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IMPLEMENTATION OF PSYCHORELIGIOUS DHIKR THERAPY IN SCHIZOPHRENIA PATIENTS WITH AUDITORY HALLUCINATIONS IN THE WORKING AREA OF THE SUKODONO LUMAJANG COMMUNITY HEALTH CENTER.

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ABSTRACT

Introduction: Mental health is important for individuals to lead productive lives. Mental disorders, such as schizophrenia, are serious mental health problems characterized by sensory perception disorders in the form of hallucinations, particularly auditory hallucinations. Psychoreligious dzikir therapy can be used to control auditory hallucinations in patients with schizophrenia. This study aimed to measure the success rate of psychoreligious dzikir therapy in controlling hallucinations in patients with schizophrenia. **Methods:** This study used a case study design involving from a total population of 93 patients with schizophrenia in the Sukodono Lumajang Community Health Center area, one foster family was selected to participate in the study based on the inclusion and exclusion criteria. This study was conducted over 2 weeks with seven visits, and the media used were SAP, leaflets, and SOP for dzikir therapy. The AHRS was used as the measuring instrument in this study**. Results:** Before the intervention, a score of was 20 obtained for the moderate hallucination category. After implementing psychoreligious dzikir therapy three times, the AHRS score decreased to 11 in the mild category, accompanied by SP education for families and participants to improve their ability to independently control hallucinations. **Conclusion:** Psychoreligious dzikir therapy is effective in controlling auditory hallucinations in patients with schizophrenia.

Keyword: Auditory Perception; Complementary Therapies; Hallucinations; Schizophrenia; Spiritual Therapies.

INTRODUCTION

A family is a group of people bound by marriage, birth, and adoption to enhance the physical, mental, emotional, and social development of each member (1). In this context, mental and emotional development is an important aspect, especially when a family member has schizophrenia. Family support has a major influence on achieving maximum recovery during treatment and home care (2).

According to Riskesdas data (2018), the estimated prevalence of schizophrenia in Indonesia is 6.7 per 1,000 households,

meaning that for every 1,000 households, there are 6.7 households with schizophrenia. In East Java, there are 6.4 per 1,000 households with schizophrenia (3). According to data from the Lumajang Health Office (4), 1,998 people suffer from schizophrenia in Lumajang. Based on data from the Sukodono Community Health Center in December 2024, approximately 93 individuals were diagnosed with schizophrenia.

Schizophrenia is a mental disorder characterized by disturbances in thinking, emotions, and behavior caused by chemical imbalances in the brain that disrupt nerve impulses and nervous system function (4). The causes of schizophrenia are usually biological, genetic, and psychosocial in nature. Individuals with schizophrenia typically exhibit characteristics and symptoms such as delusions, disorganized communication, and confusion. However, patients with schizophrenia have primary symptoms that are sensory perception disorders in the form of hallucinations (5). Auditory hallucinations are the most prevalent. Patients often hear voices that are not real (6). If hallucinations are not treated immediately, they can have negative effects, such as suicidal thoughts (7).

According to the PPNI (2018), efforts to control hallucinations in patients with schizophrenia are carried out through primary nursing interventions, namely hallucination management. Hallucination management refers to how individuals can identify and manage increased safety, comfort, and reality orientation. This is in line with the provision of psychoreligious dzikir therapy, which can improve the symptoms of schizophrenia patients (8). Dhikr therapy can be used to control patients experiencing hallucinations because, when practiced diligently and with perfect concentration (especially when hallucinations occur), it can help patients control the voices that appear (9). Meanwhile, other efforts made by families to care for family members with schizophrenia to control hallucinations include five family health tasks. Families can recognize, decide, care for, modify, and utilize health facilities (1). Nurses also play an important role by providing health education or interventions in the form of appropriate implementation strategies (IS) that can be carried out by families (10). Based on research results according to Akbar (11) from the results of applying psychoreligious dzikir therapy to two respondents for three days, there was a decrease in auditory hallucination symptoms using the AHRS measurement scale, with results of 6 and 9 out of 11 symptoms after three days of application. Only three and four symptoms appeared, only 3 and 4. Research results according to Asmara dkk.(9) After receiving psychoreligious therapy in the form of dzikir forthree3 days, the nursing problem ofsensory perceptionn was asfollowsn:auditory hallucinationssin patientss showed that patients were able to control hallucinations by reciting dzikir. Therefore, this study aimed to determine the effect of psychoreligious dzikir therapy on controlling auditory hallucinations in patients with schizophrenia.

