Threats Against Clinicians: A Preliminary Descriptive Classification

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Threats against psychiatrists are common, but existing studies on the subject lack descriptive information about the nature and resolution of the threat. In the present study, clinicians who had received threats were interviewed in person or by telephone, and case histories were summarized. Threats were classified as situational and transferential. Demographic factors, precipitating events, and legal actions taken are described. The manner in which clinicians reacted to threats is also discussed.

"No physician, however conscientious or careful, can tell what day or hour he may not be made the object of some undeserved attack, malicious accusation, blackmail, or suit for damages. . . ."[1] Since this observation was published in 1892, threats against clinicians remain ubiquitous. Yet the nature of the threats is the subject of limited research and of only few clinical studies. Miller,[2] surveying forensic psychiatrists who reported having been harassed, found that 42 percent of the sample had been threatened, while only 3 percent had actually been assaulted. Bernstein,[3] reporting on verbal threats made on mental health practitioners, found that 20 patients threatened a fight, 16 patients threatened to shoot with a gun, 7 patients threatened to assault with a knife, and 7 patients threatened assault with an office object. Faulkner,[4] analyzing threats on psychiatrists, found that 45 threats were written, 91 were verbal, 52 were delivered over the telephone, and 5 via a third person.

With the exception of Miller's[2] study of forensic psychiatrists, these studies lack descriptive information concerning the threats, thus making it difficult to understand how and in what context the

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threats occurred. These studies do not describe how patients' threats are managed and ultimately resolved. And finally, there is no classification system that allows a more systematic approach to the study and understanding of the threat situation. To address these issues, the authors undertook to examine in more detail threats that took place in clinical practice settings. Our current study describes 19 cases of threats against clinicians. Based on these cases, a preliminary classification of threats will be proposed.

Methods

Clinicians who were known to have been threatened in the past and who consented to discuss their experiences were interviewed by telephone or in person. For the purposes of this study, threats were defined as any hostile statement or action that fell short of physical contact with the clinician involved. The clinicians were identified in two ways: first, from workshops conducted by the American Psychiatric Association's Task Force on Clinician Safety at several annual meetings; and second, from private cases brought to the attention of the authors (J.R.L. and W.R.D.). Sixteen cases involved psychiatrists or psychiatric residents, two cases involved surgeons, and one case involved a clinical psychologist. All case histories are summarized in the appendices.

Results

Types of Threats We found that threats could be classified roughly into two types: the situational threat and the transferential threat, based on whether a therapeutic relationship existed between the patient and the clinician. Situational threats occurred in clinical situations in which the psychiatrist happened to be present either as an administrator, or as a clinician momentarily caring for the patient, in a setting such as a general psychiatric ward or an emergency room. While transference may play a role in the situational threat, the predominant characteristic is the denial of a wish by the clinician with the immediate response, a threat, by the patient. Examples of situational threats are presented in *Appendix I.* In contrast, transferential threats usually occurred during an ongoing psychotherapeutic relationship, most often in an outpatient setting. The patients appeared to react to their therapists as a function of the intimacy inherent in the treatment paradigm. Transference-related threats, in retrospect, generally appeared to evolve slowly and insidiously, even though there was often a precipitating event for the utterance of the actual threatening remark. Examples of transferential threats are presented in *Appendix II*

Demographics Table 1 describes the data for 10 threats of the situational type and 9 threats of the transferential type. The average age of the clinician is approximately the same in both categories. Residents appear to be equally likely to be the object of either category of threat.

