The Client Exhibiting Aggression, Hostility, and Violence

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The Client Exhibiting Aggression, Hostility, and Violence

Chapter Outline (continued)

Behavioral Interventions
Evaluation

Legal and Ethical Issues Related to Violence
When Violence Occurs: Stress Debriefing
The Role of the Nurse
The Generalist/Staff Nurse
The Advanced-Practice Psychiatric Registered Nurse (APPRN)

The Nursing Process
Assessment
Diagnosis
Outcome Identification/Planning and Implementation
Nursing Interventions
Evaluation

Nursing Research

Competencies

Upon completion of this chapter, the learner should be able to:
1. Understand causative factors of aggression, hostility, and violence.
2. Identify high-risk factors for aggressive and violent behavior.
3. Recognize behaviors that preclude aggression.
4. List the steps of defusing and de-escalation.
5. Discuss the role of the nurse in caring for the client who exhibits or is at risk for aggression, hostility, and violence.
6. Identify legal and ethical responsibilities about violence and threats to harm others.
7. Discuss the purpose and major aspects of stress debriefing.

Key Terms

Acting-Out: Refers to living out unresolved developmental issues or fantasies impulsively in behavior.
Agitation: To give motion to or disturb. It also refers to a state of increased mental and motor activity.
Aggression: Refers to hostile, injurious, or destructive behavior or outlook, particularly when caused by frustration.
Assault: A violent physical or verbal attack.
De-escalation: Refers to verbal interventions that aim to defuse potentially and actual volatile situations using empathetic, calm, yet firm limit-setting approaches.
Defuse: To reduce tension and harm in a potentially violent situation.
Frustration: A condition that emerges when a goal is blocked. The stronger the frustration, the greater the potential for aggression. It is the single most potent means of provoking aggression.
Hostility: Refers to overt antagonism, opposition, or resistance in thought or principle.

Impulsivity: Closely related to disinhibition and central to conceptions of attention-deficit/hyperactivity disorder (ADHD) and personality disorders and the aggressive spectrum or disruptive behaviors disorders.
Physical Assault: Attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as knives, firearms, or bombs.
Physical Restraint: Any physical or mechanical device, material, or equipment that is attached to or placed adjacent to the client’s body that cannot be removed easily by the client and limits freedom of movement or normal access to one’s body.
Restraint: A physical or chemical way to stop a client from being free to move in order to prevent injury.
Seclusion: Placing and keeping a client in a bare room (free of sharp or dangerous objects) for the purpose of containing a clinical situation that may evolve or has evolved into an emergent situation.

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A 36-year-old man shows up in the emergency department (ED) smelling of alcohol and demanding to be seen. He is pacing, talking loudly, and cursing nursing staff. This scenario occurs often in EDs and psychiatric, geriatric, and primary care settings. Nurses are on the frontline of health care and at great risk of harm unless they are appropriately trained to defuse these situations and recognize that violence in any form must be taken seriously. **Defuse** means to reduce tension and harm in a potentially volatile situation. **De-escalate** is another term that applies to tense situations. Nurses use de-escalation by employing verbal limit setting or interventions that aim to defuse potentially and actual volatile situations.

The prevalence and nature of client aggression and violence in health care have long been minimized and neglected. Client aggression occurs more often than client violence, with a substantial number of psychiatric nurses generally being threatened. Anecdotal data suggest that psychiatric nurses are less likely to report violent incidents, hence the failure to implement proactive policies for preventing violent events. This premise supports the debate that violence is often seen as part of the job. Fortunately, nowadays, concerns about the severity and frequency of client violence toward nurses and other health care providers are being reported more frequently perhaps because of the resulting serious morbidity for clients and staff (Morrison, 1998; Owen, Tarantello, Jones, & Tennant, 1998).

Violence in various practice settings, including psychiatric inpatient, geriatrics, ED, and inpatient settings, is well documented and has become a significant health care concern in many facilities (Levin, Hewitt, Misner & Reynolds, 2003; May & Grubbs, 2002; Nolan, Soares, Dallender, Thomsen & Arnetz, 2001). According to a survey of health care workers at one ED in Vancouver, respondents in this study reported a 1-year prevalence of 92 percent for physical assault and 97 percent for physical threats, and 66 percent reported verbal abuse at least once per shift. Nurses and male physicians were at a greater risk of assault, and receptionists were at the least risk (Fernandes et al., 1999).

Violence is not limited to the ED although it has become the portal for persons with psychiatric disorders who lack access to health care. Data from several studies exploring the risk of violence in inpatient psychiatric facilities demonstrate that violence is most likely to occur during times of high activity and interactions with clients, such as meal times, bathing hours, and client transportation. Violence is also likely to occur when services are denied, when clients are involuntarily admitted, or when health care providers set limits on eating, drinking, smoking, or consuming other drugs (Badger & Mullan, 2004; Felton, 1997; Hesketh et al., 2003; Lipscomb, 1999; Trenoweth, 2003). One particular study conducted by Grilly, Chaboyer, and Creedy (2004) showed that most nurses (n = 71) in their study of violence in the ED found that clients were often seen during the evening hour, under the influence of alcohol and other drugs, and exhibited behaviors and symptoms of mental illness. Many studies show that assaults usually occur when there is interaction between nurses and clients, for instance, when clients are asked to take medication, and use of duress or limit setting (Cheung Schweitzer, Tuckwell & Crowley, 1997; Holzworth, 1999; Ray & Subich, 1998).

There are conflicting data concerning the impact of staff gender on the incidence of client aggression and violence. One study (Vanderslott, 1998) found that male nursing staff were more likely to be attacked than female staff. In contrast another study found that staff gender had little impact on the incidence of violence (Gordon, Gordon, & Gardener, 1996). Inadequate training and inexperience have also been associated with incidents of violence (Chou, Lu, Chang, 2001; Vanderslott, 1998).

The aim of this chapter is to introduce the learner to major assumptions and theories associated with violence and aggression across the life span. It also emphasizes the significance of personal, staff, and client safety; preventive approaches to violence; and legal implications. Finally, it describes the role of the nurse and the implementation of the nursing process when caring for the client at risk for violent and aggressive behaviors.
DEFINITIONS

Agitation originates from the Latin word *agitation* and means "to give motion to or disturb." It also refers to a state of increased mental and motor activity. Clients exhibiting agitated states are often verbally and physically threatening and can abruptly become violent.

Aggression stems from the Latin word *aggressus*, which means "to attack." It is further defined as a forceful unprovoked act described as hostile, injurious, or destructive, particularly when caused by frustration. Aggressive behaviors involve those that are marked by combative readiness, driving forceful energy, or initiative. Perception, intolerance, miscommunication, and a sense of powerlessness or helplessness often fuel aggression.

Assault stems from the French word *assaultus*, which means "violent or verbal attack and effort to do harm to another."

Hostility, or hostile, is marked by unfriendliness, antagonism, or opposition and stems from the Latin word *hostis* and "relates to the enemy." Hostile people are distant, distrustful, and antagonistic and are in a mode that prepares them to defend themselves by attacking others. Behaviors associated with hostility include restlessness, defensiveness, argumentativeness, pacing, irritability, and agitation.

Impulsivity has become a key concept in the determinants of violence and aggression. Impulsiveness and impulsive aggression have significant correlation with physical violence. Loss of impulse control is associated with disinhibition and is central to conceptions of borderline, antisocial and other personality disorders, attention-deficit/hyperactivity disorder (ADHD) and medical conditions such as delirium and dementia, and substance-related disorders.

Violence, or violent, refers to the Latin word *violare*, which means "to violate." Violence is linked to hostility and aggression and generates high energy in both the survivor and perpetrator. Examples of violence include kicking, beating, grabbing, spitting, choking, pushing, forcing sex, and using a weapon.

Perhaps the single issue that concerns most nurses is the client at risk for aggression and violence. Clients exhibiting violent and aggressive behaviors evoke fear, anger, a sense of helplessness, and thoughts of retaliation. Despite these challenges nurses can successfully manage personal reactions by making personal safety a priority and by implementing proactive interventions that reduce the risk of violence and promote personal safety.

Knowledge of causative and risk factors associated with aggression and violence can help nurses assess and manage risk. The following section discusses the epidemiology and incidence of violence and reviews major underpinnings associated with aggressive and violent behaviors.

EPIDEMIOLOGY AND INCIDENCE

Growing empirical studies implicate psychiatric disorders as a risk factor for aggressive and violent behaviors across the life span (Arsenault, Moffitt, Caspi, Taylor & Silva, 2000; Nestor, 2002; Swanson et al., 1997). Higher rates are now firmly established most prominently for persons with diagnoses of substance-related disorders, followed by cluster B personality disorders (e.g., borderline, antisocial) and less frequently in persons with schizophrenia (Johnson, Cohen, 2000). While violence is less likely to occur in persons with schizophrenia, researchers submit that persons with schizophrenia and bipolar mania, particularly with active psychotic symptoms and specifically paranoid delusions and command hallucinations, have been associated with a history of assaults (Link, Stueve, & Phelan, 1998). Albeit delusions can precipitate violence in some cases, there is a lack of consensus that show that they increase the overall risk of violence in persons with mental illness discharged from acute inpatient units (Appelbaum, Robbins, & Monahan, 2000; Junginger, Parks-Levy, & McGuire, 1998). Despite this debate, nurses must assess for delusions and other psychotic symptoms and base their assessment of the potential for aggression and violence on individual symptoms and risk factors (e.g., comorbid substance-related disorders).

Further research is necessary to determine the degree to which a single factor is predominant in causing assaults committed by individuals over time. Despite controversy, the risk of violence results in serious morbidity in nurses caring for persons with sundry psychiatric disorders. While there is a high prevalence of violence among clients with psychiatric disorder, not all violent people are mentally ill nor are all persons with psychiatric conditions violent. Comprehending the etiology of aggression and violence offers nurses a rational basis for using the nursing process to assess, diagnose, identify outcomes, utilize nursing interventions, and evaluate treatment outcomes involving aggressive and violent behaviors.

CAUSATIVE FACTORS

Aggression results from the interaction of an array of systems and processes. It can be defined as predatory, impulsive, or it can stem from underlying medical conditions. Environmental stress or trauma, dysregulation of multiple biochemical processes including dopamine and serotonin transmission, and alterations in neuroanatomical structures within the context of impulsivity heighten the likelihood of aggressive and disruptive behaviors.

Collectively interactions among systems interfere with the person’s ability to reason, control impulses, and employ nonviolent means and effective coping skills and expand the risk of violence. This section reviews various theories that have been proposed to account for aggression and violence.

Psychodynamic Theories

Sigmund Freud’s (1960) psychoanalytic theory views aggression as a basic drive (like thirst). He held that many of our actions are determined by instincts, particularly sexual. When expression of these instincts is frustration, aggressive drives emerge. He believed that from birth to death a person
possesses two conflicting instincts: a life instinct (eros) that encourages a person to grow and survive, and a death instinct (thanatos) that drives people to redirect the death instinct or self-destructiveness from self toward others. His theory also proposes that the body constantly generates energy for self-destructiveness and if the individual fails to channel or modulate this energy effectively, it eventually amasses and is released in a maladaptive or aggressive manner. He also submitted that antisocial behavior involves a defective ego that is combined with an immature or ineffective superego, resulting in the individual being unable to control or modulate his or her behavior, but experiencing little guilt due to his or her inability. His theory also proposed that one way to minimize accumulation of noxious energy was to drain it off safely through catharsis (a Greek word for purification or cleansing) through crying, verbalization, physical activities, or various symbolic means. Freud’s theory on aggression has been criticized for its failure to delineate factors that could be used to predict aggression or its specific character.

