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Stressors and coping mechanisms of people with mental disorders in the community

Original Article

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Abstract: **Background:** People with mental disorders often experience human rights violations, discrimination, exclusion, and stigma.
Objective: To determine the stressors and coping mechanisms of people with mental disorders in society.
Methods: This research is a qualitative phenomenological research. We wanted to explore and describe the experiences of mentally ill patients in the community at the rehabilitation stage in stress management, including the stressors in people with a mental health condition and the coping mechanisms used. Data collection was carried out using in-depth interviews with 15 participants.
Results: The results of this study show that the stressors of mental illness patients are a less-accepting environment, feeling of shame, fear of being excluded, having no income, and side effects of drugs.
Conclusions: The coping mechanisms used include carrying out activities, telling stories to others, and diverting emotions.

Keywords: *coping mechanism • mental disorders • qualitative research • stigma • stressor*

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1. Introduction

Mental health contributes to poor health, premature death, human rights violations, national and global economic losses, and living with disabilities.[1] Globally, the number of people with mental disorders, including schizophrenia, is estimated as 450 million.[2] Mental disorders are the most significant cause of disability (years lived with disability [YLDs]), being 14.4% globally, 13.5% in Southeast Asia, and 13.5% in Indonesia. The prevalence of mental disorders in Indonesia based on the 2018 Basic Health Research increased to 7 per household. It means that for every 1000 households, there are 7 households having people with mental disorders, so that the number is estimated at around 450,000 people with severe mental disorders.[3]

People with mental disorders face many problems in society, which become a stressor for both patients and their families. People with mental disorders often experience human rights violations, discrimination, and stigma.[1]

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The prevalence of stigma among schizophrenia patients varies from 6% to 87%.[4] Stigma is still an issue for most Indonesians. The family and society still consider it a disgrace if a member of the family or community has a mental disorder so that the sufferer is hidden, ostracized, and even shackled.[3] People with mental disorders also face medical problems. Most patients reported experiencing at least one side effect because of their treatment (86.19%). Only 42.5% reported full adherence. Most of the side effects were associated with a significantly reduced chance of adherence.[5] The number of stressors stated above affects the recurrence of mental disorders.

The high rate of recurrence of mental illness in patients is due to, among others, the inability to cope with stress, resulting in the irregular intake of medication, failure to resolve conflicts with family, or the environment.[6] Patients in the post–mental hospital treatment stage need time to adapt to the conditions of the home environment. Regulatory problems in life, family background, work status, and medication adherence significantly affect mental illness recurrence.[7] Some of the factors that increase the risk of recurrence of mental disorders are living alone, not adhering to medication, no environmental support, common spiritual belief, and the side effects of drugs.[8] Based on these conditions, effective management is needed for patients in dealing with stressors to reduce recurrence and increase the patient's ability to adapt to the environment.

Stuart's stress adaptation model views human behavior from a holistic perspective, i.e., as an integrated biological, psychological, and sociocultural unit.[9] Stress management capabilities include determining the factors causing stress, the precipitation factors, assessment of stressors, sources of coping, and knowing the coping mechanisms used in dealing with stress.[9] A good understanding of stress management is expected to use constructive coping mechanisms to deal with stress. The patient's inability to undertake stress management results in the recurrence of mental illness in patients.

A preliminary study conducted in the Psychiatric Ward of Banyumas Hospital found that 70% of the treated patients were recurrent patients. In the Kebasen Puskesmas area, one of the areas with superior mental nursing, the number of patients detected with mental disorders as of January 2020 was 111. Management of patients with mental disorders has been carried out using the following approaches: namely, routine medication, examinations, and referrals if needed. Most patients were 20–45 years old (in the productive age span), and 70% were patients hospitalized after discharge. This study aims to determine the stressors and coping mechanisms of people with mental disorders in society.

