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Original Article

Exploring the use of the transtheoretical model in psychiatric nursing counseling for women with schizophrenia experiencing intimate partner violence: A clinical case study from Indonesia

Prasetyo Aji Nugroho[1*], Somporn Rungreangkulkij[2], Muliantika[3]
[1] Psychiatric and Mental Health Nursing, Nursing, ITEKES Muhammadiyah Kalimantan Barat, Kubu Raya, Indonesia
[2] Khon Kaen University, Thailand
[3] Klinik Utama Sungai Bangkong, Pontianak, Indonesia

***Corresponding Author:**
Prasetyo Aji Nugroho
Psychiatric and Mental Health Nursing, Nursing, ITEKES Muhammadiyah Kalimantan Barat, Kubu Raya, Indonesia
Email: yoaji.nu@itekesmukalbar.ac.id

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Abstract

Background: Intimate partner violence (IPV) is a major global public health concern associated with severe psychological consequences, particularly among women with pre-existing mental disorders. Survivors with chronic mental illness often experience complex psychological challenges that may hinder recovery and increase vulnerability to repeated abuse. However, structured psychiatric nursing approaches addressing survivors' readiness for behavioral change remain limited.
Objective: This study aimed to explore the application of the Transtheoretical Model of Change within psychiatric nursing counseling for women with schizophrenia experiencing intimate partner violence.
Methods: A qualitative clinical case study design was employed involving two female participants with schizophrenia receiving psychiatric nursing care in Indonesia. Data were collected through clinical observation, nursing assessments, therapeutic communication, counseling session documentation, and nursing care records. Counseling interventions were implemented using experiential and behavioral strategies aligned with the stages of change framework. Data were analyzed using thematic content analysis focusing on patterns of psychological responses, coping processes, and behavioral changes observed during counseling..
Results: Clinical observations indicated that experiential strategies, including consciousness raising, self-reevaluation, and dramatic relief, were associated with increased recognition of abusive experiences and reduced self-blaming responses. Behavioral strategies such as self-liberation, reinforcement management, and counterconditioning were observed alongside the development of adaptive coping behaviors, emotional regulation, and greater engagement in daily functioning. Participants demonstrated individual variations in readiness for change throughout the counseling process.
Conclusion: Transtheoretical Model may provide a useful framework for tailoring psychiatric nursing counseling according to survivors' readiness for change and clinical context. However, findings should be interpreted cautiously given the qualitative case study design and small number of participants. Further research involving larger samples and standardized outcome measures is needed to strengthen understanding of stage-based counseling approaches among survivors of intimate partner violence with chronic mental illness.

Background

Intimate partner violence (IPV) remains a major global public health problem affecting millions of women worldwide. The World Health Organization estimates that approximately one in three women globally has experienced physical or sexual violence by an intimate partner during their lifetime (World Health Organization, 2021). A large global analysis also reported that the prevalence of lifetime IPV among women ranges between 26% and 30% in many countries (Sardinha et al., 2022).

In the Indonesian context, violence against women remains a significant and underreported public health issue. Recent national data from the 2024 National Women's Life Experience Survey (SPHPN) conducted by United Nations Population Fund indicate that approximately one in four women in Indonesia has experienced physical, sexual, or psychological violence within the past year, and more than 40% have experienced violence by an intimate partner over their lifetime (UNFPA, 2024). Despite the high prevalence, reporting rates remain disproportionately low, as official administrative records capture only a small fraction of actual cases, reflecting substantial gaps between reported and experienced violence (UNFPA, 2024; Badan Pusat Statistik, 2021).

Barriers to disclosure and reporting in Indonesia are strongly influenced by socio-cultural factors, including stigma, fear of social consequences, unequal power relations, and cultural norms that prioritize family harmony over individual safety (UNFPA, 2024; Yoshihama et al., 2009). These barriers are further compounded among women with mental illness, who often face dual stigma as both survivors of violence and individuals with psychiatric conditions (World Health Organization, 2022).

In addition, access to mental health services in Indonesia remains limited and unevenly distributed. Mental health care resources are constrained by shortages of trained professionals, limited funding, and inadequate integration of gender-sensitive services, particularly at the primary care level (World Health Organization, 2022; Kementerian Kesehatan Republik Indonesia, 2023). Stigma surrounding mental illness and lack of awareness further reduce help-seeking behavior, contributing to delayed treatment and poor psychosocial outcomes (World Health Organization, 2022).

