# Victims and Families of Violent Psychiatric Patients

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**Previous studies that have addressed the issue of violence committed by psychiatric patients have primarily been concerned with determining the incidence of violence and defining the characteristics of the offenders. This study addresses the issues of who are the likely victims when psychiatric patients are violent and what are the situational and interpersonal factors that relate to this violence. Medical records of 300 patients admitted to a locked university-based short-term treatment unit were extensively reviewed to assess the presence or absence of preadmission violence. Fifteen percent of the 300 patients assaulted another person within two weeks prior to admission. Fifty-four percent of the violent patients assaulted a family member. There were no differences in demographic characteristics between violent patients who assaulted a family member and violent patients who assaulted someone outside the family, except for with whom the violent patient was living at the time of the assault. Patients who assaulted a family member were significantly more likely to live with family than were patients who assaulted someone outside the family.**

**Sixty-four percent of the patients who assaulted a family member planned to return home to their family after discharge. We identified four types of families within which patients assaulted family members: multiple mental illness families, multiple violent families, delayed help-seeking families, and prompt help-seeking families. The implications of our findings for prevention of future violence are discussed, including the issue of outpatient civil commitment.**

Previous studies that have addressed the issue of violence committed by psychiatric patients have primarily been concerned with determining the incidence of violence[1-8] and defining the characteristics of the offenders.[1-3,9,10] Fewer studies have focused on the victim of attack by psychiatric patients. The few studies that have addressed the victims have suggested that family members are the most likely targets.[11-13] In addition, contemporary views of violence stress the importance of conceptualizing violent behavior as a function of the interaction of personal and situational variables.[14,15] Yet, studies of violence in psychiatric patients have neglected the situational factors such as the interpersonal context in which such violence occurs.

This study will address the issue of who are the likely victims of violence when it is committed by psychiatric patients in the two weeks prior to their psychiatric hospitalization, and what are the situational and interpersonal factors

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that relate to this violence. We will first describe the characteristics of our patient population and the incidence of violence preceding admission to compare our patient population with those reviewed in previous studies. We will then examine the characteristics which differentiate those patients who assault family members from those who assault someone outside their family. We will then look at the discharge plans for patients who had assaulted family members and will examine specific types of situations which are associated with family violence.

For the purposes of this study, violence is defined as a physical attack on another person, including hitting, pushing, choking, etc. This definition is consistent with that used in the studies of Tardiff and Lagos.[1,2,9,11]

## Method

This study was conducted on a locked university-based short-term treatment inpatient psychiatric unit serving a largely middle class urban catchment area with many intact families. As a part of a previous study comparing the rate of violence preceding admission during different years, 150 unduplicated admissions were randomly selected for each of the years 1973 and 1983. For this study, we pooled the data from the 300 charts. In order to justify this pooling of data, we employed log linear models for contingency tables to test whether year was a confounding variable.[16] Year was found not to be a confounding variable for any of the comparisons between violence and the demographic variables used in this study, suggesting that pooling of data from the years 1973 and 1983 was justified.

The medical records of each of these 300 patients were reviewed for the presence or absence of violent attacks against persons which had occurred within two weeks prior to admission. If violence had occurred, the victim of violence was noted. Charts were also reviewed for demographic information including sex, age, ethnic group, marital status, education, occupational status, and discharge psychiatric diagnosis using ICD-9-CM. Educational and occupational data were combined to yield a measure of social class ranging from I (highest) to V (lowest) on the basis of Hollingshead's formula for the Two Factor Index of Social Position.[17] Data were also gathered regarding with whom the patient resided prior to admission and with whom the patient planned to live after discharge.

Charts were initially reviewed by six experienced clinical staff members of the inpatient unit including a clinical psychologist, a licensed clinical social worker, three clinical nurse specialists, and a psychology graduate student. Before beginning the chart reviews, all of the raters completed training in ratings of violence to a criterion interrater agreement of .80 as measured by kappa.[18] When patients were found who committed violence against family members, these patients' charts were extensively rereviewed by us to gather more specific data about the situations in which violence occurred.

