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Original Article

Violent patients within Psychiatric Intensive Care Units: treatment approaches, resistance and the impact upon staff

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Abstract

It has become evident that Psychiatric Intensive Care Units (PICU) accept aggressive, violent patients often with criminal histories and personality disorders. This paper aims to document the effects that this patient group can have on a PICU and the significant role that psychotherapy can offer this complex patient group. The conclusions have been drawn from psychotherapeutic work on a PICU (Pathways on Tagore, NELMHT). Such patients present unique therapeutic and emotional challenges to staff. As a result staff need to recognise and address these issues. This paper identifies and discusses a number of central themes, challenges and practical skills that may be important in enabling the successful treatment of such patients within a PICU setting.

Keywords:

Anger management; violence; PICUs

INTRODUCTION

Violence and aggression are often key aspects of referrals to Psychiatric Intensive Care Units (PICU's). Staff working with such patients may be presented with particular therapeutic and emotional challenges during treatment that are not necessarily covered during training. The paper will consider some of the main themes that may emerge when working with this patient group; issues such as power and status, the choice to be aggressive and aggression being used as a problem solving/coping strategy. The practical concerns and emotional challenges for staff will also be highlighted. By doing this the paper will hope to enhance clarity and understanding for staff when working with this important sub group within a PICU setting.

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THE PICU AND VIOLENT PATIENTS

The Glancy report (DHSS, 1974) called for facilities to be set up for psychiatric patients who were violent or unmanageable in open wards. As a result, a number of existing open units upgraded to locked status and some new units were opened. These were called Psychiatric Intensive Care, special care, extra care or high dependency units (Beer et al., 2001).

The PICU accepts a range of vulnerable patients often with complex needs, thus they present 'additional problems which further complicate their treatment' (Atakan, 2001). Many are potentially aggressive and antisocial, violent, presenting challenging or unpredictable behaviours and are at an increased risk of absconding, self-harm or suicide (Pereira et al., 1999; Michalon & Richman, 1990; Birnie, 1988; Mitchell, 1992).

Violence by psychiatric patients has long been recognised as a major problem (Ekblom, 1970; Blomhoff et al., 1990; Barlow et al., 2000). Importantly for the present paper, *aggression/physical violence is one of the primary reasons for admission to a PICU* (Pereira, 2001; Barlow et al., 2000; Smith, 1997). With this in mind, it is ironic that few PICUs offer structured anger management programmes. Indeed, an informal survey covering all PICUs in the United Kingdom, identified that only 6% provided anger management programmes to address the root of this violence.

In terms of admission, there is a misnomer that PICUs only admit and treat certain types of psychopathology, such as schizophrenia. In fact, the PICU population is not an homogeneous group; Affective Disorders, Schizoaffective, Substance use problems and Personality Disorders, to a lesser number constitute the patient population (Beer et al., 1997; Goldney, 1985; Wolferdorf et al., 1997; Adler, 2000; Savage & Salib, 1999). However, there is no clear consensus as to who is the most violent or who poses the highest risk of violence in psychiatric patients (Sheridan et al., 1990; Kho et al., 1998; Saverimuttu, 2000; Walsh et al., 2001).

TYPOLOGIES OF VIOLENT PATIENTS

Clinical experience at Pathways PICU has identified several typologies of patients that present aggressive and antisocial behaviours. The following categories are by no means mutually exclusive and so patients may fit into one or more of the groups.

Mentally disordered offenders

A mentally disordered offender can be defined as a patient who is suspected or convicted of committing a criminal/index offence[1] and who is suffering from a mental illness.

Personality disordered patients

Such patients will often present aggressive and antisocial behaviours as a consequence of a personality disorder.

[1]The FBI define two types of criminal offence; type 1 offences as the most serious (murder, manslaughter, assault) while type 2 are those less serious in nature (forgery, drug offences).

Forensic complex needs patients

These patients present a broad range of criminogenic needs (McGuire, 1995) such as employment problems or drug misuse alongside criminal, aggressive and difficult to manage behaviours that are not related to their psychopathology.

Within these primary typologies it is likely there are several motivational and explanatory factors. Brief descriptions are provided below and each of the following factors will be considered in more detail later.

