

MANAGEMENT OF AGGRESSION

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I. OVERVIEW

- A. Numerous definitions are used for these terms. For the purpose of this lecture, they will be used as follows:
 - 1. Aggression: behaviors leading to non-accidental harm
 - 2. Violence:
 - a. Subtype of aggression involving non-accidental physical harm by one individual toward another
 - b. Violent behavior causes (or is likely to cause) death, physical injury, or psychological harm.
- B. Aggression encompasses violence, in addition to non-accidental property destruction and verbal abuse during periods of agitation. Self-injurious behavior is also often classified as a form of aggression. However, for the purpose of this lecture, aggression will refer only to harming others.
- C. Professionals from various disciplines have studied the antecedents and manifestations of violent behavior. Professions specifically interested in studying violence include mental health scholars, legal scholars, criminologists, sociologists, and biologists, to name a few.

II. IMPACT OF VIOLENCE WORLDWIDE

- A. According to the WHO, approximately 1.6 million people lose their lives to violence each year. There are, of course, many contributing factors beyond simply mental illness. Mental illness is frequently used as a scapegoat in the wake of violent acts.
- B. Annually, nations pay billions of dollars to cover costs associated with law enforcement, health care for victims, and lost productivity at work.

- C. Psychological manifestations of violence are difficult to quantify, but undoubtedly magnify the scope of the problem.
 - 1. Victims of single-incident or repeated violence (such as childhood abuse or domestic abuse) can experience psychological manifestations for years, including additional lost productivity at work.
 - 2. Surviving victims' quality of life is often impacted, resulting in a range of potential problems. The development of PTSD is only one of many possible outcomes that can affect the victim.

III. IMPACT OF VIOLENCE ON MENTAL HEALTH PROVIDERS

- A. Staff injuries are alarmingly common, particularly on inpatient treatment units. Injuries can lead to lost productivity at work, arguments between staff members, and early staff burnout.
- B. Mental health nurses are frequent targets of violence. Hesketh and colleagues (2003) reported that over 20 percent of mental health nurses reported being physically assaulted, and over 50 percent verbally assaulted, at least once during their previous five shifts.
- C. Recent mental health nursing study showed similarly high numbers based on long-term reports (Moyle & Cullinan, 2011)
 - 1. This study involved data from 110 nurses at five institutions, of which 80 percent reported being assaulted, 65 percent reported being injured, and 26 percent reported being seriously injured.
 - 2. The frequency and severity of nursing injuries had increased significantly since a similar study by Moyle in 1996.
 - 3. Nurses who had been injured decided to restrain later in the progression of aggression than those who had not been injured. This was contrary to the researchers' initial hypothesis.
- D. Antonius and colleagues (2010) estimated that 30 to 50 percent of psychiatric residents have been physically assaulted.

IV. CLASSIFICATION OF AGGRESSION

- A. Regarding individuals with psychiatric conditions, providing a thorough assessment and establishing accurate diagnoses are essential.

1. Aggressive behaviors displayed by two different patients can appear identical despite involving completely different contributing factors.
 2. Unique elements leading to the aggressive behaviors must be considered to formulate an appropriate treatment plan for each patient.
 3. There is **no single approach** that will be effective for every patient, nor will a single approach always be ideal for the same patient.
- B. In addition to accurately determining the patient's primary diagnosis, analyzing the type of aggression displayed is also important when formulating a plan to manage their aggressive behaviors.
- C. One such system involves categorizing each aggressive act of psychiatric patients as psychotic, impulsive, or organized.
1. Psychotic acts occur in response to delusional beliefs and do not have a clear rational alternative motive.
 2. Impulsive acts are generally immediate responses to provocation or perceived provocation. The patient may seem agitated, out-of-control, hostile, and threatening. The aggressive act is typically not related to long-term goals or secondary gain.
 3. Organized acts generally involve planning, social motives, and/or secondary gain. They are premeditated and predatory in nature.
- D. Taking a patient's pattern of behavior into consideration helps guide the treatment team's clinical management. Knowledge about patterns of behavior can also help the staff avoid future incidents.
- E. Individual patients can display different types of aggression, even within short periods of time. Single acts of aggression may also contain elements of more than one type of aggression.
- V. MANAGING PSYCHOTIC AGGRESSION
- A. Mental health providers often perceive this to be the most tolerable form of assault, based on the understanding that symptoms drove the behavior.
 - B. Adequate treatment of the patient's underlying psychotic symptoms is the primary way to target psychotic aggression.
 - C. If the patient remains chronically agitated while initiating or restarting antipsychotic medications, short-term treatment with benzodiazepines may be

necessary to maintain safety for staff and peers.

- D. It is important for all hospital staff to be informed about the patient's delusional beliefs and past reactions to help them avoid becoming victims.

