



Violent images, anger and physical aggression among male forensic inpatients



Stine Bjerrum Moeller^{a,*}, Matthias Gondan^a, Raymond W. Novaco^b

^a Department of Psychology, University of Copenhagen, Øster Farimagsgade 2A, 1353 København K, Denmark

^b Department of Psychology & Social Behavior, University of California, 4343, SBS Gateway Bldg, Irvine, CA 92697-7085, United States

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ABSTRACT

Purpose: The present study of forensic hospital patients examined whether their imagination of violence is related to self-reported anger, psychological distress, and to staff observations of aggressive behaviour in hospital. In view of the relevance of psychological trauma for anger and aggression, we further investigate whether the associations of imagined violence to anger and aggression are stronger when the patient has trauma-related intrusion symptoms.

Methods: Participating male forensic inpatients ($N = 54$) were individually tested and followed-up for five months. Aggressive episodes were measured using the Staff Observation Aggression Scale-Revised.

Results: Patients who imagine violence, compared to those who do not, were higher in psychological distress (anger, symptoms of PTSD, psychosis, depression, and anxiety), and displayed more aggressive acts both retrospectively and during the follow-up period. Imagined violence and trauma-related intrusions separately contributed to anger and aggressive behaviour.

Conclusions: The study calls attention to violent images as an important variable involved in aggressive responding. The role of violent images as a mediator of the well-established association between anger and aggression, including symptom severity as a potential moderator, needs further investigation. Therapeutic strategies focusing on forensic patients' violent images may improve treatment response in the prevention of aggression.

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1. Introduction

The relationship between imagining violence and violent behaviour is an important subject for psychiatric patients for many reasons. Violent fantasies are judged by clinicians in acute, chronic, and forensic types of hospitalization to be strong indicators of violence risk (Elbogen, Mercado, Scalora, & Tomkins, 2002), and violent fantasies are prevalent among adolescent and adult mass murderers (Meloy et al., 2004), adolescent sex offenders (Leclerc, Beauregard, & Proux, 2008), and have been identified as a driving mechanism for serial and sadistic sexual murder (MacCulloch, Gray, & Watt, 2000). Violent fantasies have been found to be common and to be associated with physical aggression among college students (Kenrick & Sheets, 1993), early adolescents (Su, Mrug, & Windle, 2010), and psychiatric patients (Grisso, Davis, Vesselinov, Appelbaum, & Monahan, 2000).

The present study of forensic hospital patients examines whether imagination of violence is related to self-reported anger and psychological distress. It also examines whether patient imagined violence is

retrospectively and prospectively related to staff observations of their aggressive behaviour in hospital. In view of the relevance of psychological trauma for anger and aggression (Olatunji, Ciesielski, & Tolin, 2010), we further investigate whether the associations of imagined violence to anger and to aggression are stronger when the patient has trauma-related intrusion symptoms.

1.1. Violent images, anger and psychological distress

Violent images are rooted in violence experience, whether real or vicarious. Violence victimization has high prevalence among forensic populations in prisons (e.g., Wolff, Shi, & Siegel, 2009) and in hospitals (e.g., Novaco & Taylor, 2008), as well as among psychiatric patients in general (e.g., Fortugno et al., 2013; Sturup, Sorman, Lindqvist, & Kristiansson, 2011), and having a history of violence victimization is associated with anger (Novaco & Taylor, 2008) and increased psychological distress (Weaver & Clum, 1995). With the construction of the Schedule for Imagined Violence (SIV) that was used in the landmark MacArthur project on violence and mental disorder (cf. Monahan et al., 2001), Grisso et al. (2000) found that imagining violence (SIV positive) while in hospital was significantly related to anger in hospital (assessed by the instrument used in the present study). They also

* Corresponding author at: Psychiatric Research Unit, Mental Health Centre North Zealand, Dyrehavevej 48, 3400 Hillerød, Denmark.

E-mail address: Stine.bjerrum.moeller@regionh.dk (S.B. Moeller).

reported that patients with high symptom severity (Brief Psychiatric Rating Scale; BPRS) had more than double risk of being SIV positive than those patients with low symptom severity (40% versus 17%). Gilbert, Daffern, Talevski, and Oglhoff (2013) found that SIV “frequency” was significantly associated with “trait” anger. The relevance of anger for violent behaviour by psychiatric patients, forensic and non-forensic is well-established (cf. Novaco, 2011; Swogger, Walsh, Homaifar, Caine, & Conner, 2012; Sturup, Monahan, & Kristianson, 2013; Ullrich, Keers, & Coid, 2014; Moeller, Novaco, Heinola, & Hougaard, 2015).

