Proceedings International Conference on Nursing Relateded to Palliative Care
Vol. 1 (2025): 21 November 2025

Case report on a schizophrenia patient with sensory perception disturbance at Ghrasia mental Hospital Yogyakarta

Rias Fadzilah Sari*, Prastiwi Puji Rahayu

Nursing Study Program, Universitas Aisyiyah Yogyakarta, Indonesia
Email: akunrias@gmail.com

Abstract

Schizophrenia is a description of a syndrome with many unknown causes, and the course of the disease is not always chronic or worsening. Some consequences depend on the balance of genetic, physical, and socio-cultural factors. Schizophrenia is a type of psychotic disorder, especially characterized by a loss of understanding of reality and self-awareness. This case study involved a client, Mrs. A, aged 42 years, female, and Javanese, with a diagnosis of schizophrenia. The diagnosis in this case is abnormal sensory perception, and the intervention provided was hallucination management. The purpose of this scientific work is to provide protective mental care for patients with the main problem of sensory perception disorder in the Srikandi room of Grhasia Mental Hospital. This case study employs an observational approach, beginning with assessment, identifying data focus, diagnosis, setting goals and action plans, implementation, and evaluation. Conclusion: After four days of implementation in the case of Mrs. A, her sensory perception disorder related to auditory hallucinations was partially resolved.

Keywords: Sensory Perception Disorder, Hallucination, Auditory Hallucination, Schizophrenia.

1. Introduction

According to Health Law Number 17 of 2023, mental health is a condition in which an individual can develop physically, mentally, spiritually, and socially so that they are aware of their abilities, can cope with stress, work productively, and contribute to their community. Meanwhile, People with Mental Disorders, hereinafter abbreviated as ODGJ, are people who experience disorders in thoughts, behaviors, and feelings that are manifested in the form of a collection of symptoms and/or significant behavioral changes and can cause suffering and obstacles in carrying out the functions of people as human beings (Prabawati, 2019). Mental functions include thought processes, emotional states, desires, psychomotor behavior, and speech. One form of mental disorder is schizophrenia (Afconneri & Herawati, 2021).

Schizophrenia is described as a syndrome with a wide variety of unknown causes. Its course isn't always chronic or extensively deteriorating, with outcomes often dependent on a balance of genetic, physical, and socio-cultural factors. It's classified as a psychotic disorder, primarily characterized by a loss of understanding of reality and impaired insight. In schizophrenia, individuals may experience severe mental disorder symptoms such as hallucinations, delusions, disorganized behavior, and disorganized speech, as well as negative symptoms (Yudhantara & Istiqomah, 2018).

According to World Health Organization data (2022) there are 300 million people worldwide who suffer from mental disorders such as depression, bipolar disorder, and dementia, including 24 million people with schizophrenia. Data from the Indonesian Health Survey (SKI, 2023). The prevalence of schizophrenia and psychosis in families in Indonesia is 4 per thousand, or approximately 315,621 people. In Yogyakarta province alone, the figure is 4,957 people, or approximately 9.3 per thousand. This means that for every 1,000 households in Indonesia, 4 families have schizophrenia.

Schizophrenia is characterized by the patient's difficulty distinguishing between reality and imagination, which can manifest as delusions or hallucinations. The most common type of hallucination experienced by patients is auditory hallucinations, accounting for approximately 70% of cases. Visual hallucinations are second, with an average of 20%. Other types of hallucinations, such as gustatory (taste), olfactory (smell), tactile (touch), kinesthetic, and cenesthetic hallucinations, collectively account for only 10%. Signs that a patient is experiencing auditory hallucinations include appearing to talk or laugh to themselves, sudden outbursts of anger, or covering their ears because they perceive someone speaking to them (Siringo-ringo & Nasution, 2023).

