan data hasil penelitian. Dukungan keluarga terhadap pasien gangguan jiwa pasca pasung didapatkan dua tema besar yaitu; perilaku pasung terhadap pasien gangguan jiwa dan dukungan keluarga. Perilaku pasung terhadap pasien gangguan jiwa meliputi; alasan, keputusan, metode, pembebasan dan dampak pemasungan. Dukungan keluarga meliputi; dukungan penilaian, instrumental, informasional dan dukungan emosional. Hasil tema penelitian secara lengkap tampak pada gambar.

## Pembahasan

1. Perilaku pasung terhadap pasien gangguan jiwa

1) Alasan pemasungan

Tindakan pemasungan diakibatkan oleh berbagai alasan yang dikemukakan oleh keluarga. Keluarga menjelaskan bahwa alasan anggota keluarga yang mengalami gangguan jiwa adalah melakukan perilaku kekerasan,




**Gambar 1 Analisis tematik fenomena pasung dan dukungan keluarga terhadap pasien gangguan jiwa pasca pasung**

membantu kesembuhan, keluyuran dan tidak mampu merawat.

(1) Perilaku kekerasan

Perilaku kekerasan yang diperoleh pada penelitian ini adalah perilaku kekerasan terhadap diri sendiri, upaya melukai diri untuk bunuh diri dengan cara terjun ke dalam sumur. Perilaku kekerasan terhadap orang adalah tindakan agresif yang ditujukan untuk melukai atau membunuh orang lain (Yusuf, 2015). Penelitian ini menemukan bahwa perilaku kekerasan terhadap orang lain yang dilakukan oleh pasien gangguan jiwa adalah mengancam dan memukuli orang lain. Perilaku kekerasan terhadap orang adalah tindakan agresif yang ditujukan untuk melukai atau membunuh orang lain. Penelitian ini menemukan bahwa perilaku kekerasan terhadap orang lain yang dilakukan oleh pasien gangguan jiwa adalah mengancam dan memukuli orang lain. Hasil penelitian Wahyuningsih (2014) menemukan bahwa alasan pemasungan adalah merusak lingkungan, melukai orang lain dan risiko membunuh.

(2) Membantu kesembuhan

Keluarga mengungkapkan bahwa alasan pemasungan adalah untuk membantu kesembuhan. Keluarga mendapatkan informasi dari tetangga bahwa dengan dipasung, pasien bisa menjadi sembuh dari ngamuk-ngamuk dan merusak barang-barang

Hal ini ditemukan pada 3 dari 9 partisipan (P3, P5 dan P7). Semua partisipan yang mempunyai alasan bahwa memasung untuk kesembuhan mempunyai tingkat pendidikan rendah, yaitu lulusan SD. Keluarga melakukan pemasungan mempunyai harapan bahwa pasien yang dipasung dapat sembuh dari amuk dan merusak barang.

(3) Keluyuran

Alasan lain yang dikemukakan keluarga adalah keluyuran sejumlah 2 partisipan. Partisipan (P4) mengatakan bahwa pasien keluyuran dengan berjalan kaki berhari-hari dan membuat keluarga cemas, sehingga keluarga besar memutuskan untuk memasung pasien dengan memasang rantai pada kaki. Partisipan (P3) juga mengungkapkan bahwa pasien pergi bahwa pasien pergi dengan jalan kaki, singgah di rumah orang dan bingung pada saat hendak pulang, sehingga keluarga harus menjemput pasien walaupun malam ataupun dini hari. Hasil penelitian Minas dan Diatri (2008) dalam Daulima, (2014) serta hasil penelitian Wahyuningsih (2014) menemukan bahwa salah satu alasan pasung adalah agar pasien tidak keluyuran dan lari sehingga dapat membahayakan orang lain. Penelitian ini menemukan bahwa pasien keluyuran berhari-hari dengan berjalan kaki (P4) dan keluarga memutuskan untuk memasung pasien dengan tujuan agar pasien tidak keluyuran. Keluarga mengungkapkan bahwa takut terjadi sesuatu dengan pasien saat keluyuran, seperti tertabrak kendaraan bermotor, jatuh ke sungai, dan sebagainya.

(4) Ketidakmampuan keluarga untuk merawat

Beban keluarga dapat diartikan sebagai stres atau efek dari adanya pasien gangguan jiwa dalam keluarga (Mohr, 2006 dalam Daulima, 2014). Beban keluarga merupakan tingkat pengalaman *distress* keluarga sebagai efek dari pasien gangguan jiwa terhadap keluarganya. Kondisi ini dapat memicu meningkatnya stres dalam keluarga. Penyimpangan perilaku yang terjadi pada pasien menyebabkan keluarga menanggung beban yang lebih berat dibandingkan pada saat pasien belum terjatuh ke dalam kondisi gangguan jiwa.

Pasien yang BAB dan BAK sembarangan, menyebabkan keluarga harus mengeluarkan tenaga, pikiran, dan waktu yang ekstra untuk membersihkan lingkungan rumah. Penelitian ini menemukan bahwa kondisi keluarga partisipan tingkat pendidikannya yang rendah yaitu lulusan SD dengan kondisi ekonomi yang terbatas dan jauh dari fasilitas pelayanan kesehatan jiwa. Keterbatasan-keterbatasan sumber pengetahuan dan faktor ekonomi untuk merawat pasien dan lingkungan rumah menyebabkan keluarga tidak punya pilihan hingga memilih untuk memasung pasien.

Penelitian ini menemukan bahwa keluarga tidak mempunyai pilihan untuk bisa merawat pasien sehingga dengan terpaksa harus memasung pasien. Partisipan mengungkapkan bahwa, apabila pasien tidak dipasung, maka keluarga tidak bisa bekerja mengurus lahan pertanian karena menghabiskan waktu untuk merawat pasien. Pekerjaan sebagai buruh tani yang dijalani oleh keluarga, menuntut untuk bekerja atau tidak mendapatkan upah yang akan digunakan untuk menafkahi

pasien dalam kehidupan sehari-harinya. Keluarga mengungkapkan bahwa dengan terpaksa harus memasung pasien untuk dapat melaksanakan perannya dalam keluarga sebagai pencari nafkah.

2) Keputusan pemasungan

Keputusan pemasungan yang ditemukan dalam penelitian ini ada 2 pelaku, yaitu dilakukan oleh keluarga dan masyarakat.

(1) Keluarga

Keputusan pemasungan yang diambil oleh keluarga ditemukan bahwa 4 partisipan mengungkapkan bahwa pengambil keputusan pemasungan adalah kepala keluarga dan seorang partisipan mengungkapkan bahwa pengambil keputusan pemasungan adalah anak pasien gangguan jiwa. Hampir seluruh partisipan (kecuali P3) berjarak lebih dari 10 km dari fasilitas pelayanan kesehatan terdekat dengan kemampuan penanganan gangguan jiwa, serta belum berjalannya program kesehatan jiwa secara optimal pada Puskesmas di Kabupaten Banyumas menyebabkan Pemantauan Wilayah Setempat (PWS) terhadap gangguan jiwa dan pasung masih belum maksimal. Penelitian ini juga tokoh masyarakat yang memberikan kontribusi dengan memberikan persetujuan terhadap terjadinya pemasungan. Berdasarkan teori *Green*, faktor-faktor tersebut mempunyai kontribusi terhadap terjadinya kasus pasung di Kabupaten Banyumas, sehingga perlu edukasi terhadap masyarakat tentang gangguan jiwa, serta Pemantauan Wilayah Setempat terhadap gangguan jiwa dengan lebih optimal.

Kepala keluarga memutuskan secara sepihak karena mereka selama ini yang bertanggung jawab terhadap adanya kerugian yang dialami oleh tetangga sekitar akibat perilaku kekerasan yang dilakukan pasien. Keputusan pemasungan yang diambil oleh anak terjadi pada pasien gangguan jiwa yang sudah lanjut usia. Anak berinisiatif memasung karena mereka khawatir terhadap keamanan pasien apabila keluyuran. Selain itu dengan memasung, istri pasien juga tenang karena selalu cemas apabila pasien keluyuran.

(2) Masyarakat

Pemuka masyarakat mendukung keluarga melakukan pasung karena ketidaktahuan keluarga, rasa malu, penyakit yang tidak kunjung sembuh, tidak adanya biaya pengobatan, dan tindakan keluarga untuk mengamankan lingkungan. Hal tersebut sesuai penelitian Minas dan Diatri (2008, dalam Daulima, 2014) yang menemukan bahwa pada hampir semua kasus dalam riset mereka tentang pasung pada pasien gangguan jiwa, tindakan pasung ini juga mendapat dukungan dari pemuka masyarakat, sehingga keluarga dan pemuka masyarakat berinisiatif untuk melakukan pasung dan bertanggung jawab sepenuhnya untuk mempertahankan tindakan tersebut.

3) Metode pemasungan

Delapan partisipan mengatakan bahwa anggota keluarga mereka dipasung dengan cara dikurung, sedangkan 2 partisipan mengatakan bahwa anggota keluarga pernah dipasung dengan cara diikat.

Penelitian ini mengidentifikasi bahwa metode pemasungan dengan cara dikurung dilakukan dengan cara bervariasi, yaitu dengan dikurung di dalam kandang yang menyerupai kandang ternak (P1, P5, P6, P7, P8 dan P9) dan dalam kamar (P2 dan P3). Kamar yang digunakan untuk mengurung adalah kamar yang telah dimodifikasi sedemikian rupa sehingga pasien tidak bisa keluar, misalnya dengan menggunakan pintu besi dan jendela yang dibuat kecil. Hasil wawancara mendalam dalam penelitian ini ditemukan bahwa masyarakat yang mengambil keputusan pasung terhadap pasien gangguan jiwa berinisiatif membuatkan kandang dengan bergotong royong (ditemukan pada P6, P8 dan P9) dan membuatkan pintu besi (ditemukan pada P2). Sedangkan kandang yang dibuat oleh keluarga untuk pasien gangguan jiwa ditemukan pada P1, P5 dan P7, serta kamar yang dibuat oleh keluarga untuk memasung pasien gangguan jiwa ditemukan pada P3.

Metode pemasungan yang pernah dilakukan lainnya adalah diikat menggunakan rantai. Penelitian ini menemukan bahwa keluarga memasang belenggu berupa rantai pada salah satu kaki pasien, rantai ini kurang lebih sepanjang 2 meter dan ditambatkan pada kayu tempat tidur. Dengan metode ini pasien gangguan jiwa melakukan segala aktifitas di dalam kamarnya termasuk BAB, BAK, makan dan lain-lainnya.

Penelitian ini menemukan bahwa sebagian besar metode pemasungan di Kabupaten

Banyumas adalah dengan dikurung (P1, P2, P3, P5, P6, P7, P8 dan P9). Hal ini sesuai dengan yang ditemukan oleh Minas dan Diastri (2008, dalam Daulima, 2014) dalam risetnya dengan metode cross-sectional, menemukan bahwa jenis pasung yang paling sering ditemukan adalah pengisolasian dalam ruangan atau gubuk kecil.

Hasil penelitian Hasmilasari (2009) sebagaimana dikutip oleh Wahyuningsih (2014) menemukan bahwa bahwa di daerah Bierun, Nangroe Aceh Darussalam ditemukan sebagian besar kasus pasung, pasien dikurung dalam kamar atau ruangan tertentu di sekitar rumah. *The Council of Europe Steering Committee on Bioethics Working Party on Psychiatry* (2000) merekomendasikan pelatihan teknik *physical restraint* harus diberikan untuk staf yang bekerja di unit mental akut. Pengekangan terhadap pasien gangguan membuat pasien gangguan jiwa tidak mendapatkan pertolongan yang segera berkaitan dengan sakit medis fisiknya. Terlambat mendapatkan pertolongan ini akan berakibat kepada buruknya harapan kesembuhan pada pasien dan menurunkan kualitas hidupnya (Andri, 2012 dalam Wahyuningsih, 2014).

Metode pemasungan dengan cara dikurung dalam kandang dipilih keluarga dengan alasan bisa mengamankan pasien dari perilaku kekerasan yang dilakukannya. Partisipan juga mengungkapkan metode ini murah dan mudah dalam memperoleh bahan-bahan untuk membuat kandang yang tersedia di sekitar rumah partisipan. Seluruh partisipan berada pada wilayah pedesaan yang kaya dengan bahan-bahan material berupa kayu dan bambu yang dibutuhkan dalam pembuatan kandang untuk pemasungan.

4) Pembebasan pasung

Kasus pemasungan yang dibebaskan oleh Puskesmas ditemukan sebanyak 5 (lima) kasus, oleh Polsek sebanyak 2 (dua) kasus, petugas Koramil 1 (satu) kasus dan 1 (satu) kasus oleh staf Wakil Bupati Banyumas yang kemudian dalam pelaksanaannya ditindaklanjuti oleh Puskesmas.

Inisiator yang teridentifikasi membebaskan pasung menurut partisipan yang dilakukan melalui Puskesmas adalah oleh tenaga kesehatan yaitu Bidan (P3, P4 dan P7) dan Perawat (P2 dan P5). Selain tenaga kesehatan, profesi lain adalah Polisi (P1 dan P8), TNI (P6) dan staf Setda Kabupaten Banyumas (P9).

Kebijakan pemerintah untuk melarang pasung sebenarnya sudah ada sejak tahun 1966 melalui UU No. 23 Tahun 1966 tentang Kesehatan Jiwa menyatakan bahwa pasien dengan gangguan jiwa yang terlantar harus mendapatkan perawatan dan pengobatan pada suatu tempat perawatan. Surat Menteri Dalam Negeri Nomor PEM.29/6/15, tertanggal 11 Nopember 1977 yang ditujukan kepada Gubernur Kepala Daerah Tingkat I seluruh Indonesia meminta kepada masyarakat untuk tidak melakukan pemasungan terhadap penderita gangguan jiwa dan menumbuhkan kesadaran masyarakat untuk menyerahkan perawatan penderita di Rumah Sakit Jiwa. Surat tersebut juga berisi instruksi untuk para Camat dan Kepala Desa agar secara aktif mengambil prakarsa dan langkah-langkah dalam penanggulangan pasien yang ada di daerah mereka.

Demikian pula dengan Provinsi Jawa Tengah melalui Peraturan Gubernur (Pergub) No. 1 Tahun 2012 tentang Penanggulangan Pasung di Provinsi Jawa Tengah. Hingga diterbitkannya UU No. 18 Tahun 2014 tentang Kesehatan Jiwa, dimana tertulis dalam pasal 86:

"Setiap orang yang dengan sengaja melakukan pemasungan, penelantaran, kekerasan dan/atau menyuruh orang lain untuk melakukan pemasungan, penelantaran, dan/atau kekerasan terhadap ODMK dan ODGJ atau tindakan lainnya yang melanggar hak asasi ODMK dan ODGJ, dipidana sesuai dengan ketentuan peraturan perundang-undangan."

Ancaman pidana sesuai dengan yang tertulis dalam pasal 86 UU No. 18 Tahun 2014 tersebut menegaskan bahwa, setiap orang yang terlibat dalam pemasungan dapat dikenakan pasal-pasal yang ada dalam Kitab Undang-undang Hukum Pidana (KUHP) dan diproses secara hukum sebagai pelaku kriminal. Hal ini menyebabkan segenap komponen pemerintah selain Puskesmas, baik pemerintah daerah hingga TNI dan Polri melakukan pendataan secara proaktif untuk membebaskan pasung.

5) Dampak pemasungan

Penelitian ini menemukan bahwa metode

pemasungan dan lamanya pemasungan mempengaruhi timbulnya akibat pemasungan yang berupa kecacatan pada pasien gangguan jiwa yang pernah dipasung. Ditemukan bahwa metode pemasungan dengan mengurung pasien di dalam kandang yang sempit yang menyebabkan keterbatasan pergerakan pada pasien menyebabkan kecacatan fisik. Kecacatan fisik yang ditemukan adalah atrofi otot kaki dan kontraktur pada sendi lutut yang disebabkan karena pasien harus menekuk lutut selama dipasung bertahun-tahun. Dalam penelitian ini pasien yang mengalami kecacatan fisik ditemukan pada penderita yang dipasung dengan dimasukkan ke dalam kandang yang sempit selama sedikitnya 2 (dua) tahun.

Dampak pemasungan ada 2, yaitu dampak psikologis dan dampak fisik. Menurut Lestari, Choiriyyah, & Mathafi (2014) dampak psikologis pemasungan adalah trauma, dendam kepada keluarga, merasa dibuang, rendah diri, putus asa, lama-lama timbul gejala depresi dan bunuh diri. Dampak fisik pemasungan adalah keadaan atrofi otot kaki dan kontraktur sendi dimana kasus pemasungan penderita skizofrenia di Samosir, Sumatera Utara, dan Bireuen, Aceh ditemukan bahwa pada pasien gangguan jiwa yang dipasung adalah kaki dan tangan mengecil (Lestari, 2014). Penelitian ini menemukan bahwa kondisi atrofi otot kaki ditemukan pada pasien yang dipasung selama 2 (dua) tahun dengan metode pemasungan menggunakan kandang yang sempit (P8). Keluarga menjelaskan bahwa, kandang yang dibuat berbentuk persegi, sempit dan tidak memungkinkan pasien yang dipasung menggerakkan kakinya dengan bebas.

Menurut Daulima (2014), pasien gangguan jiwa seharusnya bukan dipasung bila mendapatkan terapi yang tepat. Penanganan yang tepat terhadap pasien gangguan jiwa (Hawari, 2001; Yusuf, 2015) adalah dengan terapi psikofarmaka, terapi somatik dan terapi modalitas. Pasien gangguan jiwa seharusnya dibawa ke rumah sakit untuk mendapatkan penanganan.

Penelitian ini menemukan bahwa pasien dipasung bervariasi dari 7 hari hingga 24 tahun, semakin lama dipasung mengakibatkan pasien tertunda untuk mendapatkan perawatan pada fasilitas pelayanan kesehatan. Hal ini mengakibatkan semakin parahnya kondisi gangguan jiwa yang dialami pasien, bahkan setelah dilepaskan dari pasung dan pulang dari rumah sakit dan menjadi tanggung jawab keluarga dalam perawatan dan pemenuhan kebutuhan ADL (*Activity Daily Living*) pasien sehari-hari. Metode pemasungan dalam tempat yang sempit dan dalam waktu yang lama mengakibatkan dampak fisik berupa kecacatan yang menyebabkan kebutuhan dukungan keluarta yang lebih besar terutama dukungan instrumental dalam pemenuhan kebutuhan pasien sehari-hari.

2. Dukungan Keluarga

1) Dukungan penilaian dari keluarga terhadap pasien gangguan jiwa pasca pasung

Penelitian ini menemukan bahwa kemampuan keluarga untuk memberikan dukungan penilaian terhadap pasien gangguan jiwa pasca pasung sangat minimal. Keluarga hanya akan bisa memberikan dukungan penilaian apabila keluarga memahami bahwa pasien gangguan jiwa sedang sakit dan membutuhkan bantuan. Masih adanya pemahaman bahwa pasien mengalami kesurupan dan anggapan bahwa pasien bukan orang baik-baik, merupakan hambatan keluarga dalam memberikan dukungan penilaian.

Gejala gangguan jiwa yang menonjol adalah unsur psikisnya, tetapi yang sakit dan menderita tetap sebagai manusia seutuhnya (Maramis, 2010; Yusuf, 2015) menjelaskan bahwa gangguan jiwa merupakan berbagai bentuk penyimpangan perilaku dengan penyebab pasti belum jelas. Keluarga seharusnya dapat mengenal bahwa pasien gangguan jiwa adalah berada dalam kondisi sakit, sehingga dapat memahami penyimpangan perilaku yang timbul pada pasien dan menentukan pemecahan masalah terhadap masalah kesehatan pasien sesuai dengan tugas kesehatan keluarga (Yusuf, 2016; Laeli, 2017).

Adanya kesalahan persepsi terhadap kondisi sakit yang dialami pasien adalah tanda tidak berjalannya tugas kesehatan keluarga, dimana menurut Suprajitno (2004) dan Mubarak, (2009) tugas kesehatan keluarga yang pertama adalah mengenal kesehatan keluarga. Keluarga yang masih menganggap bahwa pasien gangguan jiwa mengalami kesurupan atau bukan orang baik-

baik berarti keluarga tidak dapat mengenal masalah keschatannya.

Kurangnya keluarga dalam memberikan perhatian terhadap pasien gangguan jiwa pasca pasung juga ditemukan dalam penelitian ini, dimana hanya 2 dari 9 partisipan yang ditemukan memberikan perhatian kepada pasien gangguan jiwa pasca pasung. Menurut Friedman (1998) dalam Murniasih (2007) dukungan penilaian merupakan dukungan yang terjadi apabila ada penilaian yang positif terhadap individu. Lebih lanjut Friedman (1998, dalam Murniasih, 2007) menjelaskan bahwa individu mempunyai seseorang yang dapat diajak bicara tentang masalah mereka. Penilaian positif didapatkan apabila anggota keluarga memberikan perhatian terhadap pasien.

2) Dukungan instrumental dari keluarga terhadap pasien gangguan jiwa pasca pasung

Penelitian ini menemukan bahwa seluruh keluarga membantu memenuhi kebutuhan pasien dalam menyediakan makan dan minum. Keluarga adalah sumber bantuan praktis bagi pasien dalam pemenuhan kebutuhannya. Bentuk bantuan jasa yang diberikan keluarga dengan mengambilkan obat ke rumah sakit. Bantuan ini diberikan karena ketidakmampuan pasien untuk dapat pergi sendiri ke pelayanan kesehatan. Meskipun semua pasien gangguan jiwa pasca pasung dalam penelitian ini memiliki Kartu Jamkesmas sehingga pasien tidak memerlukan biaya pengobatan di rumah sakit, namun biaya, waktu dan tenaga untuk mengambil obat di rumah sakit ditanggung oeh keluarga.

Adanya keluarga dengan gangguan jiwa merupakan beban untuk keluarga. Pasien yang tidak dapat berfungsi secara ekonomi dan keterbatasan dalam pemenuhan kebutuhan sehari-hari, mengharuskan keluarga untuk dapat memenuhi kebutuhan pasien tersebut yang termasuk beban obyektif keluarga. Hal tersebut sesuai dengan pendapat Mohr (2006, dalam Ngadiran, 2010) beban obyektif adalah masalah yang berhubungan dengan pelaksanaan perawatan pasien, yang meliputi: tempat tinggal, makanan, transportasi, pengobatan, keuangan dan intervensi krisis.

3) Dukungan informasional dari keluarga terhadap pasien gangguan jiwa pasca pasung

Keluarga memberikan dukungan informasional dengan cara memberikan informasi untuk minum obat dengan teratur. Sebagian besar partisipan mengungkapkan bahwa kunjungan rumah dan pendampingan oleh Petugas Puskesmas hanya dilakukan pada saat sebelum pasien akan dibebaskan dari pasung. Pendampingan dan kunjungan rutin dari Puskesmas ditemukan pada P2 dan P6. Keterbatasan pengetahuan dan sumber informasi yang didapatkan keluarga merupakan penyebab minimalnya dukungan informasional yang dapat diberikan oleh keluarga. Keluarga membutuhkan informasi kesehatan untuk dapat memberikan solusi terhadap masalah pasien dengan gangguan jiwa pasca pasung. Sumber informasi yang dapat diakses oleh keluarga adalah institusi pelayanan kesehatan seperti Puskesmas dan rumah sakit, buku, koran, majalah ataupun sumber ahli lainnya.

Partisipan tidak mengakui bahwa tindakan mengurung di dalam kandang dan di kamar sebagai pemasungan. Pemasungan dalam perspektif keluarga dalam penelitian ini adalah perlakuan mengunci kaki dengan balok. Hal ini membuktikan sangat kurangnya pengetahuan partisipan tentang tindakan pasung. Partisipan mengatakan bahwa pasien saat ini tidak dikurung lagi, karena tidak boleh oleh aparat setempat dan petugas Puskesmas, tanpa dapat menyebutkan alasan dengan benar. Terbatasnya informasi yang dimiliki keluarga menyebabkan kurangnya dukungan informasional yang diberikan keluarga terhadap pasien gangguan jiwa pasca pasung. Dalam proses penyembuhannya, keluarga membutuhkan informasi yang tepat tentang gangguan jiwa, agar dapat dicapai kondisi pasien yang dapat berfungsi secara sosial.

4) Dukungan emosional terhadap pasien gangguan jiwa pasca pasung

Penelitian ini mengidentifikasi bahwa dukungan emosional terhadap pasien gangguan jiwa pasca pasung diberikan dengan cara memberikan semangat terhadap pasien. Sebanyak lima partisipan mengungkapkan memberikan semangat cara yang berbeda-beda terhadap pasien. Satu orang partisipan (P6) teridentifikasi tidak memberikan dukungan keluarga saat menjelaskan bahwa untuk memberikan rasa nyaman dan membuat pasien berharga adalah

cukup dengan memenuhi kebutuhan sehari-hari.

Menurut Friedman (1998, dalam Murniasih, 2007) dukungan emosional memberikan individu perasaan nyaman, merasa dicintai saat mengalami depresi, bantuan dalam bentuk semangat, empati, rasa percaya, perhatian sehingga individu yang menerimanya merasa berharga. Lebih lanjut Friedman (1998, dalam Murniasih, 2007) menjelaskan bahwa dukungan emosional ini keluarga menyediakan tempat istirahat dan memberikan semangat.

Perasaan nyaman dan dicintai dibutuhkan oleh pasien gangguan jiwa pasca pasung untuk bisa mengoptimalkan kembali fungsi kognitifnya. Menurut Yusuf, Fitryasari, & Nihayati (2015) terjadinya gangguan jiwa dipengaruhi oleh masalah kepribadian awal, kondisi fisik pasien, situasi keluarga dan masyarakat.Situasikeluargayangmemberikan dukungan emosional akan membantu pasien untuk mencapai penyembuhan dengan optimal. Pasien membutuhkan motiviasi terus-menerus untuk dapat minum obat secara teratur dan yang dapat memberikan semangat untuk melakukannya adalah keluarga. Sikap empati dan rasa percaya dari keluarga sangat dibutuhkan oleh pasien untuk mencegah kekambuhan.

## Simpulan

Perilaku pasung yang dilakukan keluarga terhadap pasien gangguan jiwa merupakan cara penanganan yang tidak tepat terhadap pasien gangguan jiwa. Perilaku pasung yang ditemukan dengan alasan pasien melakukan perilaku kekerasan, membantu kesembuhan pasien, pasien keluyuran dan keluarga tidak mampu merawat pasien. Keputusan pemasungan yang ditemukan dilakukan oleh masyarakat dan keluarga. Cara pemasungan pasien gangguan jiwa yang ditemukan adalah dengan dikurung dalam kandang atau kamar dan diikat dengan rantai. Pembebasan pasien gangguan jiwa dari pasung dalam penelitian ini seluruhnya dilakukan oleh sistem sosial yaitu Polsek, Koramil dan Puskesmas. Akibat pemasungan yang ditemukan adalah kecacatan fisik apabila metode pemasungan dengan cara dikurung dalam tempat yang terbatas dan sempit. Meskipun demikian, keluarga masih tetap memberikan dukungan kepada pasien, walaupun kurang memadai.

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**Lampiran 1.2;**

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# GAMBARAN SPIRITUALITAS REMAJA YANG TINGGAL DI SEKITAR EKS-LOKALISASI

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**Abstract:** Spirituality is one of the most influential dimensions in adolescent development. Adolescent with good spiritual sees life with optimism, clean mind and soul. Environment will affect the spiritual development of adolescents. This research aimed to understanding the adolescent spirituality living around ex-localization. This research used qualitative research design of phenomenology with in-depth interview with semi structured interview and observation. Participants were junior high school teenagers, Moslems living around ex-localization, Kota Surabaya, choose by purpossive sampling. The data analysis in this study using thematic analysis with nine steps Collaizzi. result of this research got 18 theme that is adolescent perception, adolescent behavior, adolescent relationship with parents, interaction of adolescent with society, interaction of adolescent with opposite sex, adolescent knowledge, adolescent relationship with self, autonomy, feeling during worship, SWT, the purpose of human creation, religious analysis, Allah's incomprehension, the timeliness of worship, obstacles, life goals, hopes, spiritual experiences, ways of dealing with problems, lifestyles, self-image. Adolescents who live in an ex-localization will interact with peers and the surrounding community in the neighborhood. These reciprocal relationships affect the spiritual values in teenagers. The existence of the control of parents can control the interaction process that occurs between adolescents with the surrounding community who live in ex-localization so that formed the spiritual character of adolescents.
Keyword: spirituality, adolescence, ex-localization

**Abstrak:** Spiritualitas merupakan salah satu dimensi yang berpengaruh dalam perkembangan remaja. Remaja dengan spiritual yang baik akan memandang kehidupan dengan optimis, jiwa dan pikiran bersih. Lingkungan akan mempengaruhi perkembangan spiritual remaja. Tujuan penelitian ini adalah untuk mengetahui gambaran spiritualitas remaja yang tinggal disekitar eks-lokalisasi. Penelitian ini menggunakan desain penelitian kualitatif fenomenologi dengan metode *indepth interview* dengan wawancara semi terstruktur dan observasi. Partisipan adalah remaja Sekolah Menengah Pertama, beragama Islam yang tinggal di sekitar eks-lokalisasi, Kota Surabaya, dipilih secara purposif sampling. Analisis data dalam penelitian ini menggunakan teknik sembilan langkah Collaizzi. hasil penelitian ini didapatkan 18 tema yaitu persepsi remaja, perilaku remaja, hubungan remaja dengan orang tua, interaksi remaja dengan masyarakat sekitar, interaksi remaja dengan lawan jenis, pengetahuan remaja, hubungan remaja dengan diri sendiri, otonomi, perasaan saat beribadah, identifikasi Allah SWT, tujuan penciptaan manusia, analisis agama, ketidakyakinan Allah SWT, ketepatan waktu beribadah, hambatan, tujuan hidup, harapan, pengalaman spiritual, cara menghadapi masalah, gaya hidup, gambaran diri. Remaja yang tinggal di eks-lokalisasi akan menjalin interaksi dengan teman sebaya dan masyarakat sekitar di lingkungan tempat tinggal. Hubungan timbal balik tersebut mempengaruhi niali-nilai spiritual dalam diri remaja. Adanya kontrol dari orang tua mampu

mengendalikan proses interaksi yang terjadi antara remaja dengan masyarakat sekitar yang tinggal di eks-lokalisasi sehingga terbentuklah karakter spiritual remaja.

***Kata kunci : spiritualitas, remaja, eks-lokalisasi***

## PENDAHULUAN

Remaja merupakan masa transisi dari masa anak-anak menuju masa dewasa yang ditandai dengan berbagai perubahan. Miller (1993) dalam Baihaqi et all (2010) mengatakan bahwa masa remaja *"may be seen in the descriptive label given in this periode of life as a "storm and stress" period"*. Pada masa remaja, seseorang mengalami beberapa perubahan, baik secara fisik maupun secara psikis yaitu perubahan dalam proses biologis, psikologis, sosiologis dan spiritual. Perubahan yang terjadi akan mendorong remaja dalam melakukan perilaku yang positif maupun negatif yaitu kecenderungan untuk melakukan kenakalan remaja Mufna, Hardjajani (2004).

Fenomena kenakalan remaja maupun kecenderungannya mayoritas dilakukan oleh remaja di bawah usia 21 tahun (Kartono, 2006). Penelitian yang dilakukan Kemenkes 2009 menunjukkan bahwa sebanyak 35.9% remaja di Surabaya sudah pernah melakukan hubungan seksual sebelum menikah. Bahkan, 6,9% responden telah melakukan hubungan seksual pranikah. Kemenkes 2016 melaporkan sebanyak 82,8% jumlah HIV pada usia 11-29 tahun ditularkan melalui hubungan seksual, baik lesbian, homoseksual ataupun hubungan normal. Rentang usia remaja antara 13–18 tahun yang pernah melakukan hubungan seks di luar nikah tercatat di Surabaya mencapai 54%, di Medan 52%, Bandung 47%, dan Jogjakarta 37% (Kemenpora 2009; Kementerian Kesehatan RI 2016; Sulistiawan et al. 2010).

Data yang bersumber dari Badan Pusat Statistik bulan Februari 2016 jumlah penduduk remaja berusia 15-24 tahun di Indonesia sebanyak 43.668.757 dengan pravalensi sekitar 50% sudah memiliki tanggung jawab sebagai angkatan kerja. Sedangkan survei yang dilakukan Badan Pusat Statistika Kota Surabaya pada tahun 2014 penduduk remaja berusia 15-24 tahun berjumlah 186.672 jiwa (Badan Pusat Statistik Republik Indonesia 2013; BPS 2014). Surabaya sendiri sebagai kota metropolitan kedua setelah Jakarta juga memiliki jumlah kenakalan remaja yang tinggi. Kecamatan Sawahan merupakan wilayah yang mencakup salah satunya adalah eks lokalisasi, artinya fenomena perilaku seksual yang terjadi di wilayah eks lokalisasi berdampak buruk terhadap masyarkat sekitarnya termasuk remaja dan dapat berujung pada penyakit HIV (BNN 2015; Indonesia 2012).

Setyaningsih (2006) mendefinisikan kecenderungan kenakalan remaja sebagai perilaku remaja yang mengarah pada perilaku asosial akibat ketidakmampuan remaja untuk menjalin hubungan baik dengan lingkungan dan menjalankan norma masyarakat. Kecenderungan kenakalan remaja dipengaruhi oleh faktor internal dan eksternal. Salah satu faktor internal penyebab kenakalan remaja diduga terkait dengan ketidakmampuan remaja untuk mengontrol tingkah lakunya dalam menghadapi berbagai pola perubahan kehidupan yang bersamaan dengan perubahan fisik, psikis, sosial cukup membingungkan (Hurlock 2004).

Erikson dalam Baihaqi dkk (2010) mengatakan bahwa identitas remaja merupakan konsep integrasi antara individu itu sendiri dengan lingkunganya. Dapat ditarik kesimpulan bahwa selain lingkungan, ada sesuatu atau pedoman dalam diri individu yang mampu membentuk diri remaja. Sedangkan pendapat Wahl dkk (2008) dalam Alexis & Gowri (2014) menjelaskan tingkatan dalam diri invididu yang mampu mengatur dan memberikan kenyamanan serta memotivasi diri untuk melakukan sesuatu sesuai dengan kaidahnya disebut dengan spiritual (Baihaqi et all 2010); Alexis & Gowri 2014).

