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Research Paper

Examining the challenges encountered by community health workers and empowering them to address mental health disorders: A qualitative study in Indonesia

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ABSTRACT

Objectives: Addressing the issue of mental health disorders in the community is a significant challenge for Indonesia's healthcare professionals. This study aimed to explore the challenges that community health workers (CHWs) encounter while providing mental health services in the community.

Methods: Forty CHWs were selected to participate in the study by purposive sampling method from July to August 2023 in seven primary health centers (PHCs) among three cities of Indonesia. Focus group discussions were used to collect data. All of data were analyzed using the interpretive phenomenological analysis method.

Results: Considering the participants' voluntary CHW role, the results were organized into five themes. These comprised two themes of challenges—family stigma and limited understanding of mental disorders, and three themes regarding efforts to overcome the challenges—maintaining self-motivation, fostering self-efficacy, and using communication skills when approaching families and patients.

Conclusions: Upskilling and empowering CHWs helps to enhance community mental health. Thus, it is crucial to support CHWs through training programs that aim to improve mental health literacy and communication skills and diminish family stigma.

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What is known?

- Community health workers (CHWs) encounter challenges such as rejection by patients and their families. Families often decline CHWs' assistance, fearing that the community will discover the patient's mental health condition.
- This rejection hinders the CHW's ability to deliver thorough and effective support to individuals dealing with mental health disorders.

What is new?

- CHWs observe various family expressions that enable them to perceive family stigma regarding the patient's condition. Additionally, CHWs often face internal challenges, such as limited knowledge about mental health disorders, while performing their duties.
- Serving as a CHW is a voluntary commitment. Nonetheless, CHWs find motivation in their ability to assist others and offer solutions to community challenges, particularly those involving mental health issues. Their confidence in doing their best reinforces their determination to fulfill their responsibilities.
- Very often, CHWs struggle to gather accurate information, as families feel embarrassed to share their situation with individuals outside their family. To address this problem, CHWs employ various communication strategies, including seeking

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detailed information, listening actively, and clarifying any ambiguous statements from family members.

1. Introduction

Mental health problems are a growing concern worldwide and remain a difficult challenge as the number of patients with psychiatric problems continues to increase. WHO reported that 300 million people worldwide were experiencing mental disorders in 2022 [1]. In 2023, the number of mental disorder in Indonesia was reached 4% [2]. This increase is related to the high number of patient recurrences. Relapse events are associated with a patient's behavior, such as irregular medication, failure to schedule regular follow-ups with health services, and drug withdrawal. Recurrence can also be influenced by low-income family and community support [3,4]. Managing mental disorders requires collaboration involving both the patient's family and community [5]. Community involvement to assist families in caring for patients could reduce the burden of care and increase patient acceptance in the community [6,7].

Community health workers (CHWs) are one of the elements of society closest to families and patients and play an important role in connecting health services with patients and families [8]. CHWs function as auxiliary staff of the primary health center (PHC) in performing their duties, such as accompanying patients with mental disorders and their families who care for them. They are members of the lay community who receive special training and become volunteers or are paid incidentally and willing to collaborate with local health service systems in rural and urban areas [9]. CHWs act as frontliners who can help vulnerable communities, including patients with mental disorder and their families, to access mental health services [10]. They also help identify health and mental disorders in the community [11].

In Indonesia, CHWs help in the prevention, early detection, and assistance of patients with mental disorders at the community level [12]. Early detection and effective treatment are necessary to reduce the occurrence of symptoms in people with mental health disorders [13]. A previous study in Mozambique showed that CHWs are responsible for providing screening, referral, and follow-up facilities for people with psychosis in rural settings [14]. The role of CHWs in more modern countries is educational, navigational, and supportive [15]. For CHWs, performing their duties is not simple, as they have to face various challenges originating from situations relating to patients, families, communities, and internal CHW issues [16]. CHWs face obstacles in the form of rejection from both patients and families, where the family refuses the CHW's arrival to accompany the patient because they are afraid that the latter's mental disorder will become evident in the community [17]. This rejection has an impact on the effectiveness of the CHW's role in providing comprehensive assistance to patients with mental disorders, one of which is reducing the opportunity to ensure patient compliance with treatment. CHWs need self-confidence to surmount these obstacles and perform their duties in assisting patients with mental disorders and their families.

