



# Handbook for Working with Mentally Disordered Offenders



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The Federal Judicial Center  
Court Education Division

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# **HANDBOOK FOR WORKING WITH MENTALLY DISORDERED OFFENDERS**

**Federal Probation  
and Pretrial Services**

Developed by the  
Federal Judicial Center's  
Court Education Division

Washington, D.C.  
April 1994

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## Introduction

*Handbook for Working with Mentally Disordered Offenders* is a reference guide for federal probation and pretrial services officers. The handbook provides basic information on selected mental health disorders and strategies for identifying and supervising mentally disordered offenders. It includes a list of training videos on mental health topics available from the Federal Judicial Center (FJC) Media Library, a list of national and state mental health resources and agencies, a glossary, and a bibliography.

This handbook does not provide all the information you need to work effectively with this offender population. To enhance your ability to work with mentally disordered offenders:

- Refer to the *Guide to Judicial Policies and Procedures* and applicable district policies for guidance on confidentiality, third-party risk, and other supervision issues related to mentally disordered offenders.
- Refer to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* for more information on mental health disorders, including specific diagnostic criteria for each disorder.
- Consult with your mental health specialist or community mental health professionals regarding case-specific characteristics and treatment strategies.
- Staff cases with colleagues and management to determine the most effective supervision plan based on the resources available in your district.
- Work with your training coordinator to develop in-service training conducted by community mental health professionals or the district's mental health specialist.
- Broaden your knowledge of mental disorders by reading journals and books, viewing videos, and attending seminars.

## Chapter 1: Case Management and the Mentally Disordered Offender

This chapter contains clinical information on selected mental health disorders. It also contains general strategies for supervising all mentally disordered offenders, as well as information for supervising offenders with a particular mental health disorder. Medical terms are defined in the glossary.

The diagnostic criteria and associated features for the mental health disorders are taken directly from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*.<sup>1</sup> Consult the *DSM-III-R* for additional information.

All statistical and treatment information is adapted from the *Synopsis of Psychiatry*.<sup>2</sup>

Information on the relationship between violence and mental health disorders is adapted from *Drugs and Violence in America*,<sup>3</sup> and the article "Mental Disorder and Violent Behavior" published in *American Psychologist*.<sup>4</sup>

Supervision strategies and case-management techniques are adapted from the *Guide to Judicial Policies and Procedures*<sup>5</sup> and from information provided by experienced senior officers and mental health specialists in federal probation and pretrial services.

The Office of General Counsel of the Administrative Office of the U.S. Courts reviewed information about legal issues in this chapter.<sup>6</sup>

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1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (3d ed., rev.). Washington, D.C.: APA, 1987, pp. 187 - 296, 336 - 358.

2. Kaplan, Harold I., and Sadock, Benjamin J. *Synopsis of Psychiatry* (6th ed.). Baltimore, Md.: Williams & Wilkins, 1991, pp. 320 - 342, 363 - 415, 443 - 448, 525 - 542.

3. Monahan, John. "Causes of Violence." In *Drugs and Violence in America*, edited by the United States Sentencing Commission. Washington, D.C.: GPO, 1993, pp. 77 - 85.

4. Monahan, John. "Mental Disorder and Violent Behavior." *American Psychologist*, 47, no. 4 (April 1992): 511 - 520.

5. Administrative Office of the U. S. Courts. *Guide to Judicial Policies and Procedures* (Volume X, Chapter XI). Washington, D.C., January 1990, pp. 1 - 2, and 24 - 38.

6. David Adair, Assistant General Counsel, Office of General Counsel, Administrative Office of the U. S. Courts. Review of *Handbook for Working with Mentally Disordered Offenders*, November 22, 1993.



## Introduction to Mental Health Disorders

The *Guide to Judicial Policies and Procedures* (Volume X, Chapter XI) states that an individual is considered mentally disordered when behaviors or feelings deviate so substantially from the norm as to indicate disorganized thinking, perception, mood, orientation, and memory. Mental health disorders range from mildly maladaptive to profoundly psychotic and can result in

- unrealistic behavior;
- marked inability to control impulses;
- grossly impaired judgment;
- aberrant behavior;
- an inability to care for oneself or meet the demands of daily life;
- a loss of contact with reality; or
- violence to self or others.

### *DSM-R-III*

Mental health professionals use the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, developed by the American Psychiatric Association, to diagnose mental health disorders. The *DSM-III-R* defines mental health disorders in terms of descriptive symptoms and behaviors. The manual does not generally address the causes of a psychiatric disorder based on any one psychological theory.

The *DSM-III-R* employs a classification system that consists of five axes:

- Axis I: Clinical syndromes, including major psychiatric disorders.
- Axis II: Developmental disorders and personality disorders.
- Axis III: Physical disorders that are relevant to etiology or case management.
- Axis IV: Severity of psychological stressors.
- Axis V: Highest level of adaptive functioning.

Psychiatrists and psychologists may use all five axes to diagnose an individual. This multiaxial system, a comprehensive or holistic approach to evaluation that considers the psychological, biological, and social components of an individual, leads to an accurate diagnosis and prognosis, and effective treatment planning. The appendix to this handbook provides an overview of the *DSM-III-R* classification system.

The axes that are most relevant to officers are Axis I and Axis II, the axes that classify mental health disorders.

### Axis I

Axis I disorders are the major psychiatric disorders that most laypersons associate with mental illness. The Axis I disorders included in this handbook are

- mood disorders, including major depression and bipolar disorders;
- schizophrenia;
- anxiety disorders, including panic disorder, phobias, post-traumatic stress disorder, and obsessive-compulsive disorder; and
- paraphilias.

Almost all Axis I disorders are treatable with medication and therapy. Psychotropic medications include the antidepressant, antimanic, anticonvulsant, antianxiety, and antipsychotic medications listed in Chapter 3. In general, individuals with an Axis I disorder are amenable to treatment. They tend to talk about their difficulties and feel pain and discomfort because of their mental health disorder. Psychiatric and treatment information for these Axis I disorders is given later in this chapter.

### Axis II

The key to understanding Axis II personality disorders is the word "personality." Personality is defined as all the emotional and behavioral traits that characterize a person in day-to-day living under ordinary conditions. These traits, which differ from individual to individual, define who we are, how we see the world, and how the world sees us.

In mentally healthy individuals, the emotional and behavioral traits that compose their personalities are relatively stable, consistent, and predictable. These traits, although dominant, are also flexible and adaptive. This flexibility allows the individual to survive stress and to function within an ever changing environment.

In contrast, individuals with a personality disorder have traits that are inflexible, maladaptive, and destructive. These traits begin in early adulthood and are present

in a variety of contexts. Rather than adapting to their environment, individuals with personality disorders expect the environment to adapt to them. Unlike persons diagnosed with Axis I disorders, persons diagnosed with Axis II personality disorders generally do not feel anxiety or distress about their maladaptive behavior. When they feel pain and discomfort, they rarely assume there is anything wrong with them. Rather, they think the difficulties lie outside themselves.

The *DSM-III-R* classifies personality disorders into three clusters:

- Cluster A includes the paranoid, schizoid, and schizotypal personality disorders.
- Cluster B includes the antisocial, borderline, histrionic, and narcissistic personality disorders.
- Cluster C includes the avoidant, dependent, obsessive-compulsive, and passive-aggressive personality disorders.

According to the *DSM-III-R*, many patients exhibit traits that meet the diagnostic criteria for more than one personality disorder.

Individuals with personality disorders often deny their problems, refuse psychiatric help, or resist treatment. The pervasive and inappropriate character traits associated with personality disorders cannot be treated with medication; therapy is the treatment of choice for personality disorders. Occasionally, medication may be prescribed to treat other psychiatric symptoms, such as depression or anxiety. Psychiatric and treatment information for personality disorders is given later in this chapter.

## Introduction to Supervision Issues

Officers who work with mentally disordered offenders must be patient and flexible, must have a knowledge of mental health disorders, and must develop the skills necessary to effectively work with this offender population. Supervision strategies may vary because of the unique problems and needs associated with each mentally disordered offender; however, there are common considerations. This section reviews these common issues. The remaining sections in Chapter 1 identify treatment and supervision issues specific to selected mental health disorders.

### Treatment Issues

Mental health treatment should begin with an assessment that, among other things, highlights risk factors that may be evident during pretrial release and probation supervision. Treatment consists of therapy or medication or both, provided by professional mental health treatment practitioners.

**Therapy.** Therapy can be provided by a psychiatrist, psychologist, social worker, or other licensed counselor. Whenever possible, refer a mentally disordered offender to a therapist experienced in treating similarly diagnosed patients, or to a clinic that provides treatment for specific disorders, such as depression or panic disorder.

Only psychiatrists and other medical doctors can prescribe medications. Psychotropic medications should be prescribed in conjunction with a structured therapeutic plan. Consider the offender to be in treatment as long as he or she is taking medication.

**Medication.** Familiarize yourself with the intended effects and side effects of medications taken by mentally disordered offenders. Some medications cause side effects, ranging from mild, such as dry mouth or drowsiness, to severe, such as low blood pressure or involuntary muscle spasms. Offenders experiencing side effects may refuse to take their medication. Remind offenders that the medication may not be effective unless taken every day. Encourage offenders to discuss the side effects with their mental health treatment providers.

Ask the prescribing physician about the interaction of the medication and alcohol. Some medications, such as antianxiety medications, increase the effects of alcohol. Share information regarding offenders' alcohol use or abuse with treatment providers. Warn offenders about the danger of mixing alcohol and some medications.

If an offender continually stops taking prescribed medication, consider asking the prescribing physician to take blood tests to help monitor compliance with the

medication regime. You may request tests, but may not demand them without a special condition of supervision. Advise the offender that he or she is not required to provide blood samples, but that a refusal to do so could be reported to the court and the conditions of supervision modified to specifically require that the tests be conducted.

**Release of confidential information.** Have the offender sign release of confidential information forms so that appropriate information can be shared by the officer and treatment providers.

### **Treatment Termination**

Treatment termination should be a joint decision by the officer, the treatment provider, and the offender. Each should feel confident that the offender is symptom-free and has benefited as much as possible from the therapeutic process.

Occasionally, a mental health treatment provider will recommend terminating treatment because the provider feels the offender is not participating or cooperating in therapy, or because the provider feels that the offender has progressed as far as possible. When a treatment provider recommends terminating treatment, determine the reason and request a written report. Depending upon district policy, submit the report to the court. If you are concerned or disagree with the provider about terminating treatment, discuss the case with the district's mental health specialist, your chief or supervisor, or seek the opinion of another treatment provider.

Treatment should not be terminated if you believe any of the following to be true:

- The offender is dangerous to self or others, for example, potentially suicidal, noncompliant with medication regime, or unable to care for self.
- The offender's condition may deteriorate or the offender may become dangerous without treatment. Even though the offender may be making minimal or no progress, continued treatment enables the treatment providers to monitor the offender's mental state.
- The offender continues to have symptoms of a mental health disorder. If necessary, refer the offender to another mental health professional.

Because mentally disordered offenders are prone to relapse, many mental health specialists recommend that the treatment condition not be removed when treatment is terminated. The standard mental health treatment condition is sufficiently broad to permit treatment termination without the officer asking the court to remove the special condition. The court should be informed that the offender is no longer in treatment and that the officer will monitor the offender's behavior for signs of relapse.

*Note:* Follow all applicable policies regarding the imposition, modification, and removal of special conditions of release or supervision.

### **Crisis Intervention**

The crisis situations that mentally disordered offenders encounter most often are suicidal behaviors, psychotic episodes, and homicidal threats.

**Suicidal behavior.** Evaluate the risk posed by any suicidal threats and gestures. When an offender makes a suicidal threat, immediately ask questions about the suicide plan—ask when, where, and how the offender will execute the threat. Previous suicide attempts and the definitiveness of a suicide plan indicate the risk of suicide.

If you have reason to believe an offender is imminently suicidal, secure the offender's safety. Transporting the offender to a treatment facility yourself is too risky because the offender can open the car doors. Also, the offender may require restraint. (Similarly, suggesting that a friend or family member transport the offender presents a risk.) Therefore, consider requesting police assistance to transport a suicidal offender to an emergency psychiatric facility. In many states it is the responsibility of law enforcement officers to do so.

If the offender is not imminently suicidal, but you sense the offender is considering suicide, there are several things you can do:

- Tell the offender that you are concerned about his or her safety.
- Give the offender the telephone number of a local suicide hotline.
- If the offender has a treatment provider, make the provider aware of the concern.
- If the offender does not have a treatment provider, initiate a referral for a mental health evaluation.

**Psychotic episodes.** Psychosis is characteristic of a number of mental health disorders. During a psychotic episode an offender incorrectly evaluates the accuracy of his or her perceptions, thoughts, and moods and makes incorrect inferences about external reality. The offender's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately are impaired. Mentally disordered offenders may deteriorate into a psychotic state for a variety of reasons, such as a failing to take medication or experiencing extreme stress or anxiety.

Research studies indicate that when mentally disordered patients are experiencing active psychotic symptoms, such as delusions and hallucinations, their risk of

violence increases. Obtain immediate treatment services for an offender experiencing a psychotic episode. Arrange for transportation to a local emergency psychiatric facility and contact the offender's treatment provider.

**Homicidal threats.** Homicidal threats made by mentally disordered offenders are handled no differently than threats made by any offender. Assess the seriousness of the threat and the potential for violence; follow standard officer safety procedures; make required third-party warnings; and contact local law enforcement agencies as appropriate.

*Note:* Probation officers should follow the policies for third-party risk situations outlined in the *Guide to Judicial Policies and Procedures*. Pretrial services officers should report third-party risk to the court and the U.S. attorney's office for guidance regarding warnings or other action to reduce the risk.

### **Supervision Strategies**

In general, all mental health cases require the following supervision strategies:

- Review all the offender's psychiatric documentation and other relevant medical documentation.
- Carefully word mental health treatment conditions. Many mental health specialists find it advantageous to phrase mental health treatment conditions in a manner that provides flexibility during supervision. However, a lack of specificity in a mental health treatment condition may make the condition difficult to enforce. The offender may claim that the condition does not give the officer authority to order a particular activity. In general, the greater the deprivation of liberty the officer's directive entails, the greater the likelihood the offender will challenge the authority of the officer to order the activity. As a general rule, request specificity in the mental health condition as soon as the need for a highly restrictive form of treatment is anticipated.

For example, if you are using the general treatment condition "the offender shall participate in psychiatric services or mental health counseling as deemed appropriate by the officer" and an offender exhibits suicidal or psychotic behavior that requires hospitalization, order such treatment only on an emergency basis. Since hospitalization or any inpatient care results in a significant deprivation of liberty, ask the court as soon as possible for a modification of the condition to specify inpatient care.

- Take note of any history of dangerous behavior. Review the offender's supervision plan with your supervisor and alert the supervisor to any special issues associated with the offender.

- Identify areas in which the offender may need assistance, such as obtaining medical assistance, disability income, housing, or vocational training.
- Have the offender sign release of confidential information forms.
- Work with the mental health treatment provider to monitor the offender's compliance with the medication regime and to assess therapeutic progress.
- Familiarize yourself with the offender's psychotropic medication so that you can talk to the offender about the medication regime and can encourage him or her to take the medication as prescribed.
- Be alert to drug and alcohol abuse relapses associated with dually diagnosed offenders.
- Coordinate the offender's treatment services. Share information among the providers as needed and in accordance with confidentiality regulations and statutes.
- Schedule contact with the offender based on the severity of the offender's mental health disorder, the state of the offender's physical health, and occupational and social circumstances.
- Clearly establish and explain the limits of acceptable and unacceptable behavior. Explain the consequences of noncompliance with the conditions of supervision.
- Identify and make frequent contact with the offender's support system, that is, family, friends, employers, and others.

*Note:* Officers should not disclose any more pretrial, presentence, or supervision information than necessary to obtain requested information from collateral contacts. Although officers may say that an offender is under presentence investigation or supervision, details of the offense and of supervision should not be disclosed unless absolutely necessary to elicit information. Refer to the *Guide to Judicial Policies and Procedures* for additional guidance on confidentiality and investigation techniques.

Under no circumstances should drug aftercare information be disclosed to collateral contacts. Release of such information could subject the officer to possible criminal penalties.

- Prepare crisis intervention plans for handling suicide threats or attempts, psychotic episodes, homicide threats, and other crises that may arise from mental health disorders.



Additional supervision strategies are determined by the offender's mental health disorder and personal circumstances. For example, an offender with paranoid schizophrenia who fails to regularly take medication and who has no steady residence or source of income requires intensive supervision, including frequent collateral contact with the mental health treatment provider. In contrast, an offender with major depression who is stabilized on medication and participating in therapy and who has a supportive family and a stable job requires less frequent contact. Refer to the remaining sections of Chapter 1 for information on supervision issues unique to specific mental health disorders.

*Note:* All supervision strategies an officer uses must be in accordance with district policy.

### **Officer Safety**

Many laypersons believe that mentally disordered individuals are more prone to violence and dangerous behavior than the general population; however, research does not substantiate this belief. Studies suggest that violent acts committed by individuals with major mental health disorders account for at most 3% of the violence in American society. Some mental health disorders include features that are clearly associated with violent behavior toward self or others, such as suicidal behavior, self-mutilation, psychotic episodes, and persecutory delusions. However, violent behavior by mentally disordered persons is a function of an interaction of diverse personal, situational, and clinical factors, not simply a diagnosis of a mental health disorder. See Chapter 5 for more information regarding violence and mental illness.

In general, the unpredictable nature of mental health disorders creates the need to follow routine safety procedures when working with these offenders. Following are some general officer safety considerations:

- Be aware of the status of the offender's mental health at all times. Maintain ongoing communication with the treatment provider and collateral contacts.
- Schedule the initial contact with a mentally disordered offender in the office, treatment facility, or other safe location, not the offender's home.
- If an offender is potentially dangerous or unstable, schedule contacts in the office, not the offender's home.
- Depending on the current state of the offender's mental health, consider taking a second officer with you on home contacts during the early stages of supervision. Notify the offender ahead of time of any home contact in which another person will be present.

- When making a home contact alone, alert a colleague of the time and place of the contact, particularly if the offender has a history of being violent or not taking prescribed medication. Establish a method of soliciting assistance when in the field.
- Refrain from confronting or criticizing the offender at home.
- Never let an offender know your address or details about your family or personal life. In the office, keep pictures of your family out of sight; remove plaques or mementos that give personal information.
- During an office visit, keep the door open or slightly ajar, and let a colleague know that your appointment is with a mentally disordered offender.
- Avoid startling the offender.
- Do not tower over the offender or stare. Both you and the offender should sit, if possible, during interviews and home contacts.

## **Major Depression**

Major depression is a sustained period (at least two weeks) during which an individual experiences a depressed mood or a loss of interest or pleasure in all, or almost all, activities. During this period the individual may also exhibit other symptoms of depression. Twice as many women as men suffer from major depression.

### **DSM-III-R Diagnostic Criteria for a Major Depressive Episode**

At least five of the following symptoms have been present every day, almost all day, during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either a depressed mood or loss of interest or pleasure:

- depressed mood;
- disinterest or lack of enjoyment in usual activities;
- significant decrease or increase in weight;
- insomnia or increased need for sleep (hypersomnia);
- psychomotor agitation or psychomotor retardation;
- fatigue or loss of energy;
- feelings of worthlessness or excessive or inappropriate guilt;
- decreased concentration or ability to think clearly; or
- recurrent thoughts of death, or suicidal thoughts, attempts, or plans.

### **Associated Features of Major Depression**

- Tearfulness
- Anxiety
- Irritability
- Brooding or obsessive rumination

- Excessive concern with physical health
- Phobia or panic attacks
- Mood-congruent hallucinations or delusions

### **Treatment Regime for Major Depression**

The treatment regime for major depression includes the following:

- psychotherapy, often in conjunction with medication;
- antidepressant medications;
- antianxiety medications if the depression is accompanied by anxiety;
- antipsychotic medications for brief periods of time for severe depression with psychotic features, for example, depression accompanied by delusions and hallucinations; and
- hospitalization for severe cases.

Antidepressant medications do not take effect immediately and are generally prescribed for a period of six months or longer.

### **Supervision Issues for Major Depression**

Some studies suggest that approximately 66% of all depressed patients have suicidal ideation and 10% to 15% successfully commit suicide. For example, suicide is a possibility with the white-collar offender who becomes severely depressed upon entering the criminal justice system for the first time and losing family, job, income, or friends because of the arrest or conviction.

The risk of suicide sometimes increases as the depressed offender initially improves and regains the energy needed to plan and carry out the suicide. Monitor these offenders for suicidal thoughts and gestures.

Offenders can take medication as long as six weeks before experiencing significant relief from the symptoms of depression. Sometimes offenders with major depression will not take their antidepressant medication because of its side effects (e.g., fatigue, dry mouth, constipation, blurred vision, muscle weakness, or lightheadedness) or because they feel better. Remind the offender that for antidepressant medications to be effective they must be taken every day, not only when the offender feels depressed.

Major depression is a cyclic disorder consisting of periods of illness separated by periods of stable mental health. The psychiatrist or mental health treatment provider may recommend that the offender terminate the treatment process when the depressive episode ends. However, remain alert to renewed signs of depression. Encourage offenders to return to therapy for a progress check if mild depression returns, rather than wait until they are seriously depressed.

Severely depressed individuals generally lack the motivation or energy to act in an impulsive or violent manner. However, a depressed offender experiencing a psychotic episode needs attention and medical intervention.

## **Bipolar Disorders (Manic and Manic-Depressive Illness)**

Individuals with bipolar disorders suffer one or more manic episodes usually accompanied by one or more major depressive episodes. With manic-depressive illness, mood swings are sometimes separated by periods of normal mood. Equally prevalent in men and women, bipolar disorder affects an estimated 0.4% to 1.2% of the adult population.

### ***DSM-III-R* Diagnostic Criteria and Associated Features for a Depressive Episode**

Refer to the diagnostic criteria and associated features of major depression.

### ***DSM-III-R* Diagnostic Criteria for a Manic Episode**

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood.
- During a period of mood disturbance, at least three of the following symptoms have persisted and have been present to a significant degree:
  - inflated self-esteem;
  - decreased need for sleep;
  - more talkative than usual;
  - flight of ideas or racing thoughts;
  - distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli;
  - increase in goal-directed activity (either socially, at work, at school, or sexually), or psychomotor agitation; or
  - excessive involvement in pleasurable activities, with a lack of concern for the high potential for painful consequences, such as buying sprees, foolish business ventures, reckless driving, or casual sex.
- Mood disturbance severe enough to cause marked impairment in occupational or social functioning, or to necessitate hospitalization to prevent harm to others.

### **Associated Features of a Manic Episode**

- Inability to recognize presence of an illness; resistance to treatment
- Rapid shift to depression or anger
- Hallucinations or delusions

### **Treatment Regime for Bipolar Disorders**

The treatment regime for bipolar disorders includes the following:

- Psychotherapy is often used in conjunction with medication.
- Lithium is the standard drug treatment for acute manic episodes. Tegretol (carbamazepine) and Depakote (valproic acid) are also frequently used.
- Antidepressant medications are sometimes prescribed for bipolar disorders, but the patient must be carefully observed for the emergence of manic symptoms.
- Antipsychotic, and sometimes antianxiety, medications are occasionally used at the initiation of treatment to control agitation.
- Hospitalization may be necessary during acute phases of the illness.

Lithium can be toxic. When a patient first starts taking lithium, doctors will take blood samples frequently until they know that the proper dosage is established in the patient's bloodstream. To assure compliance with treatment, and the efficacy and safety of the drug, blood samples may be taken every three months to measure the level of the lithium in the bloodstream.

### **Supervision Issues for Bipolar Disorders**

During a manic episode, poor judgment, hyperactivity, and other symptoms of the disorder may lead an offender into activities such as reckless driving, foolish business ventures, unrestrained buying sprees, or involvement in illegal activities.

Sometimes involuntary hospitalization is required to prevent harm to the offender or others.

When an offender is experiencing a major depressed state, monitor the offender for suicidal thoughts or gestures.

Although elevated mood is the primary symptom of a manic episode, in instances where the offender is hindered or frustrated in some manner, the mood disturbance

may be characterized by complaints, hostile comments, or angry tirades. The offender may become threatening or assaultive.

Exercise caution when an offender is experiencing a manic episode. Alert the receptionist and building security that the offender will be reporting to the office. Ask another officer to observe the interview. If an offender is experiencing a manic episode during a home contact, assess the degree of danger and take appropriate safety precautions.

Noncompliance with the medication regime is a common supervision problem because of the side effects of antimanic and antidepressant medications and because many offenders like the euphoric feelings associated with manic episodes. Remind offenders that antimanic and antidepressant medications must be taken over a period of several weeks to be effective and that they must be taken every day.

Many offenders with bipolar disorder will need to take medication and participate in treatment during the entire supervision period.



## Schizophrenia

Schizophrenia is a group of disorders manifested by disturbances in communication, language, thought, perception, affect, and behavior which last longer than six months.

### *DSM-III-R* Diagnostic Criteria for Schizophrenia

- Presence of characteristic psychotic symptoms in the active phase: either (1), (2), or (3) for at least one week (unless the symptoms are successfully treated):
  - (1) two of the following:
    - (a) delusions
    - (b) hallucinations
    - (c) incoherence or marked loosening of associations
    - (d) catatonic behavior
    - (e) flatly or grossly inappropriate affect;
  - (2) bizarre delusions;
  - (3) prominent hallucinations of a voice or voices.
- During the course of the disturbance, functioning in such areas as work, social relations, and self-care is markedly below the highest level achieved before onset of the disturbance.
- Schizoaffective disorder and mood disorder with psychotic features have been ruled out.
- Continuous signs of disturbance for at least six months. The six-month period must include an active phase (of at least one week, or less if symptoms have been successfully treated) during which there were psychotic symptoms, with or without a prodromal or residual phase, as defined below.

**Prodromal phase:** A clear deterioration in functioning before the active phase of the disturbance that is not due to a mood disorder or to a psychoactive substance abuse disorder, and that involves at least two of the symptoms listed below.

Residual phase: Following the active phase of the disturbance, persistence of at least two of the symptoms listed below; symptoms are not due to a mood disorder or to a psychoactive substance abuse disorder.

Prodromal or residual symptoms:

- marked social isolation or withdrawal;
- marked impairment in role functioning as wage-earner, student, or homemaker;
- peculiar behavior, such as collecting garbage or hoarding food;
- marked impairment in personal hygiene and grooming;
- blunted or inappropriate affect;
- digressive, vague, overelaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech;
- odd beliefs or magical thinking that influences behavior and is inconsistent with cultural norms, such as a belief in clairvoyance or telepathy;
- unusual perceptual experiences, such as recurrent illusions; or
- marked lack of initiative, interests, or energy.

#### **Associated Features of Schizophrenia**

- Perplexed or disheveled appearance
- Abnormal psychomotor activity, such as rocking or pacing
- Poverty of speech: responses to inquiries are brief and unelaborated
- Depression, anger, or anxiety
- Depersonalization and derealization
- Ritualistic or stereotypical behavior
- Excessive concern with physical health

## Types of Schizophrenia

The diagnosis of a particular type should be based on the predominant clinical picture that occasioned the most recent evaluation or admission to clinical care.

- Catatonic type in which the clinical picture is dominated by any of the following:
  - catatonic stupor (marked decrease in ability to react to the environment);
  - catatonic negativism (motiveless resistance to all instructions or attempts to be moved);
  - catatonic rigidity (maintenance of a rigid posture);
  - catatonic excitement (purposeless excited motor activity); and
  - catatonic posturing (voluntary assumption of inappropriate or bizarre posture).
- Disorganized type in which the following criteria are met:
  - incoherence, marked loosening of associations, or grossly disorganized behavior;
  - flat or grossly inappropriate affect; and
  - does not meet the criteria for catatonic type
- Paranoid type in which there are:
  - preoccupation with one or more systematized delusions or with frequent auditory hallucinations related to a single theme; and
  - none of the following: incoherence, marked loosening of associations, flat or grossly inappropriate affect, catatonic behavior, or grossly disorganized behavior.
- Undifferentiated type in which there are:
  - prominent delusions, hallucinations, incoherence, or grossly disorganized behavior; and
  - does not meet the criteria for paranoid, catatonic or disorganized type.

- Residual type in which there is:
  - absence of delusions, hallucinations, incoherence, or grossly disorganized behavior; and
  - continuing evidence of illness or disturbance, as indicated by two or more of the residual symptoms of schizophrenia

### **Treatment Regime for Schizophrenia**

The treatment regime for schizophrenia includes the following:

- antipsychotic medications;
- hospitalization during acute periods of illness;
- outpatient follow-up to administer and monitor medication;
- day treatment or group home programs; and
- recreational, group, or vocational support therapy (potentially necessary to help the individual function).

Many offenders with schizophrenia can only maintain emotional and mental stability by taking medication. Although any medical physician can prescribe antipsychotic medication, a psychiatrist should be the offender's primary treatment provider because medication is such an important part of the treatment regime.

Antipsychotic medications treat the symptoms of the illness; they are not a cure for schizophrenia. Long-term use of some antipsychotic medications may result in serious side effects. For example, offenders may develop Parkinsonian effects (rigidity, shuffling gait, stooped posture, and drooling) or Tardive dyskinesia (abnormal, involuntary, irregular movements of the muscles in the head and body, including darting, twisting, and protruding movements of the tongue, chewing and lateral jaw movement, and facial grimacing around the eyes and mouth).

