VIOLENCE IN THE PSYCHIATRIC SETTING

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- **ANGER**
- **AGGRESSION**
- **VIOLENCE**
- **PSYCHIATRIC EMERGENCY**

PSYCHIATRIC EMERGENCY

Any patient- initiated threat of harm to self, health care personnel, or others in the patient's sphere of influence

VIOLENCE

- The **use of strong force or weapons to inflict bodily harm** to another person, and in some cases, to kill.
- It connotes **greater intensity and destruction** than aggression
- It can be **predatory** (purposefully planned and nonemotional) or **emotionally reactive** (enacted in response to irrational fear of attack)

THEORETICAL EXPLANATIONS FOR ANGER, AGGRESSION AND VIOLENCE

- **Biologic**
- **Psychological**
- **Social**

BIOLOGICAL THEORIES

- Brain trauma or disease triggering a negative response
- Emotional circuit between limbic system and frontal cortex affected
- Hormonal imbalances
- Low serotonin levels

PSYCHOLOGICAL THEORIES

- Instinctual urges
- Learned response
- Aggression rewarded by environment
- Irrational thoughts leading to aggression
- Coercive interactional style

SOCIAL THEORIES

- Competition and success oriented society
- Inequities in relationships
- Learned response
- Societal backlash against women's status and attempts for equality
- Combination of risk factors and environmental events

ANGER TURNED INWARD VS ANGER TURNED OUTWARD

INDICATORS OF IMPENDING VIOLENCE

Verbal

- Threats of harm
- Loud, demanding voice
- Abrupt silence
- Sarcastic remarks
- Pressured speech
- Illogical responses
- Screaming
- Statements of fear/suspicion

Behavioural

- Clenched jaws
- Frowning, glaring
- Intense staring
- Flushing of face, neck
- Smirking grin
- Pacing
- Pounding fists
- Heightened vigilance

EXPECTED CLIENT OUTCOMES:

- Identify precipitating events prior to losing control
- Refrain from self-injury and from injuring others
- Identify alternative methods for expressing anger
- Refrain from impulsive behaviour

SELF-ASSESSMENT DURING INTENSE CONFRONTATION OR INTERACTION

- Am I confident?
- How am I reacting ?
- How's my tone of voice ?
- How's my body language ?
- Check personal space
- Am I wearing anything dangerous ?
- Pay attention to "gut" feeling

COMMUNICATION STRATEGIES

- Calm appearance
- Nonthreatening manner of speaking
- Space and distance
- Respect
- Eye contact

COMMUNICATION STRATEGIES

- Verbalization of patient's feelings
- Listen to the patient
- Avoid early interpretations
- Be truthful and consistent
- Express clear expectations of control
- Acknowledge nonviolent behavior

BEHAVIORAL STRATEGIES

LIMIT SETTING

- Non-punitive and non manipulative act
- It informs patient what behavior is acceptable and what is unacceptable
- It also informs patient of the consequences for unacceptable behavior.
- **Clear, consistent, non punitive enforcement of limits is the goal**

BEHAVIORAL STRATEGIES

BEHAVIORAL CONTRACTS

To be effective it should require detailed information about the following:

- Unacceptable behaviors
- Acceptable behaviors
- Consequences of breaking the contract
- The nurse's contribution to care

BEHAVIORAL STRATEGIES

TIME-OUT

- It is a behavioral technique in which socially inappropriate behavior can be decrease by short-term removal of patient from over-stimulating and reinforcing situations.

TOKEN ECONOMY

Applicable to chronic lower functioning patient population

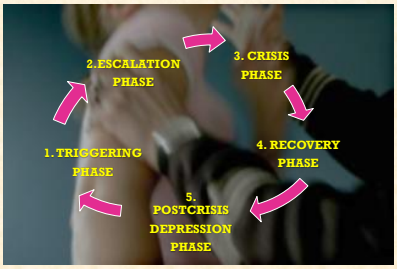
ACTIONS TO MINIMIZE PERSONAL RISK

- Using nonthreatening body language
- Respecting the patient's personal space
- Immediate access to the door
- Choosing to leave the door open
- Knowing where colleagues are

ACTIONS TO MINIMIZE PERSONAL RISK

- Removing potentially harmful objects
- Know the patient's history and personal background
- Personal control is important.
- Always demonstrate a steady, confident and dependable attitude.