Although increasing attention has been directed toward intimate partner violence (IPV) within healthcare systems, survivors living with severe mental illness present unique clinical challenges that require tailored psychosocial approaches. Women with schizophrenia who experience IPV often face overlapping vulnerabilities related to trauma exposure, impaired insight, emotional dysregulation, cognitive limitations, stigma, and social dependency. These factors may complicate help-seeking behavior, delay recognition of abusive situations, and influence readiness to engage in behavioral change processes (Oram et al., 2017; World Health Organization, 2023; Devries et al., 2013).

Insight capacity is particularly relevant in schizophrenia because fluctuations in awareness, judgment, and illness understanding may affect individuals' ability to recognize harmful interpersonal patterns and participate consistently in therapeutic interventions (World Health Organization, 2023). In addition, exposure to interpersonal trauma may worsen emotional distress, self-blame, and maladaptive coping behaviors, creating barriers to recovery and psychosocial functioning (Levenson, 2017; Oram et al., 2017). Therefore, psychiatric nursing interventions require approaches that not only address trauma-related experiences but also accommodate patients' readiness and capacity for change.

The Transtheoretical Model (TTM) provides a stage-based behavioral framework that conceptualizes change as a gradual process involving precontemplation, contemplation, preparation, action, and maintenance (Raihan & Cogburn, 2023). Rather than assuming immediate behavioral change, TTM recognizes that individuals differ in their readiness to acknowledge problems, develop motivation, and initiate adaptive coping behaviors (Prochaska & Velicer, 1997). Within psychiatric nursing practice, this framework may be particularly relevant for individuals with schizophrenia because counseling strategies can be adjusted according to cognitive readiness, emotional responses, and behavioral engagement.

Experiential processes such as consciousness raising and self-reevaluation may facilitate awareness of abusive experiences and reduce self-blaming beliefs, while behavioral processes such as reinforcement management, helping relationships, and counterconditioning may support coping development and emotional regulation (Haggerty & Goodman, 2003). Stage-based approaches may therefore offer psychiatric nurses a structured yet flexible framework for supporting survivors of IPV who experience severe mental illness (Burke et al., 2003; Chang et al., 2006).

However, important knowledge gaps remain. First, evidence regarding the application of TTM among survivors of intimate partner violence with schizophrenia remains limited, as previous studies have largely focused on general populations or specific behavioral problems (Chang et al., 2006; Raihan & Cogburn, 2023). Second, structured psychiatric nursing counseling models explicitly integrating stages-of-change principles for survivors with severe mental illness remain insufficiently described (Haggerty & Goodman, 2003). Third, contextual evidence from Southeast Asian settings, including Indonesia, remains scarce despite socio-cultural factors that may influence help-seeking behavior and intervention implementation (UNFPA, 2024; Yoshihama et al., 2009). Finally, limited clinical guidance exists regarding how psychiatric nurses can operationalize stage-based behavioral counseling strategies for individuals experiencing both schizophrenia and IPV.

This gap is further pronounced in Southeast Asian contexts, including Indonesia, where socio-cultural factors, stigma, and limited mental health resources may influence both help-seeking behavior and the implementation of psychosocial

interventions (United Nations Population Fund, 2024; Yoshihama et al., 2009; World Health Organization, 2022).

Therefore, his study aimed to describe the implementation of Transtheoretical Model–based psychiatric nursing counseling and examine observed clinical responses among women with schizophrenia experiencing intimate partner violence within a qualitative clinical case study design.

Methods

Study Design

This study employed a qualitative case study design to explore the application of the Transtheoretical Model (TTM) in psychiatric nursing counseling for survivors of intimate partner violence (IPV) with schizophrenia. This design allows for an in-depth exploration of individual experiences, behavioral change processes, and clinical interactions within a real-life context (Crowe, et al., 2011).

Sampling and setting

Participants were selected using purposive sampling based on clinical relevance. Inclusion criteria were: (1) female patients aged ≥18 years, (2) diagnosed with schizophrenia by a psychiatrist, (3) having a documented history of intimate partner violence, (4) being in a stable phase of illness (no acute psychotic symptoms), and (5) able to communicate and participate in counseling sessions.

