การรับรู้ตราบาปและวิธีการเผชิญปัญหาของผู้ป่วยจิตเภทในชุมชนที่เลือกสรรของอินโดนีเซีย*

Tri Sumarsih M.N.S** Kritaya Sawangchareon PhD***

บทคัดย่อ

การรับรู้ตราบาปในผู้ป่วยโรคจิตเภทอาจส่งผลให้เกิดความเครียดและกลไกที่นำไปสู่การแสดงออกถึงกลวิธีการเผชิญปัญหา จึงมีความสำคัญอย่างยิ่งที่จะต้องเข้าใจประสบการณ์ของผู้ป่วยในการเผชิญกับสถานการณ์นั้น การวิจัยเชิงบรรยายนี้มีจุดประสงค์เพื่ออธิบายการรับรู้ตราบาปและกลวิธีการเผชิญปัญหาของผู้ป่วยจิตเภท ศึกษาจากผู้ป่วยจำนวน 101 ราย ในอำเภอกาบูเมน ประเทศอินโดนีเซีย โดยการเลือกกลุ่มตัวอย่างแบบสุ่มอย่างมีระบบ เก็บรวบรวมข้อมูลระหว่างเดือนกุมภาพันธ์ถึงมีนาคม พ.ศ. 2559 โดยใช้แบบประเมิน Perceived Devaluation and Discrimination (PDD) และ Maastricht Assessment of Coping Strategies (MACS) นำเสนอข้อมูลด้วยค่าเฉลี่ย ส่วนเบี่ยงเบนมาตรฐาน และช่วงความเชื่อมั่น (95% CI) ผลการศึกษาพบว่าค่าเฉลี่ยการรับรู้ตราบาปอยู่ในระดับต่ำ Mean = 2.42 (95%CI: 2.37-2.47) โดยค่าเฉลี่ยการรับรู้การถูกเลือกปฏิบัติ Mean = 2.4 (95%CI: 2.38-2.52) สูงกว่าค่าเฉลี่ยการถูกลดคุณค่า Mean = 2.39 (95%CI: 2.32-2.45) สำหรับผลการประเมินกลวิธีการเผชิญปัญหาโดยรวมพบว่ามีค่าเฉลี่ยอยู่ในระดับสูง Mean = 4.94 กลวิธีการเผชิญปัญหาที่มีค่าเฉลี่ยสูงสุด 3 อันดับแรก ได้แก่ การไม่ใช้ยานอกคำสั่งแพทย์ Mean = 6.93 (95% CI: 6.86-7.01) การควบคุมพฤติกรรมอาการ Mean = 6.0 (95%CI: 5.79-6.29) และการกินยาตามแพทย์สั่ง Mean = 5.71 (95%CI: 5.38-6.05) ในภาพรวมผู้ป่วยโรคจิตเภทยังคงเผชิญปัญหาโดยไม่ใช้ยานอกเหนือที่แพทย์สั่ง พยายามควบคุมพฤติกรรมอาการ และใช้ยาตามแพทย์สั่ง

คำสำคัญ : จิตเภท ตราบาป กลวิธีการเผชิญปัญหา

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*วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต หลักสูตรนานาชาติ คณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น

**นักศึกษาพยาบาลศาสตรมหาบัณฑิต (หลักสูตรนานาชาติ) คณะพยาบาลศาสตร์มหาวิทยาลัยขอนแก่น

***รองศาสตราจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยขอนแก่น

Perceived Stigma and Coping Strategies among Schizophrenic Patients in Selected Indonesian Communities*