Remaja yang memiliki spiritual yang baik akan memandang kehidupan dengan optimis, jiwa dan pikiran bersih serta tidak menjatuhkan diri kepada kerusakan yang terjadi lingkungan tempat tinggal. Dari permasalahan tersebut peneliti timbul pertanyaan tentang bagaimana spiritual pada remaja yang tinggal di eks lokalisasi, aktifitas spiritual dalam kehidupan sehari-hari sesuai dengan fenomena perilaku seksual yang terjadi di wilayah eks lokalisasi, Kota Surabaya. Berdasarkan latar belakang tersebut peneliti ingin mengetahui bagaimana gambaran spiritualitas remaja yang tinggal di sekitar eks lokalisasi, Kota Surabaya.

## METODE

Desain penelitian ini adalah kualititatif fenomenologi. Desain ini dipilih peneliti karena peneliti ingin mendapatkan gambaran pengalaman partisipan terkait spiritualitas partisipan. Partisipan dipilih secara purposif dengan kriteria inklusi yaitu remaja (usia 14-16 tahun), tinggal di sekitar eks-lokalisasi, kota Surabaya. Pengumpulan data dilakukan dengan wawancara semi terstruktur, dengan alat bantu; pedoman wawancara, catatan lapangan, dan *recorder* berupa *voice recorder*. Peneliti memperoleh data remaja dari kelurahan setempat dan kemudian mendatangi remaja dan memberikan *inform consent* pada orangtua remaja setelah memberikan penjelasan penelitian terlebih dahulu pada orangtua remaja dan remaja. Setiap sesi wawancara dilakukan selama 30-45 menit selama 2-3 kali pertemuan. Analisis data dilakukan dengan metode Collaizi. Analisis data dilakukan bersamaan dengan proses pengumpulan data. Saturasi data didapatkan pada partisipan ke delapan. Analisis data denngan menggunakan metode Collaizi dilakukan dengan membaca kembali transkrip hasil wawancara dan mengutip pernyataan-pernyataan yang bermakna, Menguraikan arti yang ada dalam pernyataan-pernyataan signifikan, Menguraikan arti yang ada dalam pernyataan-pernyataan signifikan, Mengorganisir kumpulan-kumpulan makna yang terumuskan ke dalam kelompok tema, Menuliskan deskripsi yang lengkap, Menemui partisipan untuk melakukan validasi deskripsi hasil analisis, Menggabungkan data hasil validasi ke dalam deskripsi hasil analisis.

### Keabsahan Data

Peneliti melakukan validasi transkrip verbatim kepada partisipan. Peneliti juga melakukan triangulasi metode pengambilan data yaitu wawancara dan observasi serta terakhir adalah validasi kembali ke partisipan. Untuk menjamin kualitas data, peneliti juga melakukan prinsip konfirmabilitas yaitu melakukan konsultasi ke ahli yaitu supervisor penelitian yang sudah ahli dalam bidang spiritualitas.

### Etik Penelitian

Penelitian ini telah mendapat persetujuan dari Komisi Etik Penelitian Kesehatan Fakultas Keperawatan Universitas Airlangga dengan nomor sertifikat laik etik 375-KEPK tanggal 12 Juni 2017.

## HASIL

Mayoritas partisipan berusia 14 tahun, 4 orang pria dan 4 wanita, jarak tempat tinggal dengan eks-lokalisasi antara 50 – 100 meter, lama tinggal di wilayah tersebut antara 5 sampai 15 tahun. Secara lengkap seperti pada tabel 1.

Penelitian ini menghasilkan 18 (delapan belas) tema yang dijabarkan sesuai tujuan penelitian.

Tabel 1 Karakteristik Partisipan

| No | Inisial | Jenis Kelamin | Usia (tahun) | Lama Tinggal (tahun) | Jarak ke eks-lokalisasi (meter) |
|---|---|---|---|---|---|
| 1 | P1 | L | 14 | 14 | 100 |
| 2 | P2 | p | 14 | 7 | 50 |
| 3 | P3 | p | 14 | 14 | 50 |
| 4 | P4 | p | 16 | 16 | 50 |
| 5 | P5 | L | 15 | 15 | 50 |
| 6 | P6 | L | 14 | 14 | 100 |
| 7 | P7 | L | 14 | 5 | 80 |
| 8 | P8 | P | 15 | 15 | 75 |

## PEMBAHASAN

### Persepsi Remaja terhadap teman sebaya.

Persepsi remaja terhadap teman sebaya yang tinggal di sekitar eks-lokalisasi adalah adanya kenakalan remaja. Kenakalan pelajar atau remaja adalah hal yang dilakukan pelajar sebagai individu dan tidak sesuai dengan norma hidup yang belaku dalam masyarakat. Remaja yang tinggal di sekitar eks-lokalisasi ditemukan tiga bentuk kenakalan remaja yaitu merokok, minum-minuman dan ugal-ugalan (suka ngebut, berbicara semaunya, nada keras, arogan). Dua partisipan memandang bentuk kenakalan remaja yang dilakukan adalah merokok. Berdasarkan catatan lapangan diketahui bahwa kegiatan merokok tersebut tidak hanya dilakukan oleh anak SMP bahkan SD.

Penelitian Sulistiowati 2015 menjelaskan pengaruh interaksi yang terus-menerus dengan teman sepermainan akan memberikan pengaruh kuat berupa tuntutan konformitas. Konformitas merupakan tekanan atau tuntutan untuk mengikuti teman-teman sebayanya dan ini dapat bersifat positif maupun negatif (Papali, D. E & Fredlman 2009). Sehingga, efek yang diberikan teman sebaya yang berada di lingkungan eks-lokalisasi tersebut memberikan pengaruh besar terhadap remaja di sekitarnya.

### Perilaku remaja

Perilaku remaja dengan teman sebaya yang tinggal di sekitar eks-

lokalisasi terdapat perilaku yang positif dan negatif. Perilaku negatif meliputi kematangan psikis, emosional dan merusak lingkungan. Perilaku manusia dibangun dari kepekaan sosial, kelangsungan perilaku, orientasi pada tugas, usaha dan perjuangan.

Teori psikologi lingkungan menjelaskan bahwa perilaku manusia dapat merubah lingkungannya dan lingkungan juga dapat mengundang serta mendatangkan perilaku (Nuqul 2015). Berdasarkan catatan lapangan, partisipan yang bersekolah di lingkungan sekolah *full day school* tidak memiliki waktu untuk melakukan perilaku diluar sekolah bahkan di lingkungn rumah tak mampu berinteraksi dengan sebaya. Kesimpulan yang dapat diambil bahwa lingkungan eks-lokalisasi pada remaja dengan jam sekolah *full day* maupun remaja yang tidak melakukan interaksi dengan teman sebaya di lingkungan rumah tidak memberikan dampak perilaku negatif.

**Pengetahuan remaja tentang lingkungan tempat tinggal**

Hubungan remaja dengan lingkungan digambarkan melalui pengetahuan remaja tentang lingkungan itu sendiri. 2 dari 8 partisipan dalam penelitian ini belum mengetahui sejarah lingkungan eks-lokalisasi. Tiga partisipan yang mengetahui sejarah lengkap wilayah tempat tinggal mereka dahulunya merupakan eks-lokalisasi. Tiga partisipan lainnya menjelaskan wilayah tempat tinggal sesuai dengan keadaan lapangan yang mereka amati sehari-hari yaitu banyaknya lalu-lalang waria di sekitar tempat tinggal.

Penelitian Amaliyasari dan Nunik (2008) informasi tentang seksual responden berhubungan dengan perilaku seksual responden. Dalam penelitian ini menyimpulkan pengetahuan remaja tentang lingkungan eks-lokalisasi mempengaruhi sikap remaja dalam berinteraksi dengan masyarakat di sekitar lingkungan tempat tinggal.

**Hubungan**

Hubungan merupakan proses dalam kehidupan sosial. Dalam penelitian ini, tema hubungan diperoleh empat subtema yaitu interaksi remaja dengan masyarkat sekitar, interaksi remaja dengan lawan jenis, hubungan remaja dengan orangtua, hubungan remaja dengan diri sendiri.

Hubungan tersebut dibentuk dan dipengaruhi oleh lingkungan. Interaksi dengan lawan jenis terjadi secara langsung maupun tidak langsung. Interaksi langsung dilakukan ketika malam minggu sedangkan interaksi tidak langsung dilakukan setiap hari melalui telepon seluler.

Kualitas religius masyarakat Indonesia yang baik akan memberi kontribusi yang positif bagi bertumbuhnya nilai-nilai moral, etik dan spiritual yang diyakini banyak kalangan dan menjadi penangkal untuk melakukan aktivitas seksual (Pradisukmawati and Darminto 2014). Ditarik kesimpulan bahwa nilai spiritual yang baik dapat mengurangi hubungan dengan lawan jenis terutama pada usia remaja yang memiliki nilai-nilai moral yang mesti dianutnya.

Hubungan remaja dengan orang tua dipengaruhi oleh perang orang tua dalam perkembangan religius dan spiritual remaja. Orang tua merupakan kunci bagi segala kegiatan agama, kepercayaan dan praktik dalam kegiatan spiritual. Orang tua dianggap memberi landasan bagi pengembangan keyakinan dan praktik keagamaan kaum muda. Disamping itu, adanya dorongan keluarga dapat meningkatkan perkembangan religius dan spiritual pada anak-anak

melalui proses pengajaran formal, diskusi orang tua, pemodelan peran, dan coparticipation dalam doa dan ritual lainnya. Kualitas hubungan orang tua dan remaja adalah kunci proses sosialisasi keagamaan (King and Roeser 2008).

**Otonomi**

Otonomi dalam penelitian ini digambarkan melalui dua kategori yaitu pengambilan keputusan oleh diri sendiri dan orang tua. Remaja masih dalam tanggung jawab orang tua, ia belum mampu menafkahi diri sendiri sehingga dalam pengambilan keputusan seharusnya juga ditentukan oleh orang tua.

Dik (2009) dalam penelitiannya menjelaskan adanya mekanisme lain dimana spiritualitas dan agama seseorang dapat mempengaruhi pengambilan keputusan. Otonomi menuntut bahwa kita sendiri menentukan siapakah kita ini dan bersedia untuk bertanggung jawab atas pilihan itu (Hacho 2014).

Dalam penelitian satu partisipan menjelaskan bahwa pengambilan keputusan terkadang ia lakukan sendiri dengan menghiraukan keputusan yang diberikan orang. Partisipan delapan memaparkan hal yang berbeda, ia menyakini tetap mengikuti keputusan orang tua dengan berbagai keadaan serta sebab-akibat yang terjadi.

**Perasaan saat beribadah**

Perasaan adalah suatu keadaan dalam kesadaran manusia yang karena pengaruh pengetahuannya dinilai sebagai keadaan positif dan negatif. Tema perasaan saat beribadah dibagi menjadi dua sub tema yaitu adaptif dan maladaptif. Perasaan adaptif digambarkan melalui dua kategori tenang dan perasaan memiliki. Sub tema maladaptif digambarkan melalui kategori biasa saja.

**Identifikasi Tuhan**

Idcntifikasi Tuhan artinya penetapan identitas secara khusus oleh individu (Chaplin 2011; Yusuf dkk 2017). Dalam penelitian ini, identifikasi Tuhan Allah SWT digambarkan melalui dua kategori yaitu Maha Esa dan Maha Pencipta. Satu partisipan mengidentifikasikan Allah sebagai Tuhan yang Maha Esa hal tersebut sesuai dengan pedoman ajaran islam yang termaktub dalam Kitab Suci Al-Qur'an. *"Katakanlah (Muhammad), "Dialah Allah Yang Maha Esa[1], (Allah) tidak beranak dan tidak pula diperanakkan[3]"* (QS. Al-Ikhlas : 1&3).

**Tujuan Penciptaan Manusia**

Manusia dapat disebut juga spiritual. Spiritual didefinisikan menurut bahasa adalah satu zat atau makhluk immaterial, biasanya bersifat ketuhanan menurut aslinya, yang diberi sifat dari banyak ciri karakteristik manusia. Manusia sebagai makhluk spiritual akan senantiasa berpikir tentang apa dan mengapa ia diciptakan.

Kitab Suci Al-Quran menyebutkan *"Dan tidaklah Aku menciptakan Jin dan Manusia kecuali hanya untuk beribadah kepada-Ku"* (QS Adzariyat : 54). Allah SWT sudah menyebutkan secara pasti bahwa pada dasarnya tujuan penciptaan manusia adalah untuk beribadah kepada-Nya.

**Analisis Agama**

Tema analisis agama dapat ditentukan melalui pandangan terhadap agama yang sama yaitu agama islam secara subjektif. Subtema subjektifitas remaja terhadap analisis agama diperoleh empat kategori yaitu *voluntaristik* (menekan kemauan), *intelektualistik* (menegaskan kepercayaan), *afektivistik* (menyangkut perasaan), dan *historistik* (menggambarkan pengalaman). Penelitian yang dilakukan David ett all (2000) menyatakan adanya keterkaitan erat

antara agama dengan spiritualitas yang tinggi. David juga menjelaskan bahwa spiritualitas merupakan bagian dari kehidupan remaja.

Berdasarkan catatan lapangan diketahui bahwa partisipan menganalisis agama sesuai dengan pengetahuan yang dimiliki. Kategori *intelektualitas*, partisipan menegaskan besarnya kepercayaan yang dimiliki sesuai dengan ilmu-ilmu tentang agama yang dipelajari sejak kecil. Pada kategori *historitik*, partisipan memiliki pengetahuan tentang agama berasumber dari pengalaman-pengalaman yang dimiliki.

**Keyakinan terhadap Tuhan**

Tema keyakinan terhadap Allah SWT digambarkan melalui dua subtema yaitu menjalankan ritual dan tidak menjalankan. Sub tema menjalankan ritual dijelaskan melalui tiga kategori shalat, ngaji, puasa.

Hal-hal yang menjadi pilar Islam terjewantah dalam lima perkara atau disebut juga rukun Islam. 1)Mengucapkan dua kalimat syahadat, 2)Mendirikan shalat, 3)Menjalankan puasa Ramadhan, 4)Menunaikan zakat, dan 5)Pergi haji ke Baitullah bagi yang mampu. Hasil yang dapat disimpulkan dalam penelitian bahwa kegiatan ritual agama islam seperti shalat, ngaji dan puasa dapat menggambarkan spiritual individu.

**Usaha yang dilakukan**

Dalam menjalankan ibadah individu tidak boleh melanggar dalam tatanan aturan termasuk waktu. Waktu beribadah agama Islam dalam sehari dibagi menjadi lima. Setiap waktu beribadah baik ibadah wajib seperti shalat dan puasa di bulan Ramadhan memiliki batasan-batasan yang telah diatur. Pada penelitian ini, diketahui bahwa terdapat satu partisipan yang menjalankan ibadah sesuai waktunya. Usaha tersebut dilakukan dengan memasang alarm ketika akan bangun subuh dan sesegara mungkin ke masjid ketika adzan berkumandang ataupun ketika waktu shalat telah tiba.

**Hambatan beribadah**

Hambatan dalam melakukan kegiatan ibadah dalam penelitian bukan merupakan hambatan yang serius. Hambatan terjadi diakibatkan faktor yang berasal dari diri sendiri dan lingkungan. Pada diri sendiri hambatan yang terjadi karena malas dan kesiangan. Faktor lingkungan terjadi karena perubahan jadwal dan kelelahan. Faktor-faktor tersebut seharusnya dapat diantisipasi dengan keinginan yang kuat dari individu. Peneliti menyakini bahwa partisipan memang tidak memiliki keinginan untuk beribadah dengan sungguh-sungguh, terlihat ketika diajukan pertanyaan berbagai alasan diajukan partisipan.

**Tujuan Hidup**

Perasaan mengetahui makna hidup, yang kadang diidentifikasikan dengan perasaan dekat dengan Tuhan, merasakan hidup sebagai suatu pengalaman yang positif seperti membicarakan tentang situasi nyata, membuat hidup lebih terarah, tujuan masa depan dan merasa mencintai dan dicintai oleh orang lain.

Pada penelitian ini, tujuan hidup dibagi menjadi dua yaitu tujuan hidup akan dunia dan tujuan hidup akan akhirat. Banyak partisipan yang masih berada dalam tahap *early adolescent* mengakibatkan kecenderungan partisipan belum mampu lepas dari tahap anak-anak. Hal tersebut terlihat dalam setiap jawaban partisipan mengenai tujuan hidup yang masih abstrak.

**Harapan**

Harapan merupakan proses dimana secara cukup intensif dan menetap

menstimulasi potensi perubahan fisiologi serius (Yusuf dkk 2017 ; Breznitz dalam Appley & Trumbul 1986).

Pada penelitian ini harapan remaja yang tinggal di eks-lokalisasi dibagi menjadi dua subtema yaitu harapan jangka panjang dan harapan jangka pendek. Harapan jangka panjang artinya harapan yang diperoleh dalam kurun waktu yang tidak dapat ditentukan. Harapan jangka panjang yang ditemukan dalam penelitian ini terkait tentang ibadah dan cita-cita. Harapan jangka pendek berarti sebaliknya yaitu harapan yang diperoleh dalam kurun waktu yang dapat ditentukan. Harapan jangka pendek yang ditemukan dalam penelitian ini terkait tentang harapan untuk orang tua.

Hasil lain menunjukkan bahwa individu yang memiliki hubungan spiritual yang kuat dengan kekuatan yang lebih tinggi karena motivasi intrinsik dan harapan yang cenderung lebih percaya diri dalam kemampuan mereka untuk membuat keputusan karir dan terbuka untuk mengeksplorasi berbagai pilihan karir (Laubach 2004).

**Pengalaman Kehidupan**

Pengalaman kehidupan merupakan bagian spiritual pengalaman transeden. Transendensi mengacu pada kesadaran atau keterikatan terhadap sesuatu yang melampaui diri, dapat mencakup Tuhan atau kenyataan transenden, namun juga dapat melibatkan aspek kehidupan yang dijiwai dengan kualitas seperti ilahi, seperti imanensi, tanpa batas, dan kekekalan (King and Clardy 2014)

Knoers dan Haditono (1999) dalam Asih (2006) mengatakan bahwa pengalaman merupakan suatu proses pembelajaran dan penambahan perkembangan potensi bertingkah laku baik dari pendidikan formal maupun non formal. Hubungan antara tubuh, pikiran dan spirit menyatu membentuk aspek dalam spiritualitas manusia. Pengalaman dalam kehidupan merupakan bagian dari spiritualitas. Penelitian ini menemukan dua macam pengalaman yang terjadi dalam kehidupan. Pengalaman sebagai sumber pengetahuan dalam melakukan kegiatan mendatang, pengalaman dijadikan pelajaran dalam kehidupan sehari-hari (Haugan 2013).

**Cara menghadapi masalah**

Remaja menghadapi masalah dengan berbagai cara. Pada penelitian ini ditemukan dua cara menghadapi masalah yaitu dengan pengalihan dan curhat. Pengalihan perhatian dilakukan remaja untuk melupakan masalah yang terjadi sedangkan kegiatan curhat dilakukan untuk meringankan beban masalah. Aktifitas pengalihan paling sering dilakukan oleh remaja laki-laki, sedangkan pada remaja perempuan sering kali melakukan curhat dengan teman sebaya untuk meringankan masalah yang terjadi.

**Gambaran diri**

Gambaran diri merupakan bagian dari konsep diri. Konsep diri merupakan gambaran yang dimiliki seseorang tentang dirinya. Konsep diri dibentuk melalui pengalaman-pengalaman yang diperoleh dari interaksi dengan lingkungan (Agustiani 2009).

Sebuah penelitian menyatakan bahwa masa remaja merupakan periode sensitif untuk pengembangan spiritualitas. Bukti menunjukkan bahwa banyak karakteristik perkembangan normatif remaja mungkin membuat remaja lebih responsif terhadap keinginan spiritual. Karakteristik perkembangan psikologis remaja bersamaan dengan spiritualitas (Good 2008).

Sejalan dalam penelitian ini ditemukan gambaran diri remaja yang tinggal di eks-lokalisasi yaitu ringan tangan dan optimis. Gambaran diri yang optimis dilakukan agar remaja agar bertahan hidup di lingkungan tersebut. Gambaran diri positif tersebut tidak dipengaruhi oleh keadaan lingkungan yang negatif. Remaja dapat tumbuh dan berkembang sesuai keinginannya.

**Gaya Hidup**

Gaya hidup sudah terbentuk pada usia 4-5 tahun, gaya hidup itu tidak hanya ditentukan oleh kemampuan instrinsik (hereditas) dan lingkungan objektif, tetapi dibentuk oleh anak melalui pengamatan dan intepretasinya terhadap keduanya. Gaya hidup tersebut dipandang baik dan buruk berdasarkan *role model* yang ia ikuti. Kotler (1997) dalam Nadzir (2015) menyatakan bahwa terdapat dua faktor yang mempengaruhi gaya hidup manusia yaitu faktor yang bersal dari dalam individu *(internal)* dan faktor yang berasal dari luar *(eksternal).*

## KESIMPULAN

Spiritualitas remaja yang tinggal di sekitar eks-lokalisasi digambarkan melalui bagaimana remaja menjalani kehidupan dengan tujuan dan harapan yang dimiliki. Tujuan hidup remaja dapat dipengaruhi oleh bagaimana interaksi remaja dengan lingkungannya. Dalam hal ini, orang tua memiliki peran besar dalam penentuan terjadi tidaknya interaksi remaja dengan lingkungan eks-lokalisasi.

Faktor perkembangan spiritualitas remaja digambarkan melalui gambaran diri dengan nilai-nilai spiritualitas yang dianut. Remaja mampu mengatasi dan menghadapi berbagai kesulitan, perubahan dan tuntutan dari diri atau lingkungan, memerlukan pandangan atau keyakinan terhadap keseluruhan diri; meliputi konsep, asumsi, dan prinsip-prinsip yang dipegang selama hidup sehingga menjadi cermin bagi dirinya dalam memandang dan menilai dirinya sendiri.

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# *PENGGUNAAN MINDFULNESS MEDITATION DALAM MANAJEMEN STRES: SEBUAH SYSTEMATIC REVIEW*

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## *ABSTRAK*

***Background.*** *Mindfulnes meditation dan intervensi lain berbasis mindfulnes saat ini sedang populer yang terbukti bermanfaat secara luas terutama pada pasien kanker dan tenaga kesehatan profesional.* ***Objectives.*** *Tujuan dari artikel ini adalah melakukan review secara sistematic pada beberapa hasil penelitian terbaru yang menggunakan randomized controlled trials yang mengkaji efek intervensi mindfulness meditation terhadap berbagai kasus.* ***Methods.*** *Pencarian dilakukan di beberapa database elektronik dalam kurun waktu 10 tahun terakhir yang dipublikasikan dalam Bahasa Inggris. Hasil pencarian menyisakan 8 jurnal yang memenuhi kriteria.* ***Conclusion.*** *Mindfulness meditation menurunkan stres, ansietas, dan fatigue secara signifikan, tidak berpengaruh terhadap faktor metabolik pada pasien obesitas, signifikansi kurang kuat pada nyeri, depresi dan kualitas tidur. Perlu penelitian lebih lanjut penggunaan mindfulness meditation dalam menurunkan nyeri, depresi, dan peningkatan kualitas tidur serta penggunaan pada berbagai kasus.*

*Kata kunci:*
*Anxiety, Depression, Mindfulness, Pain, Stress*

## PENDAHULUAN

*Mindfulnes meditation* dan intervensi lain berbasis *mindfulnes* saat ini sedang populer yang terbukti bermanfaat secara luas terutama pada pasien kanker dan tenaga kesehatan profesional berdasarkan hasil *evidence based* (Bauwer-Wu, S & Barton, 2010). *Mindfulness* merupakan teknik yang digunakan untuk membantu memusatkan perhatian pada keadaan saat ini tanpa menghakimi atau menilai berbagai pemikiran dan reaksi emosional yang berkaitan dengan situasi atau stimulus (Arif, et.al. 2017). *Mindfulness meditation* pertama kali diperkenalkan oleh Dr Jon Kabat Zinn di dunia Barat pada tahun 1970 an. Dia memaknai mindfulness meditation sebagai "*pay attention in the present moment and non-judgementally*" (Arif, et al., 2017).

Sebagai strategi intervensi klinis berdasarkan filsafat Buddha, meditasi mindfulness telah diterapkan di beragam kelompok untuk meningkatkan kesejahteraan dan memungkinkan individu untuk mengatasi stres (Irving et al. 2009). Misalnya, meditasi mindfulness ditemukan untuk secara efektif meningkatkan kualitas dan durasi tidur pada penerima transplantasi (Kreitzer et al., 2005), dan untuk mengurangi depresi, kecemasan dan tekanan psikologis pada pasien dengan penyakit somatik kronis (Bohlmeijer et al., 2010), sakit kronis (Rosenzweig et al., 2010), gangguan kecemasan sosial (Goldin dan Gross, 2010) perhatian meditasi juga dapat meningkatkan upaya kesehatan yang positif seperti spiritualitas (Mars dan Abbey, 2010), meningkatkan stabilitas psiko emosional dan konsentrasi pada pasien dengan gangguan kejiwaan ( Rubia, 2009 ). Secara keseluruhan, praktisi klinis telah menyarankan bahwa meditasi mindfulness harus diintegrasikan ke dalam pelayanan kesehatan Barat, terutama dalam konteks psikoterapi dan manajemen stres (Galantino et al., 2005; Salmon et al., 2004).

Hasil *systematic review* sebelumnya menunjukkan bahwa *mindfulness meditation* memiliki efek yang sangat signifikan pada kesehatan jiwa, meditasi merupakan terapi modalitas yang diteliti efeknya dalam mengatasi nyeri kronik, namun signifikansi yang minimal pada nyeri kronik (Rajguru, et.al., 2014). Selain itu, penelitian tentang penggunaan *mindfulness*

*meditation* pada masing – masing penyakit masih terbatas (Chan & Larson 2015). *Review* ini dilakukan untuk menkaji efektifitas mindfulness pada kesehatan jiwa (stres, ansietas, depresi), nyeri, kualitas tidur, dan penurunan berat badan pada obesitas.

## METODE STUDI

### Strategi Pencarian Literatur

Artikel penelitian didapatkan dari pencarian *online* artikel bahasa inggris di beberapa *database* meliputi PubMed, Ebscohost, Proquest, Science direct, SAGE, Neliti, Jurnal Ners, Atlantis, Springer link dan Wiley Online Library dalam 10 tahun terakhir (2007-2017). Kata kunci yang digunakan adalah PICOT (*Population, Intervention, Comparison, Outcome, Time*) yang terdiri dari P = *student* atau *chronic disease, adult*; I = *mindfulness meditation* atau *mindfulness*; C = *No mindfulness meditation*; O = *Stress, pain, sleep quality, anxiety*; T = 2007-2017.

### Seleksi Penelitian

Hasil pencarian didapatkan 1570 jurnal yang diseleksi menyisakan 25 jurnal *fulltext* berjudul *mindfulness meditation*. Dari 25 artikel tersebut diseleksi lagi intervensi *mindfulness meditation* dan RCT sehingga hanya tersisa 8 artikel. *Mindfulness meditation* dalam bentuk MBSR (*mindfulness based stress reduction*) dieksklusikan.

### Kualitas Metodologi

Pengkajian risiko bias dilakukan dengan *the Cochrain Quality Criteria* (tabel 1). Dari 8 jurnal RCT, semua menggunakan *random generation of allocation* dan *concealment of allocation*. Delapan jurnal yang dikaji, menunjukkan risiko bias rendah yaitu 2

Tabel 1. *Judgment of Risk of Bias in the 8 Studies Based on the Cochrain Quality Criteria*

| Study | Random Generation of Allocation[a] | Concealment of Allocation[b] | Blinding of Participant and Personnel[c] | Blinding of Outcome Assessors[d] | Incomplete Outcome Data[e] | Selective Outcome Reporting[f] | Other Sources of Bias[g] |
|---|---|---|---|---|---|---|---|
| (Morone et al. 2008) | Yes | Yes | No | Yes | No | Yes | Yes |
| (Zgierska et al. 2016) | Yes | Yes | No | Yes | Yes | Yes | Yes |
| (Chen et al. 2013) | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| (Pinniger et al. 2012) | Yes | Yes | Yes | Unclear | No | Yes | Yes |
| (Arif et al. 2017) | Yes | Yes | Unclear | Yes | No | Yes | No |
| (Zwan et al. 2015) | Yes | Yes | No | Yes | No | Yes | No |
| (Bower et al. 2015) | Yes | Yes | No | Unclear | No | Yes | No |
| (Daubenmier et al. 2016) | Yes | Yes | No | No | No | Yes | Yes |

[a]Yesrated as: If sequence generated by referring to a good random technique; no: If sequence generated by poorrandom technique; unclear: Insufficient information to permit judgment.
[b]Yes refers to participants and investigators enrolling participants could not foresee assignments before assigning subjects to groups;no: If participants or investigators enrolling participants could possibly foresee assignments;unclear: Insufficient information to permit judgment.
[c]Yes indicates blinding of participants and key study personnel ensured; no: blinding of key study participants and personnel attempted;unclear: Insufficient information to permit judgment.
[d]Yes implies blinding of outcome assessment ensured; no: Blinding of outcome assessment attempted, but likely that the blinding could have been broken;unclear: Insufficient information to permit judgment.
[e]Yes implies no missing outcome data or loss to follow-up <10%;no: loss to follow-up >10%; unclear: Insufficient reporting of exclusions to permit judgment.
[f]Yes implies the study protocol is available; no: not all of the study's pre-specified primary outcomes have been reported; unclear: Insufficient information to permit judgment
[g]Yes implies the study appears to be free of other sources of bias; no: there is at least one important risk of bias; unclear: Insufficient reporting of attrition/exclusions to permit judgment

jurnal *blinding of participant and personnel* dan 5 jurnal *blinding of outcome assessors*, 6 jurnal kehilangan *follow-up* > 10%, 5 jurnal bebas dari sumber bias, sedangkan 3 jurnal lainnya minimal ada satu risiko bias.

## HASIL STUDI

*Review* ini mengkaji efek meditasi terhadap stres (3 jurnal), ansietas (3 jurnal), depresi (3 jurnal), fatique/ kelelahan (1 jurnal), kualitas tidur (2 jurnal), nyeri (4 jurnal), dan penurunan berat badan (1 jurnal). Desain pada 8 jurnal yang di*review* semua menggunakan RCT yang berada di level 2 dari 7 derajat *level of evidence* dengan random alokasi. Jenis intervensi yang direview diseragamkan hanya *mindfulness meditation*, mindfulness bentuk MBSR tidak direview.

*Mindfulness meditation* dapat menurunkan stres psikologis secara signifikan pada orang dewasa yang mengalami stres (Zwan, et al. 2015; Pinniger, et.al. 2012) dan *survivor* kanker payudara (Bower, et.al. 2015). Hasil ketiga jurnal konsisten bahwa MM dapat menurunkan stres. Instrumen yang digunakan untuk mengukur stres adalah DASS *stress* (2 jurnal) dan PSS (1 jurnal). Dari ketiga jurnal, hanya 1 terdapat risiko bias karena ada pelaksanaan MM yang dilakukan di rumah dengan alat bantu *reminder* via WhatsApp, sms, atau email, namun tidak dapat dipastikan dilakukan atau tidak oleh responden.

*Mindfulness meditation* dapat menurunkan ansietas pada orang dewasa yang mengalami stres (Zwan, et.al. 2015; Chen, et.al. 2013; Arif, et.al. 2017). Pinniger, et.al. (2012) membandingkan antara *tango dance* dengan MM,

Tabel 2. *Study Caracteristics, Interventions, and Primary Outcome Measures*

| Author | Stress | Anxiety | Depression | Fatigue | Sleep quality | Pain | Feasible acceptablesafe | Metabolic factor | Physical func | Mindfulness meditation | Duration | Sample |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Morone, Greco & Weiner 2008, Pittsburgh | NM | NM | NM | NM | NM | SD | SD | NM | SD | Mindfulness based meditation program | 90 min in 8 weekly + meditation at home | ExpM 12 Contrl 13 |
| Zgierska et al. 2016, Winscounsin | NM | NM | NM | NM | NM | SD | SD | NM | NM | Combaining MM with CBT (informal MM exercise) | 2 hr group session in 8 weekly | ExpM 21 Contrl 14 |
| Bower et al. 2015 Los Angeles | SD | NM | NS | SD | SD | NS | NM | NM | NM | Mindful Awareness Practices (MAPs) Program at UCLA | 2 hr group session Home pract 5-20 min/day in 6 weeks | ExpM 39 Contrl 32 |
| Zwan et al. 2015, Amsterdam | SD | SD | SD | NM | NS | NM | NM | NM | NM | Meditation mindfulness | 5 weeks meditation at home + follow up 6 weeks | ExpM 27 PA 23 HRV-BF 25 |
| Chen et al. 2013, China | NM | SD | NS | NM | NM | NM | NM | NM | NM | Mindfulness meditation | 30 min daily for 7 days | ExpM 30 Contrl 30 |
| Arif et al. 2017, Cardiff | | SD | SD | NM | NM | SD | NM | NM | SD | Mindfulness meditation | 40 min in 5 times face to face session in 15 weeks | ExpM 34 RT 27 |
| Pinniger et al. 2012, Sydney | SD | NS | SD | NM | NM | NM | NM | NM | NM | Mindfulness meditation | 1.5 hr in 6 week | ExpM 16 ExpT 21 Contrl 29 |
| Daubenmier et al. 2016, San Fransisco | NM | NM | NM | NM | NM | NM | NM | NS | NM | MM based eating awareness training program | 2-2.5 hr (16 session in 12 weekly, 3 biweekly, and 1 monthly) and one all day session over 5.5 months | ExpM 100 Contrl 94 |

PA=Physical Activity; HRV-BF=Biofeedback; ExpM=Experiment Mindfulness Meditation grup; ExpT=Experimental Tango Dance Group; SR=Somatic Relaxation; RT=Relaxation Technique; SME=Stress Management Education; SD=Significantly Descending; NS=Not Significant; NM=Not Measure

menunjukkan penurunan ansietas lebih banyak pada kelompok yang dilakukan *tango dance* (52%) dibandingkan kelompok MM (30%) namun lebih baik dibandingkan kelompok kontrol yang hanya 10%. Instrumen yang digunakan dalam pengukuran ansietas adalah SRAS (Self-Rating Anxiety Scale), DASS *anxiety*, dan *hospital anxiety and depression scale*. Arif, et.al. (2017) menyatakan bahwa MM lebih baik dibandingkan dengan terapi relaksasi dalam manajemen tinitus.

