

**AGGRESSIVE AND DESTRUCTIVE BEHAVIOUR IN A GROUP OF PATIENTS
WITH INTELLECTUAL DISABILITY**

ANDRE MARAIS

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IN A GROUP OF PATIENTS WITH INTELLECTUAL
DISABILITY**

André Marais

B.A. Honours (Psychology)

Mini-dissertation (manuscript format) submitted in partial fulfilment of the requirements of the degree Magister Artium in Clinical Psychology at the Potchefstroom University for Christian Higher Education.

Supervisor: Dr. E. van Rensburg

POTCHEFSTROOM

SEPTEMBER 2002

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SUMMARY

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KEYWORDS: Aggressive Behaviour, Destructive Behaviour, Intellectual Disability

Aggressive and destructive behaviour is seen as a risk factor in institutions caring for patients with intellectual disability. Certain situations may lead to or trigger aggressive and destructive behaviour. A study of the full extent of aggressive and destructive behaviour, including types of behaviour and situations in which they occur, was needed. This knowledge could help in understanding such behaviour better and help establish guidelines and intervention programs for reducing aggressive and destructive behaviour in a group of people with intellectual disability.

A semi-structured interview was conducted with both patients and staff, consisting of three questions. To patients: *What makes you angry or upset?* 2. *What do you do when you get angry or upset?* 3. *What do you do to feel calm and relaxed?* To Staff: 1. *What makes the patient angry or upset?* 2. *What does the patient do when he/she gets angry or upset?* 3. *What does the patient do to feel calm and relaxed?* The data received were then analysed, placed into categories and weighted by percentage.

Categories of responses were reported for both men and women. The most frequent categories reported by patients and staff to all questions were: conflict with patients, conflict with staff, aggressive behaviour, destructive behaviour, isolation, recreational and leisure activities, and socialization. Isolation and destructive behaviour in response to the question, *what do you do when you are angry or upset?*, were categories identified in the patient population which were not noted by the staff. Staff and patients generally identified the same categories, but with different emphasis on weight and significance to both. These categories evolved from incidents annotated of verbal aggression, swearing, teasing and threats, as well as physical aggression like hitting and biting. Incidents of destructive behaviour like breaking windows, slamming doors, invasion of privacy and theft were annotated. Physical needs identified included food, confectionery and clothes. Psychological needs identified ranged from socialization to isolation, rest or sleep, social interaction and the use of recreational facilities.

The self-reports proved useful in establishing the needs of both patients and staff, establishing staff insight as well as identifying situations and types of behaviour which manifest in patients with intellectual disability. It is suggested that these areas be focussed on in the understanding, training and planning of intervention strategies to handle problem areas such as aggressive and destructive behaviour in institutions for people with intellectual disability.

The results indicate reduced staff awareness to some dimensions of patient behaviour. A thorough knowledge of patients' needs, of the environment in which they live and their behaviour is necessary for effective management of problem behaviours and situations. Through training this knowledge should allow for a better understanding of patients, their

reactions and behaviour, which may lead to reducing aggressive and destructive behaviour.

OPSOMMING

AGGRESSIEWE EN DESTRUKTIEWE GEDRAG IN N' GROEP PASIËNTE MET VERSTANDELIKE GESTREMDHEID

SLEUTELWOORDE: aggressiewe gedrag, destruktiewe gedrag, verstandelike gestremdheid.

Aggressiewe en destruktiewe gedrag is 'n risiko in sentrums wat sorg vir pasiënte met verstandelike gestremdheid. Sekere situasies kan lei tot aggressiewe en destruktiewe gedrag. 'n Studie is onderneem van die volle omvang van aggressiewe en destruktiewe gedrag, tipes gedrag en situasies waarin hulle voorkom. Hierdie inligting kan help om gedrag beter te verstaan sodat die nodige riglyne en intervensieprogramme ontwikkel kan word om aggressiewe en destruktiewe gedrag te verminder.

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Self-rapporterende semi-gestruktureerde onderhoude is nuttig in die bepaling van dit wat die pasiënte en personeel benodig. Dit het duidelik die personeel se kennis en situasies geïdentifiseer waarbinne die gedrag plaasvind. Daar kan nou op hierdie areas gefokus word om gedrag beter te verstaan en om opleiding en intervensiestrategieë te ontwikkel. Dit sal die hantering van aggressiewe en destruktiewe gedrag vergemaklik.

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I, the co-author, hereby give consent that André Marais may submit the manuscript for the purpose of a mini-dissertation.

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MANUSCRIPT TITLE, AUTHORS AND ADDRESSES

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AGGRESSIVE AND DESTRUCTIVE BEHAVIOUR IN A GROUP OF PATIENTS WITH INTELLECTUAL DISABILITY

André Marais: B.A. Honours (Psychology)

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ABSTRACT

Aggressive and destructive behaviour is a risk factor in institutions caring for patients with intellectual disability. A semi-structured interview was conducted with 13 patients with intellectual disability and staff members who knew the patients well. Situations that angered or upset patients were identified, and their reaction to such stimuli and what they did to regain their calm and feel relaxed were recorded. Categories of responses were developed for both men and women.

