

Manuscript received July 11, 2026; revised September 21, 2026; accepted September 30, 2026; date of publication October 30, 2026

Digital Object Identifier (DOI): <https://doi.org/10.35882/ijahst.v6i5.652>

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How to cite: Asyila Aulia Putri, Miadi, Ade Andrian, and Endah Suprihatin, "Mental Health Nursing Care for Patients with Schizophrenia at Risk of Violent Behavior Using the TAK Approach Session 2 at Menur Hospital in Surabaya", International Journal of Advanced Health Science and Technology, Vol. 6 No. 5, pp. 418-425, October 2026.

Mental Health Nursing Care for Patients with Schizophrenia at Risk of Violent Behavior Using the TAK Approach Session 2 at Menur Hospital in Surabaya

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ABSTRACT Schizophrenia is a severe psychiatric disorder that may impair emotional regulation and adaptive behavioral control, creating a clinical risk of aggressive or violent behavior in some patients. In inpatient psychiatric settings, early recognition of anger and the provision of safe coping strategies are important components of nursing care. This study aimed to describe the implementation of Group Activity Therapy (TAK) Session 2, comprising deep-breathing relaxation and pillow-hitting techniques, and to document the responses of two patients with schizophrenia and a nursing diagnosis of risk for violent behavior at Menur Hospital, Surabaya. A descriptive comparative two-patient case-study design was conducted in the Kenari Ward from September 9 to 17, 2025. Data were obtained through nursing assessment, observation, interviews, documentation, and evaluation of the patients' ability to perform the prescribed coping strategies. Both patients initially demonstrated pre-aggressive signs, including irritability, loud or rapid speech, poor eye contact, emotional lability, and clenched fists when discussing personally sensitive triggers. During the nine-day care period, both patients progressed from requiring guidance to independently performing deep-breathing relaxation. Participation in pillow-hitting was initially refused but was subsequently accepted, with both patients becoming more cooperative and able to express feelings without heightened emotional responses. However, these changes occurred alongside other nursing interventions, medication adherence support, therapeutic communication, spiritual coping, peer interaction, and routine inpatient care. Therefore, the observed improvements cannot be attributed independently to TAK Session 2. The case study indicates that TAK Session 2 can be incorporated into individualized psychiatric nursing care while patient readiness, triggers, and concurrent interventions are continuously considered. Larger comparative studies using standardized outcome measures and longer follow-up are needed to examine the specific contribution of this intervention.

INDEX TERMS Schizophrenia, Violent Behavior Risk, Group Activity Therapy, Deep-Breathing Relaxation, Psychiatric Nursing.

I. INTRODUCTION

Schizophrenia is a chronic and disabling psychiatric disorder that affects perception, cognition, emotion, behavior, and functioning. Global burden estimates indicate that schizophrenia remains a substantial public health problem, affecting approximately 23.6 million people worldwide in 2021 [1], [2]. Although violent behavior is not characteristic of most people with schizophrenia, a clinically important subgroup may present aggression or violence, particularly when symptoms, impulsivity, substance use, social stressors, or other risk factors are present [3]–[6]. In psychiatric inpatient settings, aggression can endanger patients, healthcare workers, and the therapeutic environment. Consequently, psychiatric nursing requires early identification of behavioral warning signs and individualized strategies that support emotional regulation and safer responses [7], [8].

Contemporary management of aggression in schizophrenia emphasizes multimodal care rather than reliance on a single intervention. Pharmacological treatment remains important for patients with persistent or severe aggression, while psychosocial and behavioral approaches address emotion regulation, cognitive processes, communication, coping, and social functioning [9], [10]. Recent studies have examined cognitive remediation, social cognition training, cognitive-behavioral therapy, moral reasoning interventions, behavior modification, neurofeedback, and structured risk assessment as approaches to aggression management [11]–[16]. A recent scoping review of nursing strategies further identified cognitive-behavioral therapy, assertive therapy, forgiveness therapy, logotherapy, social-skills training, and de-escalation training as psychosocial approaches used to reduce violent behavior [7].

These findings support non-pharmacological strategies in psychiatric nursing while demonstrating heterogeneity in intervention content, delivery, outcomes, and study designs.

