The Dangerous Patient

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The dangerous patient requires proper management to ensure appropriate disposition and preclude injury. A safety-conscious public has propelled the issue into the courtroom, and a slowly evolving standard of care is emerging. In some states a legal duty to protect victims of violence exists. Understanding human aggression, the potentiating effects of the environment, and prior methods of coping, as well as assessing current behavioral controls and certain statistical correlates all aid management decisions. Stabilization of the dangerous patient begins with the interview and progresses to medication or restraints as the situation dictates. Once the acute crisis is resolved, attention is directed toward a more thorough review.

Family physicians, through the diverse medical population they serve, will eventually confront the dangerous patient. The broad practice realm of office, hospital ward, and emergency department further enhances the likelihood of contact. Since the dangerous patient occurs unexpectedly, arouses intense emotions in the physician, and poses unique medicolegal issues, a preventive plan is useful. By becoming familiar with salient legal issues, diagnostic clues, and management techniques, the family physician can minimize the risk of injury and maximize proper disposition. This article will review clinically relevant material to assist the physician in making difficult crisis-oriented decisions.

MEDICOLEGAL CONSIDERATIONS

The dangerous patient can promote both physical and legal injury. Being aware of pertinent legal issues will minimize the latter. The assessment and management of dangerous patients has been the focus of several famous malpractice cases. In some, liability was ascribed to medical actions. The courts have struggled with such complexities as physician-patient confidentiality vs disclosure. Confidentiality argues for preservation of a unique relationship, whereas disclosure supports public safety. From these and other arguments certain standards of acceptable professional conduct take shape. Familiarity with these emerging standards of care becomes important, as major deviation invites legal injury.

Tarasoff Case

Medical responsibility for the dangerous patient was first addressed in 1974 with the now famous court case *Tarasoff v Regents of the University of California.*[1]

Prosenjit Poddar, a student at the University of California at Berkeley, developed an obsessional attachment to Tatiana Tarasoff. Not certain whether his affections were fully reciprocated, Poddar became depressed and sought mental health counseling at the urging of friends. Following an initial psychiatric evaluation and medication prescription, Poddar was referred to a psychologist for therapy. During therapy sessions Poddar expressed fantasies of injuring Tatiana Tarasoff. Collateral information disclosed that Poddar was contemplating purchase of a gun. Justifiably concerned about Poddar's later withdrawal from therapy, the therapists contacted the campus police. Poddar denied any homicidal intent when questioned, and the campus police left. In October 1969, 2 months after the campus police investigation, Poddar killed Tatiana Tarasoff.

Civil litigation followed, alleging negligence by the university, the Mental Health Clinic, and campus police. Reviewing the case on appeal, in 1974 the California Supreme Court cited a duty to warn victims of potential violence. The volatility unleashed by this decision led the California Supreme Court to again review the case in

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1976.[2] From this review came the "duty to protect" potential victims. Such an obligation was relieved by contacting the police or the victim or by hospitalizing the patient.

The State of California was still struggling with the Tarasoff decision as late as 1985. At this time the Governor of California signed into law the psychotherapist's duty to protect identified victims by making "reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency."[3] In litigation subsequent to the Tarasoff decision, liability in one case was assessed even when no specific victim had been identified.[3] A Vermont court extended the duty-to-protect standard to include both persons and property.[4] Additional arguments have been heard in the federal and other state courts leading to varying decisions.[3]

ASSESSING THE DANGEROUS PATIENT

Controversy exists over the extent to which physicians can forecast violence. The inability to predict future dangerousness, as predicated on a review of institutional discharges, has eroded confidence. Typically, the professional overrates dangerousness, which in follow-up release studies rarely eventuates. Such studies have been widely trumpeted. An important by-product has been a reevaluation of the contribution made by physicians and mental health workers.[5] An emerging concept ties the utility of predictions temporally. Thus, the evaluation addressing imminent dangerousness may be more reliable than those evaluations projecting violence in the distant future. Logic would dictate that a basic understanding of human aggression and factors that predispose to the violent expression will aid in predicting whether a dangerous situation is imminent.

Human Aggression

Aggression can be considered to be "a constellation of specific thoughts, feelings, and actions that are mobilized by frustration of a wish or need, and whose goal is to remove the frustration in order to permit drive discharge."[6]

Violence is defined as the acting-out component. In this regard, one model identifies personality traits and situational factors as causal.[7]

Three personality traits are described in the model: internal inhibition, habit strength, and motivation. The last is subdivided into an angry and instrumental component.