Choice

The importance of choice in the uptake of aggressive and antisocial behaviours must be considered. A focus on choice would assert the individual is in part, conscious and in control of their actions.

Power/status

The actual or perceived achievement of power and status may be one potentially reinforcing variable and consequence of acts of aggression.

Aggression as a problem solving approach (Means to an end)

These are patients who adopt aggressive responses as a way to respond to problems or achieve their desires. The patients learning history, modelling, family background, culture, and the subjective experience of choice will have influenced the uptake of an aggressive problem solving approach.

Enjoyment of the act (Pleasure)

There are patients that appear to gain enjoyment through the act of aggression. Indeed, many such patients may seem addicted to aggressive acts and what it symbolises. Such behaviour is something found within patients with Personality disorders, especially Antisocial or Sadistic personality disorder. Patients may actively hold sensational interests (Egan et al., 2001) and thrive on a personal buzz (thrill seeking) achieved through violence (Goldstein, 2001).

It is our belief that a variety of treatment options on either an individual and/or group level can be made available for such patients on a

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PICU. However, what remains lacking is an evidence base for the efficacy of such treatment approaches on a PICU.

TREATMENT OPTIONS

The evidence relating to treatment options for such aggressive patients has origins in both medium and high secure settings. This research has shown that anger management appears to be effective (Novoco, 1997; Mayne & Ambrose, 1999; Serin & Kuriychuk, 1994; Stermac, 1986). As Becker et al., state (1997) from their work with aggressive patients 'these cases demonstrate, in small aggregate, multiple baseline format that intensive, non punitive, and ability enhancing behavioural interventions can eliminate chronic violent behaviours even while psychotic symptoms, diverted sexuality and/or personality disorders remain'. It is clear that anger management in conjunction with other interventions, within an already therapeutic milieu can make a significant contribution to the patients problem behaviours. However, there is no published work regarding the efficacy of anger management programmes within PICU environments. However, it is possible to pilot a continuous cycle of anger management sessions within a PICU with promising results (Sarsam et al., in press). The focus of the current paper is not to consider the various possible treatment options, but rather consider the main themes and issues that may arise during treatment. It is to these issues that we now turn.

SPECIAL ISSUES FOR CONSIDERATION WHEN WORKING WITH AGGRESSIVE AND ANTISOCIAL PATIENTS

The present aim is to highlight some of the central themes that emerge when working with aggressive and antisocial patients within a PICU setting. The following factors have emerged during individual work and anger management sessions at Pathways PICU on Tagore.

Choice

A focus upon choice would assert that the individual takes a degree of responsibility for certain decisions made within social situations. This point has been verbalised during the Pathways anger management programme in which many patients have acknowledged that they have a degree of choice as to whether or not to be violent in certain situations, as opposed to a symptom of psychopathology. It is the opinion of the authors that staff/therapists working with patients on a PICU should emphasise this important point. This is supported by various empirical theories such as 'anomie' (Spergal, 1964) and the rational choice theory of criminality[2] (Clarke & Cornish, 1985). The communication by the therapist of the option of choice may hold important considerations for the patient. Accepting responsibility for their actions may be an unwanted and difficult leap and may force such patients to re-examine emotionally painful areas of their life. This could hold serious implications on the patients' mental state and coping mechanisms, of which staff should be aware.

Power/Status

Personal power and status are deemed necessary and desired qualities by many aggressive patients within Pathways PICU. This may in fact be a common theme amongst aggressive and antisocial patients in general. Indeed, as far back as 1925, Adler described criminals as striving for personal superiority and appreciation, in which the act of crime allows them to feel admired and appreciated by their comrades (Adler, 1925).

Alice Miller (1990) expanded upon this concept by describing a process of identification with the aggressor. Within this model, Miller notes how the present aggressor was often in his or her own childhood the victim of abuse. This identification allows the aggressor to unconsciously take the role of the offender as a defence mechanism in which re-enactment of the early trauma is basis of action. This aids the aggressor in feeling powerful and blocks the underlying feelings of shame, guilt and humiliation, which are rather projected to a new victim to experience.

