

Implementation of Positive Self-Talk, Interpersonal Communication, and Activity Involvement to Manage Hallucinations in Patients with Schizophrenia

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ABSTRACT

Auditory perceptual disturbances in the form of hallucinations are commonly experienced by patients with schizophrenia and may interfere with daily functioning if not properly managed. One nursing intervention to help patients control hallucinations is the implementation of structured intervention strategies (SP I–IV). This study aimed to describe the application of these strategies in improving patients' ability to control auditory hallucinations. This study was a case report conducted on four patients with schizophrenia who experienced auditory hallucinations and were treated in the Perkutut Ward of the West Java Provincial Psychiatric Hospital. Data were collected through interviews, observation, and nursing care documentation. The data were analyzed using a qualitative descriptive approach. The results showed that the structured and routine implementation of the intervention strategies reduced the frequency and intensity of auditory hallucinations and improved patients' ability and independence in controlling them. It can be concluded that the implementation strategies are effective as part of psychiatric nursing care. Therefore, these strategies are recommended to be applied consistently in nursing practice for patients with auditory hallucinations.

Keywords: auditory hallucinations; schizophrenia; nursing implementation strategies; symptom management

INTRODUCTION

Mental disorders are psychological conditions in which individuals experience a decline in bodily functioning due to feelings of pressure, discomfort, and inability to perform their social roles [1]. Mental disorders are maladaptive reactions to stressors originating from within or outside the individual. They may lead to changes in perception, thought patterns, behavior, and emotions that are inconsistent with prevailing norms or culture, as well as disturbances in social relationships and resilience [2]. Mental disorders can occur in anyone, whether young, adult, or elderly, and may affect people living in both urban and rural areas [3]. Mental disorders consist of mild and severe conditions, and one of the most dangerous and uncontrolled severe disorders is schizophrenia [4]. An individual with a physically healthy body but experiencing mental problems such as anxiety, depression, or even hallucinations cannot be considered fully healthy [5]. True health requires a balance between a sound body, positive thinking, and supportive social relationships. Therefore, maintaining physical, mental, and social aspects in everyday life is essential [6, 7].

The World Health Organization (WHO) reported that in 2019, approximately 970 million people worldwide experienced mental disorders; 301 million suffered from anxiety disorders, 280 million from depression, 40 million from bipolar disorder, and 24 million experienced auditory hallucinations, with schizophrenia alone affecting nearly 24 million people globally [8]. Data from the 2018 Indonesian Basic Health Research (Riskesdas) showed that 11.1% of households in Indonesia had a family member with schizophrenia. The prevalence was 10.4% in Yogyakarta, 2.7% in West Nusa Tenggara, 2.1% in Aceh, 8.7% in West Java, and 2.3% in Central Java [9].

Schizophrenia is a long-term mental disorder in which patients experience hallucinations, illusions, disorganized thinking, and behavioral changes [10]. It is characterized by positive and negative symptoms. Positive symptoms include hallucinations, delusions, disorganized thinking, and bizarre behavior, whereas negative symptoms include flat affect, lack of motivation, social withdrawal, and isolation [11, 12].

Hallucinations are among the most common types of mental disturbances. Difficulties in rational thinking, emotional regulation, and social interaction are common among individuals experiencing hallucinations [13]. Hallucinations are mental conditions that disrupt brain functioning, resulting in irrational experiences in thought, emotion, perception, movement, and behavior [14]. They are characterized by alterations in perception, such as hearing voices, seeing shadows, sensing, touching, or smelling things without an external stimulus. These are false sensations not originating from reality [15, 16]. Patients perceive stimuli that are actually unreal [17]. One type of hallucination is auditory hallucination (hearing voices or sounds), which is the most frequently experienced type [18, 19]. Auditory hallucinations occur when individuals hear sounds ranging from simple noises to voices speaking about them, to which they may respond [20]. If not properly managed, hallucinations may increase anxiety, trigger aggressive behavior, cause social withdrawal, and even endanger the patient or others.

