ASSAULTIVE BEHAVIOR

Does Provocation Begin in the Front Office?

The reporting of violent acts is becoming commonplace on the nightly news, and violence affects every American household. Our culture is becoming more exposed to violent incidents on the streets, in the classrooms, and in the workplace. Healthcare settings are not immune, and patient assaults against staff are a critical issue for all health-care professionals. Modern psychiatric treatment standards simply cannot allow for a disinterested and uninvolved front office. This article will examine the issues of provocation at all levels and will demonstrate why the institutions are ultimately responsible and why administrators alone have the power and resources to provide needed assessments and instigate intervention.

Assaults threaten the welfare of the assaultive patient, other patients, staff, and visitors alike. Assaults by patients towards staff involve injury, lost time, high stress, job dissatisfaction, and lingering psychological consequences. The cost is high in terms of lost productivity, insurance and medical costs, and litigation. There has been an alarming increase in successful suits brought against health-care providers for failure to properly treat or restrain, failure to diagnose dangerousness, and, of increasing concern, failure to protect third parties from assaultive behavior (Felt-hous, 1987). Institutions bear the legal

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responsibility and liability of ensuring the rights of staff to workplace safety, specifically in relation to workers' compensation (Sales, 1983).

The literature on assault is voluminous. Prediction and prevention have been studied to decrease the frequency and severity of assaults. But despite an increase in a variety of training methods and policy interventions, the health professions have failed to deal adequately with this problem. There is strong evidence in the literature of the magnitude of underreporting of assaultive incidents. Lion and others (1981) discovered that underreporting occurs at a rate of five times that of reported assaults, and other researchers have confirmed these findings (Negley, 1990).

Assaults not only continue to occur, but they are also dangerously on the increase (Snyder, 1983). This may be explained by a number of factors. Movement towards "least restrictive" treatment creates difficulties for the management of assaultive patients. Court decisions regarding a patient's right to refuse medication may curtail chemical treatment, thus increasing the likelihood of repeated assaultive incidents (Lion, 1981). The movement toward deinstitutionalization has not yet ended, and so there are greater numbers of potentially dangerous outpatients not under direct care (Feltous, 1987). Furthermore, decreased accessibility to hospital treatment may increase the number of assaultive persons in the community. For these reasons, it is vitally important that precipitating factors and issues of provocation be identified and examined to reduce assaultive episodes.

Discussion. Some might say that incidents such as this just happen and are part of the job. Incidents like this do occur frequently. The public generally associates violence with mental illness (Skodol, 1980), and a certain amount of assaultive behavior, particularly in the psychiatric setting, is inevitable. The National Safety Council reported that assaults are the leading cause of injury for staff working in these settings (Phillips, 1977). With these facts in mind, it is imperative that solutions be explored and alternatives attempted.

Numerous incidents of provocation can be identified from the case report. The patient's history and diagnosis should have alerted the staff to the increased potential for violence. The organization of routine, the allocation of staffing, the meal times, and supervision are all provocative elements, as are taking the coffee away from the patient and the invasion of body space. Control issues of the staff, their attitude of getting their "pound of flesh" for the patient's behaviors, and the consequences are far beyond any reasonable response to the drinking of an extra cup of coffee, no matter how slow it is drunk. The authoritarian and punitive flavor of the outcome for the patient indicates that not only the milieu, but also the staff's skills, education, and even personalities should be assessed. The ultimate responsibility for this assessment lies, of course, with management, and the institution is responsible for solutions and interventions.

Risk Identification

An extensive review of the literature on assaultive behavior reveals factors that are strongly associated with violent incidents. A previous history of assault and a diagnosis of psychosis, substance abuse, organic brain disorders, dementia, and post-traumatic stress disorder are most highly correlated with assault (Blair, 1990). Environmental, demographic, and epidemiological issues have been studied extensively, with the results being either mixed or contradictory. 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 generally lack cross-validation in independent samples (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 contribute to the dynamics of assault. The sum of all these issues is complicated and confusing at best. Many doubt the usefulness of these risk factors in predicting assaultive behavior (Lion, 1981; Jones, 1985). Rossi and others (1986) find that only history of assault, diagnosis, and legal status at the time of admission are useful as risk designations.

