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Family's experience in caring for clients with suicidal risk in indonesia

La experiencia familiar en el cuidado de clientes con riesgo suicida en Indonesia

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ABSTRACT:

Suicide is one of the psychiatric emergencies that require comprehensive care because individuals are at risk of endangering themselves, others and the surrounding. Suicide in Indonesia is increasing. Families have a major role in caring for clients and preventing suicide but family burdens have not been studied profoundly. The aim of the study was to get an overview of family experience of caring for clients with suicide risk. The research design was qualitative with descriptive phenomenology approach involving six participants. Data was collected by in depth interview and analyzed using Colaizzi method. The results of the study found five themes; suicide attempts is a complex burden for families, behavioral changes as a suicide sign, concern as a form of family and community support, family perceptions about the causes and consequences of attempted suicide and coping strategies of families overcoming the impact of attempted suicide. The results of the study recommend that the family as the front social unit of suicide prevention can be more sensitive to changes in the behavior of clients and nurses as counselors can provide interventions to improve the mental health status of clients and families such as health education, family psycoeducation therapy, stress management and self help group. The conclusion that can be drawn from the five themes above is the burden of the family who provide caring for the client with the risk of suicide is heavier when the family is unable to recognize the client's suicide signs so there is a need for a support system and constructive coping.

Keywords: client with suicidal risk; family experience.

RESUMEN:

El suicidio es una de las emergencias psiquiátricas que requieren atención integral porque los individuos corren el riesgo de ponerse en peligro a sí mismos, a los demás y al entorno. El suicidio en Indonesia está aumentando. Las familias tienen un papel importante en el cuidado de los clientes y la prevención del suicidio, pero las cargas familiares no se han estudiado profundamente. El objetivo del estudio fue obtener una visión general de la experiencia familiar en el cuidado de clientes con riesgo de suicidio. El diseño de la investigación fue cualitativo con un enfoque de fenomenología descriptiva que involucró a seis participantes. Los datos fueron recolectados por entrevista en profundidad y analizados

utilizando el método Colaizzi. Los resultados del estudio encontraron cinco temas; los intentos de suicidio son una carga compleja para las familias, los cambios de comportamiento como un signo de suicidio, la preocupación como una forma de apoyo familiar y comunitario, las percepciones familiares sobre las causas y consecuencias del intento de suicidio y las estrategias de supervivencia de las familias superando el impacto del intento de suicidio. Los resultados del estudio recomiendan que la familia como unidad social de prevención del suicidio sea más sensible a los cambios en el comportamiento de clientes y enfermeras, ya que los consejeros pueden proporcionar intervenciones para mejorar el estado de salud mental de los clientes y las familias, como la educación sanitaria. terapia de psicoterapia familiar, manejo del estrés y grupo de autoayuda. La conclusión que puede extraerse de los cinco temas anteriores es que la carga de la familia que brinda cuidados al cliente con el riesgo de suicidio es mayor cuando la familia no puede reconocer los signos de suicidio del cliente, por lo que es necesario un sistema de apoyo y afrontamiento constructivo.

Palabras clave: cliente con riesgo suicida; experiencia familiar

INTRODUCTION

Suicide is one form of psychiatric emergency that requires fast and comprehensive service. In this condition, the individual can no longer control oneself; so one is at risk to harm oneself, others and the environment [(1)]. Suicide can be interpreted as thoughts or actions associated with self-mortality, often occurs in patients with schizophrenia and depression [(2).] Suicide behavior is a wrong sign that means someone feels hopeless or desperate [(3)].

WHO estimates that as many as 90% of people who commit suicide occur due to undiagnosed and untreated mental illnesses, in addition to the use of illicit drugs and alcohol consumption. This condition is a major world health problem that represents 1.4% of the world's health burden [(4)]. Preveler et al in a journal 'ABC of Psychological Medicine: Depression in Medical Patients' says the lifetime suicide risk will be experienced by people with mood disorders, especially depression at 6-15%, while schizophrenia is 4-10 %. A person who faced recent event of grieving, separation, divorce and decreased social support is a risk factor for suicide [(3)].

The age of 20-24 years in the United States has an increase in suicides of 13 per 10,000 and again increased at the age of 70 years and above [(5)]. The highest incidence of suicide occurred in America at the age of 80 years and above. The prevalence of suicidal ideation, suicide planning, and suicide attempt is significantly higher in young adults aged 18-29 years and among adults aged ≥30 years [(6)]. The number of suicides in Japan exceeds 30,000 cases each year, the highest among developing countries. In adolescent aged 15-19, suicide rates are 2.4 per 100,000 population and are the leading cause of death [(7)]. Based on these data, it was concluded that there was an increasing trend of suicidal case in all age ranges.

