

TALKING ABOUT SYMPTOMS

This section includes everything the interviewees had to say in relation to talking with patients about their symptoms, or interacting with them in ways to reduce their symptoms. Although there was some overlap between domains, we present this material separately by symptoms, as there were specific nuances to these approaches that required careful description.

Every one of the interviewees mentioned the value of medication, either regular prescriptions, as required doses, or in some cases coerced rapid tranquillisation. This is not explored in detail below. They also mentioned a number of formal psychotherapeutic approaches as applicable, including: cognitive behavioural therapy, solution focussed therapy, hearing voices groups, relaxation training, anxiety management training, anger management training, motivational interviewing, systemic family therapy. As these are all well described in textbooks, and the interviewees did not add any detail about their specific application to acute psychosis or inpatient work, these have not been further described. However there were a number of techniques the nurses did describe which would be claimed by one or other of these therapeutic approaches. As these were described in detail and repeatedly by nurses, with specific applications to acute psychosis or inpatient work, these are described below.

Apathy/withdrawal

Hearing and respecting the experience (9/28)

The emphasis for apathetic and withdrawn patients was not so much the endeavour to get them to describe it, but instead to observe, recognise, acknowledge, respect and try to understand it. This meant not pushing too hard, tolerating silence whilst still spending time with the patient. Patients could still also be asked about their feelings and experience: 'I would look at actually getting them to describe their feelings and how they feel, what's going on for them within'. Respecting that experience involved not putting such patients under pressure 'to be what they are not' by an approach which is 'too animated' or 'forcefully' putting them 'in social situations that they might not handle at that point'. It also meant not 'ignoring' the apathy and withdrawal as if it were not there, but talking about it, 'acknowledging how they're feeling' and approaching them for durations and activities that they could reasonably tolerate. Several of the nurses spoke about apathy and withdrawal being meaningful behaviours with reasons, and stated that 'you had to acknowledge that' and try to 'understand the position they are in' because 'it's always a different reason for why they are withdrawn'.

"I think it's important, if they are withdrawn there might be reasons for it, and you need to understand what reasons they are. They might be scared, they might be worried about any environment, they might not know what's going on, and so you have to respect that."

Mutually explore causes (7/28)

Nurses indicated there were 'hundreds of reasons' why someone might be in this condition, and in addition to acknowledging and respecting it, it was necessary try to 'work out from them why or explore the reasons with them, why they're feeling the

way they're feeling'. One way of getting to this information was by suggesting a task or activity to them, and then exploring their feelings about it or reasons for declining: 'say think about what might be beneficial, exploring why they haven't done that, exploring why, if there've been concerns why do they think other people are concerned'. Alternatively nurses might offer the interpretation that their experience is a 'symptom of the illness they may suffer from'.

Negotiating and agreeing a care plan (7/28)

Nurses said this was far preferable to using force or trying to coerce the patient to do things. Instead they advised negotiation, 'forming a plan with the patient' and they argued that this approach based on 'kindness' worked better. Such a plan had to be realistic in terms of what was expected from the patient given their mental state. Such agreements 'to try to do something together' could not necessarily be reached quickly with apathetic and withdrawn patients. One nurse described several days of trying to maximise and increase contact with such a patient who was virtually mute, in an unwashed and dishevelled condition and spending all of her time in her bedroom. By utilising every possible opportunity, eventually the patient spoke to her, and once communication was established a care plan was written and discussed with her, which she agreed to. Only then was it possible to get her into the bath on a consensual basis: 'just that relationship that existed between me and her enabled me to actually succeed in that'.

Structure, routine and purpose (5/28)

A number of different means to accomplish this were reported, including establishing a reward structure of some sort, utilising desired activities such as going for a walk, out to the shop, leave opportunities or progress towards discharge. Alternatively plans and timetables for the day could be agreed, diaries of activity kept so that progress can be made visible. Rating scales could be used and the results placed on a wall chart in the patient's room for the same reasons.

Step by step (6/28)

Managing a slow, staged build up of activity and social engagement on the part of the patient. One nurse described spending two months working with a patient who initially was completely isolated and could only communicate nonverbally, through gradually venturing out of their room to eating in the dining room and watching television together. Another nurse referred to this a 'graded exposure ... which can sound very technical, but it's just getting them to do little bits at a time, and they can see that they can build up to the goal'.

