Communication Breakdown and Violence

Assessment and management of violence in psychiatry

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COMMUNICATION

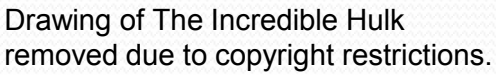
- Who says what to whom in what channel with what effect (Lasswell)
- Making of meaning and exchanging of understanding

Diagram of simple communication between a sender & receiver removed due to copyright restrictions.

Communication and violence

- Walter Fisher's Narrative Rationality
  - The way in which people communicate, explain and/or justify their behavior, whether past or future, has more to do with telling a credible story than it does with producing evidence or constructing a logical argument
  - Traditional rational paradigm → people as thinking beings reaching decisions based on evidential reasoning
  - Narrative paradigm → people are essentially storytellers, basing their decisions on reasons having to do with history, culture and perceptions about the status and character of others; narrative rationality → based on tests of probability, coherence and fidelity of the stories underlying the decisions to be made
- Disruption of the narrative
  - Mental illness imposes a dominant narrative /bias
  - Major themes - depression, psychosis, trauma, anxiety / panic
  - Anger – flowing from biological, psychological, social directions – disrupts the probability, coherence and fidelity of those themes
  - Anger as a defense mechanism – acting out, inverse of isolation of affect, displacement, projection

Upset and restless
-narrow emotional range
-simplistic communication



Magnitude of the problem (1)

- In one study half 46 medical students have been fearful of violence by patients and 4 were physically assaulted. Ellwood, A.L., and L.D. Rey. "Awareness and fear of violence among medical and social work students." *Family Medicine* 28 (1996): 488–492 .
- In another study the majority of 93 medical students surveyed had been yelled or shouted at or had been subjected to nasty or rude behavior. Sheehan, K. Harnett, David V. Sheehan, Kim White, Alan Leibowitz, and DeWitt C. Baldwin, Jr. "A pilot study of medical student 'abuse': student perceptions of mistreatment and misconduct in medical school." *Journal of the American Medical Association* 263 (1990): 533–537.
- Survey of psychiatry residents: assaults or threats of violence are some of the most difficult stressful situations during training.
- Percentage of psychiatry residents assaulted at least once during training: 36-64
- The percentage is even higher when grouping residents and junior attendings: 90 Kozlowska, Kasia, Kenneth Nunn, and Pennelope Cousens. "Adverse experiences in psychiatric training, part 2." *Australian and New Zealand Journal of Psychiatry* 31 (1997): 641–652.
- Psychiatry residents are more likely to experience longer term and higher levels of psychological distress than other medical trainees. Coverdale, John, Christopher Gale, Sara Weeks, and Sarah Turbott. "A survey of threats and violent acts by patients against training physicians." *Medical Education* 35 (2001): 154–159.

Magnitude of the problem (2)

- Assault rate during 4 years of residency: 30-40%
  - 37% of men and 34% of women - physically assaulted
  - 79% of male responders and 69% of female responders – threatened by patients
  - Of all the residents assaulted only 69% reported the incident to a supervisor
  - Of the residents reporting the assaults
    - 43% went through a debriefing
    - 33% had supportive counseling
    - 16% felt they were to blame for the altercation
  - Among the respondents:
    - 19% reported to clear policy about reporting assaults
    - 12% felt that being the target of assaults was an inherent part of the profession
  - Reasons for not reporting:
    - Poor staff support
    - Shame and guilt
    - Feeling that seeking change would be futile
    - Fear of scrutiny
    - Other staff's denial that the assault occurred

Schwartz, Thomas L., and Tricia L. Park. "Assaults by Patients on Psychiatric Residents: A Survey and Training Recommendations." *Psychiatric Services* 50 (March 1999): 381-383.

Limitation of the data

- Information is somewhat dated
- Concerns single or a limited number of programs → limited generalizability
- Methodologically: low numbers, lack of clear definition of threats / assaults or of response rates
- Predominant focus on assaults with or without physical injury and less on other forms of aggression
- Surveys asked about events happening in the past → recall bias
- Context in which the violence occurred → rarely described or presented only in a general fashion

Improving practices in the medical / psychiatric training

- Proposed curriculum changes
  - Combining didactic lectures and practical sessions
    - Causes of violence
    - Psychodynamics of aggression
    - Initial encounter and evaluation / diagnosis of violent patients
    - Psychopharmacology
    - Seclusion and restraint
    - Environmental safety
    - Forensic issues
  - Emphasis of teaching self-defense techniques
    - To anticipate and escape assaults
  - Development of reporting protocols
  - Provision of psychological support / supervision
    - To prevent / minimize post-traumatic symptomatology
    - Decreasing beliefs re: blame for the incident or that of assault as being part of the job
    - Reduce likelihood of future assaults
  - Role of simulation – both in teaching the principles of assessment and practical management

