Inpatient Psychiatric Nursing
Linda Damon, MSN, MHA, RN, is the vice president of patient care services, Butler Hospital, Providence, RI, where she is responsible for the quality of nursing care and operations of inpatient, partial hospital services, and admission services in a 147-bed hospital. She has held senior management positions at Cambridge Health Alliance Department of Psychiatry (Cambridge, MA); Horizon Health Corporation, provider of psychiatric management services (Lewisville, TX); and McLean Hospital, a private Harvard-affiliated psychiatric hospital (Belmont, MA). In addition, she has served as adjunct faculty at the Community College of RI (Providence, RI), MGH Institute for Health Professionals, Boston College (Boston, MA), and the University of Massachusetts Lowell (Lowell, MA). Her professional affiliations include membership in the American Nurses Association (member delegate from RI ‘08 and ’10), Rhode Island State Nurses Association (RISNA) American Psychiatric Nurses Association (APNA) Massachusetts Organization of Nurse Executives (MONE), American Organization of Nurse Executives (AONE), and the RI Board of Registration in Nursing.

Joanne M. Matthew, MSN, PMHCNS-BC, RN, is a nurse manager in adult intensive treatment unit at Butler Hospital, Providence, RI. She also serves as clinical instructor in psychiatric mental health nursing at the University of Rhode Island, School of Nursing. She is a member of the APNA Administrative Steering Council and a task force member of the APNA Institute for Safe Environments: Physiological Risks of Restraint and Seclusion (2009).

Judy L. Sheehan, MSN, RN, is the director of nursing education at Butler Hospital, Providence, RI. She also serves as the nurse peer review leader for the Massachusetts Association of Registered Nurses, Committee of Continuing Education and is a clinical instructor in psychiatric nursing at the University of Rhode Island College of Nursing. In addition, she has served as adjunct faculty for Salve Regina University and the Massachusetts School of Pharmacy and Allied Health. Her professional affiliations include membership in the American Psychiatric Nurses Association, The National Nurses in Staff Development Organization and the American Nurses Association. Ms. Sheehan has contributed to two books and published the CD-ROM De-Stress: Coping and Managing Computer Generated Stress.

Lisa A. Uebelacker, PhD, holds multiple appointments including staff psychologist at Butler Hospital, Providence, RI; affiliate staff, Department of Family Medicine at Memorial hospital, Pawtucket, RI; and assistant professor, Department of Psychology and Human Behavior at Brown University, Providence, RI. She serves as an ad hoc reviewer for many psychology journals and is on the editorial board of the Journal of Family Psychology. Dr. Uebelacker has published more than 45 peer-reviewed articles. She has also been the principal investigator or co-principal investigator on 10 funded research grants.
This book is dedicated to psychiatric nurses, past, present and future and the patients they serve.
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Contributors

Cynthia Belonick, APRN-BC
Nurse Educator
The Institute of Living,
Hartford, Connecticut

Ellen Blair, APRN-BC
Director of Nursing
The Institute of Living,
Hartford, Connecticut

Barbara-Ann Bybel,
DHA, MSN, NEA-BC,
PMHNP-BC
Patient Care Director
New York Presbyterian
Hospital, New York

Linda Damon, MSN,
MHA, RN
Vice President of Patient Care Services, Chief Nursing Officer
Butler Hospital, Providence, Rhode Island

Maryann DaSilva, BSN, RN
Nurse Manager of Adult Services, D3
Butler Hospital, Providence, Rhode Island

Laura Drury, MSW, LICSW
Clinical Director of Social Work
Butler Hospital, Providence, Rhode Island

Mary E. Dubreuil, RN, MA
(2012) LCDP
Director of Alcohol and Drug Treatment Services
Butler Hospital, Providence, Rhode Island

Nancy Egan, RN, MEd
Nurse Manager, Child and Adolescent Treatment Services
Butler Hospital, Providence, Rhode Island

Linda Espinosa, MS, RN
Vice President of Patient Care Services
New York Presbyterian Hospital, New York

Diane Ferreira, RN, MHA
Director of Social Services
Butler Hospital, Providence, Rhode Island
Contributors

Nicole Flanagan, BA, BSN, RN
Nurse Manager of Adult Services, D4
Butler Hospital, Providence, Rhode Island

Judith L. Giorgi-Cipriano, MS, RN
Director of Quality and Patient Services
New York Presbyterian Hospital, New York

Elizabeth Harris, RN, MA, PMHCNS-BC
Health Education Coordinator
New York Presbyterian Hospital, New York

Debora Heidtman, RN, MHA
Director of Adult Services and Kent Unit
Butler Hospital, Providence, Rhode Island

Susan Higgins, MA, OTR/L
Occupational Therapist
Butler Hospital, Providence, Rhode Island

Joan S. Kovach, RN, MS, PC
Nurse Director
McLean Hospital, South East Unit
McLean Hospital, Belmont Massachusetts

Karen Larsen, RN-BC
RN Clinical Coordinator
The Institute of Living, Hartford, Connecticut

Mary Leveillee, PhD(c), RN PCNS, MS
Director, Undergraduate Program
College of Nursing
University of Rhode Island Rhode Island

