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Symptoms of Schizophrenia and Integrated Treatment (Medical, Psychosocial, Spiritual) in Inpatients: A Qualitative Study at Yayasan X

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ABSTRACT
Schizophrenia is a severe mental disorder requiring comprehensive and continuous care. This descriptive qualitative study describes schizophrenia symptoms among inpatients and the treatment provided at Yayasan X, a mental health rehabilitation foundation in Ciomas, Serang Regency. Data were collected on 26 May 2026 through direct observation of one patient, a structured interview with one nurse, and documentation, then analyzed through data reduction, display, and conclusion drawing. The nurse reported auditory hallucinations, talking to oneself, poor hygiene, sleep difficulty, irritability, and being hard to direct as prominent symptoms, with grandiose delusions in some patients. In the observed patient, three of seven behavioural indicators appeared: muttering while alone, disorganised speech, and no apparent awareness of illness. Delusions, social withdrawal, flat affect, and aggression were not observed. Treatment comprised routine medication, psychosocial activities (psychotherapy, music therapy, morning exercise, educational games, daily schedules, and therapeutic nurse–patient interaction), and spiritual therapy; family involvement was not examined. The nurse reported less self-talk, more regular sleep, and more stable emotions. Main obstacles were medication refusal and lack of illness awareness. Limited to one patient and one nurse's account, these findings underline the need for an integrated approach to recovery.

Keywords : Schizophrenia, Symptoms, Integrated Treatment, Observation Study, Mental Health Rehabilitation

INTRODUCTION

A person's quality of life is partly determined by mental health, yet this aspect often receives less attention than physical health. Schizophrenia is among the severe mental disorders commonly encountered in mental health services. It is characterised by psychotic symptoms and, in many sufferers, is followed by a decline in the ability to fulfil social and occupational roles (Jauhar et al., 2022). According to World Health Organization (WHO, 2022) estimates, about 24 million people worldwide, or one in 300 people, live with schizophrenia. Solmi et al. (2023), analysing Global Burden of Disease 2019 data, reported that the number of people with schizophrenia worldwide rose from about 14.2 million in 1990 to about 23.6 million in 2019, while age-standardised estimates remained relatively stable. They also judged that the

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prevalence and burden of the disorder are probably still lower than the reality. In a broader scope, GBD 2019 Mental Disorders Collaborators (2022) concluded that mental disorders remain among the ten leading causes of disease burden worldwide, with no evidence of a decline since 1990.

In Indonesia, Riskesdas 2018 showed a figure of 7 per 1,000 households for schizophrenia/psychosis (Kementerian Kesehatan Republik Indonesia, 2018). This burden is not only clinical. In a systematic review of 50 articles, 32 of which came from Indonesia, Hidayat et al. (2020) found that families use pasung, that is, the restraint and confinement of people with mental disorders at home, as a last resort when no other support is available to care for the person. In Bogor Regency, Laila et al. (2018) found that families and communities considered pasung necessary because of the person's aggressive behaviour, while limited funds and dissatisfaction with services were reasons families did not seek treatment, compounded by minimal and mistaken knowledge about schizophrenia in the community. Ilmy et al. (2020) concluded that patients' aggressive behaviour was the most influential internal factor in the decision to use pasung, while stigma towards patients and their families was the most influential external factor.

The impact of schizophrenia extends beyond the sufferer. Alienation from one's surroundings, stigma, and difficulty obtaining work often accompany the diagnosis (Jauhar et al., 2022). Treatment therefore needs to be comprehensive and continuous, combining medical therapy with psychological, social, and spiritual interventions. A frequent obstacle is the sufferer's low awareness of being ill (*insight*), which is associated with poorer treatment adherence (Lysaker et al., 2018). The review by El Abdellati et al. (2020) adds that adherence to antipsychotic medication is also related to positive attitudes of patients and their families towards treatment and to family involvement. On the other hand, many people with psychosis consider themselves religious or spiritual and rely on religion to cope with their illness (Westhead & Georgiades, 2025), so the spiritual dimension deserves consideration in care.

