Understanding patient characteristics and experiences

Positive words intervention | Safewards Victoria

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This document is for use in building understanding of the Safewards Positive Words intervention. It is a useful tool for training, workshops, staff meetings and reflective supervision. It has been adapted and updated from a UK Safewards document with the title 'Understanding unsafe and risky patient behaviours'. Images used with consent from Merinda Epstein.

Sections in this document:

Understanding aggression and violence

It is important to realise from the outset that aggression is a normal human reaction and can be associated with different emotional states:

- Aggression can be associated with **anger**, which often stems from being in a situation that feels unjust or unfair.
- Aggression can be associated with the **fight or flight** response to **fear**, referring to the specific biochemical, neurological and behavioural reactions that both humans and animals experience during intense stress or fear.

Aggression is currently understood as situational, arising out of factors for individuals, interactions between individuals, and features of environments. In circumstances where conflict and aggression occur, we can all experience the unhelpful inclination to blame others. If we understand the context and drivers of aggression, we are better prepared to resist blame and to actively prevent conflict and aggression from occurring.

Aggression in mental healthcare settings can be understood as:

- A normal response to being made to be where you don't want to be
- A normal response to having restrictions placed on your behaviour, where you can go, what you can do, or your ability to make decisions about your treatment
- A normal response to being locked up and losing freedom of movement
- A normal response to intense fear

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- A result of being compelled to share a small area with a group of strangers, some of whom you may find irritating or frightening or dangerous
- A response to persistent unwanted requests or pressures
- Defence against bullying or other pressure or threats
- A response to theft of property
- A response to the intrusive or irritating behaviours of another patient or from staff

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- A response to lack of privacy, lack of opportunity to withdraw
- The result of psychiatric symptoms, either directly (irritability) or indirectly (delusions, hallucinations)
- Irritability from drug or alcohol withdrawal or intoxication
- A response to pain or persistent physical discomfort
- A response to prolonged or intense stresses in the physical environment - extremes of cold or heat, noise, odours
- Difficulty with impulse control
- Misunderstandings secondary to failure of usual cognitive abilities

- Impairment of usual coping skills as a medication side effect
- Response to other medication side effects
- Impaired impulse control or irritability due to ingestion of other substances, particularly alcohol
- Anger from events outside hospital or receiving bad news
- Being awkwardly or disrespectfully asked to do something you don't want to do
- Being awkwardly or disrespectfully asked to stop doing something you do want to do
- Being disrespectfully told 'no' in response to a request
- The provocation of inconsistent staff requirements
- The provocation of an unpredictable ward routine
- The provocation of being repeatedly ignored or kept waiting for a long time
- Habitual or learned use as a coping behaviour

More than one of these circumstances may apply at any one time. These explanations do not serve as an excuse for violence, but they contribute to an understanding of the context of aggression or violence in mental health units.

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Understanding self-harm

Self-harm is a complex behaviour which can be very distressing to experience, witness, and can be difficult to understand. There are many different ways in which people can self-harm; the most common method is cutting, but people also may bang their head, hit a wall, overdose on their medication, scratch themselves, tie a ligature, swallow foreign objects or insert them into their body.

Although people who self-harm are at a higher risk of dying by suicide, the act of self-harm is not usually life threatening, and is not usually an attempt to end life, but to cope and to continue living.

Self-harm can serve different purposes for a person. People may not always be aware of the needs that self-harm fulfils. These needs may include:

- to cope with difficult feelings or experiences, including anger and sadness
- to feel alive and connected with the world
- to forget about a distressing feeling or experience
- to punish themselves; feelings of shame
- to regain some control in their life or over their body
- to communicate their feelings

Triggers for self-harm are usually directly related to the needs that self-harm is meeting, and while someone is an inpatient these can include:

- Distressing feelings/experiences
- Not feeling safe in an environment or in relation to people in the environment
- Feeling judged or ashamed or humiliated
- Not feeling heard or supported
- Difficult life events including past trauma
- Imminent loss of support, such as discharge from hospital
- Loss of control of decisions
- Loss of control over body

There is a lot of stigma surrounding self-harm which can stop people from seeking help, and may lead to social isolation. Self-harm can have a very powerful impact on the people caring for the person who is self-harming, and can evoke a lot of difficult emotions amongst staff, such as fear, anger, upset and frustration. This can have a negative impact on the therapeutic relationship between staff and service user.

It is important to remember that people who self-harm are often experiencing a significant amount of psychological distress, and this is the best way they have found to cope with, or communicate this distress. Understanding self-harming behaviour should help staff to see past people's natural, defensive reactions, and to continue to give that person the support that they need.

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Understanding when people seek control and empowerment
(so-called ‘manipulative’ behaviour)

Historically, ‘manipulative’ behaviour has been explained with reference to psychodynamic and cognitive theories and also as a normal response to difficult situations (Bowers, 2003).

In this section the term ‘manipulative’ is put into inverted commas to acknowledge those many consumers who have said and written that this particular term feels both judgemental and therapeutically unhelpful.