Hallucinations

Hearing the experience (24/28)



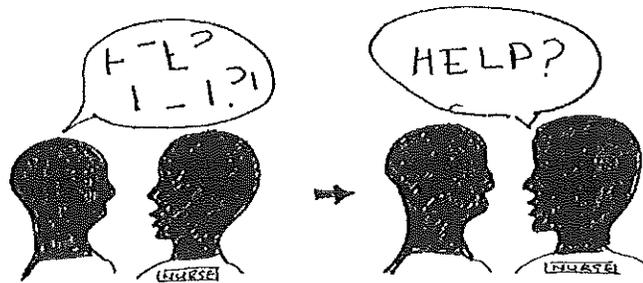
The patients experience can be explored by observing the impact voice hearing has on them, noticing their distraction, their talking back to the voices and their body language. However their experience can also be explored by asking such questions such as: 'how loud', 'how long does it last', 'how many voices', 'what do they say', 'how frequently does it happen', 'is it saying anything about me', etc., in order to 'try to get to the heart of their experience'. Some nurses used structured questionnaires in order to systematically understand what patients were experiencing. That understanding could extend into interpretations as to what the hallucinations might represent for the patient, such as 'some bereavement that they didn't address and manifesting itself at some level', or 'a reflection of some kind of relationship they've had'. Conversations might

have to be timed to periods when the patient is not actively hallucinating, or the patient might not wish to talk about them, in which case this needs to be respected.

"In some ways, I guess it's tied in with the talking about what's going on and the thinking level with the hallucinations as well, and sometimes I'll just sit down with somebody and we'll have quite, for want of a better word, crazy conversations about whatever's going on that are very left field, and just about, what that persons beliefs are, and just exploring the terrain of, all right, so you think this is possible and you see this stuff, and the implications of it and the symbolism of it."

Hearing the effect on the patient (17/28)

The interviewees stressed that it was important to be calm, accepting and not frightened of these strange experiences related by patients. Patients themselves could find their hallucinations frightening, so to hear their experience calmly 'gives people some relief', and ensures they are 'not alone in their personal hell'. The voices patients hear can be persecutory and abusive, causing them great distress. Visual hallucinations could also be frightening, with one nurse describing a patient who was reluctant to go to bed as he saw eyes all around him and thought he was a 'sitting duck' in bed. Nurses recommended talking with patients about the impact their voices were having on them, in a calm and confident manner, as a first step towards offering help. Some nurses suggested concentrating on the emotional impact of the voices more than anything else, as 'feelings are very real and the consequences of the feelings are real'.



Hearing to assess safety (9/28)

Hallucinations could posed safety risks for the patient or those around them. Examples given included 'voices that are telling them that the food is poisoning them', becoming so distressed by the voices that 'they are a serious risk to themselves', be unpredictable, 'suddenly lashing out and attacking' someone, especially in the case of auditory hallucinations that command them to do things such as harm themselves or others: 'telling them to jump off a building' or 'telling them to kill such and such a person'. Nurses needed to hear about and explore the nature of these hallucinations in order to work out how best to help the patient and keep everyone safe.

Respecting the experience (15/28)

Respecting equals openly talking about it and acknowledging its impact on communication, the disruption, distraction and difficulty that the experiences causes for the patient: 'you've got to acknowledge it and make it real, although you can't experience it you've got to act as if it's happening in the room'. Not respecting meant

'ignoring the hallucinations and talking about something else' or saying things such as 'snap out of it' or 'threatening them ... if you respond or talk to the voices, that means you stay in the hospital longer'. Totally dismissing the patients experience was also not respectful, saying things like 'you have got an illness and these are all not real and let's try and not talk about them', or it's 'all tricks in your mind, it's all in your head', or 'it's just not real, it's not happening' This 'invalidates their experience', adds to the person's distress, simply doesn't work, is not helpful to the patient and pushes them 'away from services'. Such approaches were said by one nurse to be linked to biological medical model that sees hallucinations as essentially meaningless and irrelevant psychotic phenomena. "I think people can be quite dismissive of people who are experiencing voices and think that there's no point, that actually somebody's too unwell for you to try and engage with them and I think that's thoroughly wrong. I think it doesn't matter how unwell or psychotic somebody is, you can, there's a glimmer of being able to engage with them on some level.