Furthermore, it has been noted that certain male patients hold traditional and rigid views of masculinity and the male gender role; such as the need to be strong or the non-communication of certain emotions. Their gender identity and as a

[2]Rational Choice Theory of crime assumes that specific crimes are chosen by offenders and committed for specific reasons.

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result power and status would be challenged, by themselves and their peers if they were to adopt different behavioural strategies such as avoidance of aggression i.e. walking away.

However, it is important to look beyond the individual to both cultural and sub cultural levels of achieving power and status. Many aggressive and antisocial patients have utilised aggression to obtain power and status by joining gangs. Such patients may see anger as 'cool' (Koerner, 1999) and a means of achieving group belonging, admiration and status. Several patients at Pathways PICU have reported to having been members of gangs during their life: hence it is important to understand the possible reasons that such patients are drawn to the gang identity. It would also be interesting to explore if female patients experienced similar gang membership and whether patient gangs/groups are formed while during the PICU stay.

Groups can offer the patient a haven to act out violent feelings, gaining approval and the positive reinforcement of such behaviour. Thus, such gangs appear to attract a particular grouping of individuals who may experience status problems due to their lack of success in meeting expected values and as a result compensate for this by obtaining their needs through the gang identity. Gangs and certain communities may foster a positive image of aggression. This may be done explicitly through rituals or through more subjective methods of communication as viewed in the abundance of celebrity figures that utilise, and both implicitly and explicitly condone aggression.

With these points in mind, it is important to consider how willingly such aggressive patients may engage in treatment. It may be likely that that treatment options such as anger management will be experienced as:

- An attempt by the therapist to take away their perceived power?
- A treatment intervention designed to change the individuals personal value system.
- The removal of the patient from a sub group where they have been accepted and experienced a sense of belonging.
- Experienced by males as a threat to their gender identity.

If so, such a combative approach will not be relinquished easily, especially when it has previously brought about feelings of power, status and belonging. As a result the patients motivation and willingness to change will be low making successful treatment challenging.

A means to an end

Many aggressive and antisocial patients on Pathways PICU have discussed the fact that they have consciously decided to adopt an aggressive problem solving technique in response to a problem. In such cases, aggression may be seen as long-standing aspects of the individual's behavioural repertoire in solving problems, indicating that other problem solving methods are *absent, underdeveloped or not viewed as viable*. As noted by Robins & Novaco (1999) 'Anger is often entrenched in personal identity' (p. 325). The patient's childhood experiences, peer groups, history of learning may all have introduced aggression as a means of solving problems.

To illustrate, Cordall (1999) highlights the link between a history of sexual abuse and the expression of anger within female mentally disordered offenders. In such cases, aggression is seen as a defence mechanism, to avoid being hurt, or indicative of the emotional damage caused by previous abuse (as discussed earlier within Millers' model). Either way aggression is adopted to meet a particular psychological need.

This conceptualised need of the patient to use aggression as a means to an end may result in resistance to change. Thus, new strategies presented in treatment may be viewed negatively, i.e. as weak, unsuccessful and passive. Thus, in therapy and especially during anger management it is vital to focus on teaching new adaptive problem solving skills within the context of possible resistance. It may also be beneficial to highlight the negative consequences that anger will have on the patients' life and future.

Personality disorders

Many of the aggressive and antisocial patients presenting to the PICU may have within their diagnosis a personality disorder. Personality disordered offenders are a particular concern to mental health professionals as they are 2/3 times more likely to

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re-offend than mentally disordered offenders (McMurran et al., 2001; Steels et al, 1998; Eastman, 1999). The most common of such patients is the anti-social personality disorder.

It is useful to consider broader definitions of personality disorder not solely based upon DSM/ICD criteria. One such is Kernbergs' classification (1975) system in which he describes patients with a broad ranged diagnostic spectrum in terms of their underlying personality structure. For example, he describes a core group of patients, for whom weakened ego boundaries are a key aspect of their personality structure, resulting in poor impulse control and a low frustration tolerance. Hence, impulsivity, hostility and aggression are core aspects of many personality disorders (Widiger & Trull, 1994) and have been identified as key areas within treatment with such patients (McMurran et al., 2001). Antisocial personality disordered patients may continually violate and show impulsive disregard for the rights of others through manipulation, deceit, aggression or antisocial behaviours, typically without remorse or concern. On the ward this may be observed as patients constantly challenging ward boundaries or re-creating hostile encounters with fellow patients and staff. Furthermore, a level of superficial charm may also be evident, which may deceive the staff/therapist as to the underlying surplus of hostile and destructive feelings.

