Permana et al. AJPHN 2025; 2:2 - https://doi.org/10.62377/1yjsmg47 Queeva Publishing

Patient Perceptions of Generalist Therapy for Schizophrenia with Violent Risk: A Phenomenological Study in Indonesia

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Submitted: 19.06.2025
Revised: 30.06.2025
Accepted: 30.06.2025
Published: 03.08.2025

Abstract

Background: Generalist Therapy (GT) is a nursing approach that integrates physical, psychological, social, and spiritual care tailored to individual needs. While commonly used in mental health nursing, its implementation varies across countries. In Indonesia, *GT* is delivered through culturally adapted implementation strategies. These include deep breathing exercises, pillow-punching, medication adherence, assertive verbal communication, and spiritual practices. Although *GT* has become a standard practice in Indonesian mental health services particularly in Aceh Province, research on patient perceptions, especially among those with schizophrenia and a history of violence, remains limited. This study aims to explore patients' subjective experiences of *GT*. **Methods:** This qualitative study employed a phenomenological approach. Data were collected through in-depth interviews with ten patients diagnosed with schizophrenia. The interviews were analyzed using Colaizzi's seven-step method. **Results:** Three major themes emerged from the data: (1) the effectiveness of *GT* in emotional regulation, including managing anger, promoting calmness, and the role of medication in reducing negative emotions; (2) resilience enhancement, encompassing positive meaning-making, therapy commitment, improved social functioning, and self-control; and (3) barriers to *GT* implementation, including internal (emotional issues, low insight, restrictive personal beliefs, cognitive decline, and low participation) and external obstacles (limited facilities and overcrowded wards). **Conclusion:** *GT* is perceived as helpful in emotional regulation and recovery support. It strengthens resilience and improves patient insight, especially when supported by a conducive environment. Incorporating patients' perspectives into therapeutic planning may enhance the effectiveness of mental health care.

Keywords: Schizophrenia, Risk of Violent Behavior, Generalist Therapy, Patient Perception, Phenomenology

Introduction

The World Health Organization (World Health Organization, 2022) estimates the global prevalence of schizophrenia at 0.32%. In the United States, the prevalence is reported to be under 1%, while in China, it is approximately 1% (Chen *et al.*, 2021; National Alliance on Mental Illness, 2021). In Indonesia, the Basic Health Research noted an increase from 1.7 per thousand (‰) in 2013 to 1.8‰ in 2018. However, the Province of Aceh recorded a significant rise, from 2.7‰ to 8.66‰, reaching as high as 18.77‰ in Lhokseumawe (Badan Penelitian dan Pengembangan Kesehatan, 2013, 2018). These findings underscore the heavy burden of severe mental illness in the region and the urgent need for focused policies and mental health services.

Patients with schizophrenia who exhibit psychotic symptoms such as delusions and hallucinations are prone to aggressive behaviors that may endanger themselves, healthcare providers, and others. Contributing risk factors include a history of violence, substance abuse, poor medication adherence, and social environmental stressors (Stuart, 2013). Schizophrenia is a complex condition that demands psychiatric nursing interventions beyond pharmacotherapy. It requires holistic approaches tailored to patients' emotional, cognitive, and spiritual needs. GT was developed in response to this need, a therapeutic approach designed to address patients with violent

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tendencies through physical interventions, assertive communication training, medication compliance strategies, and spiritual engagement (Keliat, 2019). *GT* has been widely implemented in psychiatric hospitals across Indonesia, including in the province of Aceh, and has shown to aid patients in recognizing symptoms, managing anger, and fostering resilience (Fahrizal, Mustikasari and Daulima, 2020; Widowati, Pratikwo and Saleh, 2023). However, the implementation of *GT* in patients with aggressive behavior is not without its challenges.

