Implementation of Deep Breathing Relaxation, Distraction Techniques, Therapeutic Communication, and Spiritual Therapy to Prevent Violent Behavior in Patients with Schizophrenia

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ABSTRACT
One of the most commonly encountered and treated mental disorders is schizophrenia, which is characterized by disturbances in reality testing, cognitive functioning, and difficulties in performing daily activities. Patients with schizophrenia tend to be at high risk of engaging in violent behavior. This study aimed to describe nursing care interventions, particularly deep-breathing relaxation, distraction techniques, therapeutic communication, and spiritual therapy, in preventing violent behavior among patients with schizophrenia. This study employed a case report method involving four patients with the primary nursing diagnosis of risk for violent behavior. Nursing care was subsequently implemented, and the outcomes were presented descriptively. The results showed that nursing therapeutic interventions enabled patients to control emotions and violent behavior through deep-breathing relaxation; patients were able to perform emotional distraction by hitting a pillow, communicate appropriately, adhere to medication regimens, and engage in spiritual activities, thereby preventing violent behavior. Nursing therapy was conducted over seven days with the implementation of SP I–V. It can be concluded that the deep-breathing relaxation technique helps patients with schizophrenia control violent behavior. Psychiatric nurses are therefore recommended to apply this technique comprehensively for patients exhibiting violent behavior.
Keywords: schizophrenia; risk of violent behavior; psychiatric nursing care; deep-breathing relaxation

INTRODUCTION
Mental well-being reflects psychological harmony, the ability to cope with challenges, the experience of happiness, and the capacity to confront aspects of oneself [1]. Individuals who are mentally healthy demonstrate the ability to adapt to themselves, to others, to society, and to their surrounding environment. Human beings consist of biological, psychological, social, and spiritual dimensions that interact with and influence one another [2]. Mental disorders may lead to problems in one or more aspects of life. In the current era of globalization, mental disorders are often associated with stressful life histories, such as difficulties in obtaining employment, family disharmony, economic hardship, loss of significant others, and broader social problems [3]. Mental disorders remain a profound health issue and rank among the four major global health problems, including in Indonesia [4].

Schizophrenia is one of the most severe mental disorders, in which affected individuals experience profound impacts on all aspects of life, characterized by specific psychotic symptoms and impaired social functioning. These include difficulties in establishing interpersonal relationships, reduced occupational performance, obstacles in abstract thinking, lack of spontaneity, and disorganized cognitive function [5]. Schizophrenia may also be described as a personality disorder marked by an imbalance among cognitive, affective, and behavioral aspects, meaning that a person's actions may not align with their thoughts or emotions [6]. Common characteristics of schizophrenia include emotional distortions such as fear, anxiety, depression, and uncontrolled excitement. In particular, anxiety in patients with schizophrenia may manifest as parathymia, in which stimuli that should evoke happiness instead trigger anxiety, sadness, and anger, potentially leading to aggressive behavior [7].

According to the World Health Organization (WHO), in 2019 an estimated 264 million people worldwide experienced depression, 45 million had bipolar disorder, 50 million had dementia, and 20 million were diagnosed with schizophrenia [8]. The National Institute of Mental Health (NIMH) reports that schizophrenia is among the 15 leading causes of disability worldwide. Nevertheless, schizophrenia appears less prevalent than several other mental disorders. Data released by the American Psychiatric Association (APA) in 2014 indicate that approximately 1% of the global population is affected by schizophrenia [9]. Schizophrenia presents positive symptoms such as disorganized thought processes, delusions, suspiciousness, hallucinations, grandiosity, excitement, and hostility, placing patients at a relatively high risk of violent behavior, estimated at about 13.2% [10].

Violent behavior is a reaction to stressors experienced by an individual and may be dangerous to oneself, others, and the environment [11]. Considering the potential harm caused, the management of patients with violent behavior must be carried out promptly and appropriately by professionals [12]. Signs and symptoms indicating a risk of violent behavior include a flushed and tense face, glaring or sharp eye contact, clenched fists, tightly set jaw, harsh speech with a loud tone, screaming or shouting, verbal or physical threats, throwing or hitting objects or others, damaging property, and difficulty preventing or controlling violent actions [13].

