Aggression Toward Forensic Evaluators: A Statewide Survey

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There is an increasing body of literature regarding violence toward mental health professionals in clinical settings, but little is known about the frequency of assaults on forensic evaluators. Forensic evaluators play a very different role in the evaluee's life than do treating clinicians. This study examined the incidence of aggressive behavior specifically directed toward forensic clinicians. Psychologists and psychiatrists (n = 190) in Massachusetts were surveyed regarding their experience of verbal threats, harassment/intimidation (H/I), and physical assault. Respondents were asked about the most distressing incident (MDI) in their forensic practices. This study found no more risk of aggressive behavior in the forensic context than the nonforensic context and concluded that forensic clinicians' concerns about their safety may be somewhat misplaced. In the 76 reported MDIs, physical injury was minimal, yet emotional distress was pronounced. Training programs and work settings should validate the legitimacy of these reactions, and help clinicians to cope with their emotional reactions.

J Am Acad Psychiatry Law 34:231–9, 2006

There is a growing body of literature regarding the nature and frequency of assaults on mental health professionals by the patients they treat. Researchers have looked at violence toward clinicians in hospital settings,[1,2] in community outreach and outpatient settings,[3–5] and in specific professional disciplines (e.g., nursing, social work, psychology, psychiatry).[6–14]

A thorough review of the literature regarding assaults on mental health clinicians was conducted by Guy and Brady.[15] They reported that most of the assaults occurred in inpatient settings, although the number of incidents of assault in outpatient settings was not inconsequential. Across settings, when such incidents occurred, there was usually no weapon involved. When a physical object was used, it was most often an object at hand, such as an ashtray. The level of physical harm sustained was mostly relatively minimal, but the level of "emotional distress" reported by the clinicians was "complex and enduring" (Ref. 15, p 403). Practitioners who had been assaulted reported an increased sense of vulnerability and fear, a decreased sense of personal competency, a sense of personal responsibility for the incident, a decreased motivation to work, and even symptoms of PTSD.

In a more recent study conducted by Sandberg *et al.*,[16] all staff members of an inpatient psychiatric unit were surveyed regarding their lifetime experiences of stalking, threatening, and harassing behavior outside of inpatient or locked settings. These findings mirror those of previous researchers; serious incidents ("stalking, obsessional following, and physical attacks") were relatively rare, while "milder forms of harassment" (e.g., threats, harassing telephone calls or letters, and unwanted following or approach) were relatively common (Ref. 16, p 227). Nevertheless, most practitioners rated these incidents as "upsetting and disruptive." The authors note that "attention to staff's responses suggests the need for intervention to reduce the risk of stress-related emotional problems that may result from the patient's behavior" (Ref. 16, p 227).

Some researchers have reported on various aspects of patient assaultiveness in forensic hospitals. Carmel

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and Hunter[8] looked at staff injuries in a large forensic hospital over a 1-year period and found that the vast majority of assaults were directed toward nursing staff, while there was not one assault on professional staff (which they defined as psychiatrists, psychologists, social-workers, and rehabilitation therapists) that year. The authors also looked at a five-year period in the same facility and found that 13 percent of all the psychiatrists who had worked there during that time had been subject to patient assault (and all were weaponless assaults).[17] Hunter and Love[18] looked at the use of weapons in a forensic facility and found that in all the incidents of assault, use of weapons was relatively rare, and when weapons were used they were usually available objects. Linhorst and Scott[19] looked at the relative rates of violence between forensic and nonforensic patients in public hospital settings. Consistent with previous studies, they found that the majority (71.5%) of patients did not commit any assaults in the 1-year period studied and that a much larger percentage of nonforensic than forensic patients committed assaults. Although the settings were forensic facilities in these studies, the role of the mental health clinicians who were assaulted was not specifically addressed.

