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## CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL

A report of the APA Task Force on Clinical Aspects of the Violent Individual

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## INTRODUCTION

The mission of this Task Force was to assemble the body of knowledge concerning the individual violent patient and the clinical issues surrounding his care. The Task Force was specifically formed to focus on the individual patient rather than on broader social issues of violence (group violence, civil disturbances) previously considered by the former Task Force on Violence and Aggression of the Council on National Affairs and Social Issues.

This report is aimed at the practicing clinician. It attempts to describe the current state of the art and provides an overview of selected literature and clinical opinion on matters of evaluation, management, and predication of violent behavior.

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## WHO IS THE PATIENT?

### *Clinical Definitions*

The Task Force defines the violent patient as a patient who acts or has acted in such a way as to produce physical harm or destruction. The emphasis of this definition is on the patient's behavior. Clinicians may also be asked to see patients who fantasize or talk about violence and in certain such cases the patient may be considered, at that point in time, as a potentially "violent patient"; however, it should be noted that violent thoughts or verbalizations are not uncommon among psychiatric patients (1, 2). We have labored long on this definition in an attempt to clarify those persons of clinical concern to the psychiatrist, realizing that not all violent persons are mentally ill and that violence can result from adverse social conditions. For example, we are aware that a rioter in an intolerable urban slum condition is not necessarily a candidate for a psychiatrist. Aggressiveness when appropriately channeled can be a positive social force.

### *Types of Patients*

Currently, we identify the following groups of patients as suitable candidates for clinical concern to psychiatrists. First, and most clearly, are those patients who themselves seek psychiatric help because of repetitive problems with aggression and impulsivity. Such "self-referred" violent patients verbalize fears of running "beserk," losing control over violent urges, or direct homicidal ideation (3). These patients often turn out to have characterological disorders, but borderline patients or psychotic individuals may also have difficulties with violent urges.

A group of persons of concern to psychiatrists are not self-referred. They are those who are already incarcerated or who are in legal difficulty because of violent criminal acts (4). Persons who have committed such acts as murder, rape, or assault and those who have been incarcerated for recidivistic violent acts may merit psychiatric attention for purposes of diagnosis, pre-sentence or pre-parole evaluation, or treatment. In legal settings, however, the term "patient" should be reserved for those persons where there exists an ongoing therapeutic relationship between the psychiatrist and the patient;

forensic evaluations would more frequently be of briefer duration and would be oriented more towards such issues as diagnosis or assessment of suitability for psychiatric treatment. Included within this group of persons with legal difficulties are those whose previous behavior may or may not have come to legal attention, but who are atypical offenders with a history of sudden, unexpected, senseless, or bizarre acts with or without psychotic behavior (5, 6). The following characteristics have been found to be associated with murder committed by mental patients (7): absence of apparent motive, no attempt to conceal the crime, action impulsive in nature, near and dear ones are the victims, murder is brutal in nature, complete emotional indifference, usually only one victim, and past history of mental disorders. There would be considerable disagreement, however, about this last point (8).

Persons with a history of child abuse may be referred for evaluation (9).

Another group of patients are those with certain childhood behavior disorders which are accompanied by psychomotor agitation, aggressiveness and belligerence. Such patients may come to psychiatric attention (10, 11).

Patients may also be seen by the psychiatrist because of assaultive or destructive behavior in association with toxic or "organic states" such as an amphetamine psychosis (12) or a viral encephalopathy (13, 14).

There is also a large group of individuals who misuse the automobile and are responsible for violence of epidemic proportions (15); society has not yet seen fit to label these patients as "violent" on the basis of this behavior alone, though histories of automobile misuse are frequently elicited from violent patients (16).

It must again be stated that not all violent behavior is symptomatic of mental disorder; neither should all violent persons be labeled or handled as "patients". Patients who are of clinical concern to psychiatrists may be distinguished from other violent persons on the basis of some or all of the following characteristics: they perceive their violent acts or urges as unwanted, as ego-alien or ego-dystonic; they exhibit a diagnosable mental disorder; their violence is associated with an underlying psychobiological abnormality, e.g., an organic state or an intoxication; their individual management is within the competence and scope of the psychiatric clinician.

## WHERE IS THE PATIENT FROM?

### *Social and Cultural Factors*

Not only must the medical milieu be considered in the evaluation of the violent patient, but the immediate social milieu as well. The rebellious and aggressive adolescent may be propelled towards violence by destructive family forces. On a psychiatric ward a patient may become destructive in response to pressures in the milieu which, when alleviated, result in a prompt reduction in aggressive behavior.

Cultural forces which may contribute to a patient's violence must also be weighed. Aggressiveness may be an important requisite of manhood ("machismo") in certain subcultures. For example, one study of cultural factors associated with homicide in Philadelphia has noted that males of a particular subculture are expected to accept no derogation about their race (even from a member of their own race), their age, or their masculinity (17). Quick resort to physical combat as a means of defending honor on these issues is sanctioned by the subculture.

Transient dissociative-like states leading to severe violence such as the "amok" syndrome have been described in other cultures (18, 19). Comparison of amok homicide with other homicides showed significant differences in the weapons used, the precipitating personal loss and incidence of suicide of the killer (18). Shame appears to play a prominent role in the culture-bound act of amok, and thus the culture can both shape and define violence and perceive the violent act as ritualistic or criminal. The patient's background should be considered when judging the explanation of the violence.

### *Epidemiological Considerations*

The majority of violent offenders are men. Rates of violence are higher for individuals in the 18-24 and 15-17 age groups than for other ages, and higher for poor under-educated individuals with few employment skills than for persons higher up in the socioeconomic ladder (20). Women account for only 10% of violent crimes (21) and a lower percentage of individuals seen in populations of violent psychiatric patients (16). Psychosocial theories have described the more

passive role women play in society and various cultures as a possible reason for their lack of participation in violent crimes. Consistent with this theory is the fact that women generally acted as supporting players to men who acted violent in the case of robbery and burglary; female offenders robbed few healthy males by themselves. Differences also emerge with regard to the participation of women in assault and homicide. Women tended to attack persons with whom they had affectional relationships, such as spouses, rather than strangers who were assaulted or killed in the course of a robbery. Women picked weaker victims when committing assault or homicide, such as an elderly person or an individual who was asleep (22).

A rising rate of violent crimes has been recently reported for women (21). This trend has been theorized to possibly result in part from the social emancipation of women (22).

The milieu of violence rather typically involves the family or other interactions between friends or associates. For example, in 1972 spouse killing spouse, parent killing child, other family killings, romantic triangles and lover's quarrels, and other arguments accounted for more than 70% of all murders. Less than 30% of all murders were of a felony or suspected felony type (23). If the amount of violence accomplished but not reported among families were better known, however, especially with regard to non-lethal assault, these figures might be even more impressive (24).

