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AGGRESSIVE BEHAVIOR: NURSE-PATIENT RELATIONSHIP IN MENTAL HEALTH SETTING

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SUMMARY

Background: *Mental disorder is known to be as a loss of existential paradigm; individual's functioning is lacking in all areas. Therefore, it is difficult to point out what the patients exactly need because their needs are set on a broad range of a difficult boundary. The level of care that follows will be complex and multifactorial because nursing will challenge the interaction with the individual as a whole: behaviors and relations with family members. At this stage exploring interpersonal conflicts, with past and present aggression behaviors will be crucial.*

Subjects and methods: *Aim of this paper is to investigate the professional experience in a work context where the patient's clinical condition poses a daily challenge from a physical and emotional perspective. Narrative investigation is performed here in order to explore the psychological load of the professional's psychological experience and its implication in facing aggressive situations. Moreover, this investigation highlights the importance of some professional and personal resources that can be made available to the operator.*

Results: *These tools could improve the understanding of the subjective experience of acute events guiding the individual through an exploration of the phenomenology of what happened decreasing the intimate stress load.*

Conclusions: *A constant updating, the knowledge of de-escalation techniques and sharing the experience in dedicated settings could be important allies in the management of risk events.*

Key words: *nurse patient relationship – mental health – aggression*

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INTRODUCTION

In mental health, nurses hold positions and functions that go beyond, in some respects, of the usual nurse task and undertake specific features. If nurse level of care consists in providing for patients' identification and needs in the psychiatric sphere the problem is more complex. Mental disorder represents the loss of existential planning skill involving human beings in all their physical and most of all psychological, rational and social dimensions (American Psychiatric Association 2013). Needs, therefore, present a very complex and lathe range consequently it is very difficult to bound competences and responsibilities. Care levels show aspects which go beyond the common health-care work. According to the department of Health Decree, n,739, 1994, nurse level care is divided into three types: technical, educational and relational (Ministero della Sanità 1995). In psychiatric patients they live in unison. Technical aspects provide for normal health care assistance such as medication, insertion of drip or detection of vital signs. Nurses must give support to patients so that they could correctly follow the course of treatment and the pharmacological and dietetic prescriptions. Moreover, they must be ready to find any non-compliant behavior and help the patient to fix it. It is also important that they could take into account patients' behaviors, pointing out what kind of relationship they have with the other family members and if there are interpersonal conflicts. As for educational aspects, nurses must explain how important health rules are together with the dietary and the behavioral hygiene rules. Educational work addresses patients, their relatives and significant figures in the relational network. Relational aspects on the other hand, give nurses the role of mediators between patients and the environment in which they live in order to make communication easier and to smooth on interpersonal conflicts in their families, working environment and society. This nurse-patient relationship is a typical helping relationship where "help" means that at least one of the two protagonist wants to encourage the development and achievement of a better way of behaving (Rogers 1951). We speak, then, of help relationship whenever one of the two people gives help and the other receives it. This kind of relationship can be stated as non-specific or generic, specific or technical and therapeutic. We speak of "generic" when the help which is offered does not require any ability or professional competence. This generic help can be given to the person by his/her family, friends, acquaintances or even strangers. We speak of specific or technical help when someone addresses a competent person, trained for a specific aid. The relationship between those who offer and receive help, between experienced and patient becomes a professional service. In this case the user turns to the expert in order to obtain a professional service and the expert gives his services regardless of the interpersonal and emotional relationship with his customers. In the help relation therapy health workers become means of therapy thanks to their ways of working, their ability in listening and encouraging and their willingness to charge for the problems.

Hildegard Peplau stresses out that in the nurse psychiatric help the leading role lies in interpersonal relationships, with a psychodynamic nursing perspective where experiences are the central point of the relation (Peplau 1952). The technical aspect is linked to all this. While preparing an intervention nurses try to establish a close contact with patients, full of emotional and relational moments strictly conditioning the effect of the intervention and its results. We can say that the nursing relationship becomes therapeutic. Dorothea Orem says that nursing basically aims at meeting human beings' requirements such as self-help, namely the care of the body and good health keeping (Hartweg 1991). Nurses help patients reach autonomy, taking care of themselves and their own health. Operator-assisted relationship develops inside a binary system whose central figures are two: the helper and the receiver. It is a complementary relationship where nurses play a leading role.