Investigation of the exposure to violence of forensic clinicians in their roles as forensic evaluators (as distinct from their clinical function) has been limited. Defined here as mental health clinicians whose client is the court or some other arbitrating body, forensic evaluators play a different role in the evaluee's life than do treating clinicians. There are several factors suggesting that they could face an even higher level of risk.[6] First, theirs is a fundamentally different role from that of most other mental health professionals. Forensic evaluators are not "helping professionals" in the traditional sense; rather, their task is to provide a neutral assessment that may or may not be helpful to the evaluee. Second, forensic evaluators frequently assess individuals with a documented history of aggressive behavior. Third, they often provide opinions to the court on matters that hold the potential for grave personal consequences for the evaluee (e.g., incarceration, termination of parental rights). Finally, the forensic interviewing process itself often delves into highly charged emotional material on a timetable driven by the demands of the court rather than the emotional needs of the individual being assessed.

Indirect evidence supporting this hypothesis comes from a study by Corder and Whiteside.[11] They surveyed 60 psychologists chosen from the state psychology association directory. Although they did not define it as such, evidently at least some of these clinicians performed a mix of forensic evaluation and straight clinical work. Eighteen percent of the respondents were subjected to physical assaults, 22 percent to serious verbal threats, and 8 percent (five people) to verbal threats accompanied by display or possession of a firearm. Because enough of these incidents occurred in the contexts of child custody cases, commitment, and "other evaluations centering around legal issues" (Ref. 11, p 68), they concluded in part that:

> Areas of practice which appeared to present most dangerous situations for survey respondents were conflicts over results in child custody, commitment or some occupationally related evaluations, and in highly conflicted marital therapy or related evaluations involving divorce or separation. Most of these evaluations were part of legal procedures [Ref. 11, p 71].

To our knowledge, there has been only one study that specifically addressed assaults on forensic evaluators. Miller[20] mailed a questionnaire to all 850 members of the American Academy of Psychiatry and the Law inquiring about their experiences with verbal harassment or physical threats or actions, "in connection with their involvement as expert witnesses in forensic cases. . . " (Ref. 20, p 337). With a 48 percent response rate, Miller found that 42 percent of this sample had been harassed in some way: 17 percent had received threats of physical harm, 13 percent had received threats of nonviolent injury, and 12 percent had received both types of threats. Three percent of the respondents had actually been physically attacked but no serious injuries were reported. Of interest, in Miller's study, slightly more than half of the reported assaults were committed by "attorneys, relatives, or others who were clearly not the ones being evaluated" (Ref. 20, p 342).

The present study was undertaken to add to the body of knowledge regarding the nature and frequency of assaults on mental health professionals in the context of their forensic practice, as distinct from their general clinical practice. An ancillary goal was to explore the strategies and precautions used by evaluators to protect themselves from aggression in the course of their professional responsibilities.

Methods

In the mid-1980s, the Massachusetts legislature authorized the Department of Mental Health to develop criteria for the training and certification of psychiatrists and psychologists who perform court-ordered evaluations under specific sections of the mental health law (e.g., competence to stand trial, criminal responsibility, aid in sentencing, civil commitment of mentally ill and substance-abusing individuals). This process led to the creation of the Designated Forensic Professional Training and Certification Program and the Designated Forensic Professional (DFP) credential. Certification as a DFP is required for all professionals who conduct court-ordered evaluations in the Commonwealth.[21] Subjects included current candidates as well as individuals who had attained the DFP credential more than a decade earlier.

A four-page questionnaire was mailed to all individuals who had ever been admitted to the DFP program from the time of its inception in the mid-1980s through November 1998. A copy of the survey instrument is available from one of the authors (N.L.). As the survey is a self-report measure, all problems inherent in an individual's perception should be considered when evaluating these findings. However, the respondents are professionals whose job it is to determine the potential for harm of those they evaluate. Thus, it is likely that they will be accurate when describing threats, associating hang-up phone calls with the correct individual (perhaps using caller ID or *69), and other behaviors targeted by the survey. In addition, the study is limited by the confines and constructs of the Massachusetts DFP system, as the sample was selected from those clinicians who had been trained and practiced in public sector forensic work.