Angela Macera, RN, MBA, BS
Patient Care Director
New York Presbyterian Hospital, New York

Joanne M. Matthew, MSN, PMHCNS-BC, RN
Director of Nursing Quality and Intensive Treatment Unit
Butler Hospital, Providence, Rhode Island

Emily McCue, BSN RN
Staff Nurse, Kent Unit
Butler Hospital, Providence, Rhode Island

Julie Armstrong Muth, MS, RN, NE, BC
Director of Nursing and Quality
New York Presbyterian Hospital, New York

Barbara Ostrove, MA, OTR/L
Director of Occupational Therapy
Butler Hospital, Providence, Rhode Island
Christopher Paiva, RN-BC, BSN
Nursing Director of the Behavioral Health Unit
Newport Hospital, Newport, Rhode Island

Michelle Pereira, RN, MHA
Director of Risk management and Business Development
Butler Hospital, Providence, Rhode Island

Idrialis Perez, RN, BSN
Clinical Assistant Nurse Manager, Senior Specialty Unit
Butler Hospital, Providence, Rhode Island

Patricia R. Recupero, JD, MD
Board Certified in Addictions and Forensic Psychiatry President/CEO, Butler Hospital, Providence, Rhode Island

Kevin Ritchie, RN, BSN
Staff Nurse, Kent Unit
Butler Hospital, Providence, Rhode Island

Kristen Sayles, BA, BS, RN
Clinical Assistant Nurse Manager, Kent Unit
Butler Hospital, Providence, Rhode Island

Judy L. Sheehan, MSN, RN
Director of Nursing Education Butler Hospital, Providence, Rhode Island

Debra Spellman, BSN, RN
Staff Nurse, Kent Unit
Butler Hospital, Providence, Rhode Island

Kristi Svendsen, RN, MA, CAGS, LCDP
Clinical Assistant Nurse Manager, Alcohol and Drug Treatment Unit
Butler Hospital, Providence, Rhode Island

Mary Trainor, RN, BSN
Staff Nurse, Senior Specialty Unit
Butler Hospital, Providence, Rhode Island

Christopher Towey, RN, BA
Clinical Assistant Nurse Manager, Intensive Treatment Unit
Butler Hospital, Providence, Rhode Island

Lisa A. Uebelacker, PhD
Research Psychologist
Butler Hospital, Providence, Rhode Island, Alpert Medical School of Brown University
Preface

Due to a changing health care landscape, inpatient psychiatric nursing practice has changed dramatically over the past decades. The patients who now receive care in an acute care setting have to be very ill and typically exhibit considerable behavioral impairments and multiple safety concerns. The average length of stay is often between 5 and 10 days, and the resources available to these patients after discharge vary considerably depending upon their own health insurance and the community from which they come. Psychiatric nurses who practice in the inpatient acute care setting find themselves challenged by a wide range of patient symptoms and behaviors that occur in the context of the complex and ever-changing treatment environment on the psychiatric unit. As we read the psychiatric nursing literature, we found that many authors focused extensively on treatment of specific diagnoses. Yet, a group of individuals with a given diagnosis are often very heterogeneous and exhibit many different types of behaviors. In the psychiatric nursing literature, there was much less information on managing specific behaviors (which may be transdiagnostic) on an acute inpatient unit. Therefore, we wanted to share our insights on the many approaches to managing the specific behaviors that psychiatric nurses see on an inpatient unit every day. This book primarily includes practice-based evidence. Wherever possible, we also tried to place our own practical experiences in the context of current literature and research.
Inpatient Psychiatric Nursing: Clinical Strategies and Practical Interventions is a handbook for psychiatric nurses, nursing students, new nurses, or other nurses who are new to working with patients having psychiatric conditions. In this handbook, we describe specific aspects of inpatient psychiatric nursing practice, with a focus on three types of inpatient treatment goals: keeping the patient safe, stabilizing symptoms, and promoting engagement in treatment. A fourth goal is discharge planning. This book is organized according to patient behaviors (Part I) and interventions that nurses can employ to manage behaviors (Part II). In Part I, there is a consistent chapter format so that specific content is easy to access, and each chapter concludes with a comprehensive table covering goals, areas of assessment, and interventions of the chapter’s covered behavior. (A PDF combining all ten of these tables is available for free download and convenient printing at springerpub.com/Damon.)

This book grew from a forum of Butler Hospital nurses who came together over a 2-year period to identify and describe successful interventions used in the inpatient psychiatric setting. Feedback from nursing students, new graduate nurses, and newly employed nurses on the inpatient units underscored the need for such a resource. Clinical Strategies and Practical Interventions represents a collaboration of the original nurses from Butler Hospital with colleagues from University of Rhode Island, McLean Hospital, New York Presbyterian, and Institute of Living.
Acknowledgments

This book is the result of extensive contributions by the many nurse authors listed on the chapters. Without all their hard work, this would not have been possible. The idea for this book originated with a group of nurses at Butler Hospital who formed a task force that documented the many nursing interventions used with our psychiatrically complex patients. These nurses built the foundation from which we all worked. I am very grateful to this team: Joanne Matthew, Maryann DaSilva, Christopher Paiva, Kristen Sayles, Janet Gould, Sherrill Magnan, Idrialis Perez, Ruth Reavey, Debra Spellman, Karen Tamburro, and Mary Trainor.

