The Character of Danger in Psychiatric Practice: Are the Mentally Ill Dangerous?

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This paper explores the question of dangerousness and the mentally ill. Research for this paper was stimulated by the death by homicide of two psychiatrists in Oregon in 1985. The paper reviews three distinct areas in the psychiatric literature: the arrests of mental patients, assaults against psychiatrists and other mental health professionals, and assaultive behaviors exhibited by patients in hospitals and other psychiatric settings. The author concludes that the risks are real but are dependent, for the most part, on setting and the acuteness of illness. Realism in regard to risk is critical for the mentally ill, their families, professional caregivers, and society in general.

During the first six months of 1985 two Oregon psychiatrists were killed by psychiatric patients. On February 6th a psychiatrist died on a general medical inpatient ward in a community hospital after being assaulted by an acutely psychotic inpatient he had met for the first time only hours before. On June 26th another psychiatrist was shot to death in his private office by a chronically mentally ill former patient with a known history of violence associated with his mental illness.

The death of these colleagues left many psychiatrists in Oregon with a sense of confusion regarding the question of whether the mentally ill are dangerous. Genuine confusion about this question remains in the scientific literature and in the lay press. Many of us were taught that the mentally ill are no more dangerous than the public at large. Although doubts have been expressed in the last decade, this wisdom persists.

The denial of the association of mental illness and violence is clearly challenged by excerpts of the following letter to Senator Edward Kennedy. I have been in contact with the writers over the past three years regarding their very personal interest in monitored outpatient treatment for insanity acquittees.

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Dear Senator Kennedy:

We are writing this letter to express views related to the recently enacted State Comprehensive Mental Health Services Act (S-1744), hoping that we can contribute in a constructive way to its implementation.

Our interest in this matter stems from the fact that our daughter is an insanity acquittee

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who is currently committed to a state mental hospital. She was found not guilty by reason of insanity in the homicide of her younger sister. The enclosed articles tell her very sad story.

Mental health advocacy groups understandably do not want to emphasize violence in the mentally ill population because of stigma-related matters such as the location of group homes and other community-based facilities. In general, this viewpoint is justified because most studies made to date seem to indicate that the incidence of violence among the mentally ill does not exceed that of the population as a whole. However, within the mentally ill population is a subgroup afflicted with paranoid schizophrenia. This subgroup commits a highly disproportionate share of violent acts occurring within the mentally ill community, causing distorted public perceptions regarding all mentally ill people. Therefore, we feel that advocacy groups and interested politicians should meet the problem head-on by promoting special procedures for dealing with cases involving paranoid schizophrenia, including those of insanity acquittees who have this disease.

The release of a hospital patient with a violent record to a group home, to his family, or to some other community-based setting involves a vital judgment which should be made only by qualified and unbiased professionals with the full approval of an *informed* legal system. These comments in many respects also apply to the commitment process. Families are often faced with agonized frustration when attempting to find safety and security for dangerously sick relatives under existing narrow definitions of dangerousness.

To provide acceptable safety and security for patients and the public, community mental health facilities, as well as hospitals, should be staffed with knowledgeable professionals who view the major mental illnesses as brain diseases, similar to Alzheimer's disease or Parkinson's disease, and who, thereby, are better able to recognize the symptoms of dangerousness.

They should realize that paranoid schizophrenics generally do well in a structured hospital environment, but frequently relapse when released. They should know that one of the characteristics of this disease is a tendency to mask dangerous delusions from even very skillful therapists. Above all, they should recognize that the prediction of violence is a very difficult matter, and most forensic authorities feel that the most reliable indicator of future violence is *past violence.* (personal communication—Mr. and Mrs. W. H.)

This letter directly highlights the issue of the dangerousness of the mentally ill. It recognizes the political nature of this issue. It focuses on the fact that our inability to separate politics from the tragic situations suffered by many families has hindered our facing the issue of violence more openly. It highlights the question of diagnosis. Is the focus on paranoid schizophrenia supported by evidence? The letter concludes with the question of the prediction of dangerousness and how this prediction effects hospitalization, treatment, and release decisions. The issues touched on in the letter are key to the basic question: Are the mentally ill dangerous? Are there certain types of mentally ill people who are more dangerous than others? Who are most likely to be harmed by the dangerous mentally ill people? In what settings are the mentally ill most likely to be dangerous? These questions form the theme of this paper.

