

**PERFORMANCE OF CAREGIVER IN TAKING CARE OF  
MENTAL ILLNESS PATIENT IN FAMILY IN ACEH TAMIANG  
DISTRICT, NANGGROE ACEH DARUSSALAM PROVINCE,  
INDONESIA**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF  
MASTER OF PRIMARY HEALTH CARE MANAGEMENT  
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MAHIDOL UNIVERSITY**

**2008**

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Thesis  
entitled

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ILLNESS PATIENT IN THE FAMILY IN ACEH TAMIANG DISTRICT,  
NANGGROE ACEH DARUSSALAM PROVINCE, INDONESIA**



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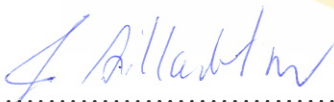
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Arbaiyah

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ABSTRACT

A cross-sectional study was conducted to identify performance of caregivers in taking care of mentally ill patients in Aceh Tamiang district Nanggroe Aceh Darussalam province, Indonesia, and to determine the association between performance and explanatory factors.

Using a structured questionnaire, data were derived from 94 caregivers taking care of mentally ill patients in Aceh Tamiang district from 1<sup>st</sup> January to 30<sup>th</sup> January 2008. Descriptive statistics were used to describe performance of caregiver level and explanatory variables while the association between these factors and caregiver's performance was determined by Chi-square test.

The average score of a caregiver's performance in a family was at a fair level. This study found there were no significant associations between performance of caregivers and both caregivers' knowledge and caregivers' attitude for predisposing factors. Enabling factors had significant association with performance of the caregivers. The majority of patients had been sick from one year to nine years. Nearly eighty percent of caregivers received overall support at a fair level and the results found association between social support and performance of caregivers. Nearly a hundred percent had a Community Mental Health Nurse (CMHN) visit their house. Nearly half of respondent received information from television.

Community based public health education should promote empathy and empowerment for better assessing and giving care to mentally ill patients.

KEY WORDS: PERFORMANCE/CAREGIVER/MENTAL ILLNESS PATIENT

100 pp.

# CONTENTS

	Page
ANKNOWLEDGEMENTS.....	iii
ABSTRACT.....	iv
LIST OF TABLES.....	vii
LIST OF FIGURES.....	viii
CHAPTER	
1 INTRODUCTION	
1.1 Rational and Justification.....	1
1.2 Research Questions.....	4
1.3 Research Objective.....	4
1.4 Conceptual Framework.....	6
1.5 Operational Definition.....	7
2 LITERATURE REVIEW	
2.1 Mental Health.....	11
2.2 Performance of Caregiver.....	13
2.3 Factor Related to Performance of Caregiver.....	18
2.4 Theoretical Model.....	31
3 RESEARCH METHODOLOGY	
3.1 Study Design.....	34
3.2 Study Population.....	34
3.3 Research Instrument.....	34
3.5 Test Reliability.....	38
3.6 Data Collecting.....	38
3.7 Data Analysis Procedures and Statistical Use.....	39

## CONTENTS

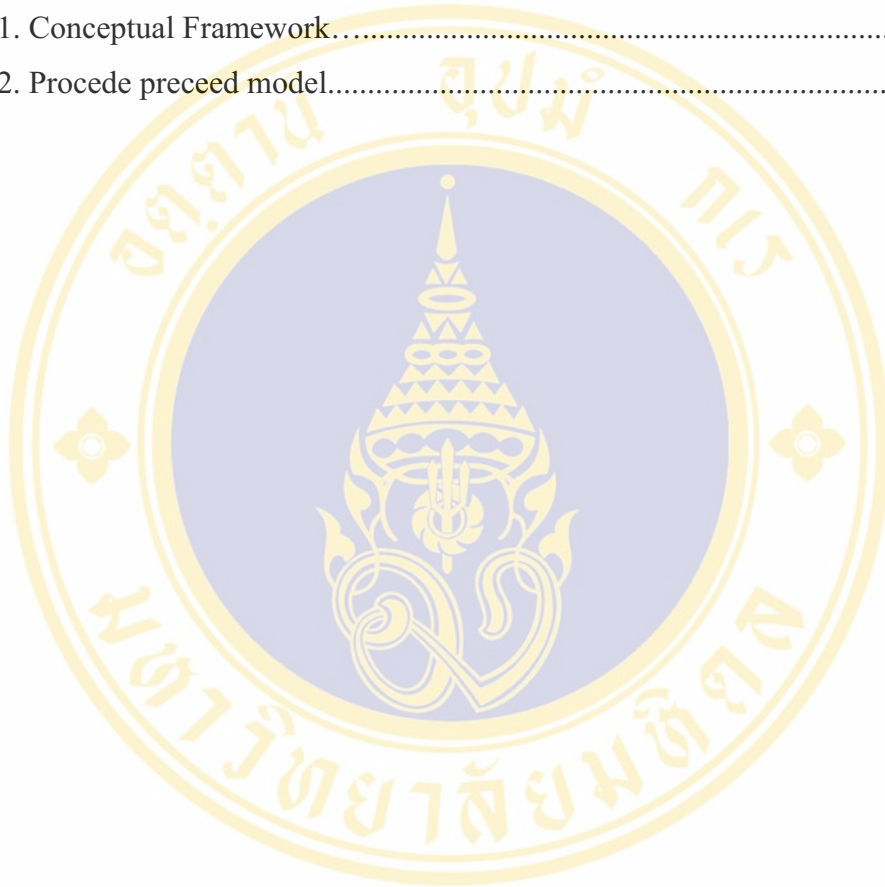
	Page
4 RESULTS	
4.1 Socio-demographic factors.....	41
4.2 Predisposing factors.....	43
4.3 Enabling factors.....	46
4.4 Reinforcing factors.....	48
4.5 Performance caregiver.....	51
4.6 Association between performance caregiver and factors.....	56
5 DISCUSSION	
5.1 Socio-Demographic Factors.....	63
5.2 Predisposing Factors.....	66
5.3 Enabling Factors.....	67
5.4 Reinforcing Factors.....	67
6 CONCLUSION AND RECOMMENDATION	
6.1 Conclusion.....	71
6.2 Recommendation.....	72
REFERENCES.....	74
APPENDIX.....	79
BIOGRAPHY.....	100

## LIST OF TABLES

TABLE		Page
1	Socio-demographic factors.....	42
2	Overall knowledge of caregiver on mental illness patient by items.....	43
3	Overall knowledge of caregiver on mental illness patient.....	44
4	Attitude toward mental illness patient by items.....	45
5	Overall attitude level of caregiver.....	46
6	Severity of symptom (enabling factors).....	47
7	Duration of sickness (enabling factors).....	49
8	Characteristic of support provided to mental illness patient.....	49
9	Overall reinforcing factors.....	49
10	Information resources.....	50
11	Media information.....	51
12	Performance caregiver's level who need complete help by items.....	52
13	Performance caregiver's level who need complete help .....	52
14	Performance caregiver's level who need some help by items.....	53
15	Performance caregiver's level who need some help.....	54
16	Performance caregiver's level who need less help by items.....	53
17	Performance caregiver's level who need less help .....	55
18	Overall performance of caregiver.....	51
19	Caregiver's performance by socio-demographic factors.....	57
20	Caregiver's performance by predisposing factors.....	58
21	Caregiver performance by enabling factors.....	59
22	Characteristic of support provided.....	60
23	Caregiver's performance by information resources.....	61
24	Caregiver's performance and media information.....	62

## LIST OF FIGURES

FIGURE	Page
1. Conceptual Framework.....	6
2. Procede preceed model.....	8



## CHAPTER 1

### INTRODUCTION

#### 1.1 Rationale and Justification.

Mental illness, neurological and behavioral disorders are common to all countries and cause immense suffering. People with these disorders are often subjected to social isolation, poor quality of life and increased mortality. These disorders are the cause of staggering economic and social costs. Hundreds of millions of people worldwide are affected by mental, behavioral, neurological and substance use disorders (1).

One study reported by World Health Organization in 2005 showed that 154 million people globally suffer from depression and 25 million people from schizophrenia (1).

People die by suicide estimated 877.000 every year. The proportion of the global disease burden due to suicide varies regionally, from 0.2% in Africa up to 2.6% in the Western Pacific Region. Suicide among young people is of significant concern: in some regions, suicide is the third leading cause of death in the age group 15-35 years. Suicide is the leading cause of death for this age group in China and the second in the European region."More than 90% of all cases of suicide are associated with mental disorders such as depression, schizophrenia and alcoholism" (2).

The rate of people worldwide is affected by mental, neurological or behavioral is steadily rising. In spite of existing knowledge about effective treatments for most psychiatric disorders, huge gaps in treatment and resources exist. World Health Organization study in 14 countries showed that, in developing countries, between 76 to 85% of serious cases of mental illness did not receive any treatment within the prior year. Mental Health Atlas 2005 shows a tremendous human resource gap in the

developing regions of the world. In order to effectively address these gaps, mental health policy, plans and legislation must be integrated into national health systems. Promoting mental health, preventing mental disorders, mainstreaming cost-effective interventions in primary health care, promoting community care, and engaging with local communities should be key components of national mental health plans and policies (2).

Conflict is also associated with an increase in the prevalence of mental disorders; there are few population-based studies of adults in conflict-affected areas and low-income countries. Among refugees, it is estimated that acute clinical depression and post-traumatic stress disorder (PTSD) range between 40 and 70%. Epidemiological studies among internally displaced persons (IDPs) and refugees on the Thai-Cambodian border, indicate that 15 to 53% suffer from PTSD as consequence of conflict. In Uganda, 71% reported major depressive disorder, and in Algeria, Cambodia, Ethiopia, and Gaza, psychopathology prevalence was 17% among non-traumatized against 44% for those who experienced violence. A study of Cambodian refugees by the Harvard Program in Refugee Trauma, significantly higher than those found among the general population (10% and 3% respectively) (3).

In Aceh the conflict has been one of Asia's longest-running internal crises. From Indonesia led by the separatist Free Aceh Movement in Indonesia they said Gerakan Aceh Merdeka (GAM) began in 1976 and was fostered and accompanied by many grievances for the Acehnese civil society relating to human rights abuses as well as to the distribution of natural resource incomes, and other side effect of conflict make many people suffer from mental illness. According to recent research conducted by Aceh health officials in three regencies, at least 5,380 Acehnese people suffer from a form of mental illness triggered by the years of conflict they endured. Such illnesses include schizophrenia, neurotic disorders, acute psychotic disorders and depression (3).

Unfortunately, in Aceh not only conflict but also tsunami catastrophe in 26 December 2004. Aceh suddenly received an enormous international attention and

support in a “powerful humanitarian context” accompanied by unexpected worldwide compassion and sympathy many NGO came to Aceh. WHO is appealing to countries to increase their support for mental health services. One study by Community Mental Health Nursing Program from WHO show 80% cause of mental illness in Aceh because of conflict and 20% because of tsunami (4).

In Aceh there are families that do not take care of patient mental illness adequately. The caregiver had not seriously giving the treatment and support to the patient. The fact about recovery said that between 70 and 90 of individuals have significant reduction of symptom and improved quality of life with a combination of medication and psychosocial treatment and support (4).

In this case, caregivers are very important people who must assume the burden of giving the patient assistance in all his activities, i.e. coping with abnormal behavior, giving emotional support and concrete assistance. They may have to assist him materially, financially and physically.

Caregiver must have good performance. In terms of providing mental illness patient :

- to take medicine regularly
- bring the patient to attendance the clinic if necessary
- personal hygiene : body, mouth, bath, hair, nail, elimination
- physical care: nutrition/food
- patient’s activities daily living
- safe time for movement
- protect them from dangers
- rehabilitation.
- giving emotional and mental care support i.e. protects from prejudice
- human right and patient’s right.
- social care support
- contacting person’s institutions in public health service to make sure that the patient receives treatment and also social rehabilitation.

According to the performance, knowledge and attitude of caregiver also influence for better or not the performance of caregiver.

The study from WHO shows a method of giving knowledge to caregivers to develop an adequate attitude and to improve the performance of caregiver to mental illness patient may positively influence the caring for mental illness patient in the future. According to the data from Basic Course CMHN November 2006, there were 112 cases mental illness patient in Aceh Tamiang district (5).

For all of the reason above, the researcher wants to explore the performance of caregiver to mental illness patients in family in Aceh Tamiang district Nanggroe Aceh Darussalam, Indonesia

## **1.2. Research Questions**

What is the performance of caregiver and related factors in taking care of mental illness patients in Aceh Tamiang district Nanggroe Aceh Darussalam province, Indonesia?

## **1.3 Research Objective**

### **1.3.1. General Objective**

1. To describe the performance of caregiver in taking care of mental illness patients in the family.
2. To identify the factors related to the performance of caregiver in taking care of mental illness patients in the family

### **1.3.2. Specific Objective:**

1. To describe the performance of caregiver in taking care of mental illness patients in family in Aceh Tamiang district Nanggroe Aceh Darussalam, Indonesia.

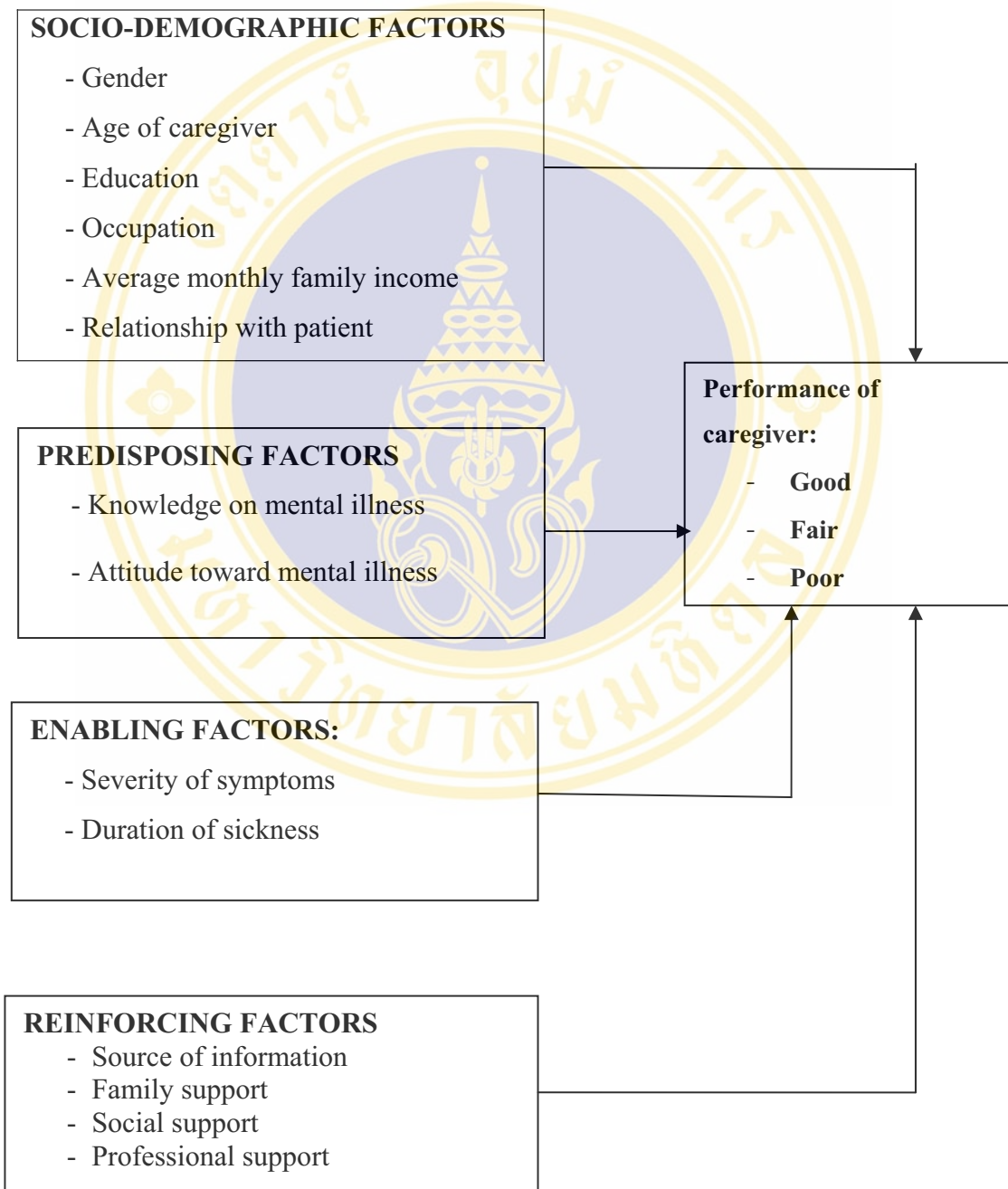
2. To describe the socio-demographic characteristic of caregiver.
3. To identify predisposing factors related to performance of caregiver
4. To identify enabling factors related the performance of caregiver
5. To identify reinforcing factors related to the performance of caregiver
6. To describe association between the performance of caregiver and socio-demographic factors, predisposing factors, enabling factors and reinforcing factors.



