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PTSD, VIOLENCE, AND TRAUMA

Violence in Bipolar Disorder

What Role Does Childhood Trauma Play?

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The relationship between mental illness and violence is controversial. On the one hand, there is considerable unfounded stigma and discrimination toward the mentally ill based on the popular notion that psychiatric patients are dangerous people. On the other hand, there is a legitimate need for psychiatrists to identify and manage what risk of violence does exist in their patients. Research that examines how and why violence occurs in the mentally ill is necessary for psychiatrists to determine as accurately as possible which patients are prone to violence and to manage their care accordingly.

Traumatic experiences in childhood have been linked to the potential for violence in adults and to vulnerability to adult psychiatric disorders.¹⁻⁵ Bipolar disorder has been linked to both traumatic childhood experience and to the potential for violence. This review aims to explain the association between bipolar disorder, trauma, and violence, and to provide guidance for assessing violence potential in bipolar patients.

Childhood trauma in bipolar disorder

Trauma is defined by DSM-IV-TR as:

- Experiencing, witnessing, or confronting an event that involves “actual or threatened death or serious injury, or a threat to the bodily integrity of the self or others”
- An emotional response to the event that involves “intense fear, helplessness, or horror”

A history of childhood traumatic experience has been associated with increased vulnerability to multiple mental disorders, including mood disorders and personality disorders.³⁻⁵ Studies have found that a high proportion (around 50%) of patients with bipolar disorder endorse histories of childhood trauma, with a high incidence of emotional abuse.⁶⁻⁹

In a group of 100 individuals with bipolar disorder, Garino and colleagues⁸ found that 37% had been emotionally abused, 24% had been physically abused, 21% had been sexually abused, 24% had been victims of emotional neglect, and 12% had been victims of physical neglect. A third of these patients had experienced 2 or more forms of trauma. A history of 2 or more types of trauma has been associated with a 3-fold increase in the risk for bipolar disorder.⁹ A history of trauma in bipolar disorder has also been associated with a worse clinical course—including earlier onset of bipolar disorder, faster cycling, and increased rates of suicide. Trauma history has further been associated with more comorbidity in bipolar disorder, including anxiety disorders, personality disorders, and substance use disorders.⁶⁻⁸

There are several pathways by which childhood trauma could lead to the development of bipolar disorder⁹:

- Affective disturbances in relationships between parents and their children directly predispose the children to affective disturbances in adulthood
- Children in whom bipolar disorder later develops are prone to more behavioral disturbances in childhood (a prodrome or early onset of bipolar disorder), which could disrupt relationships with parents and lead to dysfunctional parenting
- Children of affectively ill parents could be affected by genetic transmission of affective illness predisposition as well as by parental psychopathology, which increases the likelihood of childhood trauma

Any one or a combination of these pathways could be operational in the development of bipolar disorder in individuals who have experienced childhood trauma. Thus, either the trauma itself or the factors that lead to trauma—or both—could affect the development and course of bipolar disorder.

The link between trauma and violence in bipolar disorder

Childhood trauma history has been found to correlate with increased aggression in adults with and without affective disorders.^{1,2,10} In addition, there is an overlap between the neurochemical changes found in adults with histories of traumatic stress and those in adults with increased impulsive aggression, in particular, increased functioning of both the catecholamine system and the hypo-thalamic-pituitary-adrenal axis.¹¹

CHECKPOINTS

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The prevalence of childhood trauma in persons with bipolar disorder combined with the risks that arise from the symptoms of the disorder itself renders bipolar patients especially at risk for violent behavior. As mentioned, childhood trauma has been associated with a worse clinical course of bipolar disorder,

including earlier onset and a greater number of episodes, which means more cumulative time when aggressive behavior is at its most likely. In addition, a history of trauma has been associated with an increase in rates of substance abuse among bipolar patients, which itself is associated with significant violence risk.¹² Moreover, borderline personality disorder, which has been associated with a history of childhood trauma, has been linked to increased impulsive aggression in bipolar patients during periods of euthymia.^{5,13}