Within this context, Group Activity Therapy (Terapi Aktivitas Kelompok/TAK) provides a nursing approach that can facilitate adaptive emotional expression and behavioral control through guided therapeutic activities. The present study focuses specifically on TAK Session 2, consisting of deep-breathing relaxation and a pillow-hitting activity for managing physical expressions of anger. Previous clinical reports have described relaxation and physical-channeling techniques for patients at risk of violent behavior; however, recent international literature is more heavily concentrated on standardized psychosocial programs, cognitive interventions, pharmacological management, or risk-prediction approaches [7], [10]–[16]. Evidence concerning how individual patients with different psychosocial triggers respond to a staged TAK Session 2 implementation during routine inpatient nursing care remains limited. This issue is relevant because aggression is heterogeneous and may be influenced by symptom severity, impulsivity, psychosocial circumstances, substance use, and individual history [4], [5], [17], [18].

The research gap is therefore not simply whether deep breathing or pillow-hitting can reduce violent behavior. Rather, there is a need to document how patients with the same nursing diagnosis but different psychosocial triggers participate in and respond to TAK Session 2 while receiving concurrent psychiatric nursing interventions. This study addresses the gap through a descriptive comparative two-patient case study at Menur Hospital, Surabaya. The aim was to describe the implementation of TAK Session 2 and document changes in participation, independent use of deep-breathing relaxation, cooperation, and adaptive expression of feelings among two patients with schizophrenia at risk for violent behavior. Because no control participant was included, the design does not permit causal attribution of observed improvement to TAK Session 2 alone. Recent evidence similarly indicates that aggression-management interventions should be interpreted according to patient characteristics, intervention components, and clinical context [19], [20].

This study contributes in three ways. First, it provides patient-level clinical documentation of responses to TAK Session 2 within a real inpatient psychiatric nursing context. Second, it highlights the importance of considering individual psychosocial triggers and readiness when implementing behavioral interventions. Third, it clarifies the interpretive limitation created by concurrent interventions and the absence of standardized quantitative outcome measures, thereby identifying priorities for future comparative research. The remainder of this article presents the methods and case-study procedures, reports the observed clinical findings, discusses their interpretation in relation to recent evidence, and concludes with clinical implications and directions for future research.

II. METHOD

A. STUDY DESIGN AND SETTING

This study used a descriptive comparative two-patient case-study design to document the implementation of Group Activity Therapy (Terapi Aktivitas Kelompok/TAK) Session 2 within routine psychiatric nursing care. The case-study

approach was selected because the study focused on patient-level responses within a real inpatient setting and incorporated information from direct observation, interviews, nursing evaluations, and clinical documentation. Case-study methodology is appropriate when clinical phenomena need to be examined within their real-world context, particularly when contextual factors and concurrent components of care cannot be separated from the intervention being observed [21], [22]. Data collection was prospective because both patients were followed during a defined nine-day period from September 9 to 17, 2025. The study was not an experimental or randomized study; no random allocation, comparison group, or control participant was used.

The study was conducted in the Kenari Ward of Menur Hospital, Surabaya, Indonesia. The participants were two male inpatients aged 21 and 25 years, respectively, with schizophrenia documented in their clinical records and a nursing diagnosis of risk for violent behavior. Participants were selected purposively from patients available in the ward who met the requirements for participation. The inclusion criteria were: (1) documented schizophrenia as an inpatient diagnosis; (2) a nursing diagnosis of risk for violent behavior; (3) sufficient clinical stability and ability to participate in the planned nursing activities; and (4) willingness to participate after the intervention had been explained. Participation was temporarily excluded when a patient demonstrated acute agitation, an unsafe condition for the planned activity, or unwillingness to participate. Because only two patients were included, the sample was intended for descriptive clinical comparison rather than statistical generalization.

B. MATERIALS AND INTERVENTION PROCEDURE

The intervention was implemented according to the hospital Standard Operating Procedure (SOP) for TAK Session 2 and was incorporated into the patients' ongoing psychiatric nursing care. The materials and clinical resources consisted of the nursing assessment and evaluation forms, patient interview and observation records, the hospital TAK Session 2 SOP, and a pillow for the physical activity component. TAK Session 2 consisted of a sequence of nursing strategies designated SP1–SP5: deep-breathing relaxation for managing anger-related responses, controlled pillow hitting as a physical outlet for anger, adaptive verbal expression of feelings, spiritual coping, and support for medication adherence. These components were delivered as part of routine nursing care rather than as an isolated experimental treatment. This approach is consistent with recent evidence emphasizing psychosocial and nursing interventions as components of broader, context-dependent management of violent behavior in schizophrenia [23], [24].

