ASSAULTIVE BEHAVIOR

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Dramatic increases in violent crime in our society are a growing national concern, and incidences of violence in health-care settings reflect this trend. Assaultive behavior in patient populations is a problem for all concerned. Violence is a threat to the welfare of patients themselves, other patients, visitors, and staff. Of great concern is that assaults by patients on staff involve injury, lost time, high stress, job dissatisfaction, and subsequent psychological consequences. The price is high; patient assaults incur costs in lost productivity, insurance and medical costs, and monetary losses from litigation (Calhoun, 1980). Despite the voluminous amount of literature on assaultive behavior, these issues remain poorly understood and are increasingly problematic.

Legal liability and claims of negligence are also an alarming issue, and litigation is becoming much more commonplace (Calhoun, 1980). Felthous (1987) notes a shocking increase in successful suits brought against treaters for failure to predict dangerousness, for failure to properly treat or restrain, and, of increasing concern, for failure to protect third parties from assault. Sales (1983) identifies the legal responsibilities and liability of institutions in ensuring the rights of staff to safety in the workplace, specifically in relation to workers' compensation.

For these reasons, it is vital that healthcare providers understand these responsibilities and liabilities, and in which settings and under what conditions assaults are most likely to occur. Treaters must have an awareness of the incidence of assaults, and understand why healthcare providers are being placed in situations of higher risk by various political and economic factors. And finally, treaters must be familiar with the various risk factors that have been identified in the literature as opposed to those that reflect older, traditional ways of thinking about assault. If the issues of violence are to be properly addressed, clinicians must begin to use findings reported in the literature.

Scope and Incidence
There is a great deal of statistical information in the literature to attest to the incidence of assaultive behavior in health-care settings. Assaultive behavior is encountered in a wide variety of health-care arenas. High assault rates have been reported in outpatient clinics, nursing homes, and emergency departments (Drummond, 1989). But by far the highest incidence of assaults to staff occur in psychiatric settings (Sheridan, 1990), and injury to staff on psychiatric units is identified as a major occupational risk (Carmel, 1989). The National Safety Council reported that assaults are the leading cause of injury for staff in psychiatric facilities (Phillips, 1977).

Skodol and Karasu (1980) state that society in general tends to associate violent behavior with mental illness and that a certain amount of assaultive behavior, particularly in the psychiatric setting, is inevitable. Up to 60% of psychiatric patients seen in the emergency room (Suh, 1979) or admitted to psychiatric units are physically assaultive (Tardiff, 1980). Furthermore, nearly 75% of these patients report a history of assault (Hagen, 1972).

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Jones (1985) found that 65% were against staff, whereas only 32% involved other patients or property. The most frequent victims are nurses and nursing assistants (Lanza, 1988), and nursing staff are considered most vulnerable to attack and injury (Rada, 1981). Alder (1983) reports that the number of staff injured by patients increased by more than five times over a 5-year period, and many estimate that this trend will continue (Drummond, 1989). Madden and others (1976) report that half of all health-care professionals will be assaulted during their careers. In a large psychiatric facility, Lion (1981) reported that 3.94% of patients were assaultive in a single year. Reid and others (1985a) reported 2.54 assaults per bed per year in psychiatry and 0.37 assaults per bed per year in a nonpsychiatric setting.

Also of concern is the agreement in the literature of the frequency of underreporting of violent incidents. In an important study done by Lion and others (1981), it was found that significant and severe underreporting occurs at a rate of five times that of reported assaults. Convit and others (1988) discovered that assaults occur 50% more often than reported, and involve 34.5% more patients than reported. Later studies have confirmed the magnitude of underreporting (Negley, 1990). This occurs for a number of reasons, both administrative and psychological, but the evidence is that assaults continue to be drastically underreported (Aiken, 1984).

A number of factors may explain why the incidence of assault is increasing. The trend for more humane and “least restrictive” treatment creates difficulties for the management of assaultive patients. Court decisions regarding the right to refuse medication may curtail chemical treatment, and some feel that this increases the likelihood of repeated assaultive incidents (Lion, 1981). Some researchers (Feltlous, 1987) point out that the movement toward deinstitutionalization has created greater numbers of potentially dangerous outpatients not under direct care. Additionally, economic factors have decreased accessibility to hospital treatment, and thus increased the number of assaultive persons in the community who might then be more likely to become acute. Furthermore, the conventional rationale for hospitalization is dangerousness to self or others, and this has become a legal criterion for forced hospitalization (Madden, 1976). Most states now set standards limiting civil commitment to severe mental impairment or dangerousness, resulting in a larger concentration of aggressive and violent patients in psychiatric units.