I will review four distinct but interrelated groups of papers that examine: the arrests of mentally ill patients; assaults against psychiatrists and other mental health professionals; assaultive behavior exhibited by psychiatric patients in hospitals and other psychiatric settings; and the murder of psychiatrists. It is important to realize at the outset that in all four of the areas we review the literature is recent and imperfect. It suffers from

many definitive and methodological problems. However, despite these shortcomings, I believe it is possible to begin to understand where and in what circumstances danger may lurk for us, our patients, their families, and for society as a whole.

Arrests of the Mentally Ill

Over the last decade the use of arrest data has become of increasing interest to those investigating the question of the dangerousness of the mentally ill. Prior to Zitrin *et al's.*[1] 1976 paper it was generally assumed that the mentally ill were no more dangerous and were considered by many to be less dangerous than nonmentally ill persons. Zitrin *et al.* examined the arrest records of patients admitted to an acute psychiatric ward in New York City. He found that these formerly hospitalized patients were arrested more frequently than the general population. He also described a subgroup of schizophrenic patients arrested for violent crime. He felt that a link between schizophrenia and violence remained in dispute.

This paper stimulated a reexamination of the question of the association of mental illness and arrests. It was followed quickly by publications from Wyoming[2] and California,[3] which supported Zitrin *et al.*'s findings. It soon became accepted that certain groups of formerly hospitalized mentally ill patients were arrested more frequently than the general population. Many questions remained as to why this was happening. Dramatically diverse hypotheses were advanced to explain the arrest data; one poses the theory of the medicalization of criminals, whereas for the other the explanation lies in the criminalization of the mentally ill.

The medicalization of criminals found its most articulate spokesman in the work of Steadman. In 1978, Steadman *et al.*[4] found three factors that contributed to the increased arrest rates of former hospital patients. The patients with arrests were younger, had hospital admitting diagnoses of substance abuse or personality disorders, and were more likely to have prior arrests. In comparing arrests of mental patients and criminal offenders, Steadman *et al.*[5] found that patients who had no arrests prior to psychiatric hospitalization had subsequent arrest patterns no different from the general population. However, patients with multiple arrests before psychiatric hospitalization had subsequent arrest rates indistinguishable from rates of criminal recidivists. These papers demonstrated that there was a subgroup of formerly hospitalized patients who were arrested on multiple occasions, and that these patients distorted the arrest rates for the larger group of hospitalized patients. The studies concluded that "the issue is not so much that there are more mentally ill people at risk for criminal activity in the community; more accurately the problem seems to be that there are more criminals in the mental hospitals in the first place." Monahan and Steadman[6] concluded that criminal activity is not related in a significant way to mental illness but is controlled much more by age, sex, race, socioeconomic status, and past criminal activities.

The criminalization of the mentally ill as an explanation for increased arrests also had its supporters. Guze[7] commenting on the Steadman research emphasized the need for studies that look carefully at psychiatric diagnosis and criminal history. Grunberg *et al.*[8,9] suggested that the increased arrests of mental patients are related to the increased liberty enjoyed by the traditional hospital patients. Sosowsky[10] published a cautionary note to Steadman's conclusions. In reviewing his own data, Sosowsky[10] found that patients without previous arrests had posthospital arrest rates markedly higher than those of the general public. He felt that Steadman's conclusions were premature.

Two papers from our department[11,12] focused on 189 patients who entered the Oregon civil commitment system through the University Hospital emergency room. We found significant psychopathology in this group of patients and at follow-up found significant morbidity and mortality in the sample. We examined the arrest records of these involuntary patients compared to a group of 95 voluntary patients who entered the same acute psychiatric unit during the same time period. We found that 59 percent of the involuntary patients and 45 percent of the voluntary patients had prior arrests. The involuntary patients with prior arrests included a significantly greater percentage of schizophrenics when compared to involuntary patients without prior arrests. We also found a large percentage of character disordered patients in the arrest group. To a certain extent our findings agreed with both hypotheses in that our arrest group contained a large number of schizophrenics and young character disordered individuals. The character disordered patients were entered into the initial phases of the civil commitment process with few actually being committed. For the schizophrenics, we postulated a relationship between the effectiveness of community care, civil commitment, and arrests. We do not feel that liberty automatically leads to more arrests. We postulated an intervening variable, the quality of the community care system which leads the mentally ill to the mental health or to the criminal justice systems. Because of these system relationships we felt that different researchers working in different jurisdictions could find dramatically different association between types of patients and prior arrests.