2. Methods

This study used a qualitative research design, which is a way to study problems based on a complex and holistic picture, manifested in words, presented in the form of detailed information, and placed in natural situations.[10] The approach used in this research is phenomenology, which is a scientific method to describe certain phenomena as life experiences. Participants in this study were chosen by determining the appropriate population and then selecting samples using a simple random-sampling technique, namely, the sample selection method. This study focused on 21 patients with mental disorderswho were in the recovery stage and routinely consumed drugs (for therapy) in the Kebasen District, Banyumas Regency. This number is obtained when saturation is met.[11] Meanwhile, Windarwati—in 2021—recruited 23 participants in a similar study, in which data saturation was obtained.[12]

Data collection used 2 MP4 recording devices to record the information provided by participants due to the clear sound quality and easy to operate to create verbatim Interview guides in the form of semistructured questions were developed to help researchers so that the questions asked led to the research objectives, and field notes were taken to record participants' nonverbal responses and conditions that affect the interview process; the researcher was the one who used the research instrument.

2.1. Testing of research instrument

The interview guide was administered to people with a mental health condition similar to that in the participants of the Kebasen Community Health Center. Moreover, these patients were not included among the study participants.

The data collection process included 3 stages: preparation, implementation, and termination. This study used the Colaizzi data analysis method, where the steps taken include describing the phenomenon under study, collecting descriptions of phenomena through participants' opinions, reading all reports submitted by participants, rereading the interviews' results, and quoting meaningful statements.

3. Results

3.1. Participant profiles

Participants in this study included 21 people from several villages in the Kebasen Community Health Center region. Data on participant profiles can be seen in Table 1.

Participant code	Gender	Age (years)	Education level	History of being treated	Marital status	Working status	Caregiver (yes/no)
P1	M	46	High school	4 times	Married	Tailor	Yes
P2	F	28	High school	2 times	Single	Labor	Yes
P3	F	44	Junior high school	5 times	Married	Housewife	Yes
P4	M	53	Primary school	8 times	Married	Farmer	Yes
P5	M	22.	Junior high shool	1 time	Single	Unemployed	Yes
P6	M	43	Primary school	3 times	Married	Labor	Yes
P7	M	37	Junior high school	2 times	Married	Labor	Yes
P8	F	52	Primary school	7 times	Married	Housewife	Yes
P9	F	35	High school	4 times	Married	Housewife	Yes
P10	M	33	Junior high school	2 times	Married	Labor	No
P11	F	43	Junior high school	4 times	Married	Farmer	Yes
P12	M	31	Junior high school	3 times	Single	Unemployed	Yes
P13	F	43	Primary school	6 times	Married	Housewife	Yes
P14	M	23.	High school	2 times	Single	Unemployed	Yes
P15	M	40	High school	6 times	Married	Labor	No
P16	M	32	Primary school	2 times	Single	Unemployed	Yes
P17	M	22	Primary school	1 times	Single	Unemployed	Yes
P18	F	45	Primary school	3 times	Married	Farmer	Yes
P19	M	22	High school	3 times	Singled	Labor	No
P20	F	35	Junior high school	4 times	Married	Unemployed	Yes
P21	F	40	Primary school	2 times	Single	Unemployed	Yes

Table 1. Characteristics of the participants.

The data presented in Table 1 show that there were more male participants than women, namely, 12 (57%) males and 9 (42%) females. Participants' ages ranged from 22 years to 53 years, and overall, participants were in the productive age group. The number of participants who were in the late adolescent group (17–25 years) was 4, early adulthood (26–35 years) was 6, middle adulthood (36–45 years) was 8,and early elderly (46–55 years) was 3.

From the educational aspect, participants had low-to-moderate or medium education levels. The majority of participants (n=15, 71%) had low education (primary and junior high school), , and only 6 (29%) persons had a middle-level education (high school). Therefore, education can influence the participants' assessment of their stressors and the coping mechanisms adopted by the participants.

There were 11 (52%) unemployed people considering the professional aspect, and the other participants had varied roles, such as laborers, farmers, and tailors.

The history of being treated in a mental hospital was as follows: 2 persons (9.5%) were treated once, 10 (47.6%) were treated 2–3 times, and 9 people (42.9%) were treated >3 times.

The participants' marital status was predominantly married (n=13; 62%); the remaining 8 (38%) were unmarried. More number of participants, i.e., 18 (86%), were accompanied by a caregiver such as wife, husband, parents, children, or siblings; a caregiver did not accompany only 3 (14%) individuals.

3.2. Overview of the topic

3.2.1. Stressors for people with mental disorders in society

The stressors experienced by people with mental disorders in the community, determined in this study, are as follows.

3.2.2. The community is less accepting

The first stressor is that the environment does not accept people with mental health conditions in the community.