Konrad Lorenz (1966), an ethologist, endorsed Freud’s theory of catharsis, and asserted that people should engage in competitive sports in order to reduce aggression. His theory also emphasized the innateness of aggression based on animal studies. He submitted that people share certain instincts with other organisms and that aggression is spontaneous and crucial for survival. He further submitted that aggression stems from territoriality and an innate drive to gain and defend property. He also postulated that a certain balance exists between inclinations to fight and flight, with the inclination to fight being the strongest in the center of the territory and the inclination to flight being the strongest when it was farthest from the center. Based on his assertions, aggression emerges as a function of the sum of accumulated energy and the presence of aggression-releasing stimuli.

Social Learning Theories
Social learning theorists view aggression as a learned response that is based on the assumption that role modeling, identification, and human interactions shape learning and behavior (Dutton, 2000; Trocki & Caetano, 2003). This model stresses the role of transmitting both specific behavior and emotional responses. Aggression can be learned through observation or imitation, and the more often it is reinforced, the more likely it occurs. According to Albert Bandura (1977; 1986), observing violence is likely to lead to violence, particularly during childhood and adolescence. This argument has been strengthened by recent studies that implicate exposure to family violence and temperament as a predictor of adult antisocial behaviors (Dutton, 2000; Trocki & Caetano, 2003). Most people have observed children imitating adults in a variety of ways, such as reading the newspaper and yelling at the dog. Another example of observation and imitation is a child who observes a parent hitting the family pet and later mocks the parent by hitting the pet. The relationship between exposure to aggression in the media and children’s aggression has been well researched (Robinson, Wilde, Navracruz, Haydel, & Varady, 2001).

In addition, children who experience abuse or severe punishment are likely to be more aggressive than average; the parents role model the learned behavior. A number of children who participated in studies involving exposure to violent video games and subsequent violent and aggressive behavior found that the students rated their peers’ aggressive behavior and reported that they perceived the world as scary and mean. Hence, observing violence introduces new ways to be violent and activate cardiovascular arousal, diminishes helping behaviors, and makes violence more sociably acceptable. Data also showed that playing video games could lead to the automatic learning of aggressive self-views (Anderson, 2004; Uhlmann & Swanson, 2004). Most studies indicate that irrespective of age, observing violence with repeated exposure to real life and entertainment may alter cognitive, affective, and behavioral processes, perhaps resulting in desensitization. Albeit these findings are disturbing, new data indicate that when interventions to reduce television, videotapes, and video games were implemented, aggression in elementary children was decreased. These data support the causal relationship between media and aggression and the potential benefits of reducing media exposure in this age group (Uhlmann & Swanson, 2004; Robinson et al., 2001). (See Controversy Box.)

**CONTROVERSY BOX**

**DO VIOLENT VIDEO GAMES AND OTHER MEDIA REALLY CONTRIBUTE TO VIOLENCE IN OUR YOUTH?**

There is growing evidence that link media violence with childhood and adolescent aggression and violence. Some argue that violent video games and other media violence have minimal impact on violence in these age groups and that this controversy is overemphasized. Others disagree with this notion and have strong evidence that strengthens the argument that exposure to media violence and violent video games have a definite negative impression on children and adolescents and increase the risk of aggression and violence. Regardless, nurses must develop proactive approaches and educate parents, teachers, religious organizations, and youth about the potential harmful effects of media violence, including violent video games, on violence and aggression among our youth and society.
While some theorists assert that psychodynamic and social factors may explain some aspects of violent and aggressive behaviors, most believe that they fail to explain the complexity of innate and social and complex biological and genetic influences associated with violence.

**Biological Theories**

Technological advances in neurobiology provide a better explanation of the role of genetics and complex biological processes that mediate stress, environmental, and social factors in the etiology of aggression and violence (Volavka, 2002).

**Neurobiological and Neuroanatomical Factors**

The advent of brain imaging research makes it possible to directly assess brain functioning. Typically, emotion is regulated in the human brain by a complex circuit comprised of the orbitofrontal cortex, amygdala, anterior cingulate cortex, and several interconnected pathways. Genetic and environmental factors mediate the structure and function of this circuitry. Faulty wiring of this neural circuitry pathway or emotional modulation is a possible prelude to impulsive aggressive and violent behaviors (Tateno, Jorge & Robinson, 2003; King, Tenney, Rossi, Colamussi & Burdick, 2003).

In addition, the hippocampus and amygdala (located within the temporal lobe), which are involved in emotional responsiveness, may be activated by an interpersonal trigger. This process is facilitated by serotonin in the orbitofrontal cortex (OFC) and anterior cingulated gyrus (ACG) regions (Best, Williams & Coccaro, 2002; Fuster, 1997). The ACG region is implicated in the affective-cognitive activity, and the OFC is implicated in the sensory processing and possibly fear-generating stimuli. Dysfunction or decreased activation or damage in the OFC and ACG regions may play a role in the regulation of negative emotion through reduced serotonin-mediated activation of the prefrontal cortex, and heighten the risk of impulsive aggression, hostility, and violence (Tateno et al., 2003; King et al., 2003).

Several studies also implicate abnormalities in the amygdala and the prefrontal cortex with the hyperarousal-dyscontrol control states observed in clients with intermittent explosive disorder (IED) and antisocial personality disorder (van Elst, Woermann, Lemieux, Thompson, & Trimble, 2000). Other studies have substantiated these conclusions and found that persons with IED exhibited poor impulse control, explosive aggressive outbursts, and lack of sensitivity in response to interpersonal emotional cues such as perceived rejection or disrespect. These behaviors often occurred within the context of intact cognitive, motor, and sensory function (Best et al., 2002; Fuster, 1997).

A host of additional brain regions, such as white matter tracts in impulse-control disorders are associated with violence and aggression (Hinshaw, 2003; Jeste & Finkel, 2000). Specifically, persons with histories of traumatic brain injury (TBI) and other brain disorders have exhibited poor impulse control and behavioral symptoms due to neurophysiological deficits. Aggressive behaviors associated with post TBI and other neuropsychiatric conditions, especially during the acute period, can prevent clients from receiving necessary care and disrupt their rehabilitation process. These behaviors must be quickly assessed and managed to facilitate positive treatment outcomes. Neuroanatomical alterations resulting from TBI may result in deactivation of the lateral and dorsal prefrontal cortices and enhance activation of various limbic structures, including the amygdala (Jorge et al., 2004). Implications from these findings suggest that these clients have difficulty modulating their emotional response and are at high risk for impulsive aggression and violence. Likewise, clients with other compromised frontal lobe and executive function neurophysiological deficits (e.g., Alzheimer’s disease), particularly with psychosis, are also at a greater risk of these behaviors (Giancola, 2000; Jeste & Finkel, 2000). Other studies indicate that hypometabolism or atrophy in the right inferior frontal region and orbital frontal areas correlate with clinical severity of delusions in AD (Sultzer et al., 2003).

**Neurophysiological Influences**

Early scientists suspected that gross brain dysfunction increased the risk of violent behaviors. Studies using electroencephalogram (EEG), and neurological and cognitive tests in clients with partial seizures who exhibited violent behavior repeatedly found the temporal lobe to be the brain region responsible for aggressive behavior. These findings, however, were mainly nonspecific and researchers were unable to replicate them owing to methodological flaws (Mark & Ervin, 1970; Raine, Lencz, Bihrlle, LaCasse, & Colletti, 2000). Despite these early assertions, the role of the temporal lobe, epilepsy, and violence continues to be debated.

Contemporary studies continue to link various brain regions, including specific areas in the temporal lobe, to aggressive and violent behaviors. In a study of the relationship of EEG abnormalities and violent criminal behavior in 222 defendants referred for psychiatric evaluation, Pillman and his colleagues (1999) discovered left hemispheric focal (temporal lobe) abnormalities in a large number of violent offenders. Most of these cases were comorbid with other brain disorders, including intellectual disabilities, epilepsy, or early brain damage. Findings from this study strengthen the debate that links the propensity for violence in individuals with abnormalities in the temporal lobe brain regions (Pittman et al., 1999).

**Biochemical Theories**

There is compelling evidence that links abnormalities in central serotonin activity to impulsive aggression (Coccaro et al., 1997; Coccaro, Kavoussi, Hauger, Cooper, & Farris, 1998; Dolan, Anderson, & Deakin, 2001). Supposedly, reduced central serotonin (5-HT) system function is associated with decreased behavioral constraint and subsequent higher risk of aggressive behaviors. Many behavioral problems and violent impulse control exhibited in persons with ADHD and antisocial personality appear to be mediated by...
brain serotonergic systems. Most data support the notion that decreased cerebrospinal fluid (CSF) and 5-HT metabolite, 5-hydroxyindoleacetic acid (5-HIAA) may be a biological marker of impulsivity rather than a specific type of violence. Furthermore, these findings indicate that 5-HT plays a role in inhibiting, aggressive behavior in persons with personality disorders and may play a role in suicide and other aggressive behaviors (Coccaro et al., 1997; Coccaro et al., 1998; Hinshaw, 2003; King et al., 2003).

Additional biochemical theories associated with impulsive aggression and violence involve aberrations in dopaminergic and noradrenergic systems that are limbic in nature. Abnormalities in these regions and neural pathways may also contribute to cognitive impairments, as manifested by executive function deficits, reduced moral reasoning, and impaired empathetic ability and the likelihood of adult antisocial behavior and violent impulse-control disorders (Hinshaw, 2005).

**Neuroendocrine Theories**

Many hormones, including testosterone, progesterone, luteinizing hormone, renin, ß-endorphin, prolactin, and melatonin are involved in the mediation of aggressive behavior. Most studies involving animal and human subjects indicate that aggression is mediated by the hypothalamus-pituitary-adrenal (HPA) axis and that stimulation of various brain regions in this area and activation of cortisol, past experiences, and social influence play critical roles in the neuroendocrinology of aggression. Findings from animal studies show that mild electrical stimulation of specific brain regions in the hypothalamus produce aggressive and sometimes fatal behavior. In contrast studies using higher mammals, such as nonaggressive patterns of aggression, showed that aggression was controlled by the cortex and influenced by experience and social influences.

Biological markers involving the neuroendocrine system have been indirectly corroborated by neuroendocrine challenges. Specifically, neuroendocrine challenges using a single dose of fenfluramine increase plasma levels of prolactin. Serotonin mediates this response; hence the prolactin elevation measures central 5-HT activity (Coccaro et al., 1997). Prolactin response is reduced in aggressive subjects and is believed to be more sensitive than the CSF 5-HT. As previously discussed the aggressive behaviors are associated with dysregulation of serotonin activity (Coccaro et al., 1997).

Studies assessing CSF 5-HIAA concentrations or neuroendocrine responses to challenge doses of 5-HT agonist (fenfluramine) have consistently demonstrated either inverse correlations with indices of aggression and prolactin response (Coccaro et al., 1998) or diminished function in some aggressive individuals. One study that examined the relationship between central 5-HT function and aggression in prepubertal boys with ADHD discovered no clear evidence that linked prolactin response to aggression. These data implicate that the differences between adult responses to the neuroendocrine challenge and those found in prepubertal boys may be associated with their age or ADHD (Schultz et al., 2001).