The suicide case in Indonesia is increasing. WHO estimates that suicide case reached 1.6-1.8 per 100 thousand population or approximately 5 thousand population per year with the tendency of productive age. In 2012, the estimated number of suicides increased to 4.3 per 100,000 people or about 10,000 lives per year [(4)].

Research by Mclaughlin, Mcgowan, Neill, & Kernohan in 2014 suggests that families have a major role in caring for family members with risk of suicide and suicide prevention but the impacts and burdens of the family have not been studied in depth. This study produced a big theme that represents the whole sub-theme: " hard work for the whole family " and four sub-themes: 1) family burden, 2) competition and pressure, 3) confidentiality/cover-up and shame and 4) helplessness and guilt [(8).]

Phenomenological qualitative research conducted by Keyvanara and Haghshenas in the Republic of Iran with Indepth Interview, addressed to 14-17 years old who have

tried to commit suicide by drinking toxins and burning themselves has produced 5 themes namely despair, failure of love, family problems, pressure due to high expectations, and poverty. This research focuses on the socio-cultural context with the perpetrator as participants [9].

The novelty of this research lies in selected participants including nuclear families and extended families and clients who are still helped by attempted suicide. This study has also not been studied by previous researchers, especially in Indonesia.

RESEARCH METHODS

Design

The research applied qualitative with phenomenology approach. Qualitative methods are chosen because it explores more deeply about the family's experience of caring for clients with the suicide risk. The approach used is descriptive or transcendent phenomenology consisting of four stages: bracketing, intuiting, analyzing, and describing [10].

Sample

Samples in qualitative research are called participants. This research implemented purposive sampling technique in which the determination of participant oriented on the research objectives and selected according to pre-determined inclusion criteria of participants [11]. Creswell explains purposive sampling is a deliberate technique of selecting information-rich individuals to understand central phenomena [12]. Participant data obtained from RSUD Dr. Saiful Anwar Malang, Dr Radjiman Wediodiningrat Lawang mental hospital and Bantur Puskesmas. Participants are 6 persons. Selection of participants based on criteria, among others: a). Family members who have the roles and responsibilities of caring for their family members with the risk of suicide (caregiver), b). Family members who live in one house with clients who has suicide risk, c). Family members who are able to communicate well in Bahasa Indonesia. Client criteria are a person who has attempted suicide by any method of suicide and living in a house with participants.

Procedure

Data collection was conducted in hospital counseling room and participant's house. After the data collection process on the first participant is completed, the interview result is made in transcript form and analyzed data and continued to the next participant. The reporting is done from January to the end of May 2017.

Ethical considerations

The analytical method used Colaizzi's approach. The ethical considerations of the research are concerns to the researchers hence the subject is protected by observing aspects of autonomy, anonymity, confidentially, justice, beneficence, and non-maleficence [10].

There are three basic principles of ethics in the standard research of beneficence, respect for human dignity and justice. This study does not pose a danger to the life-

threatening participants. Researchers used participant code in each research report. The anonymity principle is met by not listing the participant's name and initials but giving the code in the form of P1 for the first participant, P2 for the second participant, and so on until the sixth participant. The principle of confidentiality is applied by storing research data in a safe place that can only be accessed by researchers. Data are analyzed and stored in a safe place, and only researchers have passwords to access it. The record data is stored in the gmail program of drop box and will be destroyed in 5 years. Justice means that all participants receive equal treatment and rights to participate in research [(11)]. Researchers strive to fulfill the principle of beneficence by avoiding questions that can cause participants' discomfort and researchers will not force participants to express things they do not want to tell. This study has passed the ethical test in the Research Ethics Committee Faculty of Nursing, University of Indonesia No.45/UN2.F12.D/HKP.02.04/ 2017.

RESULT AND DISCUSSION

Participants in this study are 6 persons and all of them are women. The age of the participants was ranging from the youngest was 41 years old and the oldest was 68 years old. Marital status consists of 2 widows and 4 married. The educational status of the participants is primary school and junior high school. Participant relationship with the client is biological mother, stepbrother, wife and cousin. The process of collecting data through in-depth interviews was conducted from March 24, 2017 to April 19, 2017.

This research identifies 5 themes, namely:

1). Suicide attempts become a complex burden for families.