Risk factors (1)

- Type of factors in aggression
  - Patient
    - Demographic and personal history variable
      - **History of violence**: recency, frequency, patterns of escalation, associated symptoms, context, planned vs. impulsive, attitudes toward violence, perpetrator vs. victim
      - **Violent threats and fantasies**: seriousness, extent of planning, preparation, means to carry it out
      - **Age**: often in young people but also in the elderly with cognitive impairment
      - **Gender**: males > females in the community, males=females in acute inpatient settings; in the community females are more likely to target family members
      - **History of victimization**: victim as a child and growing in a violent home
      - **Culture**: violence perceived as acceptable in gang subculture
      - **Socio-economic status (SES)**: low SES associated with higher likelihood of violence
      - **Intelligence**: MR associated with aggressive behavior in institutionalized populations

Risk factors (2)

- Clinical variables
  - Diagnosis:
    - schizophrenia, bipolar disorder, cognitive disorders (e.g. TBI – temporal and orbito-medial part of frontal lobe, delirium, dementia)
    - substance uses disorder (disinhibition, grandiosity, suspiciousness → delusional beliefs, disorganization, withdrawal delirium, substance procurement)
    - Personality disorders: antisocial and borderline: association between psychopathy and violence; more likely to be relevant for the long-term risk of violence
    - ADHD, intermittent explosive disorder
    - Neurological conditions (e.g. epilepsy), pain, sleep disorder (disorders of arousal like sleepwalking or sleep terrors), post traumatic stress disorder
  - Symptoms:
    - Acute findings on mental status examination: hostile – suspiciousness, agitation – excitement and thinking disturbance (i.e. conceptual disorganization, hallucinations, unusual thought content)
    - Anger: propensity for anger and difficulty in controlling it
    - Aggressive attributional style: response to stress with perceptions of threat, suspiciousness and hostility → threat/override delusions: psychotic thoughts that cause a person to feel personally threatened or involve the intrusion of thoughts that can override self-controls
    - Command AH

Risk factors (3)

- Cognitive bias when making decisions under conditions of uncertainty
  - Neglecting base rate information
  - Selectively attending to information confirming one's initial assumptions
  - Ignoring disconfirming evidence
  - Including an uncommon event as likely to occur because it is easily recalled

- Medications /street drugs
  - Alcohol
  - Stimulants
  - Benzodiazepines
  - Steroids
  - Antidepressants
    - through medication –induced activation, disinhibition, paradoxical reactions, behavioral toxicity)

THE MacARTHUR VIOLENCE RISK ASSESSMENT STUDY *(1)*

- ***September 2005 Update of the Executive Summary***
- ***Factors significantly related to violence:***
  - *At least one violent act in the 20 weeks following discharge was committed by 18.7%*
  - *Gender:*
    - *Men were more likely than women to be violent*
    - *Violence by women: more likely to occur at home, to be directed against family and not to result in arrest of medical treatment*
  - *Prior violence: strong prediction for future violence*
  - *Childhood experiences: prediction of violence if*
    - *Childhood marked by serious and frequent physical abuse*
    - *Parent, in particular father, who was substance abuser or criminal*
  - *Neighborhood and race*
    - *Same rate of violence in African American and whites living in comparably disadvantaged neighborhoods*
  - *Diagnosis*
    - *Diagnosis of major mental illness, especially schizophrenia, was associated with a lower rate of violence than a diagnosis of personality or adjustment disorder*
    - *Co-occurring substance abuse was strongly predictive of violence*
  - *Psychopathy*
    - *As measured by the Hare Psychopathy Checklist: very strong predictor*
    - *The antisocial behavior component more than the emotional detachment component accounted for the effect*
  - *Delusions*
    - *Type and content was not associated with violence but general suspiciousness was*

THE MacARTHUR VIOLENCE RISK ASSESSMENT STUDY *(2)*

- Hallucinations
  - Hallucinations in general did not elevate the risk of violence
  - Specific command hallucinations did
- Violent thoughts
  - Persistent thoughts or daydreaming about harming others was associated with violence
- Anger
  - Direct correlation with the Novaco Anger Scale

NAS

- **Novaco Anger Scale**
  - *Total*: General inclination toward anger reactions, based on Cognitive, Arousal, and Behavior subscales.
  - *Cognitive*: Anger justification, rumination, hostile attitude, and suspicion.
  - *Arousal*: Anger intensity, duration, somatic tension, and irritability.
  - *Behavior*: Impulsive reaction, verbal aggression, physical confrontation, and indirect expression.
  - *Anger Regulation*: Ability to regulate anger-engendering thoughts, effect self-calming, and engage in constructive behavior when provoked.