Tri Sumarsih M.N.S** Kritaya Sawangchareon PhD***

Abstract

Stigma among schizophrenic patients may increase the potential of stress and has powerful mechanism and expression of coping strategies. It is important to understand the coping experience of them to mediate the situation. This descriptive study aimed to describe perceived stigma and coping strategies among 101 schizophrenic patients in Kebumen district, Indonesia. Respondents were selected by systematic random sampling technique. Data were collected during February 01, 2016 to March 06, 2016 using the Perceived Devaluation and Discrimination (PDD) questionnaire (score 1-4) and Maastricht Assessment of Coping Strategies (MACS) questionnaire (score 1-7). Data analysis using mean, standard deviation and 95% confidence interval. For the result; On the PDD, the average of perceived stigma was 2.42 (95% CI: 2.37-2.47). On subscale of stigma were 2.45 (95% CI: 2.38-2.52) for perceived discrimination, 2.39 (95% CI: 2.32-2.45) for perceived devaluation. The findings described low levels of perceived stigma and they perceived more discrimination than devaluation. On the MACS, the total mean score of coping strategies was 4.94. The respondents sometimes used all types of coping strategies. The top three subscales of coping strategies were not use non-prescribed substances 6.93 (95% CI: 6.86-7.01), controlled symptomatic behavior 6.04 (95% CI: 5.79-6.29), and used prescribed medication 5.71 (95% CI: 5.38-6.05). Overall, most of participants did not usually use non-prescribed substances, they have usually controlled to symptomatic behavior, and frequently used prescribed medication as their coping strategies.

Keywords : perceived stigma, coping strategies, schizophrenic patients

*Thesis of Master of Nursing Science (International Program), Faculty of Nursing, Khon Kaen University

** Student of Master of Nursing Science (International Program), Faculty of Nursing, Khon Kaen University

** Associate Professor Faculty of Nursing, Khon Kaen University

Introduction

Schizophrenia is a psychotic disease that becomes the top level among mental disorders. The incidence rate is one percent of the world population.[1] Patients with schizophrenia have reached to 24 million people worldwide. It was around seven per one thousand of the adult population and more than 50 % did not receive the right treatment.[2] In ASEAN countries, Indonesia has the highest prevalence of active schizophrenia.[3]

Most schizophrenic patients may face with some forms of stigmatization.[4] Stigma is the major problem in mental illness across different societies.[2] Stigma is usually referred to a set of attitudes and beliefs that motivate a person to be afraid, avoid, resist, and discriminate against another person with mental health problem.[5] Many studies in Western, Africa and Asia countries have reported on stigmatization of people with mental illnesses.[6] Studies related to stigma from Western and some African countries showed high perceived stigma.[7] Comparable to Western countries, there is a widespread tendency of stigma among people with mental illness in Asian communities.[8]

Stigma may work across perceptions and emotions of people with schizophrenia, even surpassing the impacts of discrimination directly by other people.[9] Stigma is a barrier healing of schizophrenia.[10] Other impacts of stigma include low self-esteem, decline of self-efficacy and depression.[9]

Personal stigma has become a priority concern rather than social stigma because it can importantly impact the feeling of shame and cause the poorer outcome of treatment on people with schizophrenia.[18] Perceived stigma has the potential to affect how the patients respond to symptoms of schizophrenia. The patients may cope with stress which they endure as affects of their stigmatized status.[11]

Coping is the strategy used to minimize the effect of perceived stigma. Previous findings showed that patients with mental illness who used constructive coping strategies had better mental health status.[12] Stigma of schizophrenia is the consequences of prejudice which is caused by discrimination led by stigma.[13] It is necessary to understand stigma, coping responses and stigma consequences.[21]

The typical coping mechanisms of schizophrenic patients are active problem solving (APS), passive illness behavior (PIB), active problem avoiding (APA), passive problem avoiding (PPA) and symptomatic behavior.[14]

Based on the pilot study, patients stated that discrimination, shame and hopelessness they had were caused by their mental illness. Some of them stayed at home and did not want to go out. They believed that their illness could not be healed completely, and they needed a long-term treatment. Role of psychiatrists and mental health nurses in caring for people with schizophrenia in communities was still less recognized by people. Moreover, a study reported that Indonesia had an extensive health care infrastructure but mental and psychiatric health care remained scarce. Mental and psychiatric health facilities currently do not have adequate resources and trainings to help patients with schizophrenia, and they have a lack of evaluation process.[15]

The study related to perceived stigma and coping strategies in patients with schizophrenia has never been conducted in Indonesia. Therefore, this study aimed to describe perceived stigma and coping strategies among schizophrenic patients in selected Indonesian communities.