A recent series of articles by Teplin[13] further challenged the usefulness of arrest data as a means of measuring the dangerousness of the mentally ill. She concluded that arrest data are poor measures of true criminality and dangerousness, and that arrests often have little resemblance to actual events or to the results of the criminal justice process. She developed a methodology which catalogued the encounters between police and citizens in order to determine frequencies of crimes attributed to both mentally and nonmentally ill persons.[14] She found the mentally ill in her sample were more frequently police suspects, but they had not committed serious crimes any more frequently than their nonmentally ill counterparts. Her data

did not find the mentally ill as dangerous.

We are left in this debate with a confusing picture regarding the arrests of the mentally ill. Each of the hypotheses and the methodologies appear to have some validity. We are forced to conclude that arrest data are currently too indirect, too global, and lacking in diagnostic sophistication to lead us to sound conclusions of dangerousness.

Assaults Against Mental Health Professionals

I have been able to identify six survey papers that attempt to develop prevalence data regarding assaults on psychiatrists and other mental health professionals. Each paper has a slightly different methodology and different definitions of assault, yet each contributes to the developing picture of a profession that has risks attendant to its practice.

Two papers appeared in 1976. The first, by Madden *et al.*,[15] surveyed 115 psychiatrists who had academic appointments in the department of psychiatry at the University of Maryland. The authors were able to obtain a 100 percent response to their questionnaire. Of the 115 psychiatrists surveyed 48 (42%) reported that they had been physically assaulted at some point during their careers. Most of the assaults took place early in the psychiatrist's career, most often during training, and most of the assaults were reported as resulting in minor injuries although one psychiatrist had been shot and wounded by a patient. Seventy-two percent of the assaultive patients had psychotic diagnoses, by far the largest group being schizophrenic. Psychiatrists who reported more than one assault worked either in forensic settings or emergency rooms. The authors concluded that although assaults seemed to cluster by setting and experience of the therapist, there were reports that cut across all practice settings. They also highlighted the underreporting and minimizing of assaults by psychiatrists.

Whitman *et al.*[16] approached the problem in a different manner. These investigators sent questionnaires to 184 psychiatrists, psychologists, and social workers in the Cincinnati, Ohio, area. They asked each therapist to report the number of times they felt threatened or were assaulted by a patient in a single year, 1972. Fifty-five percent responded to the questionnaire. Slightly over half of the responders were psychiatrists or psychiatric residents. Twenty-four percent of the responders reported being assaulted during 1972. Broken down by profession, 34% of the psychiatrists, 20% of the social workers and 7% of the psychologists reported an assault during the year. No differences were found by sex, setting, and years of experience for the group as a whole. In this study the likelihood that a therapist would be assaulted by any particular patient was low and was related to the total number of patients seen by therapists. This study was heavily outpatient oriented with 80 of the therapists working primarily in outpatient whereas 21 worked in inpatient settings. The authors recommended training for therapists to make them as prepared to cope with the inevitable assaultive patient.

In 1980, Ruben *et al.*[17] reported the results of a survey of 19 second-year and 12 third-year residents in the USC psychiatric training program. The authors determined the prevalence of assault and whether assaults might have been related to factors in the resident's current situation or past history. Fifteen of the 31 residents (48%) reported being assaulted at least once during the time they were in the training program. The most common patient diagnosis was paranoid psychosis. Assaults took place in all areas of the hospital. A positive correlation was found between resident irritability and assault. No correlations were found for stressful life events. Fourteen of the 15 residents who had been assaulted felt that they had done something to trigger the attack.