Exclusion criteria included: (1) patients experiencing acute psychotic episodes, (2) severe cognitive impairment affecting comprehension, and (3) high risk of immediate harm requiring intensive psychiatric intervention.

The study was conducted at Klinik Utama Sungai Bangkong in Pontianak, Indonesia. Two female patients diagnosed with schizophrenia and with documented histories of intimate partner violence participated in the study.

Participant 1 (Miss I) was a 36-year-old woman with a history of multiple abusive relationships and childhood trauma. Participant 2 (Miss C) was a 61-year-old woman who experienced long-term psychological abuse within an arranged marriage.

Both participants demonstrated chronic low self-esteem, emotional distress, and impaired coping related to their experiences of intimate partner violence.

Instruments

No standardized quantitative instruments were used. Data sources included nursing assessments, clinical observations, therapeutic communication records, counseling session documentation, and nursing care notes. Clinical evaluation focused on qualitative indicators including self-esteem, emotional regulation, adaptive coping, and functional functioning.

Intervention

The counseling intervention was delivered by an advanced practice psychiatric nurse with clinical experience in mental health nursing and direct experience caring for individuals with schizophrenia and psychosocial problems related to severe mental illness. No formal certification in IPV counseling was held; however, the intervention provider had clinical experience in psychiatric nursing and received ongoing supervision from senior psychiatric clinicians.

The counseling intervention was conducted over a two-week period, consisting of 4–6 sessions per participant, with each session lasting approximately 60–90 minutes. The intervention followed the stages of the Transtheoretical Model, integrating experiential and behavioral strategies.

Each session had specific objectives: Session 1–2 (Precontemplation–Contemplation): consciousness raising and self-reevaluation to increase awareness of abusive experiences; Session 3 (Preparation): environmental reevaluation to build motivation for change; Session 4–5 (Action): self-liberation and helping relationships to support coping and decision-making; Session 6 (Maintenance): reinforcement management and relapse prevention strategies. All sessions were documented, including client responses, emotional expressions, and behavioral changes.

TTM-Based Counseling Intervention Protocol

The counseling intervention was structured according to the five stages of the Transtheoretical Model: precontemplation, contemplation, preparation, action, and maintenance. Each stage was associated with specific therapeutic goals, counseling strategies, and nursing activities

tailored to participants' psychological readiness and clinical condition.

The intervention emphasized both experiential and behavioral processes, with flexibility to revisit earlier stages depending on participants' emotional responses and level of insight.

Each counseling stage was implemented through structured therapeutic interactions and adapted based on participants' responses. Movement between stages was not strictly linear; participants occasionally revisited earlier stages depending on emotional readiness and situational triggers. Clinical evaluation at each stage was based on observable changes in cognition, emotional expression, coping behavior, and engagement in the counseling process, as documented in session notes.

Table 1. TTM-Based Counseling Sessions

TTM Stage	Goal	Counseling Strategy	Nurse Activity	Client Response	Clinical Evaluation
Precontemplation	Increase awareness of IPV experiences	Consciousness raising	Provide psychoeducation about IPV, normalize experiences, gently explore past relationships	Initially denies or minimizes abuse → begins to recognize harmful patterns	Increased awareness of abusive experiences
Contemplation	Reduce self-blame and enhance insight	Self-reevaluation, dramatic relief	Facilitate emotional expression, guided reflection on self-worth and experiences	Expresses sadness, guilt, or anger; begins to question self-blame	Improved insight and emotional processing
Preparation	Build motivation for change	Environmental reevaluation, social liberation	Discuss impact of IPV on self and family, explore support systems	Shows ambivalence but expresses desire for change	Verbal commitment to change and help-seeking
Action	Develop adaptive coping and decision-making	Self-liberation, helping relationships, counterconditioning	Assist in goal setting, coping skills training, strengthening support networks	Practices new coping strategies, sets personal goals	Observable behavioral change and improved coping
Maintenance	Sustain behavioral change and prevent relapse	Reinforcement management, stimulus control	Provide positive reinforcement, relapse prevention planning, strengthen autonomy	Maintains adaptive behaviors, increased confidence	Improved functioning and consistency in coping

Data Collection

Data were collected through clinical observation, nursing assessments, therapeutic communication, and documentation of nursing care interventions over several consecutive sessions. Nursing interventions were guided by the Transtheoretical Model integrated with experiential and behavioral strategies as proposed by Haggerty and Goodman (2003). Each session was documented in detail, including client responses, emotional expressions, behavioral changes, and self-reported perceptions of progress.

