

CLINICAL ASSESSMENT AND USEFUL THERAPEUTIC STRATEGIES IN VIOLENT BEHAVIOR

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Abstract:

Aggressive behavior represents a symptom, a clinical predominant syndrome and, in many cases, it may be associated with psychomotor agitation. In the clinical assessment of violent behavior, particular attention will be paid to matters affecting the patient's past or present situation, such as aggressive ideas, plans and acts of violence, careless driving, acts of vandalism, family history of violence. In order to administer therapy in aggressive or violent cases, infringement and seclusion techniques are sometimes necessary.

Keywords: aggressive behavior, violence risk, pharmacological management

Rezumat:

Comportamentul agresiv reprezintă un sindrom predominant clinic, un simptom care se poate asocia cu agitație psihomotorie. În evaluarea clinică a comportamentului violent, se acordă o atenție deosebită factorilor care afectează situația actuală sau istoricul anterior, precum ideile agresive, planuri, acte de violență, acte de vandalism, istoric familial de violență. Administrarea terapiei în cazurile violente sau agresive necesită, uneori, contenție.

Cuvinte-cheie: comportament agresiv, risc de violență, management farmacologic

Violence is a serious issue for staff working in mental health services, in both emergency departments and community services. Early recognition of potentially dangerous situations is the most efficient way to avoid violence. We stress out that not any act of violence is associated with mental disorder, it often can be found in individuals considered as "normal" in tensed or frustrating situations. The concept of "aggressiveness" has a broader scope than violence; in a narrower sense, it refers to a person that attacks with a sudden and unexpected brutality. In a broader sense, it includes all hetero-aggressive or self-destructive tendencies. In the emergency department, the physician may frequently encounter agitated and/or violent patients. It is necessary to determine whether there is immediate risk of danger.

Aggressive behavior can be recognized by identifying several factors, such as: (1)

- the presence of a primary psychiatric disorder (schizophrenia, manic episodes in a bipolar affective disorder, dementia of various etiologies, personality disorders) or a secondary mental disorder (alcohol and/or drugs intoxication, adverse effects of improper or excessive use of medication for somatic background);
- personal history: the patient was the victim of mistreatment, physical or sexual abuse in childhood or adolescence, or showed impulsive acts in the past as well;
- psychological factors: low tolerance to frustration, low self-esteem, low relationship abilities and communication capacity, intolerance to criticism;
- social and demographic factors: male, younger age (15 – 24 years), educational shortcomings, lack of family support, low social integration, minimal financial resources.

Violent patient assessment is difficult in many cases, for the following reasons:

- there is strong pressure from the family and the care staff to act as quickly as possible, a factor that can disrupt the examination;
- occurrence of a state of nervousness and fear on the part of the medical staff that determines the application of primitive measures;
- hazard assessment should be made in a careful and documented way, taking into account the legal implications and possible future consequences for patients. (2)

Emergency services staff must be in a sufficient number and trained to observe and monitor aggressive patients' behaviors and to implement effective and appropriate isolation and seclusion techniques. When initiating interviewing a potential violent patient, we observe several signs, such as:

- the attitude expresses a state of tension and increased muscular tension manifested by tight-fisted hands, struggled jaws;
- the behavior reveals a state of psychomotor restlessness which exacerbates quickly, the patient is walking around the room aimlessly, unable to rest seated during the examination;
- the mood records reactions of anger and outbursts of fury, in which the patient breaks furniture and other objects, slams doors, and so on;
- the speech is becoming ampler and faster, his voice is strident, threatening or derogatory;
- presence of recent acts of violence.

In the emergency situation, in which the physician decided to use verbal approach, without any physical intervention, it is important to take into account the following aspects:

- the doctor's way of addressing to the patient should be calm, quiet, respectful;
- comments on the obvious problems will be made in a neutral and concrete way;
- direct eye contact will be avoided because it can be interpreted as intimidation or confrontation;
- patient's reports will be carefully listened to, without frequent interruption, in an empathic, uncritical manner;
- during the conversation, provocative or derogatory comments, that may leave the impression that the patient is charged or tried, will be avoided;
- the clinician will record the allegations in the order described by the patient, even if they don't coincide with the information provided by the family;
- the doctor will try to find out the patient's point of view regarding the event that triggered the episode of violence;
- in the presence of a mental disorder, or of alcohol or drugs intoxication, the clinician will address, repeatedly, simple, concise questions;
- the doctor will not make false promises, which he can't meet, such as: ensuring that the patient won't be hospitalized.

The interview will take place in a spacious room, free from sharp or heavy objects (ashtrays, pencils) that can be used as weapons. This room must be equipped with at least two doors that can't be blocked from the inside, with panic buttons and alarm systems. During the interview, the doctor will keep a considerable distance from the patient, will not turn away from him/her, will avoid any sudden movement and try to control the situation in a calm and resolute manner. In case that the

violent patients cannot be addressed verbally, other techniques such as isolation and seclusion will be used. (3) The main indications of the former are:

- to prevent imminent harm to patient or other persons when other control methods have proved unsuitable or ineffective;
- to prevent environmental damage;
- to implement and carry-on the pharmaco- and psychotherapeutic program.