### **Supervision Issues for Schizophrenia**

Many offenders with schizophrenia are impaired in several areas of routine daily functioning, such as work, social relations, and self-care. Placement in a group house may be necessary to ensure that the offender is properly fed and clothed and to protect the individual from the consequences of poor judgment, impaired thinking, or actions based on hallucinations or delusions. Some offenders require these support services for the duration of the supervision period.

The *DSM-III-R* indicates that patients with schizophrenia have a higher rate of suicide than the general population, and some studies indicate that approximately 50% of all patients with schizophrenia attempt suicide and approximately 10% succeed. Monitor offenders with schizophrenia for suicidal thoughts or gestures.

Noncompliance with the medication regime as a result of the medication's side effects is a common supervision problem. Offenders with schizophrenia may become noncompliant with other conditions of supervision or dangerous to themselves or others when they stop taking their medication. Monitor offenders' behavior for indications of not following the prescribed medication regime.

Many offenders with schizophrenia require mental health treatment throughout their supervision period.

Research indicates that violence is no more common in patients with schizophrenia than in the general population. Be alert to the potential for violent behavior when the offender has a history of aggressive and assaultive behavior, is noncompliant with the medication regime, or is experiencing a psychotic episode.

**Paranoid schizophrenia.** The *DSM-III-R* lists violence as an associated feature of paranoid schizophrenia. This can become a third-party-risk issue or an officer-safety issue, particularly if an offender forms persecutory delusions concerning the officer. Only office contacts should be scheduled with offenders who exhibit paranoid symptoms and who do not take their medication regularly. Alert the receptionist and building security that the offender will be reporting to the office.

## **Panic Disorder**

Panic disorder is characterized by recurrent panic attacks (i.e., discrete periods of fear or discomfort often accompanied by a sense of impending doom).

### ***DSM-III-R Diagnostic Criteria for Panic Disorder***

- At some time during the disturbance, one or more panic attacks have occurred that were unexpected and were not triggered by situations in which the person was the focus of others' attention.
- Either four attacks occurred within a four-week period, or one or more attacks were followed by at least a month of persistent fear of having another attack.
- At least four of the following symptoms developed during at least one of the attacks:
  - shortness of breath or smothering sensations;
  - dizziness, unsteady feelings, or faintness;
  - palpitations or accelerated heart rate;
  - trembling or shaking;
  - sweating;
  - choking;
  - nausea or abdominal distress;
  - depersonalization or derealization;
  - numbness or tingling sensations;
  - hot flashes or chills;
  - chest pain or discomfort;
  - fear of dying; or
  - fear of going crazy or doing something uncontrolled.

- During at least some of the attacks, at least four of the above symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first symptom.

### **Associated Features of Panic Disorder**

- Nervousness or apprehension between attacks
- Coexisting depressive disorder
- Alcohol abuse or antianxiety medication abuse

### **Treatment Regime for Panic Disorder**

The treatment regime for panic disorder includes the following:

- behavior therapy;
- insight-oriented psychotherapy; and
- antianxiety medications.

### **Supervision Issues for Panic Disorder**

A panic attack generally begins with a ten-minute period of rapidly increasing symptoms and lasts twenty to thirty minutes. During an attack, the individual may appear confused, have trouble concentrating, experience physical symptoms, such as sweating or shaking, and not be able to name the source of the fear. If you observe an offender having a panic attack, quietly and calmly reassure him or her that the attack will pass, that he or she will be fine, and that you will not leave. After the attack, encourage the offender to contact his or her treatment provider.

## **Phobias**

A phobia is a persistent or irrational fear of an object, situation, or place accompanied by a powerful desire to avoid that object, situation, or place.

### **DSM-III-R Diagnostic Criteria for Simple Phobia**

- Persistent fear of a circumscribed stimulus (object or situation) other than fear of having a panic attack (as in panic disorder) or of humiliation or embarrassment in certain social situations (as in social phobia).
- During some phase of the disturbance, exposure to the specific phobic stimulus (or stimuli) almost invariably provokes an immediate anxiety response.
- The object, situation, or place is avoided, or endured with intense anxiety.
- Fear or the avoidant behavior interferes with the individual's normal routine or with social activities or relationships with others, or there is marked distress about having the fear.
- Realization that the fear is unreasonable or excessive.
- The phobic stimulus is unrelated to the content of the obsessions or obsessive-compulsive disorder or the trauma of post-traumatic stress disorder.

### **Associated Features of Phobias**

- Generalized anxiety
- Panic disorder or other phobia
- Depression

### **Subtypes of Phobias**

- Social phobia is characterized by the following:
  - persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing;



- phobic situation(s) is avoided, or is endured with intense anxiety;
- avoidant behavior interferes with occupational functioning or with usual social activities or relationships with others, or there is marked distress about having the fear; and
- person recognizes that his or her fear is excessive or unreasonable.
- Panic disorder with agoraphobia is characterized by the following:
  - meets the criteria for panic disorder; and
  - fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of a panic attack. As a result of this fear, the person either restricts travel or needs a companion when away from home, or else endures agoraphobic situations despite intense anxiety. Common agoraphobic situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and traveling in a bus, train, or car.
- Agoraphobia without history of panic disorder is characterized by the following:
  - fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of suddenly developing a symptom that could be incapacitating or extremely embarrassing; and
  - has never met the criteria for panic disorder.
- Simple phobias, such as
  - acrophobia: fear of heights;
  - claustrophobia: fear of closed spaces;
  - blood-injury phobia: fear of witnessing blood or tissue injury;
  - fear of animals; or
  - fear of air travel.

### **Treatment Regime for Phobias**

The treatment regime for phobias includes the following:

- behavior therapy;
- insight-oriented psychotherapy; and
- antianxiety or antidepressant medications during acute phases of illness.

### **Supervision Issues for Phobias**

Most offenders with phobias live relatively normal lives because they simply avoid the phobic object or situation. However, some phobias may require special accommodations. For example, an offender with a phobia involving elevators or heights may not be able to report to the probation office if it is in a high-rise building. The contact could be scheduled in the building lobby or the offender's home. Do not allow an offender's phobia, susceptibility to panic attacks, or other anxieties to keep the offender from complying with the conditions of supervision.

## Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is characterized by the development of distinctive symptoms following a psychologically distressing event outside the range of normal human experience, such as military combat, rape, assault, or natural disaster.

### *DSM-III-R* Diagnostic Criteria for Post-Traumatic Stress Disorder

- The individual has experienced a traumatic event that would markedly distress almost anyone.
- Reexperience of the traumatic event in at least one of the following ways:
  - recurrent and intrusive distressing recollections of the event;
  - recurrent distressing dreams of the event;
  - suddenly acting or feeling that the event is reoccurring; or
  - intense psychological distress when exposed to events that symbolize or resemble an aspect of the traumatic event.
- Persistent avoidance of stimuli associated with the traumatic event or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
  - efforts to avoid thoughts or feelings associated with the trauma;
  - efforts to avoid activities or situations that arouse recollections of the trauma;
  - inability to recall an important aspect of the trauma;
  - markedly diminished interest in significant activities;
  - feelings of detachment or estrangement from others;
  - restricted range of affect (e.g., unable to have loving feelings); or
  - sense of foreshortened future (e.g., does not expect to have a career or children).

- Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
  - difficulty falling asleep or staying asleep;
  - irritability or outbursts of anger;
  - difficulty concentrating;
  - hypervigilance;
  - exaggerated startle response; or
  - physiological reaction upon exposure to events that symbolize or resemble an aspect of the traumatic event.
- Duration of the disturbance (symptoms) of at least one month.

#### **Associated Features of Post-Traumatic Stress Disorder**

- Depression
- Anxiety
- Impulsive behaviors
- Symptoms of an organic mental disorder, such as failing memory, difficulty in concentrating, or headaches
- Feelings of guilt about surviving when others perished

#### **Treatment Regime for Post-Traumatic Stress Disorder**

The treatment regime for post-traumatic stress disorder includes the following:

- psychotherapy, including behavior therapy, cognitive therapy, and hypnosis;
- family therapy and group therapy, particularly for Vietnam veterans; and
- antianxiety or antidepressant medications during acute phases of illness.

### **Supervision Issues for Post-Traumatic Stress Disorder**

The *DSM-III-R* indicates that emotional liability, depression, and guilt may result in self-defeating behavior or suicide. Hospitalization may be necessary when there is a risk of suicide or other violence.

Substance abuse or dependence is a complication of this disorder. Monitor the offender's drug use.

## Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is characterized by recurrent obsessions or compulsions that are distressful and interfere significantly with the individual's normal routine.

### *DSM-III-R* Diagnostic Criteria for Obsessive-Compulsive Disorder

- Either obsessions or compulsions:

#### Obsessions

- recurrent and persistent ideas, thoughts, impulses, or images that are experienced, at least initially, as intrusive and senseless (e.g., a parent's having repeated impulses to kill a loved child or a religious person's having recurrent blasphemous thoughts);
- the person attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action;
- the person recognizes that the obsessions are created within his or her own mind and not imposed from without; and
- if another Axis I disorder is present, the content of the obsession is unrelated to it (e.g., the ideas, thoughts, impulses, or images are not about food in the presence of an eating disorder, about drugs in the presence of a psychoactive substance abuse disorder, or guilty thoughts in the presence of a major depression).

#### Compulsions

- repetitive, purposeful, and intentional behaviors that are performed in response to an obsession or according to certain rules or in a stereotyped fashion;
- the behavior is designed to neutralize or prevent discomfort or some dreaded event or situation; however, either the activity is not connected in a realistic way with what it is designed to neutralize or prevent, or it is clearly excessive; and
- the person realizes that the compulsions are excessive and unreasonable.

- The obsessions or compulsions cause marked distress, are time-consuming, or significantly interfere with the person's normal routine, or occupational and social functioning.

### **Associated Features of Obsessive-Compulsive Disorder**

- Depression and anxiety
- Tension if the compulsive activity is not performed
- Avoidance of situations that involve the content of the obsession

### **Treatment Regime for Obsessive-Compulsive Disorder**

The treatment regime for obsessive-compulsive disorder includes the following:

- behavior therapy;
- psychotherapy; and
- antianxiety or antidepressant medications during acute phases of illness.

### **Supervision Issues for Obsessive-Compulsive Disorder**

Approximately one-third of those diagnosed with obsessive-compulsive disorder develop major depression. Monitor these offenders for signs of suicidal thoughts and gestures.

The *DSM-III-R* indicates that alcohol abuse is a complication of this disorder. Monitor the offender's alcohol use.

## **Paraphilias**

The essential feature of disorders in this subclass is sexual arousal in response to objects or situations that are not part of normal sexual arousal activities. It may interfere with the individual's capacity for normal, reciprocal, affectionate sexual activity. An individual may suffer from several types of paraphilia, and the *DSM-III-R* classifies the severity of the sexual urges as mild, moderate, or severe.

### ***DSM-III-R* Diagnostic Criteria for Paraphilias**

- Recurrent, intense sexual urges and sexually arousing fantasies involving:
  - nonhuman objects;
  - children or nonconsenting adults; or
  - the suffering or humiliation of oneself or one's partner.
- The person has acted on these urges, or is markedly distressed by them.

### **Associated Features for Paraphilias**

- Use of specific paraphilic stimuli or imagery in sexual fantasies
- Personality disturbances that may be severe enough to warrant an Axis II diagnosis
- Decreased ability or inability to participate in normal, affectionate sexual relationships
- Denial that the paraphilic behavior is a source of stress for the individual, and the assertion that problems emerge from society's reaction to the behavior

### **Types of Paraphilias**

- Exhibitionism: intense sexual urges and sexual fantasies associated with exposing one's genitals to a stranger; individual does not engage in further sexual activity with the stranger.
- Fetishism: intense sexual urges and sexual fantasies involving the use of nonliving objects.



- Frotteurism: intense sexual urges and sexual fantasies involving touching or rubbing against a nonconsenting person.
- Pedophilia: intense sexual urges and sexual fantasies involving sexual activity with a child.
- Sexual masochism: intense sexual urges and sexual fantasies involving the act of being humiliated, bound, beaten, or otherwise made to suffer.
- Sexual sadism: intense sexual urges and sexual fantasies involving acts in which the individual causes psychological or physical suffering, humiliation, or harm to another person.
- Transvestic fetishism: intense sexual urges and sexual fantasies involving cross-dressing.
- Voyeurism: intense sexual urges and sexual fantasies involving observing unsuspecting people (usually strangers) who are naked, disrobing, or engaging in sexual activity.
- Paraphilia not otherwise specified (NOS): paraphilias that do not meet the criteria for any of the other types of paraphilia. Examples include:
  - telephone scatologia (lewdness);
  - necrophilia (corpses);
  - partialism (exclusive focus on one part of the body);
  - zoophilia (animals);
  - coprophilia (feces);
  - klismaphilia (enemas); or
  - urophilia (urine).

### **Treatment Issues for Paraphilias**

The treatment regime for paraphilias includes the following:

- specialized sex offender psychotherapy;
- sex hormone treatment in extreme cases; and

- antidepressant medications to treat compulsive sexual behaviors.

Depo-Provera, a hormone that decreases sexual drive, is sometimes used to treat paraphiliacs. It also decreases the severity and frequency of aberrant sexual fantasies. The medication is administered by injection on a weekly basis. Its use is highly controversial and has been the subject of a great deal of litigation. It may be administered only if the offender has consented to its use.

### **Supervision Issues for Paraphilias**

Many offenders with paraphilias do not respond well to traditional psychotherapy. Whenever possible, refer the offender to a therapist or clinic specializing in the treatment of paraphilia.

Sex offender treatment teaches coping skills to help the offender resist acting on his or her sexual preference; it does not cure the paraphilia. Relapse prevention is a critical part of the treatment regime and the offender should be closely monitored by the officer. Relapse prevention generally consists of requiring the offender to attend aftercare groups and focusing therapy on the offender's sexually abusive or deviant behavior. Offenders should be in treatment throughout the supervision period.

Managing risk is the primary focus of supervision and necessitates an extraordinary amount of contact with both the offender and the treatment provider. Consider the following supervision strategies:

- Restrict the offender's employment and recreational activities. Offenders with paraphilia should not be able to come in contact with potential victims. For example, pedophiles and child molesters should not be allowed to work in a day-care center, drive a school bus, or frequent public swimming pools, school playgrounds, or video arcades. In general, no arrested or convicted sex offender should be allowed to work in an adult bookstore.
- Restrict the offender's travel. Offenders with paraphilia often travel to find new victims.
- Monitor the offender's contact with the victim. The offender's victim should be told that any contact with the offender should be brought to the immediate attention of the probation or pretrial services officer.
- Maintain liaison with local law enforcement. Establish a working relationship with law enforcement agencies that investigate sex-offense related crimes. In the federal system, this includes U.S. Customs, U.S. Postal Inspectors, and the FBI. Most metropolitan police departments have units that specialize in the investigation of sex offenders.

Some states now require that sex offenders register, be photographed, and keep their addresses current with local law enforcement. Failure to register as required may constitute a violation of state law, which in turn constitutes a violation of the conditions of release.

- Request a sex offender evaluation that assesses the range of the offender's sexual offenses and sexual attractions. This information is useful when recommending special conditions of release or supervision.

Treatment providers use several tools to make this assessment. One is the Abel and Becker Cognition Scale, which determines an offender's potential thought distortions regarding sexual arousal and activity. Another is the Abel and Becker Sexual Interest Card Sort, which requires the offender to rank his or her arousal to specific sexual activities.

Another assessment tool is the penile plethysmograph. This instrument, which is attached to the individual's penis, determines sexual orientation and patterns of sexual arousal; it does *not* predict future behavior. There are cases pending in the federal courts regarding the constitutionality of mandating its use on federal probationers.

Suicide is a possibility with some sex offenders who experience severe depression upon entering the criminal justice system. For example, a middle-class offender who loses family, friends, job, and personal reputation because of an arrest or conviction for child molestation may become suicidal.

## **Paranoid Personality Disorder**

Paranoid personality disorder involves a pervasive and unwarranted tendency to interpret the actions of others as deliberately threatening and demeaning. This disorder is more commonly diagnosed in men than in women.

### **DSM-III-R Diagnostic Criteria for Paranoid Personality Disorder**

To be diagnosed as having paranoid personality disorder, an individual must exhibit at least four of the following:

- expects, without sufficient basis, to be exploited or harmed by others;
- questions, without justification, the loyalty or trustworthiness of friends or associates;
- reads hidden demeaning or threatening meanings into benign remarks or events (e.g., suspects that a neighbor put out trash early to annoy him or her);
- bears grudges or is unforgiving of insults or slights;
- is reluctant to confide in others because of the unwarranted fear that the information will be used against him or her;
- is easily slighted and quick to react with anger or to counterattack; or
- questions, without justification, fidelity of a spouse or sexual partner.

### **Associated Features of Paranoid Personality Disorder**

- Hostility, defensiveness, or stubbornness
- Seriousness, lacking a sense of humor
- Inability to relax
- Avoidance of intimacy or group activities
- Excessive need for self-sufficiency
- Restricted affect that prevents individual from being warm, affectionate, or emotional

- Interest in mechanical, electronic, and automated devices
- During periods of extreme stress, transient psychotic symptoms, but usually of insufficient duration to warrant an additional diagnosis

### **Treatment Regime for Paranoid Personality Disorder**

The treatment regime for paranoid personality disorder is psychotherapy, preferably individual therapy.

### **Supervision Issues for Paranoid Personality Disorder**

Offenders with paranoid personality disorder are sometimes argumentative, hostile, irritable, or angry. Often, these offenders experience lifelong problems with working and living with others. In extreme cases, the offender's paranoid ideation or delusional thinking can lead to threatening or assaultive behavior, particularly if the officer is a part of the offender's paranoid or persecutory ideation.

## **Schizoid Personality Disorder**

Schizoid personality disorder is characterized by a lifelong pattern of social withdrawal and a restricted range of emotional experience and expression.

### **DSM-III-R Diagnostic Criteria for Schizoid Personality Disorder**

To be diagnosed as having schizoid personality disorder, an individual must exhibit at least four of the following:

- neither desires nor enjoys close relationships, including being part of a family;
- almost always chooses solitary activities;
- rarely, if ever, claims or appears to experience strong emotions, such as joy or anger;
- indicates little, if any, desire to have sexual experiences with another person;
- is indifferent to praise or criticism;
- has no close friends or confidants other than immediate family; or
- displays constricted affect; is aloof and cold and rarely reciprocates gestures or facial expressions, such as smiles or nods.

### **Associated Features of Schizoid Personality Disorder**

- Inability to express aggressiveness or hostility
- Inability to define goals; indecisive, self-absorbed, and absent-minded

### **Treatment Regime for Schizoid Personality Disorder**

The treatment regime for schizoid personality disorder is psychotherapy.

## **Schizotypal Personality Disorder**

Schizotypal personality disorder involves a pervasive pattern of peculiarities of ideation, appearance, and behavior.

### **DSM-III-R Diagnostic Criteria for Schizotypal Personality Disorder**

To be diagnosed as having schizotypal personality disorder, an individual must exhibit at least five of the following:

- ideas of reference (excluding delusions of reference);
- excessive social anxiety (e.g., extreme discomfort in social situations involving unfamiliar people);
- odd beliefs or magical thinking which influences behavior and is inconsistent with subcultural norms, such as clairvoyance, telepathy, or a sixth sense;
- unusual perceptual experiences, such as illusions or sensing the presence of a force or person not actually present;
- odd or eccentric behaviors or appearance, such as talking to oneself or other unusual mannerisms;
- no close friends or confidants other than immediate family;
- odd speech, such as impoverished, vague, or digressive speech;
- inappropriate or constricted affect, such as silly, aloof, or inappropriate facial expressions or gestures; or
- suspiciousness or paranoid ideations.

### **Associated Features of Schizotypal Personality Disorder**

- Anxiety or depression
- Features of borderline personality disorder
- Eccentric convictions

- During periods of extreme stress, may experience transient psychotic symptoms, but these symptoms are usually of insufficient duration to warrant an additional diagnosis

### **Treatment Regime for Schizotypal Personality Disorder**

The treatment regime for schizotypal personality disorder is psychotherapy.

### **Supervision Issues for Schizotypal Personality Disorder**

Offenders with schizotypal personality disorder are likely to be involved in bizarre groups, cults, or strange religious practices. The offender's companions may be eccentric and unpredictable. As a precaution, the first contact with the offender should be in the office. To the extent possible, before making subsequent home contacts determine who is living with the offender or who frequently visits the home.

Of all patients with schizotypal personality disorder, 10% percent commit suicide. Monitor offenders with this disorder for signs of suicidal thoughts and gestures.



## **Antisocial Personality Disorder**

Antisocial personality disorder is characterized by an inability to conform to social norms and a continuous display of irresponsible and antisocial behavior. A diagnosis of antisocial personality disorder can only be made after age eighteen and must include evidence of antisocial conduct which began prior to age fifteen. This disorder is more common in men than in women. As many as 75% of prisoners may have antisocial personality disorder.

### **DSM-III-R Diagnostic Criteria for Antisocial Personality Disorder**

- Current age at least eighteen.
- Evidence of conduct disorder with onset before age fifteen, as indicated by a history of three or more of the following:
  - was often truant;
  - ran away from home overnight at least twice while living in parental or parental surrogate's home;
  - often initiated physical fights;
  - used a weapon in more than one fight;
  - forced someone into sexual activity with him or her;
  - was physically cruel to animals;
  - was physically cruel to other people;
  - deliberately destroyed others' property (other than by fire-setting);
  - deliberately engaged in fire-setting;
  - often lied (other than to avoid physical or sexual abuse);
  - has stolen without confronting the victim on more than one occasion; or
  - has stolen and confronted the victim (e.g., mugging or armed robbery).
- A pattern of irresponsible and antisocial behavior since the age of fifteen, as indicated by at least four of the following:

- unable to sustain consistent work behavior, as indicated by any of the following:
  - significant unemployment for six months or more within five years when expected to work and work was available;
  - repeated absences from work unexplained by illness of self or family; or
  - abandonment of several jobs without realistic plans for others
- fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest;
- is irritable and aggressive, as indicated by physical fights or assaults;
- repeatedly fails to honor financial obligations, such as defaulting on debts;
- fails to plan ahead or is impulsive, as indicated by either one or both of the following: a lack of a permanent address and traveling from place to place with no purpose in mind;
- has no regard for truth, as indicated by repeatedly lying or the use of aliases;
- is reckless regarding his or her own safety or others' safety;
- if a parent or guardian, fails to function as a responsible parent, such as failing to properly feed a child, failing to get a sick child medical care, or failing to arrange for a caretaker when away;
- has never sustained a totally monogamous relationship for more than one year; or
- lacks remorse.

### **Associated Features of Antisocial Personality Disorder**

- Use of alcohol and drugs and engaging in casual sexual intercourse in early adolescence and adulthood
- Signs of personal distress, such as tension, depression, or boredom
- Inability to form or sustain healthy, loving relationships with family, friends, or sexual partners

### **Treatment Regime for Antisocial Personality Disorder**

The treatment regime for antisocial personality disorder is psychotherapy.

### **Supervision Issues for Antisocial Personality Disorder**

Some mental health providers find antisocial personality disorder difficult to treat and may refuse to take a referral. Prognosis for successful treatment is extremely poor with this offender population.

Rely on supervision strategies, more than treatment, to manage risk. Some offenders with this disorder are very charming and manipulative. Set, clarify, and enforce limits on behavior. Monitor these offenders for drug and alcohol use and antisocial acts such as physical fights and assaults, association with those in illegal professions, reckless speeding, or drunk driving.

Antisocial personality disorder, in the presence of a history of aggressive behavior, increases the likelihood of continued aggressive behavior.

## **Borderline Personality Disorder**

Borderline personality disorder is characterized by a pattern of unstable mood, self-image, and interpersonal relationships. This disorder is more prevalent in women than in men.

### **DSM-III-R Diagnostic Criteria for Borderline Personality Disorder**

To be diagnosed as having borderline personality disorder, an individual must exhibit at least five of the following:

- a pattern of unstable and intense interpersonal relationships characterized by alternation between extremes of overidealization and devaluation;
- impulsiveness in at least two areas that are potentially self-damaging, such as excessive spending, casual sex, shoplifting, reckless driving, or binge eating;
- marked shifts in mood, leading to depression, anxiety, or irritability;
- inappropriate displays of anger or a lack of control concerning anger;
- recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior;
- marked and persistent identity disturbance, as evidenced by at least two of the following: uncertainty about life issues, sexual orientation, life goals, career choices, and choice of friends and values;
- chronic feelings of boredom and emptiness; or
- frantic efforts to avoid real or imagined abandonment.

### **Associated Features of Borderline Personality Disorder**

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Pessimistic outlook and social contrariness
- Depression
- Alternation between self-assertion and dependency

- During periods of extreme stress, may experience transient psychotic symptoms, but they are usually of insufficient duration to warrant an additional diagnosis

### **Treatment Regime for Borderline Personality Disorder**

The treatment regime for borderline personality disorder includes the following:

- psychotherapy;
- behavior therapy--sometimes useful to help the individual control impulses and anger;
- social skills training--sometimes useful to help the individual improve interpersonal skills;
- antidepressant medications--prescribed occasionally to treat depression and mood swings; and
- antipsychotic medication--prescribed occasionally to control anger, hostility, and brief psychotic episodes.

### **Supervision Issues for Borderline Personality Disorder**

Prognosis for treatment is extremely poor. These offenders may play the treatment provider and the officer against each other. If possible, make referrals to a mental health treatment provider experienced in treating persons with borderline personality disorder. At the beginning of the treatment regime, schedule a meeting with all parties to discuss treatment goals. Remain vigilant to the offender's manipulative gestures throughout the supervision period.

Recurrent suicidal threats and behavior, or self-mutilation (e.g., slashing one's wrists or arms) are common in the more severe cases. Although the suicide or self-mutilating gestures may be manipulative, attention-seeking behaviors, treat these incidents as life-threatening situations.

Hospitalization may be required when an offender is excessively self-destructive or self-mutilating. Placement of the offender in a halfway house or group home may provide a helpful support system.

Because of their unpredictable and impulsive behavior, offenders with borderline personality disorder are often in a state of extreme crisis involving problems with finances, health, relationships, or other areas of their lives. Focus supervision strategies on setting limits (i.e., defining acceptable and unacceptable behavior and the parameters of compliance) and providing structure that will enable the offender to be in compliance with the goals of supervision.

Monitor offenders' drug or alcohol use.

These offenders demonstrate poor judgment in relationships and frequently change partners. As a precaution, attempt to find out whom the offender is living with prior to making a home contact.

Female offenders with borderline personality disorder are often seductive and may have trouble maintaining appropriate boundaries. Thus, it is often best to have another officer accompany you on home contacts.

A diagnosis of borderline personality disorder does not itself suggest violent, aggressive behavior toward others. It does suggest violent, destructive acts towards oneself and an impulsivity and anger that may at times result in violent acts toward others.

## **Histrionic Personality Disorder**

Histrionic personality disorder is characterized by excessive emotionality and attention-seeking. This disorder is more commonly diagnosed in women than in men.

### **DSM-III-R Diagnostic Criteria for Histrionic Personality Disorder**

To be diagnosed as having histrionic personality disorder, an individual must exhibit at least four of the following:

- constantly seeks reassurance, approval, or praise;
- is inappropriately sexually seductive in appearance or behavior;
- is overly concerned with physical attractiveness;
- emotional expressions are inappropriately exaggerated, such as embracing casual acquaintances with excessive ardor or sobbing uncontrollably on minor sentimental occasions;
- is uncomfortable in situations in which he or she is not the center of attention;
- displays rapidly shifting and shallow expression of emotions;
- is self-centered and has no tolerance for delayed gratification; or
- has a style of speech that is excessively impressionistic and lacking in detail (e.g., says "My vacation was fantastic!" without being able to provide details).

### **Associated Features of Histrionic Personality Disorder**

- Is lively and dramatic
- Craves novelty, stimulation, and excitement, and is easily bored with routine
- Has superficial personal relationships
- Lacks interest in intellectual pursuits
- Is impressionable and easily influenced; is drawn to strong authority figures and thinks that they can provide a magical solution to his or her problems

- Frequently complains about poor health
- During periods of extreme stress, may experience transient psychotic symptoms, but they are usually of insufficient duration to warrant an additional diagnosis

### **Treatment Regime for Histrionic Personality Disorder**

The treatment regime for histrionic personality disorder is psychotherapy.

### **Supervision Issues for Histrionic Personality Disorder**

Offenders with histrionic personality disorder have superficial relationships, although they have strong dependency needs. Seductive behavior is common in both male and female offenders. Be careful not to fall into the sexually seductive relationship offered by the offender. Define the parameters of the officer-offender relationship throughout the supervision period. To the extent possible, make home contacts in teams.

Offenders with histrionic personality disorder sometimes appear to be in crisis because they are excessive in their expression of emotion. They are sensation seekers who may get into trouble with the law, abuse drugs, or act promiscuously.



## **Narcissistic Personality Disorder**

Narcissistic personality disorder is characterized by a heightened sense of grandiosity in fantasy or behavior, hypersensitivity to evaluation by others, and a lack of empathy.