When experiencing hallucinations, patients may display both adaptive and maladaptive responses. Adaptive responses occur when patients receive appropriate stimuli that help them regulate emotions, demonstrate appropriate attitudes, and interact socially. Maladaptive responses, in contrast, include social withdrawal, loss of emotional control, reduced interest in social relationships, and inability to regulate emotions [21]. Persistent auditory hallucinations may lead to aggressive behavior, disturbances in the nervous system, and even suicide attempts. Proper management is therefore required due to the negative consequences of hallucinatory behavior [22]. Not only patients bear the burden, but families are also significantly affected. The burden includes financial strain due to treatment costs, emotional stress from interacting with patient behaviors, social challenges related to stigma toward individuals with schizophrenia, and physical burden from caregiving responsibilities [23]. This condition indicates that auditory hallucinations are not only an individual problem but also a family and societal issue.

Nursing interventions to manage and help patients overcome hallucinations include implementing structured intervention strategies: rebuking the voices heard (SP I), engaging in conversation with others (SP II), performing scheduled activities (SP III), and training patients to take medication regularly (SP IV). These strategies involve identifying hallucinations and controlling them through rebuking techniques, which have been shown to be effective in helping patients manage hallucination problems [24].

Several factors may contribute to relapse risk in individuals experiencing hallucinations, including high expressed emotion in families, limited family understanding of the condition, accessibility of health facilities, household income level, and patient adherence to medication [25]. Studies conducted in the United Kingdom and the United States indicate that families with high expressed emotion—characterized by hostility, excessive criticism, and overinvolvement—tend to experience relapse within nine months, with approximately 57% of rehospitalization cases originating from such family environments [26].

In clinical practice, patients with schizophrenia and auditory hallucinations are still found to be unable to control their symptoms independently, thus requiring intensive nursing assistance. Therefore, comprehensive nursing care is needed to illustrate the application of nursing interventions as a form of scientific contribution and evidence-based practice. This study aims to describe the implementation of structured intervention

strategies (SP I–IV) in controlling auditory hallucinations in patients with schizophrenia and is expected to serve as a reference for nurses in providing effective and structured psychiatric nursing care.

METHODS

The study was conducted from 14–21 October 2025 over a seven-day period in the Perkutut Ward of the West Java Provincial Psychiatric Hospital. This study employed a case report design aimed at describing the implementation of nursing care for patients with sensory perception disturbances in the form of auditory hallucinations [27]. The study subjects were four patients with schizophrenia who experienced auditory hallucinations and were hospitalized in the ward. Participants were recruited using purposive sampling with the following inclusion criteria: diagnosed with schizophrenia, experiencing auditory hallucinations, able to communicate, and willing to participate as respondents.

Data were collected through interviews, observation, and documentation using psychiatric nursing assessment forms and nursing records. The study procedures included patient assessment, formulation of nursing diagnoses, intervention planning, implementation of structured intervention strategies (SP I–IV), and evaluation of nursing care outcomes [28]. Data were analyzed using a qualitative descriptive approach by comparing patients' conditions before and after the interventions.

RESULTS

Table 1 presents data on the patients' characteristics, including sex, age, and precipitating factors. The first patient, Mr. E, aged 30 years, began experiencing hallucinations several weeks after going through a divorce. He frequently reported hearing a male voice calling his name and threatening to take his child away, especially at night between 22:00 and 02:00 when he was alone in his room. The voice appeared three to four times per day and was accompanied by anxiety and fear. Clinically, when hallucinations occurred, the patient stopped his activities, looked to the left and right, and spoke softly as if responding to the voice.

The second patient, Mr. I, aged 22 years, experienced hallucinations particularly when at home during family conflicts. These typically occurred in the afternoon between 16:00 and 18:00, when the home environment was busy and stressful. The patient reported hearing a voice telling him that he was "not liked" by family members. The episodes occurred two to three times per day, especially when he felt sad or angry. During hallucinations, he appeared restless, had difficulty concentrating, and sometimes covered his ears to avoid the voice.

