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ABSTRACT

Physical aggression among psychiatric inpatients is a concern to those responsible for their clinical management. Three models have been used to explain the occurrence of physical aggression among these patients. The Personological model emphasizes the role of dispositional variables; the Social-Environmental model stresses the importance of the physical environment and the social organization; and the Interpersonal model focuses on the nature and quality of the patient-staff interaction. A study was conducted to identify the key interactional factors, identified by staff members of a large state mental hosipital, that contribute to or effectively prevent physical aggression. Skilled nursing staff members, selected by their supervisors, were interviewed about interactions and communication in two cases of potential violence between patients and staff, one in which violence occurred and the other in which violence was prevented. The interview data indicate the importance of interpersonal factors in the incidence of aggressive behavior among psychiatric inpatients and suggest that the application of communication skills in a supportive context, organized on the basis of mutual respect and the assumption of patient competence is a major deterrent to violence in psychiatric hospitals. (NB)

Interpersonal Factors and Violence

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The incidence of physical aggression among psychiatric inpatients has long been a concern of those reponsible for the clinical management of this group. One recent survey of 5,164 psychiatric patients hospitalized for one month or longer, indicated, that the 7% of this group had physically assaulted another person in the hospital at least once during the preceding 3 months. Recent funding cut-backs, emphasis on rapid discharge, and high readmission rates appear to have compounded this problem.

There are at least three models that have been used to explain the occurrence of physical aggression among psychiatric in-patients. The Personological model emphasizes the role of dispositional variables such as age, sex, race, diagnosis, and frequency and length of hospitalization as causal factors in the occurrence of physical aggression. Evidence suggests for example, that violent behavior is correlated with schizophenic thought disorder (Yesavage, et. al., 1981,) psychotic symptoms such as hallucinations, delusions, motor agitation and negativism (Tardiff and Sweillam, 1982), youth, and more frequent and longer hospitalizations.

The Social-Environmental perspective stresses the importance of both the physical environment and the social organization as important determinants of aggressive patient behaviors. Factors such as overcrowding, boredom and staff shortages have been

identified as contributors to inpatient aggresive behavior (Straker, et. al., 1977). Unit social disorganization, lack of availability of professional staff and conflicts between staff or staff and patients have also been found to be important causal factors (Sacks and Carpenter, 1974; Stanton and Schwartz (1954).

Finally, the Interpersonal paradigm focuses on the nature and quality of the patient-staff interaction in understanding aggressive behavior (Levy and Hartocollis, 1976; Lion, 1972). Staff mismanagement of interactions with patients (Straker, et. al. 1977, Whitehead, 1975) and a staff culture of confrontation (Joy, 1981) have been cited as important triggers of patient violence.

This study attempted to identify the key interactional factors, identified by staff members of a large state mental hospital, that contribute to or effectively prevent physical aggression. A semi-structured format was utilized to interview a sample of nursing staff at a large state mental hospital. Supervisory staff on all shifts in all psychiatric units were asked to identify one or more staff members who they had supervised or worked with directly and who in their opinion, were highly effective in communicating with and "defusing" angry, potentially violent psychiatric patients. These supervisors (42) identified 76 "skilled staff" members who consented to be interviewed for approximately 1 hour regarding their experiences

with aggressive patients. Each interviewee was asked to first think of two situations in which they had been directly involved or had observed. Each situation was to involve incidents on the unit involving staff and patients in which there was high potential for aggressive behavior, or in which aggressive behavior had occurred. One incident was to involve a "negative" outcome, i.e., violence occurred; the other was to involve a "positive" outcome, i.e., violence was avoided. All interviewees were readily able to recall and describe in detail both positive and negative outcome situations. Interview questions were designed to elicit information about interactions and communication in each case. Notes of the interviews were categorized into skills statements by two raters; these statements were then grouped into categories representing the initial 2 stages of the Interpersonal Incidents Model presented in Figure 1.

Insert Figure About Here

Stage 1. Skills These descriptions emphasized the preventive value of clarity about rules, fairness, familiarity, and close ongoing interaction with patients; along with a positive, competence based unit atmosphere. Several comments are paraphrased below to represent the most common positive outcome statements obtained.

- " It is important to be available to the patients...to be willing to work closely with them, to read their social history and admission notes in the chart...so you can work on prevention not just intervention."
- "Always make rules and expectations clear in advance, be patient and willing to sit down and explain things over and over."
- "Get to know patients, spend time finding out what is going on with them so when they seem agitated you can communicate."
- "Use meetings and groups to get to know one another, encourage people to be responsible to one another and for their own progress."

Stage 2. Intervention strategies for situations in which negative emotions are apparent and escalating, focused more on particular interactive skills and attitudes that are effective in avoiding violence. These strategies are described below in descending order of frequency.

Interventions: Positive Outcome

1. Talk to the patient in a calm, firm, matter of fact manner that conveys caring and concern and confidence that things can be worked out.
2. Move the patient from the immediate situation to a quiet place where you can talk.
3. Listen without disagreeing. Find out the patient's point of view.

4. Be willing to explain things calmly over and over.
5. Help the patient refocus by offering coffee or a cigarette, and never take their anger pesonally.
6. Let them know that you realize that anger is a reasonable and real emotion that we all experience, and help them to focus on ways to handle situtions so anger doesn't get out of hand.

Negative interventions were viewed as major contributors to the occurrence of patient aggressive behavior. Countless examples were described by interviewees of interactions in which the staff response to escalating anger on the part of the patient was a key factor in triggering patient violence. In general these responses included angry reactions, sarcasm, argument, verbal threats and premature efforts to physically control the patient.