Tiga jurnal menyatakan MM menurunkan depresi secara signifikan (Pinniger, et.al. 2012; Zwan, et al. 2015; Arif, et.al. 2017), sedangkan 2 jurnal menyatakan tidak signifikan (Bower, et.al., 2015; Chen, et.al., 2013). Dari kelima jurnal terdapat hasil yang tidak konsisten. Instrumen yang digunakan untuk mengukur depresi menggunakan DASS *depression, hospital anxiety and depression scale*, CES-D (*Center for Epidemiologic Studies Depression Scale*), dan SRDS (*Self-Rating Depression Scale*).

Dua jurnal yang direview menunjukkan perbedaan efek MM terhadap kualitas tidur. 1 jurnal menyatakan MM tidak perpengaruh terhadap kualitas tidur pada mahasiswa sosial dan ilmu perilaku (Zwan, et.al., 2015), sedangkan 1 jurnal menyatakan MM dapat meningkatkan kualitas tidur secara signifikan pada pasien kanker payudara (p=0.015) (Bower, et al., 2015). Kedua jurnal menunjukkan hasil yang tidak konsisten (berlawanan). Kedua jurnal menggunakan instrumen kualitas tidur yang sama yaitu PSQI.

Tiga jurnal menyatakan bahwa MM dapat menurunkan *cronic low back pain* secara signifikan (Morone, et.al. 2008; Zgierska, et.al., 2016) juga menurunkan skor VAS (*visual analogue scale*) pada timitus (Arif, et.al., 2017), sedangkan 1 jurnal menyatakan penurunan nyeri (BCPT/*Breast Cancer Prevention Trial Symptom*) tidak signifikan (Bower, et.al., 2015). Terdapat perbedaan hasil penurunan nyeri dari ke 4 jurnal yang dikaji.

Selain berpengaruh terhadap kondisi kejiwaan, MM juga berpengaruh terhadap *fatigue*. Satu jurnal yang direview menunjukkan MM dapat menurunkan kelelahan (FSI/ Fatigue Symptoms Inventory) secara signifikan (p = 0.007) (Bower, et al., 2015). MM tidak berpengaruh dalam memelihara glukosa puasa, profil lipid, dan penurunan berat badan pada penderita obesitas (Daubenmier, et.al., 2016).

## PEMBAHASAN

Hasil *review* 8 artikel ini menunjukkan bahwa *mindfulness meditation* efektif menurunkan stres, depresi, ansietas, dan fatigue. MM juga dapat meningkatkan kualitas tidur dan tidak berpengaruh dalam penurunan berat badan pada orang dewasa yang mengalami obesitas. Meditasi mindfulness dapat memperbaiki perubahan fisiologis yang menyertai stres mental dan emosional kronis, meningkatkan profil sekresi kortisol dan memberikan perubahan anatomis bermanfaat dalam otak (Arif, et.al., 2017).

Terdapat beberapa hasil penelitian yang tidak konsisten yaitu tentang efek MM terhadap depresi, nyeri, kualitas tidur. 4 artikel yang di*review* tentang nyeri menunjukkan hasil yang berbeda, 3 menyatakan terjadi penurunan yang signifikan sedangkan 1 jurnal menyatakan tidak. Hasil *review* menunjukkan bahwa penggunaan MM dalam manajemen nyeri kronik secara statisik memiliki signifikansi minimal (rendah) (Rajguru et al. 2015). MM dapat menurunkan ansietas lebih baik dibandingkan kelompok kontrol, namun bila MM dibandingkan dengan *tango dance*, efek tango dance lebih signfikan dalam menurunkan ansietas dibandingkan dengan MM (Pinniger, et.al., 2012).

Selain berpengaruh terhadap kondisi kejiwaan, MM dapat menurunkan kelelahan secara signifikan (Bower, et al., 2015), namun hanya diwakili 1 jurnal sehingga kurang kuat untuk digeneralisasi untuk menurunkan *fatigue*. MM tidak berpengaruh dalam memelihara glukosa puasa, profil lipid, dan penurunan berat badan pada penderita obesitas (Daubenmier, et.al., 2016). Hasil *review* sebelumnya menunjukkan bahwa MBSR inkonsisten dalam mempengaruhi kesehatan fisik (Ledesma & Kumano, 2009). MM terhadap fisik merupakan efek tidak langsung dari minfulness.

Penggunaan *mindfulness meditation* pada penurunan nyeri pasien *survivor kanker* payudara hanya diwakili 1 jurnal, sehingga masih perlu diteliti lebih lanjut. Penggunaan *mindfulness* yang telah banyak dilakukan pada pasien kanker adalah MBSR, namun tidak di*review* dalam artikel ini. MBSR efektif meningkatkan

kondisi psikososial pada pasien kanker payudara, namun tidak bisa digeneralisasikan pada semua populasi kanker (Ledesma & Ã 2009). Intervensi berbasis *mindfulness* merupakan prediktor kualitas hidup, kondisi emosional, dan kesehatan yang signifikan dan direkomendasikan penggunaan pada pasien kanker payudara (Abdollahi & Khan 2015). Penggunaan MM pada pasien yang dalam perawatan dalam berbagai kasus belum ditemukan misalnya pada stroke, atau penyakit lainnya.

Dari 8 jurnal, 3 jurnal masih terdapat faktor bias karena ada pelatihan yang dilakukan di rumah yang tidak bisa diketahui bahwa responden melakukan intervensi atau tidak, sehingga hasilnya belum bisa dipastikan apakah efek positif yang dihasilkan merupakan akibat dari intervensi *mindfulnes meditation* ataukah karena faktor yang lain.

*Mindfulness meditation* sangat aman dilakukan dan hanya memiliki sedikit risiko. Kadang seseorang mengalami peningkatan ansietas sementara ketika mempraktikkannya, ketika mereka keluar dari rutinitas dan permasalahan sehari – hari dan sadar dengan hal – hal yang mengganggu pikiran dan perasaan (Bauwer-Wu, S & Barton, 2010). Sering juga partisipan *mindfulness* yang melaporkan kembalinya ke memori masa lalu pada kondisi yang sangat stres (Creswell & Lindsay 2014). Bagi praktisi meditasi lanjutan yang terikat dalam waktu lama dan intens memiliki risiko tambahan dan membutuhkan pendamping ahli selama periode pelatihan yang intens (Bauer-wu et al. 2010)

## KESIMPULAN

Tujuan dari *systematic review* ini adalah mengkaji kemungkinan penggunaan *mindfulness meditation* sebagai intervensi terapeutik pada kasus kesehatan jiwa (stres, ansietas, depresi), kualitas tidur, nyeri, dan penurunan berat badan pada obesitas. 8 jurnal RCT yang direview menunjukkan MM efektif menurunkan stres, ansietas, dan fatigue, dan tidak berpengaruh terhadap faktor metabolik pada pasien obesitas. Terdapat hasil penelitian yang inkonsisten pada pengaruh MM terhadap penurunan depresi, nyeri, dan peningkatan kualitas tidur, sehingga hasil *review* ini belum bisa digeneralisasi pada ketiga variabel tersebut. MM terbukti aman untuk diaplikasikan dengan efek samping minimal. Namun, efek MM pada semua kasus penyakit belum diketahui. Secara umum hasil *review* ini kurang kuat untuk digeneralisasikan pada semua kasus. Perlu penelitian lebih lanjut tentang penggunaan MM terhadap berbagai kasus penyakit yang berbeda dan kondisi yang berbeda.

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**Lampiran 1.4;**

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# *INTERVENSI NONFARMAKOLOGIK UNTUK MENURUNKAN KECEMASAN PADA PASIEN PREOPERASI: LITERATURE REVIEW*

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## *ABSTRAK*

*Pendahuluan: Kecemasan merupakan suatu hal yang biasa terjadi pada pasien yang akan menjalani pembedahan. Kecemasan yang terjadi pada pasien pre operasi dapat dirasakan sejak mulai dijadwalkan untuk operasi hingga waktu operasi tiba. Intervensi nonfarmakologi dapat diberikan pada pasien yang mengalami kecemasan preoperasi. Tujun literatur review ini untuk memberikan gambaran mengenai beberapa intervensi nonfarmakologi yang dapat diberikan untuk menurunkan kecemasan pada pasien yang mengalami kecemasan preoperasi. Metode: Metode yang digunakan dalam literature review ini diawali dengan pemilihan topik, kemudian ditentukan keyword untuk pencarian jurnal menggunakan Bahasa Inggris melalui beberapa database antara lain Sciencedirect, Ebscho, dan Pro Quest. Hasil: Didapatkan beberapa intervensi nonfarmakologi di dalam review ini yang dapat menurunkan kecemasan pada paslen pre operasi. Intervensi teresebut adalah edukasi preoperatif, pemberian minyak lavender, Wack Wednesday, healing touch, dan hand reflexology. Kesimpulan: Banya intervensi nonfarmakologi yang telah dikembangkan untuk menurunkan kecemasan pasien preoperasi. Pemberian edukasi merupakan cara yang paling sederhana untuk menurunkan kecemasan pasien preoperasi.*

*Kata kunci:*
*Kecemasan, Nonfarmakologi, Preoperasi*

## PENDAHULUAN

Kecemasan merupakan suatu hal yang biasa terjadi pada pasien yang akan menjalani pembedahan. Kecemasan yang terjadi pada pasien pre operasi dapat dirasakan sejak mulai dijadwalkan untuk operasi hingga waktu operasi tiba (Poorolajal, Ashtarani and Alimohammadi, 2017). Kecemasan tersebut tidak hanya berupa kecemasan terhadap proses yang terjadi saat operasi, tetapi juga komplikasi yang kemungkinan bisa didapatkan setelah dilakukan pembedahan. Kecemasan sebelum pembedahan juga tidak hanya memberikan efek terhadap psikologis, tetapi juga pada aspek fisiologis seperti timbulnya, takikardia, peningkatan tekanan darah, mual, dan berkeringat (Wilson *et al.*, 2016).

Menurut Trotter, Gallagher and Donoghue (2011) bahwa didapatkan sebanyak 24% hingga 72% pasien yang akan menjalani tindakan PCI mengalami kecemasan. Peneliti lainnya, Brand, Munroe and Gavin (2013) mengatakan bahwa perasaan cemas adalah kondisi stres yang biasa terjadi pada pasien yang akan menjalani tindakan CABG *(Coronary Artery Bypass Graft)*. Didapatkan juga sekitar 25% hingga 80% pasien mengalami kecemasan sebelum dilakukan pembedahan jantung

Kecemasana yang diami pasien pada pre operasi juga dapat menurunkan kepuasan pasien terhadap pelayanan yang diberikan. Salah satu penelitian menyatakan bahwa seorang perempuan yang mengalami cemas sebelum dilakukan pembedahan caesar memberikan tingkat kepuasan yang rendah dan dengan penyembuan luka yang lebih lama (Hobson *et al.*, 2006). Kecemasan yang dirasakan sebelum pembedahan juga berpengaruh terhadap keberhasilan dari pembedahan tersebut dan akan dapat berisiko menghasilkan komplikasi post operasi. Kecemasan pada preoperasi akan dapat meningkatkan kortisol yang dapat menghambat penyembuhan luka operasi (Hughes *et al.*, 2016).

Pasien yang mengalami kecemasan preoperasi sering diberikan terapi farmakologi untuk menurunkan kecemasan yang dirasakan. Obat-obatan yang diberikan tidak sedikit memberikan efek negatif pada tubuh pasien, seperti rasa kantuk dan depresi pernapasan yang

dengan hal tersebut dapat menghambat fase pemulihan post operasi. Intervensi nonfarmakologi juga dapat diberikan pada pasien yang mengalami kecemasan preoperasi. Intervensi nonfarmakologi dapat berupa pendidikan untuk menjelaskan proses yang akan terjadi seblum hingga setelah operasi serta memberikan teknik relaksasi untuk dapat menurunkan kecemasan pasien. Intervensi nonfarmakologi ini memiliki resiko yang sangat randah bahkan hampir tidak ada resiko yang akan terjadi pada pasien selama diberikan untuk mengatasi kecemasan (Brand, Munroe and Gavin, 2013). Oleh karena itu, literatur review ini bertujuan untuk memberikan gambaran mengenai beberapa intervensi nonfarmakologi yang dapat diberikan untuk menurunkan kecemasan pada pasien yang mengalami kecemasan preoperasi.

## METODE STUDI

Metode yang digunakan dalam *literature review* ini diawali dengan pemilihan topik, kemudian ditentukan *keyword* untuk pencarian jurnal menggunakan Bahasa Inggris melalui beberapa *database* antara lain *Science direct, Ebscho*, dan *Pro Quest*. Pencarian ini dibatasi untuk jurnal mulai 2010 sampai dengan 2017. *Keyword* Bahasa Inggris yang digunakan adalah *"Management stress", "preoperative", "pre surgery"*.

## HASIL STUDI

Didapatkan beberapa intervensi nonfarmakologi di dalam review ini yang dapat menurunkan kecemasan pada pasien pre operasi. Intervensi teresebut adalah edukasi preoperatif, pemberian minyak lavender, *Wack Wednesday, healing touch*, dan *hand reflexology*. Edukasi preoperatif merupakan intervensi keperawatan yang diberikan pada hari ketiga atau pertama sebelum dilakukan operasi pada pasien yang akan menjalani bedah jantung. Edukasi ini berisi tentang persiapan operasi, kemudian tinggal di ICU setelah operasi, setelah itu kembali ke bangsal jantung, dan keluar rumah sakit untuk persiapan rawat jalan. Edukasi ini disampaikan secara verbal kepada responden selama 15-20 menit. Selain itu juga disajikan dalam bentuk leaflet dan menyarankan pasien tersebut membawa leaflet ketika keluar rumah sakit. intervensi edukasi preoperatif memberikan hasil penurunan kecemasan lebih cepat dibandingkan pasien yang tidak diberkan intervensi tersebut (Poorolajal, Ashtarani and Alimohammadi, 2017).

Minyak lavender merupakan ekstrak dari lavandin (lavandula bybrida). Minyak lavender ini dapat diberikan pada pasien yang akan menjalani operasi untuk menurunkan kecemasan pasien tersebut. Lavandin memiliki efek relaksan dan sedatif seperti lavandulol, linalool, linalyl acetate. Minyak lavender dapat diberikan dengan topikal atau sebagai pengharum yang diletakkan di sekitar pasien. Efek relaksan akan bisa langsung dirasakan jika diberikan dengan pengharum karena langsung akan dapat merangsang olfaktorius, sedangkan secara topika efek dapat didapatkan dalam 10 hingga 90 menit. Minyak lavender ini terbukti menurunkan kecemasan pada pasien yang akan menjalani operasi dan diambil secara random. Minyak lavender juga bersifat sederhana, beresiko rendah, hemat biaya, dengan memiliki potensi untuk memperbaiki hasil kecemasan pre operatif serta meningkatkan kepuasan klien (Braden, Reichow and Halm, 2009).

*Wacky Wednesday* merupakan salah satu istilah metode distraksi yang dilakukan pertama kali oleh seorang ibu ketika menemani anaknya yang menjalani perawatan kanker. Ibu tersebut mendesain sebuah kostum dengan penuh desain warna yang dapat disukai anak-anak. Wacky Wednesday juga dapat diekspresikan dengan mendesain ruangan yang penuh dengan karakter yang disukai anak serta seseorang dengan kostum tertentu juga dapat menambahakan distraksi dengan membawa dan membagikan mainan ke anak sebagai pasien. Intervensi Wacky Wednesday sebagai metode distraksi dengan pendekatan humor dapat menurunkan kecemasan pada anak-anak yang akan menjalani operasi dan hasilnya berupa penurunan kecemasan sudah dapat diperoleh sebelum menjalani operasi (Braden, Reichow and Halm, 2009).

*Healing touch* adalah pengembangan dari magnetic clearing, yaitu penyembuhan dengan mengirimkan energi tertentu ke pasien. Healing touch adalah penyembuhan dengan mentransfer energi ke pasien melalui sentuhan. Healing touch dilakukan oleh orang tertentu setelah

melewati pelatihan. Perawat dapat memberikan healing touch pada pasien pre operasi untuk menurunkan kecemasan pre operasi, tetapi perwat harus mampu melakukannya dan belajar melalui pelatihan terlebih dahulu. Pada penelitian didapatkan bahwa healing touch yang diberikan satu kali sehari selama tujuh menit secara signifikan dapat menurunkan level nyeri, nausea dan kecemasan segera setelah dilakukan intervensi pada hari pertama dan kedua pasca operasi. Nyeri dan cemas semakin turun pada hari ketiga dibandingkan pada saat pre-intervensi (Braden, Reichow and Halm, 2009).

*Hand reflexology* pada pasien pre operasi dilakukan untuk menurunkan kecemasan pasien. Hand reflexology dilakukan dengan memberikan pijatan ke beberapa titik-titik tertentu pada telapak tangan. Seorang perawat dapat memberikan intervensi ini dengan mengikuiti pelatihan terlebih dahulu. Pasien disarankan dengan posisi duduk dan rileks, kemudian diberikan pijatan ke titik-titik tertentu pada telapak tangan. Titik-titik refleksologi dipijat sebanyak 14 kali. Kecemasan akan dapat berkurang pada 30 sampai 60 menit setelah diberikan intervensi (Braden, Reichow and Halm, 2009).

## PEMBAHASAN

Secara umum semua intervensi nonfarmakologik yang dilakuan review dapat menurunkan kecemasan. Perbedaanya terdapat pada pelaksana dan alat dan bahan yang dibutuhkan Ada beberapa intervensi yang harus dilakukan oleh orang yang terlatih. Ada juga beberapa intervensi yang harus diberikan dengan alat bantu serta bahan yang dibutuhkan. Intervensi yang telah dijelaskan lebih ke arah relaksasi dan distraksi.

Relaksasi dapat diperoleh pasien melalui intervensi minyak lavender, healing touch, dan hand reflexology. Sedangkan distraksi dapat diberikan melalui intervensi Wacky Wednesday. Selain itu, menurunkan kecemasan juga dapat dilakukan dengan memberikan pemahaman kepada pasien mengenai apa saja yang akan terjadi dari preoperasi hingga post operasi melalui pendidikan kesehatan yang diberikan kepada pasien.

Relaksasi dan distraksi merupakan teknik nonfarmakologi yang dapat meningkatkan self esteem dengan mempengaruhi status mental dan emosional sehingga dapat menurunkan kecemasan (Anderson *et al.*, 2015). Metode relaksasi dengan healing touch dapat menurunkan kecemasan 20% lebih dibandingkan sebelum diberikan intervensi tersebut (Mobini-Bidgoli *et al.*, 2017). Hand reflexology dengan dengan pendekatan relaksasi melalui pijatan juga menurunkan kecemasan dari 57,54 menjadi 55,47. Sedangkan melalui edukasi, kecemasan dapat menurun dari mean 3,5 menjadi mean 0,7 (Guo, East and Arthur, 2012)

Penjelasan tersebut lebih menekankan bahwa semua intervensi yang direview menurunkan kecemasan. Tetapi, pemberian edukasi merupakan intervensi yang bisa dilakukan oleh semua petugas kesehatan tanpa perlu mengikuti pelatihan terlebih dahulu dan tidak membutuhkan banyak alat dan bahan yang dibutuhkan. Menurunkan kecemasan dengan pendidikan dapat dilakukan hanya deneg memberikan penjelasan kepada pasien dan leaflet untuk dapat memperoleh informasi untuk bisa dibawa pulang.

## KESIMPULAN

Kecemasan preoperatif merupakan kondisi emosi yang tidak menyenangkan yang dapat disebabkan oleh tindkan pembedahan yang akan dilalui. Banya intervensi nonfarmakologi yang telah dikembangkan untuk menurunkan kecemasan pasien preoperasi. Pemberian edukasi merupakan cara yang paling sederhana untuk menurunkan kecemasan pasien preoperasi.

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Original Research

# Predictors of Family Stress in Taking Care of Patients with Schizophrenia

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## ABSTRACT

**Introduction:** Taking care of schizophrenia patients is challenging and causes stress for the family involved. The study was conducted to identify the predictors of family stress present when taking care of a patient with schizophrenia. The ABCX Stress Theory of Hill was used as the theoretical framework.

**Methods:** This study used a correlational design. The sample was 137 families who were caring for patients with schizophrenia at the Menur Mental Hospital, Surabaya, Indonesia. The sample was obtained by way of purposive sampling. The data was collected by a questionnaire and analysed by multiple regression to determine the relationship of the family's structure, family knowledge, the burden of care, stigma, social support, the patient's illness duration, the patient's frequency of relapse and the patient's severity level with family stress.

**Results:** The results showed that the family's stress was predicted by the family's structure (p=0.029), stigma (p=0.000), the burden of care (p=0.000), and the patient's frequency of relapse (p=0.005). The burden of care was the strongest predictor of family stress (Beta= 0.619).

**Conclusion:** The patient's frequency of relapse and stigma were other kinds of family stressor. The stressors stimulated a negative perception, called the care burden. Limited adequacy of the family structure-function will inhibit the family in using other resources, creating family stress. Nurses may develop an assessment format that consists of the family stress predictors in order to create a nursing care plan specific to reframing the techniques of family stress management.

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## INTRODUCTION

Schizophrenia is a chronic mental disorder and is a cause of morbidity. Schizophrenia is a persistent and serious brain disease that results in psychotic behaviour, concrete thinking difficulties, an inability to communicate, abnormal affection and difficulties in solving problems and meeting daily needs (Levine & Levine, 2009; G. Stuart & Sundeen, 2012). The prevalence of severe mental illness, including schizophrenia, according to Riskesdas (Kemenkes RI, 2013) is 1.7 per 1000 inhabitants, meaning more than 400,000 people suffer from severe mental disorders in Indonesia. The incidence percentage of schizophrenia in East Java was 0.22%, while in Surabaya, it was was 0.2%. The incidence rate of schizophrenia is difficult to decrease due to the high recurrence rates. Based on a preliminary study at the Menur Soul Hospital of Surabaya conducted February-April 2016, the number of inpatients reached 5,925 patients, where 90% had schizophrenia. The data showed that 80% of patients with schizophrenia had been treated in previous psychiatric care or had a relapse (Medical Record RSJ Menur, 2016).

Schizophrenia, not only cause suffering for the patients, but also for the people who are closest to the patient as well. Usually, the family is the most affected by the mental disorder. In the interviews with 10 families of patients during the preliminary study at Menur Hospital, 100% stated that the family experienced high tension during the treatment of the schizophrenic patients at home. The families feel anxious, sad, depressed and angry when faced with

uncontrollable patient behavior. The families also complained about being physically exhausted by having to keep up with the patient at all times. Additionally, 4 out of 10 families complained of frequent headaches, hypertension, and gastritis after more than 2 years of treating patients with schizophrenia. The families felt like there was a lack of time to do activities because they must always keep with the patients with schizophrenia every day. The situation experienced by families over a long period of time can cause the family to experience stress and anxiety (Biegel, 1995; Stuart & Sundeen, 2005). Suhita's (2015) study of 87 family members acting as the main caregiver in East Java's Kediri City stated that 75% had moderate to severe stress.

With the presence of schizophrenia patients being a stressor in the family system, 67.8% of them feel pressure (Darwin, Hadisukanto, & Elvira, 2013). Families, as the main caregiver, are susceptible to psychological problems, fostering family conflict and mutual abuse. 76.7% of families show negative symptoms, including depression and influencing family behavior when treating patients at home. The family often induces irritation due to their inability to cope with the burden. This is done by blaming the patient and disregarding the patient's condition (Brilliarita & Munawir, 2014; Pharoah, Mari, Rathbone, & Wong, 2010).

Stress experienced by the family is caused by the high burden of care, including feeling worried about the patient's condition related to their health status, future, financial condition, and the fulfillment of their daily needs. The financial condition of the family experienced problems during the treatment of a 12-month schizophrenia patient, as a result of financing the treatment, the fulfillment of the patient's needs, hospital transportation and accommodation costs (Djatmiko, 2007; Ennis & Bunting, 2013; Hadryś, Adamowski, & Kiejna, 2011). The presence of schizophrenia patients makes the family face social stigma. Related to the stigma attached to both the patients and their families, 37.5% of the families had a negative perception of the illness suffered by the patients with schizophrenia. The families are embarrassed and often excluded from community activities involving all family members. The magnitude of the burden, the strength of the stigma both from the family and society, the lack of support for the family and the fluctuating condition of the patients may cause family stress. There are many obstacles faced by the family when taking care and living together with the schizophrenic patient. The lack of knowledge about schizophrenia, the social stigma and social alienation, the cost of treatment, the decrease of the families' health, anxiety, depression, and other things are a series of social problems encountered in the family with the schizophrenic patient (El Tantawy, Raya, & Zaki, 2010; Suhita et al., 2015). An insurmountable family stress situation creates an unfavorable environment and causes the schizophrenia patients to relapse. The inability of the family to control the emotions and the existence of a stressful family life causes issues and continuous criticism is a cause of patient relapse (Akbar, 2008; Amaresha & Venkatasubramanian, 2012; Fadli & Mitra, 2013).

ABCX Hill's Theory, stated by Rice (1987), is the theory that was used in this research study. The theory explains if the families facing uncomfortable situations represented by the letter A, they will make an adaptation effort by utilising social support and personal strengths of the family which are described as letter B. Letter C explains the family's perception during a stressful event, which includes how the family defines the uncomfortable events in their life. The letter X represents the degree of crisis experienced by the family as a result of the interactions between letters A, B, and C. Based on this model, families who care for schizophrenic patient have limited resources and have a negative view of the situation. They will experience a crisis or more severe stress than other families who are faced with the same pressing event who are better adapted.

The researcher, as a mental health nurse, tried to combine Hill's theory with the assessment stage of Family-Centered Nursing theory (Friedman, 2003). Family-Centered Nursing is a family theory with a nursing care approach. An important step in this theory is the nurse's ability to conduct a family situation assessment, which includes assessing the family and patient factors. The family factors are the strength of the family structure, their economic capacity and the level of family knowledge about schizophrenia. The patient factors are the frequency of relapse, the duration of illness and the illness severity. Based on Hill's theory, Family-Centered Nursing theory (Friedman, 2003) and some of the studies discussed above, the burden of care, stigma and social support for families has the potential to affect the stress experienced by the involved families. This study aims to analyze the influence of family structure, economic ability, knowledge level, the burden of care, stigma, social support, the frequency of relapse, the duration of the illness and the patient's severity level as the predictors of family stress. The results of the study are expected to contribute to nursing science in determining the stress's predictors on the families who care for patients with schizophrenia.

## MATERIALS AND METHODS

### Research Design

This study used a correlation research design that explained the relationship of the factors causing family stress when treating patients with schizophrenia. The study was conducted from June through to September 2017. The study involved 137 family members as respondents, who were obtained by purposive sampling. The inclusion criteria were the families being the primary caregivers of the patients, the patient being more than 20 years old

and them living in one house with the patient for at least one year. The patient should have been diagnosed with schizophrenia for at least three years (proven by medical records), and have already experienced at least one recurrence. The dependent variable was family stress, while the independent variables included family structure, knowledge level, care burden, stigma, social support, the patient's duration of illness, the frequency of relapse and severity.

## Instruments

The data was obtained through of a questionnaire. The demographic data was assessed using a single item: age. Economic status was measured using a closed questionnaire with questions about the average family's fixed income in a month. The family's structural variables were adapted from the family assessment questionnaire as according to Friedman (2003). The respondents were asked what is their role was when related to the patient (mother, father, spouse, child or other family member).

Family knowledge about schizophrenia was measured using a questionnaire modified from McCubbin & Thompson (1991). Ten-item questions assessed the family knowledge related to the definition of illness, the effect on the family and the schizophrenia treatment. Each item was rated on a scale of 1 (strongly disagree) to 5 (strongly agree). The items were summed, with the higher scores indicating higher knowledge.

The burden of care variable instrument was prepared based on the Caregiver Strain Index questionnaire (Thornton & Travis, 2003) and the concept of burden according to the World Health Organization (2008) modified according to the condition of the family who cared for the schizophrenia patient. The instrument consisted of eight-item statements on subjective and objective burden measured using a Likert-scale ranging from 1 (never) to 5 (always). The stigma instrument was developed based on the stigma's dimension (Goffman, 1963) and the definition of stigma (Link & Phelan, 2001). The instrument consisted of ten-item statements asking about labelling, stereotyping, separation and discrimination. They were measured on a five-point scale (1: strongly disagree to 5: strongly agree). The social support variable was obtained by way of a modified instrument of the Social Support Index (H. I. McCubbin, Paterson, & Glynn, 1987). The instrument consisted of ten-item statements focused on emotional, informational, instrumental and award support. Frequency was measured on a five-point scale (1: never to 5: always).

The data from the patients was collected related to their illness history. The patient's duration of illness was explained as the first time that the symptoms of schizophrenia appeared up to the current date, expressed in years. The frequency of relapse referred to the number of recurrences and hospitalisations within a year. The severity of illness was measured using the modified Brief Psychiatry Rating Scale (BPRS) (Overall & Gorham, 1988) 1988). The questionnaire consisted of 18-item statements filled in by a doctor or nurse in charge, assessing the positive, negative and affective symptoms performed by the patient. Each item was rated on a scale of 1 (no symptoms) to 4 (severe). All items were added together, while ahigher score indicated higher severity symptoms.

The family stress variable was measured using a modified questionnaire using the Symptom Rating Test (Kellner & Sheffield, 1973). The questionnaire consisted of a ten-item statement on the psychological and physical symptoms felt by the family over the last three months, rated in 5-point of scale ranging from 1 (never) to 5 (always). All items are totalled, with a higher score indicating a higher severity of family stress. All of the instruments had been already tested for validity and reliability, in a pilot study consisting of 25 respondents. Each item in the statements reached validity ($r>0.514$) and each questionnaire reached reliability as well (>0.8).

## Data Analysis

Descriptive analysis was used for the respondents' characteristic and for the variable description (Table 1 and 2). We used multiple regression analysis to identify the predictors of family stress during the treatment of patients. We created a p-value table between the independent variables and the dependent variable (Table 3). Based on this table, we removed economic status, family knowledge and social support from the regression model because these three independent variables have a p-value <0.25. Further testing was performed to determine which variables are valid for being a family stress predictor. A regression test was done until all of the variables had a value< 0.05. Valid variables that can be used as a predictor of family stress are family structure, maintenance burden, stigma and the frequency of relapse. The four variables have been able to prove the existential assumptions (mean: 0.000, SD: 5.824), interdependence assumptions (Durbin Watson: 1.913), linearity assumptions ($p = 0.000$), homoscedasticity (norms of data spreads along or zero) data (normal distributed data and on PP Residual Plot of data spread around the diagonal line) and the multi-collateral assessment (VIF <10). The four independent variables were used in simultaneous regression analyses. The level of statistical significance was set at $p <0.05$.

## Ethical clearance

The respondents were families who accompanied patients to the outpatient unit of the Mental Hospital of Menur. The participants were recruited on the basis of ethical principles. The participants involved in the study had previously received a written explanation of the purpose of the research, and the procedures, rights and obligations, benefits and

disadvantages involved in the study. Only the participants who had been given informed consent were involved in the study. This study was given ethical approval from the Ethical Committee of Menur Mental Hospital, number 423.4 / 72/305/2017.

## RESULTS

### Characteristics of the respondent

The characteristics of respondents have been presented in Table 1. The majority of respondents were between the ages of 46 to 65 years old. A lot of them were the mother of a patient with schizophrenia. The others were made up of their siblings, relatives, children, spouse and father. Almost half of the monthly family income was more than 4.000.000 IDR. Most of the patients had been diagnosed with schizophrenia for more than ten years and almost half of them were experience relapse one to three times each year.

### Variables description

The variables' description has been explained in Table 2. The average of family knowledge was 37.93 (SD= 3.843). The family-felt burden of care average was 23.39 (SD=7.792). The family also experienced stigma from the environment, which averaged 25.09 (SD= 6.358). The family receiving social support had an average of 31.10 (SD= 5.721). Schizophrenia patients had a level of severity of 28.11 (SD 6.954). The overall family experiencing stress had an average of 27.08 (SD=10.524)

### Variables' correlation

Pearson's correlation was computed between the family's stress and all of the research variables (table 2). The result of testing on the nine research variables showed that there was a strong relationship between burden of care (r = 0.804; p = 0.00) and stigma (r = 0.677; p = 0.00) on family stress. Subsequently, there was a weak correlation between the patient's duration of illness (r = 0.193, p = 0.024), the patient's frequency of relapse (r = 0.392, p = 0.00) and the level of severity (r = 0.267, p = 0.002) with family stress. The variables of economic status, family structure, knowledge and social support are not related to family stress during the care of patients with schizophrenia.

### Predictors of family stress

As shown in Table 4, the higher the burden of care (p = 0.000; Beta = 0.619), the more frequent the patient's frequency of relapse (p = 0.005; Beta = 0.145), the higher the perceived family stigma (p = 0.000; Beta = 0.194) and the lower functioning of the family structure (p = 0.029; Beta = -0.106). The aforementioned will increase stress in the family. All of the independent variables may explain the variation of family stress as 69.4% (R2=0.694). The variable that has the greatest role as a predictor of family stress is the burden of care (Beta = 0.619).