This theme is derived from 9 categories which are anxiety, mourning, guilt, anger, shock, physical problem, financial problem, disrupted daily activities and family conflicts. Some of the participant quotes that represent this theme include:

"I'm worried in the kitchen. I am afraid and anxious at night, uncomfortable "(P1)
"Actually my heart is sore and scream" (P1)
"Destroyed until now" .. (P2)
"My heart sometimes blames myself…" Lord, what is my fault? "... (P6)
"My heart sometimes gets angry. It's hard to get him to the hospital… I'm annoyed "(P6)
"I was shock … My husbanddid surgery on his own stomach .." (P4)
"I was immediately shock… I carried my grandchildren and instantly fainted, yes I am so tired…" (P4)
"The problem is money because I don't have much money I have to borrow them for my son…" (P1)
"I can't do chores for the sake of caring him…" (P6)
"When his grandfather got angry with me then approached my son, my son will be morose…" (P1)

Family burden is a response that appears to families who have family members with suicide risk [(8)]. Such responses include both psychological and emotional responses. Other burdens perceived by family are financial burdens, limited family activities and family relationships disruption.

Families are embarrassed by the growing stigma in society about attempted suicide. This is in accordance with the opinion of previous researcher that the stigma is the attitude of family and society who thinks if one member of his family suffered psychotic or other mental disorders, it is a disgrace for the family. Research by Mclaughlin, Mcgowan, Neill, & Kernohan also produced one of the sub themes of shame as a family experience of caring for clients [8].

2). Behavior change as a suicide attempt sign.

This theme is derived from 7 categories; withdrawal, loss of interest, laziness, aggressive behavior, addictive behavior, suicidal expressions and suspicious behavior, such as the following participant expressions:

"He became a silent person… did not want to go anywhere right then" (P1)
"He used to be a cheerful person, passionate, love hearing music but then he changed" (P6)
"He didn't want to eat. I spoon-fed him. Usually he showered with cold water at 5 o'clock. But then he did want to even with warm water, he is just sitting and staring at blank, not even blink, not as he used to be"(P6)
"My son is angry at me… easily angered.". (P6)
"Always on smoking" (P4)
"Why do not I just die? My pain cannot be healed. I cannot get treatment"(P5)

Suicide clients have many different clinical behaviors [3]. This is in line with changes in client behavior expressed by the participants that are withdrawing, lost interest, lazy, aggressive, the verbal expression of wanting to end life and suspicious behavior.
The ability to recognize changes in client behavior should be done by family members or people with frequent contact intensity with clients. Ongoing family contact with clients will have the potential to raise awareness of significant signs and symptoms [1]. All suicidal behavior is seen as an attempt to escape from uncomfortable or unbearable life situation [3].

3). Caring as a form of family and community support.

This theme is derived from seven categories: empathy, mentoring, caring, compassion, giving advice, seeking information and treatment, awareness and 3 sub themes: nuclear family support,extended family support, and community support such as:

"When he came to me I always fed him, I launder his cloth even when it's very dorty" (P3)
"There's my mother who provide caring at day then it's my turn at night"(P6)
"My mother's sibling is a lot, they gave suggestions which essentially prayers from the elders" (P2)
"Neighbors are all caring… They also give him job to fix the wall, crafting bird cages so he has something to do " (P5)

Family support related to supportive functions (13). Family abilities for early detection are influenced by family knowledge and information obtained. Most of the participants revealed that the family got information from neighbors, relatives, friends and health workers, namely nurses. It is able to motivate families to bring clients to the hospital.

One of the factors that can suppress the desire for client suicide is social support. Clients who have good interactions with family can suppress the appeared idea of suicide. It also applied to a close friend who can provide emotional support so that clients feel heard and cared for. This form of awareness helps the client to be able to view his or her positive world so that it can lower the thoughts of suicide [14].

The mental health nurse must have a strong foundation for risk reduction and suicide prevention [15]. Observing each suicide clients as well as expressing concern [3]. Removing dangerous items from clients gives a message of concern and this can be done by nurses, families and communities. Participants also revealed that one of the efforts to save clients is to keep away clients from objects that could endanger their lives [3].

4). Family perception on attempted suicide causes and consequences.