## 1.4 Conceptual Framework

### Independent Variable

### Dependent Variable



**Figure 1 Conceptual framework**

## 1.5 Operational Definition

### 1.5.1 Socio-demographic factors

Includes gender, age, monthly income, education, and occupation with the following:

**Gender** refers to sex of caregiver, divided into two: male or female

**Age of care giver** determined by complete years of age of caregiver at the time of answering the questionnaire in full year.

**Education** is the highest educational attainment of caregiver according to the Indonesia education system six years primary school, three years of secondary school, three years of high school, and university/college. In this research also will be added; no schooling and other education of caregiver.

**Occupation** is the employment of caregiver which spends most of their time during the year. It is divided into eight groups: laborer, farmer, trader, government official, worker in private company, housewife, unemployment and others.

**Average monthly family income** in this study is the total monthly income of caregiver, which comes from all family members.

**Relationship** refers to the people had the connection with the patient. It is divided into six group: father/mother, grandfather/grandmother, children/grandchildren, sibling, relatives and others.

### 1.5.2 Predisposing factors

Include a person's knowledge and attitudes (i.e. caregiver knowledge and attitude for performance to mental illness patients. Predisposing factors interact with genetic predisposition. Some types of knowledge and skills may serve both predisposing and enabling functions in supporting different types of behavior, like as

today's reinforcement becomes tomorrow's predisposing. Predisposing factors also include the early childhood experiences that created the attitude, values and perception in the first place (4).

**Knowledge on mental illness** refers to the knowledge and understanding of caregiver about mental illness: cause of mental illness patient, symptom, treatments for caring and improving the rehabilitation for mental illness patient at home. We classified the knowledge into three groups: good, fair and poor.

**Attitude toward mental illness** refers to degree of the feelings, beliefs and intention of caregiver on mental illness patient, cause of mental illness, (if a care giver has a favorable or unfavorable of caring mental illness patients, caregiver have the feeling of satisfaction or pleasure, and favorable attitude toward the patient, then they develop compassion and the need to take care of the patient. On the other hand, if the caregiver develops a bad or unfavorable attitude toward the patient, the feeling of burden will arise).

### 1.5.3 Enabling factors

Mostly conditions of the environment, enabling factors facilitate the performance of an action by individuals or organizations. They were factors antecedence to behavior that allows a motivation or aspiration to be realized. The absence of adequate enabling conditions inhibits action. Those skills (i.e. severity of condition and duration of sickness). That caregiver can help the mental illness patients at home.

**Severity of symptom** refers to symptom which made caregiver decide to take the patient to public health center. We divided into six groups: disorder of motor activity, disorder of affect, disorder of content of thought, disorder of perception, disturbance of consciousness, others.

**Duration of sickness** refers how long the patient get mental illness disease from the first time until at the time of the answering the questionnaire by caregiver.

### 1.5.4 Reinforcing factors

The reward received and the feedback the learner receives from others following adoptions of a behavior may encourage or discourage continuation of the behavior (e.g. mass media influence and social support). In performance settings, it may come from family, nurse, doctor, friend and other sources.

Reinforcing factors also include adverse consequences of performance, or punishments that can lead to the extinction of a positive performance. Reward also can reinforce performance that is not conducive to health.

In this study focused on sources of information, family support, social support and professional support and resources, with the following:

**Source of information** refers to information resources on caring mental illness person, which the caregiver received from, doctor, nurse, family, friend mass media, leaflets and others.

Mass media refers to book, newspaper, magazine, television, radio.

**Family support** refers to a man or women to support by family member to mental illness patients about financial, emotion, information support or recreation.

**Social Support** refers to the supports/assistance received from society including neighborhood, community and friends in term of encouragement, acceptance, empathy and empowerment for mental illness patients.

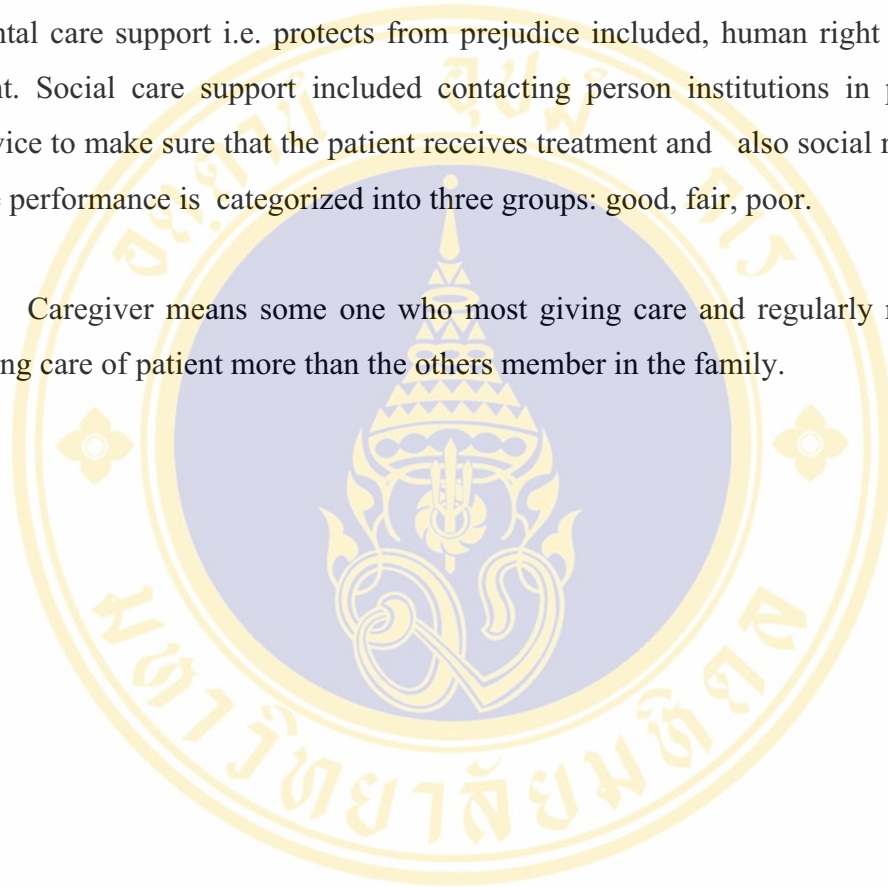
**Professional support** refers to professional of people in supporting to caring mental illness patients, like Community Mental Health Nursing, (CMHN), doctor, etc.

### 1.5.5 Performance of care giver

Performance of care giver refer to practice in taking care of mental illness patient, it measure the performance from how caregiver take care mental illness patient, physical care, mental care/ support, social care/support. The performance of

caregiver can be good if the caregiver take care mental illness patient to medical regularly, bring the patient to attendance the clinic if necessary, providing personal hygiene care to patient including : body, mouth, hair, nail, elimination, For physical care of patient included: nutrition/food, patient's activities of daily living, safe time for movement, protect from dangers, and also rehabilitation. Giving emotional and mental care support i.e. protects from prejudice included, human right and patient's right. Social care support included contacting person institutions in public health service to make sure that the patient receives treatment and also social rehabilitation. The performance is categorized into three groups: good, fair, poor.

Caregiver means some one who most giving care and regularly responsibility taking care of patient more than the others member in the family.



## CHAPTER 2

### LITERATURE REVIEW

A review of literature and previous studies on performance of caregiver to mental illness patients of this study includes;

- 2.1 Mental Health.
- 2.2 Performance of caregiver
- 2.3 Factors related to performance of caregiver.
- 2.4 Theoretical Model

#### **2.1 Mental Health**

Mental health is defined as a state of well-being including social, spiritual, cognitive and emotional aspects, in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. People with these disorders are often subjected to social isolation, poor quality of life and increased mortality. These disorders are the cause of staggering economic and social cost (9).

Mental illness is a disorder of the cognition (thinking) and/or the emotions (mood) as defined by standard diagnostic systems such as the International Classification of Disorders, 10th Edition (ICD 10) or the American Psychiatric Association's Diagnostic and Statistical Manual, Revised 4th Edition (DSM IV-R) (9).

Psychosocial disorders relate to the interrelationship of psychological and social problems, which together constitute the disorder. The term psychosocial is used to underscore the close and dynamic connection between the psychological and the social realms of human experience. Psychological aspects are those which affect

thoughts, emotions, behavior, memory, learning ability, perceptions and understanding (9).

Social aspects refer to the effects on relationships, traditions, culture and values, family and community, also extending to the economic realm and its effects on status and social networks. The term is also intended to warn against focusing narrowly on mental health concepts (e.g., psychological trauma) at the risk of ignoring aspects of the social context that are vital to wellbeing. The emphasis on psychosocial also aims to ensure that family and community are fully integrated in assessing needs and interventions (9).

### **2.1.1 Mental Health and Conflict.**

Mental health is gradually being recognized as an important development issue, especially in the case of conflict-affected countries. Although mental health issues have received increased attention in post-conflict settings, there has been a tendency to implicitly assume that the impact of trauma caused by mass violence may be transitory and non-disabling, and that interventions in the emergency phase are sufficient. However, a small but growing body of research on factors affecting mental health and effective treatment in post-conflict settings casts doubts on both assumptions (7).

Effect of every conflict is insecurity, which fractures social ties, breaks up families and communities, and displaces populations. As of end-2003, there were an estimated 38 million uprooted people (13.7 million refugees and 24.5 million internally displaced persons), of which almost 16 million were in Africa. WHO 2002 estimated that during the 21st century 191 million people lost their lives directly or indirectly due to collective violence, of which 60% were people not engaged in fighting (8).

Insecurity, violence and displacement cause the breakdown of social services such as health and education. The stateless and displaced are unable to engage in

productive activities, and combined with weak or absent social safety nets there is a slide into poverty or dependence on humanitarian assistance. In addition, traumatic experiences directly related to conflict, often involving the loss of family members, participation in or witnessing of violent acts, and conflict-induced physical disabilities, cause further distress and hamper post-conflict reconstruction and development efforts (11).

According to recent research conducted by Aceh health officials in three regencies, at least 5,380 Acehnese people suffer from a form of mental illness triggered by the years of conflict they endured. Such illnesses include schizophrenia, neurotic disorders, acute psychotic disorders and depression (8).

## **2.2 Performance of Caregiver**

The performance of caregiver can be good if the caregiver take care mental illness patient to take medicine regularly. Bring the patient to attendance the clinic if necessary, personal hygiene: body, mouth, bath, hair, nail, elimination. About physical care: nutrition/food, patient's activities daily living, safe time for movement, from dangers, and also rehabilitation. Giving emotional and mental care support i.e. protects from prejudice, human right and patient's right. Social care support, contacting person's institutions in public health service to make sure that the patient receives treatment and also social rehabilitation. According to the performance, knowledge and attitude care giver also influence for good bad performance of care giver.

Over one-third of all family members or friends who take care of a person diagnosed with a mental illness also work outside the home. There is great physical and emotional stress that comes with providing care. One-third of caregivers who work report that it interfere with their paying jobs. Many caregivers have chronic health problems, experience depression, and suffer excess stress when the burden of

work or care giving increases (8). Other problem of caregiver i.e. stresses, anger, and grief related to care giving can lead to depression.

Performance of care giver in this research is evaluated with five categorized consisted of medical, personal hygiene, physical care, emotional/mental care support, social care support.

### **2.2.1 Medical**

#### **- Medicine**

Mental illness patient must take drugs regularly and for long period. Some of them may even have to take medicine for the rest of their lives. Therefore, their caregiver play a very important role in monitoring and assisting patient' medical treatment program. However, Hatapanom, V. et all in 1986 discovered that 82,67% of the relatives still misunderstood about helping patients follow the doctor's orders. As a result, the patient has to return to the public health service or the psychiatric hospital because of lack of medicine. Consequently, it is cautiously necessary for the caregivers to be concerned about drug usage and side effects, and how to take care of patients. Psychotropic drugs relieve physical and behavior symptoms. Psychotropic drugs are very effective medicine to cure various causes of mental illness (10).

#### **- Attendance to clinic**

If caregiver or someone close to you shows signs of mental illness, it is important that you seek treatment as soon as possible. Talk to a regulated health professional (e.g. family physician, psychologist, mental health nurse, social worker) or another trusted professional - such as a counselor or religious leader - about your concerns (15).

### **2.2.2 Personal hygiene**

Mental illness person need personal hygiene include body wash, and oral hygiene, clean hair, cut the nail, wash the genitals or anus with water after defecating or urinating urinal. The caregiver has to care personal hygiene of patient and depend

on condition of patient. Sometime patient can do it by him self, sometimes need assistant to help him. Personal hygiene means physical act of cleansing the body to ensure that the skin, hair and nails are maintained in an optimum condition. Oral hygiene means effective removal of plaque and debris to ensure the structures and tissues of the mouth are kept in a healthy condition. Healthy mouth means clean, functional, and comfortable oral cavity, free from infection (33).

### **2.2.3 Physical care**

#### **- Nutrition/ food**

Care giver can help the mental illness patient with the following suggestions for develop and maintain positive mental health. Eat a well-balanced diet to Healthy Eating;

Avoid overuse of alcohol, such as binge drinking or drinking to cope with problems. Avoid the use of illegal drugs, learn to deal with the stresses of modern life and take steps minimize the stress in your life; and (15).

Diet and nutrition may help some people with mental illnesses manage their symptoms and promote recovery. For example, research suggests that eliminating milk and wheat products can reduce the severity of symptoms for some people who have schizophrenia and some children with autism. Similarly, some holistic/natural physicians use herbal treatments, B-complex vitamins, riboflavin, magnesium, and thiamine to treat anxiety, autism, depression, drug-induced psychoses, and hyperactivity (23).

#### **- Activity Daily Living.**

Take part in physical activity regularly; get enough sleep each night. Problem of mental illness patient at home: for example can not attend to others' needs, overwhelmed by chores or household expectations, can not keep up with housework, and instigates arguments and fight with family, passively or actively. Poor self-care: does not take care of appearance or cleanliness, does not eat enough, or

overeats, does not attend to finances, insurance bills, vehicle, etc, pays little or no attention to physical health (9).

### - Rehabilitation

The social point of view and reaction commonly does not accept mental illness persons as a part of society, so they must rehabilitate quickly. Tamroj, K and Nuttarangsee, J in 1995 have given the meaning of mental illness rehabilitation. It is a process of mental, physical and emotional development, or maximum learning development, which allows patients to be able to adapt themselves in society and earn a living.

