

INFORMASI ARTIKEL

Received: January, 02, 2026

Revised: January, 25, 2026

Available online: January, 26, 2026

at: <https://e-jurnal.iphorr.com/index.php/mhc>

Laughter therapy for the risk of violent behaviour in people with severe mental disorders: A case study report

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Abstract

Background: The risk of violent behaviour is an angry response that can arise and can injure oneself, others, and the environment. Laughter therapy has become one of the complementary approaches believed to reduce emotional tension and help control anger.

Purpose: To analyse laughter therapy in reducing the risk of violent behaviour in people with severe mental disorders.

Method: A qualitative approach method with the Case Study Research (CSR) strategy.

Results: There was a decrease in scores on the observation sheet of signs and symptoms in patients at risk of violent behaviour, with the score before laughter therapy being 8 and decreasing to 2 after laughter therapy was administered.

Conclusion: Laughter therapy is one of the non-pharmacological therapies to reduce anger, especially in patients at risk of violent behaviour.

Keywords: Laughter Therapy; Mental Health; Nursing Care; Risk of Violent Behaviour.

INTRODUCTION

Mental disorders are one of the main health problems in the world, including in Indonesia. Schizophrenia is a severe mental disorder characterized by changes in thoughts, emotions, perceptions, and behaviour. Patients with schizophrenia often show violent behavioural symptoms that can endanger themselves, others, and the environment (Viana & Gati, 2023). The risk of violent behaviour is an angry response that can arise and can injure oneself, others, and the environment. Signs and symptoms of violent behaviour risk can include changes in cognitive, affective, physiological, behavioural, and social functions. The risk of violent behaviour usually arises due to the patient's inability to control anger, the presence of hallucinations, delusions, or

environmental stressors (Pardede, Siregar, & Halawa, 2020). The impact caused by patients experiencing violent behaviour is a loss of self-control, where the patient will be dominated by their anger so that the patient can harm themselves, others, and the environment. If not handled properly, violent behaviour can lead to loss of control, and the risk of violence towards oneself, others, and the environment.

The number of people with schizophrenia reaches more than 20 million worldwide (World Health Organization, 2023). In Indonesia, the prevalence of severe mental disorders such as schizophrenia also continues to increase every year. The number of schizophrenia patients increased significantly between 2017 and 2022. One of the

main symptoms that often appears is the risk of violent behaviour, which requires serious treatment both pharmacologically and non-pharmacologically. A non-pharmacological approach that is increasingly being developed is complementary therapy, one of which is laughter therapy. This therapy has been proven to provide a relaxing effect, improve positive mood, and reduce stress levels. Through laughter therapy, the body will release endorphins, making the body more comfortable and relaxed (Febiona, Fitri, & Hasanah, 2024).

Laughter therapy is easy to understand and remember among the public and has many benefits, such as stimulating mood, improving brain function, protecting the heart, relaxing feelings, reducing stress, and increasing hormones, while stress hormones can suppress the human immune system, which can increase the number of things that can cause arterial disorders and increase blood pressure. Previous research showed that patients with violent behaviour experienced a decrease in anger scores after being given interventions in the form of laughter therapy. After laughter therapy was given to patients, there was a change in violent behaviour scores. Most showed a decrease in violent behaviour scores after several laughter therapy interventions were given to patients. In Mrs. R, initially there were 6 signs (66.7%) of violent behaviour risk, after laughter therapy and deep breathing, it decreased to 3 signs (33.3%). In Mrs. S, initially there were 5 signs (55.6%), then it also

decreased to 3 signs (33.3%) (Febiona et al., 2024).

RESEARCH METHOD

This research using a qualitative approach method with the Case Study Research (CSR) strategy. Before doing nursing care, author ask for informed consent. It is obtained at each meeting with the client. This research has passed the ethical test by the Research Ethics Committee (KEP) of Universitas Muhammadiyah Palembang with No: 000002/KEP IKesT Muhammadiyah Palembang/2025, which was declared ethically appropriate according to the 7 WHO 2011 standards. Nursing care plans for clients are developed based on 4 days of mental nursing intervention. The initial process is building a trusting relationship with the patient. Interventions are given to mental patients with violent behaviour risk using implementation strategy to help control the patient's anger. The implementation strategy begins by identifying the causes of anger, knowing the clinical manifestations of anger, teaching patients how to control anger with physical exercise, hitting pillows and mattresses, and laughter therapy, in addition to providing health education on medication therapy (Muhith, 2025). The goal of nursing interventions in this case is to reduce signs and symptoms of violence, teach emotional control methods, and increase the patient's self-awareness of anger responses. Implementation was carried out for 4 consecutive days. Each session lasted approximately 20 minutes.

