

Assaults Against Psychiatrists and Other Mental Health Professionals

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A few weeks ago, I was interviewed for an article on attacks on mental health professionals by psychiatric patients. That prompted some reconsideration of a topic colleagues and I studied many years ago, and the realization that it needs an update. Here are some thoughts about this important and often misunderstood subject.

Note that most of the comments below are aimed at protecting psychiatrists and other clinicians, helping them to avoid assault and minimize their risk of injury. This is not a discussion of how to decrease patients' violent impulses or treat the causes of their assaultive behavior. It's about making you generally aware of risk and keeping you safe.

What's the Risk?

Fatal or otherwise severe attacks on clinicians such as psychiatrists and psychologists are rare. The comments below are not meant to imply that very many psychiatric patients are "violent" or "dangerous." On the other hand, most mental health professionals deal with hundreds of patients (at least) every year, and thousands over a career. There are many serious attacks and a few fatalities each year, by a small minority of the several million psychiatric patients in North America, on a small minority of over 60,000 psychiatrists and hundreds of thousands of psychologists, therapists, and counselors in the United States, Canada, and Mexico.

These assaults happen in a variety of settings and contexts, from hospitals, to offices, to clinicians' homes, to public places. It is tempting to focus on emergency rooms and acute or "intensive care" psychiatric units, and these are indeed sites of increased risk. On the other hand, clinicians and other mental health staff tend not to be injured when they are aware of risk and take logical steps to decrease it. Staff on units for extremely violent patients and for patients with histories of severe assault are usually well versed in safety procedures; the physical setting is also designed to prevent problems.

The process of controlling and restraining agitated patients (for example, subduing them to prevent injury to others and transporting them to a seclusion area) was formerly associated with a markedly increased risk of injury to both staff and patient. The progress made in

safe, effective, and humane physical management of on-unit agitation is one of the success stories of inpatient psychiatric care; training for proper decision-making and action in such situations is now routine in inpatient mental health facilities in the United States and Canada.

Some of the greatest risk to clinicians lies in situations in which potential danger goes unrecognized or is not clinically intuitive. Child psychiatrists and child psychologists, for example, who become involved in child custody or child protection matters should understand that this is one of the most volatile areas of both the law and the mental health professions. Other examples, and a few suggestions, are discussed below.

The "reasons" for attacks by psychiatric patients vary, but there is often no logical rationale. For example, the act may occur in a context of psychosis. Even then, it may be goal-directed but outside reality-based thinking (e.g., the result of a paranoid delusion or hallucination), or a result of general anger or irritability. A clinician may be caught in a flurry of generic patient agitation, as is sometimes seen in dementia or as a result of brain injury or other causes. He or she may be severely injured in an assault meant for someone else. The violence may come from a paranoid but otherwise nonpsychotic patient, such as one with a delusional disorder. The violent behavior may simply arise from characterologic factors, such as antisocial or paranoid personality disorders and traits. Posttraumatic dissociative states may arise in a few patients with posttraumatic syndromes, particularly those associated with military combat. Violence can also occur as part of self-destructive behavior by patients, in which the aim (rational or not) is suicide, but in the course of which others are also placed in danger.

Substance abuse is a common correlate of assault. Impulse control is routinely altered in intoxicated patients, with subsequent danger of specifically directed attacks at one end of the spectrum or wild, undirected

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delirium at the other. Some withdrawal syndromes create a potential for direct attack or general agitation. Substance abuse disorders are also associated with precipitation or kindling of Axis I symptoms, such as mania, which may render the patient psychotic or otherwise unpredictable or prone to assault.

Of course, the reason a victim is a target of assaultive behavior may not be related to the fact that the assailant has a psychiatric disorder. Many assailants, of many kinds, have psychiatric disorders, and many of these individuals are, coincidentally, patients of some mental health professional and/or clinic. This column does not consider general dangers such as that of being mugged by a drug-seeking criminal or being shot in a robbery by someone who also happens to meet criteria for a DSM disorder. My comments here are limited to situations in which there is (or has been) a clinician-patient relationship of some kind, or in which the clinician-victim has some association with the assailant's care (such as being a staff member of a clinic in which he or she is being, or has been, treated).

As in other parts of life, some injuries and fatalities are reasonably preventable, and some are not. Being alert to risk and mitigating it is the point—such alertness and mitigating behavior are often unrelated to our “clinical” skills and experience. Please remember that your clinical experience and ability to assess patients psychiatrically are very often irrelevant to keeping you safe, and may even interfere with your safety (see below).

What Can You Do About It?