All types of rehabilitation can be characterized into the following aspects:

1. Physical rehabilitation is the process of recuperation that employs several medical concepts such as physical therapy, and any activity concerned with the movement of body parts. The caregiver can participate in helping the mental illness person to regain their physical ability by encouraging the patients to exercise, such as walking, swimming, jogging, etc.
2. Psychological rehabilitation is the process of recuperation that provides education about how to control emotions. The caregiver can help and support the patient by accepting patient's individualism, and respecting patient's right. Furthermore, positive reinforcements are essential for the patients when they express their emotions and thoughts properly.
3. Social rehabilitation means the recuperation that skill training helps the patients to adjust relationships themselves, with their families and others.
4. Occupational rehabilitation is considered as skill training, which is provided for patients to earn a living according to their existing ability. This type of recuperation helps the patient to feel proud of them by not depending on other people. Obviously, all patients do not lack ability and potential,

therefore the caregiver should support them to work in a job according to their ability. And sometimes, the caregivers should give suggestions about job seeking to the patient by considering the patients interests, skills and proficiencies.

5. Community rehabilitation is the method of training that teaches the patients to be able to express their opinion about other members of the community. The exercise also helps the patients to create the ability of mood control, which will lead to them being accepted by society, and to negotiate for mutual understanding with others.

#### **2.2.4 Emotional /Mental care**

##### **- Protect from prejudice**

Bigotry and extreme prejudice are repugnant to many, including the victims and those engaged in furthering progressive social values. Various attempts have been made to encompass that reaction in social mores and attitudes. A new approach among certain mental health professionals to get extreme prejudice to be declared a diagnosable mental illness included in the official list of diagnoses superficially bears promise in objective zing that repugnance (20).

It presents the argument of some that extreme prejudice is so compulsive and damaging to the prejudiced person that it should be viewed as a mental illness deserving its own diagnosis. While radicals and progressives may be tempted to jump on this bandwagon as a weapon in their battle to have racism and prejudice recognized for the personal and social harm they cause, this effort is unjustifiable intellectually and is politically likely to backfire. Those who argue for extreme prejudice as psychopathology claim that it constitutes obsessive abnormal behavior that, depending on the author, either is claimed to cause subjective distress to the perpetrator or to the victim. The second argument is that extreme prejudice causes subjective distress and/or restriction of functioning in the prejudiced; at least when they are faced with those they are prejudiced against (31).

### - **Human right**

Human Rights are universal legal guarantees protecting individuals and groups against actions which interfere with fundamental freedoms and human dignity. Some of the most important characteristics of human rights are that they are: guaranteed by international standards, legally protected, focus on the dignity of the human being, oblige states and state actors, cannot be waived or taken away, interdependent and interrelated, and universal (21).

### - **Patient's right**

Principles for the protection of persons with mental illness and the improvement of mental health care (Adopted by General Assembly resolution 46/119 of 17 December 1991) Application: these Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth (19). Mental health care" includes analysis and diagnosis of a person's mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness (18).

#### **2.2.5 Social care/support.**

##### - **Social rehabilitation**

Every person with a mental illness shall have the right to live and work, as far as possible, in the community (19). Give the chance for mental illness patient to talk to others - your family, friends, and colleagues - about things that concern you. Sharing feelings and anxieties can help you cope with them.

## **2.3 Factor related to performance of caregiver**

### **2.3.1. Socio-demographic factors.**

#### **- Age of patient**

Studies show that 15 to 25 percent of elderly persons exhibit some serious symptoms of mental disorder (25). Prevalence and age-of-onset of mental disorders unlike most disabling physical diseases, mental illness begins very early in life. Half of all lifetime cases begin by age 14; three quarters have begun by age 24. Thus, mental disorders are really the chronic diseases of the young. For example, anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20's. Unlike heart disease or most cancers, young people with mental disorders suffer disability when they are in the prime of life, when they would normally be the most productive (20).

The risk of mental disorders is substantially lower among people who have matured out of the high-risk age range. Prevalence increases from the youngest group (age 18-29) to the next-oldest age group (age 30-44) and then declines, sometimes substantially, in the oldest group (age 60) (29).

#### **- Gender**

Gender is a social description and sex is biological one. The relationship between gender and mental health is complex and it contains a core contradiction generally women are more likely to receive a psychiatric diagnosis though, this claim is sometimes contested. On the other men are more likely to be treated coercively within specialist mental health services. And although secure mental health services are overwhelmingly populated by male patients, women can be found in them. Females have higher rates of mood and anxiety disorders. Males have higher rates of substance use disorders and impulse disorders (29).

Sociological, psychological, and feminist theories of gender differences in support provide many reasons for the greater likelihood of women being helpers.

These include the following: Providing care may be central to women's identity; daughters have a special sense of attachment to their mothers; societal support of women as helpers is reinforced by social ideologies, devaluing of women's paid work, and inadequate government support. The support literature suggests that older men and women have personal networks of different size and composition in which male and female network members typically provide different types of support (31).

These differences have been mirrored in care giving studies that note that men and women provide different types of care giving assistance. In addition, there is some evidence that adult children may be more likely to provide care to a parent of the same gender. Thus, support relationships may be influenced by the gender of the caregiver and the gender of the helper and also by the combination of gender of caregiver and helper (42).

- **Relationship**

The patient's family or the people near him, such as parents, spouse, children, brothers and sisters, or near relatives are important people who must assume the burden of giving the patient assistance in all his activities, i.e. coping with abnormal behavior, giving emotional support and concrete assistance. They may have to assist him materially, financially and physically. Also they must love and comprehend the sick person and have a positive relationship with mental illness person. The most important feature of public rehabilitation is a group of caregivers who help the patients to experience a true sense of community by letting them participate in several public activities (42).

The explanation from others literatures showed relationship of helper. In American society might expect that adult children will be the most important sources of support to their parents. The others research, investigated the matching between four sources of support for spouse caregivers (i.e., adult children, other relatives, friends/neighbors, and formal helpers). We assume that the primacy of the parent-child relationship and the history of emotional attachment associated with parent-

child roles will be satisfied most strongly when emotional support is provided by adult children compared with other sources of support (42).

### **2.3.2 Predisposing Factors**

#### **- Knowledge toward mental illness patient**

In the past, human being did not correct understanding about mental illness, and could not explain what it was. So, they assumed that the illness was a curse, and used magic and other types of superstitious powers to describe the causes or factors. They believed that all abnormal behaviors and conducts were a form punishment by supernatural power such as being possessed by evil spirits, being under magical spells, etc (42).

The treatment was conducted only by a “witch doctor” that performed some sacred ceremony to expel the spirit. Some others also believed that drinking holy water accompanied with magic spell could cure the disease. If the symptoms still existed, then they would chain up and imprison the patients. After the year in 1911; the belief of supranatural objects and black magic started to decline, and the scientific reasoning began to change the view of mental illness. Human being began to develop understanding about psychotic conditions, by noticing that the causes are due to physical, mental and environmental aspects, and form of psychotic treatments (40).

According to the study conducted by T. Skul, J in 1981, she found that caregivers do not have clear understanding and knowledge about the illness. In addition, Hatapanom, V.et al in 1986 had conducted research on the factors concerned with the recurrence of the illness. They discovered that the return of the illness is due to medical deprivation. Thus, all medial personnel must attempt to distribute knowledge and understanding to the psychiatric patients and caregivers. Therefore, studying the caregiver knowledge about the illness is very interesting and important, since many people have gained such understanding in recent years. In order for a group of people to do things properly, they must comprehend about the concepts first because understanding is the basis of thinking, considering, and making decisions. Phumipak,

in 1980 stated that caregivers must have full understanding about the illness and the correct treatment (43).

A previous study found that caregiver have Family-led education programs for caregivers of people with serious mental illness empower them with information they need to provide necessary support to loved ones as they recover. Caring for a family member with serious mental illness can be a daunting experience to someone who lacks knowledge and resources. However, a study of an eight-week, mental illness course shows it successfully equips some caregivers with new information to help them do a better job (44).

Previous study explained that to determine the extent that Journey of Hope helped family members gain knowledge of mental illness, Pickett-Schenk investigated knowledge levels and information needs of 462 family members of adults with serious mental illness from December 2000 to June 2004 at three different time points: Pickett-Schenk evaluated family members using the 40-question Family Knowledge Scale, which included questions about the various topics covered in the course, and the Family Information Needs Scale, which asks participants to rate their interest in learning about 45 topics ranging from medications to coping strategies. She evaluated all participants at baseline and then at three and six months later and found that compared with those in the control group, respondents who participated in the course had significantly increased their knowledge and decreased their need for more information ( $p < .001$ ) (46).

#### **- Causes of mental illness**

A complex interplay of many factors cause mental illness. Contributing factors include: genetic, biology, personality, socio-economic status and live event. Much medical expertise has characterized the causes of mental illness into three groups: 1. hereditary factor. The theory is based on the idea that mental abnormality can be transferred from parent to children. The mental conditions are specified as: Alzheimer's disease and Senile dementia. 2. Organic factor. Most of us understand

that brain disease or abnormal metabolism is a primary cause. Moreover, the state of equilibrium of substances in the brain such as amine, serotonin, dopamine and acetylcholine has negative effects on people's minds. 3. Environmental factor. The situation has an enormous influence upon mental health and behavior. Character and personality are significantly affected by family environment. The differences in ideas, in equality, and in adaptation therefore depend upon how the children are brought up (16).

#### - **Symptoms of mental illness**

Mental illnesses take the form of changes in thinking, mood or behavior or some combination of all three. The person affected shows symptoms of significant distress and the inability to function as needed over an extended period of time. These symptoms can vary from mild to severe, depending on the type of mental illness, the individual, the family and the patient's environment (26).

Mental illness is a representation of failure in self adaptation. The symptoms do not appear directly or clearly, but they occur as symbols which describes the state of the unconscious' mind. The chance of a patient to recover from the sickness is greater if his caregivers can assess the symptoms correctly. Mental illness symptoms can be categorized into 7 main groups:

1. Disorder of motor activity. The symptoms, for example are stereotypy, negativism, tics mannerism, rigidity, compulsion and agitation.
2. Disorder of content of thought. The symptoms for example are delusion, delusion of persecution, delusion of grandeur, delusion of reference, delusion of jealousy and thought broadcasting.
3. Disorders of form of thought. The symptoms for example are incoherent or circumstantial, blocking, neologism, and flight of ideas.
4. Disorders of affect. The symptoms for example are anxiety, panic, phobia, labile affect, flat affect, elation and inappropriate affect.
5. Disorders of Perception. The symptoms for example are illusion and hallucination.

6. Disturbance of consciousness. The symptoms for example are confusion, clouding of consciousness, delirium and disorientation.
7. Disorder of memory. The symptoms for example are anterograde or retrograde amnesia, a patient who suffers specific disorders has short-term memory (confabulation) also (26).

#### - **Treatment of mental illness**

Most mental illnesses can be effectively treated. Treatment methods may include one or more of the following: medication, scientifically based psychotherapies such as cognitive therapy, which help patients learn to effectively change their thinking, feelings and behavior, counseling, community support services and education (15).

There are four types of therapy are employed:

1. Somatic therapy consists: drugs therapy (psychotropic drugs), Electroconvulsive therapy.
2. Psychotherapy consist: Insight psychotherapy, supportive psychotherapy
3. Milieu therapy
4. Behavior therapy.

#### - **Attitude toward mental illness patient**

The word "attitude" comes from the Latin word "Aptus", which means readiness or tendency of committing to something, Attitude is a hypothetical construct that represents an individual's like or dislike for an item. Attitudes are positive, negative or neutral views of an "attitude object": i.e. a person, behavior or event. People can also be "ambivalent" towards a target, meaning that they simultaneously possess a positive and a negative bias towards the attitude in question (14).

Attitudes come from judgments. Attitudes develop on the ABC model (affect, behavioral change and cognition). The affective response is a physiological response that expresses an individual's preference for an entity. The behavioral intention is a

verbal indication of the intention of an individual. The cognitive response is a cognitive evaluation of the entity to form an attitude. Most attitudes in individuals are a result of observational learning from their environment. The link between attitude and behavior exists but depends on human behavior, some of which is irrational (13).

Attitude also means being ready to express specific behavior; for example, if the patient's caregiver have the feeling of satisfaction or pleasure, and favorable attitude toward the patient, then they develop compassion and the need to take care of the patient. On the other hand, if the caregiver develops a bad or unfavorable attitude toward the patient, the feeling of burden will arise. They may want to avoid taking care of them, or giving care to the patients. Therefore a favorable attitude is an important guideline which will direct how to behave caregivers to be successful in taking care of the patients (14).

### **2.3.3 Enabling Factor**

#### **- Severity of condition**

Severity of condition like disorder of motor activity, disorder of affect, disorder of content of thought, disorder of perception, disturbance of consciousness, others. Severity and co morbidity of mental disorders in the reports say that even though mental disorders are widespread throughout the population, the main burden of illness is concentrated in those with a severe disorder - about 6 percent. A "serious" disorder involves a substantial limitation in daily activities or work disability, or a suicide attempt with serious lethal intent, or psychosis. The serious group reported a mean of 88.3 days — nearly 3 months of the year — when they were unable to carry out their normal daily activities (29).

Unfortunately, say the researchers, individuals with one mental disorder are at a high risk for also having a second one (co morbidity). Nearly half (45 percent) of those with one mental disorder met criteria for two or more disorders, with severity strongly related to co morbidity. This finding supports the suggestion by a growing

portion of researchers that the boundaries between some diagnostic categories may be less discrete than previously believed (29).

- **Duration of sickness**

Duration of sickness refer how long the patient get mental illness disease from the first time until at the time of the answering the questionnaire by care giver. Everyone gets "the blues" occasionally and feels pessimistic, sad, apathetic, withdrawn, and has low energy. These bouts are usually of short duration and characterized by overcoming the cause of the problem. Some people, however, suffer from severe or clinical depression, the average episode of which lasts four months. More than half of people with one episode of major depression will have a second (30).

**2.3.4 Reinforcing Factor**

- **Source of information**

Caregiver can get information resources on caring mental illness person received from mass media, leaflets, nurse, doctor, family, friend and others. The other study said that, the leaflet made by professionals, or if caregiver obtained the leaflet from health sector, health education opportunity, the leaflet could be effective information resource for them. Moreover, one merit or leaflet is can be kept in hand and read repeatedly when they want to (25).

At previous study explained that to determine the extent that Journey of Hope helped family members gain knowledge of mental illness, Pickett-Schenk investigated knowledge levels and information needs of 462 family members of adults with serious mental illness from December 2000 to June 2004 at three different time points: Pickett-Schenk evaluated family members using the 40-question Family Knowledge Scale, which included questions about the various topics covered in the course, and the Family Information Needs Scale, which asks participants to rate their interest in learning about 45 topics ranging from medications to coping strategies. She evaluated all participants at baseline and then at three and six months later and found that

compared with those in the control group, respondents who participated in the course had significantly increased their knowledge and decreased their need for more information ( $p < .001$ ) (46).

#### **- Media information**

Information along with resources caregivers may need additional information with regards to their service. The link below provides additional helpful information to those providing care. Families were recruited to participate through newspaper articles and advertisements, televised public-service announcements, and flyers featuring information about the study.

Previous study found that for available resources caregivers have a variety of needs. Finding resources to meet those needs can be a difficult and challenging task. Follow the link below for information regarding resources available for a caregiver.

