ANGER, AGGRESSION & VIOLENCE PREVENTION

NCLEX Mental Health • 2026 Test Plan • Psychiatric Nursing Essentials

PRIORITIZATION | SAFETY | PHARMACOLOGY | RESTRAINTS | DE-ESCALATION

1. DEFINITION & OVERVIEW

ANGER
A normal **emotion/feeling** — internal response to frustration, threat, or loss. Can be adaptive.

AGGRESSION
Behavior intended to harm — verbal (threats, shouting) OR physical (hitting).

VIOLENCE
Extreme physical aggression that **causes harm** to self, others, or property.

Why it matters: Nurse safety ranks #1 — you can't care for a patient if you're injured. NCLEX tests your ability to **recognize escalation early**, use the **least restrictive intervention**, and follow **restraint protocols**.

2. PATHOPHYSIOLOGY (SIMPLIFIED)

TRIGGER
loss, threat, frustration, pain

→

LIMBIC ON
amygdala fires

→

FIGHT-or-FLIGHT
↑ epinephrine, cortisol

→

PFC OFFLINE
↓ impulse control & logic

→

AGGRESSION
verbal / physical

TOP RISK FACTORS (KNOW THESE!)

#1 PREDICTOR:
History of violence

Substance use / withdrawal

Psychosis / mania

Dementia / delirium / TBI

Antisocial or Borderline PD

Hx of abuse / trauma

Command hallucinations

Access to weapons

3. SIGNS & SYMPTOMS — 5-PHASE AGGRESSION CYCLE

① TRIGGERING (EARLY) — INTERVENE NOW
Anxiety, restlessness, pacing, tapping, irritability, clenched fists/jaw, raised voice, sarcasm, rapid speech, facial flushing.

② ESCALATION — VERBAL LIMITS
Loss of rationality, shouting, swearing, threats, invading personal space, glaring, demanding, refusing redirection.

③ CRISIS RED FLAG
Loss of control — throwing objects, hitting, kicking, biting, assault, self-harm, destruction of property. **Call for help, use chemical/physical restraint as last resort.**

④ RECOVERY — REASSURE
De-escalation, muscle relaxation, lower voice, willingness to talk. Offer quiet space.

⑤ POST-CRISIS / DEPRESSION
Exhaustion, remorse, guilt, crying, apology, withdrawal. Good time for therapeutic debrief.

4. PRIORITY NURSING INTERVENTIONS

SAFETY FIRST (ABCS → YOU FIRST)

- **Call for help** before approaching
- Position yourself **near exit** — never let patient block door
- Keep **2 arm-lengths distance** (personal space)
- **Remove objects** that can be weapons
- **Do NOT turn your back** or corner the patient
- Remove other patients from area

VERBAL DE-ESCALATION (PHASE 1–2)

- Use **calm, low, slow** voice
- **Short simple sentences** (1 idea at a time)
- **Validate**: "I can see you're upset"
- Offer **choices**: "Would you like to walk or sit?"
- Offer **PRN medication early**
- **Do NOT** touch, argue, or match their tone

CRISIS RESPONSE (PHASE 3)

- Call **security/behavioral code**
- **Chemical restraint** (IM meds) before physical
- Physical **restraint = LAST RESORT**
- Least restrictive type that works
- Seclusion if less restrictive & appropriate

POST-CRISIS

- **Debrief** with patient & staff
- Identify triggers & warning signs
- Document objectively (quotes, behaviors)

🪜 THE "LEAST RESTRICTIVE" LADDER — NCLEX GOLD STANDARD

Always try the **lowest rung first**. Climb only if the current rung fails.

① **Verbal de-escalation & therapeutic communication** — LEAST RESTRICTIVE
② **Environmental changes (quiet room, dim lights, remove stimuli)** ↓
③ **PRN medications — oral > IM (offer first, less traumatic)** ↓
④ **Seclusion (locked, unlocked, or voluntary time-out)** ↓
⑤ **Physical restraints (requires MD order)** — MOST RESTRICTIVE

⏱ RESTRAINT & SECLUSION TIME CLOCK (memorize this!)

Face-to-face MD/LIP evaluation after order	**within 1 hr**
Order renewal — Adult (≥18 yrs)	**every 4 hrs**
Order renewal — Adolescent (9–17 yrs)	**every 2 hrs**
Order renewal — Child (<9 yrs)	**every 1 hr**
Max orders before new in-person eval	**24 hrs**
Observation & safety checks (circulation, skin, ROM)	**every 15 min**
Offer food, fluids, toileting	**every 2 hrs**
PRN orders for restraints	**✕ NEVER**
Restraints for staff convenience / punishment	**✕ NEVER**