For these reasons, there has been more effort to identify risk factors for violent behavior in hopes that these factors could be used to predict which situation or patient is more prone to or “at risk” for assaultive episodes. Risk identification should enable appropriate prevention, prevention, and management of assaultiveness. Incidence of assault is high, and underreporting is considerable, yet as many as half of reported incidents of assault are thought by victims to be avoidable (Aiken, 1984). It is clear, then, that understanding this serious problem of violence and risk is timely.

Risk Factor Identification

For decades researchers have been correlating various factors with incidence of assault, and the literature addressing the prediction of violence is extensive. Those authors who have attempted to predict assaultive behavior based on identified risk factors obtain only low levels of accuracy in their predictions, and their results lack cross-validation in independent samples, or from one setting to another (Convit, 1988). One conclusion that can be drawn is that assaultive behavior is precipitated by a combination of personal risk factors, situational factors, and treatment characteristics. The combination of various risk factors and their interaction with the patient’s pathology also contributes to the dynamics of assault. The sum of all of these issues is complex at best. Nevertheless, the determination and examination of these factors must be made, at least to educate and raise awareness. Certain factors can then be assessed in relation to specific patients, the milieu, and treatment setting, and would thus enable more meaningful and informed treatment designs and interventions.

By far, the most common factor associated with assaultive behavior is a history of assault (Drummond, 1989; Lanza, 1988; Rossi, 1986). There have been many studies correlating criminal violence in the community with risk for assault in a hospital setting. Yet, assaultiveness in the community and its relationship to assaults in the hospital is unclear. The Veterans Administration examined assaults with regard to civilly committed patients (Rofman, 1980), and Steadman (1981) studied assaults by criminally committed patients. Both studies conclude that different dynamics are related to assault in the community and assault in the hospital. This supports an issue discussed later that suggests that assaults in the hospital may be related more to the treatment setting itself rather than to individual characteristics. Although a patient’s violent behavior in the hospital may be qualitatively different from violence in the community, the literature unequivocally shows that a history of assault in a treatment setting is by far the most widely recognized risk factor for assault.

Diagnosis is the second most frequently correlated factor with assaultive behavior.
tive behavior, and in studies over the past 20 years, there is strong agreement regarding which diagnostic categories are most at risk. Drummond and others (1989) found that 65.9% of assaults were by patients with a psychiatric diagnosis, 25% by patients diagnosed with substance abuse or alcohol intoxication, and the remainder were a medical diagnosis. Jones (1985) found that 85% of all diagnoses associated with assault were psychiatric conditions or substance abuse. Intoxication alone has a high association with violence (Lanza, 1988; Rada, 1981), and Drummond and others (1989) found that 72.7% of assaultive patients have substance abuse as a primary or secondary diagnosis. Post-traumatic stress disorder is reported to have a high association with violent behavior (Lanza, 1988).

Extremely high numbers of assaults involve organic brain disordered or dementia patients (Craig, 1982; Jones, 1985; Tardiff, 1979). The high numbers are presumably due to the fact that these disorders involve recurrent loss of impulse control and confusion (Rossi, 1986). Injuries resulting from these assaults are more likely to be less severe or minor in nature, and more often go unreported (Palmstierna, 1987). Another diagnosis highly associated with assault is schizophrenia, and in particular, paranoid schizophrenia or other psychotic disorders involving paranoid delusions (Aiken, 1984; Craig, 1982; Rada, 1981). Other diagnoses associated with high incidence of violence are epilepsy of all types and temporal lobe abnormalities (Rada, 1981).

Diagnosis may be helpful in a systematic attempt to assign risk for assaultive behavior, but Rossi and others (1986) point out that the diagnosis in and of itself is not definitive. Rather, it is the severity of the pathology that is the predisposition to violence, making diagnosis only indicative at best.

Demographic and epidemiologic factors have been studied in relation to assaults. Age, sex, race, marital status, education, and socioeconomic level have all been examined; data have been mixed and contradictory (Rossi, 1986). Social learning and family roles in relation to violence, cultural values associated with violence, and crowding have been examined. In all these cases, some low levels of association were found, but not to the extent that these factors are useful in predicting violence. Rossi (1986) concluded that demographic variables are not useful in predicting violent behavior. Others agree on the lack of usefulness of these factors and that interventions based on these factors would be ineffective (Jones, 1985; Lion, 1981). Rossi (1986) found that only a history of assault, diagnosis, and legal status at admission were useful risk designations.

