

CHAPTER II

LITERATURE REVIEW

2.1 Fundamental Concepts of Chronic Low Self-Esteem

2.1.1 Definition and Classification of Low Self-Esteem

Self-esteem is a fundamental element of the self-concept, representing an individual's subjective evaluation of their overall worth, value, and existence. According to the Indonesian Nursing Diagnosis Standards (*Standar Diagnosis Keperawatan Indonesia* [SDKI]), chronic low self-esteem is defined as a prolonged and continuous negative evaluation or feeling toward oneself or one's capabilities, characterized by feelings of insignificance, worthlessness, and helplessness. This condition reflects deeply internalized cognitive and emotional deficits, wherein individuals perceive themselves pessimistically and persistently doubt their personal capacity to meet the demands of life (Zhu et al., 2025).

Clinically, self-concept disturbances manifested as low self-esteem are classified into two primary categories:

Table 2. 1 Classification Low Self-Esteem

Classification of Low Self-Esteem	Clinical Characteristics	Cognitive Mechanisms	Behavioral Impact
Situational Low Self-Esteem	Occurs abruptly as a direct response to a specific traumatic event or loss (e.g., surgical procedures, accidents, divorce, or unemployment).	The core self-concept structure remains relatively adaptive but undergoes transient functional decline due to acute stressors	Manifests as temporary expressions of helplessness; the individual retains the latent potential to return to their

Classification of Low Self-Esteem	Clinical Characteristics	Cognitive Mechanisms	Behavioral Impact
		that exceed coping capacity.	baseline functional level once the crisis is resolved.
Chronic Low Self-Esteem	Long-standing negative self-evaluations that are established well before the onset of physical illness or psychiatric institutionalization.	Permanent internalization of negative cognitive schemata; the patient rejects positive feedback from the environment and exaggerates personal failures.	Consistent social withdrawal; the patient exhibits extreme passivity, reluctance to engage in novel activities, and a slumped, lethargic posture.

Source: PPNI. (2017). *Standar Diagnosis Keperawatan Indonesia: Definisi dan Indikator Diagnostik* (1st ed.). DPP PPNI.

2.1.2 Etiology and Influencing Factors

The development of chronic low self-esteem results from a dynamic interaction between historical internal factors that shape the personality structure (predisposing factors) and current precipitating events that strain the individual's psychological resilience (precipitating factors) (Wijayati et al., 2020).

1. Etiology Based on the Indonesian Nursing Diagnosis Standards (SDKI)

According to the SDKI (2017) guidelines, several primary etiologies underlie the manifestation of chronic low self-esteem as a nursing diagnosis, including:

- 1) Repeated exposure to traumatic situations that compromise psychological integrity.
- 2) Recurrent failures in achieving life goals or social roles.
- 3) Deficits in genuine valuation or appreciation from significant others.
- 4) Ineffective coping mechanisms regarding processing loss (*coping with loss*).
- 5) Concomitant psychiatric disorders (such as schizophrenia or chronic affective disorders).
- 6) Continuous reinforcement of negative feedback (destructive criticism, ridicule, or adverse appraisals).
- 7) Incongruence between cultural values/demands and the actual capacity of the individual.

In the context of psychiatric-mental health nursing, schizophrenia is one of the primary psychiatric disorders or medical conditions that most frequently underlies chronic low self-esteem. Patients with schizophrenia experience distortions in thought processes, perceptual disturbances, and significant declines in social functioning. Cognitive impairments and negative symptoms of schizophrenia (such as avolition and social withdrawal) impede the patient's ability to fulfill social roles, thereby triggering negative self-appraisals that culminate in chronic low self-esteem.

2. Predisposing Factors

Predisposing factors represent historical risk factors that establish an individual's cognitive vulnerability regarding self-perception. These factors include:

- 1) **Parenting Styles and Childhood History:** Parental rejection, inadequate praise for achievements, and overprotective or authoritarian parenting styles. Rigid parenting forces children to behave solely to fulfill parental expectations without autonomy of expression, thereby inhibiting the development of self-confidence and independence.
- 2) **Developmental Tasks of Adolescence and Early Adulthood:** Frequent blameworthy experiences in childhood cause individuals to mature with pervasive feelings of worthlessness. During adolescence, their presence may be undervalued by peer groups, offering minimal opportunities for personal growth. By early adulthood, the accumulation of academic, occupational, or social failures triggers severe ego decompensation (Wijayati et al., 2020).
- 3) **Self-Confidence and Role Factors:** These include the formulation of unrealistic ideal selves, high dependency on external validation, lack of ownership over personal responsibilities, and rigid cultural or gender role demands.