"If put on the spot by a patient, instead of contradicting the patient's experiences, nurses recommended simply saying 'you may see, hear or smell so and so, but I don't',

thus acknowledging their experience without affirming or confirming it, or the beliefs that are attached to it. Colluding with the patient's hallucinatory experience, perhaps by agreeing with their interpretation of it, was not seen as at all helpful or respectful.

Stress management (6/28)

Several nurses identified a link between stress and the experience of hallucinations, and suggested 'identifying the external stressor', taking action to ameliorate or remove it, and teaching relaxation skills or deep breathing exercises to the patient experiencing the stress in order to reduce their response to it:

'trying to get them to relax and be able to switch off anything which is happening internally ... like a low level meditation, and however they got themselves there whether it was through music or doing relaxation techniques, I'd always aim to try and get them to, where they'd be able to have no internal talk or hallucinations happening'.

The focus here would not be so much on the hallucinations themselves, but 'why this has happened at this time in your life, what do you think is going on?'

Negotiating and agreeing a care plan (6/28)

The nursing response to hallucinations needs to be negotiated with the patient concerned. Some are not distressed by the experience, and do not want the nurses to do anything, others wish 'to ride through the experience and discuss it afterwards'. By discussion and negotiation, strategies that patients have used successfully in the past can be supported by nurses during the current admission. With some patients it is possible to agree a graded response based upon the intensity and severity of the symptoms, with an agreement as to when additional medication will be used.

Distract (15/28)

Patients could be distracted from their hallucinatory experiences by 'talking about something else or doing something else', and suggestions included 'talking and walking', 'watching TV', 'listening to music', having a 'game of pool' and 'reading a book'. It was noted that patients are very individual in what they find helpful in these circumstances, so the strategy has to suit them or be discovered through trial and error.

"So I think there are times to talk about hallucinations and how they affect you but I think that engaging in different activities like playstation, football, their interests, getting them to socialise with other people ... can be really useful."

Bolster coping (10/28)

In addition to distraction techniques, nurses mentioned the use of earplugs as helpful to some patients, asking the voices to go away for a fixed period of time, or telling them to go away. Being in a room with others can help some patients with their hallucinations, but makes others worse. Normalising the experience helped some by reducing their anxiety, letting them know that it is 'not uncommon' to hear voices.

Casting doubt and challenging (8/28)



Nurses described several ways of gently (and sometimes more strongly) challenging patients experiences with voices. For example, oblique reassurance, not directly contradicting what the voices were saying, but alleviating concern nevertheless. The example given was of a patient whose voices had told him police and gypsies were outside wanting to get him, to which the nurse responded 'well, there aren't any in here at the moment, are there?' Similar example was given about how to respond to a patient experiencing persecutory voices, with the nurse talking 'to really reinforce their own sense of self and who they are and know they're not this most appalling person which the voices are trying to convince them that they are'. One nurse described using one sense to cast doubt upon the hallucinatory sense. A patient was seeing snakes all over, and was encouraged to touch the floor and the walls, 'so they could feel the solidness' and realise that they weren't there, getting temporary relief. Others spoke about openly doubting what the voices were saying, or their reality, by remarking gently on how strange the experience was or occasionally, in appropriate cases, direct authoritative contradiction could bring the patient some relief of anxiety and perplexity.

Delusions

Acceptance and listening (18/28)

Nurses responses reflected the fact that patients had a need to talk about their delusions, 'so giving them that space to talk about them, and to feel that you're actually listening to them I think is very important'. This importance to listen derived from the fact that 'for that person their world is real, what's happening to them is very real'. Many nurses enjoyed or were fascinated by patients strange ideas about 'what was happening to them, their family, the government or the country, ... so I like listening'. One nurse gave the example of a patient who believed he was a member of the Royal Family (who had even had an official card printed for him and had on one occasion tricked the Police), 'and he told me everything about it ... and nothing that he said was true ... but talking to him about what he believed to be the truth built a relationship'. Another remarked that 'sometimes it just pays to be quiet and listen and see that stuff come past' after relating the case of a patient who had 'grandiose beliefs about his part in the world and the Iraqi conflict' and spent all his time 'shouting his beliefs at me'. The interviewees also recommended attending carefully to the emotions engendered by the delusions, mentioning fear, elation, anger, distress and upset as possibilities. Exploring those delusions was not always just a matter of passive listening. In addition it required nurses to ask about how the delusions started, how intensely it is believed, what sense they make of it and how it relates to their background, upbringing and culture. Such enquiries could be quite extensive, as delusions were usually part of a whole belief system that could take time to unravel and understand. In order to make this telling safe for patients, it was necessary for