Recent studies of low resting cortisol levels and aggression in preadolescents and adolescents have generated considerable interest. This potential biological marker or predictor of dyscontrol behaviors in this age group continues to be debated, while some studies indicate that it may be predictive of personality traits (e.g., antisocial) over time (McBurnett, Lahey, Rathouz, & Loebel, 2000; Pajer, Gardner, Rubin, Perel, & Neal, 2001; Shoal, Giancola, & Kirillova, 2003). Similar findings have been seen in children with comorbid ADHD and conduct disorders (CD) that demonstrated lower cortisol concentrations at rest and response to stress (King, Barkley, & Barretttq (1998). Even as the precise mechanism that links low cortisol concentration and persistent aggression is poorly understood, results from some animal studies implicated prenatal and early developmental stress that produced alterations of the HPA axis (Levine, 1994).

The ability to modulate these complex process is guided by numerous factors, including biochemical, neuroanatomical, and neurobiological processes that may be compromised in persons already at high risk for impulsive aggression or violence, such as those with major psychiatric disorders and medical conditions. Adaptive physiological arousal and responsiveness to a threatening or fearful event are likely to enable the client to resolve the situation effectively. Failure to mediate adaptive process increases the risk of frustration and aggressive or destructive behavior.

**Neuroimaging Studies**

Neuroimaging studies consistently demonstrate abnormalities in three brain regions: dorso-lateral prefrontal cortex, regions of the basal ganglia, and the cerebellum. Abnormalities in these regions are found in persons with ADHD when compared to control groups (Giedd, Blumenthal, Molloy, & Castellanos, 2001; Pine, Grun, & Peterson, 2001). Abnormalities in these structural regions have also been found in adults with antisocial personality disorder and disruptive behaviors associated with ADHD and CD. Hereditary influences, neuroimaging data, and the efficacy of psychopharmacological agents as anti-aggressive agents strengthen the connection between ADHD and aggressive and violent behaviors and biological substrates (see Chapter 17, The Client with Attention Deficit/Hyperactivity Disorder).

**Genetic Influences**

There is a preponderance of evidence from family, pedi- gree, twin, adoption, and molecular genetic studies of the heritability of some psychiatric disorders such as ADHD, disruptive behavior disorder (DBD), oppositional defiant disorder (ODD), and CD. Data from these findings suggest that these and other disorders associated with aggression are highly heritable and are impacted by environmental influences (American Psychiatric Association [APA], 2000; Kutcher et al., 2004; Scourfield, van den Bree, Martin, &
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McGuffin, 2004). The notion that a child with ADHD is likely to have at least one parent with this disorder also implicates the role of genetic vulnerability.

Several studies directed at elucidating the link between genetic predisposition of violence show variation in physical aggression and heritability estimates as high as 0.58 in adults and 0.32 in adolescents (Miles & Carey, 1997; Rowe, Almeida, & Jacobson, 1999). Regardless of diagnosis, some scientists have attempted to subtype aggression that can be demonstrated in various psychiatric conditions, including ADHD, DBD, borderline personality disorder, ODD, exacerbation of psychotic conditions, and neurodegenerative disorders.

Gender

People often assume that men are more violent than women with psychiatric disorders because in the general population, men are more physically aggressive than women on numerous measures of aggression (Maguire & Pastore, 2003). Findings from some studies indicate the opposite and suggest that psychiatric disorders actually reduce the gender difference and in some cases eliminate them completely (Krakowski & Czobor, 2004; Hiday, Swartz, Swanson, Borum & Wagner, 1998). More detailed analysis of violence showed that male clients have a greater prevalence of more serious violence involving weapons and injury in the 4 months preceding hospitalization than women, but there were no gender differences when measures of violence that were more inclusive were used. Other data suggest that women were more violent than men during the 3 days post admission (Krakowski & Czobor, 2004; Lam, McNeil, & Binder, 2000). Most researchers assert that there is an overlap in the expression of violence and in the factors that contribute to its emergence in men and women, specifically psychosis and behavioral disturbances and other inclinations that vary according to gender. For example, in women, physical violence may occur with high arousal and excitation associated with acute psychosis, whereas acute symptoms in men may play a lesser role in the emergence of violence, but psychosis may foster more chronic inclinations associated with antisocial behaviors (Krakowski & Czobor, 2004).

Findings from recent research are consistent with previous studies that show that staff often underestimate violence among females and overestimate it among males (Stueve & Link, 1998). For these reasons, data continue to support the premise that injuries to staff members on inpatient units treating men and women are as likely to be caused by women as by men. Implications from these findings suggest that when a female exhibits signs of escalation, her behavior should not be minimized on the basis of gender (Lam et al., 2000).

Mood Disorders

In addition to previously discussed psychiatric disorders, mood disorders, particularly bipolar disorders, increase the risk of violence. Agitated psychotic depression associated with hypomania or mania refers to a mixed state manifested by depressed mood, psychomotor agitation, and flight of ideas. Like other psychiatric disorders, these symptoms increase the risk of violence. Additional symptoms of agitated depression in bipolar I disorder (history of at least one manic episode) include severe agitation, intractable insomnia, suicidal obsessions and impulses, restlessness, racing thoughts, despair, depressed mood, and unendurable sexual excitement (APA, 2000; Koukopoulous & Koukopoulous; 1999; Maj, Pirozzi, Magliano, & Bartoli, 2003). Other psychiatric disorders not mentioned in this chapter, such as post-traumatic stress disorder, are also associated with aggression and assaultive behaviors.

Environmental and Socioeconomic Factors

Environmental factors often contribute to aggression and violence such as exposure and learned behavior either prenatally, due to childhood abuse; witnessing violence either through one’s family, culture, or the media; or owing to socioeconomic factors such as poverty and family disorganization. Prenatal influences include exposure to toxins, such as alcohol and resultant brain damage that results a high propensity for neurobehavioral anomalies, cognitive deficits, and impaired executive function (Connor, Sampson, Bookstein, Barr, & Streissguth, 2000; Mattson & Riley, 1998). Home environments play a prominent role in shaping behavior, including violence (Dutton, 2000; Ehrensaft et al., 2003), and are continuously mediated by genetic and other environmental influences. Childhood frustration, violence in the home, oppression, and hostility have been linked to various psychiatric conditions where individuals are at a high risk of aggressive behaviors, such as intermittent explosive disorder (APA, 2000). Accessibility to guns and exposure to violent media, videos, and television are linked to violence among children (Miller et al., 2000).

Psychosocial Factors

Psychosocial factors associated with aggression and violence include inadequate social skills required to resolve conflicts or violent encounters. This belief suggests that anger is morally and social acceptable or expected. Numerous studies link ineffective anger management with violence, particularly among persons with intellectual disabilities, and psychiatric and medical disorders that involve impaired cognitive and executive functioning (Cornell, Peterson, & Richards, 1999; Novaco & Taylor, 2004).

Common causes of anger and aggression also include a sense of powerlessness, loss of self-esteem, or the belief that someone else has been treated unfairly. In addition, ineffective coping skills and an inability to cope with and manage anger effectively, misinterpretations of the intentions of others, low self-esteem, and a sense of hopelessness about the future are key contributors to aggression across the life span.
SAFETY CONSIDERATIONS

A safe environment is everyone’s responsibility. There is no single solution to preventing violence or ensuring workplace safety. However, proactive and preventive measures are necessary to ensure workplace safety and afford emotional support during the aftermath of a violent or traumatic incident. The following section focuses on the role of administrators and staff in creating a safe work environment.

Administrative and Staff Responsibilities

Personal and staff safety must be a priority for all nurses regardless of their practice setting. Several strategies are required to ensure personal safety. First, administrative staff must create a culture of zero tolerance of violence. Policies must be established that guide staff, consumers, and clients and their families about this expectation. Environmental factors that increase the risk of violence include a lack of administrative support to maintain a safe work environment, including poorly written policies that fail to mandate annual training for all staff. See Box 1 for additional environmental factors that reduce workplace safety. Additional administrative responsibilities that foster safer work environments include:

- Allocating and implementing emergency signals, alarms, and monitoring systems
- Installing security devices such as metal detectors, strategically placed cameras, and good lighting in the hallways and parking areas
- Providing security escorts to the parking lot at night
- Developing waiting areas to accommodate and assist visitors and clients
- Designing the triage area, emergency rooms, and other public areas to reduce the risk of assault
- Establishing a call system that alerts teams to assist staff involved in potential and actual violent situations

Awareness and Training

One of the most critical components of a facility or agency’s violence prevention is training. Training is necessary for nurses and other employees and supervisors who may be involved in responding to violent incidents. Participation in training sessions helps staff recognize and report incidents of violence, intimidation, and threatening and disruptive behaviors. Developing policies and providing staff training on the management of disruptive behaviors enable nurses to advance proactive activities within their organization and create safer workplaces. Ideally, annual training concerning the prevention and management of disturbed behaviors should be provided, and policies that delineate zero tolerance of violence should be implemented. Non-mental health staff may opt for annual training that entails verbal de-escalation and escape techniques. Refer to the dialogue box for an example of how to communicate with an aggressive client.

Secondly, prior to taking a client into a room, particularly alone, it is imperative to inquire about weapons, such as “Mr. Jones, are you carrying a weapon?” Any object can be used as a weapon. Nurses should never see an armed client. Remember, most clients carrying or holding a weapon are just as frightened as the nurse. All weapons must be surrendered to trained security. In the event that a client brings a weapon into the assessment or evaluation area, it important for the nurse to remain calm and use strategies listed in the dialogue box “When a Client Has a Weapon.”

Thirdly, if the client is deemed dangerous (e.g., yelling, physically aggressive, threatening) before taking him or her into the office, a decision of whether to actually see the client in the waiting area, a safe place (e.g., security), or an office alone must be made immediately. If the nurse opts to see the client alone in an office, the door must remain open and a third person should stand near or outside the door to ensure safety. It is imperative to afford adequate personal space to reduce anxiety and mitigate the client’s symptoms and defuse a potentially volatile situation. A failure to create and maintain a safe work environment places the nurse, staff, and clients at risk of dire consequences, including serious injury and death.

Finally, provisions for safety also involve arranging furniture that allows the nurse to sit between the client and the door without obstructing the space. Easy access to the door

Box 1: Risk Factors for Violence—Environmental

- Working with high-risk groups
- Transporting clients
- Long waits for service
- Working alone
- Poor environmental design
- Inadequate or inappropriately trained security or staff
- Crowdedness
- Loud noises
- Access to firearms and other weapons
- Inappropriate interviewing or treatment arranged room
- Lack of staff training and policies on the prevention and management of disturbed behaviors
- Lack of administrative support for zero tolerance of workplace violence
- Unrestricted movement of the public
- Poorly lit corridors, rooms, parking lots, and other areas
affords a safe escape in the event of an escalating or violent episode and/or the need to summon assistance. Chairs should be equal in height and the nurse must avoid towering or standing over the client or vice versa. Remove all dangerous objects, such as scissors and other sharps from the desk. It is imperative to be familiar with policies and procedures concerning restraints, seclusion, and the use of panic buttons. Uninformed staff may perceive panic buttons or alerts as a false sense of security. Depending on the workstation, staff response to panic alerts varies and is often unreliable.