### ***DSM-III-R* Diagnostic Criteria for Narcissistic Personality Disorder**

To be diagnosed as having narcissistic personality disorder, an individual must exhibit at least five of the following:

- reacts to criticism with feelings of rage, shame, or humiliation;
- is exploitative: takes advantages of others;
- has a grandiose sense of self-importance;
- believes that his or her problems are unique and can only be understood by other special people;
- is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love;
- has a sense of entitlement: an unreasonable expectation of favorable treatment;
- requires constant attention and admiration;
- lacks empathy; or
- is preoccupied with feelings of envy.

### **Associated Features of Narcissistic Personality Disorder**

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Depression
- Preoccupation with grooming, personal health, and youth
- Rationalizing or lying about personal deficits

### **Treatment Regime for Narcissistic Personality Disorder**

The treatment regime for narcissistic personality disorder is psychotherapy.

### **Supervision Issues for Narcissistic Personality Disorder**

The offender with narcissistic personality disorder is often arrogant, aloof, superior, and condescending. He or she is likely to play power games with the officer, and winning any of these games will only reinforce the offender's behavior. In addition, these offenders have fragile self-esteem and are prone to suicide.

Individuals with narcissistic personality disorder respond negatively to aging and are susceptible to midlife crises because they place excessive value on youth, beauty, and strength. Major depression can occur during this time.

Because these offenders frequently experience interpersonal problems and exploit others to achieve their ends, rely on supervision strategies, more than treatment, to manage risk. Set, clarify, and enforce limits on behavior. Intensive supervision is recommended for the duration of supervision.

## **Avoidant Personality Disorder**

Avoidant personality disorder is characterized by a pervasive pattern of social discomfort, fear of negative evaluation, and timidity.

### **DSM-III-R Diagnostic Criteria for Avoidant Personality Disorder**

To be diagnosed as having avoidant personality disorder, an individual must exhibit at least four of the following:

- is easily hurt by criticism or disapproval;
- has no close friends or confidants other than immediate family;
- is unwilling to get involved with people unless certain of being liked;
- avoids social or occupational situations that involve significant interpersonal contact;
- is reticent in social situations because of a fear of saying something inappropriate or foolish, or being unable to answer a question;
- fears being embarrassed by crying, blushing, or showing signs of anxiety in front of others; or
- exaggerates the potential difficulties, physical dangers, or risks involved in doing something ordinary but outside his or her usual routine.

### **Associated Features of Avoidant Personality Disorder**

- Depression, anxiety, or anger at himself or herself for failing to develop social relationships
- Specific phobias, such as social phobia

### **Treatment Regime for Avoidant Personality Disorder**

The treatment regime for avoidant personality disorder includes the following:

- psychotherapy; and

- assertiveness training--sometimes useful in building social and interpersonal skills and improving self-esteem.

### **Supervision Issues for Avoidant Personality Disorder**

Whereas the offender with schizoid personality disorder avoids social contact because he or she prefers to be alone, the offender with avoidant personality disorder avoids social contact for fear of rejection. Many offenders with avoidant personality disorder are able to function as long as they are in a safe, protected family environment. Should this support system fail, however, they may experience anger, depression, or anxiety.

Offenders with avoidant personality disorder generally respond poorly to the slightest perceived rejection or criticism and on rare occasions may avoid an officer because they are angry or hurt by something the officer said or did.

## **Dependent Personality Disorder**

Dependent personality disorder is characterized by a pervasive pattern of dependent and submissive behavior. This disorder is more commonly diagnosed in women than in men.

### **DSM-III-R Diagnostic Criteria for Dependent Personality Disorder**

To be diagnosed as having dependent personality disorder, an individual must exhibit at least five of the following:

- is unable to make everyday decisions without an excessive amount of advice and reassurance from others;
- allows others to assume responsibility for major decisions;
- agrees with people when he or she believes they are wrong because of a fear of being rejected;
- has difficulty initiating projects or doing things on his or her own;
- volunteers to do things that are unpleasant or demeaning in order to get others to like him or her;
- feels uncomfortable and helpless when alone, or goes to great lengths to avoid being alone;
- feels devastated or helpless when close relationships end;
- is frequently preoccupied with fears of being abandoned; or
- is easily hurt by criticism or disapproval.

### **Associated Features of Dependent Personality Disorder**

- Features of other personality disorders may be present and severe enough to warrant more than one diagnosis
- Depression and anxiety
- Lack of self-confidence

- Belittling personal assets and abilities
- Seeking or encouraging relationships in which they are overprotected or dominated by others

### **Treatment Regime for Dependent Personality Disorder**

The treatment regime for dependent personality disorder includes the following:

- psychotherapy, including behavior therapy, family therapy, and group therapy; and
- assertiveness training--sometimes useful for improving self-esteem.

### **Supervision Issues for Dependent Personality Disorder**

Offenders with this disorder will most likely have a long-standing relationship with one person upon whom they are grossly dependent. Should anything happen to that person or to the relationship, the offender might develop depression. Be aware of the status of this offender's relationship with his or her significant other and remain alert to the signs of possible depression, or suicide, when the relationship is unstable.

An offender with dependent personality disorder may be involved in an abusive relationship, for example, he or she may have a physically abusive, unfaithful, or alcoholic spouse. The abuse may increase as the offender becomes more self-sufficient through therapy and begins to display what the abusive partner perceives as independent or defiant behavior.

## **Obsessive-Compulsive Personality Disorder**

Obsessive-compulsive personality disorder is characterized by restricted emotions, orderliness, indecisiveness, perfectionism, and inflexibility. (*Do not confuse this personality disorder with the Axis I obsessive-compulsive disorder.*) This disorder is more commonly diagnosed in men than in women.

### **DSM-III-R Diagnostic Criteria for Obsessive-Compulsive Personality Disorder**

To be diagnosed as having obsessive-compulsive personality disorder, an individual must exhibit at least five of the following:

- perfectionism that interferes with task completion;
- preoccupation with details and organization, rules, order, or schedules to the extent that the major point of the activity is lost;
- unreasonable insistence that others submit to his or her ways of doing things, or unreasonable reluctance to allow others to do things because of the conviction that things will be done incorrectly;
- excessive devotion to work and productivity to the exclusion of leisure time and friendships;
- indecisiveness;
- overly conscientious, inflexible, and scrupulous concerning matters of morality, ethics, or values (not accounted for by cultural or religious identifications);
- restricted expression of affection;
- stinginess with time and material possessions when no personal gain is likely to result from sharing; or
- inability to discard worn-out or worthless objects.

### **Associated Features of Obsessive-Compulsive Personality Disorder**

- Difficulty expressing warm and tender feelings or affection
- Indecisiveness that leads to personal distress

- Depression
- A need to control others or situations; individual ruminates or becomes angry if control cannot be attained
- Extreme sensitivity to social criticism

### **Treatment Regime for Obsessive-Compulsive Personality Disorder**

The treatment regime for obsessive-compulsive personality disorder is psychotherapy.

### **Supervision Issues for Obsessive-Compulsive Personality Disorder**

Anything that threatens to upset the offender's daily routine or rituals may cause the offender a great deal of anxiety. For example, unannounced home contacts are not recommended.



## **Passive-Aggressive Personality Disorder**

Passive-aggressive personality disorder is characterized by a pervasive pattern of passive resistance to demands for adequate performance in social and occupational functioning.

### **DSM-III-R Diagnostic Criteria for Passive-Aggressive Personality Disorder**

To be diagnosed as having passive-aggressive personality disorder, an individual must exhibit at least five of the following:

- procrastinates;
- becomes sulky, irritable, or argumentative when asked to perform a task he or she does not want to do;
- seems to work deliberately slowly or to do a bad job on tasks that he or she does not want to do;
- protests, without justification, that others make unreasonable demands of him or her;
- avoids obligations by claiming to have "forgotten" them;
- believes that he or she is doing a better job than others think;
- resents suggestions from others concerning how he or she could be more productive;
- obstructs efforts of others by failing to do his or her share of the work; or
- unreasonably criticizes people in a position of authority.

### **Associated Features of Passive-Aggressive Personality Disorder**

- Is dependent and lacks self-confidence
- Is pessimistic about the future
- Is unable to realize that his or her behavior causes difficulties

### **Treatment Regime for Passive-Aggressive Personality Disorder**

The treatment regime for passive-aggressive personality disorder is psychotherapy.

### **Supervision Issues for Passive-Aggressive Personality Disorder**

Offenders with passive-aggressive personality disorder may become sulky and irritable or argumentative when asked to comply with the conditions of supervision. They may protest that the conditions are unreasonable and may resent an officer's directions or guidance, or may criticize or scorn the officer.

According to the *DSM-III-R*, major depression is a complication of this disorder. Monitor the offender for signs of suicidal thoughts and gestures.

The *DSM-III-R* indicates that alcohol abuse or dependence is also a complication of this disorder. Monitor the offender's alcohol use.

## Chapter 2: Dually Diagnosed Offenders

"Dual diagnosis" is a term used by mental health professionals to describe an individual who suffers from both a mental health disorder and a drug or alcohol abuse problem. Mental health professionals estimate that as many as half the individuals with a mental health disorder abuse alcohol or drugs. Examples of dual diagnosis disorder are depression and alcohol abuse or antisocial personality disorder and alcohol and drug abuse.

Researchers and medical professionals debate whether mental health disorders lead to substance abuse or vice versa. A mentally disordered individual may self-medicate to ease the symptoms of mental health disorders, thereby creating a substance abuse problem. Research indicates that excessive use of alcohol and drugs can result in mental health disorders, such as anxiety and depression.

### Treatment Issues

Many mental health and drug abuse therapists disagree on how to treat the dually diagnosed individual. For example, some mental health therapists believe that sobriety must be achieved before treatment for a psychological or psychiatric disorder can begin. Conversely, some drug treatment providers will insist that the offender be psychiatrically stabilized before admission to their program. Some drug abuse facilities endorse a drug free philosophy and refuse to treat offenders who are taking psychiatric medication. Many treatment programs are not designed to address the unique treatment needs of the dually diagnosed offender. Some treatment providers recommend treating whichever of the two problems was first manifested.

Direct the dually diagnosed offender to whichever facility will begin treatment immediately; then, locate a treatment provider for the unaddressed problem. Coordinate the various treatment programs, making sure that all the offender's problems are addressed. Ensure medication information is shared among all the treatment providers involved in the offender's case.

Generally, a dually diagnosed offender will require treatment throughout the supervision period.

### Supervision Issues

Because offenders with dual diagnosis suffer from two problems, they have a higher incidence of hospitalization, violent and criminal behavior, noncompliance with the

medication regime, housing instability, and homelessness than other mentally disordered offenders.

Depending on the mental health disorder, some offenders may attempt suicide. Monitor the offenders for suicidal thoughts and gestures.

For offenders with a history of dual diagnosis, a very strict urine collection regimen should be maintained to determine if they are using drugs.

Accidental death by overdose is a risk with this population. Offenders should be educated regarding the hazards of mixing illicit drugs and prescribed medication.

Generally, do not schedule a home contact without first meeting the dually diagnosed offender in the office, treatment facility, or other safe location. Subsequent home contacts should be made with care and caution, preferably with another officer.

In addition, a history of violence, substance abuse, or previous psychotic episodes increase the potential for violence and third-party risk.

## Chapter 3: Psychotropic Medications

Following are the major psychotropic medications listed by generic name, brand name, and commonly prescribed daily dosage.<sup>7</sup>

### Antidepressant Medications

#### Monoamine Oxidase (MAO) Inhibitors: Psychic Energizers

• Isocarboxazid	Marplan	10–30 mg
• Nialamide	Niamid	75–200 mg
• Phenelzine	Nardil	45–75 mg
• Tranylcypromine	Parnate	20–30 mg

#### Non-MAO Inhibitors: Psychostimulants, Tricyclics, and Selective Serotonin Reuptake Inhibitors (SSRI)

• Amitriptyline	Elavil	75–150 mg
• Amoxapine	Asendin	200–300 mg
• Clomipramine	Anafranil	25–250 mg
• Desipramine	Norpramin	75–150 mg
• Doxepin Hydrochloride (HCL)	Sinequan	75–150 mg
• Fluoxetine HCL	Prozac	20–60 mg
• Imipramine	Tofranil	75–150 mg
• Maprotiline	Ludiomil	25–150 mg
• Nortriptyline	Aventyl; Pamelor	20–100 mg

7. Information in this section is from Yudofsky, Stuart C., Hales, Robert E., and Ferguson, Tom. *What You Need to Know About Psychiatric Drugs*. New York: Ballantine Books, 1991, pp. 367 - 592; Silverman, Harold M., and Simon, Gilbert I. *The Pill Book* (5th ed.). New York: Bantam Book, 1993, pp. 11 - 967; and Dr. Thomas Oglesby, M.D., *Review of Handbook for Working with Mentally Disordered Offenders*, February 1994.

• Paroxetine HCL	Paxil	20-50 mg
• Sertraline HCL	Zoloft	50-200 mg
• Trazodone	Desyrel	150-400 mg
Aminoketone		
• Bupropion HCL	Wellbutrin	200-300 mg

### Antimanic Medications

• Lithium	Eskalith; Lithane; Lithonate	900-1,200 mg
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### Anticonvulsant Medications

• Carbamazepine	Tegretol	200-1,200 mg
• Valproic Acid	Depakote	7-250 mg

### Antianxiety Medications (Minor Tranquilizers)

#### Benzodiazepines

• Alprazolam	Xanax	0.75-4 mg
• Chlordiazepoxide	Librium	15-100 mg
• Clorazepate Dipotassium	Tranxene	15-60 mg
• Diazepam	Valium	4-40 mg
• Flurazepam	Dalmane	4-30 mg
• Lorazepam	Ativan	0.5-2 mg
• Oxazepam	Serax	30-120 mg
• Prazepam	Centrax	20-60 mg
• Temazepam	Restoril	15-30 mg

#### Noncontrolled Substance

• Buspirone	BuSpar	15-60 mg
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## Antipsychotic Medications (Major Tranquilizers)

### Phenothiazines

- Demethylamine Subgroup
  - Chlorpromazine      Thorazine      30–1,200 mg
  - Methoxypromazine      Tentone      50–1,500 mg
- Piperidyl Subgroup
  - Mezazine      Pacatal      50–400 mg
  - Thioridazine HCL      Mellaril      30–800 mg
- Piperazine Subgroup
  - Fluphenazine HCL      Prolixin      1–20 mg
  - Perphenazine      Trilafon      6–64 mg
  - Perphenazine-  
  Amitriptyline HCL      Triavil      2–50 mg
  - Prochlorperazine      Compazine      15–150 mg
  - Trifluoperazine      Stelazine      2–30 mg

### Tricyclic Dibenzodiazapine (Atypical Antipsychotic)

- Clozapine      Clozaril      25–300 mg

### Other

- Haloperidol      Haldol      2–15 mg
- Loxapine      Loxitane      10–50 mg
- Thiothixene      Navane      6–30 mg

## Chapter 4: Child Molesters

This chapter describes child molesters and provides information to help officers identify this type of offender and better manage the third-party risk associated with the case.<sup>8</sup>

### Pedophile or Child Molester?

What is the difference between a child molester and a pedophile? For many, the terms have become synonymous. The media frequently makes no distinction and uses these terms interchangeably. There are clear differences between the two types of individuals who sexually abuse children, and law enforcement officers handling such cases need to make distinctions between them.

A pedophile experiences recurrent, intense sexual urges and sexually arousing fantasies involving sexual activity with a child. Although a pedophile may have a sexual preference for children, if the pedophile does not act on this preference by actually molesting a child, that person is not a child molester. For example, some individuals engage in pedophilia by fantasizing and masturbating, or by simply watching or talking to children and later masturbating. Some have sex with dolls or mannequins that resemble children. Still others engage in sexual activities with adults who look like children (small stature, flat-chested, no body hair) or dress or act like them. Others act out child fantasy games with adult prostitutes.

Conversely, not all child molesters are pedophiles. A person who prefers sexual relations with an adult may, for any number of reasons, have sex with a child. Such reasons might include availability, curiosity, stress, sexual experimentation, or a desire to hurt a loved one of the child. Since this individual's sexual preference is not for children, he or she is not a pedophile.

Dr. Park Elliot Dietz divides child molesters into two broad categories: situational and preferential child molesters. Expanding on Dietz's ideas, Kenneth Lanning of the Behavioral Science Unit of the FBI developed a typology of child molesters for use by criminal justice professionals. Lanning avoids using diagnostic criteria and instead uses descriptive terms. The purpose of this typology is not to gain insight into *why* child molesters have sex with children in order to help or treat them, but to

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8. The material in this chapter is adapted from pages 5-9, 15-21, and 37-40 of *Child Molesters: A Behavioral Analysis* ©1992, authored by Kenneth V. Lanning in cooperation with the Federal Bureau of Investigation, U.S. Department of Justice and published by the National Center for Missing and Exploited Children. It is reprinted with permission of the National Center for Missing and Exploited Children, Arlington, Virginia, USA. All rights reserved.



recognize and evaluate *how* child molesters have sex with children in order to identify, arrest, and convict them. What evidence to look for, whether there are additional victims, how to interview a suspect, and so on, depend on the type of child molester involved.

## **Situational Child Molesters**

The situational child molester does not have a true sexual preference for children, but engages in sex with children for a number of reasons. For such a child molester, sex with children may range from a once-in-a-lifetime act to a long-term pattern of abusive behavior. The more long-term the pattern of abuse, the harder it is to distinguish from preferential molesting. The situational child molester usually has fewer child victims. Other vulnerable individuals, such as the sick, elderly, or disabled, may also be at risk of sexual victimization by a situational child molester. Some law enforcement officials indicate that cases involving this type of child molester are increasing. Also, most of the profiles of sexually motivated child murderers developed by the FBI's Behavioral Science Unit involve situational child molesters. Members of lower socioeconomic groups tend to be overrepresented among situational child molesters.

There are four types of situational child molesters: regressed, morally indiscriminate, sexually indiscriminate, and inadequate.

### **Regressed Child Molester**

The regressed child molester usually has low self-esteem and poor coping skills; the offender turns to the child as a sexual substitute for the preferred peer sexual partner. Precipitating stress may also play a role in the molester's behavior. The regressed child molester chooses victims based on availability, which is why many of these offenders molest their own children. The molester's method of operation is to coerce the child into having sex. This type of situational child molester may or may not collect child or adult pornography. If the molester does have child pornography, it will usually be the best kind from an investigative point of view: home videos or photographs of the offender's victims.

### **Morally Indiscriminate Child Molester**

The morally indiscriminate child molester abuses everyone in his or her life—spouse, children, co-workers. The molester is a user and abuser of people. The sexual abuse of children is simply part of the molester's general pattern of abusive behavior. This individual lies, steals, or cheats whenever possible and molests children for a simple reason—"why not?" The molester selects victims based on opportunity and vulnerability—if the molester has the urge and a child is available,

the molester will sexually abuse the child. The morally indiscriminate child molester typically uses force, lures, and manipulation to obtain victims. The molester may violently or nonviolently abduct victims. Although most victims are strangers, this type of molester may victimize his or her own children. The morally indiscriminate child molester frequently collects detective magazines or adult pornography of a sadomasochistic nature, and may collect child pornography, especially that which depicts pubescent children. Because this type of molester is an impulsive person who lacks a conscience, he or she is an especially high risk to pubescent children.

### **Sexually Indiscriminate Child Molester**

The sexually indiscriminate child molester's pattern of behavior is the most difficult to define. Whereas the morally indiscriminate molester is often a sexual experimenter, the sexually indiscriminate molester is discriminating in behavior except when it comes to sex. The sexually indiscriminate child molester will try anything sexual. Much of the molester's behavior is similar to and often confused with that of the preferential child molester. While the sexually indiscriminate molester may have a clearly defined paraphilic or sexual preference—bondage or sadomasochism—he or she has no real sexual preference for children. The molester's basic motivation is sexual experimentation, and he or she appears to have sex with children out of boredom. The molester's main criteria for children is that they are new and different, and he or she involves children in previously existing sexual activity. The indiscriminate child molester may abuse strangers or his or her own children. Although much of the molester's sexual activity with adults may be legal, such an individual may also provide his or her children to other adults as part of group sex, spouse-swapping activities, or even some bizarre ritual. Of all the situational child molesters, this type of molester is by far the most likely to have multiple victims, be from a higher socioeconomic background, and collect pornography and erotica. Child pornography, however, will only be a small portion of the molester's large and varied collection.

### **Inadequate Child Molester**

The inadequate child molester's pattern of behavior is also difficult to define and such molesters include those suffering from psychoses, eccentric personality disorders, mental retardation, or senility. In layperson's terms, this type of molester is the social misfit, the withdrawn, the unusual. The molester might be the shy teenager with no friends or the eccentric loner who still lives with his or her parents. Although most such individuals are harmless, some can be child molesters, and in a few cases, child killers. The inadequate child molester typically becomes sexually involved with children out of insecurity or curiosity. Victims are chosen because they are non-threatening objects that allow the molester to explore sexual fantasies. The victim may be a relative, a friend, or a complete stranger. In some cases the child victim might be a specific "stranger" selected as a substitute for a specific adult (possibly a relative of the child) whom the molester is afraid of approaching directly.

Often the molester's sexual activity with children is the result of built-up impulses. Some of these individuals find it hard to express anger and hostility, which builds until it explodes—possibly against a child victim. Because of mental or emotional problems, some molesters take out their frustrations in cruel sexual torture. The molester's victims could be the elderly as well as children, or anyone who appears helpless at first sight. The inadequate child molester may collect pornography, but it will most likely be of adults.

Almost any child molester is capable of violence or even murder to avoid identification. With a few notable exceptions—Theodore Frank in California and Gary Arthur Bishop in Utah—most of the sexually motivated child murders profiled and assessed by the FBI's Behavioral Science Unit have involved situational child molesters, especially the morally indiscriminate and inadequate patterns of behavior. Low social competence seems to be the most significant factor in why a child molester might abduct a victim.

## **Preferential Child Molesters**

Preferential child molesters have a definite sexual preference for children, and their sexual fantasies and erotic imagery focus on children. They have sex with children not because of some situational stress or insecurity but because they are sexually attracted to and prefer children. They can possess a wide variety of character traits but engage in highly predictable sexual behavior patterns. These patterns are called sexual ritual and are frequently engaged in even when they are counterproductive to getting away with the criminal activity. Although they may be smaller in number than situational child molesters, preferential child molesters have the potential to molest a larger number of victims. For many of them, their problem is not only the nature of the sex drive (attraction to children), but also the quantity (need for frequent and repeated sex with children). They usually have age and gender preferences for their victims. Members of higher socioeconomic groups tend to be overrepresented among preferential child molesters.

There are three types of preferential child molesters: seductive, introverted, and sadistic.

### **Seductive Child Molester**

The seductive child molester "seduces" children—courting the child with attention, affection, and gifts. Over time this behavior gradually reduces the child's sexual inhibitions. Frequently the victims reach a point where they are willing to trade sex for the attention, affection, and other benefits they receive from the molester. Many seductive child molesters are simultaneously involved with multiple victims, operating what some law enforcement officers call a child sex ring (i.e., a group of children in the same school class, neighborhood, day care center, or scout troop). The

characteristic that makes the seductive child molester so successful is his or her ability to identify with children. This type of molester knows how to talk to and listen to children. The molester's status and authority as an adult are also an important part of the seduction process. In addition, this type of molester often selects children who are victims of emotional or physical neglect.

The seductive child molester generally prefers victims of a particular sex and age, such as blond, 12-year-old boys, and will seek a new victim when the current victim ages or is no longer considered desirable. Generally the offender's biggest problem is not obtaining child victims but getting rid of a victim when the child becomes too old or unattractive. These offenders may use threats and physical violence to avoid identification and disclosure or to prevent a victim from leaving before the molester is ready to "dump" the victim.

### **Introverted Child Molester**

The introverted child molester has a preference for children but lacks the interpersonal skills necessary to seduce them. Therefore, the molester typically engages in a minimal amount of verbal communication with the victim and usually victimizes strangers or very young children. In many ways, the introverted child molester fits the old stereotype of the child molester (for example, a man who hangs around playgrounds, exposing himself to children, watching them or engaging them in brief sexual encounters). The molester may also make obscene phone calls to children. Unable to gain access to children any other way, this molester may use child prostitutes, or may even marry and have children, later molesting them as infants. The introverted child molester is similar to the inadequate situational child molester except that he or she has a definite preference for children and the selection of only children as victims is more predictable.

### **Sadistic Child Molester**

The sadistic child molester not only has a sexual preference for children, but also must inflict physiological or psychological pain on the child in order to achieve sexual arousal. (The molester is aroused by the victim's response to the infliction of pain and suffering.) The sadistic child molester often uses lures or force to gain access to the child, and is more likely than the other preferential child molesters to abduct and murder victims. Although there are few sadistic child molesters, they are very dangerous.

### **Identifying Preferential Child Molesters**

Preferential child molesters exhibit several predictable and repetitive behavior patterns. These behavior patterns serve as indicators or red flags. If the officer notes

that an offender exhibits several of these behaviors, he or she will be able to assess the need for recommending that the offender receive a sex offender evaluation and, possibly, a condition for sex offender treatment. The following are the behavior patterns exhibited by preferential child molesters.

- Long-term and persistent pattern of behavior
  - *Sexual abuse in the offender's background.* Research indicates that many child molesters were sexually abused as children, although not all sexually abused children grow up to molest children. It is well worth the officer's time and effort to determine if an offender has ever been a victim of sexual abuse and, if so, the nature of the abuse.
  - *Limited social contact during adolescence.* Sexual preference for children usually appears during adolescence, and early pedophilia behavior may be indicated by a lack of interest in adolescent peers. Like several of these indicators, however, this characteristic alone means little.
  - *Frequent and unexpected moves or premature separation from the military.* When discovered, pedophiles are sometimes asked to leave town in lieu of being prosecuted. It is helpful to look for a pattern of frequent moving or job changes. Frequently there is no formal documentation of what actually happened, so moving patterns can sometimes be detected by other indicators such as driver's license records. Premature separation from the military with no specific reason given or available may also be a red flag worth noting.
  - *Prior arrests.* Any arrest for child abuse or contributing to the delinquency of a minor is a red flag requiring investigation. However, there might also be other prior arrests not involving sexual abuse that may also be less obvious indicators of pedophilia, such as falsifying a teaching certificate or impersonating a police officer. All arrest records and court documents should be analyzed to determine their significance.
  - *Multiple victims.* The greater the number of victims, the more likely the offender is a pedophile. In addition, if the offender is a known or suspected pedophile, investigate for multiple victims, because there is a high probability that the offender molested more than one victim.
  - *Means of obtaining victims.* If the offender used clever and skillful planning to obtain victims or made high-risk attempts to obtain victims, such as snatching a child from a parked car, the chances are high that the offender is a pedophile.

- Children as preferred sexual objects

- *Is unmarried, lives alone or with parents, or dates infrequently.* By itself, this characteristic means nothing. It only has significance when combined with several other characteristics. Since pedophiles usually have some difficulty performing sexually with adults, they typically do not date, marry, or have a sexual relationship with another adult. They often live alone or with their parents. However, some pedophiles marry to gain access to potential victims.
- *Has a dysfunctional relationship with spouse.* If a pedophile is married, it is unlikely that he or she has a normal marital relationship with a spouse. Male pedophiles often marry women who are either very strong and domineering or very weak and passive. Because the pedophile is not sexually attracted to his or her spouse, sexual problems in the marriage are not uncommon. Although they may not readily reveal this information, wives, husbands, ex-spouses, and significant others should be considered important collateral contacts.
- *Associates and circle of friends are young.* Pedophiles frequently socialize with children and get involved in youth activities. Suspicion should be raised when an offender clearly prefers to be around or socialize with young people, tending to hang around the school playground, the neighborhood video arcade, or the shopping center. The offender's friends may be male or female, or members of both sexes, and they may be very young or teenagers, all depending on the age and gender preference of the offender.
- *Shows excessive interest in children.* This is not proof that someone is a pedophile, but it is reason to be suspicious. It becomes more significant when this excessive interest is combined with other characteristics.
- *Has limited peer relationships.* Pedophiles cannot share their sexual interests with other adults, so they tend to avoid socializing with peers. The majority of pedophiles only seek the company of other pedophiles in order to validate their lifestyle. If a suspected pedophile has a close adult friend, the possibility that the friend is also a pedophile must be considered.
- *Has an age and gender preference.* Most pedophiles prefer children of a certain sex and age range. The older the age preference, the more exclusive the gender preference. For example, a pedophile attracted to toddlers is likely to molest boys and girls; a pedophile attracted to teenagers is more likely to prefer either boys or girls exclusively. The preferred age bracket for the child may also vary; one pedophile might prefer boys 8 to 12, whereas another might prefer boys 6 to 12. How old a victim looks and acts is more important than actual chronological age. A 13-year-old who looks and acts like a 10-year-old could be the victim of a molester preferring 8- to 10-year-old victims. For the introverted child molester, how old the child looks is more important

than how old the child acts. Puberty seems to be an important dividing line for many pedophiles. This is only an age and gender preference, not an exclusive limitation. Any offender expressing a strong desire to adopt or care for a child of a specific age and sex should be viewed with suspicion.