This topic was obtained from the following interview results:

"Want to go out…embarrassed…just embarrassed. Many people avoid me" (P5).

"Already lazy everywhere…I was teased by young children, thinking I was crazy. I'm not a crazy person" (P6).

"It's hard to find a job…no one wants to accept me" (P10).

"There are no friends, ma'am. Nobody wants to tell stories, and sometimes I go to my brother's place" (P14).

3.2.3. Feelings of shame

The tendency of participants to avoid the social environment is triggered by external aspects and the internal conditions of the participants themselves, precisely, feelings of shame. This topic was obtained from the following interview results:

"I am shy. I'm an insane person" (P4).

"I want to go out but am embarrassed...just embarrassed" (P11).

"I'm just at home, taking care of the house, never attending meetings for women...I'm embarrassed" (P13).

"I am ashamed to be a burden on my family…" (P21).

3.2.4. Fear of being ostracized

This topic was obtained from the following interview results:

"I rarely get together with neighbors. I'm afraid that I will be teased because I used to be that kind of person/ crazy person" (P9).

"When I go everywhere, I am afraid that many will make fun of me" (P8).

"Many people avoid me. They seem afraid" (P10).

"Sometimes I just help [with] work at the neighbors... if others don't seem to accept me" (P19).

3.2.5. Have no income

"I'm confused, don't have money, sorry for my parents" (P2, P5).

"Want to have money, want to work like before" (P7, P12).

"There are no activities at home, confused about not having money" (P2).

"I want to have income for my family… but what should I do?" (P19).

"What's good about what I do, ma'am?… I want to work (P17, P21).

3.2.6. Uncomfortable side effects of drugs

Another factor that becomes a stressor is discomfort with the side effects of taking medication.

"I often felt uncomfortable after taking medicine, was sleepy so that I couldn't work" (P1).

"After taking medicine, it feels dizzy" (P3).

"I've been taking medicine for a long time. It doesn't taste good" (P15).

"I'm sleepy after taking medicine" (P16).

"It feels stiff…" (P19).

3.3. The coping mechanism used by patients with mental disorders in dealing with stress

The study results show that the participants used a variety of coping mechanisms.

3.3.1. Distract with activities

"Instead of no activity, I sew anything like making pillowcases or something" (P1).

"Instead of daydreaming, I cleaned the house" (P8).

"If I keep quiet, I get dizzy. I help my neighbors clean the garden" (P10).

"Planting vegetables in front of the house to fill the time" (P11).

3.3.2. Confide in others

"When I am not strong, I usually cry… Sometimes paying attention to my family" (P3).

P3 cries when he feels insecure when experiencing the stressors. In addition, he also sometimes tells his family to express all the feelings they are going through. Thus, this approach of looking for or devoting attention to the family was also adopted by many other participants, such as P4, P7, P8, and P11. It is only when complaining about their condition (mental disorders) and dealing with the stigma from society that the participants are forced to limit their social interactions.

3.3.3. Distraction of emotion

"Usually, when I feel dizzy, I stay quiet, don't leave the house" (P2).

"When I'm tired and dizzy, sometimes I get angry with myself" (P7).

"Sometimes I get angry with my nagging wife or neighbor" (P12, P15).

"When angry, sometimes rampage" (P5).

"I want to scream. My chest feels tight…" (P20).

4. Discussion

4.1. The stressors of people with mental disorders in society

This study found 5 stressors experienced by patients with mental illness: less-accepting environment, feeling of shame, fear of being excluded, not having an income, and uncomfortable side effects of drugs. The stressor is any situation or stimulus considered a threat or anything that causes or increases stress.[14] Stressors are classified into bioecological factors, psycho-interpersonal factors, and social factors.

