FORENSIC LD: LECTURE SERIES 3/12

ANGER AND AGGRESSION IN PEOPLE WITH INTELLECTUAL & DEVELOPMENTAL DISABILITIES:

CASE PRESENTATION AND DISCUSSION

as one
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AIMS

- Discuss 3 case vignettes
- Explore the differing ways in which anger and aggression can manifest in MSU
- Discuss structured approach to formulation and treatment

PATIENT A

- 46 year old man
- Admitted to MSU while on remand, charged with Arson and Threatening Communication
- Assessed in prison due to concerns regarding mental state, with low mood and aggression toward himself and others
- Initially detained under s36 initially, while on remand; with detention under s37 after he pleaded guilty to the second charge

10-POINT TREATMENT PROGRAMME

(1) a multi-axial diagnostic assessment
(2) a collaboratively developed psychological formulation
(3) risk assessments and management plans
(4) a behaviour support plan
(5) pharmacotherapy
(6) individual and group psychotherapy, guided by the psychological formulation
(7) offence-specific therapies
(8) education, skills acquisition and occupational / vocational rehabilitation
(9) community participation through a system of graded leave periods
(10) preparation for transition

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Degree of LD
- Cause of LD and their behaviour phenotypes
- Presence of other dev disorders: ASD, ADHD
- Mental illness
- Personality disorders
- Substance misuse
- Physical illnesses (eg: epilepsy)
- Psychosocial stress factors (eg: experience of trauma)
- Challenging behaviour

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Degree of LD
  - Developmental delays
  - Attendance at special schools
  - Limited scholastic achievement
  - Known to CLDT, but with no active input
- Cause of LD and their behaviour phenotypes
  - No known syndrome
- Presence of other dev disorders: ASD, ADHD
  - Nil noted

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Mental illness
  - Recurrent Depressive Disorder
- Personality disorders
  - history of impulsivity, aggression, substance misuse, repeated acts of self-harm, poor frustration tolerance, and mood instability.
  - best categorised as having an Emotionally Unstable Personality Disorder.
- Substance misuse
  - Pattern of alcohol dependency
  - Notable factor in index offence

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Physical illnesses (eg: epilepsy)
  - History of Non-Epileptic Attacks
  - These continue on the ward
- Psychosocial stress factors (eg: experience of trauma)
  - Bereavement of mother shortly prior to offence
- Challenging behaviour
  - Frequent episodes of aggression on the ward – physical and verbal
  - Assaultive behaviour toward staff; and threats to fellow patients
  - Lengthy periods of seclusion
  - Destruction of property
  - Episodes of DSH also – primarily by ligature