Controlling auditory hallucinations can be achieved through four key strategies: confronting the hallucinations, taking medication regularly, engaging in conversation with others, and participating in

scheduled activities. Medication adherence is a crucial indicator in a patient's recovery. Consistent medication intake can extend a patient's remission period by over a year and prevent psychotic symptoms from worsening. Patients who relapse take longer to return to their baseline condition, and repeated relapses can lead to a deteriorating state that is increasingly difficult to reverse (Darmawan et al., 2024).

Based on observations and assessments conducted on a patient at Grhasia Mental Hospital Yogyakarta from December 17-19, 2024, I'm interested in managing schizophrenia patients with sensory perception disturbances by providing comprehensive nursing care. Therefore, I've decided to compile this final nursing scientific paper titled, "Case Report on a Schizophrenia Patient with Sensory Perception Disturbance at Grhasia Mental Hospital Yogyakarta".

2. Method

This scientific paper presents an observational case study that follows a systematic process, beginning with assessment, identifying key data, formulating diagnoses, setting goals and action plans, and finally implementing and evaluating the interventions. The subject of this research is a patient diagnosed with schizophrenia and experiencing sensory perception disturbance in the Srikandi room of Grhasia Mental Hospital. The data collection techniques used in this case study include interviews, observation, and medical records. Data collection for this scientific paper was conducted in December 2024. The process began with assessment, followed by determining nursing diagnoses, setting nursing goals, outlining nursing care interventions, and finally, implementing and evaluating nursing care.

3. Results and Discussion

3.1. Results

Based on the assessment conducted on December 17, 2024, with Mrs. A, a 49-year-old woman whose last education was a Bachelor's degree, the patient was diagnosed with F20.0 (schizophrenia), with the main symptom being a disturbance in sensory perception. Upon admission to the emergency room, she was screaming. During the assessment, she was able to engage in conversation, but her speech was rambling and convoluted. The predisposing factor identified was that the patient had a history of a mental disorder seven years ago. The precipitating factors in the patient are that the patient said they participated in the Hajj companion selection but did not pass, separation from her husband and child, and medication non-adherence. The medical therapy given to the patient was trihexyphenidyl 2 mg twice a day, lorazepam 2.5 mg twice a day, and risperidone 2 mg twice a day.

During the interview, the hallucination identified was auditory hallucinations, with the following subjective and objective data. Subjective Data: The patient states that she often hears whispers instructing her to perform religious rituals and go to a certain place without her realizing it. Objective Data: The patient appears confused, speaks in a convoluted manner, and seems worried. The nursing diagnosis for the patient is disturbed sensory perception related to auditory hallucinations.

Nursing interventions for Mrs. A, using the Indonesian Nursing Intervention Standards (SIKI), involved hallucination management with code I.09288. During the implementation for the patient with a nursing diagnosis of disturbed sensory perception related to auditory hallucinations, a meeting strategy involving training on how to control hallucinations was carried out. The first implementation strategy focused on recognizing and confronting hallucinations, which included identifying the type, content, time, frequency, and the patient's response to hallucinations, as well as controlling hallucinations by confronting them. The second implementation strategy involved controlling hallucinations by training the patient to engage in conversation with others. The third implementation strategy was to control hallucinations by regularly taking medication (following the five correct principles of medication administration). The final or fourth implementation strategy involved controlling hallucinations by engaging in scheduled activities (those typically performed by the patient).

Evaluation of Nursing Interventions for Mrs. A's Hallucination Control. The nursing interventions implemented for Mrs. A aimed to control her hallucinations. During the first implementation strategy, the client was able to identify her hallucinations and practice confronting them, though the hallucinations were still present. With the second implementation strategy, the client demonstrated the

ability to converse with others as a way to control her hallucinations. The third implementation strategy showed progress, as the client was able to control her hallucinations by consistently taking her medication, and the hallucinations began to decrease. For the fourth implementation strategy, the client was capable of writing down and performing her usual daily activities. By the fourth day of implementation, a reduction in the signs and symptoms of hallucinations was observed. Initially, the client exhibited symptoms such as screaming, rambling speech, reporting hearing her deceased mother's voice, and whispers commanding her to always be devout in worship. After the implementation of these strategies, the client no longer screamed, spoke more coherently, and reported a decrease in the whispers.