In 1981, Bernstein[18] reported the results of a survey of 998 psychiatrists, psychologists, clinical social workers, and marriage and family counselors in San Diego County. This questionnaire was designed to measure lifetime experience with threat and assault. With a return rate of 46%, 14% reported having been assaulted on at least one occasion. Psychiatrists were found to be "by far more fearful, threatened, and assaulted than any other group." Extrapolating from their data, they concluded that 61 percent of the psychiatrists in their sample would have been threatened by a patient at some point during their careers and 42 percent would have been assaulted. This compares to only 10 percent of the other disciplines experiencing an actual assault. As with previous studies, assaults took place in most settings but were most heavily concentrated on inpatient units, and younger professionals were more likely to have experienced assault. Very few therapists actually notified the police regarding either threatening or assaultive behavior and very few of the therapists felt that they were able to anticipate the threat or assult.

Haffke and Reid[14] surveyed all 88 psychiatrists in practice in Nebraska and reported their findings in 1983. Two-thirds responded and, of these, 32 percent had been assaulted at some point during their careers, and 9 percent had been assaulted within the past year. Most were minor assaults. Again threats were much more common than assaults, and legal action was taken in only a very few cases. Assaults tended to be committed by patients from lower socioeconomic status who were inpatients in large institutions.

Reid and King[20] attempted to establish the prevalence of serious assault in outpatient practice with serious assault defined as one resulting in an injury which caused at least one missed work day. They surveyed psychiatrists, psychologists, and family practitioners using a randomized national sample. Data was also gathered on nonwork-related assaults. Responses came from only 33 percent of the psychiatrists and family practitioners, and 67 percent of the psychologists. Less than 5 percent of the psychiatrists and family practitioners reported ever experiencing a serious assault, and these percentages were no greater than assaults experienced in their nonwork setting. They concluded that they could not support contentions that

psychiatrists were more likely to be victims of assault than other medical practitioners nor could they confirm contentions about the dangerousness of mental patients in the outpatient setting. They also could not confirm a positive association between inexperienced practitioners and the likelihood of serious assault. They concluded that assaults took place unpredictably.

Some interesting trends emerge from these six studies. Although these papers suffer from a lack of consistent definition of assault and some from inadequate return rate, nevertheless, it appears that some type of assault is particularly prevalent in the practice life of a psychiatrist. They tend to occur early in the psychiatrist's career, which links them to certain settings and the experience of the practitioner. Where diagnosis is reported, most assaults involve seriously ill patients. Finally, although the lifetime prevalence of some type of assault may be relatively high, most assaults result in minor physical injuries, and the likelihood of a psychiatrist being assaulted by a given patient is quite low.

Assaults by Psychiatric Patients: Hospital and Outpatient Settings

Hospitals The preceding sections of this paper lead us clearly to an exploration of dangerous behavior in and around the hospital setting. When we look at this data, we find evidence of significant problems both before and during hospitalization.

The most consistent body of data in this area has been developed by Tardiff in a series of papers exploring assaultive behavior in various hospital settings[21] both before and during hospitalization. In an initial study Tardiff and Sweillman[22] examined computerized admission data on all patients (N = 9,635) admitted, 1974 to 1975, to several New York public mental hospitals. Ten percent of the sample had assaultive acts listed as one of the computerized problem areas at the time of admission. These patients were more likely to be referred to hospitals by police or courts, with diagnoses of organic mental disorders, paranoid schizophrenia, and personality disorders.

Tardiff[23] found similar preadmission assaultive behavior in patients admitted to private hospitals. He examined the hospital records of all patients (N = 1,603) admitted in a one and one-half year period to the private psychiatric services of two university hospitals. Again, 10 percent were listed as assaultive prior to admission, with diagnoses of acute schizophrenia or mania, and to some degree, organic mental disorders.

To determine the prevalence of assaultive behavior during hospitalization, Tardiff[24] reviewed records on 5,164 patients hospitalized for longer than one month in two New York state hospitals. Seven percent of these patients were assaultive within three months prior to the survey date. Younger patients and those who suffered from nonparanoid schizophrenia, organic mental disorders with psychosis, and other nonpsychotic disorders, and those with seizure disorders and mental retardation were overly represented in the assaultive group. Para-

noid schizophrenics were not significantly represented in this group.

Other researchers confirmed Tardiff's findings. Lagos *et al.*[25] examined hospital admission data on 400 patients admitted to four New Jersey psychiatric facilities and found 38% with a history of some form of violent behavior prior to admission. Twenty percent were described as physically violent to persons or objects. After eliminating patients with diagnoses of personality disorder or substance abuse from the sample, 35 percent of the remaining group of patients evidenced histories of some form of violent behavior with 18 percent described as physically violent. They concluded that it was reasonable to be fearful of the mentally ill and advocated for more realistic community treatment and education programs.