Counsellors and guidance practitioners need to understand severe mental disorders in order to recognise signs of psychological disturbance, give appropriate initial support, and refer to professionals when needed. For prospective Islamic education counsellors, this demand includes the ability to distinguish spiritual support that strengthens the patient from religious beliefs that are themselves part of the symptoms. Uludag and Zhao (2024) emphasise that delusions can have religious themes and that the way professionals handle them affects the outcomes of both psychotherapy and pharmacotherapy. A direct picture of how schizophrenia symptoms appear and how treatment proceeds in a rehabilitation setting can bridge classroom theory and field reality.

The literature on schizophrenia symptoms and therapy is already fairly extensive, but a picture of how those symptoms appear and how integrated treatment is carried out day to day at a mental health rehabilitation foundation in Indonesia still needs to be presented, especially from the perspective of prospective counsellors who will later work with sufferers and their families.

This study aims to describe (1) the symptoms of schizophrenia among inpatients at Yayasan X and (2) the treatment given to patients with schizophrenia at the foundation. The expected

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contribution is a richer understanding of how schizophrenia is treated in practice, and material for reflection for the foundation and for prospective counsellors.

LITERATURE REVIEW

Schizophrenia and its diagnostic criteria

Schizophrenia is a mental disorder with psychotic symptoms that, in many cases, is accompanied by a decline in social and occupational functioning. Its prognosis is not always bleak, as about 40% of sufferers reach a good outcome (Jauhar et al., 2022). DSM-5-TR sets the diagnosis when at least two of five symptoms are present, namely delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, and negative symptoms. At least one of these must be delusions, hallucinations, or disorganised speech, and signs of the disturbance must last at least six months (American Psychiatric Association, 2022).

No single symptom can be used on its own to establish a diagnosis. Waters and Fernyhough (2017) reviewed studies comparing hallucinations across several diagnostic groups and concluded that an approach relying only on the presence or absence of hallucinations is not helpful as a diagnostic tool, and that particular features of hallucinations should not be used as the sole basis for diagnosing schizophrenia. Diagnostic assessment therefore remains the responsibility of mental health professionals, while counsellors' role is to recognise signs and refer.

Symptoms of schizophrenia

Positive symptoms include delusions, hallucinations, and formal thought disorder that appears as speech that is hard to follow, whereas negative symptoms take the form of reduced drive for activity, poverty of speech, and flat affect. Factor analysis supports a division into three groups: reality distortion (delusions and hallucinations), disorganisation, and negative symptoms (Jauhar et al., 2022). Cognitive impairment is now also recognised as part of the clinical picture, and in chronic schizophrenia negative symptoms contribute substantially to poor social and occupational functioning (Jauhar et al., 2022). A delusion itself is a fixed belief that does not change despite evidence to the contrary. In grandiose delusions, the person is convinced that they have extraordinary abilities, position, or fame (American Psychiatric Association, 2022). The background of the disorder is multifactorial: polygenic genetic factors, early neurodevelopmental disturbance, and neurochemical abnormalities, especially of dopamine, all play a role (Jauhar et al., 2022).

Negative symptoms deserve special attention because they are hard to recognise and hard to treat. Correll and Schooler (2020) reported that up to 60% of sufferers may have prominent negative symptoms that require treatment. Primary negative symptoms arise from the pathophysiology of the illness itself, whereas secondary negative symptoms are related to psychiatric or medical comorbidity, medication side effects, or environmental factors. Secondary symptoms can improve when symptoms in other domains are treated, while primary negative symptoms are generally less responsive to available antipsychotics (Correll & Schooler, 2020).

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Sleep disturbance also commonly accompanies schizophrenia. According to Kaskie et al. (2017), most sufferers report sleep abnormalities that tend to precede the onset of the illness and can predict acute relapse of psychotic symptoms. Sleep disturbance accompanying schizophrenia carries its own risks, namely worsening psychotic symptoms and reduced quality of life, while information on effective strategies to manage it remains limited (Kaskie et al., 2017).