This theme is formed from several keywords that ended up in 3 categories; perception of the value of suicidal behavior causes, family perceptions about the causes of factual suicide attempts, and family perceptions about the consequences for clients such as the statement of participants below:

"The test from God…That's why my son is the way he is now…" (P6)
"I thought he was possessed because in Java we still believe on mystical peripherals"(P6)
"Because of congested pain and kidney stones… It was not healed then he hanged himself in about four years" (P5)
"He was unconscious…seizure then taken to the hospital" (P6)

Family response to suicide attempts is how families respond to a condition. Family coping mechanisms are determined by family perception of suicidal behavior, perception of cause and effect for client. The perception of some participants on attempted suicide behavior is due to possession. Most clients and families cannot explain what happened to him so that the majority of these events are unreported or linked to mystical occurrences [7].

The most common cause of suicide by participants is depression. Life events that cause stress and tension or difficulty in life are two things that cause stress [3]. The emergence of many increased stressors with inadequate coping mechanism makes the client depressed. Four of six attempted suicide clients had a medical diagnosis of severe depression. In accordance with research that says that about 60% of client's risk of suicide reported experiencing anxiety, depression or a combination of both [14]. Supporting statements were also obtained from the results of a study who reported that depression patients were 7 times more likely to die of suicide. Responding to this, Huang et al recommends education for all family members about the association of depression with the risk of suicide [14]. Early detection of depression as a psychological support for clients is a key element in suicide prevention [4].

The family revealed that the client's attempted suicide caused a harmful consequence for the safety of the client from difficulty of breathing to death. Attempted suicide is an act of self-action taken by someone who will cause death if not stopped. Suicide is a self-inflicted death in the form of injury, poisoning, and clogged breath proving that the dead person intends to kill himself [3].

5. Family coping strategies to overcome the impact of attempted suicide.

This theme is formed from several categories and 3 sub themes of internal family coping, external coping families which are both positive family coping and negative family coping like the following participant statements:
"I discussed with dad, siblings, and nephew " (P1)
"Well I ask around for remedy and related information" (P1)
"Praying, recital, and night praying every night " (Mother cried) (P4)

The impact of psychosocial conditions requires a thorough handling including family involvement. Family support is an important support system provided by families to prevent mental disorders in coping with family burdens.

Internal coping of family is by discussing problem solving with all family. External coping is using health service facilities and perform spiritual activities [(7)].

Nurses have a central role as professionals in client care. How to conduct an assessment in nursing is how a nurse gets information about the condition of the client and the reasons treated [(6)]. Nurses have a very important role in early detection. Nursing interventions cannot be separated from family involvement [(2)].

Families with clients of suicide risk undergo many changes in their lives. In the process of adaptation, the spiritual need to seek meaning in life arises that makes them able to survive in suffering [(16)]. The family reveals that by doing spiritual activity it can give strength. This spiritual activity is one of the external coping mechanism of the family which are 5 times praying, night praying, prayers, remain grateful and closer to God. This is in line with the research that explains that individuals with psychosocial problems must have spiritual resilience and wellbeing to be adaptive (17). Another study mentions that religious beliefs contribute to as many as 34.4% of suicide prevention factors because clients can achieve serenity, peace and stability when spending time praying in places of worship. Religious activity can also decrease an individual's anxiety level [(18)].

CONCLUSION

The study produced five themes to support a family experience of caring for clients with a suicidal risk involving six participants and formed from 32 categories and 5 sub themes. The first theme is a suicide attempt into a complex burden on the family. The second theme is behavior change as a suicide attempt signs. The third theme is caring as a form of family and community support. The fourth theme is the family's perception of the causes and consequences of attempted suicide. The fifth theme is the coping strategy of families overcoming the impact of attempted suicide. The conclusion that can be drawn from the five themes above is the burden of the family who provide caring for the client with the risk of suicide is heavier when the family is unable to recognize the client's suicide signs so there is a need for a support system and constructive coping.

Recommendation

Health center management can use the results of this study to develop prevention, promotion and rehabilitation programs on risk clients such as Self Help Group and Stress Management. With Self Help Group therapy, it is expected that clients are able to express emotions and feelings and gain support system from the group. The output of this program is the depression handling module that is compatible with the World

Health Organization program for clients, families and nurses. The results of the study can be a guide to recognize behavioral changes and the preparation of Standart Operational Procedure's or instruments for early detection of attempted suicide.

Future researchers need to conduct quantitative research for the preparation of guidelines or instruments of early detection for suicide risk, appropriate interventions for clients and families such as stress management and family psycoeducation therapy as well as research to identify suicide rates in Indonesia because Indonesia has no exact data on national suicide incidence. Future researchers may also conduct qualitative research on client-focused suicide risk with a major medical diagnosis such as schizophrenia or major depression.

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