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#### **- Family support**

How can family members and other supporters help? Many activity for take care mental illness patient with the permission of the person who has experienced psychiatric symptoms, you can help by: reading the educational handouts used in the program, attending some sessions with the practitioner and the person who has experienced psychiatric symptoms, reviewing the educational handouts with the

person, helping the person develop and implement plans for coping with symptoms, reducing relapses, and pursuing recovery goals (22).

The family institution is considered one of the most important and basic institutions for patients in rehabilitating their social skill. The treatment can be done by letting patients participate in family activities such as family dinners and family recreation. It will, therefore, give the feeling of self- value to the patients (22).

Families provide tangible, informational, appraisal and emotional support over time, and at a distance. Education and support is needed for family members so they can be supportive. The networks of those with psychiatric illnesses also tend to include more family members. However, Holmes-Eber and Riger found for those individuals with chronic mental illnesses, when the frequency and length of admissions increase, there are fewer friends and relatives in their networks. Further, if the size of the networks remains the same, they are comprised of those met through the mental health system and based on short-term relationships (46).

The kind of support provided by others can be classified into multiple types, including: informational support, emotional support, appraisal support, and instrumental support (Weber, 1998). Informing an individual of the typical course of illness provides support through information giving. Expressing care and affection for someone provides emotional support. Providing evaluation about a person's ability to achieve a goal is appraisal support. Providing material resources such as food or money that assists a person is instrumental support (46).

Families of the persistently mentally ill assist one of the most disabled and underserved populations in our society. Understanding the nature of their burden is significant because most of these family caregivers. This essay explores the family's care giving experience in mental illness, with emphasis on the relationship between the informal and formal systems. It proposes that the strain experienced in caring for a mentally ill relative is related to: structural changes in the family, or informal care

system; normative conflicts underlying family care of mentally ill adults; and changes in the formal care system in relation to the preferred locus of care and conceptions of mental illness. Taken together, these factors produce burden defined as an imbalance between the demands of caring and a family's capacity to meet those demands (46).

Structural Changes in the Family if without sufficient resources to house and support those who are mentally ill, the trend toward community-based care has increased families' care giving responsibilities. While the demands associated with family care of those who are mentally ill are escalating, the family's structural capacity to meet those demands is diminishing Furthermore, family historians and sociologists note a narrower time frame for transitions into adult roles with greater uniformity and rigidity in life transitions (46).

**- Social support**

Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible. Every patient shall have the right to treatment suited to his or her cultural background (19).

For recovery mental illness patient need a comprehensive continuum of services and supports including prevention, mental health promotion, treatment, and rehabilitation could be achieved by integrating funding access and establishing standards and research among team members and systems. Collaboration is critical among all stakeholders, which include professional groups, governments, non-governmental community agencies, and occupational therapy organizations. All of the aspect from community should be together (24).

The people in a social support network can help a person find solutions to problems, validate an individual's identity, direct the individual to helpful

information, and provide comfort when that is all that can be done. Connection to others contributes to a sense of well being and gives meaning to life. It is no wonder that social support has been identified as one of the determinants of health, i.e., a factor believed to contribute to our overall health. Schizophrenia is an illness that can cause disorganized thinking, hallucinations, and delusions. It can cause a person to feel depressed or flat and lack the motivation to act. As a serious mental illness, at different stages it can inhibit the ability to make meaningful connections with others. Over time, due to the social stigma associated with serious mental illness, developing and maintaining relationships can be difficult. A support system is vital for people living with schizophrenia yet at the same time the illness places relationships at risk (46).

Social support is a multidimensional construct and differentially defined (Weber, 1998). For the purpose of this research, social support was conceptualized as “perceived social support” which entails a cognitive appraisal of being connected to others Barerra, (1986). Two key dimensions of perceived social support are perceived availability and perceived adequacy of supportive connections Barerra (1986). Social support networks as a determinant of health are believed to have a positive impact on health outcomes Social support can provide a sense of well-being, serve as a source of information, act as a form of coping enhance self-esteem, or provide access to material needs .Social network analysis studies a number of characteristics of the network, including size, composition, number of contacts, type of relationship, physical proximity of individuals to each other, and type of contacts. Social support analysis examines the perceived value or helpfulness of the support provided. Hence, in social support the perceptions of the recipient of social support are important in determining the effectiveness of support (46).

#### **- Professional support**

Mental health professional refers to those who work with people with mental health problem. A variety of occupational groups specialize in the field, notably, psychiatrist, clinical psychologists, mental health nurses, mental health

occupational therapist, and mental health social worker, Other groups to be found are counselors.

Mental health professionals exist to improve an individual's mental health. Most qualified mental health professionals will refer a patient or client to another professional if the specific type of treatment needed is outside of their scope of practice. Psychiatrists are physicians who specialize and are certified in treating mental illness using the biomedical approach to mental disorders including the use of medications. Psychiatrists may also go through significant training to conduct psychotherapy and therapy; Psychiatric Nurses or Mental Health Nurse work in primary care, evaluate and provide care for patients who have anything from psychiatric disorders, medical mental conditions, to substance abuse problems. Social workers in the area of mental health assess and support, and sometimes diagnose and treat, individuals with mental health (particularly psychosocial) problems (24).

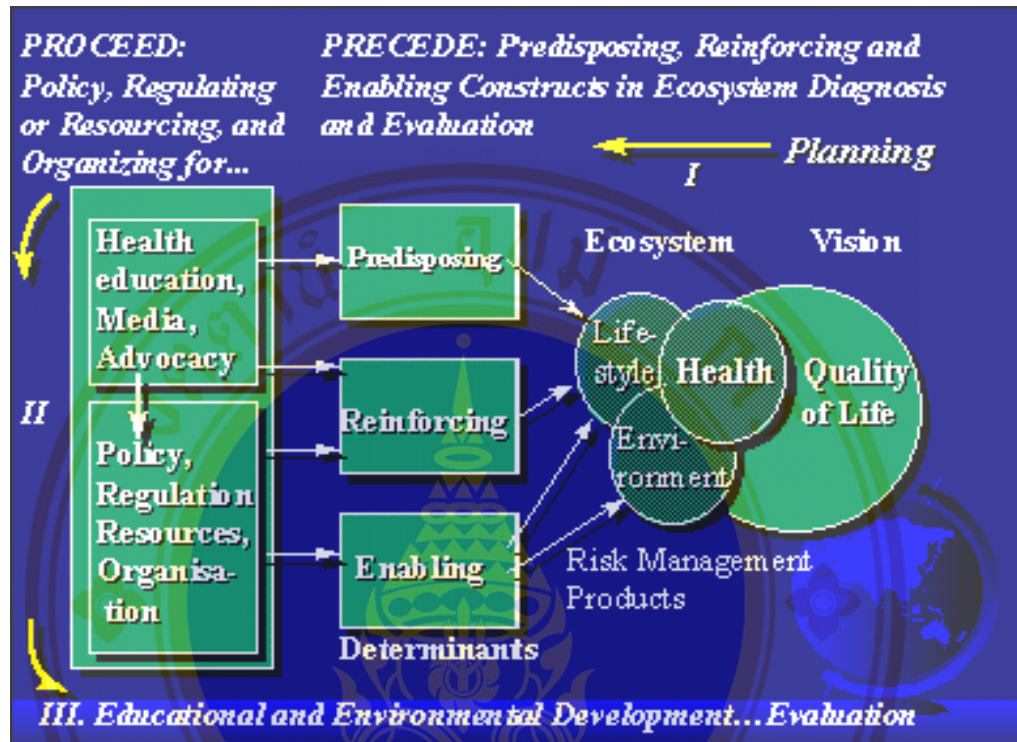
## 2.4 Theoretical Model

### 2.4.1 Precede model

The **precede** model is a framework in the **precede proceed** model (respectively, for Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis, Evaluation and Policy, Regulatory and Organization Constructs in Educational and Environmental Development) model developed by Lawrence W.G and Marshall W.K as a planning and evaluation logic model and procedural model for health education programs. It can be applied in various health areas such as smoking, exercise, HIV/AIDS education, cancer prevention, consumer behavior, (caregiver behavior), and the settings particularly relevant to community and organizational (5).

The **precede** component proposes three set of causal factors are identified, predisposing factors, reinforcing factors and enabling factors influencing or supporting behavioral and environmental change. The critical element of the phase is

the selection of the factor that, if modified, will be most likely to result in behavior change. This selection process includes identifying and sorting.



**Figure 2** The Precede-Proceed Model of Health Program Planning & Evaluation

#### 2.4.2 Predisposing factors

Include a person's knowledge, attitudes, beliefs, values, perceived needs and abilities that facilitate or hinder motivation for behavioral change (i.e. care giver knowledge and attitude for performance to mental illness persons. Predisposing factors interact with genetic predisposition. Some types of knowledge and skills may serve both predisposing and enabling functions in supporting different types of behavior, like as today's reinforcement becomes tomorrow's predisposing. Predisposing factors also include the early childhood experiences that created the attitude, values and perception in the first place (5).

Behavior may not change immediately in response to new awareness or knowledge, but the cumulative effects of heightened awareness increased understanding, and greater command (recognition and recall) of fact will seep into the

system of beliefs, values, attitudes, intentions, self-efficacy, health literacy, and eventually behavior

### **2.4.3 Enabling Factors**

Mostly conditions of the environment, enabling factors facilitate the performance of an action by individuals or organizations. They were factors antecedence to behavior that allows a motivation or aspiration to be realized. The absence of adequate enabling conditions inhibits action. Those skills (i.e. severity of condition and duration of sickness) community resources or barrier (i.e. is medicine available at public health service, available at home) that care giver can help the mental illness person at home (5)

### **2.4.4 Reinforcing factors**

The reward received and the feedback the learner receives from others following adoptions of a behavior-may encourages or discourage continuation of the behavior (e.g. mass media influence and social support). Reinforcing behavior produces lifestyles (enduring pattern of performance), which in turn influence the environment through social norms, political advocacy, consumer demand, or cumulative actions. In performance settings, it may come from family, nurse, doctor, friend and other sources (5)

Reinforcing factors also include adverse consequences of performance, or punishments that can lead to the extinction of a positive performance. Reward also can reinforce performance that is not conducive to health.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 Study Design

The study design was cross sectional study on performance of caregiver in taking care of mental illness patients in Aceh Tamiang district Nanggroe Aceh Darussalam province, Indonesia. The data was collected by CMHN nurses by interviewing caregiver in Aceh Tamiang District Nanggroe Aceh Darussalam Indonesia based on questionnaire.

#### 3.2 Study Population

The study population of this research were the caregivers who regularly responsible in taking care of mental illness patients in the family in Aceh Tamiang district Nanggroe Aceh Darussalam, Indonesia. Total registered mental illness patients in Aceh 112 cases. Therefore the researcher took all of them into the sample study, however only 102 were obtained because of the difficulty in accessing to all due to geographical barriers.

#### 3.3 Research Instrument

A structured questionnaire was employed in this study by trained interviewers. The questionnaire mostly close ended question and consisted of 6 parts as follows:

Part 1 Socio-demographic factors

Part 2 Knowledge about caring mental illness patients

Part 3 Attitude toward mental illness patients

Part 4 Enabling factors regarding on performance caregiver.

Part 5 Reinforcing factors: information resources about financial, information or advise, family support, social support and professional support.

## Part6 Performance of caregiver

### 3.3.1 Questionnaires

A structured questionnaire was used as the research instrument for data collection. Initially, the questionnaire was prepared in English by the researcher, and then translated into Bahasa Indonesia for convenience of collecting data. The questionnaire mostly closed ended question, consisting from six parts. The data was collected from the response of care giver to the questions in the questionnaire and were then stratified.

#### Part 1 Socio-demographic

Socio-demographic characteristic of respondent include gender, age of caregiver, education, occupation, average monthly family income and relationship with mental illness patient.

Among quantitative data (e.g. age, average family monthly income), the number, percentage, mean and standard deviation were obtained. Among qualitative data, the number and percentage were obtained. Average monthly family income levels were categorized into three groups:

Rp 300,000, -- 672,595

Rp. 672,596,--1,079,351

Rp.1.079,352,--2,500,000

#### Part 2 Knowledge about caring mental illness persons

Knowledge part consisted from 17 questions. The score was given for each question according to the answer either “true” or “false” or “don’t know”. Score 1 will give for correct answers and “0” will give for an incorrect answer and don’t know. The range of the score is zero to seventeen. Total score will summarize and categorize. For descriptive analysis, caregiver’ knowledge level was divided into three groups:

Good : Total score  $> \text{Mean} - \text{S.D}$

Fair : Total score between Mean  $- .\text{SD}$  to Mean  $+\text{S.D}$

Poor : Total score  $< \text{Mean} - \text{S.D}$

### **Part 3 Attitude toward mental illness persons**

The attitude part consisted of 6 questions. The score was given in positive statements, 2 scores for an agree answer, 1 score for the answer uncertain, and 0 score for disagree answer. In negative statements, 0 score for agree answer, 1 scores for the answer uncertain, and 2 score for disagree answer. The score range wills 0 to 12. Finally, the total scores will summarize. For descriptive analysis, level of attitude of the students will divided into two groups:

Favorable attitude : Total score  $\geq \text{mean}$ .

Unfavorable attitude : Total score  $< \text{mean}$ .

### **Part 4 Enabling factors regarding on performance caregiver.**

This part was consisted of 7 questions, severity of symptom six questions, for duration of sickness one question. The answer for each question was either “Yes” or “No”.

### **Part 5 Reinforcing factors**

#### **Part 5-1 Family support.**

This part was consisted from fiver questions, regarding to support from other family member. The answer for each question is either “Yes” or “No”. Total score will summarize and categorize. For descriptive analysis, family support level was divided into three groups:

Good : Total score  $> \text{Mean} - \text{S.D}$ .

Fair : Total score between Mean  $- .\text{SD}$  to Mean  $+\text{S.D}$

Poor : Total score  $< \text{Mean} - \text{S.D}$

**Part 5-2 Reinforcing factors: social support.**

This part consisted of six questions, regarding to support from neighbor and community. The answer for each question for is either “Yes” or “No”. Total score will summarize and categorize. For descriptive analysis, family support level was divided into three groups:

Good : Total score  $> \text{Mean} - \text{S.D.}$

Fair : Total score between  $\text{Mean} - \text{S.D.}$  to  $\text{Mean} + \text{S.D.}$

Poor : Total score  $< \text{Mean} - \text{S.D.}$

**Part 5-3 Reinforcing factors: professional support.**

This part was consisted from three questions, regarding to support from other doctor and nurse. The answer for each question is either “Yes” or “No”. Total score will summarize and categorize. For descriptive analysis, family support level was divided into three groups:

Good : Total score  $> \text{Mean} - \text{S.D.}$

Fair : Total score between  $\text{Mean} - \text{S.D.}$  to  $\text{Mean} + \text{S.D.}$

Poor : Total score  $< \text{Mean} - \text{S.D.}$

**Part 5-4 Reinforcing factors: information resources, financial, information or advice.**

This part asked 11 kinds of sources of information including mass media and persons give good performance of caregiver do the activities for mental illness patient. The answer for each question for each question is either “Yes” or “No”

**Part 6 Performance care giver**

The performances score was measured by using five categorized consisted of medical, personal hygiene, physical care, emotional/mental care and social care, summarize activity frequency questions about care giver in the past week. The performance divided into three parts, performance caregiver for patient who need complete help, second for patient who need some help and third for patient who need

less help. Questions were concern about essential need daily living for mental illness persons.

