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Progress in Neuro-Psychopharmacology & Biological Psychiatry 30 (2006) 586–598
Progress In Neuro-Psychopharmacology & Biological Psychiatry
www.elsevier.com/locate/pnpbp

Review article

Managing the aggressive and violent patient in the psychiatric emergency

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Accepted 30 January 2006
Available online 6 March 2006

Abstract

Throughout history most societies have assumed a link between mental disorders and violence. Although the majority of users of mental health services are not violent, it is clear that a small yet significant minority are violent in inpatient settings and in the community. The assessment of a violent patient may be very difficult due to the lack of a full medical and psychiatric history and the non-cooperativeness of the patient. Thus a full assessment is important for the early decisions that the clinician has to take in a very quick and effective way. The primary task and the short term outcome in a behavioral emergency is to act as soon as possible to stop the violence from escalating and to find the quickest way to keep the patient's agitation and violence under control with the maximum of safety for everybody and using the less severe effective intervention. The pharmacological treatment of acute, persisting and repetitive aggression is a serious problem for other patients and staff members. Currently, there is no medication approved by the Food and Drug Administration (FDA) for the treatment of aggression. Based on rather limited evidence, a wide variety of medications for the pharmacological treatment of acute aggression has been recommended: typical and atypical antipsychotics and benzodiazepines.

Keywords: Aggression; Antipsychotics; Benzodiazepines; Psychiatric emergency; Violence

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Abbreviations: BPSD, Behavioral and psychological symptoms of dementia; ECA, Epidemiological Catchement Area; FDA, Food and Drug Administration; GABA, γ-Aminobutyric acid; MOAS, Modified overt aggression scale; OAS, Overt aggression scale; PET, Positron Emission Tomography; PTSD, Posttraumatic stress disorder; PANSS, Positive and Negative Syndrome Scale; PANSS-EC, Positive and Negative Syndrome Scale Excited component; SCL-90, Self-report symptom inventory.

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doi:10.1016/j.pnpbp.2006.01.015

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1. Introduction

Aggression and violence have various meanings. Aggression may be defined as an intentional act that inflicts physical or mental harm on somebody. Some studies have referred to violence as an aggressive act that causes physical injury; for others it has to be associated to both verbal and physical aggression (Barratt et al., 1997; Filley et al., 2001; Moeller et al., 2001). In this paper, we adopted the Webster Dictionary (1993) definitions. Violence is "the exertion of any physical force so as to injure or abuse; an instance of violent treatment or procedure; injury in the form of revoking, repudation, distortion, infringement or irreverence to a thing, notion or quality filthy valued or observed" (Webster Dictionary, 1993). The focus is mainly on acts and on interactions between two or more people, thus we use the expressions violence, violent and aggressive behavior as synonymous. Violence is not always physically acted, because also a mental attitude, an interpersonal relationship or an institution can be violent (ethically, morally, etc.).

Aggression has a broader meaning that goes from "an offensive action or procedure" to "a form of psychobiological energy either innate or arising in response to or intensified by frustration" (Webster Dictionary, 1993). Often this drive does not produce an open form of violence but can be transformed by high mental processes, such as introjection and sublimation, and become something useful for the individual and socially accepted like compete for career or playing sports. In a recent review on qualitatively distinct subtypes of human aggression the dichotomy between impulsive–reactive–hostile–affective subtype and a controlled–proactive–instrumental–predatory subtype has emerged as the most promising construct (Vitiello and Stoff, 1997).

In a traditional categorical approach aggression and violence are not a diagnostic entity although they are present as symptoms in many mental disorders. That is way they have a transnosographical meaning. On the other hand in many studies and meta-analysis (Lindenmayer et al., 2004; Akiskal et al., 2003) the factor analysis of data allows to describe the dimension aggression–violence. This is very useful in the research field to address new studies and in clinic to target the management and the pharmacological treatment of patients.

Although clinicians prefer to assess the patients through the unstructured clinical observation (Allen et al., 2001) the use of rating scales can be helpful to better measure and document the aggression and the violent behavior. There are many specific tools ideated for this purpose. The most used in research are self-assessment scales, like the Buss Durkee Hostility-Inventory (Buss and Durkee, 1957) and the Self-report symptom inventory 90 (SCL 90) Anger–Hostility Subscale (Derogatis et al., 1970), good to assess aggression in fully cooperative people. Of course with violent and uncooperative real patients observer rating scales are needed. They can be specially tailored for this purpose or sub-scales derived by component of general scales. The most used are: Overt Aggression Scale (OAS) (Yudofsky et al., 1986), Modified Overt Aggression Scale (MOAS) (Kay et al., 1988), PANSS Excited Component Score (PANSS-EC) (Kay et al., 1987; Lindenmayer et al., 2004).

Aggressive and violent symptoms vary from threatening behavior and agitation to assault and can be seen in patients with the following diagnoses: organic psychoses, such as after head injures, cerebral infections, metabolic diseases, drug intoxication, etc.; personality disorders such as borderline and antisocial personality disorders; developmental disabilities; dementia; bipolar affective disorders and schizophrenia, most often during acute psychosis. Violence is one of the most detrimental factors in the continued stigmatisation of mental illness.

Several recent large-scale studies have determined that there is a relationship between mental disorders and violence. Although the majority of users of mental health services are not violent, it is clear that a small yet significant minority are violent in inpatient settings and dangerous for the community (Swanson et al., 1990; Hiday, 1997).

The rates of violence differ across diagnostic categories, suggesting that it is essential to examine the diagnostic condition separately in relationship to the risk of violent behavior (Swanson et al., 1990; Steadman et al., 1998). An important study used a sample of 10059 adult residents from Epidemiologic Catchment Area (ECA) study sites and examined the relationship between violence and psychiatric disorders (Swanson et al., 1990). Eight percent of those with schizophrenia alone were violent, compared to 2% of those without mental illness. Comorbidity with substance abuse increased this percentage to 30%. Another community-based study of follow-up at 1-year (Steadman et al., 1998) showed that only 17.9% of mentally ill patients without a substance use diagnosis were violent, which was equal to the rate of violence among non-mentally ill persons who did not abuse of substances. Rate rose to 73% in people with mental illness and substance use and up to 240% if the substance was used by patients with personality disorders.

A review (Nestor, 2002) examines the relationship of a greater risk of violence among persons with certain mental disorders in terms of four fundamental personality dimensions. Low impulse control and affective regulation was found to increase the risk of violence across various disorders, especially for primary and comorbid substance abuse disorders, while paranoid cognitive personality style and narcissistic injury was found to increase the risk of violence respectively in schizophrenia spectrum disorders and personality disorders.