The most frequent categories reported by patients and staff were conflict with patients and conflict with staff. Reactions included aggressive behaviour, destructive behaviour, isolation, socialization and engaging in recreational and leisure activities. Staff and patients largely identified the same categories but the importance varied between the groups. Self-reports were found to be useful in establishing the needs of both patients and staff. Staff insight into patient behaviour and the identification of specific situational and behavioural characteristics could also be established. The information could be useful in the understanding of behaviour as well as for training and intervention strategies in the reduction of aggressive and destructive behaviour in patients with intellectual disability.

ACKNOWLEDGEMENTS

My heavenly Father who has protected and guided me through this life, making the journey to this point possible and amazing. Thank You.

I wish to express my sincere appreciation and gratitude to the following people:

- My parents, André and Sandra, for their continued support, love, encouragement and belief in me. Thank you for an instilled appreciation of life, the little things and for showing me the value of being true to yourself.
- Jean-Pierre and Michelle for sharing with me the special gift of family love.
- Dr. Coert Mommsen, head of the Psychology Department, Community Psychiatric Services (CPS), at Witrand Hospital, for his time and effort in scrutinizing and analyzing the data. His encouragement with enthusiastic support, motivation and endless patience is a boundless inspiration.
- Prof. Faan Steyn, of the Statistical Consulting Services of the Potchefstroom University, for his respectful, courteous manner, clear guidance and positive recommendations.
- Ockert Coetzee, for his assistance, time and effort in scrutinizing and categorizing the relevant data.
- To Witrand Hospitals' Management, for allowing this study.
- To all the staff at Witrand Hospital who are special, caring people, making a huge difference in caring for those with special needs, may you be blessed.
- Last, but not the least, Dr. Esmé van Rensburg, for her skilled guidance, unrelenting effort, exceptional management and incredible work ethic. Thank you for your kindness, support and inspiration, for being a colleague and a friend and for touching my life.

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AGGRESSIVE AND DESTRUCTIVE BEHAVIOUR IN A GROUP OF PATIENTS WITH INTELLECTUAL DISABILITY.

INTRODUCTION

It is well documented that patients with intellectual disability have a high frequency of aggressive and destructive behaviour (Benson, 1985; Dura, 1997; King, Lancaster, Wynne, Nettleton & Davies, 1999; Allen, 2000; De Smedt, Gagliano, Read & Thorpe, 2002). Surveys report a significant prevalence of aggressive and destructive behaviours and a broad range of behaviour that is labelled as aggressive (Sigafos, Elkins, Kerr & Attwood, 1994; Dudley, Ahlgrim-Dezell & Calhoun, 1999; De Smedt *et al.*, 2002).

Anger is seen as a risk factor for aggressive and destructive behaviour among the intellectually disabled (Novaco, 1994). Certain situations in which the intellectually disabled find themselves may be anger-inducing and lead to aggressive and destructive behaviour. The nature of anger as described by Novaco is an emotional state which has three components, namely physiological, cognitive and behavioural (Rose, 1996). Rose describes these three components as being inter-related with both anger and the environment (Rose, West & Clifford, 2000). Rose quotes Novaco, who describes the treatment of anger as having components of cognitive restructuring, arousal reduction and behavioural skills training (Rose *et al.*, 2000). Assessment of anger in the intellectually disabled has been difficult for researchers. The reliability of subjective reports by the intellectually disabled regarding their emotions has been questioned, the argument being whether anger might not be an adaptive response to some situations (Benson, 1985; Stenfert-Kroese, Dagnan & Loumidis, 1997; Rose *et al.*, 2000; Allen, 2000).

The etiology of aggressive and destructive behaviour is complex. It involves biological and socio-cognitive developmental deficits, with substantial variability from person to person. These clinical pictures are not capable of distinguishing discrete etiological contributions to mental retardation and destructive behaviour; this type of behaviour remains under-researched and under-treated (Benson, 1985; Davidson, Jacobsen, Cain, Palumbo, Sloane-Reeves, Quijano, Van Heyningen, Glesgow, Erhart & Thomas, 1996). The behaviours manifest in a variety of forms, ranging from physical assault and destruction of property to self-injurious behaviour (Davidson *et al.*, 1996).

Benson's treatment model as adapted for the intellectually disabled by Rose *et al.* (2000) consists of group sessions with the involvement of caretakers as well as the use of role-play of aggressive reactions to certain situations. This treatment model is more behavioural/educational in nature (Rose, 1996). It involves teaching emotional recognition, doing role-plays and relaxation. These interventions are accompanied by self-regulation and ownership of behavioural problems (Benson & Fuchs, 1999). Interventions also focus on replacing provocative emotional stimuli with new role-played coping strategies, leading to behavioural change (Benson, 1985; Rose, 1996; King *et al.*, 1999; Rose *et al.*, 2000; Allen, 2000;). The study of these behaviours for intervention planning is an essential part of patient care.

Services and supports to reduce or eliminate these behaviours, whether by way of behavioural analysis, psychotherapeutic, psycho-pharmacological methods of anger

control, or even a combination of these, are often not successful (Benson, 1985; Smith, 1986; Davidson *et al.*, 1996).