For SP1, the nurse explained and demonstrated deep-breathing relaxation and guided each patient to practice the technique when emotional tension or anger was identified. The nurse subsequently assessed whether the patient required assistance or could perform the breathing technique independently. For SP2, pillow hitting was introduced as a controlled physical activity for expressing anger safely. Participation was guided according to the patient's readiness and clinical safety. Both patients initially refused the activity; therefore, the procedure was not forced. Following reassessment and therapeutic communication, both patients subsequently participated. SP3 addressed adaptive verbal

expression of feelings, while SP4 involved a spiritual coping approach. SP5 focused on medication adherence as part of the established nursing care plan. The inclusion of breathing and relaxation was also consistent with recent clinical research examining structured breathing and relaxation training among individuals with schizophrenia [25].

C. DATA COLLECTION

Data were collected prospectively through direct observation, patient interviews, nursing evaluation forms, and clinical documentation. Direct observation focused on behavioral and emotional indicators associated with the nursing diagnosis, including irritability, loud or rapid speech, emotional lability, poor eye contact, clenched fists, cooperation, participation, and the presence or absence of violent behavior. Interviews were conducted to identify patient-reported triggers, emotional responses, willingness to participate, and subjective responses following the activities. Nursing evaluation forms and clinical documentation were used to record the progression of each patient across SP1–SP5.

The principal descriptive outcomes were the patients' ability to participate in the intervention, level of assistance required, independent performance of deep breathing, response to pillow hitting, cooperation, adaptive expression of feelings, spiritual coping, medication adherence, and observed behavioral changes. For SP1, progression was recorded from requiring guidance to performing deep breathing independently. For SP2, the evaluation documented initial refusal, subsequent participation, cooperation, and the patients' reported subjective response. SP3–SP5 were evaluated according to the patients' ability to express feelings adaptively, engage in spiritual coping, and follow medication-adherence recommendations. Repeated observation of aggression-related behavior is relevant in psychiatric inpatient care because changes in behavioral risk and nursing responses may vary across time and clinical context [26].

D. DATA ANALYSIS

Data analysis was descriptive and comparative at the patient level. Observations were organized chronologically according to the implementation of SP1–SP5 and then compared between the two patients. The comparison considered demographic characteristics, psychosocial triggers, initial behavioral manifestations, participation, response to each intervention component, and observed behavioral changes during the nine-day observation period. No inferential statistical analysis was conducted because the sample consisted of only two patients, no control condition was available, and standardized quantitative outcome scores were not collected. The analysis therefore aimed to describe implementation and individual clinical responses rather than estimate treatment effectiveness or establish causality. This approach is consistent with case-study methodology, in which detailed contextual information and multiple sources of evidence are used to characterize clinical phenomena [21], [22].

Several potentially relevant clinical variables were not available in the source records and were consequently not included as analytical variables. These included duration of illness, formal diagnostic instruments or diagnostic criteria, psychiatric or medical comorbidities, medication names and

doses, and standardized baseline severity or frequency scores. Medication adherence, therapeutic communication, spiritual coping, peer interaction, and other routine nursing interventions occurred concurrently with TAK Session 2. Therefore, their individual contributions could not be separated from the observed patient responses. This distinction was maintained during interpretation because psychosocial interventions for violent behavior are generally implemented within broader psychiatric and nursing management, and their observed responses may depend on patient characteristics and clinical context [23], [24].

III. RESULTS

This study was conducted at the Kenari Ward of the Menur Mental Health Clinic in Surabaya, located at Jl. Raya Menur No. 120, Kertajaya, Gubeng District, Surabaya, East Java 60282. This ward is an inpatient facility specifically designed for male patients experiencing various mental health issues, such as schizophrenia, aggressive behavior, hallucinations, and other psychological problems. The Kenari Ward covers an area of 1,935 m². It consists of a Class III ward with a capacity of 62 beds and a Class III isolation ward with a capacity of 12 beds. The Kenari Ward is an inpatient care unit specifically designed for male patients with various mental disorders, such as schizophrenia, violent behavior, hallucinations, and other mental health issues.