nurses not to leap in with contradictory evidence or identify glaring holes in the argument, instead listening with 'attentiveness', 'respect' and 'not disagreeing with the delusion, but maybe thinking about the effect of the delusion on somebody'. Seeking to 'pick holes in them' or 'show they are wrong' during conversation 'is going to have an atmosphere of threat to it' and is an unsuccessful strategy, as 'we all hold our beliefs strongly and defend them'.

"Just taking the heat out of them by listening, and respecting the emotional impact of them is a good way to take some of the sense of isolation away that comes with thinking differently to other people."

Explore to understand the person (16/28)

Accepting and listening to delusional material was a way to generate a deeper understanding of the patient and their experience. Nurses spoke about this as getting to grips with the 'texture' of patients delusions, how they all 'link together', what the underlying 'concept' or 'symbolism' might be, 'tuning in to the underlying feelings', 'learning what it actually means for them' and understanding how delusional systems may have a protective function. Occasionally this level of understanding was capable of generating interpretive insights, linking delusional material to the past or current real experiences of patients, 'making sense of it' in ways that could sometimes be shared with the patient concerned.

"It's to not necessarily just chuck it in the medical box as a symptom, so therefore we are, or down medication, but to try and unlock it really. What might be the idea, why are they experiencing that? Where's that come from?"

Explore delusions to assess risk (7/28)

Interviewees realised that delusional beliefs had the capacity to be linked to actions that risked the safety of the patient or others. They therefore specifically explored the potential for such actions to occur. One nurse gave two clear examples of this. In the first case, a patient had delusions about a woman living in the flat below, that she was making noises that were 'threatening to him or sexual towards him', and the nurse explored what contact the patient had with her, and asked what was the likelihood he was going to act on those beliefs and in what ways that might be. The second example was of a patient who believed he was on a mission that meant he should jump out of a third story window, and the nurse explored how important the mission was, and whether the patient was making any plans about beginning the mission.

Monitor delusions for incorporation (9/28)

Occasionally nurses get incorporated into patients' delusion systems in a negative way, becoming part of the conspiracy against them in some way. This could result in patients becoming hostile and antagonistic towards the nurse concerned, and when this did occur, care had to be swapped to other nurses who were not incorporated in the delusional system in this way, because contact could lead to the patient becoming distressed, or in extreme circumstances, violent. Nurses suggested this could be averted by 'constantly checking' with the patient, 'being mindful' and evaluating 'how you are perceived, how you are seen'. Sometimes it was necessary to explain in great detail why you wanted to ask certain questions before asking them, or maybe even checking with the patient first whether you could ask them, so as to minimise and feeling of threat or loss of control. Staying 'neutral, professional and appropriate' was important, as was not insistently arguing with them that their delusions were false.

Don't deny or dismiss (23/28)

The nurses were generally agreed that it was not helpful or successful to deny the delusion, 'shout at the patient saying it was not real', or disrespectfully dismiss it, 'belittling' them: 'oh don't be so stupid, that's not true', 'that's total rubbish' or 'it's just your mental illness'. Doing this was said to 'completely break down any sort of relationship', sometimes make the patient angry, turns the nurse into an 'adversary' and 'can make the person stop communicating'. Alternatively, with someone who is 'fragile and vulnerable or where the delusion is particularly sensitive or protective of patients' emotions, a denial can 'shatter' them, make them 'distressed' or precipitate 'depression and possible self-harm attempts'. In addition not listening 'doesn't really take you anywhere', prevents proper understanding of the person, and a correct assessment of the level of risk.

