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# Identification and Prevention of Schizophrenic Aggression in Psychiatry

N El Moussaoui[1*], S Bahetta[1], F Laboudi[1], A Ouanass1

[1]University Psychiatric Hospital Ar-razi, CHU Rabat-Salé, Morocco

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***Corresponding author:** N. El Moussaoui
University Psychiatric Hospital Ar-razi, CHU Rabat-Salé, Morocco

**Abstract** **Original Research Article**

Schizophrenia is a chronic mental pathology with polymorphous symptoms, disabling on the emotional, relational, behavioral and social levels. In some cases, it can increase the risk of self- and heteroaggressive violence, requiring adapted care protocols, proposed in particular in psychiatric units. Violence has always been a major concern in psychiatry, which is considered to be a place with a high prevalence of violence. Patients with mental illnesses, particularly schizophrenia, are the most likely to become violent, and the staff working in psychiatric facilities are the most at risk. It is therefore important to know the impact on caregivers, and how they manage this violence. The present study, carried out in the Ar-razi hospital in Salé, has the following objectives to know the risk that the nursing staff in a psychiatric hospital is facing, to identify the behavior to be held to manage the violence of the schizophrenics, and identify preventive measures against violence.

**Keywords:** heteroaggressive violence, Schizophrenia, Psychiatry, caregivers.



## INTRODUCTION

During the last decade, there has been a growing interest in the relationship between mental disorder and violence. A number of large-scale, methodologically sophisticated epidemiological studies have been carried out in several countries of the western world, focusing on the question as to whether mental disorder elevates the risk of violence. Usually, the relative risk, that is the ratio of risk among the exposed to the risk among the unexposed [1], served as the measure of association. Alternatively, the odds ratio has been used as an approximation. This allows making statements about the causal role of mental disorders in the occurrence of violence. However, as has been pointed out by Arboleda-FloÂrez *et al*., [2], from the point of view of public health, the relative risk is not the best measure to quantify the risk to the population. The population-attributable risk appears to be more suitable, which is defined as the proportion of all cases in the total population that can be attributed to exposure to the factor [1]. It answers the question of how much of the risk in exposed individuals can be ascribed to the exposure and how much of the risk in exposed individuals can be eliminated if the exposure could be reduced or eliminated. The attributable risk is a measure of the risk incurred by the population, informing about how much of the violence in the community can be attributed to mental illness. While the assessment of relative risk is of great interest for psychiatric researchers who are trying to identify factors which may increase or decrease the risk of violent behaviour among the mentally ill, which in turn may provide some clues as to how to intervene best in order to reduce the risk, the attributable risk is of special interest for the public since it informs about the risk of becoming victim of a violent act committed by someone who is suffering from a mental disorder. In view of this, the relationship between schizophrenia and violence will be discussed in the following.

Schizophrenia is a chronic mental pathology with polymorphous symptoms, disabling on the emotional, relational, behavioral and social levels. In some cases, it can increase the risk of self- and heteroaggressive violence, requiring adapted care protocols, proposed in particular in psychiatric units.

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impact on caregivers, and how they manage this violence.

The present study has the following objectives to know the risk that the nursing staff in a psychiatric hospital is facing, to identify the behavior to be held to manage the violence of the schizophrenics, and identify preventive measures against violence.

**ETUDE CLINIQUE**

**Materials and Methods**

This is an analytical cross-sectional study conducted through the distribution of a self-questionnaire, which was published online and on paper, in the Arrazi Hospital in Salé, aimed at nursing staff: Nurses, Doctors and Psychologists.

