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The influence of dysfunctional impulsivity and alexithymia on aggressive behavior of psychiatric patients



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ABSTRACT

Current approaches in Dutch mental health care institutions towards inpatients' aggression have focused predominantly on environmental factors, such as training the staff in aggression management. However, personality traits might be an important factor in patients' aggression – as shown by incidents in the wards. This study explores the influence of dysfunctional impulsivity and alexithymia on psychiatric patients' aggressive behavior, through self-reports and through involvement in aggressive incidents. Personality traits influencing patients' aggression emphasize the importance of a more direct approach to their aggression. Clinical patients at Dutch mental health care institution Emergis ($n=84$) filled out questionnaires about their aggressiveness (using Buss and Perry's Aggression Questionnaire Short Form), dysfunctional impulsivity and alexithymia. Multiple regression analyses indicated that dysfunctional impulsivity positively related to self-reported aggressive behavior. The relationship, however, could not be confirmed for inpatients' aggression as reported by the staff on the wards. Unexpectedly affective alexithymia negatively related to hostility. Gender differences in self-reported aggression were found. Female patients showed higher levels of hostility. Regression analyses indicated that the male gender positively related to physical aggression. Findings emphasize the importance of a new approach in Dutch mental health care, in which patients may engage in aggression-regulation training programs.

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1. Introduction

1.1. Aggressive incidents

In the past decade, the aims of research on aggressive incidents in mental health care institutions have largely been limited to reducing the use of coercive measures (Noorthoorn et al., 2015; Vruwink et al., 2012; Steinert et al., 2010; Raboch et al., 2010; Bowers et al., 2006). The approach to aggressive incidents in mental health care institutions in the Netherlands, as manifested in the wards, has predominantly focused on the environment of the patient, e.g. through offering a friendly atmosphere at the ward and training the staff in risk assessment or other specific methods (Vruwink et al., 2012). Less research has focused on how personality traits of patients in mental health care influence their control of emotional arousal.

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An emotional aggressive reaction is caused by personality traits and by aggression-arousing cues in the environment (Berkowitz, 1979; Frijda, 1999). Building on Berkowitz' theory on reactive (or emotional) aggression, many studies try to disentangle the role of personality variables associated with aggressive behavior. The five factor model (FFM; Costa and McCrae, 1992) and Gray's (1987) behavioral inhibition system / behavioral activation system (BIS/BAS) are prominent theories of personality dimensions, which contribute to our knowledge of the link between aggressive behavior and personality variables, like impulsivity. We will refer to these models in the next paragraph. Despite the development of many models and theories on aggressive behavior, however, a better understanding of the complex dynamics among personality variables, situational variables and aggressive behavior is still needed (Bettencourt et al., 2006).

In the present study we explore if personality traits of psychiatric patients in mental health care influence their self reported aggression and their incident involvement in the wards. In the sections that follow, we will first elucidate the way in which personality variables, specifically dysfunctional impulsivity and alexithymia, are

related to aggressive behavior in (clinical) psychiatric patients. Then we will further explain the implications of influences of personality traits on improving the current intervention programs. And we present our hypotheses. This will be followed by a presentation and discussion of findings of our research.

1.2. Personality traits and aggression

Several studies on personality and aggression among psychiatric patients focused on personality disorders (e.g., psychopathy or borderline personality disorder) to identify patterns of traits or multidimensional traits that are associated with aggressive behavior. In adults having a borderline personality disorder (BPD) several positive relationships to higher levels of aggressive behavior have been found. These are higher levels of BPD symptoms (Herr et al., 2013), the presence of maladaptive coping mechanisms for emotional distress (Gardner et al., 2012) and poor emotion-regulating properties (Selby and Joiner, 2013). Related research, however, indicated that lower-order, unidimensional traits may provide more precision in identifying specific aspects of personality that are associated with aggression than patterns of traits in personality disorders or multidimensional traits do (Miller et al., 2012). For instance, externalizing behaviors in general (e.g. substance abuse and antisocial behavior) are associated to aggression and also strongly correlate to lower-order traits related to personal antagonism, poor impulse control and heightened negative emotionality. These lower-order traits can be associated with aggression as well (Miller et al., 2012).

