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How patients with schizophrenia "as a Victim" cope with violence in Indonesia: a qualitative study

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Abstract

Background: There is increasing concern about the level of violence and people with schizophrenia. However, research about violence in correlation with schizophrenia mostly focuses on patients as offenders rather than victims. Phenomenology was chosen to explore experience of patients with schizophrenia as a victim coping with violence in Indonesia.

Results: Of the 40 interviewees, average age was 35.8 years old (range 21–43). The 40 patients with schizophrenia comprised 26 males and 14 females. Violence typically included pushing, punching, or kicking, and restrained. The patient's coping experiences as victims of violence were categorized into three themes: submission (n = 28), expression of anger to object (n = 33), and positive coping strategy (n = 23).

Conclusion: To shorten the evaluation required to choose coping strategies, domestic violence education/ psychoeducation would be relevant.

Keywords: Schizophrenia, Violence, Victim, Coping, Qualitative study

Background

Schizophrenia is a group of disorders which severely disrupts the memory; visual and auditory perceptions; and problem-solving, social, and cognitive abilities of the persons affected [1–3]. Schizophrenia is a major mental illness in contemporary society which affects about 1% of the world population [1]. Providing optimal treatment for people with schizophrenia is a challenge for clinicians and healthcare providers. Violence is a great concern in the practice of psychiatry [4, 5]. There is also increasing concern about the level of violence and people with schizophrenia [6, 7]. Several studies disclose that half of patients with mental illness face harsh treatment such as the use of legal force known as "a show of force" [8, 9]. On the other hand, it is patients who are seen dangerous to nurses, mainly patients with raging, furious, aggressive, or threatening condition under the influence of addictive substances [10]. Healthcare professionals are held liable for violations of the rights of patients, such as isolation, medication control without an informed consent, and restriction in the aggressive behavior of the patient [8, 9]. However, study revealed that violence in patients with mental illness is most frequently done at family members, and most often takes place at home [11]. However, research about violence in correlation with schizophrenia mostly focus on patients as offenders rather than victims [12–15].

Most patients cannot adapt to coping that is associated with violence in schizophrenia [16, 17]. Coping is defined as continuing psychological-behavioral efforts to reduce psychological trauma (such as that induced by violence) [18]. There is no unique coping pattern; each traumatic situation has specific coping strategies that are

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successful [19]. In addition, several studies indicate that youth at risk for psychosis report using more maladaptive coping strategies [20]. In principle, someone's mistake in responding to traumatic situations (maladaptive coping mechanism) will bring a serious impact on the person's mentality [21]. Specifically, an adaptive coping response for patients in the case of violence may be analogized to the case of exposure to the terror, as the study reported by [22] concludes that the most prevalent coping mechanism is active information search about loved ones and social support. Some qualitative research is also undertaken on family violence by people with schizophrenia, including the coping mechanism of parents who witness violence from adult children with schizophrenia. Another study has described aggression regulation, such as the use of drugs, as one coping mechanism [23]. However, these previous studies did not provide specific information on how patients cope with violence. The aim of this study was to explore experience of patients with schizophrenia as a victim coping with violence in Indonesia.

Methods

Design

Phenomenology was chosen for this research because the goal was to identify and explain experiences of the participants in dealing with violence. Data were gathered through in-depth semi-structured interviews and content analysis. Phenomenology is connected with the extensive investigation of human experience systems of meaning [24, 25]. This phenomenological research offers knowledge of conceptual essences, i.e., inherent sense mechanisms in the perception of aggression in patients with schizophrenia.

Participants

Patients were primarily assigned by physicians and nurses in hospitals. The study adopted a purposive sample of 40 patients from the psychiatric ward of large mental hospitals in West Java, Indonesia. For qualitative study, there was no restriction on sample size, instead of reaching saturated data. However, Colvin et al. [26] mentions the number of participants in qualitative research as many as 3 to 10 participants. The inclusion criteria for patients were the following: age over 18 years old, confirmed diagnosis of schizophrenia by physicians, and able to give informed consent.

