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# Management of the Acutely Violent Patient

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Violence, constantly highlighted and sensationalized in the news media, television, music, video games, and movies, has, lamentably, not spared the workplace. Although the US Justice Department data [1] have shown that the nation's murder rate in 2001 and 2002 was 5.6 per 100,000 population, similar to the rates seen in the late 1960s, violence seems to have become a daily occurrence and will be encountered in some fashion by a health professional working in an acute care setting.

Recently published studies show that thousands of assaults occur in American hospitals each year; the mental health sector and emergency departments are becoming serious occupational hazard sites [2,3]. It is well documented that mental health workers are at an increased risk of experiencing work-related violence, and studies conducted on board-certified psychiatrists have shown that there is a 5% to 48% chance of being physically assaulted by a patient during their careers [4]. Surveys conducted on psychiatry residents have found that assaults are twice as high among psychiatry residents as among medical residents. Studies have shown that 40% to 50% of psychiatry residents will be attacked physically during their 4-year training program [5]. In a survey of psychiatry residents, two thirds of the residents felt either untrained or undertrained in dealing with violent patients [6]. Even in the prehosptial sector, emergency medical service providers are at an increased risk for encountering violence; factors highly associated with episodes of violence were male gender, age, and hour of the day [7]. As the front-line staff in patient care, nurses also are at an increased risk of experiencing emotional, verbal and even physical abuse by not only the patients but family members and visitors as well [8,9].

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Acute care settings such as emergency departments, psychiatric emergency rooms, and inpatient or outpatient psychiatric settings should be considered high-risk work sites, given the degree of acuity and potential for seeming chaos. These settings are prime examples of workplaces that can create or exacerbate volatile situations, potentially ending in violent acts. Because these are volatile work places, potentially fraught with danger and at times violence, it is imperative that safety is a top priority and that education and continuous inservice training of all staff is an ongoing part of an acute care setting. Studies have shown that educational programs can help to reduce the number of violent events, especially when the events are focused at staff who are less experienced or have less formal training. Violence prevention management, inservice training on the use of restraints, careful screening of violence-prone individuals, and security personnel training and response are methods that have been recognized to be effective in improving safety and increasing awareness among staff [10]. Many studies have shown that some form of pre- and post-critical incident stress management can significantly reduce staff assaults [11].

Additionally, psychiatrists are frequently required to assess violent patients, especially in acute care settings. Because all of these settings are different in terms of size, staff composition, room and patient allocation, and security presence and especially in training institutions (with the presence of new and untrained staff), the following principles are discussed as general recommendations in the assessment and management of the violent patient. First, basic safety considerations are crucial, and it is imperative to have a clear management approach when dealing with these situations and patients. There are some basic tenets of safety that must be adhered to at all times when in an acute care setting (Table 1) [12,13]. The key is to make sure at all times that patients', staff members', and personal safety are maintained and that patients are always monitored for possible violence. It is the adequate and prompt assessment of the situation and the implementation of well-coordinated management responses to a potentially violent patient that maximize the outcome for the patient and safety for the staff.

Agitation, aggression, impulsivity, and violence are behaviors that may arise from innate drives or as a response to frustration, and they can be manifested by destructive and attacking behaviors or covert attitudes of hostility and obstruction. These behaviors sometimes can manifest as a verbal assault or physical action directed toward others, such as hospital staff or other patients. They can be triggered by a trivial event or may be unprovoked and find an external expression; they also can fluctuate and overlap with many other conditions. These behaviors additionally cut across both medical and psychiatric conditions.

Violence, more specifically, is defined as the behaviors used by individuals that intentionally threaten or attempt to or actually inflict harm on others. Over the years there has been a reported increase in the number of aggressive and violent patients who present to emergency departments [14].

