Preventing Violence

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Personal Significance of Violence for Americans

25% of Americans say they have personally been threatened with a gun
9% reported that they had been shot at
45% keep a gun at home

Post-ABC Poll May 1999.

Childhoods of Violent Adults

- Parental brutality (especially a risk for boys)
- Juvenile delinquency and arrest at a young age
- Attention-deficit/hyperactivity disorder
- Childhood fire setting
- Cruelty to animals
- Sexual violence

A Developmental Model of Violence

Volavka Model of Development of Violence

Offspring witnesses abuse
Offspring abused
Offspring neglected

Role modeling and head injury
Inadequate supervision and head injury
Violent Offspring

Obstetric Complications and Parenting in Violence

- Study of 15 117 persons born in Stockholm, Sweden, in 1953 and followed up to age 30 years.
- Inadequate parenting increased risk of violent offending (men, 2.02 times; women, 2.09).
- Obstetric complications without family problems didn’t increase risk of offending.
- Combination of pregnancy complications and inadequate parenting in 4% did not increase the risk, except for an increase in the risk of violence offending in men (2.80 times)

What Prevents Violence in Children at Risk

Robust data re: reducing violence and antisocial behavior:

- Increase the predictability and parental monitoring of children
- Decrease negative parenting methods
- Improve intra-family relations.

Significance of Violence for Mental Health Professionals

Numbers assaulted at some point in their career:
• 80% of psychiatric nurses
• 40% of psychiatrists
• 20% of psychologists
• 10% of social workers
- 1/3 of attacks are in private offices
- Only 1/4 to 1/3 of professionals have a current plan for action around an attack


Violence in the ER:
Surveying Health Care Workers

➢ Over one fourth of respondents took days off as a result of violence, and 12 of the 18 respondents who had left the ER reported that violence had been at least a part of their reason for leaving.

➢ Most useful potential interventions included 24-hour security and a workshop on violence prevention strategies.

➢ Coping strategies most commonly reported were physical exercise, sleep, and the company of family and friends.


Risk to PES Professionals: Assaults

- 46.5% loss of work
- Range 0 - 117

Allen and Currier AAFP Survey
### Inpatient Violence
- **Study in Sydney Australia:**
  - 1,289 violent incidents over 7 months.
  - 58% of the incidents were serious.
  - 78% were directed toward nursing staff.
  - Decreased risk with more nursing staff (of either sex), more non-nursing staff on planned leave, more patients known to instigate violence, a greater number of disoriented patients, more patients detained compulsorily, and more use of seclusion.
  - Decreased risk with more staff under 30 years old, more nursing staff on sick leave, more admissions, and more patients with substance abuse or physical illness.
- In total these factors accounted for 62 percent of the variance in violence.

### Violence and Aggression in Psychiatric Units. Owen, Cathy et al.
- Of the 174 patients involved in violent incidents, 20 (12 percent) were recidivists. They accounted for 69 percent of violent incidents.
- Recidivists were significantly older.
- Men recidivists were more likely to have an organic brain syndrome, and women recidivists were more likely to have a personality disorder.
- Violence occurred among recidivists despite their giving more warning signs than non-recidivists, suggesting that recidivists’ threats were not taken seriously.

### ECA Data on Violence Risk
- Swanson study found that 2% of subjects with no psychiatric diagnosis admitted to committing violence in the past year.1
- 10% if SMI. 20% if alcohol dependent. 30% if dependent on another substance.
- May reflect willingness of SMI to acknowledge deviant behavior.

### McArthur Foundation Study Assessment of Violence
- Discharged psychiatric inpatients vs. general population.
- Substance abuse is the major predictor of violence in the seriously mentally ill.
- Without substance abuse, violence in the SMI group is roughly the same as in the general population.
- For the first few months after discharge SMI patients with substance abuse are more likely to be violent than the general population with substance abuse.
- Violence committed by people discharged from a hospital is similar to violence committed by others living in their communities in terms of type (i.e., hitting), target (i.e., family members), and location (i.e., at home).

### Assaults in the VA Health System
- VA Survey of all facilities looking at violence in 1990
- During the survey year, 24,219 incidents of assaultive behavior were reported by 166 VA facilities; 8,552 incidents involved battery or physical assault.
- Weapon possession by perpetrators was common (8.5 percent of incidents), and weapons were used in 130 assaults (1.5 percent of assaults).

