Addressing Aggression in Patients With Mental Illness
Learning Objectives

• Evaluate the risk of violence in patients with mental illness by understanding the contribution of biological and environmental factors to violent behavior

• Apply evidence-based strategies to optimally treat and manage violence and aggression
Pretest Question 1

John is a 24-year-old patient with ADHD who has recently been admitted as an inpatient subsequent to several violent outbursts. When treating violence associated with ADHD, which treatment is recommended first line?

1. Atomoxetine
2. Guanfacine
3. Propranolol
A 45-year-old woman with untreated schizophrenia and a complicated medical history presents to the emergency department severely agitated. Which agent is most appropriate for treating acute agitation while avoiding both extrapyramidal symptoms (EPS) and orthostasis?

1. Olanzapine
2. Ziprasidone
3. Fluphenazine
California State Hospital Violence Assessment and Treatment (Cal-VAT) Guidelines

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- Shannon Bader  CA Dept. of State Hospitals; Dept. of Psychology, Patton State Hospital
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Stahl et al. CNS Spectrums 2014; in press.
Why Are Individuals Violent or Aggressive?

VIOLENCE RISK EVALUATION
Violence Risk Evaluation

- Violence risk evaluation should include a systematic collection of patient information and delineation of empirically derived violence risk factors
- Evaluation should include the appropriate use of violence risk assessment instruments

Stahl et al. CNS Spectrums 2014; in press.
Violence Risk Evaluation

• Violence risk assessment tools include
  – Actuarial assessments
  – Structured clinical judgment assessments
  – Recent literature describes continuum rather than dichotomy
Actuarial Assessment

• "Actuarial" indicates that a mathematical relationship has been established between the predictors and the outcome event
Structured Clinical Judgment

- Guided professional assessment
- Includes dynamic risk factors
Review Prior History

- Frequency, severity, and typology of violence
- Patient and environmental factors associated with violence
- Cause of latest decompensation
- Comorbid factors associated with violence
- Evaluate previous treatments and treatment efficacy
- Review all incident reports, progress notes, laboratory reports, prior psychological and neuropsychological testing results, treatment team documents, and court records
- Include collateral reports of previous violence incidents, if available
- Interview treatment team members and level of care staff
- Conduct a clinical interview with the patient, including a full mental status examination
Violence Risk Assessment Tools

• Structured professional judgment violence risk assessment instruments
  – Historical Clinical Risk Management-20 (HCR-20)
  – Short-Term Assessment of Risk and Treatability (START)
  – Violence Risk Screening-10 (V-RISK-10)

• Psychopathy
  – Psychopathy Checklist-Revised (PCL-R)
  – Psychopathy Checklist-Short Version (PCL-SV)

• Actuarial violence risk assessment instruments
  – Classification of Violence Risk (COVR)
  – Violence Risk Appraisal Guide (VRAG)
  – Violence Risk Scale (VRS)

• Observational rating scales and checklists
  – Dynamic Appraisal of Situational Aggression (DASA)
  – Staff Observation Aggression Scale-Revised (SOAS-R)
  – Buss-Perry Aggression Questionnaire
  – Brief Psychiatric Rating Scale (BPRS)
  – Cohen-Mansfield Agitation Inventory (CMAI)

Planned behavior not typically associated with frustration or response to immediate threat
Might not be accompanied by autonomic arousal
Planned with clear goals in mind
Also called predatory, instrumental, proactive, or premeditated aggression

Organized
29%

Psychotic
17%
Associated with positive symptoms of psychosis, typically command hallucinations and/or delusions

Impulsive
54%
Characterized by high levels of autonomic arousal
Precipitated by provocation
Associated with negative emotions, such as anger or fear
Usually represents response to perceived stress
Also called reactive, affective, or hostile aggression

What Can We Do to Ameliorate Violent and Aggressive Behavior?