I have been blessed to work on this endeavor with such an extraordinary team both at Butler Hospital and at other Ivy League Hospitals, including the Institute of Living, New York Presbyterian, McLean Hospital, and the University of Rhode Island. Without their labor of love, this would not have been accomplished.

I give special thanks to Patricia R. Recupero, MD, JD, President and CEO of Butler Hospital. She encouraged and supported our work. She knew the importance of writing down our successful interventions so that others could learn from them. I also thank Dr. Steve Rasmussen, Medical Director at Butler Hospital, for facilitating my introduction to Lisa A. Uebelacker, PhD, researcher. We, as nurse authors, are forever indebted to Dr. Uebelacker for her collaboration with us. She has been a mentor, teacher, and friend. In addition, I thank my coeditors,
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Lastly, I thank each and every nurse who cares for patients with psychiatric illness. Your work is challenging, your commitment inspiring!

Linda Damon, MSN, MHA, RN
PART I: MANAGEMENT OF SPECIFIC BEHAVIORS

The Patient With Anger

Joanne M. Matthew, Kristen Sayles, and Maryann DaSilva

BACKGROUND AND DESCRIPTION

Anger is a basic human emotion that is normal and expected under certain situations. Anger serves as an energizing function that enables an individual to act on perceived threats (Novaco, 1976). However, the individual’s expression of anger or behavior when angry can become a problem for the individual and others. Some individuals escalate quickly from annoyance or frustration to rage and may have a reduced ability to exercise control over their angry responses (Murphy & Carsen, 2010). In fact, individuals who are quick to anger may have more sensitive or dysfunctional central nervous system, which governs wakefulness and vigilance; these individuals are highly alert to potential threats and consequently respond rapidly to perceived threats (Murphy & Carsen, 2010; Perry & Szalavitz, 2006). Research demonstrates that individuals with high levels of anger arousal are at risk for violent behaviors and cardiovascular diseases (Murphy & Carsen, 2010; Novaco, 2007.)

Anger can be distinguished from aggression, which is a physical or verbal action of directed harm to objects or others (Hollinworth, Clark, Harland, Johnson, & Partington, 2005; Murphy & Carsen, 2010; Thomas, 2001). In this chapter, we focus on early identification of anger and
preventative interventions to interrupt the escalation of anger to aggressive or violent behaviors.

**Behavior**

Some of the behaviors associated with anger are a reflection of a patient’s state of physical arousal. During the early phase of anger, the patient may be quieter but will still demonstrate identifiable body language and behaviors, such as turning away from a group, muttering, or beginning to make hostile comments to staff and peers. Her face may redden, and her fists or jaw may clench. Sometimes, the individuals’ actions may not be notable, but the way that they change positions more abruptly, move quickly, or act more forcefully will provide some indication of a changing emotional state from mild annoyance or irritation to anger.

In contrast, sometimes the angry patient is easy to identify, as he will be very active, may pace back and forth, and have trouble sitting still. This individual may speak loudly, often in clipped tones or in a rapid manner, while making wild gestures, poking a finger at others, or shaking his fists. The angry patient may begin to stomp his feet, slam doors, or put down a magazine or other object with more force than is required.

The emotion of anger is thought to be experienced similarly across gender although the expression of anger is modified by social roles (Fischer, Mosquera, Van Vianen, & Manstead, 2004). Beliefs about proper expression of anger can be different for cultures considered to be more individualistic (e.g., the United States) compared with more collectivistic cultures (e.g., Japan). In a collectivistic culture, the expression of anger may be seen as a threat to the important value of harmony in relationships and therefore individuals may try to suppress overt signs of anger. In contrast, an individualistic culture will value socially appropriate expressions of
anger as being needed to protect individual rights and freedom (Hollinworth, et al., 2005). However, because there can be a wide range of behaviors and attitudes within any given cultural group, it is important to consider each patient individually when assessing ability to manage angry feelings.

With regard to gender differences, there are inconsistencies in the body of literature that examines gender differences in emotions and the expression of emotion (Cheung & Park, 2010; Fischer, et al., 2004). Some studies have found that anger is more often outwardly expressed by men than women; however, these differences may be less distinct in some cultural groups (Safdar et al., 2009). Further, across genders, the trait of expressing anger outwardly is associated with increased cardiovascular risk factors.

Cognition

An individual’s appraisal of a situation, as well as her expectations for what should occur, can lead to anger. Anger is often a response to a perceived injustice, a perceived disrespect, a personal insult, or a physical threat to personal safety (Hollinworth et al. 2005; Murphy & Carsen, 2010). A patient who is angry may believe she has been mistreated or treated unfairly. Another individual may feel trapped, that she has no choices, or that she must defend herself. Sometimes the trigger to the angry response is not clear to the staff or the individual.