Gently question, cast doubt (18/26)

Introducing questions or doubts about the delusional beliefs could be done and might be helpful. However the nurses indicated that you first needed to have a good, trusting relationship with the patient concerned, and that the strongest and most central parts of the delusional system should be left alone whilst doubt is introduced around the edges, with less strongly held and perhaps less emotive beliefs. This work could not, therefore, easily be done early in the patient's admission before confidence in the staff had been established, the delusional system was thoroughly known and good relationships formed. At this point, slightly challenging questions (not direct contradictions) could be introduced, say through expressing puzzlement about the gaps between the delusional belief and the evidence, or gaps in the patient's explanations, such as 'when did they do it', 'how did they do it', 'why did other people do this', or by suggesting alternative explanations, or by getting them to test the beliefs out. These interventions should be targeted at 'little points of movement' or 'ambivalence'.

Directly challenge the delusion (9/28)

A smaller number of nurses suggested that there were occasions when this could be helpful. When a delusion was linked to an intention to harm another person, then a stronger challenge was absolutely necessary. However another nurse related an occasion when one member of the nursing team directly challenged a patient's delusions, and the challenge led to discussions and the first cracks on the overall delusional system and a step towards recovery. The pre-existing relationship with the patient was a very important foundation for this intervention. In fact a longstanding nurse-patient relationship in which the same delusional system had been recounted many times sometimes enabled nurses to be dismissive of delusional talk with not great impact: 'she phones me quite often from the ward when she's unwell, and says, oh I'm off to Monte Carlo with my millionaire husband, and I can now say to her, yeah whatever; I've heard it all before'. With yet other patients, delusions could be soft and malleable, enabling nurses to argue and present evidence that was quickly reassuring for the patient, by checking under beds, in rooms and cupboards etc., for the threats the patients believed were there, or demonstrating that the things with which patients were preoccupied were not actually occurring. Reassurance in such cases tended to only work on a short term basis, 'because it comes back very quickly', but was helpful to the patients concerned.

Don't collude (17/28)

Agreeing with the patient about the veracity of their delusions, perhaps in order to avoid difficult or tense conversations, or for fear of what might happen if they challenge the delusion, or to get the patient to go along with a particular course of action. This was not seen as acceptable behaviour. Many nurses indicated that this was primarily a matter of being honest with the patient. While not wanting to dismiss or deny their

delusions, nurses could not allow themselves to confirm them either. So if a patient put them in a position where they had to express a judgment, the nurse would say things like 'I understand that these are the thoughts you are having' but that the belief was not shared. In this way nurses could maintain themselves as a 'reference point' for patients.

Ignore the delusions (6/28)

With fixed and longstanding delusions, some nurses indicated that it was better to ignore them and give up on any attempts to change them: putting them on the back burner and not putting an emphasis on them sometimes can be really useful as well'. Instead they suggested 'looking again at what might be meaningful activities in his day, and what he might like to do, and being positive about other activities', 'making the most of bits that aren't affected by the delusion'.

Find workarounds (9/10)



When the delusions are of an intensity of nature that they interfere with patients' daily lives, particularly basic functions like eating, drinking and washing, then ways to work around the delusion have to be found. Several nurses spoke about dealing with patients who thought the food and/or drink was being tampered with or poisoned, and suggested allowing the patient to select his own food, tasting it first for them, or providing it as supplied in sealed containers that the patient can undo themselves.

Thought disorder

Overall, thought disorder was not clearly understood by all the interviewees, and advice on how to deal with it and respond to it as a topic rather scant. Several interviewees considered that thought broadcasting and thought insertion (with related delusional ideas) were thought disorders.

A number of different suggestions were mentioned by only one interviewee as opposed to several, including: distracting the patient; reminding them they have got through this experience before; not challenging the thought content; explaining the physiological cause; and helping family and friends to understand.

Acceptance and listening (15/28)

Nurses answers did not so much focus on thought disorder as a topic of conversation or a therapeutic target; instead they circled around what it was like to try to engage in normal conversation with a patient who was severely thought disordered. In this regard it was noted that 'the conversation can veer very quickly to all kinds of places' and 'cover some very whacky themes', nevertheless to stay with the conversation meant 'you could have a social connection with a person when perhaps that's quite rare for them'. To accomplish this required nurses to give plenty of time for the patient to express themselves, be 'calm', 'non threatening', 'not putting too much pressure' and 'not bombard them with questions'.

"I follow people's tangents that they go on, I'll just go with them on the ride essentially. And often I think people on the surface are not making much sense, but ... even if you range over many topics you often will, it will fall around particular themes which then gives you an insight into who that person is, and what's most important for them as well. And also how that style of thinking is affecting them as well, and what's preoccupying them and how that might get in

the way of them doing what they want and what they value in the world, and how they might live what they value."