Aggressive patients with schizophrenia face multiple barriers in undergoing *GT*. Key internal barriers include communication and cognitive deficits that hinder patients' understanding of therapeutic instructions or expressing their needs, often leading to agitation and deteriorating social interactions (McCutcheon, Keefe and McGuire, 2023; Jimeno, 2024). Stigma and social isolation further complicate their conditions, making them reluctant to participate in community-based therapies that could support their recovery (Adil, Atiq and Ellahi, 2022). Additionally, side effects from antipsychotic medications such as sedation and fatigue frequently reduce motivation to engage in therapy (Guo *et al.*, 2023). The lack of spiritual integration in therapy also limits patients' emotional involvement in the healing process (Das *et al.*, 2023). Even during symptomatic remission, many patients still experience high levels of stress and limited adaptive coping, which diminish the long-term effectiveness of the therapy (Shoib *et al.*, 2021). In practice, the application of *GT* is also inconsistent. Physical strategies such as pillow-punching, for example, may exacerbate agitation, whereas relaxation techniques and spiritual approaches have proven more effective (Kjærvik and Bushman, 2024).

Although various challenges have been identified from clinical and theoretical perspectives, there is a significant gap in research exploring patients' subjective experiences with GT, particularly in the context of violent behavior risk. Understanding patients' perspectives is crucial for designing interventions that are more adaptive, context-sensitive, and humane (Välimäki *et al.*, 2022; Daliri *et al.*, 2024).

Based on this background, this study aims to explore the perceptions of patients with schizophrenia and a risk of violent behavior regarding the implementation of *GT* at Aceh Psychiatric Hospital. A descriptive phenomenological approach was employed without using a specific theoretical framework, allowing for the identification of meanings, lived experiences, and perceived challenges in *GT* participation. The findings are expected to provide a foundation for more effective and relevant psychiatric nursing interventions.

Methods

This study employed a descriptive phenomenological approach to explore patients' lived experiences regarding the implementation of *GT*. The primary focus was to understand how patients perceive the effectiveness and challenges of *GT* in their therapeutic journey.

Sample Size and Setting

The study was conducted in the Intermediate Ward of a government-owned psychiatric hospital in Aceh Province, Indonesia. This facility consistently implements *GT* as a standard component of nursing care, particularly for patients with schizophrenia and a risk of violent behavior. *GT* at this institution includes strategies such as deep-breathing exercises, safe emotional release techniques (e.g., punching pillows or mattresses), adherence to regular medication intake, assertive verbal communication training, and spiritual practices. Additionally, the hospital offers group activity therapy and psychosocial rehabilitation programs to support patients' recovery processes.

Ten patients with schizophrenia who exhibited a risk of violent behavior were purposively selected as informants. This number was considered sufficient to explore their experiences in depth, consistent with phenomenological research standards that prioritize the comprehensive understanding of subjective meanings. Each interview lasted between 20 and 40 minutes and yielded rich, diverse narratives. Data saturation was reached by the tenth interview, as no new themes or insights emerged during subsequent analysis.

Selection criteria were based on several considerations: participants had to be in a stable psychological condition, as assessed by a psychiatrist and trained general practitioner using the PANSS-EC score (≤10); they had to possess clear and comprehensible verbal communication skills; and they were required to have been hospitalized at least twice as an indicator of treatment experience. Only those who provided informed consent willingly and were capable of signing it were included in the study. Patients with severe active psychotic symptoms such as extreme agitation, dominant hallucinations, or uncontrollable aggression as well as those with serious psychiatric or neurological communication disorders were excluded.

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Description of Procedures

Interviews were conducted near the inpatient ward in a quiet and safe environment to ensure participants' psychological comfort. The interviews were conducted by the lead researcher, a psychiatric nurse with over ten years of clinical experience in a mental hospital. Although the researcher had no prior formal experience in qualitative interviewing, the data collection process was closely supervised by academic advisors with expertise in qualitative methods. To mitigate potential bias, bracketing techniques were applied throughout data collection and analysis. The researcher maintained a reflexive journal to monitor assumptions and ensure objectivity, and participated in regular peer debriefing sessions with academic supervisors to enhance reflexive awareness and reduce interpretive bias. Before formal data collection began, the semi-structured interview guide was pretested with two eligible psychiatric patients (not included in the final sample) to evaluate the clarity, flow, and contextual appropriateness of the questions. Feedback was used to refine wording and structure to better align with participants' comprehension and cultural context. Prior to the interviews, the researcher established informal rapport with participants to foster trust and encourage open sharing of personal experiences. A flexible and empathetic approach was employed, providing informants with space to express their views deeply and without pressure.