Patient data for threats indicated a slightly older age of patient for the situational threat when compared with the transferential threat and a high predominance of male patients who became threatening. The diagnostic groups present for both types of threat are psy-

Table 1
Threat Overview Data

	Total Threats n = 19	Situational n = 10	Transferential n = 9
Average clinician age	40	40	39
Clinician male:female	11:8	7:3	4:5
Incident when resident	6	3	3
Prior training in aggression management	4	3	1
Threatened or assaulted on other occasion	9	4	5
Inpatient:outpatient	8:11	6:4	2:7
Average patient age	32	34	31
Patient male:female	15:4	9:1	6:3
Psychotic disorder	8	5	3
Personality disorder	7	3	4
Known substance abuse	5	5	0
Legal action taken or attempted	8	3	5
Precipitating event	16	10	6
Weapon used	2	0	2
Change in professional life	13	6	7
Change in personal life	5	0	5

chotic disorders and personality disorders, with substance abuse being present as a secondary diagnosis only in the inpatient subset of situational threats.

Precipitating Events A precipitating event was identified by the practitioner in all 10 of the situational threats and in 6 of the transferential threats. Each situational threat involved a precipitating event; these included refusal of discharge or admission, refusal to endorse a report of disability, suggesting the patient take a medication that the patient did not want, testifying that the patient was unable to manage his funds, and refusal to give a copy of the patient's records to her. Six of the nine transferential threats involved a specific precipitating event that included the therapist stating that she would be moving out of the state, the therapist falling asleep during a session, dissociative state of the patient, the patient's being discharged from a clinic against his wishes, the psychiatrist missing a therapy session, and too intense a closeness in the transference.

Weapons The only two cases in which a weapon was involved were both classified as transferential-type threats, and both involved guns. One of the cases involved firing a shot through the window of the clinician's house (case T3). The other case of a patient wielding a gun was in an outpatient clinic where the psychiatrist was held at gunpoint for seven minutes (case T8). Neither of the clinicians in

either of these cases was injured. In the one case in which a clinician was hurt, the threats escalated into an assault when the patient pushed and hit the clinician (case S7).

Legal Action Legal action (filing formal charges) was taken or attempted following five of the transferential threats and three of the situational threats. In two of these cases, either police or attorneys indicated to the clinician that there was insufficient evidence to file charges, although the clinician expressed interest in doing so. In another case, the state's attorney had a threatening patient in a state hospital moved to another unit after state hospital staff refused to do so. The difficulty of seeking prosecution was mentioned by several clinicians.

In ongoing threats, involvement of the legal system did not provide the relief that the clinicians had expected. In one of these cases, the patient was informed by the Federal Bureau of Investigation (FBI) that it was illegal to write threatening letters. After receiving this warning, the patient began to write threats on the outside of the envelope, which were then considered too vague for prosecution. In another case, the patient was given probation because of a mental health history, which upset the clinician, who felt that for her safety the patient should have been incarcerated. In another case, the clinician was shocked to be told by police and the FBI that she was unreliable and must be fabricating at least some aspects of the incident.

Life Changes A total of 14 clinicians made changes in their professional or personal lives after being threatened by a patient. The changes reported for situational threats included taking a more thorough history of violent behavior, refusing to do future disability evaluations, carrying a portable alarm during interviews, having security provide an escort to the car while on hospital grounds, attempting to be less confrontational in therapy, and generally being more cautious. Changes reported after transferential threats included keeping more therapeutic distance, reducing the number of therapy patients, having alarm systems installed in the office, hiring an answering service to take phone calls, learning techniques to adequately intervene with violent patients, performing a more thorough assessment of the patient's potential for violence, carrying mace, changing the phone number to an unlisted number, requesting police patrol of the neighborhood, and hiring a detective. This type of threat created intense family stress for the clinicians, some of whom felt they had "failed" their families, and added restrictions on family activities because of increased security measures.