Witrand Hospital in Potchefstroom, in the North West Province, Republic of South Africa, is an institution for people with intellectual disability. The hospital administration often experiences problems regarding the management of patients with a high frequency of aggressive and destructive behaviour. A wide range of behaviours is encountered at this institution, ranging from self-injurious behaviour, aggression towards other patients, aggression towards staff (hitting, biting, pinching, throwing objects), the breaking of windows and doors, to verbal aggression. The researcher proposed to the hospital's Management and Ethics Committee that this problem be scientifically investigated in order to make recommendations regarding training and intervention programmes.

In the proposed study the following was to be established: The full extent of aggressive and destructive behaviour; the types of aggressive and destructive behaviour which manifests at Witrand Hospital; the situations in which these behaviours occur; and lastly, the adaptive responses patients employ to manage anger-inducing situations. Once these questions were answered, formal guidelines could be prepared and treatment programmes compiled. This may not only improve the quality of life of patients, but also that of the staff who have the frustrating task of handling aggressive and destructive patients. This could in turn enhance the quality of the staff's functioning, the effective use of policies, an increase in job satisfaction and a decrease in work stress (Allen, 2000; Rose *et al.*, 2000). Patients would also benefit, as aggressive behaviour is often an obstacle regarding

successful community placement and integration. This has an impact on educational, residential and vocational progress (Bruininks, Olson, Larson & Lakin, 1994).

RESEARCH METHOD

PARTICIPANTS

Two groups of participants were identified, namely patients with intellectual disability and the ward staff working as their caretakers.

Patients at Witrand Hospital were referred to the researcher by the multidisciplinary team for this research. The team consists of a medical doctor as chairperson, a clinical psychologist, physiotherapist, occupational therapist and professional nurses from the ward. The participants who were referred to the researcher by the multi-professional team exhibited aggressive and destructive behaviour over a four-month period. The participants' intellectual ability fell within the range of moderate to mild mental retardation (DSM-IV-R, A.P.A, 1994) and each had an acceptable level of communication (i.e. verbal expression). Wherever possible, consent from the patients' family was obtained and in cases where the participants' families were unknown, consent was obtained from the Hospital General Manager, as guardian of the patients. Confidentiality was a priority at all times.

The participants (5 women and 8 men) ranged in age from 17 years to 53 years of age with a total mean age of 34 years, the mean age of the men being 34,6 years and the mean age of the women 33,4 years. In this institutional setting living arrangements are in single rooms, twin bedrooms and dormitories.

The other group of participants consisted of three staff members (2 female and 1 male) who knew the patients well. The mean age of the staff members was 43,3 years and the mean duration of working years is 16 years.

PROCEDURE

Participants who were known for their aggressive and destructive behaviour, or who displayed aggressive and destructive behaviour within a four-month period were referred by the multi-professional team to take part in the research. Semi-structured interviews were conducted with these patients. Rapport was established before semi-structured interviews were conducted.

Semi-structured interviews were also conducted with the staff members who knew the patients well. The following questions were asked during the interviews:

Questions: To patients

1. What makes you angry or upset?
2. What do you do when you get angry or upset?
3. What do you do to feel calm and relaxed?

Questions: To staff members

1. What makes the patient angry or upset?
2. What does the patient do when he gets angry or upset?
3. What does the patient do to feel calm and relaxed?

The responses were written down verbatim and multiple answers were permitted if offered.

Responses to the questions were grouped into categories by three psychologists. A fourth psychologist verified the resulting categories. The final categories were discussed with each psychologist in order to reach consensus.

RESULTS

Table A

Table A summarizes the percentages of responses given by both groups of participants (staff as well as patients) to the various categories. Percentages are reported because of the variation in the number of responses to the questions. All responses were given an equal weight.

The following is a discussion of the response categories obtained from the semi-structured interview.

QUESTION 1

*What makes you angry or upset? (To patients)/What makes the patient angry or upset?
(To staff)*

There were five main categories of responses to this question. Analyses of the patients' responses indicated that conflict with co-patients accounted for 53% of the responses and conflict with staff 19%. Conflict with co-patients included accusations, verbal aggression

such as swearing, insulting, teasing and threats. In the category "other", theft, physical assaults and invasion of privacy were included.

The staffs' responses to the same question shows conflict with patients (44%) and conflict with staff (24%). They identified patient conflict to be teasing, interpersonal relationship conflict, and lack of social control and verbal aggression. Invasion of privacy and theft were also noted.

These are common problems found in the literature for people with intellectual disability. Benson found these and similar areas as a frequent source of anger (Benson & Fuchs, 1999). The resulting anger could have been misattribution of the intentions of others. Benson and Fuchs (1995) are of the opinion that people with intellectual disability have problems identifying emotions, and therefore understanding the intentions of others (in this case fellow patients). This being so, patients with intellectual disability have less adaptive ability and difficulties with their problem-solving skills (Smith, 1986; Short & Evans, 1990; Priest-Jacobs, 1994; Stenfert-Kroese *et al.*, 1997). Intellectually disabled patients seem repeatedly to use ineffective strategies or repetitiously use past strategies to solve current problems without adapting to new stimuli or new task demands (Smith, 1986; Priest-Jacobs, 1994; Dudley *et al.*, 1999).