First of all, impulsivity is an important personality trait that has been shown to enhance externalizing behaviors and aggression. Building on Gray's (1987) behavioral inhibition system / behavioral activation system (BIS/BAS), research revealed that a high BAS is associated with impulsivity in addition to a tendency to externalize problems (Bijttebier et al., 2009). Impulsivity itself, however, is not a unidimensional concept; its various components may be differently related to aggression. For example, a study of Miller et al. (2012), examining relationships between aggression and broad domains of personality variables, as included in the models FFM and BIS/BAS, revealed that two domains of traits which consistently related to aggression were: interpersonal antagonism and impulsivity-related traits. They further suggested that conscientiousness-related forms of impulsivity (i.e., failing to think of the consequences before acting) and neuroticism-related forms of impulsivity (i.e., acting impulsively when emotionally dysregulated) can be considered significant correlates of aggression. Consistent with these results, related studies revealed that the impulsivity traits that are most relevant to sexual aggression appeared to be the tendency to act impulsively when experiencing intense emotions, and when a lack of forethought and planning (premeditation) is present (Mouilso et al., 2013). Garcia-Forero et al. (2009) suggested a higher order variable, such as emotional processing, to mediate the relationship between aggressiveness and impulsiveness traits.

Dickman distinguishes two components of impulsivity: functional and dysfunctional impulsivity (Dickman, 1990; Claes et al., 2000). Functional impulsivity refers to a tendency to decide quickly when this style is optimal, whereas dysfunctional impulsivity relates to a tendency to make non-reflective decisions with negative consequences. Dysfunctional impulsivity in particular has been shown to be associated with aggression (Kumari et al., 2009). Similarly, Caprara et al. (2002) found a lack of self-regulatory efficacy, which enhances acting impulsively, to be associated to aggressive behavior. A study by Vigil-Colet et al. (2008) reported positive correlations between dysfunctional impulsivity and several scales of Buss and Perry's (1992) Aggression Questionnaire among different samples. Other studies also revealed strong relationships between

dysfunctional impulsivity and aggressive tendencies both in the general population, among (forensic) psychiatric patients (Mudde et al., 2011) as well as among patients with a specific diagnosis, i.e., BPD, (Johnson et al., 2003) and schizophrenia (Kumari et al., 2009; Krakowski and Czobor, 2013).

Another construct related to aggressive behavior is alexithymia, which refers to a person's inability to reflect upon and to differentiate between emotions. Taylor et al. (1985) initially refer to four essential elements of alexithymia: (1) a reduction of or incapacity to experience emotions; (2) a reduction of or incapacity to verbalize emotions; (3) a reduction of or incapacity to fantasize; and (4) an absence of a tendency to think about one's emotions. A fifth element 'a difficulty in identifying emotions' was added as a new characteristic (Taylor et al., 1985). Building on these five elements of alexithymia Bermond and Vorst (2001) developed the Bermond Vorst Alexithymia Questionnaire (BVAQ), which distinguishes between an affective and a cognitive composite, respectively referring to a conscious awareness of the arousal of emotions versus a conscious interpretation of emotions. Alexithymia is implicated in a wide variety of psychological problems, such as depression, schizophrenia, autism spectrum disorder and obsessive-compulsive disorder (Samur et al., 2013; Ogrodniczuk et al., 2012; Daeyoung et al., 2011; Wout, 2006). Studies also revealed that alexithymia is indeed associated with aggressive behavior (Teten et al., 2008; Parry, 2012; Manninen et al., 2011).

In summary, we argue that specific components of impulsivity as well as traits involving dysregulation of emotions offer insight into psychiatric patients' aggressiveness. Of these traits, dysfunctional impulsivity and alexithymia appear to be most relevant, which is why we included these variables in our study.

1.3. Aim of this study

Personality traits influencing psychiatric patients' aggression emphasize the importance of a more direct approach to their aggression. For instance through attending aggression regulation programs or receiving treatment addressing specific personality traits.

Although patients' verbal or physical aggression, as manifested in the wards, can be severe and cause damage to persons or materials, it is seldom a (primary) treatment goal in mental health care institutions in the Netherlands. As stated in Section 1.1. the present approach includes staff training and other environmental measures. It is debatable to what extent these measures contribute to the reduction of the incidence of aggressive acts. Noorthoorn et al. (2015) found positive effects on the duration – not the frequency – of specific coercive measures in psychiatry. A study in British mental health care institutions did not show a reduction in aggressive incidents after staff training programs (Bowers et al., 2006). Research of Heckemann et al. (2014) in acute hospital settings, found comparable results.

The broad introduction of environmental measures, was the response of the Dutch mental health care institutions to the government's demand in IGZ (2002) to reduce the application of coercive measures (e.g. seclusion). Coercive measures often had negative effects on patients' mental health or recovery in treatment (Stolker et al., 2004; Welles and Vuur, 2009; Welles and Widdershoven, 2007). Notwithstanding the positive effects of the environmental measures (Lendemeijer, 2000), they fail to provide patients a more active role. Measures directly aimed at patients' own initiatives to control their aggressive impulses and to cope with their aggressive feelings themselves, could improve current intervention programs.

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