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Management of patients with aggression

J.Mano Ranjini*, Sandhya Negi

Nursing Tutor, Swami Rama Himalayan University, Dehradun, Uttarakhand, India

ABSTRACT

Human being is an only social animal to smile, so they are said to be social being. Anger and aggression are the factors to show the maintenance of equilibrium between external and internal stimuli. This paper discuss about various theories related to violent behavior, expression of anger, relation between anger and mental illness, management techniques, its hierarchical method of applications on the patient according to the felt-needs and the emergency situation. The aim of this paper is to explore various aspects of violence and aggression in and the various evaluative programs designed to prevent and manage violence and aggression in clinical settings.

Keywords: aggression, management, patient.

Introduction

Violence and aggression in inpatient units constitute a major workplace hazard for mental health nurses, who must take account of many considerations when dealing with potentially aggressive or violent patients. Each day throughout the world, caring professionals do their best to provide quality care for patients within their organizational and legislative frameworks. Despite their compassion and empathy, many health care workers are the target of acts of violence and aggression. Aggression is a complex human behavior that has been developed through evolution to enhance the individual's and group safety and survival. Violence refers to the intentional use of physical force or power against oneself, another –person, or against group or community where as acting out refers to the problem behavior that is physically aggressive, destructive to property, verbally aggressive or otherwise more severe than simple misbehavior.[1]

Aggression and mental illness

Various research states that there is link between mental illness and violence but the findings remains contradictory. Research shows that demographic factors such as age, gender, race, marital status, education and socioeconomic factors are the predictors for the violent behaviors.

*Correspondence
J.ManoRanjini , Nursing Tutor, Swami Rama Himalayan University, Dehradun, Uttarakhand, India
E Mail: manopriyasri87@gmail.com

The prevalence of aggression and violence is 12 times greater with alcohol abusers and 16 times greater with other drug abuser. A high incidence was associated also with psychotic symptoms such as command hallucinations, severe thought disorder, and delusional ideation with violent Finally, a patient's appraisal of situation and level of perceived environmental, cognitive, and communication stress affect one's response level. Bipolar Affective Disorder [BPAD] with mania commonly have an increase in energy, pressured speech, aggressiveness, intolerance or intrusiveness may be due to the co-morbid conditions such as, substance intoxication and dependence.[2] Antisocial personality disorder reported various violent behaviors, acting-out natured behavior. Borderline personality disorder [BPD] is an increased risk of violence, impulsive behavior, which includes physical aggression. Schizophrenia also associate with this violent behavior and the prevalence rate is high when there is case history of childhood disorders such as behavioral and conduct problem. Childhood disorders has an increased act of violence such as deliberate self harm, violence against animals, school truancy, running away, vandalism, stealing and so. Substance use also has various indications for violent behavior, most commonly during the period of intoxication.

Theories of aggression

A number of theories have been developed that endeavor to explain the causes of aggressive behavior and have influenced the treatment of violent patients.

They can be categorized as biological, psychological, socio-cultural and other theories, etc.,

Biological Theory

It is associated with the mediation of basic drives and the expression of human emotions and behaviors such as eating, aggression and sexual response. In particular, the Amygdala part of the limbic system is responsible for the expression of rage and fear. Lesions and disease in the limbic system may cause aggressive act. Hypothalamus is the alarm system of the brain. Due to the repeated stimulation, the system may respond to the traumatic stress in childhood may permanently enhance one's own potentiality for violence. Neurotransmitters are brain chemicals that transmit across synapses that lead to brain communication which either increase or decrease the behavior.

Psychological Theory

One psychological view of aggressive behavior suggests the importance of certain factors that limits the person's capacity to adopt the non-violent coping mechanism. The major suggestion is that a disruption in the mother infant bonding process can lead to the development of poor interpersonal
behavior that may increase the likelihood of violent behavior. [3]

Psychoanalytical Theory

Anger is instinctual and seeks expression as the self destruction behavior. Anger may be displaced into an object resembling the original of anger and aggression. Apart from this, certain disease conditions are the indicators of the internalized anger.