The interview setting was arranged to minimize institutional pressure and create a naturalistic atmosphere, allowing authentic patient opinions and emotions to emerge. Questions were formulated in simple language, grounded in the patients' everyday experiences, and avoided technical jargon that might cause confusion. Questions were asked gradually, beginning with general inquiries about hospitalization experiences and narrowing down to their perceptions of *GT* implementation, including the meaning they attributed to each intervention strategy introduced by nurses. Sample interview questions such as "Can you describe a typical day during your stay in this hospital?" and "Can you share an experience where a therapy activity or session made a difference in how you felt or behaved?" are provided in Appendix A.

Interviews were audio-recorded using an Android smartphone, with participants' permission. A second smartphone was prepared as a backup in case of technical issues. A trained research assistant took observational field notes focusing on non-verbal cues and environmental context, without directly interacting with participants. The assistant received prior ethical orientation. The recordings were manually transcribed by the primary researcher. All interviews were conducted in Bahasa Indonesia and then translated into English by the lead researcher. Back-translation procedures were performed to ensure the accuracy and preservation of intended meanings. After each interview, participants were given the opportunity to revise or add information if necessary. Member checking was conducted by confirming the accuracy of the transcripts with participants to ensure faithful representation of their experiences (Creswell and Creswell, 2017).

Data Analysis

Data were analyzed using Colaizzi's seven-step method (Praveena and Sasikumar, 2021), a structured and in-depth approach to understanding participants' lived experiences. The analysis followed these steps:

1. Reading all interview transcripts repeatedly to gain a comprehensive understanding of the informants' narratives.
2. Identifying significant statements that reflected the informants' perspectives, emotions, or experiences regarding *GT*.
3. Formulating meanings from each significant statement, considering the social and psychological contexts of each participant.
4. Clustering these meanings into thematic categories based on shared patterns of experience.
5. Constructing an exhaustive description that captured the essence of patients' experiences with *GT* implementation.
6. Synthesizing this description into a fundamental structure of the studied phenomenon.
7. Validating the findings through member checking to ensure interpretive accuracy.

To enhance data credibility and trustworthiness, the researcher engaged in regular peer debriefing with two academic advisors experienced in qualitative research. To minimize potential bias, the researcher maintained reflexive journals and engaged in peer debriefing. Manual transcription was performed by the lead researcher to maintain closeness to the data. All coding procedures were documented in a thematic summary table. Data analysis was conducted concurrently with data collection to allow iterative reflection and deeper inquiry in subsequent interviews.

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Ethical Considerations

This study was approved by the Ethics Committee of the Faculty of Nursing, Universitas Syiah Kuala (Approval No. 112006210924, dated October 11, 2024). In addition, official permission to conduct the study was obtained from the management of a mental hospital in Aceh Province. All participants provided written informed consent after receiving a comprehensive explanation about the study's purpose, procedures, benefits, potential risks, and their rights as research participants. Participation was entirely voluntary, and they were informed that they could withdraw at any time without any consequences to their treatment or care. Interviews were conducted using therapeutic communication in a calm and secure environment, with consideration for participants' psychological conditions. Audio recordings were stored on password-protected devices and backed up securely to ensure confidentiality. The study was entirely self-funded by the primary investigator.

Results

The demographic characteristics of the participants showed variation in terms of age, hospitalization history, gender, educational background, employment status, and marital status. The average age of participants was 37.5 years (middle adulthood), with a standard deviation of ±7.89 years. The mean of hospitalizations was 6.1 times, with a standard deviation of ±2.51. Detailed information is presented in Table 1.