Craig[26] studied 876 patients admitted to two New York public mental hospitals during 1975 and 1976 using a method similar to that used by Tardiff and Sweillam.[22] The three computerized problem areas described in this study were agitation, anger, and assaultiveness. Craig found 11 percent demonstrated some type of assaultive behavior prior to admission. Patients suffering from schizophrenia and organic mental disorders showed significantly higher percentages of assaultive behavior than did other patients. For the schizophrenics, agitation, anger, and assaultiveness were significantly associated. Whereas Tardiff emphasized an association between age, sex, and diagnosis in assaultive patients, Craig was struck with the clear relationship of diagnosis and assault.

Hospital charts or incident reports have been used by several other researchers to determine frequencies of assaultive behaviors during hospital stay. Dietz and Rada[27,28] studied violent behavior in a forensic hospital. They carefully distinguished between assault as threatening behavior and battery as a physical attack on another person. They found that there were significant numbers of batterees in the forensic setting. Unfortunately, their data did not allow for diagnostic classification of the batterers.

In an often quoted paper, Lion *et al.*[29] studied incident reports, looking for reports of assault in a Maryland state hospital. As data collection proceeded, the researchers learned about many unreported assaults. Expanded data collection revealed about five times as many assaults actually take place as compared to those reported. Underreporting of assaults was felt to be related to the additional paperwork requirements of reporting, along with staff feelings that assaults were part of the job and being a victim of assault represented a failure in therapeutic effectiveness. Most assaults took place on admission units and most were committed by acutely psychotic or manic patients.

Lion *et al.*'s findings are echoed in a 1983 paper by Lanza[30] which reported the results of assaults against nursing staff in a Veterans Administration neuropsychiatric hospital. Lanza retrospectively reviewed assault reports for a one-year period and identified a total of 91 assaults involving 67 nursing staff members. Forty of these staff members were interviewed. She found that staff with

the longest work experience and those who worked on acute psychiatric admission units or on the psychiatric emergency team reported higher numbers of assaults. Injuries sustained by these nursing personnel were often serious. It was noted that the overt reaction of victims was often muted and that psychological sequelae lasted far longer than time lost from work because of physical injury. Shader *et al.*[31] reviewed 14-hour nursing reports in a teaching hospital over a six-month period looking for episodes of violent acts directed at others. Seventy-nine patients were identified as having been violent. Of this group, 45 (57%) were schizophrenic. In comparing subtypes of schizophrenics, an overrepresentation of schizoaffective patients was found in the violent group compared to a control group of nonviolent schizophrenics. They found no consistent relationship between paranoid schizophrenia and violence.

Both Lion *et al.*[29] and Tardiff[21] raised concerns about the influence of the newly defined right to refuse treatment on safety in hospitals. In exploring this issue in Oregon's state hospitals,[32,33] we raised concerns regarding the apparent infrequent use of seclusion, restraint, and/or emergency medications during the refusal period and raised issues of ward safety.

Reid *et al.*[34] compared assaults in a variety of psychiatric inpatient and general medical units in 16 different hospitals. Results were expressed in rates of assault per bed per year. Psychiatric hospitals, categorized by type, showed a low rate of 1.2 for private hospitals to 6.9 for security hospitals, with state hospitals holding an intermediate position of 3.3 assaults per bed per year. The mean for all units was 2.5. Nonpsychiatric units had an overall mean rate of 0.4, with the highest being 1.7 for medical intensive care units. Significant differences were found when psychiatric units were compared to all nonpsychiatric units, when security psychiatric units were compared with all other psychiatric units, and when medical intensive care units were compared to all other medical units. In addition to the mean values, the ranges in many cases were quite wide, demonstrating that individual sampling would produce wide differences in assault rates. These researchers also found that of the assaults reported, few resulted in any lasting injuries. They reported that the rare severe injuries were inflicted by patients early in their hospital stay.