In summary, interview data indicates the importance of interpersonal factors in the incidence of aggressive behavior among psychiatric inpatients. The application of communication skills in a supportive context, organized on the basis of mutual respect and the assumption of patient competence is a major deterent to violence in psychiatric hospitals.

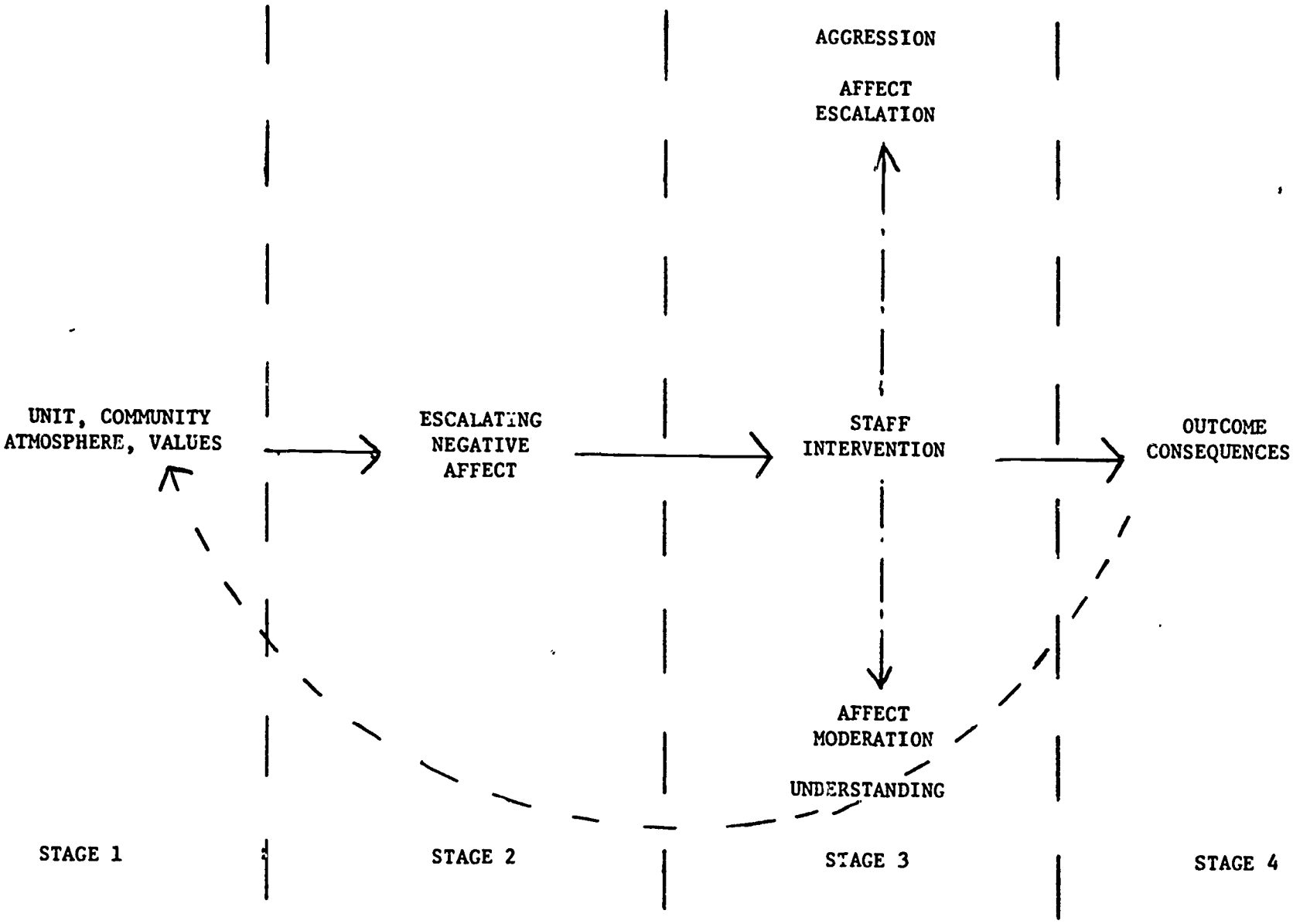

FIGURE 1. A Four-Stage Model of the Resolution of Aggressive Incidents

References

Joy, D. S. (1981). The maintenance of order on an adolescent inpatient unit: An analysis of work on the evening shift. Psychiatry, 44, 253-262.

Levy, P., & Hartocollis, P. (1986). Nursing aids and patient violence. American Journal of Psychiatry, 133:4, 429-431.

Lion, J. R. (1972). Evaluation and management of the violent patient. Thomas; Springfield, Illinois.

Sacks, M. H., & Carpenter, W. T., Jr. (1974). The psychotherapeutic community: An examination of antitherapeutic forces in psychiatric units. Hospital and Community Psychiatry, 25, 315-318.

Straker, M., Carman, P., Fulton, J. & Smith, J. (1977). Assaultive behavior in an institutional setting. Psychiatric Journal of the University of Ottowa, 41, 185-189.

Stanton, A. H., & Schwartz, M. S. (1954). The mental hospital. Basic Books, New York.

Tardiff, K. & Sweillam, A. (1982). Assaultive behavior among chronic inpatients. American Journal of Psychiatry, 139:2, 212-215.

Whitehead, J. A. (1975). Violence in institutions. International Journal of Offender Therapy and Comparative Criminology, 19:1, 87-89.

Yesavage, J., Werner, P., Becker, Jr., Holman, C., & Mills, M. (1981). Inpatient evaluation of aggression in psychiatric patients. Journal of Nervous and Mental Disease, 169:5, 299-302.