RESEARCH RESULTS

Table 1. Patient Case Summary

Variable	Description
Name	Mr. T
Age	42 Years
Medical Diagnosis	Schizophrenia with risk of violent behavior
Reason for Admission	Frequent anger, aggression, arguments, and destruction of property
Current History	Non-compliance with medication for $\pm$ 1 month due to lack of insight

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Present Condition	Restlessness, pacing, insomnia, incoherent speech, poor emotional control
Recent Trigger	Anger episode after being reprimanded for playing with fire
Past History	One previous psychiatric hospitalization; history of substance use
Current Medication	Trihexyphenidyl, clozapine, haloperidol, olanzapine
Physical Condition	Full range of motion, normal limb function
Vital Signs	BP 124/97 mmHg, HR 89 bpm, RR 20/min, T 36.8°C, SpO ₂ 98%

This table summarizes the demographic data, clinical history, psychiatric diagnosis, current condition, treatment, and vital signs of a 42-year-old male patient with schizophrenia who was admitted due to aggressive behavior, medication non-compliance, and impaired emotional control, with a recent anger episode as the triggering factor.

Table 2. Observation of Signs and Symptoms

Signs and symptoms	Before Intervention	After Intervention		
		Day-1	Day-2	Day-3
Subjective				
Threat expression	-	-	-	-
Expressions of harsh words	✓	✓	✓	-
Expressions of hitting/hurting	✓	-	-	-
Objective				
Face flushed and uptight	✓	✓	-	-
Sharp eyes	✓	✓	✓	✓
Clench jaw tightly	✓			
Clench fists	✓	✓	✓	
Speak harshly	✓	✓	✓	
High pitched voice, screaming or shouting	✓	✓	✓	✓

This table presents the changes in subjective and objective signs and symptoms of aggressive behavior before and after the intervention over three days. Check marks indicate the presence of specific behaviors or symptoms. Overall, the table shows a gradual reduction in verbal and physical aggression after the intervention, although some signs such as sharp eye contact and high-pitched or loud voice persisted during the observation period.

DISCUSSION

The patient was brought to the hospital by their family due to frequent outbursts and anger at home.

The client also constantly fought with people at home over trivial matters, always getting angry and often

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destroying things around them. The client stated that for approximately 1 month, they had refused to take medication and refused follow-up appointments/treatment because they felt they were not sick. The day before admission, the client had an outburst after being reprimanded by their sibling for playing with fire in the backyard. The client also has a history of drug use and one previous admission to a mental hospital. The client stated that there was someone who often talked to them, but the client did not know where the voice came from. It appeared when the client was alone and disappeared at night. The voice appeared approximately 2 times a day for about 3 minutes. If the voice appeared and was not followed, the patient felt uneasy. The client stated that the voice told them to throw things. The client's speech was loud, using a high tone, appeared suspicious, and when answering questions, the client responded briefly and clearly. The client appeared restless during the interview, often clenching their hands, had sharp eyesight, made little eye contact with the researcher, and was easily offended. During interaction, the client's responses varied, suddenly daydreaming, talking to themselves, often smiling, and sometimes getting angry without clear reason. The client was easily offended when things did not support them (Alnemari, Ismail, Ubeeri, Alzahrani, Alharthi, Althaqafi, & Alharthi, 2024).

During the interview, the client was uncooperative, their face appeared tense, and sometimes the client used a high tone when speaking. Often, the client looked away when being spoken to, thus not focusing on the interlocutor, which reduced eye contact. The client stated that they often had outbursts and got angry. When angry, the client usually shouted, yelled, and sometimes threw things. The client admitted to having difficulty controlling themselves when upset, often expressing it through outbursts. The client stated that they always fought with people over trivial matters. The client often got into conflicts with roommates and nurses over small things, for example, feeling offended when reprimanded (Andriany, Sari, & Moulisya, 2023).