This study was conducted from September 9 to 17, 2025, with the data collection process lasting 9 days, beginning with patient admission, followed by an assessment of both patients, planning for Group Activity Therapy Session 2 : which included pillow pounding and deep breathing relaxation techniques, the implementation of Group Activity Therapy Session 2, and finally, an evaluation following the Group Activity Therapy Session 2 intervention at the Kenari Unit of Menur Hospital, located in Surabaya.

The assessment was conducted on September 9, 2025, in the Kenari Room at Menur Hospital in Surabaya, and both clients were male. Neither client had a history of mental illness nor any family members with mental illness. Client 1, a 21 year-old unmarried man, was admitted to the hospital because he frequently flew into rages, destroying all the belongings in his home and setting fire to items and trash. This behavior was triggered by demands from his father and his disappointment with his mother, whom he blamed for having kicked him out, neglecting him, and making him feel useless. Client 2, a 25 year-old unmarried man, was admitted to the hospital because he frequently flew into rages, disturbed the neighborhood by harming his neighbors, damaged their property, and slapped a neighbor's child with a sandal; this behavior began after both of his parents died in 2021. Both clients are experiencing severe stressors due to the loss of their parents and a lack of social support, which has led to an inability to control their emotions.

One of the main issues with Clients 1 and 2 is the risk of violent behavior. This is based on assessment results that indicate the presence of signs and very strong predisposing factors pointing to the potential for aggressive behavior. Both clients exhibit rapid speech and a loud tone of voice, labile affect with sudden emotional shifts, and interactions

characterized by irritability and poor eye contact. Client 1 initially showed signs of a risk of violent behavior when, in the session room, they were very active in interacting with other clients; they were cooperative when asked questions, but if the conversation went on too long, they would become angry. Furthermore, when discussing their family or work issues, they clenched their fists, indicating emotional sensitivity to certain stimuli. Meanwhile, Client 2 initial signs of a risk of violent behavior emerged when asked why they had been admitted to Menur Hospital; the client gave no response and appeared to be holding back their emotions. However, when the questioning continued regarding their parents, Client 2 began to exhibit behavioral changes clenching their fists, speaking in a loud tone, and glaring as signs of pre aggression [17].

Based on the assessment results, both clients were diagnosed as being at risk for violent behavior. The intervention provided was Group Activity Therapy Session 2, which included deep breathing relaxation techniques and pillow-hitting techniques in accordance with Implementation Strategies 1–5. SP 1 focuses on building a relationship of mutual trust, identifying the causes and signs of violent behavior, and training clients in deep breathing relaxation techniques through TAK Session 2 so that they can recognize and control their emotions. SP 2 trains clients to physically control their anger using the pillow-punching technique as part of TAK Session 2 and to create a daily activity schedule. SP 3 helps clients express anger verbally in an appropriate manner without harming themselves or others. SP 4 teaches emotional control through spiritual approaches, such as praying or worshipping according to the client's beliefs. SP 5 emphasizes the importance of medication adherence to control schizophrenia symptoms and prevent relapse. Meanwhile, the family based SP could not be implemented because the families of both clients were absent during the treatment period [18].

The implementation of strategies related to the risk of violent behavior in Client 1 and Client 2 began with the implementation of Implementation Strategy (SP) 1 on September 9, 2025. The implementation of SP 2 continued on September 12, 2025. The implementation of SP 3 continued on September 15, 2025. The implementation of Implementation Strategy 4 took place on September 16, 2025, and Implementation Strategy 5 took place on September 17, 2025.

The implementation of SP 1 for Client 1 and Client 2 took place from September 9, 2025, through September 17, 2025. On the first day, neither client was able to use deep breathing relaxation techniques independently. On the second day, both Client 1 and Client 2 were able to use deep breathing relaxation techniques when angry, but initially required guidance. On the third day, both clients were able to use deep breathing relaxation techniques independently when angry, without needing to be prompted. Clients 1 and 2 were able to carry out and complete SP 1 over the course of 3 days.

