

# Women Clinicians and Patient Assaults

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**Although there has been an increased awareness of the problem of assaults against clinicians, this is the first report to specifically focus on issues related to women clinicians and patient assaults. The author discusses issues related to women's feelings of vulnerability and lack of authority. She describes special risks for women clinicians including sexual assaults, rape fantasies, and maternal transferences, which can lead to assaults, and vulnerability during pregnancy. In addition, the author discusses psychological reactions after assaults and makes recommendations for preventing assaults.**

Studies have shown that between 40 and 50 percent of psychiatrists will be assaulted by a patient during the course of their professional lives.<sup>1,2</sup> Although there are no large scale studies about the rate of assaults against women clinicians compared with men clinicians, most of the studies that have been done suggest that women are at least at an equally high risk as men for being assaulted.<sup>3-8</sup> As is the case with men, women are most vulnerable to assaults when working in psychiatric emergency rooms and in acute hospital settings,<sup>1,3</sup> although assaults also occur in outpatient settings.<sup>9,10</sup> Although both women and men clinicians are assaulted, there are some gender differences, including preg-

nancy, that may affect a clinician's subjective feelings of vulnerability, risk for the type and likelihood of assault, and reaction to having been assaulted. To my knowledge, this is the first article to specifically focus on issues related to women clinicians and patient assaults. Many of the examples in this paper have been drawn from reports made by women clinicians to the American Psychiatric Association Task Force on Clinician Safety, which has been collecting information about assaults against clinicians.

## **Women's Subjective Feelings of Vulnerability**

Many authors have noted that women, in general, feel vulnerable to being attacked by men because of men's greater physical size and strength. This has been true throughout history and in many different societies.<sup>11,12</sup> It is also true for women clinicians. One woman resident noted that she experienced a

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pervasive feeling of vulnerability when she was assigned to the Veterans Hospital. She was acutely aware that she was a woman and that nearly all of the patients were men.

Seiden<sup>13</sup> points out that women's feelings of vulnerability are reinforced from early childhood. She notes that families are more likely to chaperone little girls than little boys. She also notes that the fear of being raped affects the psychology of all women including those who have not been raped.<sup>13</sup> Many women are encouraged to take self-defense classes or at least be trained in the basics of personal safety.<sup>12, 14</sup>

In addition, some women psychiatrists have reported that patients have seen them as lacking authority. One woman resident reported to the Task Force on Clinician Safety that she was asked by the staff to intervene in an incident that occurred in the dayroom on an inpatient unit. Several patients were arguing and she told them to stop and return to their rooms. The patients ignored her. She stated that she finally had to call a male resident who went into the dayroom and said the same thing that the woman had said. The patients responded to the male resident's authority and dispersed to their bedrooms. One minority woman resident noted that this problem was even more difficult for her. She stated that one patient kept referring to her as a member of the housekeeping staff even though she wore her stethoscope, white coat, and name tag.

Levy and Harticollis<sup>15</sup> have pointed out that there are cultural expectations

related to masculine authority and that male personnel have traditionally been employed to contain aggressive patients by a show of muscular force. They reported that on an inpatient unit staffed only by women nurses, the nurses and also some patients felt vaguely anxious without the presence of men, especially during the night shift.<sup>15</sup> When women psychiatrists feel that their authority is not being respected, many feel even more vulnerable to being attacked by patients.

A woman clinician's feelings of vulnerability may be exacerbated during her pregnancy. As Nadelson *et al.*<sup>16</sup> point out, pregnant clinicians experience increased physical and emotional vulnerability. One woman psychiatrist reported that she ordinarily did not have concerns for her safety when working with patients. When she became pregnant, however, she felt concerns for her unborn child and felt that she needed to take extra security precautions.