Explore how it affects them (4/28)

Some interviewees tentatively suggested trying to explore with the thought disordered patient the effect it was having on them, and on their relations with others.

Upset/distress

Acceptance and listening (25/28)

Nurses' responses on this topic emphasised giving time in a quiet, private environment, 'allowing them to be upset' and 'just being with them', eventually moving to asking 'if they want to talk about it' or suggesting that it might 'help to talk about it'. Gentle prompts and questions then allowed nurses to draw out from patients their thoughts, feelings and the events which were distressing them. Taking a distressed person to a private place could also usefully prevent other patients from also getting distressed in sympathy. Time had to be spent with someone in being with them and hearing them, before it was possible to move on to talk about coping, otherwise 'the person can feel invalidated' and that 'you are trying to push their feelings away, sweep it under the carpet'. The interviewees were also careful to state that patients' wish to speak should be respected, and that they shouldn't be put under pressure to expose the causes of their upset, or as put by one nurse: 'not prying'. Being with some 'in silence' and 'not saying anything' can be perfectly acceptable ways to respond, instead 'waiting until they are ready to talk'. If a person is upset and angry, too many questions might 'increase their distress'.

Give time alone (3/28)

If it was what the patient wanted, and an offer of comfort and listening came too soon or was rejected, a distressed patient could be given some time alone, 'but not indefinitely'.

Stay calm and neutral (4/28)

Hearing upset was difficult, but in order to patients to be able to share the depths of their feelings, nurses had to be able to tolerate the distress without becoming 'uncomfortable' themselves. If the nurse themselves can't contain their response to the patient's distress, then the patient will feel less able to be distressed, and communication is hindered. If the nurse responds with overly sympathetic distressed feelings, it can unhelpfully amplify the patient's distress as opposed to helping resolve it, or patients can feel they 'have to protect' the nurse 'from their distress'. The correct response was therefore 'remain calm and show you are interested'.

Don't close them up (11/28)

Perhaps because it is hard to tolerate distress, the interviewees noted that acceptance and listening were sometimes avoided. They therefore suggested that responses to the distressed patient should not include fatuous reassurance, such as 'stop crying, don't worry, everything's going to be OK', or 'it's not that bad, you'll get over it'. Nor was it acceptable to dismiss how someone was feeling, make light of it or try to coerce a better mood through shouting at them or 'telling them to pull themselves together'.

"And I think you've got to be careful, as the practitioner, you're not shutting them up because you're finding it difficult to be around."

Persist to find out cause (7/28)

While patients should not be put under pressure to reveal all, nurses did recommend gentle persistence in order to find out what underpinned patients' distress. Overcoming reticence could be done by repeated contact and offers ('putting in opening gambits every now and again'), spending time in silence with the upset person ('understanding that it might take quite a long time to get to the bottom of it'), finding the right place on the ward, or just homing in on the right moment when the patient was ready to talk.

Explore solutions (9/28)

These can either be offered as possibilities by the nurse, or the patient can be asked what support would help them: 'how can we make this better for you?' A helpful move could be to ask if they have felt this way before, and what has happened previously, what has helped and what hasn't. Alternatively, to elicit their own ideas, the patient could be asked 'what would you tell a friend in your situation?'

Take action to relieve cause (6/28)

If it is something causing the distress that the nursing team can remedy in some way, then appropriate action can be taken. No specific examples were given.

Distraction (6/28)

Involving the patient in various activities was recommended as a way of distracting them from their distress: walks, meals, self-care activities, socialising with fellow patients were all things mentioned by interviewees.

Assess suicide risk (2/28)

Two nurses suggested that distress might indicate raised risk of suicide, and that risk needed to be re-evaluated and assessed when patients were upset.

High arousal

Many interviewees gave mixed responses under both agitation/overactivity and aggression irritability. It was therefore difficult to treat these two areas separately, and they have been merged and considered together under this single heading.