Illness awareness and treatment adherence

Low illness awareness (*poor insight*) is commonly found in schizophrenia across cultures and stages of illness. It predicts poorer treatment adherence and therapeutic alliance, more severe symptoms, and more impaired community functioning (Lysaker et al., 2018).

The systematic review by El Abdellati et al. (2020) of 26 studies on factors related to adherence found that adherence to antipsychotic medication is related to the positive attitudes of patients and their families towards medication, family involvement, and illness awareness. Non-adherence itself has adverse effects on patients' clinical outcomes. These findings indicate that adherence is not solely the patient's concern but is also influenced by the surrounding social environment.

Treatment of schizophrenia

Antipsychotic drugs block dopamine D2 receptors and are the only class of drugs with proven efficacy for schizophrenia. They relieve symptoms (especially positive ones, and some negative ones) and improve social functioning. However, their side effects are considerable, and about 20–30% of patients respond only slightly or not at all (Jauhar et al., 2022). Treatment is therefore usually accompanied by psychological and psychosocial interventions. Compared with usual care, family interventions, family psychoeducation, and cognitive behavioural therapy are more effective in preventing relapse within one year (Bighelli et al., 2021).

Other forms of non-medical therapy are also reported to be beneficial, although the available evidence is not entirely uniform. Music therapy as an addition to standard care improves global state, mental state (including negative and general symptoms), social functioning, and quality of life, but the size of the effect differs between studies and depends on the number of sessions and the quality of the therapy (Geretsegger et al., 2017). On exercise, the meta-analysis by Firth et al. (2017) of 10 controlled trials with 385 patients showed that aerobic exercise improves cognitive functioning, with larger effects in programmes supervised by physical activity professionals. On the spiritual dimension, the picture is double-edged. Positive religious coping is associated with better wellbeing, quality of life, hope for therapy, and medication adherence, whereas negative religious coping is associated with more severe positive symptoms and longer illness. Religious explanations of illness are likewise related to more severe symptoms and delayed recovery (Westhead & Georgiades, 2025).

Delusions can also have religious themes. Uludag and Zhao (2024), in a literature review, concluded that the severity of religious delusions can differ according to religious and cultural values, that religious delusions can affect adherence to antipsychotic medication, and that the way professionals handle them influences the outcomes of both psychotherapy and

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pharmacotherapy. Spiritual companions therefore need to be sensitive to the difference between religious practice that strengthens coping and belief content that is part of the symptoms.

Social context: stigma, pasung, and the role of the family in Indonesia

The course of care for people with schizophrenia in Indonesia cannot be separated from its social context. Hidayat et al. (2020) concluded that reducing pasung requires a mix of interventions at the individual, interpersonal, community, and policy levels. Laila et al. (2018) recommended strengthening basic mental health services and health education about schizophrenia, especially in rural areas. Care at facilities such as rehabilitation foundations can thus be understood as part of a broader continuum of services, not the sole determinant of recovery.

Families continue to play an important role after the person leaves a situation of restraint or care. Through interviews with caregivers of people living post-pasung in Jember, Mata et al. (2023) found that the caregiving burden persisted in the post-pasung period, including anxiety and stigma from family and community, although lighter than during the pasung period. Siregar et al. (2024) reported that family psychoeducation greatly helped improve the knowledge and perceptions about the disorder among families of people with schizophrenia who had been subjected to pasung. These findings are consistent with evidence that family interventions and family psychoeducation are more effective than usual care in preventing relapse over one year (Bighelli et al., 2021).

From this review, ideal treatment of schizophrenia combines medical, psychological, social, and spiritual elements, but how these elements are carried out day to day in rehabilitation facilities still needs to be described. This study fills that gap through an examination of a single facility.

METHODS

Research design

The approach used was descriptive qualitative, chosen because the study aims to describe field reality systematically, namely schizophrenia symptoms and their treatment, without testing hypotheses. The research site was Yayasan X, one of the foundations providing mental health services and rehabilitation for people with mental disorders in Ciomas, Serang Regency. Data collection took place on 26 May 2026, starting at 12:30 WIB (Western Indonesia Time), for approximately one hour.

