



Case Report

TALKING THERAPY TO REDUCE AUDITORY HALLUCINATIONS IN SCHIZOPHRENIA PATIENTS: A CASE STUDY AT SOCIAL REHABILITATION

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Abstract

Schizophrenia is a serious mental disorder characterized by perceptual changes, including auditory hallucinations. Non-pharmacological interventions are needed to help patients manage these symptoms. This case report describes nursing care for two schizophrenia patients with auditory hallucinations using talking therapy. Assessment was conducted on two patients at the Social Rehabilitation Unit through interviews and observations. The nursing diagnosis established was sensory perception disturbance: auditory hallucinations. Planning involved implementing talking therapy interventions based on Indonesian Nursing Intervention Standards. The intervention was conducted once daily for three consecutive days, with each session lasting approximately 30 minutes. Results showed a decrease in hallucination frequency in both patients after three days of intervention. Patient one showed significant improvement in using conversation as a distraction, while patient two showed reduced response to commanding hallucinations. Talking therapy showed improvement in reducing auditory hallucinations by shifting focus from internal stimuli to external reality through social interaction.

Keywords: Auditory Hallucinations, Case Report, Nursing Care, Schizophrenia, Social Rehabilitation, Talking Therapy

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Introduction

Schizophrenia is a serious mental disorder characterized by changes in a person's perception, thoughts, emotions, and actions (Rosada et al., 2025). One of the symptoms that appear in schizophrenia sufferers is hallucination (Wahyuni et al., 2022). Hallucinations are the most common symptoms found in schizophrenia patients, which are perceptual experiences that have no real basis (Atmojo & Fatimah, 2023). This condition is caused by central nervous system dysfunction, especially dopamine imbalance in the mesolimbic pathway (Shao et al, 2021). In the Indonesian Nursing Diagnosis Standards (SDKI), this condition is categorized as sensory perception disturbance: auditory hallucinations. According to WHO (2025), schizophrenia affects about 23 million people or 1 in 345 people worldwide. Data from the 2023 Indonesian Health Survey shows around 4.0% of people have symptoms and are diagnosed with schizophrenia (Kemenkes RI, 2023). In East Java, 90.6% of schizophrenia patients experience hallucinations (Reliani & Rustarafaningsih, 2020). Preliminary studies at Social Rehabilitation UPT Pasuruan (February 2026) showed that an estimated 65% of mental disorder patients experience hallucinations. If not handled properly, patients can experience loss of self-control which can cause them to harm themselves or others (Dewi & Pratiwi, 2021). Handling can be done pharmacologically and non-pharmacologically. Talking therapy intervention referring to Implementation Strategy 2 in the Indonesian Nursing Intervention Standards is part of therapeutic communication that helps patients recognize and manage their hallucination experience verbally (Firdaus et al., 2023). However, most implementation is done in

mental hospitals. Meanwhile, in social rehabilitation settings where patients live long-term, the application of talking therapy is rarely documented systematically. Based on this, the author is interested in knowing the application of talking therapy intervention in social rehabilitation settings.

Presentation of the Case

a. Patient Information

The report contains de-identified patient-specific data. This study involves two patients at Social Rehabilitation City Pasuruan. Patient 1 (Ny. L.) is a 44-year-old woman, married, with junior high school education. She has been in care for 11 years without family contact. Her medication includes Risperidone 2x2 mg, Clozapine 25 mg, and Trihexyphenidyl 2 mg. She was brought to rehabilitation due to aggressive behavior. Patient 2 (Ny. S.) is a 40-year-old woman, unmarried, with junior high school education. She has a history of trauma from a failed marriage plan. Her medication includes Trifluoperazine 2x5 mg and Trihexyphenidyl 2x2 mg.

b. Clinical Findings

Patient 1 heard voices calling her name almost every time she was not active, with varying durations. Her response included difficulty sleeping, restlessness, talking to herself, and staring in one direction. On the second day, she reported voices commanding her to hurt herself. Patient 2 heard whispering voices 1–2 times a day, dominantly at night before sleep. Her response included restlessness when alone, daydreaming, poor eye contact, and whispering to herself.

c. Timeline

Tabel 1

Timeline of three patients

Day	Activity	Patient 1 response	Patient 2 response
1	Assessment & SP 1-4 Education	Cooperative, talkative but sometimes tangential	Cooperative, open to communication
2	Talking Therapy Intervention	Reported commanding hallucinations	Voices changed to commands
3	Evaluation	Symptoms reduced to 3 indicators	Symptoms reduced to 2 indicators

Tabel 2**Pre and Post Intervention Comparison**

Indicators	Patient 1- Pre	Patient 1- Post	Patient 2 - Pre	Patient 2 - Post
Hearing voices	Every time inactive	Only vague voices	1-2 times/day	Only at night
Talking to self	Frequent	Pausing when voices appear	Frequent	Minimal
Restlessness	High	Needs reminders to talk	Moderate	Need reminders to talk
Poor eye Contact	Present	Improved	Present	Improved
Daydreaming	Frequent	Reduced	Frequent	Reduced
Response to commands	Present	Controlled	Present	Controlled
Sleep disturbance	Present	Improved	Present	Improved
Self-awareness	Low	Improved	Low	Improved
Social interaction	Limited	Improved with prompts	Limited	Improved with prompts
Emotional stability	Unstable	More stable	Unstable	More stable

d. Diagnostic Assessment

Sensory perception disturbance: auditory hallucinations was the priority nursing problem. This was validated by major symptoms found in both subjects, including perception of whispering voices, sensory distortion, and irrelevant behavioral manifestations.

e. Therapeutic Intervention

Talking therapy intervention (Implementation Strategy 2 Indonesian Nursing Intervention Standards) was used. Interventions were given with a frequency of one session per day for three days consecutively, with each meeting allocated approximately 30 minutes.