## Results

***Statistical Data*** The demographic characteristics of the entire 300 patients were as follows: 45 percent were female and 55 percent were male; the mean age was 37.3 years (SD = 15.8, range, 18 to 92 years); 68 percent were Caucasian, 14 percent were black, 11 percent were Asian, and 7 percent were of other ethnic backgrounds; 68 percent were in the lowest social class (Class V of Hollingshead's Two Factor Index of Social Position); 51 percent were single, 17 percent were married or living together, and 31 percent were separated, widowed, or divorced; 57 percent resided with family, and 43 percent did not live with family. The entire 300-patient sample included these diagnostic groups: schizophrenic disorders (42 percent), affective disorders (23 percent), personality disorders (10 percent), substance abuse disorders (6 percent), and other diagnoses (11 percent). Fifteen percent (n = 46) of the 300 patients assaulted another person within two weeks prior to admission.

When we looked more closely at the victim of the violence, we found that 54 percent (n = 25) of the violent patients assaulted a family member. These 25 patients directed 29 assaults toward family members, of which 34 percent (n = 10) were directed toward a parent, 24 percent (n = 7) toward a spouse, 21 percent (n = 6) toward a sibling, 10 percent (n = 3) toward a child, and 10 percent (n = 3) toward a niece or nephew.

We utilized the chi-square statistic to identify demographic characteristics which might differentiate assaultive patients who assaulted a family member (n = 25) from assaultive patients who assaulted someone outside the family (n = 21) (Table 1). No significant associations were found between the victim of violence and any of the demographic variables (sex, age, ethnic group, marital status, social class, or diagnosis), except for with whom the assaultive patient was living at the time of the assault. Patients who assaulted a family member were significantly more likely to live with family than patients who assaulted someone outside the family ($\chi^2 = 8.56$, $df = 1$, $p < .03$). Nevertheless, 55 percent of the assaultive patients who assaulted someone outside the family also lived with their families and yet did not assault family members.

We then looked at the discharge plans for the patients who had assaulted family members. Of the 25 patients who assaulted a family member, 64 percent (n = 16) planned to return home to their family after discharge, whereas 36 percent (n = 9) planned to live elsewhere.

***Descriptive Data*** Next, we reexamined the records of the patients who assaulted family members to see if we could discern the context of the violence and contributory factors within the family.

We developed a classification system based on a set of inclusion and exclusion criteria (Fig. 1) which allowed us to classify each assaultive patient's family into one of four family types (Table 2). The rationale for this classification is that different treatment strategies would be

**Table 1**
**Characteristics of 25 Patients Who Assaulted Family Members and 21 Patients Who Assaulted Someone Other Than Family**