Sampling

The observation subject was one inpatient with the initials GAW. The subject was selected purposively (deliberately), not randomly, because the aim of this study is to describe directly how symptoms appear in an inpatient, so a subject who was undergoing care at the foundation and could be observed directly during the visit was needed. The criteria for selecting the subject were (a) an inpatient at Yayasan X with a diagnosis of schizophrenia according to information from the foundation, (b) present at the site and observable during data collection, and (c) permitted by the nurse and the foundation to be observed and in a

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condition that allowed the observation to be carried out safely. The patient with the initials GAW was chosen because the patient met all three criteria and could be observed directly during the visit, in line with the aim of comparing directly observed symptoms with the nurse's account. Observing this one subject was intended as an example of direct observation compared with the nurse's account, not to represent all patients. According to the researchers' observation, the subject's schizophrenia had improved considerably (the subject appeared calm and showed only a small portion of the symptoms); this assessment comes from the researchers' observation and is not a clinical assessment. Besides the subject, the researchers observed nurse–patient interaction and the physical condition of the foundation. The interview informant was a nurse working at the foundation, whose account reflects the condition of patients at the foundation in general.

Data collection

There were three primary data collection techniques. The first was direct observation of the subject, the care environment, and foundation activities, guided by a prepared observation sheet. The second was a structured interview with the informant based on ten questions divided into two themes, namely schizophrenia symptoms and patient treatment. The third was documentation, in the form of notes on interview results and findings on the observation sheet, as well as photographs of activities. Secondary data were taken from relevant scientific literature to support the analysis and discussion.

Measures

The research instruments consisted of an observation sheet and an interview guide. The observation sheet had two parts, namely schizophrenia symptoms (seven behavioural indicators, namely auditory hallucinations, disorganised speech, delusions, lack of awareness of being ill/anosognosia, social withdrawal, flat or inappropriate emotional expression, and aggressive or agitated behaviour) and patient treatment (six indicators, see Table 2). Each indicator was rated Observed (O) or Not Observed (NO) and accompanied by a remarks column. A rating of Observed on a symptom indicator was interpreted as an indication of observed behaviour, not confirmation of the patient's internal experience. Table 1 contains nine rows: seven are indicators on the observation sheet, while the other two (personal hygiene and sleep disturbance) are symptoms mentioned by the informant and are not observation sheet indicators, so they were not rated Observed or Not Observed. The interview guide contained five questions about symptoms and five questions about treatment.

Data analysis and ethics

Data were analysed using descriptive qualitative analysis in three stages: data reduction, data display in the form of narrative description and tables, and conclusion drawing linked to the theoretical review. To maintain confidentiality, the observation subject was anonymised with initials, the informant was not named, and the institution's name was disguised as Yayasan X.
In terms of research ethics, first, the study was carried out with the permission of Yayasan X, which approved the interview, observation, and documentation activities on its premises. Second, the patient's involvement as an observation subject was carried out with the

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permission of the foundation as the party authorised over the patient's care, and the observation was purely observational, without intervention in the patient. Third, the nurse interviewed stated willingness to be an informant after being given an explanation of the study's aims. Fourth, documentation in the form of photographs of activities was used only with the foundation's consent, and photographs showing patients were not published or were anonymised so that patients could not be recognised. Fifth, this study was a field observation carried out with the foundation's permission and has not gone through formal ethics committee approval; therefore, the presentation of findings is limited to information that does not reveal the identity of the subject or the institution.

RESULTS

The results are presented following the two research questions, namely the description of schizophrenia symptoms and the treatment efforts for patients.

Description of schizophrenia symptoms

The nurse explained that the symptoms most often seen in patients at the foundation were poor personal hygiene (*personal hygiene*), talking to oneself, hallucinations, and sleep disturbance. The dominant hallucinations were auditory. Patients hear voices in their heads, including voices that forbid them from taking care of their personal hygiene, so many of them neglect it. The accumulation of voices also makes it hard for patients to sleep.

