Violence

Last updated: April 24, 2019

Evaluation steps:
1. Establishing etiology
2. Assessment of dangerousness

ETIOLOGY

- interplay between innate psychobiologic factors and external environment.

Biologic factors

1) serotonin is involved in violent behavior in same way that it is involved in suicidal behavior [i.e. lower levels of 5-hydroxyindoleacetic acid (5-HIAA) are found in CSF of offenders who kill with unusual cruelty than in CSF of nonviolent offenders].
2) androgens may be involved; but *antiandrogen treatment* is not effective in decreasing violence.
3) premenstrual syndrome is implicated in aggressive behavior in women.

Psychosocial factors

1) **developmental factors** - patient who was abused /witnessed abuse as child is at increased risk of becoming abusive adult.
2) **environment**: crowding increases potential for violence; hot weather increases aggression (aggressive behavior diminishes in very hot weather).
3) **socioeconomic factors**: nonwhite populations experience higher rates of violence (as both victims and aggressors) – because of severe poverty and marital disruption, not race or economic inequality.

Certain diagnoses are more likely to be associated with violence:

1) **psychotic disorders** (mania, command hallucinations, paranoid schizophrenia, paranoid disorders)
2) **delirium, dementia**
3) **intermittent explosive disorder**
4) **PTSD** (esp. trauma victims who have also committed acts of violence, e.g. combat veterans)
5) **personality disorders**: borderline, antisocial, paranoid.
6) **adult attention deficit disorder**
7) **substance abuse**: alcohol decreases impulse control and impairs judgment (clear association between alcohol intoxication and violent behavior!); drugs with similar effect: amphetamines, cocaine, phencyclidine, sedative-hypnotics.
   Alcohol intoxication is most common cause of violent behavior in American culture!
8) **CNS disorders**: traumatic brain injuries (incl. birth injury), temporal lobe epilepsy (considered cause of violence, although violence during seizure is rare; whether violent behavior is increased between seizures is controversial), infection, degenerative processes, etc.

ASSESSMENT OF DANGEROUSNESS

Immediate assessment of dangerousness of patient's behavior is essential:

1) **patient behavior** - loud, agitated, angry, and threatening behavior.
2) patient who is brought in handcuffed or is otherwise **restrained** should be assessed cautiously despite **calm** / **withdrawn** behavior - patient may be calm as result of external control (withdrawing this control prematurely → escalation of agitated behavior).
3) **reports** of dangerousness **from family members and others** must be investigated.

- secure surroundings that provide safety and comfort for both evaluator and patient;
  - staff members should check for presence of **weapons** and confiscate any that are found before further evaluation takes place.
  - **physical setting** should be quiet, open, and sparsely furnished with minimum of objects that may be used as weapons; interviewer and patient should have unobstructed exit from room; call button to summon immediate help must be easily accessible to interviewer; have **immediate access to exit** from examining room.
  - both patient and examiner should **sit during interview**.
  - **trained assistants** (inside or just outside of interview room) who provide show of force and can subdue agitated patient should be readily available.
    N.B. do not examine patient alone!
  - **verbal and nonverbal expressions of expectation regarding patient self-control** and responsibility for her own behavior may be necessary; patient may need to be reminded that external control is also available.
  - **physical restraint** in form of two- or four-point leather restraints is indicated if patient cannot respond to verbal limit-setting and reassurance; clinician should recognize restrained patient's vulnerability and helplessness and treat her with respect and compassion; patient should not be restrained supine, but on side or with head elevated to prevent aspiration if vomiting occurs; patient in restraints requires constant monitoring.
- identification of crisis
  a. **overt crisis** is immediately apparent from patient's behavior or circumstances surrounding arrival in ED.
  b. **covert crisis** - patient is calm and superficially cooperative; following factors should raise index of suspicion:
  - history of alcoholism, violence, command hallucinations.
  - *vague, evasive, or qualified answers* to questions in crucial areas such as suicide, homicide, impulse control.
  - discrepancies between patient's history and reports of others.
- medical examination should pay particular attention to evidence of drug intoxication, withdrawal symptoms, and neurologic disease.
- laboratory studies - blood and urine tests for toxic agents may be particularly helpful in emergency situation.

Assessment for future violent behavior

- ***balance*** between individual's internal state (including degree of tension and control over expression of aggression) and environment; clinician must identify when patient is approaching loss of control and assaultiveness.
- extent to which current setting recreates previous situation that resulted in loss of control should be examined.
- *patient's perception of external danger* (real or imagined) and need for self-protection are important factors.
- **patient's thoughts and fantasies about violence** (e.g. sadistic fantasies or violent ruminations).

- risk factors:
  1. History of violent behavior (esp. before puberty) - most reliable predictor of future violence!
  2. History of impulsive or self-destructive behavior.
  3. Males 16-25 years of age.
  4. Recent major life change.
  5. Availability of and familiarity with weapons; exposure to violence through media and video games
  6. Participation in gangs.
  7. Current use of drugs and alcohol.
  8. Neglect or abuse in childhood (witnessed or experienced).
  9. Childhood history of cruelty to animals.
  10. Command hallucinations to hurt others.
  11. Escalating delusional perceptions of external danger
  12. Any evidence of confusion
  13. Organic mental disorder
- note throughout interview: fluctuation in patient's level of agitation, impulse control and judgment.
- *thoughts of patient's family and friends* concerning her potential for violence.
- assess whether potential victim behaves in *challenging or provocative way toward patient*.
- *interview with both patient and possible victim* - to observe behavior toward each other and to determine whether crisis is resolved.
- persistent **physician feelings** of fear or unease are important clues that further investigation is necessary.