Internal inhibition is essentially the complex psychological process that screens incoming insults and determines what action, if any, is taken. At one extreme are those individuals who never adequately internalized substantial control mechanisms. Because frustration tolerance is low and desire for quick gratification is high, impulsiveness becomes characteristic of the individual's chaotic life. Strained interpersonal relationships marred by abuse, infidelity, fights, and general irresponsibility are matched by similar performance at work.

The other extreme is manifested by overcontrol. The overcontrolled individual portrays an orderly existence, often presenting a calm, collected exterior. This façade belies cognitive agitation. Subject to insult after insult without adequate means of expression, this individual is akin to the pressure cooker minus the safety valve. Episodic, severe violence may also occur in this individual.

The second personality trait, habit strength, is a reflection of the past successful use of violent behavior. Individuals who reap rewards through violence have a well-developed habit strength. Their goals are met and subsequently reinforced by violent behavior. Such a history suggests that in stressful dilemmas, violence is the chosen option.

The third personality trait is motivation, which can be further subdivided into angry and instrumental. Violence motivated by anger reflects a desire to injure someone while receiving satisfaction through the victim's suffering. Instrumentally motivated violence is used as a means to effect an end, as for example, silencing a witness through murder would allow the perpetrator to avoid prosecution.

In this model, personality traits do not stand alone, but intertwine with situational factors to determine acts of violence. Those situational factors that contribute to violence include the presence of a lethal device and the cultural sanction of violence. The presence of onlookers diminishes expression, while the attitude of the victim is complex yet influential.

Statistical Profile

According to actuarial correlates, the typical profile of the violent individual is a nonwhite man younger than 30 years and of the lower socioeconomic class who has a past history of violence.[7] A careful scrutiny of the profile will assign differing levels of reliability to each. The single, best predictor of violence is a history of prior violence. Violence, as measured by homicide rates, also increases during periods of social upheaval, the summer, and on Saturday.[8] Both in act and fantasy, family members are the most frequent targets.[9]

Substance Abuse

Any disorder that impairs cognition or judgment increases the risk of violence. The aggressive, belligerent individual primed with alcohol has less control. In fact, whatever

controls are present, substance abuse diminishes them. Sixty percent of those arrested are under the influence of alcohol.[10] Drugs, particularly those creating physiologic arousal and cognitive impairment, such as amphetamines, cocaine, and phencyclidine, are dangerous. Withdrawal states with associated psychological and physiological distress also increase irritability.

Mental Illness

The presence of a severe mental illness can also heighten the prospects of violence. The paranoid patient who interprets all interventions as potential assaults may need little additional provocation to strike. Such a person is habitually suspicious, distrustful, and defensive, and acting out is most likely to occur when he or she feels trapped.

The psychotic individual, driven by a pernicious delusion, can be dangerous also. Bereft of rationality, the usual logic persuasive to others will be missing. Command hallucinations, which direct a certain activity, should be elicited and carefully evaluated.

Other medical conditions that exhibit conceptual disorganization should be considered as time permits, including dementia, delirium, and seizure disorders.

BEHAVIORAL CLUES

Certain behavioral clues cross diagnostic boundaries and suggest impending violence.[11] The patient's posture, speech, motor activity, and startle response are all affected.

The patient who sits uncomfortably on the edge of the chair, perhaps tightly gripping his knees, is attempting to control underlying tension. There is an inverse relationship between speech volume and control; the louder the patient becomes, the less control exists. The agitated, pacing individual who is unable to sit down has already lost some physical control, and this behavior is a good harbinger of violence. In a similar manner, an easily evoked startle reaction indicates the tenuousness of control.

The absence of emotional withdrawal, specifically hypervigilance and attentiveness, is also correlated with assaultive behavior.[12]

MANAGEMENT OF THE DANGEROUS PATIENT

Management of the dangerous patient is a dynamic exercise closely intertwined with ongoing assessment.[13] As the level of dangerousness fluctuates, so must the response. Stabilization of the dangerous patient, while affording universal safety, is the goal. To achieve stabilization, a series of steps designed to augment impulse control is needed. Appropriate conduct of the interview may suffice. In other cases security personnel, restraints, and medication are required.

The Interview

Conduct of the interview is the first step toward stabilization.[12] A nonconfrontational approach is most useful. Minimizing eye contact is nonthreatening. If the patient is loud, as the examiner lowers his voice, the patient may respond in kind. The interviewer should leave the examination room door open and should be nearest the door to forestall a hostage attempt and to marshall resources as necessary. With the paranoid patient certain specific techniques are useful.[14] The therapist should be honest and explain in some detail the nature of the evaluation. The consequences of acting-out and its impermissibility provide structure to the frightened paranoid patient.