💊 5. PHARMACOLOGY

DRUG / CLASS	MECHANISM (SIMPLE)	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Haloperidol (Haldol) *1st-gen antipsychotic*	Blocks dopamine D2 → calms agitation & psychosis	EPS (dystonia, akathisia), NMS ☠, ↑QT, sedation, anticholinergic	Monitor ECG (QT), temp (NMS), muscle rigidity. Have **benztropine** ready for EPS.
Olanzapine (Zyprexa) *2nd-gen antipsychotic*	Blocks D2 + 5-HT2A	Sedation, weight gain, ↑glucose, metabolic syndrome	Do **NOT** give IM olanzapine + IM benzo together (severe hypotension/resp depression). Monitor glucose, lipids.
Risperidone (Risperdal) *2nd-gen*	D2 + 5-HT2A antagonist	EPS (dose-related), ↑prolactin, orthostasis	Teach slow position changes, report breast changes, galactorrhea.
Lorazepam (Ativan) *Benzodiazepine*	↑GABA → CNS depression; rapid sedation	Resp. depression ☠, sedation, paradoxical agitation (elderly)	Monitor **RR, LOC, BP**. Antidote = **flumazenil**. Avoid alcohol.
Lithium *Mood stabilizer*	Stabilizes neuronal membranes — for bipolar mania / aggression	Tremor, polyuria, toxicity ☠ at >1.5 mEq/L (N/V, confusion, seizures)	Therapeutic = **0.6–1.2 mEq/L**. Adequate **Na+ & fluid intake**. Monitor lithium levels, TSH.
Valproic acid (Depakote) *Mood stabilizer / anticonvulsant*	↑GABA, ↓impulsivity	Hepatotoxicity ☠, pancreatitis, thrombocytopenia, teratogenic (Cat X)	Monitor **LFTs, platelets, ammonia**. Avoid in pregnancy.
SSRIs (sertraline, fluoxetine) *Long-term impulse control*	↑serotonin → mood regulation	GI upset, sexual dysfunction, serotonin syndrome ☠	4–6 wks for full effect. Monitor for suicidal ideation in young adults.
Propranolol *Beta-blocker (off-label)*	Blocks sympathetic surge — reduces aggression in TBI/dementia	Bradycardia, hypotension, bronchospasm	Hold if **HR <60** or **SBP <90**. Don't stop abruptly.

💣 **"B-52" Emergency IM Chemical Restraint (classic NCLEX cocktail): Benadryl (diphenhydramine) 50 mg + 5 mg Haldol + 2 mg Ativan — given IM for severe acute agitation. Monitor: RR, LOC, BP, EPS, QT prolongation.**

⚠ 6. NCLEX TEST TRAPS

Trap #1: Answer choices that say "restrain the patient" **first**. ✕ Restraints are **LAST resort**.

Trap #2: Choosing to "touch the patient's shoulder to calm them." ✕ **Never touch** an escalating patient.

Trap #3: "Confront the patient about their behavior." ✕ Don't argue, reason, or debate in crisis.

Trap #4: PRN orders for restraints. ✕ Restraints require a **new, specific order each time**.

Trap #5: "Stay with the patient alone in the room" during escalation. ✕ Get help; position near the exit.

Trap #6: Confusing **validation** with **agreement**. "I see you're angry" ≠ "You're right to throw the chair."

Trap #7: Removing restraints "all at once" when calm. ✕ Remove **one at a time** to assess.

Trap #8: Choosing the "most restrictive" intervention for safety. ✓ Pick the **LEAST restrictive that works**.

Trap #9: Ignoring early-phase signs (pacing, clenched jaw). ✓ This is **prime intervention time**.

🎓 7. PATIENT EDUCATION

🧠
Identify triggers
Keep an anger journal — people, places, times.

⏸
Time-out technique
Leave situation, count to 10, return when calm.

🫁
Deep breathing
4-7-8 method: inhale 4, hold 7, exhale 8.

🏃
Physical release
Walk, run, punch a pillow — channel energy safely.

💬
"I" statements
"I feel ___ when ___" — avoid "you" accusations.

🧘
Relaxation skills
Progressive muscle relaxation, guided imagery.

🚫
Avoid substances
Alcohol & drugs ↓ impulse control → ↑ aggression.

💊
Med adherence
Don't stop abruptly — discuss SE with provider.

👥
Support groups
Anger management, CBT, family therapy.

☎
Crisis plan
Know hotlines, emergency contacts, safe place.

🧠 8. MEMORY BOOSTERS — MNEMONICS & PATTERNS

🚩 "TRAPPED" — SIGNS OF ESCALATION

- **T** ense body / posture
- **R** aised voice, rapid speech
- **A** ggressive stance
- **P** acing
- **P** rofanity, threats
- **E** ye contact — glaring
- **D** emanding / defiant

🕊️ "CALMER" — DE-ESCALATION

- **C** alm voice, calm face
- **A** cknowledge & validate feelings
- **L** isten actively, don't interrupt
- **M** aintain safe distance (2 arm lengths)
- **E** mpathize without agreeing
- **R** espect personal space & autonomy

🔒 "SAFER" — RESTRAINT RULES

- **S** afety first — yours, then patient's
- **A** ssess every 15 min (ROM, circulation)
- **F** ace-to-face MD order within 1 hr
- **E** valuate every 2 hrs (food, water, toilet)
- **R** eorder — 4/2/1 hr (adult/teen/child)

⚡ **Quick Pattern Recognition:** **Pacing + clenched fists = INTERVENE NOW** (Phase 1) • **Thrown objects = CRISIS** (call code) • **"I'll hurt you" = verbal aggression** (not violence yet — de-escalate!) • **History of violence = #1 predictor** of future violence • **Always pick LEAST restrictive option** on NCLEX