



CHAPTER V

DISCUSSION

This section discusses some of the significant findings from this study

In the considered period, 246 cases, 145 men (58.9%) and 101 women (41.1%) were admitted to the Psychiatric ward. Patients are mostly brought in by family members and admissions were mainly involuntary. Patients' mean age was 36.36 (\pm 9.03) years. Of the admitted cases, 133 were married followed by 73 unmarried (single), 16 separated, 18 divorced, 6 widows or widowers. The most frequent diagnoses were schizophrenia (43, 17.5%), schizoaffective disorder (37, 15%), bipolar disorder mania (39, 15.9%), BPD depression (9, 3.7%), mixed episode (26, 10.6%), unipolar depression (10, 4.1%), post partum depression (5, 2.0%), psychotic disorder NOS (43, 17.5%), delusional disorder (9, 3.7%), alcohol abuse (5, 2.0%), substance related disorder (4, 1.6%), personality disorder (7, 2.8%), delirium (1, 0.4%), psychotic disorder due to general medical condition (4, 1.6%), obsessive-compulsive disorder (OCD) (2, 0.8%) and Munchausen's syndrome (2, 0.8%). Aggressive cases were 65 (26.4%), violent cases were 105 (42.7%), and aggressive and violent seen together cases were 76 (30.9%). Cases showing physical harm directed towards staff were 113 (45.9%) cases, towards other patients in 95 (38.5%) cases, visitors 46 (18.7%) cases, and towards property in 115 (46.7%) cases. No patient was moved from the PICU to intensive medical care units because of treatment-related side effects. No fatality occurred. Seclusion was never used. Most

assaults were not a significant threat to the attacked person, but few were highly dangerous. Violent cases were younger in comparison with the other two groups. There was no association seen between aggression and violence and marital status which were found dissimilar to the previous studies. Hospitalization was longer in violent than in aggressive cases. There was no difference among the three groups in terms of years of education and social class. Negative association was seen between suicidal risk and .Regarding diagnosis, personality disorder, alcohol and substance abuse and psychotic symptoms was more frequent in the violent than in the other two groups, depression was more frequent in the aggressive group. Violence was also associated with low income group.

IMPACT OF GENDER ON AGGRESSION AND VIOLENCE

This study showed a mixed picture as far as the effect of gender on aggression and violent behaviour is concerned. While there was a statistically significant increase in aggression noted amongst women, violence was significantly higher among men. This inconclusive picture is seen in other studies too. Several studies have reported a higher rate of violence among female patients than among male patients, and others have found no association of violence with gender. It is possible that gender itself is not an important risk factor for violence among inpatients and that other factors, such as type of patient population, study setting, patients' underlying psychopathology, and situational variables, may be more crucial determinants.

IMPACT OF AGE ON AGGRESSION AND VIOLENCE

Again a mixed picture was seen here. Only aggression and only violence was prevalent in younger age groups whereas when aggression and violence were taken together, incidence was higher in above 50 age group and it was statistically significant.

IMPACT OF DIAGNOSIS ON AGGRESSION AND VIOLENCE

In this study, mental illness was classified according to DSM-IV criteria and different diagnosis showed different correlation with violence and aggression. Substance abuse had significant impact on level of violence which was highest in this group. Violence was also high in severe mental illness such as schizophrenia, psychosis in this study, patients with psychotic symptoms were more likely to be violent rather than aggressive whereas patients with mood disorders were more likely to show signs of aggression but this is not statistically significant.

IMPACT OF SOCIOECONOMIC STATUS ON A & V

Effect of income: This shows an inverse correlation, as income decreases, violence increases and this is statistically significant.

Effect of Education: unlike some other studies the level of education (or the lack of it) did not have a statistically significant influence on aggression and violence.

Effect of Employment: similar to education, the level or degree of employment did not have statistically significant impact on aggression and violence.

Effect of residence: the quality of residence (which varied from no house to owner occupied house) did not have statistically significant impact on level of aggression and violence.

IMPACT OF SUICIDE RISK ON AGGRESSION AND VIOLENCE

This showed an interesting trend. While the patients with suicide risk were found to be more aggressive, they were less violent and both were statistically significant.

IMPACT OF LENGTH OF STAY ON AGGRESSION AND VIOLENCE

There was statistically significant influence of the length of stay in the hospital with an increase in aggression and violence seen only. This could be influenced by the fact that those with more severe illness will most likely to have an increase duration of in stay care. This finding is similarly seen in other studies too. Alternatively, it is possible that the hospital environment leads to social breakdown that affects the behavior of institutionalized persons. Health care providers face cost pressure to discharge patients as soon as they show a low risk of self-harm or aggression. Thus the second explanation for the association between longer hospitalization and increased violence is more likely.

IMPACT OF MARITAL STATUS ON AGGRESSION AND VIOLENCE

Unlike other studies, being single (divorced/ separated/ widowed) or married had no significant effect on aggression and violence displayed. Therefore, we can summarize that the level of aggression and violence in the study are influenced by the following factors:

A. Factors related to the illness:

- Diagnosis
- Length of stay
- Risk of suicide

B. demographic factors:

- Income
- gender

Some of the methodological difficulties of earlier work about violence are overcome in this study by the use of a standard definition of violence, clear distinction between physical incidents and verbal threats (the latter are often neglected in research studies), and specified targets of incidents (such as property as well as persons).