The nurse also mentioned that some patients have delusions: some feel they are messengers of God and some believe they are a *wali* (an Islamic saint). In terms of emotion and behaviour, patients tend to be easily angered and hard to direct. Symptoms differ from one patient to another. Some are dominated by hallucinations, some often get angry and cannot control themselves, and some injure themselves.

In direct observation, the subject was seen muttering while sitting without interacting with anyone. This behaviour may be an indication of auditory hallucination, but it is not enough to establish that the subject experienced it, because the subject's experience was not asked about directly; what was observed was behaviour, while hallucination is only a presumed interpretation. The subject's sentences jumped around and were sometimes unrelated to one another. The subject appeared calm and showed no sign of being aware of his or her condition, which may be an indication of low illness awareness (*anosognosia*). This is only a behavioural indication, since concluding that the subject was unaware of being ill would require an insight assessment or additional information that was not carried out in this study. On the other hand, delusions, social withdrawal, flat or inappropriate emotional expression, and aggressive or agitated behaviour were not observed during the observation. Of the seven behavioural indicators on the observation sheet, only three were observed (muttering, disorganised speech, and not appearing aware of being ill), and all three were read as behavioural indications, not confirmation of a diagnosis or of the subject's internal experience, so that, in the researchers' judgement, the subject's schizophrenia had improved considerably. The subject also appeared clean, because the foundation takes care of the subject's cleanliness, and sometimes experienced sleep disturbance; neither is an indicator on the observation sheet. The comparison between the nurse's account and the observation

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results is presented in Table 1, which contains the seven observation sheet indicators and two additional symptoms (personal hygiene and sleep disturbance) that come only from the interview.

Table 1. Description of schizophrenia symptoms based on interview and direct observation

No	Symptom	Interview with informant (patients at the foundation)	Direct observation (one subject)
1	Auditory hallucinations	Reported; voices in the head that, among other things, forbid patients from taking care of personal hygiene	Indication observed; muttering while sitting without interacting with anyone (observed behaviour; hallucination cannot yet be confirmed)
2	Disorganised speech	Not mentioned by informant	Observed; sentences jump around and are sometimes unrelated
3	Delusions	Reported; feeling like a messenger of God and a *wali*	Not observed
4	Poor *personal hygiene*	Reported	Not an indicator; subject appeared clean because cared for and cleaned by the foundation
5	Sleep disturbance	Reported; related to the many voices in the head	Not an indicator; subject sometimes experiences sleep disturbance
6	Irritability, hard to direct, aggression	Reported; some patients cannot control themselves and hurt themselves	Aggressive or agitated behaviour: not observed
7	Lack of illness awareness (*anosognosia*)	Reported as a challenge; patients do not feel they are ill	Indication observed; subject calm and showed no sign of being aware of his or her condition (not yet assessed with an insight assessment)
8	Social withdrawal	Not mentioned by informant	Not observed
9	Flat or inappropriate emotional expression	Not mentioned by informant	Not observed

Treatment efforts for patients with schizophrenia

The nurse stated that the treatment given consists of psychological therapy and spiritual therapy. Rehabilitation activities consist of psychotherapy, music therapy, exercise every

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morning, and educational games. Observation also showed that medication is given routinely, with the nurse distributing it to patients one by one on a regular schedule. Patients are cared for for an average of three to six months, depending on the family's financial ability. Grouped according to the three aspects in the study title, treatment at the foundation covers the medical aspect, in the form of routine medication; the psychosocial aspect, in the form of psychotherapy, music therapy, morning exercise, and educational games, plus therapeutic nurse–patient interaction, a posted daily activity schedule, and a special room for group activities with patients (Table 2); and the spiritual aspect, in the form of spiritual therapy. On the psychosocial aspect, the data show joint activities and nurse–patient interaction, but details of how those social activities were carried out were not recorded. Family involvement was neither asked about nor observed; the only family-related data is that the length of care depends on the family's financial ability.