Content of Threat Table 2 examines details surrounding each threat. The means of communicating the threat included direct verbal communication, telephone calls, physical action or agitation, letters, and verbal communication by means of a third party. The content of the threats included death, assault, sexual assault, defamation, harm to the clinician's family members, and revenge. Whereas threats of death and assault are most common in both categories of threat, threats of revenge, harm to family members and

Table 2
Threat Details

	Total	Situational	Transferential
Means of communicating threat			
Verbal	7	5	2
Phone calls	4	1	3
Physical action	6	3	3
Letters	5	0	5
Via third party	1	0	1
Content of verbal threat			
Death	9	5	4
Assault	5	2	3
Sexual assault	2	1	1
Defamation	2	0	2
Harm family	1	0	1
Revenge	1	0	1
Resolution			
Resolved threats	16	10	6
Unresolved threats	3	0	3
Resolved threats: means of resolution			
Patient actually assaulted clinician	1	1	0
Patient made no further contact	2	1	1
Legal action	4	2	2
Administrative/security discharge	3	3	0
Hospitalization/medication	2	1	1
Confrontation in therapy	1	0	1
Doctor removed self from setting	2	2	0
Gave patient more control in interview	1	1	0
Unresolved threats: attempted means of resolution			
Legal action	3		
Moved to new location	3[a]		
Security systems	2		
Patient referred to other provider	3[a]		

[a] In one case this was the precipitating factor.

defamation were limited to the transferential type threat.

Resolution of Threats The majority (16) of the threats eventually ceased, 10 of these being situational and 6 transferential. All three unresolved threats (cases T2, T3, and T9) are of the transferential type. In the cases of unresolved threats, all three clinicians moved to new houses, referred the patient to another provider, and took legal action against the patient, all to no avail.

Discussion

Types of Threats We have divided threats into two categories: situational and transferential. In a situational threat, patients are responding to the denial of a wish, the precipitant is readily identified, and the threat is usually resolved with immediate intervention. In contrast, a transferential threat occurs against a clinician who is actively involved in the treatment and may result from a distorted transference. While situational threats

usually occur in a hospital or emergency department setting, the transferential threat usually occurs in an outpatient setting. In the situational threat, the clinician is usually treating the patient only for the circumscribed time that he or she is in the hospital setting. Most of the transference threats occurred against a psychiatrist who was involved in ongoing psychotherapy with the patient.

Transferential threats were much more disruptive to psychiatrists' personal lives and had a direct impact on their families. The transferential threats seemed to be more protracted and difficult to resolve and were the only category of threats that remained unresolved. Yet while these threats were disruptive, intrusive, and frightening to the psychiatrist, no one was actually injured in this threat category.

Management of Threats A major impediment to the successful management of threats appears to be the psychological defense of denial. The clinicians who were the victims in those cases that were chronic and lasted for years exhibited emotions ranging from persistent anxiety to detachment and indifference. In the latter instance, denial seemed to play a large role and enabled the therapists to ignore the threat and continue their work. Dubin[5] found that of 59 percent of the psychiatrists who continued to see a patient who had assaulted them, 21 percent did not discuss the attack with the patient. The negative effect of such denial on the potential escalation of violence has been described by both Lion[6] and the American Psychiatric Association's Task Force on Clinician Safety.[7] We were surprised by not only the chronicity of some of the threats that came to our attention, but also by their intensity and dangerousness.

The resolution of threats requires that the clinician acknowledge the threat and then consider appropriate action. As such, threats represent urgent pleas for attention on the part of the patient; unheeded, such statements may increase in intensity. Confrontation of the threatener is usually necessary. Statements such as "you're scaring me with your threats" can, if appropriate, defuse a dangerous situation. The setting of firm limits in an outpatient setting has been described by Billowitz[8] as important in resolving a transference-related threat, and the use of multiple staff to dilute a dangerous transference has been described by Richmond.[9]

Situational threats resolve quickly once the situation has changed (commitment completed, patient discharged, patient transferred to another service, medication given) through clinical intervention. Suggestions for reducing this type of threat are to use a calm interpersonal style to reduce the chance that patients will respond to external cues such as tone of voice; involve the treatment team in informing patients of decisions likely to be seen as refusals, to dilute the threat among many staff; and give patients as much control over their situation as possible, so that they will not find a threat (or assault) the only means of reasserting their power.