Hear the patient, listen (26/28)

Nurses indicated that it was a mistake to prejudge the aroused patient, or to think of them as being bad, or badly behaved. Instead the correct approach was based on the assumption that 'something has made them feel that way, and it's trying to discover what that something is'. So, when the person concerned may be 'pacing', 'snappy', 'hostile', 'cross', 'looking at you in an intimidating way', 'shouting and hitting the walls', 'threatening verbally', or 'screaming', the first question is 'can you tell me what's going on?' This gave an opportunity for patients to ventilate and communicate their feelings, which was sometimes all that they required to recover their equanimity: 'sometimes people just need to go blah and get it all out of their system ... it gives them a chance to just spew out a bit of info and feel a little less isolated with that, they may be carrying



the world's survival on their shoulders according to what their beliefs are, so that's incredibly daunting'. Many different causes for high arousal were mentioned, including 'fear', 'anxiety', 'being bullied', mood disorder, auditory hallucinations, ideas of reference, real failures on the part of psychiatric services and workers, conflict between patients, 'somebody's said something, looked at somebody in the wrong way, has taken away something that they've been expecting such as having a cigarette or going out for a walk or having their leave, seeing the doctor, not seeing the doctor, not being discussed where they said they were going to be discussed, family not coming up to the ward', or 'distressed, frightened or disturbed about what's going on around them'. There were some cautions and provisos in relation to this recommendation to listen and find the reasons behind the high arousal level. One nurse suggested that with some patients, exploring the cause of their arousal could lead to an increase, even a sudden increase in their anger: 'you can turn the heat up really quickly, without meaning to'. Sometimes the patient is unwilling to co-operate with this process of exploration, with one nurse recounting how a physically strong and fit martial artist paced up and down the ward muttering curses and imprecations, and rejected any attempt to speak with him by walking away, resulting in 'total failure'.

Exercise, physical activity (4/28)

A few nurses indicated that physical exercise, either by allowing the patient to 'stomp around outside' or by gym based activities and exercise, would use up 'their excessive energy'.

"I've had a client before who when he's felt the mania coming on, he's gone running, because he was a runner anyway, so he'd go and jog for three or four miles, and come back and feel a lot calmer about things."

Distract, calming activity (9/28)

If a patient is becoming irritable or agitated, it can sometimes avert escalation, or even resolve the situation, if they are distracted by engagement in other activities. Nurses suggested 'watching a movie', 'playing pool or table tennis', 'a jigsaw puzzle', 'listening to music', 'looking at the paper', 'walking or pacing', cup of tea or coffee, converse about other non stressful topics such as their 'family or job' or recent nice events on the ward.

Request lowered arousal (6/28)

When a patient is becoming more irritated and agitated within the course of an interaction with staff, they might not be fully aware that they are raising their voice and starting to shout. It is possible at this point to

'just ask them to, I am here, I am listening and I want to help you to think but actually I can't really understand what you're saying when you're shouting, you might want to sit with me or you might want to talk to me more quietly and then maybe I can think about what you're saying'.

Relaxation (7/28)

Simple relaxation techniques could be offered and taught to patients, including slow, deep breathing:

"I've seen nurses do relaxation techniques that I would never have thought that someone that agitated would be able to manage and they have managed it so

yeah, as I say I was quite surprised, I didn't think at that level of arousal that relaxation would work but it did.

Don't argue or confront (14/28)

Becoming aggressive, raising one's voice with all the accompanying body language, was widely reported to be counter productive. This was referred to in different ways, including being 'threatening', 'inflexible', 'confrontational', 'over challenging', 'laying down the law', 'too hard', or 'pushy'.

Relationship leverage (7/28)

A pre-existing good, trusting relationship with the aroused patient can help any crisis calm down much more quickly. Nurses recounted specifically referring to and using their previous relationship with the patient who is aroused, reminding them who they are and how long they have been working together:

you can refer to your relationship you have with them, you can say we, I know this is something that keeps cropping up and really rubs you the wrong way, I remember we spoke about that ... people are less likely to try and take a swipe at you for a start.

Give choices, empower (14/28)

Once the initial complaint or issue had been thoroughly explored and defined, the interviewees spoke of the necessity to involve patients in decision-making and finding an acceptable resolution. Such resolutions could result in issues being raised with the patient's consultant psychiatrist or other practical changes. Involving patients and giving them options gave them 'routes out of the situation', and meant they were not placed in 'a psychological corner' from which they might come out fighting. Finding compromises and solutions through negotiation meant that nurses had to be 'flexible' rather than rigid about ward rules, what could and could not be done. Where the high arousal was a consequence of psychiatric symptoms, it was not so easy to find ways to solve them, other than enhancing the patients own coping strategies or other interventions as explored in previous sections, whilst waiting for treatment to take effect.