Table 1. Characteristics of the respondents

| Variable | Frequency | Percentage |
|---|---|---|
| **Age (years)** | | |
| 26-35 years old | 19 | 13,9 |
| 36-45 years old | 20 | 14,6 |
| 46-55 years old | 34 | 24,8 |
| 56-65 years old | 43 | 31,4 |
| >65 years old | 21 | 15,3 |
| **Family's structure** | | |
| Father | 11 | 8.0 |
| Mother | 41 | 29.9 |
| Spouse | 13 | 9.5 |
| Child | 18 | 13.1 |
| Siblings | 30 | 21.9 |
| Relatives | 24 | 17.5 |
| **Family monthly income** | | |
| <3.500.000 IDR | 54 | 39.4 |
| 3.500.000 – 4.000.000 IDR | 20 | 14.6 |
| > 4.000.000 IDR | 63 | 46.0 |
| **Patient's duration of illness (years)** | | |
| 3 years | 16 | 11.7 |
| >3-5 years | 18 | 13.1 |
| >5-10 years | 31 | 22.6 |
| >10 years | 72 | 52.6 |
| **Patient's frequency of relapse (times)** | | |
| 1-3 X | 63 | 46.0 |
| >3-5 X | 41 | 29.9 |
| >5 X | 33 | 24.1 |

Table 2. Variables' description

| Variable | | Mean | SD |
|---|---|---|---|
| Dependent | Knowledge | 37.93 | 3.843 |
| | Burden Care | 23.39 | 7.792 |
| | Stigma | 25.09 | 6.358 |
| | Social Support | 31.10 | 5.721 |
| | Level of severity | 28.11 | 6.954 |
| Independent | Family Stress | 27,08 | 10,524 |

## DISCUSSION

Stress experienced by the family in assisting and treating patients with schizophrenia can be predicted using the variables burden of care, stigma from the environment, the patient's frequency of relapse and the functioning within the family structure. The results of this study are in line with family stress according to Hill (Rice, 1987), which mentions that family stress is caused by the interaction between stressors, family perception, and the resources owned by the family. The patient's frequency of relapse and the stigma from the environment is a stressor for the family. Stressors cause a negative perception for the families in the form of care burden. A lack of adequate functioning in the structure of the family means that the family cannot utilise the resources they own, so then the

Table 3 Inter-correlation of the variables

| | Family structure | Knowledge | Burden of care | Stigma | Social Support | Patient's duration of illness | Patient's frequency of relapse | Level of severity | Family's stress |
|---|---|---|---|---|---|---|---|---|---|
| Monthly family income | 0.311** | 0.481** | 0.085 | 0.125 | 0.163 | 0.208* | 0.098 | -0.107 | -0.093 |
| Family structure | | 0.492** | 0.046 | 0.010 | 0.132 | 0.195* | 0.016 | 0.038 | -0.074 |
| Knowledge | | | -0.072 | -0.102 | 0.291** | 0.070 | -0.019 | -0.134 | -0.159 |
| Burden of care | | | | 0.731** | 0.027 | 0.173* | 0.330** | 0.189* | 0.804** |
| Stigma | | | | | -0.093 | 0.072 | 0.221** | 0.234** | 0.677** |
| Social Support | | | | | | 0.086 | 0.027 | 0-.037 | -0.027 |
| Patient's duration of illness | | | | | | | 0.507** | 0.174* | 0.193* |
| Patient's frequency of relapse | | | | | | | | 0.603** | 0.391** |
| Level of severity | | | | | | | | | 0.267** |

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Table 4. Regression of the family's stress on family structure, care burden, stigma and patient's recurrence

| Independent Variables | Dependent Variable: Family stress | |
|---|---|---|
| | Beta | p-value |
| Family structure | -0.106 | 0.029 |
| Burden of care | 0.619 | 0.000 |
| Stigma | 0.194 | 0.007 |
| Patient's frequency of relapse | 0.145 | 0.005 |
| R2=0.694;Adjusted R2 =0 .684 ; (p= 0.000 ) | | |

families experience stress when caring for patients with schizophrenia.

The stressors perceived by the family comes from within the family, namely the patient's frequency of relapse. The other stressors come from outside the family, including stigma. The findings of the study showed that out of all of the family members with schizophrenia, 46 % experienced a relapse at least one to three times and the others, more than three times. If repeated relapse continues in patients with schizophrenia, it can have negative consequences for the caregivers (Rexha, Jose, Golay, & Favrod, 2006). Recurrent schizophrenic patients exhibit uncontrollable behavior, such as being angry without cause, and suspicious excessive and unnatural behavior. The behavior is often exhibited not only at home, but also within the environment, which causes unrest in the community. An unpleasant response from the environment related to the patient's behavior is the stigma towards patients with schizophrenia and their families (Arianandа, 2015).

Stigma becomes a stressor for the families. Stigma is the assessment of a situation or object that is considered to be a bad thing, so their value is lower than that of a normal person. This assumption causes the family to experience discrimination and thus to lose the opportunity to engage in activities that are important in life. Stigma keeps the family impeded from the activities of daily life (Goffman, 1963 in Heatherton, 2003). The dominant stigma felt by families in this research study were discrimination and separation. The local community treats the family differently, with them being disallowed from participating in community activities involving all of the family members. Community concerns about the uncontrollable behavior of schizophrenia patients cause people to distance themselves from the patients and their families during joint activities. Neighbours who live near the family also rarely visit and avoid communicating with the patients. The results of this study are in accordance with the research of Arianandа (2015), which conveyed that the community avoids interactions involving the presence of patients and their families. Stigma causes the family to have negative perceptions, affects their emotions and causes stress (Raguram, Raghu, Vounatsu, & Weiss, 2004; Singh, Matto, & Grover, 2016). The high amount of stigma and the patient's frequency of relapse are stressors for the family, and affect the family's perspective of caring for schizophrenic patients at home.

The stress experienced by the family is influenced by the family's perception of the perceived stressors. The results showed that the families, in treating patients with schizophrenia, felt various forms of care burden. The perceived burden is the result of the perceptions regarding the presence of the schizophrenia patients and high stigma from the community. Treatment burden occurs as a result of the family interaction process with the sick family member in order to provide treatment. The burden

felt is both subjective and objective (Chou, Fu, & Lin, 2011). The treatment and care of schizophrenic patients takes a long time. The family, as the closest environment, should be able to accept the fact that sick family members should be helped to achieve better conditions for the patient. In line with the opinion of Chou (2011), this explains that the caregiver's perception of an objective burden is influenced by a number of care needs that must be met by the caregiver. The state of the schizophrenia patient is less independent and has many needs that must be fulfilled, both in relation to the needs of treatment and daily needs. This situation requires the family to provide time, energy, thought and funds. This situation creates an inconvenience for other family members. Families limit the time they have to work and interact with the social environment because they have to treat the patients with schizophrenia. Several studies have concluded that the suffering experienced by schizophrenia patients also interferes with the caregiver's comfort because they feel burdened by the regular and continuous care (Fitrikasari, Kadarman, & Woroasih, 2012; Maldonado, Urizar, & Kavanagh, 2005; Ochoa et al., 2008). The prolonged course of the disease, uncertain patient behaviour and family incompetence to care for the disease causes discomfort and affect the family's perspective. This study proves that the burden of patient care in relation to schizophrenia one of the predictors of family stress. The burden felt by the family is perceived negatively by the family as it is an uncomfortable situation and poses a threat to the stability of family life. Negative perceptions that continue to grow and that are not managed properly will cause the family to fall into a stressful situation.

The process of stress in the family is also influenced by the resources owned by the family. The results showed that one family resource, namely the family structure, has a role in reducing family stress. The family structure is the strength that is owned by the family to arrange their values, communication patterns and family role as a lifestyle so then the family is able to perform its function properly (Friedman, 2003). The dominant family structure in this study was the role of the mother as the primary caregiver of the schizophrenia patients (29.9%), followed by sibling and child. The situation is influenced by the cultural structure of Indonesia that still holds true to strong family ties, so if there is one family member who is sick, then the nuclear family will take on the caregiver role to provide care. Parents or children as part of the nuclear family is a family structure that plays an important role in providing long-term care to family members who experience chronic disease, such as mental disorders (Karp, 2001; Sapin, Widmer, & Iglesias, 2016).

This situation is also in line with the research conducted in India, in that the core family in Asian families is strong enough that the family members consider caregiving as their moral obligation (Kate, Grover, Kulhara, & Nehra, 2012). Families have a tendency to regulate their family structure when they know that one member of their family is experiencing schizophrenia. Mothers who act as the household manager will have a greater parenting role compared to the fathers, who have to work for a living. Similarly, siblings, only when the family has no parents, become the managers of the household and will therefore be selected as the primary caregivers for the familial schizophrenia patient. Effective role sharing will help the families accept reality more quickly so as to reduce the stress experienced. An important role in the family when caring for a sick family member involves the process of making the decision to seek immediate solutions and to begin the treatment process (Carpentier, 2013; Sapin et al., 2016). However, it is possible for there to be a conflict within the family due to an imbalance of role sharing within the family structure (Sapin et al., 2016; Widmer, 2010). The primary caregiver feels a heavier burden than the other family members who do not accompany the patient. Therefore, the family needs resources from outside of the family, such as social support from the environment. The social support received by families is a positive indicator of the family burden during the care of patients with schizophrenia (Chow, 2013 in Poegoeh & Hamidah, 2016). The results of this study found that social support is not a predictor of family stress. According to Widmer (2010) and Sapin (2013), social support sourced from the environment (community and extended family) is very effective and necessary for the families caring for schizophrenia patients early in their treatment that does not impact on long-term care. Sadath (2017) explained that social support is not one of the factors that determines the emotional expression of families that have been predicted to experience family stress. This is because families have limited access to social support while caring for patients. Families who treat patients with schizophrenia tend to limit themselves in order to take advantage of the social support provided by the surrounding environment. The family assumes that the existence of the patient is a disgrace to the family (Hawari, 2009), so the family feels that they do not want to tell anyone about the illness. In addition to these assumptions, families who have tried to ask for support from neighbours and their extended families, do not feel the benefit, so the family feels isolated and discriminated against by the environment. As a result of resource utilisation in reducing stress, families choose to optimise the family structure when caring for schizophrenic patients and do not use social support from the environment.

**Research implications**

The research findings reinforce the ABCX theory according to Hill (Rice, 1987). The frequency of patient relapse and the stigma experienced by the family were stressors. The presence of stressors is interpreted by the family as a burden of care.

Families try to optimise the family's strength, called family structure, as a resource for managing stressors, but if the family may think that if the stressors are threatening to the family stability, then this may result in a family burden. This situation brings families into stressful situations. Nurses, as health professionals who are willing to interact directly with the family, can develop family nursing interventions, especially in relation to stress management. Nurses can do stimulations that helps the families to modify the family perceptions of the stressor which was originally considered to be a challenge in treating patients with schizophrenia.

The findings of the study have proven that the patient's frequency of relapse, stigma, the burden of care, and family structure can predict the stress experienced by the families during the care of schizophrenic patients. Based on the theory of family centre and nursing (Friedman, 2003), the results of this study have implications for nurses. This is as they seek to conduct a family assessment which pays attention to the patient factors, especially the frequency of patient relapse. The nurses also must be attentive to the family factors, namely family structure and the family perceptions related to burden and stigma. The nurses should be able to identify the patient's relapse frequency, family structure, the burden of care and stigma as the family's stress indicators, so they can help the family to manage stress.

### Research limitation

This research has several limitations. The sample of the study was obtained from the families who accompany the patients to the outpatient unit. The perception of stress experienced by the family was strongly influenced by the situation and the acute condition of the patient at that time. This caused less access to the social support that was used. Another limitation is that the results of this study has a limited potential for generalisation, especially for the family's stress when the patients are hospitalised.

## CONCLUSION

The stress experienced by the family when taking care of patients with schizophrenia is determined by the family's perception of the stressor. Family stress can be predicted based on the patient frequency of relapse, the stigma felt by the family, the large burden of care and the family structure, which may not function optimally. Nurses as health care providers can develop an assessment format that focuses on the family stress predictors, helping them to develop family stress management that focuses on establishing positive perceptions and enhancing the functioning of the family structures, enabling them to manage the burden of care and stigma experienced.

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# Pengaruh *Millieu Therapy* Metode Kreasi Seni membuat Gelang terhadap Penurunan Kesepian (*Loneliness*) Lansia

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**Abstrak**

Kesepian merupakan perasaan terasing dan tersisihkan yang sifatnya subjektif, dimana individu merasa kesepian. Semua lansia tentunya berkeinginan untuk dapat hidup sejahtera dalam masa tuanya bersama anak dan keluarganya dalam rumah sendiri. Namun pada kenyataanya tidak semua lansia dapat mencapai hal tersebut karena berbagai hal seperti karena faktor kemiskinan, tidak mempunya keturunan ataupun keluarga yang dapat merawat lansia serta ketidakmampuan keluarga dalam memberikan perawatan pada lansia, sehingga banyak lansia menjadi terlantar.Tujuan penelitian ini adalah menjelaskan pengaruh *millieu therapy* metode kreasi seni membuat gelang terhadap penurunan kesepian lansia. Penelitian ini menggunakan pr-experimental one-group pre-post test design. Populasi dalam penelitian ini adalah 76 lansia. Sampel dari penelitian ini 12 responden dengan teknik purposive sampling. Variabel independen dari penelitian ini *millieu therapy* metode kreasi seni membuat gelang sedangkan variabel dependennya yaitu penurunan kesepian lansia. Pengumpulan data menggunakan lembar kuesioner dan dianalisis dengan menggunakan Uji Wilcoxon Signed Rank Test. Hasil dari penelitian menunjukkan ada pengaruh *millieu therapy* metode kreasi seni membuat gelang dapat menurunkan kesepian lansia. Uji Wilcoxon Signed Rank Test dengan signifikasinya yaitu $\alpha = 0{,}05$. Uji ini menunjukkan hasil $\alpha = 0.035$ yang berarti ada pengaruh *millieu therapy* metode kreasi seni membuat gelang dapat menurunkan kesepian lansia. Pengaruh *millieu therapy* metode kreasi seni dapat dijadikan alternatif untuk menurunkan kesepian lansia karena dengan metode kreasi seni lansia dapat menyalurkan kreativitasnya, menghasilkan suatu karya, mengisi waktu luang, dapat bekerja sama satu sama lain dan dapat menstimulasi secara kognitif, afektif, psikomotor, sosio-emosional, dan harga diri. Peneliti juga dapat menggunakan *millieu therapy* untuk mensupport dan membantu kesepian lansia agar menghasilkan kualitas terbaik di kehidupannya.

**Kata Kunci:** Gelang, kesepian, lansia millieu therapy.

***Abstract***

*Loneliness is a feelings of isolation where people felling lonely. All the elderly certainly desire to prosper in his old age but the fact isn't all the elderly can reach it due to various reasons such as poverty, currently didn't have offspring or family who can care for the elderly and the inability of the family in providing care to the elderly, so many elderly people become homeless. In this results used pre-experimental one-group pre-post test design. The population in this research is elderly with amount 76 people. Sample was 12 people taken by purposive sampling technique. Collected data conducted by using a questionnaire and analyzed used the Wilcoxon Signed Rank Test with significance $\alpha = 0.05$. The results of research concluded that millieu therapy methods the creation of art made bracelet could be decreased loneliness of life of the elderly it can stimulate the cognitive, affective, psychomotor, sosio-emotional and self-esteem. Further research is expected to use control groups and researching other factors that influence loneliness the elderly. Researcher can use millieu therapy in supporting and helping the elderly yo live a best quality.*

***Keyword:*** *Bracelet, elderly, loneliness, millieu therapy.*

## Pendahuluan

Lanjut usia adalah seseorang berusia 60 tahun atau lebih (WHO, 2010). Di Indonesia telah terjadi peningkatan jumlah lansia secara dramatis, dengan perkiraan 11,34% dari keseluruhan populasi penduduk Indonesia pada tahun 2020 dan usia harapan hidup sebesar 71,1 tahun. Semakin terus meningkat populasi maka semakin banyak pula masalah yang terjadi, seperti banyaknya lansia yang tidak berdaya untuk melakukan pekerjaan sehingga tidak memiliki penghasilan, atau bergantung pada orang lain dalam kehidupan sehari-hari.

Semua lansia berkeinginan untuk dapat hidup sejahtera dalam masa tuanya bersama anak dan keluarganya dalam rumah sendiri. Semua bentuk perhatian dan peran aktif keluarga maupun masyarakat akan menimbulkan pengaruh kondusif bagi pemeliharaan kesehatan fisik maupun mental lansia. Namun pada kenyataanya tidak semua lansia dapat mencapai hal tersebut karena berbagai hal seperti karena faktor kemiskinan, tidak mempunya keturunan ataupun keluarga yang dapat merawat lansia serta ketidakmampuan keluarga dalam memberikan perawatan pada lansia, sehingga banyak lansia menjadi terlantar. Berbagai upaya telah dilakukan pemerintah antara lain mendirikan panti wredha untuk memberikan kesejahteraan pada lansia, dengan harapan lansia dapat menikmati hidupnya dengan tentram, aman dan sejahtera.

Selain dampak positif yang ditimbulkan oleh panti, juga terdapat kondisi bahwa didalam panti hubungan antar individu sangat renggang membuat hidupnya terasa sepi. Di dalam panti, semua kegiatan telah diatur dan mobilitas setiap individu dibatasi, dan interaksi sosial terbatas. Terlebih lagi jika hubungan antara lansia dengan keluarganya terputus sama sekali sejak masuk panti, sehingga lansia merasa bahwa hidupnya di panti benar-benar merupakan bentuk isolasi sosial terhadap dirinya. Lansia yang secara sengaja dipindahkan keluarga ke panti wredha diidentifikasi sebagai alasan utama kesepian.

Kesepian adalah suatu keadaan mental dan emosional yang dicirikan oleh adanya perasaan terasing dan ketidakpuasan karena adanya kesenjangan antara hubungan sosial yang diinginkan dengan hubungan sosial yang dimiliki (Brehm, M., Perlman, 2002). Data statistika Indonesia mencatat estimasi angka kesepian, termasuk lima besar negara dengan jumlah penduduk lanjut usia terbanyak di dunia yakni mencapai 18,1 juta jiwa pada 2010 atau 9,6 % dari jumlah penduduk (Menteri Koordinator Kesejahteraan

Rakyat RI, 2010). Dengan ini dapat diketahui bahwa semakin meningkatnya jumlah lansia maka angka kesepian pun juga semakin meningkat apabila tidak ditangani dengan baik dan benar. Apabila terjadi peningkatan dampak yang akan terjadi makin banyaknya lansia yang mengalami depresi dan mudah terserang penyakit. Berdasarkan hasil survey awal peneliti tahun 2016 dengan menggunakan lembar kuesioner *UCLA* dengan 20 item pada lansia di UPTD Griya Wredha Surabaya sebanyak 30 lansia didapatkan 65,2% lansia merasa kesepian. 25,7% lansia merasa kadang merasakan kesepian. 10,3% lansia tidak merasa kesepian.

Seiring dengan pertambahan usia, terjadi perubahan psikosial pada lansia yaitu pensiun, pindah tempat tinggal, menjanda/menduda, identitas sering dikaitkan dengan peranan pekerjaan, sadar akan kematian teman dan keluarga, kehilangan hubungan dengan teman-teman dan keluarga, penyakit kronis & ketidakmampuan, perubahan terhadap gambaran diri; konsep diri, dan masalah psikologis yang banyak dialami oleh lansia yaitu kesepian (*loneliness*). Kesepian merupakan suatu keadaan mental dan emosional yang terutama dicirikan oleh adanya perasaan terasing (Padila, 2013). Perubahan mental (psikologi, sosial dan ekonomi) dapat mengakibatkan masalah kesehatan jiwa seperti gangguan cemas, depresi, insomnia, demensia, dan masalah kesepian, duka cita, dan psikosis pada lansia (Depkes RI, 2005, Darmojo, B. D. M., 1999)

Perasaan kesepian dapat dibagi dalam dua jenis yaitu kesepian emosional dan kesepian sosial. Dalam kesepian emosional, seseorang merasa tidak memiliki kedekatan dan perhatian, merasa tidak ada satu orang pun yang peduli terhadapnya, sedangkan kesepian sosial muncul dari kurangnya jaringan sosial dan ikatan komunikasi atau dapat dijelaskan sebagai suatu respon dari tidak adanya ikatan dalam suatu jaringan sosial (Weiss, 1997). Para lansia mengalami perasaan kesepian karena banyak keluarga yang mengabaikan kesejahteraan para lansia dan mereka pun ditinggal sendiri hingga merasa kesepian. Di samping itu, peningkatan jumlah lansia ini seharusnya ada peningkatan kualitas hidup (Widyati,d., Yusuf, a., Fitriyasari, 2014), tidak sekedar tua, tapi juga berkualitas (Akbar, H., 2014).

*Millieu Therapy* adalah sebuah perencanaan lingkungkan perawatan dimana kejadian dan interaksi setiap hari dirancang secara terapetik dengan tujuan meningkatkan ketrampilan sosial, membangun rasa percaya diri dan meningkatkan

harga diri (Aronson, E., wilson t. D., & akert, 2010). Terapi lingkungan dapat meningkatkan pengalaman positif pada pasien dengan cara membantu individu dalam mengembangkan harga diri, menumbuhkan sikap percaya pada orang lain, mempersiapkan diri kembali ke masyarakat, dan mencapai perubahan yang positif (Stuart, G. W., 1998). Beberapa jenis kegiatan terapi lingkungan yaitu terapi rekreasi, terapi kreasi seni, terapi dengan menggambar dan melukis, literatur atau *bibliotherapy*, *pet therapy*, dan *plant therapy*. Peneliti memilih jenis metode kreasi seni dengan membuat gelang dari tali karena pasien dapat melakukan kegiatan secara konstruktif dan menyenangkan serta mengembangkan kemampuan hubungan sosial. Dalam kehidupan sehari-hari seni digunakan untuk menggambarkan rasa cinta, kasih sayang, dan keindahan. Kelebihan dan keuntungan dari metode kreasi seni ini lansia dapat menyalurkan kreatifitasnya, menciptakan suatu hasil karya, mengisi waktu luang, dan dapat bekerja sama untuk melakukan suatu hasil karya.

Terapi lingkungan metode kreasi seni mampu mengisi waktu luang pasien dengan memotivasi pasien ikut serta dalam aktivitas lingkungan yang sesuai dengan minat, kemampuan, dan tingkat perkembangannya (Yusuf, Fitrasari, Nihayati, 2015). Kreasi seni membuat gelang dapat melatih kesabaran, ketelitian, kreativitas, kerjasama dengan yang lain, dan keuletan pada lansia. Berdasarkan uraian diatas dan melihat fenomena yang terjadi, maka bermaksud meneliti pengaruh *millieu therapy* dengan metode kreasi seni membuat gelang terhadap penurunan kesepian lansia.

## Metode

Desain penelitian menggunakan *Pra Eksperimental* dengan metode *One Group Pre-Post Design.* Sampel berjumlah 12 responden yang dibagi dalam 3 kelompok dengan 4 responden tiap kelompok. Cara pengambilan sampel menggunakan *purposive sampling* yaitu memilih sampel diantara populasi sesuai dengan kriteria penelitian, yaitu; tinggal di griya wredha, mengalami kesepian, kooperatif, bersedia menjadi responden. Variabel independen adalah *Millieu Therapy* metode kreasi seni dengan membuat gelang dan variabel dependen adalah penurunan kesepian (*loneliness*) pada lansia. Instrumen yang digunakan yaitu kuisioner UCLA.

Data yang telah terkumpul dianalisis dengan uji *wilcoxon signed rank test* untuk membandingkan data ordinal pre test dan post test intervensi. Uji statistik menggunakan

tingkat signifikasi $\alpha = 0,05$, yang artinya bila nilai $\alpha \leq 0,05$ maka ada perbandingan data sebelumnya dan setelah dilakukan intervensi terhadap kesepian lansia. Data hasil analisis kemudian ditampilkan dalam bentuk tabel.

**Hasil**

Hasil deskripsi demografi menunjukkan bahwa responden terbanyak pada kelompok usia 70-79 tahun sebanyak 7 lansia (58%), berjenis kelamin perempuan (67%), tidak sekolah (42%) yang paling lama di panti yaitu 0-5 tahun (67%) dan aktivitas sehari-hari mengisi waktu luang yang paling banyak dilakukan yaitu tidur (67%). (Tabel 1)

**Tabel 1 Karakteristik Demografi Responden (n = 12)**

| Data Demografi | Kategori | f | % |
|---|---|---|---|
| Umur | 60-65 | 4 | 33% |
| | 66-70 | 1 | 8% |
| | 71-75 | 2 | 17% |
| | 76-80 | 5 | 42% |
| Jenis Kelamin | Laki-laiki | 4 | 33% |
| | Perempuan | 8 | 67% |
| Pendidikan | Tidak Sekolah | 5 | 42% |
| | SD | 4 | 33% |
| | SMP | 1 | 8% |
| | SMA | 2 | 17% |
| | Perguaruan Tinggi | 0 | 0% |
| Aktivitas Sehari-hari Mengisi Waktu Luang | 1 = Menonton TV | 2 | 17% |
| | 2 = Tidur | 7 | 58% |
| | 3 = Mengobrol dengan Teman | 3 | 25% |
| Lama Menghuni | 0-5 Tahun | 8 | 67% |
| | 5-10 Tahun | 4 | 33% |
| | > 10 Tahun | 0 | 0% |

Karakteristik berdasarkan data makna hidup sebelum diberikan terapi menunjukkan jumlah lansia yang mengalami kesepian sedang sebanyak 6 lansia (50%) sedangkan kesepian lansia sesudah diberikan *millieu therapy* metode kreasi seni membuat gelang di UPTD Griya Wredha Surabaya yang mengalami kesepian rendah sebanyak 9 lansia (75%). (Tabel 2)

**Tabel 2 Kesepian lansia sebelum dan setelah dilakukan intervensi**

| Kesepian | Kategori | f | % |
|---|---|---|---|
| Pre test | Tidak Kesepian | 1 | 8% |
| | Kesepian Rendah | 5 | 42% |
| | Kesepian Sedang | 5 | 42% |
| | Kesepian Tinggi | 1 | 8% |
| Post test | Tidak Kesepian | 2 | 17% |

| | | |
|---|---|---|
| Kesepian Rendah | 9 | 75% |
| Kesepian Sedang | 1 | 8% |
| Kesepian Tinggi | 0 | 0% |

Hasil uji statistik Wilcoxon Sign Rank Test menunjukkan hasil $p = 0{,}035 < \alpha$ yang bermakna $H_0$ ditolak dan H1 diterima, sehingga ada pengaruh *millieu therapy* metode kreasi seni membuat gelang terhadap penurunan kesepian lansia.

**Pembahasan**

Kesepian lansia sebelum diberikan intervensi, responden sebagian besar (42%) menunjukkan kesepian sedang yaitu responden merasa tidak mempunyai teman dekat, merasa tidak mempunyai tempat berbagi, merasa sendirian, merasa tidak seorangpun dekat dengannya, merasa dijauhkan, dan merasa malu dengan orang sekitar. Terdapat 1 responden masih ditemukan dengan kesepian yang tinggi. Kesepian lansia yang tinggi dipengaruhi oleh jenis kelamin, tingkat pendidikan, dan aktivitas.

Kesepian merupakan perasaan yang sifatnya subjektif, dimana individu merasa sendirian. Kesepian merupakan hal yang bersifat pribadi dan akan ditanggapi berbeda oleh setiap orang, bagi sebagian orang kesepian merupakan yang bisa diterima secara normal namun sebagian orang kesepian bisa menjadi sebuah kesedihan yang mendalam (Tomaka, J., Thompson, s. & Palacios, 2006). Pada kenyataannya beberapa penelitian menunjukkan bahwa orang yang kesepian bukan tergantung dari kuantitas tetapi tergantung dari kualitas hubungan tersebut. Menurut hasil pengamatan peneliti yang diketahui dari sumber lapangan, lansia sedih dan merasa sepi terpisah dari keluarganya.

Perempuan lebih rentan untuk ansietas dibanding laki-laki karena perempuan lebih mudah dipengaruhi oleh tekanan-tekanan lingkungan. Perbedaan gender juga merupakan salah satu faktor yang mempengaruhi psikologis lansia, sehingga akan berdampak pada bentuk adaptasi yang digunakan (Kaplan & Sadock, 2007). Hasil pengamatan peneliti menunjukkan perempuan menganggap masalah penyesuaian diri terpisah dengan keluarga seringkali menjadi hal yang sangat sulit. Perempuan lebih

banyak mengalami stress karena lebih sering terpajan dengan stressor lingkungan dan ambangnya terhadap stressor lebih rentan bila dibandingkan laki-laki.

Tingkat pendidikan juga merupakan hal terpenting dalam menghadapi masalah, semakin tinggi tingkat pendidikan seseorang, semakin banyak pengalaman hidup yang dialaminya, sehingga akan lebih siap dalam menghadapi masalah yang terjadi (Meiner, S. E., 2006). Tingkat pendidikan seseorang dapat mempengaruhi kemampuan untuk mendengar dan menyerap informasi yang didapatkan, menyelesaikan masalah, merubah perilaku serta merubah gaya hidup (Anny, 2012) .

Lansia merasa kesepian karena cukup banyak waktu luang yang tidak dimanfaatkan untuk melakukan kegiatan. Bagi lansia yang tinggal dipanti diberikan aktivitas yang tidak monoton dan didorong untuk bersosialisasi satu sama lain dengan lansia yang lainnya. Hasil pengamatan menunjukkan bahwa lansia yang memiliki banyak waktu luang hanya digunakan untuk tidur.

Kesepian lansia setelah diberikan intervensi didapatkan hasil yang meningkat dan menunjukkan sebagian besar (75%) responden mengalami kesepian rendah yaitu responden merasa menjadi bagian dari teman, merasa termasuk orang yang ramah dan mudah bergaul, merasa dekat dengan orang sekitar. Tidak hanya *millieu therapy* metode kreasi seni yang dapat menurunkan kesepian lansia, dipengaruhi oleh kegiatan lain yang ada di panti yaitu shalat wajib, dzikir dan do'a setiap hari. Namun masih didapatkan lansia yang mengalami kesepian sedang yang ditunjukkan dengan merasa tidak mempunyai tempat berbagi apabila ada masalah, merasa tidak ada seorangpun yang dekat dengannya, dan merasa usulannya tidak ditanggapi oleh orang lain.

*Millieu Therapy* adalah sebuah perencanaan lingkungan perawatan dimana kejadian dan interaksi setiap hari dirancang secara terapeutik dengan tujuan meningkatkan ketrampilan sosial, membangun rasa percaya diri dan meningkatkan harga diri (Aronson, E., wilson t. D., & akert, 2010). *Millieu Therapy* dapat menjadi alat terapeutik yang ampuh untuk mengatur dan mengubah hubungan sosial seseorang dan memberikan hasil yang menguntungkan dalam meningkatkan fungsi yang optimal. Tujuan dari *millieu therapy* yaitu membantu individu dalam meningkatkan harga diri, meningkatkan kemampuan berinteraksi dengan orang lain, dan menumbuhkan sikap percaya diri pada orang lain (Stuart, G. W., 1998) .

Metode Kreasi seni membuat gelang dapat dapat menyalurkan kreatifitasnya, menciptakan suatu hasil karya, mengisi waktu luang, dan dapat bekerja sama. Hal ini dibuktikan dengan terjadinya perubahan yang signifikan terhadap kesepian lansia yang mengalami penurunan dalam aspek kognitif, afektif, psikomotor, sesio-emosional, harga diri, dan akan menurunkan kesepian lansia (Yusuf, A., Indarwati, Jayanto, 2010). Agama dapat memberikan pengaruh terhadap kesedihan atau kesepian. Gender, kelas sosial, dan budaya dapat mempengaruhi rohani seseorang terhadap kesedihan dan kesepian (Meiner, S. E., 2006).

Tugas seorang perawat dalam metode kreasi seni yaitu sebagai leader atau bekerja sama dengan orang lain yang ahli dalam bidangnya karena harus sesuai dengan bakat dan minat, serta memberikan kesempatan pada klien untuk menyalurkan/ mengekspresikan perasaannya. Dengan metode kreasi seni membuat gelang lansia dapat melatih kesabaran, ketelitian, dan keuletan, sehingga lansia dapat mengembangkan kemampuan berpikir dan bertindak secara kreatif. Hal ini dibuktikan dengan terjadinya perubahan yang signifikan terhadap penurunan kesepian lansia yang menjadi lebih baik dalam aspek kognitif, afektif, psikomotor, sosio-emosional, dan harga diri.

Berdasarkan hasil observasi saat intervensi pertama, lansia masih merasa malu untuk menanyakan kreasi seni seperti apa yang akan dibuat, merasa tidak cocok dengan teman kelompoknya, merasa sendiri, dan merasa tidak mempunyai tempat berbagi. Pada intervensi pertama ini peneliti memfokuskan agar lansia berani untuk berkomunikasi dan mengungkapkan pendapatnya, dan menghasilkan suatu karya seni. Saat intervensi kedua, lansia sudah berani untuk mengungkapkan pendapatnya, dan berkomunikasi dengan teman kelompoknya. Saat intervensi ketiga, keempat, kelima dan keenam lansia mengalami perubahan yaitu lansia sudah mau membantu teman kelompoknya untuk mengerjakan karya seni, saling berbagi, merasa dekat, tidak merasa dijauhkan dengan yang lain, dan dapat mengisi waktu luang dengan kegiatan yang bermanfaat.

*Post test* yang dilakukan setelah intervensi dalam penelitian ini, responden yang mendapat intervensi yaitu membuat gelang mengalami penurunan kesepian. Artinya bahwa *millieu therapy* metode kreasi seni membuat gelang tidak hanya sekedar kreasi seni yang menyenangkan tetapi juga merupakan salah satu metode pengisian waktu luang di panti. Dalam hal ini, perawat memegang peranan penting sekaligus sebagai peluang untuk lebih meningkatkan kompetensi dan kreativitas perawat terutama

keperawatan jiwa dan gerontik dalam memberikan asuhan keperawatan (Yusuf, Nihayati, Iswari, miranti, Okviasanti, 2016).

## Simpulan

Hasil penelitian ini membuktikan dan dapat menjadi acuan ilmiah bahwa *millieu therapy* metode kreasi seni membuat gelang dapat menurunkan kesepian lansia. Saran bagi pengelola griya wredha atau *care giver* lansia di rumah dapat menggunakan *milieu therapy* untuk mengisi aktivitas rutin harian dan menurunkan tingkat kesepian lansia.