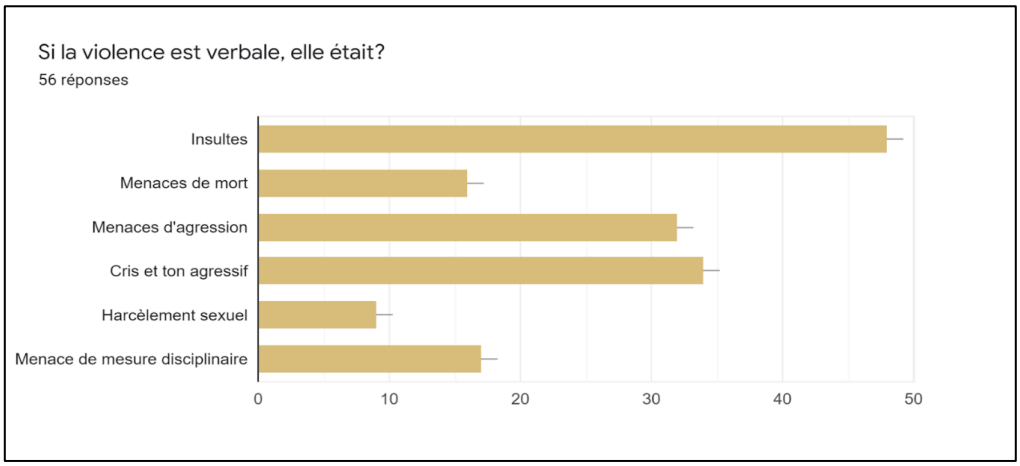
The questionnaire focuses on aspects concerning their socio-demographic conditions, psychiatric history, the place, nature and impact of this violence, with details of the reaction to this violence and the proposed courses of action. Data collection was done using Google Forms.

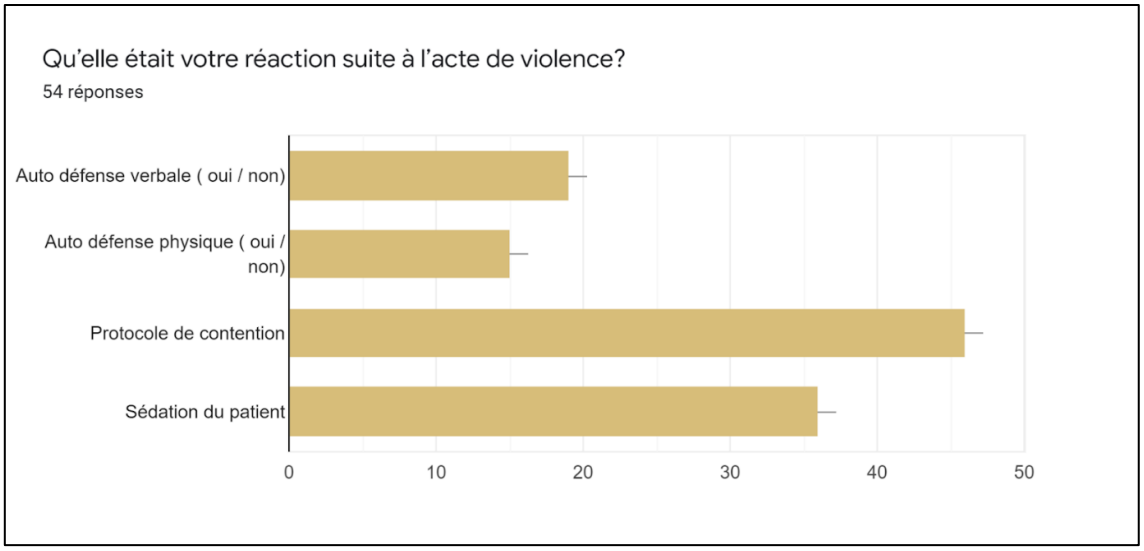
## RESULT

We collected 63 responses.

| VARIABLE | | POURCENTAGE |
|---|---|---|
| Age moyen | 32 ans | |
| Sexe | Masculin | 27,2% |
| | Féminin | 73% |
| Lieu de vie | Salé | 63,5% |
| | Kénitra | 61,5% |
| | Rabat | 4,8% |
| | Témara | 7,9% |
| Statut Marital | Célibataire | 49,2% |
| | Marié | 41,3% |
| | Divorcé | 7,9% |
| | Veuf | 1,6% |
| Enfants | Oui | 58,3% |
| | Non | 41,7% |
| Antécédents | Psychiatrique | 7,9% |
| | Médico-chirurgicaux | 17,6% |
| | Conduites addictives | 4,8% |
| | Familiaux | 29,9% |
| Profession | Médecin | 41,3% |
| | Infirmier | 55,6% |
| | Psychologue | 3,2% |
| Ancienneté en psychiatrie | Inférieure à 5 ans | 63,5% |
| | Entre 5 ans et 10 ans | 23;8% |
| | Plus de 10 ans | 12,7% |