"If you give them a choice at all time, they may remain very agitated but at least then it can be channelled hopefully in the most, safest way."

Explain what the rules are and the reasoning behind them (15/28)

To the aroused, irritable patient, any constraints on their behaviour can elicit angry outbursts. Nurses gave examples such as asking the patient to go to bed at a reasonable hour, eat, wash, wear sufficient clothing, not expose themselves, not come into the ward office, not shout be abusive or racist, not threaten or bully others, not leave the ward, not damage the furniture and fittings, etc. Demands from patients could also be unrealistic given the workload of the ward or other constraints. The nurses stressed that it was most important to explain to patients why these boundaries existed, and to explore with patients ways that their needs and desires could be met without the rules being broken: 'it's just giving them reasonable boundaries but most importantly saying why you're giving them the boundaries'. Several nurses mentioned that instructions could be given quite forcefully, without the nurse themselves leaking any anger, frustration or irritation: 'firm but not threatening', 'assertive but not aggressive'. It was possible to be forceful 'without shouting at someone who is already irritable and aggressive, and telling them what they've got to do, it can provoke patients'.

"Honesty and empathy and if that means that you're trying to get somebody to avoid doing something that they want to do then you have to explain that that's what it is you're trying to achieve for them."

Describe consequences (5/28)

Nurses also stated that it was sometimes necessary to explain to patients what would happen if they continued to behave aggressively or became physically violent. These nurses suggested that patients could feel 'out of control' and needed the staff to show competence, confidence, and the ability to contain their behaviour. They spoke of explaining 'consequences', 'repercussions' and being a 'little bit inflammatory, a little bit threatening'. References in the text made clear that these consequences included severe containment methods (restraint, coerced medication, seclusion).

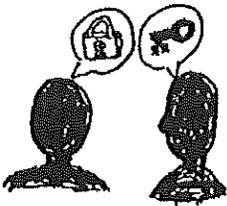
Forceful containment (16/28)

In acute situations, where necessary to preserve the safety of patients and those around them, nurses spoke about manually restraining the highly aroused patient, given sedating medication (by injection if necessary), or placing the patient in seclusion. However three nurses' recounted incidents where they had seen patients restrained too quickly, before any discussion had taken place with them about why they were angry, and objected to this, considering it to be poor practice.

Debrief later (7/28)

When there has been a violent incident, then at a later point, perhaps the next day, this needs to be explored and discussed with the patient concerned, 'you need to try and let me understand what's going on, how can we stop that from happening again'. This process involved asking the patient what had happened, to give reasons for behaving the way they did, and exploring with them what the consequences were for others and themselves, all with a view to increase the patient's empathy, understanding, anger management skills and social skills in conflict expression. Perhaps also identifying trigger points where interventions could be made by the staff and patient together at an earlier stage, should the situation be repeated. This was also an opportunity for the staff to explain to the patient why they did what they did (for example, seclude the patient for an hour), in an attempt to prevent the patient from 'holding any grudges'. If there has been a conflict between two patients, then a similar process can be undertaken: 'I'll always get them to sit down and talk to each other'.

Advance directives (8/28)



Outside of a crisis situation, when the patient is relatively well, not agitated, overactive, irritable or aggressive, then is the time to negotiate what to do and how to handle the situation should it recur. The patient can then choose what he or she feels is the best strategy that is most likely to succeed. One nurse gave a detailed account about how such an advance directive could be negotiated, with the nurse utilising the patients history and case record, reminding the patient what had happened before, and tempering their suggestions into a realistic applicable plan about what should happen in the scenarios most likely to recur: 'how do you want us to work with you in that situation ... how would you want us to approach you ... what happens if you say no?' If such negotiation and planning has already been done and the patient is highly aroused now, then the advance directive should be implemented. The presence of such a planned strategy makes the situation much more predictable for the patient as well, and there 'not quite so scary for them', and because of that, less likely to end in a struggle of some kind.

Reference

Bowers, L., Brennan, G., Winship, G.,
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