METHOD

This case study used qualitative methods. The study was conducted in March 2025, with a total population of 93 patients with schizophrenia in the Sukodono Lumajang Community Health Center. One foster family was selected to participate in the study based on the inclusion and exclusion criteria. The inclusion criteria for this study were patients who showed major symptoms of sensory perception disorders: at least 80% hallucinations with or without minor symptoms; patients living in the Sukodono Community Health Center working area, specifically in Bondoyudo village, and willing to sign an informed consent form; Muslim patients; cooperative patients; patients with the main symptom of auditory hallucinations; and patients receiving drug therapy. The exclusion criteria were patients with violent behavior and those who refused to be respondents. The data obtained will be analyzed using data collection, data reduction, data presentation, and conclusion techniques using family nursing care combined with mental health nursing care.

The researchers obtained permission from LP2M, the Lumajang District Health Office, and head of the Sukodono Lumajang Community Health Center. Coordination was carried out with nurses, followed by observation to identify participants who met the inclusion criteria and did not meet the exclusion criteria. Data analysis was conducted through interviews, observation of the level of hallucinations, and documentation; the results were measured using a questionnaire consisting of 11 questions with categories 0 (no hallucinations), 1-11 (mild hallucinations), 12-22 (moderate hallucinations), 23-33 (severe hallucinations), 34-44 (very severe hallucinations). This study was approved by the Health Research Ethics Committee of Jember University (No. 042/UN25.1.14/KEPK/2025).

RESULT

Based on research conducted in the working area of the Sukodono Community Health Center, Lumajang Regency, from March 12 to 26, 2025, the following are the nursing care results obtained from each visit to Mr. A's family, which focused on the treatment of Mrs. R with a diagnosis of Sensory Perception Disorder: Auditory Hallucinations.

During visits 1 and 2 on March 12, 13, and 2025, an assessment was conducted using the Mutual Trust Relationship Building (BHSP) approach. Mrs. R was found to experience auditory hallucinations in the form of loud noises like those in the market, which caused dizziness, talking to herself, and wandering away from home. Mrs. R had a history of bullying trauma, sexual abuse, and pressure from her mother (Mrs.R). M), who often compared her with her sibling. The family only dealt with the problem by telling Mrs. R to take medication without understanding the root of the problem or effective coping strategies. The initial hallucination score (pretest) was 20, which was classified as moderate.

Visit 3 on March 16, 2025, involved the implementation of psychoreligious dzikir therapy and the monitoring of hallucination levels. The researcher monitored the hallucinations and explained how to control them using the Hallucination Disruption Strategy (SP 1-4), which involves scolding the voices, taking medication regularly, talking, and engaging in activities. Dhikr therapy was introduced for the first time and was performed for 10-25 minutes. Subjective and objective evaluation results showed that Mrs. R felt calmer, although the frequency of hallucinations was still 3-4 times a day with a duration of 2-3 minutes. The problem was declared unresolved and the intervention was continued.

Visit 4 on March 19, 2025, was conducted for Therapy Application and Control Improvement Evaluation. During this visit, Mrs. R was able to remember and began applying SP 1-4 and dzikir therapy to control her hallucinations. The frequency of hallucinations decreased by 2-3 times per day. Mrs. R reported being able to control her desire to become angry or run away by reciting prayers and performing activities. The evaluation showed that the problem had begun to be partially resolved and the intervention was continued.