Patients with fears of losing control over violent urges may be seen by the psychiatrist at any time or in various settings. Epidemiological studies, however, have rather consistently indicated that the rates of *accomplished* violence are very much higher within poorer areas of dense, overcrowded populations (e.g., the central city) and vary as a function of social need (25, 26). There is a remarkable concentration of reported episodes of homicide or aggravated assault occurring on Fridays, Saturdays and Sundays between evening hours and early morning (25, 27).

#### *Evaluation Issues*

With respect to the evaluation, the economic status of the patient often plays a role in the examiner's assessment of violence. The assaultiveness of a patient from an upper socioeconomic class, or that of a private psychiatric patient may be too quickly dismissed. A violent patient in a conventional psychiatric setting may be labeled as merely "alcoholic" or "psychopathic". A skew in the other direction may occur when the patient is seen in prison and when a propensity toward violence may be too readily assumed.

Certain patients are in delicate social or occupational positions,

and the assessment of their violent tendencies become urgent. Potentially violent patients who bear weapons such as policemen, or operators of motor vehicles require careful evaluation since they are capable of harm while working.

## WHO ASKS ABOUT THE PATIENT?

Clinicians may be asked to see a violent patient because another therapist or individual is frightened of him. This fear may be rational or irrational; strong countertransference elements come to play in the evaluation and treatment of violent patients (28). For example, anger at a violent patient may be handled by projection, and the clinician may distort the patient's dangerousness by defensively viewing him as very threatening. Colleagues can shunt violent individuals to state facilities, fearing involvement with them. In such cases, clinicians may have to deal with their colleagues' anxieties as well as with the patient himself. In a school setting teachers may ask about the need for medication for an aggressive youngster, and the appropriate treatment may be psychotherapeutic instead, and oriented towards pathological interaction between patient and teacher. Other members of the patient's family may request that he be seen.

Intense social pressure can be generated on the psychiatrist to evaluate a violent adolescent, senile patient, or psychotic individual. In some cases, the patient can advantageously be hospitalized on a voluntary basis so that he can be evaluated without urgency (29). Requests for evaluation of a violent patient usually have a *dispositional quality* and the clinician must avoid merely being an accomplice of the referring agent. A member of the legal or judicial profession may request data about a patient's potential for future violence, his tendency to repeat a crime or engage in further criminal acts. The response to such questions will require a formal report which will have a profound effect on the patient's future. This aspect of prediction will be discussed further below.

## WHAT PROBLEMS DOES HE HAVE?

The patient may fear, threaten, or act; he may be anxious about impending violent acts which he contemplates, or he may be brought to psychiatric attention because he has verbalized homicidal threats, or because he already committed a violent act. The violent patient may direct hostilities against property and people. With regard to property, he may destroy articles in his home, become involved in auto accidents, or commit arson. The violent patient may also be assaultive or sexually violent to children or adults (30, 31, 32).

### Typologies

The patient's pattern of violent behavior may reveal recurring, labile outbursts such as encountered in the Antisocial or Explosive or Passive-aggressive personality types. In contrast to these types of "undercontrolled" patients, the clinician may see patients who are more "overcontrolled" and who demonstrate brittle defenses against hostile urges (33, 34, 35). Such patients may demonstrate rare aggressive outbursts which are extremely violent in character. Finally, the patient may be overtly psychotic and harbor hallucinations which propel him towards violence to justify a delusional belief (36, 37, 38). A variety of studies have categorized murderers on the basis of motives or personality types. One worker has classified murderers as "normal, sociopathic, alcoholic, avenging, schizophrenic, temporarily psychotic, genocidal, homosexual, passive-aggressive, and sadistic" (39). Other authors have described "jealous" murderers (40) or murderers who are depressed (41), while another worker has listed (female) murderers as falling into groupings of "masochistic, overtly hostile violent, covertly hostile violent, inadequate, psychotic, and amoral" (42). Classifications of the above type must be reconciled with a formal psychiatric diagnosis.\*

\* A 1963 classification of violent offenders devised in California included the "culturally violent" who grew up in a subculture where violence is an accepted way of life; the "criminally violent" who will commit violence, if necessary, to gain some end, as in robbery; the "pathologically violent" who are mentally ill or who suffer brain damage; the "situationally violent" who under extreme provocation commit a rare act of violence; the "accidentally violent" who injure others accidentally; and the "institutionally violent" who commit violence while incarcerated. These classifications have subsequently been related to the type

## Dynamics

The chief complaint of the violent patient reveals something about the intensity and target of any anger that is present, the state of his inner controls, and the precipitants for his current crisis. Some patients present to the clinician vague fears of doing "something" terrible; no object of harm is verbalized. The diffuseness of the patient's anger in such cases may be defensive, and may prevent him from realizing the true aim of his anger which is usually directed at an ambivalently held object (3). For example, such patients may have intense mixed feelings about early parent figures which they cannot resolve. They adopt a brittle reaction formation against negative feelings for the parent which results in an exquisite sensitivity to any slur on the parent's name or character. The defenses against rage break down under appropriate psychological stress and lead to a pervasive anger which protects the patient from realizing the true source of his rage.

A core dynamic theme seen in violent patients is helplessness (45). Patients may defend against passivity, helplessness and underlying homosexual strivings by adopting a hypermasculine stance whereby they become aggressive as a way of preserving their masculinity. A child-battering patient may have a brittle reaction formation against her own helplessness; when she sees her children become ill and cry excessively this helplessness may become revived and her unexpressed rage may erupt into assaultiveness. In another patient, unresolved maternal abandonment can become reactivated in situations when a spouse leaves the patient. Morbid jealousy is well described as one dynamic of importance in certain violent patients, both psychotic and nonpsychotic, and in clinical experience is a frequent manner of presentation (36, 40, 46). Violent patients are seldom randomly or irrationally violent but respond with violence in response to dynamically significant stresses and situations.

of criminal career, occupational-educational history, and demographic features of offenders (43). Such classifications have not, however, found widespread usage to date.

Another group of workers have distinguished two groups of violent patients who markedly differ from each other in regard to diagnosis, course, prognosis, and family history. The first group of patients are distinguished by the early onset of violent behavior and include a number of individuals who can be diagnosed as "antisocial" or "explosive" personalities. The second group is more heterogenous and includes diagnoses such as paranoid syndromes, psychosis, or severe manic excitement. The prognosis in this latter group depends on the treatability of the primary disorder (44).

In the absence of accepted "typologies" of violent persons the Task Force has elected to identify those types of patients encountered by the psychiatric clinician (see above) and to discuss factors relevant towards understanding and treating their violence.