Data collection

Data were collected between May 2018 and August 2018. Prospective patients with schizophrenia and their parents have been reported by nurses and physicians of hospitals. Before the interviews, the psychiatric nurse found the patients to be psychologically healthy in relation to their psychiatric symptoms. Trust relationships with the participants have been established. Patients were initially invited and prepared by nurses. The researcher interviewed patients following a mutual agreement to engage in an in-depth, semi-structured personal interview. Semi-structured interviews are performed within an open environment that allows for concentrated, conversational, and two-way interaction. Each interview lasted about 1 h. Patients and parents have been interviewed separately. In addition, the researchers of this study performed the interviews. The interviews were tape-recorded and transcribed verbatim with permission.

Interview guideline

The interview guideline was constructed through literature review and expert discussion with experts in both qualitative research and mental health psychiatry. Before interviewing patients, the researchers asked a question to parents or legal guardian about the years diagnosed with schizophrenia. Key questions were as follows: (1) Have you ever been treated harshly, felt threatened by nurses or family? (2) How do you cope with all experienced violence you have ever received?

Data analysis

The data analysis process has been driven by the content analysis approach. Interviews have been transcribed and analyzed. This study offers realistic and efficient procedures for the standardization and presentation of qualitative analyses, demonstrating the relationship between simple (lowest-order pre-set interviews), arranging (groups of basic themes together based on basic rules), and global (groups of organising themes describing the underlying themes) themes.

Ethics approval and consent to participate

Ethical approval was granted to the Institutional Review Board (UNIMAS/NC-21.02/03-02 Jld.2 (11)). Studying this sensitive issue, particularly those who may be vulnerable, posed unique ethical concerns related to research method and approach used. Researchers have their professional experience in a number of clinical procedures in psychology and academic fields, including nurses. A detailed assessment of potential participants ensured that the patients had capacity to agree to interview by both the psychiatrist and nurses. Details on the research were presented at the time of initial screening. Participants were told of the voluntary aims of the research, the independent consent, the parental consent, the non-binding consent, the right to withdraw, and the privacy of the results. Silent consent is not appropriate. Written informed consent was obtained prior to data collection from the patients and confirmed with their

legal guardian. The informed consent provided opportunity for participants to address their inquiries, sufficient interview, and active listening. However, issues such as the transportation problems of the studied participants which has joined in this collaboration and in-depth conversations with hospitals may be addressed in the context of this violence research issue.

Rigour

Researchers and professional registered nurses performed the interviews. Independent review of the interviews was conducted by two professional coders. Strategies were introduced to encourage the credibility, context, skills, and expertise of the researchers; a thick overview of the interesting experiences of the participants; regular debriefing periods; and discussions that equipped the researchers an opportunity to test the ideas and perceptions between them and to scrutinize the analysis. A detailed explanation of the context, identification, and descriptions of respondents and data collecting procedures, and a rich representation of the results, along with relevant quotes of the participants' own words, were given in order to promote transferability. The research design was specifically defined to promote dependability. Findings to ensure reliability were also explored by the researchers. For confirmation, an explanation of the results has been sent to the respondents; none of that was contested.

Results

Demographic characteristics

Of the 40 interviewees, average age was 35.8 years old (range 21–43). The 24 patients with schizophrenia comprised 26 males and 14 females. Their average number of years since the onset of schizophrenia was 16.3 years old (range 7–24). All patients reported experience of violence which typically included pushing, punching, or kicking, and restrained. About 60% of participants reported that violence by family or health care staff commonly happens related to the attacks of disease or during remission.

The patient's experiences of violence were not linear, but rather it was a complex experience of being a perpetrator, yet at the same time as victim of violence. Hence, they have to struggle in their everyday living trying to cope with violence from both inside and outside. Furthermore, the patient's coping experiences as victims of violence were categorized into three themes: submission (n = 28), expression of anger to object (33), and positive coping strategy (23).

Submission

Submission is the action or fact of accepting or the authority of another person as a nurse or hospital manager. The keywords that arise from the patient indicating a submission are as follows: "I am weeping alone," "I am remaining quiet alone," "I just obey it," "I am not able to do so," "No power to do so," "I choose to be in silent."