Violence and aggression in bipolar disorder

Studies have found that just under 50% of people with bipolar disorder have some history of violent behavior.¹⁴ Bipolar patients are prone to agitation that may result in impulsive aggression during manic and mixed episodes.¹⁵ However, depressed states, which can involve intense dysphoria with agitation and irritability, may also carry a risk of violent behavior.¹⁶ Even during euthymia, bipolar patients—especially those with comorbid features of borderline personality disorder—may have chronic impulsivity that predisposes them to aggression.¹³

Impulsive aggression (as opposed to premeditated aggression) is most commonly associated with bipolar and other affective disorders. In animal models, premeditated aggression corresponds to predatory behavior, while impulsive aggression is a response to perceived threat (the fight in fight-or-flight).^{13,17} As either a state or trait, increased impulsive aggression is driven by an increase in the strength of aggressive impulses or a decrease in the ability to control these impulses. Neurochemically, impulsive aggression has been associated with low serotonin levels, high catecholamine levels, and a predominance of glutamatergic activity relative to g-aminobutyric acid (GABA)ergic activity.¹⁷

Assessing violence risk in bipolar patients

In many ways, the assessment of violence risk in people with bipolar disorder is similar to risk assessment in any patient. Certain data from the patient's history and mental status examination are universally important:

- Always ask about a history of violent acts, especially recent ones and especially if there were any legal consequences.¹⁸
- Assess the extent of [alcohol](#)([Drug information on alcohol](#)) and drug use because there is a strong association between substance abuse and risk of violence.¹⁹
- Although trauma history has a unique relationship with bipolar disorder, it should be assessed in all patients to determine the risk of violence. Trauma is associated with increased aggression in adults in general, regardless of whether an affective disorder is present.^{1,2}
- Other important historical data include demographic information (young men of low socioeconomic status who have few social supports are the most likely to be violent) and access to weapons.²⁰
- In the mental status assessment, it is important to note psychomotor agitation as well as the nature, frequency, and severity of violent ideation.^{20,21}

- Use of an actuarial instrument, such as the Historical, Clinical, and Risk Management-20 (HCR-20) violence assessment scheme, can help integrate systematic inquiry about evidence-based risk factors into assessment of the clinical scenario.^{22,23} Although such instruments are often developed for use in forensic populations, they can be integrated into the assessment of other populations; for example, the 10 historical items of the HCR can be used as a structured checklist in conjunction with a clinical assessment (**Table 1**).²⁴

Table 1
Ten historical items from the Historical, Clinical, and Risk Management (HCR-20) violence assessment scheme²¹
<ul style="list-style-type: none"> • Previous violence • Young age at first violent incident • Relationship instability • Employment problems • Substance use problems • Major mental illness • Psychopathy • Early maladjustment • Personality disorder • Prior supervision failure

The following issues in risk assessment are specific to patients with bipolar disorder.

Recognition of mixed and manic mood states. Bipolar patients are most prone to violence during manic or mixed states—when maximum behavioral dyscontrol is combined with unrealistic beliefs.¹⁵ Patients with dysphoric mania and mixed states may be at especially high risk; the assessment for concurrent depression in a manic patient should therefore be a priority.²⁵

History of trauma. As noted, a history of childhood trauma predicts a more severe course of bipolar disorder, with more rapid cycling, more episodes, and more comorbidity—including substance use disorders. Knowing whether a bipolar patient has a history of childhood trauma is especially important in determining risk and prognosis.

Comorbid borderline personality disorder. Symptoms of bipolar disorder often overlap with those of borderline personality disorder. Comorbid borderline personality disorder, which is often associated with trauma history, has been shown to predict violence potential in bipolar patients, especially during periods of euthymia.¹³

History of impulsive acts. Impulsivity is a prominent feature of bipolar disorder. Information about previous impulsive acts, especially acts of impulsive aggression, can give the clinician an idea of a person’s likelihood to commit violence on impulse.

Substance abuse. Bipolar patients commonly use alcohol and other drugs to self-medicate mood episodes or as part of the pleasure-seeking behavior of a manic episode.

In assessing patients with bipolar disorder, pay special attention to violent behavior that may have occurred when the person was manic. Also consider violence during euthymic periods, especially in patients who are substance abusers or who have axis II comorbidity. If at all possible, obtain collateral information about the history of violence. Patients may minimize previous violent actions or not remember them, especially if they were in the midst of a manic episode.²⁶

Table 2
Seven steps to prevent and manage violence in bipolar patients
<ul style="list-style-type: none"> • Establish a positive treatment alliance • Treat mood episodes and psychotic symptoms • Involve significant others

Prevention and management of violence in bipolar patients

The bipolar diagnosis introduces some unique aspects to violence prevention and management, although the general principles are similar to those for patients with other disorders. Below are summaries of 7 areas (listed in **Table 2**) that are particularly important in the prevention and management of violence in bipolar patients.

