

# Threats and Assaults Against Psychiatrists

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In this article, the authors review the literature on surveys pertaining to threats and assaults on psychiatrists and report the results of a questionnaire sent to Oregon psychiatrists. Although the responding psychiatrists were experienced clinicians, they appear to have had relatively little life experience with aggression. Assaults and threats were frequent in their careers, occurred across a variety of clinical settings, and involved a wide range of patients. The authors discuss specific strategies for psychiatrists to minimize the effects of patient threats and assaults and suggest ways in which organized psychiatry can help with the danger and sequelae of patient violence.

During 1985 two Oregon psychiatrists were killed by psychiatric patients. One psychiatrist died on a general medical inpatient ward in a community hospital, and the other psychiatrist was shot to death in his private office. These tragic incidents raised questions in the minds of many Oregon psychiatrists about the inherent dangers involved in the practice of psychiatry. In an attempt to address this issue, the Oregon Psychiatric Asso-

ciation (OPA) established an *ad hoc* committee in 1986 to review the available literature pertaining to threats and assaults against psychiatrists and to develop and distribute to OPA psychiatrists a questionnaire concerning their experiences with patient threats and assaults.

In this article, we will present the results of the OPA *ad hoc* committee efforts. We begin with a brief review of the survey literature pertaining to patient threats and assaults on psychiatrists. We then report the results of the OPA questionnaire and discuss conclusions based on the data and their possible implications for both psychiatrists and organized psychiatry.

## A Review of the Survey Literature

In Table 1 we summarize seven survey studies of threats and assaults against psychiatrists.<sup>1-7</sup> The studies document a wide range in the percentage of psychi-

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**Table 1**  
**Survey Studies of Threats and Assaults Against Psychiatrists**

Senior Author (Date)	Study Location	Study Description	No. Surveyed	Response (%)	Threatened (%)	Assaulted (%)
Whitman (1976)	OH	Experience in 1972	96	53 (55)	28 (53)	18 (34)
Madden (1976)	MD	Career experience	115	115 (100)	—	48 (42)
Rubin (1980)	CA	2 year experience 2nd and 3rd year residents	31	31 (100)	—	15 (48)
Bernstein (1983)	CA	Career experience	171	—*	— (61)	— (42)
Hatti (1982)	PA, UK	Career experience	725	436 (60)	—	90 (21)
Haffke (1983)	NE	Career experience	88	54 (61)	23 (43)	17 (31)
Reid (1986)†	USA	Career experience	470	156 (33)	—	5 (3)

\* Overall usable response rate by psychiatrists, psychologists, social workers, and marriage and family counselors was 43%.

† Assaults defined as causing injury requiring at least one day of missed work or convalescence.

atrists who report threats or assaults and also demonstrate a number of methodological inconsistencies that could account for much of the variance. Only the study by Reid and Kang<sup>7</sup> defines what the authors mean by "assault." The study by Whitman *et al.*<sup>1</sup> provides data for just one year, that by Rubin *et al.*<sup>3</sup> for two, and the rest<sup>2,4-7</sup> are for the entire career of the psychiatrist with no documentation of how long that time might be. Response rates vary from 33 percent<sup>7</sup> to 100 percent.<sup>2,3</sup> Despite these and other methodological problems, the studies seem to indicate that threats and assaults are a relatively common part of a psychiatrist's experience.

These seven studies also reveal a number of other findings. The Whitman, *et al.*<sup>1</sup> study reported that 2.4 percent of the patients seen in 1972 posed a physical threat to the psychiatrist and 0.9 percent actually assaulted the psychia-

trist. The experience of the psychiatrists did not appear to be a factor in determining whether or not they were assaulted. Whitman *et al.* concluded that attacks are "an infrequent but also inevitable phenomenon that may occur at some time to every therapist." They also noted that "responses to the threat of patient attack are stereotyped and instantaneous" and recommended that therapists engage in "discussion, rehearsal, and other forms of training so that useful techniques can be employed without delay" in a crisis situation.

