

## Lessons learned about violence

I woke up searching frantically for my glasses on the night stand—knocking over a glass of water before touching the wire rims. Putting them on, I saw it was 4 a.m. I was in a cold sweat and my heart was pounding. I could hear Henry pacing in the hallway shouting at the voices only he could

hear. The thought to talk with him never entered my mind—I had been up late trying to convince my brother he needed to go back on the medicine, but all I accomplished was to further agitate him. Listening to his side of the heated argument, I started imagining him bursting through the door with a knife in his hand. I couldn't go back to sleep. I swung my legs over the bed and walked to the door with my head hung low in shame and weariness; I locked it.



**Xavier Amador, PhD**

My research and book *I am Not Sick, I Don't Need Help! How to Help Someone with Mental Illness Accept Treatment* (Vida Press, 2000) are frequently cited by advocates who promote assisted outpatient treatment (see [www.psychlaws.org](http://www.psychlaws.org)) and by advocates who oppose involuntary treatments on the grounds they would not be needed if adequate outpatient treatments such as LEAP (see Lessons Learned in *SZ Digest*, Winter 2007) were available. I can see the wisdom in both sides of the debate. That said, until suicide, gross self-neglect, other forms of self-harm and violence stemming from psychotic states can be reliably controlled, involuntary treatments will always be needed. To turn our heads and look the other way would be criminal.

Which brings me to the focus of this column: Are people with schizophrenia more apt to commit violent crimes and acts compared to “the chronically normal,” as my friend Dr. Fred Frese (a consumer with schizophrenia) would say? On a more personal note: Should I have been afraid of my brother who, before he became ill, I trusted more than anyone?

### **Research on violence and schizophrenia**

When giving seminars I often say “Individuals with schizophrenia are no more violent than the general population” and then go on to cite the research that backs me up.

For nearly two decades this statement has been a mantra for many of us who are advocates for better treatments, services, and laws for persons with schizophrenia. But more recent, well replicated, research indicates the story is not so simple.

In a recent national study of violent behavior in persons with schizophrenia the authors found that symptoms of losing contact with reality, such as delusions and hallucinations, increased the odds of serious violence by nearly three times the normal rate. Results of the study, which was conducted on patients in real-world community settings as part of the NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), are consistent with previous independent studies. Most studies show that when hallucinations and delusions are worsened, the potential for violence increases dramatically.

As a forensic expert who has worked on more than 30 death-penalty cases involving persons with schizophrenia and related disorders that have committed homicides, I can say unequivocally that the anecdotal evidence is overwhelming. The story was the same in every case I worked on. When hallucinations, thought disorder, and delusions worsened, the defendants became frightened and angry and, in some cases, coolly planned how they would commit murder. More often than not we are talking about people who became paranoid and/or grandiose, people who, for example, felt convinced they had to defend themselves from their relatives who had become possessed by evil spirits, or accomplish some other delusion-based imperative such as saving the earth from alien invasion by killing a radio talk show host who was broadcasting the beacon they were using to coordinate their attack.

### **Impaired insight causes medication nonadherence, which increases the risk of violence**

Most, not all, persons with schizophrenia benefit from treatment with antipsychotic medication. When we look at the majority—those who do respond to treatment—we find that the most common cause of medication refusal and partial nonadherence is poor insight. Consequently, if we want to decrease the rate of violence in the population of persons with schizophrenia we have to break the cycle caused by poor insight: Believing “I am not sick” leads to the conclusion, “I don't need to take medicine” which, in turn, leads to a worsening of those symptoms that cause otherwise-peace-