Individuals exhibiting violent behavior often experience behavioral changes such as pacing, aggressiveness, highly enthusiastic speech, and excessive elation [14]. Cognitive disturbances may also be identified through speech patterns. Other changes include reduced problem-solving capacity, disorientation to time and place, and restlessness [15]. The nurse's role in implementing the strategy of implementation (SP) for patients at risk of violent behavior involves several steps: identifying the causes of violent behavior risk, recognizing its signs, identifying the forms of violent behavior, and training patients to control violent behavior physically through deep breathing (SP I); hitting a mattress or pillow (SP II); training patients to control violent behavior verbally by requesting, refusing, and expressing anger appropriately (SP III); controlling violent behavior spiritually (SP IV); and finally training patients to control violent behavior through medication adherence (SP V). In addition to pharmacological therapy, violent behavior may also be prevented through various non-pharmacological interventions, one of which is breathing exercise therapy [16]. Therapeutic techniques applied to patients with violent behavior aim to ensure that the skills taught can be integrated into daily routines, thereby supporting patients' independence in applying these abilities [17].

One therapeutic approach in managing aggressive behavior is behavioral therapy involving relaxation techniques. These techniques aim to reduce tension beginning from the physical level, which ultimately decreases psychological tension [18]. Relaxation methods may be performed through breathing techniques by regulating respiratory mechanisms or muscle activity at a lower tempo or intensity. Consistent breathing patterns, especially with an appropriate rhythm, produce both mental and physical relaxation. Gradual muscle training improves muscle flexibility, enabling responses to emotionally triggering stimuli without stiffness [19]. Two effective alternatives for reducing the risk of violence are breathing techniques and pillow-hitting exercises [20].

Deep-breathing relaxation therapy is a method that trains patients to inhale slowly and maximally, followed by slow exhalation. In line with various implementations of deep-breathing relaxation therapy applied over one week, a reduction in the risk of violent behavior has been observed in male

patients [21]. Furthermore, the pillow-hitting technique is intended to transform maladaptive behavioral disturbances into adaptive behavior. Patients' adaptive capacity needs to be restored so that they can function normally again [22, 23].

The purpose of this study was to provide an overview of nursing care, particularly deep-breathing relaxation, distraction, therapeutic communication, and spiritual therapy, in preventing violent behavior among patients with schizophrenia. The benefit of this study is to enrich references for nurses, students, and mental health service providers in delivering nursing care, particularly psychiatric nursing interventions including deep-breathing relaxation, distraction, therapeutic communication, and spiritual therapy.

METHODS

This study was conducted at the Camar Nuri Ward of the West Java Provincial Mental Hospital from 14 to 21 October 2025, over a period of seven days. The design of this study employed a qualitative case report approach. A case report is an intensive, detailed, and in-depth scientific examination of a program, event, or activity at the level of an individual, group, institution, or organization in order to obtain comprehensive knowledge about a particular phenomenon. Typically, the event referred to as a case represents an actual real-life event that is currently occurring [9]. The subjects of this study consisted of four clients with the primary nursing problem of risk for violent behavior. Participants were recruited using a purposive sampling technique based on clinical considerations relevant to the nursing diagnosis.

Data were collected using a psychiatric nursing care format with a qualitative approach. The implementation of nursing care served as the primary method of data collection, and findings were analyzed descriptively to capture patient responses to the interventions. The results of the study were presented narratively in descriptive form to illustrate the implementation process and patient outcomes during the nursing care period.