| Characteristic | Family Victim (N = 25) | | Other Victim (N = 21) | | Total (N = 46) | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Sex | | | | | | |
| Female | 8 | 32 | 10 | 47 | 18 | 39 |
| Male | 17 | 68 | 11 | 52 | 28 | 61 |
| Age | | | | | | |
| 18–30 | 7 | 28 | 11 | 52 | 18 | 39 |
| 31–40 | 9 | 36 | 4 | 19 | 13 | 28 |
| 41–50 | 1 | 4 | 3 | 14 | 4 | 9 |
| 50+ | 8 | 32 | 3 | 14 | 11 | 14 |
| Ethnic group | | | | | | |
| Black | 2 | 8 | 5 | 24 | 7 | 15 |
| Caucasian | 12 | 48 | 12 | 57 | 24 | 52 |
| Asian | 4 | 16 | 2 | 10 | 6 | 13 |
| Other | 7 | 28 | 2 | 10 | 9 | 20 |
| Social class | | | | | | |
| I | 1 | 4 | 0 | 0 | 1 | 3 |
| II | 0 | 0 | 0 | 0 | 0 | 0 |
| III | 0 | 0 | 1 | 7 | 1 | 3 |
| IV | 2 | 9 | 4 | 27 | 6 | 16 |
| V | 20 | 87 | 10 | 67 | 30 | 79 |
| Unknown | 2 | | 6 | | 8 | |
| Marital status | | | | | | |
| Single | 13 | 52 | 11 | 55 | 24 | 53 |
| Married or living together | 8 | 32 | 4 | 20 | 12 | 27 |
| Separated, widowed, divorced | 4 | 16 | 5 | 25 | 9 | 20 |
| Unknown | | | 1 | | 1 | |
| Diagnosis | | | | | | |
| Schizophrenic disorders | 12 | 48 | 9 | 43 | 21 | 46 |
| Affective disorders | 6 | 24 | 3 | 14 | 9 | 20 |
| Personality disorders | 0 | 0 | 2 | 9 | 2 | 4 |
| Substance abuse disorders | 1 | 4 | 1 | 5 | 2 | 4 |
| Other | 6 | 24 | 6 | 29 | 12 | 26 |
| Reside with* | | | | | | |
| Live with family | 24 | 96 | 11 | 55 | 35 | 78 |
| Not live with family | 1 | 4 | 9 | 45 | 10 | 11 |
| Unknown | | | 1 | | 1 | |

* ($\chi^2 = 8.56$, $df = 1$, $p < .03$).

indicated for each type of family. The four types of family situations are:

*Multiple Mental Illness Families* In addition to the identified patient, these families included at least one other individual who was severely mentally ill. In family meetings, many of these families would exhibit pathologic interaction similar to that described by authors studying communication deviance.[19] We defined "severe mental illness" as either carrying a diagnosis of schizophrenia, affective disorder, or organic brain syndrome. We also included families where another member had been in psychiatric treatment for some other severe

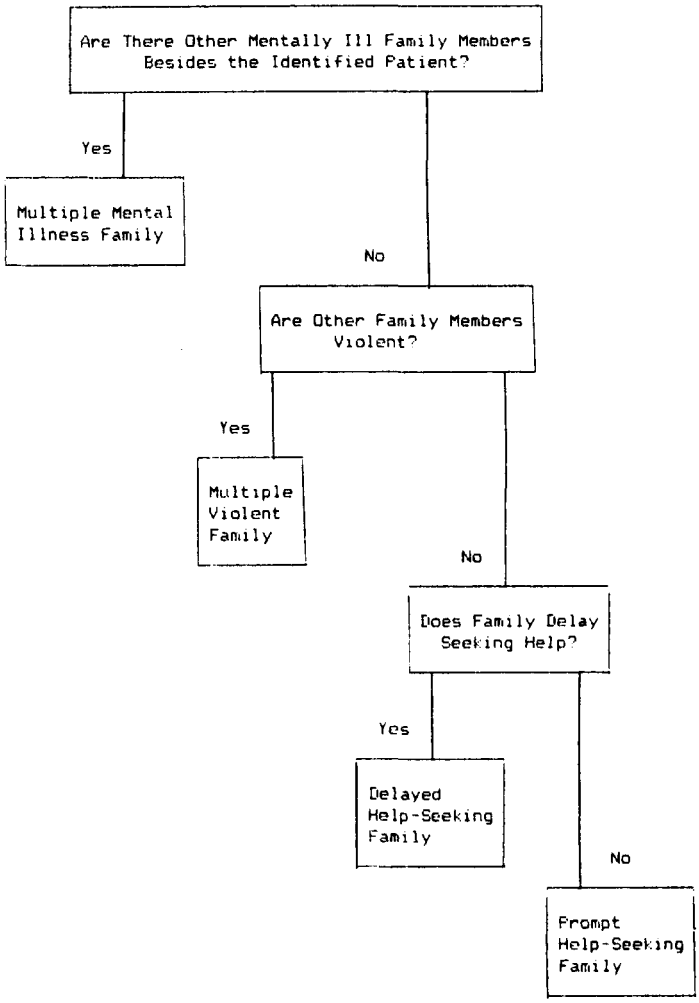


Figure 1. Classification system for families containing patients who assaulted a family member.

psychopathology, e.g., a patient with dysthymic disorder or borderline personality who had made a suicide attempt. We excluded drug abuse and alcoholism from the diagnosis of severe mental illness unless the addiction had led to psychiatric hospitalization.