3. Precipitating Factors

Precipitating factors act as immediate proximal stimuli that trigger the clinical manifestation of diminished self-esteem. These stressors are categorized into:

- 1) **Psychological Trauma:** Experiencing or witnessing life-threatening events, or being a victim of sexual or psychological abuse.
- 2) **Role Strain:** Profound dissatisfaction or frustration with the social role functions expected by society.
- 3) **Shift in Normative Expectations:** Alterations in social demands that occur concurrently with age transitions and maturation.
- 4) **Situational Role Transitions:** Abrupt changes in family composition or structure triggered by the death of a family member or divorce.
- 5) **Health-Illness Role Shifts:** Changes in health status due to chronic physical illness or surgical interventions that permanently alter the size, shape, appearance, or function of an organ, thereby disrupting the patient's body image (Wijayati et al., 2020).

2.1.3 Clinical Signs and Symptoms

According to the Indonesian National Nurses Association (*Persatuan Perawat Nasional Indonesia* [PPNI], 2017), establishing a nursing diagnosis of chronic low self-esteem requires high clinical precision. The clinician must confirm that at least 80% of the major signs and symptoms are present during the assessment.

Table 2. 2 Clinical Signs and Symptoms Low Self Esteem

Data Category	Major Signs and Symptoms	Minor Signs and Symptoms
Subjective Data (SD)	1. Negative self-appraisal (feeling useless, helpless, or worthless).	1. Difficulty concentrating during communication.

Data Category	Major Signs and Symptoms	Minor Signs and Symptoms
	3. Expressing excessive shame or guilt. 4. Feeling incapable of taking action. 5. Underestimating personal ability to cope with loss. 6. Perceiving a total lack of personal strengths or positive abilities. 7. Exaggerating negative self-evaluations. 8. Rejects positive validation from others.	2. Complaining of insomnia secondary to anxiety. 3. Verbally expressing feelings of hopelessness.
Objective Data (OD)	1. Reluctance to try new things or avoiding life challenges. 2. Walking with a downward gaze. 3. Slumped, flaccid, or lethargic body posture.	1. Severely diminished eye contact or avoiding the nurse's gaze during communication. 2. Appearing lethargic, apathetic, and unmotivated during activities. Speaking in a highly diminished volume, whispering, slowly, or passively. 3. Exhibiting non-assertive and submissive behaviors. 4. Seeking excessive reassurance or praise to alleviate anxiety. 5. Marked dependency on the opinions or decisions of others. 6. Demonstrating profound difficulty in independent decision-making.

Source: Adapted from PPNI (2017); Stuart & Laraia (2005)

2.1.4 Response Continuum

The self-concept is not static; rather, it moves dynamically along a continuum known as the self-concept response range. This continuum illustrates fluctuations in ego-adaptive capacity, spanning from the most adaptive state (psychosocially healthy) to the most maladaptive state (severe psychiatric impairment).

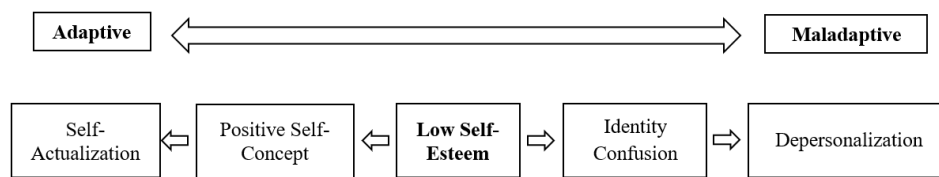


Figure 2. 1 Response Continuum of Low Self-Esteem

The stages within the self-concept response continuum are delineated as follows:

1. **Self-Actualization (Most Adaptive):** The highest level of functioning, where the individual realistically recognizes, develops, and expresses their full potential, talents, and capabilities based on successful experiences that are positively received by their social environment.
2. **Positive Self-Concept:** Positioned within the adaptive spectrum, characterized by healthy psychosocial experiences, a proportional acceptance of personal strengths and weaknesses, and optimism in fulfilling social roles.
3. **Low Self-Esteem:** Serves as a transitional phase or boundary shifting from adaptive to maladaptive responses. Negative self-appraisals begin to dominate cognition due to an inability to adapt to stressors, although ego boundaries regarding objective reality are still maintained.