Interpersonal Theory

Any anxiety producing situation has potential for provoking anger and aggression. Emotion of anger gives one feeling of power that compensate for an underlying anxiety. It attempts to destroy the object or the situation that produce anxiety said to be a catastrophic reaction.

Behavioral Theory

Anger results from frustration in achieving goal. Anger is learned through socialization process by observation and modeling. Anger is an energy that propels people to new learning thus enhancing feeling of adequacy as a person.[4]

Existential Theory

Anger is suffering that gives the people an opposition to find new meaning in life.

Socio-cultural Theory

Social and cultural factors may also influence aggressive behavior. Cultural norms help to define acceptable and unacceptable means of aggression behavior. A person with good assertiveness can handle the anger and aggression behavior in a healthy manner.

Development and expression of anger (Shown in figure 1)

Figure 1: Development and expression of anger

Management techniques

Problems are common but they must be solved before they end up in serious consequences. If not, they remain as unresolved conflicts repressed in the unconscious part of the mind that deliberately burst into socially unacceptable behaviors. Such behaviors are common in adolescents and early adults resulting in series of serious physical and mental illnesses.

Managing techniques falls into two categories; they are Physical and Psychosocial interventions for anger and aggression behavior (Figure 2).

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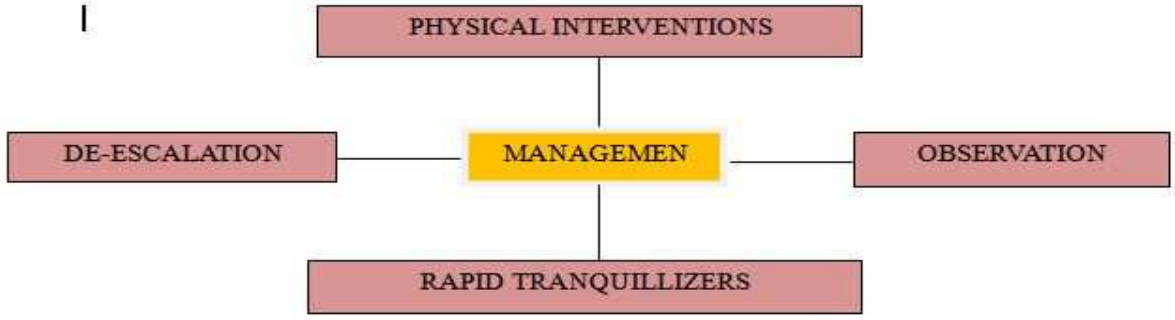

Figure 2:Management techniques

Physical Interventions

Physical interventions are commonly used in the short-term management of disturbed / violent behavior. Physical intervention is predominantly described in the name of Restraints. Mechanical restraints are used purely in the concern of immobilizing the individual safely. Challenges in acutely ill patients with mental health problem are multifaceted and complex. The aim is to quickly and effectively address the nature of the emergency & identify various factors that may have contributed to the same in an attempt to minimize the chance of recurrence in the near future.Despite of various interventions including talking down the patients & the use of medications to de-escalate emerging agitation, violence and the risks may persist or increase. In such extreme situation, the temporary uses of mechanical restraints are necessary to ensure the patient safety themselves, other patients, patient carers and staffs.Mechanical Restraints used appropriately & judiciously is an effective short term strategy to de-escalate the violent situation. Mechanical Restraint also has certain serious complication, including dislocation, ischemia of limbs & asphyxia. Therefore its use needs to be carefully considered, employed and monitored by trained staff members.

Standard Operating Procedures of Mechanical Restraint in Violent and Agitated patients