For each part the activity score was given in statement of performance to mental illness person, 2 score for the answer “always”, 1 score for the answer “sometime” and 0 score for the answer “rarely” answer. The score range was 0 to 9. Finally, the total scores were summarizing. For descriptive analysis the summarized total score of care giver activity was divided into three groups:

Good : Total score  $> \text{Mean} - \text{S.D.}$

Fair : Total score between  $\text{Mean} - \text{S.D.}$  to  $\text{Mean} + \text{S.D.}$

Poor : Total score  $< \text{Mean} - \text{S.D.}$

### 3.4. Test of Reability

Prior to the data collection, the questionnaire was pre-tested at Aceh Tamiang district on January 2008. The reability coefficient for attitude questions was fair (Cronbach's Alpha). Regarding on knowledge questions, 30 questionnaires will provide for the first pretest and the reability coefficient (The Kuder-Richardson Formula:  $K_{20}$ ). The reliability coefficient for knowledge was 0.784 and Attitude was 0.686

### 3.5 Data Collection

The data was be collected by interviewing using constructed questionnaire. The questionnaire was prepared in English by the researcher, and then translated into Bahasa Indonesia for convenience of collecting data. The interviewer was the 22 Community Mental Health Nurses working in the village of study. They trained by researcher and were supervised by researcher and research assistance during data collection. The completeness of the questionnaire was revised according to the thesis committee before distributed for pre-test prior the real data collection in the communities of other district

### 3.6. Data Analysis Procedure and Statistical Use.

The data entered into computer by using Epidata 3.0. Minitab version 14 was used for analysis data. As the study was a cross-sectional, frequency and relative percentage was used to the distribution for all variables, mean and standard deviation, minimum, maximum to explain the variables.

After frequency distribution, analysis did with Chi-square test and Fisher's exact test then assess the relationship between independent variables and dependent variable. Fisher exact test used if the result showed one or more expected frequencies of each cross tabulation are found less than 5. Association was determined as significant level if  $p$  value  $< 0.05$ .

## CHAPTER 4

### RESULTS

This study was conducted to identify predisposing factors, enabling factors and reinforcing factors influencing performance of caregiver to mental illness patient at Aceh Tamiang district Nanggroe Aceh Darussalam, Indonesia.

The data collection was collected on 1 January until 30 January 2008 at Aceh Tamiang district. Out of the total 102 questionnaires distributed for 10 Health Center, 5 returned questionnaires were not returned on time and 3 questionnaires were rejected due to missing data. The final sample therefore consisted of 94 subjects.

For further analyzing, descriptive techniques and analytical methods were applied and the results were presented by six parts:

1. Socio-demographic factors
2. Predisposing factors
3. Enabling factors
4. Reinforcing factors
5. Performance of caregiver
6. Association between performance of caregiver and predisposing factor, enabling factors and reinforcing factors.

The result of this study was shown in table as frequency and percentage distribution of the samples, and Chi-square test showed the association between of independent variables and dependent variable. The level of significance for all comparisons was set up at 0.05.

#### 4.1 Socio-demographic factors.

The distribution of respondent in term of gender, age, education, occupation, relationship and monthly income in family were presented in Table 1.

More than half of total respondents (63.83%) were female and the majority of respondent belonged to older age group. The mean age of respondent was 44.3 years and the youngest and oldest of age were 20 years and 69 years respectively.

Regarding the education, most of the respondents got only primary level of education represented 44.68%. About two-fifth (42.56%) of them got education from secondary school up to high school 1. However, there were still 6.38% that had no education.

According to the occupation of respondents, 31.91% or one-third of respondents was farmer. More than one-fourth of respondent (31.91%) belonged to the group of housewife. However, there also had unemployed represented 3.19%.

Minimum average monthly income of respondent was 300,000 and the maximum 2,500.000 Rupiah. More than a half (55.32%) of respondent got average monthly income at moderate level (672,597 – 1,079,351Rupiah).

The relationship of respondent with the patient was found in this study. Majority were father/mother (28.72%), while one-fourth was relatives and sibling, Only 2.13% was grandfather/grandmother of the patient.

**Table 1** Socio-demographic factors

General characteristic	N=94	(n)	(%)
<b>Gender</b>			
Male		34	36.17
Female		60	63.83
<b>Age of caregiver (years)</b>			
20 – 36		12	12.77
37 – 53		40	42.55
54 – 70		42	44.68
Mean = 44.30	SD = 11.30 (years)	Max = 69	Min = 20
<b>Educational level</b>			
No education		6	6.38
Primary school		42	44.68
Secondary school		20	21.28
High school		20	21.28
College and higher		6	6.38
<b>Occupation</b>			
Laborer		6	6.38
Farmer		30	31.91
Trader		09	09.57
Government official		08	08.51
Private Company		1	1.06
Housewife		27	28.72
Unemployed		3	3.19
Fisherman		10	10.64
<b>Average monthly income (Rupiah)</b>			
Rp. 1,079,352 — Rp. 2,500,000		35	37.23
Rp. 672,596 — Rp.1,079,351		52	55.32
Rp. 300,000 — Rp. 672,595		7	7.45
Mean = 709,574	SD = 369,777	Min=300,000	Max=2,500,000
<b>Relationship with mental illness patient.</b>			
Father/mother		27	28,72
Grandfather/grandmother		2	2.13
Children/grandchildren		23	24.47
Sibling		18	19.15
Relatives		24	25.53

## 4.2 Predisposing factors

### 4.2.1 Knowledge on mental illness patient

**Table 2** Overall knowledge of caregiver on mental illness patient by items

No	Statement	N=94	Correct Answers	
			(n)	(%)
<b>Cause of mental illness patient</b>				
1.	Disappointed from education can cause mental illness.		64	68.09
2.	Disappointed from love cannot cause mental illness.		56	59.57
3.	Addictive substances such as cannabis can cause mental illness.		68	72.34
4.	Prolong social problems can cause mental illness.		76	80.85
5.	Addictive substances such as cannabis can cause mental illness.		77	81.91
6.	Mental illness occurs due to abnormality of chemical substances in the brain.		35	37.23
7.	Mental illness cannot transmit from heredity		34	36.17
<b>Symptoms of Mental Illness patient</b>				
8.	Mental illness patient usually are not out of reality and unable to control themselves.		3	3.19
9.	Mental illness patient have weird, abnormal behavior i.e. walking for a whole day		88	93,62
10.	Mental illness patient have hallucinations such as seeing what others cannot; seeing what does not exist and hearing strange noises.		75	79.79
11.	Mental illness patient has abnormal affects or inappropriate affect. They laugh or cry without reasons		89	94.68
12.	Mental illness has unrealistic or delusion thought such as being hurt by others; thinking of being important and powerful persons		76	80.85

**Table 2** Overall knowledge of caregiver on mental illness patient by items (cont.)

No	Statement	N=94	Correct Answers	
			(n)	(%)
<b>Treatment of Mental Illness patient</b>				
13.	While having medication, mental illness patient can drink alcohol.		83	88.30
14.	Rewarding and encouraging the patient for their proper behaviors will make them repeat those behavior		72	76.60
15.	Treatment by psychotherapy cannot make mental illness understand and change their behavior.		64	68.09
16.	Treatments for mental illness does not take a long time nor involve continuity of treatments		68	72.34
17.	Mental illness patient should stop the medication if they feel better.		61	64.89

Seventeen items pertaining to mental illness knowledge of caregiver were included in part 3 of the questionnaire. Related to the frequency distribution of knowledge by question item Table 2 showed that more than a half of respondent (61.70%) knew the cause of mental illness patient. 70.42% of respondent knew symptom of mental illness patient, and 74.04% of respondent knew how to treatment mental illness patient. The low rate of correct answer was found on the main symptom of mental illness patient 3%.

**Table 3** Overall knowledge of caregiver toward mental illness patient

Knowledge level	N=94	Number	Percent
		(n)	(%)
Good ( 15-16)		13	13.83
Fair ( 8 - 14)		69	73.40
Poor ( 4 - 7)		12	12.77
Mean=11.585	SD= 2.909	Min=4	Max=16

The knowledge of caregiver in this study were categorized into three groups of the knowledge as good, fair and poor and it was presented in table 3. Good knowledge was those who had score from 15-16 while a fair knowledge group were those with score of 8-14, and a poor knowledge group was those with score of 4-7.

It was noted that the majority of respondent had fair represented 73.40% and only 13.83% had good knowledge.

#### 4.2.2 Attitude caregiver toward mental illness patient

**Table 4** Attitude toward mental illness patient by items

No	Statement	N=94	Level of attitude					
			Agree		Uncertain		Disagree	
			(n)	(%)	(n)	(%)	(n)	(%)
1.	Allowing mental illness patients to be responsible for daily activities can help them feel more valuable		80	85.11	6	6.38	8	8.51
2.	Mental illness patient require a lot of mental support.		88	93.62	1	1.06	5	5.32
3.	Mental illness patient cannot responsible for house work.		27	28.72	25	26.60	42	44.68
4.	Mental illness patient are still useful and productive		81	86.17	8	8.51	5	5.32
5.	Mental illness patient are not usually lazy		28	29.79	25	26.60	41	43.62
6.	Mental illness patient cannot give responsibility		28	29.79	36	38.30	30	31.91

The attitude caregiver toward mental illness patient was asked by six questions of attitude. Table 4 showed the attitude caregiver toward mental illness patient, and Table 5 showed the level of attitude of caregiver

As presented in table 4 the majority of respondent expressed their feeling mainly on “agree” with the score up fifty percent (62.58%) in almost all attitude items and also they mention about one-fourth (25.00%) on “disagree” in several negative statement items. However, quite low percentage of score (12.41%) of the respondents who mentioned on “uncertain”.

**Table 5** Overall attitude level of caregiver

Attitude level		N=94	
		Number (n)	Percent (%)
Favorable	(score $\geq$ 8)	72	76.60
Unfavorable	(score $<$ 8)	22	23.40
Mean= 8.777	SD= 1.803	Min=5	Max=12

According to the mean and standard deviation, the attitude of caregiver towards mental illness patient, in this study was classified into two groups, considered as favorable attitude and unfavorable attitude. The favorable attitude group was those who had score more than and equal to 8. And for those with less than 8 were unfavorable attitude group.

The table 5 revealed that the respondents who had favorable attitude was about 3 times more than the unfavorable attitude (76.60% and 23.40%). The mean attitude was 8.777, the minimum score was 5 and maximum was 12.

### 4.3 Enabling Factors

The frequency distribution of enabling factors among total number of respondents was presented in Table 6. Majority of mental illness patient were perceived by their caregiver as severe in their symptom of aggressive behavior 85.11%, hallucination 87.23%, and emotional feeling dysfunction 82.98%. The symptom that the caregiver perceived less among their mental illness patient were distortion of idea/version 59.57% disturbance of consciousness 54.26%.

Regarding duration of sickness, the most of the respondent (89.36%) said that the patient have been sick 1-9 years. However, there were 1.06% of respondent said that the patient have been sick 19-27 years. The mean score was 4.564 years, with minimum 1 year and maximum 25 years among total number of respondents.

**Table 6** Severity of symptom (enabling factors)

Severity of symptom	N=94	Yes		No	
		(n)	(%)	(n)	(%)
Disorder of motor activity (aggressive behavior)		80	85.11	14	14.89
Disorder of content of thought (hallucination)		82	87.23	12	12.77
Disorder of affect (emotion/feeling dysfunction)		78	82.98	16	17.02
Disorder of perception (distorted of idea/version)		56	59.57	38	40.43
Disturbance of consciousness (do not understand what other people say with him)		51	54.26	43	45.74

**Table 7** Duration of sickness (enabling factors)

Duration of sickness	N=94	Frequency	
		Number	Percent
1 - 9 years		84	89.36
10 - 18 years		9	9.57
19 - 25 years		1	1.06
Mean=4.564	SD= 3.746	Max= 25	Min=1

## 4.4 Reinforcing factors

### 4.4.1 The level of support

Fourteen items pertaining to reinforcing factors support provided to mental illness patient were included three part of the questionnaire.

Table 7 showed the level of reinforcing factors. Concerning three parts, it was found that 74% of respondent got support from family, while 21.28% did not. Regarding kind of family support, more than half of respondent (63.51%) answered that they got financial support for the patient. About fifty percent got information and emotional support, only one fourth (25.68%) of patient got recreation support.

With connection to the question got help from the neighbor, most of respondent (70.21%) received it. According to social support from community, nearly a hundred percent (92.55%) of the respondent answered the community gave them social support.

Regarding the kind social support received from neighbor and community, the majority 76.60% and 74.47% received was acceptance and encouragements. More than half patient (59.57) got empathy and empowerment.

Related to professional support, it was found that two third of them were easy to get treatment from the doctor. Nearly a hundred percent of respondent (85.11%) of respondent received clear explanation from doctor. And the importance one was almost a hundred percent (98.94%) of respondent said that Community Mental Health nurses paid them visiting to teach them how to take care mental illness patient.

**Table 8** Characteristic of support provided to mental illness patient

Variable	N=94	Yes		No	
		(n)	(%)	(n)	(%)
<b>Family support</b>		74	78.72	20	21.28
<b>Kind of family support*</b>					
Financial support		47	63.51	27	36.49
Emotional support		36	48.65	38	51.35
Information support		40	54.05	34	45.95
Recreation		19	25.68	55	74.32
<b>Social Support **</b>					
Get support from neighbor		66	70.21	28	29.79
Get support from community		87	92.55	7	7.45
Encouragement		70	80.46	17	19.54
Acceptance		72	82.76	15	17.24
Empathy		59	67.82	28	32.18
Empowerment		56	64.37	31	35.63
<b>Professional support</b>					
Easiness to get therapy from doctor		65	69.15	29	30.38
Doctor give clear explanation		80	85.11	14	14.89
CMHN nurse home visit		93	98.94	1	1.06

\*Only N=74

\*\* Only N=87

**Table 9** Overall reinforcing factors

Variable	N=94	Good		Fair		Poor	
		(n)	(%)	(n)	(%)	(n)	(%)
<b>Overall reinforcing factor</b>		17	18.09	66	70.21	11	11.70
Family support		22	29.73	52	70.27	0	0
Social support		30	31.91	54	57.45	10	10.64
Professional support		55	58.51	39	41.49	0	0
Mean= 0.6936	SD= 0.1413			Min=4		Max=16	

According to overall reinforcing factor, majority of the support at fair level were represented 70.21%. For family support and social support, most of respondent got support at fair level, only professional support more than a half in good level.

#### 4.4.2 Information resources

Table 10 showed the frequency distribution of the information sources. Nearly a hundred percent of respondent (92.55%) got mental illness information from nurse when the nurse visits to their house. And more than fifty percent (68.09%) got information of respondent from the doctor.

**Table 10** Information resources

Variable	N=94	Yes		No	
		(n)	(%)	(n)	(%)
Ever heard about mental illness		93	98.94	1	1.06
Doctor		64	68.09	30	31.91
Nurse		87	92.55	7	7.45
Family		64	68.09	30	31.91
Friend		49	52.13	45	47.87
Religion		11	11.70	83	88.30

Table 11 below showed the media information about mental illness. Nearly a half (46.81%) of respondent answered that they got information from television. However, only 4.26% respondent got from leaflet.

**Table 11** Media information

Variable	N=94	Yes		No	
		(n)	(%)	(n)	(%)
Book		17	18.09	77	81.91
Newspaper		24	25.53	70	74.47
Magazine		14	14.89	80	85.11
Television		44	46.81	50	53.19
Radio		17	18.09	77	81.91
Leaflet		4	4.26	90	95.74

#### 4.5. Performance caregiver.

##### 4.5.1 Performance caregiver's level with patient need complete help (totally).

According to mean and standard deviation, the performance caregiver in this study was classified into three groups, as good, fair and poor level.

The good performance group was those who had score 17 – 20, the fair performance group was those who had score 13 – 16, and for those with score 9-12 were the poor level.

