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Management of patients who are at risk of violent behaviour: A case study report

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Abstract

Background: Risk of Violent Behavior is a manifestation of uncontrolled anger, which can cause harm to oneself, others, and the environment, both physically, emotionally, and sexually. This problem has to do with a strong range of emotions, in which anger arises in response to situations that offend self-esteem, unmet needs, or expectations that do not correspond to reality.

Purpose: To explain the management of patients at risk of violent behavior.

Method: A case study with stages of study, diagnosis, intervention, implementation, and evaluation for 4 days. The intervention focused on the implementation of Implementation Strategies (SP) 1-4, including deep breathing relaxation techniques and pillow beating, medication adherence, assertive communication, and spiritual approaches.

Results: The results showed an improvement in self-control skills, a decrease in anger intensity, and emotional stability in patients.

Conclusion: SP 1-4 interventions have been shown to be effective in reducing the risk of violent behavior so that the problem of violent behavior risk can be resolved.

Keywords: Nursing Intervention; Risk of Violent Behavior; Self-Control Skills.

INTRODUCTION

Mental disorders are expressions of behavioral deviations due to emotional distortion, resulting in behavioral deviations (Ausrianti & Andayani, 2022). This occurs due to a decline in all mental functions. Mental disorders are a syndrome or pattern of psychologically or clinically significant behavior that occurs in a person and is characterized by distress, such as pain or disabling symptoms, or impairment in one or more important areas of functioning that are associated with or related to a significant increased risk of death, illness, disability, or loss of freedom (Panjaitan & Hidayat, 2024). A common nursing problem encountered in patients with mental disorders is the Risk for Violent Behavior. This problem is related to a strong range of emotions,

where anger arises in response to situations that offend self-esteem, unmet needs, or unrealistic expectations (Nora & Putri, 2022). The Risk for Violent Behavior is a manifestation of uncontrolled anger, which can cause harm to oneself, others, and the environment, whether physically, emotionally, or sexually (Pertiwi, Fitri, & Hasanah, 2023).

Globally, the prevalence of violent behavior is around 24 million cases, and >50% of them go untreated (Gerungan & Egeten, 2021). A review conducted at various hospitals worldwide reported that the prevalence of patients with violent behavior varies across countries. The highest reported rate was in Sweden at 42.90%, followed by the United Kingdom at 41.73%, Australia at 36.85%, Canada at

32.61%, the United States at 31.92%, the Netherlands at 24.99%, Norway at 22.37%, and Italy at 20.28%. The lowest rate was reported in Germany at 16.06%. Meanwhile, in Indonesia, according to 2017 national data, the prevalence of patients with violent behavior was reported at around 0.8% per 10,000 residents, or around 2 million people. Violent behavior can occur due to prolonged frustration and unfulfilled hopes for something or failure, which triggers someone to behave aggressively (Prasetya, Fauzi, & Ramadhani, 2019). Patients with problems at risk of violent behavior will show several signs and symptoms (Sari, Hasanah, & Fitri, 2025). There are two types of signs and symptoms: major and minor. Subjective major signs include threats, swearing, loud voices, and curt speech (Isnani & Putra, 2020). Objective signs include attacking others, destroying the environment, and aggressive or berserk behavior. Minor signs and symptoms, however, lack subjective characteristics, but do include objective signs such as bulging eyes or a sharp gaze, clenched fists, a clenched jaw, a flushed face, and a stiff posture (Sari, Fitri, & Hasanah, 2024).

To reduce the risk of violent behavior in patients, pharmacological treatment is carried out by administering antipsychotic drugs (Islammarida, 2022). Meanwhile, non-pharmacological therapy with Implementation Strategy (IS) 1-4 is aimed at determining the risk of violent behavior on the patient's mental health. Furthermore, SP 1-2 can be used and is very effective in reducing the risk of violent behavior (Waty, Abdullah, Harun, & Mahmud, 2024).