Visit 5 conducted the SAP with the family. The researcher provided counseling on schizophrenia and hallucinations in the family. The family was trained to create a supportive environment and recognize signs of relapse that required referral to a health facility.

Visit 6 involved a family evaluation, with the results showing that the family had a good understanding of how to care for or support Mrs. R during the treatment process, including being able to explain SP 1-4 again with the help of a leaflet.

Visit 7 on March 26, 2025, involved a final evaluation, and the progress showed significant improvement. Mrs. R was able to remember and apply dzikir therapy and SP 1-4 well. The frequency of hallucinations decreased dramatically to only 1-2 times a day, with a duration of approximately 1 min. The hallucination score (posttest) decreased

to 11 (mild). Mrs. R reported feeling calmer, which was also influenced by her mother's change in attitude who had become more supportive.

DISCUSSION

3.1 Sensory perception disorders characterized by auditory hallucinations

Based on the results of this case study. Based on gender. According to the theory of Lestari et al. (12), there is a relationship between sex and incidence of schizophrenia. Males are 2.805 times more likely to suffer from schizophrenia than females. According to the theory (13), women can experience schizophrenia due to a combination of biological, hormonal, and psychosocial factors. A decrease in the hormone estrogen, which is protective against psychotic symptoms, can increase the risk of schizophrenia, especially during menstruation, childbirth, and menopause. Childhood trauma, especially sexual abuse, significantly increases the risk of schizophrenia in women. According to the authors, the facts and theory are consistent, even though statistically, women have a lower risk than men. In these cases, the hormonal and psychosocial trauma experienced by women can explain the emergence of schizophrenia.

Schizophrenia was diagnosed based on age (18 years). According to (14), adolescents and young adults or those around the age of 15-45 are indeed at high risk of developing schizophrenia because this stage of life is full of stress and social pressure, which are causes of schizophrenia. Middle age, which is characterized by heavy responsibilities and various roles that take up time and energy, is also a cause of schizophrenia. Genetic, traumatic, behavioral, and environmental factors can also cause schizophrenia in adolescents and adults aged 15-45 years.

According to the theory of Jusuf et al. (15), married people usually live happily, but many also experience problems that can cause stress, leading to symptoms of schizophrenia. According to the author, these facts and theories align, although data show that unmarried individuals have a higher risk of developing schizophrenia than married individuals. Marriage often provides social support and happiness, which can protect someone from stress. A real-life example is the case experienced by Mrs. R, in which other factors such as family pressure also played a role.

Environmental factors cause hallucinations. According to the theory proposed by Sitanggang et al. (16), environmental factors can influence the development of schizophrenia, such as divorce stress, family disharmony, job loss, loss of a loved one, or traumatic experiences such as bullying, sexual abuse, and physical or emotional violence. The presence of these factors causes a person to experience depression, which triggers schizophrenia including hallucinations. According to the author, this is in line with the participant's case, where environmental factors, such as stress, family pressure, and traumatic experiences, play a major role in triggering schizophrenia, including hallucinations.

Education is the factor contributing to hallucinations. Mrs. R is a junior high school graduate, which is consistent with research conducted by Darsana and Suariyani (17) that mental disorders with a diagnosis of schizophrenia are more prevalent among those with a low educational background because they tend to pay less attention to their quality of life. According to the author, between fact and theory, educational factors play an important role in the occurrence and progression of schizophrenia, especially in terms of the emergence of hallucination symptoms. Good education not only provides knowledge, but also shapes healthy attitudes and behaviors in maintaining mental balance.

