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Adaptation of Interactions between Parent and People with Psychotic Mental Disorders

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Abstract

Many families in Wonogiri Regency faced challenges caring for people with psychotic mental disorders. Having a mental disorder is not only a burden for the sufferer but also a burden for the family who takes care of him. People with mental disorders are generally unable to carry out daily activities. However, the families should communicate and interact with people and their mental disorders, even though in disabled, to support their healing. This research used a qualitative method to know how the adaptation patterns of interactions occurred in communication activities, especially between parents and people with psychotic mental disorders. The research data were collected through in-depth interviews with parents taking care of family members with mental disorders, as well as through document studies. The data were analyzed using descriptive and interpretive analysis. The research results indicated that interaction adaptation occurred verbally and non-verbally. The pattern of compensation and reciprocity was shown by parents when communicating with people with psychotic mental disorders. Parental awareness of psychological disorders experienced by people with psychotic disorders significantly affects understanding during the adaptation process.

Keywords: *Interpersonal Communication; Interaction Adaptation; Mental Disorders*

Introduction

Mental disorders are often abnormal behavior, where deviations are in thoughts, feelings, and actions (Kusnanto, 2019). People with mental disorders in Indonesia are known as ODGJ or People with Mental Disorders. Isesel *et al.* (2016) revealed that families with mental disorders face difficult situations. Based on an economic perspective, they experience financial constraints and considerable pressure because the reasonable costs of caring for people with mental disorders are not small, resulting in loss of income.

Mental disorders can cause various psychosocial problems such as decreased quality of life for family members and increased social distance for sufferers and their families who care for them. Psychosocial challenges are enhanced by the stigma attached to mental illness, which affects patients and families as a whole. The mental health of parents and other family members is also impaired due to pressure, conflict, shame, and loss of self-esteem (Addington *et al.*, 2005; Boydell *et al.*, 2013; Gutierrez-Maldonado *et al.*, 2005; Parabiaghi *et al.*, 2007). Furthermore, Özçelik and Yıldırım (2018) describe that supporting the recovery of people with mental disorders requires a healthy family environment.

Based on the 2018 Regional Health Research by the Indonesian Ministry of Health, there were 282,654 adults with psychotic mental disorders or schizophrenia in Indonesia and 706,689 above 15 years old depression sufferers spread across various regions. Additionally, there were 44 Mental Hospitals (RSJ) consisting of 34 government-owned hospitals, nine privately owned hospitals, and a Drug Dependence Hospital (RSKO) for treating mental disorders in Indonesia, spread across 28 provinces. In addition, of the 9000 existing health centers, only 30% provided mental health services (Indrayani & Wahyudi, 2019). The number of health facilities was not proportional to many people with mental disorders in Indonesia.

One of the areas in Indonesia with a high number of people with psychotic mental disorders is Wonogiri District, Central Java. Psychotic mental disorder or psychosis is a condition that shows a person has lost contact with reality, including delusions or believing something that is not under reality and hallucinations or seeing or hearing things that do not exist in real situations (Kusnanto, 2019). Furthermore, Yuliansyah (2017) says that people with psychotic disorders experience personality disorders entirely without adjusting to expected and general norms. Psychotic mental disorders are classified according to severity and grouped into organic and inorganic psychoses. People who experience psychotic mental disorders usually experience symptoms and behaviors including 1) Do not touch and even lose touch with reality; 2) There are maladaptive behaviors such as hallucinations, daydreaming and autism, illusions, and delusions. 3) Creating a new world by withdrawing from reality; 4) Disorganized thoughts or words, emotions expressed in abnormal ways, excessive arousal, confusion, depression and usually accompanied by suicidal thoughts, fears, unreasonable suspicions; and 5) Personality disintegration (Kusnanto, 2019:47).