An example of a violent patient from this type of family is:

> A 59-year-old single man with paranoid schizophrenia lived with his 82-year-old mother with organic brain syndrome. He became increasingly paranoid and agitated and pushed his mother down the hall, fracturing her hip and clavicle. In the hospital, the patient remained delusional and was deemed to be dangerous. When the ward staff attempted to get the patient transferred to the state hospital and placed on a six-month involuntary commitment as a danger to others, the mother came into court and pled for her son, saying that he

**Table 2**
**Types of Families Containing Patients Who Assaulted Family Member (N = 25)**

| Family | N | % |
|---|---|---|
| Multiple mental illness | 6 | 24 |
| Multiple violent | 4 | 16 |
| Delayed help seeking | 11 | 44 |
| Prompt help seeking | 4 | 16 |

was a "good boy" and that she wanted him to come back home with her.

*Multiple Violent Families* In addition to the identified patient, these families included at least one additional individual who had been violent. In these families, violent behavior was an accepted mode of interacting among members and multiple family members would engage in violent acts toward each other. The identified violent patient had a major psychiatric disorder but the violence seemed as much related to the family's customary pattern of interacting as it was to the psychiatric disorder.

An example of a violent patient from this type of family is:

> A 23-year-old single, unemployed woman with schizo-affective disorder was living with her family including an alcoholic abusive father. She was admitted with paranoid ideation after becoming assaultive at home and threatening to kill her family with knives. The police told us that they know the family well because they were repeatedly called upon by family members or neighbors to settle violent arguments. Sometimes the police would arrive at their home and were told by the family, "We were arguing about which television channel to watch but now it's settled so you can leave."

*Delayed Help-seeking Families* In these families, violent behavior was viewed as deviant and was construed by family members as related to the mental illness of the identified patient. In family meetings, other members of the family besides the patient did not display grossly disturbed patterns of behavior. Although the families recognized the deteriorating condition of the patient, they attempted to manage the patient without outside help.

We defined "delayed help" as not seeking professional treatment despite the fact that the identified patient had floridly psychotic symptoms for more than two weeks or had been violent more than two times. There may be many reasons for families not seeking help. For example some authors have noted that patients in lower socioeconomic classes are often reluctant to seek psychiatric treatment.[20] In addition, cultural factors can delay help seeking as described in a previous report of a Chinese family who waited for 15 months before seeking involuntary inpatient treatment for a psychotic woman who had been throwing excrement at neighbors and chopping down trees with a meat cleaver.[21] Other reasons which we saw in this sample of patients related to families' sense of loyalty and lack of knowledge.

An example of a violent patient from a family where loyalty was the central issue is:

> A 92-year-old married man with senile dementia and paranoid ideation lived with his 85-year-old wife. He was admitted after striking his wife multiple times. The patient's violent behavior related to his suspicious and paranoid feelings about his wife and also to his anger because his wife would not allow him to leave the house without her. His wife stated that she had tolerated this behavior in the past because she felt loyal to him and did not want him institutionalized in a nursing home.

An example of a violent patient from a family where lack of information was the central issue is:

> A 33-year-old single man with chronic paranoid schizophrenia lived with his mother, father, niece, and grandnephew. He was hospitalized after he threatened to cut off his grandnephew's head and fingers and hang them

outside. For two months, he had been delusional, threatening and assaultive to family members (throwing objects at them, hitting in face and pushing). The family said that they did not seek help earlier because the patient did not have Social Security or insurance benefits, and they thought there was no way to pay for any help.