Conceptual Framework

The stressful situations are caused by perceived stigma in relation to schizophrenia. Stigma can be a source of stress for stigmatized person with schizophrenia and their responses to the stress should be examined. The literature on stress and coping indicates that people with schizophrenia have many responses to stress including physiological, cognitive, emotional, and behavioral responses.[16, 17]

According to cognitive appraisal, coping strategy is formulated and stigma as mediating variables between the stressor of schizophrenia and coping strategies in patients with schizophrenia.[16] The transactional theory of stress and coping developed by Lazarus & Folkman is the most used framework to evaluate the processes of coping with stressful incident. Based on this theory, the stressor is appraised by a person and the resources that are available to solve the stressor should be evaluated.[18] Schizophrenia contributes to the patient's perception of stigma, recovery barriers, treatment delays and inaccess to care.[19]

Stigma creates inferiority on individuals with Schizophrenia. Stigma in most personal psychology research focuses on personal identity resulting from cognitive, behavioral, and affective processes.[20] Coping strategies mean the specific efforts, involve behavioral and cognitive that persons use to overcome, tolerate, and reduce the stress. Stress responses take place only when the schizophrenic patients perceive a self-concerned with threat and believe that they do not have the ability to cope with the threat. By understanding the patterns of better and effective coping strategies in schizophrenic patients and knowing the factors that affect strategies to cope with the perceived stigma as the life threatening or stressful situation may decrease the stress because of stigma, develop their self-esteem, enabling them to get better protection from other impacts of the illness, as well as enabling them to give other patients the advantages of their experiences in dealing with schizophrenia. [14]

Methods

Study Design and Setting

This study was a cross-sectional descriptive study. Data were collected from 101 schizophrenic patients using PDD and MACS questionnaires in three sub-districts (primary health care units of Kutowinangun, Sempor 1, and Puring) in Kebumen district, Central Java, Indonesia from February 1st to March 6th, 2016.

Population and Sample

The population in this study was schizophrenic patients who received health care services from the study settings. Inclusion criteria for the study participants were: 1) have a diagnosis of schizophrenia which was determined by a psychiatrist, 2) have a stable condition which indicates the absence of significant pathology using the Brief Psychiatric Rating Scale (BPRS) which was used to screen the patient by a psychiatrist, 3) age 18 years old and over, 4) be able to communicate in Indonesian language, and 5) be willing to participate in this study. Participants who had the following characteristics were excluded from the study: 1) disagree to be the respondents and 2) have a mental retardation which was determined by a psychiatrist.

The study used systematic random sampling and the sample size was calculated based on Lemeshow's et al.[21] The study used a level of confidence of 95%, standard deviation 0.95% and the proportion of the estimation of 23%. As a result, 101 schizophrenic patients were recruited in this study.

Instruments

Perceived Devaluation and Discrimination (PDD) is a 12-items agreement which measures the extent to which an individual believes that most people will discriminate or devalue against a person who has a mental illness. PDD is rated on a four-point Likert scale with scores from 1 to 4 (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). The higher score indicates the higher level of perceived stigma. The English version of PDD instrument has excellent psychometric properties and has been used across the countries. Item 1, 2, 3, 4, 8, and 10 are reverse-scored. [22,23]

MACS is a measurement comprising 14-items which assess coping with the symptoms of schizophrenia. MACS has been modified by the researcher based on an original concept from Bak M, van der Spil F, Gunther

N, Radstake S, Delespaul P, van Os J.[14] MACS is measured on a 7-point Likert scale with possible scores ranging from 1 to 7 (1 = never, 2 = rarely, 3 = occasionally, 4= sometimes, 5 = frequently, 6 = usually, 7 = every time).[34] Item 5, 11, and 14 are reverse-scored. Fitting into the five types of coping strategies, comprised Active Problem Solving (APS) including distraction, problem solving, and help seeking; Passive Illness Behavior (PIB) including prescribed medication, non-prescribed substances, physical change; Active Problem Avoiding (APA) comprising shifted attention, socialization, task performance, and indulgence; Passive Problem Avoiding (PPA) including isolation, non-specific activities, and suppression; and Symptomatic Behavior, so that a higher score mean effective coping. Active Problem solving (APS) is one of type of coping strategies which is more useful for schizophrenic patients during their recovery. [22]

The questionnaires were translated from English into Indonesian language by a bilingual individual from a health research center, Muhammadiyah University of Yogyakarta. The back-translations had been compared with attention given to equivalent meaning and grammar. In this study, PDD had an internal consistence of Cronbach's alpha for the total score was 0.82. The MACS questionnaire in this study which was modified from the MACS was considered for its content validity by four experts who specialized in schizophrenic patients care, including one psychiatric nurse and three psychiatric nursing educators. The result of I-CVI from experts was 0.914. The reliability test used 25% of the sample size to be the number of participants for pilot study. It is considered to be highly successful. The questionnaires were tested on 25 patients. The internal consistence of Cronbach's alpha for MACS was 0.864.