### ECA Data on Violence Risk

![Graph showing ECA Data on Violence Risk]


### Assumptions in the VA Health System
- Assaults occurred most frequently in psychiatric units (43.1 percent), followed by long-term-care units (18.5 percent) and admitting or triage areas (13.4 percent).
- Assault-related injuries were most common among nursing personnel.
- Perpetrators were most typically diagnosed as having psychoses, substance use disorders, or dementia.
- On inpatient psychiatry units, an inverse correlation was found between expenditures on staffing and the frequency of assaultive incidents.
Violence After: A Prospective Study...

Interviewed patients at admission and 2 weeks post-discharge. Of 430 interviewed, 16 were violent within 2 weeks post-discharge.

- No differences on gender, race, diagnosis, substance use or compliance with medication after discharge.
- Violence in hospital did not predict violence after discharge.
- Patients violent in month prior to admission more likely to be violent and generally preyed on same target
  - Usually family member or spouse.
- Personality disorder most common diagnosis predicting violence.


Assessment and Management of the Violent Patient

- The Context
- Significance
- Assess
- Act
  - Verbal Intervention
  - Pharmacologic Intervention
  - Physical Intervention
- Treat
  - Definitive Assessment
  - Definitive Treatment

General Profile of the Violent Individual

Demographic, historical and environmental factors.

Young males.
- Peak age for violence is 15-25. Men are ten times more likely to be violent than women(1). Peak age for violence in schizophrenics is 25-35.
  - Poverty and disrupted family including child abuse / physical abuse

Diagnoses Associated With Violence

- Paranoid Schizophrenia, risk is greater outside the hospital where better organization increases access to weapons.
- Substance Abuse, major risk factor, especially with SMI.
- Mania, especially mixed mania.
- Depression, with anger outbursts, or agitated depression.
- Psychosis, especially with delusions about the therapist.
Diagnoses Associated With Violence

- **Personality disorders:** explosive, borderline, antisocial.
- **Attention Deficit Disorder**
- **Intermittent Explosive Disorder**
- **Head injury,** including obstetrical complications.
- **CNS disorders without Delirium.**
- **Delirium**

Agitation in Different Clinical Disorders: Underlying Pathophysiology

- Agitated depression
- Mania
- Panic disorder
- Dementia
- Delirium
- Substance-induced
- Acute psychosis
- Akathisia
- Aggression

- Increase in serotonin, decrease in GABA
- Increase in dopamine
- Increase in dopamine, decrease in GABA
- Increase in norepinephrine
- Increase in norepinephrine, decrease in serotonin


Agitation: Causes

- Agitated Psychosis -- Increased DA
- Agitated Depression -- Decrease in 5HT
- Agitated Anxiety -- Increase in NE, Decrease in GABA
- Mania -- Increase DA
- Aggression / agitation -- Increase in NE, Decrease in 5HT
- Delirium / Dementia -- Decrease in GABA

Lindenmayer JCP 2000

Assessment of Violent Individuals

How well planned is the threat? (Analogy to suicide screening).
- More risk if the plan is well thought out and coming from someone who does not repeatedly threaten.

Available means...
- 50% of households in the US have guns.

Assessment of Violent Individuals

Alcohol and drug use and withdrawal...
- Of concern during use or withdrawal:
  - alcohol, barbiturates, other sedatives, anxiolytics.
- Of concern during use:
  - amphetamines, other sympathomimetics, cocaine, PCP, other hallucinogens, anticholinergics, steroids, glue sniffing.

Violence in the Hospital

The authors proposed model:
- Patient's psychopathology and distorted cognitions are exacerbated by environmental and communication stressors found on psychiatric wards.
- Repeated inpatient aggression may be the result of a vicious circle.
- Patient's violent behavior is followed by an increase in stress on patient caused by environmental or communication factors, increasing risk of another outburst of violence.

Psychiatric Services v50 n6, pg. 832-834. A Tentative Model of Aggression on Inpatient Psychiatric Wards.
Assessing the Violent Patient (Expert Consensus)

- This guideline refers to a situation in which a patient is agitated uncooperative, or dangerous in ways that prevent the assessment that might otherwise be recommended,
- The same factors that interfere with assessment may compel the psychiatrist to intervene with only limited data available.