In contrast to those in the Whitman *et al.*<sup>1</sup> study, the psychiatrists in the Madden *et al.*<sup>2</sup> survey indicated that most assaults had occurred early in their career. They also reported that 72 percent of the assaultive patients had schizophrenia or another psychosis, 68 percent were 30 years old or younger, and 57 percent were involved in active treat-

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ment at the time of the assault. Most of the assaults evidently caused only minor injuries. In retrospect, 55 percent of the psychiatrists said they could have anticipated the assault, and 53 percent felt they had contributed to the assault through their "provocative manner." Assaults were found to have occurred not only in settings traditionally considered to be dangerous but also in private practice and other settings as well. Madden *et al.* concluded that "denial plays a heavy role in both the ways clinicians deal with patients who might be assaultive and their recollection of assaults." They recommended that "clinicians become sensitive to their role in dealing with potentially violent patients so that they can institute effective intervention policies."

Agreeing with the psychiatrists in the Madden *et al.*<sup>2</sup> survey, 93 percent of the psychiatric residents in the Rubin *et al.*<sup>3</sup> study who had been attacked felt they had done something to trigger the patient's action, usually something which had frustrated the patient. Residents also reported that attacks occurred in a variety of different treatment settings with or without other people present. Patients were most frequently described as having a paranoid psychosis, and two-thirds were male. Ninety percent of the attacks were by patients who had not seen the resident before. Attacks were not related to life change stresses experienced by the residents, but residents who were more irritable, who spoke up when mildly angry, and who were willing to fight when faced with a physically threatening situation outside of the hospital were more likely to be the ones who had been at-

tacked. Rubin *et al.* advocated that residents become more aware of their own personality style and "approach sensitive, potentially frustrating situations carefully to avoid being hit by a patient."

Most of the data presented in the Bernstein<sup>4</sup> study pertains to threats and assaults directed toward psychiatrists, psychologists, social workers, and marriage and family counselors as a group. Although the pooled data revealed that 77 percent of the threats and assaults were directed toward male therapists, this figure is only slightly larger than that anticipated by the sex distribution of the returned surveys. Most of the therapists involved were relatively inexperienced. Seventy-six percent of the assaultive patients had a past history of violence, and about 35 percent had a past history of a suicide attempt. Threats and assaults occurred over a range of inpatient, outpatient, and private practice settings. The therapists reported that they were able to predict only 9 percent of the incidents. Nine percent of the episodes were reported to the police. Most therapists indicated that their response to being threatened or assaulted was only rarely a "planned strategy" and "felt that their best protection was to deal with the situation as they intuitively felt."

As in the Madden *et al.*<sup>2</sup> study, the psychiatrists in the Hatti *et al.*<sup>5</sup> survey reported that assaultive patients were most frequently young males with schizophrenia. The fact that 48 percent of patients had a diagnosis other than schizophrenia and that most had no previous history of substance abuse, childhood violence, or criminality, however, led the authors to conclude that "violent

patients are not a homogeneous group.” The location of assaults were almost equally divided between inpatient and outpatient settings. To carry out the assaults, patients used their fists in 25 percent of the episodes, guns in 24 percent, knives in 11 percent, and other objects in 39 percent. In response to the attack, psychiatrists used help from other staff to control the patient in 40 percent of the cases, talked with the patient until the violent impulse ended in 35 percent, and ran away from the patient in 7 percent. In 18 percent of the episodes, the patient calmed down after throwing an object. Sixty percent of the psychiatrists felt they could identify a precipitant for the assault, which was usually due to a conflict in therapy, paranoid ideation, or transference problem. Hatti *et al.* commented that “defenses such as denial, withdrawal, or reaction formation” interfere with a psychiatrist’s assessment of potentially violent patients and suggested that “the clinician may best be served by directing attention to his own anxiety and fears” so that he “can maximize his most important asset for dealing with violence—his verbal skills.”

