The Effect of Assertive Acceptance Commitment Therapy on the Ability to Control Violent Behavior of Schizophrenic Patients

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Keywords: Assertive Acceptance Commitment Therapy (AACT), Violent behavior, Schizophrenia.

Abstract: Violent behavior is a behavior that uses physical force or power to threaten oneself, others, groups or communities and environments that can result in injury, death, psychological harm and environmental damage. Violent behavior is often recurrent even though the patient has had the ability to control his violent behavior. So, it is required a more optimal handling. One therapy used is Assertive Acceptance Commitment Therapy (AACT) which is integration between Assertive Therapy (AT) and Acceptance Commitment Therapy (ACT). This study aims to analyze the effect of AACT on the violent behavior of schizophrenic patients. The design of this study was *quasi-experimental pretest-posttest with control group*. The population of the study was patients with violent behavior problems in inpatient wards of Menur Mental Hospital Surabaya. Sample size of 32 respondents taken by simple random. The independent variables were AT, ACT and AACT. Dependent variable was violent behavior. Data were collected by filling in the observation sheet. Data processing was by using Manova statistical test. There were differences in violent behavior of patients after given intervention AT, ACT, AACT, and implementation strategy with p value = 0.04 ($p < 0.05$). The AACT intervention group was better than AT (with mean diff = 0.75), ACT (with mean = 1.25) and implementation strategy (with mean diff = 0.000). AACT can reduce the patient's violent behavior by optimizing the personal and interpersonal system by mutually providing support through a commitment to maintain adaptive behavior.

1 BACKGROUND

Violent behavior is one of the nursing problems that arise in patients with schizophrenia. Schizophrenic client disorders such as behavior derangement, perceptive, cognitive disability will cause the client can't take care of himself adequately (Yusuf, 2017). Violent behavior in schizophrenia is caused by the previous experience of a stressful stressor that threatens the ego, the threat is perceived to interfere with the self-concept or self-integrity, while the patient's actualization has not been reached, resulting in the patient experiencing low self-esteem. If this condition is going over time, the patient will be depressed and continue to be schizophrenic. In a maladaptive condition, schizophrenic patients experience violent behavior and hallucinations (Stuart & Laraia, 2012).

Mental disorder is the problem with cognitive and mal-adaptive behavior (Yusuf, 2015b). Violent behavior is often recurrent even though the patient has had the ability to control his violent behavior. Violent Behavior is a condition in which a person performs actions that can be physically harmful to oneself, others and environment verbally and non-verbally (Keliat BA, 2006, Isaacs, 2005).

The impact of violent behavior on self is in the form of attempted suicide or allowing self in the form of self abandonment. The extreme impact of violent behavior is death for patients themselves. Violent behavior in others is aggressive action aimed at injuring or killing others. Violent behavior in the environment is such as environmental destructive behavior (As'ad & Sucipto, 2010). Annually more than 1.6 million people die from violent behavior, especially males aged 15-44, while survivors experience physical, sexual, reproductive and mental health disorders (Hawari, 2012).

There are about 236 millions people in Indonesia with a mild mental disorder of 6% (14,160,000 people) while those with severe mental disorder is 0.17% (401,200 people) (RISKESDAS, 2013). 68% of patients with severe psychiatric disorder (or about 272,816 people) experienced re-hospitalization due to violent behavior (Wiyati, 2010).

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The prevalence of severe mental disorder (schizophrenia) in East Java is 1.4% from 38,318,791 residents or about 536,464 people, while in Surabaya 0.2% of 1,602,875 people or about 3,206 people (RISKESDAS, 2013). The results of the assessment at Menur Mental Hospital on February 1st, 2017, the top five diagnoses during the last month were Violent Behavior (32%), Sensory Perception Disorder: Hallucinations (29%), Self-Care Deficit (24%), Self-Withdraw (10 %) and Low Self-Esteem (5%).

Violent behavior is influenced by two factors: predisposing and precipitation factors. Predisposing factors that cause violent behavior include psychological, socio-cultural and biological factors (Wahyuningsih, 2009). Psychological factors include loss, failure that can lead to frustration, strengthening and support for violent behavior. Socio-cultural factors are related to the norms about which angry expression is acceptable or unacceptable, so it will determine how individuals express their anger. Biological factors are caused by disorders of the limbic system, the frontal lobes, hypothalamus and neurotransmitters. Changes in the limbic system will lead to an increase or decrease in the risk of violent behavior. Frontal lobe damage results in impaired decision making, impairment of judgment, inappropriate behavior and aggression. The hypothalamus produces dopamine, where excessive dopamine will result in anxious and aggressive behavior. Neurotransmitters can facilitate or inhibit aggressive impulses (Stuart & Laraia, 2012).

Precipitation factor that causes violent behavior is divided into two namely internal factors and external factors. Internal factors include physical weakness, despair, helplessness and lack of confidence. While being included in external factors is the commotion, loss of valuable people or objects and social interaction conflicts (Yosep, 2011).