RESULTS

Table 1 presents data on identity, age, and precipitating factors of the four patients. The first patient, Ny.T, was a 40-year-old female whose precipitating factor was anger toward her sibling. The second patient, Ny.R, was a 30-year-old female who felt unfairly treated by her family. The third patient, Ny.H, was a 29-year-old female whose condition was triggered by stress following conflict with her partner. The fourth patient, Ny.N, was a 25-year-old female whose precipitating factor was pressure related to job loss.

Table 1. Assessment of patients with violent behavior

Category	Mrs. T	Mrs. R	Mrs. H	Mrs. N
Sex	Female	Female	Female	Female
Age	40	30	29	25
Precipitating factors	Outburst due to anger toward her sibling	Feeling unfairly treated by her family	Stress resulting from conflict with partner	Pressure due to job loss

Table 2. Nursing implementation and evaluation in a patient with risk of violent behavior (Mrs. T)

Time	Nursing Implementation	Evaluation
15 October 2025, 10:00–10:30	1. Establishing therapeutic trust with the patient. 2. Identifying causes, signs, and symptoms of violent behavior risk. 3. Assisting the patient in practicing physical anger-control technique I (deep breathing). 4. Incorporating activities into the daily schedule.	S: Patient responded to greetings, stated full name and preferred nickname, and mentioned causes and signs of violent behavior. O: Patient sometimes appeared confused and restless when recounting reasons for anger. A: Therapeutic relationship established; patient able to identify causes and practice deep breathing. P: Maintain rapport; continue to SP II.
16 October 2025, 09:30–10:00	1. Evaluating daily activity schedule. 2. Training physical control technique II (pillow-hitting). 3. Adding activity to the daily schedule.	S: Patient repeated previous activity and stated she would use breathing techniques when angry. O: Patient practiced breathing and followed instructions for pillow-hitting. A: SP I and II achieved. P: Continue to SP III.
17 October 2025, 10:30–11:00	1. Evaluating previous activity. 2. Practicing verbal anger-control techniques. 3. Recording in daily schedule.	S: Patient reported sometimes practicing breathing and pillow-hitting. O: Eye contact good; patient appeared calmer. A: Verbal control skills not yet fluent. P: Continue SP III.
18 October 2025, 10:30–11:00	1. Evaluating daily schedule. 2. Continuing verbal control training. 3. Recording in schedule.	S: Patient reported using breathing and pillow-hitting when angry. O: Patient calmer and able to demonstrate techniques. A: Patient able to perform verbal control. P: Continue to SP IV.
19 October 2025, 09:30–10:00	1. Evaluating previous activity. 2. Practicing spiritual coping strategies. 3. Recording in schedule.	S: Patient reported increasing prayer and remembrance when angry. O: Patient able to perform SP I–IV and appeared calm. A: Still requires guidance in spiritual practice. P: Maintain SP IV.
20 October 2025, 10:30–11:00	1. Reviewing previous activities. 2. Practicing prayer/spiritual coping. 3. Re-evaluating breathing technique. 4. Recording schedule.	S: Patient reported performing prayer daily and using breathing during emotional episodes. O: Patient appeared calmer, relaxed, and spoke more softly. A: Patient able to control emotions. P: Maintain SP I–IV; continue to SP V.
21 October 2025, 11:00–12:00	1. Reviewing previous activities. 2. Practicing medication adherence training. 3. Evaluating SP I–IV.	S: Patient reported consistent use of breathing techniques and medication twice daily. O: Patient calm and able to repeat learned activities. A: Medication adherence and emotional control achieved. P: Implementation discontinued; maintain daily schedule.