TREATMENT OF VIOLENCE AND AGGRESSION
Psychosocial Interventions

- Both medications and therapeutic interventions may be needed to impact change
- Pairing medication with appropriate psychosocial interventions can impart new coping strategies and increase medication adherence
- Psychosocial interventions should also give weight to the etiology of the aggression
  - Once an etiology has been identified, a behavioral treatment must be further individualized based on the patient's needs and capabilities as well as other logistical limitations
- Offer high-standard training on de-escalation and prevention strategies such as awareness of one's presence (body posture), content of speech, reflective listening skills, negotiation, positive affirmation, and offering an alternative solution
- Provide supportive and nonjudgmental briefing sessions to staff involved in incidents to discuss their subjective experience

Stahl et al. CNS Spectrums 2014; in press.
Psychotic Aggression

Psychosocial Interventions: Psychotic Aggression

• General factors
  – Good communication is essential
  – Multiple and coordinated treatment approaches, including administrative, psychosocial, and psychotropic approaches, should be used
  – A sufficient dose of the selected treatment should be administered
  – Treatment integrity, including well-trained staff, supportive administration, and well-coordinated evaluation efforts, is vital
  – Treatment should be tailored to the individual
  – There should be a clear connection between risk assessment and treatment

Stahl et al. CNS Spectrums 2014; in press.
PSYCHOPHARM – DR. STAHL
Treating Psychotic Aggression Associated With a Primary Psychotic Disorder

- Although no response by weeks 4-6 of adequate to high-dose antipsychotic treatment portends a poor outcome, many patients show ongoing improvement for many weeks to months following a favorable, albeit partial, response to early treatment.

- Some patients may require higher than cited antipsychotic plasma concentrations to achieve stabilization.

Stahl et al. CNS Spectrums 2014; in press; Morrissette DA. CNS Spectrums 2014; in press.
Antipsychotic Treatment Algorithm for Long-term Care of Patients With Psychotic Aggression

1. 4–6-week trial of antipsychotic monotherapy at standard dose

2. Inadequate treatment response
   - Obtain plasma drug level of antipsychotic

3. Plasma drug level within therapeutic range
   - Adverse effects present
     - Switch to different antipsychotic monotherapy
   - Adverse effects absent
     - Possible pharmacodynamic failure (higher dopamine D2 receptor occupancy required)

4. Plasma drug level below therapeutic range
   - Ensure treatment adherence (consider using a long-acting depot antipsychotic)
   - Possible pharmacokinetic failure (rapid hepatic metabolism or drug interactions with hepatic inducers)

5. Possible pharmacodynamic failure (higher dopamine D2 receptor occupancy required)
   - Clozapine monotherapy (standard dose for adequate duration)
   - Conventional antipsychotic monotherapy (standard dose for adequate duration)

6. Inadequate treatment response
   - Obtain plasma drug level of antipsychotic
   - Antipsychotic polypharmacy

7. Obtain plasma drug levels of both antipsychotics
   - Back to antipsychotic monotherapy

References:
# Dosing Recommendations: Conventional Antipsychotics

<table>
<thead>
<tr>
<th>Medication (Brand)</th>
<th>Recommended Dose Range</th>
<th>High-Dosing Recommendations</th>
<th>Recommended Plasma Concentration</th>
<th>Long-Acting Depot Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine <em>(Thorazine)</em></td>
<td>300-1000 mg/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluphenazine <em>(Prolixin)</em></td>
<td>6-20 mg/day</td>
<td>20-60 mg/day</td>
<td>0.8-2.0 ng/mL Up to 4.0 ng/mL may be required</td>
<td>2–3-week depot available 25-100 mg/14 days</td>
</tr>
<tr>
<td>Haloperidol <em>(Haldol, Serenace)</em></td>
<td>6-40 mg/day</td>
<td>20-80 mg/day Higher doses especially when failing to respond to doses up to 20 mg/day</td>
<td>5-20 ng/mL Up to 30 ng/mL may be required</td>
<td>4-week depot available 200-300 mg/28 days after loading with 200-300 mg/weekly times 3</td>
</tr>
<tr>
<td>Loxapine <em>(Loxitane)</em></td>
<td>30-100 mg/day</td>
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<tr>
<td>Perphenazine <em>(Trilafon)</em></td>
<td>12-64 mg/day</td>
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<tr>
<td>Thiothixene <em>(Navane)</em></td>
<td>15-50 mg/day</td>
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<tr>
<td>Trifluoperazine <em>(Stelazine)</em></td>
<td>15-50 mg/day</td>
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</tbody>
</table>

See full prescribing information for details.