Data Analysis

Data were analyzed using thematic content analysis, focusing on patterns of client change corresponding to the stages of change framework (Ahmed, et al., 2025). Coding categories were developed based on the theoretical constructs of the model and refined through iterative analysis of nursing session transcripts. Triangulation was

conducted through member checking, documentation review, and peer debriefing to ensure data credibility and confirmability.

Ethical Considerations

This study received ethical approval from the ITEKES Muhammadiyah Kalimantan Barat Ethics Committee (Approval No: 394/II.I.AU/KET.ETIK/XII/2022).

Prior to participation, written informed consent was obtained from all participants after providing a clear explanation of the study objectives, procedures, potential risks, and benefits. Given that participants were individuals diagnosed with schizophrenia, their capacity to provide informed consent was carefully assessed by the clinical team. Capacity assessment included evaluation of participants' orientation, comprehension of study information, ability to communicate a choice, and understanding of potential consequences. Only participants who demonstrated adequate decision-making capacity were included in the study.

Confidentiality and privacy were strictly maintained. All data were anonymized using pseudonyms, and any identifying information was removed from transcripts and reports. Counseling sessions were conducted in a private and secure clinical setting to ensure participants' safety and comfort. Data were stored securely and accessed only by the research team.

Considering the sensitive nature of intimate partner violence, trauma-informed approaches were applied throughout the study to minimize the risk of re-traumatization. Participants were informed that they could pause or discontinue participation at any time without consequences. Emotional responses were continuously monitored during counseling sessions. If signs of distress occurred, immediate supportive interventions, including grounding techniques and emotional stabilization, were provided.

In cases where participants experienced significant psychological distress or crisis, referral mechanisms were activated. Participants were referred to psychiatric services within the same clinical setting for further evaluation and management. Safety planning, including identification of trusted support persons and coping strategies, was incorporated into the intervention process to enhance participants' psychological safety and well-being

Clinical Case Findings

This study involved two female clients who experienced intimate partner violence (IPV) with chronic mental illness, particularly schizophrenia, resulting in chronic low self-esteem. Both participants received advanced nursing interventions based on the Transtheoretical Model, integrating experiential and behavioral strategies.

Both participants had been previously diagnosed with schizophrenia by a psychiatrist based on standard clinical diagnostic criteria (DSM-5 or ICD-10/ICD-11) as documented in their medical records.

At the time of the intervention, both participants were in a clinically stable phase of illness, characterized by the absence of acute psychotic symptoms such as severe hallucinations, delusions, or disorganized behavior that could interfere with communication and participation. Although mild residual symptoms were present, both participants were able to engage in conversation, express thoughts, and participate in structured counseling sessions.

Both participants were receiving ongoing pharmacological treatment, including antipsychotic medication, and were under routine psychiatric follow-up. Medication adherence was monitored as part of standard clinical care.

The level of insight and emotional regulation varied between participants, reflecting typical characteristics of schizophrenia. These factors were considered during the counseling process, with interventions adapted to participants' cognitive capacity, attention span, and readiness for change.

The inclusion of participants in a stable clinical phase was essential to ensure meaningful engagement in counseling and to minimize the risk of symptom exacerbation during discussions of trauma-related experiences.

Table 2. Implementation of Stages of Change Intervention

Stage	Intervention Strategy	Observed Psychological Response	Observed Clinical Indicators
Precontemplation	Consciousness raising	Recognition of abusive experiences	Increased willingness to discuss past experiences
Contemplation	Self-reevaluation	Reflection on self-blaming beliefs	Greater emotional expression during counseling
Preparation	Environmental reevaluation	Consideration of personal and family impact	Verbalized motivation for future changes
Action	Self-liberation and helping relationships	Engagement in coping discussions	Attempts to identify coping strategies and support resources
Maintenance	Reinforcement management	Increased confidence discussing future plans	Continued participation in adaptive daily activities

Clinical Outcome Assessment

Clinical outcomes in this study were assessed using qualitative indicators derived from nursing observations, counseling session notes, and participants' verbal responses. No standardized quantitative measurement instruments were used, as the study aimed to explore individual behavioral change processes within a case study design.

