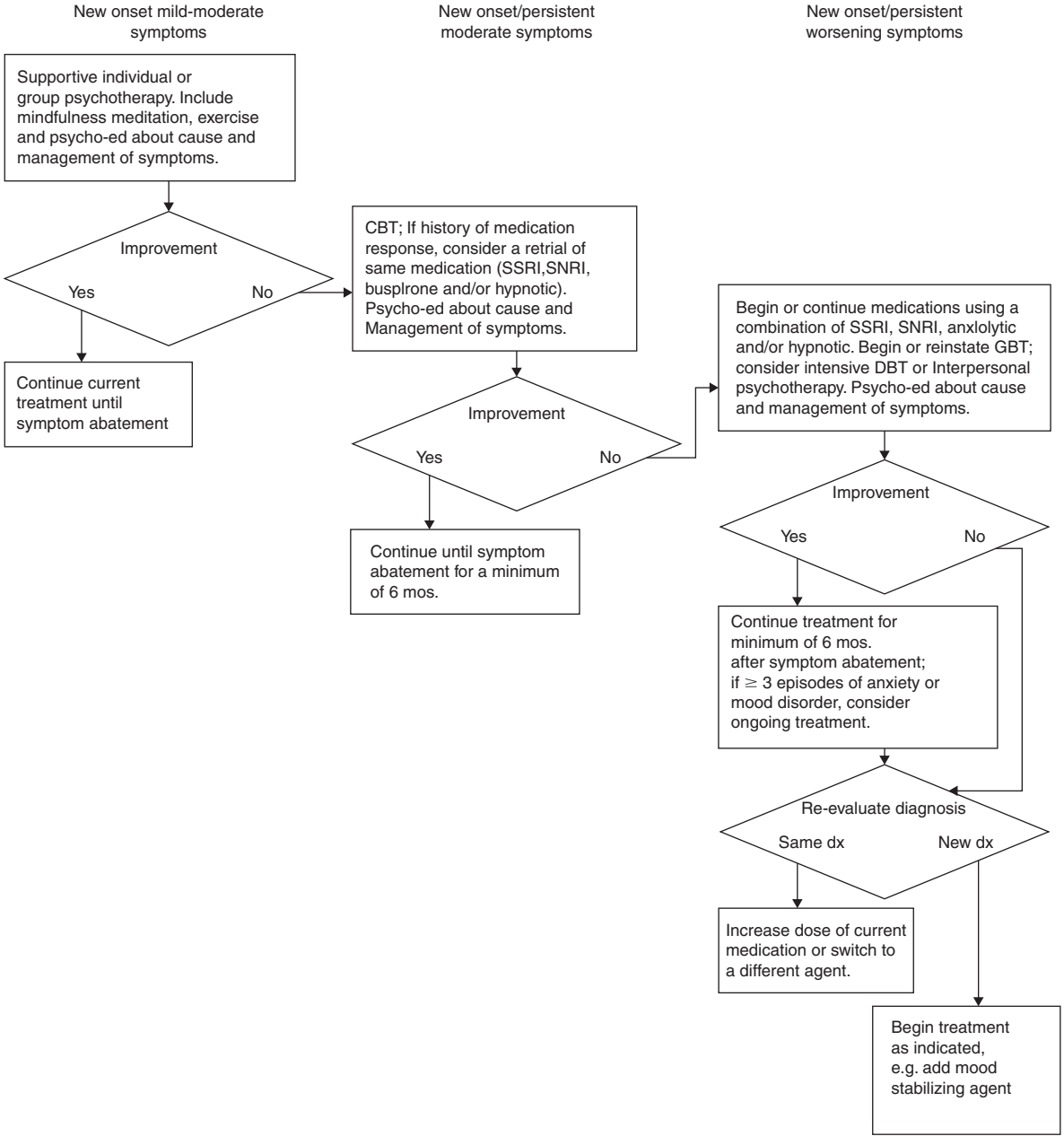

Figure 9-3 Decision Tree for Anxiety

avoidant behavior, maladaptive cognitions, and poor coping or problem-solving skills, and parent characteristics including overprotection, modeling anxiety, and criticism or conflict. These efforts have shown efficacy in reducing anxiety symptoms and related behaviors, though follow-up has not been long enough to establish the persistence of these gains in later life. An Internet-delivered intervention for college students with elevated anxiety sensitivity demonstrated significant treatment effects on anxious cognitions and depressive symptoms (Kenardy, McCafferty, & Rosa, 2006), which suggests that online interventions may be an effective and efficient means of targeting individuals at risk.

School-based universal interventions that teach coping and emotion-management skills to elementary and secondary school children have been shown to reduce the likelihood that students will develop anxiety problems (Barrett, Farrell, Ollendick, & Dadds, 2006). Bienvenu and Ginsburg (2007) recommend a larger role for education as a prevention strategy. This could take the form of a public health campaign to educate the populace about anxiety disorders, as well as educational efforts focused on primary care providers, who could play an important role in identification, initial treatment, and referral for anxiety-related problems.