Murder followed by suicide, which was the case for one third of all murders in England from 1952 to 1960, is remarkable in the marked predominance of domestic type killings of spouse, child, or lover. Feelings of despair, as much or more than that of hostility, would seem to characterize these cases (47).

## Organic Aspects

Brain dysfunction such as epilepsy as a prime or contributing etiology in a violent patient's behavior has been described by some workers (48, 49, 50, 51) but questioned by others (52, 53). A patient with repetitive, paroxysmal outbursts of violence such as seen in an Explosive Personality may occasionally have an underlying seizure disorder of a psychomotor type (16, 45, 48, 54). Electroencephalographic (EEG) recordings may confirm a clinical diagnosis or may reveal nothing (45, 55). Neurophysiologic studies have shown that epileptogenic foci may be detected only with depth electrodes in patients with clinical psychomotor seizures and a normal surface EEG (56). Violence as a direct seizure manifestation is very rare (52, 57, 58, 59). Some workers have described hostile attacks which correlate with seizure EEG discharges (48, 50), but other workers have found that any violence that patients might show during a seizure disorder would be a function of attempts to restrain the patient or might result from some higher level of irritability which accompanied the interictal phase (52, 60).

Literature exists on the issue of whether or not psychomotor epileptics are more prone to violence than other types of epileptics (61, 62). This issue remains unresolved at the present time; all that can be said is that the vast majority of epileptics are not violent (63, 64, 65).

In those patients who are violent and are demonstrated to show epilepsy, attention should be paid to environmental and social factors which may play a role in the genesis of the aggressive behavior (52, 53).

Abnormal EEG patterns have been found to be of increased frequency in association with certain types of violence such as unmotivated murderers, psychotic murderers, and recurrently violent individuals (66, 67, 68). The casual nature of these findings is undetermined and the abnormal patterns could not be said to be specific for violence.

The term "minimal brain dysfunction" has more recently been used in conjunction with the psychological and neurological findings in certain young adult patients who are prone to impulsiveness and aggressiveness (69, 70). This clinical area deserves further study.



On the basis of prevalence studies of the proportion of chromosomal variants found in institutionalized populations, certain investigators suggested a link between the XYY variant and violence and aggression. Four recent and thorough reviews of the more extensive data now available in this area would all indicate, however, that such an assertion is presently not justified (71, 72, 73, 74). The earlier prevalence studies did not take into enough account such items as selection factors that might lead to institutionalization, as well as other social determinants (e.g., poor family background of the studied cases) which might have explained the findings.

## WHAT IS HIS HISTORY?

Questions about the violent patient's history should be frank and direct, much as though one were questioning the suicidal patient. The patient should be asked how much he has thought about violence, what he has done about it, what weapons does he have, what preparations he has made, how close has he come to being violent, and what is the most violent thing he has done. Corroborative data from a spouse, relative, or friend is sometimes necessary in problem cases.

A detailed anamnesis is essential for some determination of risk, treatment, and prognosis. The violent patient should be queried with regard to neuropathic traits indicative of violence, such as temper tantrums, enuresis, pyromania, and cruelty to animals; histories of such traits are frequently obtained from violent patients in different clinical settings (75). It should be noted, however, that the prognostic value of these traits is undetermined. The existence of psychosomatic problems such as dermatological conditions, gastrointestinal disorders, hypertension, or migraine gives a clue regarding the somatic expression of aggression and the conflicts which the patient has about expressing violent urges. School behavior, military adjustment and work history give clues to the clinician about the patient's ability to function under stress and cope with impulsivity. A thorough criminal history should be elicited tactfully, and corroborated, by formal police reports in certain high risk cases. A driving history gives clues regarding danger on the highway. The physician must inquire about lethal skills, ownership of weapons and any past use of these.

A social history frequently reveals that the violent patients have come from homes where there was previous violence or parental deprivation. Alcoholism and parental brutality are commonly noted in violent patients' histories (5, 76, 77). The prognostic value of these findings is uncertain, but may help the clinician in certain instances to better understand the patient's behavior. Inquiry should be made into the patient's current marriage, violence within that marriage and disciplinary attitudes toward children. A prenatal, birth, or early childhood history may reveal traumatic conditions conducive to brain dysfunction. In the developmental history, in-

quiries should be made about head injury, events suggestive of learning disabilities, motor clumsiness or hyperkinesis (69, 70).

Dynamic, situational, and organic factors are not mutually exclusive. A patient's history may reveal organic dysfunction which impairs his ability to deal with specific psychological stress.

## WHAT IS THE PATIENT LIKE NOW?

Delusional patients with violent fantasies should be taken seriously. Suicidal patients should also be carefully evaluated; in certain instances, they may be homicidal, and questions should be asked regarding this. The patient may consider, for example, killing his family prior to killing himself, and his hopelessness may signal serious risk. Borderline patients can internalize and externalize aggression freely in states of ego dissolution (78).

The mental status examination reveals some aspects of the patient's immediate potential for violence. Patients may present states of incipient psychosis and their fear of losing control over aggressive urges is prominent. Anxiety is often present in such cases. Delusional patients with violent fantasies should be evaluated carefully as they may be propelled toward violence on the basis of a thought disorder. Certain more schizoid or obsessive patients may report violent urges in a clinically detached way, without much anxiety. The calmness of these patients is defensive and such patients should be carefully evaluated. Patients with personality disorders such as those of the Explosive, Antisocial, or Passive-aggressive types must be asked questions about past acts of violence as they are apt to reveal little overt psychopathology.

The ability of the patient to translate agitation and anger into some degree of verbalization is important in assessing immediate risk. Sullen, negativistic and recalcitrant patients who refuse any degree of introspection remain capable of translating stress into behavior and hence require close follow up.

A prime determinant of the evaluation of the patient is the relationship which is established between the patient and the clinician. Trust and the formation of a therapeutic alliance are factors which are vital in assessing the patient's potential for violence and his willingness to change through treatment.

The above types of observations are derived from clinical material and experience. It should be emphasized that from the epidemiological perspective, no positive association has been demonstrated to exist between actual clinical diagnosis (e.g., schizophrenia) and crimes of violence (38, 79).

## WHAT SPECIAL EXAMINATIONS SHOULD BE PERFORMED?

Special examinations include psychological testing, when complemented with observational data and past history regarding violence. Projective portions of the test can assess impulsivity and hostility (80). Important dynamic themes may emerge. A variety of rating scales such as the Buss-Durkee or Schier-Cattell have been used to derive an objective measure of hostility and agitation (81). Organicity and impulsivity can be detected by certain tests, such as the Bender-Gestalt or Porteus Maze test (82). Other tests, the 4-3 MMPI profile and the Hand Test, are noted in the following section concerning predictions of violence.