This study aimed to examine the power of CHWs from the perspective of structural empowerment theory [18]. This theory states that personal impact at work is associated with the adequacy of formal and informal support provided by the organization where they work. An individual's ability to realize their personal effects on themselves will help them work more effectively. The ability of CHWs to work well even while facing various challenges is a manifestation of their strength. This theory guides researchers in developing research questions to explore CHWs, especially regarding their impact while facing challenges when performing

their duties in the community. A few studies have been conducted on how CHWs execute their role, however, studies focusing on handling families that are not cooperative when working with CHWs are limited. This study aimed to delve deeper into the various challenges that CHWs encounter while providing mental health services in the community and their efforts to overcome them.

2. Methods

2.1. Study design

This study utilized a qualitative descriptive design employing focus group discussions (FGDs) to explore the experiences of CHWs in carrying out their community duties. This research was conducted over two months between July and August 2023.

2.2. Participants and recruitment

The sample comprised CHWs at PHCs in three Indonesian cities. Purposive sampling techniques were used to recruit 40 CHWs from 7 PHCs. The inclusion criteria were being a CHW from a PHC, being aged at least 18, actively implementing their duties, having at least one year of experience working as a CHW, having basic training in community mental health services, and having interaction with patients and families caring for patients with mental disorders. No participants were related to the researchers.

2.3. Ethical considerations

Participants were recruited based on ethical principles. All study participants were explained the objectives, rights, obligations, research procedures, and the benefits of participating in the research, after which they signed an informed consent form. Notably, no participant refused or dropped out until data collection was completed. The Ethical Committee approved this research with reference number (2921- KEPK).

2.4. Data collection

Based on a pre-prepared question guide, city-wise data were collected through FGDs conducted three times (FGD1, FGD2, and FGD3). Before data collection, the research instrument was tested. The question guide was tested by interviewing three participants who were not selected. The trial results showed that several words were difficult for the participants to understand, so the interviewer had to repeat and add words that clarified the questions until the participants could answer directly. Changes in the use of words made in the interviews were outlined and conveyed to the research team, which discussed and agreed to the revisions made to the questions for data collection. The results showed improvements in words that were easier for participants to understand. Each FGD was conducted for 70–90 min in a discussion room. Participants were asked to discuss two main questions: "What challenges do CHWs encounter when performing their duties in the community while accompanying patients with mental disorders and their families?" and "How do CHWs overcome such challenges while conducting their duties in the community?" Questions about overcoming the challenges were developed from the perspective of structural empowerment theory [18]. The questions were open-ended, and answers were recorded using a voice recorder. The discussion process was implemented until data saturation. The FGD team comprised six researchers; all were lecturers with PhD degrees and experience conducting FGDs and qualitative research. Two researchers conducted FGD 1, three FGD 2, and one FGD 3. One researcher was male, and the others were female. Before the FGD,

the researchers held a Zoom meeting to discuss equality in perceptions regarding the procedures and strategies for the discussion process and agreed to keep the length of FGD between 70 and 90 min. They prepared a closed room conducive to discussions and comfort and recorded all the activities using a voice recorder. The recordings were transcribed verbatim after each FGD was completed.

2.5. Data analysis

The data were analyzed manually and interpreted using interpretive phenomenological analysis (IPA) [19], which comprises six steps: 1) reading and rereading the verbatim transcripts, 2) initial noting, 3) developing emergent themes, 4) searching for connections across emergent themes, 5) moving on to subsequent cases, and 6) seeking patterns across cases. Data analysis was conducted alongside data collection until data saturation. The research team held online discussions thrice for result analysis and reviewed them with senior researchers to validate the findings and finalize the integration of the research findings.

2.6. Trustworthiness

This study's trustworthiness was upheld through an audit trail by detailed documentation of all research activities, starting from developing the study's research questions, selecting research designs, determining participants' criteria, and the data collection method. Audit trails are also conducted by documenting the data collection and analysis process, which includes location, place, date, and time, as well as the various procedures involved in data collection, transcription, and analysis. Data credibility was determined at the end of the FGD through the research leader conveying the FGD's general conclusions to the participants. The audit trail was conducted by a research supervisor and an external reviewer with experience in qualitative research; this ensured that the research process and findings were credible and reliable.

3. Results

3.1. Participant characteristics

This study involved 40 CHWs (17, 10, and 13 participants in FGDs 1, 2, and 3). All CHW members from PHCs were women aged between 27 and 50. Their education levels varied from elementary school to university. While all the participants had worked as CHWs for at least one year, the longest tenure was 10 years. [Appendix A](#) presents the participants' detailed characteristics.

