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Nursing Care for Mrs. S With Sensory Perception Disorder: Auditory Hallucinations Due to Schizophrenia

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Abstract: This case study on patients with auditory hallucinations was taken as this scientific research, because hallucinations are a symptom that is often found in people with mental disorders, especially schizophrenia. The purpose of making this scientific paper is to gain knowledge, skills, insights and real experience in providing comprehensive nursing care. The method used by the author is a descriptive method through case studies with data collection and observation techniques. The subject of the study is schizophrenia with auditory hallucination nursing problems which are carried out starting from the assessment, diagnosis, intervention, implementation, and evaluation stages. Hallucinations are a condition that describes the presence of a wrong sensory perception, which may affect one of the five senses. Nursing care was carried out for 5 days (April 26 - May 1). The author found two problems experienced by the patient, namely sensory perception disorder: auditory hallucinations and self-concept disorder: low self-esteem. However, the focus or main goal of providing this nursing care is to improve the patient's perception, and the patient can relate to reality. The author also carried out nursing actions using the principles of therapeutic communication, motivating the patient to control her hallucinations. The author evaluated the nursing implementation so that we obtained data that the patient was able to control her hallucinations even with the support of the nurse.

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Introduction

Based on Undang-Undang (Law) No. 18 of 2014 concerning mental health, mental health is a condition in which an individual can develop physically, mentally, spiritually, and socially so that the individual is aware of his/her own abilities, can cope with stress, can work productively, and is able to contribute to his/her community. According to Keliat (2014), mental health is a mental condition of well-being that allows individuals to live harmoniously and productively by paying attention to all aspects of human life with the characteristics of being fully aware of their abilities. Able to face life's stress reasonably, able to work productively and meet their life needs, can participate in the living environment, accept what is in themselves and feel comfortable with others.

Mental disorders are syndromes or behavioural patterns that clinically mean suffering and cause abnormalities in one or more functions of human life. Disturbed mental functions such as biological, psychological, social, and spiritual functions. In general, mental disorders experienced by an individual can be seen from their appearance, interactions, thought processes, communication and daily activities (Keliat, 2014).

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A person is mentally healthy if he can control himself by always thinking positively in facing environmental stressors without any pressure, either physical or psychological, so that he is able to work productively and be able to behave adaptively. On the other hand, a person is said to have a mental disorder if they are unable to carry out a role in carrying out satisfying interpersonal relationships or cannot be done because of the limitations of the relationship between the individual and their surroundings (Manwell et al., 2015).

Schizophrenia is a major disorder that affects the thought process and causes disharmony between the thought process, feelings and emotions. The causes of schizophrenia are usually caused by biological, genetic, and psychosocial factors. Patients with schizophrenia will have signs and symptoms, namely hallucinations, low self-esteem, risk of violent behaviour, social isolation (Videbeck & Sheila, 2022). Schizophrenia is a serious mental disorder with clinical manifestations such as delusions (false beliefs), hallucinations, loss of contact with reality (psychosis), abnormal thoughts that can interfere with daily activities (Patimah, 2021). Schizophrenia can interfere with a person's emotions, perceptions, thoughts, movements, and behaviour (Videbeck & Sheila, 2020).

Schizophrenia is a disease that affects thought patterns, emotional levels, attitudes, emotions, and social life so that there is a separation of thoughts, emotions, and behaviour that causes a discrepancy from reality and is also a severe mental disorder that has dominant symptoms of hallucinations. One of the positive signs that someone has schizophrenia is hallucinations. The most common hallucinations are auditory hallucinations. Hallucinations are a mental disorder in which the client experiences changes in sensory perception, feels false sensors in the form of sound, sight, taste, touch, or smell (Abdurakhman & Maulana, 2022). According to Yosep (2016), auditory hallucinations are stimulus disorders in which the client hears voices, especially people's voices. Usually hear the voices of people talking about what they are thinking and ordering them to do something.

According to Ermawati (2014), explains that there are several nursing problems that may arise in clients with auditory hallucinations including sensory perception disorders: auditory hallucinations, low self-esteem, social isolation, and violent behaviour. Auditory hallucinations are characterized by the behaviour of someone who suddenly appears to laugh alone, talk to himself, get angry, to cover his ears because the patient thinks someone is talking to him (Erviana, & Hargiana, 2018).

Auditory hallucinations require good treatment so that a person can control themselves from the impacts that will occur. The impacts that occur in someone with auditory hallucinations such as loss of self-control so that they are more easily panicked, hysterical, weak, excessive fear, bad behaviour such as doing dangerous things or aggressive actions so that they are at risk of injuring themselves and their surroundings (Harkomah, 2019).