COUNTERTRANSFERENCE REACTIONS TO VIOLENT PATIENTS

- angry, agitated, and threatening patient is likely to frighten physician → further response to patient:
  a) **no reaction**.
  b) physician may become **angry** and argue with patient; he may challenge and humiliate patient, escalating already dangerous situation.
  c) **counterphobic reaction** - physician may act as though he is in control of situation.
  d) **overly frightened reaction** - physician overestimates patient's violent potential and feels unnecessarily anxious and self-protective.
- intense, unacknowledged countertransference reactions can *interfere with clinical judgment and treatment* (overly concern with control, even punitive, releasing patient prematurely or permitting her to escape to avoid dealing with her) - potential victims may remain in considerable danger.

MANAGEMENT

Acute management:

1. **Seclusion** – decrease in noise and activity (may be enough to reduce agitation!).
   - it is important to act calmly!
   - speak softly in nonauthoritarian way.
2. **Drug therapy** IM or IV:
   a) **benzodiazepines** - act more quickly (within few minutes); may cause confusion or disinhibit violent behavior!!!; preferable over neuroleptics in cases of drug withdrawals;
      e.g. LORAZEPAM 0.5–4 mg q 0,5-1 h IM (deltoid) or IV prn
   b) **antipsychotics** (typically conventional antipsychotic, but 2nd-generation drug may also be used; lower seizure threshold – less desirable in certain situations [e.g. cocaine intoxication]);
      e.g. HALOPERIDOL (rapid onset of action; minimal serious side effects; can make phencyclidine intoxications worse) 2-10 mg IM (deltoid) or IV q 0,5-1 h prn (max. 100 mg/d)
      ZIPRASIDONE 10 mg q2h or 20 mg q4 h (max 40 mg/d).
   c) combination.
   d) **barbiturates** – last resort; useful in managing aggressive behavior in patients with seizures.
3. **Physical restraints** (last resort!) – to hold patient long enough to undergo complete assessment.
   - contraindications: extremely unstable physical and mental conditions; delirious or demented patients unable to tolerate environment of reduced stimulation; overtly suicidal patients who could use restraint as suicide device; convenience of staff.
   - one person should be positioned at each extremity and another at patient's head (i.e. at least 5-6 persons for one agitated patient).
   - applied under direction of licensed independent practitioner (LIP).
   - patients in restraints must be ***continuously observed by trained sitter***.
   - LIP must provide assessment within 1st hour of restraint placement; order for continued restraint may be written for up to 4 h at time; at 8 h, LIP must re-evaluate patient in person before continuing restraint order.
   - mask may be placed on spitting patient.
4. **Responsibility to warn and protect others** as result of *Tarasoff decision*.

For chronic treatment to reduce impulsiveness / aggressiveness → see "Intermittent Explosive Disorder (s. Episodic Dyscontrol Syndrome)" in Psy45 >>

BULLYING

- intentional infliction of psychologic / physical damage on less powerful children.

- **cyber-bullying** is newly described form in which bullies use e-mail and instant messaging to convey threats.
- bullies act in order to inflate their sense of self-worth (bullying creates feelings of power and control).
- victims are at risk for physical injury, poor self-esteem, anxiety, depression, and school absence.
  - victims often tell no one about being bullied due to feelings of helplessness, shame, and fear of retaliation.
- bullies are likely to be incarcerated; they are less likely to remain in school, be employed, or have stable relationships as adults.

FAMILY (DOMESTIC) VIOLENCE – SPOUSAL ABUSE

- *rate is increasing* (5%-20% families have abused member, and 25% murders occur among family members) - probably result of improved case detection and reporting.
- pervasive in all socioeconomic classes.
- frequently associated with **neglect**.
- mental / emotional abuse can be as harmful as overt physical abuse; it is also more difficult to detect and treat.
- most abusers ***do not have history of major psychiatric problems*** (incidence of concurrent psychiatric problems is estimated at 5-15% of abusive parents - essentially population norm).
- individuals who abuse family members often have ***history of recurrent abuse or deprivation as child*** - most abusers (80%) were abused;
  - only 1/3 individuals who were abused are seriously abusive or neglectful parents;

  - for others who do not become abusers crucial factor is presence of supportive person (e.g. parent, sibling, teacher) who helps them to realize that they did not deserve abuse.
- many abusers offer bland, or idealized, portrayals of their parents, often with major discrepancies between their global appraisal and details they report.

  e.g. She was perfect mother. Well, there was time I fell and broke my wrist, but didn't tell Mom or Dad for over week because I knew they would get mad at me.
- because situation may be chronic, with certain equilibrium, both partners may resist intervention.
- tendency to abuse family is exacerbated by following factors:
  1) severe social / economic stress.
  2) poor social support systems.
  3) stressful interactions with abused person.

     e.g. 25% premature infants (vs. 8% full-term infants) are abused; premature infants are more difficult and demanding - create more stress for their parents.
  4) problems with drug and alcohol abuse (many violent acts are committed while aggressor is intoxicated!).
- assess homicidal potential of both partners (victim and abuser);
  - any question about lethality of situation or psychopathology of partners → **psychiatric consultation**.
  - high risk of lethality or future injury → battered partner should not return home; options:
    a) staying with friends or family
    b) referral to safe house
    c) hospitalization.
  - treatment should always be offered to abusing spouse.
  - **child welfare agency** should be notified.

BIBLIOGRAPHY for ch. "Psychiatry" → follow this LINK >>