CHARACTERISTICS OF AGGRESSION AND VIOLENT BEHAVIOUR AMONG PSYCHIATRIC INPATIENTS IN PSYCHIATRIC WARDS OF A TERTIARY HOSPITAL IN NEW DELHI

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ABSTRACT: The main objective of this study was to investigate the characteristics of aggressive and violent behaviour among inpatients in the psychiatric unit of a acute hospital in New Delhi, India. Notes of all inpatients at the psychiatric unit of RML hospital were reviewed from September 2005 to December 2007 and 246 patients aged between 18-60 years showing signs of aggression and violence were identified. Predesigned per forma were used together further information on these patients so that this could be analyzed to ascertain those characteristics which are associated with aggression and violence. Descriptive analysis has been used to characterize the demographic profile of the study population. Data analysis was done by using SPSS 13.0 programme. Chi-square test was used to analyze the association between independent and dependent variables. Results following analysis showed that aggression alone was seen in 26.4% subjects, violence alone in 42.7% and aggression and violence together in 30.9% of admitted cases. Exclusion was never used. Those factors which showed a significant association with violence were male gender, diagnosis of personality disorder, psychotic symptoms, substance and alcohol related disorders, low income, suicidal risk and increased stay in the hospital. Factors significantly associated with aggressive behaviour were female gender, diagnosis of depression and alcohol abuse. The findings of the study replicate some findings of earlier studies and also show some important differences. Some significant associations found in this study are likely to be epiphenomena, not directly related to aggressive and violent behavior but indicators of other variables more directly predictive. Thus it is important that a more comprehensive analysis be undertaken to investigate the characteristics of aggression and violence among various cultural and ethnic populations.

Key words: Aggression, Violence, Inpatients, Psychiatry, India

INTRODUCTION: Hostility and violence have long been a matter of concern in inpatient psychiatry. Violence of inpatient psychiatric units is a distinct character from outpatient violence. Of inpatients, 18% to 25% exhibit violent behavior while in the hospital, as per various studies. Of violent acts, most of them are directed to nurses, with other targets being (in descending order of frequency) fellow patients, property, self, physicians, psychologists, family members, and housekeeping staff. Ten to 45% of patients with schizophrenia exhibit aggressive or threatening behavior during hospitalization. Since violence is a complex behavior related to clinical as well as social components and approaches of psychiatric care, it is particularly important to investigate the aggressive and violent behavior of psychiatric patients in different settings and countries in order to find out risky or protective factors. The aim of the present study was to find out the characteristics of aggression and violence in psychiatric inpatients.

MATERIALS AND METHODS: The study was carried out at 40 bed psychiatric unit of Dr Ram Manohar Lohia Hospital New Delhi which provides round the clock mental health care. Patients below 18 years and over 65 years were excluded. There were two wards, one for male and other for female
patients. 5 psychiatrists, 1 psychologist, 18-20 nursing staff and upto 5 interns at a time. Family members actively participate in the assessment and management of their relative. Around 350 outpatients are seen daily by 10-15 doctors. The department serves a catchment area that covers large parts of the state, but people with acute psychiatric emergencies are largely referred by general practitioners or acquaintances from the neighboring towns and villages, or from emergency services of this and other hospitals. Patients are mostly brought in by family members, who stay with them in the emergency room until discharge (around 50% are discharged in four hours). Treatment is provided on a voluntary basis but non-consenting patients are admitted under provisions of the Mental Health Act, 1987. Diagnosis was based on DSM-IV criteria. Performa was filled using past records of 2 years where information collected by psychiatrists, nurses and junior doctors. Factors commonly associated with inpatient violence were examined which were age, gender, diagnosis, socioeconomic status, alcohol and substance abuse, length of admission, marital status and suicide risk.

Five types of aggression were studied which includes verbal aggression, physical harm to staff, physical harm to other patients, physical harm to visitors and destruction of property. To assess socioeconomic status five different categories were studied years of education, the employment status of the patient and family, residence of the patient and monthly income. Suicidal risk was assessed by a questionnaire including 5 yes/no answers and at least two yes answers were considered to be necessary to define the suicidal risk present. The $\chi^2$ test was used to analyze categorical variables and statistical significance was set at $p<0.05$.