Certain clients may pose a greater risk of violence than others do. Clients who are overtly confused or delirious, intoxicated or in withdrawal from a substance, or exhibiting high-risk behaviors such as yelling or threatening either verbally or with a weapon are at high risk for violence. Nurses must immediately summon appropriately trained security. Delusions must be assessed for degree of severity, nature, and power to influence the client’s action. Never approach an openly hostile client alone. Common sense is a critical part of personal and staff safety regardless of whether you know the client. (See Box 2: Individual Characteristics Associated with Violence).

### Box 2: Individual Characteristics Associated with Violence

- Loner
- Withdrawn
- Poor interpersonal skills
- Unemployment
- Suspicious of others
- Problems with authority figures
- Mental illness (acute exacerbation of symptoms)
- Frequent mood swings
- History of violence, including domestic violence
- Child abuse history
- Personality disorder (e.g., borderline, antisocial)
- Low frustration tolerance
- Blames other for problems
- Bullied
- History of incarceration
- Juvenile delinquency
- Economic instability
- Brain injury
If you feel uneasy about a clinical situation based on “gut feelings” or assessment of nonverbal cues such as increased agitation, yelling, or restlessness before or during an interview, it is imperative to discontinue the assessment and seek assistance. In the event of escalating circumstances or overt aggression and violence, personal safety skills listed in Box 3 are helpful in de-escalating and defusing a situation. In addition, set firm limits to assist the client in maintaining control by using the following suggestions:

- Be clear, direct, and supportive.
- Exhibit respect for others.
- Offer options if possible (e.g., medication).
- Seek to ensure personal dignity and establish a therapeutic relationship.
- “I understand that you are upset, but it is difficult to assist when you are yelling and threatening.”
- “How can I help you?”
- Offer food, beverage or other assistance, or voluntary medication before moving to more intrusive interventions.
- “I will do whatever is necessary to assist you and help you regain control.”
- State consequences if necessary.
- Immediately remove yourself from the area and call for assistance if the client continues to escalate or when the violence is imminent.

Box 3: De-escalation: Personal Safety Skills

- Be concerned about personal safety.
- Use common sense.
- Remain calm and convey being in control.
- Use a normal voice tone.
- Give suggestions, not orders.
- Avoid matching the threats.
- Avoid personalizing comments.
- Approach the client in an unhurried manner.
- Use active listening skills.
- Acknowledge the client’s feelings, such as “I know you are angry and upset.”
- Afford adequate space—at least a leg’s length.
- Avoid using threatening body language (e.g., pointing, hands on hip, yelling, standing over the client, making sudden movements, touching).
- Consider restraints when the client is deemed so dangerous to self or others that he or she poses a severe threat that cannot be managed using least restrictive measures. Typically, parenteral medications, such as antipsychotic medication, as needed to ensure safety and facilitate the psychiatric assessment. During this period, the client must be closely monitored for side effects, such as emesis or seizures.
- Prevent an involuntary client from eloping before assessment or transfer to a locked facility (sometimes).

Normally, restraints or seclusion are used as a temporary intervention to receive medication, or longer if medication is inappropriate. It is important to explain reasons for using restraints and conditions for them to be removed. Staff training about the application of these procedures and devices is imperative, and every effort must be used to provide the least restrictive measures before putting the client in restraints. Never bargain with a violent client about restraints/seclusion once the decision has been made to use these interventions. For further information about restraints and seclusion refer to:

- Your facility’s policies and procedures for the use of restraints and seclusion
- Standards stipulated by the Joint Commission on Accreditation of Health Organizations (JCAHO) (see Internet Resources)
- Legislation stipulated by the Center for Medicaid and Medicare Services (CMS) (see Internet Resources)

Albeit there is no precise measure to predict violence, remember, given the right set of conditions or circumstances, everyone has the potential for violence in order to regain control. Nurses must pay attention to situation-specific cues for the aggressive behaviors in their clients. They must also employ common sense to determine and secure personal safety when assessing, planning, and working with actual and potentially violent clients. It is prudent to ensure personal safety before interviewing a client, particularly before taking a client into a room or area alone. Most clients exhibit warning cues before becoming physically violent. Clients are most likely to exhibit impulsive aggressive or violent behaviors when they are acutely ill and cognitively impaired, such as with withdrawal or delirious states. Using an unhurried and calm approach and using astute observational skills are essential steps in creating a safe work environment. When verbal de-escalation fails to reduce violence, other steps must be taken to ensure staff and client safety, such as restraints and seclusion, as a last resort.

Restraints and Seclusion: Life Span Considerations

Historically, restraints and seclusion were overused to control disruptive and dangerous behaviors, which ultimately resulted in negative treatment outcomes. Excessive reliance
on these methods interfered with nurses and other staff creating therapeutic environments and fostering environments that helped clients develop adaptive coping skills to manage stressors in the community. Today, there is a greater public concern and legislation that emphasizes on the least restrictive approach to manage aggressive and violent behaviors in adults that involves more behavioral interventions. Most of these changes occurred as a result of heightened media and legislative attention on the use of restraints and seclusion in psychiatric settings, especially among the youth and other populations. As a result of these concerns the Department of Health and Human Services and Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services, were created. This legislation was mandated in August 1999, the Interim Financial Rule, for the use of seclusion and restraint in all psychiatric treatment facilities that receive government funding (DHHS, HCFA, 1999). This document was published in the Federal Register on January 22, 2001 (see Box 4: Legislative Guidelines on Restraints and Seclusions). Nurses must follow policies and guidelines of their organization for these interventions.

Lastly, seclusion and restraints must never be used to punish the client. Nor should they be applied when the client has a history of previous self-harm or aggressive behavior. Each incident must be individually assessed and based on the current situation and symptoms.

Adequate staff training is imperative to ensure client and staff safety. Once a decision is made to restrain or seclude, the client must be given ample time to comply. Before placing a client in a gown, he or she must be searched for sharps, belts, or any potentially dangerous object. (See the Legal and Ethical Considerations chapter for further discussion about legal and ethical issues.)

Box 4: Major guidelines stipulated by the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (Department of Health and Human Services, HCFA, 2001)

- The authority to order the use of restraint and seclusion in psychiatric inpatient facilities lies with a board certified psychiatrist or licensed physician with specialized training and experience in diagnosing and treating psychiatric disorders.
- Inpatient services for persons under 21 must be provided under the direction of a physician, who must certify in writing that inpatient services are necessary in this setting.
- Any order for restraint or seclusion must be the least restrictive intervention that can safely resolve the situation and must be limited to the duration of the emergent situation.
- If the physician is not available, a registered nurse may obtain a verbal order.
- The physician must sign the verbal order as soon as possible and he/she must be available to staff at least via phone for the duration of the restraint or seclusion to ensure safety.
- Within 1 hour the initiation of the emergency safety intervention requires a face to face assessment of the physical and psychological status of the client (by the physician or clinically prepared registered nurse). Findings must be documented before the end of the shift.
- Parents or legal guardians must be notified when a client who is a minor is restrained or secluded. Notification must take place as soon as possible and include documentation in the client’s record.
- Circumstances that lead to the use of restraints and seclusion must be quickly assessed to determine if they are necessary and to identify alternatives to reduce or eliminate their use. This must be done within 24 hours and involve a face to face interaction with the client when appropriate.
- Debriefings are part of this process to ensure the client safety.
- Staff training and refresher courses are a critical part of safe administration of seclusion and restraint, particularly in application and implementation of these intervention and alternative techniques to avoid restraints when appropriate.
- Additional information can be obtained from the following address: DHHS, HCFA: Medicaid Program: Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals Under 21, http://paprovers.org/pages/infos%20achieve/HFCA%20S&R%20Final%Rule%20 Obtained from Web site April 27, 2004
VIOLENCE AND AGGRESSION ACROSS THE LIFE SPAN

The next section focuses on specific implications for nurses caring for clients exhibiting aggression and violence across the life span.

Childhood and Adolescence

Aggressive and disruptive behaviors in our youth are common and pose serious health care concerns. The precise basis of these behaviors continues to be debated. However, most researchers and clinicians agree that they are multifaceted and stem from psychiatric disorders, neurobiological processes, genetic influences, and social and environmental factors.

Violence in any form during childhood and adolescence has potentially debilitating effects on healthy growth and development in children and adolescents. Its effects have been especially devastating to males and minority youth. Exposure to violence during childhood at home, in school, or in the community is predictably associated with violence and aggression across the life span (Ellickson & McGuigan, 2000; Veenema, 2001). It produces psychological distress, such as depression, poor school and academic performance, and subsequent injury. Most researchers assert that these behaviors also predict poor treatment outcomes and heighten the risk of serious antisocial behaviors in adulthood.

A study conducted by Kosterman, Graham, Hawkins, Catalana, and Herrekenkohl (2001) of violent behaviors in children and young adults between the ages of 13 to 21, identified predictions of violence at age 10. Logistic regression was used to determine the developmental patterns of violence in this group. They found that male gender childhood fighting, early individual characteristics, and early antisocial influences best predicted violence in adolescence. In comparison, these data showed that Asian male gender, prosocial development, female gender, and early school achievement were protective against violence during this period. These results have implications for prevention of violence, particularly during early childhood (Kosterman et al., 2001).

Critical Thinking

1. Karen is a 30-year-old client seen in the emergency department. During the visit she starts pacing, yelling, and wringing her hands. What is the most appropriate initial response to this situation?
   a. Alert the security guard because she is dangerous.
   b. Touch her on the shoulder and provide reassurance.
   c. Approach her cautiously and maintain a safe distance.
   d. Ignore her behavior and let her calm down.

2. Mr. Jones, who has a diagnosis of chronic schizophrenia, walks into the community mental health center and accuses staff of stealing his money. He is agitated, irritable, and intrusive. What is the most appropriate response to this patient?
   a. “Mr. Jones, it sounds like you are pretty upset, how can I help you?”
   b. “I am afraid you are mistaken. No one in the clinic would steal your money.”
   c. “Mr. Jones, our staff is very honest and we resent your accusations.”
   d. “You are right, let me talk to my supervisor about your concerns.”

3. An angry family member approaches you and demands information about one of your clients. She is loud, rude, and threatening. What is the most appropriate response?
   a. Tell her you cannot provide information due to confidentiality issues.
   b. Ask her to leave until she gets herself under control.
   c. Acknowledge her anger, but let her know that it is difficult to assist when she is yelling and threatening.
   d. Touch her on the shoulder and let her know that her family member is doing fine.

4. Marty is a 20-year-old client who is brought to your facility by the local police after he is picked up for shouting and threatening his supervisor. He is currently being treated for bipolar disorder, manic episode. What is the most appropriate initial nursing intervention?
   a. Attempt to establish rapport and maintain a safe distance.
   b. Ask the police to leave the room to ensure confidentiality.
   c. Put him in restraints and medicate him as soon as possible.
   d. Let him know that his behavior is inappropriate.
Obviously, the transition from childhood to adolescence to adulthood requires adequate adult supervision and guidance, especially including an awareness of the youth’s friendship network. Aggression during this period requires immediate attention and interventions, and must be distinguished from normal childhood and adolescent acting out and rebellious behaviors. Acting out refers to living out unresolved developmental issues. Acting out may also be associated with early childhood trauma and conflicting parental attitudes and behaviors and failure to form healthy parental relationships.