*Stahl et al. CNS Spectrums 2014; in press.*
Dosing Recommendations: Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Medication (Brand)</th>
<th>Recommended Dose Range</th>
<th>High-Dosing Recommendations</th>
<th>Long-Acting Depot Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole (Abilify)</td>
<td>10-30 mg/day</td>
<td>Higher doses usually not more effective and possibly less effective</td>
<td>4-week depot available</td>
</tr>
<tr>
<td>Asenapine (Saphris)</td>
<td>10-20 mg/day</td>
<td>High dosing not well studied</td>
<td>No depot available</td>
</tr>
<tr>
<td>Clozapine (Clozaril)</td>
<td>150-450 mg/day</td>
<td>FDA max 900 mg/day Doses &gt;550 mg/day may require concomitant anticonvulsant administration to reduce seizure risk</td>
<td>No depot available</td>
</tr>
<tr>
<td>Iloperidone (Fanapt)</td>
<td>12-24 mg/day</td>
<td>High dosing not well studied</td>
<td>No depot available</td>
</tr>
<tr>
<td>Lurasidone (Latuda)</td>
<td>40-160 mg/day Must be taken with food Nightly administration may improve tolerability</td>
<td>High dosing not well studied, but some patients may benefit from doses up to 160 mg/day</td>
<td>No depot available</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>10-30 mg/day</td>
<td>40-60 mg/day Up to 90 mg/day for more difficult cases</td>
<td>2-week and 4-week depots available</td>
</tr>
<tr>
<td>Paliperidone ER (Invega)</td>
<td>3-12 mg/day</td>
<td>Max dose is generally 12 mg/day</td>
<td>4-week depot available 234 mg followed after 1 week by 156 mg, then continuing at 117-234 mg/28 days</td>
</tr>
<tr>
<td>Quetiapine (Seroquel, Seroquel XR)</td>
<td>300-750 mg/day</td>
<td>Up to 1800 mg/day; more for difficult cases</td>
<td>No depot available</td>
</tr>
<tr>
<td>Risperidone (Risperdal)</td>
<td>2-8 mg/day</td>
<td>FDA-approved up to 16 mg/day Very high doses are usually not well tolerated</td>
<td>2-week depot available</td>
</tr>
<tr>
<td>Ziprasidone (Geodon)</td>
<td>80-160 mg/day Must be taken with food</td>
<td>Up to 360 mg/day for difficult cases</td>
<td>No depot available</td>
</tr>
</tbody>
</table>

See full prescribing information for details.
IMPULSIVE AGGRESSION – DR. WARBURTON
Impulsive Aggression

Treating Impulsive Aggression

• Confirm that the patient's violent or aggressive behaviors result primarily from impulsive aggression
  – Characterized by a reactive or emotionally charged response; patient exhibits a loss of behavioral control and failure to consider consequences
  – Associated with
    • Schizophrenia spectrum disorders
    • Cognitive disorders
    • Attention deficit hyperactivity disorder (ADHD)
    • Bipolar disorder
    • Depressive disorders
    • Cluster B personality disorders
    • Intermittent explosive disorder
    • Posttraumatic stress disorder
    • Traumatic brain injury (TBI)

• Strongly associated with substance use disorders
• Past history of psychological trauma increases the risk of impulsive aggression and is often comorbid with substance use disorders and personality disorders
Psychosocial Interventions: Impulsive Aggression

• Goal of treatment is to increase behavioral control and decrease emotional dysregulation
  – Dialectical behavior therapy (DBT)
    • Established as a validated treatment for borderline personality disorder and self-injurious behavior
  – Reinforcement/behavioral interventions
  – Positive coping
  – Individual therapy: exploration of impulsive episodes, coping, and triggers
  – Group therapy: anger management and social skills

Psychosocial Interventions: Impulsive Aggression With a Trauma Component

- History of psychological trauma increases the risk of impulsive aggression and is often comorbid with substance use disorders and personality disorders.
- Treatments that incorporate trauma-informed strategies may be effective for impulsive aggression that is not responsive to other interventions.
- Previous victimization experiences often lead to difficulties in forming close relationships and ineffective coping strategies.
- Special emphasis on safety and therapeutic alliance.
- May be incorporated into many existing treatments, especially those for ongoing mood disorders or substance use disorders.
- In the case of trauma, be mindful of restraint conditions, which may re-traumatize.
- Exposure therapy may be useful for aggression stemming from PTSD or other traumatic experiences.

