

Dr. White, without shifting his gaze from his wounded victim. The shaken resident slowly left the room, leaving the door ajar. The ward was evacuated and police were called. Bill allowed them to remove Dr. Black and in the silence that followed, the ambulance could be heard speeding from the hospital. A four-hour siege ended with Bill's ultimate surrender and arrest.

Dr. Black died of severe brain trauma two days later, never regaining consciousness. Bill was charged with murder and sent for forensic assessment to the state's maximum-security hospital. After two years of treatment, he was finally deemed competent to proceed with the trial, and two-and-a-half years after the murder, was found not guilty by reason of insanity.

He remained at the maximum security hospital for eight more years, and at his family's request, was transferred to a maximum-security hospital in their home state, some 600 miles away. He was discharged to his family's care six months later, judged no longer dangerous to himself or to others (adapted from Ebert, 1987).

What can we learn from tragedies such as this? Could it have been prevented if the clinicians involved had been trained in violence prediction? Could anyone be expected to predict the behavior of a psychotic, agitated patient? Certainly the clinicians in this case knew Bill, knew his diagnosis of paranoid schizophrenia, and his history of suicide attempts. They also knew that he had been recently assessed by a forensic clinician who said he was both suicidal and homicidal. In addition to these facts, they were aware that he had left the hospital with the stated intent of buying a gun, albeit to kill himself. Was this information sufficient to predict his dangerousness?

Take a moment to put down this book and consider your current criteria for a dangerousness assessment in this case. Draft a list of those factors you consider of highest priority. Put the list aside and be prepared to consult it and to modify it as your reading proceeds.

How much information is enough information if the goal is to try to prevent such terrible events? How much do you need to know about the patient sitting in front of you? Do you need a full and complete history, dating back to early childhood, or is it sufficient to have a current mental status that delves into the individual's thoughts and fantasies? Would it have helped the clinicians to know that Bill's agitation was based in part on his recent discovery that his mother planned to marry a man whom Bill despised? Could the clinicians have known that Bill had spent the morning drinking in order to build up the courage to kill himself, and by the time he entered the ward, he was intoxicated? How much is enough? How much data is too much, a flooding of information? Is there ever enough?

The purpose of this book is to try to prevent violence by learning enough about those salient factors that enable us to anticipate when it will (or might) occur. If, as a result of understanding contemporary thinking about violence