Ethical considerations

The study proposal was approved by the Ethical Committee of Human Research of The Khon Kaen University, Thailand and The City's Development Planning Board Kebumen District, Central Java, Indonesia. A formal letter of permission was sent to the Department of Health Kebumen District and was submitted to the Primary Health Care Unit in Kebumen District. The information related to the study was given to the respondents confidentially. Informed consent was sought for each potential subjects who agreed to participate in the study and fulfilled the inclusion criteria. Data were collected in private room. Identities will remain anonymous and identified with a numerical code.

Data Collection and Analysis

Data were collected by questionnaires with the Indonesian version using socio-demographic data, clinical characteristic, and psychotic symptoms. PDD and MACS questionnaires using self-rating scale were used to collect data of perceived stigma and coping strategies. The researcher gave the questionnaires to the respondents who then answered it independently. The time required for completing the questionnaires took approximately no longer than 30 minutes for all items.

Data were coded and entered to SPSS windows version 17.00 program for analysis. Descriptive statistic (frequency, percentage, mean value, standard deviation, maximum, and minimum values) were used for socio-demographic, clinical characteristic, and psychotic symptoms. Mean value, standard deviation distribution, and 95% confidence interval were used to describe perceived stigma and coping strategies.

Results

A total of 101 respondents participated in this study with a 100% response rate. All respondents completed to fulfill the questionnaires properly.

Clinical Characteristics

Regarding the clinical characteristics of respondents, they were treated for ≤ 1 year (41, 40.6%), had duration of illness ≤ 1 year (29, 28.7%), followed–up to clinic appointment (74, 73.3%), and did not have difficulties of antipsychotic medication (75, 74.3%) (Table 2).

Table 2 Distribution of clinical characteristics of respondents (n=101)

Clinical characteristics	Frequency	Percentage
1. Duration of the treatment		
$\bar{X}$ ±SD (2.09±2.33) (Min= ≤ 1 year; Max= ≥ 11years)		
≤ 1 year	41	40.6
2-5 years	24	23.8
6-10 years	22	21.8
≥11 years	14	13.8
2. Duration of illness		
$\bar{X}$ ±SD 2.09±2.33 (Min= ≤1 year; Max= ≥ 11years)		
≤ 1 year	29	28.7
2-5 years	28	27.7
6-10 years	26	25.7
≥11 years	18	17.9
3. Follow-up adherence to clinic appointment		
Yes	74	73.3
No	27	26.7
4. Difficulty of adherence To antipsychotic drug		
Yes	26	25.7
No	75	74.3

Psychotic Symptoms Characteristics

As regards to psychotic symptoms characteristics of respondents, mean value and standard deviation were 6.39±2.62**.** The most characteristic of psychotic symptoms on schizophrenic patients was excitement (53, 52.5%), followed by anxiety (51, 50.5%), depressive mood and elevated mood had equal proportion (48, 47.5%,), somatic concern (47, 46.5%), hallucination (46, 45.5%), and tension (45, 44.6%)

Score of Perceived Stigma

Mean value ($\bar{X}$**)**, standard deviation (SD), and 95% confidence interval of perceived stigma in respondents were 2.42±0.28, CI: 2.37-2.47, perceived discrimination with $\bar{X}$**±**SD were 45±0.36, CI: 2.38-2.52, and 2.39 ±0.33, CI: 2.32-2.45 for perceived devaluation (Table 3).

Table 3 Score of perceived stigma responses of respondents (n=101)

Perceived Stigma	($\bar{X}$±SD)	95 % CI
Perceived Discrimination	2.45±0.36	2.38-2.52
Perceived Devaluation	2.39±0.33	2.32–2.45
PDD	2.42±0.28	2.37–2.47

Abbreviation: PDD, Perceived devaluation and Discrimination

Note: PDD was the average of perceived discrimination and devaluation

Score of Coping Strategies

Regards to mean value, standard deviation, and 95% confidence interval of coping strategies among respondents, the total of average scores was 4.94 ± 1.23. The highest to the lowest mean score and standard deviation of coping types were symptomatic behavior (6.04±1.26), then passive illness behavior (5.84±0.91), active problem solving (4.66±1.28), active problem avoiding (4.20±1.56), and the passive problem avoiding (PPA) (3.96±1.13). The highest mean score and SD of coping strategies in APS type was help seeking (5.17±1.74, CI: 4.82-5.51); 6.93±0.38, CI: 6.86-7.01 for non-prescribed substances; 4.54±1.92, CI: 4.17-4.92 for task performance; 4.55±1.91, CI: 4.18-4.93 for isolation (table 4).