The possibility also exists that these patients could be victims or targets of teasing by other patients. The participants reported incidents that upset them which were congruent with findings in other studies. Benson & Fuchs (1999) used a similar self-report of anger-arousing situations in a study, consistent with the events identified as stressful by people

with intellectual disability, drawn from a non-clinic sample/population (Bramston & Fogerty, 1995; Bramston; Fogerty & Cummins, 1997). Bullying, arguing, fighting and teasing were rated by people with mild and moderate intellectual disability as part of a list consisting of 31 stressors (Bramston, Fogerty & Cummins, 1999). The consistency across other studies adds credence to the responses reported in this study.

The staff and patients identified similar conflicts in this category. The staff did not however, mention the categories of threats, accusations and physical aggression by patients or staff. This could indicate that even though the staff mentioned most categories, they could be focussed more on their own role, i.e. problems they face in the ward themselves, rather than the problems their patients might be experiencing. The staff did not identify the category of physical aggression identified by the patients. Safety, security and physical integrity are synonymous with patient care.

It is imperative and non-negotiable that staff should ensure the safety of patients at all times (Sigafoos *et al.*, 1994, Dudley *et al.*, 1999). The staff might not have mentioned physical aggression or assault as it is possibly a part of everyday routine. Conflict with staff constitutes 19% of the category "*What things make you angry or upset?*" according to patients. It included things like accusations, verbal aggression, swearing, insults, threats, teasing, reprimands, physical aggression, non-compliance with ward rules and exclusions from ward activities and privileges (such as work and church). In this category staff reported that conflict with staff and conflict with patients were the main problem area. The staff indicated physical needs as 15% and psychological needs as 14%, followed by environmental changes as being 3%.

This category and the ways in which problems between patients and staff manifest do not seem to differ much from the interaction and problems between patients. When authoritarian activity results in provocation and escalation in patients' problem behaviours, aggression and destruction will logically follow. As mentioned, these behaviours could be misattribution by patients of the intentions of others (Benson & Fuchs, 1999), linked to the problems of misinterpretations of facial emotional expressions and therefore of their intentions (Short & Evans, 1990; Benson & Fuchs, 1995; Benson & Walz, 1996; Priest-Jacobs, 1994; Stenfert-Kroese *et al.*, 1997). The intellectual social skills of the disabled are slower in developing and not adaptable, with many misinterpretations (Bruininks *et al.*, 1994; Dudley *et al.*, 1999). When patients experience problem situations they need an authority figure to assist them. If the assistance offered by authority is ineffective, the patients would have no way of dealing with their problems. Inexperienced staff, with prior/set and inappropriate interaction styles, might reinforce aggressive behaviour (Wehmeyer & Kelchner, 1994; Allen, 2000). Combining these factors with inappropriate and dysfunctional environments within which patients with intellectual disability might find themselves, their expressions of anger or aggression may be viewed as legitimate responses to unacceptable conditions (Harris & Rice, 1992; Blumreich & Lewis, 1993; Allen, 2000).

Physical needs shared equal weight with the category of psychological needs, as noted by the patients, both being 12%. Physical needs included sufficient food, rest/sleep, clothes/shoes, confectionery and financial means. These are basic needs, which should be met as outlined as part of government's commitment or promise of care to patients.

The staff seemed to be in agreement with patients regarding the category of physical needs (15%). They state food, financial problems and confectionery as the main problem areas within this category. The staff fails to mention or realize that clothes, shoes, rest and sleep are problematic to their patients. The staff has identified an area of controversy, and part of physical needs, the need for tobacco/nicotine. The staff state that patients are very difficult when this physical need is not met. This is a controversial point, as new legislation does not allow smoking in public areas.

These physical needs are basic needs that should be met, as they fit in with Maslow's theory. This theory focuses on the development of healthy, well-functioning people. In his theoretical hierarchy, basic needs are believed to be universal and intrinsic. These include physical needs, like hunger and thirst. Only when these basic needs are satisfied do higher-level needs feature. They could include safety and security, moving higher to shelter, affection, belonging and self-esteem. These needs include the maintenance of stability and security in protected individuals. When all these are met, even higher needs follow. These are needs that are more growth-oriented, such as freedom and justice. The highest level in Maslow's hierarchy is the need for self-actualization, the achievement of one's complete potential (Kaplan & Sadock, 1989).

The need for family contact (a psychological need) was expressed by 12% of the patients with intellectual disability, as well as social support in the form of interpersonal relationships and friendships. Furthermore, communication and a sense of understanding coupled with a need for authority was identified.

The staff noted psychological needs of patients (14%), to be a need for family contact, social support and religious contact. Patients with problem behaviours, aggression and destruction are in more need of assistance with regard to all professional services. In general, psychological services also seem to be less available to patients with intellectual disability who display problem behaviours. Socialization, communication and interaction with patients with intellectual disability who have such problem behaviour are also less (Bruininks *et al.*, 1994).