The first section of the survey included questions about demographic characteristics of the subjects and the nature and frequency of threats, acts of harassment or intimidation (H/I), and acts of physical aggression they had encountered over the course of their professional careers. In the second section, subjects were asked to select and describe the most distressing incident (MDI) that had occurred in the context of their forensic work and to respond to questions regarding the circumstances of the assault and characteristics of the assailant. In the third section, subjects were asked to list safety precautions that they employ in their practices. The survey was anonymous, although subjects were given the option of identifying themselves if they were willing to be contacted for a telephone interview regarding the information they had provided.

This study was approved by the State of Massachusetts Department of Mental Health Central Office Research Review Committee (CORRC).

Results

Of the 190 surveys that were mailed, 103 were returned completed, yielding a response rate of 54 percent. This response rate is within the range of those obtained with comparable published surveys.[3,7,9,10,20,22–24]

The respondents were 42 percent female and 57 percent male with a much higher proportion of psychologists (85%) than psychiatrists (15%) represented. This uneven breakdown by discipline is representative of the population of Massachusetts Designated Forensic Professionals, as many more psychologists than psychiatrists enter DFP training for various system-related reasons.

The respondents were relatively experienced, both clinically (mean years in clinical practice, 16; 77% of the respondents had been in practice for 10 or more years) and forensically (mean years in forensic practice, 9; 49% had been in the forensic field for 10 years or more). Thirty percent of the sample were devoting their entire professional practices to forensic work at the time of the survey. About a third of the sample were devoting at least half their professional practice to forensic work in the adult criminal area, while nearly three-quarters of the respondents did no probate work and over half did no work in the juvenile courts. Because the respondents worked predominantly in the adult criminal arena and a very small percentage devoted any significant time to probate or juvenile work, the seemingly different rates of aggression among the forensic settings tend to reflect the amount of time spent in each setting rather than meaningful differences in the occurrence of violence in each setting.

Threats

This category consisted of verbal threats only and included threats toward self, toward family, of property damage, of sexual assault, and of assault with a weapon.

Table 1 Aggressive Behavior Toward Evaluators by Type and Context

Aggressive Behavior Context	Threats (1 or More)	Harassment/Intimidation (1 or More)	Physical Aggression (1 or More)
Nonforensic	29	37	29
Forensic			
Adult criminal	31	51	15
Probate	7	17	1
Other adult	19	23	11
Juvenile	9	16	8

Data are percentages of the total number of returned surveys (n = 103).

Almost two-thirds (65%) of the respondents reported that they had been threatened at some point in their professional careers (i.e., clinical and/or forensic practice). Respondents were asked to break down the percentage of threats they had experienced into five contexts: four forensic and one nonforensic (Table 1). Threats reported in the various contexts were: (1) adult criminal (31%); (2) probate (includes child custody and guardianship hearings) (7%); (3) other adult civil (involuntary commitment, competency to make treatment decisions) (19%); (4) juvenile (includes delinquency hearings, transfer hearings, as well as issues regarding child protection and termination of parental rights) (9%); and (5) nonforensic (psychotherapy, psychopharmacology, psychological testing) (29%). An independent t test yielded no gender differences in the frequency of threats.

Of those who had been threatened (in any of the five contexts), the overwhelming majority of the incidents fell into the category of "threats to self" (all 65% of those who had been threatened reported at least one threat to self), and there were relatively few incidents of threats of property damage (15%), threatened weapon use (8%), threats toward family members (5%), or threat of sexual assault (4%).

To determine the effect of threats in forensic and nonforensic settings, we performed a within-subject ANOVA on the number of threats in each setting (Table 2). To control for the amount of each forensic evaluator's practice spent in each setting, we divided the respondents into two groups: those who spent less than 50 percent of their time in nonforensic practice (n = 68) and those who were engaged in nonforensic practice 50 percent or more of the time (n = 35).