What has been identified in the literature are the issues of provocation (Blair, 1990). Provocation is an important risk predictor because these issues can be recognized, assessed, and appropriate interventions can be implemented to reduce the associated risks. It is only by the reduction of such "non-fixed" risk factors that any reduction of assaults can be accomplished.

The literature provides clues as to why—despite the increase in policies and procedures, assaultive behavior workshops, inservice programs, and violence management classes—assaults continue

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to increase. Assaultive behavior may be poorly understood due to the natural avoidance associated with violent acts, and the fear and denial that accompany it. Incidents of assault are high and the underreporting is flagrant, yet as many as half of reported incidents of assault are thought to be avoidable by the victims (Aiken, 1984). It is clear, then, that understanding the confusing problem of assaultive behavior is imperative.

**Provocation**

Rada (1981) states that the common perception is that the assaultive patient views his victims as provoking the assault. There are certainly unprovoked assaults from demented patients, those suffering seizure activity, or psychotic patients experiencing bizarre or threatening delusions. Assaults in these circumstances are not goal-directed; rather they are random and generalized. Findings indicate that the majority of assaults are not predicted by staff, so precipitating factors have been difficult to identify and examine (Convey, 1986; Rada, 1981). It would seem, then, that the issues that provoke assaults are not readily apparent to staff.

Involuntary admission has been identified as a risk factor and can certainly be considered a provocation. Readmissions are overrepresented among assaultive patients, and patients who were involuntary admitted were 82% more assaultive than those admitted voluntarily (Rossi, 1986). Up to 60% of psychiatric patients seen in the emergency room or admitted to psychiatric units are physically assaultive (Tardiff, 1980), and nearly 75% of these patients report previous assaults.

In patients with organic brain disorders or dementia, the extremely high incidence of assault is associated with performing or assisting with activities of daily living, eg, toileting, bathing, and dressing (Jones, 1985; Lanza, 1988). The high incidence is presumably due to the fact that these disorders involve recurrent loss of impulse control (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). It is presumed that any activity involving the invasion of personal space increases the risk for assault in these patients (Jones, 1985). Donat (1986) studied assaultiveness in a psychogeriatric setting and found that invasion of personal space is an important provocation to assaultive incidents. Negley and Manley (1990) agree, and designed environmental changes to reduce the invasion of personal space of these types of patients.

A third factor of provocation is limit setting. Lanza (1988) identifies limit setting as having an extreme level of provocation and found that physically setting limits caused some assaults, particularly among patients with organic brain disorder or dementia. But a greater number of assaults occurred when staff used only verbal limit setting. This would implicate the skill level, style, and educational preparation of the staff involved. Dubin and others (1988) state 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 involving the moving of a patient to another area, placing limits on eating or drinking certain foods or beverages, and limitations on cigarettes were the most risky. This agrees with the theory that losses are more important and have greater impact on people than possible gains (Kahneman, 1984). Viewed within this framework, taking something away from a patient—cigarettes, food, drinks, status, or self-esteem—would increase risk for assault towards the limit setter. Taking these ideas a bit further, Tversky and Kahneman (1981) propose that limits be framed in terms of choices, and that a choice in terms of a loss should always be avoided, whereas a choice that emphasizes a gain would be preferable.

Staff attitude is another factor that has been identified as a provocative issue. Assaulted staff generally report that they "didn't like" the patient; perhaps this animosity is projected to the patient (Madden, 1976). Dubin (1988) found that aggressiveness on the part of the care provider is more likely to provoke assault. 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.

Denial also plays an important role and should be considered a provocative ingredient. 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, staff deny the possibility of assaults against themselves, and thus place themselves at risk for assault (Lion, 1973). Madden and others (1976) report 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. On an institutional level, denial may account for the lack of motivation for the innovative development of adequate assessments and interventions to reduce violent and assaultive behaviors.

The educational level and clinical expertise of staff are obviously related to inadvertent provocation. Of all assaults in health-care facilities, 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. Of the staff assaulted, 88% are nursing assistants, student
nurses, or nurses (Rada, 1981). Because nursing assistants and student nurses have a higher incidence for assault, this suggests that skill level or experience plays an important role in predicting assault (Rubin, 1980). In a definitive study by Infantino and Musingo (1985), it was shown that staff who were trained in limit setting and other techniques had a significantly lower assault rate than did a group that was not trained.