Outcome indicators were defined a priori based on clinical relevance and the Transtheoretical Model framework. These included:1. Self-esteem: expressed self-worth, reduced self-blame, and positive self-appraisal during counseling sessions; 2.Emotional regulation: ability to identify, express, and manage emotions without overwhelming distress; 3.Adaptive coping: use of constructive coping strategies such as seeking support, problem-solving, and reframing negative thoughts; 4.Functional independence: engagement in daily activities, decision-making ability, and initiation of personal goals.

Changes in these indicators were evaluated across sessions by comparing initial and subsequent responses, behavioral observations, and narrative expressions documented during the counseling process.

The observed improvements in self-esteem, emotional regulation, adaptive coping, and functional independence were interpreted based on qualitative clinical indicators.

For example, improvements in self-esteem were reflected in participants' verbal expressions indicating reduced self-blame and increased recognition of self-worth. Emotional regulation was observed through participants' ability to discuss traumatic experiences with less distress and greater emotional control over time.

Adaptive coping was indicated by the participants' use of healthier strategies, such as seeking social support, engaging in meaningful activities, and reframing negative thoughts. Functional independence was reflected in participants' increased involvement in daily activities, decision-making, and future planning.

These changes were documented progressively across counseling sessions and interpreted within the stages of change framework.

Case 1: Miss I

During the assessment phase, Miss I (36 years old) reported a history of physical, psychological, and sexual violence experienced across childhood and adulthood. She expressed persistent feelings of worthlessness, dependency, difficulty trusting others, self-blame, and low self-confidence. Nursing assessment identified chronic low self-esteem and ineffective coping associated with prolonged exposure to intimate partner violence. The care plan focused on enhancing self-awareness, strengthening emotional regulation, reducing self-blame, and supporting adaptive coping and personal autonomy.

Based on these findings, nursing diagnoses included chronic low self-esteem and ineffective coping related to prolonged exposure to intimate partner violence. The care plan was developed to enhance self-awareness, reduce self-blame, improve emotional regulation, and support the

development of adaptive coping strategies and personal autonomy.

The intervention was delivered through a series of structured counseling sessions lasting approximately 60–90 minutes each. Sessions focused on emotional exploration, identification of maladaptive patterns, and development of future-oriented goals, including economic independence.

Interventions were implemented using the Transtheoretical Model of Change. Experiential strategies, including consciousness raising and self-reevaluation, were used to help Miss I recognize patterns of abuse and reframe her self-perception. Dramatic relief facilitated emotional expression related to past trauma. Behavioral strategies such as self-liberation, reinforcement management, and helping relationships were applied to support goal setting, strengthen coping skills, and build supportive social connections.

Her interventions began with consciousness-raising, which helped her acknowledge her abusive experiences and recognize that she did not deserve such treatment. Through self-reevaluation, Miss I developed self-worth and recognized that the violence she experienced was not her fault. Dramatic relief allowed her to express grief for her lost idealized relationships while acknowledging the harm. Environmental reevaluation made her aware of the impact of abuse on her adopted son and family, while social liberation provided her with a new perspective on societal norms against IPV. In the behavioral phase, self-liberation empowered her to set safety plans and future goals. Reinforcement management and helping relationships strengthened her confidence and trust in social relationships. Counterconditioning and stimulus control helped prevent regression into unhealthy relationships. By the end of the intervention, Miss I exhibited improved self-esteem, expressed interest in starting a small business, and demonstrated increased coping and autonomy.

Evaluation across counseling sessions indicated observable clinical changes. Miss I increasingly verbalized recognition that abusive experiences were not her fault and demonstrated greater willingness to discuss emotional experiences during counseling. She also expressed interest in initiating future independent activities, including economic planning, and described intentions to strengthen supportive relationships. These observations were interpreted as indicators of evolving coping processes and increased engagement in future-oriented planning.

