People who self-mutilate respond best to a nonjudgmental and accepting attitude, a caring approach, and limit setting to minimize the potential for physical injury. It is a delicate balance between keeping these individuals safe versus giving them as much control as possible over their lives. It is also understandable that staff members may react with frustration and even guilt when clients choose to harm themselves despite well-planned interventions and a caring approach (Livesley, 2003; Weber, 2002).

There are three basic goals in helping clients manage their self-harmful behavior. The first goal is to encourage communication about self-injury since clients are often secretive and shamefied about the behavior. Supportive listening may help them communicate and thus feel less isolated. The second goal is to improve the related quality of life, such as through reducing their shame and isolation, decreasing their self-criticism, and ensuring that they receive adequate medical attention. The nurse’s ability to respond without blame or shame may help clients begin the process of self-healing. The third goal is to diminish or extinguish the use of self-mutilation as a coping tool. As client understanding of their own experiences grows, they will improve their ability to manage, live with, or cease their behavior.

Box 8.3 describes appropriate nursing interventions when intervening with people who self-mutilate. Finding alternatives to self-harming behaviors is a critical step for people who wish to stop hurting themselves. Sometimes this means learning new skills in the areas of problem solving or coping skills is an appropriate intervention. Box 8.4 lists noninjurious alternatives clients may wish to consider.

**Box 8.3** Behavior Management: Self-harm

**Identify the Functions of the Behavior**
- In a nonjudgmental manner, ask, “How does this help you?” or “What does this do for you?” This will increase clients’ self-understanding and decrease feelings of shame.

**Identify the Triggers**
- Have clients keep a journal describing the stressors preceding the behavior, situations in which the behavior occurs, and the effect on others.

**Use Behavioral Contracts**
- Contracts focus on the fact that clients are responsible for their own behavior and they have to live with the consequences of their behavior.
- Contracts include a clear understanding of treatment goals and mutual expectations of behavioral change.


**Box 8.4** Alternatives to Self-mutilation

**Nonharmful Symbolic Enactments**
- Draw the “blood” or “cuts” on paper.
- “Injure” a toy or stuffed animal.
- Make marks with red marker or crayon on your skin.

**Physical Awareness**
- Breathe slowly and mentally scan each part of the body.
- Stroke your arm or leg, place ice on your skin, snap a rubber band on your wrist.

**Distraction**
- Promise yourself to wait 5 to 10 minutes before self-injuring.
- Read a book, watch a video, go to a movie.

**Interpersonal Contact**
- Call a friend; talk about the impulse toward self-harm.
- Call a support group member.

**Physical Activity, Tension Reduction**
- Exercise, dance, play a physical game.

**Art and Writing Activities**
- Draw the feeling or the memory.
- Write about your feelings; write a letter to a significant person.

**Expressive Anger Activities**
- Pound a tennis racket on a bed; pound pillows.
- Break old dishes or glasses in safe ways; throw ice cubes; smash aluminum cans.


**CLIENTS WHO ARE AGGRESSIVE**

Physical aggression and destruction of property are among the most severe and frightening client behaviors, which occur in treatment settings, as well as in the home. Violence is often directed at family members, friends, and acquaintances and may result in physical injuries. When violence occurs in treatment settings, professionals or other clients are often the victims. Aggression affects every person in the environment in which it occurs. A violent client may be injured directly from the aggressive behavior or during a restraining procedure. Other clients and staff members may be purposefully or accidentally injured. Studies show that nurses are threatened, verbally abused, and physically assaulted at higher rates than other professionals. Psychiatric nurses are at the highest risk of violence compared with other hospital nurses. Out-of-control behavior frightens everyone, and violence disrupts the unit or home environment (Chen, Hwu, & Williams, 2005; Kindy, Petersen, & Parkhurst, 2005).

Aggressive behavior is a complex phenomenon that may occur in clients with schizophrenia, mood disorders, bor-