Stahl et al. CNS Spectrums 2014; in press.
Treatment Algorithm for Violence Associated With Cluster B Personality Disorders

Antipsychotic  Mood stabilizer  SSRI

Inadequate treatment response

Obtain plasma drug level

Adherent to oral medication

Oral antipsychotic  Lithium  Valproate  Carbamazepine  Phenytoin

Nonadherent to oral medication

Long-acting depot antipsychotic

Inadequate treatment response

Obtain plasma drug level

Consider clozapine

**Treatment Algorithm for Violence Associated With Bipolar Disorder**

- **Mania**
  - 2-week trial of lithium
  - Antipsychotic
  - 2-week trial of valproate
  - Rapid cycling or mixed state

  **Inadequate treatment response**

  Ensure treatment adherence by obtaining plasma drug level (consider long-acting depot antipsychotics)

  **Lithium + antipsychotic**
  **Valproate + antipsychotic**
  **Benzodiazepine + antipsychotic***

  **Inadequate treatment response**

  - Add levothyroxine

  **Inadequate treatment response**

  Consider clozapine or ECT

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* Benzodiazepines are primarily used as adjunctive treatment for insomnia, anxiety, and agitation. Use caution when combining carbamazepine with an antipsychotic because carbamazepine is a hepatic enzyme inducer that can increase the metabolism of antipsychotics by up to 40%.

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Treatment Algorithm for Violence Associated With Intermittent Explosive Disorder

6–12-week trial with an SSRI

Inadequate treatment response

Ensure treatment adherence by obtaining plasma drug level*

6–12-week trial of phenytoin

6–12-week trial of carbamazepine or oxcarbazepine

6–12-week trial of lamotrigine

6–12-week trial of topiramate

6–12-week trial of valproate

6–12-week trial of lithium

*Consider a long-acting depot antipsychotic, as these do have a second-line use in this disorder, albeit not very well supported by data

Treatment Algorithm for Violence Associated With PTSD or Trauma-Related Disorders

6–8-week trial with an SSRI   6–8-week trial with an SNRI

Inadequate treatment response

Ensure treatment adherence by obtaining plasma drug level

Atypical antipsychotic   Mirtazapine

Inadequate treatment response

Ensure treatment adherence by obtaining plasma drug level (consider long-acting depot antipsychotics)

Augment with an atypical antipsychotic

Sleep disturbance/nightmares

Augment with prazosin

Residual insomnia without nightmares

Augment with trazodone, mirtazapine, ramelteon, melatonin, or selective sedative

Treatment Algorithm for Violence Associated With Traumatic Brain Injury

- 4–6-week trial of propranolol
- 4–6-week trial with an atypical antipsychotic
- 4–6-week trial of valproate
- 4–6-week trial of lithium

Inadequate treatment response

Ensure treatment adherence by obtaining plasma drug level (consider long-acting depot antipsychotics)

Patients with traumatic brain injury may be more susceptible to seizures. Use caution with agents that may lower the seizure threshold (eg, antipsychotics).

PREDATORY AGGRESSION – DR. WARBURTON
Predatory Aggression

I want that car!

Treating Predatory Aggression

• Confirm that the patient's violent or aggressive behaviors result primarily from instrumental/organized aggression
  – Purposeful, planned behavior that is associated with the attainment of a goal
  – Some patients who engage in predatory acts may have the constellation of personality traits commonly known as psychopathy

• Avoid countertransference reactions
Treating Predatory Aggression (cont.)

