# Characteristics of assaultive psychiatric inpatients: Updated review of findings, 1995-2000

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## Abstract

*The present paper reviewed the studies of the characteristics of assaultive psychiatric inpatients from 1994 to the present. These studies partially confirmed earlier findings that assaultive patients are older persons with a diagnosis of active psychosis or other neurological abnormality and histories of violence toward others and substance-use disorder. However, the recent studies also document the profile of a second group of assaultive patients: younger females with personality disorders and histories of violence toward others, substance-use disorder, and personal victimization. Since there is a paucity of published empirical research on Alzheimer's and dementia patients for this topic, the implications from the present findings for long-term care and clinical intervention are examined.*

*Key words: assault, dementia patients, inpatient settings, long-term care, personality disorder, psychiatric patients, psychosis*

## Introduction

Psychiatric patient assaults on staff have been a serious issue in psychiatric inpatient settings and have resulted in medical injury, medical and legal expense, and lost productivity. In the early 1990s, three papers[1-3] reviewed the empirical findings concerning the characteristics of these assaultive inpatients. The papers suggested that male patients with a diagnosis of psychosis with actively impaired thinking or other neurological abnormality and histories of violence toward others and substance-use disorders were the more likely to present an increased risk for assaultive behavior.[3]

During the past decade, there have been fundamental changes in the national health care system including downsizing, privatization, the emergence of community-based services, and the implementation of various managed care initiatives. During this period, there has also been a sharp decline in the total number of psychiatric inpatients in state facilities. These changes have raised several important questions about inpatient assaults in this new era. Has the level of violence in these facilities declined? Has the nature of these assaults become more or less severe? Have the characteristics of those who may remain assaultive changed in fundamental ways? In the absence of a more recent review of the literature, these questions and any possible overall trends in the literature have remained unexamined.

The purpose of this paper is to review the published empirical findings on the characteristics of assaultive psychiatric inpatients since 1994, the date of the last detailed review on this topic. Since there is a paucity of published empirical research on Alzheimer's and dementia patients for this topic, practitioners will need to rely on the available data based on the long-term care setting.

## Review of empirical findings

Table 1 presents a summary of the major, peer-reviewed, data-based studies of the characteristics of assaultive psychiatric inpatients that have been published in journals since 1994.[4-11] Empty cells in the table indicate that no data were reported for that variable in a given study.

While many of the studies have methodological weaknesses, such as differing definitions of violence and the problem of under-reporting,[3] the bulk of the evidence available from these studies[4-11] suggest that in state hospitals older (mean age = 40 years), male (54 percent) and female (46 percent) inpatients with diagnoses of psychosis, organic brain syndrome, and personality disorder and histories of violence toward others and substance-use disorder continue to present increased risk for assault.

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**Table 1. Characteristics of assaultive psychiatric inpatients**

| Study | N | Total assaults | Setting | Age | Gender | | Diagnosis | Past violence | Substance abuse | Personal victimization | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | M | F | | | | | |
| Tam, Engelsmann & Fugere (1996)[4] | 39 | 123 | General hospital | 42.5 | | | Organic brain syndrome, Schizophrenia | | | | 15 repeat offenders for 100 assaults (75%) |
| Rasmussen & Levander (1996)[5] | 52 | 1,945 | Forensic hospital | 29.2 | | | Schizophrenia, BPD | | | | |
| Flannery, Hanson, Penk, *et al.* (1997)[6] | 327 | 327 | State hospital | 40 - 49 (38%) | 182 (56%) | 145 (44%) | Schizophrenia (85%), Affective disorder (10%) | | | | Involuntary (91%) |
| Swett & Mills (1997)[7] | 335 | 47 | State hospital | 37.1 | 207 (61%) | 128 (39%) | Post-traumatic stress disorder (27%), Bipolar disorder (16%), Schizophrenia (11%), BPD (81%) | | 47 (14%) | 11 (3%) | |
| Lamb (1997)[8] | 101 | 44 | Locked, state community facility | 38 | 59 (58%) | 42 (42%) | Schizophrenia (67%), Schizoaffective (26%), Bipolar disorder (16%) | 77 (76%) | 71 (70%) | | Involuntary (89%), Poor medication compliance (96%) |
| Owen, Tarentello, Jones, *et al.* (1998)[9] | 174 | 752 | State hospitals (5) | 60.6 | | | Organic brain syndrome | 174 (100%) | | | Involuntary (50%) |
| Flannery, Irvin & Penk (1999)[10] | 125 | 125 | State hospital | 31 | 48 (42%) | 72 (58%) | Psychosis (61%), BPD (88%) | 110 (88%) | 53 (44%) | 78 (63%) | Involuntary (90%) |
| Flannery, Schuler, Farley, *et al.* (2001)[11] | 707 | 707 | State hospitals (6) | 38 | 412 (53%) | 365 (47%) | Schizophrenia (53%), Affective disorder (9%), BPD ( 12%) | 402 (87%) | 214 (46%) | 271 (59%) | |

Embedded within the findings of some of the later studies[7,10-11] has been the emergence of a more recent type of assaultive inpatient, that of the younger, female, personality-disordered inpatient who also has a history of violence toward others, substance-use disorder, and personal victimization. The most common form of diagnosed personality disorder in these studies was borderline personality disorder (BPD).