Employment is the factor that causes hallucinations. The role of Mrs. R as a housewife who does not work. This is in line with the theory of Chairil and Intan (18) that

employment is a risk factor associated with schizophrenia, whereby someone who does not work can experience stress, depression, and a weakening of their mental condition, because people who do not have a job feel helpless and pessimistic (lack of confidence) about the future. Another theory proposed by Fadlillah and Husniati (19) states that housewives often experience significant stress due to pressure from their partners, children, and the family environment. Unmanaged stress can develop into depression and, in certain cases, has the potential to trigger mental disorders such as schizophrenia. According to the author, the facts and theories are consistent. Mrs. R, a housewife who does not work, supports the theory that not having a job can cause stress, helplessness, and depression. Additionally, the pressures of being a housewife, such as family pressure, can also be a source of prolonged stress. If not managed, this condition can develop into mental disorders such as schizophrenia, including hallucination symptoms.

From the assessment data, Mrs. R said that she often heard whispering voices, or, in nursing diagnosis terms, sensory perception disorders: hallucinations (20). According to a study by Yin et al. (21), auditory hallucinations are a common symptom that often occur in patients with schizophrenia and are often associated with an increased risk of suicidal thoughts or behavior. According to the author, facts and theory are consistent because people with schizophrenia most commonly experience auditory hallucinations. Mrs. R. was instructed to do something that could harm herself, which would have a negative impact on her condition.

3.1 Implementation of Psychoreligious Dzikir Therapy Nursing

The goal of the intervention was to enable participants to hear less whispering, experience less sensory distortion, exhibit less hallucinatory behavior, withdraw less, and respond better to stimuli. Meanwhile, the goal of family SP is for families to care for their loved ones by providing support and attention to their health problems. The standard to be evaluated is that the family should be able to explain the meaning of schizophrenia with hallucinations, signs and symptoms, causes, impacts, and family management, as well as provide full support to the participant.

Mrs. R received therapy at every mental health clinic checkup and regularly for approximately 7-8 years. She took CPZ, Haldol, and Trahex once a day for one month. The mental health clinic check-ups were held every three months. According to Syarif et al. (22), patients with schizophrenia must comply with the medication prescribed by their doctor. This treatment aims to relieve psychotic symptoms quickly, prevent recurrence, and reduce the risk of more severe symptoms. Regular therapy for one year can reduce the risk of relapse. According to Jusuf et al. (15), the function of medications for mental disorders is to inhibit dopamine activity in the brain. Examples of antipsychotic drugs that inhibit dopamine receptors are CPZ and Haldol. According to the author, there is consistency between facts and theory in the important principle of long-term and regular treatment for patients with schizophrenia. However, its implementation in this field remains suboptimal. Providing sufficient medication for only one month while conducting check-ups every three months creates the potential for treatment gaps. If family support and supportive therapy are not balanced, this can increase the risk of relapse.

The intervention given to the participant according to the SIKI is hallucination management using distraction techniques and psychoreligious dzikir therapy. According to SIKI, Mrs. R was given behavioral monitoring to identify hallucinations, monitor and adjust activity levels and environmental stimuli, monitor the content of hallucinations, maintain a safe environment, encourage self-

