

Demographics: Individual Level

- 15-30 year old men, some repetitively violent (7% - 79% repeat violence)
- Impulsive, low IQ
- Hyperactive/attention impaired
- Oppositional/resistant to control
- Vindictive
- Easily angered
- Deliberately annoying
- Blame others

Demographics: Individual Level

- These traits are largely inherited.
- The presence of a mental illness or substance abuse increases risk of violence independent of gender and age.
- Poor compliance with treatment increases risk.

Demographics: National Level

- Societies can vary significantly, becoming more or less warlike or crime prone during certain periods. (In the USA, there were wild swings of violence in the 60's and late 80's, but down in the 90's.) These variations are not well understood.

Wisconsin

- There were 12,238 violent crimes in 2002.
- In 2003, there were 12,095.

Juvenile Violence

- Leading cause of injury, death, and mental health problems in adolescents. 40 children are killed each week. Teenaged boys are more likely to die of gunshot wounds than from all other natural causes combined. The homicide rate for children in the USA is 12x the combined rate of the 25 leading industrialized countries.
- Nonetheless, violence in young people is decreasing. Juvenile arrests for murder in 2000 (1200) were 30% of those in 1993.

Wisconsin

- Homicide is the 3rd leading cause of death in young people 10-24 years old.
- From 1993-95, 240 teens died of homicide, 82% involved firearms.

Natural History

- Physical aggression peaks around the age of two, then usually decreases as the child develops empathic attachment for others.
- There is a high prevalence of mental illness among offenders - up to 60% in some studies.
- 30% of teens engage in in one violent act, but most stop antisocial activity by late adolescence.
- A small number of teens continue to become chronic offenders. Being able to identify them is important, because incarcerating limited offenders increases their risk to become chronic.

Consequences of Early Exposure to Violence

■ Alcoholism	7.4%
■ Drug Abuse	10.3%
■ Depression	4.6%
■ Suicide Attempts	12.2%
■ Promiscuity	3.2%
■ COPD	3.9%
■ Heart Disease	2.2%
■ Liver Disease	2.4%

Risk Factors

- Conduct Disorder

Early conduct disorder is ominous. Conduct disorder first appearing at 6 years old doubles the risk of criminal adult antisocial behavior (71%), compared to those children who first develop conduct disorder at 12 years old.

■ Individual

- Perinatal toxicity
- Difficult temperament
- Poor social skills
- Friends who engage in problem behavior
- Innate predisposition for violence

■ Family

- Poverty
- Overcrowding
- Poor housing
- Parental drug abuse
- Domestic violence

■ Family (cont)

- Inadequate, coercive parenting
- Child abuse
- Insufficient supervision

■ School

- Disadvantaged school setting
- Poor school performance beginning in elementary school

Protective Factors for Conduct Disorder

- High intelligence
- Easy disposition
- Ability to get along well with others
- Ability to do well in school
- Competence in social problem solving

Risk Factors

- Firearms are the single greatest risk factor. 28% of families keep guns at home, 39% are unlocked or loaded or both.
- Alcohol - 40% of all 15-24 year old homicide victims are intoxicated.
- Bullying - 30% of 6-10th graders are involved in moderate to frequent bullying.
- Mental Illness - among offenders, up to 60% in some studies.
- Media Violence - may effect vulnerable children and teens, but there is no evidence it has a general impact on violence.

Risk Factors

- Family who is dismissive and permissive, allowing unsupervised access to the internet, too much privacy.
- Schools where bullying and standby behavior are tolerated, mean cliques in charge, conspiracy of silence among students.

■ Adult crime - Adult time

- Juveniles moved to adult court are more likely to receive prison time than adults for the same crime

■ What doesn't work

- Arrests for minor offenses
- Scared straight/boot camp approaches
- D.A.R.E.
- Home detention, intensive parole

■ What does work

- Prenatal nurse visits to high risk homes
- Head start programs
- Anti-bullying programs
- Life skills classes, programs aimed at risk factors
- Training in thinking skills

Violence in the Workplace

- Homicide is the second leading cause of death in the workplace. 20 employees are murdered each week, 18,000 assaulted.
- Three categories:
 - Perpetrator enters work to commit criminal act - taxicab drivers, gas station attendants, convenience store clerks
 - Perpetrator is a recipient of service - healthcare, social services
 - Perpetrator is a fellow worker - no distinctions