Assess:
Initial Medical Evaluation (Expert Consensus)

**Rank Order of medical screening procedures**

- **Vital Sign**
- Medical history
- Visual examination of patient (e.g. eyeballing)
- Urine toxicology screening
- Cognitive examination
- Pregnancy testing for fertile women
- Cursory physical examination (e.g. medical clearance)
- Focused Methodical physical examination

**Bold italics = assessment of choice**

Scope of Assessment Necessary to Create a “Plan of Care”

<table>
<thead>
<tr>
<th>Type of assessment needed to create a plan of care</th>
<th>Preferred</th>
<th>Also Cc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief assessment leading to determination of a general category (e.g. intoxication, psychosis)</td>
<td>Attending psychiatrist with training and/or experience in emergency psychiatry</td>
<td>Nurses with psy experience or a training</td>
</tr>
<tr>
<td>Comprehensive leading to a more detailed assessment</td>
<td>Attending psychiatrists without training and/or experience in emergency psychiatry</td>
<td>Psychiatric residents</td>
</tr>
</tbody>
</table>

**Bold italics = assessment of choice**

Assessment:
Other Important Information

**Most important initial information to obtain**

- Determining if patient has any drug allergies
- Determining if there is a causal medical etiology that should be managed first
- Determining if patient has history of adverse reactions to the medication you are considering
- Determining if a medical contraindication to medication is present
- Locating and reviewing prior medical records (if available)
- Determining presence of substance abuse

**Also Useful**

- Obtaining a history of prior medication response
- Determining patient preference for treatment

**Bold italic = Information of choice**

Expert Consensus: Assessing Medical Agitation

- **Patient confused, uncooperative, and requires immediate intervention**

**Preferred Strategies:**

- **Vital signs**
- Gather history from family or other sources
- **Talk to the patients**
- Visual examination of patient
- Request Consultation with medical emergency department
- Perform tests such as pulse oximetry, blood glucose, toxicology screen

**Alternate Strategies:**

- Intervene with physical restraints to ensure patient safety
- Administer parenteral medication
- Attempt to transfer patient to the medical emergency department
- Focused methodical physical examination
- Cursory physical examination
- Offer oral medication

**Bold italic = intervention of choice**
Assessing Medical Agitation (2)

Patient confused but responsive to directions; no immediate danger to self or others

- Preferred Strategies:
  - Vital signs
  - Talk to the patient
  - Gather history from family or other sources
  - Perform tests such as pulse oximetry, blood glucose, toxicology screen
  - Request consultation with medical emergency department
  - Focused methodical examination
  - Visual examination

- Alternate Strategies:
  - Attempt to transfer patient to the medical emergency department
  - Cursory physical examination
  - Complete history and physical examination
  - Offer oral medication

Assessment of Delirium

- Mental status assessment of the psychiatric patient
  - 1. Always test attention in a confused or psychotic patient
  - 2. Always assess orientation
  - 3. Always test short-term memory
  - 4. Consider testing calculation and construction

- Neurologic assessment of the psychiatric patient
  - 1. Always assess symmetry of movement and facial expression
  - 2. Always assess meningeal signs in the confused or other high risk patient
  - 3. Consider assessing reflexes, drift, fine and gross coordination, frontal release signs, graphesthesia, vision and fundus, cranial nerves

- Historical assessment of the psychiatric patient
  - 1. Review of vital signs and anesthesia record if postoperative
  - 2. Review of general medical records
  - 3. Careful review of medications and correlation with behavioral changes

- Basic laboratory assessment of the psychiatric patient
  - 1. Blood chemistries: electrolytes, glucose, calcium, albumin, blood urea nitrogen (BUN), creatinine, SGOT, SGPT, bilirubin, alkaline phosphatase, magnesium, PO4); Complete blood count (CBC)
  - 3. Electrocardiogram, chest x-ray, measurement of arterial blood gases or oxygen saturation
  - 4. Urinalysis

- Advanced laboratory assessment of the psychiatric patient
  - consider if specific indications exist
    - 1. Urine culture and sensitivity (C&S), urine drug screen,
    - 2. Blood tests (e.g., Venereal disease research laboratory (VDRL), heavy metal screen, B12, and folate levels, lupus erythematosus (LE) prep, antinuclear antibody (ANA), urinal porphyrins, ammonia, human immuno deficiency virus)
    - 3. Blood cultures
    - 4. Measurement of serum levels of medications (e.G., digoxin, theophylline, phenobarbital, cyclosporine)
    - 5. Lumbar puncture
    - 6. Brain computerized tomography (CT) or magnetic resonance imaging (MRI)
    - 7. Electroencephalogram (EEG)