4. **Identity Diffusion (Confused Identity):** A maladaptive response characterized by the individual's failure to integrate various aspects of childhood self-identity into psychosocially mature personality structures during adulthood.
5. **Depersonalization (Most Maladaptive):** The most extreme manifestation of self-concept disturbance, wherein the individual experiences perceptual distortions, feeling estranged, unrealistic, and detached from their own body or mind. This condition is closely linked with panic-level anxiety and a loss of ego boundaries (the inability to differentiate self from others) in psychotic disorders.

2.1.5 Impact of Chronic Low Self-Esteem

In patients with schizophrenia, chronic low self-esteem acts as a negative symptom component that exacerbates the disease trajectory and leads to several significant clinical impacts (Setiani, 2023).

1. Progressive Decline in Psychosocial Functioning

The patient's motivation to engage in activities of daily living (ADLs) decreases drastically. Pervasive feelings of worthlessness cause the patient to neglect personal hygiene (self-care deficit), lose interest in hobbies, and experience functional regression, which increases dependency on caregivers.

2. Perpetuation of the Pathological Cycle of Social Isolation

Profound shame and fear of interpersonal rejection—driven by the stigma of schizophrenia—compel the patient to utilize defensive coping mechanisms such as withdrawal. Patients restrict verbal

communication, avoid social interactions, and adopt a passive stance, which ultimately severs access to the social support networks essential for psychiatric rehabilitation.

3. Elevated Risk of Relapse and Destructive Behaviors

Prolonged psychosocial distress resulting from social isolation and feelings of inferiority exacerbates anxiety and can disrupt neurotransmitter equilibrium in patients with schizophrenia. This exacerbation precipitates the recrudescence of positive symptoms, such as auditory hallucinations or delusions. If left unmanaged, this chronic stress leads to clinical relapse, increased rates of rehospitalization, and a strong propensity for self-harm and suicidal behavior (Ambar Widyowati et al., 2025).

2.1.6 Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES), developed by Morris Rosenberg in 1965, is a gold-standard psychometric instrument widely utilized to evaluate global self-esteem across both clinical and non-clinical populations. The RSES assesses an individual's holistic attitude toward themselves through two primary pillars: self-acceptance and self-respect (Maulida, 2023).

1. RSES Item Structure

The original RSES instrument comprises a 10-item questionnaire (Faizah et al., 2020). In its standard format, the items are divided equally into 5 positive (favorable) statements coded as items 1, 2, 4, 6, and 7, and 5 negative (unfavorable) statements coded as items 3, 5, 8, 9, and

10. However, in certain revised adaptation studies (Rosenberg Self-Esteem Scale-Revised [RSES-R]), researchers have utilized a structure of 6 favorable items and 4 unfavorable items to achieve a more robust factor structure model fit within the Indonesian population.

Table 2. 3 Sample Statement of RSES

Statement Type	Item Numbers	Sample Statement (Indonesian Adapted Version)
Favorable (Positive)	1, 2, 4, 6, 7	"I feel that I'm a person of worth, at least on an equal plane with others." "I feel that I have a number of good qualities."
Unfavorable (Negative)	3, 5, 8, 9, 10	"All in all, I am inclined to feel that I am a failure." "I feel I do not have much to be proud of."

Source: Rosenberg, M. (1965). adapted version by Supratiknya, A. (2014).

2. Scoring Methodology and Calculation

According to psychometric evaluations conducted by Faizah et al. (2020), the RSES utilizes a 4-point Likert scale response format:

- a. Strongly Agree (SA)
- b. Agree (A)
- c. Disagree (D)
- d. Strongly Disagree (SD)

Scoring is calculated by converting response choices into numerical values, incorporating reverse scoring for unfavorable items:

Favorable Item Scores	—————▶	SA=4	A=3	D=2	SD=1
Unfavorable Item Scores (recoded)	—————▶	SA=1	A=2	D=3	SD=4

The global total score is obtained by summing the scores across all ten items:

$$\text{Global RSES score} = \sum_{i=1}^{10} Y_i$$

Where Y_i represents the numerical score of the i -th item following the reverse-scoring protocol for negative items. The global score ranges from 10 to 40 :

- **Score < 15:** Indicates clinically low self-esteem.
- **Score 15–25:** Indicates self-esteem within the normal (moderate) range.
- **Score > 25:** Indicates high self-esteem.