These can be seen from the following data:

(C8)—"When I am bound, I am weeping alone"
(D1)—"Yes, I succumb to my mother's fate, I won't strive, and I remain to be quite alone"
(D5)—"In my heart, I want to rebel, but I could not, instead I just obeyed"
(D2)—"I was tied to my bed; I want to fight but I was incapable of doing so"
(D8)—"I have once wanted to fight, but I have no power to do so"
(D9)—"I chose to be in silent, as I was afraid to be hit again when fight."

Expression of anger to object

In addition to expressing anger to family, neighbor, or nurses through verbal, patients also express their anger by destroying objects. The items around their house like "mattress, pillows, and furniture" were used as the object to express their anger. This patient's emotional expression is a form of communication in which they told their neighbor that they "disagree". It means, according to the patient, that the problem could not be solved anymore with usual communication. The data that appeared are as follows:

(D1)—"There were whisperings of demons and voices that ordered me to burn mattress."
(D9)—"Beating, awry, amok, burning cushions, removing furniture"
(C4)—"Initially, I was going berserk in my house ..."
(DI)—"I want to hit; I went berserk at my home"

Positive coping strategy

The new findings in this study were the emergence of a theme "Positive Coping Strategy," conducted by those patients with schizophrenia. Although the literature and some previous studies explained that positive compensation is only possibly used by a healthy person or mental health nurse, it can be done using a positive action or positive activity such as: "Do carry out anything," "take a deep breath," "ask God's forgiveness," "sing songs alone," "Go out hallucinations you're not real, did introspection". For more details, see the following excerpts:

(A7)—"When I am dejected, I do carry out anything as requested"
(A8)—"In order not to be angry I take a deep breath, while utter astaghfirullah to ask God's forgiveness, I have to engage in many activities..."

(C2)—"Whenever I feel angry, I sing songs alone"
(C8)—"I tell to myself when I heard voices, go…go you voices! (Hallucinations) You're not real, I closed my eyes"
(D9)—"I am tied because of my wrongdoing, so I did introspection"

Discussion

The new findings of this study are the emergence of special coping in patients with mental disorders when violence happens. In the condition of "Helplessness," many patients tried to explore specific coping in the context of religion. The coping is "submission". This is revealed in the form of data from many patients: "When I am banded, I am weeping alone, trust only to God," "Yes, I submit to my mother's fate, I won't strive, I am remain quiet alone and pray," "In my heart, I want to rebel, but I did not, I just obey it, Surrender," "I am tied on the bed, I want to fight but I am not able to do so, I Surrender," "I once had thought to fight, but I have no power to do so," "I choose to be in silent, as I am afraid to be hit again when I am fighting..." A Muslim psychologist [27] explained that the concept, technique, and benefit of submission especially for patients and family with mental health problem were backgrounded with the religion. Most of the patients in mental hospitals of West Java embraced Islamic Religion. Muslims are required to believe in God's provision called destiny. Everything that has happened was the fate of God. Most patients believed that all the good or bad destiny that has happened with full of wisdom. So, Muslims in certain condition are required to "surrender to God" or in Indonesian terminology it is said as "berserah diri". In addition, the word of Islam in Arabic means "surrender," which it reflects, to submit the main tenant to the will of God [28]. With "submission," after all efforts, the patient hopes that the power of God becomes a "reward" or inspiration to get "the way out" of the problem in life.

In psycho-religious concept, there are three techniques to apply "surrender and submission," especially for psychiatric patients. First, patients should see that both of pleasure and difficulty are a trial from God, for example, when a patient gets restrained in a mental hospital, this can be a stimulus for the patient to remember his/her God. This is in accordance with the following findings, "In order not to be angry I take a deep breath, while utter astaghfirullah to ask God's forgiveness, I have to engage in many activities..., I am tied because of my wrong doing, so I did introspection". Second, patients should feel confident that God will not give a burden beyond of human capability. God has measured every load adjusted to the maximum ability of human. For example, the patient should think that restraint is temporary and impermanent; after that, Allah will give to the patient a reward for struggle and patience. Third, the patient should find the positive side of all difficulties after doing the maximum effort, for example, during the hospitalization the patient should think that it was a form of mercy from God that the patient must break from routine and daily busyness.