The research findings revealed five themes. These included 1) family stigma and 2) limited understanding of mental disorders, as challenges that CHWs encounter while accompanying patients with mental disorders and their families in the community; 3) maintaining self-motivation, 4) fostering self-efficacy, and 5) using communication skills, which indicate efforts made to overcome challenges while performing the CHW duties. Based on the research objectives, the themes are explained below.

3.2. Challenges encountered by CHWs while accompanying patients with mental disorders and their families in the community

While working in the community, CHWs interact with families and observe family expressions that help them determine whether there is any family stigma regarding the patient's condition. This situation creates challenges that must be overcome so CHWs can perform their duties. Other challenges include internal issues of CHWs and the limited understanding of mental disorders. The

themes were derived from CHWs' perceptions of challenges while providing mental health services.

3.2.1. Theme 1: family stigma

This theme was classified into three sub-themes. According to CHWs, the family shows resistance, differentiates the patient from other family members, and gives negative labels to the patient. Some CHWs say that families that find it difficult to deal with the patient's behavior show resistance to the presence of mental disorders; these families refuse to care for patients and decline to take them to health services for treatment, with some families not caring about patients at all.

"His mother didn't supervise his daily activities, didn't bathe him, didn't check whether he had eaten. She just left him. She didn't notice that his clothes were ragged." (FGD1-P5)

"The child didn't take medicine, yet he wasn't forced to. It was difficult to tell his family." (FGD2-P8)

"He also doesn't respond to the patient. So, it's up to you. We can give advice, but the family doesn't want it." (FGD3-P7)

"The patient's mother said her son (patient) had several relapses; it seemed like he wouldn't recover." (FGD1-P4)

The CHWs discussed the problem of negatively labeling patients in the family. The family said that the patient looked deranged, especially when they were unable to control their anger. The family believed that it was difficult to cure such patients, considered mental disorders to be a cursed disease and that the patient's behavior embarrassed them.

"The patient's father said his son's (patient) emotions are unstable; he can't control his emotions; it's dangerous. Hence, his sister was always (at night, morning, and afternoon) on guard, afraid that his anger would get out of control." (FGD2-P6)

"His family believes that this is a curse." (FGD3-P8)

"When asked, his family doesn't answer, which makes him embarrassed ... not invited out of the house, once when he was invited, his family was embarrassed." (FGD1-P15)

Regarding family stigma, CHWs also found that families differentiated patients from other family members for the use of personal equipment, and the patient did not get a share of the family's inheritance.

"Everything was separated: cutlery was washed in hot water, and shelves were also separated." (FGD2-P4)

"He said his sister would not be given an inheritance; she had already spent the money." (FGD3-P10)

"His father told him (patient) that you don't need to be included in the sharing of inheritance." (FGD1-P5)

3.2.2. Theme 2: limited understanding of mental disorders

The limited understanding of CHWs was grouped into three sub-themes. They did not understand the types and symptoms of mental disorders, had misperceptions about the causes of mental disorders, and lacked skills when dealing with patients suffering from mental disorders. Incomprehension was emphasized in the variety of extreme symptoms displayed by patients, from being irritable to not wanting to talk about it.

"I was just confused, you know ... each patient has different symptoms, sometimes they get angry, some are pushy, but sometimes the patient does not want to speak, becomes very silent ... what's wrong with them?" (FGD3-P9)

Moreover, CHWs perceived that mental disorders were the outcome of something other than the patient's psychological condition, such as heredity and the impact of God's retribution for the evil actions of other family members.

"The patients were sick (mental disorders) because of heredity, as their grandfather was also like that." (FGD2-P1)

"The illness was because of their mother's behavior; their mother was evil with the siblings. Therefore, God punished them by their child becoming so sick (mental disorders)." (FGD3-P5)

CHWs have difficulty responding to patients' behavior, especially when patients are angry, refuse to take medication and perform daily activities such as bathing.

"While talking to the patient, suddenly he became angry; I didn't know what to do. I was afraid of being hit, so I shouted for help from the neighbors." (FGD1-P2)

"... because I'm too confused; I don't know what to do if the patient was silent for a thousand words, refuses to take a shower ... really, he doesn't want to; refuses to take medicine, there's nothing he can do about it." (FGD2-P6)

3.3. Efforts made by CHWs to overcome challenges while performing their duties

The efforts made by CHWs include maintaining self-motivation, strengthening self-efficacy, and using communication techniques when approaching the patient's family.