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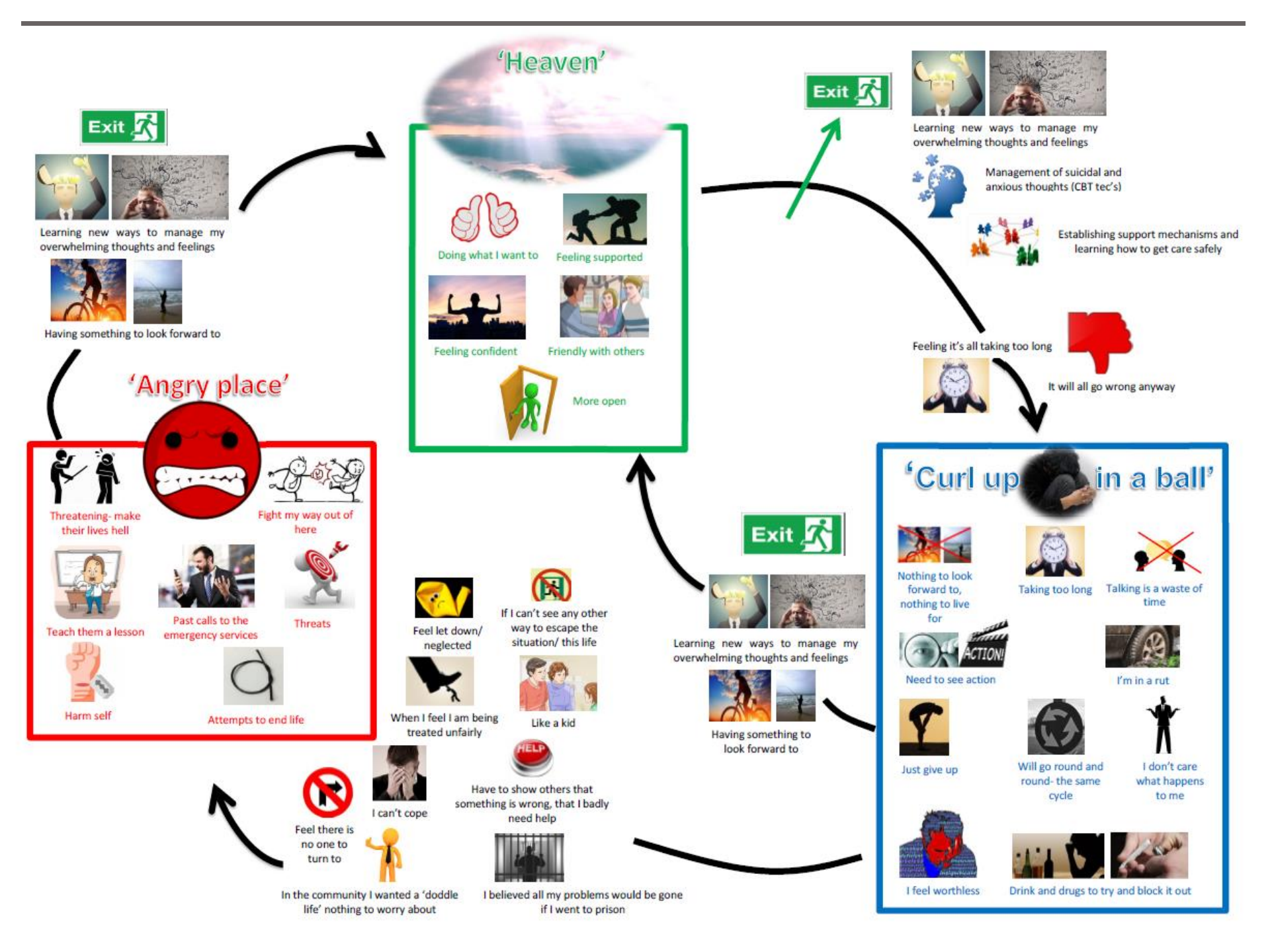
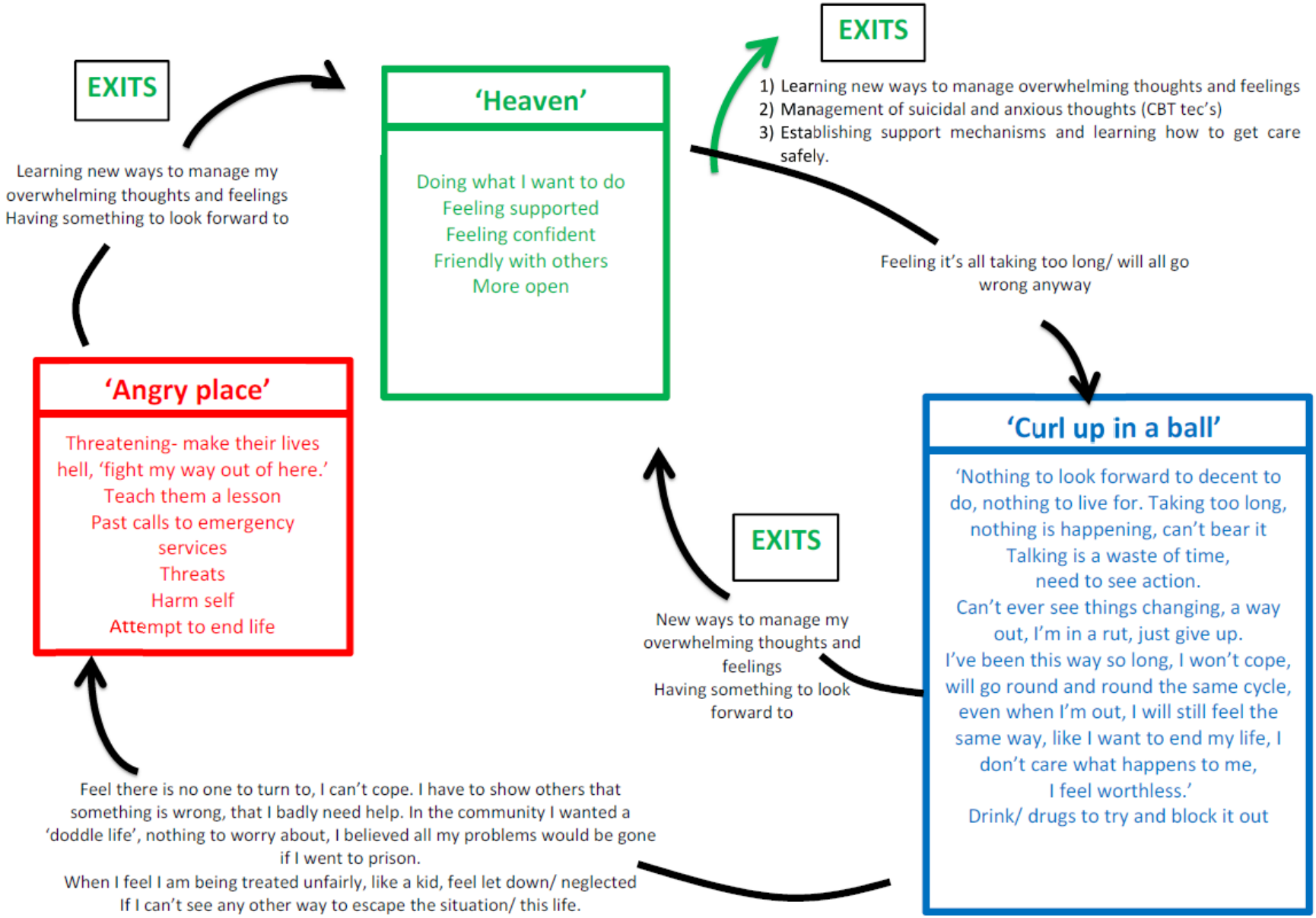
PHARMACOTHERAPY