Environmental issues have been studied in relation to assaults with similar outcomes. Day of the week, time of day, hospital shift, type of unit, and audience at time of assault have all been examined, with the results being inconclusive or contradictory (Jones, 1985). Number of staff and the sexual makeup of staff have been examined, and results have also been inconclusive (Lanza, 1988). Changing staffing patterns to reduce assault has not been supported in the literature as an effective approach; rather, it seems to be the individual personalities and style of specific staff members and how much direct contact staff have with patients that is important to consider on designing interventions (Blair, 1991).

Denial plays an important role and can be considered a risk factor. Madden (1977) points out that violent patients themselves use denial of violent impulses as a defense for a fragile ego or low self-esteem. Likewise, when staff deny the possibility of assaults against themselves, they are placed at risk for assault (Lion, 1973). Madden (1976) reported that more than half of psychiatric staff who were assaulted conceded that they could have anticipated the assault had it not been for their denial. Denial on an institutional level may account for the lack of motivation or innovation in the development of adequate controls for violent and aggressive behaviors.

**Issues of Provocation**

Certainly, there are unprovoked assaults from patients with organic brain disorder or dementia, from those suffering from seizure activity, or from psychotic patients experiencing bizarre or threatening delusions. Assaults under these circumstances are not goal-directed, but are random and generalized. Findings indicate that the majority of assaults are not predicted by staff, so precipitating factors have been difficult to identify (Convey, 1986; Rada, 1981). Yet, the literature has been able to identify certain factors of provocation, and it is important to examine these. It is quite likely that seemingly unprovoked assaults were, in fact, provoked by circumstances of which staff are unaware.

Rada (1981) states that a common perception of assaultive patients is that patients view their victims as provoking the assault. Morrison (1990) agrees, and finds that often the reported motivation for an assault was to get staff off my back.” Sheridan (1990) states that patients are more likely to view interpersonal conflict with staff as a precipitant to violent acts.

A primary factor of provocation is that of limit setting. Lanza (1988) identifies limit setting as having a high level of provocation, and reports that physically setting limits provoked assaults with organic or demented patients. But a greater number of assaults occurred when staff used only verbal limit setting. This would implicate the style and the skill level of the staff involved. Dubin (1988) states that failure to set effective limits may lead to escalation and assault. Madden (1977) demonstrated increased risks of assault when limit setting was inconsistent. Lanza (1988) studied the types of limits and their association with assault. Limits that involved moving a patient to another area, placing limits on eating or drinking certain foods or beverages,
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and limitations on cigarettes were the most risky. Taking something away from a patient drastically increases the likelihood of assault.

Staff attitude is another issue of provocation. Assaulted staff generally report that they “didn’t like” the patient, and perhaps this animosity is projected onto the patient (Madden, 1976). Others have found that aggressiveness on the part of the terer is more likely to provoke assault (Dubin, 1988). Rubin and others (1980) discovered that 83% of staff who said they would “fight back” were assaulted, whereas only 38% of assaults were against those staff members who said they would not fight.

The educational level and clinical expertise of staff is obviously related to these issues. Nursing assistants and student nurses have a higher incidence of assault, which suggests that skills and experience play an important role (Rubin, 1980). In an important study by Infanitno and Musingo (1985), it was shown that staff who had training in limit setting and control techniques had a significantly lower assault rate than did a group without training. Another consideration is the fact that hospitals, and in particular psychiatric settings, use nonprofessional personnel for most patient care duties. Kavanaugh (1988) points out that this group of workers has a more authoritarian and inflexible style of working with the mentally ill. An authoritarian system of management leads to high isolation of staff from patients. Several authors have demonstrated that authoritarian, overcontrolling staff rarely socialize with patients and have little person-to-person contact with them unless the interaction involves limit setting or confrontation (Hodges, 1986; Sanson-Fisher, 1979).

Locked units and severe structure may increase the risk for assaultive behavior by implying that abnormal or disturbed behavior is acceptable in such settings. Assaults become an expected occurrence—just “part of the job” (Weaver, 1978). All too often, job performance is defined as keeping the patients under control. Frequent heavy use of medications, restrictions, seclusion and restraints are used to maintain this control, all of which are intrusive and provocative. Such settings may change the nature of potentially violent situations or alter the expectation of violent acts. Violent behavior may play a role in getting staff attention, or may lead to a tangible reward (Reid, 1985b). Strict structure negates a positive milieu and renders staff incapable of responding with sufficient sensitivity or empathy to the warning signs of distress and behavioral cues that precede violence.