Another important consideration is the fact that psychiatric facilities tend to use nonprofessional personnel for most patient care duties. Kavanaugh (1988) points out that this group of workers has a much higher incidence of authoritarian and inflexible styles in working with the mentally ill, and thus increases the likelihood of provocation due to style or personality.

Since Stanton and Schwartz published their classic studies of the milieu and patient dynamics, it has been understood that staff issues and conflict, as well as institutional problems, can influence patient behaviors (Stanton, 1954). These ideas have been refined by other researchers, and various factors have been specifically identified as affecting incidence of assaults. Tardiff and Swellam (1982) identify understaffing, conflict between staff, and low morale as risk factors for violent acting out.

Madden (1977) challenges the institution itself. Institutional denial of the problem can contribute to high numbers of assaults. If an institution denies that patients are as assaultive as they are, the scope of underreporting, or the level of dysfunction of the unit staff, then no reflective examination is ever conducted and interventions never implemented. If the institution views assaultive behavior as simply a symptom of mental illness rather than a product of the situation in which a patient finds himself, the structure of the treatment setting then becomes one of controlling aggressiveness by restrictive and intrusive interventions. Morrison (1990) states that patients view assaultive episodes in terms of response to these intrusive limits and structure, and "to get staff off my back."

If poor leadership, inept treatment practice, and staff conflict are seldom viewed as being related to assaultive behavior, then the process is never interrupted and the problems of assault will continue. If disharmony between the hospital administration and nursing staff exists, staff may become either over- or undercontrolling. Tardiff and Swellam (1982) note that the reaction to these circumstances is an authoritarian, nonflexible approach to treatment by the staff, and identify this as major provocation for assault.

All too often, adequate job performance is defined as simply keeping the patients under control. Frequent use of medications, restriction, seclusion, and restraints are used to maintain this control—all of which are intrusive and provocative.

Economic factors in a facility also affect this dynamic. Understaffing, overwork, a poor physical environment, or poorly educated staff lead to care providers who have a limited knowledge base and no confidence in themselves or their fellow workers for their own safety. They may then attempt to gain control by more authoritarian means. Strict, inflexible structure and inappropriate consequences for behavioral problems set the stage for assaultive behavior.

In an important study by Brailsford and Stevenson (1973), it was found that the manner in which units are run and the way in which patients and staff are managed correlates with incidents of assault. If political or economic issues affect nursing staff, the staff is left feeling powerless with high levels of stress and anxiety. This leads to the adoption of constricted, controlling, and negativistic behaviors by staff, which are characteristic of an authoritarian system of patient management. This system also leads to high isolation of staff from patients. Some authors have demonstrated that authoritarian, overcontrolling staff rarely socialize with patients and have little person-to-person contact with the patient unless the interaction involves limit setting or confrontation (Hodges, 1986).

Furthermore, this type of situation impedes the therapeutic milieu and renders it incapable of responding with sufficient sensitivity or empathy to the warning signs of distress and behavioral cues that precede violence. It severely limits the options left to patients when they experience impulsive urges, anger, fears, doubts, or frustrations brought about by treatment. These conditions, then, would seem to provoke violent episodes. 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, threatening, or frightening.

Patients accept treatment under the terms set by staff. Staff have this control and are rarely challenged about its use, nor is there often examination of the staff's role in violent incidents. Mental illness and the limits of an inpatient setting impede the patient's ability to react suitably to difficult circumstances and limit the patient's ability to respond appropriately to conflict. The milieu may limit the options to only disruptive, desperate, or violent acts. Violence might be a symptom of the situation and not the disease. A severely restrictive and controlled milieu may provoke the assaultiveness that it is intended to control. Harrington (1974) believes that violence in a hospital setting is seldom a symptom of illness, but rather a reaction to a situation in which a patient finds himself.

Locked units and severe structure may also imply that abnormal or disturbed behavior is acceptable in such settings, and assaults may become an expected occurrence, just "part of the job" (Weaver, 1978). Such settings may
change the nature of potentially violent situations or alter the expectations of violent acts (Reid, 1985). Violent behavior may play a role in getting staff attention, or may lead to a tangible reward. Brailsford (1973) emphasizes the role of frequent contact and interaction between patients and staff, and suggests that a seclusive, isolated, and authoritarian staff is the most important and profound issue of provocation for assault.