3.2. Discussion

The assessment findings for Mrs. A were gathered using the established nursing assessment format. The psychiatric nursing assessment phase included collecting the patient's general data, identifying the chief complaint, examining predisposing and precipitating factors, reviewing her previous health history, assessing stressors, identifying coping resources and coping mechanisms, conducting a psychosocial assessment and mental status examination, determining discharge preparation needs and discharge planning, detailing medical therapy, and performing a category score assessment.

Data was collected through direct interviews with the patient, observation, and the patient's medical records. During the assessment, the patient appeared cooperative but spoke incoherently throughout the interview. The patient stated that she often heard whispers instructing her to perform religious rituals and go to certain places without her conscious awareness. She appeared confused, spoke ramblingly, and seemed worried. According to her medical records, the patient was brought to Grhasia Mental Hospital by her neighbor because she was pacing around the mosque, sweeping the yard at midnight, had slept naked in the mosque, rarely bathed, and frequently saw ghosts at home. Her neighbor also reported that there was a lot of trash and dirt around the patient's house.

The assessment of stressors revealed that cognitively, the patient experienced medication non-adherence because no one was there to pay attention to or remind her to take her medication. Affectively, the patient felt restless when hearing whispers. Physiologically, upon hearing whispers, the patient became disorganized and confused. The diagnosis of disturbed sensory perception was chosen because the data gathered from the patient aligned with the defining characteristics of hallucinations, including hearing voices/whispers, seeing unreal things, restlessness, pacing, and worry.

In this managed case, the sensory perception outcome (L.09083) was used, with the following criteria: verbalization of hearing whispers improved from a score of 2 (moderately increased) to 5 (decreased), and hallucinatory behavior improved from a score of 3 (moderate) to 5 (decreased). The nursing intervention used was hallucination management (I.09288), which included the following actions. Observation: Monitor behaviors indicating hallucinations and monitor the content of hallucinations. Therapeutic: Maintain a safe environment, implement safety measures when behavior cannot be controlled, discuss feelings and responses to hallucinations, and avoid debating the validity of hallucinations. Education: Encourage self-monitoring of situations where hallucinations occur and teach hallucination control techniques. Collaboration: Collaborate on medication administration.

Education provided to patients with sensory perception disorder (auditory hallucinations) consists of four key areas: recognizing and confronting hallucinations, engaging in conversation with others, taking medication regularly, and performing scheduled activities. This approach is supported by research from (Meylani & Pardede, 2022), which indicates that generalized therapy for hallucination control is effectively implemented using these practical strategies.

Nursing implementation refers to a series of activities performed by nurses to help clients achieve a better health status, reflecting desired outcome criteria (Ramada, 2020). On December 17, 2024, implementation strategy 1 was carried out. This involved helping the patient recognize and confront the content, frequency, timing, precipitating situations, feelings, and responses associated with her hallucinations, as well as practicing controlling hallucinations by confronting them. The patient stated that she still heard whispers and recalled going somewhere and leaving her motorcycle there. She

appeared restless, confused, and spoke incoherently. When taught how to confront the hallucinations, the patient seemed to follow along and was able to demonstrate what she had learned.

Implementation Strategy 1 aims to help clients recognize the hallucinations they are experiencing. This approach involves discussing what the client hears, when the hallucinations appear, how often they occur, the situations or conditions that trigger them, and the client's response when hallucinations happen. Confronting (menghardik) is a self-control technique for hallucinations, achieved by rejecting the content of the emerging hallucination. Clients are trained to say "no" to the hallucination or to ignore it. If the client can apply this technique consistently, they will be able to control themselves and not follow the commands or urges from the hallucinations. Although hallucinations may still appear, this ability helps the client avoid becoming engrossed or influenced by the hallucinations they experience (Meliana & Sugiyanto, 2019).

