VIOLENT BEHAVIOUR IN PSYCHIATRIC INPATIENTS

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ABSTRACT

A study of violent behaviour among psychiatric inpatients in a large general hospital is presented. Over the study period of one year a total of 36 incidents of violence involving 26 patients were recorded. Schizophrenia was the most common diagnosis among assailants. Fellow patients were the main victims. Incidence of serious violence was low. Most incidents occurred in the night hours, from inmates of acute wards and mostly without any provocation.

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KEY WORDS : Violent behaviour; Psychiatric patients

Introduction

Violence is a behaviour motivated by the wish to injure, remove or destroy a threatening object. Though violence is at times wrongly equated to psychiatric illness, it is a rare occurrence in psychiatric patients. What makes violence unique in psychiatric practice is its unprovoked nature and lack of motive. Hence any one in the surrounding can be the victim of it or else it may be directed at self or property. Systematic study of violence in the psychiatric patients can be said to have begun with the work of Fottrell [1,2]. Subsequently several workers largely confirmed the findings of Fottrell [3,5]. Studies conducted in general hospitals, on patients of surgical and medical wards have brought out that majority of patients showing violence were alcohol or drug abusers [6]. With the concept of general hospital psychiatric units (GHPU) coming in-to vogue, studies of violence occurring in a GHPU setup became a necessity. This prospective study was undertaken to study the setting in which the violence occurs and the factors contributing to it.

Material and Methods

The study was carried out at a large Armed Forces hospital with bed strength of over 1000. There is a sixty bedded psychiatric unit

in the hospital typical of any GHPU. For administrative reasons only male psychiatric patients are hospitalised in the psychiatric unit. The psychiatric unit has three separate wards of keeping acute, subacute and chronic patients. The study was carried out over a 12 months period from 01 Jul 92 to 30 Jun 93. The average daily bed occupancy during the study period was 56.47.

Criterion for calling an act of violence was the assaultive, intrusive or attacking behaviour directed against self, others or property [7]. Aggressive behaviour comprising of abusiveness and use of threatening language was not considered a violent act. If two patients behaved violently towards each other then two incidents were recorded. The degree of violence was classified in to three grades, directly in relation to the seriousness of the injury inflicted on the victim [1].

Grade I : An assault not resulting in any detectable injury. Grade II : An assault resulting in minor physical injuries such as bruising, abrasions or small lacerations. Grade III : An assault resulting in major physical injuries including large lacerations, fractures, loss of consciousness or any assault requiring subsequent investigations or treatments, or when a permanent physical disability or death resulted on account of violence.

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Psychiatric nursing assistant's report book had been the basis of recording violence wherein he reports on physical and mental condition of the patients under his charge and any unusual incident. Depending on the severity of violence, he is also required to call for the help of the psychiatrist if needed. Details of incident were noted. Medical documents of the concerned patient, specifically the clinical examination findings and treatment were reviewed. As such it was ensured that no incident of violence went unreported during the period of the study.

Results

During the entire period of the study 36 incidents of violence involving 26 patients were reported. Of these 10 were involved in two incidents each and the rest a single episode each. Age, marital status, educational status and diagnosis of the patients are shown in the Table 1. Twentyeight (78%) of the incidents were of grade I severity, 6(17%) of grade II and only 2 (5%) were of grade III severity.

In 16 of the incidents, fellow patients were the victims while in 8 violence was directed at self. One of the patients attacked his father who had come to meet him and another, a guard looking after him. The nursing staff were the victims in 12 incidents but analysis of individual incidents showed that only in 2 such incidents nursing staff were directly attacked; in the remaining 10, staff became secondarily involved due to intervention.

Length of military service had no relationship to violence. Fourteen of the 26 patients involved in violence were married, however none of them had been living with family in their duty station prior to the admission to hospital. Majority of cases (24 of the 26) were under treatment for psychotic illnesses (Table 1). Evaluation of the mental status of the patients following the acts of violence seen in the light of symptoms prior to the violent incident showed that the violent behaviour was related not only to the symptomatology and type of the psychiatric illness, but also to the personality make up of the patients. All

TABLE 1
Characteristics of the violent patients

Characteristics	No.	Percentage
<i>Age (in years)</i>		
< 25	8	31
25-35	12	46
> 35	6	23
<i>Marital status</i>		
Married	14	54
Single	12	46
<i>Education</i>		
< 5 std	2	8
6-10 std	14	54
> 10 std	10	38
<i>Diagnosis</i>		
Schizophrenia	10	38
Mania	6	23
Organic psychosis	4	15
Major depression	2	8
Alcohol dependence syndrome	2	8
Other nonorganic psychosis	2	8

the 10 schizophrenics whether they were of first breakdown or relapse had active psychotic features in the form of hallucinations and persecutory delusions. The circumstances at the time of act and the targets of violence showed that the victims were suspected to be either persecutors or their collaborators. In patients of organic psychosis too the violent act appeared to be determined by the active symptoms of psychosis. In the six manic patients, five were suffering from grandiose delusions and resented continued hospitalization. They were irritable and turned violent when the staff enforced better compliance to regulations of the psychiatry ward. Both patients of alcohol dependence syndrome turned violent on refusal of out-pass. It appeared that the violent acts were more determined by their premorbid personality traits as they had shown clear evidence of aggression as predominant trait in their personality. In 33% of the cases there was no provocation for violence and it was not possible to correlate the symptomatology or premorbid personality with the acts of violence.