### **Special Risks for Women Clinicians**

**Sexual Assault** Some women clinicians have reported being sexually assaulted. In one incident, a patient suddenly assaulted a group psychotherapist during an inpatient group. He rushed over to her and rubbed his hands up and down her body including fondling her breasts. The patient was quickly removed from the room and could not explain his behavior except to say that she was pretty. Chaimowitz and Moscovitch<sup>7</sup> stated that one of their res-

idents reported being sexually assaulted twice, although no details were given.

In addition, women may experience threats of sexual assault. For example, a woman psychiatrist who worked in a state hospital reported to the Task Force on Clinician Safety that she was threatened by a schizophrenic patient who insisted that he was ready to leave the hospital. When the doctor refused to discharge him, the patient said that he would rape and kill the doctor. Subsequently, the patient apologized to the doctor, but then the same scenario with the same threats occurred multiple times. The doctor stated that she was terrified and kept asking the clinical director to transfer the patient to another psychiatrist, and this was finally done.

**Rape Fantasies** In a tragic case, a patient developed a rape fantasy about a social worker who was his therapist. The social worker learned of this fantasy and discontinued the therapy. According to the court records, the patient felt betrayed and resolved to get revenge by making her suffer similar emotional anguish. He set fire to the social worker's house, which resulted in her husband's death and left her badly disfigured from severe burns.<sup>17</sup>

**Maternal Transference** Although both male and female clinicians may be attacked because of patient's misperceptions derived from transference feelings,<sup>1</sup> women may be more likely than men to have maternal transferences develop toward them, and these may lead to assaults. A maternal transference may evoke positive feelings from many patients but may also lead to hostile ag-

gressive feelings in certain situations. For example, a woman resident on an acute inpatient unit met with her schizophrenic patient and explained to him that she would be taking a one-week vacation. In his childhood, the patient had been temporarily abandoned by his mother and had been transferred back and forth between his mother and a series of foster homes as he grew up. He also had a history of assaulting his mother. As the resident explained her vacation plans to the patient, his face took on a strange and menacing appearance. When she asked him what was going on, he said, "I'm going to beat you up." The resident became quite frightened and said in a quiet, non-threatening voice, "Hey, remember me, I'm your friendly doctor. I'm not anyone else. I'm your doctor." The patient backed off temporarily and she fled the room. The patient had clearly seen her as his abandoning mother.

Another example of a frightening maternal transference was related by an older woman psychiatrist who had evaluated a patient before he was sent to state prison for stabbing his ex-wife. When in prison, he stated that he thought that the psychiatrist was his mother. He stated that he intended to live with her when he was released. The woman psychiatrist asked to be notified upon his release. She is understandably concerned about the aggressive potential of this patient who has a history of assaulting a relative who rejected him. She worries that the patient might try to assault her, and she plans to increase security precautions.

***Pregnancy as a Stimulus or Deterrent to Assault*** Both Lax<sup>18</sup> and Benedek<sup>19</sup> have noted that pregnancy may evoke in patients feelings of sibling rivalry, oedipal conflicts, envy, rejection, and abandonment. In addition, the therapist's pregnancy serves as an obvious reminder of her sexuality, and this may trigger many thoughts and fantasies in patients. Berman<sup>20</sup> compared the patients of nine women psychiatrists during a period in which the therapists were pregnant with a period in which the therapists were not pregnant. She found that during pregnancy, patients, especially those who were impulsive and borderline, were more likely to act out. Paluszny and Poznansky<sup>20</sup> describe several cases where patients became aggressive toward pregnant therapists. In one case, an 11-year-old was admitted to a hospital for repeated aggressive behavior. With treatment, his outbursts became less frequent. However, when it became obvious that his therapist was pregnant, his outbursts again became frequent. During one outburst, he hit a pregnant staff member. The authors commented on the fact that this boy had fears of abandonment and severe sibling rivalry. In a second case, they describe a 38-year-old woman with breast cancer who was treated by a woman therapist who became pregnant. As the pregnancy became noticeable, the patient showed tremendous anger and hostility. She saw the baby as new life and contrasted this with her own impending death. The authors describe a third case of a 21-year-old woman who was in therapy with a pregnant therapist for anxiety and

depression. The patient became angry in therapy and had the image of "twisting somebody's head off." She pictured the "somebody" as a child and thought that it might be her brother. In subsequent sessions, the patient felt angry at the therapist and had fantasies of killing both the therapist and the baby. She concluded that she must have felt the same way when her brother was born.<sup>21</sup>