Table 1. Participant Demographics

Variable	Category	n (%)	Mean ± SD
Age (years)	–	–	37.5 ± 7.89
Rehospitalization	–	–	6.1 ± 2.51
Gender	Male	7 (70%)	–
	Female	3 (30%)	
Education Level	Primary	5 (50%)	–
	Secondary	4 (40%)	
	Tertiary	1 (10%)	
Employment Status	Civil Servant	1 (10%)	–
	Farmer	1 (10%)	
	Welder	1 (10%)	
	Construction Worker	1 (10%)	
	Plantation Worker	1 (10%)	
	Trader	2 (20%)	
	Unemployed	3 (30%)	
Marital Status	Married	1 (10%)	–
	Widowed	3 (30%)	
	Single	6 (60%)	

Thematic analysis of the interview data revealed three major themes that represent the perceptions of patients with schizophrenia regarding the implementation of *GT*. Three primary themes emerged from the analysis, reflecting participants' emotional responses, coping strategies, and perceived barriers to therapy. These are: (1) Emotional Regulation, (2) Strengthening Resilience, and (3) Barriers to *GT* Implementation. A detailed description of each theme is provided below:

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Table 2. Themes, Subthemes, and Codes from Thematic Analysis

Themes	Subthemes	Codes
1. Emotional Regulation	1.1 Emotion regulation techniques	Minimizing anger, Increasing calmness, Reducing negative thoughts
	1.2 Role of medication	Decreasing negative emotions
2. Strengthening Resilience	2.1 Positive meaning-making in the recovery process	Recovery and emotional control, Commitment to continuing therapy outcomes, Ability to resume normal activities, Enhanced social functioning
3. Barriers to *GT* Implementation	3.1 Internal barriers	Emotional problems, Low insight, Lack of participation, Personal beliefs, Cognitive decline
	3.2 External barriers	Inadequate facilities, Overcapacity

1. Emotional Regulation

GT was perceived to help reduce emotional turbulence, including anger and negative thoughts. Strategies employed included breathing techniques, spiritual practices, and consistent medication intake. Patients reported that *GT* had a calming effect, enabled better anger control, and helped lighten their thoughts. Deep breathing exercises were considered effective for emotional relief, while spiritual activities such as prayer and Qur'anic recitation provided inner peace. Adherence to medication also contributed to emotional stability, including improved sleep quality.

Participants described how these methods contributed to emotional clarity and helped them regain composure during distressing moments. One participant shared how breathing techniques helped de-escalate anger and supported social reintegration:

> *"...when I'm angry, I usually take a deep breath... once I calm down, I can hang out with friends again."* (Ps8)

Spiritual practices were also emphasized as an integral part of emotional regulation. One participant explained:

> *"...praying... reciting Yasin... reading short surah... brings relief..."* (Ps5)

The importance of medication adherence was also highlighted. Participants noted that taking medication consistently not only reduced emotional tension but also improved physical well-being:

> *"...taking medicine regularly... makes the body feel good... calmer, the way I speak too..."* (Ps2)

Overall, *GT* was seen as a practical and culturally appropriate approach to managing emotional instability, providing patients with multiple pathways behavioral, spiritual, and pharmacological to cope with daily challenges.

2. Strengthening Resilience

GT was seen to rebuild hope, develop emotional self-control, and reinforce commitment to the recovery process. In this context, resilience was not merely defined as the absence of symptoms, but as the ability to sustain therapeutic outcomes and reintegrate functionally into social life.

Several participants expressed a conscious desire to better manage their emotions and actively engage in healing. One participant noted:

> *"...I want better emotional control... first, I must recover."* (Ps1)

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The aspiration to return to normal life also emerged, particularly through hopes of resuming daily routines and reconnecting with the social environment. As another participant stated:

> *"...so that I can recover... do things like ordinary people again... return to normal."* (Ps3)

In addition to these goals, some participants demonstrated an internalized awareness of the importance of maintaining therapeutic gains. They emphasized the need to not disregard what had been learned during treatment. For instance:

> *"...I must not forget... I must make sure to apply what I've learned..."* (Ps2)

These reflections highlight a growing sense of agency among participants marked by motivation to heal, responsibility for emotional regulation, and commitment to sustaining their progress beyond the clinical setting.