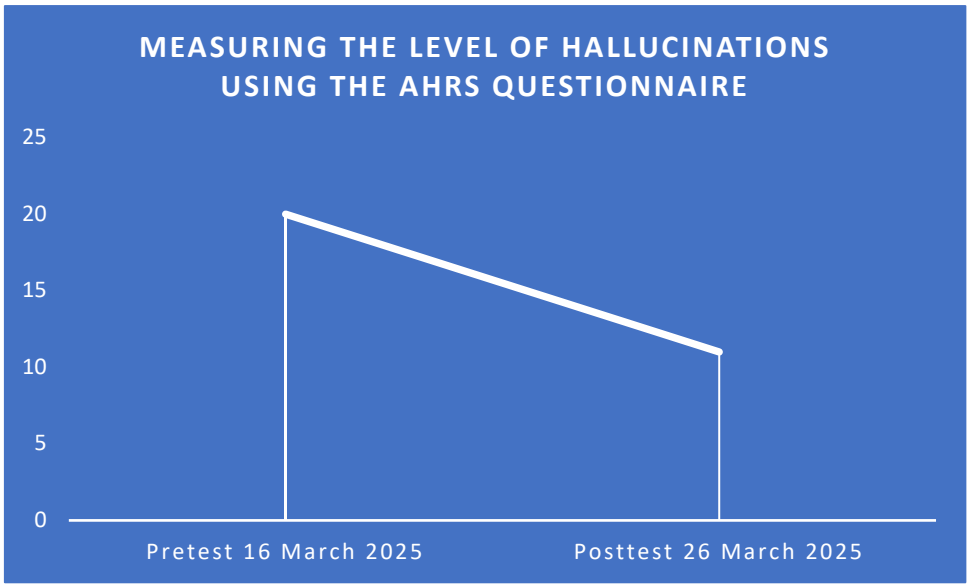
monitoring of situations where hallucinations occur, encourage talking to trusted people to provide support and corrective feedback on hallucinations, recommend distraction by providing psychoreligious dzikir therapy, teach patients and families how to control hallucinations, collaborate on the administration of antipsychotic drugs, and introduce health problems experienced by one of the family members by providing counseling to the family and participants, while also educating the family that the support provided by the family has a major impact on the participant's health problems. while also providing participants with a flipped calendar regarding SOP for psychoreligious dzikir therapy.

Supportive interventions were carried out in accordance with the established nursing diagnosis, namely, the provision of psychoreligious dzikir therapy. According to Arisandy et al. (23), the SOP for administering dzikir therapy involves reciting the basmalah, followed by istigfar 33 times, tasbih 33 times, tahmid 33 times, and takbir 33 times, performed for 20-30 minutes. It is recommended to perform wudu and wear a mukena before therapy and to sit calmly. After therapy, the participants' feelings were evaluated following dzikir therapy.

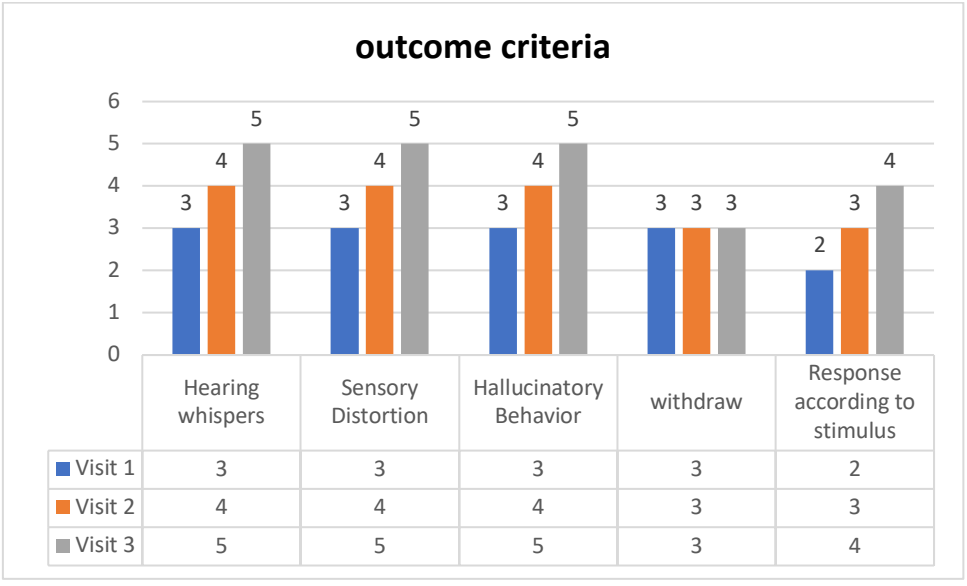
According to Yosep (5), psychoreligious therapy is a form of psychotherapy that combines modern mental health interventions with religious aspects to help patients overcome their problems by enhancing coping mechanisms. This intervention is used as an alternative approach in managing psychotic symptoms, which not only relies on medication but also involves spiritual and religious elements repeated by participants to produce endorphins (6). According to the author, this approach is worthy of being a complement to psychotic treatment, as not all patients feel satisfied with medical therapy and require spiritual support for meaningful recovery. The standard operating procedures (SOP) for psychoreligious therapy are as follows: The Standard Operating Procedure (SOP) for Psychoreligious Therapy through Dhikr in patients with schizophrenia experiencing auditory hallucinations is designed to enhance the patient's ability to control hallucinations and promote inner calm. The procedure began with preparing worship materials according to the patient's gender and ensuring appropriate clothing, followed by establishing a therapeutic relationship through greetings, orientation, explanation of goals, and obtaining the patient's consent. The nurse then facilitates the patient to perform ablution when possible and prepares the necessary items, such as sarung or mukenah, sajadah, and tasbih. The patient was instructed to sit comfortably and engage in a structured dhikr sequence, which included reciting basmallah, istighfar, tasbih, tahmid, and takbir, each repeated three times in a calm and focused manner. Upon completion, the nurse evaluated the patient's comfort, emotional response, and changes in hallucination control, as well as the overall effectiveness of the intervention in promoting relaxation and strengthening the patient's coping ability.