Based on the results of the managed case study, it was found that the core problem is risk of violent behaviour, it is caused by hallucinations and low self-esteem and results in self-harming behaviour,

harming others, and the environment, so there is no gap found between theory and the data found in the problem tree. Violent behaviour is part of the maladaptive anger response continuum (Stuart, 2016). Rage is destructive and uncontrolled behaviour, strong anger and hostility accompanied by loss of self-control that can harm oneself, others, or the environment. This main nursing diagnosis is supported by supporting data that Mr. T said he often argued and caused fights in his home. The client also said he often destroyed items in his own home using his hands because he felt constantly forced to take medication by his family. The risk of violent behaviour is an emotional response in the form of uncontrolled anger that can lead to actions of harming oneself, others, or the environment (Sutejo, 2018). This behaviour has serious physical, psychological, and social impacts. The stressors faced by a person in committing acts of violence against themselves and others usually use direct and indirect sentences. This violent behaviour can also be interpreted as an act of harming oneself/others, verbally, physically, psychologically, causing physical, psychological, and even fatal harm and trauma (Stuart, 2022). The impact caused by patients experiencing violent behaviour is a loss of self-control, where the patient will be controlled by their anger so that the patient can harm themselves, others, and the environment. If not handled properly, violent behaviour can result in loss of control, risk of violence towards oneself, others, and the environment (Bahari & Lorica, 2019).

Nursing care plans for clients are developed based on 4 days of mental nursing intervention. The initial process is building a trusting relationship with the patient. Interventions are given to mental patients with RPK problems using SP to help control the patient's anger. The implementation strategy begins by identifying the causes of anger, knowing the clinical manifestations of anger, teaching patients how to control anger with physical exercise, hitting pillows and mattresses, and laughter therapy, in addition to providing health education on medication therapy. The goal of nursing interventions in this case is to reduce signs and symptoms of violence, teach emotional control methods, and increase the patient's self-awareness of anger responses (Dziegielewski, 2023).

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Implementation was carried out for 4 consecutive days. Each session lasted approximately 20 minutes. On the first day, the author built a trusting relationship with the patient. The nurse approached with therapeutic communication, provided a sense of security, and built trust with the patient. The patient was invited to communicate to recognize their feelings of anger and was explained and taught how to control anger. The patient was taught how to slowly inhale through the nose, hold for a few seconds, then slowly exhale through the mouth. The exercise was repeated so that the patient became accustomed to calming down when starting to get angry. After doing so, the author provided positive reinforcement, which rationally can provide appreciation for the success of Mr. T. There were observed actions of wanting to hit friends and throw objects during the observation period (Goodenough, Low, Casey, Chenoweth, Fleming, Spitzer, & Brodaty, 2022).

On the second day of implementation, the primary focus of care remained directed at preventing violent behaviour, but interventions began to be enriched with more consistent self-control exercises and the application of laughter therapy as a complementary effort. The nurse repeated deep breathing relaxation techniques and hitting pillows and mattresses to help the patient reduce emotional tension. In this meeting, the patient said that laughter therapy was like exercising and made them feel better. After laughter therapy, the patient appeared very happy, and the author praised the patient's success. Then the author made a time contract for the next meeting, which was to teach the third generalist therapy, which is how to control anger spiritually, such as praying, dhikr, and salat, and to provide laughter therapy again. On the third day, nursing implementation focused on strengthening the patient's ability to control emotions, expanding adaptive coping strategies, and maintaining the success of previous interventions. The nurse continued to train the patient to perform deep breathing relaxation techniques when anger arose. In this session, the patient was invited to participate in structured group laughter therapy, where the patient was more enthusiastic doing laughter therapy. The results of the third day's implementation showed increasingly clear positive changes. The

fourth day's implementation focused on the stage of consolidation and patient independence in emotional control. The nurse continued to provide guidance on the use of deep breathing relaxation techniques and hitting pillows and mattresses, good verbal communication, spiritual activities, medication, and training in good communication to express feelings appropriately. Interventions were directed so that the patient could not only restrain anger when there was a trigger but also anticipate situations that could potentially lead to conflict. In addition, laughter therapy was continued as part of complementary therapy. The results of the fourth day's implementation showed increasingly better development. Subjectively, the patient stated that they felt calmer and were not easily provoked by others' words. They also reported using deep breathing techniques more often independently when they started to feel annoyed, and said they felt happier and relieved after participating in laughter therapy (Kanbur & Baştumur, 2023).