- Initial treatment with antidepressants; with second antidepressant introduced
- Hypnotic
- Benzodiazepine
- Mood stabiliser
- Antipsychotic

INDIVIDUAL AND GROUP PSYCHOTHERAPY

- Attended EQUIP programme – anger management, moral reasoning and social skills
- Individual CBT
- EMDR
- Visual PBS plan and Formulation


'Heaven'
Exit
Learning new ways to manage my overwhelming thoughts and feelings
Having something to look forward to
Doing what I want to
Feeling supported
Feeling confident
Friendly with others
More open
Exit
Learning new ways to manage my overwhelming thoughts and feelings
Management of suicidal and anxious thoughts (CBT tec's)
Establishing support mechanisms and learning how to get care safely
Feeling it's all taking too long
It will all go wrong anyway
'Curl up in a ball'
Nothing to look forward to, nothing to live for
Taking too long
Talking is a waste of time
Need to see action
I'm in a rut
Just give up
Will go round and round- the same cycle
I don't care what happens to me
I feel worthless
Drink and drugs to try and block it out
Exit
Learning new ways to manage my overwhelming thoughts and feelings
Having something to look forward to
If I can't see any other way to escape the situation/ this life
Like a kid
Have to show others that something is wrong, that I badly need help
I believed all my problems would be gone if I went to prison
Feel let down/ neglected
When I feel I am being treated unfairly
I can't cope
Feel there is no one to turn to
In the community I wanted a 'doddle life' nothing to worry about
'Angry place'
Threatening- make their lives hell
Fight my way out of here
Teach them a lesson
Past calls to the emergency services
Threats
Harm self
Attempts to end life