There are also situations where pregnancy exerts a calming influence on patients. For example, a woman psychiatrist reported that when she was 9 months pregnant, she was doing an evaluation of a schizophrenic, agitated patient. The patient started to yell at the psychiatrist and then noted her obvious pregnancy. Immediately, the patient calmed down and apologized profusely to the psychiatrist. He hoped that he had not upset her and that his yelling had not harmed the baby.

***Psychological Reactions after an Assault*** The psychological effects of an assault on a clinician can be devastating. Both men and women clinicians can have psychological sequelae such as considering a change in career and developing the symptoms of posttraumatic stress disorder. For example, one woman resident reported that after she was assaulted, she had nightmares, intrusive images, and crying spells. She also had difficulty concentrating and was fearful of taking further nightcall. Women may be especially vulnerable to having an assault impact on their children. For example, one woman noted that her children were upset after she was assaulted. She said that even at the

present time her children ask her when she returns from work, "Are you okay? Did you get hurt today?" After an assault, women clinicians often experience similar reactions to rape victims.<sup>22</sup> They are sometimes embarrassed and have concerns that others may blame them, and may even blame themselves. If a woman clinician has been sexually assaulted in the past, the assault by a patient can bring up memories of the earlier assault.

### Recommendations

The following recommendations are made to lessen the number of attacks on women in clinical settings. Many of the recommendations also apply to men clinicians.

1. Since men and women clinicians are at risk for being attacked during and after their training, there should be required courses in violence prevention and management during professional training. The courses should include information about ensuring a safe environment in which to see patients, strategies to defuse potentially explosive situation, and self-defense techniques. Many women feel vulnerable and, in fact, can be easily overpowered by most men. Therefore, they may decide to take even more security precautions.

2. Clinicians should take a careful history of whether a patient has a history of violence. If the patient has a history of violence, the therapist needs to monitor factors that may lead to future violence, e.g., use of drugs or alcohol, and noncompliance with medications. If the patient has a history of aggression to

women, the woman clinician should be especially aware of the patient's violence potential. She needs to carefully monitor the transference to elucidate negative and aggressive feelings directed toward her.

3. If threats or hostile fantasies arise in treatment, the clinician should consider seeking consultation about how to manage the patient. When appropriate, patients can be transferred to other therapists or several other clinicians can intervene to try and dilute the transference. Other techniques such as limit setting should also be used.

4. A woman clinician needs to be especially cautious with patients who display boundary violations such as the new male patient who addresses her by her first name, telephones at odd hours, or is overly familiar or controlling. Limit setting should be used and evaluation should be done as to the meaning of these behaviors.

5. Women clinicians need to weigh the risks and benefits and make an informed decision about working in violence-prone settings, such as emergency rooms and acute inpatient units during their pregnancies. As suggested by Baum and Herring,<sup>23</sup> it is important for residency programs to be flexible in working out assignments for pregnant residents.

6. After an assault occurs, there should be a policy that immediate and follow-up counseling is offered to the victim. For residents, this can be offered through the residency training program. For practicing clinicians, this can be offered through medical staff committees or through professional societies. Gen-

der-specific issues, especially the fact that women may have similar reactions to rape victims and may have a history of being assaulted, need to be addressed in the counseling.

7. There needs to be ongoing monitoring of assaults against women and men clinicians at an institutional and national level. As more women are entering medical schools, more women are also entering psychiatric residency programs and are being exposed to potential violence by patients. Therefore, data that were gathered in the past about assaults against women clinicians may not be applicable to current practice. More information is needed about incidence, risk factors, psychological sequelae, and prevention of these assaults.

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