



# A prospective examination of the stability of hostile-dominance and its relationship to paranoia over a one-year follow-up

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## ABSTRACT

A hostile-dominant interpersonal style and paranoia increase the risk of aggression in psychiatric in-patients. Paranoia is also associated with hostile-dominance; however, the nature of this relationship is unclear. This study evaluated the relationship between hostile-dominance and paranoia over a one-year period. One hundred and twenty-two patients admitted to hospital for psychiatric treatment were recruited, 43 were available for follow-up. Forty-two participants provided usable data, including 20 men and 22 women, with an age range of 18–63 ( $M = 41.02$  years,  $SD = 13.00$  years). At recruitment and follow-up, the psychiatric symptomatology and interpersonal style of each patient was assessed using the Brief Psychiatric Rating Scale-18 and the Impact Message Inventory-Circumplex. Results showed that hostile-dominance was relatively stable over time even though symptoms of paranoia subsided. Higher levels of hostile-dominance were associated with higher levels of paranoia at both recruitment and follow-up. The implications of this research for understanding the relationship between interpersonal style, paranoia and aggression during psychiatric hospitalisation are discussed.

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## 1. Introduction

Aggression in psychiatric units is distressing to both staff and patients; it impacts negatively on the therapeutic environment and the operation of psychiatric services (Daffern & Howells, 2002; Middleby-Clements, 2009). Accordingly, considerable research over many years has attempted to elucidate the clinical, psychosocial, behavioural, and situational precursors of aggressive behaviour (Cheung, Schweitzer, Crowley, & Tuckwell, 1997). Recent research has emphasised the importance of studying multiple interacting causal factors, including characteristics of the patient, the staff, and the hospital setting (Daffern, Howells, & Ogloff, 2007). Central to this approach is the interpersonal style of staff and patients (Daffern, Duggan, Huband, & Thomas, 2008; Daffern et al., 2010). Interpersonal style describes how individuals typically communicate with others and how people perceive themselves in relation to others (Daffern et al., 2010). Cross-sectional studies (Daffern et al., 2010) have previously established a positive correlation between hostile-dominance and paranoia in patients admitted for short-term psychiatric hospitalisation. This study was designed to examine the stability of hostile-dominance in patients

with psychiatric illness so as to clarify the nature of the relationship between hostile-dominance and paranoia.

### 1.1. Aggression, mental illness and interpersonal style

A robust body of evidence now exists to indicate a small but clinically significant association between certain symptoms of mental illness and aggression (Link & Stueve, 1994; for review see Douglas, Guy, & Hart, 2009). Patients with certain active psychotic symptoms, including thought disturbance, auditory hallucinations, paranoia, delusions and conceptual disorganisation are at an increased risk for aggression during psychiatric hospitalisation (McNiel & Binder, 1994). An important limitation of this research is that mental illness is associated with numerous other variables (e.g., substance use), many of which in turn increase the odds of aggressive behaviour (Elbogen & Johnson, 2009). One variable that has been found to be associated with both aggression and mental illness is interpersonal style (Daffern et al., 2010; Dolan & Blackburn, 2006).

Interpersonal style refers to “recurrent patterns of reciprocal relationship present among two persons’ covert and overt actions and reactions” (Kiesler, 1996, p. 7). According to interpersonal theorists (e.g., Kiesler, 1987; Leary, 1957), interpersonal behaviour can be understood in relation to two core dimensions of human interaction: *control*, which ranges from dominance to submission, and *affiliation*, which ranges from hostility to friendliness (Blackburn

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& Renwick, 1996). Individuals interacting with one another in social encounters repeatedly negotiate how friendly or hostile they will be, and how much control each will have in these encounters (Kiesler, 1996).

Recent research with patients with personality disorder and mental illness in both civil and forensic psychiatric services has shown that a hostile-dominant interpersonal style is associated with aggression during psychiatric hospitalisation (Daffern et al., 2008, 2010; Dolan & Blackburn, 2006). These studies have however rarely examined the impact of psychiatric symptomatology on interpersonal style, until Daffern et al. (2010), determined the relative importance of hostile-dominance whilst controlling for psychiatric symptoms. In Daffern, Thomas and colleagues' (2010) study a hostile-dominant interpersonal style accounted for a greater proportion of the variance in aggressiveness than psychiatric symptoms. However, in this study hostile-dominance was strongly positively correlated with paranoia. As this study was cross-sectional it was incapable of determining whether hostile-dominance is a dynamic characteristic that changes according to fluctuations in paranoia; that is, whether paranoia creates or exaggerates a hostile-dominant interpersonal style, or whether hostile-dominance is a stable personality characteristic that is minimally affected by paranoia.