Implementation Strategy 2 focuses on evaluating the hallucination-confrontation technique and practicing talking with others. This involves teaching the patient to initiate conversations with peers in their living unit. They can start by introducing themselves, then discuss hobbies, daily activities, and so on. The results showed that Mrs. A appeared able to converse with her housemates. This conversational therapy aims to reduce, manage, or control recurring hallucinations by keeping the patient engaged in conversational activities (Alfaniyah & Pratiwi, 2021).

On May 19, 2024, Implementation Strategy 3 was carried out, focusing on regular medication intake and evaluating previous activities. The patient was taught the "5 Rights" of medication administration: right patient, right drug, right dose, right route, and right time. The patient appeared attentive during the explanation, which involved using a paper containing the names and benefits of the medications she was taking. This approach aligns with Jannah's research, which suggests that support from healthcare professionals—such as providing information about the patient's condition, dosage, frequency, and timing of medication, the benefits of medication adherence, and actively listening to patient complaints during treatment—can serve as a significant motivator for patients to be more compliant (Jannah, 2021). With information from healthcare professionals, individuals with schizophrenia are expected to manage their symptoms better and adhere to their medication regimen. Furthermore, applying the "5 Rights" principle benefits patients by upholding their right to know all information related to their illness, including those with schizophrenia. Therefore, nurses are obligated to provide patients with necessary information. During medication administration, nurses must involve the patient and provide knowledge about the medication, including its type, dose, timing, administration method, and the consequences of non-adherence or potential side effects (Darmawan et al., 2024).

Implementation Strategy 4 was carried out on May 20, 2024, and involved evaluating the previous activities of confronting hallucinations, engaging in conversation, taking medication regularly, and practicing scheduled activities. Scheduled activities serve as a vital intervention in controlling hallucinations; by keeping patients occupied with various tasks, their attention can be diverted from the hallucinations. This aligns with research by Siringo-ringo & Nasution (2023), which found that patients showed a decrease in hallucination signs and symptoms from a score of 14 to 3. The remaining signs and symptoms included rapid eye movement, brief attention spans, and sweating. Furthermore, patients were able to identify the content, type, time, frequency, and precipitating situations of their hallucinations and explain their responses to them. Mrs. A reported that her hallucinations had decreased and that she understood the information provided. She appeared to speak more calmly and was able to interact with other residents in the living unit.

Nursing care was provided for four days, involving generalist therapy Strategies for Implementation (SP) 1-4. The result was hallucination control achieved by implementing generalist therapy, which includes recognizing and confronting hallucinations, engaging in conversation with others, taking medication regularly, and performing scheduled activities. Following the nursing care aimed at controlling hallucinations, the client experienced a reduction in the signs and symptoms of hallucinations after the interventions. This aligns with research by Makhruzah et al., (2021), which indicates the influence of implementing these strategies on the signs and symptoms of schizophrenia. The application of these strategies by nurses requires strong communication skills; with good communication, nurses can achieve the desired outcome of positive and constructive behavioral

changes in patients. The success of the implementation can be observed through each evaluation conducted during the provision of nursing care. Mrs. A demonstrated an ability to recognize that hallucinations were disruptive, and positive changes, both verbal and non-verbal, were noted through a decrease in signs and symptoms from the first day of care until the last (Dewi & Rahmawati, 2023).

4. Conclusion

This case report concludes that hallucinations are false perceptions where patients with mental disorders hear whispers or voices that aren't real and respond to them. The implementation of the strategies outlined in this report proved effective, marked by a reduction in the signs and symptoms of hallucinations. It's hoped that this decrease in symptoms after the intervention will enable patients to control their hallucinations independently and continue their recovery at home.

Acknowledgements

All nurses of Wisma Srikandi, Grhasia Mental Hospital, Yogyakarta, for providing facilities and assistance that supported the smooth implementation of the research process.

Reference

Afconneri, Y., & Herawati, N. (2021). PERBEDAAN KEMAMPUAN MENGONTROL HALUSINASI PASIEN SKIZOFRENIA MELALUI TERAPI AKTIFITAS KELOMPOK STIMULASI PERSEPSI. *JKJ): Persatuan Perawat Nasional Indonesia*, *9*(2), 445–452.

Alfaniyah, U., & Pratiwi, Y. S. (2021). Penerapan Terapi Bercakap-cakap Pada Pasien Gangguan Persepsi Sensori: Halusinasi. *Seminar Nasional Kesehatan*, 2398–2403.

Darmawan, A. S., Mawaddah, N., & Mujiadi. (2024). *INTERVENSI LATIHAN MINUM OBAT MENINGKATKAN KEPATUHAN MINUM OBAT PASIEN SKIZOFRENIA DI RS RADJIMAN WEDIODININGRAT LAWANG*. *5*(2).

Dewi, L., & Rahmawati, A. N. (2023). Asuhan Keperawatan pada Pasien Halusinasi Pendengaran dengan Penerapan Terapi Generalis. *Community Health Nursing Journal E*, 2988–1269. https://cmhn.pubmedia.id/index.php/cmhn/index

Jannah, L. M. (2021). *KEPATUHAN MINUM OBAT PADA PASIEN SKIZOFRENIA: LITERATURE REVIEW*. https://digilib.unisayogya.ac.id/5590/1/Latifah%20Miftahul%20Jannah_1710201044_S1%20Keperawatan-dikonversi%20-%20Latifah%20Miftahul%20Jannah.pdf

Makhruzah, S., Putri, V. S., & Yanti, R. D. (2021). Pengaruh Penerapan Strategi Pelaksanaan Perilaku Kekerasan terhadap Tanda Gejala Klien Skizofrenia di Rumah Sakit Jiwa Daerah Provinsi Jambi. *Jurnal Akademika Baiturrahim Jambi*, *10*(1), 39. https://doi.org/10.36565/jab.v10i1.268

Meliana, T., & Sugiyanto, E. P. (2019). PENERAPAN STRATEGI PELAKSANAAN 1 PADA KLIEN SKIZOFRENIA PARANOID DENGAN GANGGUAN PERSEPSI SENSORI HALUSINASI PENDENGARAN. *Jurnal Manajemen Asuhan Keperawatan*, *3*, 37–45.

Meylani, M., & Pardede, J. A. (2022). *Penerapan Strategi Pelaksanaan (SP) 1-4 Dengan Masalah Halusinasi Pada Penderita Skizofrenia: Studi Kasus*. https://doi.org/https://doi.org/10.31219/osf.io/c8vzb

Prabawati, L. (2019). *GAMBARAN GANGGUAN SENSORI PERSEPSI HALUSINASI PENDENGARAN PADA PASIEN SKIZOFRENIA DI WISMA SADEWA RUMAH SAKIT JIWA GRHASIA DAERAH ISTIMEWA YOGYAKARTA*.

Ramada, R. K. (2020). *Studi Dokumentasi Risiko Perilaku Kekerasan Pada Pasien Dengan Bipolar*. Akademi Keperawatan "YKY" Yogyakarta.

Siringo-ringo, F. P., & Nasution, R. A. (2023). ANALISIS ASUHAN KEPERAWATAN JIWA PADA TN.R GANGGUAN PERSEPSI SENSORI : HALUSINASI PENDENGARAN DENGAN PENERAPAN LATIHAN DISTRAKSI BERCAKAP-CAKAP DAN KEGIATAN TERJADWAL DI RUANG SIGMA RSJD PROVINSI JAMBI TAHUN 2023. *Pinang Masak Nursing Journal*, *2*(2), 42. https://online-journal.unja.ac.id/jpima

SKI. (2023). *Survei Kesehatan Indonesia*.

WHO. (2022, June 8). *Mental Disorder*. https://www.who.int/news-room/fact-sheets/detail/mental-disorders