ASSESSMENT AND MANAGEMENT OF THE VIOLENT PATIENT

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This article provides guidance on how to manage the unavoidable challenge of aggression in psychiatric relationships. Accordingly, this article addresses issues of personal safety and how to manage potentially violent patients, defuse situations that threaten imminent violence, and manage emergent violence. In addition, a useful chart is highlighted that differentiates different types of violence. (*J Natl Med Assoc.* 2000;92:247–253.)

Key words: violence ♦ aggression ♦ violent patients

Eventually, issues of aggression are introduced into all relationships. The relationship between psychiatrist and patient is no different. Accordingly, a crucial aspect of psychiatric training is how to manage of aggression and how to assess and manage the violent patient. The purpose of this paper is to highlight some paradigmatic principles that can be used as guidelines for psychiatrists who are confronted by violent patients. This article dicusses issues of personal safety, management of three levels of violence, and how to respond to different types of violence.

PERSONAL SAFETY

When confronted with an aggressive, potentially violent patient, personal safety should always be a prime concern. Unfortunately, because of practitioner experiences and attitudes, this concern may not be manifest. Practitioner experiences and attitudes may also be a strength in appropriately assessing and treating the aggressive, potentially violent individual. Proper supervision and training can correct for experiential and attitudinal hindrances in practitioners that make them less effective and efficient in managing violent patients. Additionally, supervision can build upon assets in staff to make them more competent and capable for handling violent individuals.

Psychiatrists must have appropriate attitudes regarding violence and follow some basic principles to maintain personal safety. Consequently, it is important to discuss the psychiatrist's mission as it relates to being victimized by violence. Although the physician's mission may be to save lives, lessen suffering, and do no harm, to fulfill this mission the physician must be safe from harm. Thus, effective leaders should tell practitioners that they have a right to self-defense when threatened with bodily harm. Such leadership emphasizes the staff member's right to personal safety and places the issue in consciousness. In addition, it removes some potential immobilizing ambivalence or confusion about how to proceed if attacked. In keeping with the right to self-defense to safeguard personal safety when attacked, the "next level higher" violence intervention principle should be followed. This precept is embodied by the old martial arts saying "If you break my skin, I will break your bones; if you break my

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Table 1. Hierarchy of Aggression

1. Lowest level of aggression	1. Alertness, initiative, curiosity, motivation, attentiveness, and exploratory behavior
2. Self-assertion	2. The attempt to establish, maintain, and expand one's boundaries and integrity while not intruding into territory of others.
3. Dominance	3. The capacity to exert an influence on the behavior of other people or groups in an intended direction (also known as power). The foundation of dominance tends to be grounded in coercion—i.e., the expectation of great rewards or great punishments for certain kinds of behavior.
a. Authority	a. Dominance, which is legitimized by legal, professional, or social mores.
I. Legitimate	i. Conferred by virtue of a law or formal designation.
II. Charismatic	ii. Bestowed by virtue of having "winning ways with people."
III. Traditional	iii. Granted out of respect for elders.
4. Hostility	4. Behavior or attitudes intended to hurt or destroy an object or the self.
a. Violence	a. Subcategory of hostility that occurs when there is the use of force to physically injure.
5. Hatred	5. Occurs when the injury or destruction of an object, self, or situation is the end rather than the means to an end.

bones, I will take your life." Thus, practitioners should always be prepared for how to manage an actual attack by a patient. This does not mean maintaining a hypervigilant, cautious, paranoid attitude, but it does suggest maintaining a healthy fear of being harmed.

Regarding managing nonviolent, aggressive patients, the "least aggressive" intervention principle should be followed. According to this principle, as long as the psychiatrist isn't actually being injured, they should use the least aggressive intervention possible in managing an individual's aggression. It is important to understand that violence is aggressive but that not all aggression is violent and thus requires a different management approach. Table 1 further defines the hierarchy of aggression.[1]

The least form of aggression includes alertness, initiative, curiosity, motivation, attentiveness, and exploratory behavior. Following this level of aggression comes self-assertion, i.e., the attempt to establish, maintain, and expand one's boundaries and integrity while not intruding into another person's territory. Next in the hierarchy is dominance, which is the capacity to exert an influence on the behavior of other people or groups in an intended direction (also known as power). The foundation of dominance is grounded in coercion—the expectation of great rewards or great punishments for certain kinds of behavior. Dominance legitimized by legal, professional, or social mores is known as authority.[2] Legitimate authority is conferred by virtue of a law or formal designation, charismatic authority is bestowed by virtue of having "winning ways with people," and traditional authority is granted out of respect for elders. Hostility is manifested by behavior or attitudes with the intent of hurting or destroying an object or the self. Hostility may arise from the need to obtain a goal (e.g., bullying the doctor to get drugs) or the need to hurt or destroy anything that frustrates goal-directed activities such as self-assertion, exploration, or dominance. Hostility may come from the need to protect oneself from a threat or actual trauma. Violence occurs when there is the use of force to physically injure. Hatred occurs when the injury or destruction of an object, self, or situation is the end rather than a means to an end. Having some understanding of this hierarchy helps to structure the psychiatrist's response to the various levels of aggression.