PRACTICAL CONCERNS FOR STAFF WORKING WITH SUCH PATIENTS

So far we have described many key themes and potential challenges that violent, aggressive and antisocial patients present during treatment. However, PICU staff are expected to treat these challenging patients with no/little extra training to aid them. It is to some of these practical concerns, skills and emotional challenges that we now turn.

Therapeutic style

When working with such patients staff members should consider, or be aware of the need for a specific therapeutic style. Such a specific approach would involve a clear process of verbalisation and be consistent in the communication of negative consequences. To illustrate, Koerner (1999) postulates that anger management groups may receive indifferent results if they adopt a neutral communication style. Using words such as error, irrational thinking and mistake are vital in unequivocally communicating to the patients the impact of destructive behaviour. This direct approach may evoke possible negative therapeutic reactions; such as resistance or abandoning therapy as it is viewed as confrontational or hostile by the patient. Indeed, it may widen an already large gap in power dynamics between staff and the patient. *If the patient holds such views then these need to be recognised and addressed within treatment.* Hence, it is important to communicate to the patient that the aim of treatment is to help the person to find skilful adaptive approaches to life situations (Novaco, 1997).

Time

Therapists should be aware of the effect that long-term institutionalisation may hold for patients later presenting at a PICU. Renwick et al. (1997) discusses the interesting notion that time for many aggressive patients may move at a slower pace due to extended periods of incarceration i.e. in prisons or secure units. It is important to consider that many aggressive patients will present from such custodial or secure environments and as such may struggle to adapt to the intensive pace of the PICU and group work. Therefore, tasks may take longer than expected to complete and there may be an unwillingness to plan ahead. Knowing this possible effect and working with it within treatment will be imperative to aid in the transition of each patient to the intensive and short term treatment plan of the PICU.

Traumatic history

Aggressive and antisocial patients may often present with traumatic life histories. This may manifest itself within the therapeutic relationship both in and outside group work in a mistrustful, suspicious attitude, a fear that therapy may be used to judge them or a feeling that no one will want to or be able to help them. Renwick et al. (1997) highlights this, and introduced a preparatory stage in groupwork where the importance of a bond/rapport between the therapist and the patient is developed to overcome resistance. The working alliance between the patient and therapist

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is pivotal for successful treatment and should be given priority during the early stages of treatment, thus aiding the development of a therapeutic relationship. The therapist should take an active role in the development of the therapeutic connection with forensic patients but be aware that such a bond may possibly take longer to cultivate when compared to other psychiatric patients. It is important for the therapist/staff to anticipate a period of time within treatment, in which the patient may challenge and test the staff members resilience. Trust in others is not easily achieved in such patients. Ways of working with such patient's uncertainty and mistrust will hence be important to incorporate into the treatment programme.

Practical skills

The therapist requires special skills to work successfully with aggressive and antisocial patients. Whyte (2001) surveyed all levels of security including prisons, low secure, medium and high secure units. A list of six core skills required to work with such patients were captured:

1. Basic interpersonal skills (tolerance, understanding)
2. Humanity (empathy, warmth, non-judgemental attitude)
3. Knowledge base (mental disorders, criminology, offending behaviour)
4. Communication skills
5. Personal qualities
6. Teamwork skills

Many if not all of the above skills will be needed to successfully treat such patients. These skills may be learned through practical experience of working with such patients, not only through academic teaching/supervision.