Table 12, showed sixteen respondents take care of the patient with need complete help. Almost all (87.50%) of the respondent, their performance was at fair level.

**Table 12** Performance caregiver's level with patient need complete help (totally) by item (n=16)

Statement	N=16	Performance caregiver							
		Always		Sometime		Rarely			
		(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Patient need complete help (Totally)									
a giving medicine 3 time a day		14	87.50	0	0	2	12.50		
b attending to clinic when necessary		4	25.00	10	62.50	2	12.50		
c giving the patient daily bathing		12	75.00	3	18.75	1	6.25		
d giving the patient tooth brushing		2	12.50	13	81.25	1	6.25		
e change dressing for the patient everyday		13	81.25	3	18.75	0	0		
f prepare food for the patient 3 time a day		14	87.50	2	12.50	0	0		
g going outside together with patient		1	6.25	6	37.50	9	56.25		
h rehabilitating such as give the patient simple physical activity		2	12.50	7	43.75	7	43.75		
i give positive reinforcement when the patient do the right activity		12	75.00	3	18.75	1	6.25		

**Table 13** Performance caregiver's level with patient need complete help (totally)

Performance of caregiver level	N=16	Number	Percent
		(n)	(%)
Good ( 17 - 18)		2	12.50
Fair (13 - 16)		14	87.50
Mean= 14.813	SD= 1.377	Min= 13	Max=18

#### 4.5.2 Performance caregiver's level with patient need some help (partially).

The result showed that the performance of caregiver divided into three groups. Based on mean and SD with the formula Mean  $\pm$  SD, good level was those who had score 17 – 22, the fair performance group was those who had score 11 – 16, and for those with score 9-10 were the poor level.

Table 14, Thirty-nine respondents take care of the patient with need some help. Regarding performance of caregiver to the patient with condition of patient need some help, the majority of the respondent (71, 79%) had fair level. However, there were 5.13% at poor level.

**Table 14** Performance caregiver's level with patient need some help by items (n=39)

Statement	N=39	Always		Sometime		Rarely	
		(n)	(%)	(n)	(%)	(n)	(%)
<b>Patient need some help (Partially)</b>							
a remind the patient to take medicine 3 time a day		23	58.97	16	41.03	0	0
b accompany him/her to attend clinic when necessary.		16	41.03	18	46.15	5	12.82
c facilitate the patient daily bathing		16	41.03	21	53.85	2	5.13
d facilitate the patient to brush his teeth		15	38.46	22	56.41	2	5.13
e help him change dressing everyday		25	64.10	12	30.77	2	5.13
f prepare food for eating 3 time a day		16	41.03	22	56.41	1	2.56
g accompany him/her to going outside		21	53.85	15	38.46	3	7.69
h rehabilitating such as give the patient simple physical activity		14	35.90	14	35.90	11	28.21
i give positive reinforcement when the patient do the right activity		18	46.15	10	25.64	11	28.21

**Table 15** Performance caregiver's level with patient need some help

Performance of caregiver level	N=39	Number	Percent
		(n)	(%)
Good (17 - 22)		9	23.08
Fair (11 - 16)		28	71.79
Poor (< 11)		2	5.13
Mean= 14.774	SD= 2.872	Min=9	Max=22

#### 4.5.3 Performance caregiver's level for patient who need less help.

The performance caregiver's level with patient who need less help divided into three groups. Based on mean and SD with the formula  $\text{Mean} \pm \text{SD}$ , good level was those who had score 17 – 22, the fair performance group was those who had score 11 – 16, and for those with score 5-10 were the poor level.

The result showed that, more than fifty percent (66.67%) of caregiver's performance performed their job at fair level and 5.13% at poor level.

**Table 16** Performance caregiver’s level with patient who need less help by items (n=39)

Statement	N=39	Always		Sometime		Rarely	
		(n)	(%)	(n)	(%)	(n)	(%)
Patient need complete help (Totally)							
a check availability of the medicine		28	71.79	10	25.64	1	2.56
b suggest the patients to consult to clinic if necessary.		16	41.03	19	48.72	4	10.26
c facilitate the patient daily bathing		12	30.77	13	33.33	14	35.90
d facilitate the patient to brush his teeth		11	28.21	12	30.77	16	41.03
e facilitate him change dressing everyday		16	41.03	10	25.64	13	33.33
f prepare food for eating 3 time a day		23	58.97	5	12.82	11	28.21
g accompany him/her to going outside		2	5.13	17	43.59	20	51.28
h make the patient be active participatory to rehabilitation.		17	43.59	15	38.46	7	17.95
i give positive reinforcement when the patient do the right activity.		20	51.28	15	38.46	4	10.26

**Table 17** Performance caregiver with patient who need less help

Performance of caregiver level	N=39	Number	Percent
		(n)	(%)
Good (20 - 27)		11	28.21
Fair (12 - 19)		26	66.67
Poor (< 19)		2	5.13
Mean= 16.590	SD= 4.247	Min= 10	Max=27

#### 4.5.4 Overall performance caregiver's level

Table 18 showed the overall level of performance caregiver with the combined all of the performance caregiver for “totally help”, “partially help” and “less help”. The good level was those who had score 20 – 27, the fair level were those who had score 12 – 19, and for those with score 4-11 were the poor level. Approximately 72.34% of performance caregiver was in the fair level.

**Table 18** Overall performance of caregiver

Performance of caregiver level		N=94	Number (n)	Percent (%)
Good	(20 - 27)		22	23.40%
Fair	(12 - 19)		68	72.40%
Poor	( 4 - 11)		4	4.26%
Mean=	15.521	SD= 3.445	Min=9	Max=27

#### 4.6 Association between performance caregiver and factors.

##### 4.6.1 Performance caregiver's and socio-demographic factors

The result in Table 19 indicated that there was statistically significant relationship between occupation and average monthly income and level of caregiver's performance.

**Table 19** Caregiver's performance by socio-demographic factors

General Characteristic N=94	Performance caregiver			$\chi^2$	p
	Good %	Fair %	Poor %		
<b>Gender</b>					
Male	17.65	76.47	5.88	0.985	0.321
Female	26.67	70.00	3.33		
<b>Age of caregiver</b>					
20-36	30.00	65.00	5.00	0.617	0.552
35-53 and 54-70	21.63	72.32	4.05		
<b>Education</b>					
No Education/primary	22.91	72.92	4.17	0.013	0.909
Secondary school/high-school/ college	23.91	71.74	4.35		
<b>Occupation</b>					
Laborer/farmer/trader/ fisherman/private company	19.64	76.79	3.57	5.830	0.045*
Government official	0	87.50	12.50		
Unemployed and housewife	36.67	60.00	3.33		
<b>Average monthly income (Rupiah)</b>					
300,000 – 672,597	37.14	57.14	5.72	4.132	0.042*
672,597 – 1,079,351and 1,079,352 – 2,500,000	15.25	81.36	3.39		
<b>Relationship</b>					
Father/mother	18.52	77.78	3.70	0.546	0.761
Grandfather/grandmother/ children/grandchildren	24.00	72.00	4.00		
Sibling/relatives	26.19	69.05	4.76		

<sup>a</sup> P-value by Chi-Square \*relationship

#### 4.6.2 Caregiver's performance and predisposing factors

The results of study showed in Table 16. It revealed that knowledge and attitude were not significantly associated between performance caregiver and predisposing factors ( $p > 0.05$ ).

**Table 20** Caregiver's performance by predisposing factors

Predisposing factors	N=94	Performance caregiver			$\chi^2$	p
		Good %	Fair %	Poor %		
<b>Knowledge</b>						
Good		46.15	53.85	0	0.022	0.883
Fair/Poor		19.75	75.31	4.94		
<b>Attitude</b>						
Favorable		23.61	70.83	5.56	0.349	0.555
Unfavorable		22.73	77.27	0		

#### 4.6.3 Caregiver's performance and enabling factors

According to study relationship between performance caregiver and enabling factors, the result revealed that disorder of perception had significantly association with performance caregiver ( $p = 0.002$ ).

**Table 21** Caregiver performance by enabling factors

Enabling factors	N=94	Performance			$\chi^2$	p
		caregiver				
		Good	Fair	Poor		
		%	%	%		
<b>Severity of symptom</b>						
Disorder of motor activity (aggressive behavior)						
Yes		20.00	75.00	5.00	1.899	0.168
No		57.14	42.86	0		
Disorder of content of thought (hallucination)						
Yes		24.39	71.95	3.66	0.049	0.825
No		16.67	75.00	8.33		
Disorder of affect (emotion/feeling dysfunction)						
Yes		21.79	73.08	5.13	0.124	0.724
No		31.25	68.75	0		
Disorder of perception (distorted of idea/version)						
Yes		30.36	64.29	5.36	3.248	0.002*
No		13.16	84.21	2.63		
Disturbance of consciousness (do not understand what other people say with him)						
Yes		29.41	64.71	5.88	3.248	0.072
No		16.28	81.40	2.33		
<b>Duration of sickness</b>						
1 - 9 years		21.43	75.00	3.57	2.791	0.095
10 - 18 years/19 – 27 years		40.00	50.00	10.00		

\*relationship

#### 4.6.4 Caregiver's performance and reinforcing factors

##### 4.6.4.1 Caregiver's performance and characteristic of support provided.

Regarding to study relationship between performance caregiver and reinforcing factors. The result revealed that social support had significantly association with performance caregiver ( $p=0.049$ ).

**Table 22** Characteristic of support provided

Reinforcing factors N=94	Performance caregiver			$\chi^2$	p
	Good %	Fair %	Poor %		
<b>Overall support provided</b>					
Good	47.06	41.18	11.76	1.293	0.255
Fair/Poor	18.18	79.22	2.60		
<b>Family support (n=74)</b>					
Good	27.27	63.64	9.09	1.384	0.239
Fair/Poor	21.15	76.92	1.92		
<b>Social support</b>					
Good	33.33	56.67	10.00	6.040	0.049*
Fair/Poor	18.75	79.69	1.56		
<b>Professional support</b>					
Good	25.45	69.09	5.45	0.700	0.403
Fair/Poor	20.51	76.92	2.56		

\*relationship

#### 4.6.4.2 Caregiver’s performance and information resources

On the study of relationship between performance caregiver and information resources. The results of study revealed that there was not significantly associated to performance caregiver ( $p>0.05$ ).

**Table 23** Caregiver’s performance by information resources

Reinforcing factors N=94	Performance caregiver			$\chi^2$	p
	Good %	Fair %	Poor %		
<b>Ever heard about mental illness</b>					
Yes	22.58	73.12	4.30	2.644	0.276
No	100	0	0		
<b>Doctor</b>					
Yes	25.00	71.88	3.13	0.022	0.883
No	20.00	73.33	6.67		
<b>Nurse</b>					
Yes	20.69	74.71	4.60	3.286	0.070
No	57.14	42.86	0		
<b>Family</b>					
Yes	23.44	71.88	4.69	0.046	0.830
No	23.33	73.33	3.33		
<b>Friend</b>					
Yes	22.45	75.51	2.04	0.514	0,473
No	24.44	68.89	6.67		

#### 4.6.4.3 Caregiver's performance and media information

Regarding to study relationship between performance caregiver and reinforcing factors. The result indicated that media information there was not significantly association with performance caregiver ( $p>0.05$ ).

**Table 24** Caregiver's performance by media information

Media information	N=94	Performance caregiver			$\chi^2$	p
		Good %	Fair %	Poor %		
<b>Book</b>						
Yes		29.41	64.71	5.88	0.605	0.437
No		22.08	74.03	3.90		
<b>Newspaper</b>						
Yes		16.67	83.33	0	1.946	0.163
No		25.71	68.57	5.71		
<b>Magazine</b>						
Yes		14.29	85.71	0	1.470	0.225
No		21.28	59.57	4.26		
<b>Television</b>						
Yes		27.27	70.45	2.27	0.147	0.701
No		20.00	74.00	6.00		
<b>Radio</b>						
Yes		29.41	70.59	0	0.032	0.858
No		22.08	72.73	5.19		
<b>Leaflet</b>						
Yes		25.00	75.00	0	0.015	0.903
No		23.33	72.23	4.44		

## CHAPTER 5

### DISCUSSION

A cross sectional study was conducted in order to identify the relationship between performance of caregiver of mental illness patient and factor influencing. Performance of caregiver is of immense importance, as one of the most negative consequences of bad performance of caregivers is causes of suicide, as described in earlier chapters. Performance of caregiver was the dependent variable of this study. Methodological concerns and important issues are discussed in this chapter.

The factors included in this study were predisposing factors such as gender, knowledge, attitude, enabling factors such as type of mental illness, severity of symptoms, duration of sickness, and relationship with patient and reinforcing factors such as sources of information and support from family, social and professional.

The discussion as followed is from the finding on the study related to factors influencing performance caregiver among 94 respondents of student, based on objectives as following;

- 5.1 Socio-demographic factors
- 5.2 Predisposing factors
- 5.3 Enabling factors
- 5.4 Reinforcing factors

#### **5.1 Socio-demographic factor**

This study did not find gender to be significantly associated with performance caregiver ( $p=0.500$ ). Normally, we can expect that caregiver usually female. A previous study reported that the ratio of female to male caregivers in this study was

about four to three. Few health and well-being effects of care giving were found to differ by gender; there were no differences between men and women in care giving effects on depression. (41) in the result gender proportion of total respondents for female two to one (63.83%) if compared with male (36.17%). Others result from previous study in Northeastern Psychiatric Hospital in Thailand found the gender of caregiver most of them (55.7%) were female.(14) . Previous study showed that, the caregivers in the 1991 survey, they were predominantly female (79 %) (42).

The theories explained that sociological, psychological, and feminist theories of gender differences provide many reasons for the greater likelihood of women being helpers. These include the following: providing care may be central to women's identity; daughters have a special sense of attachment to their mothers; societal support of women as helpers is reinforced by social ideologies, devaluing of women's paid work, and inadequate government support. The literature suggests that older men and women have personal networks of different size and composition in which male and female network members typically provide different types of support. The studies note men and women provide different types of care giving assistance. In addition, there is some evidence that adult children may be more likely to provide care to a parent of the same gender. Thus, support relationships may be influenced by the gender of the caregiver and the gender of the helper and also by the combination of gender of caregiver and helper (42).

Related to the age, the average age of respondent belonged to older age group, while 37-53 years 42.55% and 54-70 years was 44.68%, with mean 44.30. Canadian classification, this group is considered to be adult, or considered to be senior. (43) For caregiver this age very sufficient for caring the patient. However, the result of association between age and performance there was not significant at  $p\text{-value}=0.405$ . From data showed that young or old was not directly influence with the performance someone. Previous study showed that, the caregivers in the 1991 survey ranged in age from 36 to 82 years with a mean age 60 or older. This is nearly the same accordance with other previous the study of Muangnang, R at Northeastern Psychiatric Hospital

in Thailand, which showed the largest (53.7%) of caregiver were age between 41-60 years (14).

For education status for caregiver, this study found it was predominantly primary school graduates, 44.68% among the respondent, and 6.38% had no education. In term of association with performance caregiver, the result of this study showed that there was no relationship. That was quite the same with previous study at Northeastern Psychiatric Hospital in Thailand that showed almost all of caregiver (86%) had only primary school education.

Concerning occupation of the respondents who were belonged to farmer and housewife showed significant association. This is nearly the same accordance with other previous the study of Muangnang, R at Northeastern Psychiatric Hospital in Thailand, showed around 54,6% occupation of caregiver were farmer and house keeper(14). However the result at previous had not explain the association with the performance caregiver.