All six treatment indicators on the observation sheet were observed to be carried out (Table 2). The nurse was seen going around monitoring patients one by one while speaking in a gentle tone. The environment appeared clean and free of dangerous objects, and a special room was available for group activities with patients.

Table 2. Results of observation of patient treatment

No	Treatment indicator	Result	Remarks
1	Routine medication/medical therapy	Observed	The nurse distributes medication to patients one by one on a regular schedule
2	Structured rehabilitation activities or daily activities	Observed	A daily activity schedule is posted on the foundation's wall
3	Nurse/medical staff actively monitor patients' condition	Observed	The nurse goes around monitoring each patient's condition one by one
4	Nurse–patient interaction is therapeutic	Observed	The nurse greets patients and talks to them in a gentle tone
5	Care environment is conducive and safe	Observed	The room is clean, there are no dangerous objects, and the atmosphere is comfortable
6	Social or group activity programme	Observed	There is a special room for group activities with patients

The nurse reported changes for the better after patients underwent treatment, namely less self-talk, more regular sleep, and more stable emotions. The greatest difficulties in caring for patients include uncontrolled emotions, being hard to direct, reluctance to take medication, and not feeling ill.

DISCUSSION

Summary of findings

This study was conducted to describe the symptoms of schizophrenia and its treatment among inpatients at Yayasan X. Regarding the first aim, the nurse described symptoms that varied

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between patients, with auditory hallucinations the most prominent, while observation of one subject showed behavioural indications of muttering and apparently minimal illness awareness. Regarding the second aim, treatment combined medical, psychosocial, and spiritual aspects, and the nurse reported progress alongside obstacles in the form of medication refusal. The main contribution of this study is a field portrait that links the symptoms that appear to the forms of treatment carried out.

Positive symptoms: hallucinations and delusions

Auditory hallucinations belong to the reality distortion group, the core positive symptoms of schizophrenia (Jauhar et al., 2022). The nurse linked hallucinations containing prohibitions against maintaining cleanliness to patients' poor personal hygiene, and the abundance of voices to sleep disturbance. This relationship comes from the nurse's account and was not tested in this study. Even so, it suggests that patients' everyday behaviour can be shaped by the content of their psychotic experience, so that patients' neglect of personal hygiene is not seen merely as laziness. The observed subject did appear clean, but this more likely reflects care and cleaning by the foundation than the absence of any influence of hallucinations on personal hygiene, so it does not contradict the nurse's account. The subject also only occasionally experienced sleep disturbance, in line with a condition that had improved considerably. The subject's muttering and jumping speech can also be consistent with the picture of hallucinations and formal thought disorder in the literature (Jauhar et al., 2022), but muttering is not enough to establish that the subject experiences hallucinations, because the behaviour can have other explanations and the subject's experience was not asked about directly. The behaviour was therefore treated as an indication that deserves attention, not a confirmed symptom. Waters and Fernyhough (2017) likewise caution that particular features of hallucinations should not be used as the sole basis of diagnosis. Observing someone muttering to themselves is therefore a reason to refer to a professional, not to make a diagnosis.

Grandiose delusions, namely feeling like a messenger of God or a *wali*, were reported by the nurse but not observed in the subject. A delusion is a fixed belief that is not changed by contradictory evidence (American Psychiatric Association, 2022), and sometimes only comes to light when the patient is engaged in conversation. There are two possible explanations for the non-observation of delusions, withdrawal, flat affect, and aggression. First, in the researchers' judgement, the subject's schizophrenia had improved considerably, so these symptoms were no longer prominent, in line with the positive progress reported by the nurse. Second, the observation covered only one subject for about one hour. The non-observation is therefore better read as a reflection of the subject's condition and the limits of the observation than as evidence that these symptoms are absent in other patients at the foundation. Information about these symptoms came entirely from the nurse, not from direct observation.

The delusion themes reported by the nurse are both grandiose and religious. Uludag and Zhao (2024) concluded that the severity of religious delusions can differ according to religious and cultural values, and that such delusions can affect adherence to antipsychotic medication. For spiritual companions at the foundation, this means that a patient's statements about his or her

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religious standing need to be understood first as possible symptoms to be handled together with medical staff, not immediately treated as a true or false religious experience.