On the fourth day of SP 2, both clients still refused to participate in group activity therapy. Client 1 chose to talk with his roommate and did not exhibit aggressive behavior,

although he still appeared tense and occasionally withdrew. Meanwhile, Client 2 said he would do it the next day. On the fifth day, both clients agreed to participate in Session 2 of the group activity therapy—punching pillows—and reported feeling slightly relieved after completing the session, expressing a desire to repeat it the following day. On the sixth day, both clients participated enthusiastically and cooperatively in Session 2 of the group activity therapy: punching pillows. Clients 1 and 2 successfully completed Phase 2 over the course of three days.

The SP 3 was presented to Clients 1 and 2 on September 15, 2025. The steps implemented on the seventh day for clients exhibiting violent behavior included reviewing their daily routines and providing support to help them express their anger verbally in an appropriate manner. Clients 1 and 2 had previously completed SP 1 and SP 2; they were able to complete SP 3 in one day. Because Clients 1 and 2 were able to express their anger verbally in an effective and cooperative manner, neither of them had any difficulty doing so.

SP 4 was administered on September 16, 2025. The implementation on the eighth day for Clients 1 and 2 allowed them to complete SP 4 in a single day because the clients cooperated by following the nurse's instructions to practice prayer or draw closer to God in order to feel calmer and avoid the risk of reoffending with violent behavior; both clients had already completed SP 1, SP 2, and SP 3 in accordance with the objectives and outcome criteria.

The implementation strategy (SP 5) was provided to Clients 1 and 2 on September 17, 2025. Clients 1 and 2 were able to complete SP 5 in one day because they had already completed SP 1, SP 2, SP 3, and SP 4 in accordance with the objectives and outcome criteria; they had no difficulty controlling violent behavior with medication, as both clients adhered to taking their medication regularly according to the schedule established by the ward nurse.

In the nursing evaluation, Clients 1 and 2 achieved SP 1 on the third day. On the first day, neither client was yet able to perform deep breathing relaxation techniques independently. Client 1 still felt angry toward his father and disappointed in his mother, while Client 2 still frequently felt angry since the death of both parents. Objectively, both clients still displayed unfriendly facial expressions and poor eye contact, although they began to appear calmer. On the second day of SP 1, both clients were already able to perform deep breathing relaxation techniques when angry, but still required guidance. Objectively, both appeared calmer, more cooperative, and began to follow the nurse's instructions in managing their emotions. On the third day of SP 1, both clients were able to perform deep breathing relaxation techniques independently. Both began to feel calmer, were able to express their feelings, made better eye contact, and were able to control their emotions. The nursing issues in Phase 1 were deemed resolved, so the intervention proceeded to SP 2.

In SP 2, both clients met the outcome criteria on the sixth day. the fourth day, both were already able to control their emotions using deep-breathing relaxation techniques. Objectively, both clients appeared calmer, more cooperative, and did not exhibit aggressive behavior; however, they still

refused to participate in the TAK Session 2 activity involving hitting a pillow. On the fifth day of SP 2, both clients began to be able to control their anger, appeared calmer and more cooperative, and did not exhibit aggressive behavior. Both were also willing to participate in the TAK Session 2 activity involving the pillow-hitting technique. On the sixth day of SP 2, both clients felt calmer, were able to recognize and control their emotions, and cooperated in participating in TAK Session 1 using the pillow-hitting technique. The nursing issues in SP 2 were deemed resolved, so the intervention proceeded to SP 3.

In SP 3, Clients 1 and 2 met the outcome criteria: they were able to accept their family situations and no longer felt angry. Objective data for Client 1 indicated that the client appeared cooperative, exhibited polite and courteous behavior, and was able to express feelings without heightened emotions. Meanwhile, subjective data from Client 2 indicated that the client felt more relieved after participating in group activities and talking with a roommate. Objective data for Client 2 showed that the client appeared cooperative, demonstrated polite and courteous behavior, and was able to express feelings without heightened emotions. The nursing problem was resolved, and the program proceeded to SP 4.

In SP 4, Clients 1 and 2 met the outcome criteria on Day 8. Subjective data from Client 1 indicated that they felt more relieved after being able to forgive their family. Objective data for Client 1 showed that the client appeared cheerful, actively participated in group activities, and did not exhibit angry or aggressive behavior. Meanwhile, subjective data from Client 2 indicated that they felt more relieved after being able to forgive their family. Client 2 objective data showed that the client appeared cheerful, actively participated in group activities, and did not exhibit angry or aggressive behavior. The nursing problem was resolved, and the plan proceeded to SP 5 [19].