3. Validity and Reliability of the RSES in Indonesia

To ensure clinical utility in Indonesian nursing research, the RSES instrument has undergone formal cultural adaptation using standardized back-translation guidelines. Key psychometric studies validating this scale in Indonesia are outlined below :

Table 2. 4 Validity and Reliability of the RSES in Indonesia

Researcher & Year	Method of Analysis and Sample	Reliability Value	Construct Validity Results
Maroqi (2019)	Confirmatory Factor Analysis (CFA) via LISREL 8.70; Sample: $N = 198$ students in Tegal, Central Java.	Proven reliable for the Indonesian adolescent population.	Demonstrated that 7 out of 10 items were strictly unidimensional, confirming that Rosenberg's original one-

Researcher & Year	Method of Analysis and Sample	Reliability Value	Construct Validity Results
			factor model is acceptable.
Faizah et al. (2020)	Cronbach's Alpha Reliability Analysis; Sample: $N = 179$ undergraduate students in Malang, East Java.	High internal consistency coefficient ($\alpha = 0.836$).	Item discrimination indices ranged from 0.379 to 0.667, indicating excellent psychometric discriminative power.

2.1.7 Mental Health Nursing Problem Tree Analysis

A problem tree is a structured clinical analysis method that illustrates the causal relationships among various psychiatric nursing problems experienced by a patient (Saripah et al., 2014).

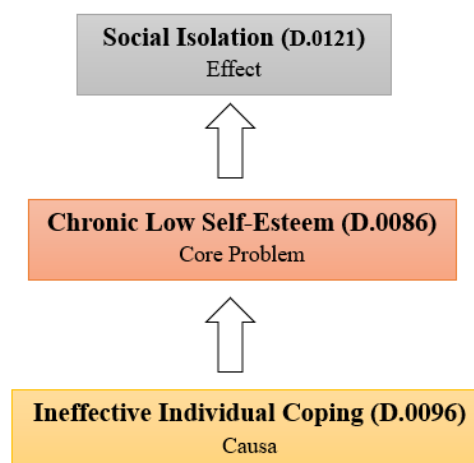


Figure 2. 2 Problem Tree Visual Structure

The logical and clinical relationships of the problem tree components are explained below:

1. **Root Cause (Causa) – Ineffective Individual Coping:** The root of this pathology stems from cognitive and behavioral deficits in processing

stressors adaptively. An accumulation of past failures, social rejection, or ineffective management of loss causes ego defenses to collapse. Consequently, the patient utilizes maladaptive defense mechanisms such as denial or avoidance, which impede constructive problem resolution.

2. **Core Problem – Chronic Low Self-Esteem:** Persistent coping failures in the absence of positive external reinforcement translate into chronic low self-esteem. Patients internalize these failures, viewing themselves as useless, shameful, or guilty, which erodes self-confidence. This problem becomes the central pathological axis governing emotional distortions and behavioral deficits in patients with schizophrenia.
3. **Effect – Social Isolation:** As a direct consequence of chronic low self-esteem, patients develop severe anxiety regarding social rejection and stigma. To shield their fragile ego from external criticism, patients withdraw from social spheres, diminish eye contact, exhibit passivity, and isolate themselves. This withdrawal warrants the nursing diagnosis of social isolation. If left unaddressed, the patient's sensory stimulation decreases drastically, increasing the vulnerability to more profound psychiatric conditions, such as a risk for disturbed sensory perception: auditory hallucinations (Saripah et al., 2014).

2.2 Concepts of Occupational Therapy

2.2.1 Definition of Occupational Therapy

Occupational therapy integrates science and art to guide an individual's active participation in selected, therapeutically designed tasks

or activities. This approach serves as a cornerstone of holistic, client-centered psychiatric nursing care, aimed at facilitating the acquisition of functional skills necessary for environmental adaptation. Etymologically, "occupation" refers to meaningful activities that populate human daily life, while "therapy" denotes the process of recovery or healing. Thus, occupational therapy in mental health nursing is conceptualized as a nursing care process that utilizes structured motor, cognitive, and social activities as media to rehabilitate compromised psychosocial functioning (Rini, 2023).