The Haffke and Reid<sup>6</sup> survey also revealed that most assaultive episodes resulted in minor injury. Evidently only one psychiatrist required medical attention. Six percent of the incidents resulted in legal action against the patient involved. Haffke and Reid recommended increased “recognition of problems or improper handling of violent confrontations” in order to prevent the escalation of potential danger.

Reid and Kang<sup>7</sup> found no evidence to

indicate that psychiatrists were at greater risk than family practitioners for serious assault by their outpatients. No relationship could be established between clinical inexperience and assault, but males seemed to be more at risk than females. Reid and Kang concluded that “most assaults occur unpredictably or take place within situations that may arise for any therapist or staff member,” and that “most serious assaults could only be prevented through extraordinary, impractical vigilance.” They also advocated that “victims be treated as such, and not as willing participants in their misfortune.”

### Methods

In 1986 a questionnaire concerning patient threats and assaults against psychiatrists was developed and mailed to all 270 current members of the OPA. The questionnaire solicited information on four major areas: (1) the demographics, training, experience, and practice characteristics of the psychiatrists themselves; (2) the career experience of the psychiatrists with patient threats and assaults; (3) the nature and effect of the psychiatrists’ most serious patient threat or assault; and (4) the psychiatrists’ opinions about training that is useful in managing aggressive patients.

### Results

Of the 270 questionnaires mailed to OPA psychiatrists, 150 were completed and returned for a response rate of 56 percent.

**Characteristics of the Responding Psychiatrists** The median age of the responding psychiatrists was 40 to 50 years. Seventy-seven percent were male,

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72 percent lived in a metropolitan area, 32 percent had armed services experience, 36 percent had experience with contact sports or hunting, 61 percent claimed to be knowledgeable about firearms, 41 percent possessed a firearm, 17 percent had experienced some type of neighborhood or domestic violence, and 77 percent claimed to have been reared in a nonviolent atmosphere.

Ninety-three percent of the psychiatrists had completed three or more years of psychiatric training, 40 percent had received some type of violence management training, and 64 percent had training in behavioral techniques. The median length of time the psychiatrists had been practicing psychiatry was 14 years. Seventy-nine percent treated greater than 100 patients per year. Seventy-three percent spent some of their clinical time working in an outpatient office, 67 percent in a hospital, and 32 percent in a mental health clinic. Table 2 contains the psychiatrists' estimates of the relative risk of violence in these three practice settings. Although a majority believed the risk was low in all settings, hospitals were considered to be much more risky than either mental health clinics or outpatient office settings.

***Career Experiences with Patient Threats and Assaults*** Table 3 lists the

different types of patient threats of physical harm and actual assaults the responding psychiatrists have experienced during their professional careers. Most psychiatrists have been threatened in multiple ways, many on several different occasions, during their careers. Many psychiatrists have also been assaulted in one way or another. Most of these attacks have resulted in injuries which might be described as being minor, but

**Table 3**  
**Types of Career Threats of Physical Harm and Assaults (N = 150)**

	N	%
Types of Threats of Physical Harm		
Written threat	45	30
Verbal threat	91	61
Phone threat	52	35
Threat reported to 3rd person	5	3
Other threat	4	3
Types of Assaults		
Serious physical harm requiring medical treatment (e.g., concussion, stabbing)	10	7
Moderate physical harm requiring medical treatment (e.g., eye patch, tetanus shot)	7	4
Mild physical harm not requiring medical treatment (e.g., scratch, bruise)	57	38
Potential for harm (e.g., chair thrown, gun brandished)	70	47
Aggressive intent (e.g., poke, shove)	83	55

**Table 2**  
**Psychiatrists' Estimates of Risk of Violence in Different Practice Settings**

Practice Setting	Survey Response	Risk of Violence					
		Low		Medium		High	
		N	%	N	%	N	%
Outpatient Office	103	93	90	7	7	3	3
Hospital	96	50	52	9	9	37	39
Mental Health Clinic	48	37	77	5	10	6	13

about one in ten of the psychiatrists have been hurt badly enough to require medical treatment.