The most common nursing diagnoses found in mental hospitals in Indonesia were hallucinations, low self-esteem, violent behaviour, suicide risk, social isolation, self-care deficits, delusions, and thought process disorders (Sutejo, 2017). Based on records from the Ministry of Health of the Republic of Indonesia in (2019), the highest prevalence of mental disorders was in the Provinces of Bali and Yogyakarta with each prevalence showing figures of 11.1% and 10.4% per household suffering from schizophrenia. Data from Kemenkes RI (2019) showed that severe mental disorders such as schizophrenia reach around 400 thousand people or as many as 1.7 per 1000 population.

According to Kemenkes RI (2019), the prevalence of schizophrenia in Indonesia is estimated at around 450,000 people in Indonesia suffer from schizophrenia. In 2018, the prevalence of households with household members with schizophrenia in West Java was measured at 5.0 per thousand households. This number is equivalent to 55,133 people who experience or suffer from schizophrenia in West Java. The highest prevalence of mental disorders is Bogor (23,998 people) and Bandung (15,294) people.

Based on data obtained from the Nur Illahi Clinic in Samarang, the number of patients with mental disorders, especially those who have been diagnosed from January to June 2024, is described in the following table:

Table 1. Data on Mental Health Nursing Problems at Nur Illahi Assani Clinic, Samarang, January-June 2024 Period

No	Nursing Problems	Number of people
1	Hallucinations	12
2	The risk of violent behavior	11
3	Low self esteem	7
4	Social isolation	5
5	Self-care deficit	0
6	Delusion	2
	Total	37

The Garut Regency Health Office reported that in the period May 2023-2024 there were 3,935 people experiencing mental disorders with medical diagnoses, namely bipolar affective disorder as many as 1,988 people, schizophrenia as many as 1,353 people, drug abuse as many as 389 people, and mental retardation as

many as 205 people. The data was obtained on the number of people with mental disorders at the Nur Illahi Assani Samarang Clinic for the period January to June 2024, it was reported that there were several medical diagnoses including bipolar affective disorder as many as 27 people, schizophrenia as many as 8 people and mental retardation as many as 2 people and it was reported that there were several nursing diagnoses, namely sensory perception disorders hallucinations as many as 12 people, risk of violent behaviour as many as 11 people, low self-esteem 7 people, social isolation 5 people, delusions 2 people and no self-care deficit problems.

Documentation study at the Nur Illahi Assani Clinic in Samarang, shows that hallucination cases are the highest cases that occur at the Nur Illahi Assani Clinic in Samarang and the number of schizophrenia patients is 8 people. However, the subject in the provision of psychiatric nursing care is 1 person with an auditory hallucination patient with the initials Mrs. S, the client made the subject because the client has not been able to overcome her hallucinations. So, the purpose of the nursing care that will be carried out is to teach the implementation strategy (IS) (IS 1 - 4) of auditory hallucination problems when Mrs. S experiences hallucinations. Based on the background, the author is interested in taking the title "Nursing Care for Mrs. S With Sensory Perception Disorders: Auditory Hallucinations due to Schizophrenia at the Nur Illahi Assani Clinic in Samarang".

Method

In compiling this scientific paper, the study method used was a descriptive method with a case study technique and applying nursing care through a nursing process approach to Mrs. S which consists of assessment, diagnosis, intervention, implementation, and evaluation. While the data collection techniques used are as follows:

1. Interview

One of the author's data obtained was through interview techniques conducted directly on clients, nurses, and families who know about the client's health history.

2. Observation

Observation is a method of collecting data obtained through observations of the client's condition in the context of nursing care, a data collection method that uses the sense of sight to observe the physical condition of the client's living environment and obtain objective data. Observations are carried out directly in connection with the health problems that befall them.

3. Documentation Study

Collection of data obtained from client data and reports from health workers through documentation records of nursing care that have been carried out and studying books or references that are useful for obtaining theoretical bases related to the case at hand, so that it can be used as a basis for providing nursing care.

4. Literature Study

This data collection technique is carried out to report theoretical bases related to the case at hand, so that it can compare the theory obtained with the facts in the field of practice, obtain gaps, causes and problem solvers.

Result and Discussion

In this discussion, the author will describe the gap that occurs between the theoretical review and the case review in "Nursing Care for Mrs. S with Sensory Perception Disorders: Auditory Hallucinations Due to Schizophrenia at the Nur Illahi Clinic, Samarang". The discussion begins through the stages of the nursing process including assessment, diagnosis, intervention, implementation, and evaluation.