2.2.2 Goals of Occupational Therapy

The primary objective of occupational therapy is to restore functional independence in executing daily roles and tasks, which span self-care (activities of daily living [ADLs]), productivity, and healthy leisure utilization. For patients with severe mental illness, specific goals of this intervention include (Rini, 2023) :

1. Assisting patients in identifying, testing, and developing their remaining potential, talents, and work capacities to optimize community reintegration.
2. Facilitating the adaptive, productive, and directed channeling of emotions, anxiety, and negative psychic energy through physical activity media.
3. Improving cognitive skills (such as attention span and concentration) and rehabilitating fine and gross motor coordination degraded by disease pathology or pharmacotherapeutic side effects.

4. Assisting in clinical data collection to aid healthcare professionals in establishing functional diagnoses and formulating continuous psychosocial interventions.

2.2.3 Principles of Occupational Therapy

The execution of occupational therapy in clinical and community settings is governed by structured principles to maintain therapeutic efficacy (O'Callaghan & McKay, 2026). According to psychiatric nursing literature, selected activities must satisfy five core principles:

1. **Purposeful:** Every occupational nursing action must be designed to achieve a specific clinical target, such as enhancing attention span or managing psychopathological symptoms, rather than serving as aimless busywork.
2. **Meaningful:** Activities must be aligned with the patient's cultural background, personal interests, spiritual values, and developmental stage to stimulate intrinsic motivation for participation.
3. **Active Participation:** The therapy must encourage both physical and mental involvement, even if engagement is minimal during initial sessions.
4. **Prevention of Deterioration:** Activities are graded progressively to preserve residual functional capacities and counteract cognitive decline associated with institutionalization or prolonged social isolation.
5. **Encouragement of Life Motives:** Nursing interventions must provide realistic success experiences to foster hope, self-confidence, and recovery motivation within the patient (Aini et al., 2025).

2.2.4 Occupational Therapy in Psychiatric Patients

In patients with psychiatric disorders, particularly those with schizophrenia experiencing disturbed sensory perception in the form of auditory hallucinations, occupational therapy serves as a highly effective non-pharmacological intervention to minimize symptoms. The pathophysiology of hallucinations involves a failure in cognitive self-monitoring, causing patients to attribute internal stimuli (voices in their head) to external sources. Occupational therapy is applied as a form of directed distraction involving concrete physical activity. When a patient engages in physical tasks demanding visual, motor, and spatial concentration, cognitive focus is diverted from internal hallucinatory stimuli toward objective external tasks. This mechanism not only reduces the frequency of hallucinations but also provides patients with enhanced cognitive control to mitigate sensory distortions (Ikiugu et al., 2015).

2.2.5 Role of Occupational Therapy in Psychosocial Rehabilitation

Psychosocial rehabilitation is defined as clinical and social efforts aimed at restoring the independent functional capacities of individuals with severe mental illness to facilitate their productive reintegration into the community. Within this framework, occupational therapy holds a central role in bridging the transition from hospital-based care to independent community living (*community-based care*). It helps reconstruct the patient's daily behavioral patterns through social skills training, time management, and the reintroduction of work routines. Through structured activities, functional barriers caused by self-isolation and passivity can be systematically eroded, enabling patients to assume meaningful roles within

their families and communities (Kinasih, Rohmi, Agustiningsih, et al., 2017).

2.3 Theoretical Framework Supporting Occupational Therapy

2.3.1 Model of Human Occupation (MOHO)

The Model of Human Occupation (MOHO), pioneered by Dr. Gary Kielhofner, is one of the most widely adopted theoretical frameworks in contemporary occupational therapy practice. The core premise of this model posits that humans develop, adapt, and maintain health through active engagement in meaningful occupations (Taylor et al., 2023). MOHO views the individual as a dynamic open system, wherein occupational behavior is the product of continuous interaction among four internal and external components:

1. **Volition (Motivation):** Includes internal drives, personal values, interests, and beliefs regarding personal efficacy (*personal causation*). Volition dictates the patient's decisions to select, initiate, and sustain an activity.
2. **Habituation (Habits):** Refers to the organization of routines, recurrent daily behavioral patterns, and the internalization of social roles that guide how individuals respond to routine demands.
3. **Performance Capacity (Capability):** The subjective physical and mental abilities (including cognitive, neurological, and musculoskeletal functions) that underlie the execution of a task or physical activity.

