

Take caution: Look for DISTURBED behaviors when you assess violence risk

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A common misconception is that persons who are mentally ill are inherently dangerous. However, there is, at most, a weak overall relationship between mental illness and violence. Increased violence is more likely to occur during periods of acute psychiatric symptoms.¹ Because few patients evaluated in most clinical settings will commit a violent act, it is important to assess for specific risk factors for violence to guide clinical decision making.

The acronym **DISTURBED** can be a reminder about important patient-specific features that correlate with violence. There are several variables to consider when identifying persons who are more likely to commit acts of violence.²

Demographics. Young age, male sex, cognitive deficits, less formal education, unemployment, financial hardship, and homelessness are associated with an increased risk of violence. A person's living environment and ongoing social circumstances are important considerations when assessing violence risk.

Impulsivity. Persons who display impulsive behaviors generally are more likely to behave violently. This is particularly true in persons who have been given a diagnosis of antisocial personality disorder or borderline personality disorder. Impulsivity often can be treated with medication, behavioral therapy, and other psychotherapeutic modalities.

Substance use is associated with an increased risk of violence in people with

and without other mental health issues. Alcohol can increase the likelihood of violence through intoxication, withdrawal, or brain changes related to chronic drinking. Some illicit drugs are associated with violence, including phencyclidine, cocaine, methamphetamine, inhalants, anabolic steroids, and so-called bath salts. Be cautious when treating a patient who is intoxicated with one or more of these substances.

Threats. Persons who express a threat are more likely to behave violently³; those who voice threats against an identified target should be taken seriously. The more specific the threat, the more consideration it should be given. In a clinical setting, the potential target should be informed as soon as possible about the threat. If a patient is voicing a threat against a person outside the clinical setting, you may have a duty to protect by reporting that threat to law enforcement.

Untreated psychosis. Be aware of patients who have untreated or undertreated symptoms, including psychosis and substance intoxication. Patients in a triage setting or who are newly admitted to an inpatient unit often present the greatest risk because their symptoms have not been treated. People with paranoid delusions are at a higher risk of assaulting their perceived persecutors. Those who are highly disorganized also are more prone to lash out and commit a violent act.^{4,5}

Repeat violence. The best predictor of violence is a history of violence. The severity of the violent acts is an important consideration. Even a person who has only a single

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Increased violence is more common during periods of acute psychiatric symptoms

(known) past violent act can pose a high risk if the act was murder, rape, or another highly violent assault. Learning details about past assaults, through reviewing available records or gathering collateral information, is important when assessing violence risk.

Behaviors. There are physical warning signs that often are observed immediately before a person commits a violent act. Potential warning signs include: punching a wall or breaking objects; tightening of facial muscles; clenching of fists; and pacing. These behaviors suggest a risk of imminent violence and should be closely monitored when assessing a patient who might be prone to violence. If a patient does not respond to redirection, he (she) may require staff intervention.

Eagerness. Much like when assessing the risk of suicide, intent is an important consideration in assessing the risk of violence. A person who is eager to commit an act of violence presents significant risk. Basic inquiries about homicidal ideation are insufficient; instead, explore potential responses to situations that might have a direct impact on the individual patient. For example, if the patient has had frequent disagreements with a family member, inquiring about hypothetical violent scenarios involving that family member would be valuable.

Distress. Persons who are concerned about safety often are inclined to lash out

in perceived self-defense. For example, fear often is reported by psychiatric inpatients immediately before they commit an act of violence. In inpatient psychiatric units, providing a quiet room, or a similar amenity, can help prevent an assault by a patient who feels cornered or afraid. The staff can ease patients' concerns by taking a calm and caring approach to addressing their needs.

Valuable tool for maintaining a safe environment

We recommend that clinicians—especially those who have little clinical experience (medical students, residents)—refer to this mnemonic before starting work in emergency and inpatient psychiatric settings—2 settings in which assessment of violence risk is common. The mnemonic will help when gathering information to assess important risk factors for violence.

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