Forensic evaluators whose practice was predominantly forensic had an average of 1.9 threats in the forensic setting and 3.0 threats in nonforensic settings, whereas forensic evaluators whose practice was predominantly nonforensic had an average of 1.3 threats in the forensic setting and 3.3 threats in the nonforensic setting. The ANOVA found no effect of setting. Thus, when the variability in the amount of the forensic evaluators' practice in each setting was accounted for, there was no significant difference in the number of threats received by evaluators in forensic versus nonforensic settings.

Incidents of Harassment or Intimidation

These types of behavior tend to be more subtle forms of aggression. To ensure that they were not overlooked, we listed seven cue categories, and asked respondents to check all that applied. Because it seemed unlikely that respondents would be able to provide an accurate estimate of the frequency of some of these events (e.g., staring, looming), we asked them instead to estimate the overall number of

Table 2 Effect of Setting and Aggression Controlling for Amount of Nonforensic Practice

		Threats		Harassment/Intimidation	
	n	Mean	SD	Mean	SD
Forensic Setting					
<50% nonforensic	68	1.9	3.3	15.5	28.7
≥50% nonforensic	35	1.3	2.5	4.4	6.6
Nonforensic Setting					
<50% nonforensic	68	3.0	17.7	9.2	28.8
≥50% nonforensic	35	3.3	8.0	10.3	21.7

times they had been subjected to acts of H/I during the course of their professional careers. The categories and proportion of respondents who checked each category were: instances of glaring/staring, 65 percent; abusive or obscene language, 51 percent; invasion of personal space/looming, 41 percent; telephone calls, 23 percent; letters, 21 percent; stalking, 10 percent; repeated telephone hang-ups, 10 percent; and other, 6 percent.

Acts of H/I were the most frequent type of aggression experienced in the sample; 85 percent of the respondents indicated that they had been subjected to at least one such act. Respondents were asked to categorize the incidents of H/I in the five settings that were used to categorize threats, and the pattern of results was similar (Table 1). Most incidents occurred in the context of adult criminal matters (51%) and adult other (23%), while the fewest occurred in probate (17%) and juvenile (16%) proceedings. Seventy-one percent reported that they had been subjected to at least one act of H/I during the course of forensic work, and 37 percent had had some such experience in the course of nonforensic practice. As with threats, an independent *t* test yielded no difference between male and female respondents in the frequency of incidents of H/I.

To determine the effect of H/I in forensic and nonforensic settings, we performed a within-subject ANOVA on the number of reported acts of H/I in each setting (Table 2). The proportion of practice (predominantly forensic versus predominantly nonforensic) for each forensic evaluator was controlled for in the same manner as the analysis of threats.

Forensic evaluators whose practices were predominantly forensic had an average of 15.5 instances of H/I in the forensic setting and 9.1 instances of H/I in nonforensic settings, while forensic evaluators whose practices were predominantly nonforensic had an average of 4.1 instances of H/I in the forensic setting and 10.3 reports of H/I in the nonforensic setting. The ANOVA demonstrated no main effect of setting. However, there was a significant interaction between the setting and the amount of each forensic evaluator's practice that was nonforensic ($F_{(1,101)} = 4.57, p = .035$). Forensic evaluators who spent more than half of their practice in the forensic setting reported significantly more H/I in both the forensic and nonforensic settings, compared with their colleagues whose practices were predominantly nonforensic.

Acts of Actual Physical Aggression

Respondents were asked the number of times they had been the target of acts of actual physical aggression and were asked to report the incidents in seven categories, as follows: "without weapon" (defined as incidents of spitting, pushing, hitting, kicking, biting, scratching, and the like); "with weapon" (gun, knife, blunt object, and other); "sexual assault" (incidents of inappropriate touching, exposing him/herself, as well as any forced sexual acts), "assaults toward family, without weapon," "assaults toward family, with weapon," "property damage," and "other acts of violence."