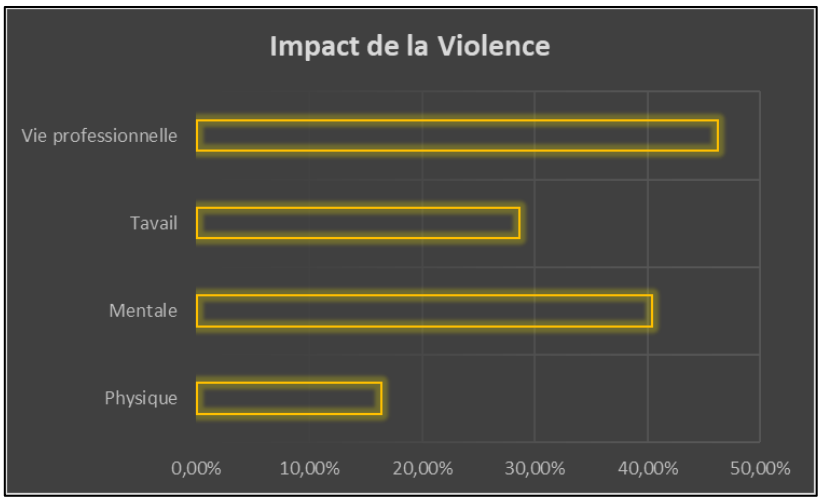
84.1% of our sample had already experienced hospital violence from a schizophrenic patient. This violence occurred in 87.7% of cases on the ward, and 89.5% occurred during the day with an average frequency of 1 time per month. Verbal violence was much more frequent than physical violence.






Verbal self-defense was the most frequent reaction to violence, with restraint protocol as the most adopted medical attitude.56.1% of our sample did not complain about the violence experienced, 50% of them considered that it was useless and that no action would be taken, 47.2% found the incident unimportant, and 19% did not know the procedure.

This violence had a physical impact in the form of scars, bruises and pain. A feeling of hopelessness was observed in 62.5% and it caused 25% of our sample to stop working for a few hours, 33.3% for 1 day and 41.7% for 5 to 10 days. 58% of them thought of changing jobs as a result of these incidents and 8.3% even thought of stopping work permanently.




Among the procedures and means that were suggested to reduce violence in hospitals: respecting the number of patients per department, increasing the number of caregivers, the presence of support staff day and night, the availability of the necessary equipment to isolate patients in agitated situations, and finally, a strict medical/nursing follow-up and an effective treatment during the first days of hospitalization, with the introduction of occupational activities and psychotherapy...

## DISCUSSION

In 2002, the World Health Organization (WHO) published in its "World Report on Violence and Health" the results of the first study conducted on all aspects of violence at the global level. This three-year study, conducted by more than 160 experts from around the world, highlights the fact that: "Violence has probably always been a part of human life. Its various consequences can be seen in all regions of the world. Violence, whether self-inflicted, collective or directed against others, claims more than one million lives a year and many more are injured. Globally, violence is among the leading causes of death in the world for people aged 15-44" (WHO, 2002, p. 27). As the WHO points out, violence seems to have always been a part of human life and remains present in all regions of our world.

But is Man by nature a violent being? According to psychiatrist and psychoanalyst Morasz (2002): "As a social component inherent to human functioning, violence is a process that awakens in each

of us complex and multiple representations that nevertheless have one point in common: the strong emotion it arouses". According to WHO Director General Gro Harlem Brundtland (2002), violence is omnipresent and affects us all to varying degrees. There is therefore no single representation of violence. Violence would evoke multiple complex representations in each of us. Violence would also have the power to trigger strong emotions and intense reactions. Moreover, the process of violence would be a common point to all the Men, an inseparable component of the Human Being and its social relations.

Violence seems to be an integral part of human nature and social relationships. Indeed, if violence is part of human life, do the various care environments escape this phenomenon? According to psychologist Danancier (2005), violence was initially perceived as a manifestation confined to specific care sectors. However, violence has gradually spread to all types of institutional care and to all populations.