RESEARCH METHOD

A case study of nursing care encompasses assessment, diagnosis, intervention, implementation, and evaluation, focusing on the implementation of the risk for violent behavior Implementation Strategy (IS). The subject of this case study is Mr. I, with a medical diagnosis of risk of violent behavior. This case study approach focuses on one individual intensively, in-depth, and comprehensively to gain a comprehensive understanding of the implementation of nursing care for patients at risk of violent behavior. Implementation activities were carried out over 4

meetings, with the implementation of the Risk of Violent Behavior Implementation Strategy (IS) as the main focus of the intervention. Data from the case management results are then presented in descriptive form to illustrate the process and results of providing nursing care in real terms.

The established nursing diagnosis is Risk of Violent Behavior (D.0146). The goal of nursing care is focused on improving the patient's ability to control anger and prevent violent behavior. Prevention of Violent Behavior (I.14544) is the intervention used in this case. The interventions provided include observation of anger triggers and dangerous objects, a therapeutic approach with calm and empathetic communication, and education in the form of anger management exercises through 4 implementation strategies (IS). These strategies consist of deep breathing relaxation techniques and pillow hitting (IS 1), medication adherence (IS 2), assertive communication or speaking nicely (IS 3), and a spiritual approach (IS 4). In addition, collaboration is carried out with the administration of antipsychotic drugs and mood stabilizers such as Risperidone, Frimania, Clozapine, and Trihexyphenidyl. The implementation carried out on Mr. I was to provide interventions from SP 1-4 for four consecutive days, namely October 22-25, 2025. On the first day after being given deep breathing relaxation exercises and pillow hitting (IS 1), the patient was able to follow the exercises well and felt calmer. The second day, IS 2 intervention was carried out in the form of education on medication adherence. The patient began to understand the importance of taking medication regularly to maintain emotional stability and stated that he would continue after returning home. On the third day, verbal/assertive communication training was carried out (IS 3). The patient appeared enthusiastic, began to lower his voice tone, and tried to speak in a good way when feeling angry. On the fourth day, spiritual training was given (IS 4), and the patient appeared calmer, his gaze relaxed, his voice was not loud, his curt speech decreased and his emotional affect was more stable. Based on the evaluation results, the problem of the risk of violent behavior was considered resolved, with increased self-control and decreased aggressive behavior.

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RESEARCH RESULTS**Table 1. Respondents' Diagnostic Biodata**

Variable	Results
Biodata	
Age	33 Years
Gender	Male
Education	Senior High School
Occupation	Unemployed
Physical Examination	
Awareness	Composmentis Glasgow coma scala (GCS):E ₄ M ₆ V ₅
Blood Pressure	120/80 mmHg
Pulse	82 x/minute
Height	168 cm
Weight	65 Kg
Identify Diagnosis	
Subjective	The patient often became angry when his parents didn't give him money for cigarettes. He also expressed a grudge following physical abuse at age 18 and in 2021, which he believes triggered his aggressive behavior. Furthermore, after receiving education about the importance of medication adherence, the patient expressed his willingness to take his medication regularly after returning home.
Objective	The patient appeared agitated, with a sharp gaze, a loud and sharp tone of voice, and an unstable affect. The patient had a history of mental disorders since 2010 and had been hospitalized seven times due to relapses due to non-compliance with medication. Family history also indicated a mental disorder in his biological father. The patient had exhibited aggressive behavior such as hitting when angry. Physical examination results showed compos mentis consciousness with vital signs within normal limits, namely blood pressure 120/80 mmHg, pulse 82 beats per minute, height 168 cm, and body weight 65 kg. During the IS 1–4 intervention, objective changes were observed in the form of decreased voice intensity, a more relaxed gaze, and increased self-control.