1. Use of Restraints needs to include, the entire treating professionals including all the members Of Health care team
2. It entails the use of standard method of treatment
3. The patient needs to be transport to the ICU for the period of time in case of any complication raised out of restraints
4. It was indicated subsequently transferred back to the respective ward
5. The decision to use restraint is made only by the Psychiatrist after reviewing the failure of chemical restraints
6. Medication order need to be reviewed & modified as necessary to decrease the likelihood of recurrent use of restraint
7. The indication and reason for restraint in use have to be documented in the patient record
8. Time of commencement and cessation of the restraint must be recorded in the patient record
9. The duration of restraint is for the least time possible. If need for on-going restraint the reason must be mentioned in the patient record
10. General instructions for the members of health care team,
    a. Checking for the injuries, adequacy of the blood flow to the peripheral & clear airway, breathing after application of the restraints
    b. 15 minutes once monitoring of cardinal signs
    c. 30 minutes once monitor Mental Status Examination
    d. Informing the patient cares of eye to eye monitoring, not leaving the patient

unattended, not opening the restraint themselves, informing the staffs if the patient have difficulty breathing, If become unresponsive, they need to be documented as, having been informed to the carers and consent to be signed by the carers

e. Inform the Psychiatrist for the cessation of the restraint for the patient[5]

Physical restraint must be a last resort, only being used in an emergency where there appears to be a real possibility of significant harm if withheld. It must be of the minimum degree necessary to prevent harm and be reasonable in the circumstances.

Seclusion

Seclusion is the formal placing of a service user in a specially designated room for the short-term management of disturbed/violent behavior. Its sole aim is to supervise confinement of a patient in a room, which may be locked to protect others from significant harm. Seclusion should be used as a last resort; for the shortest possible time. Seclusion should not be used as a punishment or threat, as part of a treatment programme because of shortage of staff where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.Seclusion must be differentiated from asking a service user to go to a designated room for the purpose of calming down. The latter is a de-escalation technique and the seclusion room should not routinely be used for this purpose. Seclusion, if not viewed as a therapeutic intervention, it simply allows for a period of calming in the service user. It should always be managed in a designated room for secluding, thereby separating the service user from other service users and placing them in a positive milieu.

De-escalation techniques

De-escalation refer to as [defusing or talk-down] involves the use of various psychosocial short-term techniques aimed at calming disruptive behavior and preventing disturbed/violent behavior. Every effort is made to avoid confrontation. It is "talking the patient down" often known as verbal de-escalation. It is actually a complex, interactive process in which a patient is redirected towards a calmer personal space. There is a need to observe for signs and symptoms of anger and agitation, approaching the person in a calm controlled manner, giving choices and maintaining the service user's dignity. Even it is a complex process there is no very effectiveness in the utilization of such above technique.[6]

Observation

Observation has been undertaken in relation to the management of suicide and self-harm. It focuses on the short-term management of disturbed/violent behavior in psychiatric in-patient settings. Observation is a 'core nursing skill' and arguably a primary intervention in the recognition, prevention and therapeutic management of violence in addressing acute concerns such as suicide and self-harm. In such concerns the observation techniques can be utilized in 4 different levels of observation – General observation, Intermittent observation, Within eyesight, Within arms length.

Rapid Tranquillizations

It is known as Urgent Sedation, the use of medication to calm/lightly sedate and reduce the risk to self and/or others. The aim is to achieve an optimal reduction in agitation and aggression. Drugs used for rapid tranquillization are benzodiazepines and antipsychotics. Benzodiazepines are frequently used as first line treatments for rapid tranquillization. Diazepam, have erratic and slow absorption intramuscularly and are associated with prolonged sedation following repeated doses. Lorazepam has a shorter elimination half-life which limits the risk of excessive sedation due to the cumulative effects of the drug. Combinations of a benzodiazepine, an antipsychotic, and other drugs may be given either deliberately for rapid action. It has become common practice to co-administer both a benzodiazepine and antipsychotic together.

Conclusion

Anger and aggression are the common and complex human behavior. Aggression is an emotional and the automated response for the stimuli. An uncontrollable anger, unresolved conflicts are the root causal for the effect known as Violence. Such violence turns into both self-directed violence and deliberate harmness for others that make the life into risk.Violence and aggression, the base of much research in recent years, is a major professional issue for nurses who work in mental health inpatient facilities. Health service organizations everywhere have been introducing various strategies in an attempt to minimize the problem, a major innovation being the introduction of aggression minimization programs. Further research on

aggression minimization programs is indicated to establish best practice guidelines to minimize patient violence, which has such a profound impact on patients, nurses and the therapeutic relationship.

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