The physical exam may demonstrate old scars resulting from knife or bullet wounds.

Physical tests include a neurological exam for brain dysfunction. When seizure disorders are suspected, repeated sleep EEGs are recommended (83).

## WHAT ARE PREDISPOSING AND CONTRIBUTING FACTORS?

### *Previous Mental Illness*

Whether the existence of psychiatric illness or past hospitalization can be considered a predisposing factor towards violence is very doubtful. Follow-up studies of released psychiatric patients have given mixed results. Some studies have found higher than expected rates for certain crimes-against-persons for such patients, e.g., robbery committed by men, aggravated assault committed by women, crimes against persons committed by functionally psychotic discharged male veterans (84, 85, 86). Other studies suggest different conclusions (87, 88, 89). The interpretation of these studies is complicated by methodological inadequacies. The statement of certain authors seem relevant: "We think it is fair to conclude that an individual with a label of mental illness is quite capable of committing any act of violence known to man but probably does not do so with any greater frequency than his neighbor in the general population" (90). Additional and more adequately designed studies are required to determine whether any subpopulation of the mentally ill are at any higher risk for violence.

### *Drugs*

Alcohol is a common contributing factor to violence, both in crime and automobile fatalities (91, 92). Alcohol may lead to what has been described as a state of "pathological intoxication", a transient psychotic-like condition sometimes accompanied by violent behavior (3, 16). Alcohol has been reported to activate psychomotor epilepsy (93). Other work indicates the drug to have no activating EEG properties when administered in a laboratory setting to men who complained of such violent "blackouts" (94). The interpretation of conflicting data of this type is perhaps one illustration of the importance of environmental setting in the pathophysiology of violence.

Isolated reports of violence associated with amphetamine use and usage of hallucinogens such as LSD has been reported (12, 95, 96). Barbiturates have been reported to enhance the expression of violence in aggressive youths (97, 98). One recent study indicates that among a large population of arrestees, barbiturate users had a

higher rate of aggravated assaults when compared with amphetamine and heroin users (99). The same study also found a greater concentration of arrest charges for non-drug users compared to drug users (irrespective of type of drug used) for serious crimes against persons, including criminal homicide, forcible rape, and aggravated assault (100). A weakness of this study was that alcohol use was not considered. Base rate data among general populations is necessary to resolve controversies in the area of drug use and violence.

There is much public concern linking heroin to violence. Available data (101, 102, 103, 104) does not, however, show heroin users to be over-represented and very probably they are under-represented, among those who accomplish violence. A difficulty in interpretation in the above types of studies depends upon whether or not the crime of robbery is included as a crime of violence. Including robbery as a crime of violence does increase the number of person crimes associated with heroin use (102, 104). It should be noted that the relationship between drugs, including alcohol, and violence is not simple. Needed to be considered is the social setting accompanying the use, the pharmacologic effects of the drug, as well as related behavioral or group patterns which might predate or be associated with the drug or alcohol consumption (105).

#### *Victims*

Victims should be considered contributing factors toward violent behavior (106, 107). Victims can subtly or very directly provoke violence. It is known that violence occurs more between people who are friends or acquaintances and much violence occurs within families. The fact that the patient has intimate acquaintance with his potential assailant is no deterrent to violence actually taking place.

#### *Weapons*

The availability of weapons is a contributing factor (108, 109). The possession of guns and ammunition, knives, and other weapons should be asked about by the clinician. The epidemiology of aggravated assault and homicide is very similar (27). The difference between the two may well lie in the type, lethality, and availability of weapons involved (110). The proportion of homicides due to firearms is increasing (111). In light of the problems relating to predictions of violence discussed below, a decrease in the availability of lethal weapons to potentially violent persons and to their victims should be regarded as a prime strategy in the prevention of violence. Not only should the clinician ask about the availability of weapons to the patient, but also the availability of weapons to the patient's potential victim.

#### *Medical and Organic Conditions*

Another contributing factor to be considered is premenstrual tension in women, a period in which various emotional outbursts, including those of a criminal and aggressive type, have been noted (112). In one study, nearly one-half of all crimes (49%) were committed by women during menstruation or in the premenstruum; a correlation between "bad behavior" in prison and menstruation was also noted (112). Other endocrine concomitants of aggression, hostility and violence, such as testosterone levels, have been studied (113, 114, 115). No definite conclusions can be made regarding their predisposing role in violent behavior in man. Other organic factors have been noted in association with violent behavior. For example, tumors of the limbic system (116, 117, 118), normal pressure hydrocephalus with dementia (119) and, as noted above, certain encephalitic disorders (13, 14) or metabolic conditions such as hypoglycemia (120) have been related to aggressiveness. There is insufficient information which would allow the clinician to reliably sort out patients with these conditions from other aggressive patients; however, these differential diagnoses should be entertained especially in patients manifesting medical or neurological abnormalities and demonstrating behavior quite out of character with pre-morbid functioning or in patients whose violence or aggressiveness would be quite untypical for the age group concerned. The type of violence or aggression described in these "organic" cases is frequently of a primitive sort, e.g., reports of biting or scratching (13, 117, 119).

#### *Social Environment*

The clinician should look not only at the violent patient, but at the environment. Work regarding the body buffer zone would suggest that spatial overcrowding might be a precipitant of violence in predisposed individuals (121). Certain situations are conducive to violence and create role demands whereby clues are provided and violence is sanctioned or elicited. In one study, volunteers acting as prison guards very quickly became aggressive toward other student volunteers acting as prisoners (122).

Whether or not patients in mental hospitals are dangerous to the employees and other patients in the hospital was studied (123). The author, reviewing assaults in Swedish hospitals, concluded that employees and patients in mental hospitals run only a small risk of being seriously injured by patients and that exemptees from legal punishment and patients already labeled as "dangerous" were apt to be more physically dangerous to others. Other conditions involving risk were male sex, diagnosis of schizophrenia, recent admission,

unfamiliarity with the language, understaffing of the ward, and the mixing of young aggressive patients with older, feeble patients. The various social and psychological factors on a ward setting and their interaction which may have led to violence have been retrospectively studied for assaultive psychiatric patients (124).

This last cited work is illustrative of the multiple factors that might need to be considered in assessing the "contributing" factors or social precipitants to violent behavior. For example, it is noted that the following considerations associated with hospitalization might, in a given instance, tip the scales and produce a violent response: patient boredom, the feeling of helplessness of the patient before hospital authorities, the provocation of other patients, overcrowding, or staff "abuse" of the patient of a subtle or psychological sort. In the cases discussed, the use of psychotropic drugs, the role of intoxicants and possible provocation by victims is also considered. The author concludes, however, that the increase in assaultive behavior during a certain period in his hospital was due primarily to racial tensions and the social climate at that time, even though the assaultive patients were all psychotic and nearly all suffered from significant paranoid feelings.