The third patient, Mr. G, aged 29 years, stated that his hallucinations often appeared after returning from work, particularly at night between 20:00 and 23:00, when he felt tired and worried about financial problems. He heard voices criticizing and blaming him for his difficulties. These hallucinations occurred daily, about four to five times per day, and intensified when he felt stressed by work. Observationally, the patient appeared anxious, frequently stared in one direction, and suddenly stopped speaking.

The fourth patient, Mr. A, aged 27 years, began experiencing hallucinations a few days after breaking up with his partner. The hallucinations usually appeared in the morning between 05:00 and 07:00 when he had just awakened and still felt sad. He heard a female voice blaming him and threatening to "leave forever." These hallucinations occurred once or twice daily but lasted relatively long, about 10–15 minutes. During the episodes, the patient appeared withdrawn, avoided eye contact, and tended to isolate himself.

Table 1. Assessment of patients with sensory perception disturbance: auditory hallucinations

Category	Mr. E	Mr. I	Mr. G	Mr. A
Sex	Male	Male	Male	Male
Age	30 years	22 years	29 years	27 years
Precipitating factors	Divorce	Family conflict / parental disputes	Work pressure and economic demands	Breakup with partner

Table 2. Implementation of interventions in patients with sensory perception disturbance: auditory hallucinations

Day/Date/Time	Mr. E	Mr. I	Mr. G	Mr. A
Tuesday, 14 October 2025, 08:00	SP I: Establishing therapeutic rapport; identifying type, content, timing, frequency, situation, response, and triggers of hallucinations. Teaching SP I (rebuking the voices) and guiding rebuking statements.	SP I: Establishing rapport; identifying characteristics of hallucinations and triggers. Teaching SP I and introducing SP II to shift focus from hallucinations.	SP I: Establishing rapport; identifying characteristics and triggers. Educating SP I and attempting distraction techniques; modeling rebuking statements.	SP I: Establishing rapport; identifying hallucination characteristics. Teaching SP I–SP II and encouraging conversation to reduce hallucinations.
Wednesday, 15 October 2025, 08:30	Repeating SP I practice, modeling rebuking, providing reinforcement.	Repeating SP I, modeling rebuking, retrying SP II.	Repeating SP I training, giving reinforcement.	Repeating SP I and practicing SP II with reinforcement.
Thursday, 16 October 2025, 08:50	Guided repetition of SP I.	Practicing SP I independently; initiating brief SP II (2–3 minutes); reinforcement.	Repeating SP I regularly.	SP II: Reevaluating SP I–II; practicing longer conversation.
Friday, 17 October 2025, 08:15	SP II: Evaluating SP I; teaching short conversations; training conversational focus.	SP II: Evaluating SP I; practicing SP II for 5–10 minutes; training conversational responses.	SP II: Evaluating SP I; practicing SP II to improve communication response.	SP III: Reevaluating SP I–II; engaging in scheduled activities.
Saturday, 18 October 2025, 07:30	SP III: Evaluating SP I–II; initiating simple scheduled activity (morning walk).	SP III: Evaluating SP I–II; teaching structured activities such as morning walks.	SP III: Evaluating SP II; engaging in scheduled activities.	SP IV: Evaluating SP I–III; educating medication adherence and guiding medication intake.
Monday, 20 October 2025, 08:00	SP IV: Evaluating SP I–III; practicing medication adherence; education on its importance.	SP IV: Evaluating SP I–III; practicing medication adherence; education on benefits.	SP IV: Evaluating SP I–III; practicing medication adherence; education on medication effects on hallucinations.	Reevaluating SP I–III; continuing SP IV practice.
Tuesday, 21 October 2025, 09:00	Evaluating SP I–IV; strengthening hallucination control ability; reinforcement.	Evaluating SP I–IV; reinforcement.	Evaluating SP I–IV and independence in daily activities; reinforcement.	Evaluating SP I–IV; practicing daily schedule planning; reinforcement.