- *Idealizes children.* Pedophiles tend to refer to children in idealistic ways. Frequently they describe children and childhood as clean, pure, or innocent. Sometimes they refer to children as objects, projects, or possessions. For example, a pedophile might say, "I've been working on this project for six months."
- Well-developed techniques to obtain victims
  - *Is skilled at identifying vulnerable children.* Some pedophiles can watch a group of children for a brief period of time and then select a potential victim. More often than not, the victim turns out to be from a broken home, or the victim of physical or emotional neglect.
  - *Identifies with children.* Pedophiles usually can identify with children better than they can with adults. This trait makes pedophiles masters of seduction. They know how to talk to children and how to listen to children.
  - *Has access to children.* This is one of the most important indicators of a pedophile. Pedophiles will seek employment and volunteer work that gives them access to children. Examples are teacher, clergy, police officer, coach, scout leader, Big Brother, or foster parent. The pedophile will also find ways to get the child into a situation where other adults are absent. For example, on a scout trip the pedophile will volunteer to stay with the scouts while the other scout leaders go into town to purchase supplies.
  - *Seduces children.* This is the most common characteristic of pedophiles. They literally seduce children by spending time with them, listening to and paying attention to them, and buying them gifts. As occurs in the courtship process, the victim often develops positive feelings for the molester. This is one reason some children are reluctant to report a molestation.
  - *Manipulates children.* The pedophile uses seduction techniques, competition, peer pressure, child and group psychology, motivation techniques, threats, and blackmail to obtain victims. Part of the manipulation process is the lowering of the child's inhibitions. A skilled pedophile who can get children into a situation in which they must change clothing or stay overnight will almost always succeed in seducing them. However, not all pedophiles possess these skills. The introverted child molester lacks these abilities.
  - *Has toys and playthings.* The pedophile is likely to have toys and playthings at home that appeal to children, such as model boats or planes, dolls, video

games, or magic tricks. A pedophile interested in older children may lure victims with pornography, alcohol, or drugs, or pretend to have a hobby or interest in things that interest an adolescent, such as stereo equipment or computer games. A house full of children's playthings may indicate pedophilia, particularly if the offender is not a parent; however, this indicator by itself means little. It only has significance when combined with other indicators.

- *Shows sexual materials to children.* Any adult who shows sexually explicit material to children should be viewed with suspicion. This behavior is usually part of the seduction process intended to lower the child's inhibitions. A pedophile may also encourage children to call a dial-a-porn service or send them sexually explicit material via a computer as part of the seduction process.
- Sexual fantasies focusing on children
  - *Has youth-oriented decorations in house or room.* The homes of some pedophiles have been described as shrines to children or as miniature amusement parks. For example, a pedophile attracted to teenage boys might decorate his home the way a teenage boy would with stereos, rock posters, computers, weight equipment, and so on.
  - *Photographs children.* Many pedophiles enjoy taking photographs of their victims, preferably during sexual behavior. Some, however, photograph children fully dressed. For example, a pedophile may go to baseball games or the playground to photograph children. After developing the pictures, the pedophile fantasizes about having sex with the children in the photographs. Such an individual might also frequent youth athletic contests, child beauty pageants, or child exercise classes and photograph them.
  - *Collects child pornography or child erotica.* Most pedophiles collect child pornography. The offender uses the material for sexual arousal and for seducing new victims. An interest in child pornography should always be a red flag indicating possible pedophilia.

Not to be confused with child pornography, child erotica is any material relating to children that serves a sexual purpose for a given individual. Erotica includes nonpornographic photographs of children, children's clothing, and accessories. Just as pictures of children in underwear or swimwear may be very arousing to the pedophile, combs, barrettes, purses, and other accessories might also be used for sexual arousal. In addition, pedophiles sometimes keep a memento or trophy of their victims, such as a pair of underpants or a lock of hair.



## Reactions After Identification

When a child molestation case is uncovered and the offender is identified, there are several predictable reactions by the offender. This is especially true of the preferential child molester. Knowledge of these reactions will help officers investigate the case.

- **Deny the incident.** When a child molester is arrested, his or her first reaction is usually complete denial. The offender will act shocked, surprised, or even indignant about the allegation. The offender may claim to not remember the incident or deny the intent involved sexual gratification. The offender may imply that his or her actions were misunderstood and that a mistake has been made. For example, the offender may state, "I didn't know hugging and kissing my son goodnight was a crime!" This denial may be aided by friends and relatives, who may hinder the police investigation or be uncooperative collateral contacts.
- **Minimize the incident.** If evidence rules out total denial, the offender may minimize the incident, especially in terms of quantity and quality. The offender might claim that it happened once or that he or she only touched or caressed the victim. The offender might admit certain acts, but deny that he or she was engaged in the acts for sexual gratification. For example, the offender may say, "Yeah, I admit I may have fondled my daughter once or twice, but I never had intercourse with her." The daughter explains that in actuality, her father raped her repeatedly over a six-month period. The offender may also admit to lesser offenses or misdemeanors. Victims may sometimes minimize the incident or deny certain aspects of the sexual behavior. For example, many adolescent boys will often deny being victimized.
- **Justify the incident.** Many child molesters, especially preferential child molesters, spend their lives attempting to convince themselves that they are not immoral, sexually deviant, or criminals. They prefer to believe that they are loving individuals whose behavior is misunderstood or politically incorrect at this time in history. Recognizing this rationalization system is key to interviewing these offenders. For example, a pedophile may justify the incident by stating that stress or drinking led to the sexual behavior, or by declaring that he or she cares more for the child than the child's parents do. If the offender is the father of the victim, a standard justification is that he is best suited to teach his child about sex. The most common rationalization centers on blaming the victim—the child seduced the offender or initiated the sexual activity, or the child is promiscuous or even a prostitute.
- **Fabricate a reason.** Some of the more clever child molesters come up with ingenious stories to explain their behavior. For example, a doctor may claim to be doing research on pedophilia; a teacher may explain that he or she was providing sex education; a father may claim he slept with his child only because the child

had a nightmare and couldn't fall asleep; or a neighbor may claim that neighborhood children made the sexually explicit video, which he kept only to show the children's parents. Some offenders have recently claimed they are artists victimized by censorship and their pornography collections are works of art protected by the First Amendment. These stories work particularly well when the child molester is a professional, such as a teacher, doctor, or therapist. Law enforcement officials and prosecutors must be prepared to confront such stories and disprove them. Finding child pornography or erotica in the offender's possession is one effective way to do this.

- **Feign mental illness.** The child molester may feign mental illness. It is interesting to note, however, that child molesters will admit mental illness only after they are identified or arrested, or after all other tactics fail. If all pedophiles are not necessarily child molesters, then pedophilia alone cannot be the cause of their child molesting. However, if the behavior of a child molester is considered to be the result of mental illness, then the offender requires treatment. The seriousness of the offenses and the effectiveness of the treatment must be carefully evaluated by the court. Treatment and punishment are not mutually exclusive.
- **Elicit sympathy.** Pedophiles may resort to the "nice guy defense." In this defense, the offender expresses deep regret and attempts to show how he or she is a pillar of the community, a devoted family person, a church leader, a military hero, a nonviolent individual with no prior arrests, or a victim whose many personal problems led to some sort of breakdown. Many traits described by the offender as evidence of good character in fact contribute to the offender's ability to access and seduce children.
- **Attack.** The identified pedophile may become threatening and assaultive during the investigation or prosecution. This reaction consists of attacking or going on the offensive. For example, the offender may harass, threaten, or bribe witnesses and victims, attack the reputation and personal life of the officer or prosecuting attorney, raise issues such as gay rights if the victim is the same sex as the offender, or enlist the support of groups or organizations. In extreme cases violence is a possibility. Pedophiles have been known to murder their victims or witnesses to avoid identification and prosecution.
- **Plead guilty, but not guilty.** Some offenders will try to make a deal to avoid a public trial. Although this results in the highly desirable objective of avoiding child victim testimony, the unfortunate aspect of this situation is that the offender is often allowed to plead, in essence, "guilty, but not guilty." This sometimes involves a plea of *nolo contendere* to avoid civil liability. On other occasions the offender pleads not guilty by reason of insanity or agrees to plead guilty to less severe charges, such as contributing to the delinquency of a minor, lewd and lascivious conduct, or indecent liberties. These are all tactics to escape

prosecution, keep the public from fully understanding the arrest or charge, and prevent the pedophile from acknowledging his or her behavior.

- **Commit suicide.** This extreme reaction is possible for some pedophiles, especially middle-class offenders with no prior convictions. Arrest or conviction may cost them their job, family, or reputation, leading to severe depression and possibly suicide.

## Chapter 5: Violence and Mental Health Disorders

This chapter reprints three articles that discuss recent studies on the relationship between violence and mental health disorders, and violence and third-party risk:

- Causes of Violence;
- Mental Disorder and Violent Behavior;
- Limiting Therapist Exposure to Tarasoff Liability.

Chapter in United States Sentencing Commission (Ed.), (1993). Drugs and Violence in America. Washington, D.C.: U.S. Government Printing Office.

## CAUSES OF VIOLENCE

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I have been asked to summarize everything we really know about the biological, sociological, and psychological causes of violence - in 20 minutes or less. Unfortunately, I think I can do it.

But I warn you in advance that what I cannot do - what no one can honestly do - is offer a neat, simple story that explains why there is so much violent crime in America. Only people on the extremes of the political spectrum have that luxury and that conceit. The root cause of violence, says the right, is bad genes or bad morals. Not so, says the left; the root cause of violent crime is bad housing, bad schools, or dead-end jobs.

I am here to tell you that while doing something about the causes of violence surely requires a political ideology, the only way we have a prayer of finding out what those causes are in the first place is if we check our ideologies at the door and try to keep our minds open as wide, and for as long, as we can bear it. I urge you to give it a try. If you do, what I think you will find is that violence does not have one root cause. Rather, violence has many tangled roots. Some grow toward the left, and some grow toward the right. We have to find the largest ones, whichever way they grow, and only then can we debate how best to cut them off.

Let's talk about the biological causes first. They are the easiest to talk about because there is not much to say. Many biological or health factors have been nominated as candidates for causes of violence—hormones like testosterone, transmitters in the brain like serotonin, and blood abnormalities like hypoglycemia are only a few that have been mentioned. Biological factors do not have to be hereditary. They can be caused by environmental events, such as exposure to lead paint, head injury, or poor nutrition.

Fortunately for us, the National Academy of Sciences just reviewed hundreds of studies on the relationship between biology and violence and it came to one clear bottom-line conclusion: "No patterns precise enough to be considered reliable biological markers for violent behavior have yet been identified."<sup>1</sup> The National Academy found many promising leads that should be vigorously pursued by researchers, but so far nothing it could point to as a proven or even close-to-proven biological risk factor for future violence.

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1 A. Reiss and J. Roth (Eds.), Understanding and Preventing Violence 116 (1993). [Hereinafter referred to as the National Academy Report.]

Next come the sociological causes. We know the most about social factors and violence because social factors, such as demography, are relatively easy to measure and because people have been measuring them for a long time. What do we know? We know a great deal about a relatively small number of things.

- We know that to live in America is to live in the land of the brave as well as in the home of the free. We are all familiar with depressing statistics about our trade deficit with Japan. But more depressing is our crime surplus. Compared with Japan, a nation of roughly comparable industrialization, with cities much more crowded than ours, our homicide rate is more than five times higher, our rape rate is 22 times higher, and our armed robbery rate is an astounding 114 times higher.<sup>2</sup>
- We know that, within America, violence is subject to great regional variation. The murder rate, for example, is almost twice as high in the South as it is in the Northeast, but the robbery rate is almost twice as high in the Northeast as it is in the South.<sup>3</sup>
- We know that communities within all regions of America differ drastically among themselves in how violent they are. In general, the smaller the community, the lower the rate of violence. Within the same city, some neighborhoods have rates of violent crime 300 times higher than other neighborhoods.<sup>4</sup>
- We know that people who commit violence on the streets are disproportionately poor and unemployed; jail inmates had on average an annual income prior to their arrest at about the federal government's official "poverty level," and about half were unemployed at the time they committed a violent crime.<sup>5</sup>
- We know that the overwhelming majority - close to 90 percent - of the people arrested for crimes of violence are men and that, despite enormous changes in gender roles in recent decades, this 90 percent figure has not budged for as long as we have kept criminal records.<sup>6</sup> Indeed, there is no place in the world where men make up less than 80 percent of the people arrested for violence, now or at any time in history.<sup>7</sup>
- We know that violence is primarily the work of the young. People in their late teens and 20s are much more likely to be arrested for violence than younger or older people.<sup>8</sup>

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2 T. Westermann and J. Burfeind, Crime and Justice in Two Societies: Japan and the United States (1991).

3 R. Nisbett, "Violence and U.S. Regional Culture," 48 American Psychologist 441-449 (1993).

4 National Academy Report, at 88.

5 U.S. Department of Justice, Bureau of Justice Statistics, Report to the Nation on Crime and Justice 49 (1988).

6 National Academy Report, at 72.

7 J. Wilson and R. Herrnstein, Crime and Human Nature (1985).

8 A. Blumstein, J. Cohen, J. Roth, and C. Visher, Criminal Careers and "Career Criminals" (1986).

- We know that the arrest rate - and the victimization rate - for violent crime for African-Americans is now about six times higher than for Whites.<sup>9</sup>
- Finally, we know that official violent crime rates, as high as they are, drastically underestimate the actual rate of violence in America, particularly violence within the family.<sup>10</sup>

After this, what we know about the sociological correlates of violence falls off rapidly. Note that I said "correlates," and not "causes." Two problems keep us from knowing which of these things really matter in causing violence and which are irrelevant. One problem is that each of these factors relates not only to violence but to other sociological factors as well. Call this the "ball of wax" problem. Poverty and race, for example, are related not just to violence, but to each other. If you take poverty into account, the effect of race on violence decreases drastically, and in some studies disappears entirely. The second problem is that it is sometimes hard to tell which came first, the sociological factor or the violence. Call this the "cause and effect" problem. It is true, of course, that violence does not cause people to be male or to be young. But whether unemployment leads people to commit violent acts, or whether for at least some people their violent acts lead employers not to want to hire them, is not so clear. (It is also possible that, at least for some people, a third factor - like an "impulsive" temperament - causes them both to be violent and to be unlikely to keep a steady job.)<sup>11</sup>

Finally come the psychological causes. If research on violence were like stock on Wall Street, then where I would put my money right now is on psychology. By this I most emphatically do not mean mental disorder. The best epidemiological evidence indicates that major mental disorder accounts for at most three percent of the violence in American society.<sup>12</sup> What I mean instead are the developmental processes that we all go through, most of us more or less successfully, but some of us with great difficulty. I mean particularly the family<sup>13</sup> - the filter through which most of the sociological factors, such as a parent's being unemployed, and many of the biological factors, like poor nutrition, seem to have their effect on a child growing up.

There is a risk, of course, whenever someone talks about families and children, that he or she is invoking images that may never have existed except on 1950s television and, even if they did once exist, surely no longer reflect the great variety of relationships in contemporary America. But whether we prefer Ozzie and Harriet Nelson or Murphy Brown, there is one important thing we

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9 National Academy Report, at 71.

10 J. Weis, "Family Violence Research Methodology and Design." in L. Ohlin and M. Tonry (Eds.), Family Violence 117-162 (1989).

11 J. Monahan and L. Walker, Social Science in Law: Cases and Materials (1994).

12 J. Monahan, "Mental Disorder and Violent Behavior: Perceptions and Evidence." 47 American Psychologist 511-521 (1992).

13 R. Loeber and M. Stouthamer-Loeber, "Family Factors as Correlates and Predictors of Juvenile Conduct Problems and Delinquency," in M. Tonry and N. Morris (Eds.), 7 Crime and Justice: An Annual Review of Research 29-149 (1986).

should not forget, and that is that all types of families share something in common. Whether they are married or cohabiting, biological or adoptive or foster, single or dual, gay or straight, and whatever their ethnicity, virtually all parents try to raise their children to be neither the victims nor the perpetrators of violence. Fortunately, most of each of these types of families succeed. Unfortunately, some of each of these types of families fail.

What do we know about families and children and violence?

- We know that while many aggressive children go on to be law-abiding adults, aggression at age eight significantly predicts violent convictions well into the 30s in every culture in which it has been studied.<sup>14</sup>
- We know that while most children who have been physically abused by their parents go on to be perfectly normal adults, physical abuse doubles the risk that a boy will have convictions for violent crime as an adult.<sup>15</sup>
- We know that failure of a child in school is one of the most enduring correlates of later violence. Four out of five violent offenders in prison never finished high school.<sup>16</sup>
- We know that stability matters; the more changes of placement a foster child experiences while he or she is growing up, the more likely he or she will later be arrested for a violent crime.<sup>17</sup>
- We know that a lack of parental supervision has been consistently related to delinquency, including violent delinquency. One study, for example, found that ten percent of non-delinquents were poorly supervised by their parents, one-third of one- and two-time delinquents were poorly supervised, and more than three-quarters of repeat offenders were poorly supervised.<sup>18</sup> Another study found that for children growing up in very disadvantaged and violent neighborhoods, who look like they have everything going against them, the one factor that seems to protect against the child growing up to be violent is having a parent - overwhelmingly, a mother - who supervises her child very strictly and who nips misbehavior in the bud rather than waiting for the principal to call or the police officer to knock on the door.<sup>19</sup>
- Finally, we know much about the relationship between illegal drugs and violence - information that others on this panel are presenting. But it is important to remember that the

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14 D. Farrington, "Childhood Aggression and Adult Violence: Early Precursors and Later-Life Outcomes," in D. Pepler and K. Rubin (Eds.), The Development and Treatment of Childhood Aggression 5-29 (1991).

15 C. Widom, "The Cycle of Violence," 244 Science 160-166 (1989).

16 U.S. Department of Justice, Bureau of Justice Statistics, Report to the Nation on Crime and Justice 48 (1988).

17 National Academy Report, at 243.

18 G. Patterson and M. Stouthamer-Loeber, "The Correlation of Family Management Practices and Delinquency," 55 Child Development 1299-1307 (1984).

19 H. Wilson, "Parenting in Poverty," 4 Journal of Social Work 241-254 (1974).



connection between one legal drug - alcohol - and violence is beyond dispute. About one-third of all violent offenders are alcoholic, and the earlier an adolescent starts to drink, the more likely he or she will be violent as an adult.<sup>20</sup>

These findings are not immune from either "ball-of-wax" or "cause-and-effect" problems. Failure in school, for example, is associated not only with violence but with poor parental supervision as well. And it is not obvious whether frequent changes of placement for a foster child lead to violence, or whether a child's violence at home leads foster parents to give him or her back to the agency. But surely the accumulated findings give us reason to believe that families have an enormous influence, for better or worse, on how children develop.

None of this in any way negates the influence of social conditions in giving rise to violence. Poor people without adequate child care, for example, may have a much more difficult time monitoring their children's behavior than affluent people with live-in help. Nor do they necessarily negate the possible influence of biological factors. Nutrition, to give another example, is something that parents literally put on the table for the child to eat. But it is through the family that these things have their effects and through the family that those effects might best be redirected.

So we know some important things about violence, and particularly about the home environment and violence. But we do not know nearly enough about how to prevent violence in the first place or how to stop it from happening again once it begins. How can we learn more, so that ten years from now, at the U.S. Sentencing Commission's Tenth Symposium on Crime and Punishment, it will take a bit longer to summarize the field?

We can learn more if we do four things:

First, we have to make a long-term national investment in research and development for a safer America. It takes resources to isolate the biological, sociological, and psychological factors that are associated with violence, to untangle the ball of wax we find them in, and to determine which are the causes of violence and which are its effects. The National Academy of Sciences just conducted an audit and concluded that the federal government spends a total of \$20 million a year on violence research, which works out to about \$3 per violent victimization.<sup>21</sup> I know researchers always say that more money is needed for research, and I know we have to be smarter about how we spend existing resources. But try as I might, I cannot resist pointing out that the nation's budget for research on violence is considerably less than one-half what the federal government will spend this year on mohair price subsidies.<sup>22</sup> I have nothing against goats, but a shortage of fuzzy sweaters is not what is keeping people behind locked doors at night.

Second, we have to have a coherent and coordinated federal strategy for studying violence. Organizational responsibility for research on violence is spread across a number of federal agencies: the National Institute of Justice, the National Institute of Mental Health, the National Science Foundation, the Centers for Disease Control, and several smaller programs.<sup>23</sup> We surely do not need

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20 National Academy Report, at 185.

21 National Academy Report. at 345.

22 U.S. Congress, Budget of the United States Government: Fiscal Year 1993, Appendix One-349 (1992).

23 National Academy Report. at 349.

a "Violence Czar" to provide central management of the nation's research on violence. But we do need to be sure that everyone is reading from the same page, and that there is a forum where innovative ideas can be shared and followed-up quickly. Partnerships with private foundations may be particularly cost-effective. The collaboration between the MacArthur Foundation and the National Institute of Justice in funding the Program on Human Development and Criminal Behavior is an exciting example of strategic leveraging of public and private resources.<sup>24</sup>

Third, we need to implement a comprehensive and inclusive violence research agenda. That agenda must have headings on it for all three of the kinds of research I have been talking about: biology, sociology, and psychology. And it has to study them not in isolation from one another but together, as different pieces of the same puzzle. As I said, I think that the time is ripe to give some priority to studying developmental influences and the effect of the family environment on violence. But this has to include health-related and biological factors that are mediated through the family, as well as social and psychological influences. You cannot paint a full and life-like picture of the causes of violence if, before you start painting, you take a corner of the canvas and mark it ideologically off limits.

Fourth, we need to put at the top of this agenda a program of rigorously evaluated interventions to reduce violence. We will know that we have finally understood the causes of violence when we can take a group of children at high risk of becoming violent and ethically offer them opportunities and services to defy our predictions. The interventions should be intensive and broadly based in practice but, at first, small-scale in scope. We simply do not know enough to mount major national programs to attack the causes of violence, even if we had the money to do so. But we certainly do know enough to start trying many things in a completely voluntary way, without unnecessarily labeling anybody, and see what works.<sup>25</sup>

Here is one modest idea. It derives from the research on childrearing that finds parental supervision so important in preventing crime and violence. Taking our cue from studies like this, we could offer to a random group of parents whose children are enrolled in federal child care programs<sup>26</sup> an intensive, long-term, state-of-the-art education and training program in how to monitor their children's behavior effectively, how to recognize potentially serious misbehavior when it occurs, and how to discipline their children consistently but fairly in response to misbehavior.<sup>27</sup> If this worked - if, compared to a control group, the children whose parents received the program had lower levels of aggression and other social problems - we should gradually expand the program, rigorously evaluating its effects each step of the way. If it did not work, we should go back to the drawing board, roll up our sleeves, and try something different. A dozen ideas like this - none of them panaceas - could be derived from research on children and families and tried simultaneously in different parts of the country. If even a few of them worked, we would have taken a giant leap forward in violence prevention.

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24 *Id.*

25 E. Mulvey, M. Arthur, and N. Reppucci, "The Prevention and Treatment of Juvenile Delinquency: A Review of the Research," 13 Clinical Psychology Review 133-167 (1993).

26 E. Zigler and S. Styfco (Eds.), Head Start and Beyond: A National Plan for Extended Childhood Intervention (1993).

27 M. Gottfredson and T. Hirschi, A General Theory of Crime (1990).

The short of it is that we need first to make a national scientific commitment to understanding the causes of violence, and then to make a national political commitment to doing something about them.

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## Mental Disorder and Violent Behavior

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### *Perceptions and Evidence*

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*Throughout history and in all known societies, people have believed that mental disorder and violence were somehow related. The consensus of modern scholarly opinion, however, has been that no such relationship exists. Recent epidemiological studies cast doubt on this no-relationship position. Evidence now indicates that mental disorder may be a consistent, albeit modest, risk factor for the occurrence of violence. Denying that mental disorder and violence may be in any way associated is disingenuous and ultimately counterproductive. Dire implications for mental patient advocacy, for mental health law, and for the provision of mental health treatment need not follow from candidly acknowledging the possibility of a limited connection between disorder and violence.*

Is there a relationship between mental disorder and violent behavior? Few questions in mental health law are as empirically complex or as politically controversial. On the one hand, the general public and their elected representatives appear firmly committed to the view that mental disorder and violence are connected. On the other hand, many social science researchers and the patient advocates who cite them seem equally convinced that no such connection exists. Although I have long been in the latter camp (e.g., Monahan, 1981), I now believe that there may be a relationship between mental disorder and violent behavior, one that cannot be fobbed off as chance or explained away by other factors that may cause them both. The relationship, if it exists, probably is not large, but may be important both for legal theory and for social policy. In this article, I lay before you the evidence and the inferences that have persuaded me to modify my views. I first consider the relationship between mental disorder and violence as it has been perceived by public and professional audiences, and then present an epidemiological framework within which the question can be empirically addressed.

### **Mental Disorder and Violence: Public and Professional Perceptions**

Beliefs that mental disorder is linked to violent behavior are important for two reasons. The first is that such beliefs drive the formal laws and policies by which society attempts to control the behavior of disordered people and to regulate the provision of mental health care. Coherent theories of mental health law can be constructed that are not premised on the assumption that the mentally disordered are more prone to violence than is the rest of the general population (e.g., "Developments in the Law," 1974). But there can be little doubt that this assumption has played an animating role in the prominence of *dangerous to others* as a criterion for civil commitment and the commitment of persons acquitted of crime by reason of insanity, in the creation of special statutes for the extended detention of mentally disordered prisoners, and in the imposition of tort liability on psychologists and psychiatrists who fail to antic

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ipate the violence of their patients (Appelbaum, 1988; Grisso, 1991).

The second and perhaps more important reason why beliefs in the violence potential of the mentally disordered are important is that they not only drive formal law and policy toward the mentally disordered as a class, but they also determine our informal responses and modes of interacting with individuals who are perceived to be mentally ill. An ingenious study by Link, Cullen, Frank, and Wozniak (1987) vividly makes this point. These researchers investigated the extent to which a person's status as a former mental patient fostered social distance on the part of others, measured by questions tapping the willingness of the respondent to have as a co-worker or neighbor someone described in a vignette as having once been a patient in a mental hospital. Consistent with much prior research (e.g., Gove, 1980), Link et al. (1987) found no main effect of the former-patient label. But when they disaggregated their subjects—adults drawn from the open community—by means of a "perceived dangerousness scale" into those who believed that mental disorder was linked to violence and those who did not, strong labeling effects emerged. Remarkably, people who believed that there was no connection between mental disorder and violence exhibited what might be called an affirmative action effect: They responded as if they were more willing to have as a co-worker or neighbor someone who had been a mental patient than someone who had never been hospitalized. People who believed that the mentally disordered were prone to violence, however, strongly rejected and wished to distance themselves from the former patient.

Before considering the contemporary nature of public and professional perceptions of the relationship between mental disorder and violence, it may be useful to briefly set the topic in historical and cultural perspective.

#### *Perceptions in Other Times and Other Places*

From the very origins of Western civilization, most people's experience with the mentally disordered have led them to assume that there was a connection of some kind between mental disorder and violence (Monahan, in press-a). References in Greek and Roman literature to the violence potential of the mentally disordered date from the fifth century before the Christian

era began. As the historian George Rosen (1968) noted, in the ancient world "two forms of behavior were considered particularly characteristic of the mentally disordered, their habit of wandering about and their proneness to violence" (p. 98). Plato, for example, in "Alcibiades II," records a dialogue between Socrates and a friend. The friend claimed that many citizens of Athens were "mad." Socrates refuted this claim by arguing that the rate of mental disorder in Athens could not possibly be very high because the rate of violence in Athens was very low.

How could we live in safety with so many crazy people? Should we not long ago have paid the penalty at their hands, and have been struck and beaten and endured every other form of ill usage which madmen are wont to inflict? (cited in Rosen, p. 100)

Likewise, Plautus, in a play written about 270 B.C., titled *Casina*, wrote of a maid who had taken up a sword and was threatening to murder a lover. One character describes the situation: "She's chasing everyone through the house there, and won't let a soul come near her, they're hiding under chests and couches afraid to breath a word." To this, her lover asks, "What the deuce has gotten into her all of a sudden this way?" The answer he received seemed to suffice for an explanation: "She's gone crazy" (cited in Rosen, p. 99). Advice to those responsible for the care of the mentally disordered in Greece and Rome often made reference to their dangerousness and to the necessity of keeping them in restraints, lest their caretakers be injured.

It is important to emphasize that even in ancient times, the public perception was not that all or most or even many of the mentally disordered were violent, just that a disproportionate number were. The Roman philosopher Philo Judaeus, for example, divided the mentally disordered into two groups. The larger one was made up of disordered people "of the easy-going gentle style," and the other, smaller one, consisted of those "whose madness was. . . of the fierce and savage kind, which is dangerous both to the madmen themselves and those who approach them" (cited in Rosen, 1968, p. 89).

Such public attitudes persisted throughout the Middle Ages and the Renaissance. Care of the disordered was left to family and friends; "only those considered too dangerous to keep at home . . . were dealt with by communal

authorities" (Rosen, 1968, p. 139). An early form of the *dangerousness standard* for civil commitment is illustrated by the 1493 German case of a disordered man who had committed a violent act and was ordered locked up in a lower of the city wall. When he no longer appeared violent, he was released from the tower to the custody of his family,

upon condition that they would confine him themselves should he again become violent. In this event, his wife would confine him in her house or arrange to keep him elsewhere at her expense. If required, the council would lend her a jail. (Rosen, p. 143)

Little in terms of public attitudes changed as the Renaissance gave way to the modern era. In 1843, the *London Times* publishing the following ditty on its editorial page on the day after Daniel McNaughten was acquitted by reason of insanity of murdering the secretary to the prime minister:

Ye people of England exult and be glad  
For ye're now at the mercy of the  
merciless mad!