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iginal Article

# erceived barriers on mental health services by the family of patients ith mental illness

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ABSTRACT

*Background:* Various efforts have been made by the Indonesian government to improve mental health services. In 2014, the government established Law no 18, which is about mental health and the treatment of people with mental illness covered by the universal health coverage. However, many people still experience difficulty in accessing mental health services. In Indonesia, family plays the role of a caregiver to people with mental illness.

*Objective:* This study aims to identify the perceived barriers on mental health services by families whose members suffers from mental illness.

*Methods:* This study is a qualitative research study with a phenomenological approach. Sampling was conducted by purposive sampling with a sample size of 12 participants. Data were collected using semistructured in-depth interviews. Thematic analysis was performed using Colaizzi steps.

*Results:* The obtained results presented three themes. Theme 1, mental health service affordability; theme 2, mental health service availability; and theme 3, negative attitudes (stigma).

*Conclusion:* Families whose members suffered from mental illness still experienced barriers in relation to mental health services even with universal health coverage. Improved mental health services are related to the health insurance coverage, affordability, availability of mental health services and stigma reduction in the health professionals and wide community.



## Introduction

Universal health coverage aims to protect each individual to sure that they get equal treatment in terms of getting access to alth care. Universal health coverage is one of the World Health ganization (WHO) global priorities for their sustainable devel- ment goal (SDG) program [1]. The universal health coverage in donesia, also known as the National Health Insurance program, s initially conducted in early 2015. Indonesian Law No. 18 was tablished in 2014; this law provides support to health services for ople with mental disorders. Various efforts have been made by e Indonesian government in dealing with issues related to mental sorders; these efforts include the following: 1) applying a mprehensive, integrated and sustainable mental health services community; 2) providing facilities, infrastructure, and resources required for mental health services in all regions of Indonesia, including drugs, medical devices, health professional and health workers and 3) actuating the community to implement preventive and promotive efforts, and also the early detection of mental disorders and implement rehabilitation and mental disorder reintegration into society [2]. However, many perceived barriers against people with mental disorders are mainly related to mental health services. People with mental disorders are often marginalised and discriminated, which is contrary to their healthy rights. A number of barriers, both at the social and organisational levels, have contributed in this regard; these barriers include comorbidity, stigma, difficulty in accessing mental health services and lack of resources in the mental health services in various countries [3]. Although various efforts have been made, Rusdi (2012) showed that 91.08% of respondents can not access the mental health services available in formal health care facilities [4].

The number of people with mental disorders in Indonesia is 1.7 per 1000 of the population, or approximately 400,000 people [2] at the time of data collection. This number shows high concern regarding mental disorders in Indonesia. The East Java Social

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: stated that the number of people with mental disorders in va reaches 2369 people by 2016. This number increases by mpared with that in 2015 (1619). The number of people with l disorders who are being restrained also increases; in East ıe number of such people is 712, which is different from the ɔtained from Menur Mental Health Hospital, which records 1650 persons in the same region. Only two mental health ıls are available in East Java. Therefore, in-patient rooms for with mental disorders requiring hospitalisation are erably limited. The treatment process should be focused on thin community settings by utilising first-level health centre :s (*puskesmas*) in the area.

ınges in the national universal health coverage system has sulted in changes to the treatment of people with mental ers. An example of change is that related to the length of al stays (close to 2 weeks, with drugs that can be taken at by the patient; these drugs are also limited to only two . but their stocks are previously available for one month). heless, other people with mental disorders still receive no ehensive mental health treatment. Comprehensive treatshould be received both in hospital and community settings. ier caused by an individual with a mental disorder is that they o treatment [5]. Perceived barriers can be obtained from both tients and the involved healthcare professionals. Some of the rs related to mental health care are the stigma [6], treatment ack of knowledge, and isolation [7]. Other studies indicated igma is an insignificant barrier [8].

ntal disorders affect the person diagnosed and the family. mily must provide housing, income assistance, daily living ınce, emotional support, medications and hospitalisation Family plays an important role in caring for the family ers suffering from a mental disorder, especially as a caregiver. amily is a support resource during patient recovery and ilitation; the support provided by the family can prevent e in people with mental illness. Mental illness exerts kable effects because of costly treatment, loss of productive nd issues related with legal jurisdiction (committing violence ustice actions). Mental illness increases the psychological n and the social and economic burden on the community and otential number of physical diseases [11]. Mental health nent should be carried out with attention to the service ent aspects in order to identify the barriers in each aspect. ng care can also be provided comprehensively.

e present study explored the perceived barriers on mental n services from the patient's family perspective. The users of al health services, namely, the patient and their family, were tigated. The perceived barrier of mental health services from ser's perspectives was expected to increase the mental health e details. Consequently, they can be administered signifi- so as to reduce the recurrence rate and new severe mental s case findings.

## ethod

is study aimed to explore the barriers experienced by the nt's family regarding mental health services. A qualitative od with a phenomenological approach was used.

### Participants

e population included families whose family member are ing from mental illness and who have been treated in Menur's al Health hospital in Surabaya. Sample was obtained by pure sampling. The inclusion criteria were as follows: 1) outpamental disorder patients with family; 2) aged> 20 years; 3) the family had been the patient's caregiver for at least 1 year and 4) can communicate well using Indonesian language (*bahasa*) or regional language (Java), which was understood by both the participants and researchers and subsequently translated into English language. The sample size was 12 participants.

### 2.2. Data collection

The interview guide was developed from the main requirements for health service and health service access of Penchansky and Thomas [12]. Prior to data collection, the researchers carried out interview guidance trial tests on two participants to validate the questions that were listed with the assistance of a supervisor involved in mental health nursing. The participants were recruited on the basis of ethical principles (confidentiality, beneficence and informed consent). The researcher established the trust in the researcher-participants relationship by conducting 2–3 meetings in a place that was agreed by both. Hence, the participants were relaxed during the interview process. The researcher also cross-checked and compared information with other family members to avoid the Hawthorne effect, which may result in minimal findings [13].

A total of 12 participants were included in this study. Questions to the participants were preceded by an opening question, namely, 'how long have you been caring for your family member who is suffering from a mental illness?' and 'explain to me your experience in the use of mental health services while caring for your family member with a mental health disorder.' Subsequent question explored the perceived barriers and family expectations in caring for family members (health facility, health professional, medication, treatment, universal health coverage, costs and policy). The researchers also made some observations in the form of written field notes after the interview process.

The interview process was carried out until no new themes and data were observed. Interviews were conducted in the room that was provided in the hospitals and recorded. Interview results were written as verbatim transcripts and constructed after each completed interview with one participant.

### 2.3. Data analysis

Data analysis was performed using Colaizzi steps [14], which starts with writing the interview in written form (verbatim). Afterward the verbatim transcript of all of the participants was read repeatedly to identify sentences or words with a particular meaning and provide them with a code based on the similarities and differences. The process also involved explaining the meaning of the significant sentences and collecting and organising the formulation of category descriptions into a collection of themes, which resulted in the validation theme. Categories and themes were extracted from the main idea of the statement and the sentence stated by the participants during the interview process. Data collection was conducted simultaneously with data analysis process until data saturation occurred.

### 2.4. Data validity

The researchers validated the data accuracy by performing two methods of data collection [15], namely, interviews and observations of the participants. Subsequently, they matched that data with the verbatim interpretation of the results among the three researchers. The researchers also returned the transcript of the interview to the participants to validate or clarify things that were not understood.

## tesults

This study included 12 participants (Table 1): eight women and men aged 30–69 years old. The participant's job varied: three sewives, two civil servants, four self-employed, one retired, one son who was a scavenger and one person did not have a job. st of the participants finished with a high school education level ven), two participants completed undergraduate education, one son obtained a diploma, one person obtained a Master's degree one completed secondary school education. Eleven of the ticipants were Javanese, and one participant was from the bon tribe. Eleven participants used Universal Health Coverage one participant used private health insurance (public). The ticipants started being a caregiver for the mental health patients he range of 1–20 years ago. Mothers and fathers with a care- r role had the mean age (years) of 49.25 and 62, respectively, their mean caregiving duration was 11.2 years. Sisters and thers with caregiver roles showed a mean age of 41 and 39, pectively, with the mean caregiving duration of 3 years. Wife husband with the caregiver role presented a mean age (years) 8 and 69, respectively, with the mean caregiving duration of 3 rs. Grandfather with average age of 67 years provided care- ng role for 2 years. Daughters with mean age of 43 years played egiving role for 3 years.

The emerging theme was formulated on the basis of the participants' answers to the interview questions and the field notes ing the interview process. This study obtained four themes that re explained in order to reflect the purpose of study.

### *Mental health services affordability*

With regard to the theme of mental health services affordability, tances, transportation means and cost categories were obtained. Distance hindered the access to mental health services in terms geographical affordability, as stated by the participants:

*'It is so far away; if I want to come here (psychiatric hospital), I must take a bus of about a 4–5 h drive'* (P1);

*'Hospital is only available here (Surabaya) ... In my district (rural area), there is no mental health hospital so I must come here and must take a long bus ride . ....'*(P6) (P7);

*'The closest health centres (puskesmas) are almost 2 h away from my house ...'* (P1)

Other barriers related to mental health service affordability luded transportation means, as stated by the participants:

*'To come here from my village is difficult in terms of transportation means ...* '(P1)

le 1
nographic data of participants.

| o. of participants | Gender | Relationship to patient | Education |
|---|---|---|---|
| | Female | Mother | No education |
| | Female | Mother | Senior high school |
| | Male | father | Senior high school |
| | Male | Husband | Master Degree |
| | Male | Brother | Senior high school |
| | Female | Sister | Diploma Degree |
| | Male | Brother | Bachelor Degree |
| | Female | Daughter | Senior high school |
| | Female | Mother | Senior high school |
| 0 | Male | Grandfather | Junior high school |
| 1 | Female | Wife | Senior high school |
| 2 | Female | Mother | Senior high school |

In terms of cost as a barrier, participants stated the following:

*'I've spent a lot for the travel costs ....'* (P1) (P6)

### *3.2. Mental health services availability*

With regard to mental health services availability, data collection obtained three categories: health professionals, medicine and the mental health hospital.

For health professionals category, participants stated the following:

*'There was no medical doctor with psychiatric specialization in health centre (puskesmas) (psychiatrists).'* (P6)

*'I'd like to see a psychologist but I do not know where to find it here ....'* (P7)

*'There is not a mental health nurse there, so I should brought him here (mental health hospital).'* (P10)

In the medicine category, participants stated the following:

*'Yaa that's ya ... several medicines were not on the list of insurance coverage ... finally, I have to buy my own.'* (P4)

*'Sometimes, the medicines are not available in the health centre; we have to wait long time to take medicines; sometimes, I have to wait for 2 weeks ....* ' (P1)

*'The medicine counters for mental illness patients in health centre are opened on Thursday and Tuesday, that is, two days a week for a limited time of 4 h, which starts from 10 am to 14 pm, and long queued up; when it's closed, the worker asked us to come in the next day ... .'*(P1)

In the mental health hospital category, participants stated the following:

*'We found it different between health centre and mental health hospital; in mental health hospital, there were examination, hospitalization and treatment but not in health centre; so it should be a referral to the mental health hospital . ....'*(P9)

### *3.3. Negative attitudes (stigma)*

Three categories were obtained for the negative attitude: self, health professionals, and the community.

On the self category, participants stated the following:

*'Yeah, sometimes I feel afraid, because if relapse occurs, he often hit me, and I think that he is dangerous ....'* (P11)

*'I think that he is hard to be told, I say this, and he never likes what I've said ... .'* (P2)

*'I ask to talk about something, but it has no connection with my speech (incoherent) .... I can't understand her answer."* (P9)

*'I have been caring for her in a long time; it's difficult to take care of her and give advice; she is also difficult to be talked to ....* ' (P12)

*'Um ... sometimes, I think it's useless to treat or care for him; now, he practically recovered and can be brought home and then he relapse again; he often has relapse ....* ' (P4) (P5)

terms of the health professionals category, participants stated llowing:

*m just a poor person; sometimes, there is a health professional no looks down to us and speaks to us rudely. I know that not all alth professionals are like that, but sometimes they do.'* (P1) (P9)

*'hen hospitalized, it will need long duration; there is still no fa- ity to care for basics human need, such as defecation and bath- g, so we have to ask or hire other person to care for....'* (P4)

*metimes, the information from nurses or doctors was less clear d less complete.'*(P4)

the community category, the following statements were nted by the participants:

*verybody made a distance from us; no one wants to be close with .'* (P5)

*lost people consider us as danger because he acts violently, such hitting, destroying plants, and talking rudely.'* (P1) (P6)

*lostly people do not want to go near us because of scare or afraid be beaten ...'* (P2)

*eople often do verbal bullying with nicknames of crazy person or sane ....'* (P1) (P2)

## iscussion

/ith regard to mental health service affordability, the distance ental health service hospital was limited and considerably far ome people. Transportation difficulties were also a challenge in ing health service, especially for participants from rural areas. ransportation costs that must be spent to reach health services also perceived as barriers by the participants. Five of the cipants were from rural areas that were distant from Surabaya. n of the participants who lived in Surabaya indicated no bar- related to mental health service affordability. Data were istent with those of Syed et al. (2014), who stated that rural and n areas differ in terms of transportation, transportation op- , transit cost and availability and distance from the mental th service [16]. Differences in the level of ease of geographical ss to the mental health services resulted the difference in tional costs for transportation to the destination place. Barriers ed to costs according to four of the participants were in rdance with those of Jack and Uys study regarding financial iers [17]. Patients' families were familiar with the heavy burden ng-term care and the transportation costs mainly by the fam- from rural area. Under Law No. 18, Indonesia's free restraint ram in 2017 is a government program related to mental health. program involves all aspects of society, including the head of village, subdistrict head police and health workers. Village tal health programs should be reactivated to improve the tal illness case findings and the mental health services in the

n terms of mental health services and health facility availability gories, some of the participants explained that no psychiatrists, hologists and nurses with mental health training were avail- in the health centre. The participants stated that in their home l area, no health professional with psychiatric speciality was lable. The national ratio of the health professionals who work in nesia exceeds the ratio recommended by the WHO, which is physician per 1000 of the population [18]. The number of health professional workers in Indonesia is increasing in terms of quantity and quality, but the level of the equitable distribution of health professional workers (not limited to general health practitioners and physicians with special expertise) is still lacking. The inequitable distribution of health profession workers with specialised skills results in barriers to accessing mental health services. Other studies also reported unequal distribution of health profession workers, especially when related to the region's policies about the minimal number of health professional workers [19], low salary, lack of facilities and future uncertainty [20]. The uneven distribution of health professional workers is an important issue because it relates to community needs, particularly care in remote areas. Data from the Ministry of Health in Indonesia consists of 87 regions in the 27 provinces (out of a total of 33 provinces) that are lacking in terms of health services [20]. This issue can be addressed by providing health professional workers with adequate skills through training related to the early detection of mental illness, the investigation of people with mental disorders and psychiatric problems and the treatment of people with mental illness. The government also plays an important role related to policies in the region or districts about mental health and the mental health program's sustainability.

Participants also indicated barriers related to the limited medicine for people with mental illness. Some of the participants stated that the medicine stocks for people with mental illness in health centres were low, and the operational hours of taking and providing medicine were limited that is, 4 h (two days a week from 10:00 a.m. to 14:00 p.m.). The medication of people with mental illness is not sold freely in drugstores or pharmacies. Thus, the lack of medication for patients or the family interferes with the prescribed compliance suggested for medication. In addition, we obtained data stating that the number of drugs in health centres for mental illness patients is limited [21,22]. Patients reported a reduced drug stock allocation of only two weeks (the patients can previously access a one-month stock allocation of medicines). Consequently, mental illness patients therefore need to come to the health centre every two weeks [23–25]. Barriers in the schedule and limited operational hours were also observed by Langholz.

Langholz further determined barriers to drug access. Several people are forced to change medication because the medicine is not covered by insurance or universal health coverage. The same case was also expressed by four of the participants who stated that some medications must be purchased at their own expense because they are not covered by the universal health coverage. This observation suggested that although some medical costs can be covered with the insurance, the mental health patients' families and still suffer from other costs associated with the treatment of mental illness, such as transportation. This problem can result in the decreased patient care management [26]. The drug and medicine supplication process is changed in the health facilities by using an e-catalogue and e-purchasing, which exhibit both advantages and disadvantages. One disadvantages is that if the medicines stock is insufficient or not ordered by the e-catalogue or e-purchased previously, then a considerable amount of time is needed to obtain the medicine required for the first time. Patients treatment is not only about taking of medicine. Mental illness problems also include psychosocial disorders. Consequently, treatments also include psychosocial interventions, such as psychotherapy and counseling. The skills of health professional workers in psychological interventions for people with mental illness should be enhanced. Furthermore, family involvement in the treatment of their family member should be increased. Hence, health professional workers should improve their family knowledge and skills.

Other barriers were the negative attitude (stigma) towards people with mental illness. Two participants perceived that the

tment of their family member who was suffering from a mental ess was ineffective or that no change was observed in the pa- ts after treatment. Consequently, the family or patients decided to continue the treatment because they considered the mental rder treatment a failure. Such situation occurs because the ma can affect someone's behaviour. Several examples of nega- perception (stigma) by the community were also stated by five ticipants. Two participants stated that they suffered from ative experience with their health care workers. Previous study 28] results showed that the health workers' attitude showed no erence from that of general society with regard to the associated ma towards patients with mental illness. Hansson et al. stated t the health professional workers' attitude towards people with ntal illness is the most pronounced negative attitude compared h those in other in-patient wards. Research findings [29] also wed that a negative experience with the provider will cause the r to stop the treatment that they are receiving or select another lth service for the care of people with mental illness. Stigma in onesia is still a considerable problem, which extends towards families of people with mental illness [30]. Some efforts related stigma reduction in health care workers, families and the com- nity should be further made. Family knowledge about mental ess should be improved, and positive information about mental ess patients should be provided intensively.

## Conclusion

The present results indicated that the families of people with ntal disorders encounter barriers associated with mental health vices. Mental health services are centralised in major cities, and mental health services in rural areas are minimal. To obtain an ective mental health service and reach all places, a government licy related to the equitable distribution of health personnel with ecial skills and mental health facilities is needed.

## Ethical clearance

This study received a certificate of ethical clearance from Menur rabaya Hospital No. 423.4/6787/305/2016.

## Study limitation

The interview guidance was developed by the researcher using e access concept developed by Penchansky and Thomas [30] who alysed the five access dimensions: availability, accessibility, ordability, accommodation and acceptability. The interview ide showed limitations. This guide was not tested by experts in a nical setting (the interview guidance was tested by our super- sor). The sample was selected without any inclusion criteria lated with the mental disorder patient, such as illness duration, e. disease severity and origin of the participants (rural and ur- n). The study cannot investigate family burden because the rrier may differ among participants who come from rural and ban areas.

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ginal Article

# mily members' perspective of family Resilience's risk factors in king care of schizophrenia patients

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A B S T R A C T

*Objectives:* The study was conducted to illustrate the risk factors of family resilience when taking care of patients with schizophrenia.
*Methods:* The research used qualitative design with an interpretive phenomenology approach, with in-depth interviews. The subjects were 15 family members who cared for patients with schizophrenia at the Menur Mental Hospital, Surabaya, Indonesia. The samples were obtained by purposive sampling technique. The data was collected by interview and using field notes, then analyzed by Collaizi technique.
*Results:* This research produced two themes, they were care burden and stigma. Care burdens felt by families were confusion about the illness, emotional, physical, time, financial and social burdens, which leads to decrease in family quality of life. Families also experienced stigma called labeling, stereotyping, separation and discrimination. Stigmas meant that families faced psychological, social and intrapersonal consequences. This decreased the family quality of life and functionality of the family, and there were opportunities for negative results to family resilience. Health workers, especially psychiatric nurses, should review care burdens and stigma to develop nursing interventions so families are able to achieve resilience.
*Conclusions:* This research explained how care burden and stigma are risk factors that must be managed by families to survive, rise up, and become better in caring for patients with schizophrenia. Nurses have a central role in assessing the level of care burdens and stigma in order to help families achieve resilience. Further research may focus on family-based nursing interventions to lower care burden, and community-based interventions to reduce stigma.


## Introduction

Schizophrenia is one type of mental health disorder that is still a mplicated problem. The prevalence of severe mental illnesses, cluding schizophrenia, based on Riskesdas 2013 [1] is present in per 1000 people, which means more than 400,000 people suffer m severe mental disorders in Indonesia. The incidence of izophrenia is difficult to decrease due to high recurrence rates. e recurrence rate of schizophrenia patients in Indonesia is 50%–% [2], 57% within 3 years [3] and 70%–82% in the first five years .

Based on a study by Kusumawardani [5] at the Menur Mental Hospital, Surabaya, Indonesia, 90% of patients are diagnosed with schizophrenia. Majority of them (80%) already experienced recurrences. The cause of relapse, according to Fadli & Mitra [6], is the inability of the family to control emotions, and the existence of stressful family life problems [7], so continuous criticism from the family is the cause of patient recurrence [8]. The phenomenon shows families have not been able to care for family members who have schizophrenia. The inability is influenced by the various stressors. The stressors involve many kinds of care burden [9], negative perceptions or stigma [10] and a lack of support from their surrounding environment. The stressors experienced by families may be mediated by resilience [11], the ability of families to survive and rise up to determine what they will do, and the capability to care for family members suffering from schizophrenia. Family resilience is a dynamic process between risk factors and protective factors [12]. Risk factors can encourage negative outcomes in

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es, while protective factors help reduce the negative out- [13]. Protective factors interact with risk factors and ate power for family to overcome the adversity.

owing the ability of family resilience is not an easy effort. es should be able to identify risk factors and manage these to e a dynamic family situation and have the ability to survive caring for patients with schizophrenia. Families need help health professionals, such as psychiatric nurses, to identify anage family risk factors. There have been several studies of resilience in caring for patients with mental disorders ling schizophrenia, but the study focuses more on family nce indicators [14–17]. The study has not yet exploited risk s for family resilience. The research is expected to comple- the pre-existing theory by adding components in risk factors Theory of Resiliency Model of Family Stress, Adjustment and ation by McCubbin and McCubbin [18]. This theory explains the resilience process consists of two stages, namely the tment stage and the adaptation stage. Each stage describes the y's ability to deal with stressors from outside the family (risk s) using family strength, family resources and problem- g abilities in the family (protective factors). Families in the tment phase will encounter accumulated demands (risk fac- in the form of stressors, tensions or transitions. Meanwhile, amily's protective factors present themselves in the form of y functions, family resources, family coping and problem- ng. The family conducts the assessment process by focusing e stressors (the existence of the demands of risk factors) and ting in an understanding that the accumulation of demands is vere, thus the family falls into a crisis phase. The family be- es inadequate and disturbs the pattern of family functions, and on to run into imbalances and dissonance. Families at a given ent will be able to respond to the demands of the crisis and e changes in the assessment process, in which the family now into the adaptation phase, where the focus of family assess- t is based on the real situation. Families are able to balance the factor with the protective factor. So, the family reaches a bal- , rises from a family crisis situation, and is able to deal with lems well. The family regains the family function, can walk in ony and balance, and even has more power to grow into a g family, which is when the family has reached resilience.

his study aims to describe the risk factors of family resilience ng the care of patients with schizophrenia using qualitative arch methods with a phenomenology approach. Identifiable factors are expected to serve as a review component for the tal health nurse, thus more quickly stimulating families to eve family resilience.

## Material and methods

### Research design

he research was performed as qualitative research based on a rpretive phenomenological approach. A qualitative research gn was used to answer the research objective in getting expe- ial meaning from research subject related to risk factors of ly resilience during the caring of patients with Schizophrenia.

### Participant and recruitment

he population was family members who cared for patients schizophrenia at Mental Hospital Menur, Surabaya, Indonesia. study involved 15 family members as participants obtained by posive sampling techniques. The inclusion criteria were family nbers as primary caregivers of patients, more than 20 years old, g in one house with the patients and have been caring the patients for at least 1 year. The patient should be diagnosed as having schizophrenia for at least three years, proved by medical records, and have already experienced at least one recurrence. Participants were family members who accompany patient at the outpatient unit of the Mental Hospital Menur. The participants were recruited on the basis of ethical principles. Participants involved in the research have previously received a written explanation regarding the purpose of research, procedures, rights and obligations, benefits and disadvantages during the study. Only participants who have given informed consent were involved in the study. This study has obtained ethical approval from the Ethical Committee of Menur Mental Hospital with the number 423.4/72/305/2017.

### 2.3. Data collection and analysis

Before starting the data collection, the researchers carried out interview guidance trial tests on three participants to validate the questions that were listed with the assistance of a supervisor involved in mental health nursing. Data were collected by in-depth interviews using semi-structured interview guides and completed with field notes Formal interviews were conducted at participant home and take 44–60 min for each participant. Participants were asked the question *'could you please explain the difficult problems which are hard to be overcome during caring for patients with Schizophrenia?'* and *'according to the difficult problems, what situations contribute to the complication and inhibition of the family's capability to survive and overcome the problem?'*. Questions were open-ended and interviews were recorded by a voice recorder. The interview process was carried out until no new data founded. Three researchers conducted the interviews, namely, R.F., R.D.T. and H.E.N. All of them already have experienced, as found in an in-depth interview, performing the duty of mental health nursing lecture and have undertaken qualitative research before. Interview results were written as verbatim transcripts and constructed after each completed interview with one participant. Regular discussion between three researchers was done in order to integrate the research finding.

Risk factors for family resilience were analyzed and interpreted using analytic analysis according to Collaizi [19] consisting of nine steps. The analysis includes: 1) describing phenomena to be studied, 2) collecting descriptions of phenomena through participants' opinions, 3) reading the entire description of phenomena submitted by participant, 4) re-reading interview transcripts and citing meaningful statements, 5) making outlines of meaningful statements, 6) organizing collections of meanings formulated into groups of themes, 7) writing complete descriptions, 8) meeting participants to validate the compiled descriptions and 9) incorporating validation results data into full description. Data collection was conducted simultaneously with data analysis process until data saturation occurred. Demographic data was described and presented in the table of participants characteristic.

## 3. Results

### 3.1. Demographic data

Descriptive statistics of the characteristics of participants are shown in Table 1. This study followed 15 family members as primary caregivers of schizophrenia patients (10 females and 5 males), aged within the range of 26 years–58 years old. The educational level of participants varies from unschooled to university. Most of the participants (10 people) are working, as civil servants, private or self-employed, while five people are not working. The majority of participants are parents (7 mothers and 2 fathers), 2 spouses of the

e 1
acteristics of participants.

| | Gender | Age (Year) | Relationship | Duration of Care (Year) | Occupation | Education |
|---|---|---|---|---|---|---|
| | Female | 52 | Mother | 6 | No Work | Elementary |
| | Male | 58 | Father | 5 | Self-employment | Senior High |
| | Female | 49 | Mother | 5 | No Work | Elementary |
| | Male | 48 | Spouse | 15 | Private-employment | Junior high |
| | Female | 36 | Siblings | 4 | No Work | Senior High |
| | Female | 45 | Mother | 5 | No Work | No |
| | Female | 56 | Mother | 6 | Private-employment | Elementary |
| | Male | 54 | Siblings | 5 | Private-employment | Junior high |
| | Female | 51 | Mother | 8 | No Work | No |
| 0 | Female | 40 | Sister in Law | 4 | Private-employment | University |
| 1 | Male | 58 | Father | 10 | Self-employment | Elementary |
| 2 | Female | 47 | Mother | 6 | Private-employment | Senior High |
| 3 | Female | 26 | Child | 5 | Civil-government | University |
| 4 | Female | 54 | Mother | 5 | Private-employment | Elementary |
| 5 | Male | 58 | Spouse | 23 | Self-employment | University |

ient, 1 child, 2 siblings and 1 sister-in-law. Family members who suffering from schizophrenia (6 female and 9 male) are aged in range of 20–60 years old. Most schizophrenia patients do not rk, only two people work at home as a tailor and a painter. Most them (12 people) regularly control their illnesses with health vices and are taking regular medication. All patients experienced a recurrence more than three times in one year and are eady diagnosed with schizophrenia at least 5 years ago.

### ?. Risk factors of family resilience

Two themes were abstracted from the family members' experiences related to risk factors of family resilience in taking care of tients with Schizophrenia. The themes are care burden and igma (Table 2). The details of each theme are described.

#### 2.1. Care burden

Care burdens felt by the participants is classified into six kinds, ey are confusion about the illness, emotional, physical, financial, me and social burden. The family members complained confusion out the disease process of Schizophrenia. They have asked many mes "can schizophrenia be cured?". Family members are also nfused about patients' behaviors: sometimes they looked normal t sometimes they seem abnormal. Emotional burden is felt by all participants, they complained of sadness due to unmanageable patient behavior, feel fear of patient's harmful behavior, embarrassment due to poor patient behavior in society, worrying about the patient's future and angry with uncontrollable patient behavior thus making the family lose control of their emotions. The physical burden experienced is being physically exhausted, because they have to take care of the patient every time, and have no time for resting. This situation decreased the family health status due to the condition of being continuously physically exhausted accompanied by psychological problems. Families suffered from physical illnesses such as high blood tension and digestive problems.

The financial burdens experienced by participants are medical expenses and daily needs cost of patients with schizophrenia. Medical expenses are used for regular control at health service centers, drug purchase, and transportation to health service centers. While the daily needs cost are used for meals, pocket-money, snacks and patients' personal needs. The participants' time burdens include complaining of having to always take care of the schizophrenic patient, causing participants do not have enough time to do personal interests, such as to relax and pamper themselves. The social burden experienced by participants is an obstacle to not being able to work or having to sacrifice their working time due to taking care of the patient.

The care burden felt by the participants during taking care of

ble 2
ntified resilience risk-factor themes and exemplary significant statement from family of schizophrenia patient.

| Theme | SubTheme | Significant Statement |
|---|---|---|
| Care burden | Confusion about the illness | *'Maybe he (patient) can heal but he needs a long time ... but even when he recovered, he relapsed again, our family does not understand this disease (Schizophrenia)' (P13) (P8)* |
| | | *'Every moment, I can't escape thinking of him ... his future, his fate ....' (P3) (P11)* |
| | Emotional Burden | *'When the voices come (hallucinations) at night, his behavior begins to get strange and I can't sleep, I'm afraid he will hit me or damage the house ... ' (P8)* |
| | | *'when he relapses ... he can go out without wearing clothes, go anywhere ... as his mother I am very ashamed ... ' (P6)* |
| | | *'I feel annoyed almost every day, and when I can't stand it, I hit her (patient)' (P12) (P7)* |
| | Physical Burden | *'I never get good sleep every night, morning is coming soon ... I had to wake up again to care for her (patient) again' (P1)* |
| | | *'my head becomes dizzy, my neck too tense ... it always happens when she relapses ... I feel like I will explode ... ' (P15) (P4)* |
| | Financial Burden | *'We should sell our motorbikes, sometimes sell our bird collection ... yes for treatment for him (patient), his meals and daily needs ... ' (P11)* |
| | Time Burden | *'He (the patient) must be watched from afar, especially if he is on the porch of the house, there are passers-by who call out and spit on him ... if he is not guarded, there is always a problem .... must always be guarded' (P8)* |
| | Social Burden | *'I have not been working for 2 weeks ... because he was hospitalized again .... (must keep in hospital)' (P14)* |
| Stigma | Labelling | *'The neighbor sometimes calls him (patient) ... "madman"' (P3) (P8)* |
| | | *'He's such a disgrace to the family' (P2) (P10)* |
| | Stereotype | *'His behavior is sometimes strange ... all day sitting on the edge of the trench in front of the house while daydreaming' (P8)* |
| | | *'when he relapses ... he will be dangerous, sometimes uncontrollable' (P6) (P14)* |
| | Separation | *'Neighbors who do not dare come here (to the house), afraid of him' (P6) (P8)* |
| | Discrimination | *'We are rarely invited to public events, if invited, they (neighbor) always order us to come alone, and that my father (patient) should stay at home' (P13)* |

ts with schizophrenia is perceived as a situation which can in negative outcomes for the family to survive, rise up and ›me problems. The following is a psychological burden quote : family:

*ring for such patients (schizophrenia) makes us unable to enjoy ', and strange behavior often embarrassment of the family .... netimes he can go out without wearing clothes, go anywhere ... his mother I am very ashamed' (P6)*

*Stigma*

ıe stigma experienced by participants is divided into four ., namely labeling, stereotyping, separation and discrimina- Labeling is felt by participants because of special terms ɔssed by the public to schizophrenia patients. They are called lman" and say schizophrenia cannot be cured. Stereotypes are rienced by expressions of thinking and behavior of schizo- nic patients who are considered threatening and endangering eir environment. Participants perceived separation by a social ınce from the environment, for example, neighbors keep their ınce between them and the family and the patient with zophrenia in daily activities. The family experienced discrimi- ɔn, as they are not involved in surrounding environment ac- ies due to unpredictable patient behavior.

he different types of stigma felt by participants come from the ily itself and from the community being a risk factor for the ily in fostering the ability of family resilience, as seen in the ›wing phrase:

*We (the family) ourselves feel the presence of him (patient) as a stain on the family, so badly ... and there is no one, the neighbors will hang out and keep their distance from us (family) ... from him (patient), sometimes they closed the door when he (patient) was passing their home ... ' (P3) (P6) (P8)*

## Discussion

Researchers made efforts to ensure the trustworthiness of data ained through three ways, namely built a trusting relationship ɔport) with participants before the study begins, conducted mber checks and peer checking [20–22]. Rapport was built by earchers through a one-off home visit before a formal interview. researchers familiarize themselves with discussing the devel- nent of the condition of schizophrenic patients while fostering researcher's sensitivity to the participant's lifestyle in treating izophrenic patients. Member check carried out by returning the nscripts once to the participant to perform data validation. Peer cking is done through a reanalysis of data by A. Y and N as senior litative research by giving double coded of the transcripts to ɔrm the coding framework and ensure a robust analysis.

Themes associated with risk factors of family resilience which ing care of schizophrenia patients was identified in this research l be discussed below.