Transferential threats may take a long time to resolve because of the intense emotions engendered by the therapeutic process. Due to the possible difficulty of resolving this type of threat, it is important that transference be monitored

closely. The difficulties of monitoring transference and countertransference are described elsewhere.[10, 11] In instances in which threats do not recede with time and intervention, termination of treatment and even prosecution may be necessary.[6, 7]

The small number of cases in this report make our proposed classification highly preliminary. As our database of threat events increases, we hope to be able to determine whether the two currently proposed categories are adequate and accurate.

The prevention of threats and assaults remains problematic in clinical practice. The American Psychiatric Association Task Force Report on Clinician Safety[7] has reviewed some steps therapists can take to make the workplace safer, and other authors have suggested such interventions as prosecution[12–14] to preserve a therapeutic mileu. Health-care work safety is becoming increasingly recognized as important.[15] The classification and understanding of threats and assaults is a step toward controlling the dangers of hospital and outpatient work.

Appendix I. Situational Threats

S1. A 26-year-old male diagnosed with schizophrenia felt that he was ready to leave the hospital. When his treating psychiatrist explained that she did not think that he was ready for discharge, he threatened to rape and kill her. Later the patient apologized, but this pattern of threat and apology was repeated over several months. The doctor initially ascribed the threatening behavior to psychosis and believed it would resolve after medication therapy. When it became clear that the threats were going to continue, the patient was transferred to another service, and the physician received no further threats from the patient.

S2. A 25-year-old male with a diagnosis of borderline and antisocial personality and a history of alcoholism was not improving on medication. After he was refused discharge by the treating resident psychiatrist, he contained his anger until he was off the unit and then threw a ceramic object at another patient. After being escorted to the seclusion room by staff members, he yelled at the psychiatrist "I'm going to kill you, bitch." The attending psychiatrist decided to discharge the patient because the patient repeated his threats the next day. The patient was escorted out of the hospital by security personnel and was placed on the hospital's "do not admit" list. He has had no contact with either doctor since discharge, although it is believed he may have called the nursing station occasionally.

S3. A 50-year-old male with a history of bipolar disorder and cocaine and alcohol abuse was uncooperative with the evaluation in the medical emergency room. A psychiatric consultation was obtained on this patient, who was well known to the psychiatric emergency service. When the psychiatrist noticed alcohol on the patient's breath, she told the patient to leave, as per the treatment contract that had been previously established with this patient. The patient exploded and stated "It's your life lady, and it's over." Security personnel were called to escort the patient out of the hospital. Charges were filed against the patient for "terroristic threatening," and he is no longer allowed on the grounds of that hospital. There were no further threats from this patient.

S4. A 36-year-old male with a diagnosis of antisocial personality, alcohol dependence, and explosive personality disorder called his inpatient treating psychiatrist and threatened to kill him after the patient was discharged from the hospital at the patient's request. The threat resolved spontaneously, since the patient never contacted the clinician again.

S5. A male in his mid-thirties was diagnosed as malingering by the neurosurgeon who was evaluating him for a disability claim. After learning that disability had been denied, the patient came to the office demanding to see the clinician, threatening to kill him. The doctor left the office by a rear exit. After being told that the doctor was not in the office, the patient walked out and never returned to the office or threatened this clinician again.

S6. A 28-year-old male with a diagnosis of schizophrenia agreed to be interviewed in front of a class of medical students. He responded to the

senior psychiatrist's question of what had happened to his mother prior to his admission with "do you want me to punch you in the face?" The clinician gave more control by stating that he did not want to be hit and then by asking what the patient would like to talk about. The interview proceeded uneventfully, and the patient was returned to the inpatient unit and made no further threats.

