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Article

Correlation between family support with work productivity of people with severe mental disorders (PSMD) in Bantur Community Health Center, Malang, Indonesia

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Abstract

Introduction: One impact on People With Mental Disorders (PSMD) is decreased productivity. As the closest people, families are expected to support PSMD to be productive in the community. Therefore, this study aimed to identify the correlation between family support and the work productivity of people with mental disorders.

Design and Methods: This observational analytical study with a Cross-Sectional approach was conducted in the working area of the Bantur Community Health Center. Purposive sampling was used to obtain 107 samples. Data on family support were collected using a questionnaire and tested for validity, while the Endicott Work Productivity Scale (EWPS) questionnaire was used to measure PSMD work productivity.

Results: The results showed a significant correlation between family support and PSMD work productivity, p = 0.028. The correlation was negative, meaning lower PSMD work productivity implied higher family support. Furthermore, emotional support was the most form of support provided by family members to PSMD. Work productivity is generally low, with PSMD work attitudes in the high category only in sub-variables.

Conclusions: Family support is needed for people with mental disorders to be productive. Future studies should examine other factors that affect PSMD work productivity. Additionally, health services should innovate to create work programs that stimulate PSMD's potential and ability.

Introduction

The mental health problem is global, with about 35 million people with depression, 60 million with bipolar, 21 million with schizophrenia, and 47.5 million with dementia. In 2018, the estimated number of people with mental disorders in Indonesia was 18.5 million. East Java had 2,370,000 people, while Malang Regency had 156,000 people with mental disorders.[1] People with mental disorders experience decreased work and social abilities and cannot sustain their lives.[2] Mental disorders affect work productivity in patients.[3]

World Health Organization estimated the aggregate cost of all mental disorders in the UK at £32 billion (1996/97 prices), 45% of which is lost productivity. The estimated total burden of mental health problems in Canada for 1998 was at least Can$14.4 billion, with Can$8.1 billion and Can$6.3 billion for lost productivity and treatment, respectively.[1] Furthermore, WHO-led studies estimate that depression and anxiety disorders cost the global economy US$1 trillion annually in lost productivity. Mental disorders cause productivity problems that result in economic losses. The global cumulative impact of mental health problems on lost economic output is estimated to reach $16.3 trillion between 2011 and 2030.[4]

Indonesia aims to realize optimal mental health degrees for every individual, family, and community with promotive, preventive, curative, and rehabilitative approaches.[5] According to Indonesian Law number 18 of 2014, mental health rehabilitation efforts aim to prevent or control disability, restore social and occupational functions, and empower PSMD to be independent in the community.

Caring for a family member diagnosed with mental illness requires a holistic support system because some families experience burden, loss, and stigma. Therefore, studies on the family experiences of mental illness are crucial. Family empowerment emerged as the grand theme from the perceived effects of mental illness, coping, and their perspectives on empowerment grounded on family experiences.[6]

The factors supporting the recovery process in bipolar sufferers are religious values, family support, the presence of friends, and drugs.[7] Family support contributes 69.9% to the social functioning of schizophrenic patients, while 30.1% is influenced by factors such as environment, culture, genetics, treatment, and disease severity.[8] Therefore, family support is the closest supporting factor for PSMD.

Previous studies found that 51.04% of family support did not provide care for schizophrenic patients. This study also found that support for patients is low.[9] In a study on stigma and family support, 60% of respondents stated that family support in caring for PSMD was poor.[10] Shankar and Collyer (2002) found that some families did not support PSMD to work.[11]

Significance for public health

The work productivity of people with mental disorders affects their quality of life, prevents relapse, and reduces social stigma. Families should recognize the patient's needs and empower them to be financially independent. Moreover, community or primary health care centers should formulate strategies to increase family support for people with mental disorders to be productive. This study aimed to describe the correlation between family support and the work productivity of people with mental disorders.

A preliminary study on September 13, 2019, found that the number of PSMD in the work area of the Bantur Health Center, Malang, Indonesia was 146 people as of July 2019. These people are spread over Bantur, Wonorejo, Srigonco, Bandungrejo, and Sumberbening. Regarding the independence level of PSMD assessed based on the Barthel index, 105 people (72%) showed independent dependency, 28 people (19%) showed partial dependence, and 13 people (9%) indicated total dependence. From the 105 PSMDs with independent dependency levels, 39 people (37%) could meet their daily needs but could not work and produce, while 66 people (63%) could return to work.