*Care burden*

The results showed various types of burdens, they are confusion ut the illness, emotional, physical, financial, time and social den. The findings of this study are consistent with some pre- us investigations of families caring for chronic and schizo- enic patients which are subjected to both subjective and ective burdens, and can be physical, psychological or emotional, social and financial [23–25]. Family members feel a burden during caring because Schizophrenia is a chronic disease and takes a long time for treatment.

One of the burdens found is confusion about the illness as they do not understand schizophrenia. The perceived confusion is uncertain, a volatile behavior of patients with schizophrenia, susceptible to change and no symptoms of recovery while the family still hopes that the patient can recover as before. The findings of this study are supported by the opinion by Lim and Ahn [26] where a poor family understanding of schizophrenia may affect family perception about the perceived burden of care. Families have thought schizophrenia is like a physical disease that will recover quickly, so the patient returns to normal after taking medicine given by the doctors. But in fact, the patient's condition does not improve as expected, the patient still behaves strangely, is difficult to control and even worsens despite taking the medicine. This situation makes families confused because it is not in line with their expectations. Inadequate information about Schizophrenia causes false perceptions as stated by Chou [27], the burden felt by caregivers is a subjective perception based on the gap between expectations and existing abilities and reality. It is therefore imperative for mental health personnel (nurses or doctors) in hospitals to explore the level of family understanding of schizophrenia and provide appropriate and complete information on causes, disease prognosis, treatment and healing processes of schizophrenia. Through the provision of information about Schizophrenia, the family will have a realistic expectation of the future prognosis of schizophrenia and may reduce the burden of care [26,28,29].

The confusion about the illness during caring for of the patient may be unresolved, affect the family emotionally and develop into a emotional burden. The emotional burden as a result of this study is in line with some previous research, where families experience feelings of sadness, shame, worry, suffering and fear during accompanying and caring for patients with Schizophrenia. Families feel worried about the future, are stressed, and feel unable to cope with problems [25,30]. The behavior displayed by schizophrenic patients directed to family members, communities and surrounding environment often foster feelings of distress. Family members experience prolonged sadness and fearfulness when finding difficulty to direct the patient's behavior, especially when the patient is behaving aggressively. The emotional burden experienced by families is also reinforced by family concerns about the future of the patient [31]. Research data shows that most participants (66.67%) are mothers as the primary caregiver, and deeply think about who will care and meet the daily needs of patients if the mother is gone. Research conducted by Hanzawa [32] also stated that mothers will have more concern than other family members when providing care to sick family members.

Feelings of sadness, fear, and worry felt by the family increase emotional burdens when the family must deal with the community. Families who care for patients with Schizophrenia still think Schizophrenia is a disgrace, and the presence of schizophrenia patients as family members cause feelings of shame. The family attempts to hide unruly behavior of patients and keep patients at home to reduce feelings of shame. The family effort has a limited ability when the family is not able to cover the shame, while the behavior of the patient with schizophrenia also cannot be controlled, and will bring up another subjective burden directed to patients with Schizophrenia, which is anger. Some families describe expressive and passive expressions of anger toward the patient, other family members and the environment as an outburst of unstoppable emotion during caring for the schizophrenic patient. The entire psychological burden found in this study illustrates the negative feelings of the family during the care of patients with

izophrenia. Negative feelings can have a negative impact on the ily functioning as caregivers [25].

The care burden experienced by the family becomes more se- when the family is faced with demands of physical conditions primary caregiver, material needs and demands from surnding environments and work, which in this study is a maniation of objective burden. According to World Health anization [30], objective burden includes disturbance of reonships among family members, limitations of social relations work activities, financial difficulties and negative impacts on physical health of family members. Physical burden found in study is in line with physical burden conveyed by World Health anization [30], where the family feels exhausted because of ing to keep the patient in recurrence, having physical comints such as high blood pressure and digestive problems. The ily also feel difficulty in sleeping at any moment thinking of the izophrenic patient's condition. Decreasing the family health tus illustrated subjective families' psychological burden [33,34]. This study also identifies financial burden, which includes the t of treatment and patient's needs [29,30]. Cost of treatment was d for medical expenses, hospital visit costs, hospitalization and ommodation costs to health services. Schizophrenic patients ve higher frequencies of eating (more than three times a day) ich causes an increase in daily financial needs. It is underndable because patients who take antipsychotic drugs have an rease in appetite. Increasing financial needs causes families to perience financial problems related to needs of shelter, food, nsportation, medicine, finance, and crisis intervention [29,35]. clining and limited financial conditions of families have the tential to reduce family economy, affect subjective perceptions of nily and become a burden of care that negatively impacts on the ality of family life [25].

This study also identifies families' burden of time because they ed to monitor the patient at all times. These findings are in line th some studies, and the amount of time required by caregivers one day is related to objective caregiver's level [36–38]. The data ys the family should limit the time to work, must go home on ne and often having difficult ways to perform personal activities ch as watching television comfortably, sleeping and doing a bby. Caregivers spending time with sick family members have an pact on fulfilling personal needs and causes a burden for carevers [37].

This study finds that because families feel a social burden, they ve limited time for working in the work environment and society cause they have to treat patients with Schizophrenia. This finding in line with several studies, because of the family task to care for k family members, they must be willing to resign from their jobs d not be included in social environment activity, and eventually ve limited social activities in society and are perceived as a social rden [24,39,40]. This situation has serious consequences for milies who care for patients with Schizophrenia. A father in this udy had permission not to work in one day because of taking tients with Schizophrenia to health care services, and he would t a cut of his salary for one day. These conditions lead to creased work productivity, lowered family income, and creased social activity in the work environment and led to social rdening and degrading of quality of family life [41].

All different types of burdens, called confusion about the illness, notional, physical, time, financial and social burden generated in is study, are risk factors for families' resilience during the caring ocess of patients with Schizophrenia. Risk factors are indicators at influence the dynamics of family resilience where the risk ctor is perceived to encourage negative outcomes in the family 3,14]. The mind and psychological burdens experienced by the mily will raise negative feelings affecting the role and family function in caring for the patients. Physical, financial, time and social burdens were felt by the family which may degrade the quality of family life. The decrease in family functionality and quality of family life have the potential to be a risk factor for family resilience. The mental health worker, a psychiatric nurse, should be able to assess the family situation in detail, especially the various burdens of care felt by the family during the caring process of patients with Schizophrenia. Nurses should intervene to reduce the burden of care, which impacts on improving the quality of family life and family functions to strengthen family resilience during caring for patients with Schizophrenia.

### 4.2. Stigma

This study identifies stigma as risk factors experienced by families during the care of patients with schizophrenia. A stigma is a negative feature possessed by a person, being an individual or group attribute, and can be a barrier to gaining attention, opportunity and social interaction [42,43]. The perceived family stigma results in the presence of schizophrenia patients in the family, who, by the environment, are considered to have special characteristics in terms of abnormal thinking and negative behavior. The results show family perception about stigma, based on families' attitudes and responses from society related to schizophrenia patients, are in line with stigma dimension according to Link & Phelan, namely labeling, stereotype, separation, and discrimination [43].

Labeling is felt by the family when the surrounding community, such as neighbors or extended family, calls a family member suffering from schizophrenia by a term of "madness", also indicating that the patients are hard to cure. Labeling is a differentiator, stamp or naming based on the special features of community members [43]. The term becomes accepted by the family and is perceived as a disgrace to the family, which causes the family to feel ashamed about the existence of schizophrenic patients as a family member. Embarrassment is an indicator of stigma because the family feels blamed by the environment, the family is considered responsible for the illness, and the family has a close relationship with the patient [44,45]. Embarrassment due to the stigma has an emotional consequence that affects the quality of family life and decreases family function [45].

A stereotype in this study is perceived by the family as a description of schizophrenic patients' behavior delivered by the community, such as unkempt appearance, illogical mindset and aggressive behavior. Stereotypes are defined as attributes belonging to certain social groups with special features, in which Schizophrenia patients have been treated in mental health services, have unnatural behavior and tend to disrupt the environment [46–48]. Families often feel uncomfortable with environmental assumptions about sick family members, but families also acknowledge the truths that are conveyed. Families feel that the situation is experienced as creating a bad reputation for the family, which causes social consequences both to the patient and social environment around the family, such as blaming the patient, avoiding interaction with the patient and not engaging the patient in interacting with the environment [49]. The social consequences experienced by families can degrade the quality of family life and have an impact on the declining of family functionality [45].

Separation was experienced by families involved in this study as a form of the community response to the existence of patients with Schizophrenia that affects the family. The family feels shunned in the sense that neither friends nor extended family wants to engage with the families in a variety of matters because they do not want to be affected by the unnatural and dangerous behavior of Schizophrenic patients. Separation is a distance of an unstigmatized group from a stigmatized group, is and known as a success the labeling

s with negative attributes to individuals or groups [43]. ıtion is experienced by patients with Schizophrenia, and an led family is a tangible form of stigma, often dodging or g away from the family and the patient with Schizophrenia. ıtients are considered to harm other people and their envi- :nt and cause unwanted problems [46,50]. Separation is enced by families, resulting in interpersonal consequences ıiding social relationships with the environment, tending to he patient's existence, and making them the family's big se- uch interpersonal consequential situations cause the family emotionally exhausted, thus degrading the quality of family d affecting the family's ability to function optimally in caring tients [45].

crimination is felt by the family through perceiving different iors by the community. Families often do not get their rights d to social activities in the community, because they think the it's behavior related to family involvement will affect the ıg of social activities. Discrimination is a negative and ding behavior because of the connection of a person to an irable group [48,51]. Discrimination received by families who for patients with mental disorders leads to feelings of nfort, neglect, and are not considered to exist in society [52]. mination can occur because the family has a close relation- with both interactions and genetics with the patient, so not ving the family is an option that cannot be avoided by the ıunity. Discrimination is one of the social consequences that be borne by the family and will affect the quality of family life decrease family function in caring for patients with ›phrenia.

gma is experienced by the family in labeling, stereotyping, ation and discrimination, in this study based on family per- ›ns, which is part of the risk factors for family resilience. A risk is an aspect whose presence is perceived to induce negative mes for the family [13,14]. Labeling perceived by the family ead to emotional consequences, stereotypes, and difference social consequences, while separation leads to interpersonal equences. The three consequences, emotional, social and ›ersonal according to [45], will affect the quality of family life. situation can encourage negative outcomes in the family, ially in supporting the family functionality and becomes a r of families' vulnerability in growing resilience.

ealth workers, especially nurses, must be able to assess family ions and conditions related to family perceptions of perceived ıas due to the presence of schizophrenic patients. Then, ng interventions can be planned to increase the resilience of ies facing stigma. It is important for nurses to develop nuous efforts to provide interventions for community envi- ıent to reduce stigma. These interventions are expected to ove the quality of family life and have an impact on improving y functions to strengthen family resilience skills in caring for nts with Schizophrenia.

### Research implication

his study yields important information about family members' riences with care burdens and stigma that can lead to negative ts in achieving family resilience during the care of patients Schizophrenia. These findings are expected to be a basis for levelopment of early detection assessment forms, especially sychosocial problems related to family resilience in caring for ophrenia patients. Other information obtained in this study is xistence of family risk factors that must be managed to achieve y resilience, meaning that this study can be used to develop a y resilience model, especially in families with Schizophrenic nts. The study also yielded information that in growing resilient families with schizophrenic patients, families experienced care burdens and stigma as risk factors which can strengthen and be integrated with the theory of Resilience Model of Family Stress, Adjustment and Adaptation by McCubbin and McCubbin [18] as variables constructing risk factors. The nurse, as a health service worker, in conducting a family assessment is expected to identify the care burden and stigma experienced by the family and develop interventions to assist families in minimizing risk factors in order to help families in achieving resilience skills faster.

### 4.4. Research limitation

This research has several limitations. The design used was a qualitative approach, and the results are qualitative in nature in which need to be re-examined with another research design that can test the validity and reliability until the data can be used as an instrument standard. Another limitation is related to the persistence of other unexamined factors in family resilience, that is a family protective factor which is may overcome negative outcomes generated by risk factors.

## 5. Conclusions

This research explained care burdens and stigma as risk factors that must be managed by family members to survive, rise up and become better in caring for patients with Schizophrenia. Nurses as health service workers have a central role in assessing the level of care burden and stigma experienced by family members in order to help family in achieving resilience.

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## Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.ijnss.2018.06.002.

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# Intention to Stay Model of Nurse Staff in Hospital

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## ABSTRACT

The high turnover caused the non-fulfillment of the number of nurses. The purpose of this study was to develop the model of intention to stay (ITS) of nurses in hospital. This research included quantitative research with cross sectional study design, using survey method. Research sites took place in four private hospitals and one public hospital. The population was all nurses with non permanent employees amounted to 214 people. The number of samples was 171 respondents. The results showed that ITS was influenced directly and indirectly by organizational identity (OI). Directly and indirectly affected by perceived internal respect (PIR), also directly and indirectly influenced by job satisfaction (JS). ITS was directly influenced by organizational commitment (OC) with the greatest path coefficient and directly influenced by job security (JSe) and indirectly effected by perceived external prestige (PEP). PIR had the greatest total effect on ITS and was the main determinant of ITS. The novelty found that ITS nurses were comprehensively influenced directly by PIR, OC, JS, OI and JSe. Indirectly influenced by per through OC. OC was directly influenced by JS, PEP and PIR. PEP and PIR directly affected OI. The implementation of model can be done are involving all parties in preparing a programmed and sustainable nursing policy.

*Keywords: Intention to stay, Perceived internal respect, Organizational commitment, Job security, Organizational identity, Job satisfaction, Perceived external prestige.*

## INTRODUCTION

Turnover becomes an important thing to note, because it could disrupt the sustainability of the company and would be very detrimental. According to Lephalala (2006) turnover in an organization should be identified. Causes of turnover to be identified were voluntary or involuntary turnover. A high turnover rate in the involuntary indicated that organizations should be more careful in recruitment, selection, training and motivation improvement. A high voluntary turnover signified that the organization needed to find out the cause of the employee's resignation[1]. Turnover was defined as the voluntary or involuntary resignation of an organization[2]. High resignations resulted in increased recruitment, selection and training costs. A high degree of resignation may impair the efficiency of the company's management if the knowledgeable and skilled personnel left so that substituted must be founded and prepared to continue the position of responsibility. This study special for voluntary turnover, were chosen based on the consideration that the nurses were voluntary.

The results of several theoretical studies provided information that there are various factors that affect the ITS. Affective commitment and normative commitment was the best predictors of intention to leave (ITL) or intention to stay (ITS)[3]. The relationship between affective and cognitive concepts might affected ITS nurses on nurse job positions[4],[5]. The reason nurses stayed in the hospital because of respect, prestige, job satisfaction, job environment, job opportunity, and job security[6].

For this study developed the theory of cooperative behavior in groups Tyler and Blader[7] was devoted to the construct of influenced on behavior for

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ITS. This theory was part of the process of social identity. The theory explained how individual motivations could created and enhance felt of self-worth, which consist of group status (prestige) and individual self-esteem (respect). The level of self-esteem was able to explain the level of one's involvement in the group. In particular, this social identity processed can motivated a person to act that benefits the group. Based on this perspective, the individual could work with his group. When someone was identified as with his or her group, it was easier to cooperatively invested his time and energy in working for the success of his group. The stronger the identification with the group, the more important the group's success would be, gave that their self-awareness would be stronger to the group. Through a good group image, it could benefit his image. They seek to maintain a good self-image through group identification.

Through his membership status in a group, a person attempted to blend in with the concepts in his group. by helping their group, in essence, also help themselves. This research in addition to develop the theory of cooperative behavior in group for the concept of influences on behavior ITS Tyler and Blader[8] also took some determinants of ITS theory Cowden et al.[9] by adopting JS and OC as determinants of ITS. This theory also explained that the behavior of group cooperation is divided into 2 forms, that is, individuals engaged in groups according to mandatory cooperative behavior and individuals engaged in groups caused by indirect requests of rules or norms group (discretionary cooperative behavior). Tyler and Blader[10] explained that discretionary behavior was a major factor that built or shapes attitudes and internal values held by individuals. The perception of one's OI is based on two assessments, namely the assessment of the status of the group (pride) and its status in the group (respect)[10]. Pride refers to an individual's assessment of the status of an organization while respect refers to an assessment of the status of an individual within the organization. Positive evaluation results would enhanced the identity (group). The term pride is replaced by Smidts et al.[11] and Carmeli[12] with PEP, while the term respect by Fuller et al.[13] was replaced by PIR by Dutton et al.[14], pride was termed construed external image. In this research the term used is PEP and PIR. In addition, this research also involved JSe based on consideration of previous empirical studies.

The purpose of this study was to develop ITS model of nurses in hospital. This study was classified as quantity study, with study cross sectional, and using survey method. Research sites placed in 5 hospitals: 4 private hospitals, and 1 public hospital. The population was all nurses whom are nonpermanent employees (daily freelance, honorary, and contract) and amounted to 214 people. The criteria sample was nurses registered in those 5 research sites, and work in all nursing units. This consisted of those whom were nonpermanent employees, have worked for (at least) a year, and are under 36 year-old. Sample size was 171.

## MATERIALS AND METHOD

The research design was quantitative with cross sectional study design, using survey method. The aim of this study was to explain the causal relationship between the variables and the research was designed to develop the ITS model on the nurses in the hospital. The research was conducted at Hospital A, B, C, D and E in Makassar. The locations of the study were determined by the trend of turnover rate in the last three years. Three hospital of public private hospitals with an increasing trend of turnover rate each year, while one represent public private hospital with a trend of declining turnover rates in the last three years. In this study, the study population was considered to be lacking, so an addition of 1 hospital was decided because of the closest similarity in location and sample characteristics with the other four research sites. The last hospital was selected as an additional research site. The population was nurses with non permanent status (freelance, honorary, contract, and intern permanent) for all hospital (214 people).

The instrument used to measure ITS was developed from Abelson[15]. The external prestige perceived measuring instrument is developed from Mael and Ashforth measuring instruments[16]. PIR gauges were developed from Tyler[10] and quality nursing work of life by Brooks and Anderson[17]. The OI measures were developed from the theories of Edward and Peecei[18]. Work satisfaction measuring tool developed from JS measure for nurse by Kudo et al.[19]. The OC gauge is developed from the OC tool Mowday et al.[20]. The JSe measure is developed from Probst[21] theory. Researchers also developed a JSe measure based on interviews on JSe with nurses in the field. The answers to the hypotheses were answered based on the path analysis using Partial Least Square (PLS).

## FINDINGS

The results showed that ITS was directly (β=0.174) and indirectly (β=0.209) affected by organization identity. ITS was directly (β=0.206) and indirectly (β=0.232) affected by PIR. ITS was directly (β=0.140) and indirectly (β=0.091) affected by JS. ITS was directly influenced by OC, with the greatest path coefficient (β=0.261). ITS was directly affected (β=0.166) by JSe and indirectly affected (β=0.127) by PEP. PIR had the largest total (direct and indirect effect) influence (β=0.438) on ITS. Therefore, PIR was the main determinant of ITS nurse force which means having the most important role to ITS nurses. This research is different from Tyler and Blader's[8] which explained that PEP was the main determinant of ITS. Goodness of Fit indicates that the model deserves to be accepted. The model also shows a significant influence between each variable.

This study proved that ITS on nurses were comprehensively influenced directly by PIR, OC, JSe, OI and JS. ITS was indirectly influenced by PEP through OC. OC was directly influenced by JS, PEP and PIR. PEP and PIR directly affect the identity of the organization. This study proved that the main determinant of ITS was PIR. Unlike the case with Tyler and Blader[8] which stated that PEP as the main determinant of ITS. The difference of factor loading value of each indicator to latent variable. The loading factor could indicated the size of the indicator in the construct of the variable. The indicator that had the largest loading factor value showed the most belligerent indicator built the variable. Information was obtained that PEP of medical staff had the greatest loading factor to PEP. Increased PEP of medical staff directly increased the value and purpose similarity between nurses and hospitals. Increased PEP of medical staff directly also increased the commitment of non permanent nursing organizations. Feeling assessed its contribution had the largest loading factor (0.885) to PIR. Increased sense of contribution was assessed by the hospital improving the value and purpose between the nurse and the hospital. Increased sense of contribution was assessed by the organization can increase OC and ITS afloat and not looking for another job. The direct effect of influence between PIR toward ITS had the second largest coefficient value of 0.206.

Increasing the similarity of values and goals between nurses and hospitals had the largest loading factor (0.876) on OI. Increasing the value and purpose similarity between nurses and hospitals directly increases the ITS afloat and not seek other jobs. Line of influence between the identity of the organization with ITS has a coefficient of 0.174. Factors related to nursing practice have the biggest loading factor (0.833) to JS. Increasing JS in nursing practice directly increases the ITS afloat and not look for another job. Line of influence between JS with ITS has a coefficient of 0.140. Increasing JS in nursing practice directly increased OC.

Increased OC could directly increase the ITS afloat and not looking for another job. Line of influence between OC with ITS had a coefficient of 0.261. It could be concluded that OC was the most important factor in its role to the intention to survive and not seek other work. The path of influence between JSe satisfaction with ITS had a coefficient of 0.166. Increased JSe satisfaction can directly increase the ITS afloat and not looking for another job. The model of ITS on nurses had two lines of influence: direct and indirect effects. Based on the influence of direct or indirect of each variable to ITS could be seen in Table 1.

**Table 1. Direct and Indirect Effects to Intention to Stay**

| Variables | Direct effects | Indirect effects | Total effects |
|---|---|---|---|
| Perceived External Prestige | - | 0.127 | 0.127 |
| Organizational Identity | 0.174 | 0.209 | 0.383 |
| Perceived Internal Respect | 0.206 | 0.232 | 0.438 |
| Job Satisfaction | 0.140 | 0.091 | 0.231 |
| Organizational Commitment | 0.261 | - | 0.261 |
| Job Security | 0.166 | - | 0.166 |

Smidts et al. state that OC affects ITS. High JS has a significant effect on ITS. Hospital organization climate affects ITS[11]. Research from Castle et al. explained that high JS was negatively related to intentions of out, thinking of looking for work and looking for other work and turnover[22].

## DISCUSSION

Nurses who were sampled in a special study on a single profession only. Whereas the number and types

of professions in the hospital was very varied, besides that turnover was also quite high in other professions. Turnover rate data was still considered confidential organizational data that can not be published, so it takes a good approach to the hospital. Tribes, education levels, and employee status types, are dominated by certain characteristics, so that the resulting model had not been able to generalize in all types of hospitals. PIR analysis in the specially generated model has not distinguished between group of medical staff (group) and hospital (organization). This study adopted measuring instruments Mael and Ashforth which in the question item there was a statement "thinking" which in the study of psychology has not been entered in the sphere of perception[16].

## CONCLUSION

The novelty of the research explained the model that proved ITS nurses were comprehensively influenced directly by PIR, OC, JSe, OI and JS. ITS was indirectly influenced by PEP through OC. OC was directly affected by JS. PEP and PIR. PEP and PIR directly affected the identity of the organization.

Suggestion that implementation of the ITS model can be done through improving PIR, OC, JSe, OI, JS, and PEP. Enhanced PIR can be done through the awarding of all contributions of non permanent nurses in the work. Feedback on performance and achievement they had made was also important. Increased OC can be achieved through efforts to nurse the commitment of nurses, so that they would contribute more for the sole purpose of the hospital. Recommended, from the beginning of entering the hospital, nurses were introduced with the vision, mission, goals, objectives, and values of the hospital. The description of the vision, mission, and goals of the organization (hospital) must be clear. This commitment must also start from top management. Increased JSe can be achieved through the policy procedures employee status determination, career guarantees, promotion and sustainability of the work clearly for non-permanent nurses at the hospital. Increased OI can be achieved through the dissemination and translation of the values and objectives of the hospital clearly. It was important to improve the similarity of values and goals between nurses and hospitals. Increased JS can be achieved through the fulfillment of the hope of nurses, especially about nursing practice. Nursing practice should work well in relation to task assignments, instruction delivery, nursing methods, and fair supervisory treatment. Increased PEP especially in medical staff could be achieved through the effort to grow the value of pride to be medical staff at the hospital where they work today. Forms of effort can be programmed and sustainable. The effort involved the management of the hospital, including the head of the room, the team leader and all the nurses in the hospital by formal and informal activities.

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# Return Migration of Nurses: A Concept Analysis

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## ABSTRACT

**Background:** Return migration is a complex, challenging phenomenon and to date it remains a concept that is not well understood. A concept analysis would help to clarify what is meant by return migration. This paper aims to report on an analysis of the concept of return migration of nurses.

**Design:** Concept analysis using the Walker and Avant approach.

**Data Sources:** Google Scholar, Pubmed, EBSCO, JSTOR and Web of Science databases were searched without a timeframe. Twenty-one articles meeting the inclusion criteria were included.

**Method:** This study employs eight steps of Walker and Avant's method to conduct the concept analysis.

**Results:** Return migration of nurses can be defined by five attributes: the motivation and decisions of migrant nurse, return as human right, resource mobilisation, reintegration and return itineraries. Antecedents of return migration include the economic, social, geographical, political, family and life cycle that comprise the cause and effect framework. With regards to return migration, the consequences are beneficial or detrimental depend on the point of view migrant nurses, source country, receiving country, nursing profession and country health system. Empirical referents have been identified and support potential area to undertake a research on return migration.

**Conclusion:** This concept analysis has clarified current understandings and enhance the clarity of return migration concept. It recognises the centrality of return as a component in migration stage that needs a comprehensive approach.

***Keywords:*** *concept analysis, return migration, nurse migration, brain gain.*

## INTRODUCTION

Migration of skilled health workers in a global context has increased significantly over the last two decades.[1-3] Nurses as a large part of professional health care workforce have contributed to the significant flows of this migration movement.[3-5] Migration has long been assumed as a one direction process,[6] such that migrants who emigrated would permanently stay in the destination country. However, there is increasing evidence showing that the migrants are returning to their country of origin known as return migration.[7-9]

Acknowledging the importance of return migration, The International Centre of Nurse Migration recognised this movement as a means of benefiting the countries of origin and called for serious attention.[10] The International Organization for Migration (IOM) also support this idea by emphasising on the need for comprehensive and cooperative approaches to managing return as a part of the human movement.[11] The issue of return has become increasingly significant among immigrants although in the absence of statistical data. The study pointed out the need for global attention on the nurses' return migration that is highly complex and needs further action from nursing profession.[10]

Concept analysis as Walker and Avant (2005) has argued can provide a knowledge base to get a clear picture of phenomenon, object or idea.[12] The aim of this concept analysis was to examine the concept of return migration as it is used in global nurses' migration, to provide a brighter understanding of the phenomenon and suggestion for future study can be developed and measured.

**Data sources:** An electronic search using the keyword "return migration nurse", "return emigrant nurse", "return immigrants nurse" was undertaken using databases relevant to nursing, medicine and social sciences, Pubmed, EBSCO, JSTOR, Web of Science and Google Scholar.

**Data Selection and Analysis:** The final sample of 21 documents was selected with inclusion criteria for the selection of papers were: a) reported on migrants returning or having returned to their country of origin; and (b) focused on qualified nurses.

## RESULTS

**Uses of the concept in literature:** There is no available definition of return migration from commonly referred dictionaries, Oxford and Merriam-Webster dictionary. The first definition of return migration proposed by Bovenkerk (1974) which define as the return of people after emigrating to origin country for the first time.[13] Above terms have various interpretations. For example with regards to the movement, Dumont and Spielvogel (2008) define the movement as the initial migration only to be called return migration.[14]

**Defining attributes**

**Motivation and decisions of nurse migrant:** Individual motivation and decision for going back to the country of origin is one of key distinctive associated with return nurse migration. It has been argued that individual decision to return home as a response of personal factor, career path and others.[15,10] Individual initiatives to return has been decided on the early stage of migration or during they stay in foreign country.[16,17] Motivation to return home was reported influenced the willingness and readiness of migrant which consider the circumstances in both, home and host countries.[18]

**Return as human right:** Freedom of return under the umbrella of migration was described in the literature on return home. Recognising the significant mobility on health professional, the WHO issued the global code by recommending the Member States to take into account individual right to migrate and leave any country.[19]Recalling resolution WHA57.19 in which the World Health Assembly requested the Director-General to develop a voluntary code of practice on the international recruitment of health personnel in consultation with all relevant partners; Responding to the calls of the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2\u20137 March 2008 Back to the past, referring to the article 13 section 2 of The Universal Declaration on Human Rights stated that "Everyone has the right to return to his country".[20] The positions statement by International Council of Nurses (2007) recognise the potential benefit of migration and call for support to nurse who wishes to return home by putting the nurses right on priority.

**Resource mobilization:** Bringing resources back to the countries of origin marked the character of return migration. Nurse returnees not only bringing the financial capital but also human and social capital.[21] It is undeniable that the flow of remittances to the low and middle- income countries plays a significant role in the nation's development.[21] Even though we are a lack of data on the impact of remittances from nursing workforce, evidence showed that in Philippine as a source country of nurses share 10% remittances of Gross Domestic Product, 14 % for Jamaica and 8.5% for Uganda.[22] Brain gain is the most expected of returned migrants which brings new skill, knowledge and idea to contribute to the advancement of their origin's country.[23] Studies of return migration in Jamaica and Pacific Island countries described that most returnees have gained new or additional capabilities.[21,10]

**Reintegration:** Return migration was characterised by reintegration phase into the family, group and society in his or her country. Reintegration found quite complex, dynamic and challenging aspect of return migration.[11] Reintegration to be influenced by situation and condition in both countries.[24] When migrants feel that they have achieved their goals, they are more ready to reintegrate into the home country.[18] Complex reintegration problems have been investigated by Arowolo for instance joblessness, social maladjustment, boredom and frustration among non-nurses migrants.[25] This study consistent with research of nurses migrant who returns to Indonesia, the majority of nurses were unemployed and faced difficulty in building a career.[26]

**Return itineraries:** The journey of return was complex which generally divided into voluntarily and involuntarily. These types were explained in the literature of return migration of nurses. Majority the studies support the benefits of voluntarily return as a form to contribute in the nation development.[27] Voluntary return due to the completion of work contract, and goals achievement was reported by another study.[16] However, some study also noted that forced return migration might become the push factor from country of residence to make them back home.[10]

**Model case of return migration of nurses:** In the Walker and Avant method, model case was constructed to further clarify the concept. The case may be derived from our real life, invented or found in published document.[12] A model case adapted from return migration study in which exist in real life context.

Sumiati (Pseudonym) is a 28 years old who hold a bachelor's degree in nursing. She has been working in Japan for three years as foreign nurses. Working as nurses in Japan allows her to earn around 2000 USD per month, eight times higher than Indonesia. Having this wage, she was thinking to return home after she reaches her personal goals. She also sent the money back to home country for her family. After Tsunami disaster hit Japan in 2011, her family was worried about her safety and tried to persuade her for return. Even though she has passed the Japanese Nursing Examination and eligible to stay in Japan for unlimited periods, finally she decided to go back to Indonesia and tried to find a new job. While waiting for the job interview, she was running a small business from the saving money in Japan. She was shocked to find out that living in her city was challenging and difficult to find a job. She thought that she must rebuild her career from zero as a new nurse.

All attributes arise in this case describe the complexity of the concept. Sumiati demonstrated individual motivation in her decision to return home. Her return was influenced by the achievement of her personal goals, crisis, and her family. Financial capital was obviously observed from her situation to support her family and herself at home country. Lastly, return home positioned her on the difficulty finding a job and struggles to seek a new vacancy for her future.

**Additional cases: related case:** There is one case related to return migration concept of which have some attributes of return migration but actually different. Following is an example of related case.

Denias (Pseudonym) was left his job to migrate to Australia because of the war happened in his home country. After arriving in Australia, the immigration office found him without a legal document. Only two months ahead of his arrival date, the Australian government has decided to deport him back to his country of origin.

Denias case only has one attribute, his return itinerary was forced by the state to expel from the host country (involuntary return migration). This type of return repeatedly showed by refugees and asylum seekers that flow to developed countries.

**Antecedents:** The cause and effect model is the most prevalent framework for explaining return migration of nurses.[10] The antecedents for return migration of nurses are social, economic, geographical, political, family or life cycle.[6] Cause and effect factors drive nurses to return to the country of origin which affected by circumstances in the host and home country.[6] Economic motives for example when the job arrangement reaches the end of the contract, it might be a cause factor to leave host country.[8] On the other side, enough saving in country of origin might become an effect factor to return home. Non-economic consideration also having more influenced for return home than economic reason.[6]

**Consequences:** Mount evidence showed the positive and negative impact of return migration on various players on this movement.[10] The players include migrant nurses, nursing profession, host and home country. For instance, developing countries who have a surplus of nursing workforce could gain benefit for the return of migrant nurses. The brain gain is much more expected than brain drain particularly from the middle and low-income countries.

**Table 1: Concept on return migration of nurse: antecedent, attributes and consequences**

| Antecedents | Attributes | Consequences |
|---|---|---|
| **Drivers influencing motivation to return (cause and effect)** | **Motivation and decisions of nurse migrant** | **Beneficial and detrimental depending on:** |
| Social | Return as human right | Individual |
| Economic | Resource mobilization | Source country |
| Geographical | Reintegration | Receiving country |
| Political | Return itineraries | Nursing profession |
| Family/Life Cycle | | National health system |

**Empirical referents:** Measuring return migration can be challenging as there is still confusion on the definition and data availability as well.[28] How was country dealing with this issue by lack of system to track the returnee obviously appeared on the published literature.[29] Mostly country relies on the census, survey, population registries, labour force survey, country social survey, and data from employment services.[28] A study from most developed countries conveys a message that there is a need of established tools to measure the return migration.

The attributes, antecedents and consequences of return migration of nurses can be scrutinised using mixed methods, either quantitative or qualitative. The need to develop instrument or scale to measure return migration is necessary particularly for the standard measurement among countries to allow greater understanding of this issues.

## DISCUSSION

In this concept analysis, the discourse of return migration on nurses has been elaborated in the systematic approach with implication on nursing research, education, and practice. According to this analysis, we need a specific scale to measure this phenomenon in standard ways. This study also highlights that return migration in nursing societies is occasionally approached in a holistic manner. International organisation in nursing has proposed a position statement on the important aspect addressing the global nurse migration.[10] In the global connectedness and interdependence between countries on the issues of migration, return issue will become more prevalent.