Negative symptoms and sleep disturbance

The non-observation of withdrawal and flat affect in the subject also needs to be read carefully. According to Correll and Schooler (2020), negative symptoms are divided into primary and secondary. Secondary symptoms can be related to medication side effects and environmental factors, while primary symptoms are generally less responsive to antipsychotics. A structured and safe environment as seen in Table 2 could theoretically reduce the environmental factors that trigger secondary negative symptoms, but this supposition was not tested in this study. Because the subject's condition was observed for only about one hour, the absence of signs of negative symptoms cannot be used as a basis for concluding that the subject is free of them.

The sleep disturbance reported by the nurse and experienced occasionally by the subject is consistent with the literature. Kaskie et al. (2017) state that sleep abnormalities are reported by most people with schizophrenia and can predict acute relapse of psychotic symptoms. In this study, the nurse described more regular sleep as one sign of patient progress. In light of Kaskie et al. (2017), sleep patterns deserve systematic monitoring by the foundation as a marker of patient condition, although this study did not measure it.

Illness awareness and treatment adherence

Low illness awareness (*anosognosia*), which appeared in the subject as a behavioural indication but was not assessed with an insight assessment, was named by the nurse as one of the greatest obstacles among patients at the foundation. Lysaker et al. (2018) showed that *poor insight* predicts poorer treatment adherence, weaker therapeutic alliance, and more severe symptoms. Patients at the foundation who feel they are not ill and therefore refuse medication fit that pattern, and this suggests that giving medication is not sufficient if patients do not understand why they need treatment. El Abdellati et al. (2020) add that adherence is also related to the family's positive attitudes towards treatment and to family involvement, so efforts to improve adherence at the foundation should not stop at approaching the patient.

Integrated treatment and the spiritual dimension

The treatment pattern at the foundation is in line with an integrated approach. The three aspects in the study title are represented as follows: the medical aspect through routine medication; the psychosocial aspect through psychotherapy, music therapy, exercise, educational games, therapeutic nurse–patient interaction, and group activities; and the spiritual aspect through spiritual therapy. The part of the psychosocial aspect that concerns the family is not yet represented because family involvement was not examined. Routine medication matches the position of medication as the main therapy (Jauhar et al., 2022), although the nurse did not mention the type of medication, so this cannot be confirmed. Music therapy has evidential support as an adjunctive therapy that improves mental state and quality of life (Geretsegger et al., 2017), while exercise improves cognitive functioning, especially when supervised by professionals (Firth et al., 2017). Morning exercise at the

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foundation can be seen as consistent with that evidence, but this study did not record who supervises the activity. The progress reported by the nurse, namely less self-talk, more regular sleep, and more stable emotions, may be related to the combination of these therapies. However, that progress rests only on the nurse's report and was not measured systematically, so it cannot yet be taken as evidence of the effectiveness of each component.

Spiritual therapy at the foundation is consistent with findings that religion often serves as a means of coping for people with psychosis, and that positive religious coping is related to better medication adherence (Westhead & Georgiades, 2025). However, some patients have religious-themed delusions (messenger of God and *wali*), while religious explanations of illness are associated with delayed recovery (Westhead & Georgiades, 2025). Spiritual guides therefore need to distinguish support that strengthens coping from religious beliefs that are part of delusions.

Aggression, the role of the family, and social context

The nurse mentioned that some patients are easily angered, hard to direct, and even injure themselves. In the Indonesian literature, patients' aggressive behaviour is seen as the most influential internal factor in families' decisions to use pasung (Ilmy et al., 2020). Laila et al. (2018) also found that families and communities consider pasung necessary for safety because of sufferers' aggressive behaviour. Hidayat et al. (2020) add that families choose pasung as a last resort when no other support is available. The foundation's environment, which appeared clean and free of dangerous objects, and the nurse's gentle interaction (Table 2) are consistent with a non-violent approach, but this study did not ask whether physical restraint has ever been used at the foundation, so this cannot be assessed.