4. **Environment:** The physical, social, cultural, and economic surroundings that offer opportunities, support, or constraints to an individual's occupational engagement.

The MOHO framework is applied through an integrated bead-stringing activity as a functional psychiatric nursing intervention. Bead-stringing represents a form of meaningful occupation that is straightforward, engaging, and accessible for psychiatric patients. The sequential structure of the activity allows patients to achieve concrete success experiences during therapy (Kielhofner, 2002). Repeated success in completing bead strands directly stimulates volition by triggering interest and restoring lost personal causation, while simultaneously activating performance capacity through fine motor coordination and cognitive concentration. Through this stimulation, patients establish new, productive daily routines (habituation) (Taylor et al., 2023). The ultimate outcome of this therapeutic cycle is the enhancement of occupational competence and the reconstruction of occupational identity, whereby patients transition from viewing themselves as helpless disabled individuals to empowered agents capable of creating valuable, aesthetic work (Kielhofner, 2002).

2.3.2 Self-Efficacy Theory

Albert Bandura's Self-Efficacy Theory focuses on an individual's subjective belief in their capability to organize and execute courses of action required to manage prospective situations and achieve specific performance outcomes. In the rehabilitation of patients with schizophrenia, self-efficacy acts as a crucial cognitive predictor; individuals with higher self-efficacy

demonstrate superior adaptive coping toward hallucinatory symptoms, enhanced medication adherence, and elevated self-acceptance during social recovery (Bandura, 1982 cited in Yulitasari 2020).

According to Bandura, self-efficacy beliefs are constructed through the cognitive appraisal of information from four primary sources:

1. **Mastery Experience:** The most potent source of efficacy information, grounded in actual personal attainment. Successes achieved through independent effort strengthen self-efficacy, whereas repeated early failures undermine it.
2. **Vicarious Experience:** A social modeling process wherein individuals observe the successes of peers with similar characteristics. This observation generates a cognitive appraisal that the observer also possesses the functional capacity to achieve comparable outcomes.
3. **Verbal Persuasion:** Emotional support, coaching, and positive feedback from others (such as nurses, family members, or therapists) that reassure patients of their innate potential to overcome challenges.
4. **Physiological and Emotional States:** The subjective interpretation of somatic and affective states (e.g., anxiety, tension, or stress). A calm physiological state and stable emotions are interpreted as indicators of readiness to perform effectively (Yulitasari, 2020).

In this clinical project, the intervention focus is specifically directed toward leveraging Mastery Experience as the primary catalyst for enhancing self-efficacy. Patients with schizophrenia who experience hallucinations and social isolation often succumb to learned helplessness, perceiving a total

loss of control over their cognitive and physical functions due to constant symptom recrudescence (Munawaroh & Yulianto, 2023). When the nurse trains the patient in bead-stringing therapy, each successful step—from selecting bead colors and threading the line to completing a cohesive bracelet or necklace—serves as an observable, direct mastery experience. This physical accomplishment delivers a powerful cognitive feedback loop, signaling that their functional capacities remain intact. Clinically, acquiring these success experiences bolsters self-efficacy, thereby motivating patients to actively manage their symptoms independently (Ridiansyah & Alfi Zarocho, 2022).

2.4 Concepts of Bead-Stringing Occupational Therapy

2.4.1 Definition of Bead-Stringing

Bead-stringing, recognized within psychiatric rehabilitation as beadwork therapy or handicraft therapy, is a craft-based occupational therapy modality involving arranging, threading, or uniting various perforated objects (such as beads, seeds, wood, or shells) using binding media like thread, string, or monofilament line following specific patterns. Clinically, bead-stringing is categorized as a structured, repetitive functional task of fine motor coordination. This activity demands spatial precision, visual alignment, and the manipulation of small physical objects within a predefined timeframe (Munawaroh & Yulianto, 2023).

2.4.2 Goals of Bead-Stringing

The application of bead-stringing therapy within psychiatric nursing care targets specific functional rehabilitation goals, including:

1. **Enhancing Concentration:** Directing the patient's entire cognitive attention toward the fine details of bead perforations and string paths, thereby redirecting focus away from distressing sensory distortions or hallucinatory stimuli.
2. **Improving Motor Coordination:** Training the small muscles of the fingers, enhancing tactile dexterity, and refining visuomotor coordination.
3. **Boosting Self-Confidence:** Presenting graded task challenges that patients can successfully complete, providing a sense of achievement derived from their own labor.
4. **Fostering Creativity:** Providing an aesthetic space for patients to determine color combinations, textures, and structural forms according to their imagination (Zakia et al., 2025).