3.3.1. Theme 3: maintaining self-motivation

Even though they do not have an easy job, CHWs want to continue because they have special motivations, such as gaining knowledge and experience, expanding their network of friends, establishing a good relationship with their PHC, and receiving incentives. Many such aspects had motivated them to become CHWs. Their reasons for becoming CHWs were to learn about mental problems and gain opportunities to participate in training programs organized by the PHC.

"I was interested in the information; I mean the psychological part. I learned about dealing with people having mental disorders." (FGD3-P11)

"I can exchange information about dealing with patients with mental disorders when invited to the primary health center for a meeting. I am enthusiastic about learning new things." (FGD2-P2)

The CHWs are happy to make new friends (e.g., fellow CHWs, families, and patients) and develop acquaintances.

"I have made more friends from another village and also widened my social circle." (FGD2-P8)

"I added friends, my friends increased, new family, new friends, new patients, more friends to exchange ideas with." (FGD1-P6)

Another motivation was forging good relationships with the

PHC health workers and making it easier for them to access health assistance if required.

"I got to know and can collaborate with health workers, doctors, nurses, administrative staff. I am enthusiastic because if there is a need, they will quickly help us." (FGD2-P3)

"I'm happy to know how they work (nurses). We provide information about the patient's condition. The nurse also taught me what to do if he (the patient) has a relapse; so, I am close to the primary health centers' personnel and have good relationships with them." (FGD3-P1)

Meanwhile, PHCs and local health services have allocated several funds to pay CHWs their regular salaries, honorariums for participating in activities, and transport money for activities. Many such aspects motivated them to become CHWs.

"Every month I am given work pay, not too much but it is enough to keep me enthusiastic. I am happy." (FGD2-P10)

"Every time we are invited to a health training program or an activity, we receive a monetary reward, pocket money plus transportation fee; it's very meaningful for me, a housewife." (FGD2-P1)

3.3.2. Theme 4: strengthening self-efficacy

Becoming a CHW is a voluntary task; however, CHWs believe that by helping others, providing solutions when the community faces problems—especially those related to mental disorders—and assuring themselves that they can do their best, they can strengthen and support their desire to continue their duties. Families always need help, especially when patients experience a relapse and when families are too tired from dealing with patients. CHWs are happy to help by taking patients to a hospital.

"Families are often confused if patients have relapses. I always help by accompanying them or taking them to the hospital. It's a pity that the family needs help, and I will ..." (FGD1-P7)

"Every help I give makes me feel more efficient, and when they are getting better, it makes me always want to help, especially when they have given up (facing patients)." (FGD3-P12)

Very often, CHWs provide information regarding patients' progress at home, teach patients to communicate well with people, and provide information regarding patients' latest conditions to the community nurses.

"I advised him (the patient) on how to talk nicely with people so that he would not be labeled as a mentally ill person. He tried so that he would soon be called a healthy person and succeeded. He was happy that I was happier and more enthusiastic about being a good person." (FGD2-P7)

"I can become an informant when nurses ask me how patients A or B behave at home, whether they take their medicines, and if their behavior is good. At least the nurses don't need to make home visits because my information answers their questions." (FGD1-P9)

Confidence about their abilities boosts CHWs' self-efficacy, and they become more positive about performing their duties and believing that they can do their best even though their services are voluntary.

"Being a good person is not easy, but I try to impart what I know; I observe his (patient's) condition daily. Maybe he needs help, which,

makes me feel, better for him (the patient) and his family.” (FGD3-P13)

“I saw him (the patient) getting better. After I taught him, slowly, he could bathe himself and talk to other people. I felt relieved and good about his (patient’s) development.” (FGD1-P6)

3.3.3. Theme 5: using communication techniques

When CHWs interact with patients suffering from mental disorders, they are unable to obtain good data at the beginning of the interaction, as patients are still ashamed to discuss their condition with people outside of their families. Therefore, CHWs use communication techniques, such as obtaining detailed information, becoming active listeners, and using clarification methods for unclear family statements. This strategy also ensures that family members, patients, and CHWs are consistent in their perceptions. The use of various communication techniques helps CHWs to perform their duties in the community.

While assessing families, CHWs must gather detailed information by discussing general issues and focusing on the abnormal behavior displayed by their patients.