Physician's Attitude

The dangerous patient transmits the imminent threat of personal injury. The physician will be confused and frightened. The natural fear engendered by this situation, if not masked, actually helps the physician because he or she will evoke a less confrontational approach. For the interviewer with a plan of action, his or her subjective experience of fear also serves as an early warning sign. The necessary actions to protect oneself and others can then be instituted. Ignoring fear and replacing it with a false bravado can lead to devastating consequences. The physician should avoid becoming angry or confrontational, as such an approach will surely escalate a precarious situation to an unpleasant climax. By acknowledging increasing personal fear, the physician will be consulting a valuable gauge.

Safety Factors

The most important issue in dealing with the dangerous patient is maintaining safety. In the emergency department or hospital ward, the physician should alert security police whenever a compromising situation is evident. When interviewing the dangerous patient in the hospital setting, the door should be left open to allow egress and forestall an attempt by the patient to take the interviewer hostage. In many cases the mere presence of security personnel is sufficient to restore a certain calm. Under no circumstances should the physician attempt to disarm a

dangerous patient. In a similar vein, the physician should refuse any demands by the dangerous patient to remove security forces as a condition to dialogue. At the same time that security is notified of impending violence, the nursing staff should also be instructed to ready an appropriate medication such as haloperidol. Through such efforts as the situation dictates the physician can resort to a show of force, physical restraints, or medication.

If a patient becomes violent in the office, the prudence of prior planning becomes evident. A telephone call to the front desk or an urgent plea for assistance directed from outside the office should bring support. Involuntary hospital commitment for observation would be an appropriate sequela.

Consultation

When the indications of violence in a dangerous patient continue to escalate, and where the services are readily available, psychiatric consultation should be sought. The psychiatrist should be familiar with dangerous patients. The recommended interviewing techniques, supervision of restraints, and administration of medications are within the psychiatrist's expertise. The psychiatrist should also be aware of involuntary commitment statutes. Since many dangerous patients are acting under the influence of drugs or alcohol, specific medical guidance can be obtained. The same recommendation for psychiatric help applies to those who are mentally ill.

Restraints

The dangerous patient whose aggressive behavior continues to escalate threatens the safety of himself and others. External controls become mandatory. Application of restraints should not be discussed with the patient until security personnel and the involved staff are prepared. Often when the dangerous patient sees the additional personnel, the crisis fades to a more manageable level. In the remaining cases, violence is inevitable, and the order for restraints must be given. With a minimum of four well-trained personnel, restraints can be applied. The physician should remain apart from the struggle and closely direct the activity. It is important to remind all concerned that with limbs pinioned, biting is a risk. Once restraints are applied, the patient must be visibly monitored. In many cases the restraints are sufficient; however, continued struggling, spitting, biting, and other exhausting activities require medication so the patient can finally achieve control over impulses.

Medication

In addition to restraints, medication is useful in the crisis management of the dangerous patient. In such cases injectable haloperidol is the drug of choice. The dangerous patient, agitated through psychosis, dementia, delirium, or manic states, can be managed effectively with haloperidol.[15] Haloperidol should be administered at a frequency of one intramuscular injection every 30 to 60 minutes until symptom control is achieved.[16] Typically, one to three injections of 5 to 10 mg is sufficient. The dosing, however, must remain flexible, with symptom resolution the final determinant. The major side effect is an acute dystonic reaction, which can be relieved with 50 mg of diphenhydramine given intramuscularly.

Clinical Case

A 21-year-old single man was accompanied to the physician's office by his supervisor. The hospital-based office was in proximity to a psychiatric unit.

After entering the physician's office, the patient became noticeably agitated. Refusing to sit down, he paced nervously about the room. He displayed tortured facial features, increasingly excited manners, and disorganized speech. He was clearly out of control. In the physician's judgment hospital admission was indicated. This action was conveyed to the patient in terms of helping him regain mastery of frightening impulses. In the presence of the patient, the physician called the psychiatry department, explained the situation, and requested assistance. Awaiting the psychiatric escorts, the physician reiterated his rationale for admission and dealt with the patient's anxieties through firm reassurance.

SUMMARY

The dangerous patient presents a crisis management problem. This article has focused on providing the clinician with practical guidance. Central to this theme is an understanding of human aggression. Violence, the behavioral expression of aggression, is influenced by environmental factors, family dynamics, drug ingestion, and mental illness. Certain specific behavioral clues, such as the startle response, predict the impending loss of control. Management of the dangerous patient can then be viewed as a hierarchy of external controls. Progression from interviewing techniques to physical restraints will be determined as each prior method is deemed ineffectual. In certain cases, safety demands physical restraints first. Ultimately, the clinician must remain alert and flexible. In so doing, the

best service can be provided to the dangerous patient and a safety-conscious public.

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