The need for expression and social contact in interpersonal relationships like both heterosexual partners and friends seem higher in the hierarchy of needs according to Maslow (Kaplan & Sadock, 1989). Only certain visiting hours to wards are allowed at Witrand Hospital. Friends in the same wards, however, have unlimited time available for interaction, even with the staff. But the intellectually disabled with their limited communication, social and interpersonal skills, as well as poor adaptive ability, might have some difficulty in establishing and maintaining close relationships (Kaplan & Sadock, 1989; Priest-Jacobs, 1994; Bruininks *et al.*, 1994; Dura, 1997; Dudley *et al.*, 1999).

Their inability to maintain satisfactory interpersonal relationships cause patients to become more frustrated. Anger could be seen as irritable aggression, based in frustration. When venting opportunities by means of effective communications are not available, however, frustrations and needs may be expressed by aggressive and destructive

behaviour (Bruininks *et al.*, 1994; Dura, 1997; Dudley *et al.*, 1999; Allen, 2000; De Smedt *et al.*, 2002).

The need for communication was not identified by the staff. Being under stress with a high personnel turnover and not knowing patients well, they might not realize the need for patients with intellectual disability to communicate (Sigafos *et al.*, 1994; Bruininks *et al.*, 1994).

Another explanation when considering *conflict with patients* and *conflict with staff* may be that a hostile attitude, verbal aggression, swearing, insulting and teasing as a learned behaviour influence the staff's interaction styles. This, combined with a passive role in helping patients with interpersonal problems and staff reacting to patients with physical and verbal aggression, could have a modelling influence on patient's behaviour. Thus, aggressive behaviour may have an element of learned social behaviour (Kaplan & Sadock, 1989; Harris & Rice, 1992; Blumreich & Lewis, 1993; Allen, 2000).

To the final category noted under Question 1, "*What makes you angry or upset?*", the staff and the patients indicated environmental changes at 3% and 4% respectively. Patients noted changes such as chopping down trees, closing the pool area and transfer between wards. Internal environmental changes were incidents like staff changing things in their rooms and ward atmosphere, as they have no control over their own environment.

The staff identified environmental changes related to events in the wards itself, like changes in patient's rooms and changes in routine. The patients had no choice or control

over these changes. Environmental conditions seem to increase the likelihood of aggression (Mulick & Shroeder, 1980; Harris & Rice, 1992; Blumreich & Lewis, 1993; Allen, 2000).

It was clear that there were certain categories for which consensus was reached, whilst in other categories it seems as if the staff did not really understand the frustration of the patients, as seen with regard to the responses of the participants (patients as well as the staff) to the question *"What makes you angry or upset/what makes the patients angry or upset?"*. Changes will have to be made by the staff, because staff actions or staff cultures could also unknowingly present triggers for aggressive behaviour. They are also in the position to identify particular features in the environment that could be causal factors and that could be changed (Rose *et al.*, 2000).

QUESTION 2:

What do you do when you get angry and upset? /What do the patients do when they get angry or upset?

Patients' reactions were grouped as follows: Aggressive behaviour (40%), Isolation (21%), Destructive behaviour (12%), Recreational activities (10%), and other responses (17%).

Aggressive behaviour consisted of verbal aggression, swearing, insults, threats and screams and reprimands, and physical aggression manifested as kicking, biting, hitting and wrestling with (tackling) other patients. Patients with intellectual disability may be

biased regarding their own role in problem behaviour. They may find it difficult to understand their own motives in such behaviour. This could be due to a lack of insight, and therefore little or no self-referral is done (Smith, 1986; Short & Evans, 1990; Priest-Jacobs, 1994). The participants did however indicate their awareness of the troublesome nature of their behaviour. It is therefore possible that this voluntary mentioning of their behaviour, the consequence of reported behaviour, is based on their own perceptions.

As mentioned earlier, patients with intellectual disability with limited ability to express anger are more likely to act aggressively. They seem to lack perspective and misinterpret situations, which could also lead to more aggression (Kaplan & Sadock, 1989; Benson & Walz, 1996; Benson & Fuchs, 1999). They have fewer communication and expressive skills and this, coupled with limited opportunity for the release of tension, venting or expression of anger, may lead to an increase in aberrant behaviour. Failure to communicate anger could make anger unpredictable and potentially more destructive. Aggressive outbursts would probably result, and lead to aggressive and destructive behaviour (Kaplan & Sadock, 1989). Destructive behaviour (12%) manifested in window breaking, door slamming and the destruction of furniture (chairs, cupboards, tables), and even at times the throwing about of cups of coffee or food.

The staff however identified the majority of responses in the categories of aggressive behaviour (58%) and destructive behaviour (22%) to the question: *What patients do when they get angry or upset?* The incidents recorded include verbal aggression such as swearing, insults, threats, gossip and lies, as well as physical aggression such as hitting, biting and kicking. Destructive behaviour included breaking windows and destruction of

furniture. Poor problem solving abilities, ineffective communication and lack of constructive ways of dealing with problem situations can be causative factors for the manifestation of physical aggression and destructive behaviour (Short & Evans, 1990, Priest-Jacobs, 1994; Dura, 1997). Adaptive abilities are seldom developed and the intellectually disabled need to be trained to acquire them (Bruininks *et al.*, 1994; Sigafoos *et al.*, 1994; Wehmeyer & Kelchner, 1994; Dudley *et al.*, 1999).