To appropriately judge various levels of aggression, experiences that might influence a practitioner's judgment should be explored and addressed. Thus, experiences with trauma and violence must be explored and addressed. In addition, practitioner attitudes and effects should be explored because they affect patients' responses to psychiatrists. Such attitudes and effects can be described as:

- fearful/submissive/overpermissive,
- brave/overconfident,
- overaggressive/overcontrolling/strict,
- counterphobic,
- detached/avoidant,
- concerned,
- showing active friendliness—being gregarious,

- showing passive friendliness—being helpful but not intrusive,
- having a matter-of-fact attitude.

THREE LEVELS OF VIOLENCE

Assessing the cause of the violence is important information that is useful for managing the violent patient. However, this aspect of violence management is facilitated or hindered by the availability of time. Clearly, the actual moment of being choked is not the time to gather data about why you are being choked—you need to respond physically. Thus, the amount of time available to respond to violence is more important than assessing the cause of violence as the amount of time decides the response to violence. Therefore, consideration of time is the main principle for managing violence. By using time to conceptualize types of violence, violence can be categorized as being either potential, urgent, or emergent.[3]

Potentially Violent Patients

Although all patients are potentially violent, patients with a history of violence should be considered a greater risk for being violent again. Thus, potentially violent patients are individuals who have a history of violence but who are not currently threatening to become violent. In this situation there is a lot of time to plan how to respond to the patient's violence should and when it does become manifest.

Identifying potentially violent individuals is done by obtaining a thorough history of their violence.[4,5] Such patients can also be identified by doing background checks, e.g., examining police records for occurrences of assault. Such investigations reveal that some patients are repetitively violent, whereas others have isolated incidents of violence. An important aspect of gathering a history of violence is determining the triggers that set the violence off. By knowing what provokes a patient, it is much easier to avoid provoking them. Research on violent patients reveals that patients with a history of psychosis, who have isolated incidents of violence, have their episode of violence while in the throes of an acute decompensation.[6] Alternatively, patients with a history of psychosis, who have persistent episodes of violence, are patients who also have neurological impairment.[7] Fortunately, the standard of violence prediction is not as stringent in the real-life setting as it is in the forensic setting. As a result, the clinician can maintain a high index of caution when treating patients with certain diagnoses or problems. Menninger[8] has outlined the mental illnesses that are characterized by aggression by noting where potential violence by a patient is required for the diagnosis, where potential violence is essential for the diagnosis, and where potential violence is associated with the diagnosis, but not invariably present. Various studies have shown that individuals with certain mental disorders are more likely to be violent than others. These are patients who are:

- withdrawing from drugs or alcohol;
- suffering with chronic organic brain damage who may have impulse control problems;
- suffering from acute organic brain syndromes resulting in deliriousness;
- acutely ill (e.g., those with paranoia who feel threatened, those with mania who are agitated, and those with depression who are explosive); and
- exhibiting borderline, antisocial, or paranoid personality disorders.[4,5]

A history of violence remains the most reliable predictor of future violence.[9] However, new research based on actuarial data may provide tools by which to predict potentially violent patients.[10,11]

Clinicians should use the time available from the lack of an immediate threat to develop strategies to prevent violence from occurring and deciding what to do should violence become imminent or occur. Using medications to control target symptoms of violent behavior is a useful proactive strategy.[13,14] Accordingly, antipsychotic medications, which stop command hallucinations that urge the patient to be violent, are useful. Another useful strategy is administration of antimanic medications that reduce the patient's irritability and temper outbursts. There is also some evidence that selective serotonin reuptake inhibitors may be useful in treating aggression in patients with borderline personality disorders.[12] Furthermore, beta-adrenergic receptor blockers have been effective in reducing anger and aggression in a wide range of neuropsychiatric disorders.[13,14]

Structuring the milieu to create an environment that is proactive in preventing violence is another effective approach.[15] There should be a sense that there is a "protective shield" against violence in the milieu.[16] For example, this sense can be established

by having patients walk through a metal detector portal or searched before they are examined in an emergency room setting.[2] The presence of visible restraint cots in psychiatric emergency settings sends the message that the control of out-of-control behavior is possible and, therefore, violent behavior is not tolerated. In addition, a security presence should be visible when entering a clinic setting. The degree of protective shield is determined by the setting and previous levels of violence based on an analysis of incident reports.