1. Assessment

At the data collection stage, the author did not experience any difficulties because the author had conducted an introduction and explained to the client the author's intention, which was to carry out nursing care on the client using therapeutic communication so that the client was open and understanding and cooperative. At this stage, there was also a process of human interaction and data collection from several sources, namely the client, nurse, and the client's family. The efforts made are:

a. Approaching and building a relationship of mutual trust with the client so that the client is more open, and the client is more confident by using feelings.

b. Conducting an assessment with the client through interviews. In this assessment, the author did not find any gaps because the same thing was found as in the theory: Hallucinations are a symptom of mental disorders in individuals characterized by changes in sensory perception, feeling false sensations in the form of voices (Damayanti & Iskandar, 2014). From the results of the assessment, it was found that the client often heard whispering voices saying, "you didn't pass". However, the author found a gap in the signs and symptoms that appeared in the client, that not all of them included those in the clinical theory of hallucinations according to Azizah et at., (2016) can appear in hallucinatory clients, such as Mrs. S does not

seem to suddenly get angry and attack others for no reason, does not seem to withdraw.
c. Conduct an assessment by reading the status, looking at the treatment book, asking the clinic nurse and the client's family.

From several gaps in the theoretical review, the author can conclude that there are several client behaviours that appear in the case review, this is in accordance with the theory according to Azizah et al (2016) that the signs and symptoms of hallucinations are:
1) Talking to oneself: When examined, the client often seemed to talk to himself as if there was a friend to communicate with.
2) Daydreaming: When in the room, the client tended to be alone and then daydreamed.
3) Pacing: When in the room, the client often paced back and forth and seemed confused.

Based on the data obtained, there was a gap between the theoretical review and the case review, it was found that clients with hallucinations were not always the same as the theoretical review.

2. Nursing Diagnosis

Based on the results of the case review assessment, the focus data obtained often hears whispering voices that said "you failed" the client heard the voice when alone and when daydreaming, the client said the whispering voices come more than 3 times a day, more often appear at night, and when the whispering voices come the client feels afraid and restless and tries to chase them away so that a nursing diagnosis of sensory perception disorder: auditory hallucinations appears. And there was additional data such as the client said he felt ashamed and inferior because the client did not pass the civil servant and felt like a failure because his household could not be maintained so that a nursing diagnosis of self-concept disorder: low self-esteem appeared. Based on the data obtained, the author taken the following nursing problems:
a. Sensory perception disorder: auditory hallucinations.
b. Self-concept disorder: low self-esteem.

In establishing the diagnosis there was a gap in nursing problems, according to Damayanti & Iskandar (2014) there were 3 nursing diagnoses that may appear in hallucination sufferers, namely sensory perception disorders: hallucinations, low self-esteem, and risk of violent behaviour, while in the case review only 2 nursing problems were found, so the author concluded that not all diagnoses appear in hallucination cases including in Mrs. S.

3. Nursing Intervention

Planning in the nursing process was better known as nursing care planning which is the next stage after the assessment and determination of the nursing diagnosis. At the planning stage, the author prepared a nursing action plan according to the nursing problems, namely: sensory perception disorders: auditory hallucinations and self-concept disorders: low self-esteem (Kelliat 2014).

At this stage, there was no gap between the theoretical review and the case review so that the author can carry out the actions as optimally as possible and supported by the availability of good room facilities and guidance and instructions from health workers from the mental clinic given to the author. Theoretically, a meeting strategy method was used according to the nursing diagnosis that appears during the assessment. The efforts made by the author were:
a. Sensory perception disorders: Hallucinations
1) Identify the type, content, frequency, time of occurrence, triggering situations, and responses to hallucinations.
2) Control hallucinations by scolding.
3) Control hallucinations by talking to others.
4) Control hallucinations by doing scheduled activities.
5) Control hallucinations by taking medication regularly.

b. Self-concept disorders: Low self-esteem
1) Identify the patient's abilities and positive aspects.
2) Assess the abilities that can be used.
3) Determine/have activities according to abilities.
4) Train abilities according to the chosen abilities 1.
5) Train abilities according to the chosen abilities 2.
6) Train abilities according to the chosen abilities 3.
7) Train abilities according to the chosen abilities 4.