By Nursing Outcome 5, Clients 1 and 2 met the outcome criteria of no longer being angry and wanting to improve their relationships. Objective data for Client 1 indicated that the client appeared calm and emotionally stable, was able to interact well with nurses and peers, and showed no signs of violent behavior. Meanwhile, subjective data from Client 2 indicated that the client was no longer easily angered and wanted to be more patient in dealing with situations. Objective data for Client 2 showed that the client appeared calm and emotionally stable, was able to control themselves when facing stressful situations, and interacted well with peers and nurses. The nursing problem was resolved, and SP 5 was discontinued.

IV. DISCUSSION

A. INTERPRETATION OF THE CLINICAL FINDINGS

The present descriptive comparative case study showed that both patients progressed in their ability to participate in the planned nursing activities during the nine-day observation period. At baseline, both patients displayed behavioral indicators associated with risk of violent behavior, including irritability, loud or rapid speech, emotional lability, poor eye contact, and clenched fists when personally sensitive topics were discussed. The triggers, however, differed between the

cases. Patient 1 showed emotional activation primarily in relation to family conflict and work-related concerns, whereas Patient 2 became emotionally activated when discussing the death of his parents. These findings indicate that the same nursing diagnosis may be expressed through different psychosocial contexts and that assessment of individual triggers remains important when planning psychiatric nursing care.

The most observable progression occurred during SP1. Neither patient could initially perform deep-breathing relaxation independently. On the second day, both patients were able to perform the technique with guidance, and by the third day both were able to perform it independently. At the same time, the nursing observations described calmer appearance, greater cooperation, improved eye contact, and increased ability to verbalize feelings. This pattern suggests that the intervention was feasible for both patients and that repeated guided practice may support acquisition of a simple self-regulation strategy. However, because no standardized physiological or behavioral severity scale was used, the observed change should be interpreted as a clinical progression in skill and behavior rather than a quantified reduction in aggression.

The response to SP2 was different from the response to deep breathing. On the fourth day, both patients refused the pillow-hitting activity. Patient 1 instead interacted with a roommate, while Patient 2 postponed participation. On the following day, both accepted the activity and reported feeling slightly relieved afterward; on the sixth day, both participated more cooperatively. This sequence is clinically relevant because it demonstrates that refusal did not necessarily indicate failure of the overall nursing process. Instead, readiness appeared to change across time and in response to therapeutic engagement. The findings therefore support an individualized approach in which nurses assess willingness, maintain safety, provide alternatives when appropriate, and reassess participation rather than coercing a patient to complete a behavioral activity.

The later stages of care showed that both patients were able to engage in verbal expression, spiritual coping, and medication adherence. By the final evaluation, both appeared calm and emotionally stable, interacted appropriately with nurses and peers, and showed no observed violent behavior during the documented care period. Patient 2 also reported being less easily angered and wanting to become more patient, while Patient 1 was described as able to interact appropriately and express feelings without heightened emotional responses. These observations suggest a broader change in adaptive participation across the nursing care sequence. Importantly, the outcome cannot be attributed to TAK Session 2 alone because SP1–SP5, therapeutic communication, spiritual coping, medication-adherence support, peer interaction, and routine ward care occurred concurrently.

B. COMPARISON WITH PREVIOUS EVIDENCE

Guo et al. reported that violence among male patients with schizophrenia was associated with several historical, clinical, and behavioral factors, including impulsivity and relationship instability [29]. Similarly, Sagayadevan et al. found relationships among aggression, impulsivity, symptom severity, and quality of life in patients with schizophrenia and

related psychoses [30]. These findings provide a useful context for the present cases because the two patients displayed different psychosocial triggers despite having the same documented diagnosis and nursing problem. The present observations therefore reinforce the importance of patient-specific assessment rather than assuming that all patients with a risk of violent behavior will respond identically.