S7. A 17-year-old female diagnosed with borderline personality disorder and rage attacks physically threatened her psychiatrist during the second medication evaluation visit after he refused to give her her medical records. When they proceeded to the director's office to discuss her complaint, she blocked the exit from the room with her person for both him and the clinic director. She bit the director and pushed the clinician, mildly injuring his elbow. The director called the police, who arrived and restrained the patient within minutes. Legal charges were brought against the patient; although a conviction was not obtained, the judge ordered that the patient never return to that psychiatric clinic again.

S8. A 47-year-old male diagnosed with schizophrenia threatened a psychiatrist who offered him medication. He stated that he didn't need medication and shook his fist at the clinician. The patient's wife, who was in the office, held the patient away from the clinician and took a prescription for the patient. The patient was hospitalized the next day and later apologized to the clinician.

S9. A male in his mid-forties with a diagnosis of alcoholism threatened to assault the psychiatrist after being refused admission to the hospital. Security personnel removed the patient from the hospital grounds, and the patient made no further contact with the doctor.

S10. The patient was a 44-year-old male with a diagnosis of schizophrenia. The patient was not scheduled to see the psychiatrist, but one month after the psychiatrist testified in a court hearing that the patient was unable to handle financial affairs, the patient destroyed the psychiatrist's office, breaking windows and bookcases. The psychiatrist was in the next room and heard his office being destroyed. Police were called to restrain the patient, who was later involuntarily committed to the hospital. Legal charges were filed, but district attorneys stated that they were too busy to prosecute a "misconduct" case such as this. The hospital arranged for the patient to receive care in another facility. There was no further contact with the patient.

Appendix II. Transferential Threats

T1. A male in his thirties with a diagnosis of borderline personality disorder was in therapy for over a year. During a psychotherapy session, the psychiatrist fell asleep, after which the patient angrily left the office. The psychiatrist invited the patient back to discuss what had happened. After the discussion, the psychiatrist apologized. The patient responded by smashing a clock on the floor. The psychiatrist indicated that in order to continue treatment the patient would have to talk about his feelings and not act on them. The patient agreed, but at the next session brought cans of black paint and began opening them and throwing them at the office furnishings. The patient was involuntarily committed, during which time he left messages on the psychiatrist's answering machine stating that he would "get him," and sent letters saying "kill." A restraining order was delivered to the patient by the police and after three months all threats stopped. This clinician had no further contact with this patient.

T2. A 38-year-old bisexual female with a diagnosis of depression and borderline personality had been in therapy with the psychiatrist for several years. This patient had been refused treatment by many other psychiatrists in the community, and her initial question to this doctor was "will you always be my doctor?" After the doctor notified her that she would be moving to another part of the country, the patient began threatening the doctor with letters, telephone calls, and photographs of targets. These events occurred even after the psychiatrist moved. The patient would come to the doctor's house and leave paint on the driveway and around the house. The patient took legal courses after the psychiatrist moved and then filed a suit against the psychiatrist and sent allegations of ethical violations to the state medical board, in addition to writing letters to the doctor and her husband's new office colleagues claiming they had HIV. The patient also threatened to hurt the psychiatrist's children, and threatened to car-bomb the psychiatrist. Although the frequency of the threats has declined over the past four years, the threats do continue. Legal recourse has been unsatisfactory, because the doctor says the police and the FBI stated to her that she was making up the

incident after a two-year investigation. The psychiatrist states that she copes with the situation by giving up hope that it will ever end, and by "putting it in the background."