VI. MANAGING IMPULSIVE AGGRESSION

- A. Impulsive aggression is common on acute psychiatric units and requires a multidiscipline approach.
- B. It is important for all hospital staff to be informed about the patient's typical triggers and past reactions to help them avoid becoming victims.
- C. Fortunately, there are often early physical signs indicative of impending aggression. One potential warning sign is that the patient has punched the wall or broken objects on the unit. Other early warning signs include tightening of facial musculature, clenching of fists, and pacing.
- D. Specific medications have shown varied results with different patient populations (Newman 2012). Again, a thorough understanding of the patients' diagnoses is essential.
- E. Psychotherapeutic interventions have strong support for helping to manage this form of aggression. Breathing exercises, CBT, and behavioral plans represent some useful interventions that can be employed.

VII. MANAGING ORGANIZED AGGRESSION

- A. Mental health providers often struggle the most with this form of assault. It seems the most personalized and often creates a sense of vulnerability and hopelessness among staff.
- B. Patients diagnosed with ASPD, particularly those who meet criteria for psychopathy, are highly likely to exhibit organized aggression. Treatment of psychopathy through the mental health system is challenging at best.
 - 1. There is **no medication that treats psychopathy**.
 - 2. The benefits of psychotherapeutic treatment of psychopathy remain equivocal. Attempted psychotherapeutic modalities have included therapeutic community models, psychoanalysis, and CBT, among others.
- C. There are some novel management strategies being attempted with psychopaths worldwide, though the results are yet unclear.

1. Reasoning and Rehabilitation (R&R) is the most widely adopted and investigated skills program for psychopathy (Cullen et al., 2012).
 2. Dangerous Personality Disorders Units (DPDU) have also been tried at various facilities, with mixed results. This model was first developed in England.
 - a. A clear benefit includes isolating these individuals into one location where security can be intensified and staff can be specially trained. There is also a degree of protection for other vulnerable patients from their influence.
 - b. Potential problems include collusion among the patients, staff burnout, and potential boundary violations. Staff selected to work on these units must be well trained and closely supervised.
- D. Consistent and clear consequences to behavior are important to maintain with patients who display primarily organized aggression.
- E. Pursue criminal charges when appropriate. This may require providing a detailed explanation of the situation and even a degree of advocacy by administrators to law enforcement personnel.

VIII. LARGE-SCALE APPROACHES TO MANAGING AGGRESSION

- A. Keep control of the unit and do not allow out-of-control behavior to continue for extended periods.
1. Fear is one of the primary antecedents to aggression. If patients feel that the staff has lost control of the unit, they may become more prone to act aggressively in perceived self-defense.
 2. Verbal altercations are a common precursor for physical aggression. Staff should intervene quickly as soon as patients raise their voices. Communication between staff helps understand relationship dynamics between particular patients.
- B. Have clear policies and consistent use of seclusion/restraint (S/R) techniques. Part of this involves frequent trainings and forums for staff to voice their questions and concerns about the use of S/R.
1. The American Psychiatric Association's 2006 Task Force Report on Seclusion and Restraint acknowledges that in addition to using S/R to prevent imminent harm to self or others, preventing "serious disruption to the treatment environment" is also an appropriate indication.

2. Unless staff's actions were malicious or grossly inappropriate, use less-than-ideal S/R events as teaching opportunities rather than reprimanding staff without providing the associated teaching and debriefing.
- C. Consider adding an acuity board to civil or forensic inpatient units. On the acuity board, the staff can record aggressive behaviors and other safety concerns displayed by patients.
- D. Reminders of simple concepts can help promote a safer work environment.
Encourage staff to use CAUTION:
Communication
Attire
Untreated Symptoms
Threats
Impulsivity
Options
Navigate Safely
- E. Video surveillance can provide some staff protection against accusations of inappropriate behavior, evidence for use if criminal charges are pursued, and can even be used as a training tool.

IX. PATIENT-SPECIFIC APPROACHES TO MANAGING AGGRESSION

- A. Understand the common precipitants of aggression reported by patients on inpatient units. Meehan and colleagues (2006) discussed factors identified by patients in forensic facilities as common causes of aggression (other than simply the patient population itself). The identified factors included the following:
 1. The physical environment, particularly a lack of personal space
 2. Boredom and the lack of meaningful activities
 3. Staff interactions, particularly the perception that staff adopted an air of superiority or rigidly enforced a strict hierarchy
 4. Lack of understanding of the benefits of medications; viewed them as a means of control rather than treatment
- B. Strategies can be derived from these common precipitants and used to develop proactive strategies. For instance, staff should attempt to make simple concessions when they do not negatively impact the patient's care or the security of the unit. Patients frequently report their perception of requests being ignored as a reason for assaults.

- C. When possible, have staff members who are familiar with the patient take the lead during a behavioral code. Familiarity can be comforting for the patient and also allows the staff member to draw on their past experiences.
- D. Fluttert and colleagues (2010) reported the benefits of using the Early Recognition Method (ERM) when implemented in a maximum-security forensic hospital in Norway.
- E. Fluttert and colleagues (2011) also developed the Forensic Early Warning Signs of Aggression Inventory (FESAI) to assess early warning signs of aggression. This tool can be used to directly assess the most relevant early warning signs of aggression described in the literature.

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