The observed emphasis on early behavioral signs is also compatible with current approaches to violence prevention. Contemporary risk assessment literature emphasizes the need to identify changes in behavior and other indicators that may precede aggression [31]. In the present study, clenched fists, changes in affect, loud or rapid speech, irritability, and poor eye contact became more apparent when patients discussed personally distressing subjects. Such observations are clinically useful because they provide nurses with opportunities to recognize escalating emotional activation before overt violence occurs. Nevertheless, the present study did not use a validated violence-risk instrument, so the findings should not be interpreted as evidence for a specific predictive relationship between these signs and subsequent violence.

The progression in participation and emotional regulation also has similarities with recent research on psychosocial interventions. Hsu et al. reported benefits from an integrated violence intervention targeting alexithymia, cognitive characteristics, and neurocognitive features associated with violence in schizophrenia [32]. Other studies have examined cognitive and social-cognition training, cognitive training combined with behavior modification, and structured psychosocial interventions for aggression [33], [34]. The present case study differs from these investigations in both scope and methodological strength. Rather than evaluating a standardized intervention using a control group and quantitative outcome measures, this study documented the implementation of TAK Session 2 as part of routine psychiatric nursing care. Consequently, the present findings provide contextual and patient-level information but cannot establish comparative efficacy.

The findings are also compatible with a recent scoping review of nursing strategies for violent behavior in schizophrenia, which identified several psychosocial approaches, including cognitive-behavioral therapy, assertive therapy, forgiveness therapy, social-skills training, and de-escalation-related approaches [35]. This literature supports the broader principle that non-pharmacological nursing strategies can be incorporated into violence management, while also demonstrating substantial variation in intervention content and outcome measurement. The present study adds a more specific clinical description of how two patients progressed through deep-breathing relaxation, pillow-based physical activity, verbal expression, spiritual coping, and medication-adherence support.

At the same time, the results contrast with the stronger causal conclusions that can be drawn from randomized or controlled intervention studies. For example, previous controlled research has used structured intervention protocols and standardized measures to evaluate changes in aggression-related outcomes [32]–[34]. The present study therefore provides contextual information on feasibility, patient

participation, individual triggers, and observed clinical responses in routine inpatient care.

C. LIMITATIONS AND CLINICAL IMPLICATIONS

Several limitations should be considered when interpreting these findings. First, the study involved only two patients from a single psychiatric ward, which substantially limits transferability to other populations and settings. Second, there was no control or comparison group and no randomization. Third, the observation period was limited to nine days, preventing assessment of whether the observed behavioral changes were sustained after the intervention period. Fourth, the study did not use standardized quantitative measures of aggression, symptom severity, emotional regulation, or frequency of violent behavior. The available observations therefore describe clinical change but do not provide effect sizes or statistical estimates.

Fifth, the intervention was embedded within a broader package of psychiatric nursing care. Therapeutic communication, spiritual coping, peer interaction, medication adherence, and routine ward care occurred during the same period. Medication names, doses, administration timing, and other relevant clinical variables were not available in the source record. Consequently, the independent contribution of deep breathing or pillow hitting cannot be isolated. This limitation is particularly important because previous evidence indicates that aggression in schizophrenia may be influenced by symptom severity, impulsivity, treatment factors, social circumstances, and other patient-level characteristics [29], [30]. Sixth, family-based intervention could not be implemented because the patients' families were absent during the treatment period. Finally, the source record did not provide complete information regarding illness duration, formal diagnostic instruments or criteria, psychiatric or medical comorbidities, or other baseline clinical characteristics.

Despite these limitations, the findings have practical implications for psychiatric nursing. First, nurses may consider incorporating simple, structured self-regulation activities such as deep breathing into individualized care plans when patients are clinically able and willing to participate. Second, the initial refusal of pillow hitting in both patients demonstrates the importance of assessing readiness and avoiding coercive implementation. Alternative adaptive activities and repeated therapeutic engagement may be considered when a patient is not prepared to participate. Third, assessment should document the patient's specific emotional triggers and early behavioral signs because these characteristics may differ substantially between patients. Fourth, nursing documentation should distinguish observed behavioral outcomes from causal claims and should record concurrent interventions that may influence the patient's response.