3. Barriers to GT Implementation

The implementation of *GT* for patients with schizophrenia and the risk of violent behavior encountered various internal and external obstacles. Internal challenges included low insight, cognitive impairments, and limited patient participation in applying the provided strategies. Some patients reported emotional discomfort, such as feeling embarrassed when performing emotional release techniques, even when guided by nurses. Others expressed dissatisfaction with the outcomes, despite experiencing temporary relief. In moments of intense emotion, aggressive impulses became difficult to control. Low insight was also evident when patients believed they were already healed while still undergoing treatment. Additionally, some patients did not consistently apply learned strategies after discharge. Personal or religious beliefs also influenced acceptance of certain techniques, such as assertive verbal communication.

Cognitive impairments, particularly memory problems, were barriers to recalling and applying *GT* strategies. Externally, the lack of tools for emotional release techniques, limited access to clean water affecting religious practices, and overcrowded, noisy, and unhygienic ward conditions further complicated therapy. These factors contributed to increased stress, discomfort, and potential conflicts among patients.

Some participants felt self-conscious when performing emotional release techniques in front of others. One participant shared:

> *"...after hitting the mattress with a pillow... I felt embarrassed... just embarrassed, that's all..."* (Ps1)

Another participant reported that although the technique felt relieving, it lacked lasting impact:

> *"...it felt relieving... but still not satisfying... unfulfilled..."* (Ps6)

Spiritual values also played a role in shaping perceptions of therapy. For instance:

> *"...assertive verbal communication, like asking for things—it's not appropriate... forbidden in religion..."* (Ps7)

Environmental constraints added additional stressors to the therapeutic environment. Limited access to clean water disrupted religious routines:

> *"...sometimes there's no water left in the morning... how can we perform fajr prayer?"* (Ps4)

Meanwhile, overcrowded living conditions made patients feel unsafe and uncomfortable:

> *"Too many people... it's stressful... even lice everywhere..."* (Ps5)

These internal and external barriers ranging from personal beliefs to institutional limitations interacted to reduce the effectiveness and sustainability of *GT* implementation in the clinical setting.

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Discussion

This qualitative study provides an in-depth understanding of how patients with schizophrenia and a risk of violent behavior perceive and experience the implementation of *GT*. The analysis generated three central themes: emotional regulation, strengthening resilience, and barriers to *GT* implementation. These themes reveal the nuanced ways patients internalize therapeutic strategies and navigate challenges during their recovery journey.

1. Emotional Regulation

Participants frequently described *GT* as helpful in managing emotional distress, particularly anger and negative thoughts. Breathing techniques, spiritual practices (e.g., prayer and Qur'anic recitation), and adherence to medication contributed to a calming effect and increased emotional clarity. Several patients emphasized how *GT* enabled them to regain composure and interact more positively with others.

These findings highlight the practical utility of *GT* strategies in reducing emotional dysregulation, a common challenge in schizophrenia. The therapeutic impact appears to stem from a blend of behavioral techniques and culturally grounded spiritual coping. This aligns with Plencler *et al.*, (2025), who reported that group-based mindfulness interventions significantly enhanced emotional regulation and psychological well-being in schizophrenia spectrum disorders. When coupled with pharmacological treatment, such integrative approaches foster more stable affect regulation and reduce the risk of relapse (Doane *et al.*, 2020; Pennou *et al.*, 2023).

2. Strengthening Resilience

Participants viewed *GT* as a path to rebuild hope, increase self-awareness, and commit to recovery. Several respondents expressed a desire to "return to normal," highlighting the importance of regaining social functioning and personal autonomy. For many, emotional regulation served as the foundation for further psychological growth.

This theme suggests that *GT* not only alleviates symptoms but also fosters deeper cognitive and emotional engagement in the healing process. Resilience, as observed here, includes the patient's capacity to reinterpret their condition, set recovery goals, and reestablish life meaning. Research on Mindfulness-Based Cognitive Therapy (MBCT) echoes these results, showing enhanced resilience and self-esteem among individuals with schizophrenia, alongside reduced internalized stigma (Dai *et al.*, 2024). Thus, the emotional stability gained through *GT* may serve as a catalyst for long-term psychosocial rehabilitation.