4. Nursing Implementation

Nursing actions were adjusted to the theory, when carrying out nursing actions, make a contract/promise first with the client, the contents of which explain what will be done and the role expected by the client. Then record all actions that have been carried out with the client's response, but plan to act using general and specific objectives, implemented using strategies based on nursing standards. The implementation of nursing actions on the client has been adjusted to the nursing plan that has been prepared previously. At this implementation stage, the author only addresses 2 nursing problems, namely sensory perception disorders: auditory hallucinations and self-concept disorders: low self-esteem, in the review of the case of planning the implementation of client nursing actions, it is stated that there is a strategy for

implementing nursing actions that are adjusted to the nursing diagnosis that appears that will be carried out, namely as follows:

a. sensory perception disorders: auditory hallucinations

1) IS 1: building a relationship of mutual trust, helping patients recognize their hallucinations (identifying the type, content, time, frequency, situations that cause hallucinations, responses when hallucinations appear), explaining how to control hallucinations by rebuking and being indifferent to hallucinations, teaching how to rebuke hallucinations.

2) IS 2: training to control hallucinations by talking to other people, encouraging clients to include talking to other people in their daily activity schedule.

3) IS 3: evaluating daily activity schedules, training clients to control hallucinations by doing activities (activities that clients usually do), encouraging clients to include routine activities at home in their daily activity schedule.

4) IS 4: evaluating daily activity schedules, providing health education on regular medication use, encouraging clients to include regular medication use in their daily activity schedule.

b. self-concept disorder: low self-esteem

1) IS 1: identify the patient's abilities and positive aspects, assess the abilities that can be used, determine/have activities according to abilities, train abilities according to the selected ability 1, recommend including the selected ability 1 into the client's daily schedule.

2) IS 2: evaluate the selected ability 1, train abilities according to the selected ability 2, recommend including the selected ability 2 in the client's daily schedule.

3) IS 3: evaluate the selected ability 2, train abilities according to the selected ability 3, recommend including the selected ability 3 into the client's daily schedule.

4) IS 4: evaluate the selected ability 3, train abilities according to the selected ability 4, recommend including the selected ability 4 into the client's daily schedule.

5. Nursing Evaluation

The evaluation results for Mrs. S have been implemented and the nurses has provided nursing care with the problem of Sensory Perception Disorder: Auditory Hallucinations for 4 days with IS 1 - IS 4 achieved and Self-Concept Disorder: Low Self-Esteem for 2 days with IS 1- IS 2 achieved, as follows:

a. sensory perception disorders: auditory hallucinations

1) IS 1 achieved: the client is cooperative, the client can recognize his/her hallucinations, the client can practice how to rebuke his/her hallucinations, the client is willing to include hallucination rebuke exercises in the client's daily schedule.

2) IS 2 achieved: the client can practice IS 1 again: hallucination rebuke exercises, the client is able to practice talking to others, the client is willing to include conversation exercises into the client's daily schedule.

3) IS 3 achieved: the client can practice IS 2 again, namely conversation exercises with others, the client is able to carry out scheduled activities that the client usually does every day, the client is able to carry out his/her daily activities every day.

4) IS 4 achieved: the client can mention, and practice IS 3 again, namely the client's scheduled activities every day, the client is able to understand the treatment that has been given, the client is able to include the use of medication into the client's daily schedule.

b. Self-concept disorder: low self-esteem

1) IS 1 achieved: the client can mention the positive abilities that he/she has, the client is able to determine the positive abilities that can still be done in the clinic, the client is able to sequence the selected positive abilities, the client is able to practice ability 1, namely making the bed.

2) IS 2 achieved: the client can repeat the first positive ability that has been trained and chosen by the client before, the client is able to practice positive ability 2, namely washing dishes, the client is willing to practice the abilities that have been chosen in sequence.

3) IS 3 achieved: the client can repeat the second positive ability that has been trained and chosen by the client before, the client is able to practice positive ability 3, namely sweeping, the client is willing to practice the abilities that have been chosen in sequence.

4) IS 4 achieved: the client can repeat the third positive ability that has been trained and chosen by the client before, the client is able to practice positive ability 4, namely sweeping, the client is willing to practice the abilities that have been chosen in sequence.

6. Documentation

This nursing documentation process recorded details about the care and services provided by a nurse to a client, utilizing the health care system. When documenting nursing care, the author experienced several difficulties, but with the support of theory, various reference sources, and guidance from the supervising lecturer, the author succeeded in documenting this psychiatric nursing care starting from the assessment stage, establishing a diagnosis, planning, implementation and evaluation (Damayanti & Iskandar, 2014).

Conclusion

The author can conduct complete physical and mental exams, as well as developing nursing diagnoses. Those stages are used to create nursing care plans for

problems that develop based on problem priorities, as well as to carry out nursing care actions in accordance with established plans. The collected data of Mrs. S at the Nur Illahi Mental Rehabilitation Clinic in Samarang, Garut is analyzed, and nursing care is documented.

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