Angry behavior can be fueled by certain beliefs about anger. For example, an individual may be thinking, “No one listens to me unless I yell,” or “no one respects me” (Murphy & Carsen, 2010). Another person who is distressed by his anger may believe “I shouldn’t feel like this about someone,” or “I am not a good person if I feel this way.”
When a person is extremely angry, cognitive processes may be impaired. The individual may act before evaluating the consequences of his actions. In addition, the individual may have difficulty reflecting on his behavior or processing multiple or complex instructions or requests (Murphy & Carsen, 2010; Novaco, 1976).

Affect

Anger is a natural human emotion and can serve as an adaptive function, such as a signal that there is a problem in the individual’s environment. The expression of anger occurs on a spectrum of emotion from mild annoyance or irritation to frustration or anger and to rage and possibly aggression (Murphy & Carsen, 2010). For some individuals, feelings of vulnerability, sadness, shame, or fear can lead to anger (Davila, 1999; Tangney, Wagner, Fletcher, & Gramzow, 1992). The individual’s experience of anger can be extreme and personally distressing. For some, anxiety and guilt may occur in response to feeling angry (Thomas, 2001).

Context

Difficulty coping with anger and rapid escalation to rage or aggression sometimes occurs in individuals with psychiatric diagnoses such as bipolar disorder, posttraumatic stress disorder (PTSD), substance abuse or dependence, major depression, and personality disorders, especially Cluster B (Murphy & Carsen, 2010; Novaco, 2007). An acute exacerbation of these conditions can make angry feelings and behaviors even more difficult to manage. Individuals who have a medical condition that decreases their ability to regulate their emotions or increases their impulsivity, such as stroke or traumatic brain injury (TBI), could also have problems coping with anger (Murphy & Carsen, 2010; Quanbeck & McDermott, 2008).
There are other contexts for anger as a problem as well. Individuals who have few positive coping skills or who have experienced childhood neglect or trauma may have problems managing their emotions, including anger (Murphy & Carsen, 2010). Anger can be a stage in the grief process, and patients who have experienced multiple losses or one significant loss may experience anger. Some individuals may have frequent angry responses on the inpatient unit, in part, because it is a restrictive, highly regimented, and controlled setting (Murphy & Carsen, 2010).

Finally, there is a Korean anger disorder called “hwa-byung.” The development of this disorder is ascribed to long-term suppression of anger that accumulates and results in symptoms of feeling angry, expressing anger, feeling physical sensations of heat, and feelings of hate. It is found in 4.1% of the Korean population, most often in middle-age or older women (Min & Suh, 2010).

**POTENTIAL BARRIERS TO BEING THERAPEUTIC**

Witnessing angry acts or being subjected to the angry venting of a patient can bring up feelings of fear, anger, helplessness, or anxiety in a nurse. Depending on the nurse’s own experiences and way of handling anger, he may feel angry toward the patient. This may cause the nurse to respond punitively to this patient. The nurse who feels fearful may avoid the patient, thus hesitating to intervene early or effectively. Finally, when angry patients make threats against the nurse and challenge her competence and livelihood, the nurse may respond defensively or hesitantly as she may begin to doubt herself. As is often the challenge with patients, the nurse must understand her own responses to anger and aggression and use that understanding to be able to respond in a therapeutic way (Murphy & Carsen, 2010).
I. Management of Specific Behaviors

OVERVIEW OF NURSING CARE GOALS

1. Safety
   - Prevent or reduce the risk for harm to others
2. Stabilization
   - Increase anger management skills
3. Engagement
   - Increase engagement in treatment

SAFETY

Subgoal: Prevent or Reduce Risk for Harm to Others

Assessment of Risk for Harm to Others

Angry patients who are in a rage present a risk for violence to others. Sometimes, this risk is the result of a direct assault. Other times, it will be inadvertent due to the patient throwing objects during an angry outburst. In this chapter, we focus on assessment and interventions that can prevent the patient progressing to this stage.

In report. The nurse will listen for specific indications that the patient has a problem with anger and/or has been violent in the past. Consequently, the circumstances of the admission, history of violence, and diagnosis are all important. Is the patient here involuntarily? Has he assaulted anyone recently or in the past? Is there any history of domestic violence, childhood abuse, or neglect? (Murphy & Carsen, 2010). The nurse will also listen for any assessment ratings that indicate anger escalation or aggression risk (see “On the unit” below). The nurse will consider whether the angry aggression is related to an acute stressor or a more permanent change in behavior. For example, is the anger or irritability related to a bipolar episode, and might the anger resolve as the episode resolves? Is the patient chronically and emotionally dysregulated, such as someone with
PTSD or a personality disorder? Is the patient intoxicated or does she have a history of a TBI? The nurse’s knowledge and understanding of the nature and chronicity of anger problems will serve to guide intervention. In some cases, treatment or resolution of the underlying problem (e.g., intoxication) will be sufficient to manage anger and prevent aggression. In other cases, when the underlying problem is more chronic, as in TBI, anger may be a problem throughout the entire hospital stay and require active management.