Delirium: Clinical Characteristics

Mental status findings
- Clouded/ fluctuating consciousness
- Impaired attention, distractibility
- Incoherent language with multiple deficits
- Impaired recent memory
- Disorientation to time, location and other people
  - Seldom disorientation to self
- Visuoconstructive deficits
- Incoherent thought
- Emotional disturbances
  - Anxiety, fear, depression, irritability, anger, euphoria, apathy, affective lability

Delirium: Clinical Characteristics

Mental status findings
- Neuropsychiatric symptoms (hallucinations, delusions)
- Perceptual disturbances including
  - Misinterpretation of perception
    - Illusions
  - Hallucinations (most commonly visual, but also auditory, tactile, gustatory, and olfactory)
  - Misperceptions may be simple and uniform or extremely complex
- Motor system abnormalities
- Sleep disturbances (cycle reversal, fragmentation)
- Electroencephalogram, diffuse slowing
Delirium:

**Subtypes Based on Motor Arousal**

<table>
<thead>
<tr>
<th>Hyperactive</th>
<th>Hypoactive</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Agitated, hyperalert</em></td>
<td><em>Lethargic, hypo alert</em></td>
</tr>
</tbody>
</table>

- Characterized by increased
  - Hallucinations
  - Delusions
  - Agitation

- Lower incidence of hallucinations, delusions, or illusions

Subtypes share a similar level of cognitive impairment. Some researchers have identified a third, “mixed” subtype characterized by alternating features of these two.

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Assessing Substance Related Agitation

**Patient intoxicated, uncooperative, and requires immediate attention**

**Preferred Strategies**

- **Vital Signs**
  - Talk to the patient
  - Gather history from family or other sources
- Perform tests such as toxicology screen
- Visual examination of patient

- **Alternate Strategies**
  - Offer oral medication
  - Administer parenteral medication
  - Cursory physical examination
  - Breath alcohol content

**Preferred Strategies**

- **Vital Signs**
  - Talk to the patient
  - Gather history from family or other sources
  - Administer parenteral medication
- Visual examination of patient
  - Offer oral medication
  - Perform tests such as toxicology screen

**Alternate Strategies**

- **Vital Signs**
  - Focus on methodical physical examination
  - Cursory physical examination
  - Observe patient and wait for substance intoxication to resolve
- **Alternate Strategies**
  - Offer oral medication

**Bold italics** = interventions of choice

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Assessing Psychiatric Agitation

**Patient agitated, uncooperative, and requires immediate intervention**

**Preferred Strategies**

- **Vital Signs**
  - Talk to the patient
  - Gather history from family or other sources
  - Administer parenteral medication
- Visual examination of patient
  - Offer oral medication
  - Perform tests such as toxicology screen

**Alternate Strategies**

- Intervene with physical restraints to ensure patient safety
- Cursory physical examination

**Preferred Strategies**

- **Vital Signs**
  - Talk to the patient
  - Gather history from family or other sources
  - Administer parenteral medication
- Visual examination of patient
  - Offer oral medication
  - Perform tests such as toxicology screen

**Alternate Strategies**

- Cursory physical examination
- Focused on methodical physical examination

**Bold italics** = interventions of choice

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Delirium: Clinical Characteristics

- Symptoms develop acutely, fluctuate in severity being most pronounced in evening
- Despite its ubiquity in medicine (10-16% of acute hospital patients, 35-80% of geriatric ward patients) delirium is infrequently recognized and badly managed
- Major diagnostic problem: delirium can result as a side effect of a large range of drugs, illnesses, and surgical procedures
- Delirious patients stay longer in hospital, suffer more complications (falls, bedsores, adverse drug reactions) and are more likely to require nursing care
- Differential diagnosis includes dementia, amnesia, catatonic stupor

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1 Lipowski ZJ. Delirium (acute confusional states). Jama 1987; 258:1789-1792
Assessment: The Common Sense Model
From Professional Assault Response Training

Violent Behavior: Fear
- **Fear**
  - **Sight:** tense & prepared to defend, hide, run away, pale/ashen, wide-eyed/fearful
  - **Sound:** whining and pleading, rapid, shallow or irregular breathing
  - **History:** withdrawal and victimization with outbursts

Violent Behavior: Frustration
- **Frustration**
  - **Sight:** tense & prepared to attack, purple or red skin, facial expression of destructive urge
  - **Sound:** menacing & aggressive voice tone; loud, deep, long breaths
  - **History:** low frustration tolerance and impulsive assault