In the United States, as in Europe, the perception of a link between mental disorder and violence is as old as recorded history. The first general hospital in the American colonies to include a ward for the mentally disordered—the cellar—was founded at the urging of no less than Benjamin Franklin. After arguing in vain that the Pennsylvania colony was morally obligated to provide for the disordered, he switched tacks and petitioned the Assembly in 1751 that

the Number of Persons distempered in Mind and deprived of their rational Faculties has increased greatly in this province. Some of them going at large are a terror to their Neighbors, who are daily apprehensive of the Violences they may commit. (cited in Deutsch, 1949, p. 59)

This argument hit a responsive chord, and the Pennsylvania Hospital still stands in Philadelphia.

The belief that mental disorder is conducive to violence runs deep in Western culture, but is by no means peculiar to it. Westermeyer and Kroll (1978) studied all persons known as *baa*, or crazy, in 27 villages in Laos, a country that at the time of the research was without a single psychiatrist, psychologist, or mental hospital. They

questioned family members, neighbors, and the people seen as *baa* themselves about the occurrence of violence and its relationship to mental disorder. They were told that 11% of their subjects exhibited violent behavior before they began acting in a *baa* manner, whereas 54% were reported to have acted violently once they became *baa*. At approximately the same time, Jones and Horne (1973) studied almost 1,000 people in four isolated aboriginal missions in the Australian desert.

Frequently, [they concluded,] an aggressive act by the patient causes him to present clinically, but with an explanation that was culturally appropriate—he would claim, for example, that his symptoms have been inflicted upon him by magical means and his aggression was his way of protecting himself. (p. 225)

Finally, Jane Murphy (1976), the noted anthropologist, reviewed in *Science* a great deal of research on responses to mental disorder among a variety of Northwestern Native American and several Central African ethnic groups. She reported great similarities among people in very different traditional societies, societies that had never had contact with one another:

There seems to be little that is distinctively cultural in the attitudes and actions directed toward the mentally ill, except in such matters as that an abandoned anthill could not be used as an asylum in the arctic or a barred igloo in the tropics . . . . If the behavior indicates helplessness, help tends to be given, especially in food and clothes. If the behavior appears foolish or incongruous . . . , laughter is the response. If the behavior is noisy and agitated, the response may be to quiet, sometimes by herbs and sometimes by other means. If the behavior is violent or threatening, the response is to restrain or to subdue. (p. 1025)

Of course, the anthropological fact that a popular belief has persisted since antiquity and is found in all known societies does not mean that the belief is true. Unfounded prejudices may also be enduring and shared. But if the assumption that mental disorder sometimes predisposes toward violent behavior is a myth, it may still be worth noting that it is a myth that is both culturally universal and historically invariant.

### *Contemporary American Perceptions*

In modern times and in modern societies, of course, we no longer have to rely on historians and anthropologists to tell us what we believe. We have survey researchers to quantify our opinions. One poll conducted by the Field Institute (1984) for the California Department of Mental Health asked 1,500 representative California adults whether they agreed with the statement, "A person who is diagnosed as schizophrenic is more likely to commit a violent crime than a normal person." Almost two thirds of the sample (61%) said that they definitely or probably agreed. In modern as in ancient times, however, the public by no means believes that mental disorder inevitably or even frequently leads to violence. In a survey of 1,000 adults from all parts of the United States, conducted by the DYG Corporation (1990) for the Robert Wood Johnson Foundation Program on Chronic Mental Illness, 24% of the respondents agreed with the statement, "People with chronic mental illness are, by far, more dangerous than the general population," whereas twice as many (48%) agreed with the proposition, "The mentally ill are far less of a danger than most people believe."

Although ancient attitudes about the relationship between mental disorder and violence were, of necessity, based on personal observation or word-of-mouth, contemporary opinions no doubt reflect the additional impact of the image of the mentally disordered relentlessly promoted by the media (Steadman & Cocozza, 1978). One content analysis performed for the National Institute of Mental Health (Gerbner, Gross, Morgan, & Signorielli, 1981) found that 17% of all prime-time American television programs that could charitably be classified as dramas depicted a character as mentally ill. Of these mentally ill characters, 73% were portrayed as violent, compared with 40% of the "normal" characters (!), and 23% of the mentally ill characters were shown to be homicidal, compared with 10% of the normal characters. Nor are such caricatures limited to television. A content analysis of stories from the United Press International database (Shain & Phillips, 1991) found that in 86% of all print stories dealing with former mental patients, a violent crime—"usually murder or mass murder" (p. 64)—was the focus of the article.

### *Professional Perceptions*

From reading the literature in this area, it would appear that there are only two identifiable groups in modern society who do *not* believe that mental disorder and violence are associated at greater than chance levels. The first group is composed of advocates for the mentally disordered, both of the traditional and ex-patient schools. The most recent pamphlet of the established National Mental Health Association (1987), for example, stated that "people with mental illnesses pose no more of a crime threat than do other members of the general population" (p. 2). Likewise, a recent volume produced by a leading ex-patient advocacy group for the California Department of Mental Health (Campbell & Schraiber, 1989) stated that "studies show that while, like all groups, some members are violent, mental health clients are no more violent than the general population" (p. 88). In making such statements, patient advocates are clearly and commendably motivated by the desire to dispel vivid homicidal maniac images pandered by the media and to counter the stigma and social distancing that are bred by public fear. Given the findings of Link et al. (1987), they surely are right to be concerned.

The second group in society that apparently believes that mental disorder is not associated with any increase in the risk of violence consists of many sociological and psychological researchers. Henry Steadman and I (Monahan & Steadman, 1983a), for example, reviewed over 200 studies on the association between crime and mental disorder for the National Institute of Justice. This was our summary:

The conclusion to which our review is drawn is that the relation between . . . crime and mental disorder can be accounted for largely by demographic and historical characteristics that the two groups share. When appropriate statistical controls are applied for factors such as age, gender, race, social class, and previous institutionalization, whatever relations between crime and mental disorder are reported tend to disappear. (p. 152)

I now believe that this conclusion is at least premature and may well be wrong. I say this for two reasons. First, to statistically control for factors, such as social class and previous institutionalization, that are highly related to mental disorder is problematic. For example, if in some

cases mental disorder causes people to decline in social class (perhaps because they became psychotic at work) and also to become violent, then to control for low social class is, to some unknown extent, to attenuate the relationship that will be found between mental disorder and violence. "The problem," as Bruce Dohrenwend (1990) has noted, "remains what it has always been: how to unlock the riddle that low SES can be either a cause or a consequence of psychopathology" (p. 45). If, in other cases, mental disorder causes people to be repetitively violent and therefore institutionalized, then to control for previous institutionalization also masks, to some unknown degree, the relationship that will be found between mental disorder and violence.

The second reason that I now think the no-relationship conclusion may be wrong is that new research—by no means perfect, yet by all accounts vastly superior to what had been in the literature even a few years ago—has become available. These new studies find a consistent, albeit modest, relationship between mental disorder and violent behavior. I will now turn to this literature, both old and new. As before (Monahan & Steadman, 1983a), I find an epidemiological framework conducive to clear thinking on this topic.

### **Mental Disorder and Violence: Evidence for a Relationship**

There are two ways to determine whether a relationship exists between mental disorder and violent behavior and, if it does, to estimate the strength of that relationship. If being mentally disordered raises the likelihood that a person will commit a violent act—that is, if mental disorder is a risk factor for the occurrence of violent behavior—then the actual (or true) prevalence rate for violence should be higher among disordered than among nondisordered populations. And to the extent that mental disorder is a contributing cause to the occurrence of violence, the true prevalence rate of mental disorder should be higher among people who commit violent acts than among people who do not. These two complementary ways of estimating relationships with epidemiological methods follow.

1. True prevalence of violent behavior among persons with mental disorder
  - a. Among identified mental patients
  - b. Among random community samples
2. True prevalence of mental disorder among persons committing violent behavior
  - a. Among identified criminal offenders
  - b. Among random community samples

Within each generic category, two types of research exist. The first seeks to estimate the relationship between mental disorder and violence by studying people who are being treated either for mental disorder (in hospitals) or for violent behavior (in jails and prisons). The second seeks to estimate the relationship between mental disorder and violence by studying people unselected for treatment status in the open community. Both types of studies are valuable in themselves, but both have limitations taken in isolation, as will become clear.

#### *Violence Among the Disordered*

Three types of studies provide data from hospitalized mental patients that can be used to estimate the relationship between mental disorder and violence. One type looks at the prevalence of violent acts committed by patients before they entered the hospital. A second type looks at the prevalence of violent incidents committed by mental patients during their hospital stay. A final type of study addresses the prevalence of violent behavior among mental patients after they have been released from the hospital. (I restrict myself here to remarking on findings on violent behavior toward others and exclude violence toward self, verbal threats of violence, and property damage. By *mental disorder*, I refer, unless otherwise noted, to those major disorders of thought or affect that form a subset of Axis I of the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised [DSM-III-R; American Psychiatric Association 1987]. Three excellent recent reviews (Mullen, in press; Otto, 1992; Wessely & Taylor, 1991) make my task of summarizing these studies much easier.

Together, these three reviews report on 11 studies published over the past 15 years that provide data on the prevalence of violent behavior among persons who eventually became



mental patients. The time period investigated was typically the two weeks prior to hospital admission. The findings across the various studies vary considerably: Between approximately 10% and 40% of the patient samples (with a median rate of 15%) committed a physically assaultive act against another shortly before they were hospitalized; 12 studies with data on the prevalence of violence by patients on mental hospital wards are found in these reviews. The periods studied varied from a few days to a year. The findings here also range from about 10% to 40% (with a median rate of 25%; see also Davis, 1991).

There is a very large literature, going back to the 1920s, on violent behavior by mental patients after they have been discharged from civil hospitals (Rabkin, 1979). The best recent studies are clearly those of Klassen and O'Connor (1988, 1990). They find that approximately 25%-30% of male subjects with at least one violent incident in their past—a very relevant, but highly selective sample of patients—are violent within a year of release from the hospital. The ongoing MacArthur Risk Assessment Study (Steadman et al., 1992) is finding that 27% of released male and female patients report at least one violent act within a mean of four months after discharge.

Each of these three types of research has important policy and practice implications. Studies of violence before hospitalization supply data on the workings of civil commitment laws and the interaction between the mental health and criminal justice systems (Monahan & Steadman, 1983b). Studies of violence during hospitalization have significance for the level of security required in mental health facilities and the need for staff training in managing aggressive incidents (Binder & McNiel, 1988; Roth, 1985). Studies of violence after hospitalization provide essential base-rate information for use in the risk assessments involved in release decision making and in after-care planning (Monahan, 1988).

For the purpose of determining whether there is a fundamental relationship between mental disorder and violent behavior, however, each of these three types of research is unavailing. Only rarely did the studies provide any comparative data on the prevalence of similarly defined violence among nonhospitalized groups. Steadman and Felson (1984) is one study that did. The authors interviewed former mental patients and a random sample of the general

community in Albany County, New York. The percentage of ex-patients who reported at least one dispute involving hitting during the past year was 22.3, compared with 15.1% for the community sample. For disputes in which a weapon had been used, the figures were 8.1 % for the ex-patients and 1.6% for the community sample. When demographic factors were controlled, however, these differences were not significant. Although the rates of violence by mental patients before, during, or after hospitalization reported in the other studies certainly appear much higher than would be expected by chance, the general lack of data from nonpatients makes comparison speculative. But even if such data were available, several sources of systematic bias would make their use for epidemiological purposes highly suspect. Because these studies dealt with persons who were subsequently, simultaneously, or previously institutionalized as mental patients, none of them can distinguish between the *participation* of the mentally disordered in violence—the topic of interest here—and the selection of that subset of the mentally disordered persons who are violent for treatment in the public-sector inpatient settings in which the research was carried out. (There is virtually no research on private hospitals or on outpatients.) Furthermore, studies of violence after hospitalization suffer from the additional selection bias that only those patients clinically predicted to be nonviolent were released. Nor can the studies of violence during and after hospitalization distinguish the effect of the treatment of potentially violent patients in the hospital from the existence of a prior relationship between mental disorder and violence.

For example, to use the prevalence of violence before hospitalization as an index of the fundamental relationship between mental disorder and violence would be to thoroughly confound rates of violence with the legal criteria for hospitalization. Given the rise of the dangerousness standard for civil commitment in the United States and throughout the world (Monahan & Shah, 1989), it would be amazing if many patients were not violent before they were hospitalized: Violent behavior is one of the reasons that these disordered people were selected out of the total disordered population for hospitalization. Likewise, the level of violent behavior exhibited on the ward during hospitalization is determined not only by the differential

selection of violent people for hospitalization (or, within the hospital, the further selection of "violence-prone" patients for placement in the locked wards that were often the sites of the research), but by the skill of ward staff in defusing potentially violent incidents and by the efficacy of treatment in mitigating disorder (or by the effect of medication in sedating patients). As Werner, Rose, and Yesavage (1983) have stated,

To the extent that hostile, excited, suspicious, and recent assaultive behavior is viewed by ward staffing as presaging imminent violence, it is the patient manifesting such behavior who is singled out for special treatment (e.g., additional medications, more psychotherapy); such selection may reduce the likelihood of engaging in violence. Thus, paradoxically, if the patient who "looks" imminently violent in this setting is given effective treatments that forestall violent behavior, he will not in fact engage in violence as predicted. (p. 824)

Because the prevalence of violence after hospitalization may be a function of (a) the type of patients selected for hospitalization, (b) the nature and duration of the treatment administered during hospitalization, and (c) the risk assessment cutoffs used in determining eligibility for discharge, these data, too, tell us little about whether a basic relationship between mental disorder and violence exists. Only by augmenting studies of the prevalence of violence among treated (i.e., hospitalized) samples of the mentally disordered with studies of the prevalence of violence among samples of disordered people unselected for treatment status in the community can population estimates free of selection and treatment biases be offered. Fortunately, a recent and seminal study by Swanson, Holzer, Ganju, and Jono (1990) provides this essential information. Swanson and his colleagues drew their data from the National Institute of Mental Health's Epidemiological Catchment Area (ECA) study (Robins & Regier, 1991). Representative weighted samples of adult-household-residents of Baltimore, Durham, and Los Angeles were pooled to form a data base of approximately 10,000 people. The Diagnostic Interview Schedule (DIS), a structured interview designed for use by trained lay persons, was used to establish mental disorder according to *Diagnostic and Statistical Manual of Mental Disorders*, third

**Table 1**  
*Percentage Violent During Past Year in ECA Sample, by Age*

Age group	% violent
18-29	7.3
30-44	3.6
45-64	1.2
65+	0.1

Note. ECA = Epidemiologic Catchment Area. From "Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Survey" by J. Swanson, C. Holzer, V. Ganju, and R. Jono. 1990, *Hospital and Community Psychiatry*, 41, p. 764. Copyright 1990 by the American Psychiatric Association. Adapted by permission.

edition (*DSM-III*; American Psychiatric Association, 1980) criteria. Five items on the DIS<sup>1</sup>—four embedded among the criteria for antisocial personality disorder and one that formed part of the diagnosis of alcohol abuse/dependence—were used to indicate violent behavior. A respondent was counted as positive for violence if he or she endorsed at least one of these items and reported that the act occurred during the year preceding the interview. This index of violent behavior, as Swanson et al. noted, is a "blunt measure": It is based on selfreport without corroboration, the questions overlap considerably, and it does not differentiate in terms of the frequency or the severity of violence. Yet there is little doubt that each of the target behaviors is indeed "violent," and I believe that the measure is a reasonable estimate of the prevalence of violent behavior.

<sup>1</sup> The items were, (a) Did you ever hit or throw things at your wife/husband/partner? [If so] Were you ever the one who threw things first, regardless of who started the argument? Did you hit or throw things first on more than one occasion? (b) Have you ever spanked or hit a child (yours or anyone else's) hard enough so that he or she had bruises or had to stay in bed or see a doctor? (c) Since age 18, have you been in more than one fight that came to swapping blows, other than fights with your husband/wife/partner? (d) Have you ever used a weapon like a stick, knife, or gun in a fight since you were 18? (e) Have you ever gotten into physical fights while drinking?

**Table 2**

*Percentage Violent During Past Year Among 18-29-Year-Olds in ECA Sample, by Gender and SES*

SES	Men	Women
1 (lowest)	16.1	9.1
2	11.7	5.0
3	8.1	2.5
4 (highest)	6.1	3.3

Note. ECA = Epidemiologic Catchment Area; SES = socioeconomic status. From "Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Survey" by J. Swanson, C. Holzer, V. Ganju, and R. Jono. 1990, *Hospital and Community Psychiatry*, 41, p. 764. Copyright 1990 by the American Psychiatric Association. Adapted by permission.

Confidence in the Swanson et al. (1990) findings is increased by their conformity to the demographic correlates of violence known from the criminological literature. As Tables 1 and 2 indicate, violence in the ECA study was seven times as prevalent among the young as among the old, twice as prevalent among men as among women, and three times as prevalent among persons of the lowest social class as among persons of the highest social class.

But it is the clinical findings that are of direct interest here. Table 3 presents the prevalence of violent behavior during the past year by *DSM-III* diagnosis. For these data, exclusion criteria were not used: A subject who met the criteria for more than one disorder was counted as a case of each.

Three findings are immediately evident: (a) The prevalence of violence is more than five times higher among people who meet criteria for a *DSM-III* Axis I diagnosis than among people who are not diagnosable. (b) The prevalence of violence among persons who meet criteria for a diagnosis of schizophrenia, major depression, or mania/bi-polar disorder are remarkably similar. (c) The prevalence of violence among persons who meet criteria for a diagnosis of alcoholism is 12 times that of persons who receive no diagnosis, and the prevalence of violence among persons who meet criteria for being diagnosed as abusing drugs is 16 times that of persons who receive no diagnosis. When both demographic and clinical factors were combined in a regression equation to predict the occurrence of violence, several significant predictors emerged. Violence was most likely to occur among young, lower class men, among those with a substance abuse diagnosis,

**Table 3**

*Percentage Violent During Past Year in ECA Sample, by Diagnosis*

Diagnosis	% violent
No disorder	2.1
Schizophrenia	12.7
Major depression	11.7
Mania or bi-polar	11.0
Alcohol abuse/dependence	24.6
Drug abuse/dependence	34.7

Note. ECA = Epidemiologic Catchment Area. From "Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Survey" by J. Swanson, C. Holzer, V. Ganju, and R. Jono. 1990, *Hospital and Community Psychiatry*, 41, p. 765. Copyright 1990 by the American Psychiatric Association. Adapted by permission.

and among those with a diagnosis of major mental disorder (see Swanson & Holzer, 1991).

One final and equally notable study not only confirms the ECA data but takes them a large step further. Link, Cullen, and Andrews (in press) analyzed data from a larger study conducted by Bruce Dohrenwend and his colleagues (Shrout et al., 1988), using the Psychiatric Epidemiology Research Interview (PERI) to measure symptoms and life events. Link et al. (in press) compared rates of arrest and of self-reported violence (including hitting, fighting, weapon use, and "hurting someone badly") in a sample of approximately 400 adults from the Washington Heights area of New York City who had never been in a mental hospital or sought help from a mental health professional with rates of arrest and self-reported violence in several samples of former mental patients from the same area. To eliminate alternative explanations of their data, the researchers controlled, in various analyses, for an extraordinary number of factors: age, gender, educational level, ethnicity (Black, White, and Hispanic), socioeconomic status, family composition (e.g., married with children), homicide rate of the census tract in which a subject lived, and the subject's "need for approval." This last variable was measured by the Crowne-Marlowe (1960) Social Desirability scale and was included to control for the possibility that patients might be more willing to report socially undesirable behavior (such as violence) than were nonpatients.

The study found that the patient groups were almost always more violent than the never-

treated community sample, often two to three times as violent. As in the ECA study (Swanson et al., 1990), demographic factors clearly related to violence (e.g., men, the less educated, and those from high-crime neighborhoods were more likely to be violent). But even when all the demographic and personal factors, such as social desirability, were taken into account, significant differences between the patients and the never-treated community residents remained. The association between mental patient status and violent behavior, as the authors noted, was "remarkably robust" to attempts to explain it away as artifact.

Most important, Link et al. (in press) then controlled for "current symptomatology." They did this by using the False Beliefs and Perceptions scale of the PERI, which measures core psychotic symptoms via questions such as, "How often have you felt that thoughts were put into your head that were not your own?", "How often have you thought you were possessed by a spirit or devil?", and "How often have you felt that your mind was dominated by forces beyond your control?" Remarkably, *not a single difference in rates of recent violent behavior between patients and never-treated community residents remained significant when current psychotic symptoms were controlled.* The Psychotic Symptomatology scale, on the other hand, was significantly and strongly related to most indices of recent violent behavior, even when additional factors, such as alcohol and drug use, were taken into account. Thus, almost all of the difference in rates of violence between patients and nonpatients could be accounted for by the level of active psychotic symptoms that the patients were experiencing. In other words, when mental patients were actively experiencing psychotic symptoms like delusions and hallucinations, their risk of violence was significantly elevated, compared with that of nonpatients, and when patients were not actively experiencing psychotic symptoms, their risk of violence was not appreciably higher than demographically similar members of their home community who had never been treated. Finally, Link et al. (in press) also found that the Psychotic Symptomatology scale significantly predicted violent behavior among the never-treated community residents. Even among people who had never been formally treated for mental disorder, actively experiencing psychotic symptoms was associated with the commission of violent acts.

The data independently reported by Swanson et al. (1990) and Link et al. (in press) are remarkable and provide the crucial missing element that begins to fill out the epidemiological picture of mental disorder and violence. Together, these two studies suggest that the currently mentally disordered—those actively experiencing serious psychotic symptoms—are involved in violent behavior at rates several times those of nondisordered members of the general population, and that this difference persists even when a wide array of demographic and social factors are taken into consideration. Because the studies were conducted using representative samples of the open community, selection biases are not a plausible alternative explanation for their findings.

### *Disorder Among the Violent*

Recall that there is a second empirical tack that might be taken to determine whether a fundamental relationship between mental disorder and violence exists and to estimate what the magnitude of that relationship might be. If mental disorder is in fact a contributing cause to the occurrence of violence, then the prevalence of mental disorder should be higher among people who commit violent acts than among people who do not. As before, there are two ways to ascertain the existence of such a relationship: by studying treated cases—in this instance, people "treated" for violence by being institutionalized in local jails and state prisons—and determining their rates of mental disorder, and by studying untreated cases—people in the open community who are violent but not institutionalized for it—and determining their rates of mental disorder.

A large number of studies exist that estimate the prevalence of mental disorder among jail and prison inmates. Of course, not all jail and prison inmates have been convicted of a violent crime. Yet 66% of state prisoners have a current or past conviction for violence (Bureau of Justice Statistics, 1991), and there is no evidence that the rates of disorder of jail inmates charged with violent offenses differ from those of jail inmates charged with nonviolent offenses. So I believe that data on the prevalence of disorder among inmates in general also apply reasonably well to violent inmates in particular.

Teplin (1990) reviewed 18 studies of mental disorder among jail samples performed in the

past 15 years. Most of the studies were conducted on inmates referred for a mental health evaluation, and thus present obviously inflated rates of disorder. Among those few studies that randomly sampled jail inmates, rates of mental disorder varied widely, from 5% to 16% psychotic. Roth (1980), in reviewing the literature on the prevalence of mental disorder among prison inmates, concluded that the rate of psychosis was "on the order of 5 percent or less of the total prison population" (p. 688), and the rate of any form of disorder was in the 15%-20% range. More recent studies have reported somewhat higher rates of serious mental disorder. Steadman, Fabisiak, Dvoskin, and Holohean (1987), in a level-of-care survey of more than 3,000 prisoners in New York State, concluded that 8% had "severe mental disabilities" and another 16% had "significant mental disabilities" (see also Taylor & Gunn, 1984).

Although the rates of mental disorder among jail and prison inmates appear very high, comparison data for similarly defined mental disorder among the general noninstitutionalized population were typically not available. As well, the methods of diagnosing mental disorder in the jail and prison studies often consisted of unstandardized clinical interviews or the use of proxy variables, such as prior mental hospitalization (see, e.g., Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984).

Recently, however, four studies, one with jail inmates and three with prisoners, have become available that use the DIS as their diagnostic

**Table 4**  
*Current Prevalence of Mental Disorder (%) Among California Prisoners, Chicago Jail Detainees, and ECA Sample*

Diagnosis	Prison	Jail	ECA
Schizophrenia	3.1	2.1	0.9
Major depression	3.5	3.9	1.1
Mania or bi-polar	0.7	1.4	0.1
Any severe disorder	7.9	6.4	1.8

Note. ECA = Epidemiologic Catchment Area. The data in columns 2 and 3 are from "The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees" by L. Teplin, 1990, *American Journal of Public Health*, 80, p. 665. Copyright 1990 by the American Public Health Association. Adapted by permission. The data in column 1 are from *Current Description, Evaluation, and Recommendations for Treatment of Mentally Disordered Criminal Offenders*, 1989, Sacramento: California Department of Corrections.

**Table 5**  
*Current Prevalence of Mental Disorder (%) Among Persons in ECA Sample Who Reported Violence or No Violence During Past Year*

Violence	Schizo- phrenia	Major affective	Substance abuse	Any disorder
Yes	3.9	9.4	41.6	55.5
No	1.0	3.0	4.9	19.6

Note. ECA = Epidemiologic Catchment Area. From "Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Survey" by J. Swanson, C. Holzer, V. Ganju, and R. Jono. 1990, *Hospital and Community Psychiatry*, 41, p. 765. Copyright 1990 by the American Psychiatric Association. Adapted by permission.

instrument. This not only allows for a standardized method of assessing disorder independent of previous hospitalization, it permits comparison across the studies and between these institutionalized populations and the random community samples of the ECA research.

In the first study, Teplin (1990) administered the DIS to a stratified random sample—one half misdemeanants and one half felons—of 728 men from the Cook County (Chicago) jail. In the most comparable of the prison studies, the California Department of Corrections (1989) commissioned a consortium of research organizations to administer the DIS to a stratified random sample of 362 male inmates in California prisons (see also Collins & Schlesinger, 1983; Hodgins & Cote, 1990; Neighbors et al., 1987). Comparative data from the ECA study for male respondents were provided by Teplin (1990). The findings for current disorder are summarized in Table 4.

It can be seen that the prevalence of schizophrenia is approximately 3 times higher in the jail and prison samples than in the general population samples, the prevalence of major depression 3-4 times higher, the prevalence of mania or bi-polar disorder 7-14 times higher, and overall, the prevalence of any severe disorder (i.e., any of the above diagnoses) 3-4 times higher. Although there were no controls for demographic factors in the prison study, Teplin (1990) controlled for race and age in the jail study, and the jail-general population differences persisted. Although these studies all relied on male inmates, even more dramatic data for female prisoners have been reported in one study (Daniel, Robins, Reid, & Wilfley, 1988).

These findings on the comparatively high prevalence of mental disorder among jail and prison inmates have enormous policy implications for mental health screening, of admissions to these facilities and for the need for mental health treatment in correctional institutions (Steadman, McCarty, & Morrissey, 1989). But given the systematic bias inherent in the use of identified criminal offenders, they cannot fully address the issue of whether there is a fundamental relationship between mental disorder and violence. Mentally disordered offenders may be more or less likely to be arrested and imprisoned than are nondisordered offenders. On the one hand, Robertson (1988) found that offenders who were schizophrenic were much more likely than were nondisordered offenders to be arrested at the scene of the crime or to give themselves up to the police. Teplin (1985), in the only actual field study in this area, found the police more likely to arrest disordered than nondisordered suspects. On the other hand, Klassen and O'Connor (1988) found that released mental patients whose violence in the community evoked an official response were twice as likely to be rehospitalized—and thereby avoid going to jail—than they were to be arrested. An individual's status as a jail or prison inmate, in short, is not independent of the presence of mental disorder.

As before, complementary data on the prevalence of mental disorder among unselected samples of people in the open community who commit violent acts is necessary to fully address this issue. And as before, the analysis of the ECA data by Swanson et al. (1990) provides the required information, which is summarized in Table 5.

The prevalence of schizophrenia among respondents who endorsed at least one of the five questions indicating violent behavior in the past year was approximately four times higher than among respondents who did not report violence, the prevalence of affective disorder was three times higher, the prevalence of substance abuse (either alcohol or other drugs) was eight times higher, and overall, the prevalence of any measured DIS diagnosis—which here included anxiety disorders—was almost three times higher.

## Implications for Research and Policy

The data that have recently become available, fairly read, suggest the one conclusion I did not want to reach: Whether the measure is the prevalence of violence among the disordered or the prevalence of disorder among the violent, whether the sample is people who are selected for treatment as inmates or patients in institutions or people randomly chosen from the open community, and no matter how many social and demographic factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behavior. Mental disorder may be a robust and significant risk factor for the occurrence of violence, as an increasing number of clinical researchers in recent years have averred (Bloom, 1989; Krakowski, Volavka, & Brizer, 1986; Mullen, *in press*; Wessely & Taylor, 1991).

Should further research solidify this conclusion, would it mean—to return to the points we began with—that laws that restrict the freedom of mentally disordered people for long periods of time or the pervasive social rejection of former mental patients are justified, or that the media is correct in its portrayal of people with mental disorder as threats to the social order? No, it would not and for two reasons.

First, as the Link et al. (*in press*) study makes clear, it is only people currently experiencing psychotic symptoms who may be at increased risk of violence. Being a former patient in a mental hospital—that is, having experienced psychotic symptoms *in the past*—bears no direct relationship to violence, and bears an indirect relationship to violence only in the attenuated sense that previous disorder may raise the risk of current disorder.