Several therapies that have been used to establish schizophrenia patients in controlling violent behavior include Behavior Therapy (BT), Cognitive Behavior Therapy (CBT), Logo Therapy, Reality Therapy, Family Psycho Education, Rational Emotive Behavior Therapy (REBT), Assertive Training Therapy (AT), Music Therapy and Acceptance Commitment Therapy (ACT) both done personally and interpersonally in groups (Sudiatmika, 2011, Hidayati, 2012, Aini, 2011). Assertive exercise is a therapy in which the patient learns to express feelings of anger appropriately and assertively so that the patient is able to state what he wants (Corey, 2009). Violent behavior patients can also be taught to create acceptance, attention and more openness in developing their capabilities. One of the therapies that can be given to create acceptance and commitment is Acceptance Commitment Therapy (ACT). Handling of violent behavior patients needs support from various parties from both the patient's family and the patient's environment. The family has an important role to participate in the healing process as it is a major supporter in caring for mental patients (Suhita, 2017). A family situation that provides emotional support will help the patient to achieve optimum healing (Yusuf, 2015a). Group support is also needed to help patients behave adaptively in dealing with the problem (Varcarolis, 2010, Stuart & Laraia, 2012).

In this study the authors integrate Assertive Therapy (AT) and Acceptance Commitment Therapy (ACT) into Assertive Acceptance Commitment Therapy (AACT). Assertive therapy is not enough because assertive behavior without any commitment to maintain adaptive behavior, the patient can perform repeated acts of violent behavior. This is because patients are not taught how to accept situations that cause anger and are committed to maintaining their adaptive behavior. Patients given Acceptance and Commitment Therapy (ACT) will have acceptance and commitment to maintain adaptive behavior, but they have no knowledge of how to act assertively to vent their anger. This study aims to analyze the effect of AACT on the violent behavior of schizophrenic patients.

2 METHODS

This study was designed with experimental research (pre-post test control group design), with the aim to prove the effect of AACT on the violent behavior of schizophrenic patients. The population of this study was patients with violent behavior problems at Inpatient Menur Mental Hospital Surabaya. Sample criteria: male patient, age 25 - 55 years old, medical diagnosis schizophrenia, non-destructive aggressive action with score RUFA III with score 21 - 30 and patients have received minimal 1st implementation strategy of generalist therapy (establishing relationship of trust, identification causes of feelings of anger, signs and symptoms perceived, violent behavior, consequences and 1st physical control), no severe physical illness that accompanies, the patient can communicate verbally, can write and read.

The calculation of the minimum sample size based on the calculation results using the test difference between two averages with 5% degree of significance, 95% test strength and two-sided hypothesis test was calculated based on the sample formula from Lemeshow (1997). In anticipation of drop outs, loss follow ups or subjects who are not observant in the quasi-experimental research process, the estimated sample size was enlarged with an estimated proportion of estimated drop out of 10% (f = 0.1). The number of final sample required in this study were 32 respondents divided into four groups (groups of AT, ACT, AACT and implementation strategy), each group consisted of 8 respondents.

Independent variables in this research were AT, ACT and AACT. Dependent variable in this research was violent behavior. The research instruments used in the independent variables of AT and ACT used the evaluation guidance of the implementation of AT and ACT adopted from the FIK UI Mental Health Module (2016). Assertive Acceptance Commitment Therapy (AACT) research instrument used implementation evaluation guidance modified by the researcher by considering the data requirement in this research. Research instrument of violent behavior, conducted by observation using the scale of measurement of violent behavior from Keliat (2003) which was adoption from Morison (1994) with validity test of pearson product moment with value r = 0.75 (greater than 0.30) which means valid used. Reliability was tested using Alfa Cronbach technique with the results 0.90 (Keliat, 2003).

The stages of collecting and retrieving the data by the researcher were coordinated with Menur Mental Hospital to make the form of observer team, then socialized the research implementation. The nurse is supposed to have the ability to direct the patient to follow the treatment program as planned with other health teams (Yusuf, 2016) and research instrument, Selected the respondents who meet the inclusion criteria. Divided the respondent to in three treatment groups and one control group. Each group consisted of 8 respondents, Selected respondents got pre tested with 3 days hardness (3 x 24 hours or 3 shift), Three treatment groups were given AT intervention, ACT and (AACT) AACT. While the control group given intervention of implementation strategy according to hospital standard, Intervention was given in the inpatient room where the respondent was treated, every day in a row at 09.00-12.00 hours (each intervention for 45 minutes - 1 hour), Researchers recapped the results of the evaluation of the ability of the respondents on the evaluation documentation sheet. Conducted a post test to see the ability of respondents in controlling violent behavior, by observation using the scale of measuring violent behavior for 3 days (3 x 24 hours or 3 shifts).

3 RESULTS

Before the intervention, it was obtained that p = 0,045 (p <0,05). It can be concluded that there are differences before intervention is done to patients who are given the intervention of AT, ACT, AACT and implementation strategy. After intervention, it was obtained that p = 0,013 (p <0,05). It can be concluded that there is a difference after the patient is given the intervention of AT, ACT, AACT and implementation strategy.

Statistical test of Multivariate Tests table got the value p = 0.04 (p <0.05) means there are differences of violent behavior of patient after given intervention AT, ACT, AACT and implementation strategy (Table 1).