The medical personnel have the duty to assess as precisely as they can the nature of the threat that represents an immediate danger in 2 ways:

- for the patient: both by deliberate self-harm and suicidal acts, and by psychomotor agitation and disturbance of the movement control;
- for the other persons: either by trying to injure them with a weapon or through disordered behavior that puts their life in danger.

In the clinical assessment of violent behavior, particular attention will be paid to matters affecting the patient's past or present situation, such as (4):

- aggressive ideas, plans and acts of violence (addressability, causation, premeditation or impulsivity, punishments or consequences);
- careless driving, acts of vandalism;
- family history of violence.

These findings will be completed by information obtained from family, colleagues, friends, police, or medical personnel that brought him to the emergency department. An important objective of the assessment is represented by the history of violent behavior, which is the surest predictor of the current aggressive episode. (5) We will focus on the following directions:

- the onset of the first aggressive episode and the circumstances in which it occurred;
- the chronological development of violence, the frequency of dangerous attacks, the episodic character, the duration of each episode and patient's behavior in between episodes;
- violence intensity will be determined through inquiring the patient with regard to the degree of injury or damage caused by his/her committed acts;
- history of arrests and detentions in youth or adulthood;
- the existence of associated symptoms that can precede or accompany the aggressive episode (e.g. amnesia);
- registered prior hospitalizations and treatments.

Further, the assessment will focus on describing the current situation and the factors which caused the act of violence resulting in psychiatric consultation or hospitalization.

In this context, the doctor will insist on:

- existence of ideas or plans of aggression directed towards one or more persons;
- patient's possession of weapons or recent attempts to purchase dangerous equipment;
- presence of stressful environmental factors that predisposed the patient to committing aggressive acts or the existence of conditions similar to those experienced by the patient in the past, in which he was urged or compelled to act in a violent manner;
- causing injury or significant material damage;
- decrease or loss of self-control in his/her acts.

Aggressive behavior represents a symptom, a clinical predominant syndrome and, in many cases, it may be associated with psychomotor agitation.

A one year clinical study conducted by M. Love, M. Menchetti, F. Scarlatti (2008), on a sample of inpatients diagnosed with acute psychotic disorder, showed that aggression manifested a month before hospitalization was associated with the following factors: male sex, substance abuse, presence of positive symptoms, and the existence of a personal or family history of physical aggression.

The physician will pay special attention to those cases where aggression and impulsive behavior vary in terms of clinical manifestations and complex etiology. For example, patients with bipolar disorder in a manic episode show rapid speech, high pitched vocal tone, mood swings, ironic and sarcastic speech. (6)

Among the clinical features encountered in a patient with schizophrenia, we mention: disorganized thinking and speech, delusions of influence and control, or bizarre ideational content. (7) Aggressive behavior is also to be found in patients with alcohol or drug abuse, where it is associated with halitosis, nystagmus, tremors of the extremities, and signs of intravenous drug administration.

Therapeutic management in the initial phase of violent behavior is based on medication used in similar episodes in the past. Administering medication may vary from "oral administration", in case the patients accept it, to a combination of intramuscularly antipsychotic and sedative treatment.

Violent behavior therapeutic doses include:

Drug	Route of administration	
	orally	intramuscular
Olanzapine	5 – 10 mg/d	10 mg/d
Haloperidol	10 mg/d	5 mg/d
Quetiapine	50 – 100 mg/d	-
Ziprasidone	-	20 mg/d

Antipsychotic therapy may be associated with lorazepam (1 – 2 mg/d orally or intramuscularly) in patients with psychotic or expansive episodes. Intramuscular administration of lorazepam is contraindicated in some situations, such as: severe intoxication with alcohol or sedatives / hypnotics and in case the patient is treated with leponex (clozapine). One can use typical antipsychotics such as haloperidol in doses of 5 – 10 mg / day, which may be repeated at intervals of 30 to 45 minutes if necessary. Benztropine 1 – 2 mg or diphenylhydramine 50 mg/day will be added orally, if side effects like muscular rigidity or tremor occur. Atypical antipsychotics (ziprasidone 20 mg/day, olanzapine 10mg/day intramuscularly) have proved effective in reducing psychomotor agitation and in improving psychotic and manic symptoms. In order to administer therapy in aggressive or violent cases, infringement and seclusion techniques are sometimes necessary. Long-term therapeutic management of the violent patient is based on establishing the right diagnosis and on the specific treatment of the complex symptoms.

Antidepressant medication includes both tricyclic agents and selective serotonin reuptake inhibitors. They act through the antidepressant effect and have an important role in reducing impulsivity and aggression. Lithium and mood stabilizing drugs were effective on both manic symptoms and in reducing aggressive behavior. Buspirone, a nonbenzodiazepinic compound is used to combat depression, anxiety and aggressiveness. Beta blockers, such as propranolol, proved to be useful in small doses (10 – 20 mg administered orally two or three times a day) in reducing aggressive behavior in patients with akathisia and in high doses to combat impulsivity in dementia syndromes.

Violent behavior management programs make use of psychotherapy that helps the patient to learn non-violent assertiveness techniques, such as: verbal expression of frustration and stressful situations, examining automatic thoughts and dissociating them from violent automatic behavioral responses.

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