Table 1
Ten safety do's and don'ts

| Do… | Do not… |
|---|---|
| Search all patients for contraband and remove dangerous objects. | Allow patients to keep objects that are potentially dangerous. |
| Keep the door open when interviewing patients. | Allow patients to have hot beverages, glass, or sharp objects. |
| Make sure your environment is uncluttered and "safe." | Allow yourself to become trapped or cornered in a room by a patient. |
| Make sure personal belongings are tucked away or are in sight. | Feel embarrassed or intimidated to ask for help. |
| Position yourself with a rapid means of egress. | Feel you cannot have assistance or help when conducting a patient interview. |
| Know how to get help. | Allow splitting or inconsistencies. |
| Know where your panic buttons or alarms are located. | Conduct an interview if you feel menaced or frightened. |
| Trust your "gut" feeling about patients and potentially dangerous situations. | Lay hands on or attempt to restrain the patient if you are alone or the patient is too agitated. |
| Ask patients about suicidal plans and or homicidal thoughts. | Use the most restrictive measures before trying less invasive techniques. |
| Ask patients about access to a weapon and remove weapons immediately. | Allow a patient to be alone or unattended if the patient is agitated. |

Patients may voice threats of violence, from unspecified, vague threats (eg, "I just feel like I want to hurt or kill someone") to targeted homicidal threats toward an individual (eg, "I am going to kill my wife"). Patients who are violent are not a homogenous group, although there are some common characteristics and risk factors. Table 2 lists factors associated with violence, and Table 3 cites common correlates and predictors of violence. The most important predictor is a history of violence, regardless of diagnosis, which indicates an increased risk of subsequent violent behavior [13].

Violence and homicidal threats are not unique symptoms seen only by a psychiatrist; they can be symptoms or findings in many other disorders. Table 4 shows primary psychiatric and nonpsychiatric disorders associated with violence [13]. Antisocial personality disorders, alcohol or drug intoxication, borderline personality disorder, intermittent explosive disorder, patients with mental retardation, conduct disorder, personality changes due to a general medical condition (aggressive type) are just a few possible psychiatric disorders that are associated with violence.

Patients who exhibit agitation, aggressive behavior, impulsivity, and especially violence are at risk to hurt themselves and others and require quick assessment and treatment. Safety is the number-one priority, and all efforts should be made to assess the immediate situation and try to prevent further escalation. An important task, once safety has been achieved, is the medical work-up of violent patients. This is fundamental to establishing a diagnosis and future treatment recommendations. Observations of disorientation, abnormal vital signs, head trauma, alteration in levels of consciousness, and

Table 2
Factors associated with aggression and violence

| Factors | Examples |
|---|---|
| Genetic | Possible sex chromosome abnormalities, such as XXX, XXY, or XYY. Genetic metabolic disorders such as Sanfilipo's or Vogt syndrome or phenylketonuria have been associated with aggressive personalities. |
| Hormonal | Certain hormonal changes have been associated with onset of violent acts, such as thyroid storm or Cushing's disease. Androgens, estrogens, and progestins and their regulation also have been implicated. |
| Environmental | Unpleasant surroundings, air pollution, loud and irritating noises, and overcrowded situations can enhance the likelihood of violence. |
| Historical | History of early violence, battered or abused as children, poor parental models, limited availability of significant others, poor schooling, and previous violent episodes are linked to violence. |
| Interpersonal | Low frustration tolerance, direct provocation, exposure to violence |
| Biochemical | γ-Aminobutyric acid and serotonin have been linked with impulsivity and aggression. |
| Neurologic | Brain lesions such as tumors, trauma, or seizures, eg, complex partial seizures and post-ictal states, and temporal, frontal, or limbic lesions |

no psychiatric history should lead to the consideration of "organic" causes. Even patients with a psychiatric history should undergo a complete medical work-up to rule out medical conditions. First and foremost, a serum glucose level should be determined immediately for all patients. Second, consider the following tests: complete blood count, automated serum chemistry analysis (eg, SMA-7), calcium level, creatine phosphokinase level, alcohol and drug screen, and CT or MRI as needed. Chest radiography, arterial blood gas, lipoprotein, liver and thyroid function tests should be ordered as indicated clinically.

The signs and symptoms encountered in a patient who is agitated and potentially violent are enumerated below, listed on a spectrum of severity from least agitated to outright violence. It is crucial to assess the patient in the earlier stages of agitation to institute some measure of containment and hopefully de-escalate the possibility of violence. The sooner escalating violence is responded to and resolved, the safer it will be for the patient and the staff. When a patient crosses the limit into violence and poses a threat to others, it is time to act decisively. Changes or shifts in behavior observed in the patient should be cues that escalation to full-blown violence may occur. The rule should be "ACT FAST" [12,13,15–17].