FIVE-PHASE AGGRESSION CYCLE



1. TRIGGERING PHASE

- An event or circumstances in the environment initiates the client's response, which is often anger of hostility
- Signs, Symptoms, and Behaviors
  - Mild anxiety
  - Restlessness, irritability, pacing, muscle tension, rapid breathing, perspiration, loud voice, anger

TRIGGERING PHASE: INTERVENTIONS

- Convey emphatic support
- Encourage ventilation
- Use clear, calm, nonthreatening, simple statements
- Ask patient to maintain control

TRIGGERING PHASE: INTERVENTIONS

- Facilitate problem solving by discussing alternative solutions
- If needed, ask the patient to go to a quiet and safe place
- Offer safe tension reduction method
- If needed offer PRN medications

2. ESCALATION PHASE

- Client's responses represent escalating behaviors that indicate movement toward a loss of control
- Signs, Symptoms, and Behaviors
  - Moderate to severe anxiety
  - Pale, flushed face, yelling, swearing, agitated, threatening gestures, hostility, loss of ability to solve the problem or think clearly

ESCALATION PHASE: INTERVENTIONS

- Take charge with calm firm directions
- Tell the client that aggressive behavior is not acceptable and that you are there to help him regain control
- Direct patient to a quiet room for a "time out"
- Give prn medication as ordered

ESCALATION PHASE: INTERVENTIONS

- Ask the staff to on standby at a distance
- Prepare for a "show of determination" or "show of force" to take control
  - Four to six staff members should remain ready within sight of the client but not as close as the primary nurse talking with the client

3. CRISIS PHASE

- During a period of emotional and physical crisis, the client loses control
- Signs, Symptoms, and Behaviors
  - Severe to panic anxiety
  - Throwing objects, kicking, hitting, spitting, biting, scratching, shrieking, screaming, inability to communicate clearly

CRISIS PHASE: NURSING INTERVENTIONS

- Use of involuntary seclusions
- Use of restraints
  - Four to six staff members are needed
  - There should be a doctor's order
  - Consider patient's safety
- Give prn intramuscular injections
- Initiate intensive nursing care

4. RECOVERY PHASE

- Client regains physical and emotional control
- Signs, Symptoms, and Behaviors
  - Severe to moderate anxiety
  - Lowering of voice, decreased muscle tension, clearer more rational communication, physical relaxation

RECOVERY PHASE: INTERVENTIONS

- Encourage the client to talk about the situation and what triggered the aggressive behavior
- Assist patient in relaxation techniques
- Continue intensive nursing care
- Help the patient explore other alternatives to aggression

RECOVERY PHASE: INTERVENTIONS

- Assess patient and staff injuries
- Evaluate patient's progress towards self-control
- Process the incident with the staff
  - How the episode was handled, what worked well, what needs improvement, how it could have been prevented

5. POST-CRISIS PHASE

- Client attempts reconciliation with others and returns to the level of functioning before the aggressive incident and its antecedents
- Signs, Symptoms, and Behaviors
  - Moderate to mild anxiety
  - Remorse, apologies, crying, quiet, withdrawn behavior, repression of assaultive feelings

POST-CRISIS PHASE: INTERVENTIONS

- Process incident with the client
- Discuss alternative solutions to the situations and feelings
- Progressively reduce the degree of restraints and seclusion

POST-CRISIS PHASE: INTERVENTIONS

- Client can be given feedback for regaining control, with the expectation that he will be able to handle feeling with a non-aggressive manner in the future
- Facilitate reentry to the main ward and reintegration into the milieu

EVALUATION CRITERIA

The client will:

- Refrain from verbal outbursts
- Refrain from striking others
- Refrain from violating other's personal space
- Identify factors that precipitate violent behaviours
- Identify feelings when angry or frustrated
- Vent negative feelings appropriately
- Identify alternative ways to cope with problems

REMEMBER:

- Use your therapeutic communication skills
- Self-awareness is important
- No intervention will be successful with all patients all the time.
- However, it is not the nurse's or patient's fault when an intervention is ineffective. The intervention simply did not fit situation at that particular time.

VIDEO

SECLUSION AND RESTRAINTS

NURSING MANAGEMENT

SECLUSION

- Solitary confinement in a fully protective environment with close surveillance by nursing staff for purposes of safety or behavior management
- Therapeutic use
  - Containment
  - Isolation
  - Decrease in sensory input

NURSING INTERVENTIONS

- Obtain a Doctor's order.
- Designate one nursing staff to communicate with the patient and direct other staff
- Identify for the patient and significant others those behavior that necessitated the intervention.
- Explain the procedure, purpose and the time period of the intervention
- Explain to patient and significant others the behavior necessary for the termination of the intervention.

NURSING INTERVENTIONS

- Contract with patient (as patient is able) to control behavior.
- Instruct on self- control method as appropriate.
- Assist in clothing that is safe and in removing jewelry and eye glasses.
- Remove all items from the seclusion area that patient might use to harm self and staff.
- Assist with the needs related to nutrition, elimination, hydration and personal hygiene.
- Provide appropriate level of supervision to monitor the patient and to allow therapeutic actions as needed.