The intellectually disabled with a real need for assistance in these kinds of behaviours, usually do not have their needs met and have inadequate access to support systems and services (Bruininks *et al.*, 1994).

The staff might rate individuals with intellectual disability as more problematic or angrier than do the patients with intellectual disability themselves (Lally, 1993). However, there could be a socially desirable response bias by individuals with intellectual disability (Voelker, Shore, Brown-More, Hill, Miller & Perry, 1990). The staff on the other hand, might over-estimate the difficulties they face. Their judgement could be biased because of stress, inadequate training, or lack of support services available to staff members (Benson & Ivins, 1992).

Destructive behaviour could be an attempt to change the environment or to accomplish interaction with the latter. Environmental conditions seem to increase the likelihood of aggression and destructive behaviour (Mulick & Shroeder, 1980; Harris & Rice, 1992; Blumreich & Lewis, 1993; Allen, 2000). These patients might gain some control over their environment, which might be part of the cause of their frustration. Higher

functioning patients especially, who have no alternative for tension release, could resort to destructive behaviour (Kaplan & Sadock, 1989; Allen, 2000).

In the category for isolation (21%) patients reported that they withdrew from certain situations, either by going outside, going to their room or taking a walk. Some existing facilities available were also used, but not very often. These include normal routine and stimulation programmes. In this sphere, the staff did not identify isolation as a category when asked: "*What do patients do when they get angry or upset?*" Ignoring provocation and withdrawing from situations may be positive for the prognosis of an intervention strategy when patients do not react to their low impulse control (i.e. their immediate impulses). Isolation is usually associated with lower adaptive ability (Dudley *et al.*, 1999). When patients with intellectual disability isolate themselves, they do not socialize and communicate, receiving no environmental stimulation (Priest-Jacobs, 1994; Dudley *et al.*, 1999). Non-communication further not only limits already diminished cognitive development, but also limits social opportunities, the ability to learn from the world around them and their adaptation skills (Hardy & Cull, 1974; Priest-Jacobs, 1994; Dudley *et al.*, 1999).

The staff, by not identifying isolation, seem to have little insight in this phenomenon. It might reflect that the staff do not fully appreciate the extent of the patient's behaviour especially when they are upset or angry. High turnover rates in personnel might have such an effect (Bruininks *et al.*, 1994) and may also apply to the findings in this study. There is a policy for continuous staff rotation between wards at the hospital, leading to the staff's not being familiar with patients' needs.

The use of recreational activities was categorized as 10%, in response to the question "*What do patients do when they get angry or upset?*" These included reading, watching television, listening to the radio or music, and even smoking. The staff did not identify recreational activities as a reaction by *patients when they feel angry or upset*. These recreational activities could be seen as an escape from problem situations, but it is more constructively adaptive than isolation would be. Patients still leave the source of frustration, trying to make these feelings dissipate by escaping to traditional forms of recreation, relaxation and more skilled activities.

It is disconcerting that the staff are not familiar enough with the patients' needs to realize what mechanisms should be employed or are already in place for dealing with problem situations. Patients use the few available facilities provided, but these are limited and appear insignificant to the staff, and may eventually fall into disuse. It might also be that the utility of these facilities is not recognized by staff. However, when patients are significantly occupied with structured activities, (such as these recreational activities may offer), they tend to exhibit less aberrant behaviour (Priest-Jacobs, 1994).

Responses not grouped into a specific category were placed in a category named "other". These responses included working, venting of feelings, social support, communication and eating. The responses of the patients in this group came to 17%.

The staff did not identify responses, such as working, venting of feelings or social support, in the category "other" (20%), but only identified emotional outbursts. The needs

expressed here are not always met, but form an important part of adapting. The staff identified non-compliance at times as a problem area. Non-compliance did not feature as a patient response. This may be due to poor insight, embarrassment because of emotional outbursts or the possibility of incrimination. The staff did not identify strategies which patients employ when angry or upset. This once again may be indicative of a lack of staff knowledge regarding patient needs, or options available to them.

The staff seems to lack explicit knowledge as to how patients react when they get angry or upset. They identified only aggressive and destructive behaviour. Neither isolation nor recreational and leisure activities were perceived by the staff. The staff therefore do not realize that recreational activities could improve patients' adaptive abilities and thereby decrease aggressive or destructive behaviour. Actively structuring activities, or facilitating the venting of feelings, can help with problem-solving and adaptive skills. Through their responses patients provide a range of already existing possibilities for further training and reducing aggressive and destructive behaviour. None of these are mentioned by the staff. Examples are working, venting feelings, social support and communication. Non-compliance and emotional outbursts mentioned by the staff could be reduced, should those in which this behaviour manifests receive attention. This could reduce frustration and tension.