## WHAT CAN WE OFFER THE PATIENT?

### *Immediate Management*

In the acutely agitated stage, the violent patient benefits from measures which restore a sense of mastery over impending loss of control of violent urges. Patients who verbalize fears of becoming aggressive must be told that the clinician will protect them from becoming dangerous. Agitated, angry, and potentially violent patients respond to verbal acknowledgment that anger is an unpleasant affective state. Verbal catharsis is important and medications such as the phenothiazines or benzodiazepines may be offered the patient (45). Hospitalization may also be offered certain patients who are afraid of becoming violent; violent patients, like suicidal individuals, issue a "cry for help" which should be responded to by the setting of limits. The clinician may encounter agitated and aggressive patients who do not respond to verbal measures and refuse medication. Chemical restraints, though always preferable, may be ineffective and physical restraints, humanely applied, may be necessary (125). To physically subdue a violent patient requires a team effort of sufficient staff personnel and demonstration of such personnel is often in itself sufficient to calm a patient. It should be remembered that simple sedation or restraint is not the end of treatment of a violent patient. The clinician should determine the origins and nature of any psychopathology and not assume that his job is done once the patient is quiet and no longer belligerent.

### *Continuing Treatment*

In the non-acute stage, treatment is more diverse. A large literature exists on the various psychotherapeutic treatments of psychopathic, criminal, and delinquent populations of patients; unfortunately, the patients described in various reports are not necessarily violent or aggressive and there is little literature which discusses the treatment of the violent patient specifically. Several reports have described individual psychotherapy with the violent patient or patients judged dangerous to society (45, 126, 127, 128, 129), group psychotherapy with such patients (130, 131, 132), milieu approaches (133, 134), and behaviorally-oriented approaches designed to bring about more constructive and socially acceptable conduct (135).

The clinical principles underlying the individual and group psychotherapies are relatively straightforward. The exact approach taken will depend upon the clinician's conceptualization of why the patient is or might be violent, and how this problem might be remedied. For example, it may be helpful to teach the patient to tolerate depressive affect and, via fantasy, to experience the feelings that will be the probable outcome of his future behaviors (126). Aggressive acting-out patients are, however, difficult to treat, and have problems in establishing continuing relationships and in reality testing. Limit setting is necessary. Without limit setting, therapy may be impossible (129). Whether the approach is individual or in groups, a psychotherapeutic stance with a here-and-now problem solving orientation is recommended.

The principles of therapy given in the above reports make clinical sense but adequate proof of their worth in decreasing future violence is not available.

A considerable literature is developing relating behavior approaches and learning to the modification of aggressive behaviors and affects (136, 137, 138). Treatment approaches may depend upon an initial close analysis of environmental reinforcers which may be promoting or decreasing aggressive behaviors, such as "hitting" in family groups (139). Programs to train parents of aggressive children in the use of behavioral techniques to reduce aggression appear particularly promising (140). The behaviorally-oriented treatments have been more adequately evaluated with respect to their efficacy than have the more traditional "psychotherapeutic" approaches (140).

Behaviorally-oriented treatments have the advantage of addressing, more systematically, the possible environmental precipitants of aggression. In terms of the personal and behavioral characteristics of the interpersonal milieu, for example, aggression begets aggression (141). An accurate history of when violence or aggression has occurred and the environmental stimuli which may have precipitated it may enable the clinician to recommend changes in the environment rather than directing the treatment efforts towards the violent patient per se.

Institutional and other treatments available for violent prisoners have recently been reviewed (142). There are favorable follow-up reports in the literature citing recidivism rates as a result of such institutional treatments (134, 143, 144). These published reports, however, have some rather severe methodological shortcomings (145). Treatment in these institutions is usually of the indeterminate type and consists of group and or individual psychotherapy and

milieu behavioral approaches (promotion to tiers on the basis of behavior). The constitutionality and appropriateness of such institutions, especially those with an indeterminate sentence feature, is a matter of continued debate (146, 147, 148, 149, 150, 151).

### *Biological Treatments*

The literature on the pharmacologic treatment of aggression suffers from the fact that most of the studies have shown one or another medication useful for such diverse patient types as neurotic patients with aggressiveness, psychopaths, manic patients who are combative, assaultive psychotic patients, or delinquents. Few studies have tested the effects of drugs on well defined target behaviors of violence, in contrast to extensive work in the areas of depression or anxiety. The methodological problems in assessing drug efficacy in clinical aspects of human aggression have been recently described (152). Minor (benzodiazepines) and major (butyrophenones) tranquilizers have been advocated for agitated and aggressive patients (153, 154, 155). Additional and more adequately controlled evaluation of the use of these drugs are needed.

A recent controlled study has reported lithium to be of benefit to violent prisoners in reducing aggressiveness (156). Amphetamines administered to children with the hyperkinetic syndrome may result in a decrease of aggressive behavior, noted in conjunction with the other behavioral effects of the drug (159). Anticonvulsants, sometimes advocated for impulsive and aggressive patients (158) have not in well controlled studies been shown to be of value in comparison with placebo in, for example, the reduction of childhood temper tantrums (159) or the curtailment of disruptive or aggressive behavior of delinquents (160). Newer hormone and anti-hormone agents (progestational analogs) are being tested on in the modification of sexual and aggressive behaviors (152, 161, 162).

Despite a paucity of rigorous data supporting the efficacy of various drugs in the treatment of aggression, the clinician should still consider empirical trials of drugs for patients are refractory to one or another form of medication when the situation warrants psychopharmacologic treatment. Literature (163) regarding the rationales, and uses of indications, various drugs in the treatment of aggression should be consulted.

Neurosurgical procedures such as temporal lobectomy (51), amygdalotomy (164, 165, 166) and hypothalamotomy (167) have been reported to be of value in decreasing the aggressiveness of certain epileptics and non-epileptics with severe behavior disorders. Much public controversy has recently been focused on such pro-

cedures due to ethical concerns and a need for more adequate long-term follow-up studies of patients undergoing such operations (168). Evaluation of the efficacy, possible indications, and social issues surrounding these procedures is currently under study by separate task forces of the American Psychiatric Association (Task Force on Psychosurgery), National Institute of Mental Health, and National Institute of Neurological Diseases and Stroke. (Part I of the NINDS report is now available under the title *Brain Research and Violent Behavior*. Arch. Neurol. 30:1-35, 1974.)