### 1.2. Interpersonal style and mental illness

The extant literature examining the relationship between interpersonal style and mental disorder has primarily focused on patients with personality disorder and has shown that different classifications of personality disorders can be defined according to interpersonal style (Blackburn, 1998). For instance, the cluster B personality disorders appear to fall within the hostile-dominant quadrant of the interpersonal circle, while cluster A and cluster C personality disorders show varied categorical differentiation. Schizoid, Schizotypal and Avoidant Personality Disorders typically fall in the hostile-submissive quadrant, Paranoid Personality Disorder falls in the hostile-dominant quadrant, and Dependent and Compulsive Personality Disorders fall into the submissive-friendly quadrant (Blackburn, 1998). To date, few studies have examined the relationship between interpersonal style and other types of mental disorders. Furthermore, none of the available literature on interpersonal style has examined the impact of active psychiatric symptoms on interpersonal style. As such, although there is now an emerging yet consistent body of research that has established a hostile-dominant interpersonal style as a valid predictor of aggression in psychiatric hospitals, hostile-dominance is strongly correlated with paranoia and future research needs to be conducted to delineate this relationship.

### 1.3. The effect of gender and age

Psychiatric inpatient aggression results form a complex interaction of individual and contextual characteristics, including hostile-dominance and paranoia (Daffern, Howells, Ogloff, & Lee, 2005; Daffern, Mayer, & Martin, 2004; Daffern et al., 2008; Dolan & Blackburn, 2006; McNiel & Binder, 1994). Other individual characteristics related to inpatient aggression are age and, to a lesser degree, gender (Daffern et al., 2004). In general, men are more often physically aggressive than women, although several studies have suggested that psychiatric disorders reduce the gender difference and in some cases eliminate it all together (Anderson & West, 2011; Faulkner, Grimm, McFarland, & Bloom, 1990; James, Fineberg, Shah, & Priest, 1990; Krakowski & Czobor, 2004). Although gender and age both seem to be important characteristics for the assessment of aggression, there is limited evidence to suggest how they relate to both a hostile-dominance and paranoia.

Thus, exploratory research into how these characteristics impact upon the relationship between hostile-dominance and paranoia is warranted.

### 1.4. Study aim

The present study aims to evaluate the relationship between hostile-dominance and paranoia by studying patients' interpersonal style and paranoia on admission to hospital and then at one-year follow-up. This work will determine whether a hostile-dominant interpersonal style changes over time, and whether any changes in hostile-dominance correspond with changes in paranoia. As there is more and longer-standing research available to support the paranoia-aggression relationship it is hypothesised that as paranoia improves, hostile-dominance will abate. Such findings would suggest that hostile dominance is a consequence of paranoia and that inpatient aggression is better understood by examining its root cause, i.e., paranoia. Furthermore, this study aims to examine the impact of age and gender on the relationship between hostile-dominance and paranoia. As there is no existing research to inform a hypothesis surrounding these variables this part of the study is purely exploratory.

## 2. Method

### 2.1. Participants

Participants were drawn from a pool of 122 inpatients, recruited during their admission to the two acute units at the Alfred Hospital Inpatient Psychiatry Department, Melbourne, Australia, between 1 March 2009 and 10 August 2009. During this recruitment period there were a total of 395 admissions. The average age at admission for all 395 patients was 41 years. Approximately half of all patients were male. The average length of stay was approximately 2 weeks (16.95 days). About half of those admitted were diagnosed with a psychotic illness (57.21%) and a quarter with an affective illness (24.56%). Anxiety and personality disorders (10.38%) were the next most common diagnoses.

From the 122 patients recruited, 43 (35.25%) were available to take part in a 12-month follow-up study, with 70 being lost to follow-up, two being deceased, and seven not wishing to take part. Independent-samples *t*-tests and chi-square tests of independence found that there was no significant difference at initial assessment between participants who did or did not complete the follow up on either: age ( $p = .27$ ), hospital length of stay ( $p = .24$ ), BPRS Paranoid Disturbance ( $p = .59$ ), BPRS Thinking Disturbance ( $p = .82$ ), BPRS Withdrawal Retardation ( $p = .88$ ), BPRS Anxiety Depression ( $p = .87$ ), IMI-C Hostile-Dominance ( $p = .58$ ), IMI-C Dominance ( $p = .92$ ), IMI-C Hostile ( $p = .60$ ) or gender ( $p = .52$ ).

Of the 43 patients who took part in the follow-up, 42 provided useable data and were therefore included in the analysis. This included 20 men and 22 women, with an age range of 18–63 ( $M = 41.02$  years,  $SD = 13.00$  years). The mean length of time between baseline interview and follow-up was 377.31 days ( $SD = 53.69$  days).

### 2.2. Materials

#### 2.2.1. The Impact Message Inventory-Circumplex

The Impact Message Inventory-Circumplex (IMI-C; Kiesler & Schmidt, 2006) was used to assess participants' interpersonal style. The IMI-C is a 56-item observer rated inventory that works on the assumption that the interpersonal style of one person can be measured by assessing the covert response of another person after interactions with, or observations of, the person being rated. Four

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