- Treat impulsivity and affective instability
- Treat substance use disorders
- Teach coping skills
- Manage emergencies

1. Establish a positive treatment alliance. This can be a challenge in bipolar patients who may have low motivation for treatment, especially if they have poor insight or if they enjoy their manic symptoms. In addition, a history of childhood abuse can lead to diminished capacity for trust and collaboration with the clinician.²⁷

To improve the alliance with a reluctant bipolar patient, identify his or her particular barriers to acceptance of treatment and work to diminish them. It may be helpful to normalize the enjoyment of mania and to empathize with resistance to treatment as an understandable desire to be healthy and independent.²⁸ Frame treatment that addresses aggressive behavior in a way that respects the patient's desire for control; for example, convey that the medication will help the patient control himself rather than saying that the medication will control the patient.²⁵ A collaborative approach maximizes the patient-physician alliance.²⁹

2. Treat the mood episode, if present. Because the risk of violent behavior increases during an episode, the sooner mood symptoms can be ameliorated the lower the risk.^{16,25} In addition to the agitation and hyperactivity of mania (or sometimes depression), psychotic symptoms are important targets of violence prevention. Symptoms such as paranoid delusions or command auditory hallucinations can contribute to violent behavior.^{18,30} Mixed states may be especially high-risk; these may respond better to [valproate \(Drug information on valproate\)](#) than to [lithium \(Drug information on lithium\)](#).²⁵

3. Involve significant others. Those close to a person with bipolar disorder can be both potential victims of aggressive behavior and potential sources of help in symptom monitoring, especially for patients with poor insight. Determine with the patient and family what the early warning signs of a mood episode are for that person so that intervention can be instituted early, before behavior becomes unmanageable.²⁸ Educating friends and family can prevent violence by helping them avoid behavior that could worsen the patient's aggression; teaching them when to leave a situation that may become volatile and when urgent intervention is needed (eg, calling 911).

4. Treat emotional lability and impulsivity. Bipolar patients may be impulsive even during euthymia, especially if there is comorbid borderline personality disorder. Consider referring the patient for dialectical behavioral therapy if borderline features dominate the clinical picture or if there is a significant history of impulsive risk-taking or self-harm during euthymia.

5. Treat substance abuse. Substance use disorders are highly comorbid with bipolar disorder and are a major risk factor for violence. Aggressively assess and treat such disorders, and refer the patient to specialized outpatient programs or restrictive residential programs, if needed.

6. Teach coping skills. Use assertiveness training, social skills training, anger management training, and stress management training as needed to help the person express his needs, manage potentially frustrating interactions, avoid stress, and handle any anger that arises.

7. Manage emergencies. If a bipolar patient is an acute danger to others, steps must be taken to incapacitate him. These include involuntary hospitalization and medication. Bipolar patients are most often involuntarily hospitalized during manic episodes. An aggressive pharmacological approach should be taken to address the manic symptoms so as to quickly diminish the risk for aggressive behavior.

Aside from treating the manic episode, other measures may be used if needed to quickly control aggressive behavior. These include sedating medication (eg, benzodiazepines, antipsychotics), seclusion, and restraint. It is important to provide an environment that minimizes overstimulation and includes clear interpersonal communication and limit-setting.²⁵

Summary

Bipolar disorder is associated with a high prevalence of childhood trauma as well as with the possibility of aggressive and potentially violent behavior. It is important for clinicians to assess a patient's potential for violence as accurately as possible to minimize risk. Taking historical and clinical information into account, such as violence history, substance abuse, childhood trauma, and impulsivity in addition to mood symptoms can help clinicians reach an accurate assessment. Handling emergencies and treating mood episodes pharmacologically are first steps in managing risk; this should be followed up with treating substance abuse and trait impulsivity and with involving significant others and teaching coping skills. Recognizing the impact of early trauma on a patient can help improve the therapeutic alliance and lead to better treatment outcomes.

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