Steps of Talking Therapy Intervention:**Session 1 (Day 1): Assessment and Education**

- 1) Build therapeutic rapport and trust
- 2) Assess the frequency, duration, and content of hallucinations
- 3) Educate patients about hallucinations and coping strategies (SP 1-4)
- 4) Identify triggers and early warning signs
- 5) Establish baseline symptoms

Session 2 (Day 2): Implementation of Talking Therapy

- 1) Engage patients in meaningful conversation about their daily experiences
- 2) Encourage patients to verbalize their hallucination experiences
- 3) Teach patients to distinguish between real and unreal perceptions
- 4) Practice redirecting attention from internal stimuli to external conversation
- 5) Reinforce positive coping behaviors

Session 3 (Day 3): Evaluation and Reinforcement

- 1) Evaluate changes in hallucination frequency and intensity
- 2) Reinforce successful coping strategies
- 3) Encourage patients to initiate conversations when experiencing hallucinations
- 4) Plan for ongoing support from rehabilitation officers
- 5) Document outcomes and provide recommendations

The treatment plan specifies therapeutic interventions including pharmacologic adherence and preventive measures through social interaction.

f. Follow-up and Outcomes

After three days of talking therapy, Patient 1's symptoms decreased from ten to three symptoms (hearing vague voices, pausing when voices appear, needing reminders to talk). Patient 2's symptoms decreased from eight to two symptoms (hearing vague voices at night, needing reminders to talk before sleep). Both patients showed improved ability to use conversation as a distraction.

Discussion

This study involved two respondents diagnosed with auditory hallucinations. Both respondents were in the late adult age phase (40–44 years). Findings align with studies showing that the majority of hallucination participants are in the 25–49 years age category (Jatinandya & Purwito, 2020). Implementation of talking therapy was carried out complying with Standard Operating Procedures. Data confirms that both participants showed a significant shift in clinical manifestations of auditory hallucinations post-implementation.

This finding aligns with studies published by (Wahyuni, 2025) regarding the impact of non-pharmacological interventions. (Alfaniyah & Pratiwi, 2021) also affirmed that non-pharmacological interventions are effective in reducing hallucination signs and symptoms. Talking therapy plays a role in creating comfort, reducing anxiety levels, controlling emotional responses, and optimizing patient interpersonal abilities (Suheni, 2025).

Talking therapy provides significant psychosocial impacts, such as creating a relaxation effect and stabilizing emotional conditions (Musliana et al., 2023). Post-therapy, all respondents showed the ability to identify hallucination details. The difference in response between the two patients (Patient 1: 70-80% vs Patient 2: 60-70%) can be influenced by severity categories and hallucination patterns.

Confounding Factors:

Several confounding factors may have influenced the outcomes of this intervention:

- 1) Antipsychotic Medication: Both patients were receiving antipsychotic medication during the intervention period. Patient 1 received Risperidone 2x2 mg, Clozapine 25 mg, and Trihexyphenidyl 2 mg, while Patient 2 received Trifluoperazine 2x5 mg and Trihexyphenidyl 2x2 mg. These medications

work by blocking dopamine receptors and may have contributed to symptom reduction. However, the patients had been on these medications long-term before the intervention, suggesting that the additional improvement observed was likely due to the talking therapy rather than medication changes alone.

- 2) Duration of Illness: Patient 1 had been in care for 11 years, which may affect treatment responsiveness compared to patients with shorter illness duration.
- 3) Social Support: The lack of family support was a constraint for both patients. However, the structured social environment of the rehabilitation center and support from rehabilitation officers may have enhanced the intervention's effectiveness.
- 4) Individual Differences: Variations in education level, trauma history, and personal coping mechanisms may have influenced individual responses to the intervention.
- 5) Environmental Factors: The rehabilitation setting provides a structured environment that may naturally reduce stress and hallucination triggers compared to community settings.

The constraint faced was the lack of family support, so education and further support were transferred to rehabilitation officers. However, the social system support in rehabilitation became a key success factor.

Patient perspective

Patients expressed a desire to receive instructions on how to avoid hallucinations. Both clients were cooperative and enthusiastic when invited to chat, indicating that mutual trust is an important foundation in the success of talking therapy. Patients felt calmer and more cooperative after the therapy was given.

Informed Consent

The patient should give informed consent. Informed consent is defined as patient consent provided by the researcher who has worked with clinical patients. The ethical standards outlined in the Declaration of Helsinki were upheld.

Conclusion

Talking therapy has been proven to reduce auditory hallucination symptoms in both respondents. The working mechanism of this therapy is shifting the patient's focus from internal stimuli (hallucination voices) to external stimuli (real conversation). Evaluation results showed a significant decrease in hallucination signs and symptoms in both research subjects. It is recommended that rehabilitation officers act as a support system in monitoring and inviting patients to interact when hallucination voices appear. This method should be implemented continuously as part of the social rehabilitation program.

Consent for publication

Written informed consent was obtained from the patients' legal guardians for publication of this case report and any accompanying information. A copy of the written consent is available for review by the Editor-in-Chief of this journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identities, although complete anonymity cannot be guaranteed.

Declarations

The authors confirm that all appropriate patient consent forms have been attained. The patient and her guardians consented for images and other deidentified clinical information to be published. The patient understands that her name and initials will not be published and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed. The patient and her guardians completed and signed an informed consent. The ethical standards outlined in the Declaration of Helsinki were upheld.

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