These studies also suggest other variables of importance, including some patients who are repetitively assaultive,[9] some who are medication noncompliant,[8] and many whose level of impaired functioning has resulted in involuntary admission.[3,8-10]

## Discussion

This review of the most recent studies[4-11] on the characteristics of assaultive inpatients is consistent with earlier reviews of the literature.[1-3] Assaults on inpatient staff continue, even after major changes in the health care delivery system. The recent studies have not addressed the issues of frequency or severity of assault in any systematic way and the answers to these questions remain unknown in the era of the new health care system.

The studies noted here[4-11] are also partially consistent with earlier findings about the characteristics of the assailants. Similar to the earlier studies,[1-3] the recent research documents the presence of assaultive patients with diagnoses of psychotic illness or neurologic abnormality and histories of violence toward others and substance-use disorder. A newer finding in these studies is the apparent evidence that many of these assailants may now also be female. The present studies further suggest a second potential type of assaultive patients, that of younger females with a diagnosis of personality disorder and histories of violence toward others, substance-use disorder, and personal victimization.

Of particular note is that many of these younger, personality-disordered female patients are diagnosed with BPD. In the past, patients with this diagnosis have been considered primarily a danger to themselves in the form of delicate self-cutting and the like. The recent findings[7,10-11] suggest that these patients are increasingly likely to assault others. It may be that they become assaultive when denied services,[3] perceive a shortage of resources,[12] or are returned to the general ward after having been the focus of specialized treatment approaches for BPD. In some cases the newer violence-toward-others strategies by these patients appear to serve the same need for attention.

There have now been three decades of research on assaultive psychiatric inpatients and future studies will need to address continuing methodological issues. Studies need to find an operational definition of the term "assault." Severity of assault should also be assessed and the ongoing problem of under-reporting needs to be reviewed in each study. In addition, there is a consistent body of evidence about the common characteristics of assaultive inpatients (*e.g.*, history of violence toward others, substance abuse, and personal history of victimization).[1-11] The inclusion of these variables in standardized format in future research would enhance the generalizability of findings from one setting to another. A concerted effort should be made to assess those assaultive patients in Alzheimer's centers and skilled nursing home facilities.

## Implications for long-term care settings

In the meantime, the present review documents a continuing probability of patient assaults on inpatient units and suggests the need for long-term care facilities to develop or monitor reasonable risk-management strategies to ensure staff safety.[13] Long-term care facilities may want to include standard assessments for violence potential, treatment plans with attention to possibly necessary additional medications, and training of staff in nonviolent self-defense strategies and alternatives to restraint and seclusion.[13-16] While staff may be additionally alerted to the profiles of high-risk patients, facilities should also dispel the myth that there are necessarily early warning signs of impending loss of control.[4]

Facilities may also wish to consider reviewing incident reports and developing more detailed reports with more information about the assaultive patients that are seen on their services. A detailed record of these incidents over time may reveal the presence of a repetitively violent subgroup of patients that require more structured treatment plans or the emergence of a new group of assaultive patients as the recent studies have done in documenting patients with BPD. Many states across the country are now placing their forensic patients in general ward environments and the next series of research studies may reflect these forensic patients to be a third high-risk group. Detailed facility incident reports may detect this issue before the formal studies are completed and thereby help to ensure sound risk-management strategies.

Simple interventions early in the provision of care can contribute to enhanced safety within the facility and improved quality of service delivery by a staff that is less anxious about ward safety.

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The new and noteworthy titles listed below have recently crossed the Managing Editor's desk. We hope to publish reviews for many of these works in upcoming issues. In the meantime, if any of these titles pique your interest, consult your bookseller or librarian for more information.

*Alzheimer's Disease and Related Disorders Annual* edited by Serge Gauthier, MD, and Jeffrey Cummings, MD (London: Martin Dunitz Publishers, 2000).

*Assessing Quality of Life in Alzheimer's Disease* edited by Steven M. Albert, PhD, MSc, and Rebecca G. Logsdon, PhD (New York: Springer, 2000).

*Can Do Activities for Adults with Alzheimer's Disease: Strength-Based Communication and Programming* by Eileen Eisner, CCC, SLP (Austin, TX: Pro-Ed, Inc., 2001).

*Comforting the Confused: Strategies for Managing Dementia*, 3rd Ed., by Stephanie B. Hoffman, PhD, and Constance A. Platt, MA (New York: Springer, 2000).

*Handbook on Dementia Caregiving: Evidence-Based Interventions for Family Caregivers* edited by Richard Schultz, PhD (New York: Springer, 2000).

*Interventions in Dementia Care: Toward Improving Quality of Life* edited by M. Powell Lawton, PhD, and Robert L. Rubinstein, PhD (New York: Springer, 2000).

*The Loss of Self: A Family Resource for the Care of Alzheimer's Disease and Related Dementias* by Donna Cohen, PhD, and Carl Eisdorfer, PhD, MD (New York: W. W. Norton and Company, 2001).

*Management of Challenging Behaviors in Dementia* by Ellen K. Mahoney, DNS, RN, Ladislav Volicer, MD, PhD, and Ann C. Hurley, RN, DNS (Baltimore: Health Professions Press, 2000).

*The Merck Manual of Geriatrics*, 3rd Ed., edited by Mark H. Beers, MD, and Robert Berkow, MD (Rahway, NJ: Merck Publishing Group, 2000).

*Moving a Relative with Memory Loss: A Family Caregiver's Guide* by Laurie White and Beth Spencer (Santa Rosa, CA: Whisp Publications, 2001)