



Patient characteristics associated with aggression in mental health units



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ABSTRACT

Aggression in mental health units is a significant and pervasive problem. However, the characteristics of patients associated with increased aggression propensity remain unclear and there are few attempts to expand understanding of these characteristics by drawing upon contemporary aggression theory. This study assessed the influence of interpersonal (hostile-dominance) and personality (psychopathy), General Aggression Model-specified (aggressive script rehearsal, attitudes towards violence, and trait anger), and clinical (psychiatric symptoms) factors on aggression during psychiatric hospitalization in 200 inpatients (132 men and 68 women; 19–64 years, $M=38.32$ years, $S.D.=11.13$ years). Patient characteristics were assessed on admission using structured interviews and self-report psychological tests. Patients' files were reviewed and nurses were interviewed after patients were discharged to establish whether patients were aggressive during their hospital stay. Results of univariate analyses showed that higher levels of interpersonal hostile-dominance, psychopathy and aggressive script rehearsal, positive attitudes towards violence, trait anger, and disorganized and excited type psychiatric symptoms all predicted aggression. In the final multivariable logistic regression model, only hostile-dominance remained as a significant predictor of aggressive behavior. This important personality characteristic should be considered in violence risk assessments and aggression prevention strategies.

1. Introduction

Aggression in mental health units erodes the therapeutic environment, causes psychological and physical harms to patients and staff, and ultimately impairs care (Daffern and Howells, 2002). Research into aggression within mental health units typically neglects theoretical perspectives, distal, environmental and interactional causes in favor of proximal psychiatric symptoms, consistent with an internal model of inpatient aggression (Nijman et al., 1999). In this regard extant research reveals a small but significant association between some psychiatric symptoms and aggression; active positive symptoms of psychosis including delusions, conceptual disorganisation, hallucinations and paranoia appear to have the strongest association with aggression (Swanson et al., 2006; Douglas et al., 2009). Few models of inpatient aggression incorporating personal, interpersonal and environmental factors have been developed (for exception see Nijman et al. (1999), Duxbury and Whittington (2005).

Contemporary aggression theories such as the General Aggression Model (GAM; Anderson and Bushman, 2002) consider aggression to be the product of multiple interacting factors; accordingly, distal (i.e. personality characteristics) and situational factors (i.e. provocation)

create an internal state which affects decision-making processes that determine aggressive action. According to the GAM, habitual aggression results from the acquisition of aggression-related cognitions including aggression-related behavioral scripts (i.e. scripts denoting how a person should interact with their environment), attitudes (i.e. a person's beliefs about the acceptability of aggression), and their related affective states (i.e. anger (Anderson and Bushman, 2002)). Interpersonal hostile-dominance (Dolan and Blackburn, 2006) and psychopathy (Hare, 2003) have also been associated with aggressive behavior in inpatient settings (Daffern et al., 2010). Where psychopathy is thought to comprise persistent behavioral deviancy accompanied by emotional-interpersonal detachment (Patrick et al., 2009), interpersonal hostile-dominance describes a pattern of relating to others in a manner that is antagonistic and domineering.

The current study examined the impact of interpersonal (e.g., hostile-dominance), personality (psychopathy), GAM-specified (aggressive script rehearsal, attitudes towards violence, and trait anger), and clinical (psychiatric symptoms) factors on aggression during psychiatric hospitalization. It was hypothesized that (1) the interpersonal and personality, GAM-specified, and clinical factors would all significantly predict inpatient aggressive behavior, and that (2) the

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addition of interpersonal variables would improve the prediction of aggression beyond clinical, personality and GAM-specified variables.

2. Methods

2.1. Participants

Participants were 200 patients admitted to two acute units at the Alfred Hospital Inpatient Psychiatry Unit, Melbourne, Australia, between 12th of January 2012 and 10th of October 2012. The sample included 132 men ($M=38.12$ years, $S.D.=11.14$ years) and 68 women ($M=38.69$ years, $S.D.=11.20$ years) with an age range of 19–64 years ($M=38.32$ years, $S.D.=11.13$ years). The average length of hospital stay for participants was approximately two weeks ($M=14.59$ days, $S.D.=15.96$ days).

The most common primary diagnosis (recorded on the day of the interview from case notes entered by the treating psychiatrist) was schizophrenia or another psychotic illness (55.5%), followed by unipolar depressive episode/disorder (11.5%), bipolar disorder or a manic episode (8.5%), borderline personality disorder (7.0%), alcohol or other substance induced disorders/related issues (6.5%), and acute stress reaction (4.5%). At the time of the interview, 4.0% of participants had no diagnoses, and 2.5% had other diagnoses (e.g. cluster “personality traits”). During the study period, 746 patients were admitted to the Alfred Psychiatry inpatient units and 200 (27%) chose to participate. An audit of all patients admitted to the Alfred Psychiatry Inpatient Units was conducted in 2010 (see Lee et al., 2013, for details); the current sample can reasonably be considered representative of the Alfred Psychiatry inpatient population.

2.2. Setting

Alfred Psychiatry is the main provider of public mental health services to people living in the inner southeast suburbs of Melbourne, Australia. A hospital-based acute psychiatric response is provided to adult patients via two 28-bed units. Each unit offers care in low-dependency (requiring less intensive observation) and high dependency (for patients at higher risk of harm to self or others) environments.