The physical structure of the milieu can also be a great deterrent against violence. Having windows in the doors of examining rooms allows a degree of privacy but also lends a sense of the possibility of being monitored for unacceptable behavior. Security cameras also provide a sense that behavior is being monitored. Preventing areas of relative seclusion from being used for examination purposes can also decrease the use of unmonitored areas. Such use may give tacit approval for unacceptable behavior. Panic buttons in examining rooms provides for access to help in emergencies. Posting rules and regulations in clinical settings (e.g., a sign that requests the absence of violence in the area) may discourage patients from being violent. Similarly, advertising staff's response to violence in clinics (e.g., the fact that staff will prosecute violent patients) may also deter violence. Finally, removal of potential weapons from the milieu is also a preventive strategy for managing potentially violent patients, e.g., it is not a good idea to leave scissors in a pencil cup near an agitated patient.

The emotional/attitudinal milieu of a work environment also acts to prevent violence. Milieus that are characterized by good team work/interdependence present unified fronts against the likelihood of violence. Furthermore, management styles that encourage the establishment and maintenance of good relationships will encourage staff to continue these practices toward patients, and such practices encourage "connectedness," which has been shown to discourage various violent behaviors.[17] Good relationships allow for sensitivity to patients' psychological injuries—frequently at the root of violent behavior. Such relationships also help staff in "talking a patient down" from an agitated, escalating state. In addition, such relationships assist in maintaining respect for patient boundaries—the transgression of which may trigger a violent attack.

Standard operating procedures on how to manage various levels of aggression and violence are also an integral component for addressing the potentially violent patient. Such procedures should detail how to manage urgent violence, manage emergent violence, gain access to emergency medical treatment, make a police report and press charges, file incident reports, and debrief staff involved with violent incidents. Also, a contingency planning committee should be convened to develop a manual for how to manage incidents, crises, emergencies, and disasters.

Situations That Are Urgent

Situations are urgent when an individual is escalating and about to commit violence but has not yet acted. In this situation there is a limited amount of time to intervene. Such situations should be easy to identify. Individuals will manifest behavior by clenching their fists or jaws; pacing and showing impatient behavior (e.g., repeatedly bugging the doctor about when they will be seen); sitting on the edge of their chair and clutching their arm rests of their chairs; slamming doors or banging their fists on the wall; hitting the palm of their hands with their fists; and being very jumpy and easy to startle. Individuals will talk loudly and forcefully and may use profanity while verbally threatening staff members.

Observation of this type of behavior calls for an immediate verbal intervention designed to calm the patient down and de-escalate the situation from urgent to potential. A "calming interview" based on principles of conflict resolution is very helpful in these situations.[18] The individual with escalating behavior is approached with both hands in plain view respectfully. Next, the patient is asked "Excuse me, may I talk to you for a minute?" followed by a formal introduction while maintaining a safe distance from the patient.[19] Depending on the situation, a strong, firm handshake with the introduction is suggested. It is a friendly way to show the individual that you are a serious person to be reckoned with. The interviewer's voice should be calm and firm while speaking slowly and clearly. The interviewer should mention that they noticed that the individual seemed visibly upset and asked what the problem is. The individual is then encouraged to ventilate and clarify the nature of the problem that is causing their dysphoria. Next, the interviewer should ask what can they or other staff members do to help

with the resolution of the problem. Frequently, this maneuver catches the individual off guard. In addition, it illustrates that the interviewer is not looking for a confrontation, but is willing to work cooperatively to alleviate the individual's frustration. Usually, by this phase of the intervention, the danger has passed and negotiations are beginning. The goal of negotiating is to try to establish a win/win scenario. If the individual asks for something reasonable then the conflict is solved by complying. If the individual asks for something unreasonable, then the interviewer might comment on the extreme difficulty of granting that request and make an alternate suggestion. It is important be a "real person" with the individual and try to prevent the individual from having a "loss of face." The interviewer should encourage other vegetative responses that are not complimentary with rage:

1. Humor.
2. Eating—offering some gum or something to drink or eat (it is strongly advised not to offer hot scalding coffee or cans of beverage, which can be used as projectiles to injure or cause scalding).
3. Having a seat and relaxing (we used to be able to offer a cigarette, but with rules prohibiting smoking, this option is no longer available).
4. Offering a quiet space (frequently relatives or onlookers may be instigating violence and the individual should be separated from their noxious influences, but don't take the individual back in a corner in the dark by yourself where help to prevent your being assaulted is unavailable).
5. Compliment cooperativeness.