Wonogiri Regency has a population of 957.106 people. In 2019, the Wonogiri District Health Office noted that 2.449 people with mental disorders spread across 25 sub-districts. Of this number, 2.050 were adults with psychotic mental disorders, and 399 were children with mental disorders. The cause of the high rate of psychotic mental disorders in adulthood was more due to poverty and love problems or heartbreak. On average, there were two cases of suicide deaths every month in this district.

Based on the data above, currently, in Wonogiri District, two thousand families face the challenge of treating people with psychotic mental disorders. A family is considered to be an essential milestone in a person's mental development for mental health recovery, as well as being able to change the direction of the mental disorders being experienced by people with mental disorders. Every day, families, especially parents, build interaction and communication to care for and meet the needs of people with mental disorders. They carry out an adaptation process from time to time to harmonize their behavior with each other that supports the healing of people with mental disorders. Therefore, this research specifically examined how the patterns of interaction adaptation in parents who take care of people with psychotic mental disorders in Wonogiri District.

Methodology

This research used a qualitative method. The qualitative method was an approach to understand in-depth and gained views about the way of thinking, feeling, reasons underlying behavior, attitudes, value systems, interests, motivations, ideas, culture, and lifestyles of the people being observed based on

their framework of thought (Slamet, 2019). A case study was a part of this research strategy. A case study investigated phenomena in real-life contexts, where the boundaries between phenomena and contexts were unclear and always used evidence from various sources. The research data were obtained from in-depth interviews with three families in Wonogiri District who had adult children with psychotic mental disorders. In addition to interviews, data were obtained through observation and document research regarding interpersonal communication and mental health. The collected data were analyzed descriptively and interpretively.

Results and Discussion

There were three respondents in this research:

Respondent I (*R*1) was a mother (60 years old) who has been taking care of her son (37 years old) with mental disorders since 2010. Her son often experienced psychosis by staying silent for five to ten days.

Respondent II (*R2*) was a mother (62 years old) who was taking care of a son (37 years old) who has been suffering from psychotic mental disorders since 2010. Her son had a hallucination psychosis disorder.

Respondent III (*R3*) was a mother (70 years old) who was taking care of her son (38 years old), who had a mental disorder since 2013. Her son had a psychotic disorder, in which he often shouts and talks to himself.

Adaptation of Interaction in Communication Activities of Parents Who Taking Care of People with Psychotic Mental Disorders in Wonogiri District

Interaction adaptation involves interpersonal interactions. DeVito (2016) mentions that "*Interpersonal communication is the verbal and non-verbal interaction between two (or sometimes more than two) interdependent people."* Communication in this research involved interpersonal interactions between parents and people with mental disorders who were being cared for. Berger & Charles R. *et al.* (2020), in their research, reported that interpersonal communication occurred at a combination of many dimensions of the context known as the situation. Context is important because it affects how the interpersonal communication process occurs and the results. Context affects people's actions, the form, and the content of messages that people generate (Applegate and Delia in Berger, Charles R, *et al*., 2020:43). The dimensions of the context in interpersonal communication situations for parents who take care of people with psychotic mental disorders, as expressed, were the social background of a family with a Javanese cultural background.

When parents and people with psychotic mental disorders communicated, they had a shared verbal and nonverbal code that had meaning and was known and used by family members. Through these codes, the family eventually formed one small culture. Verbal symbols are related to the selection and arrangement of speaking through language (Wood, 2013). Non-verbal symbols expressed emotional expressions, stand-alone, or were attached to verbal codes. Non-verbal symbols could be touch, self-positioning, body orientation, movement, posture in conversation, use of facial expressions and eye contact in conveying meaning, and use tone, accent, volume, and intonation when speaking. Improper use of auditory codes could create problems. Quarrels and misunderstandings in the family arose not because of the topic being discussed but because of an inappropriate way of conveying the message (Fitzpatrick: 1994).

Interacting with people with psychotic mental disorders for caring families required a process of adapting to interactions that were not easy. Adaptation provides the ability to understand the emotional state of the people around us (Hatfield, Caccioppo, Rapson, 1994; and Burgoon, 2014), the speed and rhythm of speech (Warner *et al.*, 1987, and Burgoon, 2014), and movement (Lumsden *et al.*, 2012, and Burgoon, 2014). In the adaption of interaction by Judee Burgoon *et al.* in Little John (2011), human interaction is complex and involves a combination of both motifs and patterns. Communicators had some coordinated reciprocal pattern. In addition, the way we adapt to other people was very dependent on the extent to which other people violated our expectations. The behavior between the communicator and the person being communicated (communicant) influenced each other and created patterns, like a dance. When we communicated, we had a rough idea of what would happen in communicating with other people. It was influenced by three RED factors called *Requirement*, *Expectation*, and *Desire*. All three became form factors for Interaction Position and Actual Behavior (Judee Burgoon in Little John, 2011). The data collected in this research could also be described based on the factors forming the interaction.

Requirements

Requirements were things we required in an interaction. This requirement was affected by the fulfillment of biological needs such as speaking loud enough to be heard, touching, or social requirements, the need for affiliation, friendship, or to manage fluency. There were factors of biological needs, and affection needs fulfillment given by parents to their children with psychotic disorders. Parents faced unstable emotional states and tried to avoid anger in communication. Parents who carried out daily care activities for people with psychotic mental disorders formed a habit of interacting. Parents did it as a form of responsibility and commitment to maintaining the survival of people with mental disorders. They carried out routine activities by preparing food, drinks, bathing, or inviting people with mental disorders to work. As R1 stated:

> "As a parent, I tried. I prepared for her bathing needs, food, and drink. If she needed something, I would try to give her. If she wanted something, I would try to fulfill it. I did not want her to be angry. The doctor has warned her to take care of her emotional state." (R1)

In this routine, conversations were carried out to build closeness. Conversations were carried out in a limited manner considering the unstable psychological condition of the child. Parents chose the time to talk under the child's wishes so that the people with disabilities did not become angry in interacting. Parents expected the atmosphere to be fluid so that children did not just spend time daydreaming, keeping quiet, or talking to themselves.

> "when I finished doing housework, I talked to him. Thus, he did not daydream. If he were not spoken to later, he would talk to himself and sometimes shout. I would remind him to speak politely. I invited him to watch television so that there was activity. Sometimes he talked, so he waited for him to talk if it was not according to his heart's desire, he even silenced me" (R2)

Messages were also conveyed to explore children's needs, using a soft voice. The messages conveyed by the three respondents generally asked the children's condition, such as "How do you feel?" They also asked what the children wanted or asked them to do something. "Please get the plate. Please wash the clothes. Let us go to bed." Besides, messages in the form of advice included “please take medicine to get well soon; be patient; please speak politely.”

Expectation

Expectations were patterns that we predicted would occur. If we were not familiar with other people, we would pay more attention to social norms such as politeness and aspects of the situation, such as the purpose of the meeting. However, when we knew another person well, our expectations would be primarily based on experience; that was, our knowledge of that person's behavior was based on the experience of previous interactions.

Through daily habits carried out by parents with people with psychotic mental disorders, parents hoped to get to know their children better. Through the responses given by children, parents were increasingly getting to know what behaviors they liked and what they did not like to do. However, in interacting, the people's response to mental disorders often does not match their parents' expectations, such as wasting water, wasting food, and not wanting to take medicine.

> "If he did not like the food I gave him, he would keep quiet. Therefore, I persuaded him to talk about what he did not like or ask for other food he wanted as long as he was willing to eat. I spoke softly so that he wanted to eat. He sometimes ate a little and then threw it away. Especially when he took medicine, he often refused. Therefore, I mixed it with food, and he got angry" (R3)

> "My son did not like being called crazy. He said I was not crazy, ma'am; why was I being given medicine all the time. Especially if a neighbor made fun of him, he could get angry. He did not like being given medicine, even though he had to take medicine every day. However, if he was told, he sometimes cursed by talking dirty language. If I wanted to give him medicine, he would scream on the street. Sometimes, I was shy, but later I would persuade him to give him something he liked so that he would take medicine." (R2)

> "He took meals little by little then threw it away. Furthermore, he retook it and threw it away, and showered much water thrown away. He sometimes took baths more than twice. His bedroom was often messy. When he was asked to tidy up, he said yes. It was tidied up, but yes, it was still a mess. However, yeah, I understood, he had that pain." (R1)

People with psychotic mental disorders could also tell their parents what they were feeling, for example, when they felt sick or tasted lousy food, felt hungry or thirsty, or talked when asking parents for something.

> "I could understand that he would *relapse*. He usually took me to the hospital and asked if his stomach hurt. It meant that he was going to have a relapse. Then, his father would take him to the nearest clinic. If he wanted to go to a relative's house, he would ask someone. If he were hungry or thirsty, he would ask. As long as he did not relapse, we could talk to him" (R1)

> "He usually asked if there was any food or said I was hungry. Furthermore, sometimes he wanted milk and asked for it. If he did not like to be talked to, he usually did not want to talk or get angry. Thus, for example, if we wanted to talk, I would wait for him to talk, then I answered." (R2)

Parents usually used special greetings for their children, such as *Le*, *Nang*, *Ngger*, or used smooth Javanese (*Krama Alus*). They were also treated gently so that the child did not get angry. As stated by the following parents:

> "Yes, I use smooth Javanese every day to talk to him. Therefore, he understood and knew how to speak politely. I asked, "What do you want to play, Nang?" If, for example, he spoke harshly, I would scold him. If he could not speak softly, you were better not to speak." (R2)

> "Yes, I had to be patient to serve him. He should not talk loudly. I would speak slowly while stroking his shoulder or hand. I was angry because I was tired. However, he also got angry, silent, and frowned." (R3)

> "We usually speak in Javanese. I never get angry or yell. When I had meaningful conversations with his father, he waited for him to sleep. I was aware that he had the disease. Therefore, I did not let his emotions get disturbed. For example, if he saw his parents fighting, he would not like it." (R1)

Desire

Desire was what we wanted to achieve or hope to bring to fruition. Communicating with people with psychotic mental disorders could be done when doing activities together and through conversation. Parents also desired that the attention and affection habits could encourage children to have a better recovery rate. Parents also wanted their children to have the self-awareness to live generally like adults in general. As R1 stated:

> "Yes, I wanted him to be healed and mentally healthy like everyone else. Therefore, he could work and live a normal life. It was like this. There was no hope. Yes, I have taken good care of myself as best I can." (R1)

Like R1, the other two respondents hoped that there would be healing in people with psychotic mental disorders and found a way out to organize the future.

> "For me, the important thing was that he was aware. Last time, he did not know his surroundings. However, nowadays, he knows his parents and sibling. He could be talked to even though he was silent. I have taken care of him for years. I hoped he would find a way out soon. Sorry, poor of him, if he was like this all the time. So, what is his future like?" (R2)

> "As a parent, I have taken care of him and given full attention to him. I hoped that he would be aware of himself, be healthy, and be able to work like his friends. He was just able to communicate with me. It was big progress, so hopefully, he could recover." (R3)

Interaction Position and Actual behavior

These three factors (RED) reflected IP/ *Interaction Position*. At the beginning of interacting, communicators and communicants showed a combination of verbal and non-verbal behavior that reflected the position when interacting, which was influenced by environmental factors and skill levels. Nevertheless, the initial behavior in most situations would change due to mutual influence or could be contrary to the initial behavior that we had done. Usually, both the communicator and the communicant reciprocate the behavior as an automatic response. The responses we received from interactions were called *actual behavior* (A). We could reciprocate some behaviors and compensate others at the same time. These familiar patterns could also be disrupted or inactive. This disturbed reciprocal response gave rise to a pattern of compensatory or self-defense or maintenance or acknowledgment. This pattern could occur when the interlocutor behaved negatively (oppositely) or if the IP was valenced more positively than the actual behavior. Meanwhile, if natural behavior were more positively valenced than interaction behavior, the response in the interaction would converge or reciprocate. When we liked the other person's behavior, we tended to reciprocate or make the behavior more similar to the other person. Nevertheless, when the negative interlocutor's behavior was not as we thought, what happened was the emergence of a compensatory pattern and maintaining one's style.