Table 4 Scores of coping strategies of respondents (n=101)

Type of coping	($\bar{X}$±SD)	95 % CI
1. Active Problem Solving (APS)	**4.66 ±1.28**	
Distraction	4.60 ± 1.67	4.27-4.93
Problem solving	4.22 ± 1.62	3.90-4.54
Help seeking	5.17 ± 1.74	4.82-5.51
2. Passive Illness Behavior (PIB)	**5.84 ± 0.91**	
Prescribed medication	5.71 ± 1.71	5.38-6.05
Non prescribed substances	6.93 ± 0.38	6.86-7.01
Physical change	4.89 ± 1.87	4.52-5.26
3. Active Problem Avoiding (APA)	**4.20 ± 1.56**	
Shifted attention	4.10 ± 1.87	3.73-4.47
Socialization	4.08 ± 1.92	3.70-4.46
Task performance	4.54 ± 1.92	4.17-4.92
Indulgence	4.06 ± 1.94	3.68-4.44
4. Passive Problem Avoiding (PPA)	**3.96 ± 1.13**	
Isolation	4.55 ± 1.91	4.18-4.93
Non-specific activities	3.51 ± 1.92	3.14-3.89
Suppression	3.80 ± 1.90	3.43-4.18
5. Symptomatic behavior	**6.04 ± 1.26**	
Symptomatic behavior	6.04 ± 1.26	5.79-6.29
Total score	4.94 ± 1.23	

Discussion

The aim of this study was to describe perceived stigma and coping strategies among schizophrenic

patients in selected Indonesian communities.

Perceived stigma:

These study show that overall mean score, standard deviation, and 95% confidence interval of perceived stigma was found to be 2.42 ± 0.28, 95% CI: .37-2.47. Perceived discrimination was higher (2.45 ± 0.36, 95% CI: 2.38-2.52) than perceived devaluation (2.39 ± 0.33, 95% CI: 2.32-2.45). It means that these findings describe low level agreement of perceived stigma and they perceived more discrimination than devaluation.

The enhanced of stigma in schizophrenic patients related to hopelessness, embarrassed, and social anxiety. The influence of stigma was greater among patients with longer duration of disease. Patients feel they are not taken seriously and feel discriminated because difficulty in finding job and opportunities of housing, they did not accept of appropriate health care services accessing. These findings are consistent with study by Green, S et al.[24] While, people who perceived devaluation, they are to blame and they agree that schizophrenic patients are actually to blame. The respondents perceived that they are mentally ill so they must be to blame. These findings are congruent with previous study.[25] However, the results related to perceived devaluation and discrimination are not relevant with study conducted in Ghana and Ethiopia which stated that the respondents' experiences of perceived stigma toward each item are different from the using the same tool because of differences in the culture, setting, and other factors, there is also a number of similarity reports. For example, 70.07% of Ethiopian participants agreed with the item "most employers will hire a qualified person even if he or she has been treated for severe mental illness" compared to 59.4% in this study.[7]

Coping Strategies

The total mean score of coping strategies was 4.94±1.23. Respondents sometimes used all types of coping strategies. According to the findings which state that the highest average to the lowest of mean score of coping types were symptomatic behavior (6.04±1.26), followed by passive illness behavior (PIB) (5.84±0.91), active problem solving (APS) (4.66±1.28), active problem avoiding (APA) (4.20±1.56), and passive problem avoiding (PPA) (3.96±1.13).

According to the result of mean score, It can be showed that most respondents have usually controlled to symptomatic behavior. The PIB coping strategy was frequently used by respondents. The APS and APA were sometimes used by most of respondents. While, APA was occasionally used by majority of respondents. These results showed that the highest score of coping was symptomatic behavior. It is mean, the majority of patients have managed symptomatic behavior, like hearing voices and they did not follow orders coming by hallucinations. Therefore, they have controlled the symptoms in a good way.