In interviews with 10 family members of PSMD, 7 people convey that it is okay when family members with mental disorders cannot work and produce, while 3 stated that PSMD must be supported to become productive. The respondents were asked about the reasons for family members not supporting PSMD to work and be productive. Three people were worried that PSMD fatigue would cause a relapse, while two stated that family members with mental disorders could not be invited to work. Also, two other people asserted that it was important when PSMD did not experience pain and disturb the work environment.

Eight PSMDs stated that they received good support from their families, such as being reminded to take medicine and taking them to health services for health control. People with PSMD feel they receive better support to work from health workers, mental health cadres, and friends.

The care programs aim to help PSMD comply with treatment, conduct self-care, socialize, perform daily activities, and work productively. Based on the family reasons for not supporting PSMD to work, studies examine the relationship between family support and work productivity of people with mental disorders (PSMD) in the work area of the Bantur Health Center, Malang, Indonesia.

Design and Methods

The study was conducted from November 28 to December 03, 2019, using an observational design with a cross-sectional approach. Inclusion criteria were used to select 107 respondents comprising people with mental disorders (schizophrenia) in the Bantur Health Center working area.

Purposive sampling was conducted with inclusion criteria to select respondents, including: i) the patient undergoing treatment and outpatient treatment at the Bantur Health Center; ii) the patient that communicate well (communicative); iii) the patient with family members, such as parents, spouse, children, or siblings; iv) the patient living with their families; v) the patient willing to become respondents by signing in the respondent's consent form; vi) the patient approved by family members to be respondents.

This study passed the ethical test in the Research Ethics Committee Faculty of Medicine, Brawijaya University No.319/EC/KEPK-S1-PSIK/11/2019. Family support was assessed using a questionnaire with assessment, instrumental, informational, and emotional support parameters. The assessment used a Likert scale of 1 to 4, with information (1) never, (2) rarely, (3) sometimes, and (4) often. Information on scores obtained were further categorized into low family support (score < 50), moderate (score 50-75), and high (score > 75).

The work productivity of PSMD was measured using the Endicott Work Productivity Scale (EWPS) questionnaire adapted and translated into Indonesian and tested for validity. The questionnaire had 22 negative statements using a Likert scale. The four parameters assessed on work productivity were attendance, attitude, potential and abilities, and results. Moreover, the PSMD work productivity was assessed using a questionnaire with a Likert

Table 1. Demographic data of respondents based on gender, age, marital status, education, occupation, length of sickness, and family members living with PSMD.

Characteristic		f	%
Gender	Male	54	50.5
	Female	53	49.5
Age	< 20 years old	5	4.7
	20-40 years old	49	45.8
	41-60 years old	48	44.9
	> 60 years old	5	4.7
Marital Status	Not married yet	61	57.0
	Married	26	24.3
	Divorced	12	11.2
	Death divorce	8	7.5
Education	No school	32	29.9
	Elementary school	42	39.3
	Junior high school	25	23.4
	Senior high school	8	7.5
Occupation	Farmer	48	44.9
	Seller	4	3.7
	Breeder	6	5.6
	Etc	49	45.8
Length of Sickness	< 6 months	2	1.9
	6 months- 1 year	4	3.7
	1-5 year	42	39.3
	> 5 year	59	55.1
Family Members living with PSMD	Parents	57	53.3
	Wife/Husband	16	15.0
	Child	8	7.5
	Brother/Sister	26	24.3
Total		107	100%

scale of 1 to 4, with information (1) often, (2) sometimes, (3) rarely, and (4) never. The range of scores obtained for the overall work productivity of PSMDs was 22-88. Information on the scores obtained was further categorized into low work productivity (score < 44), medium (score 44-66), and high (score > 66). The questionnaire was tested for validity using Product Moment from Pearson on 20 PSMD in November 2019, with validity on all statement items > r table (0.4227) and p-value < 0.05. Additionally, reliability was conducted by Cronbach's Alpha test, resulting in a value of 0.957. Researchers carried out the process of analyzing univariate and bivariate data using the SPSS 24 for windows program.

Results and Discussions

Table 1 shows the socio-demographic characteristics of People With Mental Disorders (PSMD). The data shows that 50.5% of the respondents are male, 45.8% are aged between 20-40 years, 57.0% are unmarried, and 39.3% have elementary education. Moreover, 44.9% of the respondents were farmers, 55.1% had been ill for > 5 years, and 53.3% lived with their parents.

Table 2 shows the level of family support for people with a mental disorder (PSMD). The data shows that 70.1% of the respondents have a high level of family support. Table 3 shows the support given by family members to PSMD. It shows that 66.4% of the assessment support, 58.4% of the instrumental support, 60.7% of the informational support, and 73.8% of the emotional support are high.