About half (49%) of the sample reported that they had been the subjects of at least one such act over the course of their entire professional careers. Of note, 29 percent of the respondents reported that at least one such incident occurred in the course of their forensic work, and an equal percentage reported experiencing at least one such incident in their general clinical (nonforensic) practice. Table 1 presents the breakdown across settings. Again, no gender differences were found.

Most of the incidents reported (42%) fell in the category of "assault toward self without a weapon." Far fewer had been subjected to any of the other types of aggression: assault toward self with a weapon (13%); sexual assault (9%); property damage (7%); other acts of violence (2%); assaults toward family with a weapon (1%); and assaults toward family without a weapon (0%).

None of the assaults with weapon (13%) included use of a gun or knife, but most often involved thrown objects (e.g., comb, cup of coffee, bottle of urine), and one involved the use of a sharpened toothbrush. There were no forced sexual acts reported; most of the sexual assaults consisted of the evaluee's exposing himself, and the next largest category was incidents of inappropriate touching. The incidents of property damage were relatively minor, such as destruction of office materials or keys dragged across the examiner's car. The one incident of aggression toward family involved slashing the tires of the evaluator's family car when it was parked at home.

Most Distressing Incident

Of the 103 people who responded to the survey, 78 (76%) chose to report the MDI they had encountered in the course of their forensic work. The following examples of these incidents were chosen to

illustrate the range of responses in terms of type, setting, and level of severity. The clinicians' reports are unchanged except for the removal of potential identifying information.

Case A

The father of a juvenile I evaluated threatened the judge, DA, me, and my family. He was seen as very dangerous, and all of us had police protection for a few days.

Case B

The most distressing incident involved inappropriate, unwarranted anger, and threats from a judge. Another judge had to intervene to calm him down, and about a year later he apologized to me.

Case C

Episodic stalking, unwelcome phone calls, letters and packages including showing up at a colleague's home and office, sending multiple mailings, frequent phone calls.

Case D

While [I was] testifying in a competence-to-stand-trial hearing, the defendant's attorney suddenly approached and began yelling at me about my opinion. The judge admonished him, and he backed off. At the conclusion of the hearing the lawyer again came toward me in the courtroom, irate about my opinion. The court officer escorted him out. I left the courthouse about one and a half hours later, after most employees had already gone for the day. This attorney entered the parking lot right behind me and got in his car. I was concerned that he would follow me or intentionally cause some type of accident because he was so angry and in poor control.

Case E

While [I was] interviewing a defendant with a diagnosis of schizophrenia [who was a] sex offender. . ., he began to masturbate under the table. In the next interview, he began to talk about violent sexual fantasies toward female staff who he was angered by and then began telling me how pretty I was and trying to get me to smile.

Case F

False complaints were filed with the licensing board against me. Since they all were taken by the board to be possible evidence of a problem due to multiple complaints, it took several years and tens of thousands of dollars to clear my name. This was without the board's ever officially hearing a full complaint against me. Although I was not hurt in the most distressing event, it caused many months of anxiety, depression, sleep disturbance, and fear of taking on new cases.

The authors classified the MDIs into the same three categories used previously: threats, acts of H/I, and acts of actual physical aggression. Twenty-six (33%) of the MDIs fell into the category of threats with 20 of the 26 categorized as threats toward self. Twenty-nine (37%) of the MDIs were acts of H/I. A review of the incidents of H/I showed that about half occurred during the interview itself (the six incidents of glaring/staring/banging on the table, five of abusive/obscene language, and four of invasion of personal space/looming). The other half appeared to have occurred some time later (seven instances of annoying phone calls, three of letters/packages, two of reports to the licensing board, and one of stalking). The former half of the incidents may be less worrisome than the latter half, which presume that the person held the grievance beyond the interview and planned further action.