Regarding on monthly income, the result of this study revealed association with performance. This might be explained that greater family monthly income enables the better care, i.e. availability the medicine, food, other facilities for patient activity daily living and recreation. The study made by Pender showed that people which low education also had a poor economic situation (48).

According to relationship of caregiver with patient, a quarter of respondent (28.72%) was their parent (father/mother) which had no association with performance of caregiver. The explanation from others literatures showed relationship of helper. In American society might expect that adult children will be the most important sources of support to their parents. The others research, investigated the matching between four sources of support for spouse caregivers (i.e., adult children, other relatives, friends/neighbors, and formal helpers) We assume that the primacy of the parent–child relationship and the history of emotional attachment associated with parent–

child roles will be satisfied most strongly when emotional support is provided by adult children compared with other sources of support (42).

## 5.2. Predisposing factors

### 5.2.1 Knowledge

Knowledge level on performance of caregiver did not have significant association with performance of caregiver. A previous study found that caregiver have Family-led education programs for caregivers of people with serious mental illness empower them with information they need to provide necessary support to loved ones as they recover. Caring for a family member with serious mental illness can be a daunting experience to someone who lacks knowledge and resources. However, a study of an eight-week, mental illness course shows it successfully equips some caregivers with new information to help them do a better job (44). This finding was in contradiction with the report of the previous study that health education program had a significant positive effect for caregiver on improvement the knowledge and practice to take care the patient mental illness well (29).

Previous study explained that to determine the extent that Journey of Hope helped family members gain knowledge of mental illness; Pickett-Schenk investigated knowledge levels and information needs of 462 family members of adults with serious mental illness from December 2000 to June 2004 at three different time points: Pickett-Schenk evaluated family members using the 40-question Family Knowledge Scale, which included questions about the various topics covered in the course, and the Family Information Needs Scale, which asks participants to rate their interest in learning about 45 topics ranging from medications to coping strategies. She evaluated all participants at baseline and then at three and six months later and found that compared with those in the control group, respondents who participated in the course had significantly increased their knowledge and decreased their need for more information ( $p < .001$ ).

### **5.2.2 Attitude**

The result of this study, attitude level toward mental illness patient did not have a significant association with performance of caregivers. However the result in this study found that attitude of caregiver toward patient 76.60% favorable.

### **5.3. Enabling factors**

According to severity of symptom, it was found there was significant association between performances of caregiver. Almost ninety percent, had disorder of motor activity (aggressive behavior), disorder of content of thought (hallucination), disorder of affect (emotion/feeling dysfunction), More than a half of patient had both of disorder, perception (distorted of idea/version), and disturbance of consciousness (do not understand what other people say with him). This might be explained in the other references that nearly half (45 percent) of one mental disorder met criteria for two or more disorders (29).

Regarding duration of sickness, almost all of patient in this study had been sick for one until nine years, while 06% of respondent have been sick nineteen to twenty-five years. And the result showed that it had no significant association with performance of caregiver. Previous study found that the serious group reported a mean of 88.3 days — nearly 3 months of the year — when they were unable to carry out their normal daily activities.

### **5.4 Reinforcing factors**

#### **5.4.1 Provided support**

The result of present study revealed that overall support, majority of the support at fair level were represented 70.21%, and both information sources and media information had no significant association with performance caregiver.

#### **5.4.1.1 Family support**

Concerning family support this study found that 74% of respondent got support from family, while 21.28% did not. It can be explained that family might not know how to take care the patient mental illness because low education level, lack of knowledge, and also lack of economic. So almost of them thought that patient need only financial support. Other kinds of support like emotional, information and recreation only some of caregiver gave it.

#### **5.4.1.2 Social support**

This study found that most of mental illness patient received social support from the neighbor (78.72%), a social support from community nearly a hundred percent (92.55%). The result showed that it had relationship with performance of caregiver. The previous study examines social support and individuals with serious mental illness, because this very important for patient's recovery (42).

Regarding the kind of social support, this research found that the majority of support that the patient received from community was acceptance 76.60% and encouragements 74.47%. More than half of patient (59.57%) received empathy and empowerment. And the result revealed that had significant association with performance of caregiver. The other references said that for recovery mental illness patient need a comprehensive continuum of services and supports. Collaboration is critical among all stakeholders, which include professional groups, governments, non-governmental community agencies, and occupational therapy organizations. All of the aspect from community should be together. The people in a social support network can help a person find solutions to problems, validate an individual's identity, direct the individual to helpful information, and provide comfort when that is all that can be done. Connection to others contributes to a sense of well being and gives meaning to life. It is no wonder that social support has been identified as one of the determinants of health, i.e., a factor believed to contribute to our overall health. A support system is vital for people living with schizophrenia yet at the sometime the illness places relationships at risk (46).

Social support is a multidimensional construct and differentially defined. For the purpose of this research, social support was conceptualized as “perceived social support” which entails a cognitive appraisal of being connected to others. Two key dimensions of perceived social support are perceived availability and perceived adequacy of supportive connections. Social support networks as a determinant of health are believed to have a positive impact on health outcomes. Social support can provide a sense of well-being, serve as a source of information, act as a form of coping, enhance self-esteem, or provide access to material needs. Social network analysis studies a number of characteristics of the network, including size, composition, number of contacts, type of relationship, physical proximity of individuals to each other, and type of contacts. Social support analysis examines the perceived value or helpfulness of the support provided. Hence, in social support the perceptions of the recipient of social support are important in determining the effectiveness of support (46).

#### **5.4.1.3 Professional support**

The results of present study revealed that nearly a hundred percent (85.11%) and (98.94%) of respondent received support from doctor and nurse. The importance one that CMHN nurses (Community Mental Health Nursing) home visits to their house every week and to teach them how to taking care of mental illness patient well. And it found there was not significant association between performance and professional support. It might be explained from the previous study that as part of the formal care system that includes health care professionals, institutions, and treatment programs, nurses can provide support to strengthen informal family care systems. Previous study showed that caregiver relationship with mental health professional, seventy-nine percent of respondent reported having contact during the past six months with one or more the mental health professionals (42). It is quite different with the others research that their findings indicate that a significant of caregivers was satisfied with the amount of their involvement with mental health professionals (46).

### 5.4.2 Information resources

Nearly a hundred percent of respondent (92.55%) got mental illness information from nurse when the nurse making home visits to their house. And more than half got information making home visit from the doctor. Half of the respondent also got information from family and friend, and that was very helpfully for caregiver improved their performance in taking care of the patient. The good result found from this research when the interviewer asked other information, and the fact the religious teacher also give information about this, it represented 11.70%.

The result of present study revealed that no one information sources had significant association with caregiver performance. For additional,

### 5.4.3 Media information

Nearly half of respondent answered that they got information from television. At previous study found that caregivers may need additional information with regards to their service provides additional helpful information to those providing care. Families were recruited to participate through newspaper articles and advertisements, televised public-service announcements, and flyers featuring information about the study. And for available resources caregivers have a variety of needs. Finding resources to meet those needs can be a difficult and challenging task for information regarding resources available for a caregiver (47).

The other reference revealed that, the leaflet could be effective information resource for them. Moreover, one merit of leaflet is it can be kept in hand and read repeatedly when they want to (14). However, only 4.26% respondent got information from leaflet.

## CHAPTER 6

### CONCLUSION AND RECOMMENDATION

#### 6.1 Conclusion

This study was community based on cross sectional descriptive study. It was conducted at Aceh Tamiang district Nanggroe Aceh Darussalam, Indonesia from January 1-30, 2007. The objectives of this study were describe socio-demographic factors of caregiver, caregiver's knowledge about mental illness patient, caregiver's attitude toward mental illness patient, enabling factors, reinforcing factors and performance caregiver. It also tried to find associations between performance caregiver and all of factors related. The subjects of this study were 94 caregivers at Aceh Tamiang district. They were interviewed by 22 Community Mental Health Nurses using structured questionnaires that had been standardized, pre-tested and modified before data collection. Using computer software, all collected data was proceed and analyzed.

The result showed the socio-demographic factors even though caregiver of patient was rather of old age and had low education level; they were adult enough to care for their patient well. Among 94 caregivers majority were mother/father, there was wide variation of average family income per month, majority at moderate level most of them a farmer. The result found occupation and family monthly income had relationship with performance caregiver.

The fair level of performance of caregiver in the family was found in this study. Base of it, this study found there were no significant associations between performance caregiver and both caregivers' knowledge and caregiver's attitude, for predisposing factors.

According to enabling factors, for severity of illness the result revealed that only disorder of perception had significantly association with performance caregiver. Majority of patient had been sick from one year until nine years.

Concerning reinforcing factors, caregiver got overall support nearly eighty percent at fair level and the result found that had association relationship between social support and performance caregiver. Sources of information about mental illness, nearly hundred percent from CMHN nurse by home visit to their house. For media information, most of respondent get information from television.

## **6.2. Recommendations**

The community based public health education should be promoted to increase knowledge and attitude for better assessing and care giving mental illness patient and preventing substantially, and hopefully in the future, no one performance of caregiver at poor level and almost all of them in good level.

The main points that must be strengthened in the community are family support, because they are very important person in patient life. And give the family information that the patient also needs emotional support and especially recreation.

To encourage and enrich caregiver's performance, the community should be promoted to increase their empathy to mental illness patient and the important one that they could together with the patient doing their work in order to make the empowerment of the patient. And also from the religious teacher could be support information for the family.

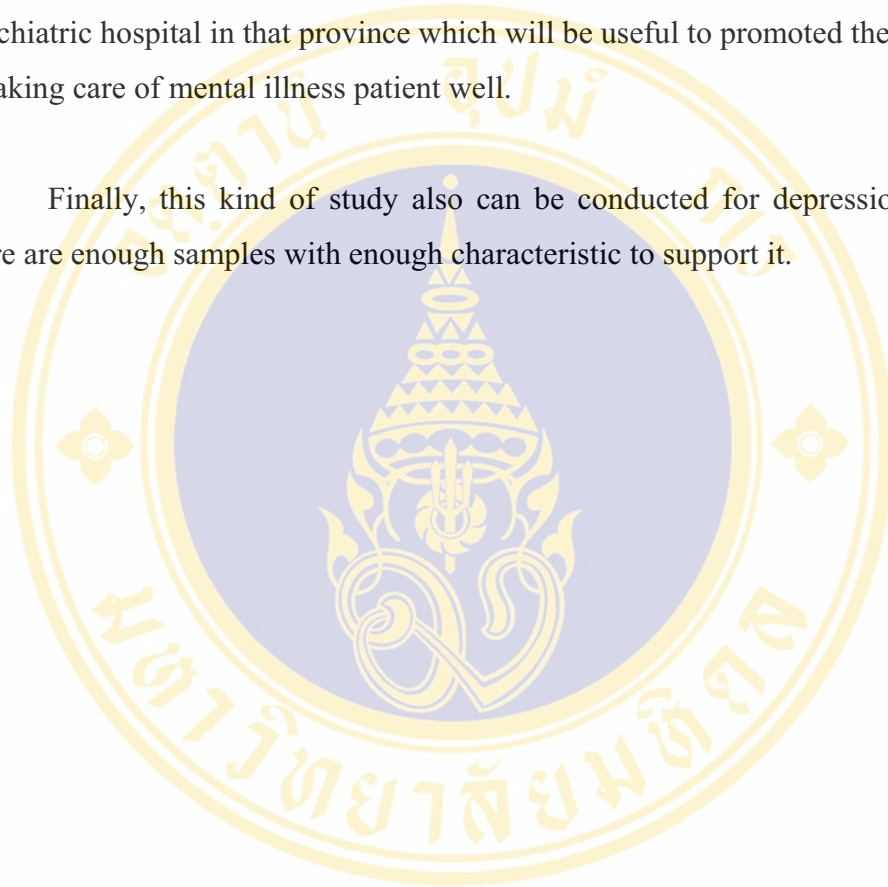
### **6.2.1 Recommendations for further studies.**

Further study should be prepare a larger population with enough amounts of caregiver to mental illness patient to get more reliable and meaningful result which can be used to formulate better health policy in large population by large research location, such as one province or more. In depth interview and observation to the

family for their practice to take care of mental illness patient also can be used to get further results of this kind of study.

Further study on caregiver's performance toward mental illness patient in the family should be conducted in parallel with studies on caregiver's performance in psychiatric hospital in that province which will be useful to promoted the performance in taking care of mental illness patient well.

Finally, this kind of study also can be conducted for depression as long as there are enough samples with enough characteristic to support it.



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## APPENDIX A

### QUESTIONNAIRE

#### PERFORMANCE OF CAREGIVER IN TAKING CARE OF MENTAL ILLNESS PATIENT IN THE FAMILY IN ACEH TAMIANG DISTRICT, NANGGROE ACEH DARUSSALAM PROVINCE, INDONESIA

This questionnaire is prepared for assessing the performance of caregiver in taking care of mental illness patient in the family. The information received from you will help improve the performance of caregiver in taking care of mental illness patient in the family in this district. Your cooperation will be highly appreciated. Your response will be kept confidential. Therefore, please feel free to answer the questions. Thank you very much for your kind and truthful.

ID. No:

Date: ...../...../.....

1. Name of respondent: .....
2. Address: .....
3. Name of interviewer: .....

*Instruction for interviewer: please read every question for interviewer in conversation and asking style where appropriate but do not change the sentence.*



## II. KNOWLEDGE OF MENTAL ILLNESS:

*Instruction: Please mark  $\checkmark$  in only one of in the box [ ] according to your understanding.*

No	Statements	True	False	Don't know
<b>Cause of Mental Illness patient</b>				
1	Disappointed from education can cause mental illness	[ ]	[ ]	[ ]
2	Disappointed from love cannot cause mental illness	[ ]	[ ]	[ ]
3	Conflict cannot cause mental illness.	[ ]	[ ]	[ ]
4	Prolong social problems can cause mental illness.	[ ]	[ ]	[ ]
5	Addictive substances such as cannabis can cause mental illness.	[ ]	[ ]	[ ]
6	Mental illness occurs due to abnormality of chemical substances in the brain.	[ ]	[ ]	[ ]
7	Mental illness cannot transmit from heredity	[ ]	[ ]	[ ]
<b>Symptoms of Mental Illness patient</b>				
8	Mental illness patient usually are not out of reality and unable to control themselves.	[ ]	[ ]	[ ]
9	Mental illness patient have weird, abnormal behavior such as sitting at the same location for a long time or walking for a whole day.	[ ]	[ ]	[ ]
10	Mental illness patient have hallucinations such as seeing what others cannot; seeing what does not exist and hearing strange noises.	[ ]	[ ]	[ ]
11	Mental illness patient abnormal affects or inappropriate affect. They laugh or cry without reasons	[ ]	[ ]	[ ]
12	Mental illness have realistic or delusion thought such as being hurt by others; thinking of being important and powerful persons.	[ ]	[ ]	[ ]

No	Statements (cont.)	True	False	Don't know
<b>Treatment of Mental Illness patient</b>				
13	While having medication, mental illness patient can drink alcohol.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Rewarding and encouraging the patient for their proper behaviors will make them repeat those behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Treatment by psychotherapy cannot make mental illness understand themselves and change behavior.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Treatments for mental illness does not take a long time nor involve continuity of treatments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Mental illness patient should stop the medication. if they feel better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### III. ATTITUDE ON MENTAL ILLNESS PATIENT:

*Instruction: Please mark  $\checkmark$  in the box  according to what you belief.*

No	Statements	Agree	Uncertain	Disagree
<b>Attitude</b>				
18	Allowing mental illness patients to be responsible for daily activities can help them feel more valuable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Mental illness patient require a lot of mental support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Mental illness patient cannot responsible for house work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Mental illness patient are still useful and productive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Mental illness patient are not usually lazy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Mental illness person cannot give responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**IV. ENABLING FACTORS**

No	Statements	Yes	No
<b>Severity of symptom</b>			
24.	What is the stage of severity of your mental illness patient? (can choose more than one)		
	a. Disorder of motor activity (aggressive behavior)	[ ]	[ ]
	b. Disorder of content of thought (hallucination)	[ ]	[ ]
	c. Disorder of affect (emotion/feeling dysfunction)	[ ]	[ ]
	d. Disorder of perception (distorted of idea/version)	[ ]	[ ]
	e. Disturbance of consciousness (do not understand what other people say with him)	[ ]	[ ]
	f. Others (Specify.....)	[ ]	[ ]
<b>Duration of sickness</b>			
25.	How many years your mental illness patient has been sick?.....years.		