Useful measures in the dynamic assessment of violence

- HCR-20
- Broset Violence Checklist
- Dynamic Appraisal Situational Aggression
- Hare Psychopathy Checklist – Revised

Actuarial vs dynamic assessment measures

HCR-20
Violence Risk Assessment (1)

- **Historical Scale**
  - H1 Previous violence
  - H2 Young age at first violent incident
  - H3 Relationship Instability
  - H4 Employment Problems
  - H5 Substance Use Problems
  - H6 Major Mental Illness
  - H7 Psychopathy
  - H8 Early Maladjustment disorder
  - H9 Personality Disorder
  - H10 Prior Supervision Failure

HCR-20 (2)

- **Clinical Scale**
  - C1 Lack of insight
  - C2 Negative attitudes
  - C3 Active symptoms of major mental illness
  - C4 Impulsivity
  - C5 Unresponsiveness to treatment

- **Risk management scale**
  - R1 Plans lack feasibility
  - R2 Exposure to destabilizers
  - R3 Lack of personal support
  - R4 Noncompliance with remediation attempts
  - R5 Stress

Each item gets a code of 0=No/Absent, 1=Partially/Possibly present, 2=Yes/Definitely present

Broset Violence Checklist

- *Confusion*
- *Irritability*
- *Boisterousness*
- *Verbal threats*
- *Physical threats*
- *Attacks on objects*

- *Items are either present or absent*
- *Well correlated with violence over the following 24 hours*

Dynamic Appraisal of Situational Aggression

- 7 factors having the highest predictive values for violence on an inpatient unit
  - Negative attitudes
  - Impulsivity
  - Irritability
  - Verbal threats
  - Sensitivity to perceived provocation
  - Easily angered when requests are denied
  - Unwillingness to follow directions
- Scored as present / absent
- Score range and violence risk
  - 0=low risk
  - 1-3=moderate risk, preventative measures to be taken
  - 4 or more=high risk

Hare Psychopathy Checklist - Revised

Factor 1

- Aggressive narcissism
  - Glibness/superficial charm
  - Grandiose sense of self-worth
  - Pathological lying
  - Cunning/manipulative
  - Lack of remorse or guilt
  - Emotionally shallow
  - Callous/lack of empathy
  - Failure to accept responsibility for own actions

Factor 2

- Socially deviant lifestyle
  - Need for stimulation/proneness to boredom
  - Parasitic lifestyle
  - Poor behavioral control
  - Promiscuous sexual behavior
  - Lack of realistic, long-term goals
  - Impulsiveness
  - Irresponsibility
  - Juvenile delinquency
  - Early behavioral problems
  - Revocation of conditional release

Traits not correlated with either factor

- Many short-term marital relationships
- Criminal versatility

Non-verbal de-escalation principles (1)

- Safety of physical location
  - Office with door open and staff waiting outside
  - Interviewing the patient with staff present
  - Having options to communicate with staff in case of danger
  - Safe furnishing of the office: no small objects to be used as weapons
  - Clinician attire to be adequate (remove neckties, jewelry, eyeglasses, religious or political symbols)
- Position
  - 1-2 arms length or farther depending on level of agitation
  - Not too far, not too close
  - Standing directly in front of the patient, at 45 degrees angle
  - Do not stand over or block exit
  - Never turn your back for any reason
  - Position yourself closer to the room entrance than the escalated client if indoors
  - At the same eye level
- Posture
  - Arms uncrossed
  - Open hands, no clenched fists, no hands behind your back or in pockets
  - Do not point or shake your finger
  - Keep a relaxed and alert posture. Stand up straight with feet about shoulder width apart and weight evenly balanced
  - Do not maintain a rigid stance
  - Intermittent eye contact
    - Loss of eye contact may be interpreted as an expression of fear, lack of interest or regard, or rejection. Excessive eye contact may be interpreted as a threat or challenge.

Non-verbal de-escalation principles (2)

- Appearance and attitude
  - Appear calm, centered, and self-assured even if you don't feel it. Your anxiety can make the client feel anxious and unsafe which can escalate aggression
  - Minimize body movements such as excessive gesturing, pacing, fidgeting, or weight shifting. These are all indications of anxiety and will tend to increase agitation.
- Facial expression.
  - Maintain a neutral expression
  - A calm, attentive attitude reduces hostility.
- Touch
  - Always inform the person where and when you will be touching him or her and why.
  - Don't touch unless necessary
  - No sudden or erratic movements
- Create Space
- Even if the person is moving in close to you, remember that he or she may perceive that you are entering his or her personal space. Create distance by moving away slowly. This simple action may help the person to feel less threatened

Verbal de-escalation principles (1)