NURSING INTERVENTIONS

- Acknowledge your presence to patient periodically.
- Administer prn medications.
- Provide for patient's psychological comfort.
- Monitor seclusion area for temperature, cleanliness and safety.
- Evaluate at regular intervals, patient's need for continued restrictive intervention.
- Involve patient when appropriate, in making decisions to move towards a more/or less restrictive intervention.
- Determine patient's need for continued seclusion.

NURSING INTERVENTIONS

- Document the following
  - Rationale for restrictive intervention.
  - Patient's response to intervention
  - Patient's physical condition
  - Nursing care provided throughout intervention
  - Rationale for terminating the intervention.

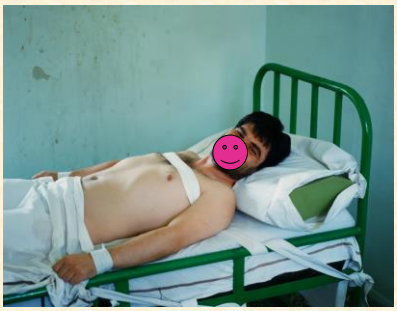
NURSING INTERVENTIONS

- Process with the patient and staff the following:
  - Termination of restrictive intervention
  - The circumstances that led to the use of the intervention.
  - Patient's concern on the intervention itself.

SECLUSION ROOM

PHYSICAL RESTRAINTS

- Application, monitoring, and removal of mechanical restraining devices or manual restraints that are used to limit physical mobility.



NURSING INTERVENTIONS

- Obtain a doctor's order
- Provide patient with a private and adequately supervised environment.
- Provide sufficient staff to assist with safe application of physical restraints.
- Designate one staff member to direct staff and to communicate with the patient during restraining.
- Use appropriate hold when restraining a patient
- Identify for patient and significant others those behavior that necessitated the intervention.

TEAM APPROACH

NURSING INTERVENTIONS

- Explain the procedure, purpose and the time period of the intervention.
- Explain the behavior necessary for the termination of the intervention.
- Monitor patient's response to the procedure.
- Avoid tying restraints on the side rails of the bed.
- Secure restraints out of patient's reach.
- Provide appropriate level of supervision to monitor the patient and to allow therapeutic actions as needed.

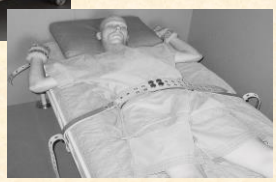
NURSING INTERVENTIONS

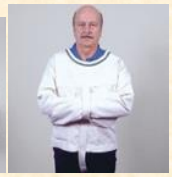
- Provide psychological comfort as needed.
- Provide diversionary activities when appropriate.
- Administer PRN medications for anxiety and agitation.
- Monitor skin condition and circulation at restraints sites.
- Provide for movement and exercise, according to patient's level of self control, condition, and abilities.
- Position patient to facilitate comfort and prevent aspiration and skin breakdown.

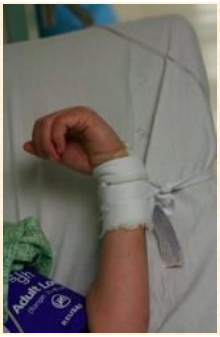
NURSING INTERVENTIONS

- Provide for movement of extremities in patient and assist with periodic changes in body position.
- Assist with needs related nutrition, elimination, hydration and personal hygiene.
- Evaluate at regular intervals, patient's need for continued restrictive intervention.
- Involve patient in activities to improve strength, coordination, judgment, orientation.

PATIENT ON PHYSICAL RESTRAINTS







NURSING INTERVENTIONS

- Involve patient , when appropriate, in making decisions to move toward a more or less restrictive form of interventions.
- Remove restraints gradually as self control increases.
- Monitor patient's response to removal of restraints.
- Process with the patient and staff the following:
  - Termination of restrictive intervention
  - The circumstances that led to the use of the intervention.
  - Patient's concern on the intervention itself.

NURSING INTERVENTIONS

- Document the following
  - Rationale for restrictive intervention.
  - Patient's response to intervention
  - Patient's physical condition
  - Nursing care provided throughout intervention
  - Rationale for terminating the intervention.
- Teach the family the risks and benefits of restraints and restraints reduction.

The goal is to use the least restrictive measures:

MOVEMENT TOWARDS A RESTRAINT-FREE ENVIRONMENT

***** Seclusion and restraint are to be used only in the case of behavioral emergency**

LET'S WORK AS A TEAM AND HELP OUR MENTALLY-ILL CLIENTS ACHIEVE THEIR HIGHEST POTENTIALS!

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