EXITS
Learning new ways to manage my overwhelming thoughts and feelings
Having something to look forward to
'Heaven'
Doing what I want to do
Feeling supported
Feeling confident
Friendly with others
More open
EXITS
1) Learning new ways to manage overwhelming thoughts and feelings
2) Management of suicidal and anxious thoughts (CBT tec's)
3) Establishing support mechanisms and learning how to get care safely.
Feeling it's all taking too long/ will all go wrong anyway
'Curl up in a ball'
'Nothing to look forward to decent to do, nothing to live for. Taking too long, nothing is happening, can't bear it
Talking is a waste of time, need to see action.
Can't ever see things changing, a way out, I'm in a rut, just give up.
I've been this way so long, I won't cope, will go round and round the same cycle, even when I'm out, I will still feel the same way, like I want to end my life, I don't care what happens to me, I feel worthless.'
Drink/ drugs to try and block it out
EXITS
New ways to manage my overwhelming thoughts and feelings
Having something to look forward to
'Angry place'
Threatening- make their lives hell, 'fight my way out of here.'
Teach them a lesson
Past calls to emergency services
Threats
Harm self
Attempt to end life
Feel there is no one to turn to, I can't cope. I have to show others that something is wrong, that I badly need help. In the community I wanted a 'doddle life', nothing to worry about, I believed all my problems would be gone if I went to prison.
When I feel I am being treated unfairly, like a kid, feel let down/ neglected
If I can't see any other way to escape the situation/ this life.

EDUCATION, SKILLS ACQUISITION AND OCCUPATIONAL / VOCATIONAL REHABILITATION

- Enjoys bicycle maintenance
- Voluntary placement found
- Benefits from community leave for cycling
- Gardening
- Boredom notable factor in aggression

- Links to community participation; later graded transition

SUMMARY

- Cluster of difficulties, interplay of which hampers effective treatment
- Behaviour is a day-to-day challenge on the ward
- Reflective of risks in the community; but perhaps exacerbated by inpatient admission
- Demonstrates value of vocational activity along with psychological intervention

PATIENT B

- 56 year old man
- Stepped down to MSU from HSU
- Index offence: Manslaughter – committed ~30 years ago
- Stabbed victim on multiple occasions during an altercation at his home address
- Had met while drinking in the pub earlier that evening

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- Psychosocial stress factors (eg: experience of trauma)
- Challenging behaviour

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Degree of LD
  - Developmental delay
  - Attendance at special school
  - Limited scholastic achievement
  - FSIQ 58
- Cause of LD and their behaviour phenotypes
  - No known syndrome
  - Mother ascribed difficulties to Patient B being dropped in bath as a child

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Presence of other dev disorders: ASD, ADHD
  - Difficulties with social communication; intolerant of change to routine or environment; circumscribed interest
  - Atypical Autism
- Mental illness
  - Schizoaffective Disorder
- Personality disorders
  - Anxious-avoidant

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Physical illnesses (eg: epilepsy)
  - Diabetes
- Psychosocial stress factors (eg: experience of trauma)
  - Recent bereavement of mother
- Challenging behaviour
  - No overt expressions of aggression on a daily basis
  - Felt by peers to be intimidating, with staring in particular notable
  - Occasional outbursts of physical aggression – primarily damage to property
  - Quiet menace