RESULTS: In the considered period, 246 cases, 145 men (58.9%) and 101 women (41.1%) were admitted to the Psychiatric ward. Patients are mostly brought in by family members and admissions were mainly involuntary. Patients' mean age was 36.36 (±9.03) years. Of the admitted cases, 133 were married followed by 73 unmarried (single), 16 separated, 18 divorced, 6 widows or widowers. The most frequent diagnoses were schizophrenia (43, 17.5%), schizoaffective disorder (37, 15%), bipolar disorder mania (39, 15.9%), BPD depression (9, 3.7%), mixed episode (26, 10.6%), unipolar depression (10, 4.1%), post partum depression (5, 2.0%), psychotic disorder NOS (43, 17.5%), delusional disorder (9, 3.7%), alcohol abuse (5, 2.0%), substance related disorder (41.6%), personality disorder (7, 2.8%), delirium (1, 0.4%), psychotic disorder due to general medical condition (41.6%), obsessive-compulsive disorder (OCD) (2, 0.8%) and Munchausen’s syndrome (2, 0.8%). Aggressive cases were 65 (26.4%), violent cases were 105 (42.7%), and aggressive and violent seen together cases were 76 (30.9%). Cases showing physical harm directed towards staff were 113 (45.9%) cases, towards other patients in 95 (38.5%) cases, visitors 46 (18.7%) cases. And towards property in 115 (46.7%) cases. No patient was moved from the PICU to intensive medical care units because of treatment-related side effects. No fatality occurred. Exclusion was never used. Most assaults were not a significant threat to the attacked person, but few were highly dangerous. Violent cases were younger in comparison with the other two groups. There was no association seen between aggression and violence and marital status which were found dissimilar to the previous studies. Hospitalization was longer in violent than in aggressive cases. There was no difference among the three groups in terms of years of education and social class. Negative association was seen between suicidal risk and aggression and violence. Regarding diagnosis, personality disorder, alcohol and substance abuse and psychotic symptoms was more frequent in the violent than in the other two groups; depression was more frequent in the aggressive group. Violence was also associated with low income group.

DISCUSSION: we can summarize that the level of aggression and violence in the study are influenced
by the following factors:

A. Factors related to the illness:
   - Diagnosis
   - Length of stay
   - Risk of suicide

B. Demographic factors:
   - Income
   - Gender

Some of the methodological difficulties of earlier work about violence are overcome in this study by the use of a standard definition of violence, clear distinction between physical incidents and verbal threats (the latter are often neglected in research studies), and specified targets of incidents (such as property as well as persons). Aggressive behavior in patients with psychiatric disorders has many possible causes. Probably the most important causes are the presence of comorbid substance abuse, dependence and intoxication. In addition, the disease process itself may produce hallucinations and delusions, which may provoke violence. Often, poor impulse control related to neuropsychiatric deficits may facilitate the discharge of aggressive tendencies. Finally, underlying personality characteristics, such as antisocial personality traits, also may influence the use of violent acts as a means to achieve certain goals. Environmental factors that are associated with aggressive behavior include a chaotic or unstable home or hospital situation, which may encourage maladaptive aggressive behaviors. Patients with psychotic symptoms usually fall into persistently violent category. This may be due to acute decompensation secondary to covert or overt noncompliance with psychotropic medication therapy. Decompensation also may be due to a failure of the current medication regimen. The clinical features expected would be a worsening of psychotic symptoms and, possibly, command hallucinations, although the importance of the latter in violent behavior is in dispute. Several strategies for managing violent behavior in psychiatric settings could be developed. Given that warning signs preceded most incidents, staff training programs could target early recognition of warning signs of violence and aim to institute early verbal de-escalation procedures. Incidents of violence can be reduced by identifying patients with a history of violence, making staff members immediately aware of this information, and planning appropriate treatment. The strengths of the study include: 1) The observation of a large series of unselected acute psychiatric in-patients who were well characterized clinically. 2) The risk of underreporting violence seems to be low because the data about patients’ violence were collected comprehensively considering several sources of information such as medical and nurses’ records, daily meetings of staff members, and patients’ and family members’ reports. Some of the limitations of this study should also be noted: 1) The study was carried out at a single facility. Specific hospital practices and regional characteristics may have influenced the results. Studies carried out in other institutions may be helpful, but there are so many differences among settings that an examination of each hospital’s unique pattern of violence is necessary. 2) The distinction between primary from secondary diagnoses can sometimes be difficult, if not impossible. Therefore, in the analysis, we considered together both the primary and secondary diagnoses of substance or alcohol related disorders and of personality disorders. 4) The unequal interval between admission and the complete neuropsychiatric assessment reflects the initial uncooperative nature of the hostile and violent cases. Clinical rather than socio-demographic variables (with the notable exception of young age and gender) appear more related to the risk of violence. This finding has practical importance because clinical symptoms are amenable to therapeutic approaches. In the present study, young age, employment status, and marital status were not related with violence. Factors associated with violence were male gender, diagnosis of personality disorder, psychotic symptoms, substance and alcohol related disorders, low income, suicide risk and longer stay in the hospital.
Factors associated with aggressive behaviour were females, diagnosis of depression, alcohol abuse.

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REFERENCES: