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Sociodemographic and Nursing Characteristics of Residents with Schizophrenia in an Indonesian Social Care Home: A Descriptive Cross-Sectional Study

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Abstract

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Background: Schizophrenia is a disabling psychotic disorder that affects perception, cognition, behavior, social participation, education, and employment. Residents of social care facilities may have additional vulnerabilities related to homelessness, disrupted family relationships, poverty, and limited continuity of care. Local descriptions of their sociodemographic and nursing characteristics can support service planning. To describe the sociodemographic characteristics and primary nursing problems of residents recorded as having schizophrenia in a social care home in Surabaya, Indonesia. Methods: A descriptive cross-sectional study used total enumeration of 80 residents with a recorded diagnosis of schizophrenia in wards A, B, C, and E of the Keputih Social Care Home. Age, sex, and educational attainment were obtained from medical records; pre-admission monthly income and marital status were collected through structured interviews; and the primary nursing problem was identified through interview and observation using a mental health nursing assessment form. Data were summarized as frequencies and percentages. Results: The largest age group was 39–46 years (23/80, 28.7%). Most residents were women (54/80, 67.5%), had completed senior secondary school (26/80, 32.5%), reported a pre-admission monthly income of IDR 0–285,000 (30/80, 37.5%), and had never married (52/80, 65.0%). Hallucinations were the most frequently recorded primary nursing problem (62/80, 77.5%), followed by risk for violent behavior (8/80, 10.0%), disturbed self-concept (5/80, 6.3%), delusions (3/80, 3.8%), and social isolation (2/80, 2.5%). Conclusion: The residents were predominantly middle-aged, female, economically disadvantaged, and never married, while hallucinations dominated the recorded nursing profile. The findings support routine multidimensional assessment, individualized symptom management, psychosocial rehabilitation, supported social participation, and coordinated plans for community reintegration.

Keywords: hallucinations; Indonesia; nursing assessment; schizophrenia; social care home; sociodemographic characteristics

INTRODUCTION

Schizophrenia is a chronic and potentially relapsing psychotic disorder characterized by disturbances in perception, thought, behavior, affect, and cognitive functioning. Globally, it affects approximately 23 million people and is associated with substantial impairment in personal, family, social, educational, and occupational functioning (World Health Organization [WHO], 2025). Hallucinations and delusions are prominent positive symptoms, while negative and cognitive symptoms may reduce motivation, communication, self-care, problem solving, and participation in community life (Owen et al., 2016; WHO, 2025).

The consequences of schizophrenia extend beyond clinical symptoms. People with the disorder experience premature mortality, disrupted education and employment, housing insecurity, stigma, discrimination, and social exclusion (Charlson et al., 2018; Hjorthøj et al., 2017; Thornicroft et al., 2016). Long-term evidence indicates that early-onset schizophrenia can adversely affect educational attainment, income, employment, and cohabitation across adulthood (Hakulinen et al., 2019). Psychological stress, anxiety, coping capacity, and the problems experienced by individuals also shape mental health outcomes, emphasizing the need for assessment that extends beyond diagnosis alone (Priyantini et al., 2021).

These vulnerabilities can be concentrated among people living in social care institutions. Residents may have histories of homelessness, family separation, poverty, interrupted treatment, and limited access to community-based services. Reviews of homeless populations have consistently identified a high burden of severe mental disorders, although estimates vary by setting and assessment method (Gutwinski et al., 2021). Institutional populations are also highly selected; therefore, their demographic composition cannot be assumed to reflect the epidemiology of schizophrenia in the general population.

Nurses in social care and rehabilitation settings require information about both sociodemographic circumstances and current nursing problems. Symptom patterns can influence immediate safety planning, therapeutic communication, medication coordination, activities of daily living, and psychosocial rehabilitation. At the same time, stigma may hinder recovery and community participation. An Indonesian educational study showed that a structured photovoice intervention improved healthcare students' perceptions of mental illness,

supporting the value of targeted stigma-reduction strategies in health-professional education (Prabawati et al., 2023b).

Evidence describing residents with schizophrenia in Indonesian social care homes remains limited. Accordingly, this study aimed to describe age, sex, education, pre-admission income, marital status, and primary nursing problems among residents recorded as having schizophrenia at the Keputih Social Care Home in Surabaya. The study was descriptive and did not test causal relationships or compare subgroups.

METHODS

Study Design and Reporting

This study used a descriptive cross-sectional design. The manuscript was prepared with reference to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement (von Elm et al., 2008). Because the investigation was designed to describe one facility-based population, no exposure–outcome hypotheses were tested.

Setting

The study was conducted at the Keputih Social Care Home (Unit Pelaksana Teknis Daerah Lingkungan Pondok Sosial Keputih), a social rehabilitation facility administered by the Surabaya Social Service in East Java, Indonesia. The facility temporarily accommodates people encountered through municipal social-service operations, including people experiencing homelessness and individuals described in facility records as having psychotic disorders. Residents are assigned to wards according to sex, clinical stability, and social-care needs. The source report described five wards; residents with schizophrenia in wards A, B, C, and E were included in the sampling frame.

Participants and Sampling

The target population comprised all residents recorded as having schizophrenia who were present in the selected wards during the study period. Total enumeration was used; all 80 residents in the sampling frame were included. The source document did not report the diagnostic classification system, clinician qualifications, duration of illness, treatment status, or explicit inclusion and exclusion criteria beyond residence in the selected wards and a recorded diagnosis of schizophrenia. These details should be verified before submission.

Variables and Data Sources

The descriptive variables were age, sex, highest completed education, pre-admission monthly income, marital status, and primary nursing problem. Age, sex, and education were abstracted from facility medical

records. Income and marital status were collected through structured interviews. Income referred to the participant's reported monthly income before admission to the social care home and was grouped into seven intervals ranging from IDR 0–285,000 to IDR 1,716,000–2,000,000. Nursing problems were assessed through structured interview and observation using a mental health nursing assessment form.

The assessment framework allowed the following nursing-problem categories: grief/loss, anxiety, disturbed self-concept, social isolation, delusions, hallucinations, risk for violent behavior, suicide risk, and self-care deficit. The reported results assigned each participant to one primary category. The source document did not specify a validated diagnostic algorithm, inter-rater reliability assessment, or whether standardized Indonesian nursing diagnosis criteria were applied. Therefore, the term 'primary nursing problem' is used rather than implying a comprehensive psychiatric diagnosis.

Data Collection Procedures

After administrative permission was obtained from relevant local authorities and the facility, the researcher coordinated with ward personnel and reviewed the records of residents with schizophrenia. Data abstraction was supported by an enumerator who prepared the medical records. Interviews and observations were subsequently conducted for variables not available in the records. Participant identities were coded during data processing. The source thesis contains an inconsistency in the collection year: the methods section states January 2019, whereas the population framework, study chronology, results, and facility description indicate January–February 2020. This manuscript provisionally reports January 2020; the authors must confirm the correct period before submission.

Statistical Analysis

Data were edited, coded, entered into statistical software, and summarized using frequencies and percentages. No inferential tests, measures of association, or missing-data analyses were reported. Percentages were calculated using the complete sample of 80 participants. Values in the manuscript were reconciled against the statistical-output appendix when the narrative tables contained transcription errors.

RESULTS

All 80 residents in the sampling frame were included in the descriptive analysis. The largest age group was 39–46 years (28.7%), followed by 31–38 years and 47–54 years (18.8% each). Women

represented 67.5% of the sample. Senior secondary school was the most frequently reported educational level (32.5%), although 23.8% had no formal schooling and only one participant (1.3%) had completed higher education. Most participants reported very low pre-admission income; 37.5% were in the IDR 0–285,000 interval. Nearly two thirds had never married (65.0%) (Table 1).