Ninety-nine of 141 (70%) responding psychiatrists considered the threat of physical harm made against them to be serious, but only 47 (47%) reported the threat to the authorities. The reasons given by the 52 psychiatrists for not reporting a serious threat of physical harm were that the patient was already confined (31%); nothing would be done about it (29%); the threatening situation was self-limiting (13%); the patient was mentally ill (12%); treatment would be jeopardized (10%); the threat was anonymous (4%); and other reasons (8%).

Ninety-one (61%) of the responding psychiatrists indicated that they had been threatened by patients in ways that did not involve physical harm. These psychiatrists had experienced at least one threat of a lawsuit (73%); a report to some type of legal or licensing authority (34%); harm to a member of their family (15%); a report to a supervisor (10%); defamation of their character (4%); or some other action (4%).

**The Most Serious Events** Table 4 contains the characteristics of the patients involved in what the responding psychiatrists believed to be their most serious patient threat or assault. The typical patient was a relatively young male with schizophrenia or a personality disorder who was being evaluated by a psychiatrist for the first time.

An analysis of 127 of the most serious events revealed that in 54 percent both the patient and the psychiatrist were male, in 22 percent the patient was fe-

**Table 4**  
**Most Serious Event—Patient Characteristics**

Characteristics	Survey Response	Mean (Years)	Median (Years)
		(N)	(%)
Age	119	34	35
Sex (Male)	122	88	72
Diagnosis	125		
Schizophrenia		52	42
Personality disorder		38	30
Mania		8	6
Substance abuse		8	6
Organic mental disorder		4	3
Depression		3	2
Posttraumatic stress disorder		2	2
Mental retardation		1	1
Medical illness		1	1
No diagnosis		8	6
Patient Relationship	125		
New		68	54
Established		47	38
Not a patient		7	6
Anonymous		3	2

male and the psychiatrist male, in 16 percent the patient was male and the psychiatrist female, in six percent both the patient and psychiatrist were female, in two percent the patient was unknown and the psychiatrist male, and in one percent the patient was unknown and the psychiatrist female. The finding that 78 percent of these incidents involved male psychiatrists must be interpreted with an understanding that 77 percent of the responding psychiatrists were also male.

Using a modification of criteria to describe dangerous behavior developed by Hiday and Markell,<sup>8</sup> we were able to discern the nature of the threat or attack that took place in 122 of these most serious events. Sixty-one (50%) were direct physical attacks against the psychi-

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atrist, 39 (32%) were threats in which the patient took some type of action to carry out the threat, and 22 (18%) were threats in which no action was taken by the patient. Of the physical attacks, patients used a part of their body such as a hand or a foot in 72 percent, some type of object such as a chair or an ashtray in 23 percent, a gun in 3 percent, and a knife in 2 percent. Of the threats with action, patients took steps to use a gun in 36 percent, a knife in 26 percent, a part of their body in 23 percent, and some type of object in 15 percent. Of the threats without action, patients were vague about their intentions in 90 percent, but five percent implied they would use a part of their body, and 5 percent said they would use a knife.

It was possible to identify where 125 of the most serious threats and assaults took place. Thirty-eight percent occurred on a psychiatric ward, 33 percent in a psychiatrist's office, 16 percent in an emergency room, eight percent in a mental health clinic, and two percent each in a courtroom, jail, or patient's home.

One hundred eighteen psychiatrists described what they believed had been their most useful response to their most serious event. The most common strategies employed by the psychiatrists were escaping from the patient (26%), talking to or verbally confronting the patient (21%), calling for help from other treatment staff or security (20%), remaining calm (17%), calling the police (14%), physically restraining and/or secluding the patient (12%), being aware of and responding to their own feelings of con-

cern and fear (8%), and not attempting to reason with the patient (3%). Seven percent of the psychiatrists did not believe they had made any type of useful responses.