Pacing
Psychomotor agitation
Threatening remarks
Combative posture and stance
Acting-out behavior
*Violent Outcome*

Guardedness
Suspiciousness
Paranoid ideation
Paranoid delusions
Carrying or access to weapons
*Violent Outcome*
Poor impulse control or low frustration tolerance
Emotional lability
Irritability and/or impulsivity
*Violent Outcome*

Violent outcomes can be considered screaming, cursing, yelling, spitting, biting, throwing objects, hitting or punching at self or others, or attacking or assault behavior [13].

There are no diagnostic measures to determine violence, but because a history of violence is the best predictor of future violence, promptly recognizing patients with histories of violence (if the patient is known to the hospital) at triage or registration is important [18]. Many hospitals have

Table 3
Common correlates and predictors of violence

| Correlates | Examples |
|---|---|
| History | Childhood abuse or neglect; history of suicide attempts or self-mutilation; previous violence and/or family violence |
| Age and gender | Young (13 to 25 years old) |
| | Male |
| Psychiatric factors | Active symptoms of psychiatric disorders (eg, command auditory hallucinations, paranoid delusions, psychotic disorganization of thought, excitability) |
| | Combination of serious mental illness and substance abuse |
| | Personality disorders |
| | Substance-related disorders such as intoxication and/or withdrawal (IMPORTANT: Chronic alcoholism is more predictive of violence than immediate alcohol use, and the higher the number of comorbid psychiatric disorders the greater the rate of violence.) |
| Emotional factors | "Acting out" behavior |
| | Angry or rageful affects |
| | Emotional lability |
| | Irritability and/or impulsivity |
| | Poor frustration tolerance |
| Social factors | Limited or poor social supports |
| | Low socioeconomic status |
| | Medication noncompliance |
| Neurobiologic factors | Delirium (eg, HIV/acquired immuno deficiency syndrome) |
| | Mental retardation |
| | Neurologic diseases |
| | Seizures; structural brain abnormalities |
| | Traumatic brain injury |

Table 4
Disorders associated with violence

| Disorders | Other causes |
|---|---|
| Primary psychiatric disorders (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) | Antisocial personality disorders<br>Borderline personality disorders<br>Conduct disorder<br>Delirium<br>Dementia<br>Dissociative disorders<br>Intermittent explosive disorders<br>Mental retardation<br>Oppositional defiant disorder<br>Personality change caused by a general medical condition, aggressive type<br>Post-traumatic stress disorders<br>Premenstrual dysphoric disorder<br>Schizophrenia, paranoid type<br>Sexual sadism<br>Substance abuse disorders (alcohol-related disorders, amphetamine, inhalant, and phencyclidine intoxication) |
| Other causes | Intracranial pathology (eg, trauma, infection, neoplasm, anatomic defect, vascular malformation, cerebrovascular accident, degenerative disease) causing dementia, delirium, affective, and psychotic syndromes or personality changes<br>Medications<br>Seizure or seizure-like syndromes, including behaviors occurring during ictal, post-ictal and inter-ictal periods<br>Systemic disorders causing dementia, delirium, affective, and psychotic syndromes or personality changes (eg, metabolic, endocrine, infectious, and environmental) |

some system to identify patients at high risk and thus take the necessary safety measures from the start, whether that means enhanced observation status, a thorough search, or a security observation. The recognition of these patients from the outset can raise a clinician's level of awareness and minimize the possibilities of acting out and thus catching people off guard. The removal of all weapons by security, whether through a manual search or with a metal detector, will vary according to each institution's policies but must be performed.

It is imperative to directly question the patient about their intent to harm themselves or harm others, possession of a weapon, formulation of a definitive plan, recent violence, current alcohol or drug use, adherence with aftercare and medication management, and associated psychiatric or medical conditions By asking these questions, preliminary information can be gathered and a relationship with the patient can be established. Remember that the higher the awareness and level of suspicion for acting

out, agitated, or violent behavior there is, the less likely an explosive situation will occur—do not be caught off guard or by surprise.