On an average 3 incidents occurred per month, maximum being 7 incidents in the month of October 92. All the 36 incidents occurred in the acute ward of the psychiatric unit. In 12 out of 36 incidents there was no

provocation. In the remaining the provocation was of minor nature like refusal of permission to leave the ward, refusal by fellow patient to offer a cigarette or instructions by the nursing staff to obey certain rules and regulations of the ward. Of the 36 incidents of violence 28 (78%) were of grade I severity, 6 (17%) were of grade II and 2 (5%) were of grade III. Of those with grade II severity, 4 patients were of schizophrenia and one each were of mania and other nonorganic psychosis. The grade III violence occurred in a patient of major depression who started hitting his head to the wall all of a sudden without provocation. The second patient with violence of such severity was an alcohol dependent who at about 1500 hours suddenly snatched a garden implement kept in the occupational therapy store and injured himself producing multiple lacerations. The injuries were nonlethal and patient's behaviour was clearly demonstrative as the patient had no significant depression and had been insisting on an early discharge from hospital. No clear correlation could be established with the sociocultural background of the patients. Twenty two of the 36 incidents occurred in the night hours between 2000 hours and 0500 hours as compared to only 14 incidents in the day hours between 0500 hours to 2000 hours. Among the latter group 4 occurred between 1700 hours and 2000 hours.

In 16 of the incidents (44%) the violent patient could be talked down without the need of a physical or chemical restraint. Four (11%) patients had to be given physical restraint for less than an hour but no additional drug other than the treatment already being administered. In 6 incidents (16%), patient needed parenteral antipsychotic drug but not physical restraint. In 10 (28%) where the violence was of severe degree, patients required both a physical restraint and chemical restraint in the form of a parenteral antipsychotic drug. In most cases in less than half an hour of the injection the physical restraint could be removed. Inj. haloperidol in a dose of 5-10 mg intramuscularly was used in 60% of such cases and in the remaining 40%, all

of whom were young adults Inj. chlorpromazine was employed in a dose of 50 mg by the same route. Due precaution like recording of blood pressure before and after parenteral chlorpromazine was taken but none had any serious hypotension. No case required repetition of the parenteral antipsychotic and all could be switched back to previolence dosage of oral medication.

Discussion

In the present study, 55% of the patients were aged less than 35 years and this was in agreement with findings of Sharma [8], who in his study of violent incidents in a large mental hospital in Eastern India reported that maximum incidents occurred among those in the age group of 20 to 40 years and males outnumbered females in behaving violently. Hodgkinson *et al* [9] too found that violence commonly occurred among those below 30 years of age and similar had been the findings of Fottrell [1] and Pearson *et al* [5]. Only Tanke and Yesavage [10] did not find any direct relationship between age and aggression. This is probably because in younger age group patients illness has more acute and active symptoms and violence is part of that, where as in later age due to chronicity more of the residual symptoms come to the fore and violence is less common in them. We have no comparison to make with the sex difference and violence as our subjects were all males.

Maximum number of violent incidents [61%] were reported between 2000 hours and 0500 hours. Only 6 incidents [16%] occurred in the morning and 4 [11%] between 1700 hours to 2000 hours. Pearson *et al* [5] have reported violence in 30% of subjects in the morning hours, but Sharma [8] reported that patients were more aggressive during 0600 hours to 0800 hours in the morning and 1500 hours to 1800 hours in the evening. He noted that violence occurred more commonly when there were minimal medical or nursing staff in the ward. The findings in the present study were not surprising considering the fact that it was in the night hours that maximum number of patients are in the ward. Seen in the light

of maximum patient- patient interaction in these periods along with minimum of therapeutic activity or organised activities like occupational therapy the results are understandable.

Schizophrenia was the most common diagnostic group among violent patients in the present study constituting 38%. In the study by Pearson *et al* [5] 56.5% of patients were schizophrenics. This is mainly due to the fact that majority of the patients in the hospital were schizophrenics and impulsivity was one of the important feature of them. Noble and Rodger [11] found that those with acute hallucinations and delusions were more likely to assault. In the present study 24 out of 26 patients (92%) had active symptoms in the form of psychomotor agitation or hallucinations or delusions.

Fottrell [1] found that staff were the commonest victims in the assaults by psychiatric inpatients, where as Pearson *et al* [5] reported assault on fellow patients more commonly than on members of the staff. In the present study most common victims were fellow patients. In many such occasions staff secondarily became victims due to intervention. Direct attack on members of the staff primarily occurred in only two of the total of 36 incidents. This could possibly be explained on the basis of proximity of fellow patients to assailants and the fact that nursing staff were trained to handle such violence tactfully.

In the present study in as many as 44% of the incidents, patients could be controlled without a physical restraint or parenteral antipsychotic, while an equal percentage required a parenteral antipsychotic with or without a physical restraint. Majority of the studies on violence in psychiatric inpatients did not elaborate on the pharmacologic aspects of the management of violence [1,2,5,8,9] however a study based on the questionnaires on the management of violent patients sent to the psychiatrists reported that majority of psychiatrists showed preference to use of physical restraint and when chemical restraint was necessary Inj. haloperidol

was the drug of choice.

Applebaum *et al* [12] in their study of 45 violent patients and 48 controls did not find any significant difference in the type and dose of medication before the violent act or afterwards. In just over 50% of the first acts of violence the psychiatrists responded by increasing the dose of the drug, the patient was already getting. In the present study despite the violent incident the patients did not need increase in the dosage of drugs.

Despite an average daily bed occupancy of 56.47 during the study period only a miniscule percentage of violent incidents were recorded. This finding is in conformity with almost all the studies on the subject.

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