Second and more important, demonstrating the existence of a statistically significant relationship between mental disorder and violence is one thing; demonstrating the social and policy significance of the magnitude of that relationship is another. By all indications, the great majority of people who are currently disordered—approximately 90% from the ECA study—are not violent. None of the data give any support to the sensationalized caricature of the mentally disordered served up by the media, the shunning of former patients by employers and neighbors in the community, or regressive “lock ‘em all up” laws proposed by politicians

pandering to public fears. The policy implications of mental disorder as a risk factor for violent behavior can be understood only in relative terms. Compared with the magnitude of risk associated with the combination of male gender, young age, and lower socioeconomic status, for example, the risk of violence presented by mental disorder is modest. Compared with the magnitude of risk associated with alcoholism and other drug abuse, the risk associated with major mental disorders such as schizophrenia and affective disorder is modest indeed. Clearly, mental health status makes at best a trivial contribution to the overall level of violence in society. (But see "Developments in the Law", 1974, on the legal justification—"because [the mentally disordered] are . . . unable to make autonomous decisions" (p. 1233)—for preventively intervening in the lives of disordered people in situations in which we do not intervene with nondisordered people, even when the nondisordered people present a higher risk of violence.)

What, then, are the implications of the conclusion that mental disorder may be a significant, albeit modest, risk factor for the occurrence of violent behavior? I see four principle ones. First, the empirical question of the relationship between mental disorder and violent behavior has only begun to be addressed. That *major mental disorder* as a generic category relates to violence would be important to know, but it is by no means all that clinicians and policymakers need to know. They need to know the specific features of mental disorder that carry the increased risk. Do disordered perceptions (e.g., hallucinations), disordered assumptions (e.g., delusions), or disordered processes of reasoning or affect relate most closely to the occurrence of violent behavior? It is unclear whether mental disorder should be unpacked by diagnosis, by course, by symptom pattern, or by specific types of offender-victim interactions for the purpose of answering these crucial questions. Indeed, the victims manner of reacting or overreacting to "fear-inducing" aspects of the disordered person's behavior may itself be a mediating factor in the occurrence of violence (Link et al., in press). Violence itself may be only a by-product of a more generic tendency to "norm violation" that accompanies some forms of mental disorder. Epidemiological methods have yielded considerable insights in this general research area to date. "It is questionable,

however, whether this group comparison approach can shed a great deal of light on more refined questions that may be posed at this point regarding the relationship between mental illness and criminality" (Mulvey, Blumstein, & Cohen, 1986, p. 60). The use of more longitudinal "career" methods at the individual level of analysis may have much to offer in this regard. Such studies could investigate, for example, how a person's likelihood of violence changes as his or her symptoms and life circumstances change.

Second, the data suggest that public education programs by advocates for the mentally disordered along the lines of "people with mental illness are no more violent than the rest of us" may be doomed to failure, as indeed research shows they have always failed (Cumming & Cumming, 1957). And they should fail: The claim, it turns out, may well be untrue. It will no doubt be difficult for mental health advocates to convey more accurate but more complex information about the relationship between mental disorder and violence in the sound bites and bumper stickers that have come to frame our public discourse. But the flat denial that any relationship exists between disorder and violence can no longer credibly be prefaced by "research shows" (Steadman, 1981). As Swanson et al. (1990), in commenting on their ECA data, stated, public fear of violence committed by the mentally disordered in the community is "largely unwarranted, though not totally groundless" (p. 769). I agree with Bloom (1989): "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" (p. 253).

Third, the antipathy toward dangerous to others as one criterion for involuntary hospitalization frequently expressed by mental health professionals and professional organizations may be unwarranted. A concern with violence to others may not be a responsibility arbitrarily foisted on the mental health professions by an ignorant public that would better be left exclusively to the police. A somewhat heightened risk of violence may inhere in the disorders that it is the business of psychologists and psychiatrists to treat. It is not unreasonable of society to ask us to attend to this risk, within the limits of our

ability to assess it (Grisso & Appelbaum, in press; Monahan, in press-b).

Finally, the data underscore the need for readily available mental health services in the community and in correctional institutions. If the experience of psychotic symptoms elevates the risk of violence and if psychotic symptoms can usually be controlled with treatment (Krakowski, Jaeger, & Volavka, 1988), then the provision of treatment to people in need of it can be justified as a small contribution to community safety, as well as a telling reflection on our common humanity.

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## Limiting Therapist Exposure to *Tarasoff* Liability

### Guidelines for Risk Containment

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John Monahan

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*The "duty to protect" third parties, first imposed by the Tarasoff case, has concerned and perplexed clinicians. A series of guidelines is offered for reducing therapist exposure to suit, based on expert witness experience in a number of cases raising this form of tort liability. These guidelines concern the assessment and management of risk, the documentation of information and activities, the formulation of written policies, and damage control when risk is realized.*

Mention the word law in conversation with practicing psychologists, psychiatrists, and social workers, and they will soon speak of *Tarasoff v. Regents of the University of California* (1976). No case is better known or evokes stronger feelings. Initially the subject of vilification by mental health professionals, the California Supreme Court's holding in *Tarasoff*—that psychotherapists who know or should know of their patient's likelihood of inflicting injury on identifiable third parties have an obligation to take reasonable steps to protect the potential victim—has become a familiar part of the clinical landscape. Although a few state courts have rejected *Tarasoff* and others have limited its scope, most courts that have addressed the issue have accepted the essence of the "duty to protect," and several have even expanded that duty to include nonidentifiable victims (for reviews, see Appelbaum, 1988; Beck, 1985, 1990; Schopp, 1991; Smith, 1991). In jurisdictions in which appellate courts have not yet ruled on the question, the prudent clinician is well advised to proceed under the assumption that some version of *Tarasoff* liability will be imposed (Appelbaum, 1985, p. 426). The duty to protect, in short, is now a fact of professional life for nearly all American clinicians and, potentially, for clinical researchers as well (Appelbaum & Rosenbaum, 1989).

I have served as an expert witness in several dozen cases in which the therapist's duty to protect others from a patient's violence was at

issue. In each of these cases, someone had been killed or injured by a patient or former patient of a psychologist, psychiatrist, or social worker. The questions put to me were always the same: Would a reasonable therapist, applying the professional standards that existed at the time of the treatment, have assessed the patient's risk of violence as sufficient to justify preventive intervention, and if so, was an appropriate intervention chosen? Initially, given my view (Monahan, 1976) that violence was virtually impossible to validly assess, I was retained solely by defense attorneys. Later, as I came to believe that risk assessment might be feasible and appropriate under some circumstances (Monahan, 1981, 1984), referrals began to come equally from defense and plaintiff's attorneys.

In working on these cases and seeing the obvious emotional, financial, and reputational costs that they placed upon the defendant therapists and their institutions (Brodsky, 1988; Poythress & Brodsky, 1992), I often thought about what the therapist could have done to have foreseen and prevented his or her patient's violence, or at least, when the violence was not foreseeable, to have reduced his or her own exposure to civil liability. In this article, I organize those reflections into a series of guidelines for violence prevention and the reduction of exposure to liability that may be useful to practicing mental health professionals. No jurisdiction currently requires adherence to all, or even to most, of these guidelines in order to meet professional standards of care for dealing

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with potentially violent patients. Thus failure to act as suggested here does not necessarily mean that liability "ought" to be found by a jury. Each of these guidelines, however, has played a prominent role in at least one "failure to predict" case on which I have been retained. The guidelines cluster in five domains: risk assessment, risk management, documentation, policy, and damage control. They are summarized in the Appendix.

### Risk Assessment

Four tasks form the basis of any professionally adequate risk assessment: The clinician must be educated about what information to gather regarding risk, must gather it, must use this information to estimate risk, and, if the clinician is not the ultimate decision maker, must communicate the information and estimate to those who are responsible for making clinical decisions.

### Education

The essence of being a "professional" is having "specialized knowledge" not available to the general public. In this context, specialized knowledge consists of both knowledge of mental disorder in general (e.g., assessment, diagnosis, and treatment) and knowledge of risk assessment in particular. In addition, one should be thoroughly conversant with the laws of the jurisdiction in which one practices regarding the steps to follow when a positive risk assessment is made.

*Clinical education.* Familiarity with basic concepts in risk assessment (e.g., predictor and criterion variables, true and false positives and negatives, decision rules, and base rates) and with key findings of risk assessment research (e.g., past violence as the single best predictor of future violence) is becoming an important aspect of graduate education in psychology, psychiatry, and social work. For clinicians whose graduate education predated this emphasis or neglected it, many books and articles are readily available (e.g., Appelbaum & Gutheil, 1991; Bednar, Bednar, Lambert, & Waite, 1991; Simon, 1987; Tardier, 1989). One does not have to commit these works to memory. But I have seen the blood drain from clinicians' faces when a plaintiff's attorney begins a cross-examination by

reading a list of well-known titles in the area and asks whether the witness has read them, and the clinician is forced to mumble "no" (see Brodsky, 1991).

It is not enough to learn the basic concepts and classic findings in the field of risk assessment once and consider one's education complete. Research findings evolve and become modified over time and the conventions of professional practice become more sophisticated. Continuing education in risk assessment through formal programs sponsored by professional or private organizations is one way to keep apprised of developments in the field. Periodically perusing original research journals (e.g., *Law and Human Behavior*, *Behavioral Sciences and the Law*, the *International Journal of Law and Psychiatry*) is another.

In the context of large facilities for assessing and treating mentally disordered people, the most efficient form of risk education may be to charge one person with the responsibility of being a "risk educator." This person's responsibilities might include maintaining a small reference library of literature on risk, keeping abreast of developments in the field, and communicating his or her conclusions to other staff through in-house workshops, reading groups, or occasional memoranda. This person might be an ideal candidate for a local consultant for cases that present difficult risk issues.

*Legal education.* The standards to which clinicians will be held in making judgments on risk are set largely by state law. In the past, these standards were usually articulated by judges who applied common law tort principles to the context of clinical risk assessment. This is what happened in *Tarasoff* and similar cases in other states. Increasingly, and after intense lobbying by professional mental health organizations, state legislatures are passing statutes to make standards for liability and immunity in this area explicit (Appelbaum, Zonana, Bonnie, & Roth, 1989). These statutes, however, will still require much adjudication to interpret inevitably ambiguous terminology (e.g., what counts as a "serious threat" or a "reasonably identifiable victim" in California's, 1990, statute?). The point here is that there is no national legal standard for what clinicians should do when they assess risk (Givelber, Bowers, & Blitch, 1984), and that it behooves clinicians to know precisely what the legal

standards in their own jurisdiction are regarding violence prevention. State mental health professional associations ought to have this information readily available.

### *Information*

Once a clinician knows what information, in general, may be relevant to assessing risk, he or she must take efforts to gather that information in a given case. Most of the *Tarasoff*-like cases on which I have worked have faulted clinicians not for making an inaccurate prediction but for failing to gather information that would have made a reasonable effort at prediction possible. There are generally four sources in which relevant information can be found: in the records of past treatment, in the records of current treatment, from interviewing the patient, and from interviewing significant others. In some criminal contexts (e.g., assessments for suitability for release on parole or from insanity commitment) additional records in the form of police and probation reports, arrest records, and trial transcripts may also be available and should be consulted. But in the civil context, these records are generally not available to clinicians.

*Past records.* The only cases in which I have been involved that were, in the words of the defense attorneys, "born dead" were those in which the patient had an extensive history of prior violence that was amply documented in reasonably available treatment records, but those records were never requested. In these cases, the clinician has been forced to acknowledge on the witness stand that if he or she had seen the records, preventive action would have been taken.

The emphasis in the previous paragraph should be on the phrase *reasonably available*. At one extreme, I served as an expert witness for the defendant in a case in which a patient was hospitalized for a few days and killed a person shortly after being released. One of the arguments of the plaintiff's attorney to support a finding of negligent-release was that the treating clinician had not written to the Philippines, where the patient had briefly been hospitalized many years earlier, to obtain the treatment records. This is clearly absurd (i.e., unreasonable), as the patient would in any event have been discharged long before the records had arrived (and had been translated from Tagalog), assuming that they ever would have been sent.

At the other extreme, however, I was the plaintiff's witness in a case in which an outpatient clinic was on the ground floor of a building that housed an affiliated mental hospital. A patient whose hospital records were replete with extreme violence was transferred from the hospital to the outpatient clinic. The hospital did not send the records with the patient, and the outpatient clinic did not request them, at least not until the staff read in the newspapers that the patient—now *their* patient—had been arrested for murder.

Somewhere between writing to the Philippines and walking upstairs, a line has to be drawn as to what constitutes a reasonable effort to obtain records of past treatment. I know of no standard operating procedure on this question. "Records" does not have to mean the entire hospital file; a discharge summary may often suffice. More of a priority might be accorded to requesting the records of patients whose hospitalization was precipitated by a violent incident, or who exhibited violence in the hospital, than to requesting the records of other patients. In the context of long-term hospitalization, of course, there will be more opportunity to obtain records from distant facilities than would be the case for short-term treatment (this opportunity to obtain records is also present for patients with repeated short-term hospitalizations). Hospitals in the same geographic area or in the same treatment system (e.g., among public hospitals in the same state or between state hospitals and community mental health centers) might be expected to have established procedures for transferring information. Records of more recent hospitalizations (e.g., within the past five years) may be more probative of risk than may older hospital records. But when indications are that the current hospitalization will be brief and when prior hospitalizations were at distant locations or occurred long ago, it is clearly not standard practice to request records. Nor should it be. It takes time and money to request, locate, copy, transmit, and read treatment records—resources that might more profitably be spent providing treatment.

*Current records.* Reading the chart of the current hospitalization when making risk judgments about hospitalized patients is essential. I am continually amazed, however, at how often clinicians peruse the chart as if it were a magazine in a dentist's waiting room. In particular, nursing notes, in which violent acts

and threats are often to be found, are frequently glossed over. Yet, I have seen plaintiff's attorneys introduce exhibits consisting of eight-foot-by-four-foot photographic enlargements of pages from nursing notes containing statements such as, "assaulted several other patients without provocation tonight," and "patient threatening to kill spouse as soon as released." These exhibits certainly concentrated the jury's attention.

*Inquiries of the patient.* Clinicians appear to question patients more often about a history of violence to self or current suicidal ideation, than about a history of violence to others or current violent fantasies. There seems little justification for this inconsistency. Directly asking patients about violent behavior and possible indices of violent behavior (e.g., arrest or hospitalization as "dangerous to others") is surely the easiest and quickest way to obtain this essential information. Open-ended questions such as "What is the most violent thing you have ever done?" or "What is the closest you have ever come to being violent?" may be useful probes, as might "Do you ever worry that you might physically hurt somebody?" The obvious problem, of course, is that patients may lie or distort their history or their current thoughts. This is always a possibility, but often corroborating information will be available from the records (above) or from significant others (below). Quite often, however, patients are remarkably forthcoming about violence. And although there may be reasons to suspect a negative answer in a given case, a positive answer should always be pursued. Unless a question to the patient is ventured, potentially valuable information on risk will not be gained.

*Inquiries of significant others.* Records are often unavailable, and patients are sometimes not reliable informants. A significant other, usually a family member, is frequently available in the case of inpatient hospitalization, however, either in person (accompanying the patient to treatment or seen later in conjunction with the patient's therapy) or at least by telephone. Asking the significant other about any violent behavior or threats in the event that precipitated hospitalization, or in the past, as well as open-ended questions such as "Are you concerned that X might hurt someone?" with appropriate follow-up questions as to the basis for any expressed concern, may yield useful information.

### *Estimation*

I have elsewhere suggested a clinical model for estimating a patient's risk of violent behavior (Monahan, 1981). Although the mental health professions have yet to demonstrate that the accuracy of their estimations of risk is high in absolute terms, it is clearly high relative to chance. For example, Kozol, Boucher, and Garofalo (1972), in one of the most cited prediction studies, identified a group of patients, 35% of whom were found to have committed a violent act within five years of release. The base (i.e., chance) rate of violence was 11%. Thirty-five percent is both much lower than 100% and much higher than 11%. Whether these clinical predictions were any more accurate than those that could have been made by nonclinicians (or actuarial tables) using simple demographic variables, however, is unknown. More recent research (e.g., Klassen & O'Connor, 1988) has demonstrated considerably more accurate predictions with narrowly defined groups of high-risk patients.

The obstacles to progress in clinical risk assessment research are formidable. To date, the range of predictor variables that have been used has been narrow, the criterion measures have been weak, the patient samples studied have been constricted, and research efforts have been unsynchronized (Monahan & Steadman, in press). Research attempting to overcome each of these limitations is under way (Steadman et al., in press).

### *Communication*

In the individual practice of psychotherapy, the clinician who gathers information on risk is also the clinician who makes decisions based on this information. But in outpatient treatment agencies and in mental hospitals, a division of labor often exists: One person may do the intake, another may be responsible for patient care, a team of several professionals may provide a variety of assessment and treatment modalities, and one person will have formal responsibility for making or approving discharge decisions. Although this division of labor may be an efficient use of resources, it does raise an issue not present in the solo practitioner context: the communication of relevant information from one mental health professional to another. Here, information must be transferred between or

among clinicians, and significant information must be made salient to the person responsible for making the ultimate decisions regarding the patient (Klein, 1986).

Placing all relevant information in the chart, of course, is the primary way of transferring information among treatment professionals. As long as the person ultimately responsible for making the institutionalization or discharge decision reads the entire file, the information is thereby communicated to the person who needs to know it.

In the real world of professional practice, however, information is not always effectively communicated by simply passing on a chart. The ultimate decision maker may be a harried senior staff member whose signature is often a pro forma endorsement of the recommendations of line staff, based only on a brief discharge summary. Or the amount of information in the chart, including information from numerous past hospitalizations, may be literally so voluminous that no final decision maker would be expected to read it verbatim.

For example, I was involved in a case in which a private hospital sought to transfer a chronic patient to a community care facility. The hospital "discharge planner" needed a dolly to move several cartons of records on this patient to the office of the community facility's intake director. Numerous violent incidents were recorded throughout this massive record, but none of them were mentioned on the hospital's upbeat discharge summary (the hospital appeared to be trying to sell the patient to the community facility). It was unreasonable, the jury believed, for the hospital to expect the community intake worker to sit down for several days and read the entire record before accepting this patient, especially because the hospital also wanted transfer decisions to be made on a number of other patients by the end of a one-hour meeting.

It is not sufficient to dump undigested information on the desk of the ultimate decision maker and to claim that he or she assumed the risk of liability by taking possession of the file. Rather, information pertinent to risk should explicitly (and in writing, see below) be brought to the attention of the decision maker. Only by making the information salient can one be assured that the decision maker has had the option to make use of it.

From the decision-maker's vantage point, the implications of information overload are equally clear: When the transfer or discharge summary prepared by others makes no explicit positive or negative reference to risk, one should directly ask what information relevant to risk is in the chart and should record the answer.

## Risk Management

For most patients, of course, the gathering of risk information will produce little or nothing of clinical interest (Monahan, 1992). But for some patients—approximately one per month according to a large survey of private practitioners in California (Wise, 1978)—information will be generated to elicit concern. Here, it is essential to develop a plan to manage the observed risk and to monitor patient adherence with that plan.

### Planning

This is not the place to recapitulate advice about the clinical management and treatment of potentially violent patients. Excellent guides to this literature exist (Roth, 1987). Whatever treatment modalities are chosen, however, two things should be borne in mind: A range of preventive actions should be considered in deciding how to safely manage the patient's risk, and consultation with other professionals should be sought in particularly difficult cases.

*Choice of a plan.* For a patient flagged as *high risk*, it is important to explicitly consider preventive action. Such actions usually fall into three categories (see Appelbaum, 1985, p. 426). Following the literature on crime prevention, the first category might be called *incapacitation*, or negating the opportunity for violence in the community by hospitalizing the patient (voluntarily or involuntarily), or if it is hospital violence that is anticipated, negating that opportunity by transferring the patient to a more secure ward until the level of risk is reduced. The second category could be termed *target hardening*, or warning the potential victim when one can be identified, so that the victim can take precautionary measures. The final category might be called *intensified treatment*, in which outpatient status is maintained but sessions are scheduled more frequently, medication is initiated or increased, or joint sessions are held

with the patient and others significant to the occurrence of violence, possibly including the potential victim (Wexler, 1981). More creative options may also be possible (Dietz, 1990).

The issue here is not that the clinician must necessarily adopt one of these violence-prevention strategies as part of a risk management plan but that the clinician consciously consider such options and make a reasoned and reasonable decision to adopt or not to adopt one of them. If the steps taken to prevent violence are seen as reasonable, the clinician should not be held liable, even if harm occurs.

*Second opinions.* The problem with choosing a risk management plan, in terms of tort liability, is that because the plan didn't work (or else there would be no law suit), the plaintiff can often retain another mental health professional as an expert witness to say, with the wisdom of hindsight, that any competent clinician would have known that the plan was defective. The more well thought out the preventive measures taken in a case, the more difficulty the plaintiff will have in finding a credible witness who can with integrity make such a claim.

One way for a clinician to immunize himself or herself from this kind of Monday morning quarterbacking is for the clinician to initiate it on Friday afternoon, by consulting with a respected colleague about a difficult case before risk management decisions are made (Rachlin & Schwartz, 1986). Getting a second opinion has two advantages. First, the clinician may learn something. He or she may learn that the consulting colleague does not think that the contemplated actions are reasonable. The clinician may have missed a significant risk or protective factor, or may be overreacting to some aspect of the case—we all have blind spots. Or, the planned course of action may be reasonable, but the consultant may have a more creative suggestion.

The second advantage of obtaining a consultation is that it is a concrete way of demonstrating that the clinician took the case seriously and considered a variety of options for violence prevention. If the consultant is an experienced clinician (perhaps the "risk educator" mentioned above), it becomes much more difficult to claim after the fact that "anyone" would have known that the risk management plan was negligent.

There are two clear disadvantages to obtaining consultation, however. The first is that it takes time to familiarize a colleague with a difficult case and to talk through strategy. In many busy practice settings, there is barely enough time to make a reasoned initial decision, much less to review that decision with someone else. The second disadvantage is that in obtaining consultation the clinician may be exposing the chosen consultant to potential liability should the patient commit a violent act (although I emphasize that I know of no cases in which consultants who have not seen the patient have been found to share liability). Perhaps the most equitable ways to obtain consultation are case conferences or grand rounds in which each clinician gets to discuss a difficult case, thereby broadly sharing potential liability with other colleagues, while incurring potential liability from their cases.

#### *Adherence*

Without doubt, the single largest category of cases on which I have served as an expert witness have involved patient noncompliance with aftercare recommendations. The typical case is one in which a patient is seriously violent when acutely disordered, is treated in a mental hospital until the disorder is under control, and is discharged with the recommendation to continue treatment as an outpatient. The patient comes to few, if any, appointments and then stops showing up altogether. No one on the hospital staff calls to find out what the problem is or to assess the patient's condition. The patient decompensates over the course of a few weeks or months and, while acutely disordered, kills someone. This situation is even more egregious when the patient is known to have a long history of noncompliance with treatment (typically, with psychotropic medication) and is also known from the record to become disordered when off medication and to become violent when disordered. It does not take the jury long to complete the syllogism and to conclude that the clinician or hospital could and should have avoided the tragedy by pursuing the missed appointments and nonadherence to treatment recommendations.

I know how understaffed many mental health facilities are. It is hard enough to see those people who do show up for aftercare treatment, much less to track down those who



do not. Furthermore, unless the former patient satisfies the criteria for civil commitment (or outpatient commitment), there may be little the clinician can legally do to force the patient to comply with treatment recommendations (but see Meichenbaum & Turk, 1987, for an excellent account of *adherence enhancement*). Yet, it is very hard to convince a jury, with the children of the deceased in the front row of the courtroom, that a good faith effort to assure the patient's compliance with treatment was not worth the clinician's time (Klein, 1986).

## Documentation

It would be an exaggeration to state that in a tort case what is not in the written record does not exist—but not much of an exaggeration. The violent event that gives rise to the suit may occur weeks or months after the patient was last seen. The resolution of the case through settlement or trial will be a minimum of several years from the time of the violent event. Memories fade or become compromised when numerous, or innumerable, other patients are seen in the interval. The record requested by telephone, the questioning of the patient or family member about violence, the hallway conversation with a colleague to communicate information, or the careful consideration of options is unlikely to be retrieved intact from memory; nor would it make much difference if it were. Juries are rightly skeptical of self-interested statements by people who have a lot to lose. "If you did it, why didn't you write it down?" they will reason. "I was busy," is not a credible retort. Unrecorded warnings to a patient's family member that he or she has been threatened with harm are useless when that family member is dead as a result of the threatened violence or is the plaintiff in a suit for damages against the therapist. From the perspective of violence prevention, the suggestions made regarding obtaining and communicating information and developing and monitoring a risk management plan are equally applicable whether or not a record is made. From the perspective of reducing exposure to liability, there is little point in doing any of them unless they are memorialized in ink or on a dated disk (or by a videotaped exit interview; see Poythress, 1990, 1991).

Documenting information received and actions taken, or "building the record," is an essential exposure-limitation technique. When recording information relevant to risk—for example, a statement from a family member that a patient made a violent threat—one should note three things: the *source* of the information (e.g., the name of the family member), the *content* of the information (e.g., the nature and circumstances of the threat), and the date on which the information was obtained or communicated. In addition, when noting an action taken in furtherance of a risk reduction plan (e.g., committing or not committing a patient, warning or not warning a potential victim), it is essential to include a statement, however brief, of the *rationale* for the action. A comment in the chart or discharge summary—for example, "Called mother on 6/21. She said that she did not take patient's threats seriously, and that he had always complied with medication in the past"—is worth its weight in gold (perhaps literally) in demonstrating a good faith effort to attend to risk.

## Policy

The time for a clinician to think through difficult issues regarding risk assessment and management is not when a patient makes a threat or misses a follow-up appointment. Rather, general policy choices should be made and reflected upon before the need for them arises in a given case. These policies or guidelines should be committed to writing and should be reviewed by experienced clinicians and lawyers. Staff should be educated in the use of the guidelines, and their compliance should be audited. Finally, forms should be revised to prompt and record the actions contemplated by the policy statement.

### Written Guidelines

Memorializing "risk policy" in writing has several virtues (Bennett, Bryant, VandenBos, & Greenwood, 1990). It promotes clarity of thought and thus is conducive to formulating effective procedures, from both the viewpoints of violence prevention and the reduction of exposure to liability. In an organizational context, it allows for consistency of application, so that staff members are not acting at cross

purposes ("I thought that it was *your* responsibility to warn the family!"). And it is efficient in the sense that novice clinicians, or clinicians new to the organization, can more quickly be brought up to the level of practitioners experienced in handling potentially violent patients. The guidelines should periodically (e.g., annually) be reviewed, with an eye to revision in light of developments in research, practice, or state law.

The absolutely essential point here is that the guidelines should reflect *the minimal standards necessary for competent professional practice* and not the ideals to which an organization would aspire if it had unlimited resources. Stating that "all records of prior treatment shall be obtained" or that "all significant others will be questioned about the patient's history of violence" are invitations to be sued. All prior treatment records often cannot be obtained (recall the case mentioned earlier in which the records were in the Philippines). All significant others can be a large group whom it would be ludicrous to survey in the typical or even the extraordinary case. The rule should be to state as policy only what you actually expect staff to do in the real resource-constrained world of clinical practice.

#### *External Review*

Experienced clinicians should be the ones to draft risk policy. But the draft should be reviewed by other clinicians from comparable facilities elsewhere (Poythress, 1987). As with securing consultation on difficult cases, discussed earlier, policy consultation serves two purposes. It allows the drafting clinicians to learn from the experience of others and, thus, to substantively improve the quality of their procedures. If the reasonableness of the policies is later impugned in a tort suit, it is very helpful to announce that they received the blessing of the most relevant slice of the professional community before the events that gave rise to the suit. A leadership role can productively be played by state and local professional organizations in drafting model guidelines in this area. Because *Tarasoff* liability applies to all mental health professions, this task is perhaps uniquely suited to interprofessional cooperation. In addition to review by external clinicians, review by house or retained counsel is also essential to make certain that the policies comport with the statutory and case law of the jurisdiction.

#### *Staff Education and Compliance*

It is not enough—indeed, it is counterproductive—to draft exemplary guidelines and subject them to clinical and legal review if the guidelines are merely to be filed in some cabinet or entombed in a staff handbook, never to be read. Again, *it is much better to have no policies at all than to have policies that are not followed in actual practice*. If one has no formal policies regarding risk, one can always try to argue after the fact that there were implied policies or understandings about how high-risk patients were to be handled. This is difficult, but not impossible. On the other hand, when clear and reasonable policies have been formulated and committed to writing by the agency itself, and those policies were violated in the case that gave rise to a tort action, the ballgame is over. It lacks credibility to dispute standards that you yourself have proclaimed. The jury, again with reason, will wonder: "If you didn't think that this was what the staff should do, then why did you tell them to do it?"

Once the staff have been educated in the use of the guidelines, their compliance should be the subject of periodic "audits." A senior colleague (perhaps the risk educator mentioned previously) should review files to see whether the guidelines are being followed in practice, whether, for example, records are requested, information is communicated, and all actions are properly documented. Corrective action—including the revision of unworkable policies—should then be taken.