1.2. Violent images and aggressive behaviour

Exposure to violence prompts the production of aggressive scripts and anger schemas. The person acquires a repertoire of aggressive behaviours, which is then readily accessed in responding to social problem situations. The social information processing model of Huesmann (1988, 1998), which features aggressive scripts, explicates how these are acquired and maintained through observational and enactive learning, and then are stored in memory, serving as guides for social behaviour. The mental rehearsal of aggressive scripts (violent imagery), particularly when angry, can increase the availability making them resistant to change, and increase the propensity for aggression. However, there is a lack of empirical evidence linking rehearsal of aggressive scripts (imagining violence) with aggression. The study by Grisso and colleagues found that patients who reported imaging violence (SIV positive) while in the hospital were significantly more likely to be violent, compared to those who were SIV negative, during a 20-week post-discharge period (Grisso et al., 2000). Surprisingly, only a few studies have pursued the imagined violence topic with regard to aggressive behaviour. Each has used the SIV measure. Nagtegal, Rassin, and Muris (2006), with a college student sample, reported that aggressive fantasies were significantly related to aggressive behaviour, although their aggression measure was self-report. In a survey based community sample, Watt, Kohphet, Oberin, and Keating (2013) reported an association between violent images and self-reported aggression, which was enhanced by alcohol consumption, although their response rate was as low as 13%. Recruiting patients from an outpatient forensic service in Australia (more than half with violent offences), Gilbert et al. (2013) found that SIV “frequency” was significantly associated with history of aggression, controlling for impression management, depression, and self-control. The aggression measure was self-report and retrospective. Closer to our study population and measures, Sturup et al. (2013), with psychiatric patients in Sweden, found a predictive association for imagined violence with respect to aggression in the community 20 weeks after discharge. However, like in the MacArthur project, the patients were non-forensic. Because violent fantasies are prevalent among murderers and sexual offenders (see above), we here seek to examine violent images in regard to physically aggressive behaviour in hospital among forensic in-patients.

1.3. Trauma-related intrusions, violent images, and aggressive behaviour

It has been evidenced that anger is more predictive of aggressive behaviour than major mental disorder (e.g. Appelbaum, Robbins, & Monahan, 2000), however patients suffering greater symptom severity would be expected to be more likely to engage in actual violence because increased stress would override inhibitory controls and limit access to infrequently rehearsed cognitive scripts. In linking major mental disorder with increased risk of aggression, specific symptoms such as persecutory beliefs and threat/control-override symptoms (TCO)¹ have been explored with varying results. Some find an association (e.g. Nederlof, Muris, & Hovens, 2011) and other do not (e.g.

Soyka, Graz, Bottlender, Dirschedl, & Schoech, 2007). Limited attention has been invested in exploring trauma-related intrusions. In exploring the relationship between PTSD and aggression, the hyperarousal symptom cluster (closely related to anger) has been associated with aggressive behaviour among veterans (Elbogen et al., 2010; Savarese, Suvak, King, & King, 2001; Taft et al., 2007). According to the survival mode theory, aggression is exaggerated by PTSD, due to heightened threat perception and arousal overriding inhibitory controls (Chemtob, Novaco, Hamada, Gross, & Smith, 1997; Novaco & Chemtob, 2002). From a large sample of Vietnam veterans with PTSD, Novaco and Chemtob (2015) reported that anger was responsible for the association between PTSD and aggressive behaviour. Moreover, anger rumination (a form of imagining violence) has been linked to PTSD's re-experiencing cluster (trauma-related intrusions, Orth & Wieland, 2006). In a review paper, McHugh, Forbes, Bates, Hopwood, and Craemer (2012) argued that visual imagery is crucial to the involvement of anger in post-traumatic stress disorder (PTSD) highlighting the primacy of trauma-related intrusions. Based on these findings, we expected an interaction effect on anger and aggression when trauma-related intrusions were conjoined with violent images.

1.4. Study hypotheses

The present study involves male forensic inpatients at a high security psychiatric hospital in Denmark. Our hypotheses are: (1) patients who imagine violence, compared to those who do not, will be higher in psychological distress (anger and symptoms of PTSD, depression, anxiety, and psychosis); (2) patients who imagine violence, compared to those who do not, will be higher in physical aggression (staff recorded); (3) the link between violent imagery and anger/aggression will be especially strong when trauma-related intrusions are high.

2. Method

2.1. Setting

The study was conducted at the 80 beds forensic psychiatric unit of the Mental Health Centre Sct. Hans in Denmark. Patients are admitted under psychiatric orders imposed by court for having committed a serious offense and being unfit to endure punishment because of severe psychopathology. The study was approved by the Danish Data Control system (2007-58-0015).

2.2. Participants

Of 88 available male forensic inpatients, 54 (61%) volunteered to participate. Participants with mild to moderate organic problems were included, because organic problems are prevalent in this population, however, patients with severe organic problems were excluded. Females were excluded, because they were limited in number ($n = 8$). Assessment of patients in acute states of illness (e.g., vivid hallucinations or in seclusion) was avoided. No patients dropped out of the study. Analysis of the characteristics of patients not willing to participate was not possible. The mean age of the patients was 36.4 years (SD 11.9, range 19 to 67) years. Additional sample characteristics are displayed in Table 1.

2.3. Procedure

Data collection was part of a larger study on clinical risk factors for aggression. The follow-up period was five months for each individual. All participants were volunteers. Written information about the study was provided, and anonymity was assured. It was emphasized that participants would not be identified in subsequent reports and that personal data would not be used in the psychiatric or the forensic system. The patients were approached on their hospital wards by the first author

¹ Threat/Control-override symptoms refer to a feeling of being “gravely threatened by someone who intends to cause harm” and of an override of self-control through external forces (Link, Stueve, Monahan, & Steadman, 1994).

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