The three RED factors in verbal and non-verbal communication by parents indicated an interaction position, which was responded to by responses from people with psychotic mental disorders. They formed a pattern of interactions that were related to one another. The pattern of interaction shown in the communication of parents with psychotic mental disorders was more compensatory. Compensation occurred when the interaction between parents in communicating was responded to by unexpected actions (actual behavior), such as staying silent, wasting food, expressing the child's anger, or not wanting to take medicine. When parents talked, some responded by yelling, getting angry. Besides, when the conversation was going on, people with psychotic mental disorders tended not to respond or talk to themselves. However, the child's behavior did not make the parents change attitudes or habits in care. There was a factor of awareness in parents who understood the impact of behavior caused by mental disorders in children. In addition, they were also aware of their roles and responsibilities as parents to help children survive in difficult situations.

Conclusion

This research described the interaction adaptation of parents taking care of people with psychotic mental disorders. Parents could build communication with children as a form of responsibility, attention, and affection even though they face psychological disorders in children. Through this adaptation, verbal interactions occurred, such as conveying messages using language that was expressed subtly and politely, not in a high tone of voice, and the use of Javanese in communicating. Parents also carried out routine care for their children and invited them to do activities together. Through daily interactions, patterns of interaction were formed. The existence of awareness of psychological disorders in people with psychotic mental disorders encouraged compensation patterns. Compensation patterns occurred because parents could understand when the child's response was negative to their interaction position.

Reference

Berger, Charle.R., Roloff, Michael E,et.al (2021). *Dimensi-Dimensi Interpersonal Komunikasi Keseehatan*: Hand Book Ilmu Komunikasi.Nusa Media

Budyatna, Muhammad. (2015). *Teori-Teori Mengenai Komunikasi antar Pribadi*. PrenadaMedia Group: Jakarta.

Slamet, Yulius.(2019). *Pendekatan Penelitian Kualitatif.* Graha Imu:Yogyakarta

DeVito, Joseph A. (2016). The Interpersonal Communication Book: Ninth Edition. Longman: NewYork.

Isesel, Masunga K, Kajula, et.al. (2016). *The Psychosocial Problems of Families Caring for Relatives with MentalIillnesses and Their Coping Strategies: a qualitative urban based study in Dar es Salaam,Tanzania.* Department of Clinical Nursing, Muhimbili University of Health & Allied Sciences (MUHAS). Iseselo et al. BMC Psychiatry 16:146 DOI 10.1186/s12888-016-0857-y

Kustanto. (2019). *Mengenal Kesehatan Jiwa*. Mutiara Aksara: Semarang.

LittleJohn, Stephen W., & Foss, Karen A. 2011. Theories of Human Communication (tenth edition). Illinois:Waveland Press, Inc.

Noller,Patricia & Fitzpatrick,Mary Anne. (1994). *Communication in Family Relationships.* Prentice Hal: Englewood Cliffs, New Jersey.

Özçelik, Ebru Karaağaç, Yıldırım (2018). *Schizophrenia patients' family environment, internalized stigma and quality of life.* Journal of Psychiatric Nursing. J Psychiatric Nurs 2018;9(2):80-87

Simanjuntak, Julianto. (2008). *Konseling Gangguan Jiwa dan Okultisme: Membedakan Gangguan Jiwa dan Kerasukan Setan*. Gramedia Pustaka Utama: Jakarta.

Wood.Julia T. (2016). *Komunikasi Interpersonal: Interaksi Keseharian.* Salemba: Jakarta

Yuliansyah, Wildan. (2017). *Kesehatan Masyarakat Kesehatan Mental*. Borobudur Inspira Nusantara: Surakarta.

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