Case 2: Miss C

During the assessment phase, Miss C reported a long history of psychological abuse within an arranged marriage. She experienced emotional suppression, loneliness, and limited autonomy in decision-making. She also expressed feelings of dissatisfaction, lack of emotional support, and difficulty asserting her needs.

Based on these findings, nursing diagnoses included ineffective coping and situational low self-esteem related to prolonged emotional abuse. The care plan focused on enhancing emotional acceptance, improving coping mechanisms, strengthening support systems, and increasing autonomy in daily life.

The intervention was carried out through multiple counseling sessions, each lasting approximately 60–90 minutes. Sessions emphasized emotional processing, strengthening relationships with supportive family members, and encouraging engagement in meaningful daily activities.

Interventions were guided by the Transtheoretical Model of Change. Experiential strategies such as self-reevaluation and environmental reevaluation were used to help Miss C reflect on her life experiences and recognize the impact of her relationship on her well-being. Emotional expression was facilitated through supportive therapeutic communication. Behavioral strategies, including helping relationships, counterconditioning, and reinforcement management, were applied to support the development of adaptive coping and more positive thinking patterns.

In consciousness-raising, Miss C recognized that her lack of happiness stemmed from marital dynamics imposed by her family. Self-reevaluation enabled her to appreciate her role as a mother and her success in raising her children. Dramatic relief allowed her to grieve unfulfilled emotional needs while accepting parts of her marriage she valued. Environmental reevaluation emphasized the role of her daughter as a key source of emotional support, while social liberation offered perspectives on changing family dynamics. In behavioral stages, Miss C engaged in self-liberation by planning new activities at home and

adjusting expectations toward her husband. Reinforcement management acknowledged her small achievements, and helping relationships emphasized the importance of maintaining supportive interactions with her children. Counterconditioning and stimulus control helped her avoid destructive thinking patterns. At the conclusion, Miss C demonstrated enhanced emotional regulation, positive self-perceptions, and improved daily functioning.

Evaluation across counseling sessions suggested gradual clinical changes. Miss C demonstrated increased willingness to discuss emotional experiences and reflected more openly on the impact of long-term psychological abuse. She described greater appreciation of existing social support and expressed plans to increase involvement in meaningful daily activities. These observations suggested evolving emotional processing and changing perspectives toward coping with life circumstances.

Miss I demonstrated improved self-esteem and began developing future plans for economic independence. Miss C showed increased emotional acceptance and improved daily functioning.

Discussion

This study suggests that the Transtheoretical Model (TTM) may provide a useful framework for guiding psychiatric nursing counseling among survivors of intimate partner violence (IPV) with schizophrenia. Rather than demonstrating definitive effectiveness, the findings indicate that stage-based interventions can help nurses tailor counseling strategies according to patients' readiness for change. This approach aligns with contemporary perspectives in behavioral health, which emphasize individualized, patient-centered care and adaptive intervention strategies (World Health Organization, 2022; Palmieri & Valentine, 2021).

From a clinical standpoint, the use of TTM allowed the nurse to match counseling techniques with each participant's stage of change. Experiential strategies, such as consciousness raising and self-reevaluation, appeared to facilitate awareness of abusive experiences and reduce self-blame—key processes in early recovery among IPV survivors (Dokkedahl et al., 2019). Behavioral strategies, including self-liberation, reinforcement management, and helping relationships, supported the gradual development of adaptive coping behaviors and increased engagement in meaningful activities. These findings are consistent with recent literature highlighting the importance of empowerment-based and stage-matched interventions in improving psychosocial outcomes among survivors of violence (Cattaneo & Goodman, 2015).

The observed progression in participants' willingness to recognize abusive experiences and discuss emotional responses is consistent with previous literature describing the relevance of TTM processes among survivors of IPV. Burke et al. (2003) reported that behavioral change among women experiencing intimate partner violence often occurs gradually and involves movement through stages of awareness, emotional processing, and action planning. Similarly, Chang et al. (2006) demonstrated that readiness for behavioral change among IPV survivors is dynamic and influenced by psychological readiness and social context. The present findings extend these observations to women with schizophrenia, a population that remains underrepresented in stage-based behavioral intervention research.