QUESTION 3:

What do you do to feel calm and relaxed?/What do the patients do to feel calm and relaxed? The following categories were compiled from the patient's responses:

Recreational and leisure activities (37%), socialization (19%), rest (13%), isolation (10%), and "other" responses (21%). In the category, Recreational and leisure activities, watching T.V, reading, smoking, knitting and religious activities, listening to the radio, music and tapes, dancing and building puzzles were recorded.

Recreational activities were discussed under Question 2. It could be seen as an escape mechanism when patients feel angry or upset. Should this be so, it might be linked with the previous category, even though these activities are intended for relaxation. Spontaneous choice is central to this category, as patients with intellectual disability choose to participate in activities which are enjoyed, in order to relax or feel calm. These could be indulged in at any time, not only when an aggressive or destructive impulse might need to be controlled.

Socialization (20%) was selected as a category for patient responses pertaining to communication, social interaction with friends and interpersonal relationship partners, as well as authority. Some patients responded with positive regard to psychotherapy, family contact and animal-companion interaction.

The intellectually disabled person could possibly even find expression or release of tension when participating in specific recreational or leisure activities. Focussing attention away from the negative, being occupied by activities and possibly acquiring some needed skills, could be of value (Hardy & Cull, 1974; Bruininks *et al.*, 1994; Priest-Jacobs, 1994; Wehmeyer & Kelchner, 1994).

The isolation category formed 10% of the responses to this question. This consisted of responses offered by the patients to *what they do to feel calm and relaxed*. These included seclusion or withdrawal to their room, going outside and avoiding or ignoring provocation. Some responses show participants remaining silent. Only two patients mentioned using existing facilities for voluntary, calming, therapeutic isolation.

Isolation has already been discussed in Question 2, *what patients do when they feel angry or upset?* . Isolation or seclusion for a relaxing and calming effect could possibly be a normal strategy to deal with events in the environment. When a person secludes or isolates himself, he establishes an environment devoid of any stimulus. This allows patients to be in control of their own environment, choosing to be in such an environment because they enjoy it, feeling calm and relaxed in it and not having to escape or deal with a troubling environment as in Question 2.

The staff also found recreational and leisure activities (54%) to be similar to what intellectually disabled patients stated. They list the same activities as the patients, including watching television, etc. The staff seems to be aware of the activities used by patients, recognizing what makes them calm and relaxed. This could be beneficial and makes it easier to handle potentially aggressive and destructive behaviour. The staff, however, may not be aware of the importance of being actively involved in fulfilling patients' needs by using these recreational and leisure activities as opportunities to facilitate new skills (Priest-Jacobs, 1994; Wehmeyer & Kelchner, 1994; Bruininks, 1994).

When considering previous categories of interaction between staff and patients as far as conflict is concerned, the staff seems more of an anger-provoking factor. Even though the staff may be aware of what has a relaxing influence on patients with intellectual disability, it is possible that they elicit the opposite behaviour from patients, thereby creating or escalating problem behaviours and creating a troubling environment (Mulick & Shroeder, 1980; Harris & Rice, 1992; Blumreich & Lewis, 1993; Allen, 2000).

Socialization as a component of "*What do patients do to feel calm and relaxed?*" was rated 11% by the staff. The staff's inactive, non-assertive role is evident from this percentage and only interpersonal relationships and friendship interaction are mentioned.

Patients with intellectual disability are known to be slow and late in the development of communication and social skills and will therefore need skilled guidance and opportunity to develop and obtain a range of such skills. Communication, venting of feelings and adapting skills could possibly reduce the incidence of aggressive and destructive behaviour (Kaplan & Sadock, 1989; Priest-Jacobs, 1994; Bruininks et al., 1994; Dura, 1997; Benson & Fuchs, 1999).

The staff allocated 22% of responses to isolation. This corresponds to some extent with the response of the patients. Patients only mentioned a few incidents where the staff arranged positive, skilled isolation. This may contribute to the development of patient's adaptive abilities.

The category of sleep or rest formed 13% of patients' responses when they were asked what they did "... *to feel calm and relaxed?*". This included sleeping or resting in the afternoons and evenings. Significant incidents were mentioned to justify a separate category, as sleep or rest could probably be seen as isolation. The causative elements and results may be similar to those of sleep and isolation. Patients exercise a choice and are therefore in control of their environment. Sleep, having more of a relaxing or calming influence, could have the effect of rejuvenation and restoring energy. This may allow for coping with interactions deemed as troubling or problematic.

The staff does not mention sleep as a separate category, but reports a few instances of this in the category of "other". The staff and hospital authority have also included sleep as part of structured activities in the daily ward routines, usually after lunch. This is a structured activity in a safe and secure environment, allowing patients to relax and be at peace.

The category "other" included responses involving going to stimulation programmes or doing physical activities like taking a walk or a run. These patient responses were rated as 21%. Eating and drinking activities to relax and voluntary use of medication were also noted.

The staff noted incidents in the category "other" 13% which were the same as those mentioned by patients. They also mentioned emotional outbursts as something patients do to feel calm and relaxed. Crying could be a form of tension release, which may also

be achieved with the use of sedative medication, in order to prevent the alternative aggressive and destructive behaviour.