2.4.3 Psychological Benefits of Bead-Stringing

Psychologically, bead-stringing yields profound therapeutic benefits for the emotional recovery of patients with schizophrenia, particularly in counteracting negative symptoms:

1. **Mitigating Passivity:** Reactivating the motor and cognitive faculties of patients presenting with social withdrawal and affective flattening, while stimulating productive behavioral initiatives.
2. **Enhancing Self-Competence:** Providing tangible proof to patients that they maintain control over their physical actions and cognitive processes to yield a functional product.

3. **Elevating Self-Esteem:** Counteracting the stigma of helplessness through social validation of their finished beadwork products, which ultimately increases global self-esteem (Ridiansyah & Alfi Zarocho, 2022).

2.4.4 Standard Operating Procedure (SOP) for Bead-Stringing

The application of bead-stringing therapy as a psychiatric nursing intervention is executed systematically through four distinct clinical phases:

1. **Material Preparation:** The nurse prepares multi-colored beads with varied perforation sizes (adjusted to the patient's baseline concentration level), elastic monofilament or beading thread, scissors, and sorting trays. All equipment must be audited to ensure safety and mitigate any risk to psychiatric patients.
2. **Patient Orientation:** The nurse establishes a therapeutic alliance (*bina hubungan saling percaya* [BHSP]), clarifies the goals and therapeutic benefits of bead-stringing, establishes a time contract (typically 30 to 45 minutes), and stimulates initial interest.
3. **Implementation:** The nurse demonstrates the threading process, beginning with a simple single-color pattern and progressing to multi-color variations. Subsequently, the nurse guides the patient to perform bead-stringing independently, offering patient accompaniment and positive reinforcement for every milestone achieved.
4. **Evaluation:** The nurse evaluates subjective responses (feelings of satisfaction, calmness, or reduced anxiety) and objective parameters (concentration capacity, task completion, manual coordination). The

session concludes with praise for the finished work and the formulation of a follow-up plan for the subsequent session (Alfianti & Pratiwi, 2025).

2.4.5 Indications and Contraindications for Bead-Stringing

Prior to implementing bead-stringing therapy, community mental health nurses must conduct a rigorous clinical eligibility assessment to minimize risk::

1. **Indication:**

- a. Patients with schizophrenia presenting with a nursing diagnosis of Disturbed Sensory Perception: Auditory Hallucinations in sub-acute or chronic phases who are cooperative.
- b. Patients with a diagnosis of chronic Low Self-Esteem requiring functional self-concept reinforcement.
- c. Patients with Social Isolation requiring parallel group activity stimulation to practice basic social interaction.
- d. Post-acute psychotic patients currently within the cognitive and motor recovery phases.

2. **Contraindication:**

- a. Psychiatric patients in the acute psychotic phase exhibiting psychomotor agitation, severe hyperactivity, or unmanageable combative/violent behavior.
- b. Patients demonstrating active suicidal ideation or a recent history of violent behavior, given the utilization of sharp implements (e.g., scissors or needles) during the crafting process.

- c. Patients with profound fine motor impairments in both hands (e.g., intense tremors secondary to severe extrapyramidal symptoms or hemiparesis) that absolutely preclude the manipulation of small objects (Amanda et al., 2025).

2.5 Evidence-Based Practice Of Bead-Stringing Occupational Therapy

The following table presents a synthesis of evidence-based practice (EBP) research supporting the implementation of bead-stringing occupational therapy within psychiatric nursing care for patients with schizophrenia:

Table 2. 5 Evidence-Based Practice Of Bead-Stringing Occupational Therapy

Author	Year	Methodology	Results	Clinical Correlate
Amanda et al.	2025	Comprehensive nursing care case study on a patient (Mrs. IRP) presenting with auditory hallucinations at Aceh Psychiatric Hospital. Interventions integrated generalist coping strategies with bead-stringing occupational therapy over 4 days (7 sessions, 45 minutes per session).	Demonstrated a significant reduction in the Auditory Hallucination Rating Scale (AHRS) score from 30 (severe category) to 15 (moderate category). The therapy also achieved observable improvements in patient concentration.	Clinically validates that integrating generalist nursing strategies with bead-stringing therapy effectively reduces the intensity, duration, and distress associated with auditory hallucinations.
Alfianti & Pratiwi	2025	Pre-experimental before-after study design involving 5 male patients with schizophrenia in a	The mean frequency of auditory hallucinations decreased from	Provides a standardized protocol framework (30-minute