Much of the current trauma-informed practice literature suggests that clinicians reframe behaviours that were once labelled ‘manipulative’ as ‘adaptive coping mechanisms’. An alternative may be ‘assertive’. The term ‘manipulative’ is not a ‘positive word’.

A lived experience perspective on ‘manipulative behaviour’

‘Most of us labelled as ‘borderline’ have a history of profound childhood trauma. When I was a child of a single-parent, there was only one person I could seek comfort and safety from, and that happened to also be a person who hurt me. I learned from a very young age to be careful with trusting anyone who claimed to care about me, and that I had to be smart to get my needs met. I don’t think of this as being ‘manipulative – it is, and always was, about getting my needs met in the safest way possible.’ (Daya, 2017).

In summary, people seeking control and empowerment can be understood as:

- Using adaptive coping mechanisms related to a history of trauma/abuse
- Moving towards recovery by attempting to take control or experience empowerment
- Expressing anger at being detained and incarcerated
- Seeking to acquire status and respect, gaining the valued role of someone who campaigns for things to be better
- A means of fighting back against a hostile and powerful system
- Indirectly expressing anger towards parent figures who were/are punitive or abusive
- ‘Grandiosity’ resulting in idealisation of some and devaluation of others
- Intense emotional reaction to criticism and rejection
- Standing up for rights / Making a complaint that enacts a right protected in the Victorian Mental Health Act
- Inner need and pain
- Struggling to contain powerful negative emotions
- Learnt behaviour that has been useful for survival

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Using these understandings may allow staff to better understand the needs and perspectives of consumers, and move beyond or even avoid feeling frustrated and upset with patients who seek control.

Trauma informed frameworks in particular emphasise the strength and resilience of people with living with the impact of adverse experiences and trauma memories. These frameworks can be particularly useful in maintaining high regard for a person whose behaviour requires a thoughtful and measured response.

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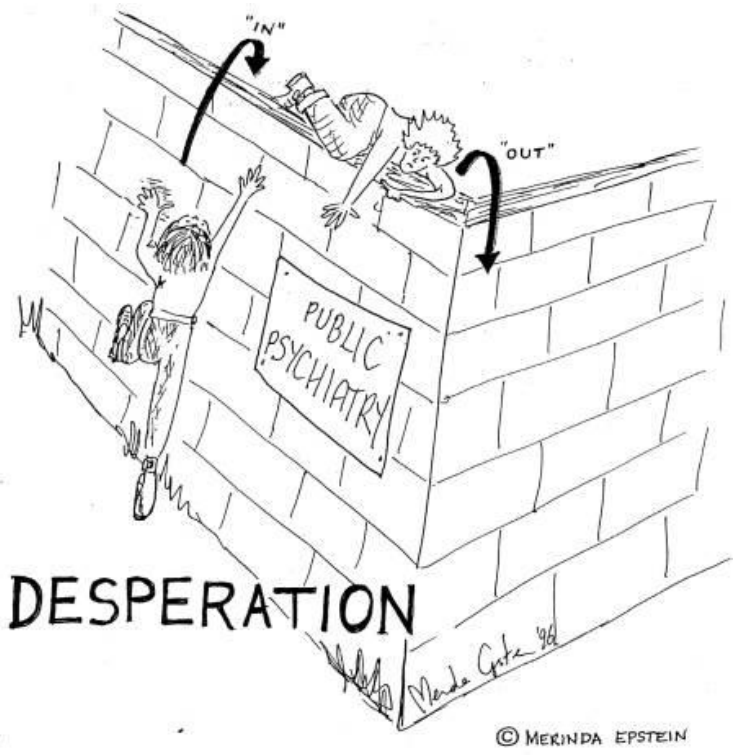
Understanding absconding

Reasons why patients abscond are diverse, with no single explanation predominant. Most patients have more than one reason for absconding from the ward. Absconding can be understood as a normal reaction to being detained against one's will.

Patients may abscond for the following reasons:

- When requests for leave or discharge are refused
- See no reason to be in hospital
- Angry with being detained, seen as unjust
- Frustration and annoyance with the restrictions of ward life
- Feelings of being trapped and confined
- Boredom, under stimulated, lack of change
- Missing friends and relatives
- Responsibilities to fulfil
- To access and consume illegal drugs and/or alcohol for enjoyment or out of dependency
- Dissatisfaction and disagreement about medication
- Dissatisfaction with meeting of basic needs, such as food, sleep
- To check on home, do household tasks
- Fear of other patients, anxiety raised by incidents, especially at night
- Psychiatric symptoms – hallucinations, delusions, anxiety, worry, restlessness, depression
- To harm self or end their life



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In the case of one event of absconding, many of these explanations may apply at the same time, as there is seldom one single reason for absconding. Even patients who are very ill have told us that they absconded because their voices told them to, and then added that also they were afraid of another patient who had suddenly grabbed their arm shortly after their admission.

Absconding generate lots of anxiety for the staff, because they are concerned about patients and fear what might happen to them. However staff need to be careful not to let this turn into anger on the patient's return to the ward. Far better to seek to understand the underlying reasons through talking with patient, and then to address their needs in ways that work well for everyone.