Table 3. Nursing implementation and evaluation in a patient with risk of violent behavior (Mrs. R)

Time	Nursing Implementation	Evaluation
15 October 2025, 10:00–10:30	1. Establishing therapeutic trust. 2. Identifying causes, signs, and symptoms. 3. Discussing deep breathing practice. 4. Recording in schedule.	S: Patient responded politely and stated identity; able to mention causes and signs. O: Patient cooperative but restless. A: Therapeutic rapport established. P: Maintain rapport; repeat SP I.
16 October 2025, 09:30–10:00	1. Evaluating previous activity. 2. Identifying causes/signs again. 3. Practicing deep breathing. 4. Planning physical technique II. 5. Recording schedule.	S: Patient repeated previous activity and followed breathing instructions. O: Patient able to repeat causes and perform breathing technique. A: Patient able to follow instructions. P: Maintain SP I; proceed to SP II.
17 October 2025, 10:30–11:00	1. Evaluating previous activity. 2. Practicing pillow-hitting technique. 3. Recording schedule.	S: Patient repeated breathing technique. O: Patient able to practice independently with guidance; no longer restless. A: Physical technique achieved. P: Maintain SP I–II.
18 October 2025, 10:30–11:00	1. Repeating physical techniques independently. 2. Recording schedule.	S: Patient reported independent breathing and pillow practice. O: Patient performed techniques independently. A: Physical control achieved. P: Proceed to SP III.
19 October 2025, 09:30–10:00	1. Evaluating previous activity. 2. Practicing verbal control strategies. 3. Recording schedule.	S: Patient reported applying SP I–III independently. O: Patient calm and able to repeat all techniques. A: Verbal control achieved. P: Proceed to SP IV.
20 October 2025, 10:30–11:00	1. Practicing spiritual coping (prayer). 2. Reviewing breathing technique.	S: Patient reported daily prayer and breathing. O: Patient calm and able to demonstrate spiritual practice. A: Emotional control improved. P: Proceed to SP V.
21 October 2025, 11:00–12:00	1. Reviewing activities. 2. Medication adherence training. 3. Evaluating all skills.	S: Patient reported taking medication twice daily. O: Patient calm and able to repeat all activities. A: Emotional control achieved. P: Implementation discontinued.

Based on Table 2, Mrs. T initially appeared restless, angry, destructive, and prone to outbursts due to anger toward her sibling. After seven days of SP I–V implementation, the patient showed stable improvement and was able to control emotions effectively. Based on Table 3, Mrs. R

initially showed irritability related to family pressure and perceived unfair treatment. After seven days of intervention, emotional regulation improved following SP I–V implementation. Based on Table 4, Mrs. H lost emotional control following a conflict with her partner, characterized by misunderstandings that caused stress. After seven days of implementation using SP I–V, the patient showed positive responses and demonstrated improved ability to control emotions.

Table 4. Nursing implementation and evaluation in a patient with risk of violent behavior (Mrs. H)