The length of care of three to six months, which depends on the family's economic condition, indicates that socioeconomic factors can influence the continuity of recovery. This is in line with Laila et al.'s (2018) finding that limited funds are a reason families do not seek treatment. Family interventions and family psychoeducation are among the psychosocial interventions that most reduce the risk of relapse (Bighelli et al., 2021), while this study did not explore whether and how families are involved in the foundation's programme. Siregar et al. (2024) reported that family psychoeducation greatly helps improve families' knowledge and perceptions of schizophrenia, and Mata et al. (2023) showed that the caregiving burden is still felt by families after the pasung period. These two points underline that continuity of recovery does not end on the day the patient leaves the foundation. Family involvement is an important note for service development.

These field findings also need to be placed in a larger picture. Solmi et al. (2023) showed that the number of people with schizophrenia worldwide keeps growing and that the burden of the illness is probably still underestimated, while GBD 2019 Mental Disorders Collaborators (2022) found no evidence of a decline in the global burden of mental disorders. In such circumstances, mental health rehabilitation foundations that reach sufferers and their families, such as Yayasan X, occupy a real role in the continuum of services, and a portrait of their practice deserves to be documented.

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Implications and directions for future research

As implications for counsellors, recognising signs such as talking to oneself, incoherent speech, and lack of awareness of one's own condition is important, followed by an empathic response and referral to professionals when needed. Diagnostic assessment is not carried out by counsellors (Waters & Fernyhough, 2017). For the foundation, a more personal approach and active involvement of families deserve consideration to address medication refusal. The main limitation of this study, namely that only one subject was observed and one informant interviewed, affects the internal and external validity of the findings (see Limitation). Future research could involve more subjects and facilities, longer observation, triangulation with medical records and family perspectives, and standardised instruments to assess symptoms and patient progress.

CONCLUSION

According to the nurse, the symptoms of patients with schizophrenia at Yayasan X are varied, with auditory hallucinations related to talking to oneself, neglect of personal hygiene, and sleep disturbance the most prominent; observation of one subject, whose schizophrenia in the researchers' judgement had improved considerably, showed behavioural indications of muttering, incoherent speech, and apparently minimal illness awareness, which cannot yet be confirmed as hallucination or anosognosia. Treatment is integrated because it combines medical (routine medication), psychosocial (psychotherapy, music, exercise, educational games, therapeutic interaction, and group activities), and spiritual (spiritual therapy) aspects, although family involvement was not examined; medication refusal and lack of awareness of illness remain the main obstacles.

The recommendations for the foundation are to develop a more personal approach that involves families in order to improve medication adherence, including monitoring sleep patterns and patient progress systematically. Prospective counsellors are advised to use field experience such as this as preparation for delivering empathic and competent services, while remaining aware of the limits of the counsellor's role and the importance of referral. The government and society are expected to expand access to affordable mental health services, while future researchers are encouraged to use a broader range of subjects and data sources.

LIMITATION

This study has several limitations. First, direct observation was carried out on only one subject, in a single visit lasting about one hour, at a single facility. According to the researchers' observation, the subject had improved considerably, so symptoms such as delusions, withdrawal, flat affect, and aggression were not observed and could not be assessed directly. This picture does not necessarily represent patients whose conditions are more severe, and the findings cannot be generalised to other patients or facilities.

Second, the picture of symptoms and treatment among patients at the foundation comes from only one informant and has not been cross-checked against medical records, the views of families, or the patients themselves. The patient's diagnosis follows information from the foundation and was not clinically verified by the researchers, and the type of medication

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could not be confirmed. Third, patient progress comes from the nurse's report without measurement before and after treatment, so it cannot be used as a basis for concluding the effectiveness of each treatment component. Fourth, the subject's muttering and apparent lack of awareness of being ill were interpreted from behavioural observation without an interview with the subject or an insight assessment, and psychosocial treatment was recorded only in outline, without data on family involvement.

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