The management of violent patients can be divided into four progressive unified approaches that are neither mutually exclusive nor absolute in their order of implementation: environmental manipulation, de-escalation techniques, physical restraint or seclusion, and pharmacological interventions. A stepwise approach should be used to manage the violent patient with the least restrictive yet effective means of control being selected. This is known as the least restrictive alternative doctrine.

## Environmental manipulation

When agitation is present, it is essential that precautions be taken to ensure the immediate safety of other patients and staff. There are several environmental variables that can be controlled or modified to decrease the potential for escalation of violence. These include: patient comfort, relative isolation, decreased time of waiting, staff attitude, and decreased stimuli. The patient should be made as comfortable and safe as possible. A quiet room or an individual examination room can decrease external stimuli, which in turn can assist in the de-escalation of a patient. Offering the patient a chair on which to sit or a stretcher on which to lie down or something to drink, such as a cup of water or juice, conveys caring and respect and can improve a potentially volatile situation.

Physicians should never place themselves or any other staff member in an unsafe situation (eg, in a closed room or where access to doors is blocked or other compromising locations). All items or objects that can be potentially dangerous should be removed or at least accounted for by the staff to prepare and minimize the danger of injury. There are certain staff approaches that should be monitored carefully especially when dealing with a violent patient. It is important both to maintain a safe distance from an agitated patient and to respect the patient's personal space. Prolonged or intense direct eye contact can be perceived as menacing by the patient. Body language and positions such as crossed arms or hands behind the back or hidden also can be considered confrontational and threatening. The most important approach is always to maintain a stance that is calm and in control. Staff should closely monitor the patient's behavior for any changes in mood, speech, and psychomotor activity (any of the above can signal an impending loss of control).

## De-escalation

Techniques of verbal de-escalation (''defusing'' or ''talking down'') should be used as the first approach with any agitated patient, including all of the verbal and nonverbal responses used to defuse or reduce a potentially violent situation. The overriding interventional principles are that the staff

conveys their professional concern for the well being of the patient, their assurance that no harm will come to the patient, and that they are in control of the situation.

The staff must appear calm and in control, speaking to the patient in a nonprovocative, nonconfrontational manner, and using a calm and soothing voice. Staff must remain at a safe distance from the patient, be prepared for potential violence, and be familiar with emergency or "panic" alarms or buttons, if the institution has them. Overt anger or hostility should never be expressed toward an agitated patient. Use empathic statements such as, "I understand you're not feeling well and that you're having a hard time," or "it sounds like you're in pain and confused." These statements can place an agitated patient at ease, especially when the statements are made in the context of genuine concern by using phrases such as, "you're here to get help, and we're going to try to figure out what's going on," or "let us help you, don't be afraid." Staff should reinforce the feeling that the patient is in a safe environment and that everyone is there to assist in the patient's evaluation and treatment. At the same time, the limits on patient behavior and consequences of present and future actions need to be verbalized. The patient should be told decisively and emphatically that the staff will ensure and maintain control and that he or she will not be allowed to harm him- or herself or others. The clinician should provide reasonable positive reinforcements and propose alternatives to aggressive behavior, such as talking with staff or making a phone call. Staff should be consistent in their approach: manipulative patients may attempt to split staff who do not have a unified strategy.

## Restraints and seclusion

Restraints and seclusion are used as a final response to emergent and imminently dangerous behavior. Seclusion and restraints are never to be used as a means of punishment or retribution for an agitated, demanding, or disruptive patient, for the convenience of staff, or as a substitute for a treatment program. It is crucial to preserve the patient's rights and dignity at all times. This can be achieved by ensuring the patient's privacy as much as possible, allowing for participation in care decisions by the patient or significant others, and by providing ongoing assessment and monitoring and the provision of physical care and comfort during the time the patient is in restraints and seclusion.