The patient is a 33-year-old man with a high school education and works as a self-employed person. On physical examination, the patient

appeared fully conscious (compos mentis) with a Glasgow Coma Scale (GCS) score of E4M6V5. Vital signs were within normal limits, with a blood

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pressure of 120/80 mmHg and a pulse rate of 82 beats per minute. Anthropometry showed a height of 168 cm and a weight of 65 kg. On diagnostic identification, subjective data indicated that the patient often became angry when his parents did not give him money for cigarettes. He also expressed feelings of resentment due to an experience of physical abuse he experienced at age 18 and again in 2021, which he believed was one of the triggers for his aggressive behavior. Furthermore, after being educated about the importance of medication adherence, the patient expressed his willingness to take his medication regularly after discharge. Objective data showed that the patient appeared agitated with a sharp gaze, a loud and curt tone of voice, and an unstable affect. The patient had a history of mental illness since 2010, and had undergone seven treatment sessions due to relapses caused by non-compliance with medication. Family history indicated that the patient's biological father also had a mental illness. The patient had a history of aggressive behavior, including hitting when angry. A physical examination confirmed stable consciousness and vital signs. During the implementation of IS 1–4 interventions, positive changes were observed in the patient, such as decreased vocalization, a more relaxed gaze, and increased self-control.

DISCUSSION

These results indicate that the implementation of IS 1– IS 4 interventions is effective in improving self-control in schizophrenia patients at risk for violent behavior. It reduces the intensity of anger and aggressive behavior. Deep breathing relaxation therapy significantly reduces anger levels and increases calmness in patients with mental disorders (Gustina, Silalahi, & Af'idah, 2025). Deep breathing relaxation helps patients channel negative emotions and improves self-control over stimuli that trigger anger (Pustikasari, 2024). Medication adherence is an important factor in reducing the risk of relapse and aggression. Non-adherence to antipsychotic therapy (medication adherence) is associated with increased relapse and symptoms of violent behavior in schizophrenia patients (Mien, 2017). High levels of medication adherence can stabilize emotional conditions, improve rational thinking skills, and

reduce aggressive behavior (Yuliana & Pratiwi, 2021; Syarif, Zaenal, & Supardi, 2020). Assertive communication skills also play a crucial role in reducing the risk of violent behavior. Individuals with good assertive communication skills tend to have better self-control over anger and are able to express emotions healthily without hurting themselves or others (Yunalia & Haryuni, 2020).

Assertive communication training can improve patients' ability to manage angry emotions effectively without causing tantrums that endanger others (Ainy, Sundari, & Imaniyati, 2023). A spiritual approach also strengthens patients' adaptive coping mechanisms. Through dhikr (remembrance of God) and listening to murotal (religious recitation), patients demonstrate increased inner calm, motivation to recover, and self-awareness of the importance of behavioral change. Spiritual dhikr therapy effectively reduces violent behavior in schizophrenia patients at risk of violent behavior (A'yuni, Septiantoro, & Apriliyani, 2024). Spiritual therapy through dhikr and listening to murotal of Surah Ar-Rahman in patients at risk of violent behavior has been shown to increase self-control and reduce symptoms of aggression (Yuliana & Pratiwi, 2021). These findings reinforce the importance of integrating spiritual aspects into psychiatric nursing in fostering emotional calm and improving patient coping mechanisms (Yuhbaba, Budiman, & Suswati, 2023). Thus, IS 1–4 interventions were proven to be effective in reducing the risk of violence and increasing patients' self-control abilities regarding anger.

CONCLUSION

The patient is included in the nursing problem influenced by predisposing factors, namely a history of mental disorders, medication history, history of violence, and family history. In Mr. I's case, the risk of violent behavior is focused on ensuring the patient can control violent behavior, understand and identify the behavior, and channel anger in a healthy way. The implementation of nursing care through IS 1-4 in schizophrenia patients at risk of violent behavior effectively increases self-control and reduces aggressive behavior. Nurses are expected to consistently implement these interventions to

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prevent relapse and improve the quality of life of patients with mental disorders.

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