Mental Health Setting

- Psychiatrists: 40%, younger and less experienced, provoking, happens during the first interview
- Psychiatric residents: 73% threatened, 36% assaulted, many repeat assaults
- Nursing staff: highest incidence, more dangerous than working in mines, construction
- Forensic workers: 17.9%
- Social workers: 20%
- Psychologists: 7-14.2%, 35.5% threatened
- Other physicians: 3.3% of family doctors

Mental Health Setting

- In the emergency room: 10% of staff are injured each year, psychiatrists more than other MD's.
- In the psychiatric emergency room: 4-7% of clients are carrying a weapon, 17% are homicidal
- Psychiatric treatment setting: 83% threatened, 65% assaulted, 39% injured. Child/adolescent treatment more dangerous. No gender difference. Most assaults during R/S. Inexperienced direct care staff and teachers most at risk.
- No correlation between length of treatment and seriousness of assault.

Mental Health Setting

■ Gender

- Males traditionally are more likely to be assaulted
- Clients are more likely to be aggressive to pregnant therapist than non-pregnant female
- Women and men can be equally dangerous: Women tend to slap and scratch - usually family members. Men punch and kick and use weapons.

■ Weapons

- Hand or foot - 72%
- Object (chair, ashtray) - 23%
- Gun - 3%
- Knife - 2%

Mental Health Setting

■ Severity

- 4% of mental health clients report homicide attempts
- Hostility, paranoia, interpersonal sensitivity distinguish the homicidal versus the assaultive clients better than diagnosis.
- Male and female clients were equally lethal
- Those with a history of suicide attempts or ideation were more likely to act on homicidal thoughts. 91% of clients attempting homicide had attempted suicide at one point.

Mental Health Setting

- Reactions to assault
 - Denial: 56% of psychiatrists continued to see the client. 21% never discussed the issue at any subsequent session. Faced with threatening statements, psychiatrists usually avoid following-up with questions. 55% recognized there were clear signs leading up to the assault.

Violence and Mental Illness

- Recent studies have demonstrated a small but increased risk of violence for the mentally ill - notably, substance abuse, cluster B personality disorders, psychotic disorders.
- A 2002 review identifies those characteristics that are associated with violence:
 - Impulse control
 - Affect regulation
 - Narcissism
 - Paranoid personality style

Violence and Mental Illness

- Violent and criminal acts attributable to mental illness account for a very small proportion of overall violence. The mentally ill are more likely to be victims than perpetrators. Their families are more likely to be the targets than unrelated people in the community.

Schizophrenia

- 4.5x general population. 10 - 15% of schizophrenics are responsible for all the violence.
- Non-paranoid psychotic symptoms probably lower the risk of violence.
- Chronic psychosis breaks down affect regulation - anger, hostility, irritability
- Paranoid clients are more likely to be violent outside the hospital, disorganized in the hospital

Schizophrenia - Risk Factors

- Past history of violence (forensic release - 50x risk of homicide)
- Substance abuse
 - More so for women than men
 - Risk of homicide 10x general population
 - Male schizophrenic AODA 17x
 - Female schizophrenic AODA 80x
- Non-adherence with treatment
- Comorbid antisocial personality
- Homelessness - 40x violent, 60x attempted murder, 25x murder

Schizophrenia - Risk Factors

- Paranoid cognitive style
- Hostility and irritability
- Command hallucinations in some clients
- Delusions - persecutory, systematized

Bipolar Disorder

- 25x general population, 49% lifetime prevalence
- Impulsivity is prominent, even when clients are asymptomatic
- Clients are gregarious one moment, hostile the next
- Children show fewer discrete episodes, more volatility and irritability at school
- Adolescents will show psychosis
- Geriatric clients will have high degree of primary CNS pathology

Substance Abuse

- 12-16x general population
- These disorders have the highest correlates to violence, more than all other disorders combined
- Impulse control and affect regulation are both impaired by these disorders.
- Alcohol is involved in most murders. Drinking more than 5 drinks on any occasion increases the likelihood of violence, either as a perpetrator or victim.
- Alcohol is present in >50% of domestic violence, violent crimes, sexual assault, child abuse and neglect.