This study found that one of the stressors experienced by patients with mental illness in the community is the side effect of drugs. Research conducted on 876 respondents found that most patients experienced at least 1 side effect due to their treatment (86.19%). Only 42.5% reported full adherence. Most of the side effects were associated with significantly reduced medication adherence. The most commonly reported side effects that were quite disturbing included difficulty thinking/concentrating (32.2%), restlessness/feeling restless (28.2%), insomnia (28.4%), weight gain (25.8%), and drowsiness (25.1%).[5] Drugs administered to patients generally cause discomforts, such as extrapyramidal syndromes, neuroleptic dysphoria, akathisia, sexual dysfunction, and weight gain. Patients on antipsychotic treatment experienced a subjective response to antipsychotics, which was defined as the patient's perception of the effects of the drug on well-being. The patient's response to the effects of the drug varied, and most found it to be unpleasant and reported that the pill makes the situation worse. The extrapyramidal side effects of antipsychotic medication can be divided into 4 groups: akinesia or rigidity (parkinsonism), akathisia (intense subjective feeling of restlessness, often manifested as a nonstop physical activity, such as pacing or marching in place), dystonia (increased muscle tone), abnormality or muscle spasm, and dyskinesia (abnormal involuntary movements). Akathisia was distressing, and some patients described the condition as more difficult to endure than the initial symptoms for which they were treated. Akinesia was also a significant source of distress for patients.[15]

Psycho-interpersonal stressors are the biggest or the most-often-experienced stressors. Psycho-interpersonal stressors comprise the perceptions of stimuli that create our mental processes (perception and interpretation), involving thoughts, values, beliefs, attitudes, opinions, and perceptions used to maintain our identity or ego.[14] Feelings of shame and fear of being excluded were the psycho-interpersonal stressors found in this study. Patients with mental disorders who get stigmatized are subjected to both cognitive assessments of stigma stress and emotional stress reactions that include social anxiety and shame. Cognitive judgments lead to self-directed decisions, such as low self-esteem, hopelessness, and maintenance of distance from the social environment.[16] Social stressors explain the suffering of individuals because they are unable to cope with their environment.[14] The social environment being less accepting and having no income were social stressors experienced by the study participants. Research on 263 respondents with mental disorders showed that they felt ostracized (54%) and felt that people ignored them or considered them less capable because they had a mental illness (20%). The feeling of shame due to mental illness made them feel strange (34%).[17]

The stressors experienced by patients with mental illness in the community are partly due to the stigma that they experience. Goffman defines stigma as a "highly discrediting attribute".[4] In addition, stigma can be a significant stressor for people with schizophrenia and other mental illnesses because it exceeds the individual's resources to cope.[18]

The stigma experienced by patients can be categorized into public (social) stigma and private (personal) stigma. Personal stigma is further understood as perceived stigma, experienced stigma, and self-stigma. In contrast, the stigma that comes from environmental assessments or outside the individual is termed social stigma.[17] The stigma experienced by the study participants, namely, the environment being less accepting and having no income (due to difficulty in getting a job due to discrimination), is classified as social stigma. Feelings of shame and fear of being excluded are classified under personal stigma.

Some of the stigmas experienced by people with mental disorders include being afraid of people with mental disorders, such as fear of contacting it, even though it is known that mental illnesses are not transmitted. In addition, discrimination is the state of being marginalized, avoided, ridiculed, and victimized by violence. Job discrimination is one of the most frequently encountered stigmas as they do not get a response when applying for work and are never accepted for work. This stigma is a stressor for people with mental disorders because they do not have a job or income.[18]

Family, friends, and work are significant for people with mental health conditions. Many cases of severe psychosis occur when social contact and structured activities cannot be carried out. Unemployment causes patients to feel more isolated and miserable.[19]

There are still conditions wherein the family—as a social environment for people with mental disorders—negatively views them. People with mental disorders are often referred to as crazy, scary, and dangerous. In addition, people with mental disorders are considered similar to people who have diseases, which makes the sufferer uncomfortable because of others' unnatural behavior. The lack of knowledge and understanding of mental disorders causes sufferers to often get unpleasant treatment from their families and even from patients themselves. Treatments meted out to people with mental disorders include discrimination, isolation, exclusion, and even incitement. Families even consider mental disorders a disgrace, so they hide the state of mental disorders in the community. Some informants still refer to people with mental disorders as crazy, scary, and dangerous.[20]

This condition explains that some families and environments still give negative stigma by giving unique labels. People with mental disorders are still considered a disgrace or disgrace to their families or relatives and as people who deserve to be ostracized.[20]

Stigma can be a major stressor for people with schizophrenia and other mental illnesses, causing emotional reactions and cognitive coping responses. Stigma is assessed as a stressor if the perceived stigma-related harm outweighs the individual's perceived coping resources.[16]

People with mental disorders experience feelings of isolation and feel ashamed because of their disease condition, so they do not want to socialize[17]—individuals with schizophrenia experience the most frequent stereotyping, exclusion, and social withdrawal.[21]

4.2. Coping mechanism

Based on this research, it can be seen that the participants of this study undertook various coping mechanisms, namely, carrying out activities, telling stories to other people, and diverting emotions. Therefore, following this theory, there are two types of adaptive coping mechanisms: activities and telling stories to other people; and a maladaptive coping mechanism in the form of distraction of emotions.

Destructive or maladaptive coping mechanisms are adopted by individuals with mental disorders. Lazarus and Folkman mentioned two coping strategies that individuals usually use: problem-solving-focused coping and emotion-focused coping[22]. In problem-solving-focused coping, individuals actively seek solutions to problems to eliminate stressful conditions or situations. In contrast, in emotion-focused coping, individuals undertake efforts to regulate their emotions to adjust to the impacts that a stressful condition or state causes. Based on this theory, there are two types of adaptive coping mechanisms: activities and telling stories to other people, and one maladaptive coping mechanism in the form of distraction of emotions.

People with mental disorders often use coping mechanisms that include changes in behavior, attitudes, and interpersonal contacts.[23] People with schizophrenia tend to use passive coping strategies and avoid stressful situations. As a result, they seem to lack purpose. On the one hand, it may help prevent stress in daily life, but it may also limit their adaptiveness.[24] As found in this study, emotions are diverted or certain activities, such as sleeping, smoking, and so on, are done to avoid stress. Other strategies focusing on emotions are intended to divert or reduce attention to the problem (stressor), such as by running away, not accepting, and comparing positively.[11]

This study found that the coping mechanism in people with a mental health condition was by telling other people their problem. The patients used a problem-focused coping strategy. Several problem-focused coping strategies for people with a mental health condition include drugs and environmental support, such as asking for help or support from family or the community. Activities such as painting workshops, music choirs, carpet workshops, and group therapy are carried out by people with mental health conditions to reduce stress. Art, in its various forms, has become a means of coping, enabling the diversion of the stresses of individuals with mental disorders.[11] The use of positive coping mechanisms can be used as the strongest mental health predictor support system, such as using Active Contact Environment (ACE) strategies to deal with stress. Research shows that ACE therapy with active/effective contact with the environmental activities supports patients to get to know the environment.[25]

A study of 104 patients with schizophrenia showed that the patients used more negative than positive strategies (mean *T*-score for negative strategies was 59.04±11.24 vs 49.5±11.8 for positive approaches). Negative strategies include escape tendency, perseveration, resignation, and self-accusation. Positive strategies include underestimation, guilt denial, diversion, compensatory satisfaction, situation control, reaction control, positive self-instruction, and the need for social support.[23]

The coping mechanism of people with mental disorders needs to be improved. Patient endurance skills need to be built along with stressor-coping skills, enhanced thinking styles, and social skills. Patients are encouraged to engage in meaningful structured activities that are less demanding. Family

psychoeducation needs to be carried out to increase patients' social support—advocating for job opportunities and workplaces conducive to the disease condition need to be evolved. Having a source of income will be very helpful in improving the socioeconomic status of this patient group, thereby reducing the recurrence rate.[7] Including coping strategies used by people with mental disorders, namely, stress transfer (emotions), finding alternative satisfaction, and controlling the situation, also helps. The results also showed that men and women with schizophrenia did not differ in terms of positive and negative coping. The most important finding is that positive coping strategies are associated with lower levels of self-stigma. It confirms our hypothesis that positive coping strategies are negatively related to self-stigma. The results also showed that patients with schizophrenia spectrum disorders used negative coping strategies to a greater extent and tended to stigmatize themselves further, especially when they were accustomed to escaping tendencies, resignation, and self-accusation. It confirms our hypothesis that negative coping strategies are positively related to the self-stigma of stabilizing the patient's condition.[21]

5. Conclusions

The stressors experienced by patients with mental illness in the community are a less-accepting environment, shame, fear of being excluded, unemployment, and the uncomfortable side effects of drugs. The coping mechanism used by people with a mental health condition in the community are engaging in activities, telling stories to others, and distraction of emotions.

Ethical approval

Ethical issues are not involved in this paper.

Conflicts of interest

All contributing authors declare no conflicts of interest.

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