- First, *do not assume you will always “know” when a patient is about to assault you, or what patient is more likely than others to vandalize, attack from hiding, or stalk or harm you or your family.* Sometimes the risk is obvious, but psychiatrists and psychotherapists often overestimate their safety.
- Remember that psychiatrists and other mental health professionals are not particularly good at “predicting” who will assault in the immediate future, when it will occur, or what form it will take (though we are fairly good at assessing risk and the need for caution). We cannot read minds any better than other professionals, especially when the patient is unfamiliar or unstable. *Do not think that your psychiatric or psychological training gives you a particular advantage in recognizing and dealing with danger from patients, unless your training focused particularly on that topic.* Even then, that training probably high-
- lighted general caution as well as recognition of specific dangers.
- *Do not allow yourself to be placed in a very vulnerable position with patients, particularly those who are psychotic, have histories of violence, are intoxicated, are delirious or demented, are unstable, or with whom you are unfamiliar.* Many assaults happen when an unsuspecting clinician tries to examine an unfamiliar, intoxicated, and/or psychotic patient in a closed room, in a room far from other people (such as well away from a nursing station or waiting area), in an emergency room cubicle, and/or in an empty or sparsely staffed after-hours clinic. Do not accommodate a patient's request for absolute privacy unless you are reasonably sure it is safe to do so (and keep in mind the cautions in the two preceding paragraphs).
- *Do not hesitate to demand a chaperone* if there is any indication—even a subtle or subjective one—that the setting is unsafe.
- *Do not try to “talk down” an agitated patient without adequate physical safety precautions.* Psychiatrists and psychologists make lousy negotiators with agitated, threatening, or intoxicated people. (Well-trained policemen do a much better job, and know how to protect themselves and the patient/threatener.)
- *Don't give personal information to patients or see patients in your home.* It is true that many patients can locate you if they try, but why increase that number or make it easy? Do not share intimate information or personal facts such as descriptions of your spouse or children. A surprising number of stalkings and injuries are prompted by patients' delusional or other potentially violent thinking after a clinician has mentioned a pregnant wife, shared a “part of himself/herself to help the patient identify,” or done something similar. Do not use personal information about yourself, your family, or your life as a means of developing the doctor-patient alliance or making the patient feel comfortable.
- *Do not think that you can adequately defend yourself alone.* Many clinicians are injured because they thought they could deal with an uncomfortable or dangerous situation without help. This includes physical help (such as security staff or a chaperone) and consultative or supervisory help (such as discussing patients with an experienced colleague, or allowing an experienced colleague to point out the inadvisability of, for example, seeing an antisocial patient alone).
- *Be aware of vulnerability related to your gender, age, and size, but don't think women and older or smaller clinicians are the only vulnerable ones.* Women and

older clinicians are more vulnerable overall, but even big, strong, young males can be severely injured or killed by psychotic or intoxicated patients, by patients who attack suddenly or from hiding, or by patients who wield weapons.

Are Certain Patients More Likely to Commit Violent Acts?

Even the most experienced clinician can't identify all, or perhaps even most, dangerous patients. Obviously high risk is not so much a problem as are unpredictable, unstable, and/or unfamiliar situations or patients. It is important that psychiatrists, psychologists, and other therapists and counselors not depend solely on their ability to recognize danger (and certainly not on their "intuition") to protect themselves or others.

Recognizing risk factors is a good thing—although efforts to recognize them should not be considered reliable enough to form the only protection a clinician needs in individual situations. Nevertheless, clinicians should be aware of the following general risk factors.

Ordinary generic risk factors for patient violence, which can be very useful for placing patients into rough groups of low, moderate, high, or very high risk. Some of those factors are alluded to above; more complete lists are widely available in the professional literature.

Interpersonal risk factors associated with the relationship between the clinician and the patient, particularly when the relationship is necessarily emotionally intense (such as an ongoing therapeutic relationship) or has particular psychological meaning to the patient (such as the erroneous but strong attachment or other meaning that borderline or paranoid patients often infer after even brief clinical interactions).

Risk associated with a particular (or perceived) role of the clinician, for example, when the clinician serves as an evaluator for child custody, employment, lawsuit damages, or a license of some sort, or assumes a role that may cause the patient to view the clinician as a persecutor, such as in some civil commitments or ordering involuntary medication.

Idiosyncratic risk, which may involve any of the above, such as a particularly personalized psychological meaning that the patient attributes to some aspect of the clinical relationship or to the clinician or his or her family; some topic related to a delusion or other disorganized thinking; or some topic related to the current treatment (e.g., a psychologically sensitive or negatively perceived clinical observation made by the clinician in the course of psychotherapy). Many of these are fairly unpredictable and unrecognizable (see "You can't read minds," above), and may come to a head either during or outside the appointment or therapy session.

The Last Word

If you have been assaulted, get experienced counseling. Clinicians, especially psychotherapists, who are severely assaulted have a number of often confusing reactions, including guilt about their behavior, guilt about their professional adequacy, guilt about what happens to the patient, anger (both visceral and counter-transferential), professional difficulties (short- or long-term), adaptation to injuries or disabilities, ambivalence about immediate post-assault behavior, ambivalence about later post-assault behavior (including law enforcement or legal involvement), and many other issues. Clinicians will almost always be much better able to recognize and deal with these reactions if they obtain competent professional help.