There were 16 (21%) incidents of actual physical aggression among the 78 MDIs reported. Of those, six were assaults with weapons (e.g., table, chairs, a lit cigarette), five were assaults without weapon (these were incidents of scratching, spitting, and putting the evaluator in a headlock), and three were sexual assaults (e.g., masturbation, talking about violent sexual fantasies). Ten incidents could not be classified in our three categories, but nine of those could loosely be termed "person was psychotic" (for example, one person reported "a young man was actively psychotic and paranoid and had difficulty controlling his paranoia and was hearing voices").

To gauge the seriousness of these most distressing incidents, respondents were asked to describe any physical injuries they sustained in the course of the event. Three people reported suffering any injury: one sustained a scratch that broke the skin, one was scratched below the eye by a person who was known to be HIV positive, and the third sustained an injury that scarred the face (no further details specified). Only one of the three sought medical attention, and only one took any time to recover from the physical injuries (three weeks).

In contrast to the relatively minimal physical injuries sustained, emotional sequelae were pro-

nounced. Twenty-seven (35%) of the respondents reported that they needed from several hours to several months to recover emotionally from the MDI. One person said she or he spent "one year watching my tracks when leaving the hospital," and another reported "a week for acute stress, but thoughts of the turmoil it caused within my family still linger." Most of the respondents took one or more actions in response to the incident; 78 percent told colleagues about the incident, 46 percent told family or friends, 16 percent arranged for hospitalization, and 4 percent notified police. Only one person elected to file charges, and the accused individual was ultimately found not guilty by reason of insanity.

By far, most of the MDIs occurred in public settings (hospital, 37%; courthouse, 28%; and jail/prison, 9%), although a small but worrisome percentage (6%) occurred at the evaluator's home. Sixty-seven percent of the MDIs occurred during the pendancy of the legal process, and 21 percent occurred after the legal proceeding had been resolved (12% did not identify the time frame).

Respondents were asked several questions about the person responsible for the most distressing incident. Fifty-eight percent of the aggressors were male and 42 percent female. Most often the aggressor was the evaluee (87%), but four percent of the aggressors were family members of the evaluee, and four percent were another person (e.g., defense attorney, judge, director of a local substance-abuse program). Two thirds (67%) of the aggressors had a known history of mental illness, over half (51%) had a history of alcohol/substance abuse, and three quarters (75%) had a history of violence toward others. Over half (53%) appeared to be actively psychotic at the time of the incident, and four percent appeared to be under the influence of alcohol or drugs.

Safety Precautions

Respondents employed various safety precautions. Two-thirds had an unlisted home telephone number and address, and several used a post office box. A fourth said they screen and limit cases, and a handful of others have some type of home or office security system, have taken some type of self-defense training, or own defensive weapons. Forty-seven percent of the group described specific precautions they employ during the evaluation itself, such as keeping the door to the interview room open, having someone close by, and informing others of their whereabouts.

Discussion

The present study revealed that 85 percent of these respondents had been harassed or intimidated, 65 percent had been threatened, and nearly 50 percent had been subjected to acts of actual physical aggression at least once during the course of their professional careers. In contrast to expectations, there was no more overall aggression in respondents' forensic practice than in their nonforensic practice. The ANOVA demonstrated that the appearance of difference was because of the higher amount of time that respondents in this study engaged in forensic work. When proportion of time spent in forensic work was taken into account, there was no difference between the forensic and nonforensic settings for threats, H/I, or acts of physical aggression.

Previous surveys of the lifetime incidence of aggressive events experienced by mental health professionals have ranged from 22 to 61 percent in the category of threats[9,11,22] and 14 to 55 percent in the category of physical aggression,[6,7,9–11,22] placing the findings of this study at the higher end of the spectrum. The incidence of physical aggression reported in the forensic context (29%) was substantially higher in the current study than the three percent reported by Miller, the one previous study focusing exclusively on the experience of forensic clinicians.[20]

Despite the greater frequency of aggressive behavior, the type and severity of harm was not dramatically different from that in earlier reports. There was very little physical injury sustained in the course of either clinical or forensic practice, and there was only one incident resulting in what may be considered serious injury (resulting in scar on the face).