### Prevention

In the area of preventive treatment experimental programs have been devised to intervene in domestic arguments which have a high potential for violence. A New York study, for example, has reported favorable preliminary results in decreasing intra-familial violence by intervention from a specially trained police unit (169). Non-medical approaches and continuing efforts in this direction are being advocated by others (170, 24).

## WHAT CAN WE PREDICT?

### *A Conceptualization of "Dangerousness"*

We elaborate in greater depth on the issue of prediction, since this issue arises so commonly in the assessment of the violent patient. The question usually is: What is the potential for future violence? Is this man "dangerous"? It is the opinion of the Task Force that such judgments are fundamentally of very low reliability, much as would be the prediction of "altruism" or other human behaviors. Furthermore, clinical judgments often have long term implications for the persons involved and the greatest caution is warranted. The following problems or issues require special comment.

Predictions of dangerousness, like those of suicide, are, with few exceptions, predictions of rare or infrequent events. For example, the clinician might be fairly confident when evaluating a parent whose past behavior has rather *clearly* and *repetitively* been that of injuring his own children, that such behavior will recur. Knowing that both the patient's two year old child and his new baby show clear evidence of abuse (e.g., burn scars, radiologic evidence of bone fractures), knowing that such episodes occur especially when the patient has been drinking, knowing that such drinking is still occurring (e.g., the two year old has been brought to the emergency room twice in the last week where the patient was noted to have alcohol on his breath), etc., the clinician then might be fairly confident that such abuse will continue. Or, in the instance of a man who can find sexual release only in setting fires, the knowledge that fires have occurred and are occurring regularly, would allow the prediction that such behavior will recur (171). The high degree of reliability of such predictions in these type cases is a function of knowing that the base rates of such behavior are very high. It would not be necessary that the patient be "mentally ill" or suffering from a psychiatric disorder in order to predict that the behavior will recur.

With respect to most predictions of violence, however, the very opposite would be the case. The likelihood of the expected behavior such as violation of parole by a released prisoner whose previous crime was one of violence (172) or the possibility of serious assault being committed by a released mental patient (88) would be very

slight. This means that even if the characteristics of such future violent patients could be specified with fairly great accuracy, predictions based upon such characteristics will identify far more "false positives" than "true positives" (172, 173, 174). Even if an index of violence proneness could be developed so as to correctly identify prior to release fifty percent of those individuals who will violate parole by committing violent offenses, the actual employment of such an index would identify eight times as many "false positives" as "true positives." This means that eight of the nine persons retained in prison as a result of application of the index would not have committed such offenses if released (172). Statistically the greatest accuracy is achieved by designating the smallest number of persons as likely to commit future violence. For further discussion of this very important issue, the clinician should consult the classical paper dealing with the prediction of the low rate behavior of suicide (175).

The category "dangerous" or "dangerously violent" is applied too indiscriminately. In ordinary discourse the term "dangerous" has multiple usages or meanings which vary depending upon the setting (use of the term by the lay public, the clinician, and in legal settings). With respect to the use of the term "dangerous behavior" in a legal setting (release from a mental institution, or release under supervision following a finding of not guilty by reason of insanity) the following meanings of the term "dangerous behavior" might be considered. "Dangerous behavior" might include only the crime for which the insanity defense was successfully raised; all crimes; only felonious crimes (as opposed to misdemeanors); only crimes for which a given maximum sentence or more is authorized; only crimes categorized as harmful, physical or psychological, reparable or irreparable, to the victim; any conduct, even if not labeled criminal, categorized as violent, harmful or threatening; any conduct which may provoke violent retaliatory acts; any physical violence towards oneself; any combination of these (176). For purposes of this report, it should therefore be remembered that violence has been defined as acts that produce physical harm or destruction, and that it is these sorts of acts that the clinician wants to predict. For example, in the case of violent offenders, the task is to determine the likelihood for violent recidivism, not just any recidivism at all. As the above list indicates; however, the definition of what is "dangerous behavior" has no unanimous acceptance by the various persons who are called to deal with violent patients such as physicians, mental health administrators, legal personnel, and the lay public.

Many state mental health laws regarding involuntary commitment (177), as well as the Model Penal Code (178) and the Model Sentencing Act (179) may in operation have the paradoxical and un-

toward effect of equating dangerousness with mental illness. The Model Sentencing Act, for example, provides that offenders be considered "dangerous" for purposes of sentencing, if and when, in addition to committing a violent crime other than first degree murder, "the court finds that he is suffering from a severe mental or emotional disorder indicating a propensity towards dangerous criminal activity" (179). Psychiatrists and behavioral scientists are expected to aid in the diagnosis of the mental disorder though the judge establishes the relationship between the mental disorder and dangerousness. The implications of this approach are quite unfortunate. Not all dangerous persons, even those who might be feared an appreciable risk for future violence, are mentally ill nor should they be so labeled in order that they might be found dangerous. Dangerousness must not be equated with mental illness, nor should mental illness be equated with dangerousness.

With few exceptions the lack of follow-up studies among persons who threaten violence prevent definite statements about their actual violence potential. In one reported study of 100 persons who threatened violence and who were followed for 5-6 years, it was shown that three persons actually did commit murder while four others committed suicide (180). The future dangerousness of persons who threaten violence would appear to be as much to self as to others (1, 180, 181). In particular, attention should be given to the suicidal potential of such persons and to any considerations that they might themselves become the victims rather than the perpetrators of violence (181).

Psychiatrists, in order to be safe, too often predict dangerousness, especially in the case of the mentally ill offenders. Absence of treatment resources, administrative oversights, and excessive reliance on conservative release policies have rather clearly resulted in severe injustice being done to such persons (182, 183).

It is too often forgotten that dangerousness is an attribute not only of persons but of situations and environmental factors; more correctly, dangerousness should be regarded as an outcome of the interaction of these various factors (184, 185) and all must be attended to when considering the "dangerousness" of an individual.

This point, that of "interaction" between personal characteristics and situations cannot be stressed strongly enough. More recent legal standards regarding "dangerousness" stress such factors as the immediacy of harm or the likelihood of harm that must be present if a person is to be found "dangerous" (186). These factors, immediacy of harm, likelihood of harm, as well as other such factors, e.g., who might be harmed, how much harm might be done, etc. would very clearly be a function of the potentially violent person's future or



expected environment and not merely a function of any existing psychopathology.

#### *Decision Rules and Issues of Social Policy*

Another very important point with respect to dangerousness relates to an area of behavioral science perhaps more familiar to sociologists than to clinical mental health personnel. This is the area of decision rules, types of error, and their consequences for medical judgments (184, 187).