• Determine potential reasons for predatory aggression
• Provide opportunities to attain acceptable goals using social learning principles, differential reinforcement, and cognitive restructuring
• Regularly evaluate the progress of predatory aggression treatment
• Consider using mood stabilizers, SSRIs, or other antidepressants for persistent tension, explosive anger, mood swings, and impulsivity
• While level of security and psychosocial interventions remain the mainstays of addressing predatory violence, preliminary data suggest that clozapine may also reduce such aggression and violence

Stahl et al. CNS Spectrums 2014; in press.
# Common Countertransference Reactions to Patients With Psychopathic Features

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic nihilism</td>
<td>Devaluing patients, condemning all patients with psychopathy as untreatable</td>
</tr>
<tr>
<td>Illusory treatment alliance</td>
<td>Opposite reaction to therapeutic nihilism; illusion that there is a treatment alliance when none exists</td>
</tr>
<tr>
<td>Fear of assault or harm (sadistic control)</td>
<td>Autonomic arousal and visceral reactions</td>
</tr>
<tr>
<td>Denial and deception (disbelief)</td>
<td>Not believing that the patient has a criminal history</td>
</tr>
<tr>
<td>Helplessness and guilt</td>
<td>Feeling helpless and guilty when a patient does not change, despite earnest efforts</td>
</tr>
<tr>
<td>Devaluation and loss of professional identity</td>
<td>Feeling despicable and devalued; experiencing symptoms of depression and burnout due to treatment failures</td>
</tr>
<tr>
<td>Hatred and the wish to destroy</td>
<td>Spontaneous homicidal fantasies</td>
</tr>
<tr>
<td>Assumption of psychological complexity</td>
<td>Belief that all patients care to understand the origins of their maladaptive behaviors</td>
</tr>
<tr>
<td>Burnout Symptoms in Mental Health Professionals Who Work With Patients With Personality Disorders</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Depersonalization</strong></td>
<td>Negative and cynical attitudes toward patients (seeing them as deserving of their troubles)</td>
</tr>
<tr>
<td><strong>Emotional exhaustion</strong></td>
<td>Physical fatigue and feeling emotionally drained from job demands and distress</td>
</tr>
<tr>
<td><strong>Personal accomplishment</strong></td>
<td>Feelings of competence and professional achievement</td>
</tr>
</tbody>
</table>

Stahl et al. CNS Spectrums 2014; in press.
The Risk-Need-Responsivity Model

• Utilize the risk-need-responsivity principles to determine risk level, treatment needs, and the best way to deliver and optimize treatment

• Risk principle
  – Assess the patient's level of risk and contributing factors to his or her aggressive behavior
The Risk-Need-Responsivity Model (cont.)

• Need principle
  – Assess criminogenic needs
    • In this context, "criminogenic needs" refer to dynamic (treatable) risk factors that are correlated with criminal behavior and that reduce recidivism when treated
  – Provide specific targets for treatment to reduce violence
    • For example, early antisocial behavior, impulsive personality patterns, negative criminal attitudes and values
• Responsivity principle
  – Individually tailor treatments to maximize the patient's ability to learn from the interventions
    • Intervention is tailored toward the patient's
      – Learning style
      – Motivation
      – Abilities
      – Strengths

Stahl et al. CNS Spectrums 2014; in press.
## The 8 Central Risk/Need Factors

<table>
<thead>
<tr>
<th>Major Risk/Need Factor</th>
<th>Treatment Intervention Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The &quot;Big&quot; 4</strong></td>
<td></td>
</tr>
<tr>
<td>Antisocial Behavior</td>
<td>Build and reinforce nonviolent and noncriminal behaviors</td>
</tr>
<tr>
<td>Antisocial Personality Pattern</td>
<td>Build self-control, delayed gratification, and effective problem solving skills; teach anger management</td>
</tr>
<tr>
<td>Antisocial Cognition</td>
<td>Build flexible thinking, taking the viewpoint of others, values, and moral reasoning; counter rationalizations with pro-social attitudes; build up a pro-social identity</td>
</tr>
<tr>
<td>Antisocial Associates</td>
<td>Gang intervention and prevention; address cognitions supportive of violence; replace pro-criminal friends and associates with pro-social friends and associates</td>
</tr>
<tr>
<td><strong>The &quot;Moderate&quot; 4</strong></td>
<td></td>
</tr>
<tr>
<td>Family/Marital Circumstances</td>
<td>Teach parenting skills; enhance warmth and caring</td>
</tr>
<tr>
<td>School/Work</td>
<td>Enhance work/study skills; nurture interpersonal relationships within the context of work and school; teach legitimate means of finding financial support</td>
</tr>
<tr>
<td>Leisure/Recreation</td>
<td>Encourage participation in pro-social recreational activities; teach pro-social hobbies and sports</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Reduce substance abuse; enhance alternatives to substance use</td>
</tr>
</tbody>
</table>