#### *Useful Forms*

The creation of user friendly forms for documenting actions called for by policy guidelines can both prompt and memorialize appropriate inquiries and responses. I have seen many a case saved for defendants by clinicians having simply checked off "no" to a list of intake questions, including the items "violent history" and "violent-ideation." Expanding that list to incorporate more items contemplated in the risk-policy statement—for example, fill-in-the-blanks for "records requested from \_\_\_\_" "concerns communicated to \_\_\_\_," and "attempted to follow-up by \_\_\_\_"—would be very useful both in terms of violence prevention and exposure limitations. Forms should facilitate, rather than impede, gathering necessary information, taking

appropriate action, and documenting both information and actions. Here again, state and local professional organizations have a leadership role to play in offering model forms to be adapted in light of an individual agency's or practitioner's circumstances.

### Damage Control

Risk assessment and risk management involve probabilistic judgments. By definition, these judgments will sometimes be wrong—not wrong in the sense of mistake, but wrong in the sense that low probability events do happen. Often, clinicians learn of their patient's violence from the evening news or the morning paper. This is followed by calls from the director of the facility or from one's colleagues, from reporters, and, much later perhaps, from a lawyer to arrange the clinician's deposition. In the context of being a mental health professional, having a patient kill or severely injure another qualifies as a major life event. I am amazed at how often clinicians panic and take actions that are unwise, unethical, and sometimes illegal. The two most prevalent forms of maladaptive clinician reaction to the stress of patient violence and the fear of liability are tampering with the record and making inculpatory public statements.

#### *Tampering With the Record*

In several of the cases on which I have served as an expert witness, a treating clinician has learned of his or her patient's violence from the media and shortly thereafter has gone to the patient's chart and inserted new material tending to support the reasonableness of the decisions that the clinician had made. In each of these cases, to my knowledge, the new material was factually correct. The clinician was not lying about the events that took place, for example, the questioning of family members about the patient's violent history or the attempt to follow up on missed aftercare appointments. But the clinician was lying about the date that these events were recorded: The entries were back-dated to appear as if they had been written before the violent act took place. In the most egregious of these cases, a patient had been released from a hospital on January 1 and had killed someone on January 10 (the dates are fictitious). In my capacity as expert witness for the defense, I reviewed the

discharge summary. It was a superb document, including a carefully justified risk-management plan and detailed recommendations to the patient and family members regarding adherence to the plan. It was dated January 1, the day of discharge and 10 days prior to the killing. I thought that the case was won: Here was the gun, and there was no smoke. Then I noticed the secretarial inscription at the bottom of the last page. It read, "D: January 11; T: January 12." My heart sank as I asked my own secretary to confirm my suspicions. The inscription was a secretarial convention for "dictated on January 11 and transcribed on January 12." The summary had obviously been written on the day after the killing and back-dated to appear as if it had been written before the patient had been discharged. Either through naiveté or a desire to avoid becoming an accomplice in fraud, the clinician's secretary had put the correct dates on the very document containing the manufactured ones. When I informed defense counsel of the ruse, she immediately decided to settle the case—which she had previously thought was eminently winnable—for the amount the plaintiff was asking, rather than risk a trial at which the tainted discharge summary would be placed before the jury.

I want to underscore my belief that everything the clinician wrote in that discharge summary was true: He had indeed developed a careful risk-management plan and communicated to the patient and family exactly as was stated. Nothing was manufactured except the date. I empathize with the plight of overworked clinicians who find it difficult to get all their paperwork (i.e., documentation) completed on time, especially when there are live bodies in the waiting room or in the ward with competing demands for the clinician's attention. I have many fewer responsibilities in my academic life, and I do not get all my work done on time, either.

Yet it should be clear why tampering with the record is *always* wrong, even when the intent is to make the record more accurately reflect what actually transpired in a case. It may be legally actionable, and it is strategically catastrophic.

If a suit has not been filed, one can argue that the record does not yet constitute evidence and so changing it is not illegal. But once a suit is filed, changing the record can constitute obstruction of justice. If the clinician is asked

under oath whether the records—and the dates of entry are part of the records—are accurate and testifies affirmatively and if the late entries come to light, the clinician is guilty of perjury, a criminal offense.

The most likely outcome of tampering with the record, however, is to completely destroy whatever chances one had of winning the case. Of course, I have no way of knowing how often records were changed and the changes went undiscovered (some clinicians may have secretaries more clever or more loyal than the hapless one in the case I described). But when the late entries do come to light, they are dispositive. The jury will reason, understandably, that if the therapist would lie about the dates of the entries, he or she would also lie about the content of the entries. It is, in short, much better to admit that you didn't keep good records and hope that the jury believes you when you tell them what happened than to manufacture good records after the fact at the cost of your own integrity and credibility.

#### *Public Confessions*

Therapists often feel responsible when a patient commits suicide. It is at least as traumatic for the therapist when a patient kills an innocent third party. Clinicians are not immune from the hindsight effect: Everything seems clear and determined in retrospect (Wexler & Schopp, 1989). Given the nature of their occupation, clinicians will often want to talk through their feelings of guilt; however, they are strongly advised to resist such public confessional urges (and might if necessary be advised to go to their own therapist to express their affect in the context of a confidential relationship). Whatever the clinician says can only hurt his or her case if a suit is filed, and, indeed, it may make the filing of a suit more likely.

I was retained on a case in which a patient discharged from a community mental health center later killed a stranger. On the day after the killing made the front page of the local newspaper, the director of the facility wrote numerous comments, in black ink, across the only copy of the discharge summary. These are some of them: "How could we have missed this!" "Somebody should have gotten his records," "Really shoddy work on our part." One can imagine the dollar signs glistening in the plaintiff's attorney's eyes when she saw this

subpoenaed document. The case, needless to say, was settled on very generous terms. While unburdening one's conscience and self-flagellation may do wonders for the psyche, they are very hard on the net worth. Indeed, after this case, the mental health center in question was no longer able to buy liability insurance. No one would sell it to them.

Clinicians must learn that when their worst fantasies come true, they should take the time-honored course of defendants in criminal cases: imitate a potted plant. Say nothing.

#### **Conclusion**

Writing of liability is not itself without risk. Clinicians can become so sensitized by the fear of litigation that clinical priorities are distorted and clinical judgment is impaired. The practice of "defensive therapy" is no less socially wasteful than defensive practice in physical medicine. If the import of my remarks is to make clinicians spend their time—and someone's money—tracking down tangentially relevant records or not-so-significant others, or rushing to consult with colleagues every time a young male patient walks in the door, then I have done neither clinicians nor their patients any service. Yet this need not be the outcome. As Richard Bonnie (1988) has written,

In most situations, in my opinion, excessive risk avoidance is attributable either to the practitioners' uncertainty about their legal obligations, or to misperceptions about the conduct required to satisfy those obligations. It follows, then, that these negative defensive practices can be reduced by clarifying the specific steps that are sufficient, if undertaken, to discharge one's legal duty. One clear example is the *Tarasoff* duty. (p. 237)

By offering a set of guidelines to clarify clinicians' legal duty to protect third parties from the violent acts of their patients, I hope to reduce the general sense of anxiety and the occasional resort to excessive precaution that have come to characterize the mental health professions in the post-*Tarasoff* era.

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## APPENDIX

### Principles of Risk Containment

#### A. Risk Assessment

1. Become educated in risk assessment, stay current with developments in the field, and be conversant with the law of the jurisdiction.
2. Obtain reasonably available records of recent prior treatment and carefully review current treatment records.
3. Directly question the patient and relevant others about violent acts and ideation.
4. Communicate information and concerns about violence to the person responsible for making decisions about the patient, and make important items salient.

#### B. Risk Management

5. For cases that raise particular concerns about violence, consider intensified treatment, incapacitation, or target-hardening.
6. For especially difficult cases, seek consultation from an experienced colleague.
7. Follow up on lack of compliance with treatment.

#### C. Documentation

8. Record the source, content, and date of significant information on risk and the content, rationale, and date of all actions to prevent violence.

#### D. Policy

9. Develop feasible guidelines for handling risk, and subject these guidelines to clinical and legal review.
10. Educate staff in the use of the guidelines, and audit compliance.
11. Revise forms to prompt and document the information and activities contemplated in the guidelines.

#### E. Damage Control

12. Discourage public statements of responsibility and tampering with the record.

## Chapter 6: Mental Health Treatment Resources

### National Associations, Agencies, and Clearinghouses

The following associations, agencies, and clearinghouses provide information, research, or educational materials on mental health disorders. Addresses and telephone numbers are current as of April 1994.

American Association of Mental Health Professionals in  
Corrections (AAMHPC)  
P.O. Box 163359  
Sacramento, CA 95816-9359

American Psychiatric Association (APA)  
1400 K Street, N.W.  
Washington, DC 20005  
(202) 682-6000

Anxiety Disorders Association of America  
6000 Executive Boulevard, Suite 513  
Rockville, MD 20852-4004  
(301) 231-9350

Bureau of Justice Assistance Clearinghouse  
Box 6000  
Rockville, MD 20850  
1 (800) 688-4252

Depression and Related Affective Disorders Association  
(DRADA)  
John Hopkins Hospital Meyer 3-181  
600 North Wolfe Street  
Baltimore, MD 21205  
(410) 955-4647

National Alliance for the Mentally Ill (NAMI)  
2101 Wilson Boulevard, Suite 302  
Arlington, VA 22201  
(703) 524-7600 (Main office number)  
1 (800) 950-6264 (Helpline)

National Association for Rural Mental Health (NARMH)  
1 West Armour Boulevard, Suite 301  
Kansas City, MO 64111  
(816) 756-3140

National Coalition for the Mentally Ill in the Criminal Justice  
System  
2470 Westlake Avenue North, #101  
Seattle, WA 98109-2282  
(206) 285-7422

National Community Mental Health Care Centers  
(NCMHCC)  
12300 Twinbrook Parkway, Suite 320  
Rockville, MD 20852  
(301) 984-6200  
(Publishes the *National Registry of Community Mental Health Services*, a  
directory of community mental health centers in each state.)

National Depressive and Manic Depressive Association  
730 North Franklin Street, Suite 501  
Chicago, IL 60610  
(312) 642-0049

National Institute of Corrections (NIC) Information Center  
1860 Industrial Circle, Suite A  
Longmont, CO 80501  
(303) 682-0213

National Institute of Justice/NCJRS  
P.O. Box 6000  
Rockville, MD 20850  
1 (800) 851-3420



National Institute of Mental Health  
Information Resources and Inquiries Branch  
Office of Scientific Information  
5600 Fishers Lane  
Room 7C-02  
Rockville, MD 20857  
(301) 443-4513

National Mental Health Association, Inc. (NMHA)  
1021 Prince Street  
Alexandria, VA 22314-2971  
(703) 684-7722 (Main office number)  
(703) 838-5011 or -5012 or  
1 (800) 969-6642 (Information Center)

National State Association of Mental Health Program Directors  
66 Canal Center Plaza, Suite 302  
Alexandria, VA 22314-1591  
(703) 739-9333

## State Mental Health Forensic Directors

The following is a list of state mental health forensic directors, who are a source of information on mental health and correctional issues at the state level. Compiled by the National Association of State Mental Health Program Directors, this list is current as of April 1994.

### Alabama

Larry D. Stricklin  
Director  
Taylor Hardin Secure Medical  
Facility  
Department of Mental Health  
1301 River Road, N.E.  
Tuscaloosa, AL 35405  
(205) 556-7060

### Arkansas

Billy Burris  
Program Coordinator/Forensic  
Services  
Arkansas State Hospital  
Division of Mental Health Services  
Department of Human Services  
4313 West Markham Street  
Little Rock, AR 72201  
(501) 686-9175

### Alaska

Patrick Aloia  
Mental Health Clinician  
Division of Mental Health &  
Developmental Disabilities  
3601 C Street, Suite 520  
P.O. Box 240249  
Anchorage, AK 99524-0249  
(907) 465-4247

### California

Rubin Lozano  
Chief  
Forensic Services Branch  
Department of Mental Health  
1600 9th Street  
Sacramento, CA 95814  
(916) 654-1471

### Arizona

John Migliaro  
Superintendent  
Arizona State Hospital  
2500 East Van Buren Street  
Phoenix, AZ 85008  
(602) 255-1298

### Colorado

William H. Ross  
Director  
Institute of Forensic Psychiatry  
Colorado State Hospital  
1600 West 24th Street  
Pueblo, CO 81003  
(719) 546-4838

**Connecticut**

Robert T. M. Phillips  
Director of Forensic Services  
Department of Mental Health  
Whiting Forensic Institute  
P.O. Box 70, O'Brien Drive  
Middletown, CT 06547  
(203) 344-7458  
(203) 566-5133 (Central office)

**Delaware**

H. Nash Keel  
Director  
Delaware State Hospital  
Division of Mental Health  
1901 North Dupont Highway  
New Castle, DE 19720  
(302) 421-6445

**District Of Columbia**

David Powell  
Acting Administrator  
Forensic Services Administration  
Commission on Mental Health  
Services  
Behavioral Studies Building  
2700 Martin Luther King, Jr.  
Avenue, S.E.  
Washington, DC 20032  
(202) 373-6283

**Florida**

Martha Larson  
Chief, Adult Mental Health  
Alcohol, Drug Abuse & Mental  
Health Program Office  
Department of Health &  
Rehabilitation Services  
Mental Health Program Office  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
(904) 487-1301

**Georgia**

Elizabeth M. Chadwick  
Legal Forensic Officer  
Division of Mental Health, Mental  
Retardation & Substance Abuse  
Department of Human Resources  
878 Peachtree Street N.E.,  
Room 306  
Atlanta, GA 30309-3999  
(404) 894-6538

**Guam**

Estellta D. Redding  
Medical Director  
Department of Mental Health &  
Substance Abuse  
P.O. Box 9400  
Tanuning, GU 96911  
(671) 646-9261, -9262, or -9263

**Hawaii**

Barry S. Carlton  
Clinical Director and Chief  
Forensic Services  
Hawaii State Hospital  
45-710 Keaahala Road  
Kaneohe, HI 96744-3597  
(808) 247-219, ext. 276

**Idaho**

Dwight J. Peterson  
Director of Forensic Services  
Department of Health & Welfare  
State Hospital South  
P.O. Box 400  
Blackfoot, ID 83221  
(208) 785-1200

**Illinois**

Michael Howie  
Acting Director  
Forensic Mental Health  
Services  
Department of Mental Health  
& Developmental Disabilities  
400 William G. Stratton  
Building  
Springfield, IL 62765  
(217) 524-0323

**Indiana**

Katherine Gerber-Gregory  
Director of Legal Services  
Legal Services Division  
Department of Mental Health  
402 West Washington Street  
Indianapolis, IN 46204-2739  
(317) 232-7853

**Iowa**

Russell Rogerson  
Superintendent  
Iowa Medical & Classification  
Center  
P.O. Box A  
Oakdale, IA 52319  
(319) 626-2391

**Kansas**

John House  
Attorney  
Department of Social &  
Rehabilitation Services  
Mental Health & Retardation  
Services  
State Office Building, 5th Floor  
Topeka, KS 66612  
(913) 269-5443

**Kentucky**

Gregory S. Taylor  
Chief Executive Officer  
Kentucky Correctional  
Psychiatric Center  
Cabinet for Human Resources  
Department for Mental Health/  
Mental Retardation Services  
P.O. Box 67  
Lagrange, KY 40031  
(502) 222-7161

**Louisiana**

Jerry Westmoreland  
Chief Executive Officer  
Feliciana Forensic Facility  
Office of Mental Health &  
Substance Abuse  
P.O. Box 888  
Jackson, LA 70748  
(504) 634-2651

**Maine**

Ulrich B. Jacobsohn  
Director  
State Forensic Service  
Department of Mental Health &  
Mental Retardation  
P.O. Box 724  
Augusta, ME 04330  
(207) 287-7290

**Maryland**

Raymond F. Patterson  
Director of Forensic Services  
Mental Hygiene Administration  
Department of Health &  
Mental Hygiene  
Clifton T. Perkins Hospital Center  
Dorsey Run Road  
Jessup, MD 20794  
(410) 792-4022

**Massachusetts**

William A. O'Leary  
Acting Commissioner for  
Forensic Mental Health  
Department of Mental Health  
25 Staniford Street  
Boston, MA 02114  
(617) 727-5600

**Michigan**

Roger Smith  
Director  
Bureau of Forensic Mental  
Health Services  
Department of Mental Health  
P.O. Box 2060  
Ann Arbor, MI 48106  
(313) 944-0800, ext. 602

**Minnesota**

William D. Erickson  
Medical Director  
Minnesota Security Hospital  
St. Peter, MN 56082  
(507) 931-7127

**Mississippi**

Reb McMichael  
Director of Forensic Services  
Mississippi State Hospital  
Whitefield, MS 39193  
(601) 939-1221, ext. 435

**Missouri**

P. Ann Dirks  
Director of Forensic Services  
& Assistant General Counsel  
Department of Mental Health  
1706 East Elm Street  
P.O. Box 687  
Jefferson City, MO 65102  
(314) 751-9395

**Montana**

Ed Amberg  
Director  
Program Development &  
Evaluation  
Montana State Hospital  
Warm Springs, MT 59756  
(406) 693-7007

**Nebraska**

Louis C. Martin  
Chief of Service Security Unit  
The Lincoln Regional Center  
P.O. Box 94949  
Lincoln, NE 68509-4949  
(402) 477-3971

**Nevada**

Carlos Brandenburg  
Director of Forensic Services  
Lake's Crossing Center  
500 Galetti Way  
Sparks, NV 89431-5573  
(702) 789-0311

**New Hampshire**

John D. Wallace  
Director, Client & Legal Services  
Unit  
Division of Mental Health &  
Developmental Services  
State Park South  
105 Pleasant Street  
Concord, NH 03301  
(603) 271-5002

**New Jersey**

John E. Main  
Chief Executive Officer  
Forensic Psychiatric Hospital  
P.O. Box 7717  
Stuyvesant Avenue  
West Trenton, NJ 08628  
(609) 633-0900

**New Mexico**

Michael Gzaskow  
Medical Director  
Las Vegas Medical Center  
P.O. Box 1138  
Las Vegas, NM 87701  
(505) 454-2100

**New York**

Joel Dvoskin  
Director  
Bureau of Forensic Services  
Office of Mental Health  
44 Holland Avenue  
Albany, NY 12229  
(518) 474-7275

**North Carolina**

Bob Rollins  
Director  
State Forensics Services  
Division of Mental Health &  
Mental Retardation  
Dorthea Dix Hospital  
Raleigh, NC 27603  
(919) 733-5525

**North Dakota**

A. A. Ismir  
Executive Director, Forensic Unit  
North Dakota State Hospital  
Department of Human Services  
P.O. Box 476  
Jamestown, ND 58402-0476  
(701) 253-3633

**Ohio**

Sharon G. Aungst  
Chief, Bureau of Forensic Services  
Department of Mental Health  
Suite 2435, 24th Floor  
30 East Broad Street  
Columbus, OH 43266-0414  
(614) 466-1064

**Oklahoma**

Woody Pendergras  
Attorney  
Eastern State Hospital  
P.O. Box 69  
Vinita, OK 74301  
(918) 256-7841

**Oregon**

Richard Vohs  
Forensic Program Director  
Oregon State Hospital  
Mental Health Division  
Department of Human Resources  
2600 Center Street, N.E.  
Salem, OR 97310  
(503) 378-2353

Mary Dolan-Leverette  
Forensic Specialist for  
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Mental Health & Developmental  
Disabilities Services Division  
Office of Mental Health  
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2575 Bittern Street, N.E.  
Salem, OR 97310  
(503) 378-2460

**Pennsylvania**

Bonnie Hardenstine  
Assistant Chief  
Division of Treatment Services  
Department of Public Welfare  
Office of Mental Health  
P.O. Box 2675  
Harrisburg, PA 17105-2675  
(717) 787-1948

**Puerto Rico**

Ramon Alonso Santiago  
Executive Director  
Forensic Psychiatry Institute  
Department of Health  
G.P.O. Box 61  
San Juan, PR 00936  
(809) 751-7060 or -0110

**Rhode Island**

Donald Galamaga  
Executive Director for  
Management & Support Services  
Division of Mental Health  
Department of Mental Health,  
Retardation & Hospitals  
600 New London Avenue  
Cranston, RI 02920  
(401) 464-2338

**South Carolina**

Donald W. Morgan  
Director for Forensic Services  
William S. Hall Psychiatric Institute  
Department of Mental Health  
P.O. Box 202  
Columbia, SC 29202  
(803) 434-4250

**Tennessee**

Marthagem Whitlock  
Director of Special Services  
Department of Mental Health &  
Mental Retardation  
706 Church Street  
Nashville, TN 37219  
(615) 741-2517

**Texas**

James E. Smith  
Superintendent  
Department of Mental Health &  
Mental Retardation  
Vernon State Hospital  
P.O. Box 2231  
Vernon, TX 76384-2231  
(817) 552-9901

**Utah**

Robert Verville  
Forensic Director  
Division of Mental Health  
120 North West, 4th Floor  
Salt Lake City, UT 84103  
(801) 538-4270

**Vermont**

Claudia Stone  
Executive Director  
Hanks Building  
Vermont State Hospital  
103 South Main Street  
Waterbury, VT 05676  
(802) 241-2604

**Virginia**

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P.O. Box 1797  
Richmond, VA 21214  
(804) 786-4837

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Richmond, VA 21214  
(804) 786-4837

**Washington**

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Mental Health Division  
Department of Social &  
Health Services  
Mail Stop OB-42F  
Olympia, WA 98504  
(206) 753-2098

**West Virginia**

Calvin Sumner  
Director of Forensic Services  
& Clinical Director  
Westin Hospital  
P.O. Drawer 1127  
Westin, WV 26452  
(304) 269-1216

**Wisconsin**

Claude Gilmore  
Forensic Program Director  
Division of Care & Treatment  
Facilities  
Mendota Mental Health Institute  
P.O. Box 7851  
Madison, WI 53704  
(608) 244-2411

Marvin Chapman  
7320 Cedar Creek Trail  
Madison, WI 53717  
(608) 833-8837



**Wyoming**

Sharon R. Batwin

Unit Manager

Forensic & Substance Abuse

Forensic Psychiatry Program

Wyoming State Hospital

131 State Highway 150

Evanston, WY 82930

(307) 789-3464, ext. 500

## Chapter 7: Training Videos

This chapter lists videos pertaining to mental health and mental health disorders that are available from the Federal Judicial Center (FJC) Media Library.

### *Depression: The Storm Within (1991)*

Against the backdrop of Hurricane Hugo's destruction, this award-winning American Psychiatric Association film depicts the effects of depression. The video explores how patients seek refuge and recovery through the help of a wide range of psychiatric treatment options. Printed material is included. Running time: 29 minutes. Producer: American Psychiatric Press, Inc. [FJC Media Catalog No. 2460-V/91]

### *Faces of Anxiety (1991)*

Patient interviews and cameo appearances depict the broad spectrum of anxiety disorders and those who suffer from the disorders, including some who self-medicate with alcohol. Flashbacks illustrate the patient's haunted pasts and their improved lives after treatment. Printed material is included. Running time: 29 minutes. Producer: American Psychiatric Press, Inc. [FJC Media Catalog No. 2459-V/90]

### *Generations of Violence (1984)*

A television documentary that explores the destructive cycle of family violence via interviews and case examples. The documentary illustrates how family violence is passed from one generation to another, as abused children often become abusive parents. Running time: 55 minutes. Producer: Filmmakers Library. [FJC Media Catalog No. 2073-V/84]

### *News From Medicine: Peace of Mind (1988)*

A cable news documentary about schizophrenia that illustrates the challenges schizophrenics face every day, and provides insight into what it means to have schizophrenia. The documentary traces the life of former NFL football star Lionel Aldridge, and provides information on medical and technical advances in the diagnosis and treatment of schizophrenia. Running time: 60 minutes. Producer: National Alliance for the Mentally Ill. [Contact Larry Meyer, In-Court Programs Branch, Federal Judicial Center (202) 273-4104]

***The Panic Prison (1989)***

In this award-winning film by the American Psychiatric Association, dramatic patient descriptions illustrate how panic attacks terrorize victims into a no-win game of avoidance. Patient and physician interactions demonstrate treatment methods, including a support group in progress. Printed material is included. Running time: 28 minutes. Producer: American Psychiatric Press, Inc. [FJC Media Catalog No. 2458-V/89]

***The Self-Medication Motive for Alcohol and Drug Abuse: Dual Diagnosis (1990)***

As Part 8 of a twelve-part series entitled *Substance Abuse: Cause, Consequences, and Treatment Choice*, this film presents, in lecture format, an assessment and treatment planning model for dual-disorder patients. The discussion focuses on psychopharmacology, psychotherapy, family milieu, and cultural considerations. Running time: 60 minutes. Producer: Center for Interdisciplinary Studies. [FJC Media Catalog No. 2209-V/90]

***Substance Abuse and Mental Disorder: Concurrent Illness (1990)***

This film is Part 12 of a twelve-part series entitled *Substance Abuse: Cause, Consequences, and Treatment Choice*. In lecture format, it presents information on why individuals with mental health disorders self-medicate with drugs or alcohol. Running time: 55 minutes. Producer: Center for Interdisciplinary Studies. [FJC Media Catalog No. 2213-V/90]

***The World of Abnormal Psychology (1992)***

This is a thirteen-part video series that covers the spectrum of psychological disorders, from simple stress to paranoid schizophrenia. In this documentary style film, noted therapists, physicians, and researchers weave their commentary on causal factors, treatments, and prognoses around the patients' own stories. Running time: 60 minutes for each video. Producer: The Annenberg/CPB Collection.

The series consists of the following videos:

1. *Looking at Abnormal Behavior* [FJC Media Catalog No. 2492-V/92]
2. *The Nature of Stress* [FJC Media Catalog No. 2493-V/92]
3. *The Anxiety Disorders* [FJC Media Catalog No. 2494-V/92]
4. *Psychological Factors and Physical Illness* [FJC Media Catalog No. 2495-V/92]

5. *Personality Disorders* [FJC Media Catalog No. 2496-V/92]
6. *Substance Abuse Disorders* [FJC Media Catalog No. 2497-V/92]
7. *Sexual Disorders* [FJC Media Catalog No. 2498-V/92]
8. *Mood Disorders* [FJC Media Catalog No. 2499-V/92]
9. *The Schizophrenias* [FJC Media Catalog No. 2500-V/92]
10. *Organic Mental Disorders* [FJC Media Catalog No. 2501-V/92]
11. *Behavior Disorders of Childhood* [FJC Media Catalog No. 2502-V/92]
12. *Psychotherapies* [FJC Media Catalog No. 2503-V/92]
13. *An Ounce of Prevention* [FJC Media Catalog No. 2504-V/92]

## Glossary<sup>9</sup>

**addict**—An individual who habitually uses habit-forming narcotic drugs.

**addiction**—Dependence on a chemical substance, resulting in a psychological and/or physiological need.

**affect**—A pattern of observable behaviors that express a subjectively experienced feeling, state, or emotion, such as euphoria, anger, and sadness. A range of affect may be described as broad (normal), restricted (constricted), blunted (reduced emotion), flat (lacks emotion), or inappropriate (emotion and content of conversation do not match).

**affective disorder**—A disorder in which mood change or disturbance is the primary symptom.

**agoraphobia**—A fear of being in places or situations from which escape might be difficult or embarrassing or in which help might not be available if needed. In the *DSM-III-R*, it is almost always a form of panic disorder, rather than a phobia.

**alcohol abuser**—Individual whose physical, mental, emotional, or social well-being is impaired by the use of alcohol.

**AMA**—Acronym for “against medical advice.” Officers may see this acronym on offenders’ mental health records.

**antidepressant drugs**—Psychiatric medication prescribed to treat the symptoms of depression.

**antimanic drugs**—Psychiatric medication prescribed to treat the symptoms associated with a manic episode or bipolar disorder.

**antipsychotic drugs**—Psychiatric medication prescribed to treat the symptoms of schizophrenia and other disorders involving psychotic episodes.

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9. Information in this section is from American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3d ed., rev.), Washington, D.C.: APA, 1987, pp. 391 - 405; Stone, Evelyn M., *American Psychiatric Glossary* (6th ed.). Washington, D.C.: APA, 1988, pp. 1 - 175; memorandum from L. Ralph Mecham to all chief judges, chief probation officers, and chief pretrial services officers, on Reimbursement/Copayment for Treatment Services—Information, dated March 22, 1993; “The Americans with Disabilities Act: Impact on Training,” *Info-Line*, no. 9203 (March 1992): 10 - 11; and *Webster’s II New Riverside University Dictionary*, Boston, Mass.: Houghton Mifflin, 1984.

**antisocial personality disorder**—A personality disorder characterized by an inability to conform to social norms and a continuous display of irresponsible and antisocial behavior which violates the rights of others. A diagnosis of this disorder can only be made after age eighteen and must include evidence of antisocial conduct with an onset prior to age fifteen.

**anxiety**—Apprehension, tension, or uneasiness that stems from the anticipation of danger without an identifiable source.

**anxiety disorder**—A mental health disorder in which anxiety is the most prominent symptom. Anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder.

**avoidant personality disorder**—A pervasive pattern of social discomfort, fear of negative evaluation, and timidity beginning by early adulthood and present in a variety of contexts.