**One-to-one contact.** During the initial nursing assessment, the nurse will want to ascertain the patient’s perception of why she is in the hospital. The nurse may ask, “Can you tell me why you are here?” “What are your goals for hospitalization?” or perhaps, “How can we help you?” If the patient can answer these questions, this is an indication that the patient is able to engage with the nurse further to develop de-escalation preferences or an initial crisis plan for coping with anger and preventing aggression. A wellness assessment or sensory assessment can also provide information about any antecedents to anger, the patient’s preferences regarding how to approach him when he is getting angry, and things that may help him calm down, such as talking to staff or being alone. Alternatively, the nurse can ask the patient, “What helps you when you feel angry?” “What should we know about you to help you if you feel angry?” “How do you relax or calm down when you get upset?” The patient may be able to give the nurse important information about how to help her avoid aggressive behavior.

If the patient responds to initial questions with a comment such as “Nothing. I do not belong here,” it could indicate an increased risk for aggression because the patient has limited insight or is angry about being hospitalized. Difficulty participating in this initial one-to-one assessment, a hostile attitude, or an irritable
mood increases the risk for aggression (Quanbeck & McDermott, 2008).

**On the unit.** The nurse will want to watch for any physiological signs of arousal in the patient, such as increased muscle tension, increased activity, or increased volume or tone during interactions. In addition, there are particular time periods that involve environmental risk factors that may increase stress and the risk of escalating anger for patients. These periods include shift changes, meals, medication administration times, visiting times, or times when the unit schedule is disrupted (Quanbeck & McDermott, 2008). The nurse will want to monitor patients who have difficulty during these times.

The Broset Violence Checklist (BVC) is a recommended assessment tool that was empirically developed using inpatient chart reviews (Almvik & Woods, 1999). In this scale, a staff is asked to rate whether a patient has been confused, irritable, boisterous, physically threatening, verbally threatening, or attacking objects. The staff rates at a specified time during the working shift. Patients receive one point for each behavior. A total score of 0 represents low risk for violent behavior; a score of 1 or 2 represents a moderate risk; and a score greater than 2 represents a high risk (Almvik & Woods, 1999). Rating the BVC allows the nurse to determine quickly who may be at high risk for violence on the next shift (Abderhalden, Needham, Miserez, Almvik, Dassen, Haug & Fisher, 2004; Almvik & Woods, 1999; Almvik, Woods, & Rasmussen, 2000; Woods, Ashley, Kayto, & Heusdens, 2008).

**Key Nursing Interventions to Reduce Risk of Aggression Toward Others**

Three essential nursing interventions for reducing the risk of angry patients acting aggressively are having a plan, managing environmental triggers, and de-escalating the patients (Murphy & Carsen, 2010). The specificity of the
plan and the degree to which environmental triggers must be managed will depend upon the likelihood that a patient will become aggressive and the likelihood that the patient will be able to de-escalate. If the nurse believes it will be difficult for the patient to de-escalate, the first two interventions (having a plan and managing environmental triggers) increase in importance.

**Have a plan for preventing aggression.** The nurse’s assessment of the patient’s current condition and history, his ability to engage in problem solving, and the assessment of his triggers to anger and skills for coping with anger provides the information that is used to develop a plan for the patient. The purpose of the plan is to prevent aggression. When a patient has been learning about coping skills, he may be able to develop a plan easily with support from the nurse. The nurse and the patient will want to discuss what “the plan” may be around an identified trigger or a difficult time. For example, if the patient has identified that raising his voice is an early sign of escalation, and that this typically happens during group, then the plan may be to have the patient and the group leader decide upon a signal for the patient to leave the group. The patient agrees to leave the group when given this signal. Alternatively, the nurse and the patient may agree that when he shows signs of becoming angry, the nurse or group leader will remind him to come out of group and choose something to help him calm down and refocus.

On some occasions, staff may anticipate the patient responding with anger and possibly aggression to a visitor, the physician, or an outside agency coming to give the patient difficult news. Even if the patient may not be aware of the fact that difficult news is forthcoming, the nurse may make a plan to have extra support for the patient, offer prn medications, and/or have the meeting in a designated safer place on the unit. The nurse’s choice of plan will depend on what has worked for this individual
in the past. In addition, staff and the patient may anticipate a trigger for aggression during a routine family visit, family meeting, or physician meeting. Together, the nurse and patient can discuss coping alternatives ahead of time and role-play any anticipated difficult moments. In addition, there may be a plan to provide the patient with support after the meeting.

Manage environmental triggers. For the patient who has a brain injury or is intoxicated or manic, the nurse will largely make the plan and manage environmental triggers as well as possible, potentially with minimal input from the patient. Based on her observations and the patient’s history, the nurse will attempt to minimize unnecessary exposure to triggers for anger or aggression. The nurse must consider the level of noise and activity on the unit at various times. Increased activity such as multiple new admissions or discharges, visiting times, or large group activities may be triggers for certain patients. Consequently, the nurse will want to consider the room assignment, location, and choice of roommate for this patient. The nurse will also want to guide the patient toward appropriate group or independent activities and potentially remove him from areas of the unit that the nurse expects to get noisy or active in the near future.

Help the patient to de-escalate when needed. De-escalation is needed as early as possible whenever there is indication that a patient is becoming more anxious, angry, or agitated. Early identification of an individual who is becoming angry is important so that the patient and nurse are able to communicate effectively. When the patient is in acute crisis, it is important to remember that she may have a decreased ability to think and communicate clearly.