Ninety-two psychiatrists described responses to their most serious event that they believed were not useful. These included feeling fearful, angry, and guilty (28%); being unaware of the threat until it was too late (23%); attempting to reason with the patient (8%); failing to escape from the patient (8%); not knowing what to do (7%); and isolating themselves from possible sources of help (4%). Twenty-nine percent of the psychiatrists believed they had made only useful responses.

The effects their most serious event had on their current practice were reported by 127 psychiatrists. The most frequent responses included being more alert and cautious around patients (33%), making sure that help was always readily available (20%), employing more strict security policies and procedures in their clinical work (14%), and refusing to see potentially violent patients (6%). Thirty-five percent of the psychiatrists believed their most serious event did not have an effect on their practice.

***Training Strategies to Manage Aggressive Patients*** Eighty-three psychiatrists described the types of training they had found to be useful in the management of aggressive patients. Their responses included formal instruction on techniques of violence assessment and management (42%), general clinical experience (22%), seminars and readings concerning aggression and violence

(16%), self-defense techniques (11%), and strategies to increase sensitivity and communication skills (10%). Eighteen percent, however, claimed they had not found any type of training to be useful.

### Discussion

Several conclusions are suggested by our data. First, the 150 OPA psychiatrists responding to our survey appear to be a diverse group of busy, seasoned clinicians with varied practice characteristics. As a group, they might be expected to have considerable practical knowledge and strong opinions about our topics. Our reading of their completed surveys supports this contention. Although the generalization of any conclusions based on the answers to our survey must naturally be tempered by our 56 percent return rate, Table 1 indicates that this rate of response is consistent with most of the other major studies in the literature.

Second, the responding psychiatrists seem to have had relatively little experience during their lives with sanctioned and nonsanctioned aggression. Although we can not draw firm conclusions here, we do wonder whether these background characteristics have anything to do with the fact that less than half of the psychiatrists had pursued any formal training in the management of violent patients. We also wonder whether these characteristics could have contributed to the nonuseful responses to the most serious events. Many psychiatrists said they were caught unaware or had no idea of what to do in those situations. For many psychiatrists, it

seemed as if such displays of aggression were so foreign to their own experiences that they were startled by their occurrence and unsure of how to respond to protect themselves or to help their patients.

Third, threats and assaults are relatively frequent occurrences in the careers of the responding psychiatrists. By combining our data with that in Table 1, we are able to draw some tentative conclusions about the risks of threats and assaults during a psychiatric career. As reported by Reid and Kang,<sup>7</sup> our data in Table 3 confirm the finding that the risk of sustaining serious physical injuries during a psychiatric career is small but significant. We would estimate the risk to be somewhere around 5 percent. The risk of receiving any type of injury as a result of an assault is much higher, perhaps 40 percent or even more. As noted in the Madden *et al.*<sup>2</sup> and Reid and Kang<sup>7</sup> studies, our data indicate that most of these injuries are minor. Our study also reveals that about 50 percent of psychiatrists can expect to be involved in an incident with a potential for serious harm or where aggressive intent is displayed by a patient. This suggests to us that the fortunate finding that most injuries are minor may have more to do with ineffective patient attack procedures, successful evasive tactics employed by psychiatrists, and luck than a lack of patient intent to cause more serious harm.

Fourth, the opinions of the responding psychiatrists about the relative risk of violence in various practice settings are not supported by their actual expe-



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riences. Although Table 2 indicates the great majority believe their outpatient offices have low risk, about one-third of their most serious events took place there. Indeed, as noted earlier, one of the murders prompting this study took place in the psychiatrist's private office. This finding is consistent with those of Madden *et al.*,<sup>2</sup> Rubin *et al.*,<sup>3</sup> Bernstein,<sup>4</sup> and Hatti *et al.*,<sup>5</sup> who also noted the occurrence of assaultive incidents across diverse clinical settings.