Finally, who are the victims of these assaults? For the assaultive hospitalized patient, clearly the most frequent victims are other patients and nursing staff, rarely psychiatric staff. For the assaults which take place prior to hospital admission the most frequent victims are family members. Tardiff[23] found more than half of the victims of assaults to be family members. Binder and McNeil[35] examined hospital records of 300 patients admitted to an acute care psychiatric unit in San Francisco to describe episodes of violence directed against others in the two weeks prior to admission. Forty-two percent of the sample were schizophrenics, 23 percent suffered from affective disorders, and 10 percent had personality disorders. Fifteen percent of their patients had engaged in some violent episode in the two weeks before

admission, and 54 percent of the victims were family members. The patients who assaulted family members were significantly more likely to have lived at home prior to hospitalization.

Outpatient Settings Little organized data exists regarding assaults in the outpatient setting. Tardiff and Koenigsberg[36] studied records of all outpatients (N=2,917) evaluated during a one and one-half year period in two university outpatient clinics. This sample included some patients seen as part of emergency room, consultation/liasion, and child psychiatric services, but excluded patients slated for hospital admission. Data were collected on assaultive behavior to others. Three percent of the sample showed evidence of some physically assaultive behavior in the days prior to outpatient evaluation. Again, family members were the victims of the assault in over 50 percent of the cases. Younger males with diagnoses of child or adolescent disorders, mental retardation, and personality disorders were more likely to be assaultive. Schizophrenics and those with affective disorders were not overrepresented in the assaultive group.

Community mental health centers are mentioned as settings where precautions against assault may be increasingly necessary[37] because of the effects of deinstitutionalization and because more seriously ill patients are now being seen in these programs. In their Nebraska survey, Haffke and Reid[19] found an average of one and one-half assaultive incidents (including verbal assaults) per year in each of the state's CMHCs and only one episode where a victim lost any time from work. Notwithstanding the low frequency of assaults found in these programs, the authors felt that assaults may be on the increase in these settings.

Armstrong[38] developed a case register of 2,732 persons evaluated at a psychiatric emergency room in a large community general hospital. In a 30-month period beginning in 1979, he identified 183 (7%) patients who were considered to be assaultive at the time of their evaluation. When compared to nonassaultive patients, these patients were younger males who were angry, belligerent, and negativistic during the interview. They had strong histories of previous violent behavior and were generally experiencing loss of interpersonal relationships. Thirty percent of the group were psychotic, but this was not significantly different compared to the nonassaultive group. Substance abuse was an important feature of their presentation.

In summary, a certain percentage, 10 to 15 percent, of mentally ill patients will be assaultive prior to admission to hospitals. These patients will be acutely psychotic, either schizophrenic or manic, with some organic or personality disordered patients in this group. When these patients live at home, as reported in more than 50 percent of the cases, family members will be the most frequent victims. Others will also be assaulted. These assaults can lead to arrests or to civil commitments, or to voluntary hospitalizations, depending on the local system.[12] Most patients who are admitted pass through emergency rooms; therefore, a recordable assault rate is

found in emergency rooms. Emergency rooms see other kinds of patients such as substance abusers, who frequently do not get admitted, thus producing a slightly different setting-specific group of assaultive patients. The same can be said of inpatient units. The earlier in the admission the more likely the assault is related to acute illness; later in the admission assault seems to be associated with different types of patients and different factors. Every inpatient unit has a measurable assault rate, more or less, depending on the nature of the unit, the type of patients it receives, and, no doubt, its policies, procedures, and staffing patterns.

Traditional outpatient settings seem to be fairly low risk environments. However, practice environments change over time. Increasing caution should be exercised in community programs. Patient populations in these programs are changing. Many centers now almost exclusively serve acutely and chronically ill patients with very serious mental illnesses with staff members unfamiliar with the proper management of such patients.

Death of Psychiatrists by Homicide

There are little organized data in this area. Homicide deaths of psychiatrists and other mental health professionals are infrequent events. Most such deaths are reported in the press and do not reach the journals. *Psychiatric News* published a two part series in 1982 focusing on the murders of three psychiatrists.[39,40] These articles pointed to the lack of hard data regarding assaults against psychiatrists, speculated on whether these deaths were part of an increasing problem, and made suggestions for management of threatening patients.