This is relevant with the previous findings.[26] They reported that the symptomatic behavior was most common form of coping strategies in schizophrenic patients identified with need for care, followed by active problem solving and passive problem avoidance.

On the other hand, active problem solving (APS) such as help seeking is more effective coping strategy than others. Based on the recent study, most of schizophrenic patients reported that they used frequently the coping strategy of "help seeking/taking medicine" (69.3%).[27] While, different finding states that people with schizophrenia often have lack the ability to solve problems and stressful life events and they rarely practiced distraction technique as well.[14] Related to the study, APS involves in category of sometimes used among patients.

1) Active Problem Solving (APS) Type

The mean of subscale "help seeking" was the highest score (5.17±1.74), followed by the subscale "distraction" and problem solving. It can be seen that most patients frequently used help seeking in type of APS as their coping strategy. These results were consistent with the previous study.[27]

2) Passive Illness Behavior (PIB) Type

The subscale with the highest score was non-prescribed substances (6.93±0.38), followed by prescribe medication and physical change. Most respondents have controlled to non-prescribe substances namely alcohol and drugs. The respondents also frequently used prescribed medication as their coping. When the individual with schizophrenia was stress, they had headache, and they could not sleep well, so they took medicine to get rid of their symptoms. This result is congruent with a previous study[40] and different result with finding by Singh., Sharan., Kulhara.[38]

3) Active Problem Avoiding (APA)

The subscale of task performance was the highest score (4.54±1.92) in this type of coping. The majority of respondents sometime used task performance as their coping strategy. It may be due to the respondents mostly stayed in community and they have very supporting family that can help and motivate them to have any activities. They have been preferring to doing hobbies when they faced problem. These are supported by previous study.[25]

4) Passive Problem Avoiding (PPA)

The subscale of isolation was the highest score (4.55 ± 1.91). followed by suppression and non-specific activities. Most respondents have been choosing isolation as their coping. The other chosen of their coping were non-specific activities and suppression. The respondents have been doing something but not specific to reducing the things that affect the onset of their problems. These findings are supported by the previous study.[29]

5) Symptomatic behavior

The average of mean score of this type of coping was 6.04±1.26, 95% CI: 5.79-6.29. It means that the majority of respondents have controlled the psychotic symptoms in a good way, like hearing voices and they did not follow orders coming by hallucinations. If people with schizophrenia can managed the symptomatic behaviour, they can do daily living better and they will be trusted by others, so it will affect to decrease their own perceived stigma.

Some studies state the congruent results that most of respondents reported using one or more strategies to cope with auditory hallucinations. The most successful strategies were talking to someone else, thinking about something else, and sleeping.[30] These findings are not relevant with the previous qualitative studies.[14,26]

Conclusion

Overall, the findings describe low level agreement of perceived stigma and they perceived more discrimination than devaluation. Most of participants did not usually use non-prescribed substances, they have usually controlled to symptomatic behavior, and frequently used prescribed medication as their coping strategies, so coping strategies that could be used by schizophrenic patients are prescribed medication, controll to symptomatic behavior, and do not use non-prescribed substances. Coping strategies are used to minimize the effect of perceived stigma among schizophrenic patients.

Implications and Recommendations

These findings can be contributed for evidence based research in order to improve knowledge of nursing and to increase nurses' understanding of perceived stigma and coping strategies of schizophrenic patients. Nurse can provide health education and information to the patients and family what the effective coping strategies used which will reduce stigmatized of patients. Psychiatric nurse as therapist can facilitate the medication and psychosocial treatments to patients and families. The treatments are helpful after patients find a medication that works. Several psychosocial treatments which can implement in patients with perceived discrimination and devaluation such as family education including ways to help the whole family learn how to cope with the illness and help

their loved one, illness management skills including ways for the patient to learn about the illness and manage it from day to day, rehabilitation program through help with getting a job and everyday living skills, self-help groups: support from other people with the illness and their families, therapy: talking with a therapist about living with the illness and learning how to manage symptoms, like hearing voices or having delusions. Therapist use personal approach how to improve self-value of patients in order to they have ability to live independently and they will more productive.

Besides, result of this study can support nurse educator take this concept when developing teaching curriculum.

The results of this study provide basic information for further study on perceived stigma and coping strategies among schizophrenic patients in Indonesia.

Limitation

This study was conducted at only three sub districts in one district in Indonesia which had different community mental health nursing care for schizophrenic patients.

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