De-escalation is the process of helping the patient to a “calmer space.” It involves respecting the patient, expressing concern for him, validating his feelings, and giving him
a choice (Johnson & Hauser, 2001). The majority of patients will respond to de-escalation as long as it is individualized for their needs and preferences. This is the intervention that is useful in all situations regardless of the patient’s diagnosis. We describe each of these steps in more detail next.

First, regardless of whether the patient is in an acute crisis, patients often say that the best nurses treat them like “human beings,” or with respect and dignity. Nurses who are successful in de-escalation first ask if they can approach or talk to the patient (Johnson & Hauser, 2001). Second, the nurse validates the patient’s feelings of anger, unfairness, or frustration and acknowledges the patient’s right to be angry (Hollinworth et al., 2005; Murphy & Carsen, 2010). For example, the nurse may say, “It makes sense that you feel this way.” The nurse should also apologize if the situation calls for that. The nurse should not become defensive or make statements about “being too busy.” At this point, it will also be helpful for the nurse to assess what may be causing the patient’s anger, and whether there is also sadness, fear, or shame. For example, consider the patient who is stating that he is going to “get out of here no matter what.” He is demanding to be discharged. Instead of immediately stating what cannot be done, the nurse should genuinely respond to the patient’s distress. Is he fearful? Has he given any sign that he is feeling trapped or his anger has been triggered by something? Sometimes, the patient can verbalize these thoughts or feelings. The nurse should look beyond the patient’s angry words and try to express to the patient that she can see that he is feeling upset or feeling bad. This can be followed with an expression of wanting to help and an offer of what can be done. This is the time to offer a chance to talk, medications, or a call to the patient’s physician to address some aspects of what the patient is experiencing.

Third, depending on the situation, the nurse tries to help the patient regain control of his feelings so that he does not escalate into rage or aggression. This is the time to offer the patient choices regarding what to do next, to avoid power
struggles with him over inconsequential things, and to allow the patient to exit the situation with his dignity intact and to “save face.” This may involve bargaining and compromise (Hollinworth et al., 2005; Lowe, 1992; Murphy & Carsen, 2010). Sometimes, the nurse cannot meet the patient’s demand (e.g., to leave the unit immediately) but can offer another solution (e.g., “I will be sure to let the doctor know how you feel”). Sometimes, the patient may identify something that the nurse can change. For example, perhaps the patient wants a different roommate or wants to make a phone call. If there is a request that the nurse can accommodate, it may help the patient tolerate denial of other requests.

This is a good time for the nurse to remember that frustration with the rules, restrictions of the setting, or some disappointing news or situation may have triggered anger for this individual. This may help increase the nurse’s empathy and enable the nurse to behave flexibly. The nurse will want to take care not to say things that come across as shaming or blaming as this may intensify the patient’s anger. This is not a good time to remind the patient of “the rules.” For example, many units have a rule that swearing or cursing is not allowed. Instead of saying “watch your language” or “we do not allow swearing here,” the nurse might say, “I know that you are upset (or really angry), but I am having trouble hearing you when you swear at me (or yell at me). What you have to say is important.” Sometimes, it is effective for the nurse to say that she does not want to fight with the patient; she just wants to help.

STABILIZATION

Subgoal: Increase Anger Management Skills

Assessment of Readiness for Anger Management Skills and Triggers for Anger

In report. The patient who has reported poor insight and judgment, is hospitalized against her will, or is actively
The observations heard in report will indicate areas the nurse needs to assess further during one-to-one contact. For example, if the patient has reported homicidal ideation that is not related to a delusional or psychotic process, the nurse will ask the patient more specific questions during their one-to-one contact and assess the patient’s willingness to learn new skills to cope with it.

In report, the nurse will want to listen for specific times or situations that may have triggered a reported angry outburst. Does the patient tend to become angry during medication administration times, visiting time, or meal times? The context of the angry outburst may be a clue to a potential trigger such as the denial of a request or the wait time after a request. The nurse can then ask the patient about the trigger and about the patient’s interest in learning new coping skills to manage that trigger.

**One-to-one contact.** The nurse will want to assess the patient’s understanding about anger, his perceptions of his angry behavior, and his readiness to learn new skills. Does the patient make statements regarding his angry behavior that place all the blame on others? Is he rationalizing or justifying his behavior? If the patient blames others for “making me angry” or insists that he would not get angry if people did not do certain things, then he may not be ready to participate in a discussion regarding his part in the escalation of anger and how he might better manage angry feelings. For example, consider the patient who is admitted after destroying property in reaction to a spouse’s infidelity. She may see her behavior as justified and not problematic.

In addition, patients who demonstrate no distress over their “angry” behavior may not be ready to try to change...
I. Management of Specific Behaviors

it or manage it. Finally, the patient who is demonstrating overt signs of angry behavior, such as yelling or slamming doors, but when asked, states that she is not angry at all is likely not ready to consider other ways of responding to angry feelings.

Alternatively, some patients will express regret and say that they wish that they could cope better. They may want to learn new coping skills. Patients who are able to discuss their feelings, their thoughts, and possible triggers to anger will be more likely to be able to learn and practice anger management techniques.