3. Barriers to GT Implementation

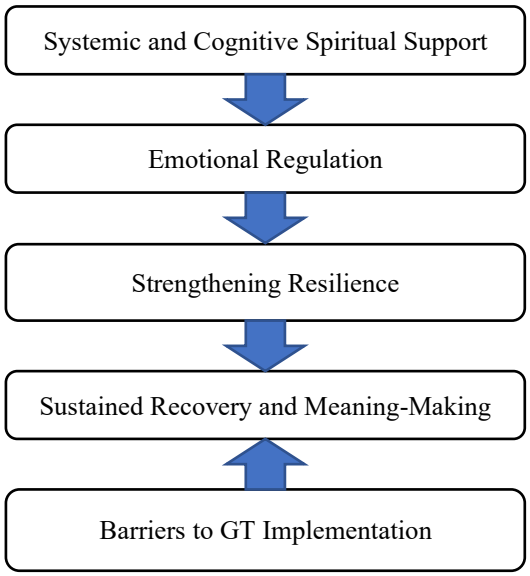
Despite its benefits, the implementation of *GT* was hindered by multiple internal and external factors. Internally, several patients reported low insight, cognitive difficulties (especially forgetfulness), and discomfort with certain *GT* strategies such as expressive techniques or assertiveness training. Some participants rejected practices that clashed with personal or religious values. Externally, issues like overcrowded wards, lack of privacy, limited resources (e.g., no tools for emotional release), and inadequate hygiene conditions disrupted therapeutic continuity.

These findings underscore that the effectiveness of *GT* depends not only on the method itself but also on the patient's cognitive capacity and the therapeutic environment. Cognitive impairments, particularly in memory, can limit a patient's ability to retain and apply learned strategies suggesting a need for remedial educational support (Tripathi, Kar and Shukla, 2018; Lysaker *et al.*, 2022). Moreover, environmental barriers confirm Lien *et al.*, (2021) conclusion that the therapeutic milieu is a critical factor in intervention success, especially for patients requiring emotional stability.

The spiritual lens through which *GT* was interpreted also added a culturally unique dimension to its reception. In Aceh, where religious identity plays a central role, the inclusion of spiritually aligned strategies was pivotal. This supports Bouwhuis-Van Keulen *et al.*, (2024), who found that interventions congruent with patient belief systems are more readily accepted and more impactful in sustaining mental well-being.

In summary, the three major themes emotional regulation, resilience strengthening, and internal/external barriers interact in a complex but cohesive manner. Emotional regulation often served as the starting point for resilience building, while the identified barriers highlighted the need for comprehensive, multi-layered support. Effective *GT* implementation thus requires attention not only to individual technique delivery but also to broader contextual factors including cognitive capacity, environmental quality, and cultural alignment. The following conceptual model illustrates the interactions discussed above.

Figure 1. Conceptual Model of Emotional Regulation in the Recovery Process



Limitations

This study has several limitations. First, the small sample size and single-institution setting may limit the transferability and generalizability of the findings to other populations or healthcare contexts. Second, data was collected through self-reported interviews, which may have been influenced by social desirability bias, especially given the hospital environment and the researcher's clinical affiliation. Despite efforts to apply bracketing and maintain reflexivity, some interpretive bias may remain. Future research should include more diverse and larger samples and explore how contextual adaptations of GT can improve long-term recovery across different settings.

Conclusion

This study highlights the perceived benefits of *GT* among patients with schizophrenia and a risk of violent behavior, particularly in regulating emotions, reducing negative effects, and fostering resilience through meaning-making and improved social functioning. However, its effectiveness is shaped by individual insight, emotional readiness, cognitive capacity, and external factors such as ward conditions and institutional support.

Based on these findings, we recommend integrating *GT* with psychoeducation and spiritual support tailored to patients' belief systems. Addressing cognitive impairments and ensuring adequate facility support may further enhance therapeutic outcomes. A patient-centered, culturally responsive approach is essential for maximizing the relevance and impact of mental health interventions in clinical practice.

Funding

This research was not funded.

Availability of Data and Materials

The data used in this study are available to the primary author upon reasonable request.

Consent for Publication

Participants provided written consent for anonymous data to be published as part of the results of this study.

Competing Interests

The author declares that there are no conflicts of interest relevant to the content of this study.

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