Based on Table 2, a gradual improvement pattern in patients' ability to follow the intervention strategies during the care period is observed. All patients initially showed better responses to SP I as the foundational hallucination control strategy, followed by improved social interaction and activity engagement after SP II and SP III were introduced. Overall, the sequential implementation of the strategies demonstrated a consistent direction of improvement in all patients, although the speed of adaptation varied. Most patients showed improved hallucination control after several days of intervention, indicating that regularly implemented strategies helped enhance patients' ability to control hallucinations. These findings suggest that structured implementation of SP I–IV supports improvement in patients' ability to manage auditory hallucinations during hospitalization.

Table 3. Evaluation of intervention implementation in patients with sensory perception disturbance: auditory hallucinations

Day/Date/Time	Mr. E	Mr. I	Mr. G	Mr. A
Tuesday, 14 Oct 2025, 08:30	Unable to perform SP I; still confused when hallucinations appear.	Unable to perform SP I-II; restless and unfocused.	Unable to perform SP I; still follows hallucination content.	Unable to perform SP I-II; withdrawn and unresponsive.
Wednesday, 15 Oct 2025, 10:30	Began attempting SP I but inconsistent; hallucinations frequent.	Hallucinations decreased after guided SP I; SP II still limited.	Began attempting SP I but not yet independent.	Attempted SP I; began brief conversation (SP II).
Thursday, 16 Oct 2025, 10:45	Able to perform SP I with guidance; hallucinations decreasing.	Able to perform SP I independently; more communicative.	SP I more stable.	More confident in SP I; beginning SP II.
Friday, 17 Oct 2025, 08:40	Began SP II with short conversation; able to maintain interaction.	Conversing 5-10 minutes (SP II); able to follow conversation flow.	Performing SP II; more responsive communication.	Beginning SP III with supervision.
Saturday, 18 Oct 2025, 08:15	Following simple scheduled activity (SP III); still needs reminders.	Following structured activities such as morning walk (SP III).	Following scheduled activities.	Learning medication adherence; occasional refusal.
Monday, 20 Oct 2025, 08:20	Taking medication regularly (SP IV) with supervision.	Taking medication with supervision; hallucinations decreasing.	Taking medication regularly; hallucinations decreased significantly.	SP I-III good; SP IV initiated but still needs motivation.
Tuesday, 21 Oct 2025, 09:30	Able to control hallucinations with SP I; SP II-IV with minimal assistance.	Stable and independent in all SP; hallucinations greatly reduced.	Fully independent in SP I-IV; daily activities running well.	Significant improvement; able to rebuke, interact, follow schedule, and take medication regularly.

Based on Table 3, there is an overall trend toward reduced intensity and frequency of auditory hallucinations after implementation of the intervention strategies. Most patients demonstrated improved ability to recognize and control hallucinations, indicated by better responses to hallucinatory experiences. Additionally, a pattern of increasing independence in applying hallucination-control techniques was observed. Over time, patients became more capable of implementing the strategies without full nursing assistance. Although the degree of improvement varied among patients, the direction of change was consistently positive. Overall, the findings indicate that the implementation of structured intervention strategies contributed to improved patient ability to control auditory hallucinations during the treatment period.

DISCUSSION

Based on the case analysis of Mr. E, Mr. I, Mr. G, and Mr. A, the primary nursing problem identified was sensory perception disturbance in the form of auditory hallucinations. Hallucinations are defined as conditions in which individuals experience disturbances in sensory perception that subsequently trigger changes in behavior and emotional responses. As a result, individuals face difficulties in performing their social roles, making timely intervention essential. One of the most common forms is auditory hallucination, which occurs when patients hear indistinct murmurs or clear voices that may appear to speak directly to them or give commands to perform certain actions [29].