*Prompt Help-seeking Families* These families were similar to the delayed help-seeking families in that no other members besides the identified patient displayed severe psychopathology. They differed in that they rapidly sought help for the identified patient. We defined "rapidly" as within two weeks of displaying flagrantly psychotic symptoms or after more than one episode of violent behavior. Despite the fact that these families acted quickly, the identified patient did assault a family member. The violent behavior was clearly related to the patient's mental disorder and in several cases was precipated by attempts to bring the patient to a treatment facility.

An example of a violent patient from this type of family is:

A 23-year-old single man with paranoid schizophrenia lived with his parents. For one week prior to admission, he had claimed he was Jesus Christ and had performed bizarre religious rituals. He ripped a phone from the wall, pulled his mother's hair, and threatened to kill her. His parents called psychiatric emergency services for help immediately after the violent behavior.

## Discussion

Our study showed that when psychiatric patients become violent, family members are at high risk for becoming the victims of the violence. In addition, we found that even after assaulting a family member, the majority of patients planned to return to live with their families after discharge from the hospital.

The question can be asked whether our sample is representative of hospitalized psychiatric patients in general. Our findings that the rate of assault preceding admission was 15 percent are similar to those obtained by other investigators. Previous reports have shown a rate of assault preceding admission ranging from 9.5 to 16 percent.[1,3,5,9]

Our findings that family members are likely victims when decompensating patients become violent, and that such patients usually do return to live with their families, emphasize the need to develop strategies for the prevention of future violence. Our finding that violent patients who lived with their families were significantly more likely to assault family members suggests that victim availability is one factor affecting who becomes the victim of violence. Factors in addition to availability appear to be important however, since many of our assaultive patients who lived with family members assaulted someone outside the family. Further studies should address factors such as family dynamics and interactional patterns which affect who becomes the victim of violence by psychiatric patients.

We have presented four categories of families where violence accompanies decompensation in the identified patient. Different intervention strategies might be appropriate for prevention of further violence in each type of family. For example, the "multiple mental illness family" would likely benefit from both family therapy and concurrent individual

psychotherapy of each severely mentally ill individual. The "multiple violent family" might benefit from interventions such as establishing impulse delay procedures and using community resources such as battered women shelters. The "delayed help-seeking families" with a sense of loyalty might benefit from family support groups who could help deal with feelings of guilt and disloyalty and the "delayed help-seeking families" who lack information would clearly benefit from education and increased knowledge about community resources. Many families of severely mentally ill patients are isolated.[22] Decreasing the families' isolation might be an important factor in decreasing violence in families with psychiatric patients.

Our findings are relevant to another intervention which might help reduce the incidence of violent behavior by psychiatric patients: increased use of outpatient civil commitment. Many of the assaultive patients in our study had chronic psychiatric disorders which could be maintained in remission with medication, but the patients would not comply with treatment voluntarily or consistently. The families of these patients would often be aware that the patient was decompensating for some time prior to the assault, but would be unable to persuade the patient to get treatment. Sometimes, the assault was precipitated by the family's attempts to take the patient to a treatment facility. Only when the patient would become violent, and thereby demonstrate grounds for commitment on the basis of dangerousness, would outside authorities intervene and force the patient to get treatment on an inpatient basis. For such patients, who repeatedly become psychotic when medications are discontinued and then become violent, court-supervised outpatient treatment might provide a way to enable the patients to live with their families and reduce the probability of violence. Such patients could be compelled to receive treatment before they actually become violent. Although previous isolated attempts to use outpatient civil commitment have been associated with problems of poor coordination between inpatient and outpatient treatment facilities and judicial authorities,[23] we believe that this legal option could provide a mechanism for reducing violence by psychiatric patients.

This study represents a preliminary investigation of the victims of violence by psychiatric patients which found that family members residing with violent psychiatric patients are a high risk group. We described four types of families where violence occurred. More studies are needed to further delineate the clinical and research utility of this classification and further address the issues of identification, prevention, and treatment of victims of violence of psychiatric patients.

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