Anything that has a relaxing and calming effect on patients should be included as part of the staff's skills. Both the staff and the patients are in agreement on this aspect. However, staff do not seem to have allocated the ideal weight to this category. Having relaxed and calm patients is therefore underrated. Incidents not mentioned could be valuable in the handling of patients who find themselves in a potential situation where aggressive and destructive behaviour could be a result. Therefore these factors which were mentioned by patients should be included in a possible intervention programme.

RECOMMENDATIONS

The following categories of recommendations can be made.

PRIMARY CARE PRINCIPLES

The safety and care of patients are of primary importance. These should be guaranteed at all times, even if constituting harmful behaviour, ranging from self-injury to injury from others (patients or staff). Patients should always feel welcome and treated with care as human beings, with no threat to, or violation of, their physical integrity, either by other patients or by staff. Basic needs such as food, clothing and sleep should be met.

FACILITATING SUPPORT SERVICES

Many allied services are needed to support the core service (patient care) of an institution. The lack of, or problems with, support services could put a strain on the effectiveness and professional level of primary-care service. Outsourcing support services to the private sector should allow management to focus on primary care, reducing the staff's frustration, increasing their effectiveness, job satisfaction and well-being.

TRAINING

Specialized-trained staff, with specialized skills, are necessary for expert care of patients with intellectual disability. The staff should give assertive and skilled guidance to patients, creating the opportunity to teach them a range of social skills. The focus should also include conflict resolution and problem solving skills. Well-trained staff should undergo continued professional development. Training should focus on sensitivity for patients' needs, facilitating the development of adaptive skills, relaxation and optimizing the development of patients in order for them to reach their full potential.

SHARED RESPONSIBILITY

Patients with intellectual disability should be more involved in the decision-making process. A proposed increased involvement of higher functioning patients in the multi-professional team meetings could result in actively shared decision-making. Patients will then share responsibility for decisions and actions concerning them.

RECREATION AND LEISURE

When patients are significantly occupied with structured activities (such as recreational activities could be), they tend to exhibit less aberrant behaviour. More recreational activities as well as leisure activities should be made available. These should include areas developing challenging consequential interaction, with the development of adaptive skills. A minimum of facilities are available, and even though they are used, the staff do not seem to realize their potential.

ENVIRONMENTAL ISSUES

Wherever possible the rotation of staff should be kept to a minimum. This will enable the staff to get to know patients well. This would enable them to understand what upsets the patients and what relaxes them. Where staff changes are inevitable, this could be on a conjoint basis, involving old and new staff of the ward, in order for knowledge to be shared. Higher-functioning patients should be placed in wards with other similarly functioning patients, to decrease frustration levels. As far as possible, the general environment should be kept stable and predictable with as few environmental changes or disruption as possible.

ESTABLISHMENT OF A PROTECTIVE UNIT

A protective unit should be established as soon as possible to protect patients from irregularities from the side of staff or patients. CCTV should be installed to assist in this protection. Patients have a right to be safe and cared for. Placement in this regard should focus on patients who exhibit uncontrollable problem behaviour. Patients exhibiting such behaviour should not be placed with other more vulnerable patients. Difficult patients

should not be living in the same dormitories; where possible, it should be arranged for such patients to live in other blocks of the wards and have their own rooms.

This study provided important and useful information to the hospital in its planning of continued professional development and management of aggressive and destructive behaviour. A non-clinical sample consisting of patients with intellectual disability with non-specific behaviours could be used for future studies. A non-clinical sample drawn from the staff could be a more valid reflection of the staff's knowledge. Here the bias was in favour of the staff as only the staff who knew the patients best (in the estimation of the author) were interviewed. In this study the full extent of behaviour was established and recommendations concerning these will be discussed in a future publication.

SUMMARY OF CATEGORIES ESTABLISHED THROUGH INTERVIEWS OF STAFF AND PATIENTS WITH INTELLECTUAL DISABILITY

TABLE A (page 6)

Question 1: To patients: *What makes you angry or upset?*

To staff: *What makes the patient angry or upset?*

<u>Categories:</u>	<u>Patients</u>	<u>Staff</u>
Conflict with patients	53%	44%
Conflict with staff	19%	24%
Physical needs	12%	15%
Psychological needs	12%	14%
Environmental changes	4%	3%
	<u>100%</u>	<u>100%</u>

Question 2: To patients: *What do you do when you get angry or upset?*

To staff: *What do the patients do when they get angry or upset?*

<u>Categories:</u>	<u>Patients</u>	<u>Staff</u>
Aggressive behaviour	40%	58%
Isolation	21%	0%
Destructive behaviour	12%	22%
Recreational and leisure activities	10%	0%
Other	17%	20%
	<u>100%</u>	<u>100%</u>

Question 3: To Patients: *What do you do to feel calm and relaxed?*

To Staff: *What does the patient do to feel calm and relaxed?*

<u>Categories:</u>	<u>Patients</u>	<u>Staff</u>
Recreational and leisure activities	37%	54%
Socialization	19%	11%
Rest/Sleep	13%	0%
Isolation	10%	22%
Other	21%	13%
	<u>100%</u>	<u>100%</u>

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