Date & time	Nursing implementation	Evaluation
15 October 2025 10:00–10:30	1. Established a therapeutic nurse–patient relationship.2. Identified causes, signs, and symptoms of risk for violent behavior.3. Assisted the patient in practicing anger-control exercise using Physical Technique I (deep-breathing relaxation).4. Included activities in the patient's daily schedule.	S: Patient responded to greetings, stated full name and preferred nickname, and was able to mention causes, signs, and symptoms of violent behavior. O: Patient occasionally appeared confused and restless when recounting the reasons for anger and aggressive behavior. A: Therapeutic relationship established; patient able to explain causes of violent behavior and re-demonstrate deep-breathing relaxation technique. P: Maintain therapeutic relationship; continue to SP II (evaluate daily activity schedule, train Physical Technique II, encourage inclusion in daily schedule).
16 October 2025 09:30–10:00	1. Evaluated the patient's daily schedule.2. Trained Physical Technique II (hitting a pillow).3. Encouraged inclusion in daily schedule.	S: Patient repeated previous activities and stated, "When I feel angry, I will use deep breathing." O: Patient performed deep breathing and followed instructions to practice pillow-hitting technique. A: SP I and SP II achieved; patient able to perform both techniques. P: Continue to SP III (evaluate schedule, train verbal control, include in schedule).
17 October 2025 10:30–11:00	1. Evaluated previous activities.2. Practiced verbal anger-control techniques.3. Included in daily schedule.	S: Patient stated, "I sometimes practice deep breathing and hitting a pillow." O: Good eye contact; patient appeared calmer. A: Patient not yet fluent in verbal control technique. P: Continue SP III (evaluate schedule and continue verbal training).
18 October 2025 10:30–11:00	1. Evaluated daily schedule.2. Continued verbal anger-control training.3. Included in daily schedule.	S: Patient reported using deep breathing and pillow-hitting when angry. O: Patient calmer, able to practice techniques; good eye contact. A: Patient able to perform verbal control technique. P: Continue to SP IV (spiritual control training).
19 October 2025 09:30–10:00	1. Evaluated previous activities.2. Conducted spiritual anger-control intervention.3. Included in daily schedule.	S: Patient stated she would increase recitation (istighfar) and worship when angry. O: Patient able to perform SP I–IV; appeared calm. A: Patient still needs guidance in spiritual practice. P: Maintain SP IV (evaluate schedule and continue spiritual training).
20 October 2025 10:30–11:00	1. Evaluated previous activities.2. Practiced spiritual techniques (prayer/worship).3. Re-evaluated deep-breathing technique.4. Included in daily schedule.	S: Patient reported practicing previous activities, praying daily though not always five times, and using deep breathing whenever emotions arise. O: Patient calm, relaxed, able to demonstrate prayer and dhikr; speech tone softer. A: Patient able to control emotions. P: Maintain SP I–IV; proceed to SP V (medication adherence training and inclusion in schedule).
21 October 2025 11:00–12:00	1. Evaluated previous activities.2. Conducted SP V (medication adherence training).3. Evaluated SP I–IV.	S: Patient reported performing previous activities, practicing deep breathing when emotional, and taking medication twice daily. O: Patient calmer; speech no longer loud; able to repeat all learned activities. A: Patient adheres to medication and can control emotions using learned techniques. P: Implementation terminated; maintain in daily schedule.

Table 5. Nursing implementation and evaluation in a patient with risk of violent behavior (Mrs. N)

Date and Time	Nursing Implementation	Evaluation
15 October 2025 10:00–10:30	1. Established a therapeutic relationship.2. Identified causes, signs, and symptoms of violent behavior.3. Discussed deep-breathing exercise.4. Included in daily schedule.	S: Patient responded to greetings, stated name and nickname, and identified causes and symptoms. O: Patient willing to shake hands and interact; eye contact present; appeared restless. A: Therapeutic relationship established. P: Maintain relationship; repeat SP I.
16 October 2025 09:30–10:00	1. Evaluated previous activities.2. Re-identified causes and symptoms.3. Conducted deep-breathing exercise.4. Discussed Physical Technique II for the next day.5. Included in schedule.	S: Patient politely responded, repeated previous activities, and followed breathing instructions. O: Patient able to restate causes and perform breathing relaxation. A: Patient able to follow instructions and maintain trust. P: Maintain SP I; proceed to SP II (pillow-hitting technique).
17 October 2025 10:30–11:00	1. Evaluated previous activities.2. Practiced Physical Technique II (pillow hitting).3. Included in schedule.	S: Patient repeated previous activities and breathing technique. O: Patient independently performed breathing and practiced physical technique with guidance; no longer restless. A: Patient able to perform physical technique. P: Maintain SP I–II; repeat SP II.
18 October 2025 10:30–11:00	1. Evaluated previous activities.2. Repeated physical training.3. Included in schedule.	S: Patient reported being able to perform both techniques independently. O: Patient demonstrated both independently. A: Patient able to perform physical technique independently. P: Maintain SP I–II; proceed to SP III (verbal training).
19 October 2025 09:30–10:00	1. Evaluated previous activities.2. Conducted verbal training (assertive refusal and requesting politely).3. Included in schedule.	S: Patient reported performing SP I–III independently and practicing breathing daily. O: Patient able to repeat all techniques; appeared calm. A: Patient able to perform verbal training. P: Maintain SP I–III; proceed to SP IV (spiritual training).
20 October 2025 10:30–11:00	1. Evaluated previous activities.2. Conducted spiritual training (prayer/worship).3. Re-evaluated breathing technique.	S: Patient reported practicing activities, praying daily though not always five times, and using breathing whenever emotions arise. O: Patient calm, relaxed, able to demonstrate prayer and dhikr. A: Patient able to control emotions. P: Maintain SP I–IV; proceed to SP V (medication adherence training).
21 October 2025 11:00–12:00	1. Evaluated previous activities.2. Re-evaluated breathing technique.3. Conducted medication adherence training.4. Evaluated all activities.5. Included in schedule.	S: Patient reported performing previous activities and taking medication twice daily. O: Patient calmer and able to repeat all techniques. A: Patient adheres to medication and controls emotions using learned strategies. P: Implementation terminated; maintain in daily schedule.