Aggressive behavior in patients with psychiatric disorders has many possible causes. Probably the most important causes are the presence of comorbid substance abuse, dependence, and intoxication. In addition, the disease process itself may produce hallucinations and delusions, which may provoke violence. Often, poor impulse control related to neuropsychiatric deficits may facilitate the discharge of aggressive tendencies. Finally, underlying personality characteristics, such as antisocial personality traits, also may influence the use of violent acts as a means to achieve certain goals. Environmental factors that are associated with aggressive behavior include a chaotic or unstable home or hospital situation, which may encourage maladaptive aggressive behaviors.

Patients with psychotic symptoms usually fall into persistently violent category. This may be due to acute decompensation secondary to covert or overt noncompliance with psychotropic medication therapy. Decompensation also may be due to a failure of the current medication regimen. The clinical features expected would be a worsening of psychotic symptoms and, possibly, command hallucinations, although the importance of the latter in violent behavior is in dispute.

Several strategies for managing violent behavior in psychiatric settings could be developed. Given that warning signs preceded most incidents, staff training programs could target early recognition of warning signs of violence and aim to institute early verbal de-escalation procedures. Incidents of violence can be reduced by identifying patients with a history of violence, making staff members immediately aware of this information, and planning appropriate treatment.

The strengths of the study include: 1) The observation of a large series of unselected acute psychiatric in-patients who were well characterized clinically. 2) The risk of underreporting violence seems to be low because the data about patients' violence were collected comprehensively considering several sources of information such as medical and nurses' records, daily meetings of staff members, and patients' and family members' reports.

Some of the limitations of this study should also be noted: 1) The study was carried out at a single facility. Specific hospital practices and regional characteristics may have influenced the results. Studies carried out in other institutions may be helpful, but there are so many differences among settings that an examination of each hospital's unique pattern of violence is necessary. 2) The distinction between primary from secondary diagnoses can sometimes be difficult, if not impossible. Therefore, in the analysis, we considered together both the primary and secondary diagnoses of substance or alcohol related disorders and of personality disorders. 4) The unequal interval between admission and the complete neuropsychiatric assessment reflects the initial uncooperativeness of the hostile and violent cases.

Clinical rather than socio-demographic variables (with the notable exception of young age and gender) appear more related to the risk of violence. This

finding has practical importance because clinical symptoms are amenable to therapeutic approaches. In the present study, young age, employment status, and marital status were not related with violence. Factors associated with violence were male gender, diagnosis of personality disorder, psychotic symptoms, substance and alcohol related disorders, low income, suicide risk and longer stay in the hospital. Factors associated with aggressive behaviour were females, diagnosis of depression, alcohol abuse.

CONCLUSION AND RECOMMENDATIONS

Aggression, like all types of behavior, involves biological forces, for example, neurobiological, genetic, hormonal, perinatal, traumatic, nutritional, and brain chemistry processes. However, biological factors alone do not determine the development of aggression. The social environment of the individual is a powerful regulator of neurobiological processes and behavior. In other words, aggressive and violent behavior is the outcome of the regulation of external and internal stimuli by living beings. Furthermore, individual differences in characteristic levels of aggression can be attributed to learning. Thus, it is important to understand the multidimensional nature of aggression.

Aggression and violence requires considerable further study, because at the moment, it is a little understood phenomenon. One important issue that I have not had the opportunity to address in this study concerns how social risk factors for aggression interaction with biological risk factors. Of critical importance is obtaining greater understanding of family circumstances. By developing a stronger knowledge base of aggression/violence, it will be possible to develop interventions that reduce these more effectively.

We have noted from the study that following factors are significantly associated with aggression and violence. Some factors are related to the illness (diagnosis, length of stay, suicide risk) whilst other are related to demographic circumstances such as gender and income.

It is evident that some of the above mentioned factors cannot be controlled or influenced such as gender, diagnosis, length of admission or stay in the hospital but the levels of aggression and violence among psychiatric inpatients can be influenced by following measures:

a) Tackling substance misuse:

This study shows that the single biggest factor contributing aggression and violence is substance abuse i.e. the catastrophic influence of alcohol and drugs. It is therefore important to have community strategies in place to tackle this misuse. Doing so will lower the level of aggression and violence in this group of patients.

b) Tackling the wider determinants of health:

Income is directly related to life chances and opportunities. Those on lower incomes start with severe disadvantages in life, they are more likely to have stresses and tensions which also increases propensity for substance misuse leading to increase in aggression and violence. Therefore, social policies to address this important issue of economic inequality and deprivation could lead to significant decrease in the level of aggression and violence in mentally ill.

c) Prompt and effective treatment of psychotic illness:

As this group of patients show a greater degree of aggression and violence, it only seems reasonable that identifying such illness as early as possible and instituting effective management for these illnesses will help to reduce the levels of aggression and violence in these patients. Prompt recognition and management in those with suicidal ideation will also help to reduce aggression in these groups of patients.

d) More research:

This is needed to answer some of these questions better. Most of the researches have been conducted in western countries and these findings may not be easily generalisable to lesser developing countries like India. Unlike western countries, this study shows less impact of social factors such as level of education or marital status and therefore it would be appropriate to conduct more research in less resource poor countries to explore some of these factors further.