Violent Behavior: Manipulation
- **Manipulation**
  - **Pattern of:** increasing accusations and aggressiveness beginning with tones intended to invoke pity
  - **Confirming history:** losing control and attacking when feeling deprived or oppressed

Violent Behavior: Intimidation
- **Intimidation**
  - **Visual / auditory cues:** unremarkable except menacing voice and threatening words or posture
  - **Pattern of:** demand, followed by threat and reminder that injury can be avoided if demand is met, followed by assault if demands are refused
  - **Confirming history:** bullying, extortion, and criminal assault

Intimidation: The Psychopathic Brain
- Psychopaths are different in that they don’t react to emotional experiences, including adverse experiences.
- Borderlines are like normals in this regard, but they tend to have difficulty modulating their facial responses to emotional experiences more than normals.
- Psychopaths are characterized by a pronounced lack of fear in response to aversive events.
- Furthermore, the results suggest a general deficit in processing affective information, regardless of whether stimuli are negative or positive.

Emotion in Criminal Offenders With Psychopathy and Borderline Personality Disorder. Sabine C. Herpertz, MD; Ulrike Werth; MD Arch Gen Psychiatry. 2001; 58:737-745.
Avoid Coercion: Pressures

- **Persuasion**: A verbal effort to get the person to do what you want that relies on reason and the subject's desire to please the persuader.
- **Inducement**: A conditional statement in which the potential patient is offered something in exchange for agreeing to your request.
- **Threats**: A conditional statement in which the potential patient is told that the threatener will do something negative if the patient does not agree to request.
- **Show of Force**: An act that demonstrates the availability of force if needed (calling for police/security, large guards).
- **Physical Force**: An act involving laying on of hands to accomplish something against the expressed choice of the patient.
- **Legal Force**: Use of authority of the courts to facilitate the admission = involuntary commitment.
- **Request for dispositional preference**: Did anyone ask what the patient wanted to do?
- **Giving Orders**: You have to do something; there is no conditional result like in a threat.
- **Deception**: Lies or deliberate deceit about what is happening to the patient.

General Principles of Crisis Intervention

**Self-control**: Have a personal plan

**Maintain affect**: Be human and allow patient to maintain as much dignity as possible

**Identification**: Listen and look for cues

**Timing**

**Communication**: Minimize speech; maximize non-verbal

**Patience**: Avoid retreat or panicking

Poor responses to violence include:
- being aggressive, confrontational or intimidating.
- Instead, when possible, leave, do nothing, and maintain patient's self-esteem.

Risk of Inpatient Violence

<table>
<thead>
<tr>
<th>Variable</th>
<th>Parameter est.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td>1.02</td>
</tr>
<tr>
<td>Initial Alliance</td>
<td>0.49</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age</td>
<td>0.18</td>
<td>0.03</td>
</tr>
<tr>
<td>BPRS Agitation</td>
<td>0.12</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Specific Intervention Techniques

**Threat reduction for fear**

**Technique**: relaxed, open posture with hands in full view, slow gestures and palms up

- Slightly to side of the threatened person

- At or below eye level with eye and physical contact depending on the person's preference

- Firm, reassuring and confident voice tone encouraging calm reflection and logic
Specific Intervention Techniques

**Control for frustration.**

**Technique:**
- Quiet, forceful delivery of repetitive, confident demands.
- Direct eye contact, physical contact only as necessary to prevent escalation.
- Acknowledge feelings.
- Do something small to help.

**Technique:**
- Closed, relaxed posture with gestures indicating disapproval or mild irritation.
- Close enough to be able to intervene, but far enough away to indicate non-involvement.
- Voice should be detached, mechanical and slightly bored; giving quiet, repetitive commands.
- Avoid eye contact, physical contact.
- When necessary should be handled as a distasteful chore and should not involve contact with the flesh.

**Detachment for Manipulation**

**Technique:**
- Closed, relaxed posture with gestures indicating disapproval or mild irritation.
- Close enough to be able to intervene, but far enough away to indicate non-involvement.
- Voice should be detached, mechanical and slightly bored; giving quiet, repetitive commands.
- Avoid eye contact, physical contact.
- When necessary should be handled as a distasteful chore and should not involve contact with the flesh.

**Consequation for Intimidation**

**Technique:**
- Poised, but not defensive posture.
- Few gestures, position of the greatest defensive advantage.
- Matter-of-fact, monotone voice communicating clear, direct statements of consequences.
- Sparing eye contact, physical contact, only as necessary; quickly, smoothly and matter-of-factly.