Once the decision has been made to proceed with restraints or seclusion, a team leader must be identified who has experience in the implementation of restraints or seclusion. There must be sufficient and trained personnel so that the procedure can be performed safely and effectively, especially if physical force becomes warranted. At all times, the staff must convey confidence and calmness and proceed with implementation as if it were a standard and familiar procedure [19–21].

## Pharmacologic interventions

Pharmacologic management of the violent or agitated patient may serve as a primary therapy or as an adjunct to other efforts at de-escalation. If the behavior is extreme or continues to deteriorate despite other management efforts, medications must be offered. Whenever possible, the patient should be given the option or choice of medication type or route, which often can assist in their ability to regain some measure of control, thus potentially defusing further escalation. The choices of possible agents and routes first must be discussed by the staff, and a unified approach must be taken when discussing these options with an agitated patient. Ideally, the patient will agree to take the medication voluntarily. Oral administration can potentially address control issues and permit the patient to retain control and dignity; if not, parenteral routes should be used. In the event that the involuntary administration of intramuscular (IM) medication is required, security and other staff must be present, and all efforts should be taken to ensure a safe and rapid intervention. The choice of IM location can be left up to the patient, (eg, deltoids, buttocks, or other sites). A thorough note should be written that describes the preceding events, the least restrictive measures attempted, the actual intervention, and patient outcome or effect.

Rapid tranquilization has become a standard of care that has been shown to be safe and effective. The goal of rapid tranquilization is simply to regain behavioral control without oversedation [22]. Traditional approaches use a typical antipsychotic such as haloperidol, with or without the use of benzodiazepines such as lorazepam. Rapid tranquilization that combines a benzodiazepine and an antipsychotic drug offers the theoretical advantage of minimizing the amount of any single drug and combining the sedation of the benzodiazepine with the behavioral modification of the antipsychotic [23,24]. Haloperidol has become the standard for rapid tranquilization because of its strength and desirable side-effect profile; it is a powerful antipsychotic with minimal sedating and cardiovascular effects. It has been shown repeatedly to be safe and effective for the control of agitated behavior in the acute setting [25]. The newer atypical agents, used widely in practice, have slower titration schedules or dose-limiting adverse effects that prevent them from becoming first-line options. Newer preparations, such as oral liquid forms, rapidly dissolving tablets (risperidone and olanzapine), and parenteral (IM) forms of ziprasidone, risperidone, and olanzapine, are becoming important and useful alternatives for the management of violence in the acute setting. Preliminary data suggest that these agents are better tolerated, have fewer side effects, are effective in reducing agitation and psychosis, and make the transition from intramuscular to oral route easier and better tolerated [26–29]. Recent studies also have shown that valproate can be effective in the management of violence, with significant decreases in the violent behaviors, especially in patients with ‘‘organic’’ causes, dementias, mental retardation, or bipolar disorder and manic type [30].

The use of benzodiazepines as an adjunct or alone in the management of agitated behavior has been shown to be effective, especially lorazepam, which has the advantage of safety, rapid IM absorption and reliability [31,32].

Ultimately, the decision about the medications to be used, alone or in combination, is a clinical one and is best discussed and reviewed among the team members when they are confronted with a potentially explosive situation. Each physician, as well as the patient, will need to be comfortable with their choice, and the implementation of chemical restraints needs to be carefully thought out, ordered, and documented. Least restrictive alternatives must be considered and documented before acute psychopharmacologic interventions are used. Remember, always use sound clinical judgment when making these decisions.

## Summary

Violence in the work place is a new but growing problem for our profession. It is likely that at some point a psychiatrist will be confronted with a potentially violent patient or need to assess a violent patient. Understanding predictors and associated factors in violence as well as having a clear and well-defined strategy in approaching and dealing with the violent patient, thus, are crucial. Ensuring patient, staff, and personal safety is the most important aspect in the management of a violent patient. All of the staff must be familiar with management strategies and clear guidelines that are implemented and followed when confronted with a violent patient. The more structured the approach to the violent patient, the less likely a bad outcome will occur. Manipulating one's work environment to maximize safety and understanding how to de-escalate potentially mounting violence are two steps in the approach to the violent patient. Restraint, seclusion, and psychopharmacologic interventions also are important and often are necessary components to the management of the violent patient.

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