A concept analysis of return migration was challenging in the absence of available data, particularly on nursing perspective. By this, nursing profession needs to take action by implementing some measures to deal with the underlying problem.

## CONCLUSION

This article provides an analysis of the concept of return migration of nurses found in published literature. The analysis proposed that return migration of nurses has been identified as having characters: individual's motivation and decision, universal human right, resource mobilisation, reintegration and return itineraries. Countries involved in this program should promote orderly and regulated return migration of nurses using a comprehensive approach.

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To
Ah. Yusuf
Nursing Faculty of Universitas Airlangga, Surabaya

Dear author/s
I have pleasure to inform you that your following Original Article has been accepted for publication in Indian Journal of Public Health Research and Development

DEVELOPMENT OF HOLISTIC NURSING CARE MODEL FOR MENTAL DISORDER PATIENTS CARE IN INDONESIA

Ah. Yusuf*, Rizki Fitryasari*, Rr Dian Tristiana*[1], Hanik Endang Nihayati*, Ahsan**, Suprajitno***

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It will be published in due course of time. It is further mentioned for your information that our journal is a double blind peer reviewed indexed international journal. It is covered by Index Copernicus (Poland), Indian Citation index, Google Scholar, CINAHL, EBSCOhost (USA), EMBASE (Scopus) and many other international databases. The journal is now part of CSIR, DST and UGC consortia. The Journal is index with Scopus and fulfills MCI Criteria as per MCI circular dated 03/09/2015.

With regards

Yours sincerely

Prof R K Sharma

Editor

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# Influence of *Picture and Picture* Method Against Moral Development of Children

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## ABSTRACT

Misbehaviour phenomenon in elementary school children can be caused by lack of moral development of children. The number of children with negative moral behaviour increases year by year both in quantity and quality. Internal and external factors can be the main effects of inadequate moral development of children. The aim of this study is to explain the effect of *picture and picture* method against moral development of children aged 10-11 years. *Pre-experimental* research with *one-group pre-post* test. Population of the research consisted of 165 children in Tanah Kalikedinding IV Elementary School. Sampling was conducted by using purposive sampling technique (n=117 respondents). The independent variable is the picture and picture method, while the dependent variable is the moral development. Collecting samples using observatory sheet and analysis using *Wilcoxon Signed Rank Test* with significant level of $\alpha = 0,05$. There was an increasing percentage from pre test and post test. *Picture and picture* method can be used as an alternative for developing children behaviour. For the future research, it is expected to use control group to examine which factors influence moral development of children.

***Keywords :*** *picture and picture method, moral, development, children*

## INTRODUCTION

According to Kohlberg's belief empirically proved that Individuals with low moral level will tend to commit violence or crime more often compared to individuals with high moral level[1]. Based on data of Child Protection Commission (Komisi Perlindungan Anak), Child Protection Cluster 2011-2016 found that from 7,690 children facing child deviation cases, 1,881 children dealt with health related issues and NAPZA (drugs), and 2,345 children experienced educational problems such as brawls and *bullying*[2]. According to First Class Bureaucracy Surabaya, the number of children facing the law in Surabaya is increasing from year to year, by evidence that there were 500 children in 2016 who need assistance and not only the number of cases increased but also the quality of the cases more complicated[3].

Based on surveys conducted by researcher on Tanah Kalikedinding IV Elementary School Surabaya from 2017 with 47 students aged 10-11 years, there were 65,96% children taunting/scorning other fellow students, 63,83% children starting physical aggression (punching, kicking and fighting), 34,04% violating school regulations, 23,40% not respecting school environment such as littering or harming school stools/ walls and 14,89% taking fellow students goods without permission.

School-aged children are individuals of 6-12 years old in development character period through verbal reinforcement, exemplary and identification. These aspects can be obtained through education at school as development of attitude and good habit[4]. Children having poor mental, moral and ethical values will be easily influenced by three main factors of juvenile delinquency, i.e. media, technology and friends[5]. Children moral development is in line with development of cognitive aspect, meaning that the stage of cognitive

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development for children aged 7-11 years old is on operational concrete phase [6], i.e. children can understand rules from conversations resulting on a logical thinking pattern and operational mentality[7]

Moral education is important point for children to avoid bad influences from their social environment, leading them to posses good behaviour and to act rightly[8]. *Picture and picture* learning model is one of the active learning methods to create cooperation among students to solve problems[9]. This method is a cooperative method, children will learn to understand rules and get moral values on right or wrong as well as the reasons through observation of pictures. According to social-learning theory, learning mostly occurs through observation-control, which leads to *vicarious reinforcement* by formulating expectation of behavioural outcomes without self-directed action. At the end of social-learning process, children will be motivated to imitate or not to imitate the behaviour model he/she observed[10]. Therefore, Based on above description, this research aims to determine the effect of *picture and picture* method against moral development for children aged 10-11 years.

## METHOD

The design used in this research was pre-experimental with *one-group pre post-test* approach. Population on this research was 165 student of Tanah Kalikedinding IV Elementary School Surabaya aged 10-11 years old. Sample size in this study as many as 117 children obtained from the calculation of sample size and sampling by using purposive sampling .The independent variable in this research was the picture and picture method while the dependent variable was the moral development. The instrument in this research used tools and materials in the form of images with phenomenon found in society.

Data collection in this research was done by observation for 3 days before intervention, then another intervention after 3 days of following intervention days, and the last observation after given intervention for 3 days prior from two following three days. Data analysis used in this research is Wilcoxon Signed Rank Test with significant level of $\alpha = 0,05$.

## RESULTS

Based on the demographic data of respondents, the major Characteristics of respondents was 10 years old, the eldest and nearly equal between male and female. Senior high school last education, Fathers' occupations were private employee and Mothers were Housewives.

### Moral Development of Children before and after intervention

Distribution of children moral development prior to intervention of picture and picture method showed on table 1.

**Table 1 Children Moral Development towards Prior Intervention**

| Moral Development | | Good | Adequate | Less | Total |
|---|---|---|---|---|---|
| Sex | Boys | 24 (40,7%) | 31 (52,5%) | 4 (6,8%) | 59 |
| | Girls | 26 (44,8%) | 30 (51,7%) | 2 (3,5%) | 58 |
| Status in the Family Order | Single/Only Child | 6 (54,5%) | 4 (36,4%) | 1 (9,1%) | 11 |
| | Eldest Child | 18 (40,9%) | 23 (52,3%) | 3 (6,8%) | 44 |
| | Middle Child | 11 (37,9%) | 17 (58,6%) | 1 (3,5%) | 29 |
| | Youngest Child | 15 (45,5%) | 17 (51,5%) | 1 (3%) | 33 |
| Mother Working Status | Working | 10 (41,7%) | 13 (54,2%) | 1 (4,1%) | 24 |
| | Unemployed | 40 (43%) | 48 (51,6%) | 5 (5,4%) | 93 |

The influence of picture and picture method on moral development of children as in Table 2.

There is an increasing trend from both pre-test and post test results. Increase based on the characteristics of the moral values of children, from which initially from average characteristic to become children with good moral characteristic. Based on statistical test results from Wilcoxon Sign Rank Test shows the results p = 0,000 <α, which means there is influence from *picture and picture* method towards moral development of children aged 10-11 years.

**Table 2 Moral development of children before and after intervention**

| Moral development | | Before | | After | |
|---|---|---|---|---|---|
| | | Freq | % | Freq | % |
| Category | Good | 50 | 43 | 74 | 63 |
| | Adequate | 61 | 52 | 43 | 37 |
| | Less | 6 | 5 | 0 | 0 |
| | Total | 117 | 100 | 117 | 100 |
| Mean | | 38.60 | | 42.63 | |
| Median | | 39.00 | | 43.00 | |
| Standard Deviasion | | 6.91 | | 7.00 | |
| Positive Ranks | | 85 | | | |
| Negative Ranks | | 6 | | | |
| Ties | | 26 | | | |
| Z | | - 7.657 | | | |
| Wilcoxon Signed Rank Test p | | 0.000 | | | |

Table 3 showed that children of male gender have more moral values in the sufficient category. Girls have better category moral values than boys. Based on the order of the child in the family and the status of working mother and not working have moral development in adequate category.

**Table 3. Characteristic of Moral Development**

| Moral value | Before | | After | |
|---|---|---|---|---|
| | Average | Category | Average | Category |
| Honest | 1,66 | Less | 2,95 | Adequate |
| Discipline | 3,22 | Good | 3,33 | Good |
| Responsibility | 2,97 | Adequate | 3,13 | Good |
| Politeness | 2,9 | Adequate | 3,17 | Good |
| Caring | 3,04 | Good | 3,18 | Good |
| Confidence | 2,47 | Adequate | 2,73 | Adequate |
| Average total | 2,71 | Adequate | 3,08 | Good |

## DISCUSSION

Based on research of moral development towards children aged 10-11 years in Tanah Kalikedinding IV Elementary School Surabaya, before the intervention found that more than a half have adequate moral, while less than a half have good moral and there is a small part of child whom had less moral. This data shows

that less and adequate moral value children still cheat very often during test/*post test* learning process, do not pay attention to the teacher during lessons, disturbing fellow friends, not dare to express opinions, etc. This corresponds to individuals who have low morals will more often commit violation or indications of crime than individuals with high moral[1]. Children with better moral values tends to be more independent and able to sort out the positive and negative vibes/values[11].

Before the intervention, the moral characteristic of the average child is in adequate category. Moral values of honesty, responsibility, politeness and self-confidence are not only influenced by external factors, but also influenced by his/her own choice such as how these children resist the temptation when dealing in a particular situation. There are 2 processes of moral behavior in children, the basic process includes the process of reinforcement, punishment and imitation that can give an individual a way to learn about a particular response and why individual responses are different from the other; and self-control and able to resist temptation by developing self-control ability to avoid stealing, cheating, and lying[12].

The majority of children who have less and adequate moral value is the boys. This is consistent with the results of the study that boys are more difficult to regulate than girls[13]. Boys tend to be more competitive, conflict-prone, egoist, risk-taker, and seek for dominance compared with girls[14]. Based on observations in the field, boys tend to pay less attention to teacher, more difficult to manage and more often annoy their friends than girls.

Level of Children moral development found that the sequence (order) of children in the family does not affect the moral development of children in particular. Whether he/she is the only child, eldest, middle or youngest child does not show any dominating characteristics in child moral development[13]. Each child has a positive and negative character, which is the eldest son has high motivation, tend to talkative and super conscientious, middle child tend to be kind and friendly but unwillingly attached, and when the eldest child has more cheerful, sociable but very sensitive trait, the only child is very dependable but irritable and less forgiving[15].

Based of working parental status whether the mothers work or not, indicated that there is no positive influence on the moral development of children. It is been proven that children with both working or not working mothers do not show any significant results in forming/teaching the moral development of children into good, enough or less categories. Factors that can affect moral development is the role of the family in providing examples and a good moral understanding for the child him/herself. Role of the family is important in the development of moral values through the behavior of people in the house, the punishment given (to the children) when doing bad things, and the role of the family in giving understanding and example of good and bad deeds[16].

Moral development after the intervention mostly shows good improvement. This improvement can be proven by children's behavior, such as not cheating during the test/post test learning, pay attention to the teacher during class, not disturbing friends, dare/able to express opinions, etc. Children whom experienced increase in moral development are mostly active children during the process of *picture and picture* methods intervention. According to social learning theory, there are four phases in social learning, which are the attention phase, the reminder phase, the motoric reproductive phase (producing observed behavior), and the last phase of motivation to perform such behavior or not[17]. When the child is active in this method, the child will be stimulated to observe the image provided by the researcher, then the process of thinking about good and bad morals occurs, and then there is guidance to him/herself to produce observed behavior, so there is a motivation to behave in a good way according to their moral values[21].

Not all children have increased in morality, but also there are small number of children whose moral values remain, and whose moral value decreased. This influenced by other factors, such as differences in ways of thinking about moral decisions and how they feel about morality. The activity level of the children in accepting this method is seen from their discussion activities in arranging the images provided by the researcher into logical sequence, in addition from that activity children also had to be active in order of responding to pictures arranged by other groups into logical sequence. Children aged 10-11 years are individuals with concrete operational thinking, i.e. the child develops anability to use logical thinking to solve concrete problems[12]. A greater consistency and generosity in elementary school children will arise when

there is mutual stimulation and acceptance of arguments among peers in addition to parental encouragement and advice[12]. Children will easily understand the importance of moral values when children able to discuss about their understanding with their peers rather than just listening lectures from teachers or parents.

The characteristics of moral values after intervention, is increasing, the average of children into good category. This increasing obtained because interaction of children in obey the rules being made, process of thinking and understanding of children in taking moral values in the process of intervention when playing using this method. The benefits of playing is to play a moral value in children by learning right or wrong when interacting with their friends and understanding the rules defined in the game[18]. Game is part of the process of child growth, and important to manage it as a means of educating children effectively[19].

The most significant improvement based on the characteristics of moral values is the value of honesty and caring. Those values have consequences to the child's belief in his religion. Religious values teachs acceptable and proper thing to done and become a 'controller' for not doing something based on his/her likes or desires[16]. The most increase in the value of honesty and care is the consequences of religion such as getting a sin when lying or not care about others, so the children will tend to do good deeds that are considered good according to his/her religion.

*Picture and picture* method is one of the active learning media that can encourage cooperation among students in solving the problem[9]. This learning method has an active, innovative, creative, and fun character[20]. *Picture and picture* method is a good play method to be applied in improving moral development of children aged 10-11 years because it suits to the child's thinking level, so there is a good process to improve the moral development of children. Based on the description above shows that there was influence from *picture and picture* method towards moral development of children aged 10-11 years.

## CONCLUSION

The children moral development children aged 10-11 years prior from the intervention of *picture and picture* shows that more than half children had enough moral development and a small part from population had less moral development, and after the *picture and picture* intervention shows an increase for most children towards better moral development. The best moral value increase is the value of honesty and care, because children tend to do good behavior according to his/her religion. The *picture and picture* method can provide self-coaching to the child through 4 phases, which is the attention phase, the reminder phase, the motoric reproduction phase, and the motivation to perform phase such behavior or not.

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# Assessment Potential of Families Increasing Ability to Care for Schizophrenia Post Restrain at East Java, Indonesia

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## ABSTRACT

After the life of the schizophrenia, post-Restrain is a person who has been free from restraining, but the burden on the client family schizophrenia post-Restrain has not been said to end the role in family factors and local cultural values.

The Aim of this research is to Assessment Potential of Families increasing ability to care for schizophrenia post-restraint. This study was an observational study with cross-sectional approach. Exogenous variables are the cultural value and the potential of the family, the endogenous variable is the ability to care for schizophrenia post-restraint. The population was 157 families, the study sample using cluster sampling method, using a questionnaire study. The analysis used is descriptive analysis and structural testing of the model with Structural Equation Model AMOS.

The result of this study Potential families increased the ability to care for schizophrenia post-restraint, family and cultural values do not increase the family's ability to care for schizophrenia post-restraint directly but must go through a potential family. The influence of a strong family culture values indirectly affects the family's ability to care for schizophrenia post restraint. Cultural values and the potential for family care for schizophrenia post-restrain families increased. Cultural values can increase the potential of the family thus increasing the family's ability to care for schizophrenia post restraint.

***Keywords:** Potential Family, Caring, schizophrenia, restrain, SEM*

## INTRODUCTION

The family is the basic unit of community services and primary caretakers of family members. Families have the experience, especially in determining how the care needed by family members [1]. One role of the family has the same properties as a member of the family role that knows the situation of family members. That situation applies to the role of families who have family members with mental illness [2].

Schizophrenia is a severe mental illness affecting (0.3%-0.7%) of the population worldwide, Characterized by three domains of psychopathology, Including the negative symptoms (social withdrawal, lack of motivation and emotional reactivity), positive symptoms (hallucinations, delusions) and cognitive deficits (working memory, executive attention function). It is Considered a leading cause of disability [3,4]. Based on the results of Health Research (Riskesdas) Ministry of Health in 2013, the prevalence of the mental-emotional disorder is indicated by symptoms of depression and anxiety for ages 15 and overreached around 14 million people, or (6%) of Indonesia's population [5]. While the prevalence of severe mental disorders, such as Schizophrenia about 400,000 people, or about 1.7 per 1,000 population. While in East Java, as many as 728 people with schizophrenia post-restraint [6].

The family cares about the development of post restrain schizophrenia, but most of them choose to

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not respond to the condition of psychiatric patients [7] .Significantly indicated resources to that experiential avoidance mediated the relationship between each of the four Recognized patterns of gender role conflict [8] .

The stigma of mental illness is a multi-faceted phenomenon requiring an understanding from the perspectives of the general public, healthcare providers, persons with mental illness, and their family members [9] .This phenomenon may assume various forms, from the limitations in interpersonal relations, through narrowing Reviews These relations to only some circumstances While the role of informal family, among others, as the originator, negotiator, barriers, ruler, crooks, followers, admission seekers, family caregivers, pioneer family, bullies, coordinator of the family, and the audience [10,11,13]. The intent was to help clinicians and Researchers identify individuals Suffering from the disorder and Facilitate assessments of severity, comorbidity, and prognosis as well as treatment options. Cultural value and potential of family members in the family take to care of patients [12, 14, 15].

## MATERIAL AND METHOD

The study design was observational with cross-sectional use. Cluster sampling was used to recruit participants from six districts in East Java. studies conducted by taking a relatively short specific time and place. The participants included 157 families with a family member who has a mental illness in East Java. The inclusion criteria were the decision-makers, Age 17 years, caring for the mentally ill, the family Treaty. sampling method using cluster sampling technique. The analysis used is descriptive analysis and structural testing of the model with Structural Equation Model (SEM) AMOS.

## FINDINGS

Tabel 1 shows Participant characteristics,

**Tabel 1 The Characteristic Of Family Caregivers N (157)**

| Characteristic Of Family Caregivers N (157) | N = % |
|---|---|
| Gender | |
| Male | 45 (29) |
| Female | 112 (71) |
| Age (M) | |
| Caregivers | 27,40 years |
| Living in one house | 27,43 years |
| Marital status | |
| Divorced/never married/widowed | 67 (43) |
| Married | 90 (57) |
| Duration of illness (M) | 3,4 years |
| Employment | |
| Full time/part time | 109 (69) |
| Unemployed/retired/student | 48 (31) |
| Education | |
| Illiterate | 45 (29) |
| Primary | 84 (54) |
| Secondary | 4 (3) |
| High school diploma | 22 (14) |
| College | 2 (1) |

*Cont.,* **Tabel 1 The Characteristic Of Family Caregivers N (157)**

| | |
|---|---|
| Residence | |
| Urban | 31 (20) |
| Rural | 126 (80) |
| Relationship: caregiver is patient's | |
| Spouse | 34 (22) |
| Parent | 77 (49) |
| Child | 12 (8) |
| Sibling | 34 (22) |

**Table 2. Causality Associated**

| Causality Associated | r | T | Cronbach's alpha | Significant |
|---|---|---|---|---|
| Potential Family | | | | |
| Family Functions | .746 | | .84-.88 | Significant |
| Stress Family | .704 | | .82-.89 | Significant |
| Family Structure | .803 | | .89-.98 | Significant |
| Stigma | .863 | | .82-.85 | Significant |
| Culture Value | | | | |
| Tolerance | .767 | | .83-.87 | Significant |
| Volunteer | .748 | | .85-.88 | Significant |
| Ability care | | | | |
| Care | .655 | | .79-.87 | Significant |
| Decision | .607 | | .87-.88 | Significant |
| Identification | .600 | | .88-.92 | Significant |
| Modification | .723 | | .89-.91 | Significant |
| (X1) cultural values (Y1) → potential family | .600 | 5.36 | | Significant |
| (X1) cultural value (Y2) → The ability to care | .259 | 1.77 | | No Significant |
| (Y1) potential family (Y2)→ ability to care for | .515 | 3.12 | | significant |
| Direct Effect Line | Immediately Effect Value | | | |
| (X1) *cultural values* (Y2) → Ability to care | (X1) *Cultural values* → (Y1) Potential Family → (Y2) ability to Care = .59 x .50 = .30 | | | |

Note. r = Correlation; T = T value

The results showed the cultural values affect the role of the family, the role of the family affects the ability to care for and the potential effect on the ability of families to take care of the results of the analysis with the software for. The Structural Equation Model (SEM) AMOS can be seen in (Table 2). Based on the results in Table 2 note that the exogenous variables affect significantly to endogenous variables, except cultural variables with variable ability to treat significant. indicators of potential family, coping strategies and indicators of treatment the ability to utilize health services are not good enough to build an endogenous variable. Table 2 illustrates that cultural values affect the ability to maintain direct stronger than cultural values affect the ability to take

care of automatically mean that the cultural value through the potential for more family greatly affect the ability of the family in care of. cultural values affect the ability to maintain direct stronger than cultural values affect the ability to take care of automatically mean that the cultural value through the potential for more family greatly affect the family's ability to care for

## DISCUSSION

Cultural values Reviews These are of immediate relevance for the regulation of the behavior of individuals in their direct community environment. The research proves that the empowerment of families has a significant impact on family coping to help people, especially schizophrenia, post-restraint. Family empowerment can be used to solve the psychological problems of the family. the socio-cultural family is an open system as a means to meet the needs of caring for [18,19].

Indicator stigma can also be explained by cultural values. Reviews. Families who have family members with schizophrenia post restrain embarrassed by the bizarre condition. It is also consistent with research, post restrain schizophrenia are often treated inappropriately by the family and society. Stereotype endorsement, discrimination experiences and social withdrawal differentially Also related to symptoms and social functioning [20, 21, 22].

Cultural values encourage the formation of family potential as a form of internal factors are derived from the family itself. Family caregivers of care recipients with chronic illnesses. Understanding what African American women who are family caregivers value are important, and giving them an opportunity to judge Reviews their Quality of Life may be empowering [25, 33]. Families affected by the potential of cultural values. So the potential for a family becomes a major factor in improving the ability to treat schizophrenia, post-restraint. So the ability to treat schizophrenia post must restrain indirectly through potential families affected by cultural values [26, 27].

Based on the research found that the indicators show a problem, decision-making, maintenance, modification, and utilize health services are very good in forming the ability to care for the client. on the results of this study also found that the ability to treat schizophrenia post restrain in recognizing the problem stems almost all clients have good skills. While the decision found that almost all of the clients have good skills [28]. While the indicators of environmental modification find most clients have skill was good, but less health care utilization indicators. it is in line with the results:

*The results showed that the participation of the family has a good impact on patient care. The impact of, among other things, improve the independence of patients, optimization role in society, and enhance problem-solving skills* [30].

Based on the explanation of the above results it can be concluded that there is a cultural influence on the potential value of the family and there is the potential ability to treat schizophrenia families post-restrain.

## CONCLUSIONS

In Summary, Cultural Values that can either create a potential family for the better. Cultural values necessary to increase the potential of the family. Tolerance among family members and volunteers have a significant influence in shaping the stigma in the family, family structure, family functioning, family coping strategies. Potential directly affect the family's ability to care for psychiatric patients post-holding. So that the potential of the family becomes a major factor in improving the ability to care for psychiatric patients post-hold in knowing the problems, decision-making, treating clients sick, modifications to the environment but to the utilization of health service indicator is not significant in shaping the ability to improve care for schizophrenia post restraint, Cultural values of good family could not be sure will make the ability to care for patients post withstand life for the better. Family culture values will affect the ability to care for psychiatric patients post-hold in East Java if through a potential family. Cultural values that can increase the potential of the family thus increasing the post-treatment restrain psychiatric patients.

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# Factors Associated to Infant Vaccination in Madurese, Indonesia

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## ABSTRACT

In Madura, a lot of infants have incomplete immunization status in which one of the areas with low immunization coverage is Burneh sub-district. The coverage of complete basic immunization in Burneh only 64% in 2015. The aim of this study was to analyze factors related to vaccination in Madurese, using cross sectional design. The sample were 97 mothers with babies 0-1 years old in Burneh sub-district. Data were collected using questionnaires, then analyzed using Chi square test. The results showed the correlation between knowledge (p = 0.027), confidence (p = 0.000), attitude (p = 0.003), culture (p = 0.000), access to health care (p = 0.013), family support (p = 0.034), and support of health professionals (p = 0.021) with the basic immunization status. Meanwhile, the support of community leaders (p = 0.054) had no correlation with the basic immunization status.

*Keywords: Culture, Family support, Immunization, Knowledge, Madurese, Confidence, Attitude, Access to health care*

## INTRODUCTION

Immunization is an induction of immunity in infants and children to protect them from various diseases so that they grow up healthy[1]. In Madura, many infants did not receive complete basic immunization which was proved by the high cases of diphtheria in Bangkalan, Madura. According to the Regent of Bangkalan, there are three villages in sub-districts of Blega, Tanah Merah and Burneh defined as areas with extraordinary occurrence of diphtheria[2]. Head of Public Health Office of Bangkalan explained that according to data compiled by Madura Terkini, the infant mortality rate has risen in 2015 as many as 154 cases. This number is greater than in 2014 with 112 cases[2].

According to preliminary study conducted by researchers on March 2016 at the Public Health Office of Bangkalan, the total infant in the Public Health Center (PHC) of Burneh region was 980, while the number of infants who have received complete basic immunization only 627. So there is only 64% infants in Burneh who were completely immunized.

Basic immunization rate in Burneh district from 2012 to 2015 has been uncertainly up and down. In 2012, the coverage of basic immunization was 60.8%. This rate declined into 58.4% in 2013. However, in 2014, the coverage increased to 68.2% which then recurrently declined to 64% in 2015.

Madura is well-known as a society which strictly upholds the cultural norms. Madurese people still believe in the statement or doctrine of the ancestors from antiquity. The people also believe in assumption that the healthy children without any disease should not be brought to health care service to get injection or other treatments. Local health professionals has been actually conducting basic counseling about immunization to mothers who have babies in Burneh district, but somehow the the immunization coverage is still below the target of 100%. Many factors affect the low coverage of immunization in infants. Based on the theory of Green (1991), the behavior of an individual as well as society is affected by three factors: predisposing factor, enabling factor, and reinforcing factor[3].

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Based on the problems above, the authors was interested to analyze factors related to basic immunization status of infants in Madurese people.

## MATERIALS AND METHOD

The population of this cross sectional were mothers with infants aged 0-1 year old in Burneh. Sample size were 97 people selected using cluster sampling. The study was conducted on July 2016. The independent variables were knowledge, beliefs, attitudes, values and norms (culture), access to health services, family support, health professionals support, and community leaders support, while dependent variable was basic immunization status. Data collected using questionnaire, then the categorical data were presented in the form of frequency table[4] and analyzed using Chi square test.

## FINDINGS

Table 1 provides a summary of the results of the correlation analysis between knowledge, beliefs, attitudes, values and norms (culture), access to health services, family support, health professionals support, and community leaders support with basic immunization status.

**Table 1. The 8 independent variables and basic immunization status as dependent variable**

| Independent variables | p-value | Interpretation |
|---|---|---|
| Knowledge | 0.027 | Significant |
| Belief | 0.000 | Significant |
| Attitude | 0.003 | Significant |
| Culture | 0.000 | Significant |
| Access to health service | 0.013 | Significant |
| Family support | 0.034 | Significant |
| Health professionals support | 0.021 | Significant |
| Community leaders support | 0.054 | Not significant |

Based on the results of hypothesis testing (Table 1) it could be interpreted that there were 7 independent variables that correlate with basic immunization status namely knowledge, beliefs, attitudes, culture, access to health services, family support and health professionals support.

## DISCUSSION

According to Green (1991) the behavior of an individual or society about health is determined by the level of knowledge in which the person have. Higher knowledge of mother about the health of the infant, especially for the provision of basic immunization, will influence the mother to visit the place of immunization service[3].

Other studies have explained that knowledge of mothers about immunization is also influenced by the level of education and occupation. Rizani et al (2009) stated that education is a very important factor in determining the behavior of mother because a mother with higher education will affect the knowledge of his family's health in which a lot of information is acquired in school. On the contrary, the mothers who did not working will have more time to gather with their children[5]. Mother's knowledge on the children's health is mostly still at level knowing and has not reached the level of understanding, applying, analyzing, synthesizing and evaluating the materials related to immunization[6]. Furthermore, a person who has fair economic and earnings will likely have a good education and knowledge. However, the study that has been done showed that there are nine women who have a good knowledge about immunization but is not practicing immunization for their infants. According to some respondents, they will understand the benefits of immunization as well, but because of busy work and the obligation of taking care the other children they did not carry their infants to the immunization services.

According to WHO the belief is often obtained from parents or grandparents. A person receives his/her belief based on trust and without evidence[7].

Education level of individual related to the level of understanding and perceptions about health and illness[7]. Someone who is highly educated will better understand and believe when their body is not going well and looking for a modern health service immediately to prevent the occurrence of disease, for example, by immunization. In addition, the number of children also will indirectly affect the mother's belief to immunization. Further, good experience and perceived benefits of immunization from previous child will certainly influence to mother's belief to basic immunization in which this belief will support the mothers to immunize their infants.

However, number of children and mothers' job in domestic work make mothers do not have enough time to bring their babies to the immunization service although the views and belief upon support good benefit from basic immunization in infants support the mother to do it. From this study, there were 25 mothers who have unsupportive belief to the immunization but still provide basic immunizations to their infant. According to Ali (2000) in Rini (2009), observation or information obtained from education, may make changes upon behavior which evolve the occurance of new behavior. All activities performed by mothers in implementing basic immunization to their infant are the results of knowledge and information from their education[8].

Attitude is a form of evaluation or feeling reactions. Attitudes towards an object can be in the form of supportive and unsupportive feeling about an object. Positive attitude can be predisposing factor which causes the mother to bring her infant to be immunized[3].

Based on research by Rizani et al (2009) which stated that people's attitude and behavior is the ability, experience and education[5]. Age and education level illustrate the maturity of an individual to behave and respond to the environment that can affect knowledge, attitude and practice especially in health behavior. Mother's experience with the perceived benefits from previous children also have positive influence to their attitude and will promote mother's behavior to bring their children to health care service in order to receive basic immunization. Furthermore, Rizani et al (2009) stated that mothers' occupation, either who work or does not work, also has relationship with their attitude towards immunization[5]. Working mothers are likely to be more informed of the disease and the benefits of immunization so they will be likely more motivated to immunize their infants.

However, this study showed that there were some women who had negative attitudes about immunization but has been completed immunization for their infants. According Notoatmodjo (2007), an attitude is not automatically realized in an action (over behavior) because to change attitude into habit needs supporting factor or a condition that make it possible, such as facilities and support of other parties[7].

Culture can be regarded as living habits in a community. Interview results by researchers showed that some societies have supportive culture upon immunization, but in practical, they did not bring their infants to the immunization services. It can be caused by the schedule in which they have to work from morning to afternoon and can not bring their infants to PHC. In some cases, the parents tended to spend their money for other daily needs rather than accomodation for immunization.

According to Lawrence Green, the reason for not carrying their children to be immunized is the lack of information about the benefits of immunization or the distance between home and immunization center which is too far[3].

This results correspond with the research of Widiastuti et al (2008) which stated that there was a significant relationship between access to health care services and the basic immunization in infants. The relationship between both variables is also influenced by occupation, income, and number of children[9]. Risnawati (2012) stated that access to health care services for getting immunization is not depend on the family income, because the immunization coverage has been covered by the government both for its budget and the accessible service by the immunization service center[10].

This study found several mothers who have access to health care service with incomplete immunization status in their infants. This phenomenon is exist because these mothers have less education and information about immunization.

According to Feiring and Lewis (1984) in Yasin

(2014), good family support is influenced by several demographic factors including: maturity in relation with mothers' age, mothers' education level and occupation[1]. The knowledge about basic immunization benefits will increase along with the maturity in which the mothers can explain to the family about those benefits so that their support for immunization will be better. The mothers who have higher education are more aware about the importance of completing basic immunization, so that they will obtain support to carry their infants to the health care service. However, the results of this study showed that there were nine mothers who receive good support from their families but the status of basic immunization were incomplete. It was caused by the mother's myriad work and responsibility to care other family members as well as children so that they can not bring their infants to health care service regardless the support.

Based on the theory of Green, the health behavior can also be determined by the availability of facilities, attitudes and behavior of health professionals which will support and strengthen the behavior development[3].

According to the most respondents, support, friendliness, and information obtained from local health professionals are very valuable and have positive impact for them. In several times, health professional along with health caders visited homes for medical examination, particularly the administration of basic immunization in infants and children. So that the mothers who work or who are busy taking care of her family will be stay informed about basic immunizations and can immunize her infant during visitation of the health professional. Although the support of health professional has been sufficient in PHC of Burneh, but there were several mothers who still refused to immunize their infant due to their low education about immunization as well as their business and occupation which makes the mothers did not have any time to provide immunization for their infants.

According Notoatmodjo (2010), Indonesian people is a paternalistic society which usually refers to the behavior of leaders, both formal and informal. The leader is a person who has influence, be honored, and well respected in the society such as public figure and religious leader in which their existence will influence the society[6]. Mostly people actully understand about the benefits of immunization, then the facility is also provided such as PHC and health care service for immunization, but they still hesitate to give immunization to their children because the leaders or public figure also does not join the immunization program for their children.

Based on Green (1991), community and religious leaders become reinforcing factor for the behavior development of an individual or a community. Therefore, the community and religious leaders have crucial role in providing support to people's view and healthy behavior for the surrounding community[3].

## CONCLUSION

Based on the results, it can be concluded that knowledge, beliefs, attitudes, culture, access to health services, family support and health professional support were related factors with basic immunization status in infants.

ADDITIONAL INFORMATION

There is no **Conflict of Interest** related to this research.

All **Funds** of this research taken from researchers.