Mental illness and the structure of an inpatient setting may also reduce the patient’s ability to react suitably when experiencing impulsive urges, anger, fear, or the frustrations of treatment. Coffey (1976) points out that treatment itself may be the single most important risk factor for assaultive behavior; particularly if treatment is perceived as coercive, controlling, or threatening. The structure may limit behavioral options to disruptive, desperate, or violent acts. Morrison (1989) finds that hospital structure is often based on the medical model; that is, that patients have an illness and assaultive behavior is viewed as a symptom of that illness. Thus, structure is designed to “control” patients.

Structure and limits place treaters in the role of enforcers and thereby establish authoritarian, coercive, inflexible, and provocative rules and regulations that often cause the behaviors that they are designed to control. Harrington (1974) believes that violence in a hospital setting is seldom a symptom of illness, but is rather a reaction to situations in which patients find themselves. Moffitt (1974) concludes that a dysfunctional milieu begets violence.

In patients with organic brain disorder or dementia, the extremely high incidence of assault is mostly associated with performing or assisting with activities of daily living; that is, toileting, bathing, dressing, and so on (Lanza, 1988; Palmierina, 1987). It is assumed that any activity that involves the invasion of personal space increases the risk for assault in these patients (Jones, 1985). Studies in psychogeriatric settings support this notion (Donat, 1986). Negley and Manley (1990) successfully designed interventions to reduce the invasion of patients’ personal space by environmental changes.

Prediction

On an immediate level, the highest predictor for assault is the “preassaultive tension state” (Lanza, 1988), or “acute excitement phase” (Craig, 1982). Arousal levels and behavioral cues are crucial predictors of impending violence (Aiken, 1984). This state is described as changes in posture, motor activity, and increased movement (Aiken, 1984). Hackett (1977) describes this tension state as anxiety, breathlessness, rigid posture, clenching of fists and jaw, hyperactivity, pacing, verbal profanity, changes in verbal content, pressured speech, loudness, overreaction, and threatening stances. These behavioral cues may seem obvious, but many times these clues go unheeded and opportunities for early intervention are lost.

Intervention

Of the various factors associated with increased risk for violence, only diagnosis, history of assaultive behavior, and the various issues of provocation are able to be specifically reduced by directed intervention. Diagnosis and history of assault can be reduced as precipitants by cuing treaters to increased risk and by preventing assaultive acts in the first place. This involves awareness and stopping the behavior immediately to prevent escalation, and implies the recognition by the staff of arousal levels and behavioral cues (Aiken, 1984). This also presumes that staff possess skills in verbal and behavioral interventions, and are able to react to patients in a nonprovocative manner (Tardiff, 1982).

Interventions that are designed along traditional lines are those that involve
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Staff training for prevention and management, organization of policies and procedures with regard to violence, and the tracking of documentation to identify assaultive patients (Drummond, 1989). Staff education and increased awareness are extremely important. But awareness must include identification of the various risk factors, development of skills, and understanding of control issues, structure, and limit setting. Teaching kung fu side steps and how to place patients in restraints would seem to have little effect on the incidence of assaultive behavior, but rather would affect outcomes once the assaultive episode has begun.

Most importantly, issues of provocation must be understood. For years, authors have examined the various risk factors, but only recently has provocation been examined in depth. Provocation by staff, both knowing and unknowing, is an extremely crucial issue. Institutional provocation through structure or organization is a factor that is rarely addressed or recognized (Blair, 1991). Routine rules and structure must be examined and reviewed, and treatment should become more flexible to accommodate individualized plans of care. Strict or harsh consequences for patients' behaviors should be assessed in terms of which needs are being met: treatment goals or staff needs for control and power. Individualized treatment plans that do not focus on strict obedience to unit rules can minimize these types of provocation.

Assaultive behavior will undoubtedly continue to occur, and incidence may continue to increase. Tragically, staff and patients alike will continue to suffer. To intervene in a meaningful way, clinicians must distinguish between those risks identified in the literature and those that are unsupported and no longer meaningful in modern psychiatric practice. It is hoped that this knowledge can be used to break the patterns of violence and can begin to reduce the ever-increasing incidence of assault.

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