**Expert Consensus: Appropriate Interventions**

| Refusal to cooperate with unit routine and increased mood disturbance | ++ in motor restlessness and purposeful movements |
| Agitation or hostility and verbal behavior | ++ in irritability and intimidating behavior |
| Patient directly threatening or assaultive |

**Physical Restraint: The Controversies**

- **Deadly Restraint**
  - A Hartford Courant Investigative Report in October of 1998 identified a number of individuals who died in restraint.
  - Clayborne’s arms were yanked across her chest, her wrists gripped from behind by a mental health aide.
  - “I can’t breathe,” the 16-year-old gasped.
  - Her last words were ignored.
  - A syringe delivered 50 milligrams of Thorazine into her body and, with eight staffers watching, Clayborne became, suddenly, still.
  - Her limp body was rolled into a blanket and dumped in an 8-by-10-foot room used to seclude dangerous patients at the Laurel Ridge Residential Treatment Center in San Antonio, Texas.
  - The door clicked behind her.
  - No one watched her die.
Physical Restraint: The Controversies

- A 50-state survey by The Courant, the first of its kind ever conducted, has confirmed 142 deaths during or shortly after restraint or seclusion in the past decade.
- But because many of these cases go unreported, the actual number of deaths during or after restraint is many times higher.
- Between 50 and 150 such deaths occur every year across the country, according to a statistical estimate commissioned by The Courant and conducted by a research specialist at the Harvard Center for Risk Analysis.
- That’s one to three deaths every week, 500 to 1,500 in the past decade, the study shows.

Physical Restraint: The Controversies

- Of the 142 restraint-related deaths confirmed by The Courant’s investigation:
  - Twenty-three people died after being restrained in face-down floor holds.
  - Another 20 died after they were tied up in leather wrist and ankle cuffs or vests, and ignored for hours.
  - Causes of death could be confirmed in 125 cases. Of those patients, 33 percent died of asphyxia, another 26 percent died of cardiac-related causes.

Physical Restraint: The Controversies

- Sakena Dorsey, 18
  Died: June 10, 1997
  Cause: Asphyxiation
  Dorsey stopped breathing while she was being physically restrained, face down. No criminal charges were filed. Dorsey had a history of asthma and problems with swollen tonsils that hindered her breathing.

Psychotherapeutic Interventions in the Management of Chronically Violent Patients

Developing a Treatment Plan

- The overall goal is to reduce precipitants and to decrease rewards for aggression (violence usually “worked” for the patient in the past).
- The approach must involve the entire treatment team, in a 24 hour facility, the treatment plan must at least be supported by the off hours shifts.
  - Involve representatives of the off hours shifts and/or the off hours nursing supervisors.
- The plan must be documented in a detailed fashion in the chart.

Developing a Treatment Plan

- Define the aggressive behavior as comprehensively as possible. Look particularly at less severe forms of aggressive behavior that may presage more violent actions.
- Look at ways of reducing the early, or escalation, phase of aggressive action.
  - Social skills training, particularly involving training with assertiveness rather than aggressiveness may help the individual feel that there are alternatives that work.
  - Many violent individuals have incredibly impoverished social skills.
  - Stress inoculation (teaching other ways of dealing with mildly frustrating or stressful situations).
Developing a Treatment Plan

• Look at ways of changing the consequences of violent behavior.
  – Often any kind of attention is rewarding, even if it is negative. Patients with poor social skills may, in fact, be right that they only really get attention when they are acting out.
  – Intervention when someone has been aggressive should be as neutral as possible.
  – Timeouts are an ideal intervention as long as the person is motivated to want to return to the environment.
  – Timeouts should be relatively brief.
  – Timeouts should be framed as the withdrawal of a reward, not as punishment, which is not effective.

• Reinforce positive or incompatible behaviors (you can’t be angry and relaxed at the same time).
• Model appropriate conflict resolution (the kids are watching).
• Extinction is effective (removing rewards), punishment is generally not.
  – Punishment may reduce the specific behaviors for a short period of time, but in the long run tends to increase violence.

Using a Token Economy

• A token economy was introduced on an acute care unit in a rural hospital, and rates of negative events were compared before and after implementation.
• The number of negative events fell significantly after the token economy was introduced, from 129 in the four months before implementation to 73 after implementation, a 43 percent reduction.
• Both staff and patient injuries were significantly reduced.
• A small increase in use of emergency medications was noted, but it was not statistically significant.