This study already has **Ethical Approval.**

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**Lampiran 3;**

Presentasi sebagai Pembicara pada Kegiatan International Weeks for Teaching Assigment (incoming) Academic Year 2017 – 2018 di Lucian Blaga University of Sibiu Romania, tanggal 14 – 22 Juni 2018

## ACTIFITY REPORT
## International Week of Lucian Blaga University of Sibiu Romania - 2018

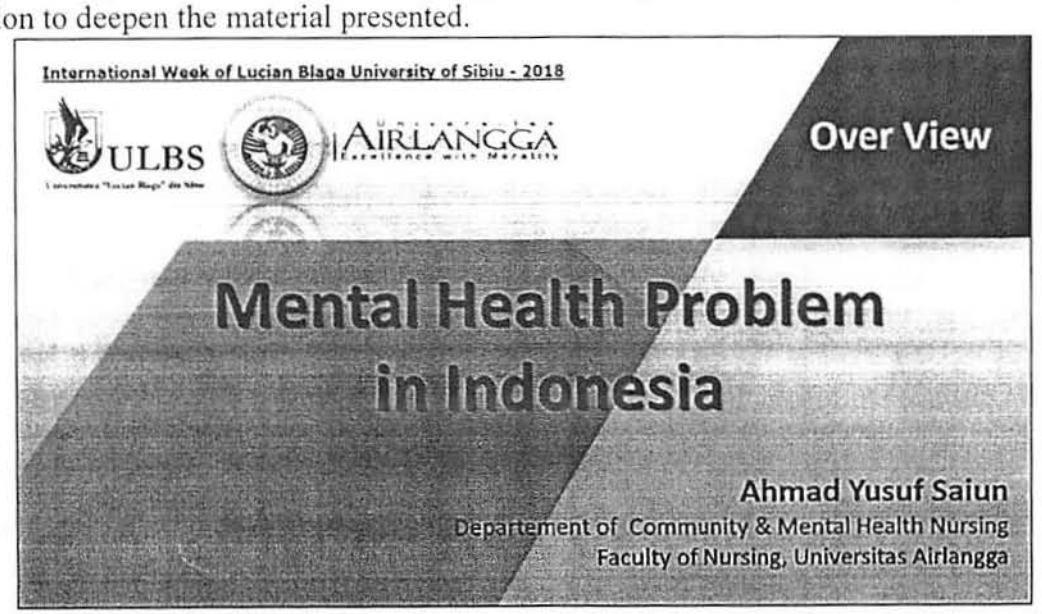
### Background

Knowledge is global, research to acquire knowledge must be carried out by transcending national boundaries. International Week activities are held to achieve the above desires, conducted for Lecturers and Students, also by the managers of international activities (international office partnership) from each campus. It is also intended to organize the International Summer School at Lucian Blaga University of Sibiu (LBUS), so that the internalization process is fun and interesting for lecturers, students, Romanians and internationally generally.

It is undeniable that globalization has turned the world into a "global village", LBUS has been trying to increase its efforts to adjust its educational demands to new international demands. LBUS is part of the Erasmus + program and has so far developed more than 350 partnerships with universities from Europe and Asia. Every year there are around 150 international students coming to LBUS and about 200 going to partner universities, for study or exchange mobility.

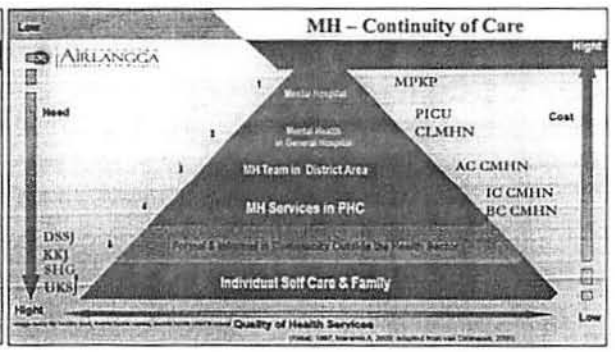
### Activity Implementation

Activities undertaken include holding guest lectures, workshops, internationalization of university management, visiting Romanian cultural heritage center, music performances and traditional dance. My lecture is about "Over View Mental Health Problem in Indonesia". Carried out on Tuesday, May 15, 2018, at 08.00 to 10.00. The lectures were held at the Faculty of Kedoteran Lucian Blaga University of Sibiu, especially to the Nursing Program students, accompanied by Lecturers from Lucian Blaga University. Lectures run smoothly with some discussion to deepen the material presented.



The soul is a human element that is non-material (there are components but not visible form), though the soul can be learned from the manifestation of the soul that is on awareness, tone of feeling, affection, emotion, thought process and psychomotor. Mental disorders are a set of symptoms of mental disorders, feelings and behavioral disorders that cause suffering and disruption of daily functions independently. Mental disorder is the existence of hendaya (limitations) in establishing relationships and limitation in relationships with himself, others and the environment.

The process of the occurrence of mental disorders can be viewed from the model; psychoanalysis, interpersonal, social, existential, supportive, communication, behavioral, medical models and adaptation models. The science of mental nursing, more often view mental disorders as a model of adaptation. Behavioral deviations occur because of the failure of adaptation to stress experienced. Basic health research data in 2013 shows there are 2 kinds of mental disorders, namely mental disorders and emotional mental disorders.


Nursing interventions can be done by helping the patient assess the stressor accurately, strengthening the source of coping in the form of training good personal habits, build positive beliefs and provide social support. The point is to give every human opportunity to achieve optimal work performance, every school children can achieve optimum learning achievement without any barriers from various parties. The mental health effort must be started before marriage, pregnancy and childbirth readiness, facilitating the first 1000 days of life until the elderly. Nursing orders are sustained from mental hospitals to families, groups and communities.

Some other lectures given by all international week participants among others;

| NAME | INSTITUTION | TOPIC |
|---|---|---|
| Beanbonyka Rim | Royal University of Phnom Penh, Cambodia | Interaction Design, Computer Vision |
| Daniel Vogel | State University of Applied Sciences in Raciborz, Poland | Joseph Conrad as an International Modernist Writer |
| Prof. Dr. Schroeter-Wittke, Harald | Universtity of Paderborn, Germany | Music as Reformation. Reformation as Music |
| Wang Yuqin | Beijing Language and Culture University, China | A Brief Introduction to Chinese Language |
| Ahmad Yusuf Saiun | Universitas Airlangga Surabaya, Indonesia | Over View Mental Health Problem in Indonesia |
| Drd. Breckner, Anne | University of Paderborn, Germany | Bible Transformations: Parodies of the Lord's Prayer |

| | | |
|---|---|---|
| Esra Kahya Ozyirmidokuz | Erciyes University,Turkey | Introduction to Management Information System |
| Nevena Dobreva | Varna Univeristy of Economics, Bulgaria | Cultural Entrepreneurship as a Sustainable Practice on International Level |
| Shaik Azahar Shaik Hussain | Universiti Malaysia Sarawak, Malaysia | Understanding Motivation among Museum Visitors in Sarawak |
| David Edward Jimenez | Ateneo de Manila University, Philippines | Quality Management for Services |
| Miletić Ivan | Kragujevac University, Serbia | Influence of the interface on cracks propagation along it and on behavior of cracks approaching interface |
| Andreea Stancu | DAAD Lectuer of LBUS | A Brief of German Culture and Civilization |
| Thibaut Desmons | French Lecturer of LBUS | 50 Year Later: What is the Cultural Heritage of May '68 in the France of Today |
| Thap Tharoeun | Royal University of Phnom Penh, Cambodia | Introduction to RF Environment Analisys in Cambodia |
| Li Xiuyuan | Confucius Institue of LBUS | Chinese History |
| Wang Jiong & Niu Tingting | Confucius Institue of LBUS | Analisys of the Influence of Chu Wu Culture on the Creation of Qu Yuan's Poetry from the Myths and Legends of Qu Yuan's Poems |
| Wang Jiong & Niu Tingting | Confucius Institue of LBUS | Introduction to Chinese Calligraphy |
| Peter Langer | Pädagogische Hochschule Tirol Pastorstraße, Austria | Austria and the PHT |
| Blagojević Mirko | Kragujevac University, Serbia | Calculation Methode in Product Development Using PLM Software |
| Joselito Olpoc | Ateneo de Manila University, Philippines | An Experiential Activity on Siloism |
| Alice Ann Madamba Parlan | Ateneo de Manila University, Philippines | Financial Triangle of Needes: An Overview of Personal Life Stages and Financial Strategies You Can Deploy |
| Fatma el Diwany | MISR University for Science and Technology, Egypt | Different Eyes and a smile Statute; Comparative Literature and Mythology |
| Esra Kahya Ozyirmidokuz | Erciyes University,Turkey | Enterprise Application Systems |
| Massoud Ghada | MISR for Science and Technology, Egypt | Tax System Structure in Egypt |
| Shaik Azahar Shaik Hussain, | Universiti Malaysia Sarawak | Developing Handcraft Entrepreneurship in Sarawak |
| Dimitra Papadimitriou, | University of Patras, Greece | Symbolic Consumption in Sport: The Case of Sport Licensing Products |

| | | |
|---|---|---|
| David Edward Jimenez | Ateneo de Manila University, Philippines | Cultural Social Enterprise - Fernandino Student Tourguides (FeST) |
| RUDYANTO, Marcellino | Universitas Airlangga, Indonesia (akan dilaksanakan menyusul karena kendala Visa) | The Role of Organic Synthesis in Pharmaceutical Field and Total Synthesis of Some Biologically Active Natural Products |
| MURSI Muhammad | MISR for Science and Technology, Egypt | Egyptian Foreign Policy and International Relations Studies an a New Era |
| Duran Gokce | Cankiri Karatekin University, Turkey | How to Integrate Literature into Language Classes |
| Matthew Chernick, | Fulbright Lecturer at Lucian Blaga University of Sibiu | British / American Literature and Film |
| EL SHAL Omaima | MISR for Science and Technology, Egypt | Egyptian Symbolism in Coptic Religious Life |
| Gewefel Hanan | MISR University for Science and Technology, Egypt | Communication & Human Relations |
| Cristina Montiel | Ateneo de Manila University, Philippines | Detecting Collective Psychology, Social Media and Social Computing |
| Joewono, Hermanto Tri | Universitas Airlangga, Indonesia | Repositioning Pregnance As Period to Prepare the Next Better Human Species Oprocot Model To Reduce Maternal Mortality In One Year |
| Gewefel Hanan | MISR University for Science and Technology, Egypt | Resonant Leadership |
| Dimitra Papadimitriou | University of Patras, Greece | Understanding the Value of the Olympic Sponsorship Programs |
| Karl-Heinz Aschenbrenner | University of Education Ludwigsburg / Pädagogische Hochschule Ludwigsburg, Germany | The Relation between Parents and Professors in Kindergarten and Primary School |
| Joselito Olpoc | Ateneo de Manila University, Philippines | An Experiential Activity on the difference between BPR, Continous Improvement and Benchmarking |
| Alice Ann Madamba Parlan | Ateneo de Manila University, Philippines | A Highway of Service Learning Programs: A Philippine Univeristy's Experience |
| Fernando Carapau | University of Evora, Portugal | Three-dimensional velocity field for blood flow using the power-law viscosity function and Numerical simulations of a third-grade fluid flow on a tube through a contraction |

| | | |
|---|---|---|
| Alime Yilmaz | Çankırı Karatekin University, Turkey | Changing the classroom atmosphere (ELT) |
| Kechagias Ioannis | TEI of Thessaly, Greece | Full factorial versus fractional factorial design; a case study |
| EL SHAL Omaima | MISR University for Science and Technology, Egypt | The Evolution of the Tomb in Ancient Egypt |
| Sibel Sert | Çankırı Karatekin University, Turkey | New Challenges in ELT in the Century of Knowledge |
| Sokha Heng | Royal University of Phnom Penh | Shading and lighting in Computer Graphics |
| OPRISIU-FOURNIER Roxana | UPJV (Université de Picardie Jules Verne), France | The role of clinical care nurses in the evaluation and follow up of eldery patients diagnosted with cancer during the oncogenetics consultations of CHU Amiens |
| POULAIN Marie-Agnès | UPJV (Université de Picardie Jules Verne), France | The wise women in France: their mission and competences to detect the coluterin cancer |
| Daniel Vogel | State University of Applied Sciences in Raciborz, Poland | Joseph Conrad and his Meetings with the Other |

In addition to the above lectures also held three workshops 1) "Workshop on Tips and Tricks in Salary Negotiations", and 3) Workshop "Introduction in Global Christinity ".

International Week activities are also on the side with a variety of cultural activities, city tours and visits to various historical places including museums, Thank you.

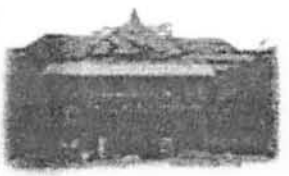
Reported by,

Ahmad Yusuf Saiun

e-mail; ah-yusuf@fkp.unair.ac.id

Lampiran 4

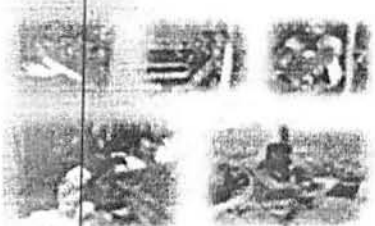
Presentasi poster pada PKB (Pendidikan Kedokteran Berkelanjutan) Psikiatri RSUD Dr. Soetomo Surabaya, tanggal 3 – 4 Februari 2018

Ah Yusuf, Fakultas Keperawatan Universitas Airlangga, email: ahyusuf@fkp.unair.ac.id

# Koping Keluarga dalam Merawat Orang Dengan Gangguan Jiwa (ODGJ) Pasca Pasung

Asuhan Keperawatan terhadap orang dengan gangguan jiwa (ODGJ) pasca pasung menjadi masalah baru dalam upaya mendeteksi bebas pasung tahun 2019. Saat ini upaya bebas pasung telah dilaksanakan dengan baik, terintegrasi inter-profesional, lintas sektor dan lintas program. Masalah baru muncul setelah masa pengobatan selesai, pasien harus kembali kepada keluarga dan masyarakat. Keluarga menolak untuk menyembuhkan pasien kembali ke rumah, akibatnya pasien ditelantarkan, kembali dipasung atau menjadi gelandangan psikotik. Penelitian ini bertujuan untuk memperoleh gambaran koping keluarga dalam merawat ODGJ pasca pasung.



Penelitian ini menggunakan desain kualitatif fenomenologi, jumlah partisipan sebanyak 7 orang dipih dengan purposive sampling. Pengumpulan data dilakukan dengan wawancara mendalam, data dianalisis secara tematik.

Hasil penelitian menunjukkan koping keluarga dalam merawat pasien gangguan jiwa pasca pasung terdiri dari 4 tema utama, 7 tema, 23 sub-tema dan 32 kategori. Tujuh tema koping keluarga meliputi: konstruktif, destruktif, tahapan proses strategi koping, dukungan intra-keluarga, public support, makna positif dan makna negatif.

Kategori koping keluarga antara lain meliputi: membawa ke dokter, mengkonsumsi obat, rawat jalan, atau dibawa ke perawat; membawa ke RSJ; rutin memberi obat; berusaha mendekatkan obat atau mengantar di Puskesmas; melibatkan pasien dalam aktivitas sosial; tetap perpersepsi positif.

Gambaran koping merupakan deskripsi kedalaman koping berupa tahapan proses strategi, dukungan koping dan makna yang keluarga rasakan selama merawat ODGJ pasca pasung. Gambaran koping memperlihatkan bagaimana keluarga memilih mekanisme koping keluarga menghadapi krisis dan stress. Koping keluarga dalam merawat ODGJ pasca pasung terbentuk melalui tahapan proses strategi. Proses tersebut dimulai saat adanya anggota keluarga yang mengalami gangguan jiwa hingga pasca pasung dan pasca pengobatan ODGJ.

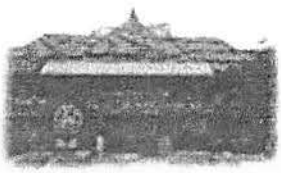
Keluarga membutuhkan intervensi pengurasan koping untuk dapat meningkatkan perawatan optimal pada ODGJ pasca pasung.

[1] Smith, J. A., Flowers, P. & Larkin, M. 2009. Interpretative Phenomenological Analysis: Theory, Method & Research. Wiangsa Saga.
[2] Yusuf, A., Fitryasari, PK., Nihayati, HE. 2015. Buku Ajar Keperawatan Kesehatan Jiwa. Jakarta Salemba Medika.

PKB Psikiatri RSUD Dr. Soetomo – FK Unair
[illegible] 3 – 4 Februari 2018

Lampiran 5

Presentasi poster pada kegiatan World of Addiction Institut of Mental Health, Addiction and Neouroscience di Jakarta Draft Buku: Terapi Modalitas dalam Keperawatan Kesehatan Jiwa, Jakarta, tanggal 16 – 17 Maret 2018

Ah. Yusuf, [illegible] Email: ahyusuf@fkp.unair.ac.id

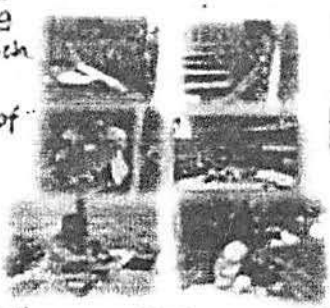
# The Factors Related to Family Heath Seeking Behavior on Clients Mental Disorders based on Plan Behavior Theory

## Introduction

Mental disorders is a brain damage which characterized by disturbance of emotions, thought processes, behaviors, and perceptions that cause suffering for patients and their families. The right treatment is needed to prevent the worse condition of mental disorders. Health seeking behavior can be predicted by using Theory of Planned Behavior approach. The purpose of this study was to analyze factors related to behavior of family in seeking treatment on

## Method & Materials

The research used descriptive correlation design with cross sectional approach. The population were all family of clients with mental disorders who were treated in Wijaya Kusuma Room. The sampling used consecutive sampling in order to obtain 19 respondents. The independent variables were attitude, subjective norms, perceived behavioral control, and intention. The dependent variable in this study was health seeking behavior. The data were collected using questionnaires and analyzed using Spearman's rho test with significance level $\alpha = 0.05$.



## Result

The correlation between factors related to family health seeking behaviour based on plan behaviour theories sowed in figure

The statistic result between attitude with intention ($p=0,003$ and $r=0,719$), subjective norms with intention ($p=0,80$ and $r=0,062$), perceived behavioral control with intention ($p=0,015$ and $r=0,549$), perceived behavioral control with health seeking behavior ($p=0,034$ and $r=0,429$), intention with health seeking behavior ($p=0,015$ and $r=0,549$).

## Conclussion

Attitude and perceived behavioral control related with the intention of seeking treatment. Subjective norm was not related to the intention of seeking treatment. Perceived behavioral control and intention related with the health seeking behavior.

**World of Addiction 2018**

Drug Addiction Management
Enhancing Competencies of Health Professionals

Jakarta 16-17 March 2018

Stop Stigma, Discrimination and Violant of Human Right for **Mental Illness**

**Lampiran 6;**

Draft Buku; Kesehatan Jiwa; Pendekatan Holistik dalam Asuhan Keperawatan

# KESEHATAN JIWA

## Pendekatan Holistik dalam Asuhan Keperawatan

**Ah. Yusuf**
**Rizki Fitryasari PK.**
**Hanik Endang Nihayati**
**Rr. Dian Tristiana**

# TENTANG PENULIS

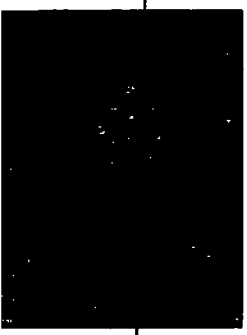
**AH. YUSUF**, lahir di Mojokerto pada tanggal 1 Januari 1967, menyelesaikan pendidikan Madrasah Ibtidaiyah Miftakhul Huda Dlanggu Mojokerto tahun 1981, Madrasah Tsanawiyah Al-Hidayah Dlanggu Mojokerto tahun 1984, SMA Al-Hidayah Dlanggu Mojokerto tahun 1987, Akademi Keperawatan Rumah Sakit Islam Surabaya tahun 1990, Program Studi S1 Keperawatan Fakultas Kedokteran Universitas Padjadjaran Bandung tahun 1998, Magister Kesehatan Jiwa Masyarakat Universitas Airlangga Surabaya tahun 2003, dan Program Pendidikan S3 Ilmu Kedokteran Universitas Airlangga Surabaya tahun 2012.

Saat ini menjabat sebagai Wakil Dekan 3 Fakultas Keperawatan Universitas Airlangga Surabaya, Bidang Penelitian, Pengabdian Masyarakat, Publikasi dan Kerjasama. Selain itu masih tetap aktif sebagai dosen di Fakultas Keperawatan Universitas Airlangga Surabaya pada Program Studi Sarjana Keperawatan, Program Pendidikan Ners, Magister Keperawatan, Magister Kesehatan Masyarakat, Program Pascasarjana S3, juga mengajar di beberapa fakultas keperawatan dan kesehatan, Sekolah Tinggi Ilmu Kesehatan di Jawa Timur.

Penulis aktif pada berbagai organisasi keperawatan, yakni Pengurus Wilayah Persatuan Perawat Nasional Indonesia (PPNI) Provinsi Jawa Timur, Dewan Pakar Ikatan Perawat Kesehatan Jiwa (IPKJI) Jawa Timur, anggota Majelis Tenaga Kesehatan Provinsi (MTKP) Jawa Timur, Anggota Satgas AFTA Provinsi Jawa Timur, Tim Riviewer LPDP, Anggota International Society of Psychiatric-Mental Health Nurses (ISPN) order number 4050236, Anggota International Association for Promotion of Healthcare and Life-Science Research (IAPHLSR), Global Research and Development Servives (GRDS), ID anggota IAPHLSR-M17159.

**RIZKI FITRYASARI PK,** lahir di Yogyakarta pada tanggal 22 Februari 1980, menyelesaikan pendidikan SDN 3 Cepu tahun 1992, SMPN 2 Cepu tahun 1995, SMAN 3 Semarang tahun 1998, Program Ners Fakultas Ilmu Keperawatan Universitas Indonesia tahun 2003, Program Magister kekhususan Keperawatan Jiwa Fakultas Ilmu Keperawatan Universitas Indonesia tahun 2009, Program Doktor Ilmu Kesehatan Fakultas Kesehatan Masyarakat Universitas Airlangga Surabaya tahun 2018.

Saat ini, penulis aktif sebagai dosen tetap di Fakultas Keperawatan Universitas Airlangga Surabaya pada Program Pendidikan Ners, Magister Keperawatan, serta aktif pada organisasi Ikatan Perawat Kesehatan Jiwa (IPKJI) Jawa Timur.



**HANIK ENDANG NIHAYATI**, lahir di Blitar pada tanggal 16 Juni 1976, menyelesaikan pendidikan SDN Kalipang 2 tahun 1990, SMPN Sutojayan 1 Blitar tahun 1993, SMAN 1 Talun Blitar tahun 1996, Akademi Keperawatan Darul Ulum Jombang tahun 1999, Program Studi S1 Keperawatan Fakultas Kedokteran Universitas Airlangga Surabaya tahun 2004, Magister Keperawatan Universitas Airlangga Surabaya tahun 2010, S3 Ilmu Kedokteran Universitas Airlangga Surabaya tahun 2015.
Saat ini, penulis aktif sebagai dosen tetap di Fakultas Keperawatan Universitas Airlangga Surabaya pada Program Studi Sarjana Keperawatan, Program Pendidikan Ners, Magister Keperawatan, serta aktif pada organisasi Pengurus Wilayah Persatuan Perawat Nasional Indonesi (PPNI) Jawa Timur dan Ikatan Perawat Kesehatan Jiwa (IPKJI) Jawa Timur.

**RR. DIAN TRISTIANA**, lahir di Magetan pada tanggal 02 Mei 1987, menyelesaikan pendidikan SDN Gondang, Magetan pada tahun 1999, SMPN 1 Barat Magetan tahun 2002, SMAN 1 Maospati, Magetan tahun 2005, Program Studi Pendidikan Ners Fakultas Keperawatan Universitas Airlangga tahun 2010, Program Magister Keperawatan Universitas Airlangga tahun 2014.
Saat ini penulis aktif sebagai dosen tetap di fakultas Keperawatan Universitas Airlangga Surabaya pada Program Pendidikan Ners, aktif di tim Penjaminan Mutu Program Studi Magister Keperawatan Fakultas Keperawatan Universitas Airlangga. Penulis juga aktif pada organisasi profesi Persatuan Perawat Nasional Indonesia (PPNI) dan Ikatan Perawat Kesehatan Jiwa (IPKJI) Jawa Timur.

# KATA PENGANTAR

Puji syukur kami panjatkan kehadirat Allah SWT, Tuhan Yang Maha Esa, atas berkat rahmad taufiq dan hidayahnya penulis mampu menyelesaikan buku "Kesehatan Jiwa; Pendekatan Holistik dalam Asuhan Keperawatan" ini dengan baik. Buku ini diselesaikan untuk memperkaya rujukan masyarakat dalam menjaga dan meningkatkan kesehatan jiwa. Ternyata masalah kesehatan jiwa bukan hanya masalah pasien, tenaga kesehatan di rumah sakit jiwa tetapi keluarga, kelompok, masyarakat bahkan masing-masing individu. Gangguan jiwa tidak hanya berbentuk gangguan jiwa berat (kelompok psikosis) tetapi juga masalah psiko-sosial, dan ternyata kontribusinya terhadap penyakit fisik sangat tinggi. Kesehatan jiwa sangat diperlukan bagi hajat hidup orang banyak khususnya untuk keberlangsungan hidup bermasyarakat. Jiwa adalah unsur manusia yang bersifat non materi, tetapi fungsi dan manifestasinya sangat terkait pada materi. Oleh karena itu, kita dapat mempelajari dan mengembangkan kesehatan jiwa melalui fungsinya dan membuktikan kesehatan jiwa melalui manifestasinya dalam kehidupan sehari-hari.

Kesehatan jiwa adalah kondisi dimana seorang individu dapat berkembang secara fisik, mental, spiritual, dan sosial sehingga individu tersebut menyadari kemampuan sendiri, dapat mengatasi tekanan, dapat bekerja secara produktif, dan mampu memberikan kontribusi untuk komunitasnya. Kenyataanya, hasil riset kesehatan dasar Kementerian Keschatan RI tahun 2013 menunjukkan 0,17 % penduduk Indonesia mengalami gangguan jiwa berat, 14,3 % nya pernah dipasung. Selain itu 6 % penduduk Indonesia mengalami gangguan mental emosional yang mengakibatkan kualitas hidup terganggu, kualitas kerja terganggu dan produktiftas terganggu. Oleh karena itu diperlukan upaya peningkatan kesehatan jiwa secara komprehensif oleh semua tenaga kesehatan dengan seluruh stake holder.

Upaya Kesehatan Jiwa adalah setiap kegiatan untuk mewujudkan derajat kesehatan jiwa yang optimal bagi setiap individu, keluarga, dan masyarakat dengan pendekatan promotif, preventif, kuratif, dan rehabilitatif yang diselenggarakan secara menyeluruh, terpadu, dan berkesinambungan oleh Pemerintah, Pemerintah Daerah, dan/ atau Masyarakat. Kenyataannya angka terjadinya gangguan jiwa tidak pernah turun, angka kekambuhan masih tetap terjadi. Upaya lepas pasung telah dilaksanakan, namun saat ini muncul masalah baru, yaitu; kesiapan keluarga menerima pasien pasca pasung. Pasung bagi pasien gangguan jiwa telah dilepaskan, diberikan pengobatan dan perawatan di fasilitas pelayanan kesehatan jiwa. Ketika pasien sudah dinyatakan membaik, boleh dilanjutkan dengan latihan dan perawatan dirumah, keluarga yang tidak siap menerima kasien kembali. Ini adalah masalah besar bagi upaya pelatihan dan pemulihan bagi pasien gagguan jiwa. Dengan demikian, penanganan masalah gangguan jiwa bukan hanya masalah pasien, dokter, psikiater, perawat, psikolog, tenaga kesehatan lain, tetapi juga masalah keluarga, kelompok dan masyarakat. Penanganan masalah kesehatan jiwa bukan hanya urusan fisik, tetapi juga urusan psikologis, sosial, spiritual dan kultutral. Keterlibatan pemerintah pusat (Kementerian Kesehatan, Kementerian Dalam Negeri, Kementerian Sosial), Pemerintah; Daerah Gubernur, Bupati, Wali Kota sampai di tingkat RT sangat diperlukan dalam mengkawal kebiajakan penanganan masalah gangguan jiwa di wilayah. Prinsipnya, upaya kesehatan jiwa adalah setiap kegiatan untuk mewujudkan derajat kesehatan jiwa yang optimal bagi setiap individu, keluarga, dan masyarakat dengan pendekatan promotif, preventif, kuratif, dan rehabilitatif yang diselenggarakan secara menyeluruh, terpadu, dan berkesinambungan oleh Pemerintah, Pemerintah Daerah, dan atau masyarakat (UU 18/2014 tentang Kesehatan Jiwa). Atas dasar kompleksnya upaya membangaun kesehatan jiwa dan

penanganan gangguan jiwa, maka penulis mencoba membahas kesehatan jiwa; pendekatan holistik dalam asuhan keperawatan.

Buku ini terdiri dari lima bagian yang difokuskan pada 13 bab, membahas tentang konsep dasar keperawatan kesehatan jiwa, konsep holistik dalam keperawatan kesehatan jiwa, sumberdaya manusia dalam pelayanan jesehatan jiwa, fasilitas dalam pelayanan kesehatan jiwa, serta peran serta masyarakat dalam upaya meningjatkan kesehatan jiwa. Materi ini merupakan hasil penelitian Hibah Kompetensi Pengembangan Model Holistik dalam Merawat Pasien Gangguan Jiwa, yang telah diterima Direktorat Riset Penelitian dan Pengabdian Masyarakat (DRPM) Kementerian Riset dan Teknologi Pendidikan Tinggi Republik Indonesia (Kemenristek Dikti) selama tiga tahun berturut-turut, ditambah dengan kajian teoritis, telaah lapangan, fokus group diskusi, konsultasi pakar, dan pengamatan tim penulis selama mengajar dan membimbing klinik di fasilitas pelayanan keperawatan kesehatan jiwa.

Harapan kami, semoga buku ini dapat meningkatkan kompetensi para penulis, bermanfaat bagi masyarakat umum dalam meningkatkan kesehatan jiwa, suatu upaya dan penganaanan kasus yang tidak sederhana.

Surabaya, 2018.
Penulis,

# DAFTAR ISI

# TERAPI MODALITAS dalam Keperawatan Kesehatan Jiwa

**Rr. Dian Tristiana**
**Ah. Yusuf**
**Rizki Fitryasari PK.**
**Hanik Endang Nihayati**

# TENTANG PENULIS

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# KATA PENGANTAR

Dengan memanjatkan puji syukur kehadirat Allah SWT, Tuhan Yang Maha Esa, penulis dapat menyelesaikan buku "Terapi Modalitas dalam Keperawatan Kesehatan Jiwa" ini dengan baik. Buku ini diselesaikan untuk memperkaya rujukan perawat yang bekerja di sarana pelayanan kesehatan jiwa dalam menyusun rencana tindakan dan intervensi keperawatan yang sering terjadi pada masalah pasien gangguan jiwa. Hasil penelitian terkini menunjukkan bahwa gangguan jiwa masih menjadi stigma baik pada keluarga, masyarakat, bahkan tenaga kesehatan sendiri. Gangguan jiwa bukan hanya masalah pasien, tetapi juga keluarga, masyarakat bahkan masalah bagi tenaga kesehatan. Gangguan jiwa terjadi karena sebab yang belum jelas, padahal upaya pengobatan dan penyembuhan sering dilakukan dengan menghindari dan menghilangkan penyebab. Oleh karena itu, buku ini sangat diharapkan dapat memberikan gambaran berbagai alternatif terapi yang dapat diberikan pada pasien gangguan khususnya bagi tenaga kesehatan yang bekerja di sarana pelayanan kesehatan jiwa.

Ilmu keperawatan adalah suatu bidang ilmu yang mencakup ilmu dasar (alam, sosial, perilaku), ilmu biomedik, ilmu kesehatan masyarakat, ilmu dasar keperawatan, ilmu keperawatan klinik, dan ilmu keperawatan komunitas, yang pada aplikasinya menggunakan pendekatan dan metode menyelesaikan masalah secara ilmiah, ditujukan untuk mempertahankan, menopang, memelihara, dan meningkatkan integritas seluruh kebutuhan dasar manusia. Wawasan ilmu keperawatan adalah mecakup berbagai ilmu yang mempelajari bentuk dan sebab tidak terpenuhinya kebutuhan dasar manusia, melalui pengkajian mendasar tentang hal yang melatar belakangi, serta mempelajari berbagai upaya untuk mencapai kebutuhan dasar tersebut. Dengan demikian, bidang garapan dan fenomena yang menjadi objek studi ilmu keperawatan adalah penyimpangan atau tidak terpenuhinya kebutuhan dasar manusia, mulai dari tingkat individu utuh, mencakup seluruh siklus kehidupan, sampai pada tingkat masyarakat, yang juga tercerminkan pada tidak terpenuhinya kebutuhan dasar pada tingkat sistem organ fungsional sampai molekular.

Kebutuhan dasar manusia adalah suatu yang dinamis. Bentuk, jenis, jumlah dan respon manusia dalam memenuhi tuntutan kebutuhannya sangatlah bervariasi. Oleh karena itu, untuk mempelajari dan mengembangkan upaya pemenuhan kebutuhan dasar manusia, diperlukan berbagai pendekatan penelitian, baik kuantitatif maupun kualitatif. Panduan pelaksanaan penelitian kuantitatif telah banyak dipublikasikan baik versi cetak maupun on-line, sementara panduan penelitian secara kualitatif masih sangat jarang.

Buku ini membahas tentang keperawatan kesehatan jiwa, terapi modalitas dalam keperawatan jiwa yang merupakan pilihan berbagai alternatif terapi yang dapat diberikan pada pasien gangguan jiwa maupun keluarga dan masyarakat. Pilihan terapi ini terdiri dari terapi individu, kelompok, keluarga atau masyarakat, baik pada tatanan rumah sakit, keluarga atau masyarakat. Prinsipnya pemberian terapi bagi yang sehat agar tetap sehat jiwa dengan promotif, yang berisiko menjadi sehat dengan tindakan preventif, dan menjadi pulih bagi yang sakit. Buku ini diharapkan dapat menjadi penyempurnaan dan operasionalisasi dari Buku Ajar Keperawatan Kesehatan Jiwa yang telah terbit sebelumnya.

Surabaya, 2018.
Penulis,

# DAFTAR ISI