Based on Table 5, Mrs. N expressed anger after feeling unfairly treated by coworkers and frequently criticized, which caused stress and eventually led to job loss. Following seven days of implementation, the patient showed progressive improvement in SP I–V skills. On the first and second days, breathing and physical techniques were still difficult. By the third day, the patient was able to perform verbal techniques. On the fourth day, spiritual practices such as prayer and dhikr helped improve emotional control. On the fifth day, medication adherence training was provided, and the patient understood the importance of medication and reported taking it twice daily. On the sixth and seventh days, the patient was able to repeat and practice all learned interventions. Overall, the table indicates a gradual improvement in the patient's ability to manage violent behavior over the seven-day intervention period.

DISCUSSION

The results of the seven-day implementation of nursing interventions among four patients exhibiting violent behavior (Mrs. T, Mrs. R, Mrs. H, and Mrs. N) indicate that although the applied implementation strategies (SP I–SP V) followed the same structured sequence, the patients demonstrated varying levels of ability in controlling violent behavior. These differences were reflected in the speed of adaptation, the degree of independence in practicing the techniques, emotional responsiveness, and the consistency with which each patient applied the learned coping strategies. Nevertheless, despite these variations, a common pattern emerged across all cases regarding which stages of intervention appeared

to be the most effective and significant in reducing violent tendencies. In particular, the early stages focusing on establishing trust, emotional identification, and physical control techniques, followed by verbal, spiritual, and medication-adherence strategies, showed a consistent positive contribution to behavioral stabilization. Previous studies have likewise demonstrated that implementation strategies (SP) are effective in reducing the risk of violent behavior among psychiatric patients [9].

This study further suggests that relapse and persistence of violent tendencies are influenced by multiple interrelated factors. These include demographic factors such as age, cognitive factors such as knowledge and education level, psychological factors such as attitude and emotional expression, and social factors such as family support. In addition, adherence to medication plays a crucial role in maintaining emotional stability and preventing recurrence of aggressive responses. Patients who possessed better understanding of their condition, received supportive family involvement, and maintained medication compliance tended to show faster improvement and stronger emotional regulation. These findings are consistent with previous evidence indicating that relapse among patients at risk for violent behavior is strongly associated with age, knowledge, education, attitude, family support, emotional expression, and medication adherence [24].

The provision of nursing care in this context represents a therapeutic process that involves collaborative interaction between nurses and patients, as well as their families or social environment, in order to achieve an optimal level of health. Psychiatric nursing care is not merely a set of technical procedures but a relational and developmental process that emphasizes patient engagement, behavioral learning, emotional stabilization, and adaptive coping. In this study, the interventions delivered to the patients were categorized as generalist nursing actions, meaning that they were structured, systematic, and based on standard psychiatric nursing competencies rather than specialized psychotherapeutic modalities. Such interventions included emotional identification, breathing relaxation, physical distraction, verbal assertiveness training, spiritual strengthening, and medication education, all of which aim to promote adaptive coping responses [25].