Decision rules are guidelines for the handling of uncertainty. Such guidelines vary within professional settings and disciplines. The basic legal decision rule in criminal law states, "When in doubt, acquit" (184). In medicine, however, where the consequences of overlooking illness may be somewhat different than the legal setting, the decision rule would lean much more heavily towards avoiding any harm consequent to missing illness than to avoiding harm consequent to suspecting it when it is absent. The medical decision rule, though certainly warranted with respect to various medical conditions, may lead to many problems when applied to issues involving judgments of dangerousness. Depending upon the setting (medical or legal), the psychiatrist, in dealing with a patient whose violence potential is uncertain, might employ a different decision rule. For example, it would be appropriate to employ the medical decision rule in deciding to phone or check on a despondent and threatening patient or perhaps in predicting a "violent" outcome when advising a disturbed alcoholic outpatient of the advisability of brief and voluntary hospitalization. Legal settings (e.g., the involuntary commitment of a threatening patient brought by the police to the emergency ward, or for the purposes of the court, the "diagnosis" or "management" of offender-patients) involve a legal decision rule. These judgments clearly involve issues of a non-clinical type. They are issues relating to community tolerance of various behaviors felt to be dangerous, the definition of what is "dangerous" behavior and the specification of measures that are felt to be appropriate to deal with such behavior. These are essentially issues of social policy (184, 188). In legal settings the clinician would be expected to abide by and be knowledgeable of legal rather than medical decision rules. Determining cut off points as to what numbers of "false positives" are acceptable to the community in allowing the retention of persons feared to be "dangerous" are socio-legal judgments and cannot and should not be made by the individual clinician (171, 189).

*"Dangerousness" is neither a psychiatric nor a medical "diagnosis".*

The implications of the above points for the clinician who is attempting to assess a patient's potential for violence are as follows.

#### *Clinical Issues*

Predictions of "dangerousness" are judgments of a "relative risk" sort, statements of comparative probabilities that are usually quite low. All that may be reasonably concluded in most cases is that in the clinician's experience, and from his knowledge of the literature,\* some persons are at a comparatively higher risk for future violence than are others. For example, a recent study determined that parolees with a history of previous violence followed over a fifteen month period of release were about three times more likely to offend again with a violent offense than were parolees without such a history (172). Other factors also associated with an increased probability of violent recidivism were previous psychiatric referral for evaluation of violence potential, history of multiple offenses, violent commitment offense, Mexican-American ethnic grouping, and severe alcohol problem. Noting or combining these factors for individual case prediction was found to be of quite limited utility. The overall rate of violent recidivism for the entire group of parolees (the base expectancy rate) was only 2.4%. For the men with a history of previous violence the rate was 5.2%. Such predictions for the individual case would therefore continue to identify large numbers of "false positives" even when sophisticated statistical procedures are employed. The authors also noted the additional problem in such judgments relating to the prediction of events which may not come to attention or be recorded by the authorities.

Other recent studies relevant to the prediction of individual violence should be noted. In a Philadelphia study of a sample of about 10,000 boys followed from age 10-18, severely recidivistic offenders (6.3 percent of those who offended) accounted for a majority of all assaults noted (190). Research regarding "dangerous" patients released from a correctional hospital found that only 2.7% of the orig-

\* The clinician who deals with violent persons should be aware that much of the literature relevant to this area is not typically found in American psychiatric journals. For example, the British Journal of Psychiatry includes articles dealing with psychiatric and medical issues of relevance to violence. Some other important journals to be consulted include Crime and Delinquency, Journal of Research in Crime and Delinquency, Crime and Delinquency Literature, The Journal of Criminal Law and Criminology, Criminal Law Bulletin, Law and Society Review, The Bulletin of the American Academy of Psychiatry and Law, The Journal of Psychiatry and Law, International Journal of Offender Therapy, and Comparative Criminology, Corrective Psychiatry and Journal of Social Therapy, and Social Problems. Federal Probation, which may be obtained free of charge from the Federal Bureau of Prisons, contains annotated reviews of important relevant articles from journals of sociology, psychology, psychiatry and criminology.

inal sample were ultimately returned to the hospital (191). These few men tended to be younger and to have a higher score on a legal dangerousness scale (a quantitative scale of the seriousness of criminal history) compared to patients not returned. However, all the men returned were not returned because of actual violent behavior. Application of scale scores to the above sample also would have resulted in over 90% of the men being misclassified as dangerous. Unfortunately, this is the state of the art. Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or "dangerousness." Neither has any special psychiatric "expertise" in this area been established. Additional studies are needed with respect to determining present dangerousness, and if a person is "dangerous," for how long, and as a result of what factors does such a state persist. For purposes of prediction severely recidivistic offenders might be considered more dangerous than non-recidivistic offenders (at greater risk for repeated violence) but the actual level of probability remains small. As noted above, it is the opinion of the Task Force that judgments regarding what sorts of probabilities for violence could be considered as indicating "dangerousness" should be a matter of social policy and societal judgment and not a matter of clinical determination.

Clinicians should also be familiar with a number of retrospective published reports which identify clusters of dynamics, symptoms, or other historical features of violent patients, particularly those who commit homicide. Filicide has been linked to depressed, suicidal mothers who are strongly overidentified with an "overloved" child (192). Homicidal juveniles have been reported to show acute mood shifts, "cries for help," use of drugs, object losses, threats to manhood, somatization, an emotional crescendo, and homosexual threats (193). Murderers have been examined and found to show intense ambivalence and inability to detach themselves from a specific relationship (194). Impulsive homicides have been committed by emotionally shallow individuals with severe personality disorganization (5). Recognition of these patterns may suggest to the clinician the advisability of overnight hospitalization or close follow-up. But such clusters are undoubtedly common within the general population never seen by psychiatrists, and could not be said to establish factual dangerousness. Other workers have summarized information which suggests that certain violent patients with psychiatric disorders exhibit stereotypic behavior which may be predictable upon recurrence of the psychiatric disorder (44). Clinical reports have to a remarkable degree (195) and with few exceptions (124) been addressed to the problem of homicidal as opposed to other assaultive patients.

### Legal Settings

The role of the psychiatrist in legal proceedings or settings relative to judgments about future dangerousness is controversial (e.g., pre or post competency to stand trial proceedings, following findings of not guilty by reason of insanity, pre-parole, or prior to release from indeterminate sentence status) (196). In the assessment of dangerousness clinical scales have been described which lack accompanying studies of predictive validity (197). Empirical studies of in-prison behavior have yielded inconclusive or contradictory results (113, 198, 199). One follow-up study of dangerous sex offenders compared post-release behavior of prisoners released by the court but still felt by clinicians to be dangerous with another group of treated patients felt to be no longer dangerous (32). The treated patients did better in the community and were less dangerous for as long as they were followed. The authors of this study find reason for optimism. Such studies are few, however, and the methodology of the study is open to criticism on the basis of an unequal period of follow-up with respect to the study groups (200).