**axes**—The *DSM-III-R* classifies mental health disorders into five diagnostic classes or axes. Each axis relates to a different area of functioning. The five axes are: Axis I: clinical syndromes, including major psychiatric disorders; Axis II: developmental or personality disorders; Axis III: physical disorders; Axis IV: severity of psychological stressors; and Axis V: highest level of adaptive functioning.

**behavior therapy**—A mode of treatment that focuses on modifying an individual's observable behavior by manipulating the environment and other behavioral variables thought to be functionally related to the behavior.

**bipolar disorder**—A mood disorder in which there are episodes of both mania and depression, sometimes referred to as manic-depressive illness.

**borderline personality disorder**—A personality disorder characterized by a pattern of extremely unstable mood, self-image, and relationships that begins by early adulthood and is present in a variety of contexts.

**child molester**—An individual who sexually abuses children. A child molester may or may not be a pedophile.

**clairvoyance**—A form of extrasensory perception or acute intuitive insight in which an individual can perceive things beyond the range of normal human perception.

**claustrophobia**—A type of phobia in which the individual has a fear of closed spaces.

**clinical psychology**—A branch of psychology concerned with the diagnosis, assessment, and treatment of psychological problems and disorders.

**compulsion**—Repetitive, purposeful, and intentional behaviors that are performed in response to an obsession, according to certain rules, or in a stereotyped fashion. Failure to perform an obsession may lead to overt anxiety.

**copayment**—The portion of the fees associated with mental health treatment that the offender pays. A copayment can be cash paid by the offender or a payment by a third party, such as private medical insurance or public assistance benefits.

**cyclothymia**—A chronic mood disturbance of at least two years duration, involving numerous episodes of mania or depression that are not severe enough to be diagnosed as major depression or bipolar disorder. Some researchers feel cyclothymia is a mild form of bipolar disorder.

**decompensation**—The deterioration of existing defenses, leading to an exacerbation of pathological behavior.

**defense mechanisms**—Unconscious intrapsychic processes that serve to provide relief from emotional conflict and anxiety. Some common defense mechanisms are disassociation, idealization, and denial.

**delirium**—An acute organic mental disorder characterized by confusion and altered, possibly fluctuating, consciousness owing to an alteration of cerebral metabolism. It may include delusions, illusions, and hallucinations.

**delusion**—False beliefs based on an incorrect inference about external reality. These beliefs are firmly held in spite of what almost everyone else believes and in spite of proof or evidence to the contrary.

**dementia**—An organic mental disorder in which an individual's previously acquired intellectual abilities deteriorate to the point that social or occupational functioning is impaired.

**denial**—A defense mechanism, operating unconsciously, that is used to resolve emotional conflict and allay anxiety by disavowing thoughts, feelings, wishes, needs, or external reality factors that are consciously intolerable.

**dependent personality disorder**—A pervasive pattern of dependence and submission beginning by early adulthood and present in a variety of contexts.

**depersonalization**—An altered perception or experience of the self in which an individual's own reality is temporarily lost. This is manifested in a sense of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size or a sense of perceiving oneself from a distance (usually from above).

**depression**—When used to describe mood, depression refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal feeling state. Depression is also a symptom of a variety of mental or physical disorders. The *DSM-III-R* classifies a depressed episode as a sustained period (at least two weeks) during which an individual experiences depression and all associated features of depression or a loss of interest or pleasure in all, or almost all, activities.

**derealization**—A feeling of detachment from one's environment.

**devaluation**—A defense mechanism in which an individual attributes overly negative qualities to himself, herself, or others.

**diagnosis**—A mental health treatment provider's professional determination that an individual has a mental health disorder based on a professional analysis of the offender's behavior and the diagnostic classifications in the *DSM-III-R*.

**Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)**—The third revised edition of the American Psychiatric Association publication used by mental health professionals to diagnose mental health disorders. The *DSM-III-R* does not generally address the causes or different theories for a psychiatric disorder, but defines mental health disorders in terms of descriptive symptoms and behaviors.

**disassociation**—The splitting off of clusters of mental contents from conscious awareness, a mechanism central to hysterical conversion and disassociative disorders; the separation of an idea from its emotional significance and affect as seen in the inappropriate affect of patients with schizophrenia.

**drug interaction**—The effects of two or more drugs or medications taken simultaneously, producing an alteration in the usual effects of either drug or medication taken alone.

**dual diagnosis**—Diagnosis given to individuals who are suffering from both a mental health or psychiatric problem and a substance or alcohol abuse problem.

**dysthymia**—A chronic disturbance of mood lasting at least two years and involving depressed mood and other associated symptoms of depression. The symptoms of depression are not severe enough to warrant a diagnosis of major depression.

**enabler**—Someone who helps the mentally disordered or substance abusing individual avoid crises and the consequences of his or her behavior.

**etiology**—The cause or origin of a disease or disorder as determined by medical or psychiatric diagnosis.



**family therapy**—Psychotherapy of more than one member of a family in the same session. The assumption is that a mental disorder in one member of the family may be manifested in other members and may affect interrelationships and functioning.

**flight of ideas**—A nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.

**grandiosity**—An inflated appraisal of one's worth, power, knowledge, importance, or identity.

**group therapy**—A form of psychotherapy in which the interaction of patients helps to modify the behavior of individual patients.

**hallucination**—A sensory perception in the absence of external stimuli; may occur in all senses.

**hallucination, auditory**—A hallucination of sound, most commonly of voices, but sometimes of clicks, rushing noises, or music.

**hallucination, visual**—A hallucination involving sight, which may consist of formed images, such as people, or of unformed images, such as flashes of light.

**histrionic personality disorder**—Colorful, dramatic, extroverted behavior accompanied by excessive emotionality and attention-seeking that begins by early adulthood and is present in a variety of contexts.

**hypersomnia**—A behavior involving excessive amount of sleep, sometimes associated with confusion upon waking. Hypersomnia may involve sleeping for a longer amount of time than usual, experiencing daytime sleepiness, or taking excessive naps.

**hypervigilance**—Behavior involving excessive alertness and watchfulness.

**idealization**—A defense mechanism in which an individual attributes overly positive qualities to himself, herself, or others.

**ideas of reference**—An idea, held less firmly than a delusion, that events, objects, or other people in the individual's immediate environment have a particular and unusual meaning for him or her.

**ideation**—To think about something or to form a mental image about an idea or concept.

**identification**—Before a professional diagnosis is made, probation and pretrial services officers may be the first to identify an offender as mentally disordered. An identification by an officer is not a clinical diagnosis. Identifications are based on facts of record, statements, and observable behavior.

**identity**—A person's global role in life and the perception of his or her sense of self.

**illogical thinking**—Thinking that contains obvious internal contradictions or is clearly erroneous given the initial premises.

**incoherence**—Speech that, for the most part, is not understandable because of a lack of logical or meaningful connection between words, phrases, or sentences; excessive use of incomplete sentences; excessive irrelevancies or abrupt changes in subject matter; idiosyncratic word usage; or distorted grammar.

**insomnia**—Inability to fall asleep or stay asleep, or early morning wakening.

**local study**—Court-ordered evaluation undertaken to assess an offender's mental health in order to determine sentencing. Local studies are conducted by a community mental health treatment provider or by the Bureau of Prisons (if the court feels there is a compelling reason the evaluation cannot be done by a community provider).

**loosening of associations**—Thinking characterized by speech in which ideas shift from one subject to another without the speaker showing any awareness that the topics are unconnected or only obliquely related to one another.

**magical thinking**—A conviction that thinking equates with doing. It occurs in dreams in children, in primitive peoples, and in patients under a variety of conditions. It is characterized by lack of a realistic understanding of the relationship between cause and effect.

**major affective disorders**—A group of mental health disorders identified in the *DSM-III-R* in which there is a prominent and persistent disturbance of mood and other associated symptoms. Mood disorders include major depression, bipolar disorders, cyclothymia, and dysthymia.

**major depression**—A mood disorder in which there is a history of episodes of depressed mood or a loss of pleasure in all, or almost all, activities, and other associated symptoms of depression.

**mania**—A mood disorder characterized by excessive elation, hyperactivity, agitation, and accelerated thinking and speaking. Mania is associated with Axis I mood disorders and certain organic mental disorders.

**manic-depressive illness**—A mood disorder characterized by periods of both mania and depression.

**mental disorder**—An illness with psychological or behavioral manifestations and/or impairment in functioning that is due to a social, psychological, genetic, physical/chemical, or biological disturbance. The illness is characterized by symptoms or impairment in functioning, or both.

**mental health treatment provider**—Any treatment source which provides treatment services to mentally disordered federal offenders. The agency may be under contract to the Administrative Office of the U. S. Courts.

**mental retardation**—Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

**monoamine oxidase (MAO)**—An enzyme that breaks down neurotransmitters (biogenic amines), rendering them inactive. Neurotransmitters are biochemicals that allow the brain's cells to communicate with one another. Inhibition of the MAO enzyme by certain antidepressant drugs (MAO inhibitors) may result in alleviation of depressed states.

**monoamine oxidase inhibitors (MAOI)**—A group of antidepressant medications that inhibit the enzyme monoamine oxidase in the brain and raise the levels of biogenic amines.

**multiple personalities**—An extreme form of disassociation in which an individual's personality is split into two or more distinct personalities, often alternating with one another. This condition is rare.

**mutism**—An inability to speak that may be caused by physical or psychological factors.

**narcissistic personality disorder**—A heightened sense of grandiosity, hypersensitivity to evaluation by others, and lack of empathy for others that begin by early adulthood and are present in a variety of contexts.

**neurosis**—In common usage, emotional disturbances of all kinds other than psychosis. It implies subjective psychological discomfort beyond what is appropriate for the conditions of one's life. In the *DSM-III-R*, the term signifies a limited number of diagnostic categories, all of which are attributed to maladaptive ways of dealing with anxiety or internal conflict.

**obsessions**—Persistent ideas, thoughts, impulses, and images that invade the consciousness and are intrusive, senseless, or repugnant, such as thoughts of violence, contamination, or doubt.

**obsessive-compulsive disorder**—Recurrent obsessions or compulsions that are distressful and time-consuming, and significantly interfere with the individual's occupational and social functioning.

**obsessive-compulsive personality disorder**—A mental health disorder characterized by restricted emotions, orderliness, indecisiveness, perfectionism, and inflexibility that begins by early adulthood and is present in a variety of contexts.

**organic mental disorder**—Transient or permanent dysfunction of the brain caused by a disturbance of physiological functioning of brain tissue at any level of organization—structural, hormonal, biochemical, electrical, etc. Causes are associated with aging, toxic substances, or a variety of physical disorders.

**orientation**—Awareness of where one is in relation to time, place, and person.

**panic**—Sudden, overwhelming anxiety of such intensity that it produces terror and physiological changes.

**panic attack**—Discrete periods of intense fear or discomfort, often associated with feelings of impending doom.

**panic disorder**—Listed in the *DSM-III-R* as an anxiety disorder, with or without agoraphobia, which includes recurrent panic attacks accompanied by various physical symptoms.

**paranoid**—A lay term commonly used to describe an overly suspicious person. The technical use of the term refers to people with paranoid ideation or a type of schizophrenia or a class of disorders called delusional paranoid disorders.

**paranoid personality disorder**—A pervasive and unwarranted tendency to interpret the actions of others as deliberately threatening and demeaning. This disorder begins by early adulthood and is present in a variety of contexts.

**paraphilia**—A condition in which persistent and sexually arousing fantasies of an unusual nature are associated with preference for or use of a nonhuman object, sexual activity with human beings involving real or simulated suffering or humiliation, or sexual activity with children or nonconsenting partners.

**passive-aggressive personality disorder**—A pervasive pattern of passive resistance to demands for adequate performance in social and occupational functioning. This behavior begins by early adulthood and is present in a variety of contexts.

**pedophile**—An individual diagnosed as having pedophilia. A pedophile may or may not be a child molester.

**pedophilia**—Intense sexual urges and sexual fantasies involving sexual activity with a child.

**personality**—Deeply ingrained patterns of behavior, thinking and feeling that an individual develops, both consciously and unconsciously, as a style of life or a way of adapting to the environment. Personality traits are prominent aspects of personality and do not necessarily imply pathology.

**personality disorder**—Pervasive, inflexible, and maladaptive patterns of behavior and character that are severe enough to cause either significant impairment in adaptive functioning or subjective distress. Personality disorders are generally recognizable by adolescence or earlier, continue throughout adulthood, and become less obvious in middle or old age.

**phobia**—A persistent, irrational fear of a specific object, activity, or situation accompanied by a compelling desire to avoid the object, activity, or situation (the phobic stimulus).

**pornography**—Sexually explicit reading or video material or photographs.

**post-traumatic stress disorder (PTSD)**—A disorder that an individual develops after experiencing a psychologically distressing event outside the range of normal human experience, such as military combat, rape, child abuse, assault, or a natural disaster.

**poverty of speech**—A restriction in the amount of speech such that spontaneous speech and replies to questions are brief and unelaborated.

**prodromal**—Early signs or symptoms of a disorder.

**projection**—A defense mechanism in which the individual unconsciously rejects emotionally unacceptable characteristics of himself or herself and attributes them to others.

**psychiatrist**—A licensed physician who specializing in the diagnosis, treatment, and prevention of mental health disorders. Training encompasses a medical degree and four years or more of approved postgraduate training.

**psychoanalysis**—A therapeutic technique developed by Sigmund Freud that is based on uncovering an individual's unconscious motives and conflicts.

**psychoanalyst**—A psychotherapist, usually a trained psychiatrist, who uses the psychoanalytic method originally proposed by Freud to treat mental health disorders.

**psychomotor agitation**—Generalized physical and emotional overactivity in response to internal stimuli, external stimuli, or both.

**psychomotor retardation**—A generalized slowing of physical and emotional reactions.

**psychosis**—A major mental disorder of organic or emotional origin in which a person's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is sufficiently impaired so as to interfere grossly with the capacity to meet ordinary demands of life. The term is applicable to conditions having a wide range of severity and duration, such as schizophrenia, bipolar disorder, depression, and organic mental disorder.

**psychosocial**—Involving aspects of both social and psychological behavior.

**psychotherapist**—A person trained to treat mental, emotional, or behavioral disorders.

**psychotherapy**—The treatment of personality maladjustment or mental health disorders by psychological means, usually, but not always, through individual counseling.

**psychotic episode**—An episode that occurs when a mentally disordered individual incorrectly evaluates the accuracy of his or her perceptions, thoughts, and moods and makes incorrect inferences about external reality. During a psychotic episode an individual's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is impaired.

**rationalization**—A defense mechanism in which the person devises reassuring or self-serving, but incorrect, explanations for his or her own behavior and the behavior of others.

**reality testing**—The objective evaluation and judgment of the world outside oneself.

**reimbursement**—The process by which an offender gives payment for court-ordered mental health treatment services directly to the probation or pretrial services officer, who then directs the payment to the Administrative Office of the U. S. Courts through the clerk of court.

**repression**—A defense mechanism in which the individual is unable to remember or to be cognitively aware of disturbing wishes, feelings, thoughts, or experiences.

**residual**—The phases of illness that occur after remission of the full syndrome.

**ruminate**—To excessively reflect or meditate on an issue, thought, or concept.

**schizoid personality disorder**—A lifelong pattern of social withdrawal beginning by early adulthood and present in a variety of contexts.

**schizophrenia**—A group of disorders manifested by disturbances in communication, language, thought, perception, affect, and behavior which last longer than six months.

**schizotypal personality disorder**—A pervasive pattern of peculiarities of ideation, appearance, and behavior beginning by early adulthood and present in a variety of contexts.

**somatic**—Of or relating to the body.

**somatization**—A defense mechanism in which the individual becomes preoccupied with physical symptoms disproportionate to any actual physical illness or injury.

**splitting**—When an individual views another as either all good or all bad; an inability to conceptually integrate the good and bad aspects of another's personality and character into a congruent whole.

**stereotype**—Persistent, mechanical repetition of speech or motor activity, observed in schizophrenia.

**suppression**—A defense mechanism in which the individual intentionally avoids thinking about disturbing problems, desires, feelings, or experiences.

**syndrome**—A group of symptoms that occur together and constitute a recognizable condition.

**thought broadcasting**—A delusion in which the individual believes that thoughts are being broadcast from his or her mind to the external world so that others can hear them.

**thought insertion**—A delusion in which the individual believes someone or something is inserting thoughts into his or her mind and that the individual's thoughts are not his or her own.

**thought withdrawal**—A delusion in which the individual believes that someone or something is removing thoughts from his or her mind.

**tranquilizer**—A drug that decreases anxiety and agitation.

**transference**—The unconscious assignment to others of feelings and attitudes that were originally associated with important figures in one's early life (e.g., parents, siblings). The psychiatrist uses this phenomenon as a therapeutic tool to help the

patient understand emotional problems and their origins. In the patient-physician relationship, transference may be negative (hostile) or positive (affectionate).

**treatment plan**—A strategy for treating the symptoms of a mental health disorder or curing a mental health disorder. Treatment plans are developed by mental health professionals and usually consist of therapy and medication, if required.

**treatment prognosis**—A professional opinion concerning the probable treatment success and recovery of an individual with a diagnosed mental health disorder.



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- *Smith College Studies in Social Work*
- *Journal of Personality Disorders*
- *Families in Society*
- *Federal Probation*
- *Federal Prisons Journal*

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**Appendix: *DSM-III-R* Categories of  
Mental Health Disorders and Classification Axes**

## Categories of Mental Health Disorders<sup>10</sup>

### Disorders First Evident in Infancy, Childhood, or Adolescence (Axis II)

- Developmental Disorders
  - Mild mental retardation
  - Moderate mental retardation
  - Severe mental retardation
  - Profound mental retardation
  - Unspecified mental retardation
  
- Pervasive Developmental Disorders
  - Autistic disorder
  - Pervasive developmental disorder not otherwise specified (NOS)
  
- Specific Developmental Disorders
  - Academic skills disorders
    - Developmental arithmetic disorder
    - Developmental expressive writing disorder
    - Developmental reading disorder
  - Language and speech disorders
    - Developmental articulation disorder
    - Developmental expressive language disorder
    - Developmental receptive language disorder
  - Motor skills disorders
    - Developmental coordination disorder
    - Specific development disorder NOS
  
- Other Developmental Disorders
  - Developmental disorder NOS
  
- Disruptive Behavior Disorders
  - Attention-deficit hyperactivity disorder
  - Conduct disorder
  - Oppositional defiant disorder
  
- Anxiety Disorders of Childhood or Adolescence
  - Separation anxiety disorder
  - Avoidant disorder of childhood or adolescence
  - Overanxious disorder

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10. Information in this section is from American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (3d ed., rev.). Washington, D.C.: APA, 1987, pp. 3 - 10.

- Eating Disorders
  - Anorexia nervosa
  - Bulimia nervosa
  - Pica
  - Rumination disorder of infancy
  - Eating disorder NOS
- Gender Identity Disorders
  - Gender identity disorder of childhood
  - Transsexualism
  - Gender identity disorder of adolescence or adulthood, nontranssexual type
  - Gender identity disorder NOS
- Tic Disorders
  - Tourette's disorder
  - Chronic motor or vocal tic disorder
  - Transient tic disorder
  - Tic disorder NOS
- Elimination Disorders
  - Functional encopresis
  - Functional enuresis
- Speech Disorders Not Elsewhere Classified
  - Cluttering
  - Stuttering
- Other Disorders of Infancy, Childhood, or Adolescence
  - Elective mutism
  - Identity disorder
  - Reactive attachment disorder of infancy or early childhood
  - Stereotypy/habit disorder
  - Undifferentiated attention-deficit disorder

### **Organic Mental Disorders**

- Dementias Arising in the Senium and Presenium
  - Primary degenerative dementia of the Alzheimer type, senile onset (after age 65)
    - With delirium
    - With delusions
    - With depression
    - Uncomplicated
  - Primary degenerative dementia of the Alzheimer type, presenile onset (age 65 and below)
  - Multifaceted dementia
  - Senile dementia NOS

Presenile dementia NOS

• Psychoactive Substance-Induced Organic Mental Disorders

Alcohol

- Intoxication
- Idiosyncratic intoxication
- Uncomplicated alcohol withdrawal
- Withdrawal delirium
- Hallucinosiis
- Amnestic disorder
- Dementia associated with alcoholism

Amphetamine or similarly acting sympathomimetic

- Intoxication
- Withdrawal
- Delirium
- Delusional disorder

Caffeine

- Intoxication

Cannabis

- Intoxication
- Delusional disorder

Cocaine

- Intoxication
- Withdrawal
- Delirium
- Delusional disorder

Hallucinogen

- Hallucinosiis
- Delusional disorder
- Mood disorder
- Posthallucinogen perception disorder

Inhalant

- Intoxication

Nicotine

- Withdrawal

Opioid

- Intoxication
- Withdrawal
- Organic mental disorder NOS

Phencyclidine (PCP) or similarly acting arylcyclohexylamine

- Intoxication
- Delirium
- Delusional disorder
- Mood disorder
- Organic mental disorder NOS

Sedative, hypnotic, or anxiolytic

- Intoxication
- Uncomplicated sedative, hypnotic, or anxiolytic withdrawal
- Withdrawal delirium
- Amnestic disorder

Other or unspecified psychoactive substance

- Intoxication
- Withdrawal
- Delirium
- Dementia
- Amnestic disorder
- Delusional disorder
- Hallucinosis
- Mood disorder
- Anxiety disorder
- Personality disorder
- Organic mental disorder NOS

- Organic Mental Disorders Associated with Axis III Physical Disorders or Conditions, or Whose Etiology Is Unknown

Delirium

Dementia

Amnestic disorder

Organic delusional disorder

Organic hallucinosis

Organic mood disorder (specify: manic, depressed, or mixed)

Organic anxiety disorder

Organic personality disorder (specify if explosive type)

Organic mental disorder NOS

**Psychoactive Substance Use Disorders**

- Alcohol
  - Dependence
  - Abuse
- Amphetamine or Similarly Acting Sympathomimetic
  - Dependence
  - Abuse
- Cannabis
  - Dependence
  - Abuse



- Cocaine  
Dependence  
Abuse
- Hallucinogen  
Dependence  
Abuse
- Inhalant  
Dependence  
Abuse
- Nicotine  
Dependence
- Opioid  
Dependence  
Abuse
- Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine  
Dependence  
Abuse
- Sedative, Hypnotic, or Anxiolytic  
Dependence  
Abuse
- Polysubstance Dependence
- Psychoactive Substance Dependence NOS
- Psychoactive Substance Abuse NOS

### **Schizophrenia**

- Catatonic Type
- Disorganized Type
- Paranoid Type (specify if stable type)
- Undifferentiated Type
- Residual Type (specify if late onset type)

### **Delusional (Paranoid) Disorder**

- Delusional,Paranoid Disorder (specify type)
  - Erotomaniac type
  - Grandiose type
  - Jealous type
  - Persecutory type
  - Somatic type

### **Psychotic Disorders NOS**

- Brief Reactive Psychosis
- Schizophreniform Disorder (specify without good prognostic features or with good prognostic features )
- Schizoaffective Disorder (specify bipolar type or depressive type)
- Induced Psychotic Disorder
- Psychotic Disorder NOS (atypical psychosis)

### **Mood Disorders**

- Bipolar Disorder
  - Mixed
  - Manic
  - Depressed
  - Cyclothymia
  - Bipolar disorder NOS
- Depressive Disorders
  - Major depression
  - Dysthymia
  - Depressive disorder NOS

### **Anxiety Disorders**

- Panic Disorder
  - With agoraphobia
  - Without agoraphobia
- Agoraphobia Without History of Panic Disorder
- Social Phobia
- Simple Phobia

- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Generalized Anxiety Disorder

#### **Somatoform Disorder**

- Body Dysmorphic Disorder
- Conversion Disorder
- Hypochondriasis
- Somatization Disorder
- Somatoform Pain Disorder
- Undifferentiated Somatoform Disorder
- Somatoform Disorder NOS

#### **Dissociative Disorders**

- Multiple Personality Disorder
- Psychogenic Fugue
- Psychogenic Amnesia
- Depersonalization Disorder
- Dissociative Disorder NOS

#### **Sexual Disorders**

- Paraphilias
  - Exhibitionism
  - Fetishism
  - Frotteurism
  - Pedophilia
  - Sexual masochism
  - Sexual sadism
  - Transvestic fetishism
  - Voyeurism
  - Paraphilia NOS

- **Sexual Dysfunctions**
  - Sexual desire disorders
    - Hypoactive sexual desire disorder
    - Sexual aversion disorder
  - Sexual arousal disorders
    - Female sexual arousal disorder
    - Male erectile disorder
  - Orgasm disorders
    - Inhibited female orgasm
    - Inhibited male orgasm
    - Premature ejaculation
  - Sexual pain disorders
    - Dyspareunia
    - Vaginismus
  
- **Other sexual disorders**
  - Sexual disorders NOS

### **Sleep Disorders**

- **Dyssomnias**
  - Insomnia disorder
    - Related to another mental disorder (nonorganic)
    - Related to known organic factor
  - Primary insomnia
  - Hypersomnia
    - Related to another mental disorder (nonorganic)
    - Related to known organic factor
  - Primary hypersomnia
  - Sleep-wake schedule disorder
  - Other dyssomnias
    - Dyssomnia NOS
  
- **Parasomnias**
  - Dream anxiety disorder
  - Sleep terror disorder
  - Sleepwalking disorder
  - Parasomnia NOS

### **Factitious Disorders**

- **Factitious Disorder**
  - With physical symptoms
  - With psychological symptoms
  
- **Factitious Disorder NOS**

**Impulse Control Disorders Not Elsewhere Classified**

- Intermittent Explosive Disorder
- Kleptomania
- Pathological Gambling
- Pyromania
- Trichotillomania
- Impulse Control Disorder NOS

**Adjustment Disorder**

- Adjustment Disorder
  - With anxious mood
  - With depressed mood
  - With disturbance of conduct
  - With mixed disturbance of emotions and conduct
  - With mixed emotional features
  - With physical complaints
  - With withdrawal
  - With work (or academic) inhibition
- Adjustment Disorder NOS

**Psychological Factors Affecting Physical Condition**

- Psychological Factors Affecting Physical Condition

**Personality Disorders (Axis II)**

- Cluster A
  - Paranoid
  - Schizoid
  - Schizotypal
- Cluster B
  - Antisocial
  - Borderline
  - Histrionic
  - Narcissistic

- Cluster C
  - Avoidant
  - Dependent
  - Obsessive-compulsive
  - Passive-aggressive
- Personality disorder NOS

### **DSM-III-R Classification Axes<sup>11</sup>**

- Axis I      Clinical syndromes and V codes. V codes are conditions not attributable to a mental disorder that are a focus of attention or treatment.
- Axis II      Developmental disorders and personality disorders.
- Axis III      Physical disorders and conditions.
- Axis IV      Severity of psychosocial stressors.
- Axis V      Global assessment of functioning (GAF) scale.

### **Examples of a DSM-III-R Multiaxial Evaluation<sup>12</sup>**

- Axis I      Major depression, single episode, severe without psychotic features.  
Alcohol dependence.
- Axis II      Dependent personality disorder.
- Axis III      Alcoholic cirrhosis of the liver.
- Axis IV      Psychosocial stressors: anticipated retirement and change in residence,  
with loss of contact with friends. Severity: 3—Moderate  
(predominantly enduring circumstances).
- Axis V      Current GAF—44; Highest GAF past year—55.

- Axis I      Schizophrenia, undifferentiated type, chronic.
- Axis II      Borderline intellectual functioning.
- Axis III      Late effects of viral encephalitis.
- Axis IV      Psychosocial stressors: Death of mother. Severity: 5— Extreme (acute  
event).
- Axis Vv      Current GAF—28; Highest GAF past year—40.

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11. Ibid., pp. 15 - 16.

12. Ibid., p. 21.

### Codes for Axis IV: Severity of Psychosocial Stressor<sup>13</sup>

<u>Code</u>	<u>Term</u>	<u>Example</u>
1	None	No apparent psychosocial stressor.
2	Mild	Minor violation of the law, small bank loan, family arguments, job dissatisfaction.
3	Moderate	Marriage, marital separation, job loss, serious financial difficulty.
4	Severe	Divorce, birth of first child, unemployment, poverty.
5	Extreme	Diagnosis of serious illness, chronic illness in self or family, death of spouse, victim of rape, sexual abuse.
6	Catastrophic	Death of child, suicide of spouse, devastating natural disaster, captivity as a hostage.
0	Inadequate information or no change in condition	

### Codes for Axis V: Global Assessment of Functioning Scale (GAF)<sup>14</sup>

The GAF scale is a continuum of mental health and mental health disorders. Intermediate codes can be used when appropriate (e.g., 45, 38, 22).

<u>Code</u>	<u>Explanation</u>
90	Absent or minimal symptoms; good functioning in all areas.
80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors; no more than slight impairment in functioning.

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13. Ibid., p. 11.

14. Ibid., p. 12.



<u>Code</u>	<u>Explanation</u>
70	Some mild symptoms or some difficulty in functioning.
60	Moderate symptoms or moderate impairment in functioning.
50	Serious symptoms or serious impairment in functioning.
40	Some impairment in reality testing or communication or major impairment in several areas such as work, school, family relations, mood, or thinking.
30	Behavior is considerably influenced by delusions and hallucinations or serious impairment in communication and judgment or an inability to function in almost all areas.
20	Some danger of hurting self or others or occasionally fails to maintain minimal personal hygiene or gross impairment in communication.
10	Persistent danger of severely hurting self or others or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death.
0	Inadequate information.