Interventions

Intervention, then, must begin with administration, and it is here where the responsibility lies. Administration has the moral and ethical duty for assessing the milieu, supporting the staff, and providing education and skills training to the staff who manage the milieu. Interventions are designed to minimize issues of provocation and to eliminate those that can be prevented. Obviously, some issues are fixed, such as legal status at time of admission or diagnosis. But the majority of provocation factors can be specifically reduced by directed intervention. An important first step in the process is the assessment of the assault itself. This can identify provocation due to certain medical causes, or it can document the extent of degeneration in patients with dementia or organic brain disorder. Medical interventions would be indicated and would appropriately address the causes of some violent episodes.

Jones (1985) demonstrated that interventions occurred after only 40% of assaults and involved seclusion, medication, or both. Rada (1981) makes the point that assessment must continue during and after the assault. Information gained from observation and assessment of the assault and post-assault phases is invaluable. It would be important to note, for example, if a seizure or acute delirium occurred. It should be noted if the assault was generalized and nondirected or focused, if delusions were an important factor, and if the assault was unprovoked. After the assault, the patient must be assessed as to mental status, orientation, presence of a postictal state (following a stroke or seizure) or confusion, the ability to express regret, or continued hostility. The assaultive behavior can then be classified etiologically as situational, organic, or functional. This, then, would dictate future treatment interventions and would also allow for assessment of provocative factors involving the staff and milieu that may have played a role in precipitating the behavior.

Drummond and others (1989) suggest conventional interventions for assaultive behavior. These involve staff training for prevention and management, organization of policies and procedures with regard to violence, tracking documentation to identify patients with a history of assault, and staff warning by way of flagging records.

The suggestion of administrative intervention as to policy and procedure reorganization denies administrative and organizational provocation of assaultive behavior. In addition, it avoids the administrative obligation of assessing staff morale, education, skill levels, and the degree of flexibility and control in the unit milieu. Policy and procedure interventions are not supported in the literature, and, in fact, contribute to the problem by reflecting denial and avoiding the more arduous task of self-examination of institutional and organizational traditions and characteristics.

The proposal to identify patients with a history of assault is, perhaps, useful, but again denies issues that are more easily and logically targeted for intervention; that is, to stop provocative processes and actions in patient interactions, which is where they make the most impact. To flag records or otherwise identify those patients with a history of assault would further presume administrative and managerial efforts to increase reporting and documentation. Management must take this initiative.

Staff education and increased awareness is of utmost importance. Staff awareness should include identification of the various risk factors; development of skills; and an understanding of structure, limit setting, and the issues of provocation. Teaching kung fu side steps and how to place patients in restraints seem to have little impact on the incidence of assaultive behavior, but it would affect outcomes once the assaultive episode has begun.

Finally, and most importantly, provocation issues must be examined and understood. The literature has examined the various risk factors for years, but it is only recently that provocation has been examined in depth. Provocation by staff, either knowingly or unknowingly, is a crucial issue. Provocation by the milieu is rarely addressed or recognized. A milieu that is inappropriate or counterproductive can only be changed by administrative assessment, staff education, awareness, and review. Routine rules and unit structure must be examined and reviewed; regulations that have been in place for years may have outlived their appropriateness. Many can be eliminated, and treatment can become more flexible to accommodate individualized treatment. Institutional provocation must also be examined; a close examination of procedures and rules may reveal provocative issues that can be eliminated or reduced. Organizational provocation is an important issue, and it, too, is often ignored when attempts are made to intervene in assaultive incidents.

Supervision of nonprofessional workers should be implemented and refined. Strict or harsh consequences for patients' behaviors should be assessed in terms of which needs are being met—treatment goals or staff needs for power or control. Again, a more individualized treatment approach that does not focus on strict obedience of unit rules and regulations can minimize these types of provocation. After all, structure is only a vehicle...
by which assessment is made and treatment directed, and it provides a measure by which resistance or treatment gains occur.

Assaults will undoubtedly continue, and incidence is likely to continue to increase as well. And the literature will continue the attempt to pinpoint specific factors or interventions aimed at reducing such episodes. Tragically, staff and patients alike will continue to suffer. Until administrations are able to look at the issues of provocation in the organization, either from the milieu itself or from the personalities and skills of responsible staff, then the problems of violence will continue to baffle and confound.

References
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