Table 1. Sociodemographic characteristics of residents with schizophrenia (N = 80)

Characteristic	n	%
Age, years		
23–30	13	16.3
31–38	15	18.8
39–46	23	28.7
47–54	15	18.8
55–62	9	11.3
63–70	4	5.0
71–77	1	1.3
Sex		
Male	26	32.5
Female	54	67.5
Highest completed education		
No formal schooling	19	23.8
Primary school	20	25.0
Junior secondary school	14	17.5
Senior secondary school	26	32.5
Higher education	1	1.3
Pre-admission monthly income, IDR		
0–285,000	30	37.5
286,000–571,000	17	21.3
572,000–857,000	13	16.3
858,000–1,143,000	8	10.0
1,144,000–1,429,000	1	1.3
1,430,000–1,715,000	5	6.3
1,716,000–2,000,000	6	7.5

Characteristic	n	%
Marital status		
Never married	52	65.0
Married	16	20.0
Widowed or divorced	12	15.0

Hallucinations were recorded as the primary nursing problem for 62 participants (77.5%). Risk for violent behavior was recorded for eight participants (10.0%), disturbed self-concept for five (6.3%), delusions for three (3.8%), and social isolation for two (2.5%) (Table 2). No participant was classified under grief/loss, anxiety, suicide risk, or self-care deficit as the single primary nursing problem in the reported dataset.

Table 2. Recorded primary nursing problems among residents with schizophrenia (N = 80)

Primary nursing problem	n	%
Hallucinations	62	77.5
Risk for violent behavior	8	10.0
Disturbed self-concept	5	6.3
Delusions	3	3.8
Social isolation	2	2.5
Total	80	100.0

DISCUSSION

This facility-based study describes a socially vulnerable group of residents recorded as having schizophrenia. The sample was predominantly middle-aged and female, with limited educational attainment, very low pre-admission income, and a high proportion of residents who had never married. Hallucinations accounted for more than three quarters of the recorded primary nursing problems. These findings provide a practical profile for local nursing and rehabilitation planning, but they should not be interpreted as estimates of schizophrenia incidence, prevalence, or causal risk factors.

The modal age interval was 39–46 years. This finding describes current age rather than age at onset, duration of illness, or timing of institutional admission. Schizophrenia commonly begins in late adolescence or early adulthood, but chronic symptoms, functional disability, social disadvantage, and recurrent care needs can persist into middle age

(Owen et al., 2016; WHO, 2025). Without onset and illness-duration data, the present distribution cannot establish whether participants developed schizophrenia earlier or later than expected.

Women represented 67.5% of the sample. Population evidence has often shown an earlier onset among men and clinically meaningful sex differences in course and outcomes (Sommer et al., 2020; WHO, 2025). The female predominance observed here should therefore not be interpreted as evidence that schizophrenia is more common among women in Surabaya. Admission pathways, ward organization, survival, family support, homelessness, referral practices, and the availability of alternative placements may all shape the sex distribution of an institutional sample. These selection processes were not measured.

The education profile was heterogeneous, but only one resident had completed higher education and nearly half had either no formal schooling or primary education. Schizophrenia may interrupt education through early symptom onset, cognitive difficulties, repeated episodes, stigma, and reduced access to accommodations. Conversely, childhood and social disadvantage can precede diagnosis. Because this study recorded only highest completed education at one point in time, it cannot distinguish educational disruption caused by illness from pre-existing disadvantage.

Most participants reported very low pre-admission income, and 65.0% had never married. Longitudinal research has linked schizophrenia with reduced employment, income, educational attainment, and cohabitation across adulthood (Hakulinen et al., 2019). However, the present study cannot determine directionality. The income categories were also based on self-report and were not compared with a contemporaneous minimum-wage threshold. These variables are best interpreted as markers of social and economic vulnerability that should inform discharge planning, supported employment, benefit access, housing support, and recovery-oriented rehabilitation.

Hallucinations were the dominant recorded nursing problem, consistent with the central role of perceptual disturbances among the positive symptoms of schizophrenia (Owen et al., 2016; WHO, 2025). For nursing practice, a label of hallucinations should lead to a more detailed assessment of sensory modality, frequency, duration, emotional impact, command content, associated delusions, insight, triggers, coping responses, medication adherence, substance use, sleep, and immediate safety.

Therapeutic communication should validate distress without reinforcing the perceptual experience, while helping the person identify coping strategies and seek assistance when symptoms intensify.

Risk for violent behavior was recorded for 10.0% of residents. This category requires careful, person-centered assessment rather than stigmatizing assumptions. Most people with schizophrenia are not violent, and risk is influenced by multiple factors such as acute agitation, command hallucinations, persecutory beliefs, substance use, previous violence, environmental stressors, treatment interruption, and access to means. Preventive nursing care should emphasize de-escalation, early recognition of escalating arousal, collaborative safety planning, least-restrictive practice, and prompt clinical review.