The emotional effect on staff

Therapists/staff working with aggressive and antisocial patients should be aware of the possible negative emotional impact that such patients may have on them. The therapist may need to overcome the realisation that the person in the group or individual session may have committed horrendous acts or still hold urges to act out violently. Therapists/staff may naturally experience a host of negative emotions; they may feel frightened, enraged and even repulsed by such patients. Winnicot (1951) emphasised the need for staff to monitor their feelings when working with patients with a history of destructive acts, emphasising the normality of negative counter transference with such patients, including feelings of hate and revenge. It is important for the therapist to recognise such emotions within themselves and find ways of adapting these feelings in a way that will not negatively effect the treatment process. The process of supervision will play a key role in this.

Aggressive and antisocial patients are often not viewed as an 'attractive' or 'rewarding' group to work with. Such individuals not only have a mental illness, but also likely to be guilty of crimes; thus making them doubly disadvantaged in terms of stigmatising views. Staff may hold such stigmas. It is possible that violent patients may *only be seen as ill* or *beyond help* and therefore be overlooked for interventions aimed to reduce aggression. Ironically, this may mirror earlier experiences in which the patient felt unsupported or abandoned. Patients may be able to detect on a non-verbal or unconscious level the feeling that they are deemed helpless to change by staff. Such patients may be treatment resistant, whereby symptoms only partially responsive to conventional treatment (Miranda, 2001) not only due to their mental state, but also due to a probable history of past failure in achieving treatment gains (Novaco, 1997). This violent behaviour is often seen as a social problem requiring retribution and penal management rather than rehabilitation and psychological intervention (Howells & Watt, 1997). From a psychological perspective, one can view such patients as psychologically 'damaged individuals' (Britton, 1997). As such, it is imperative that a developmental history (Goldstein, 2001) is taken in order to help decipher the causes of aggression. This is particularly important, as on examination, aggressive and antisocial patients personal history is likely to include emotional and psychological depravation. This needs to be understood and incorporated into the overall treatment plan.

Staff on PICUs should attempt to accept these patients as potentially capable or useful individuals; to engage them at a human level using psychological interventions in order to help them develop. Without this, a therapeutic relationship

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will be impossible and the communication of such negative feelings may destroy the working alliance and may cause irreparable damage between the therapist and patient.

THE PRESSURE OF SECURITY

In terms of admission and treatment, aggressive and violent patients have traditionally been cared for in the criminal justice system or high/medium secure units (Beck, 1995). The security evident on the PICU could lead to it being placed under pressure to accept these patients regardless of the presence or not of acute disturbance. To illustrate, Beer et al. (1997) established that nearly half of PICUs identified accepted prison transfers. Pereira et al. (in press) identified that within London, 65% of PICUs would accept patients with a violent criminal history above Grievous Bodily Harm (GBH); 94% would take patients below GBH and 100% would accept patients referred from prison. Indeed, 17% of the total London PICU population were held on forensic sections. On Pathways PICU a survey by the authors indicated that within a period of one year, a total of 25 patients have been successfully referred from prisons or have an aggressive criminal history. Many more have been referred but not accepted. This is a less than ideal mix, as these two groups will have different needs and this can only serve to compromise patient care (Pereira et al., 1999).

While the PICU has an element of security it's aims and philosophy are greatly different from a secure unit and should not be mistaken for one. For example, the average length of stay on a secure unit is far longer than the average length of stay on a PICU (Coid, 1991; Pereira et al., 1999). There are concerns that the number of such patients will increase (Atakan, 1995) and ultimately *this will have severe ramifications on PICUs*; especially in relation to the philosophy, function, aims and structure. If not addressed the basic function of the PICU could insidiously change and will no longer perform the function it was initially designed to meet.

CONCLUSION

The above paper has aimed to describe the therapeutic treatment and management of aggressive and antisocial patients within a PICU setting. Many key areas have been discussed in relation to this sub group of PICU patients. In such, four essential factors have been acknowledged and outlined. One, such patients are presenting to PICUs. Two, there are several types of violent and antisocial patient often with complex reasons for their behaviours. Three, the need for staff to recognise the resistance, for a variety of reasons, that such patients may present to treatment. Four: the possibly negative emotional responses that can be evoked in staff treating such patients. It is the belief of the above authors that the treatment of such patients is not only possible but indeed also rewarding. However, it is essential that the above concerns are acknowledged and incorporated into the overall treatment process.

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