Personality Disorders

- Cluster B (borderline, narcissistic, histrionic, antisocial) are the highest risk because of impulsivity and affect dysregulation. Also, narcissistic injury may be an important factor.
- Antisocial Personality Disorder
 - Defined in terms of both criminal and irresponsible behavior. Some are more recklessly violent than others.
- Psychopathic Personality

Psychopathy

- About 75% of prison inmates meet the criteria of antisocial personality disorder. Only 33% of these will be psychopaths. They will have the highest number of criminal charges per year, the most violent crime, be responsible for the most violence in the prisons, and be most likely to recidivate.
- The Hare Psychopathy Checklist is used to diagnose. It looks at superficiality, grandiosity, deception, lack of remorse, lack of empathy, irresponsibility, impulsivity, etc.

Organic Brain Disease

- 70% of brain injury clients have aggression and irritability as symptoms
- Epilepsy is rarely a cause of planned aggression
- Frontal Lobe Syndrome
 - Brief, unplanned, unsustained, ineffectual
- These aggressions are triggered by minor episodes, no clear aims or goals, explosive, remorse, long episodes of quiet

Medical Illnesses

- Hypoxia, Heavy metal poisoning, Electrolyte disturbances, Hepatic disease, Insecticides, Renal disease, Porphyria, Vitamin deficiencies, Systemic infections, Hypoglycemia, Cushing's Disease, Hyperthyroidism, Systemic Lupus

Geriatrics/Dementia

- In community and nursing home residents with dementia, 59% are verbally aggressive, 23.7% are physically aggressive, and 4% are sexually aggressive.
- 96% of dementia patients will be aggressive at some time during their illness, with a mean duration of 16 months.

Geriatrics/ Dementia

■ Risk factors

- Male gender
- Severity of dementia
- Comorbid psychosis
- Depression
- During intrusions into client's space
- Pain

■ Non-pharmacological treatments

- Walking, exercise, music, behavior management training, staff training, bright light, audiotapes of family members, specialized care units

Risk for Planned (Targeted) Aggression

- C: capacity to act, physical and intellectual, access to means and target, opportunity
- A: attitudes that support and facilitate violence
- U: untreated substance abuse and mental illness
- T: thresholds crossed, steps taken, laws broken
- I: intent, commitment to action
- O: others' reactions, what does he expect from the other people in his life
- N: noncompliance with risk reduction suggestions

Biological Theories

- Biological and social factors interact jointly to generate aggression. Human beings have evolved higher cortical centers that serve to suppress the emergence of aggression. The orbital prefrontal cortex plays a key role in inhibiting violence. Most adults do not become violent in their usual environment.

Biological Theories

- Serotonin: modulates inhibitory areas of the prefrontal cortex. Low serotonin is related to trait impulsivity.
- Dopamine: pleasurable stimulus during certain activities, during and after fighting
- GABA: primary inhibitory transmitter - may dampen aggression (vs. glutamate)
- Acetylcholine: nicotinic receptors reduce, muscarinic increase aggression
- Catecholamines: increased noradrenergic and dopaminergic activity increases aggression

Biological Theories

- Peptides: vasopressin, opiate binding protein, reduced cholesterol increase aggression.
- Genetics: heritability of aggression is estimated at 44-72%. There is no single gene for aggression. The MAO A variant, on the Y chromosome, is instructive for how genetics and environment interact.

Biological Theories

- Brain lesions: Nucleus accumbens, orbitofrontal cortex, and the amygdala are related to impulsivity. Hypothalamus, limbic system, and prefrontal cortex linked to aggression.
- Hormones: testosterone
- Epilepsy: can be related to aggressive and antisocial behavior
- Medical status: many conditions
- Environment: isolation, sleep deprivation, chronic immobilization increase aggression

Evaluation of Violent Client

■ Setting

- Evaluator must feel safe.
- Someone should know where you are.
- Room should have accessible exits, door should open out, means to call for help, heavy furniture, light cushions, no obvious weapons.
- You should know how to defend yourself.
- ER's are dangerous - 4-8% had weapons
- Don't see dangerous clients in their homes.