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PHARMACOTHERAPY

- Treated with combination of antipsychotic and mood stabiliser – core treatment regime stable for many years
- PRN hypnotic used fairly frequently (and appropriately)
- Rare use of PRN Lorazepam

INDIVIDUAL AND GROUP PSYCHOTHERAPY

- Extensive psychological input in HSU; but reluctant to engage following stepdown
- Little willingness to engage in group-based interventions – tends to find such environments challenging
- Has gradually engaged in further work around Relapse Prevention
- Good engagement in grief-related work following death of mother

EDUCATION, SKILLS ACQUISITION AND OCCUPATIONAL / VOCATIONAL REHABILITATION

- Notable interest in music
- Has benefitted significantly from opportunity to engage in expression of this, both within MSU and in community
- Significant impact upon sense of self-esteem, with associated reduction of risks
- Above has allowed for graded leave periods also

SUMMARY

- Lengthy period of stay in secure services
- Reluctant to move forward
- Aggressive outbursts rare, but with enduring concerns re: capacity for significant violence
- Progress facilitated by engagement in activity, as well as psychological intervention
- Engagement in meaningful activity likely to prove essential in any enduring progress toward community

PATIENT C

- 26 year old male
- Assessed in community; admitted under s37/41
- Convicted of attempting to incite a child to engage in sexual activity
- Had sought to befriend an individual he believed to be 13 years old, sending pictures of his genitals and requesting to meet her for sex

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Degree of LD
- Cause of LD and their behaviour phenotypes
- Presence of other dev disorders: ASD, ADHD
- Mental illness
- Personality disorders
- Substance misuse
- Physical illnesses (eg: epilepsy)
- Psychosocial stress factors (eg: experience of trauma)
- Challenging behaviour

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Degree of LD
  - Moderate LD
  - FSIQ 48
- Cause of LD and their behaviour phenotypes
  - No known syndrome noted
  - Small stature
  - Some dysmorphic features
- Presence of other developmental disorder
  - Nil noted

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Mental illness
  - Diagnosis of Depression – in remission
- Personality disorders
  - Nil noted
- Substance misuse
  - Some ETOH consumption; but not to dangerous levels
- Physical illnesses (eg: epilepsy)
  - Acne apparent, nil else

MULTI-AXIAL DIAGNOSTIC ASSESSMENT

- Psychosocial stress factors (eg: experience of trauma)
- Challenging behaviour
  - Initially settled; fairly quiet presentation on the ward
  - Appeared vulnerable; more likely to be victim of violence than perpretrator
  - Anger apparent when assessment work for SOTP commenced
  - Angry with Clinical Psychologist – expressing thoughts of harm towards him
  - Agitation apparent on ward also – esp. around ward boundaries such as kitchen access.

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PHARMACOTHERAPY

- Prescribed antidepressant at time of admission
- Discontinued
- Some consideration of whether this was required; but no clear history of enduring low mood, nor other symptoms associated with depression

PSYCHOLOGICAL INTERVENTIONS

(6) individual and group psychotherapy, guided by the psychological formulation

- Engaged in EQUIP

(7) offence-specific therapies

- Has commenced preparatory work for SOTP – with increase in overt expressions of anger as noted

FURTHER ASPECTS OF REHABILITATION

(8) education, skills acquisition and occupational / vocational rehabilitation

- Access to broad range of activities
- Offered opportunity to engage in education

(9) community participation through a system of graded leave periods

- Has had been granted escorted community leave, which has proceeded in a gradual manner.

(10) preparation for transition

SUMMARY

- Primary diagnosis of LD
- Anger and aggression apparent once engaged in offence related work
- Proactive engagement in group-based intervention provides framework for future work

CONCLUSION

- Explore 3 case vignettes, which demonstrate different ways in which anger and aggression can present in MSU
- Noted the diagnostic aspects which influence presentation and management
- Discussed value of holistic approach to intervention, facilitated by a structured approach to formulation and management

DISCUSSION