**Psychiatric Disorders Among Children and Adolescents**

Several factors increase the risk of aggressive behaviors in children and adolescents. Of particular interest are childhood psychiatric disorders. Attention-deficit hyperactivity disorder (ADHD) is the most commonly diagnosed psychiatric disorder in 3 to 5 percent of school-age children and adolescents (APA, 2000; Buitelaar, 2002). Clinical features of ADHD include persistent impairments in attention or concentration and/or symptoms of hyperactivity and impulsivity. This is a chronic condition, associated with poor treatment outcomes. Comorbid conditions such as conduct disorder, substance abuse, and oppositional defiant disorder (ODD) further heighten the risk of aggressive behaviors during this period. Children with ODD are likely to demonstrate sustained patterns of argumentative, hostile, resentful, and defiant behaviors toward adult authority (APA, 2000). Children and adolescents with these psychiatric conditions are likely to enter the juvenile justice system, have a history of persistent aggressive and antisocial behaviors, and develop substance-related disorders in adulthood (APA, 2000).

Substance-related disorders are the strongest predictors of violence in youth. A 2000 National Survey “Monitoring the Future” (Johnston, O’Malley, & Bachman, 2001) showed a 30-day prevalence rate for alcohol, cannabis, and amphetamine use of 22.5 percent, 10.2 percent, 2.6 percent, respectively, among boys in the eighth grade.

In a study conducted by Mason and his colleagues (2004) of children ages 10 and 11 years, they found that children who reported higher levels of behavioral problems were almost four times as likely to experience a depressive episode in early adulthood. These data offer implications for the potential value of intervening to reduce childhood conduct problems as a primary prevention approach for not only violence, but also depression (Mason et al., 2004).

**Neurobiological Factors**

The relationship between childhood and adolescent psychiatric disorders and aggression and delinquent behaviors is well documented. Implications from these findings show that these disorders have a genetic and neurobiological basis, mainly neuroanatomical dysfunction in the HPA, specifically low activity, which is a correlated with protracted and severe aggression. Delinquent behaviors in boys, particularly those exhibiting physical aggression, demonstrate that they have low resting cortisol levels. Researchers have also discovered these findings in girls with conduct disorder who had no other psychiatric condition (McBurnett et al., 2000; Vinson, Whitehouse, & Hinson, 1998). These findings are consistent with early theories and studies that implicate abnormalities in the HPA axis, specifically cortisol secretion, as a risk factor for violence across the life span in male and female adolescents (McBurnett et al., 2000; Pajer et al., 2001).

**Developmental and Environmental Factors**

Environmental factors, including perinatal exposure to toxins, child rearing, and parenting influences have been previously discussed. Prenatal and perinatal factors are also associated with genetic vulnerability and mediated by developmental and environmental factors and stress. Individual development is influenced by the quality of social systems in which the family resides or participates. Social structures provide consistency, safety, and a sense of belonging, beginning with families and, later, peers, who are nested in a larger social context. Identifying family strengths can bolster family functioning. Just as significant is identification of high-risk families; developmental, ethno-cultural, and environment factors; and implementing client and family-centered interventions that focus on these issues. These conditions often result in a stressful or unstable home life, combined with ineffective parenting practices and failure to provide adequate supervision, which produce distant and unhealthy child-parent relationships. Children whose parents have substance-related disorders are also more likely to experience difficulty coping and modulating their emotions and often exhibit aggressive behaviors (Tarter et al., 1999).

Finally, media violence has been overlooked as a contributor to childhood and adolescent aggression. Both video game and movie violence exposure have been associated with stronger proviolence attitudes. The process of playing video games, the intense emotional and physical engagement, and the propensity to be translated into the fantasy play provide a simplistic explanation for the negative impact. However, the specific impact on the desensitization varies and is based on the youth’s individual differences and vulnerabilities to violence (Anderson, 2004; Funk, Baldacci, Pasold, & Baumgardner, 2004; Uhlmann & Swanson, 2004).

Major treatment goals include early identification of high-risk youth, mitigation of symptoms, de-escalation of potentially volatile situations, promotion of healthy family systems, and adherence to treatment.

**Assessment**

Astute assessment and management of disruptive and aggressive or violent behavior in youths are a challenge for the nurse. Early identification and recognition of imminent violence and a clear understanding of the spectrum of violence are critical to ensure the safety of clients and staff. Initially, the nurse must collaborate with the family and...
client to establish rapport and trust to elicit important information about the youth's aggressive behavior, current stressors, and level of distress. This collaborative approach also enables the nurse to assess and honor client preferences and facilitate favorable treatment outcomes. It is also essential for the nurse to assess the parents' parenting skills, level of stress, and child-rearing practices. In the event of impending violence, the nurse must remove self from the situation and call for help (e.g., appropriately trained security, staff). Report all violent incidents to your manager and document the incident in a timely manner. If available seek assistance from staff involved in debriefing employees in the aftermath of a violent situation.

A thorough assessment provides crucial data about the child's psychiatric and medical status, which includes vital signs, visual examination "eyeball," medical history, and brief psychiatric assessment. This process requires talking and listening to the client; collaborating with the youth's parents, pediatrician, or provider; and obtaining information about developmental milestones and family psychiatric and mental history. A focused medical assessment must be performed to rule out medical conditions, including endocrine disorders. Drug screens and a Breathalyzer exam should be performed when alcohol intoxication is suspected. If medical conditions are the bases of the client's symptoms, these problems must be addressed and treated as soon as possible.

Assessment data must include a screening mental status examination (MSE). The mental status examination is an integral part of the assessment process and provides general information about the youth's overall appearance, attitude, mood, speech, concentration, thought processes and content, judgment, level of dangerousness to self and others, insight into illness, and motivation for treatment. All threats of violence must be taken seriously. Additional information to obtain from the youth and family include:

- Target symptoms or behaviors (e.g., restlessness, agitation, hitting)—often a reason for seeking treatment
- Severity of symptoms—guides nursing interventions
- Common triggers or precipitating factors—may range from a social situation, such as bullying by another student to exacerbation of a psychiatric condition
- Early signs of escalation
- Successful or effective interventions
- Context of past incidents (e.g., school, home)

Recent changes in the youth's behavior, including isolation from peers, drug or alcohol use, secretiveness, and increased time spent away from the house are red flags that nurses must recognize as the bases for serious psychiatric disorders such as depression (Miller et al., 2000). The following information about the family is also crucial to determining the child's level of distress and the parents' ability to provide safety:

- Quality of the couple/parent relationship
- Past and present psychiatric histories

- Past violent or aggressive episodes and methods of resolving
- Coping styles and disciplining practices (consider ethno-cultural factors)
- Parent-child relationship (e.g., conflict, abuse, neglect)
- Ethno-cultural factors that impact parental style and approaches
- Substance use
- Level of empathy

(See Chapter 5, Nursing Process, for a further discussion on data collection.)

In effect, nurses and interdisciplinary team members must quickly differentiate medical conditions from psychiatric disorders and rapidly determine whether they are conditions that warrant specific interventions (e.g., behavioral, pharmacotherapy), or if behaviors depict a misunderstood appropriate developmental incident. An accurate synthesis and interpretation of data is required to make an accurate diagnosis.

**Diagnosis**

- High risk for other violence
- Ineffective coping
- Anxiety
- Risk for self-directed violence
- Low self-esteem
- Parent-child problem
- Deficit knowledge: parenting skills, psychiatric disorder(s), and treatment considerations

An accurate diagnosis is necessary before appropriate client and family goals are established and appropriate treatment can begin.

**Outcome Identification/Planning and Implementation**

Major goals during this period are the provision of staff and client safety, maintaining client autonomy, reducing the target symptoms, and establishing a therapeutic relationship and milieu (dosReis, Barnett, Love, Riddle, & the Maryland Youth Practice Improvement Committee, 2003). During this period the nurse and interdisciplinary team must determine the level of intervention required for managing the client's symptoms when there is potential or looming danger.

**Major Nursing Interventions**

- Ensure staff and client safety.
- Establish and maintain a therapeutic relationship.
- Assess and monitor the youth's mental status and level of peril to self and others.
- Assess and strengthen the parent-child relationship.
- Administer or order appropriate pharmacological and nonpharmacological treatment.
• Provide activities to succeed and generate positive feelings.
• Assess and provide client-centered psychoeducation.

The level of interventions involves behavioral strategies that foster trust and hope, such as active listening. The primary aim of this goal is to maintain the milieu or limit setting and promote autonomy. Early intervention defuses the situation and should be implemented as soon as mild agitation is assessed.

Pharmacological Interventions
Although there is no consensus on the treatment of disruptive and aggressive behaviors, a number of studies involving children and medications used to treat these conditions show promise (Malone, Delaney, Luebbert, Cater, & Campbell, 2000). Psychotropic use of chemical restraint in youths is an evolving clinical approach. Normally, this intervention is required for the child's, nurse's, and other staff safety and to advance the medical and psychiatric evaluation.

The decision to administer psychotropic agents to children and adolescents exhibiting agitation and violent and psychotic symptoms must be determined by a differential diagnosis. Data from nurses and members of the interdiscipli- nary team or pediatric and medical consultants are crucial in making this decision.

There are controversies surrounding some of these psychotrophic agents because there is paucity of data that have focused on this subject in this population. Once a decision is made to use these agents, nurses and other providers must be aware of available options along with complications associated with their side-effect profile (Sorrentino, 2004). Nurses and other providers need to be as conservative as possible concerning safety and to reduce antipsychotic exposure when treating children.

If required, antipsychotic agents should be one of the atypical medications, such as olanzapine and risperidone rather than typical drugs, such as haloperidol, due to their side-effect profile (Sorrentino, 2004). Consider oral medications as the first-line treatment for aggression and violence, when appropriate, followed by intramuscular (injectable/parenteral) medication and seclusion; the least acceptable resort is physical restraints. Clients receiving injections perceive this as physically and mentally traumatic, and it may compromise the nurse-client relationship. Whatever measures are initiated, these considerations must go into treatment planning decisions.

Antipsychotic agents may be used to reduce severely disruptive behaviors or aggression, despite limited efficacy and safety data and side-effect profile (Malone, Maislin, Choudhury, Gifford, & Delaney, 2002). Psychostimulants have also been used to treat various disorders, such as CD and ADHD, with a lack of agreement concerning the efficacy of these agents. Lithium is safe and effective for short-term use for aggression in inpatients with CD, although it is also associated with adverse side effects. Its efficacy in treating other childhood disorders and disruptive behaviors remains controversial. Specific pharmacological interventions for psychiatric conditions in children and adolescents (e.g., CD, ADHD) are discussed in Chapter 17, The Client with Attention-Deficit Hyperactive Disorder, and other childhood and adolescent aggressive disorders.

Behavioral Interventions
The last resort for treating the child exhibiting disruptive or unmanageable behaviors is seclusion and restraints. Nurses and team members must use various guidelines previously mentioned to determine the appropriateness of chemical and physical restraints. Other interventions show great promise in reducing the progression of these behaviors and should be considered as first-line interventions, such as time-outs and other behavior interventions, family-centered care, and psychoeducation (Multisite Violence Prevention Project, 2004).

Various approaches are used to manage disruptive and unmanageable behaviors in youths. Time-out is commonly used with children exhibiting aggressive and violent behaviors, including those with psychiatric disorders and learning disabilities. This term means the restriction of the youth for a period of time to an assigned area from which the child is not physically restricted from leaving, for the purpose of providing the child an opportunity to regain self-control. This behavioral intervention reduces the use of restraint and can be used to mold the child's behavior. Children and their parents perceive this intervention as less punitive than seclusion and restraints.