T3. An 18-year-old male on an inpatient unit was being treated for schizophrenia while the psychiatrist was in her residency. The patient's condition improved while he was on medication in the hospital, and he was discharged. Later, the doctor began receiving love letters from the patient, which she ignored until he broke into her car and stole her hairbrush. At this point she involved the legal system, at the demand of her department chairman, and sent copies of all of the patient's letters to the patient, his parents, and her lawyer. A year later, she began receiving telephone calls and letters of a threatening nature, which she attributes to the patient's response to the legal action. The letters stated that he would "pull out all of the hairs on your body and cut your genitals with glass." When the psychiatrist moved, the patient moved to a house within a mile of her residence, and threats have continued intermittently over the telephone. In 1993, he fired bullets into her front window, and neighbors reported that he was seen snooping around her house. The psychiatrist reinvolved the law, who gave the patient probation and a restraining order for two years. During this time she attempted to petition for mental health treatment but was told that she could not petition for the same behavior that was in the criminal charge. She continues to receive hang-up calls which she is sure are from this patient. This threat has been ongoing for 22 years.

T4. A 28-year-old male with a diagnosis of personality disorder, possible bipolar disorder, and a history of cocaine abuse threatened to kill his psychiatrist after the psychiatrist missed one inpatient therapy session. The patient had been involved in intensive daily psychotherapy and had related personal bisexual fantasies of killing homosexual lovers. He indicated that she reminded him of his mother and that he trusted her. The threat, which was communicated to the psychiatrist by the nursing staff, later involved stalking the psychiatrist on hospital grounds. The patient stated to nursing staff that he would strangle the doctor and watch her die. The hospital administration initially refused to transfer the patient, even after the psychiatrist requested the transfer. Finally the threat resolved after the psychiatrist notified the state's attorney, who had the patient immediately moved to another unit.

T5. A 46-year-old female with a diagnosis of multiple personality disorder threatened her psychologist only when she was in the personality of a 13-year-old boy. The threat was confronted in therapy, with the therapist stating that no one has to die and that both of them could be safe in therapy. The frequency of this occurrence has lessened, and the clinician believes that the risk of danger is low because of the clinical situation in which the only threatening words are from this one personality of the patient, who presents as a frightened child.

T6. A 24-year-old male diagnosed with schizophrenia, after six months of outpatient treatment in a college mental health clinic, told the psychiatrist "time will stop for you." There was no precipitant to this statement, but the psychiatrist reported that the patient had made vague verbal threats previously, which had not been addressed by the psychiatrist. The patient then stole the doctor's watch and coat. At the next appointment, the doctor met the patient in the waiting room and told the patient that he was being transferred to another therapist, but did not confront the threat. The patient never returned to the clinic and never threatened the clinician again.

T7. A 17-year-old female diagnosed with major depression and borderline personality had been seen by the psychiatrist for four years. Ten years after treatment ended, the psychiatrist began receiving death threats by telephone and by letter. Police were involved, and the patient agreed to be evaluated and then was admitted for inpatient care. She was started on medications and at discharge was told that if there was further threatening behavior that criminal charges would be pressed. Threats have ceased, although there are occasional curse words on the psychiatrist's answering machine, but this happens with a declining frequency.

T8. A male in his mid-thirties, who had a diagnosis of schizophrenia and was in outpatient treatment, held his psychiatrist at gunpoint for seven minutes. The psychiatrist continued to see the patient for a year after this incident, and described retrospectively thinking that the therapeutic relationship with this patient had become too intense. No further details are available.

T9. The patient was a 30-year-old male with no formal psychiatric diagnosis who was seeing a resident plastic surgeon in the clinic to be evalu-

ated for a rhinoplasty. He had a history of stalking behavior and threatening with a gun, which was not known until after the incident. After multiple elective rhinoplasties, the patient became violent in the clinic and was removed and told to never return. This surgeon had completed the residency and had moved to another state, but she had been the resident surgeon on his first rhinoplasty. The patient found her through the unwitting participation of her residency department and began to write letters calling her a "butcher," and stating that "you won't be able to operate again." She notified the police, the FBI, and the postal authorities, who told the patient that it was unlawful to write threatening letters. The patient continued to write threats on the outside of envelopes. The doctor was informed that since it wasn't a letter, there was no way to press charges. The threats continue, but at a lessened frequency.

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