“The family didn’t want to tell me, but I discussed other topics first; subsequently, I directed them toward their child’s (the patient) abnormal behavior. Finally, he dared to tell me; since then, he is the one who often looks for me to discuss what happened.” (FGD3-P8)

“I asked with all my heart so as not to offend him. I asked individually, with the good intention of wanting to help so she was comfortable and relaxed. After telling me the story, she confessed that she was relieved.” (FGD2-P3)

Initially, although the family does not want to discuss all the details, CHWs should confine themselves to being active listeners, remaining patient, giving the expected responses, and not opposing what the family or patient tells them. They should make the patient and family feel comfortable and encourage them to discuss their problems.

“I don’t know enough to give a solution, but when he (the patient) is anxious and wants to tell a story, I listen patiently, don’t mind, and give a normal answer. Even if it doesn’t help him, what’s better, I just listen. He’s comfortable; he needs someone to confide in.” (FGD2-P2)

“When she (patient) talks a lot, I know she needs someone who will listen to her, even though I don’t tell her what she should do. She just needs to be heard; so, I stop myself from commenting.” (FGD2-P7; FGD1-P11)

As the obstacles experienced by patients also relate to the delivery of patient and family conversations, which could give rise to ambiguities or misinterpretations, CHWs must use clarification methods to explain or re-ask questions carefully to avoid offending patients and their families.

“Sometimes, the patient’s narration is not clear. I need to ask what she means by saying that she is the cause of the problem so that it is clear and there is no misunderstanding. Fortunately, she wants to tell the story.” (FGD1-P4)

“The family is also bored because of his emotions. Sometimes, I ask her to explain a story that is difficult for me to understand. She believes that she has been made a victim because she must wait for

his brother, who has a mental illness. I try to ask her to explain what she means by thinking like that.” (FGD2-P8)

4. Discussion

4.1. Stigma from family

Several CHWs reported about families who experienced stigma regarding patients with mental disorders. This stigma includes family resistance, negative labeling, and discrimination against the patient from other family members. Stigma refers to negative attributes attached to persons and identifies them as members of an undesirable group in a particular society [20,21]. One of the stigmas was the resistance shown by families to provide care. Refusal to provide care or participate in care activities is attributable to family members’ perception of mental health conditions [22]. Families did not seem to focus on the patient’s needs relating to self-care and medication, did not care if they were being fulfilled, and did not understand the care that should be provided. Families who are bored and tired become restive and feel they no longer need to attend to the patient’s care needs [23]. Almost all families that were the responsibility of participants cared for patients with a history of relapse. The perception that the patient’s illness is difficult to cure results in indifference, specifically the care families should provide. Family resistance becomes an obstacle when CHWs perform their duties, such as asking about the patient’s condition or checking if the patient has taken medication because the family is no longer concerned about the patient’s care and treatment process. Previous research has shown that the family appears indifferent or uncooperative and shows limited involvement in their interaction when the CHW attempts to examine the patient and evaluate treatment compliance [24]. The family experiences fatigue while caring for patients and is burdened with anxiety. This complex situation challenges CHWs in building rapport with patients’ families [25].

Family stigma was also displayed as a negative stereotype of patients with mental disorders. Negative perceptions of families involved in providing care could demean patients’ psychological condition and depress them further [26]. The results indicate a perception that patients are dangerous to both themselves and others because their condition is unstable, especially if they show aggressive behaviors. Families consider patients’ mental disorders as incurable and even deem it a curse on their family. This assumption could arise because they feel insulted or believe that the condition of a family member with a mental disorder tarnishes the family’s reputation or dignity. Various opinions arise owing to misunderstandings of mental disorders, widely accepted societal myths, and negative representations in popular culture or mass media. This situation can make it difficult for families to seek professional care, affecting their quality of life and hindering the support they receive from other family members and communities. Stigma from family becomes a barrier to providing mental health services in the community [27,28].

4.2. Limited understanding of mental disorders

Limited understanding of mental disorders remains a challenge to providing effective care for patients with mental disorders, especially in terms of the confusion regarding the types and causes of mental disorders and ignorance about dealing with such patients. CHWs have a limited understanding of mental disorders, such as schizophrenia, depression, and bipolar and anxiety

disorders, because they do not have formal education or training in mental health, owing to which they cannot differentiate between the different types of disorders or understand the specific symptoms associated with each disorder [29]. They tend to assume that all mental ailments are a form of “behavioral disorders” without understanding the difference between mood conditions (such as depression and bipolar) and psychotic disorders (such as schizophrenia). Therefore, they are surprised when some patients are aggressive while others are quiet. It is important that CHWs receive simple information on the various behavioral symptoms that appear in patients based on the medical classification of the disease.