Evaluation of Violent Client

- Doing the evaluation
 - Be sure to get outside information
 - Do a violence history as for any other symptom
 - Ask about the most violent thing they have ever done. Do a history. The probability of a 5th arrest after 4 is 80%.
 - Did they use a weapon? The difference between a homicide and an assault is the weapon used - a gun is 5x more likely to kill than a knife. 33% of all households have a gun, 20% unlocked and loaded. Ask if they've handled their gun lately.

Evaluation of Violent Client

■ Evaluating threats

- Most violence does not develop suddenly, but rather shows a progression beginning with threats.
- There is a difference between making a threat and posing a threat. Most threateners are unlikely to carry out their threat. But all threats should be taken seriously and assessed quickly.
- Level of risk
 - Low: vague, inconsistent, implausible
 - Medium: possible, thought has been given to it
 - High: plausible, specific, direct, steps taken

Categorizing Violence

Most violence is not a medical problem!

- **Predatory:** planned to achieve a goal. There is minimal affect, maximum focus, not time limited. It is not a healthcare problem. It is a law enforcement/social problem.
- **Predatory violence may be:**
 - Manipulative
 - Power seeking
 - Revenge oriented
 - Stimulation seeking

Categorizing Violence

- Habitual/Learned
 - From childhood
 - From adult environment
- Psychotic
 - Paranoid, self-protective
 - Grandiose, delusional
 - Excitable, hostile, confused

Categorizing Violence

- Affective: may be angry, reactive, easy displacement of target, public display, time limited. Types of violence related to an unstable affect include:
 - Rage: borderline, narcissistic, post-abuse
 - Antisocial recklessness, cruelty
 - Chronic emptiness/boredom
 - Inability to contain negative affect
 - Sensitivity to negative social cues/respect
 - Irritability - chronic or episodic
 - Explosive disorders

Categorizing Violence

- Brain Damage/ Environmental Dependence Syndromes: the client's inability to separate his emotional tone from what is happening around him, or to understand and conform his behavior in anticipation of consequences.

Impulsivity

- A predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to negative consequences. It is not poor judgment. It is no judgment.
- Normal brain mechanisms over the first 0.5 seconds enables the brain to screen behavior before it enters conscious awareness. (It takes 0.2 seconds for a stimulus to produce an expression on the human face. It takes >0.4 seconds to recognize an internal emotion.) This can be proven by a skin response to computer game situations. Impulsive people lack this response.

Impulsivity

- What you are impulsive about is determined by exposure in your environment, to a certain extent. You may be impulsive about shopping, gambling, sexual activity, etc. Not every impulsive person is violent.
- The causes of impulsivity are complex and involve biological, developmental, psychosocial, and cultural factors. Impulsivity is an important component of bipolar disorder, borderline personality disorder, autism, PTSD, ADHD, AODA problems, OCD, etc.

Impulsivity - Character Trait

- Cognitive/affective lability
 - Attention problems, intolerance for complexity
 - Inability to solve complicated problems
- Lack of future orientation
 - Nonplanning, ahistorical
- Impetuosity
 - Motor impulsivity
- These characteristics can make people feel hopeless without a concomitant depression. Combined with impetuosity, especially enhanced by AODA, increased suicide risk.

Impulsive Aggression

“Impulsive aggression” is characterized by a set of three features:

- Low threshold of provocation
- Lack of reflection about whether aggression is an appropriate response
- A tendency to select a maximally aggressive response

Protecting Yourself

- Be alert, as when you are safely driving a car
- Practice screaming fire or 911
- Get hands on training from an expert
- Know how you will react
 - Freeze
 - Flight
 - Fight
 - Fright
 - Faint
 - Psychotachia, tunnel vision/auditory exclusion

Protecting Yourself

- Denial

- Common defense mechanism in response to fear

- Countertransference

- Issues that are not well-integrated and are aroused by the client's behavior. The clinician may act provocatively toward the client, over-control, or ignore the client's threats.

Responding to Verbal Aggression

■ Hot Threats

- The goal is to talk down the client. Make sure escape route is available, and client can hear and understand you. Overdose with agreement. Don't argue. Remember body buffer zones. Divide attention by giving choices. Denial is a serious impediment.

■ Cold Threats

- If you feel threatened, it's a threat. Clients can intimidate by praise or threats. Share your feelings with the team. Meet with the client and tell them how you feel, confront delusions, and go to the police if appropriate. Ignoring threats invites escalation.