Forensic evaluators whose practices were predominantly forensic experienced more H/I in both their forensic and nonforensic practices than did their colleagues whose practices were predominantly nonforensic. In addition, those clinicians whose practices were predominantly nonforensic experienced significantly less H/I in the forensic setting. This finding was unexpected, and the factors contributing to the difference are not readily apparent. It may be that the clinician whose practice was primarily forensic was alert or attuned to subtle forms of aggressive behavior and was less apt to deny, minimize or ignore these occurrences. Additional investigation is needed to understand this finding.

Of the reported MDIs, it was not surprising that approximately three-quarters of the individuals who became aggressive had a history of violence toward others. In addition, two-thirds had a history of mental illness, and over half had a history of substance abuse. More than half appeared to be actively psychotic at the time of the incident. It initially seemed surprising that only four percent of the aggressors appeared to have been under the influence at the time of the MDI, but closer inspection revealed that nearly three-quarters of the MDIs occurred in institutional settings such as courthouses, hospitals, and correctional settings where the individuals may have been held for some time before being seen by evaluators.

In 9 of 10 times, the aggressor was the evaluee; the remainder of the times the aggressor was a family member or another person (e.g., defense attorney, judge, director of a local substance-abuse program). The occurrence of acts of aggression by someone other than the subject (of the evaluation or treatment) in forensic compared with clinical settings is not well documented in the literature. Further attention to these individuals could illuminate a previously unexplored source of aggression.

Respondents who were the victims of aggressive incidents did not differ by gender in any of the three categories of aggression. Among MDIs, the aggressors were 58 percent male and 42 percent female. This finding was somewhat unexpected, in light of the fact that most of the MDIs occurred in the context of adult criminal proceedings where male defendants overwhelmingly predominate. Given that nearly all of the aggressors were themselves the subjects of the evaluations, female aggressors appear to be substantially over-represented in the forensic evaluators' reports of MDIs.

In this study, we found there was no more risk in the forensic than in the nonforensic context. Anecdotal reports have suggested that aggression may be most prevalent specifically in proceedings for child custody and termination of parental rights. To address that question, further research should focus on a comparison group of clinicians whose practices are predominantly in those areas.

This study further found that forensic clinicians' concerns about their safety may be somewhat misplaced. For many mental health professionals, it is the fear of serious injury or death that looms large. In reality, it appears more likely that they will have to confront multiple aggressive incidents that leave no physical scars. Thus, to the extent that clinicians take some basic security precautions, such as maintaining an unlisted telephone number and becoming more cognizant of their safety during interview situations, they appear to be mounting a reasonable response to the true nature of physical risk. (An especially helpful and practical list of safety precautions for individuals working in the courts has been developed by Pauline Quirion, Esq.[25])

The respondents' reports of the emotional impact of the MDI was striking. Of the 78 respondents who chose to describe an incident, only 3 reported suffering any physical injury (two scratches, one injury scarring the face), and none were confronted with weapons such as guns or knives. Yet 27 (35%) individuals required from several hours to several months to recover emotionally from the event.

This survey supports previous findings that across disciplines and settings, emotional reactions to these incidents are often serious and long lasting. As other authors have noted, attention to the emotional sequelae of what may seem to be even minor aggressive incidents is warranted. This should be highlighted in training programs to help clinicians to more realistically anticipate, assess, and care for their own emotional responses to these events. On an institutional level, there may be a need to develop a culture in which strong emotional reactions to aggressive incidents are legitimized, normalized, and respected.

Acknowledgments

The authors thank Kristen Roy-Bujnowsi, BS, for invaluable assistance throughout this project and Jeffrey J. Davis, PhD, for thoughtful contributions to the conceptual framework. In addition, we extend our gratitude to Deborah Scott, Assistant Commissioner of Forensic Mental Health, Massachusetts Department of Mental Health, who consistently supported and encouraged this effort and to the Designated Forensic Professionals who took the time to complete the survey.

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