Table 4 shows the level of work productivity of PSMD. The data shows that 35.5% of the respondents have low work productivity. Table 5 shows the level of sub-variables of PSMD's work productivity. The data shows that 56.1% of the respondents have low work attendance, 38.3% have a high work attitude, 38.3% have high potential and ability, and 41.1% have medium work results.

The results showed that most respondents had high family support. This is consistent with a previous study that most PSMDs received good family support to prevent recurrence at the Mental Polyclinic of R.S Dr. Achmad Mochtar Bukittinggi.[12] Also, Ambari (2010) stated that family support is high in social functioning in post-treatment schizophrenic patients at Menur Hospital Surabaya, Indonesia.[8]

One impact of stigmatization on mental disorders was the increasing community-based psychiatric mental health restrictions in Indonesia from 2007 until 2012. The lack of family support caused improper care for schizophrenia patient.[13]

Families have the assessment, instrumental, informational, and emotional support. Appraisal support occurs through positive assessment of individuals, such as encouraging, motivating, giving positive ideas.[14] The results showed that most respondents had high assessment support. This is consistent with a previous study in 2011 which found that most respondents in RSKD, South Sulawesi, Indonesia, received good assessment support.[15] Another study stated that assessment support through positive responses, such as encouragement and praise motivates PSMD to strive and improve themselves. PSMDs need positive assessment support such as motivation and encouragement to increase their confidence in doing something.[16]

Instrumental support is the provision of services and financial and material assistance. This includes direct assistance, such as giving or lending money, helping with daily work, and providing transportation and needed tools.[14] The results showed that most respondents had high instrumental support. This is in line with a previous study that found that most PSMD respondents in RSKD South Sulawesi, Indonesia, received good instrumental support.[15] Other studies found that instrumental support is an important predictor of PSMD's recovery at home.17 Furthermore, a family with a good economic status is more easily fulfilled than one with a low economic status. A higher economic level of a family increases the level of instrumental support for the recovery of schizophrenic patients.[18]

Informational support includes a communication network and shared responsibilities, such as solving problems, giving advice, directions, suggestions, or feedback about someone's actions.[14] The results showed that most respondents had high informational support. This is in line with a previous study that informational support for PSMD in the RSKD of South Sulawesi, Indonesia, was mostly good. Another study stated the informational support provided by families to schizophrenic patients. This was seen in how the family sought information from health workers, social and mass media, and magazines.[16] Furthermore, Tempier et al. (2013)

Table 2. The level of family support to PSMD.

Level of Family Support	f	%
High	75	70.1
Moderate	22	20.6
Low	10	9.3
Total	107	100

Table 3. The form of support given by family members to PSMD.

Family Support		f	%
Assessment support	High	71	66.4
	Moderate	25	23.4
	Low	11	10.3
Instrumental support	High	63	58.9
	Moderate	30	28.0
	Low	14	13.1
Informational support	High	65	60.7
	Moderate	32	29.9
	Low	10	9.3
Emotional support	High	79	73.8
	Moderate	15	14.0
	Low	13	12.1

found that perceived informational support mediates social resources and the recovery of schizophrenic patients.[19]

Emotional support entails giving individuals comfort, love, empathy, trust, and attention, making them feel valuable.[14] The results showed that most respondents had high emotional support. This is in line with a previous study that found that the emotional support for PSMD in the RSKD of South Sulawesi, Indonesia was mostly good. Another study in 2018 found that emotional support is the greatest form of support that involves encouraging PSMD to remain strong and to pray to achieve better health development.[16] In 2016, a study found that the highest emotional support is when families accept the patients' condition, accompany them until recovery, and help them sincerely.[17] Most families sympathize with schizophrenic patients, and warmth indirectly improves recovery in people with mental disorders.[20]

The results showed that most PSMD are male, consistent with a previous study on stigma and family support in caring for PSMD.[21] Nursia examined family support for repeated treatment of PSMD and found that most respondents were male.[15] Another study stated that men have wider problem-solving abilities than women and use more effective coping strategies.[13]

Most respondents in this study live with their parents. This result contradicts a previous study which found that almost half of the respondents live with their siblings.[15] However, it is in line with Hannighofer which found the role of parents is needed in the healing process of mental patients.[18] It also supports the study of Magfiroh and Khamida discovering that the family's role is essential in nurturing, loving, and caring for schizophrenic clients.[22]