Very often, CHWs' perception of the causes of mental disorders is incorrect as they attribute mental disorders to spiritual or moral factors rather than medical conditions that are influenced by biological, psychological, and social factors [30]. This wrong perception can lead to stigma and discrimination toward patients and inappropriate approaches to treatment [31]. This research shows that such misperceptions about the causes of mental disorders are common among both families and CHWs in some communities. The research participants experienced the ignorance of CHWs about treating patients with mental disorders. Many CHWs are confused while responding to patients who are aggressive or about calming down patients with severe anxiety disorders [5]. While dealing with patients who are very silent and do not want to interact, CHWs do not realize the importance of non-verbal communication approaches or do not know how to use open-ended questions to elicit information about the patient's experience [32]. Limited understanding is a challenge because it can lead to treatment options that are ineffective or even detrimental to patients.

4.3. Maintain self-motivation

CHWs try to motivate patients by using their knowledge and experience, expanding their network of friends, establishing a good relationship with the PHC, and providing incentives. Self-motivation is an internal drive that encourages people to act and perform activities to realize the expected goals [33]. The results demonstrated that CHWs were motivated by the goals they set to achieve, such as improving their knowledge and experience of dealing with patients. Notably, CHWs were also enthusiastic about gaining knowledge on caring for patients with varied conditions and experiencing high levels of stigma attached to mental illnesses to apprise health workers at PHCs—as they are experienced in handling high-demand jobs—about the condition of patients in the community [34]. While performing their duties, CHWs are also motivated to expand their network of friends with fellow CHWs, families who care for patients with mental disorders, and health workers. Meeting more experienced people is a learning experience as it helps improve skills and widen understanding of mental health disorders [35]. Previous research in India showed that CHWs gain social recognition, develop a sense of responsibility, and acquire community trust as they play a key role in helping patients overcome health problems in the community environment [36]. Using a network of friends, mental health workers can also explore professional development opportunities, seek training, pursue courses, or discover new job opportunities in the mental health field. Another motivation for becoming a CHW is the government's regular honoraria payment. Providing consistent financial incentives for volunteer health workers, such as CHWs, is key to maintaining their motivation at work [37]. The CHWs informed that they receive incentives, such as a regular monthly salary, pocket money when participating in activities, and transportation fees. Sustaining CHWs' motivation is very important because their duties

involve providing support, care, and education to individuals who require special attention in terms of their mental health.

4.4. Growing self-efficacy

Self-efficacy is an individual's belief in their ability to complete tasks, overcome challenges, and set and achieve their desired goals [38]. For CHWs, self-efficacy refers to their ability to assist, care, and support individuals with mental disorders. Confidence in their ability to help others manage challenging situations and the belief that they can provide effective care are good initial capital for increasing the strength of CHWs. Self-efficacy can influence CHWs in solving mental health problems in the community, handling their tasks, and interacting with patients, families, fellow CHWs, and health workers [39]. Previous research has clarified that community health service providers need to build their self-confidence to sustain a positive attitude while working in an environment replete with physical challenges and psychological stress [40]. Composure and self-confidence help CHWs to handle complex or challenging situations while providing care and support to patients [41]. The CHWs who participated in this study confessed that they felt confident after successfully teaching patients to control their anger and convey their requests appropriately. In addition to patients and their families, CHWs' self-efficacy improves when they succeed in working and interacting with health workers and providing information on patients' progress. Appropriate education, training, experience, and support can help CHWs develop and maintain high self-efficacy to give care and positively impact patients and their families in the community.