2.3. Materials

The *Impact Message Inventory-Circumplex* (IMI-C; Kiesler and Schmidt, 2006) yields eight interpersonal scales (Dominant, Hostile-Dominant, Hostile, Hostile-Submissive, Submissive, Friendly-Submissive, Friendly, and Friendly-Dominant) although in this study only interpersonal hostile-dominance was evaluated since this has an established relationship with aggression in psychiatric units (Daffern et al., 2010). Internal consistency for the Hostile-Dominance scale ranges from 0.69 to 0.96, with a median Cronbach alpha coefficient of 0.81 (Kiesler and Auerbach, 2004).

The *Psychopathy Checklist: Screening Version* (PCL: SV; Hart et al., 1995) assesses psychopathic traits. The PCL: SV demonstrates good internal consistency, with a weighted mean Cronbach's alpha across 11 studies of 0.84 for the total scale (0.81 for F1 and 0.75 for F2; Hart et al., 1995).

The *Schedule of Imagined Violence* (SIV; Grisso et al., 2000) screens for aggressive scripts through participants' self-report. In the current research the frequency of script rehearsal was of primary interest and was ascertained by asking the question “How often do you have thoughts about hurting or injuring other people?” There were eight possible response options: 0= never, 1= once every few years, 2= several times a year, 3= several times a month, 4= once a week, 5= several times a week, 6= once a day, and 7= several times a day.

The *Measures of Criminal Attitudes and Associates* (Mills and Kroner, 2001) Attitudes Towards Violence scale (MCAA: ATV) mea-

sures beliefs supportive of aggression (e.g., “It's all right to fight someone if they stole from you”); respondents indicate whether they ‘agree’ or ‘disagree’ with each item. The MCAA: ATV scale demonstrates good internal consistency with a Cronbach's alpha coefficient of 0.80 in samples of incarcerated offenders (Mills et al., 2002).

The *State-Trait Anger Expression Inventory-2* (Spielberger, 1999) Trait Anger scale (STAXI-2: TA) measures the disposition to perceive a wide range of situations as annoying or frustrating, and the tendency to respond to these situations with anger (Spielberger, 1999). Good internal consistency for the STAXI-2: TA is reported in both non-clinical adults (Cronbach's alpha coefficient of 0.84–0.86) and psychiatric patients (Cronbach's alpha coefficient of 0.87; Spielberger, 1999).

The *Positive and Negative Syndrome Scale* (PANSS; Kay et al., 1987) assesses the presence and severity of positive and negative symptoms of schizophrenia, as well as general psychopathology. For the purpose of the current research, PANSS items were grouped into five subscales (Negative, Positive, Disorganized, Excited, and Emotional Distress), in accordance with Kelly, White, Compton, and Harvey (2013). Only the PANSS Positive, Disorganized, and Excited subscales were used, as aggressive behavior is most often associated with the symptoms incorporated in these subscales (Douglas et al., 2009; Bowers et al., 2011).

The *Overt Aggression Scale* (OAS; Silver and Yudofsky, 1987) was used to measure aggressive behavior (physical aggression towards others, verbal aggression towards others, physical aggression against objects, and aggression towards the self) during each participant's hospitalization. The current research utilized a dichotomous OAS score; aggressive behavior during admission was scored as 1 (*present*) or 0 (*absent*), with a score in any category of the OAS giving an overall score of 1. The OAS was scored using two data sources: (1) review of case files for the period of hospital stay; and, (2) an interview with each patient's primary nurse following the patient's discharge from hospital.

2.4. Procedure

This prospective study involved a semi-structured interview with participants and their completion of self-report psychological tests within five days of admission to the Alfred Psychiatry inpatient units. The semi-structured interview incorporated the PANSS, STAXI-2: TA, MCAA: ATV, and SIV. Following the interview, demographic data (sex, age, date of birth, diagnosis, and date of admission) was collected/confirmed through review of the patient's medical records; IMI-C was scored following the interview. The PCL: SV was completed based on the review of each patient's medical file and information collected during the semi-structured interview, while the IMI-C was completed based on the researcher's impressions during the semi-structured interview. The date of discharge was noted and the OAS completed following each participant's discharge.

2.5. Data analysis

Raw data consisted of total scores for IMI-C Hostile-Dominance and PCL: SV, answers to the ‘frequency’ item on the SIV, total scores for the MCAA: ATV, STAXI-2: TA, and three PANSS subscales (Positive, Disorganized, and Excited), and the dichotomous OAS score (aggression present or absent). The hypotheses were addressed using descriptive statistics, and univariate and multivariate parametric tests. Univariate logistic regression was used to assess the unadjusted relationship between the dichotomous OAS score and IMI-C Hostile-Dominance, PCL: SV, SIV, MCAA: ATV, STAXI-2: TA, and PANSS Positive, Disorganized, and Excited. Hierarchical multivariable logistic regression was then conducted to assess the ability of IMI-C Hostile-Dominance and PCL: SV to predict the dichotomous OAS score, after controlling for the influence of PANSS Positive, Disorganized, and Excited, SIV, MCAA: ATV, and STAXI-2: TA. The significance thresh-

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