This study revealed that most PSMD has suffered from mental disorders for more than five years. The results are in line with Nursia's study, which found that almost all respondents had suffered from mental disorders for more than one year.[15] Another study stated that almost all PSMD suffered from mental disorders for more than three years. The length of time caring for PSMD causes family members to risk experiencing stress and psychological pressure, resulting in family support.[20]

This study showed that almost half of the respondents were in the low productivity category. The results support Videbeck (2011), which stated that PSMD lacks the social or communication skills needed to maintain relationships with others. This social functioning disorder causes difficulty in meeting social demands.[23]

Most work attendance of PSMD in this study was in a low category, and almost half of the respondents had a high work attitude, medium work results, and low potential and abilities.[24] This supports Fithriyah, which stated that the work evaluation using the Global Assessment of Functioning Scale (GAF Scale) showed that PSMDs with a fairly good GAF Scale complete their work.[11] This study found that almost half of the respondents were aged between 20-40 years. The results are in line with McLaughlin's study on family support for repeated treatment of PSMD, which found that most respondents are between 20-37 years old.[25] Similarly, Ambari found that age affects social functioning in schizophrenic patients. Their functioning increases with age due to treatment that helps them be more stable.[8]

This study found that most respondents experienced mental illness for more than five years. The result is in line with McLaughlin (2012), which found that almost all respondents had suffered from mental disorders for more than one year.[25] The onset or duration of schizophrenia is an important factor affecting the patient's ability to perform social functions.[23]

This study found that most respondents lived with their parents. The results support Ambari (2010), which found that post-treatment schizophrenic patients living with their families with high emotions show low social functioning.[8] Analysis of the results using the Spearman-Rank correlation test showed a p-value of 0.028 (<0.05), meaning Ho was rejected. This implies a significant relationship between family support and work productivity of PSMD in Bantur Health Center, Malang, Indonesia. The results are consistent with a previous study that PSMD experiences increased social adaptability with family and social support.[13] Furthermore, Ambari (2010) stated that high social functioning in post-hospitalized schizophrenia patients at Menur Hospital Surabaya, Indonesia, is influenced by family support[8]. This indicates a significant positive relationship between family support and the social functioning of schizophrenic patients. Higher family support increases the social functioning of schizophrenic patients.[26]

A different result from this study is the negative relationship between family support and work productivity of PSMD in the work area of the Bantur Health Center, Malang, Indonesia. This shows that high family support does not necessarily increase PSMD's work productivity. In line with this, Latipun (2016) stated that it is not easy for schizophrenic patients to have positive and adaptive social functioning abilities.[26] This study examined the work productivity variable of PSMD, heavily influenced by factors

Table 4. The level of work productivity of PSMD.

Level of work productivity	f	%
High	34	31.8
Moderate	35	32.7
Low	38	35.5

Table 5. The level of sub-variables of people with mental disorder's work productivity.

Work productivity		f	%
Work attendance	High	10	9.3
	Moderate	37	34.6
	Low	60	56.1
Work attitude	High	41	38.3
	Moderate	30	28.0
	Low	36	33.6
Skill and ability	High	31	29.0
	Moderate	35	32.7
	Low	41	38.8
Work result	High	23	21.5
	Moderate	44	41.1
	Low	40	37.4

such as knowledge that contributes to problem-solving and creativity in completing work. Skills are operational, technical abilities, and mastery regarding certain fields of work formed from the competencies mastered by individuals.[27] Attitude is a patterned habit profitable when it has positive implications in one's work behaviors or vice versa. Behaviors are habits embedded in a person.[28]

This study could help psychiatric nurses and mental health cadres increase their awareness and efforts to support families in empowering PSMD to be independent in the community. Nursing should aim to help PSMD comply with treatment, take care of themselves, socialize, perform daily activities, and work productively. This study is the first to examine the relationship between family support and work productivity of people with mental disorders in the work area of Bantur Health Center, Malang, Indonesia. Therefore, it could be developed with further studies. This study does not specifically look at each sub-variable of family support. It is hoped that other researchers can examine more deeply for the sub-variables of family support and work productivity of people with mental disorder.

Conclusios

Most respondents stated that PSMD in the working area of the Bantur Health Center, Malang, Indonesia received high family support. The highest number of all sub-variables of family support is emotional support, and almost half of the respondents have low work productivity. Moreover, only the sub-variables of PSMD's work attitudes are high, and there is a significant relationship between family support and work productivity of PSMD.

Health services should innovate to create continuous work programs that stimulate the potential and abilities of PSMD. Also, health workers should educate and prepare family members of PSMD to provide good support. Mental health cadres should provide mutual support to families and the community to help PSMD become independent.

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