Other behavioral interventions that show promise in controlling these behaviors include therapeutic holding (Barlow, 1989; Berrios & Jacobowitz, 1998). In a study conducted by Sourander, Ellilia, Valimaki, and Piha (2002) of 504 children and adolescents, the researchers looked at the use of holding, restraints, seclusion, and time-out on an inpatient unit. Time-out was used 28 percent, holding 26 percent, seclusion 8 percent, and mechanical restraints 4 percent. Findings from this study indicated that therapeutic holding was more likely to occur with younger children less than 13 years and with diagnoses of attachment disorder and autism. In contrast children with psychosis, suicidal acts, and older than 13 were more likely to be secluded and be mechanically restrained. The researchers also concluded that the high prevalence of restraint techniques used indicated a need for nurses to receive guidelines on the use of these interventions that should consider the child's need for protection from his impulses, and the legal rights of the youth (Sourander et al., 2002).

Family Interventions
Criticism of or blaming the family is counterproductive. The family is the most immediate and influential social system for children at risk for aggression and violence (Antai-Otong, 2003a). The nurse and staff must provide feedback to the family and youth about the situation, and involve them in outcome identification and treatment planning.

During this stressful period families need emotional support and mutually defined interventions that bolster their
resources to facilitate healthy resolution of the present crisis and reduce future occurrences. Family-centered interventions need to focus on the importance of consistent child management at home, opportunities to help the youth in need of control of aggressive and disruptive behaviors. Debriefing and crisis intervention are useful strategies that can teach families about triggers, educate them about de-escalation techniques, reinforce family cohesiveness, and strengthen their ability to cope and handle future stress and crises (Antai-Otong, 2001).

Appropriate referrals for family therapy, medication management, and individual psychotherapy for the child are critical aspects of follow-up and maintenance. Parental involvement and multiple family groups also offer families opportunities to address parental practices surrounding discipline and monitoring, communication, and investment in the youth’s academic performance. Understanding parental approaches within the family and youth’s social, ethnic, and cultural communities are crucial to working with the family and child during stressful periods (Multisite Violence Prevention Project, 2004; Gorman-Smith, Henry, & Tolan, 2004). Psychoeducation is an integral part of treatment planning and provides opportunities to impart crucial health education that strengthens the client and family’s knowledge of psychiatric conditions, the importance of treatment adherence, stress management, and the significance of structure and consistent parenting in mitigating disruptive behaviors and violence.

**Evaluation**

Ideally, the nurse and appropriate staff defuse and de-escalate the situation by enlisting the client and parents/caretakers in the assessment, outcome identification, and treatment process. During this aspect of treatment it is imperative for the nurse and interdisciplinary team to discuss the situation and use it to improve treatment outcomes. It is also important for staff to discuss the situation and use it to improve health care. Feedback facilitates interactive dialogue with the family, client, and staff and facilitates greater knowledge of the risks and benefits of various interventions. Staff can also reassess the contributing or precipitating factors and determine the level of treatment and violence toward self or others.

Documentation is an integral part of this process. It should include pertinent information about triggers, early warning signs, and efficacy of interventions as evidenced by reduced symptoms or de-escalation and amelioration of symptoms.

**Adulthood**

Personal and client safety has been previously discussed as a priority in dealing with violence across the life span. Additional factors are associated with violent and aggressive behaviors such as psychiatric disorders, substance-related disorders, medical conditions, and ineffective coping styles. Presumably these factors result in ineffective coping behaviors; inability to manage frustration, anger, and stress; low self-esteem, and emotional pain and distress. Psychiatric disorders, learned behaviors, history of childhood abuse and neglect, and substance-use disorders may increase the risk of aggression and violence during adulthood.

**Assessment**

The nurse must approach the client confidently and convey caring and empathy. Establishing rapport is critical to the success of resolving potentially violent situations. Clients must be observed for signs and behaviors associated with impending violence throughout the assessment and treatment process (e.g., yelling, threatening gestures, signs of alcohol). Specific interventions were previously discussed in this chapter. Regardless of educational background, psychiatric nurses must perform a thorough biopsychosocial assessment and work with the interdisciplinary team and make a differential diagnosis. Nursing responsibilities may vary but generally include ordering appropriate diagnostic studies, including drug screens, reviewing the results, and sharing them with members of the treatment team.

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**CASE STUDY**

During lunch Melvin, a 33-year-old client with a diagnosis of schizophrenia, yelled that he was hearing voices and he wanted to eat alone. Another client inadvertently sat at his table and was struck in the face. Staff attended the assaulted client, and other staff immediately restrained Melvin from further assault and slowly put him on the floor. Throughout the course of the incident, staff talked calmly and reassured him that he was not going to be hurt. He continued to yell that he was hearing voices. Despite receiving an injection of haloperidol and lorazepam, he continued to fight and attempt to get up. The staff continued to talk calmly to him and reassure him that he was not going to be hurt and that they wanted to make sure he was safe along with other clients and staff. Within 25 to 30 minutes Melvin calmed down, became cooperative, and was able to complete his meal and return back to the unit. He was debriefed after the incident to assess his feelings about the situation and assessed for further violence. The assaulted client was also debriefed, allowed to eat, and sent back to the unit.
The case study is an example of the unpredictable nature of aggression and violence. Staff training on the prevention and management of disruptive behavior (PMDB) is crucial. Major goals in this situation included preventing further violence, protecting others from harm, and using the least restrictive interventions to defuse a violent situation. In this case, the client was physically aggressive and responding to hallucinations, which increased his risk of violence and harm. The staff responded appropriately to this violent situation by implementing physical and chemical interventions to contain the violence, reassure the client, and mitigate auditory hallucinations and anxiety. They also attended to the needs of the assaulted client.

**Diagnosis**

- Risk for other directed violence
- Acute confusion
- Risk for suicide
- Ineffective coping
- Anxiety
- Powerlessness

**Outcome Identification/Planning and Implementation**

- Prevent harm to self and others
- Maintain staff and client safety
- Improve coping skills
- Increase self-esteem

**Nursing Interventions**

Nursing interventions must be tailored to improve the nurse-client relationship, ensure safety, improve clinical skills in de-escalation and defusion, and recognize personal characteristics and interpersonal skills that impact the incidence of aggression and violence. Specific nursing interventions include:

- Establish rapport
- Observe for high-risk behaviors (e.g., restlessness, agitation, pacing)
- Remain calm
- Maintain quality nurse-client interactions
- Avoid power struggles and authoritarian approaches
- Maintain personal space
- Participate in annual training on the PMDB
- Avoid contact with an openly aggressive client alone

Major nursing interventions must focus on establishing rapport, maintaining quality nurse-client interactions, and avoiding authoritarian approaches or power struggles. Depending on the etiology of aggression and violence, interventions include behavioral or pharmacological or both.

(See the Nurse-Client Dialogue Box and Case Study.)

**Behavioral Interventions**

De-escalation and defusion have been discussed extensively in this chapter (see Box 3). The effectiveness of behavioral interventions are influenced by the nurse’s attitude and verbal and nonverbal communication. The following self-assessment checklist can be helpful:

- How am I reacting? Nervous, anxious, calm, reassuring
- How’s my tone of voice? Loud, demanding, calm, firm
- How’s my body language?
- Check personal space
- Am I wearing anything dangerous?
- What are my “gut” feelings?

When a condition involves an imminent danger to the client or others and behavioral interventions fail to de-escalate the situation, other measures, such as restraints and seclusion, are used as the last resort.

The legal tenet that determines the use of seclusion and restraint involves using the least restrictive interventions to manage imminent violence to the client and others. It also involves implementing applications that minimally deprive the client of personal freedom to achieve the purposes of the intervention (Hendricks & Barloon, 2003). When asked about their preferences for the least restrictive, most clients answered medication over physical restraint. Many clients view these interventions as a form of punishment rather than a treatment strategy (Johnson, 1998; Heyman, 1987). Implications from these perceptions include the importance of using these applications appropriately and providing health education surrounding their purpose, and debriefing to reduce stress. Some nurses believe that there will always be a need to contain a severely mentally disturbed client as a means of protection, especially when there are limited alternatives (Alty, 1997). This notion is an inappropriate reason to restrain or seclude.

**Pharmacological Interventions**

Pharmacological interventions should be considered when there are clear clinical indications, such as acute psychosis, intense agitation, severe cognitive deficits, and the threat of violence. Interventions for aggressive and violent behaviors in adults are similar to those for children and older adults. Early identification of warning cues include pacing, restlessness, physical arousal, and yelling and threatening body cues. Whether the client is angry and taking out frustration on others, or experiencing psychosis due to nonadherence to treatment, or experiencing hallucinations and delusions caused by illicit or licit drug use, staff and client safety must be a priority.

Typical medications used to treat acute agitation, psychosis, drug intoxication or withdrawal, and aggression include antipsychotic agents and benzodiazepines. For clients presenting with acute schizophrenia and mania, the drugs of choice include traditional antipsychotic agents such as haloperidol 5 mg IM and lorazepam 2 mg IM. These drugs are given in combination to reduce psychosis, agitation, and anxiety. Combined with lorazepam, the haloperidol can be reduced to minimize the potential for extrapyramidal side effects during rapid tranquilization.

Normally, violence decreases within 20 minutes after an injection of haloperidol, and improvement of psychosis
and violent behaviors in older adults result in high chemical and psychological disturbances. Unfortunately, aggressiveity, poor executive functioning, and subsequent behavioral with frontotemporal dementia, cognitive decline, impulsivity in this population and other age groups is associated orders in the older adult. As previously discussed, aggression is a common behavioral symptom of dementia, Older Adults

The Client Exhibiting Aggression, Hostility, and Violence

Evaluation

Positive outcomes for managing aggressive and violent behaviors include safety, resolution of violent situation, and implementation of appropriate intervention associated with underlying causative factors. Underlying causative factors may include amelioration of psychosis, correction of a medical condition such as diabetes ketoacidosis, or a severe adverse drug reaction. A positive treatment outcome indicates that the client’s condition is stable and there is no evidence of untoward reactions from treatment or interventions.

Older Adults

Aggression is a common behavioral symptom of dementia, delirium depression, and other psychiatric and medical disorders in the older adult. As previously discussed, aggression in this population and other age groups is associated with frontotemporal dementia, cognitive decline, impulsivity, poor executive functioning, and subsequent behavioral and psychological disturbances. Unfortunately, aggressive and violent behaviors in older adults result in high chemical restraints and caregiver distress and depression. Increased psychotropic use in older adults is likely to result in a greater risk of sensitivity to drugs, side effects, and risk of toxicity due to age-related changes.

Implications for the nurse include recognizing these changes and working with the interdisciplinary team to develop and implement age-specific interventions that reflect the individual’s preferences and cultural needs that reduce the risk of adverse treatment outcomes and facilitate a higher level of functioning.

Geriatrics and Extended Care Settings

Persons residing in nursing homes are vulnerable to intentional injury, particularly resident-to-resident violence. Aggressive behavior can lead to institutionalization, over-medication and physical restraint. Efforts to provide care and maintain the client’s dignity is a daunting task. It often requires educating the staff about alternative measures to reduce or minimize aggressive behaviors, such as implementing restraint-free environments.

High-risk factors associated with violence among residents include dementia, psychosis, male gender, younger age, pain, and facilities that have a large proportion of residents with dementia (Kolanowski & Garr, 1999; Shah, Chiut, Ames, Harrigan, & McKenzie, 2000; Shinoda-Tagawa et al., 2004). According to findings from the Centers for Medicare and Medicaid Services (CMS), close to 90,000 nursing home residents in the United States have exhibited physical aggressive behavior in the week before their assessment with theMinimum Data Set (MDS). (See Box 2: Individual Characteristics Associated with Violence).