In this case, the researcher conducted an evaluation of each implementation. The evaluation for the diagnosis of risk of violent behaviour showed that a trusting relationship was established between the researcher and the patient, where the patient was willing to get acquainted and share stories with the researcher. The patient was able to explain the cause of their anger, which was due to their mother forcing them to take medication. The patient appeared cooperative and willing to discuss the cause of their anger. The patient was also taught how to express their anger with laughter therapy. The patient said they felt more relaxed after doing the laughter therapy. The patient also said and repeated that if the patient felt uneasy or was not in the mood, the patient also started to change the intonation of their conversation with their friends (Kuru & Kublay, 2017).

In the nursing diagnosis of risk of violent behaviour, the client showed significant changes. The client could control emotions by deep breathing relaxation, hitting pillows and mattresses, applying medication correctly and regularly, and applying religious therapy of prayer. The client said that when praying, the client felt calmer, and the emotions felt subsided. In the process of evaluation, for the problem of risk of violent behaviour, the patient has

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been able to control their violent behaviour with the outcome criteria, namely, the patient has been able to identify the causes of violent behaviour, the patient has been able to identify the signs and symptoms of violent behaviour, the patient can mention ways to control violent behaviour, the patient has been able to mention the name of the medication (Lee & Sohn, 2020).

Laughter therapy is effective in reducing the signs and symptoms of the risk of violent behaviour. Laughter therapy can reduce anger levels in patients with schizophrenia. The mechanism of laughter therapy is closely related to the release of endorphin hormones which can provide a relaxing effect, reduce muscle tension, and improve mood. Laughter therapy is considered safer when used in conjunction with other medical therapies (Nuraeni & Ariani, 2022). In addition to physiological effects, laughter therapy also provides psychosocial benefits for patients. Patients become easier to interact with, more open in communication, and more able to control their emotions. This shows that laughter therapy not only impacts biological aspects but also contributes to the psychological and social improvement of patients. Laughter for 5-10 minutes can trigger the release of endorphins and serotonin, a type of morphine that combines with endogenous melatonin. These three substances are excellent for calming the brain. Their effects can significantly lower high blood pressure. Laughter increases blood circulation and oxygen, causing blood vessels to become elastic, fusion occurs, blood circulation is smoother, and blood pressure returns to normal (Ariana & Heri, 2018).

In this study, interventions were carried out on patients experiencing a risk of violent behaviour. Laughter therapy was conducted three times over three consecutive days. This was proven by the fact that before the laughter therapy intervention, there were 8 signs and symptoms of the risk of violent behaviour in patients. After the laughter therapy intervention on the first day, 6 signs and symptoms of the risk of violent behaviour were found, such as bulging eyes, clenched fists, red and tense face, cursing with harsh words, loud voice, wanting to hit/injure. On the second day, 5 signs and symptoms of the risk of violent behaviour were found, such as clenched fists, red and tense face, and cursing with

harsh words. On the third day, 2 signs and symptoms of the risk of violent behaviour were found. Thus, laughter therapy is effective in reducing the risk of violent behaviour. This change was reinforced by direct observation that patients appeared more cooperative, calm, and able to control their emotions verbally and non-verbally, such as speaking politely, performing deep breathing relaxation, and using the pillow-hitting technique (Low, Goodenough, Fletcher, Xu, Casey, Chenoweth, & Brodaty, 2024).

The implementation results show that after regular laughter therapy, there was a decrease in the score of signs and symptoms of the risk of violent behaviour. Patients appeared calmer, more cooperative, able to express their emotions in a more adaptive way, and began to show positive behaviours such as smiling and interacting with others. This proves that laughter therapy is effective as a non-pharmacological strategy in reducing the risk of violent behaviour. Laughter therapy intervention helps build a therapeutic relationship between nurses and patients. By incorporating laughter therapy into the nursing care plan, nurses can provide a holistic approach that integrates biological, psychological, social, and spiritual aspects. Thus, the application of laughter therapy intervention can provide a relaxing effect, reduce anger levels, and help patients build positive coping mechanisms, making it suitable as a mental health nursing intervention in the management of patients with a risk of violent behaviour. The application of laughter therapy in mental health nursing care can be used as an alternative complementary therapy that is easy to do, low cost, and can be integrated with other medical therapies. However, the limitation of this study is the small number of subjects because it only used a case study approach. Therefore, further research with a quantitative design and a larger sample size is needed to strengthen the results of this study (Ugwu, 2020).

CONCLUSION

Laughter therapy has been shown to be effective in reducing signs and symptoms of violent behaviour in patients at risk of violence. This intervention can increase relaxation, reduce anger levels, and improve patient coping mechanisms. Therefore,

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laughter therapy is a suitable intervention for treating patients at risk of violence.

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