Managing a Crisis

MMHI Options Continuum/Crisis Prevention Institute

- Anxiety: client is pacing, ignoring others or giving them inappropriate attention
 - Staff response:
 - Open, supportive stance at angle to client (feet apart, knees slightly bent, open hands at waist length)
 - Appropriate personal space with escape route (4-6 feet, more for paranoid, be careful of geriatric client)
 - Listen and paraphrase empathetically and calmly
 - Find out how you can help

Managing a Crisis

MMHI Options Continuum/Crisis Prevention Institute

- Defensive Stage: client begins to act irrationally, challenging authority, intimidating, threatening
 - Staff response (at least two staff is necessary)
 - Ready supportive stance (hands open at chest height)
 - Appropriate distance with escape route (10 feet, 21 feet if client has a weapon)
 - Set clear, enforceable limits
 - Remain professional - don't get provoked
 - Make sure there is no audience and allow client to vent
 - Restate limits when client can listen
 - Present positive options first
 - If no movement, or client shows pre-attack behavior, disengage to develop a plan.

Managing a Crisis

MMHI Options Continuum/Crisis Prevention Institute

- Aggressive stage: client loses control and becomes violent
 - Immediate cues to aggression
 - Posture
 - Manner
 - Appearance
 - Voice
 - Verbal abuse or threats
 - Impaired cognition
 - Approach/avoidance
 - “gut” reaction

Managing a Crisis

MMHI Options Continuum/Crisis Prevention Institute

■ Aggressive stage

- Staff response: use your agencies safety plan
 - Continue talk down
 - Identification of who you are and role
 - Physical distance
 - Keep verbal exchanges brief
 - Use a well rehearsed, planned physical response
 - Nonviolent self-defense training for staff has been shown to lead to a 23% reduction in staff assaults.

Managing a Crisis

MMHI Options Continuum/Crisis Prevention Institute

- Tension Reduction Stage: client is back in control
 - Staff response
 - Ask how the client is doing
 - Thank them for cooperating
- Return to normalcy: client is calm enough to discuss the incident
 - Staff response
 - Ask client what happened and how it could have happened differently
 - Work out a contract if appropriate
 - Thank client for their work

Treatment of Aggression

- There are almost no well-controlled studies to examine the effectiveness of any advocated means of managing aggressive behavior. Behavioral techniques work. Medications, gun control, use of static security has not been shown to work. Anger management may not work. Treatments aimed at increasing self-esteem are contraindicated.

Psychotherapy

Pay attention to emerging transference - humorous threats, preoccupation with violence, change in demeanor. Multiple therapists may help.

Paranoid clients must be dealt with honestly
Limit setting must be clear.

Consequences discussed. Offer two choices.
Client will usually choose desired behavior

Medication and Aggression

- No specific drug has been approved by the FDA for the treatment of aggression, nor have there been many helpful studies. Nearly all look at efficacy for acute agitation in clients who are willing to give informed consent. There are no effectiveness studies for long term aggression.

Antipsychotics

- Acute: All antipsychotics are anti-manic and reduce acute agitation. They reduce overstimulation, and their side effects can be sedating.
- Chronic: The antipsychotic action takes 1-3 weeks to develop. Clozapine and risperidone may have long term anti-aggression effects.

Benzodiazepines

- Acute: Effective in reducing over-arousal and anxiety. By giving 2 mg. of lorazepam every 30 minutes, 95% of clients are improved by 90 minutes.
- Chronic: There is no evidence for efficacy in long-term treatment.

Antidepressants

- Acute: No uses.
- Chronic: SSRI's, especially fluoxetine have been reported effective in aggression in personality disorders and impulsivity. TCA's have been reported to work in some violence related disorders.

Beta Blockers

- Acute: No uses
- Chronic: In theory, they would block adrenergic arousal. There is some evidence that they reduce violence in organic brain syndromes, dementia, and brain injury.

Anticonvulsants

- Acute: sedative effect in high doses, and have an anti-manic effect that takes place over a few days. They may dampen limbic irritability and rebalance GABA/glutamate.
- Chronic: Evidence is sparse. Phenytoin may work with impulsive aggression. Carbamazepine may work in head injuries. Valproate may work with impulsive aggression in borderline personality disorder with and without bipolar II, and adolescents with labile mood.