Annis *et al.*[41] in one report described the homicide death of a psychiatrist working in a community program and in another[42] the murder of a psychiatrist working in a large state hospital. Although in both papers the authors discussed possible preventative measures that might have been taken, both homicides did not seem preventable, given current practices. In both reports the patients were chronic paranoid schizophrenics who were well-known to the treatment system. Each had previous episodes of violence and poor understanding of their illnesses. There is a strong impression conveyed that no one really knew these patients, that the treatment system seemed to touch them without making real contact. Tragically, this type of anomic treatment situation exists with many seriously ill patients today.

Finally, Danto[43] presented data on two psychiatrists murdered by their patients. He emphasizes the lack of training in obtaining detailed histories regarding past violence, ownership and use of firearms, arrests, and aggressive fantasies. He draws particular attention to the paranoid patients as potentially the most lethal to their psychiatrists. He also suggests methods of interacting with potentially violent patients which may reduce the likelihood of a violent interaction.

In summary, the scant literature on homicide does not answer the question of the dangerousness of paranoid schizophrenic patients. Although identified in several of the homicide cases, further studies are needed to examine this question in more detail. What this literature does emphasize is the need to take a careful history of past violence and to integrate this inquiry into the routine psychiatric exam.

Some New Directions in Violence Management

Focusing on the potentially violent patient in various psychiatric settings is an important step in bringing awareness of both management and safety issues to the attention of caregivers. In 1973, Lion and Pasternak[44] specifically focused attention on countertransference issues in relation to violent patients. Felthous[45] described countertransference problems within a ward milieu. Gertz[46] described the development of a training program in a state hospital designed to prevent assaultive behavior. Edelman[47] focused on the development of a CMHC program to manage the violent patient.

We are beginning to see advocacy for weapon screening in psychiatric emergency rooms. Such a system was recently instituted in an urban university hospital emergency room.[48] Eight percent of 175 screened patients were found to have weapons. Staff were much more concerned than patients about the possible negative impact of screening for weapons.

A recent series of papers examined the prosecution of assaultive patients as possibly beneficial to these patients and the staff victims of assault. Phelan *et al.*[49] raised the issue of whether mental health professionals have a duty to initiate charges where serious assault has taken place, even with the patient being seriously mentally ill. Hoge and Gutheil[50] collected nine cases where prosecution was attempted for a group of predominantly mixed character disordered and mentally retarded patients. They reported very mixed results in terms both of legal outcome and staff satisfaction and recommended careful consideration before prosecution is instituted. Miller and Maier[51] described three cases where charges were brought against patients and argue for use of this procedure on a case-by-case basis. This procedure should be used only in special circumstances. Advocating the initiation of assault charges against mentally ill patients may be an open invitation to civil action for failing to protect the patient from the effects of his or her mental illness.

Finally, what can be done for professionals who are victims of physical assault? Engel and Marsh[52] presented a cogently written description of the development of a victim's assistance program as part of an employee counseling program in a Canadian general hospital where "employees who are subject to physical attacks are to be given high priority with regard to medical and psychosocial care." This policy clearly recognizes the possible psychosocial effects of the assault on the victim and the possible development of a posttraumatic stress syndrome. This paper points out

the inadequacies of previous studies that focus solely on physical injury following assault. Incorporating victim assistance into employee programs is certainly a feasible and timely step.[53]

Conclusion

Our profession does not exist in a vacuum; between 1960 and 1984 the figures for violent crime in the United States rose some 130 percent.[54] There is thus greater risk of danger in our society in general. Psychiatrists certainly share the general societal risks, but those who work in certain situations, such as acute psychiatric inpatient units, work in an environment of increased risk. The risks for families of the severely mentally ill are also real and very serious.

Earlier in this paper we spoke about the political nature of the violence question. On the one hand, few are interested in either heightening the stigmatization of the mentally ill or impeding the progress of the mentally ill in the community. Yet this progress is bound to be critically slowed without a realistic look at dangerousness. The concepts embodied in deinstitutionalization are not failed ideas. The implementation of these concepts are. An informed debate is clearly needed. Our knowledge about the nature and treatment of mental illness is clearly on the rise. Increased resources, appropriately placed, and a heightened, nonromantic, realistic view of mental illness must inform this debate. We in psychiatry must direct our efforts toward knowing where risks are most likely to be, taking steps to reduce these risks whenever possible, helping the violence prone, and appropriately treating the victims of violence.

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