SUBJECT AND METHODS

Italian psychiatric reform starts from a precise idea of the psychiatry founding fathers in the enlightenment: "to break the bonds to lunatics" as one of them, Philippe Pinel, used to say and as in those days several pictures testify (Pinel 1801).

And that is what happened in psychiatry between the sixties and seventies in the 20th century, the years of global protest. Changes in favor of patients suffering from mental disabilities found their room, thanks to the work and new ideas of centers like Trieste, Gorizia, Arezzo and Perugia where recovery and integration had been tested for a long time. A radical change of psychiatric legislation found fulfilment with new rules and outlines as to European psychiatric laws (Balestrieri 1999, Balestrieri et al. 2014). These experiences set up the framework of 180/78 law which even today rules all psychiatric activities in Italy (Ministero della Sanità 1978). It is noteworthy the episode when in 1961 Dr. Franco Basaglia, director of the Provincial psychiatric hospital in Gorizia, was asked to obtain legitimate physical restraints. His refusal opened a period of unbelievable proportion; the world was moving to a low and gradual disappearance of asylums and in Italy too thanks to this law. Psychiatric hospitalization is made by a specific ward hosted in general hospitals and can be voluntary or compulsory following the above mentioned law. The opening of asylum and in a second time of some wards, these so-called "no restraint units", where physical restraints are not practiced, are now widely accepted by the scientific community. Psychiatric patients are like the others. Their hospitalization is not intended as a suspension of their rights or as a segregation experience but continuously and in compliance with Italian constitution principles and United Nation's Convention on the Rights of Persons with Disabilities (Senato della Repubblica Italiana 1947a, Senato della Repubblica Italiana 1947b, ONU 2006). Hospitalization with open doors underlines dimensions of dignity and humanity for patients both in the critical phases and in the therapeutic everyday life which takes the form of a strong and attentive management of care needs. From rigid asylum caretaker to caregiver, nurse task has evolved professionally. From this awareness arise the tools to be implemented in one's job.

RESULTS

Aggressive behavior, lived in first person as a mental health professional and as an individual responsive to external stimuli, poses an important reflection which can be explained through comparison and support. In the experience of a mental health nursing operator patients' critical moments, hospitalization in a psychiatric inpatient unit represents memories of an experience which permeated the dyadic relationship with the patient himself, changing our way of perceiving and perceiving ourselves. Physical and verbal aggression can be frequently seen in patients hospitalized in other units and not only in the psychiatric wards (Teece et al. 2020). In this context it is more and more difficult searching for a positive communication with a psychodynamic and self-care nursing effort for the patient. A recent review reported patients' perception of their aggressive behavior that could have reduced by improving conversations and enhancing positive interactions with professionals so this kind of effort could be crucial (Tingleff et al. 2017). The first experience of aggressiveness can be remembered for its cruelty, rapidity of onset, escalation, impotence and frustration because operators want to help without knowing how, despite their training and experience.

DISCUSSION

It is not uncommon being in situations where hospital objects are thrown at you or demonstrations of violence terrorize those who want those help and find necessary resources to apply their professionalism to the patient's service. On this point, the possibility of sharing one's experiences and personal empowerment with professional training through teamwork, represent important tools for the acquisition of skills helping prevent aggressive actions and when they happen to manage them. A survey of some work experiences underline the importance of the case-manager nurse introduced in Italy by the Mental Health Actions Plan in 2013 (Amore et al. 2016, Ministero della Sanità 2013). Through the staff optimization, training and organization they aim to create a prevention model of agitation and aggression.

CONCLUSION

The management of events involves the use of de-escalation aimed at the reduction of the climax of interpersonal tension and aggression. De-escalation can be verbal language, adequate in tone and choice of words; non-verbal language such as avoiding sudden

movements and the use of physical presence which can be interpreted as a challenge to the agitated patient. In addition to subjective techniques, some precautions are also necessary, such as to try to avoid being indoors without your back to the wall, turn away from the patient, trying to study which choice might be the most appropriate as suggested by some eminent guidelines (NICE 2015). Finally having a space for decompression and sharing of the most difficult events represents an element of relevance in terms of emotional management of aggressive events. Sharing can take place on several levels: between colleagues, team members from other professions, but also through the creation of a working group including all the staff, supervised by an external psychotherapist who allows understanding and catharsis of the difficulties experienced. Indeed, literature confirmed the importance of staff debriefing in order to reduce the risk of developing discomfort, even trauma from the episode (Lanthén et al. 2015).

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Simona Moriconi: conception and design of the manuscript.

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