Nurses play a central role in establishing therapeutic relationships that allow patients to experience emotional safety, trust, and acceptance. Through this relationship, patients are encouraged to express feelings, recognize triggers of anger, and gradually develop the ability to regulate their emotional responses. The shared experience between nurse and patient becomes a medium for behavioral learning and emotional restructuring. When a therapeutic relationship is successfully formed, patients tend to be more cooperative, more receptive to interventions, and more motivated to practice self-control techniques. Therefore, the development of a therapeutic alliance is not only an ethical requirement but also a clinical necessity, as it directly contributes to reducing the risk of violent behavior among psychiatric patients [26].

Therapeutic communication serves as the primary medium through which the nursing process is implemented in mental health settings. It functions not only as a tool for data collection but also as an intervention in itself. The effectiveness of many psychiatric nursing interventions depends heavily on the nurse's ability to communicate empathically, clearly, and consistently. Skilled therapeutic communication helps patients feel understood, reduces defensive reactions, and enhances willingness to participate in treatment. In the present study, therapeutic communication was embedded in every stage of SP implementation, from the initial trust-building phase to medication adherence counseling. This supports previous findings that communication competence among nurses strongly influences the effectiveness of interventions [27]. Furthermore, therapeutic communication is not limited to patients with violent behavior but can also support recovery in patients experiencing low self-esteem, hallucinations, self-care deficits, and other psychiatric symptoms. Its role is therefore universal within psychiatric nursing, functioning as a foundational skill that facilitates emotional expression, cognitive restructuring, and behavioral adaptation. By enabling patients to articulate distress and learn alternative coping responses, therapeutic communication indirectly reduces aggressive impulses and promotes adaptive functioning [28].

One of the most common behavioral manifestations among psychiatric patients, particularly those with violent tendencies, is uncontrolled anger. Anger episodes often arise from misinterpretation of social situations, unresolved emotional conflicts, frustration, or environmental stressors. Without structured intervention, such emotional dysregulation may escalate into aggression directed toward self, others, or surrounding objects. For this reason, structured intervention frameworks are required to guide nurses in systematically addressing these risks [29].

One of the structured approaches widely used in psychiatric nursing is the implementation strategy framework (SP). This framework emphasizes the gradual development of emotional regulation through sequential stages beginning with trust formation, followed by physical, verbal, spiritual, and pharmacological coping strategies. SP functions not only as a technical guideline but also as a relational approach that strengthens the therapeutic alliance between patient and nurse. Failure to implement SP appropriately may increase the risk of harm both to the patient and to the surrounding environment, as emotional instability remains unmanaged. Therefore, SP is considered a preventive as well as therapeutic strategy in managing violent behavior [30].

The findings of this study are consistent with previous research showing that implementation strategies (SP) significantly reduce signs and symptoms of violent behavior while simultaneously improving patients' ability to control emotional responses. Improvements were observed both before and after the application of SP, indicating that structured nursing interventions can produce measurable behavioral change within a relatively short intervention period [25]. Overall, the results of this study reinforce the importance of structured psychiatric nursing interventions, therapeutic communication, and holistic patient engagement in reducing violent tendencies. Although each patient demonstrated a unique response trajectory, the general pattern confirms that systematic application of SP I–V provides a comprehensive framework for emotional stabilization, behavioral control, and long-term relapse prevention in psychiatric care.

CONCLUSION

Based on the results of nursing care provided to patients with the nursing diagnosis of risk for violent behavior, the expected care outcomes were achieved. The patients demonstrated the ability to control violent behavior by recognizing the causes of their aggression, regulating emotions through deep-breathing relaxation, practicing emotional control using physical techniques (Phase I), developing verbal communication skills for emotional regulation, adhering to medication regimens, and managing emotions through spiritual approaches.

Ethical consideration, competing interest and source of funding

-This study obtained ethical clearance and was conducted in accordance with ethical standards in nursing care. Ethical principles applied included beneficence and respect for human dignity. Ethical safeguards included informed consent, anonymity (without naming participants), and confidentiality of patient information.
-There is no conflict of interest related to this publication.
-Source of funding is authors.

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