Author	Year	Methodology	Results	Clinical Correlate
		sub-acute ward. The bead-stringing intervention was conducted 3 times weekly for 30 minutes per session.	a baseline of 31.60 to 23.00 post-intervention (a mean reduction of 8.6 with statistical significance).	duration, 3 times weekly) and evaluation metrics for tracking symptom reduction within advanced clinical nursing studies.
Kaunnil et al.	2022	Qualitative phenomenological study utilizing in-depth interviews with 7 participants with schizophrenia undergoing a craft-based rehabilitation program in Thailand.	Data analysis yielded four primary themes: sense of self and value, supporting factors, occupational barriers, and future hopes. Crafting enhanced cognitive control and emotional stability.	Supports the theoretical premise that beadwork is not merely a physical distraction but a meaningful occupation that restructures the patient's self-esteem and occupational identity.
Dwi Anugerah & Kurnia	2025	Quantitative pre-experimental design (one-group pretest-posttest) involving 24 respondents diagnosed with schizophrenia. Self-efficacy was measured using the General Self-	Paired sample t-test results revealed a mean increase in self-efficacy scores of 2.79 from baseline to post-intervention (collage art therapy), with a	Justifies the clinical assumption that achieving concrete physical outcomes through structured fine motor therapies

Author	Year	Methodology	Results	Clinical Correlate
		Efficacy Scale (GSE).	significance value of $p = 0.000$ ($p < 0.05$).	correlates positively with enhanced self-efficacy during psychiatric recovery.

2.6 Concepts of Community Mental Health Nursing

2.6.1 Definition and Goals of Community Mental Health Nursing

Community Mental Health Nursing (CMHN) is a specialized area of nursing practice that integrates mental health principles with public health nursing, focusing on the primary, secondary, and tertiary prevention of psychiatric disorders within the population. CMHN services are structured to deliver comprehensive, functional, and continuous nursing care directly within community settings (homes, primary health centers [*Puskesmas*], or community groups) rather than inside institutionalized hospital environments. The primary objectives of community mental health nursing are to maintain emotional stability within the patient's native environment, empower patients and families in illness self-management, reduce relapse and rehospitalization rates, and accelerate the independent and meaningful functional reintegration of psychiatric survivors into society (Kartikasari et al., 2024).

2.6.2 Home visit

Home visits constitute a core interventional modality for CMHN clinicians to extend psychiatric nursing care directly to the patient's

domicile. Through structured home visit programs, community mental health nurses can perform comprehensive clinical actions, including:

1. Conducting direct longitudinal assessments of the patient's mental status, ADL functional levels, and medication adherence within their natural environment.
2. Teaching, training, and evaluating symptom management techniques (such as bead-stringing exercises to manage hallucinations) directly within the home alongside family caregivers.
3. Identifying and modifying stressful environmental home factors and evaluating potential physical hazards to ensure patient safety.
4. Providing targeted psychoeducation to families to lower high expressed emotion within the household and enhance family coping capacities (Kartikasari et al., 2024).

2.6.3 The Role of the Family

The family is positioned as the primary support system and the daily de facto case manager for psychiatric patients living in the community. Without active family engagement, the continuity of post-discharge recovery remains highly vulnerable to clinical relapse. The strategic roles of the family within community psychiatric nursing care encompass:

1. **Facilitators of Recovery:** Constructing a home environment that is stable, safe, and nurturing, while minimizing interpersonal conflicts that act as stressors for the patient.
2. **Medication Regimen Supervisors:** Monitoring daily adherence to psychotropic medications in strict accordance with the doses and

schedules prescribed by the psychiatrist to prevent the recrudescence of psychotic symptoms.

3. Co-Therapists for Independent Interventions: Motivating, guiding, and facilitating the patient's regular practice of bead-stringing occupational therapy at home as a productive and therapeutic utilization of leisure time.
4. Early Detectors of Relapse: Identifying early warning signs of clinical decomposition (such as sleep disturbances, talking to oneself, or social withdrawal) and immediately reporting these markers to the public health nurse or nearest health facility (Saripah et al., 2014).