Despite this evolution, it would seem that violence tends to be naturally equated with the field of psychiatric care. According to Velpry (2011), "Associating the term violence with psychiatry or mental illness seems a given to common sense". For many, violence would therefore be a "normal" phenomenon for settings caring for patients with mental illness. However, for professionals working in psychiatric settings, the issue of patient violence does not seem to be so obvious.

According to Morasz (2002), violence has always been one of the major preoccupations of the psychiatric field, with violent phenomena accompanying psychiatric caregivers throughout their professional careers. Psychiatric caregivers appear to be more directly exposed to violence. In psychiatric settings, the risk of experiencing a violent act committed by a patient is high compared to other fields.

Psychiatric institutions are considered high prevalence places for violence [3]. Indeed, the health care profession is highly exposed to the phenomena of violence and patients with mental illnesses are most likely to develop violent behaviors [4]. Psychiatric pathologies in a broad sense represent one of the causes of aggression. According to Dubreucg, Joyal, and Millaud (2005), "Contrary to a common view in psychiatric circles, severe mental disorders alone, without substance abuse, represent a much higher risk of physical violence toward others than the general population". How is this violence perceived and experienced by caregivers? Patient aggression and violence is recognized as one of the most common sources of workload for nurses working in psychiatric hospitals [5].

These violent phenomena can have direct consequences on the mental state of caregivers, the emergence of anxiety, the appearance of depression or burnout [6]. Moreover, according to Gadon (2006): "violence generates a considerable economic and human cost: work incapacity, illness, absenteeism, demotivation, departure from the profession, high turnover, dissatisfaction."

In the interest of professionals and patients, it is therefore essential to address this issue. In view of these negative repercussions, it seems essential to look for ways to prevent and manage the occurrence of violent incidents in order to guarantee better safety for health care staff.

The WHO (1999) specifies three successive types of prevention, which are part of a continuous process that begins with preventing the onset of the disease and ends with its treatment, which we will present below:

1- **Primary prevention**: We believe that primary prevention is one of the most important preventive strategies against violence in hospitals. It allows us to anticipate violence, particularly in emergency departments, because it intervenes before the violent act occurs, as well as to avoid the appearance of new cases. Primary prevention is defined by Leavell & Clark (1965) as: "the set of methods designed to prevent the occurrence of a given disorder (or category of disorders)". (WHO, 1999). From this point of view, primary prevention encompasses the measures applicable to a given pathological situation, to limit, if necessary, the effects that could be caused by this pathology, by means of education and information for the population.

2- **Secondary prevention:** Secondary prevention encompasses: "all actions intended to reduce the prevalence of a disease in a population, and therefore to reduce the duration of the disease. It takes into account early detection and treatment of the first attacks". Indeed, this type of prevention is adapted to the hospital context, where the population of caregivers is affected by the pathological situation that constitutes "violence". It should be remembered that violence is neither a disorder nor a disease in itself, but we assume that these definitions can be applied to our prevention objective, if we start from the principle that prevention is not the prerogative of the disease, to apply it to other fields in order to improve the quality of life of the individuals in question.

3- **Tertiary prevention:** "All acts intended to reduce the prevalence of chronic disabilities or recurrences in the population, thus reducing functional disabilities due to the disease. It acts

downstream of the disease in order to limit or reduce its consequences and avoid relapses. Monnier *et al*., (1980) used the same types of prevention to define this concept (Pereira Tavares, 2009). Referring to the literature, several international organizations, working in the field of health, and many researchers also, belonging to other disciplines, have addressed the issue of prevention against violence in the workplace, and especially in the world of health.

## CONSLUSION

Studies confirm that workplace violence in the health sector is universal, despite some local differences, and impacts both men and women.

While the assessment of relative risk is of great interest for psychiatric researchers who are trying to identify factors which may increase or decrease the risk of violent behaviour among the mentally ill, which in turn may provide some clues as to how to intervene best in order to reduce the risk, the attributable risk is of special interest for the public since it informs about the risk of becoming victim of a violent act committed by someone who is suffering from a mental disorder.

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