**IV. REINFORCING FACTORS**

No	Statements	Yes	No
<b>Family Support</b>			
27	Do other family members giving support to mental illness? (to29)	[ ]	[ ](Skip
28.	If yes, in what kind support they give?(can answer more than one)		
	a. Financial support	[ ]	[ ]
	b. Emotional support	[ ]	[ ]
	c. Information support	[ ]	[ ]
	d. Recreation	[ ]	[ ]
<b>Social Support</b>			
29	Do you get help from your neighbor for mental illness patient in your house when you needed?	[ ]	[ ]
30.	Do the community give the support for the mental illness. (to32)	[ ]	[ ](Skip

30. Do the community give the support for the mental illness.   (Skip to 32)
31. What kind of support that the mental illness persons received from community. (Can answer more than one)
- a. Encouragement (give reward if patient do the right thing)
  - b. Acceptance (make patient the same level with other people)
  - c. Empathy (feeling that patient also did not want to be sick can feeling sadness of patient)
  - d. Empowerment (give patient responsibility for simple activity that patient can do)

**Professional Support**

32. Do you find it easier to get treatment from doctor for mental illness patient?
33. If you consult the mental illness patient to doctor, does doctor give help or clear explanation?
34. Do the CMHN Nurse home visit to your mental illness patient?

**Source of Information**

*Instruction: Please mark ✓ in the box [ ] that you choose.*

35. Have you ever heard about Mental illness information?  
 1. Yes  2. No
36. From whom have you got information about mental illness?  
 (Can choose more than one if had from anyone)
- 2.1. Doctors  1. Yes  2. No
  - 2.2. Nurse  1. Yes  2. No
  - 2.3. Family  1. Yes  2. No
  - 2.4. Friend  1. Yes  2. No
  - 2.5. Others (specify):.....
37. From where have you received information?

(Can choose more than one if had from any channel)

3.1. Television [ ]1. Yes [ ]2. No

3.2. Radio [ ]1. Yes [ ]2. No

3.3. Book [ ]1. Yes [ ]2. No

3.4. Newspaper/magazine [ ]1. Yes [ ]2. No

3.5. Magazine [ ]1. Yes [ ]2. No

3.6. Leaflet [ ]1. Yes [ ]2. No

37. Other (specify):.....

## V. PERFORMANCE OF CAREGIVER

*Instruction: Please mark  $\checkmark$  in the box [ ] according to what you practice.*

39. Do your Mental Illness patient able to take care of himself?

Totally (if yes go to questionnaire 40 )

Partially (if yes go to questionnaire 41)

Not at all (if yes go to questionnaire 42)

No	Statements	always	sometime	rarely
<b>The patient cannot do anything, need complete help (totally)</b>				
40.	Are you providing these following- assistance to mental illness patient?			
	a. giving medicine 3 time a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. attending to clinic when necessary.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. giving the patient daily bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d giving the patient tooth brushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. change dressing for the patient everyday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. prepare food for the patient 3 time a day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g going outside together with patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. rehabilitating such as give the patient simple physical activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. give positive reinforcement when the patient do the right activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please stop and thank you for your participant**

No	Statements	always	sometimes	rarely
<b>The patient need with some help (partially)</b>				
41. Are you providing these following care for mental illness patient?				
	a. remind the patient to take medicine 3 time a day.	[ ]	[ ]	[ ]
	b. accompany him/her to attend clinic when necessary.	[ ]	[ ]	[ ]
	c. facilitate the patient daily bathing	[ ]	[ ]	[ ]
	d. facilitate the patient to brush his teeth	[ ]	[ ]	[ ]
	e. help him change dressing everyday	[ ]	[ ]	[ ]
	f. prepare food for eating 3 time a day	[ ]	[ ]	[ ]
	g. accompany him/her to going outside.	[ ]	[ ]	[ ]
	h. rehabilitating such as give the patient simple physical activity.	[ ]	[ ]	[ ]
	i. give positive reinforcement when the patient do the right activity.	[ ]	[ ]	[ ]

**Please stop and Thank you for your participant.**

No	Statements	always	sometimes	rarely
<b>The patient able to do every thing by him self.</b>				
42.	Are you providing these following care for Mental Illness patient?			
	a. check availability of the medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. suggest the patients to consult to clinic if necessary.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. facilitate the patient daily bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. facilitate the patient to brush his teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. facilitate him change dressing everyday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. prepare food for eating 3 time a day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. accompany him/her to going outside.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	h. Make the patient be active participatory to rehabilitation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	i. give positive reinforcement when the patient do the right activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please stop and thank you for your participant.**

**GOOD LUCK AND HAPPY NEW YEAR**

**QUESTIONER**  
**PERFORMANCE OF CAREGIVER IN TAKING CARE OF**  
**MENTAL ILLNESS PATIENT IN THE FAMILY IN ACEH**  
**TAMIANG DISTRICT, NANGGROE ACEH DARUSSALAM**  
**PROVINCE, INDONESIA**

No. Identitas : .....

Tanggal: ...../.....

1. Nama responden: .....
2. Alamat: .....
3. Nama interview: .....

*Instruksi untuk interview: Silahkan baca setiap pertanyaan untuk interview, boleh menggunakan model pertanyaan di dalam percakapan yang sesuai tapi tidak merubah isi kalimat kuesioner.*



## II PENGETAHUAN TENTANG GANGGUAN JIWA

*Instruksi: Silahkan beri tanda  $\checkmark$  pada salah satu kotak [ ] sesuai dengan pengetahuan saudara.*

No	Pernyataan	Benar	Salah	Tidak Tahu
1	Kecewa karena pendidikan dapat menyebabkan gangguan jiwa.			
2	Kecewa karena putus cinta tidak dapat menyebabkan Gangguan jiwa			
3	Konflik tidak dapat menyebabkan gangguan jiwa.			
4	Masalah sosial yang berkepanjangan dapat menyebabkan gangguan jiwa			
5	Zat adiktif seperti ganja dapat menyebabkan gangguan jiwa			
6	Gangguan jiwa terjadi karena ketidakseimbangan zat kimia di dalam otak.			
7	Gangguan jiwa tidak dapat diturunkan melalui garis keturunan			
	<b>Gejala gangguan jiwa pada pasien.</b>			
8	Pasien gangguan jiwa biasanya tidak reality dan tidak dapat mengontrol dirinya sendiri.			
9	Pasien gangguan jiwa mempunyai ketidaknormalan prilaku seperti duduk di tempat yang sama dalam waktu yang lama atau berjalan-jalan sepanjang hari.			
10	Pasien gangguan jiwa mempunyai halusinasi seperti apat melihat apa yang oranglain tidak dapat melihat yang tidak ada dan mendengar suara-suara.			
11	Pasien gangguan jiwa mempunyai afek yang tidak normal atau afek yang tidak sesuai. Mereka tertawa atau menangis tanpa alasan.			
12	Pasien gangguan jiwa memiliki pikiran yang tidak			

	realistis atau pikiran delusi seperti merasa dilukai oleh orang lain, merasa jadi orang penting dan merasa mempunyai kekuatan lebih.			
	<b>Perawatan Pasien Gangguan Jiwa</b>			
13	Saat minum obat, pasien gangguan jiwa boleh minum alkohol			
14	Beri pujian dan semangat pada pasien atas tindakannya yang sesuai akan membuat mereka mengulangi kembali tindakan tersebut.			
15	Perawatan oleh psikoterapi tidak dapat membuat pasien sadar dan merubah prilakunya.			
16	Perawatan untuk pasien gangguan jiwa tidak butuh waktu yang lama dan tidak juga harus berkelanjutan pengobatannya			
17	Pasien gangguan jiwa seharusnya menghentikan pengobatan jika merasa sudah lebih baik.			

### III SIKAP TERHADAP PASIEN GANGGUAN JIWA

*Instruksi: Silahkan beri tanda  $\checkmark$  didalam kotak [ ] sesuai dengan jawaban yang diyakini.*

No	Pernyataan	Setuju	Tidak Tentu	Tidak Setuju
18	Mengizinkan pasien gangguan jiwa untuk Bertanggung untuk aktivitas sehari-hari dapat membantu mereka merasa lebih berharga.			
19	Pasien gangguan jiwa membutuhkan banyak dukungan,			
20	Pasien gangguan jiwa tidak dapat bertanggung jawab terhadap pekerjaan rumah			
21	Pasien gangguan jiwa masih berguna dan produktif			
22	Pasien gangguan jiwa biasanya tidak malas			
23	Pasien gangguan jiwa tidak dapat bertanggung jawab			

**IV ENABLING FACTORS**

No	Pernyataan	Ya	Tidak
	<b>Gejala</b>		
24	Bagaimana tahap kondisi gangguan jiwa pada pasien yang dirawat? (Dapat dipilih lebih dari satu)		
	a. Gangguan aktivitas motorik (prilaku agresive)		
	b. Gangguan isi pikir (hallusinasi)		
	c. Gangguan alam perasaan (emosi/ketidaksesuaian perasaan)		
	d. Gangguan persepsi (Ketidaksesuaian ide)		
	e. Kesadaran kacau (Tidak mengerti apa yang orang lain katakan)		
	f. Lainnya (Sebutkan.....)		

**Lamanya gejala**

25. Sudah berapa lama sakit pasien yang dirawat? .....tahun.

**Hubungan Kekerabatan**

26. Bagaimana hubungan kekerabatan dengan pasien gangguan jiwa yang dirawat?

- Bapak/Ibu
- Kakek/Nenek
- Anak/Cucu
- Saudara
- Keluarga (sebutkan.....)
- lainnya (Sebutkan.....)

**IV REINFORCING FACTORS**

No	Pernyataan	Ya	Tidak
	<b>Dukungan keluarga</b>		
27	Apakah anggota keluarga lain memberi bantuan pada pasien ini. (Jika tidak, lanjutkan ke no 29)		
28	Jika ya, Dukungan apa yang mereka beri? (dapat dijawab lebih dari satu)		



37. Dari mana informasi yang bapak/Ibu peroleh?

(Dapat diisi lebih dari satu)

- |               |          |             |
|---------------|----------|-------------|
| 3.1. Televisi | [ ]1. Ya | [ ]2. Tidak |
| 3.2. Radio    | [ ]1. Ya | [ ]2. Tidak |
| 3.3. Buku     | [ ]1. Ya | [ ]2. Tidak |
| 3.4. Koran    | [ ]1. Ya | [ ]2. Tidak |
| 3.5. Majalah  | [ ]1. Ya | [ ]2. Tidak |
| 3.6. Leaflet  | [ ]1. Ya | [ ]2. Tidak |

38. Lainnya (sebutkan) : .....

## V. PENAMPILAN YANG MERAWAT PASIEN

*Instruksi: Silahkan beri tanda ✓ di dalam kotak [ ] sesuai dengan praktek yang dilakukan*

39. Apakah pasien gangguan jiwa dapat merawat diri sendiri?

- Bantuan Total (jika ya silahkan isi pertanyaan no 40 )
- Bantuan sebagian (jika ya silahkan isi pertanyaan no 41)
- Mandiri (jika ya silahkan isi pertanyaan no 42)

No	Statements	selalu	kadang-kadang	jarang
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**Untuk pasien yang butuh bantuan total**

40. Apakah bapak/ibu melakukan hal yang tersebut dibawah ini untuk pasien gangguan jiwa?

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| a. Memberi obat 3 kali sehari   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Membawa pasien ke puskesmas bila perlu                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Memandikan pasien  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Membantu menyikat gigi pasien  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Mengganti baju untuk pasien setiap hari                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Menyediakan makanan untuk pasien 3x sehari                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Membawa pasien jalan-jalan keluar.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Rehabilitasi pasien dengan member kegiatan yang dapat dikerjakan di rumah. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Memberi pujian bila pasien melakukan sesuatu yang benar.                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Silahkan berhenti dan terima kasih.**

No	Pernyataan	Selalu	kadang-kadang	jarang
----	------------	--------	---------------	--------

**Untuk pasien yang butuh bantuan sebagian**

41. Apakah bapak/ibu melakukan hal tersebut dibawah ini untuk pasien gangguan jiwa?

- |    |   |     |     |     |
|----|---|-----|-----|-----|
| a. | Mengingatkan minum obat pasien 3 x sehari.  | [ ] | [ ] | [ ] |
| b. | Menemani pasien hadir ke puskesmas  | [ ] | [ ] | [ ] |
| c. | Menyediakan fasilitas mandi pasien sehari-hari  | [ ] | [ ] | [ ] |
| d. | Memfasilitasi pasien untuk sikat gigi   | [ ] | [ ] | [ ] |
| e. | Mengganti mengganti baju setiap hari  | [ ] | [ ] | [ ] |
| f. | Menyediakan makanan 3x sehari   | [ ] | [ ] | [ ] |
| g. | Rehabilitasi pasien seperti member kegiatan yang sederhana untuk dapat dikerjakannya. | [ ] | [ ] | [ ] |
| h. | Rehabilitasi pasien dengan car memberi kegiatan yang ringan.                          | [ ] | [ ] | [ ] |
| i. | Memberi pujian bila pasien melakukan tidakan yang benar                               | [ ] | [ ] | [ ] |

**Silahkan berhenti dan terima kasih.**

No	Pernyataan	selalu	kadang-kadang	jarang
<b>Untuk pasien yang mandiri (dapat melakukan kegiatan sendiri)</b>				
42. Apakah bapak/Ibu melakukan hal tersebut dibawah ini untuk pasien gangguan jiwa?				
a.	Mengecek persediaan obat pasien	[ ]	[ ]	[ ]
b.	Menyarankan pasien konsul ke puskesmas jika perlu.	[ ]	[ ]	[ ]
c.	Menyediakan kebutuhan mandi pasien	[ ]	[ ]	[ ]
d.	Memfasilitasi alat untuk sikat gigi pasien	[ ]	[ ]	[ ]
e.	Menyediakan baju untuk ganti setiap hari	[ ]	[ ]	[ ]
f.	Menyediakan makanan 3x sehari	[ ]	[ ]	[ ]
g.	Menemani pasien jalan-jalan keluar	[ ]	[ ]	[ ]
h.	Membuat pasien ikut aktif dalam kegiatan di rumah.	[ ]	[ ]	[ ]
i.	Memberi pujian pada pasien bila melakukan hal yang benar.	[ ]	[ ]	[ ]

**Silahkan berhenti**

**Terima kasih atas partisipasi Bapak/Ibu**

## BIOGRAPHY

<b>NAME</b>	Arbaiyah
<b>DATE OF BIRTH</b>	31 <sup>st</sup> May, 1972
<b>PLACE OF BIRTH</b>	Rantau, Kuala Simpang, Aceh Tamiang, Indonesia
<b>INSTITUTION OF ATTENDED</b>	North Sumatera University, Indonesia Bachelor of Nursing faculty 1999 – 2001 Mahidol University, Thailand ASEAN Institute for Health Development Master of Primary Health care Management 2007 – 2008
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