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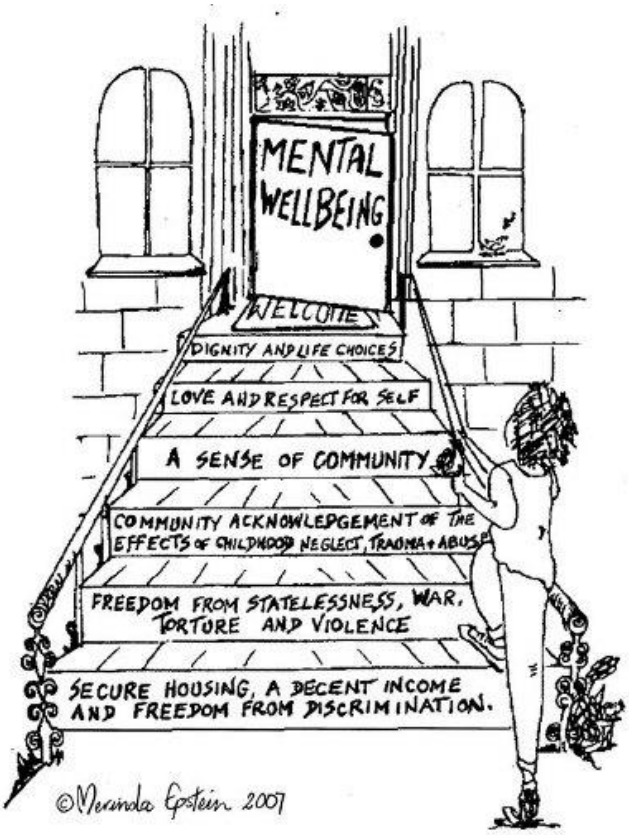
Understanding medication refusal

There are lots of reasons why patients may refuse medication. Often more than one reason may apply at the same time.

Many of the reasons patients have are just like the ones that anyone might have for not taking medication that the GP prescribes for us. Other reasons can be specifically related to mental health experiences, normal reactions to compulsory treatment, and the impacts of medication itself.

Research tells us that people may refuse medication for the following reasons:

- Unpleasant, harmful or dangerous side effects
- Past bad experiences with side effects
- Weighing up benefits and unwanted effects and preferring illness symptoms
- Believing it is the wrong medication for them
- Stronger beliefs in alternative therapies
- Preferring a different brand (shape, size, colour)
- Anxiety about medication errors
- Considering the medication to be ineffective
- Not knowing the potential benefits
- Losing hope while waiting for potential benefits
- Rejecting the stigmatised status of ‘mental illness’
- Not believing they are ill
- Believing the medication causes illness
- Potentially delusional ideas about the medication
- Rejection of an oppressive, restrictive ward
- Assertion of independence and control
- Poor relationship with the staff administering the medication or the doctor prescribing it
- Not wanting to get better to avoid some consequence



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Even a reason for refusing medication that sounds unusual can, on discussion, be found to be accompanied by a host of additional worries about medication which are quite rational.

Patients may not be able to clearly articulate or say exactly why they are refusing, or the declared reason might not be the real reason, which they may not want to share. It can take some time to establish a trusting relationship, and a lot of nonjudgmental talking to get to the bottom of a medication refusal.

As always, it is better to seek understanding and empathy rather than rush to judging the patient to be ‘foolish’, ‘ignorant’, ‘winding us up’ or ‘just being difficult’.

It is important for staff to remember that:

- Medication is ineffective for some people
- Medication is only somewhat effective for many people
- The side effects of psychiatric medications can be serious and even disabling
- Medication and symptom reduction are not always necessary for recovery
- There is good evidence for some alternatives to medication, such as psychological therapies
- It is important to remember this principle of the Victorian Mental Health Act when thinking about medication refusal (and in other treatment decisions):

> *'persons receiving mental health services should be involved in decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.'*
>
> (s.11.1(c), Mental Health Act 2014, Victoria)

- Regardless of medication, establishing a therapeutic relationship characterised by respect, empathy and understanding is beneficial per se to mental health and wellbeing.
- Patients are a valuable source of information about medication, and their feedback can assist in optimising benefits and minimising harmful or unwanted effects. Patient collaboration in medication management can improve overall health outcomes.

It is worth noting that there are many problematic or withdrawal effects (aside from re-emerging symptoms) that are associated with discontinuation of medications. These can cause distress and lead to other risk behaviours.

Many people who refuse medications also actively choose to commence another medication or to resume medication, so it is vital for nurses and others to listen and build an understanding about people's specific medication concerns to support their own decision making.

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Positive words list

Safewards Victoria

Use this worksheet to record ideas about positive, psychologically-informed ways to describe patient experiences, emotions, thoughts and behaviours.

Positive words	Negative words
Eg. Adaptive coping skills, seeking control and empowerment, assertiveness	*Eg. Manipulative behaviour*