Emergent Violence

This situation occurs when violence is actually occurring. There is no time to plan and the intervention has to be physical in nature. The overtly violent individual, now in the action of carrying out an assault, may do so because you didn't recognize their urgent levels of violence and effectively talk them down. If you are attacked and the assailant does not have a weapon, the best strategy is to clinch the individual the same way boxers do when they get into trouble in the ring. Just hold on as tight and close as possible and let the individual tire themselves out (watch out for biting). This is also a good strategy even if the individual is using a striking weapon such as a club or a chair. It takes a great deal of martial arts training to be able to hurt another person when they are hugging you and making you carry their body weight.

Once a physical attack has been spent, it is a good idea to put the patient in restraints or to restrain the patient. Ideally there should be five people helping to restrain a patient. However, in the event there are not enough people, self-defense strategies and joint immobilization techniques may be necessary. The bigger the area where restraining occurs the better. Akido training is probably the best martial art to study to become an expert in restraining patients.[20,21]

Once violence has occurred and the crisis is over; staff members need to do an "autopsy" to understand what happened, to debrief to reduce the tension of those involved, and to plan on how to better respond more effectively if possible. Critical Incident Debriefing is a standardized, easily learned technique that can be used to help staff members recover from workplace violence. Incident reports need to be filled out and reviewed regularly to detect any weaknesses in the system of management of violent individuals.

RESPONDING TO DIFFERENT TYPES OF VIOLENCE

Staff members need to have a clear understanding of the various types of violence, otherwise they will make the error of treating all violence the same way. For example, not everyone who is violent should be incarcerated; some need to be counseled. Table 2 lists various types of violence, all of which require different interventions.

TIPS AND PRINCIPLES FOR MANAGING VIOLENT PATIENTS

One key principle to remember when dealing with an angry, potentially violent patient is "behind all anger is hurt." Accordingly, directly addressing the patient's sense of being damaged or hurt in some way soothes the patient's ire. Problems occur when practitioners respond to the anger when confronted with angry behavior, rather than responding to the hurt underneath the anger. For example, when confronted with interviewing an angry patient in the emergency room, many practitioners will try to ignore the patients' wrath by doing a standard,

Table 2. Conceptual Model of Violence*

Definition: multifaceted, multi-etiologically based phenomenon
Directed toward; self, suicide; others, homicide
Outcome: lethal or nonlethal

Collective violence	Individual violence	Drug-related violence
Mob	Multicide (>1 person)	Systemic (illicit drug dealer kills drug dealer; gangs kill for terrirory)
	Mass murder (three or more)	
Collective, systematized violence (war, gangs)	Serial murder (three or more persons killed over a period of time)	Economic (addict robs to get drug money)
Hate crime violence (terrorism)	Spree murder	Pharmacologic (acute organic brain syndromes secondary to drugs)
	Predatory violence (robbery)	Negligence (drunk driver)
	Interpersonal altercation vilolence	
	Other violence	
	Mentally ill	
	Organically brain damage	

Concepts as defined by Baker and Bell.[22]

formal interview. Or the practitioner may ask the patient to calm down and compose themselves. However, if that same practitioner was asked to interview a patient who was crying, invariably they would ask the patient what was upsetting them or what was wrong. In both situations, the practitioner needs to ask the patient what is bothering them and make efforts to try to soothe the patient's state of mind. It is also important to have a good sense of boundaries and know how not avoid threatening another person's personal space. This lack of respect is often threatening and hurtful to patients and causes them to become angry.

In managing violence it is important to develop a system not an individual. An integral part of developing a system is ensuring that everyone involved practice repeatedly and run drills on managing emergent violence. Revisiting the issue of violence with staff members on a quarterly basis is another way of developing the system.

The decision to set limits should not be punitive in nature but should be presented as a measure of concern. In addition, when setting limits give "forced choices," e.g., "I feel you are out of control, and I want you to calm down; you can go into the quiet room or have some medication in liquid form or take a shot. Which do you want to do?" When conflicts do arise with an individual use "I" messages: "I get concerned when you are yelling and shouting at me, because I feel that you might try to hurt me." rather than "You are scaring me." Communication skills are critical in this process, so always tell the individual clearly and understandably what you are doing and why.

CONCLUSION

Being hurt on the job is not a part of a typical psychiatrist's job description. To avoid patient violence at work, psychiatrists need to be very clear about issues of personal safety and how to manage various levels and types of aggression and violence.

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