Target symptoms include psychosis (e.g., hallucinations, delusions, agitation) and severe agitation, which are the most common symptoms reported in clients with neurodegenerative disease. Paranoid or persecutory delusions are the most common forms of delusions, especially in those with Alzheimer’s disease (Jeste & Finkel, 2000). The significance of delusions and hallucinations in these clients is their level of distress and high risk of agitation and aggression. Typically, delusions involve a belief that people are stealing things from them, that their home is not theirs, and that their spouse is unfaithful. They are also troublesome and distressful to caregivers, which are often cited as reasons for institutionalization. Violence may also occur if the client acts on his or her delusions or hallucinations. Additional behaviors associated with these disorders include a history of sleep disturbances, apathy, pacing, noisy vocalizations, physical aggression, restlessness, hypersexuality, and confusion.

Assessment

Behavioral disturbances and psychosis are common manifestations of neurogenerative conditions and may be drug induced or linked to an underlying medical condition, or both. Regardless of the cause, safety must be a priority. It is imperative to approach the aggressive older client cautiously and maintain personal and client safety. Collaboration with the client, family, and other appropriate staff is crucial to the

occurs within 6 hours. Lorazepam has a rapid onset and produces sedation within one hour. Haloperidol is contraindicated in clients with a history of neuroleptic malignant syndrome (NMS) or tardive dyskinesia (TD).

Atypical agents, such as ziprasidone and risperidone elixir or rapid dissolving pill should be considered in clients who report a history of NMS or other serious adverse drug reactions (e.g., TD). Alternatives are oral risperidone and oral lorazepam, which show similar efficacy when compared to IM haloperidol and lorazepam (Currier & Simpson, 2001). It is noteworthy to repeat that most clients perceive IM medication as a form of mental and physical trauma. Every effort to ask the client to take oral medications, when appropriate, should be used to promote rapport and a therapeutic nurse-client relationship.

Benzodiazepines, such as lorazepam and diazepam, are part of the treatment facility’s protocol for alcohol withdrawal. Although these drugs have proven efficacy in sedating agitated clients and reducing the risk of seizures, they must be monitored closely and assessed for signs of disinhibition—a behavior that further increases the risk of impulsive aggression and violence.

Haloperidol and other typical antipsychotics should be limited to acute care and should be avoided to minimize serious adverse drug reactions. Other drugs used as maintenance treatment to manage impulsivity, aggression, and disruptive behaviors are the mood stabilizers (e.g., lithium) and anticonvulsants, such as lamotrigine and divalproex. Lithium and valproate acid have also shown promise for reducing aggressive behavior in adults, again with inconsistent results in children and adolescents (Malone et al., 2000). Monitoring and documenting the client’s response to all interventions are important nursing interventions during and after these agents are given. (See Chapter 28 for a discussion on pharmacological agents.)
data collection process and understanding the client's preferences, previous level of functioning, and quality of life. Additional questions include duration of current mental status changes (e.g., acute confusion, disorientation, agitation), current medications, recent surgeries, and medical conditions.

Considerations for age-related changes must also be taken into account, such as speaking slowly, and addressing the client by his or her preferred name per the client or family. Use an unhurried approach and allow the client and family to respond to queries. Assess and recognize the impact of age-related sensory deficits on the client's behavior and ability to respond to questions. Because of potential cognitive deficits in the older client that may stem from an underlying medical or psychiatric condition, this approach reduces anxiety and frustration even when the client is hostile. It is reassuring to the client and family when the nurse conveys patience and empathy during this difficult situation.

Screening tools, such as the Mini Mental State Exam (MMSE) is also useful in the data collection process. This 10-minute screening tool provides invaluable client data in the following areas:

- Orientation
- Attention
- Concentration
- Memory
- Language
- Visuospatial ability
- Calculation

Appropriate laboratory and diagnostic studies, such as a complete blood count with differential, a liver panel, toxicology screens, an oxometry, chemistries, Vitamin B12, folic acid, a urinalysis, and an electrocardiogram should be ordered as soon as possible to rule out underlying medical conditions.

Several psychiatric and medical conditions are associated with aggression and physical assault in older adults. The most common reasons are psychiatric disorders, acute medical conditions such as endocrine disorders and fluid and electrolyte disturbances, substance use, and neurodegenerative conditions. Neurodegenerative disorders include extrapyramidal disorders (e.g., Parkinson’s disease, Alzheimer’s disease), myelin disorders such as amyotrophic lateral sclerosis (ALS), cortical disease, dementia, and delirium. Once medical conditions are confirmed the client must be transferred to an appropriate provider, or treatment should be initiated immediately.

**Diagnosis**

- Acute confusion
- Risk for injury
- Risk for other directed injury
- Risk for self-directed danger
- Anxiety
- Disturbed sleep patterns
- Caregiver role strain

**Outcome Identification, Planning, and Implementation**

Treatment planning for Mr. Jones will focus on staff and client safety. An evaluation will be conducted of his symptoms and underlying medical conditions that may have been caused by an adverse reaction to his new medication. Outcome identification will focus on:

- Maintaining a safe environment
- Improving his mental status and restoring his baseline level of functioning
- Reducing the risk of danger and injury to self or others
- Improving his sleep patterns
- Lessening his anxiety
- Reducing his caregiver’s distress

**Interventions**

Although dementia is common in older adults, it is imperative to rule out such conditions before making assumptions.

**Pharmacological Interventions**

There is some evidence that psychotic symptoms improve modestly with antipsychotic medication. Risperidone has

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**CASE STUDY**

Mr. Jones is an 80-year-old married man who is brought to the emergency room by his 83-year-old wife, who reports that he has been accusing her of taking his things, wandering around at night, and screaming at her and their grandchildren. She reports that she is tired and depressed and needs help in caring for her spouse.

Data from the assessment reveal that Mr. Jones has been recently started on medication for arthritis (2 weeks ago). He has been taking it as ordered, but his wife reports that he has refused to take all of his medication over the past few days. She describes him as a “good-natured” man and explains that she has never seen him like this before. Mr. Jones’ mental status examination indicates that he is extremely agitated, restless, uncooperative, confused, and disoriented. The most remarkable history is his new medication for arthritis that he began 2 weeks ago. His wife denies other changes or stress in their lives. He has a negative history of alcohol or other drugs. His medical examination is unremarkable. He is admitted to the hospital to further evaluate his delirious and acute confusional state.
been the most often studied of the atypical antipsychotic agents, confirming its efficacy in reducing aggression and psychosis (Brodaty et al., 2003; De Deyn et al., 1999; Katz et al., 1999).

Typically, aggressive and violent behaviors in this age group is treated with a low-dose antipsychotic agent that reduces psychosis, agitation, and anxiety. After coaxing from the staff and his wife, Mr. Jones took a low dose (1 mg) of risperidone liquid by mouth. Several hours later he was calmer and the staff was able to complete his examination.

It is well documented that risperidone and other atypical antipsychotics, such as olanzapine, significantly improve symptoms of psychosis and aggression in persons with severe dementia (Davidson, Weiser, Soares, 2000; Jeste & Finkel, 2000; Katz et al., 1999). Major benefits of atypical medications include their favorable side-effect profile in older adults and their efficacy that is at least equal to haloperidol. Due to risk of toxicity, side effects, and drug sensitivity, older adults are usually prescribed one half or one third of adult doses.

**Behavioral Interventions**

In this case study, staff did not believe that restraints or seclusion were indicated because of the potential for actual adverse outcomes. Historically, restraints were used in various settings, including intensive care units, older age, cognitive deficits, dementia, immobility, and physical dependence. Studies that demonstrated a positive correlation between length of stay (LOS) in facilities and restraint use are well documented. The LOS was at least twice as long for the restrained client as the nonrestrained clients (DeSantis, Engberg, & Rogers, 1997). Clinical findings associated with these interventions have demonstrated negative psychological and physical consequences. These consequences include loss of muscle strength, formation of pressure ulcers, incontinence, strangulation, psychological distress, and death, regardless of whether the appliance was put on appropriately (Miles & Irvine, 1992; Parker & Miles, 1997).

Contemporary data have emerged that indicate that facilities have moved from restraints and seclusion to restraint-free or least restrictive environments (Hammond & Levine, 1999; Janelli, Kanski, & Wu, 2002). Music therapy and alarm devices and corrective environmental and equipment changes, including beds without side rails, are showing great promise in reducing aggressive behaviors, particularly in older adults with cognitive deficits and dementia.

Behavioral interventions used with Mr. Jones included reorientation, music therapy, and a restraint-free environment. He was taken off all medications to determine if one of them caused acute mental status changes. The nurse and other staff worked with the client and his wife and created a “safe” environment that allowed her to participate throughout his hospital stay and play a key role in developing client-centered and culturally sensitive health care. She also participated in a psychoeducation group that centered on medications, stress management, and treatment adherence. (See the Nursing Care Plan.)

**Evaluation**

Outcome identification was used as a parameter for the evaluation process. (See the Nursing Care Plan.)

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### NURSING CARE PLAN

#### MR. JONES (Case Study)

**Nursing Diagnosis: Acute Confusion and Anxiety**

<table>
<thead>
<tr>
<th>OUTCOME IDENTIFICATION</th>
<th>NURSING ACTIONS</th>
<th>RATIONALES</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. By [date], client will be alert and oriented to person, place and time.</td>
<td>1a. Establish rapport and reassurance that he is safe.</td>
<td>1a. Establishes therapeutic interaction. Conveys empathy, caring, and interest.</td>
<td>Goal met: Nurse forms therapeutic relationship. Client is oriented and anxiety is reduced. Client responds to orientation and reassurance and his risk of dangerousness to self and others is achieved.</td>
</tr>
<tr>
<td></td>
<td>1b. Orient the client as needed. Use short and direct sentences.</td>
<td>1b. Present reality, orientation, and reduce anxiety and agitation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1c. Allow spouse to remain with client. Assess level of dangerousness.</td>
<td>1c. Provides safety and orientation to surroundings.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1d. Observe for mood changes. Ask wife to notify staff of mood changes.</td>
<td>1d. Change in mood or anxiety level increases risk of dangerousness.</td>
<td></td>
</tr>
</tbody>
</table>

*continues*
The Client Exhibiting Aggression, Hostility, and Violence

Nursing Care Plan  (continued)

**Nursing Diagnosis: Risk for Injury**

**OUTCOME IDENTIFICATION**
1. By [date], client mental status returns to pre-confusional state.

**NURSING ACTIONS**
1a. Establish rapport and reassurance that he is safe.
1b. Orient the client as needed. Use short and direct sentences.
1c. Allow spouse to remain with client.
1d. Continuously assess the client's mood and anxiety level.

**RATIONALES**
1a. Establishes therapeutic interaction. Conveys empathy, caring, and interest.
1b. Present reality, orientation, and reduce anxiety and agitation.
1c. Provides safety and orientation to surroundings.
1d. Change in mood or anxiety level increase risk of dangerousness.

**EVALUATION**
Goal met: Nurse forms therapeutic relationship. Client is oriented and anxiety is reduced. Client’s mental status returns to pre-confusional state. Client responds to orientation and reassurance and his risk of dangerousness to self and others is achieved.