From the Multiple Comparisons table shows the difference of AACT and ACT group obtained mean value difference = 0.75. This shows that AACT intervention is better than ACT. Differences of groups AACT and AT obtained mean value difference = 1.25. This shows that AACT intervention is better than AT. Differences group AACT and SP obtained value mean difference = 0.00. This shows that AACT intervention is better than implementation strategy (Tabel 2).

4 DISCUSSION

The results showed that there were differences in violent behavior of patients after the intervention given AT, ACT, AACT and implementation strategy with p value = 0.04 (p <0.05). The AACT intervention group was better than AT (with mean diff = 0.75), ACT (with mean = 1.25) and implementation strategy (with mean diff = 0.000).

AACT is a combination of AT and ACT. AACT is provided to patients of violent behavior jointly with their group to learn to communicate needs, reject requests and express positive and negative

Table 1: Multivariate Tests.

E		Value	F	Hypo-thesis df	Error df	Sig.
Intercept	Pillai's Trace	1.00	6,603.39	2.00	27.00	0.00
	Wilks' Lambda	0.00	6,603.39	2.00	27.00	0.00
	Hotelling's Trace	489.14	6,603.39	2.00	27.00	0.00
	Roy's Largest Root	489.14	6,603.39	2.00	27.00	0.00
Method	Pillai's Trace	0.41	2.43	6.00	56.00	0.04
	Wilks' Lambda	0.59	2.73	6.00	54.00	0.02
	Hotelling's Trace	0.69	3.00	6.00	52.00	0.01
	Roy's Largest Root	0.69	6.40	3.00	28.00	0.00

Table 2: Multiple Comparisons.

Scheffe						
Dependent variable	(I) Method	(J) Method	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval
						Lower Bound
After	ACT	AT	0.50	1.38	0.009	- 3.60
		AACT	- 0.75	1.38	0.009	- 4.85
		Implementation Strategy	- 0.75	1.38	0.009	- 4.85
	AT	ACT	- 0.50	1.38	0.009	- 4.60
		AACT	- 1.25	1.38	0.008	- 5.35
		Implementation Strategy	- 1.25	1.38	0.008	- 5.35
	AACT	ACT	0.75	1.38	0.009	- 3.35
		AT	1.25	1.38	0.008	- 2.85
		Implementation Strategy	0.000	1.38	0,001	- 4.10
	Implementation Strategy	ACT	0.75	1.38	0.009	- 3.35
		AT	1.25	1.38	0.008	- 2.85
		AACT	0.000	1.38	0,001	- 4.10

feelings openly, honestly, directly in accordance with understanding, creating acceptance, attention and more openness in developing their capabilities. Group support is also needed to help patients behave adaptively in dealing with the problem. Support from family is able to prevent relapses (Tristiana RD., 2017).

In this study, the authors integrated AT and ACT. AT is not enough because by assertive behavior without any commitment to maintain adaptive behavior, the patient can perform repeated acts of violent behavior. This is because patients are not taught how to accept situations that cause anger and are committed to maintaining their adaptive behavior. Patients given ACT will have acceptance and commitment to maintain adaptive behavior, but they have no knowledge of how to act assertively to vent their anger. Assertive Acceptance Commitment Therapy (AACT) conducted on a group of violent behavior patients and provided skills to the patient to assertive behavior then they would accept the problems they experienced with adaptive behavior and finally have a commitment to maintain adaptive behavior. Commitments gained in the group would be individual commitments. The study about assertive community stated that implementation of assertive community treatment in overcoming the self-image, that is with the client's self-management (Fitriasari, 2017).

Assertive Acceptance Commitment Therapy (AACT) was implemented in seven sessions, one session identified the events, thoughts, feelings, needs and desires, behavior impact and consequences, session two identified value based on experience, a four-session trained to express anger by saying "no" to irrational requests and conveying the reason, a five-session trained patient to received events using selected values, a six-session trained patient committed to preventing recurrence and session seven maintained assertive behavior in various situations. Assertive Acceptance Commitment Therapy (AACT) interventions in schizophrenic patients who experience violent behavior taught patients to have the ability to control their violent behavior personally and committed to maintaining adaptive behavior with support within

groups built between group members, so that patients could optimize their positive abilities.

5 CONCLUSIONS

Schizophrenic patients with violent behavior in the three treatment groups are able to control their violent behavior.

A given AT is able to control the patient's violent behavior by exercising expressing verbal and nonverbal attitudes, feelings, opinions and rights, enhancing interpersonal skills for assertive behavior, understanding that aggressive behavior should be controlled and expressing anger appropriately. ACT teaches acceptance of unwanted thoughts and feelings that cannot be controlled, lead a more meaningful life without having to eliminate unpleasant thoughts that occur and practice commitment based on positive values chosen by the patient himself. AACT provides the patient with the skills to assertive behavior, then he/she will accept the problem with adaptive behavior and finally have a commitment to maintain its adaptive behavior. Assertive Acceptance Commitment Therapy AACT is more effective for controlling the violent behavior of schizophrenic patients.

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