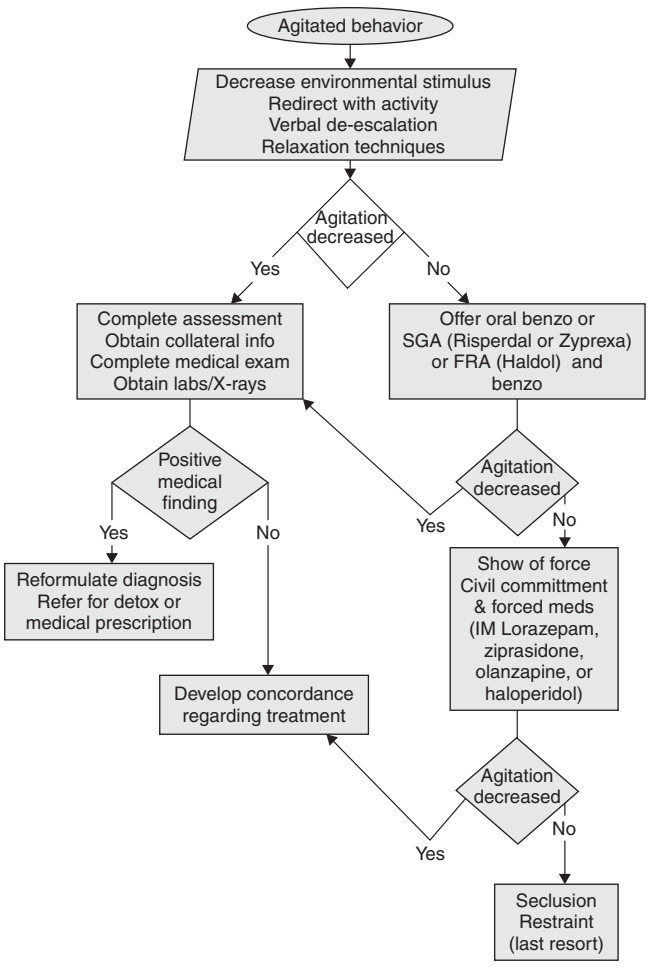

Figure 16-1 Decision Tree for Agitated Behavior

Anticipation of violence is a key point to prevention. Redirection of the potentially violent patient toward productive activity can be a good diversionary tactic that works equally well for all ages. Having quiet rooms or comfort rooms where an agitated patient can go to self-soothe is good practice (Cummings, Granfield, & Caldwell, 2010).

Attacks that are random and unprovoked must be dealt with differently by strategic planning. I have witnessed several cases in which patients with a history of violence suddenly attacked either a staff or peer and began to strike them forcefully and repeatedly. When questioned after such an attack, patients gave reasons such as they felt the victim was talking about them or threatening them, or gave no reason at all, except their perception that the victim was in the way of their goals at that moment. Safety measures when dealing with an acutely delusional or psychotic patient that is not well known to the clinician include: keeping physical distance from the patient; only speaking to a previously unknown patient in the presence of an attendant such as a psychiatric technician or mental health worker; and arranging the room so that quick egress by the clinician or patient is possible. Clinicians should not walk too closely to a patient on the patient unit, and should never turn their back on an unknown patient, or on any patient with a history of violence.

Limited restriction of patient movements on the acute psychiatric unit may be indicated in the case of repeat offenders who lash out unexpectedly at persons not known to them. This entails written orders for denial of patient rights in most states, since patients have the right to be maintained in the least restrictive environment possible. Detailed documentation of the reasons for such restrictions, such as room restrictions and so on, is imperative. Creative milieu management in these incidences can be accomplished by establishing alternate times for a violent patient to eat, exercise, and use the phone, for example, thereby reducing risk of contact with other patients and minimizing the possibility of overstimulation. One way to attempt more concordance with such a patient is to discuss with the patient ways in which they can voluntarily control their movements and aggression. Many patients will voluntarily restrict their own movements about an acute unit, self-isolating to their room when there is too much stimulation in the common areas, such as the day room. Patients can be offered PRN medication and instructed to ask for PRN medication if they feel themselves becoming agitated. Placing such patients with quieter roommates may be helpful, or if at all possible, in rooms by themselves. The same general rules may be used in pediatrics and geriatrics, with considerations in geriatrics for mobility. Minor interventions such as placing an elderly patient closer to the bathroom can greatly reduce their distress.

ACUTE AGITATION

Medication management of violence in psychiatric settings is focused on the management of acute agitation, usually in the emergency room, locked psychiatric unit, or residential psychiatric setting. Typically the techniques of management include oral and IM administration of benzodiazepines, and typical and atypical antipsychotic agents. Patients should be offered the option to take medications orally if they are able, which will help them feel as if they are more in control, and will hopefully improve trust (Mattingly & Small, 2011). Patients should be encouraged to ask for PRN medications if they feel themselves becoming anxious or agitated; patients who appear to be escalating are frequently offered PRN benzodiazepines as a means of averting acute agitation. If patients are unable to make the decision to voluntarily