Fifth, it seems prudent to consider that any patient can be dangerous and that all psychiatrists are at risk. The data in Table 4 from the most serious events do indicate that the most frequent threatening or assaultive patient is a relatively young male with schizophrenia. This finding is consistent with those of Madden *et al.*,<sup>2</sup> Rubin *et al.*,<sup>3</sup> and Hatti *et al.*<sup>5</sup> It is important to note, however, that almost one-third of the patients in the most serious events were female and that nearly 60 percent had a diagnosis other than schizophrenia. Although as in the Rubin *et al.*<sup>3</sup> study, most of the patients in the most serious events were being seen by the psychiatrist for the first time, almost 40 percent of these incidents occurred in an already established relationship. This observation is consistent with that of Madden *et al.*<sup>2</sup> As noted by Bernstein,<sup>4</sup> the percentage of the most serious events involving male and female psychiatrists is in line with their response rate to the survey. The sex of the psychiatrist does not appear to be a factor in determining these incidents. As noted earlier and as found by Madden *et al.*,<sup>3</sup> Rubin *et al.*,<sup>3</sup> Bern-

stein,<sup>4</sup> and Hatti *et al.*,<sup>5</sup> the most serious events occurred across a range of different clinical settings. These results support Hatti *et al.*'s<sup>5</sup> contention that "violent patients are not a homogeneous group" and suggest that Reid and Kang<sup>7</sup> are indeed correct when they conclude that "most assaults occur unpredictably or take place within situations that may arise for any therapist."

Sixth, although it may not be possible for psychiatrists to predict the occurrence of threats or assaults, it may well be possible for them to take steps which will minimize the effects of these incidents. As in the Hatti *et al.*<sup>5</sup> survey, our data on the most serious events indicate that most patient attacks involved a body part or an object the patient used to try to hit or stab the psychiatrist: only a few involved a gun. Similarly, most threats involved a body part or an object. To be successful with these types of attacks, most patients would need to have close physical contact with victims who were unaware of the danger, did not have help readily available or a handy escape route, and were unsure about what to say or do. These conclusions are supported by the fact that many psychiatrists in our survey, like those in the Hatti *et al.*<sup>5</sup> study, believed escape, verbal confrontation, and calling for help were among their most useful responses to their most serious event and that being unaware of the threat, failing to escape, isolating themselves from help, and being unsure of what to do were responses that were not useful. Perhaps most telling, however, is the fact that their most serious events have provoked

many psychiatrists to be much more alert and cautious, to make sure that help is available, and to be concerned with security policies and procedures in their clinical work. These results suggest that psychiatrists should increase their awareness of the possibility of danger, consider various response options in advance, and make sure their practice settings provide ready access to help and escape. This type of contingency planning is consistent with the recommendations of Whitman *et al.*,<sup>1</sup> Madden *et al.*,<sup>2</sup> Rubin *et al.*,<sup>3</sup> Hatti *et al.*,<sup>5</sup> and Haffke and Reid,<sup>6</sup> but is in contrast to the beliefs of the therapists in Bernstein's study<sup>4</sup> who "felt that their best protection was to deal with the situation as they intuitively felt."

Seventh, it seems clear from our survey that there are ways organized psychiatry can help psychiatrists deal with the danger and sequelae of patient violence. Most psychiatrists found specific training useful in the assessment and management of aggressive patients. Organized psychiatry could easily provide continuing education workshops and seminars on this topic. The fact that feeling fearful, angry, and guilty was such a common response to the most serious events suggests that organized psychiatry might also help by developing programs to support threatened or assaulted psychiatrists. This observation is in line with that of Reid and Kang,<sup>7</sup> who advocate that the "victims be treated as such."

Finally, it is important to note that our survey pertains to threats and as-

saults against living psychiatrists. Any conclusions based on our data may not pertain to homicides which may be different from other types of assaults.

In summary, our survey of OPA psychiatrists indicates that incidents of threat and assault are probably inevitable in most psychiatric careers and that no types of patients, psychiatrists, or clinical settings should be considered to be immune from risk. Despite these troubling conclusions, through their own efforts and with the help of organized psychiatry, psychiatrists may well be able to prepare for these incidents and minimize their effects.

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