On the unit. The nurses will assess the patient for any overt behaviors that suggest the patient is ready to talk about anger management. The nurse will also look for signs that the patient is not ready, such as denial of angry feelings. She will also watch for potential triggers for anger that will need to be addressed when teaching anger management skills.

Key Nursing Interventions to Increase Anger Management Skills

Make expectations clear. For all patients, the nurse will want to make certain that a clear understanding of staff expectations is provided. These expectations will likely include being respectful of others, telling staff when the individual is feeling that he is escalating toward anger, or coming to staff when she has a conflict with another patient (Lowe, 1992). This is best done when the patient first arrives on the unit and when the patient is not in a state of extreme anger. The nurse can explain that he goes over these expectations with all patients. It is important to remember that while it is the nurse’s responsibility to provide the behavioral expectations to the patient, a person in crisis may not remember or be able to follow the guidelines. Regardless of this, it is something that the nurse must do and reinforce with each patient.
Share the nurse’s assessment with the patient in real time. If the nurse has been successful in building some rapport with the patient, then sharing some of his observations can be a useful intervention. For example, if the nurse observes the patient engaging in behavior that indicates she is escalating, the nurse can step in and ask the patient if she needs help. It is helpful for the nurse to share with the patient what behavior she observed that prompted the nurse’s response. Approaching the patient in a helpful manner and avoiding judgmental statements like “remember how you got yesterday, we don’t want a repeat of that . . .” will help this intervention be more successful. In addition, the nurse will want to remember what the patient has said about preferences for contact. The goal should be to assist the patient and to de-escalate the situation so that the patient will be in a frame of mind to listen to feedback and learn from the nurse’s observations.

Provide education about the emotion of anger. Ideally, the patient and the nurse will work together to determine the patient’s educational needs. The main topics to include in anger management education are

- the purpose of anger as a basic emotion
- the physiological signs that the patient may experience when angry
- the importance of identifying the patient’s unique triggers, experiences, and reactions to anger
- ways to cope with the feeling of anger

First, the nurse will want to provide the patient with education about anger being a normal emotion. The patient should know that the purpose of anger is to alert the individual to a potential threat. Angry feelings will often dissipate naturally over time (Olatunji, Lohr, & Bushman, 2007). Second, the nurse will want to teach the patient that anger is associated with signs of arousal such as facial
flushing, increased heart rate, increased respiration, and blood pressure. In addition, the nurse may talk with the patient about the fact that the urge to react is natural but not always helpful. The patient may feel the need to run, yell, or hit something; his hands may shake; he may feel shaky and agitated; or he may feel more anxious.

When considering how to teach anger management skills, useful resources are “Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook” and “Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual.” These publications can be downloaded or ordered at no charge from the SAMHSA Web site (www.samhsa.gov). Some of the contents can be shared in a group setting or referenced to create a group that fits the patient’s needs. Depending on the organization, a staff nurse may be able to conduct a psychoeducational group about anger or advocate for a group led by another team member.

Finally, the nurse may want to educate the patient about “venting.” Physical or verbal venting of anger is commonly accepted as a good coping strategy. However, research has demonstrated that verbally or physically “acting out” angry feelings is not helpful in improving coping or reducing aggression associated with anger. In fact, ranting endlessly about angry feelings or hitting pillows and tearing up papers is associated with increased risk of future aggressive behaviors (Olatunji et al., 2007).

**Teach functional analysis.** In order to teach the patient to identify unique triggers, expressions, and reactions to anger, the nurse may use functional analysis. Functional analysis is a technique taken from cognitive behavioral therapy (CBT), which is a therapy that has demonstrated efficacy in treating anger problems (Haddock et al., 2009; Novaco, 1977) (Figure 1.1). There are many resources describing CBT techniques on the SAMSHA website (www.samsha.gov). The website also offers free publications such as “The TIPS
The process of functional analysis is described in this and other publications. For the brief inpatient stay, functional analysis provides a structure to help the patient begin to think about how her thoughts and feelings are connected and how they can influence behavior. The nurse can introduce it to a patient as a way to examine her own triggers and angry responses, and to consider alternative responses. Functional analysis can be taught either as part of a group or individually. Regardless of the setting in which it is taught, it is important to teach this as a skill that the patient can learn to do on her own, rather than simply doing it once with a clinician.

Basic functional analysis can be done in a chart form, listing the components to be examined, which include triggers to anger, feelings, thoughts, behaviors, and consequences of behaviors. Patients are instructed to consider a specific instance of anger. Then, the nurse can ask the patient to identify triggers. Triggers can be an internal experience (such as a feeling) or an external experience (such as an interaction). The patient next identifies feelings, physical sensations, thoughts, and behaviors associated with the anger. Next, the patient identifies positive and negative consequences of her actions. Finally, with or without help, the patient reflects on the whole event and identifies any alternative behaviors or coping strategies. The nurse

<table>
<thead>
<tr>
<th>Trigger</th>
<th>How did you feel?</th>
<th>What were you thinking?</th>
<th>What did you do?</th>
<th>Positive results</th>
<th>Negative results</th>
<th>Alternative strategies</th>
</tr>
</thead>
</table>

**FIGURE 1.1 Sample Format for a Functional Analysis.**

*Series: Quick Guide for Clinicians, Brief Interventions and Brief Therapies for Substance Abuse.*
can assist the patient with any part of this analysis. If the patient is having trouble completing the functional analysis, the nurse can use her own observations of the patient and general knowledge about anger to provide suggestions for what he might have been feeling or thinking; the nurse then asks the patient to decide if that applies to this particular patient in the chosen situation.