Although there are some sceptic scientists who believe that submission in psychiatric patients can be a negative meaning, in which a condition where the patients are forced to change behaviour because there was no other choice, but many psychiatrists agree that submission in relation with religion can be constructive coping and important power to consider. This is supported by [29] who revealed "in navigating the complexities of human health religious commitment is a force to consider, the patient's spiritual/religious dimension: a forgotten factor in mental health". In Islamic concepts, the benefits of the submission or *Tawakkal* to Allah SWT is the guarantee and of ease affair in the world and the Hereafter. Allah SWT said in the Holy Qur'an: "Whoever should believe in Allah and the Last day, and whoever fears Allah He will make for him a way out and will provide for him from where he does not expect. And whoever relies upon Allah, and then He is sufficient for him. Indeed, Allah will accomplish His purpose." (Ath-thalaq:1-2).

Besides that, submission or *Tawakkal* could make someone stronger and independent, as Allah said: "Put your trust in the Ever-Living (Allah) who never dies: celebrate His praise, for He Alone is sufficient to be aware of the sins of His servants. (QS. Al-furQan:58)" "But no, by your Lord, they can have no Faith, until they make you (Muhammad, peace be upon him) as a judge in all disputes between them, and find no resistance against your decisions, and accept (the decisions) with full submission." (QS. An-Nisa: 65). In fact, the patient's amuck and aggressive behaviors are often leading to inability to control themselves. In contradiction, [30] believe that the restraint in the mental hospital is a punishment for patients to reduce their aggressive behaviors. Other studies concluded that seclusion and restraint were prevented without the increase of violence in wards for men with schizophrenia and violent behavior. Nevertheless, earlier studies were not working through or reporting on submission; however, [31] have published that peacefulness is a special coping of patients with schizophrenia.

This study finds that the patients were able to find constructive coping under anger conditions. The coping includes the following: carry out anything, take a deep breath, ask God's forgiveness, sing a song alone, and introspect herself (introspection). This finding is particularly important, as it is coming from patients themselves. The problem-solving stemming from the patients is very

important, as the patients were doing their own evaluation on the effectiveness of coping in use. Several earlier studies never reported the emergence of positive coping of patient when violence occurs or anger reaches a crest. Sibitz et al. [32], on the other hand, reported that stigma resistance is the extremely important concept of patient coping. As conclusion, the patients themselves are able to find and develop constructive coping appropriate to their experiences. This is consistent with research concluding that coping is an important focus area in schizophrenic clinical interventions [33]. Another study by [34] concluded that patient coping is useful to reduce hearing hallucination (eliminate voices) by focusing attention on a distraction activity such as reading, gardening, singing, or listening to music. Anyhow, patient coping in the form of positive compensation is escape of anger offered by patients themselves.

Study limitations

First, some of our results could be difficult to generalize to other countries. However, we have noticed two features of coping that may relate to other countries. In addition, there are few qualitative researches of violence against patients as victims. As such, our findings may be important for the identification of potential idea and the developing of further research. Second, interviewees were recruited from activity groups in hospital; thus, patients who do not join these groups can have more severe cases. Third, this study did not explore any potential correlation between violence-related coping with age, education, sex, occupation, illness severity, and drugs. Thus, future studies may consider those factors to be explored in order to provide comprehensive understanding regarding how patients with schizophrenia cope with the experienced violence.

Conclusions

We identified patients coping with violence. The patient's coping experiences as victims of violence were categorized into three themes: submission, expression of anger to object, and positive coping strategy. To shorten the evaluation required to choose coping strategies, domestic violence education/psychoeducation would be relevant. Future studies should explore more regarding how process of coping and experience of violence could be imperative.

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Authors' contributions

Substantial contributions to the conception: IY, HS, LL. Design of the work: IY, HS, AS. Acquisition, analysis, and interpretation: IY, HS, AS. Creation of new software used in the work: AS. Drafted the manuscript: IY, HS, AS, LL. Critical revision of the manuscript: IY, LL. The authors have read and approved the final manuscript.

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Availability of data and materials

Data will be provided as needed

Declarations

Ethics approval and consent to participate

Ethical approval was granted by the Institutional Review Board of University of Malaya Serawak (UNIMAS/NC-21.02/03-02 Jld.2 (11)), and written informed consent was obtained prior to data collection from the patients and confirmed with their legal guardian.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no competing interests.

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