204 Loss of Control

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Definition

Loss of control generally refers to lack of the ability to provide conscious limitation of impulses and behavior as a result of overwhelming emotion. States of agitation such as fighting, screaming, and uncontrollable weeping are most often thought of as behavior illustrative of loss of control. Involuntary immobility due to extreme fear, as is seen at times after life-threatening catastrophes such as earthquakes, tornadoes, and floods, is also a form of loss of control. Such patients typically tremble and appear desperately frightened.

Technique

It is important that the physician use terms with which the patient is familiar. Patients often refer to states of agitation as times when they were "hysterical" or "wild with rage." Immobility due to extreme fear is often described by patients as times when they were in a "state of shock." The patient should be asked to describe any episodes of such behavior.

The patient should be specifically asked whether there have been any episodes of loss of control that resulted in injury to another person or in extensive property loss. Investigation of this portion of the psychiatric database enables the physician to estimate the likelihood of future episodes of loss of control. This is especially important when there is the potential for violent behavior.

Although it is true that no one can predict with 100% accuracy the fact that a person is about to carry out a violent act, most clinicians use certain factors to make judgments regarding the likelihood of violence. These include:

- Past behavior
- Presence of paranoid thinking
- Use of drugs and alcohol
- Presence of psychosis
- Exposure to a violent environment
- Presence of antisocial tendencies
- Expression of violent intentions

Perhaps the most important factor in judging potential for violence is the patient's past performance. In general, patients who have shown frequent loss of control and who have inflicted significant injuries on others must be regarded as having more potential for homicide. In one case, a man had repeatedly threatened his wife and had beaten her severely on a number of occasions. Because she was frightened of him, the wife had him arrested on numerous occasions. She did not, however, leave him. Finally, after 8 years, he killed her. In retrospect, the man had given clear evidence of his homicidal potential, and the murder could have been prevented had stronger action been taken to control him or to help the wife separate from him.

When patients feel persecuted and unable to obtain redress of fancied injustices, the likelihood of their taking violent measures to correct the situation is heightened.

In one large study, 65% of all homicides were associated with drinking on the part of the murderer. Other drugs can similarly be associated with violent outbursts. Amphetamines are especially prone to stimulate outbursts of violence. At times, psychedelic drugs such as LSD may cause terrifying illusions that lead to serious violence. Use of phencyclidine (PCP) has also been associated with violence.

If the patient is in poor contact with reality, there is increased danger that misperception of reality might lead to violent activity. This is particularly true if the patient is hearing voices commanding that someone be harmed.

Most clinicians feel that patients who have experienced extensive violence are more likely to resort to it themselves. This includes both patients who have been subjected to severe violence during their childhood and those who have been reared in situations in which violence has been regarded as an acceptable response to difficulties. It is well known that parents of battered children were usually physically abused during their own childhood.

The exposure of patients to physical or sexual abuse clearly has many long-term psychologic effects. Carmen et al. (1984) found in an examination of the life experiences of 188 male and female psychiatric patients that almost half of the patients had histories of physical abuse, sexual abuse, or both. When inquiry indicates the presence of such exposure, the physician should be alert for a wide variety of later psychiatric effects, including anxiety disorders and depression.

In general, patients who have been involved in criminal activities and show evidence of an antisocial personality disorder represent a higher risk for violence than the general population.

At times, patients will directly express their intentions to commit violence. When patients are very angry, it behooves the physician to inquire whether they have considered violence as a solution to their problem. If the patient directly expresses the intention of committing violence, this expression should be taken seriously by the physician and the patient's entire life situation carefully assessed so that appropriate measures (at times including involuntary hospitalizations can be carried out.

Basic Science

During the past 20 years, many studies have been done to judge the accuracy with which potential for violence can be assessed. Early studies emphasized the difficulty in predicting violence. Studies pointing out the inaccuracies of

predictive diagnosis of violence have been extrapolated by some groups to the inaccurate assumption that no one can ever predict violence in any patient. More recent research has focused on some of the limitations of the early research and on improvements that may be possible in predictive technology. Even though most violence is committed by people who are not psychiatrically disturbed and who are not seeing a physician for anything that might allow the physician to predict violence, it is nevertheless important that the physician be alert for signs of potential violence.

Statistically, the most likely person to commit murder is a member of the victim's own family. Reading newspaper reports of crime often leads to an erroneous impression that mental patients commit many violent acts. One reason for this impression is that newspaper reporters seem invariably to consider it important that a person's status as a current or former mental patient be reported when such a person is involved in a violent act. Often these crimes tend to be more spectacular and thus more newsworthy than homicides committed within a family. The physician should not regard mental patients as being highly prone to violent acts. Instead, the physician should be alert to the possibility of violence in any patient who shows the characteristics described above.

Clinical Significance

When a physician is convinced that a patient has serious potential for homicidal activity, several courses of action are open. In most states the physician can arrange for involuntary hospitalization of the patient for observation and diagnosis. Such involuntary hospitalization is usually for a very short time (24 to 72 hours), unless the patient is judged to have continuing evidence of potential for harm to self or others. In the latter case, involuntary hospitalization can be maintained as long as necessary for recovery.

In many instances, however, the physician will not be certain about the potential for violence and cannot take such strong measures. Nevertheless, the clinician can still proceed with efforts to prevent violence. One way of doing this is by warning the family or other threatened persons of the possibility of violence. The family can then take precautions, such as removing weapons or separating themselves from the patient. Not infrequently, families ignore obvious signs of danger out of an unconscious desire to believe otherwise. In these cases, the physician can be of great assistance in helping the family to understand the need to protect themselves against possible harm.

As the following case illustrates, the physician must at times take a very strong position in dealing with family members of a patient who is potentially violent in order to avert serious danger to them.

> A large, powerfully built 16-year-old boy was brought to treatment after having set a neighbor's house on fire. During periods of psychotic decompensation, he was subject to outbursts of rage during which he would destroy furniture and threaten family members. The physician realized the homicidal potential of this patient and urged the family to remove all weapons from the house. However, the parents did not believe that the patient would actually hurt any family member and refused to move their guns, saying that to do so would interfere too much with hunting, which was their favorite sport. The physician insisted that something be done to protect the family, and finally the parents were persuaded to move all ammunition to a hidden, locked area.
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> Several months later, the patient became enraged one evening, grabbed a butcher knife, and attempted to stab two of his brothers. Fortunately, the father and brothers were able to subdue him without serious injury. Afterward the parents were extremely appreciative as they expressed to their physician their conviction they would have all been killed if the patient had been able to obtain a loaded gun during this episode.

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