4.5. Using communication techniques

Communication enables CHWs to provide community services, especially when encountering uncooperative patients or families. In this study, the participant CHWs attempted to reveal detailed information about active listeners and used clarification methods to understand ambiguous family statements. Communication techniques are skills and strategies adopted to deliver messages, facilitate interactions, and influence understanding and responses from others [42]. These skills include using various methods, speaking styles, and techniques to communicate effectively with other CHWs, families, and patients. For instance, CHWs use three types of communication: information exploration, active listening skills, and clarifications to convey perceptions. Due to strong stigma in the community, families are unwilling to immediately communicate with CHWs when explaining the condition of their family member who has a mental disorder. Consistent with previous research, active listening using open questions, patience, withholding judgment, and empathy will help CHWs understand the needs and concerns of families and patients regarding their illness, thereby creating a supportive environment and encouraging more open communication [43]. Broadly, CHWs try to focus and use open-ended questions to explore specific issues related to their patient's progress. However, it is not uncommon for families to refuse to explain this initially. In most instances, CHWs apply their active listening skills, focus on what a person is saying, listen carefully, evince interest, and do not interrupt [44]. This skill includes verbal and non-verbal items and, as active listeners, CHWs should consider different factors, such as appropriate body language and posture to indicate interest and engagement, facial expressions, eye contact, interest in the conversation, minimum verbal encouragement, attentive silence, reflection of feelings and content, and intellectual summary of the words and their purpose [45]. Active listening communication skills help CHWs gather detailed and complete information, especially when assessing the

patient's mental disorder with the family. Applying active listening techniques helps CHWs build better relationships with patients, families, and colleagues. This improves effective communication and helps provide care that is targeted, in-depth, and sensitive to the needs of individuals requiring mental health assistance. Active listening is an extraordinary tool for CHWs to perform their duties effectively.

5. Study limitations

The researchers experienced a few limitations during the data collection process. The FGD participants, with different levels of education and experience, presented various questions and opinions that sometimes overwhelmed the FGD leader; however, given their patience and focus, the process could eventually be managed. The richness of the FGD data can be increased by combining it with other data collection methods, such as in-depth interviews with the dominant FGD participants. Furthermore, limitations related to increasing the number of interviewers within the research team, maximizing differentiated sampling, and increasing the extrapolation of the results must be considered.

6. Implications for nursing practice

Notably, CHWs encounter internal and external challenges while performing their roles in the community. This study highlights the need for CHWs to comprehend family resistance that is rooted in stigma about the patient's condition and their limited understanding of mental health issues. Therefore, equipping CHWs with cognitive and practical skills is crucial, and this can be achieved through various forums that community nurses facilitate. For instance, nurses can organize activities to provide CHWs emotional and professional support, regular and consistent supervision, and peer support groups. These initiatives allow CHWs to address challenges, share experiences, and gain the emotional backing needed to remain motivated and resilient. By implementing these strategies, CHWs can perform their duties more effectively, feel empowered, and contribute toward improved mental health care in the community.

7. Implication for nursing research

This study's results highlight several initiatives CHWs have undertaken to address various challenges faced in their community-based duties. A key effort they have made, largely through self-learning, is maintaining motivation to perform to the best of their abilities, building confidence in their roles, and developing different communication strategies to gather information and align perceptions when interacting with families and individuals with mental health issues. These important findings suggest that further research is crucial to explore how nurses can best offer mentorship, supervision, and emotional support to CHWs and identify models that strengthen the partnership between nurses and CHWs. Additionally, there is significant potential for research focused on designing and testing interventions that empower CHWs, such as structured communication frameworks or innovative tools for mental health screening and education within community settings.

8. Conclusions

The combination of strong motivation, high self-efficacy, and effective communication techniques, especially active listening, may empower CHWs to overcome family stigma and limitations in understanding mental disorders. This approach will encourage

CHWs and enable them to play an important role in helping patients and their families to overcome family stigma, provide better care, and build a supportive environment for patients to recover from their mental disorders.

Data availability statement

The datasets generated during and/or analyzed during the current study are available from the corresponding author upon reasonable request.

CRedit authorship contribution statement

Rizki Fitriyasaki: Conceptualization, Methodology, Data curation, Formal analysis, Writing - original draft, Writing - review & editing. **Marthoenis Marthoenis:** Conceptualization, Methodology, Data curation, Writing - Review & Editing. **Sri Warsini:** Data curation, Writing - review & editing. **Kim Usher:** Supervision, Writing - review & editing. **Hanik Endang Nihayati:** Data curation, Methodology, Methodology, Writing - review & editing. **Winda Kusumawardani:** Data curation, Methodology, Data curation, Writing - review & editing. **Hasmila Sari:** Data curation, Resources, Data curation, Writing - review & editing.

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Declaration of competing interest

The authors have declared no conflict of interest.

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Appendices. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijnss.2024.12.003>.

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