For future research, larger prospective studies should recruit more diverse patient populations and use standardized measures of aggression and symptom severity. Controlled comparative designs could examine whether TAK Session 2 provides additional benefit beyond routine psychiatric nursing care. Future studies should also document medication type, dose, timing, illness duration, comorbidities, and relevant psychosocial factors so that potential confounding variables can be examined. Longer follow-up would be useful to

determine whether the ability to use deep-breathing relaxation and adaptive emotional expression is maintained after discharge. These improvements would allow the clinical observations reported here to be tested more rigorously while preserving the individualized, context-sensitive approach demonstrated by the present case study.

V. CONCLUSION

This study aimed to describe the implementation of Group Activity Therapy (TAK) Session 2, particularly deep-breathing relaxation and the structured pillow-hitting activity, and to document the clinical responses of two patients with schizophrenia and a nursing diagnosis of risk for violent behavior at Menur Hospital, Surabaya. The descriptive comparative case study followed two male inpatients, aged 21 and 25 years, over a nine-day period from September 9 to 17, 2025. The findings demonstrated several patient-level changes. First, during SP1, both patients progressed from being unable to perform deep-breathing relaxation independently on day 1, to performing the technique with guidance on day 2, and to performing it independently on day 3. Second, during SP2, both patients initially refused the pillow-hitting activity on day 4, subsequently accepted the activity on day 5, reported slight relief after participation, and participated more cooperatively on day 6. Third, during SP3–SP5, both patients were able to participate in adaptive verbal expression, spiritual coping, and medication-adherence activities. Fourth, by the final evaluation, both patients were described as calmer and emotionally stable, interacted appropriately with nurses and peers, and showed no observed violent behavior during the documented care period. However, these findings represent clinical observations rather than quantitative evidence of intervention effectiveness. The study included only 2 patients, had no control or comparison group, was not randomized, used a short 9-day observation period, and did not employ standardized measures of aggression or symptom severity. Furthermore, TAK Session 2 was delivered together with therapeutic communication, spiritual coping, medication-adherence support, peer interaction, and routine inpatient care, while medication details and several baseline clinical variables were unavailable. Therefore, the independent contribution of TAK Session 2 cannot be determined. Future research should involve larger and more diverse samples, standardized behavioral and symptom measures, longer follow-up, and controlled comparative designs. Studies should also document medication characteristics, clinical comorbidities, psychosocial triggers, and other potential confounding factors to determine more rigorously how TAK Session 2 contributes to the management of violent behavior risk in patients with schizophrenia.

ACKNOWLEDGEMENTS

The authors would like to express their sincere gratitude to Menur Hospital in Surabaya, particularly the Kenari Ward, for facilitating the implementation of this case study. The authors also appreciate the nursing staff for their assistance during patient assessment, intervention, observation, and evaluation. Special appreciation is extended to the patients who participated voluntarily and provided the information

necessary for this study. The authors acknowledge all individuals who supported the completion of this manuscript.

FUNDING

This study did not receive specific financial support from any government, commercial, or private funding agency.

DATA AVAILABILITY

The data supporting this case study are derived from clinical nursing assessments, observations, interviews, and hospital documentation. Because the information concerns individual psychiatric patients, the underlying clinical records are not publicly available. Relevant non-identifiable information may be made available by the corresponding author subject to institutional requirements and protection of patient confidentiality.

AUTHOR CONTRIBUTION

Asyila Aulia Putri contributed to the conceptualization of the study, data collection, clinical observation, data analysis, and preparation of the initial manuscript. Miadi contributed to study supervision, methodological review, interpretation of the clinical findings, and critical revision of the manuscript. Ade Andrian contributed to the clinical implementation, data interpretation, literature review, and manuscript revision. Endah Suprihatin contributed to supervision, validation of the nursing care process, critical review of the manuscript, and final approval of the version to be published. All authors reviewed the manuscript, approved the final version, and agreed to be accountable for the accuracy and integrity of the work.

DECLARATIONS

ETHICAL APPROVAL

The available manuscript documents informed consent from the participating patients but does not provide an institutional ethical approval number. The authors should insert the relevant ethics committee approval information if formal ethical approval was obtained before submission.

CONSENT FOR PUBLICATION PARTICIPANTS

Written informed consent was obtained from the participating patients after the study procedures and planned nursing activities had been explained. Participation was voluntary, and patients were permitted to decline participation in an activity when they were unwilling or clinically unable to participate safely.

COMPETING INTERESTS

The authors declare that there are no competing interests that could have influenced the interpretation or reporting of the findings.

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