**Offer coping skills.** The nurse can offer the patient several active coping skills that have been demonstrated to help angry individuals reduce their arousal from the angry emotion and allow anger to dissipate naturally. These are relaxation techniques such as deep breathing counting to 10, taking a time out or removing oneself from the situation, using distraction or engaging in a soothing, relaxing, or enjoyable activity (see Chapter 13, “Relaxation Techniques,” and Chapter 14, “Sensory Interventions”). This last suggestion employs the strategy of having the individual do something that will generate a feeling different from anger (Olatunji et al., 2007). The nurse can help the patient identify what strategies she is willing to try and how she can practice or use these skills on the inpatient unit.

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**TREATMENT ENGAGEMENT**

- **Subgoal: Increase Engagement in Treatment**

**Assessment of Patient’s Ability to Engage in Treatment**

The assessment of the patient’s ability to engage in treatment is similar to the assessment of the patient’s readiness to learn anger management skills. Patients who are not cognitively able to participate and unwilling to examine their behavior will not be able to engage completely.

The nurse will want to assess barriers to engagement. Barriers to engaging the patient in treatment are related to the patient’s degree of insight, cognitive capacity for insight, and level of readiness for behavioral change.
Intoxicated patients, patients who are psychotic or manic, and patients with severe depression or brain injury will likely not benefit from traditional anger management interventions (Thomas, 2001). In addition, individuals with severe personality disturbance who do not experience any distress about their behavior or who hold certain beliefs about anger, such as “anger is always justified,” “catharsis is good,” or “I have to express anger whenever I feel it,” may also not engage in treatment for anger (Dunbar, 2004; Howells & Day, 2003).

Key Nursing Interventions to Build Trust and Rapport and Increase Engagement

Although there are patients who have barriers to engagement, there are a few interventions that can help minimize aggression and facilitate patient engagement.

Show respect at all times. In order to build trust and rapport with the patient, it is important for the nurse to spend some time with the patient expressing understanding and concern. One very important point to remember is that civility and courtesy are immensely helpful when someone is angry. The nurse should not “speak down” to the patient, dismiss his feelings and concerns, or present rigid rule enforcement. Consider the example of a patient who is leaning over the nurse’s desk or seems to be trying to get something from behind the nurse’s station. The nurse should not respond by saying “You can’t go back there,” or “Move away from the desk.” These remarks will likely trigger an angry response from an individual who may feel that he is being treated as a child. The nurse could instead say, “Do you need something? Can I help you get something?”

Acknowledge and validate the patient’s feelings. The nurse will want to acknowledge and validate the anger and
any other feelings the patient may be experiencing, such as fear, hurt, or shame. The nurse may also acknowledge real slights or omissions and apologize if it is necessary. The nurse will want to acknowledge any powerlessness the patient may feel or any feelings of perceived threat. Even if the nurse does not agree with what a patient is saying, the nurse can identify and validate the underlying feeling: for example, “It seems like you are feeling unfairly treated and that makes you angry.”

**PREPARATION FOR DISCHARGE**

For all patients, discharge planning should include education regarding medication, primary diagnosis, symptom recognition, and symptom management. For individuals who have benefited from functional analysis or anger management groups during the hospital stay, the nurse and treatment team can discuss a referral to anger management groups on an outpatient basis. Alternatively, the nurse can assist the patient in creating a plan to help cope with any external situations that the patient believes may trigger anger.
TABLE 1.1
Goals, Areas of Assessment, and Interventions for a Patient with Anger

<table>
<thead>
<tr>
<th>Goal</th>
<th>Assessment</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>Prevent or reduce risk for harm to others</td>
<td>Assess history of anger and aggression</td>
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<td></td>
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<td>Consider whether anger is an acute or chronic problem</td>
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<td>Inquire about patient preferences for and ability to participate in de-escalation</td>
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<td>Observe the patients behavior, level of physical arousal, and responses to triggers on the unit</td>
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<tr>
<td></td>
<td></td>
<td>Use standardized assessment instruments such as the Broset Violence Checklist</td>
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<tr>
<td>Stabilization</td>
<td>Increase anger management skills</td>
<td>Assess readiness to learn and practice anger management skills</td>
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<tr>
<td></td>
<td></td>
<td>Watch for denial that anger is a problem</td>
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<tr>
<td></td>
<td></td>
<td>Identify specific triggers</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Engagement</td>
<td>Increase engagement in treatment</td>
<td>Assess barriers to treatment engagement: insight, cognitive capacity, and readiness for change</td>
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<td></td>
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</tbody>
</table>
REFERENCES


1. The Patient With Anger