- Invite dialogue
- Reflect to the patient his / her behavior and emotions
- Model calm behavior
  - Slow down, tone down, soften up
  - Use a modulated, low monotonous tone of voice (our normal tendency is to have a high-pitched, tight voice when scared).
  - Do not get loud or try to yell over a screaming person. Wait until he/she takes a breath, then talk. Speak calmly at an average volume.
- Active listening
  - Accept
    - When a person tells you what they're feeling and why, be prepared to accept their statements without judgment or defensiveness. A person's feelings are felt – even if not based on reality – and must be attended to. Acknowledge the person's anger or hurt in a supportive manner.
  - Clarify
    - Attempt to prevent the "snowballing" effect of runaway anger by helping the person to focus on issues specific to their anger.
  - Respond to valid concerns
    - The person's bad feeling may be the result of an external situation that can be rectified or of a misunderstanding that can be corrected.
  - Listen
    - Use active-listening skills to let the person know that you are hearing them. When we are afraid, we tend to get rigid and quiet. This will make most people feel that we're not "with" them and intensify their anger. Loosen up, nod, gesture, say "Uh-huh", paraphrase what has been told to you, reflect feeling, etc. Permit verbal venting when possible. Allow your person to release as much energy as possible by venting verbally. Allow full expression to defuse anger before attempting to clarify or redirect.
  - Do not be defensive if comments or insults are directed at you; they are not about you.

Verbal de-escalation principles (2)

- Help Create Options
  - Offer the person choices
    - As the person becomes increasingly agitated, he or she may be gripped by a pattern of behavior and fail to see more appropriate options. Give the person as much control over the outcome as is appropriate.
    - Ask the person what could be helpful.
    - Expand the person's options
      - If the person is unable to generate options, suggest a few that might be soothing
    - Redirection
      - If appropriate, divert the person's attention from the situation that is stressful or frustrating
    - Establishing Therapeutic Expectations
      - respect of human rights
      - offering of options previously expressed by the person, during less stressful times (that the person stated would be helpful during a behavioral crisis) – for example, sensory modulation activities
      - offering of the least restrictive alternatives.
    - Limit setting
      - explain that behavior is unacceptable and maladaptive and why
      - explain the consequences if behavior persists without treats or anger
      - do it in an authoritative, firm but respectful way
- Pharmacotherapy
- Seclusion / restraint

BONNIE (1)

- **Information for the trainee**

Patient: Bonnie **Age**: 44

Occupation: currently unemployed **Educational level**: College

Diagnoses:

Depression, r/o major depressive disorder vs. bipolar disorder, depressed episode
Probable PTSD
Alcohol and cocaine abuse
Borderline and antisocial traits

Level of agitation and potential for aggression / assaultiveness:

Moderate at first but the clinical situation could become highly volatile depending on the approach / management

Clinical setting:

You are seeing this patient on an inpatient psychiatric unit after being called by the staff to evaluate escalating agitation, threatening behaviors, recurring pounding on doors and walls, suicidal statements

BONNIE (2)

- **Purpose for the SP role-play**

  - Engaging the explosive patient in a productive, respectful and safe dialogue, which allows the identification of precipitants for the current situation and the understanding of the broader psychopathological context (e.g. reasons for the admission and relevant aspects of the case). Engagement – focused history taking

  - Management / therapeutic approaches. Knowledge of non-verbal and verbal de-escalation techniques

  - Identifying the level of intervention (direct engagement – seclusion / restraints – pharmacology).

  - Becoming able to understand and address own countertransferential / physiological responses when exposed to potentially threatening patients.

BONNIE (3)

- **Your background**

  Middle-aged, single, unemployed, college-educated, presently homeless, large broad-shouldered white female with a history of extensive abuse in her childhood and as an adult, with PTSD complicated by mood instability and recurring self-mutilation. She is terrified by her abandonment promoting hostility and hopeless about her history of multiple episodes of threatening and assaultive behaviors in the context of interpersonal disputes often resulting in serious victim injury. She was brought to the hospital for evaluation of her erratic behaviors after a holiday reunion designed by her family "to finally bring everybody together and forget about the past"

- **Your symptoms**

  The apparent trigger for the current explosive episode was the perceived lack of attention paid by the staff to your needs; you wanted a particular nurse to talk to you "on 1 to 1 for at least 30 minutes right away" and the fact that she was not working that night did not seem to make a difference to you. You started pacing up and down the hallway, mumbling at first then raising your voice; swears and deprecatory remarks about nurses and mental health associates as well as about some other patients became increasingly more distinct. Attempts by staff to approach you were just making you angrier. You started punching walls, doors and windows close to the nurses' station and at one point one you were found struggling to rip a picture off the wall. You started shouting about "being watched..recorded and monitored...followed by them to be killed...having the medication changed to poison because it does not look and taste it should...all of you laughing about me behind those doors and wanting me out of here and dead".

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