3.3 Changes in Sensory Perception Disorders: Auditory Hallucinations after Psychoreligious Dzikir Therapy

The evaluation results were obtained from three meetings on the implementation of verbalization, showing a decrease in hearing voices, hallucinatory behavior, sensory distortion, moderate withdrawal, and improved response to stimuli. According to the SLKI (24), the outcome criteria for sensory perception are decreased verbalization of hearing voices, decreased sensory distortion, decreased hallucinatory behavior, moderate withdrawal, and an improved response to stimuli. The author conducted an evaluation after implementing this intervention to determine whether pasikoreligious therapy (dzikir) can control sensory perception disorders (auditory hallucinations) experienced by participants.



Based on the above image, the AHRS observation sheet results for Mrs. R. during the three implementation sessions show a change in the level of hallucinations. In the initial session, the pre-test score was 20, indicating a moderate level of hallucination. In the final session, the post-test score decreased to 11, indicating mild hallucinations. This is consistent with the results reported by Akbar et al. (11). The application of psychoreligious dzikir therapy during three sessions resulted in a decrease in auditory hallucinations from a moderate hallucination score to a mild hallucination score using the Auditory Hallucinations Rating Scale (AHRS) questionnaire. The researchers also concluded from the above evaluation that there were changes in the signs and symptoms of the hallucinations. The following is a graph of the outcome criteria results in three sessions of implementation.



	Hearing whispers	Sensory Distortion	Hallucinatory Behavior	withdraw	Response according to stimulus
Visit 1	3	3	3	3	2
Visit 2	4	4	4	3	3
Visit 3	5	5	5	3	4

Based on the results criteria table in accordance with the SLKI book, namely Sensory perception with code L.09083, a score of 1 falls into the declining category, 2 (moderately declining), 3 (moderate), 4 (moderately improving), 5 (improving). This is in line with the theory proposed by Emulyani & Herlambang (25), which states that dzikir therapy has been proven effective in reducing the signs and symptoms of hallucinations. On average, the symptoms of hallucinations after dzikir therapy were significantly lower than

before dzikir therapy. Dhikr therapy is a technique for achieving balance by creating peace and positive emotional responses that can optimize central nervous system activity, causing the brain to automatically respond by producing endorphins that make individuals feel calm and comfortable (5). This is reinforced by research by Gasril et al. (26) that psychoreligious dzikir therapy has an effect on controlling and reducing the level of hallucinations.

CONCLUSION

After seven visits of intervention, the author concluded that psychoreligious dhikr therapy intervention was proven to have a beneficial effect in controlling auditory hallucinations from a score of 20 (moderate) to 11 (mild) using the AHRS questionnaire. The benefits of this therapy will be optimal if it is carried out regularly and gradually. Therefore, nurses can use this non-pharmacological intervention to control auditory hallucinations in patients with mental disorders.

Conflicts of interest

Author declared no conflict of interest.

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