Lithium

- Acute: Anti-manic effects over several days
- Chronic: Some success with children with mental retardation, and impulsively aggressive inmates. There is a little evidence it may work for personality disorders, repetitive violence, violence associated with alcohol, “short fuses,” outbursts with a cyclical quality. It does not work with predatory violence, affective flooding, delusional violence, seizure disorders.

Staff Issues

- For clinicians who work with repetitively aggressive clients, fear and anger are the principle long term occupational hazards.
- Denial is the most frequent defense mechanism.
- The best antidote is opportunity to talk about feelings with peers and supervisors.
- The focus of these meetings is centered on the clinician, not client.

Staff Issues

■ Prosecution

- WSS 943.30: “Whoever...maliciously threatens or commits any injury with intent to compel the person so threatened to do an act against the person’s will...is guilty of a Class D felony.”
- Criteria should follow agency policy.
- Case should be reviewed by non-treating clinicians
- Treatment staff should not be responsible for filing the complaint.

Stalkers

- Repeatedly and unwantedly communicating with, following, or approaching other people causing fear is considered a violent crime.
- Lifetime prevalence
 - 8.1% women, less for men
 - Duration was 1 month to 20 years
- Perpetrators
 - 90% men, mid to late 30's
 - Above average education, unemployed, difficulty with relationships, criminal record
 - Usually a personality disorder, rather than Axis I.
 - Had relationship with the person being stalked.

Stalking of Mental Health Clinicians

- 36.8% of clinicians were stalked
- 100% female victims, 95% male stalkers
- 44.6% were 40-49, 27.8% were 50-59, 16.8% were 25-29, 11.2% were 30-39.
- 33% were stalked by a stranger, 33% by a client or supervisor, 19% by a former intimate partner, 9.5% by non-work acquaintance, 4.8% by a student

Stalking of Mental Health Clinicians

- 63.2% of stalking episodes lasted less than 1 year
- 19% had property vandalized
- 40% called the police (vs. 50% of non-clinicians)

Stalkers

- Stalking Behavior
 - Remote - phone, letters
 - Approach oriented - most common, following, watching, leaving gifts
 - Direct contact
- Types of Stalkers
 - Ex-intimate - most common
 - Grudge stalker
 - Love obsessional
 - Delusional

Stalking Violence

- Specific threats are made 54% of the time, 43% are carried out.
- Not all violence is preceded by a threat, but most is.
- Rejected and resentful stalkers are most likely to threaten.
- The more intimate the stalker has been with the victim, the greater danger.
- Non-psychotic stalkers are more dangerous.
- Erotomania is less likely to be dangerous.

Stalkers

- Risk assessment follows targeted violence principles
 - Access to victim
 - Risk may be over a very long time
 - For ex-spouses - past violence in relationship, sexual jealousy, use of weapons in past, past violations, denial, attitudes, escalation, violent plan, unabated anger.

Risk of Assault

- Past physical or sexual violence in relationship
- Sexual jealousy
- Use of weapons in the past
- Past violation of no contact orders
- Minimization or denial of violence
- Attitudes that support violence
- Poor insight into mental illness
- Poor compliance or response to treatment
- Impulsivity
- Paranoia, mania, obsessiveness, persecutory

Risk of Homicide

- Risk of homicide is low (0.25%) because stalkers don't tend to use weapons.
- Predictors of murder:
 - Threatening to harm children if victim left relationship
 - Frightening victim with weapon
 - Leaving scary notes on victim's car
 - Threatening to kill victim
 - Following or spying on the victim
 - Frightening or threatening the victim's family

Management

- Treat mental disorder
- Confront self-deceptions
- Instill empathy for victim if possible
- Address social skills of stalker
- Rejected stalker: get them to weigh risks
- Intimacy seeker: focus on mental disorder
- Incompetent suitor: tell them to stop
- Resentful stalker: recognize grievance
- Predatory stalker: manage as sex offender

Treating Stalkers

- If you treat someone for stalking, figure he will stalk you next.
- Deal with boundary probes immediately - showing up unannounced, driving by your home, joining your organization...