The findings of this study indicate that the implementation of structured intervention strategies (SP I-IV) produced positive outcomes in improving patients' ability to control auditory hallucinations. Most patients demonstrated reductions in both the frequency and intensity of hallucinations, along with increased ability to recognize early signs and apply control techniques. The gradual and continuous nature of the interventions appears to be a key factor contributing to these improvements.

From a clinical perspective, the effectiveness of these interventions may be explained by the complementary roles of each stage of the structured strategy. SP I serves as the foundational phase, enabling patients to identify hallucinations, differentiate internal stimuli from reality, and begin exercising cognitive control over their responses. This stage is crucial because insight and recognition are prerequisites for successful symptom management. SP II and SP III function as behavioral and social distraction techniques that redirect attention away from hallucinatory experiences through interpersonal interaction and engagement in meaningful activities. These approaches reduce the cognitive space available for hallucinations and reinforce adaptive behavioral patterns. SP IV strengthens the sustainability of outcomes by emphasizing medication adherence, which supports neurochemical stability and prevents symptom exacerbation.

The results of this study are consistent with previous research indicating that stepwise implementation of hallucination management strategies can improve the ability of patients with schizophrenia to control auditory hallucinations. Prior studies have reported that rebuking techniques, therapeutic communication, and participation in structured activities are effective in reducing hallucination frequency and enhancing patients' adaptation to their symptoms [30]. The present findings reinforce this evidence by demonstrating similar improvements within a short intervention period in a clinical inpatient setting.

From a theoretical standpoint, these findings align with psychiatric nursing frameworks which conceptualize hallucinations as sensory perception disturbances that can be managed through integrated cognitive, behavioral, and pharmacological approaches. The structured intervention strategies applied in this study reflect this multidimensional approach. Cognitively, patients are trained to recognize and challenge hallucinatory experiences; behaviorally, they are encouraged to engage in adaptive activities and communication; and pharmacologically, medication adherence supports symptom stabilization. Through this process, patients gradually develop more adaptive coping mechanisms, improved self-regulation, and better ability to distinguish internal perceptions from external stimuli.

In addition, the progressive improvement observed among patients suggests that consistent therapeutic interaction and repetition of strategies play an important role in strengthening learning and behavioral adaptation. Even though each patient showed a different pace of improvement, the overall direction of change was positive. This variation may be influenced by individual factors such as illness duration, emotional stressors, family support, and level of insight. Therefore, individualized pacing and continuous reinforcement from nurses are essential components of effective psychiatric nursing care.

The findings also highlight the importance of structured nursing interventions in inpatient psychiatric settings. Without systematic guidance, patients with auditory hallucinations often remain dependent on staff and may struggle to independently manage symptoms. The structured SP I-IV framework provides a practical and replicable approach that nurses can apply consistently. This supports not only symptom reduction but also patient autonomy, functional recovery, and readiness for discharge. However, this study has limitations inherent to case report designs, including the small number of subjects and limited generalizability. The short duration of observation also restricts conclusions regarding long-term relapse prevention. Future studies involving larger samples, longer follow-up periods, and mixed-method designs are recommended to further validate the effectiveness of structured intervention strategies in psychiatric nursing practice.

CONCLUSION

Based on the study findings, the structured and routine implementation of intervention strategies (SP I-IV) improved patients' ability to control auditory hallucinations. Patients showed reductions in hallucination frequency and intensity, as well as increased independence in applying

hallucination-control techniques. These findings indicate that structured intervention strategies are effective as part of nursing care for patients with sensory perception disturbances in the form of auditory hallucinations.

Ethical consideration, competing interest and source of funding

-This study adhered to research ethical principles, including informed consent, confidentiality of participants' identities, and the principles of beneficence and non-maleficence, and was declared ethically appropriate.

-There is no conflict of interest related to this publication.

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