Stahl et al. CNS Spectrums 2014; in press.
# Measuring the Progress of Predatory Aggression Treatment

<table>
<thead>
<tr>
<th>Program</th>
<th>Program Philosophy</th>
<th>Key Concepts</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasoning and Rehabilitation</td>
<td>Cognition plays a decisive role in criminal behavior; maladaptive thinking is acquired via social and developmental experiences in the same way that pro-social behavior is learned</td>
<td>Focuses on interpersonal cognitive problem solving, social skills, negotiation skills, management of emotions, creative thinking, values enhancement, critical reasoning, skills in review, and cognitive exercises</td>
<td>Acquisition of adaptive thinking: developing skills to withstand &quot;personal, situational, economic, and interpersonal pressures towards illegal behavior.”</td>
</tr>
<tr>
<td>Enhanced Thinking Skills</td>
<td>How offenders think, including how they reason and solve problems, is an important factor in their criminal behavior; introduce alternative ways of thinking and problem solving</td>
<td>Training in impulse control, flexible thinking, taking the viewpoint of others, values, moral reasoning, general reasoning, and interpersonal problem solving</td>
<td>Developing awareness of how one reacts to problems and other people; learning a new thinking and problem solving approach can prevent offending</td>
</tr>
<tr>
<td>Think First</td>
<td>Understanding the link between an individual's offending behavior and cognitive skills; focuses first on the offending behavior; conducts a complete analysis of criminal/violent event(s)</td>
<td>Targets social problems, solving such issues as problem awareness, alternative solution thinking, consequential thinking, and perspective taking</td>
<td>Acquisition of adaptive alternative solution thinking</td>
</tr>
</tbody>
</table>

Stahl et al. CNS Spectrums 2014; in press.
Psychosocial Interventions: Predatory Aggression

• Milieu
  – Highly structured environment
  – Lack of access to dangerous materials
  – Crucial for staff to have strong boundaries
  – Increased monitoring/externally imposed supervision
    • Cameras
    • Hospital security officers
  – Consider a rotation

• Every interaction between the patient and a staff member should be considered an opportunity to reinforce pro-social behaviors and practice learned skills

• Reinforce and model pro-social ways to achieve one's goals

Stahl et al. CNS Spectrums 2014; in press.
What Can We Do to Treat the Environment of Care?

SETTING AND HOUSING CONSIDERATIONS
Setting and Housing

• Make every effort to preserve the patient's self-determination, autonomy, and dignity within the treatment environment

• Avoid seclusion, physical restraint, and sedation when possible
  – Finding the right balance is key
    • For instance, staff should not avoid the use of restraint and seclusion to the point where the patient does not have to follow unit rules
• Hospitalize in an enhanced treatment unit (ETU) patients who have:
  – Recently committed/threatened acts of violence or aggression that put others at risk of physical injury and who cannot be managed in a standard treatment setting
  – Recurrent violent or aggressive behaviors that are unresponsive to all therapeutic interventions available in a standard treatment setting
  – A high risk of violence that cannot be contained in a standard treatment environment as determined by a violence risk assessment process in conjunction with clinical judgment

Setting and Housing (continued)

• Review attempted interventions to ensure that standard of care has been met
  - Communicate with treating clinicians to discuss past treatment plans
  - Review medications to determine if pharmacotherapy meets standard of care for the identified disorders
  - Review psychological assessments to determine if relevant assessments have been attempted
  - Review past psychological interventions, including behavioral plans, group treatment enrollment, and individual therapy progress

Stahl et al. CNS Spectrums 2014; in press.
Summary

• Violence is heterogeneous in nature and may occur in mentally ill patients due to a variety of biological and environmental factors.

• There are numerous tools available to aid clinicians in determining a patient's risk of becoming violent or aggressive.

• Both pharmacological and psychosocial treatment strategies for violent and aggressive behaviors should be tailored to the individual patient based on the nature of the aggression.