Experiential counseling strategies, including consciousness raising and self-reevaluation, appeared to support participants' recognition of abusive experiences and reduce self-blaming narratives. Previous trauma-informed literature suggests that survivors of interpersonal violence frequently internalize responsibility for abuse, contributing to emotional distress and impaired recovery (Levenson, 2017). Trauma-informed approaches emphasize emotional safety, trust-building, collaboration, empowerment, and validation of survivors' experiences, which may explain why participants gradually demonstrated greater willingness to discuss trauma-related experiences during counseling sessions (Palmieri & Valentine, 2021). However, unlike studies involving general IPV populations, behavioral change processes in schizophrenia may occur more slowly because emotional regulation difficulties, cognitive limitations, and impaired insight can influence engagement in therapeutic processes.

The findings also align with psychiatric nursing literature emphasizing individualized and stage-

matched interventions. Haggerty and Goodman (2003) suggested that nursing interventions grounded in stages-of-change principles may improve therapeutic engagement among individuals experiencing intimate partner violence. The current study supports this perspective by demonstrating that counseling strategies tailored to participants' readiness for change were clinically feasible within psychiatric nursing practice. Nevertheless, because this study involved only two clinical cases without standardized outcome measures, conclusions regarding intervention effectiveness cannot be established.

An important consideration emerging from this study relates to schizophrenia-specific challenges. Previous evidence indicates that fluctuating insight, cognitive limitations, stigma, and impaired social functioning may influence recovery processes and engagement in mental health interventions among individuals with schizophrenia (World Health Organization, 2023). These factors were also observed clinically during counseling sessions, where participants occasionally required repeated reflection, emotional stabilization, and reinforcement before engaging in future-oriented discussions. This finding suggests that applying TTM within schizophrenia populations may require greater flexibility than models originally developed for general behavioral health populations.

Socio-cultural context may also influence implementation. In Indonesia and other Southeast Asian settings, stigma related to both mental illness and intimate partner violence remains substantial and may influence disclosure, help-seeking behavior, and readiness for change (UNFPA, 2024; Yoshihama et al., 2009). Therefore, psychiatric nursing interventions addressing IPV within severe mental illness populations should consider not only psychological readiness but also broader cultural and social determinants affecting recovery.

Several limitations should also be acknowledged. The findings derive from two participants within a single clinical setting and rely primarily on qualitative clinical observations rather than standardized psychological measurement tools. Consequently, transferability remains limited. Future research involving larger samples, mixed-method designs, and validated outcome measures is needed to strengthen understanding regarding the feasibility and clinical applicability of stage-based psychiatric nursing counseling among survivors of IPV with schizophrenia.

Study Limitation

This study has several limitations. First, the study involved only two participants, which limits the generalizability of the findings. However, the case study design aimed to provide an in-depth exploration of complex psychological experiences among survivors of intimate partner violence with schizophrenia. Second, the findings were derived from a specific clinical setting in Indonesia, and cultural factors may influence the applicability of the results in other contexts. Future research with larger samples and diverse settings is recommended to further validate the effectiveness of stage-based counseling interventions.

Conclusion and Recommendation

This clinical case study describes the application of the Transtheoretical Model (TTM) as a structured framework within psychiatric nursing counseling for women with schizophrenia experiencing intimate partner violence. Across two clinical cases, stage-based counseling strategies were applied to accommodate participants' readiness for change and psychological conditions during the counseling process.

Observed clinical responses suggested that counseling approaches aligned with stages of change may support emotional expression, recognition of abusive experiences, and discussion of coping strategies within psychiatric nursing care. However, these observations should be interpreted with caution given the qualitative case study design, reliance on clinical observations, and the involvement of only two participants.

The implementation of TTM in women with schizophrenia experiencing intimate partner violence may require adaptation to clinical challenges including fluctuating insight, cognitive limitations, emotional vulnerability, and socio-cultural influences. Therefore, TTM should be viewed as a flexible clinical framework rather than an evidence-based intervention model for this population.

Further studies involving larger samples, diverse clinical settings, and standardized outcome measures are needed to understand better the feasibility and clinical applicability of stage-based

psychiatric nursing counseling among survivors of intimate partner violence with schizophrenia.

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