Assigning each participant to a single primary nursing problem may have underrepresented co-occurring needs. Hallucinations can coexist with social isolation, self-care deficits, anxiety, depression, suicide risk, cognitive impairment, and physical illness. A comprehensive nursing assessment should therefore avoid treating the categories in Table 2 as mutually exclusive clinical realities. Standardized symptom and functioning measures, repeated assessment, and multidisciplinary case review would strengthen care planning.

Stigma and discrimination can limit access to education, housing, employment, relationships, and general health care (Thornicroft et al., 2016; WHO, 2025). The social-care context makes rights-based and recovery-oriented practice particularly important. Staff education should address diagnostic stereotypes, respectful language, shared decision making, supported risk taking, and residents' legal and social rights. The photovoice study by Prabawati et al. (2023b) demonstrated improved perceptions of mental illness among healthcare students after a structured educational intervention. Although conducted in students rather than social-care staff, it supports the feasibility of experiential learning to reduce stigma.

Family contact and reintegration planning should be individualized and should not assume that every resident has an available or safe family network. When family caregivers are involved, their own health and quality of life require attention. An Indonesian cross-sectional study found that family caregivers of people with schizophrenia experienced clinically relevant physical-health and quality-of-life concerns, with male caregivers showing a higher prevalence of elevated blood pressure (Prabawati et al., 2023a). Care plans should therefore include

caregiver education, burden assessment, referral for health needs, crisis planning, and realistic distribution of caregiving responsibilities.

The findings support an integrated service model that combines psychosis assessment, medication coordination, physical-health monitoring, psychosocial interventions, and social rehabilitation. Evidence-based care for schizophrenia includes pharmacotherapy, psychoeducation, family interventions, cognitive-behavioral approaches, skills training, supported housing, and supported employment (American Psychiatric Association, 2021; WHO, 2025). In a social care home, nurses can contribute by monitoring symptom change and adverse effects, promoting sleep and self-care, assessing cardiometabolic risk, strengthening coping skills, facilitating meaningful daily activities, and coordinating referrals to psychiatric, primary-care, and social-protection services.

Discharge and community reintegration should begin early and include identity documentation, health insurance, continuity of medication, appointment linkage, housing, livelihood options, family or community support, and a relapse-response plan. Facility-level data systems should record diagnosis source, symptom severity, functional status, physical comorbidity, treatment, length of stay, family contact, and discharge outcome. Repeated audits would allow services to move beyond a static demographic description toward evaluation of quality and recovery outcomes.

A strength of this study was the inclusion of the complete facility sampling frame and the combination of record review, structured interview, and observation. The study also provides local information from a social care setting that is underrepresented in schizophrenia research.

Several limitations are important. First, the single-facility descriptive design limits generalizability and precludes causal inference. Second, the source of the schizophrenia diagnosis and diagnostic criteria were not reported. Third, the assessment instrument for primary nursing problems was insufficiently described, and reliability was not evaluated. Fourth, participants were assigned to one primary nursing category, which may have underestimated multimorbidity and co-occurring nursing needs. Fifth, income was self-reported retrospectively and may be affected by recall or interpretation. Sixth, medication use, substance use, physical comorbidity, illness duration, symptom severity, cognitive status, functional ability, homelessness duration, family contact, and length of

stay were unavailable. Seventh, there is an unresolved discrepancy in the reported data-collection year. Finally, the ethics approval and capacity-based consent process require clarification before publication.

CONCLUSION

Residents with schizophrenia in this Indonesian social care home were predominantly middle-aged, female, economically disadvantaged, and never married. Hallucinations were the most frequently recorded primary nursing problem, followed by risk for violent behavior. The results highlight the need for comprehensive and repeated nursing assessment, individualized management of psychotic symptoms and safety needs, physical-health monitoring, stigma reduction, psychosocial rehabilitation, and coordinated community reintegration. Future multicenter studies should use verified diagnostic criteria and standardized measures, capture co-occurring symptoms and functioning, and examine service and recovery outcomes over time.

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