**Nursing Diagnosis: Risk for Other-Directed Injury**
(same as previous interventions and goals)

**Nursing Diagnosis: Risk for Self-Directed Danger**
(same as previous interventions and goals)

**Nursing Diagnosis: Disturbed Sleep Patterns**

1. By [date], client’s normal sleeping patterns return to optimal level.

**NURSING ACTIONS**
1a. Assess normal sleeping patterns from spouse.
1b. Maintain quiet environment.
1c. Implement sleep hygiene techniques such as avoiding heavy meals and fluids 2–3 hours before sleep.

**RATIONALES**
1a. Helps nurse identify normal sleeping patterns.
1b., c. Promotes rest, sleep

**EVALUATION**
Goal met: Client’s normal sleeping patterns return and are maintained.

**Nursing Diagnosis: Caregiver Role Strain**

1. By [date], spouse and other caregiver verbalize present stressors and ways to effectively manage them.

**NURSING ACTIONS**
1a. Inquire and assess present stressors.
1b. Reassure that this is a temporary situation and that all is being done to assist spouse.
1a–c. Gathering this data helps the nurse gain a greater understanding of caregiver’s present confusional state and coping pattern.

**RATIONALES**
1a. Helps nurse identify present stressors.
1b. Present stressors and ways to effectively manage them.
1a–c. Gathering this data helps the nurse gain a greater understanding of caregiver’s present confusional state and coping pattern.

**EVALUATION**
Goal met: Client has a clearer understanding of present stressors. Client’s self-esteem increases.

(continues)
LEGAL AND ETHICAL ISSUES RELATED TO VIOLENCE

Dealing with a violent or aggressive situation requires balancing the client’s right to freedom and autonomy using least restrictive means and the communities’ right to protection from violence. Psychiatric nurses must distinguish between various forms of restraints and/or seclusion, including pharmacotherapy for personal protection, and use them to assist the client and society. Normally, restraints and seclusion are the last alternative to manage assaultive and aggressive behaviors after verbal de-escalation or defusing and other behavioral interventions fail as evidenced by continued escalation. Ideally, facilities have policies and codes that are used to guide staff in the event that physical interventions are necessary. It is imperative to explain reasons for verbal and physical interventions and ensuring that steps will be taken to help the client regain control regardless of the client’s mental status. This approach conveys concern and respect and reduces anxiety in the already agitated or aggressive client who may feel helpless and frightened. Of particular importance are the following medical and legal issues. See Chapter 8 for an in-depth discussion of legal and ethical issues involving clients exhibiting aggressive and violent behaviors.

WHEN VIOLENCE OCCURS: STRESS DEBRIEFING

Self-care during the aftermath of violence is crucial and helps nurses cope with trauma and fears associated with these incidents. Historically, psychiatric and other nurses were told that violence was part of their job. Violence should never be an acceptable part of nursing regardless of setting. Once it occurs, nurses need to seek support and opportunities to process the event and put it into perspec-

### Nursing Care Plan (continued)

<table>
<thead>
<tr>
<th>OUTCOME IDENTIFICATION</th>
<th>NURSING ACTIONS</th>
<th>RATIONALES</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1c. Convey acceptance and empathy.</td>
<td>1d. Health education helps family members understand their loved one’s medical condition and reduces undue stress and anxiety.</td>
<td>Client is able to explore options to deal with present stressors.</td>
<td></td>
</tr>
</tbody>
</table>

1d. Provide health education on various topics including delirium and acute confusion.

Client is able to explore options to deal with present stressors.

THE ROLE OF THE NURSE

Regardless of one’s role on the interdisciplinary team, violence prevention is everyone’s responsibility. Nurses must advocate for their personal safety and participate in proactive endeavors that ensure healthy work environments.

The Generalist/Staff Nurse

Generalist nurses are likely to spend more time gathering data at the bedside or in groups with individuals at high risk of violence during acute stages of their illness than other staff. Steps that facilitate and promote safe work environments have been aforementioned. The nursing process guides the interviewing process and helps the nurse make appropriate queries about the client’s symptoms, including previous history of violence, current medications, and reviewing laboratory studies to help team members determine an accurate diagnosis.

Primary responsibilities of the generalist include assessment, outcome identification, working with the interdisciplinary team, and making an accurate differential diagnosis. Major nursing interventions include medication administration, implementing behavioral interventions, and psychoeducation. Monitoring the results of laboratory and other diagnostic tests are also part of the generalist role. Reporting adverse effects, abnormal laboratory results, and worsening
violence is an integral part of this process. Throughout the assessment and treatment process the nurse must monitor and document client responses to pharmacological and behavioral interventions.

The Advanced-Practice Psychiatric Registered Nurse (APPRN)

Major responsibilities of the APPRN are the same as the generalist nurse's regarding safety issues. The APPRN also performs psychiatric and physical evaluation to rule out psychiatric and medical conditions that contribute to aggression and violence. Ordering diagnostic studies and interpreting these findings and prescribing medications are vital aspects of the APPRN's responsibilities. As a part of the interdisciplinary team the nurse also discusses relevant data to make accurate diagnosis of underlying causes and treatment to reduce these behaviors.

APPRNs must also advocate for staff and client safety by initiating dialogue and working with interdisciplinary teams and facility administrators and developing policies that mandate safe and healthy work environments. This process must also afford nurses, clients, families, and other staff opportunities to cope with immediate emotional reactions during the aftermath of violent incidents (e.g., stress debriefing).

THE NURSING PROCESS

Assessment

Major principles guiding the nursing process were discussed earlier and focused on life span issues. Strategies that facilitate differential diagnosis and guide the decision-making process in making accurate diagnosis are crucial in establishing outcome identification, treatment planning, and evaluation. (See Chapter 5, Nursing Process, for information about the nursing process.)

Diagnosis

Various nursing diagnoses involving aggressive and violent behaviors have been previously mentioned. Listed diagnoses include injury to self and others, anxiety, chronic low self-esteem, and powerlessness.

Outcome Identification/Planning and Implementation

Prevention is a key element surrounding outcome identification, planning, and implementation. Prevention of violence and mitigation of symptoms must be systemic and involve strategies that control or prevent these behaviors in clients and the workplace.

Nursing Interventions

Nursing interventions must focus on prevention and on personal, client, and staff safety. Issues such as life span considerations, differential diagnosis, and the importance of interdisciplinary teams are important components that reduce the causative factors associated with aggressive and disruptive behaviors and positive treatment outcomes.

Evaluation

Evaluations are based on treatment outcomes and the level of safety facilitated by nursing interventions.

NURSING RESEARCH

The growing incidence of workplace violence in vast practice settings is an area of interest for nursing research. Nursing theorists have explored numerous factors associated with workplace violence, the incidence of violence in specific practice settings, and interventions that reduce its incidence. There is a great need for the psychiatric nurse researcher to develop evidence-based interventions that reduce the incidence of violence across the life span.

There is also a dearth of data on the effectiveness of behavioral interventions that reduce aggressive behaviors in children and adolescents. This specialty needs further research to determine the efficacy of age-specific interventions and opportunities to discover innovative approaches to managing aggressive and assaultive behaviors in this age group.

Other areas of interest include developing models of care for the growing aging populations that exhibit aggression and violence. As our society ages, there is a growing need to develop evidence-based age-specific interventions that embrace the concept of restraint-free interventions and the role of chemical restraints that ensure safety, dignity, and respect of older adults. (See Research Abstract.)

SUMMARY

- Violence can and does occur everywhere.
- Aggressive and violent behavior across the life span is a major public health problem.
- Nurses and other health care providers are at a high risk of violence.
- Personal safety is a priority in maintaining workplace safety.
- Proactive measures are key to the prevention of workplace violence.
- Numerous factors contribute to violent, disruptive, and aggressive behaviors.
- Nurses must advocate for personal safety and dismiss the notion that workplace violence is part of their job.
- Psychiatric nurses participate in policy making and other administrative decisions to ensure their personal safety.
Nurses must work toward creating restraint-free inpatient units.

Research indicates that behavioral and pharmacological interventions are safer than seclusion and restraints in managing violence across the life span.

**SUGGESTIONS FOR CLINICAL CONFERENCES**

1. Train students in verbal de-escalation and defusing.
2. Invite an advanced-practice registered psychiatric nurse to discuss the role of the nurse in psychiatric triage or in a crisis center. Ask the nurse to focus on verbal and nonverbal cues that indicate active or imminent violence and environmental factors that create a safer workplace.
3. Set up a scenario and ask students to role play an aggressive client and nurse (switch roles) and discuss their feelings about each role, and ask them to critique the interactions.
4. Invite a nurse who has actually had a serious encounter with a violent client to discuss what happened, lessons learned, and what services the nurse used to cope with the situation.
5. Invite the program leader of the facility Critical Incident Team or someone from the American Red Cross Mental Health Disaster Team to share their goals in dealing with the aftermath of a violent incident.

**STUDY QUESTIONS**

1. Which of the following increases the risk of aggression and violence?
   a. Previous history of violence
   b. An untreated psychiatric disorder
   c. History of domestic violence
   d. All of the above
2. Which of the following statements best describes social learning theories about violence?

**RESEARCH ABSTRACT**

Client Exhibiting Aggression, Hostility, and Violence

**EVALUATING A MANAGEMENT OF AGGRESSION UNIT FOR STUDENT NURSES**


**Study Problem/Purpose**

To establish the immediate and medium-term effects of a 3-day training program for student nurses on the prevention and management of workplace aggression.

**Methods**

A repeated measure longitudinal design was used. A purpose-designed questionnaire was used to measure changes in the domains depicted in the learning objectives. A total of 243 student nurses were included in the sample. Educational interventions focused on knowledge of psychological theories and models, legal issues and principles of breakaway techniques, and risk factors. It also included attitude about patient and staff rights to safety, dangerousness, predictability, and the student nurses’ roles and designated skills, including de-escalation and escape techniques.

**Findings**

Statistical significant changes were found in several areas, including the number of risk factors identified and five factors identified from the questionnaire comments.

**Implications for Psychiatric Nurses**

Nurses in all settings need to participate in annual training about verbal de-escalation and escape techniques to ensure knowledge of high-risk groups, specific techniques, and to strengthen their attitude toward the right to a safe workplace.
aggression is learned through modeling or observation.

b. The relationship between exposure to violence in media and children has not been documented.

c. Repeated exposure to violence has little impact on behavior or emotions.

d. Frequent exposure to violence does not result in desensitization.

3. Which of the following statements best describes limit setting?

- “Ms. Marsh, it is difficult for me to help you when you are screaming.”

- “Mr. Johnson, I understand that you are upset, but please lower your voice.”

- “Jonathan, it’s time for a time-out.”

4. One of your colleagues witnessed a violent attack in the emergency room. She is overtly upset and tearful. What is the best explanation for her behavior?

- She is overly reacting because she was not physically injured.

- Her behavior is a normal reaction to an abnormal event.

- She has “personal problems.”

- Her behavior is abnormal and requires a referral to a mental health professional.

5. All nurses must be cognizant of their personal safety. Which of the following is the least proactive approach to workplace safety?

- Gather as much information about the client as possible.

- Know where staff is at all times.

- Remove all sharps from the work environment.

- Allow the client to sit between you and the exit.

6. Which of the following clients poses the least risk of violence?

- The client with acute psychosis

- The older client with Alzheimer’s disease

- The client in alcohol withdrawal

- None of the above

References


**SUGGESTED READINGS**