Two opinions of these workers though seem relevant, and in the opinion of the Task Force would apply equally well to both criminal and non-criminal patients, namely: "Dangerousness seems to be a result of multiple forces . . . There is no single test for it," and "No tests or psychiatric examinations can dependably predict a probability of dangerous behavior in the absence of an actual history of a severely violent assault on another person" (32).

It is known that crimes of violence, homicide, aggravated assault, rape and robbery are more likely committed by younger male persons and that recidivism for violent crimes is consistently less than that for property crimes (201). The more serious the initial crime committed the less the chances it will be repeated (202). Recidivism for crimes such as murder is very low, only .5 percent of released homicides offenders murder again (203). Older first offenders would appear to be better risks than younger multiple offenders. Attention to such factors requires little psychiatric expertise.

With regard to the mental state, it has been noted that "The essence of dangerousness appears to be a paucity of feeling concern for others. The potential for injuring another is compounded when this lack of concern is coupled with anger" (32). Such an approach, though perhaps clinically useful with respect to character assessment, and receiving some additional support from a second rather unusual study (204), does not emphasize enough the environmental or situational determinants of dangerousness which may or may not be present in future settings (204). The presence of psychosis would not appear to be useful for prediction unless "dangerousness" can al-

ready be determined from other criteria such as actual previous behavior. Given such behavior, severe psychosis is felt by some to increase the risk (32). This opinion requires better empirical confirmation. As noted above, follow-up studies of patients discharged from psychiatric hospitals, have given mixed results, but none would indicate any likely potential for violence on the basis of psychiatric disorder. These findings are confirmed by other follow-up studies available for patients discharged from special hospitals, e.g., post release from not guilty by reason of insanity charges, sexual psychopathy confinements, confinements for incompetency to stand trial (205, 206).

#### *Psychological Tests*

Certain psychological tests, when used in conjunction with clinical and historical material, may furnish clues for prediction but cannot be unduly relied upon. Among these are Megargee's MMPI scale for overcontrolled hostility (34), the 4-3 MMPI pattern of Davis and Sines (207, 208), and Sarbin, et al's., modifications and additions to the Wagner Hand Test (209). These tests require further validation in the prediction of future violence.

In summary, the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists or any other professionals to reliably predict future violence is unproved. Close monitoring, frequent follow-up, and a willingness to change one's mind about treatment recommendations and dispositions for violent persons, whether within the legal system or without, is the only acceptable practice if the psychiatrist is to play a helpful role in these assessments of dangerousness.

## HOW DO WE COMMUNICATE OUR FINDINGS?

What the psychiatrist writes, instructs or testifies about violent persons may be critical to the patient's future outcome. Such reports, whether verbal or written, must be of high quality. Whatever the setting or reason for the report, conclusory labels are of little help to anyone (e.g., this man is "schizophrenic" or this man is "dangerous"). In fact, such labels may be very misleading and should be avoided. What is wanted are descriptions of how specifically the person has been violent, and how and under what circumstances might he be expected to be violent in the future. What personal or mental stresses, environmental or situational factors appear to increase a likelihood of future violence? The psychiatrist should present, as well as he understands it, and without the use of jargon, the dynamics of any violence that has occurred. He should discuss what has been done so far to treat or manage the patient, and what might be done in the future to avoid the repetition of violence. Short term recommendations are always preferable to recommendations for long term treatments and dispositions.

These matters require follow-up, not pronouncements. The physician must determine how his report will be used, by whom and what specifically the question is; he should not merely perform a psychiatric examination. Sources of data and reliability must be clearly indicated. The extent of patient cooperation, what the patient was told about its purposes, and its level of confidentiality should be clearly specified. The physician should routinely request that he receive information about the uses of his report, resulting disposition, and treatment of the patient.

## WHAT DISPOSITION AND FOLLOW-UP DO WE MAKE?

Violent patients sometimes require hospitalization. If at all possible, such hospitalizations should be on a voluntary basis. Rarely, involuntary civil commitment may be warranted (171, 210, 211). Decision-making in this difficult area requires specifying the degree of immediate risk and the type of risk which the patient presents to others. It is equally important that the physician assess the actual benefits and treatments that the patient will receive as a result of hospitalization, the length of hospitalization that might be expected or warranted and whether or not less restrictive forms of treatment might be equally feasible. The involuntary handling of violent and "dangerous" persons, whether such persons are mentally ill or healthy, involves concerns and issues that go considerably beyond the framework of clinical practice, and which issues are a matter of considerable societal concern. An informative discussion of the issues with respect to civil commitment and the balancing of risks versus benefits should be consulted by all who deal with violent persons (171).

Follow-up care of violent persons is essential. For many such persons it is the major "treatment" that the physician has to offer. His continuing interest and availability may help to avoid tragedy for the patient or for others. Even in consultation work, single or "one shot" examinations should be very much discouraged. Repeat examinations allow the clinician to assess the patient in more than one environmental setting and aid in the distinguishing of situational contributions from characterologic factors.

Follow-up continues to be the vital way in which the physician may educate himself and help his patient.

## SUMMARY AND CONCLUSIONS

Violent behavior results from complex interactions, psychological, social, cultural, environmental-situational and biological factors. Despite various attempts at classification, there exists no adequate typology of violent persons. In this report the Task Force has identified a number of groups of persons who may be psychiatric patients and who are of clinical concern to psychiatrists. We have reviewed certain aspects of the approach to the patient, what facts need to be gathered or noted, and what are some of the treatment modalities under current study. For purposes of explanation and management a multicausal framework must be kept in mind. The immediate management of such patients, in terms of limit setting, judicious use of psychopharmacologic agents, and a psychotherapeutic approach is clinically apparent. Longer term treatments in the prevention of future violence are not well established, though certain behavioral approaches appear promising. The clinician should not regard the prevention of future violence as within his proven capability. Similarly, we have discussed at some length another area where a great deal of "negative" information rather than neat guidelines is available, namely the prediction of future violence. It has been noted that "dangerousness" is neither a psychiatric nor a medical diagnosis, but involves issues of legal judgment and definition, as well as issues of social policy. Psychiatric expertise in the prediction of "dangerousness" is not established and clinicians should avoid "conclusory" judgments in this regard.

From the clinical perspective perhaps the most valuable "treatment" modality that the psychiatrist has to offer is his continuing interest and availability to the patient. Patients who threaten or who have accomplished violence are difficult to treat, but the psychiatrist will continue to confront such patients in a variety of settings. He should therefore be appraised of what is currently known about such patients and their management.

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## CONFIDENTIALITY AND THIRD PARTIES

A Report of the APA Task Force on Confidentiality as It Relates to  
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