[REVIEW]

Violence Against Mental Health Professionals: When the Treater Becomes the Victim

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ABSTRACT

Violence toward mental health staff has been receiving national attention in the face of diminishing resources to treat what appears to be an increasingly violent patient population. Assaults by psychiatric patients against mental health care providers are both a reality and a concern, as the effects of violence can be devastating to the victim. Some staff rationalize that violence is an occupational hazard and believe that they are equipped to cope with it. Despite these beliefs, these victims suffer from many of the same physical and psychological sequelae as victims of a natural disaster or street crime. This review of literature will examine several studies dealing with the precipitants of violence in the mental health setting, the patient populations more likely to become violent and the mental healthcare staff at the greatest risk of becoming their victims. It will also discuss possible methods of preventing such acts of violence and techniques for both staff and patients to cope with violent behavior.

INTRODUCTION

On September 3, 2006, Wayne Fenton, a prominent schizophrenia expert, was found dead in his office as a result of a tragic assault by his 19-year-old patient with schizophrenia. This incident raised the controversial debate regarding the potential danger posed by people with mental illness, and also caused many in the mental health community to be concerned about their own safety in dealing with patients with psychoses.[1] Assaults by psychiatric patients against mental healthcare providers are both a reality and concern, as the effects of violence can be devastating to the victim. Some staff members rationalize that violence is an occupational hazard and believe that they are equipped to cope with it. Despite these beliefs, victims of violence by patients suffer from many of the same physical and psychological sequelae as victims of a natural disaster or street crime.[2]

According to the United States Department of Justice's National Crime Victimization Survey conducted from 1993 to 1999, the annual rate of nonfatal, job-related violent crime was 12.6 per 1,000 workers in all occupations. Among physicians, the rate was 16.2 per 1,000, and among nurses, 21.9 per 1,000. However, for psychiatrists and

mental healthcare professionals, the rate was 68.2 per 1,000, and for mental health custodial workers, 69 per 1,000.[1] And it appears that these events may happen early in one's career, as the literature suggests that 40 to 50 percent of psychiatry residents will be physically attacked by a patient during their four-year training program.[3]

Violence toward mental health staff has been receiving national attention in the face of diminishing resources to treat an increasingly violent patient population.[4] It is important to recognize that violence involves complex behaviors related to clinical as well as social components.[5] This review of literature will examine several studies dealing with the precipitants of violence in the mental health setting, the patient populations most likely to become violent, and the mental healthcare staff at the greatest risk of becoming their victims. We will also discuss possible methods of preventing such acts of violence and techniques for both staff and patients to cope with violent behavior.

PATIENT POPULATION

Several studies have attempted to determine which psychiatric population is at the greatest risk of committing violent acts. Violence can be affected by severe mental illness, age, and gender. It is important to note that there is no generally accepted definition of violence.[6] Some studies include verbal abuse or threatening behavior in a definition of violence, while others refer to damage to property and self harm. Some investigators were concerned with physical attacks against peers while others limited their interest to attacks on staff. Characteristics of the studies varied with size of facility, specialization of facility, and patient population served.[6]

Severe mental illness. A number of studies have examined the correlation between severe mental illness and violence, and the results were conflicting. In their Epidemiologic Catchment Area (ECA) study, the National Institute of Mental Health (NIMH) examined the rates of various psychiatric disorders in a representative sample of 17,803 subjects in five United States communities. They found that patients with serious mental illness (e.g., schizophrenia, major depression, or bipolar disorder) were 2 to 3 times as likely as people without such illness to be assaultive.[7] By contrast, in an article published in the *New England Journal of Medicine*, Friedman commented:

"Because serious mental illness is quite rare, it actually contributes very little to the overall rate of violence in the general population; the attributable risk has been estimated to be 3 to 5 percent,[8] much lower than that associated with substance abuse, for example. (People with no mental disorder who abuse alcohol or drugs are nearly seven times as likely as those without substance abuse to report violent behavior). Thus, violence in people with serious mental illness probably results from multiple risk factors in several domains."[1]

Although there is a relatively small percentage of psychiatric patients who are violent, evidence from a number of studies indicates that certain subgroups of psychiatric patients, including patients who abuse substance, have psychoses, and are nonadherent to treatment, are at a greater-than-normal risk of being violent.[9]

A study by Tardiff et al[9] examined rates of violence perpetrated by patients with mental illness prior to admission, the types of patients at greater risk of acting violently, and the nature of the violent episodes. They found that 14 percent of patients admitted to the hospital had been violent toward other persons in the month before admission. Data from Faulkner et al[10] was congruent with these findings. Their study was conducted following the tragic deaths of two psychiatrists from Oregon caused by psychiatric patients in 1985. In an attempt to address this issue, the Oregon Psychiatric Association (OPA) established an *ad-hoc* committee to review available literature pertaining to the threats and assaults against psychiatrists. They developed and distributed questionnaires to psychiatrists in the OPA concerning their experiences with threats and assaults. One particular survey of 115 psychiatrists revealed that 72 percent of assaultive patients had schizophrenia or another psychotic disorder.[10] Furthermore, Rueve and Welton[3] showed that patients who reported more than three psychiatric diagnoses were 2 to 4.5 times more likely to also report violent behaviors when compared to participants who reported only one diagnosis.[3] Several other surveys also revealed patients with multiple diagnoses to be at greatest risk of violent behavior.

Gender differences. In society, men are more physically aggressive than women on numerous measures of aggression, including arrests for homicide and violent crimes.[11] In the United States, man have perpetrated most of the interpersonal violent crimes; men comprise 90 percent of individuals convicted of murder and 82 percent convicted of other violent crimes.[12] Several studies, however, have suggested that psychiatric disorders reduce the gender difference, and in some cases eliminate it all together.[11] Tardiff et al[9] found that female patients were just as likely as male patients to have been violent, and the characteristics of the violent attacks were the same for the two genders. Violence was often directed at family members in private residences, and while weapons were used infrequently, over one-third of the attacks resulted in physical injuries.[9]

Krakowski and Czobor[11] investigated the relationship between violence and positive psychotic symptoms, and found that it was equal in men and women. However, they further hypothesized that in women, a transient flare up in physical violence may be indicative of high arousal and excitation associated with acute psychotic symptoms. In men, acute symptoms play a lesser role in the emergence

TABLE 1. Risk factors for violence

STATIC—factors that are unable to be altered	DYNAMIC—factors that may be changed to improve the outcome
• A previous history of violence • Male gender • Young adulthood • Lower intelligence • History of head trauma • History of military service • Weapons training • Past diagnoses of major mental illnesses	• Substance use • Current symptoms of major mental illness Persecutory delusions Command hallucinations Depression Hopelessness Suicidality • Treatment nonadherence • Impulsivity • Access to weapons

of violence, but psychotic symptoms may enhance more chronic predispositions to violence that reflect in part antisocial tendencies.[11]

Age. Age may also change the pattern of violence exhibited by patients with psychoses. James et al[6] compared violent and nonviolent patients on a 60-bed, acute, psychiatric ward over a 15-month period. They found that younger patients (25 years or younger) were more likely to be violent than older patients. In a survey of 115 psychiatrists, Faulkner et al[10] found that 68 percent of the assaultive patients were 30 years old or younger. Additionally, they reported that younger patients were more frequently responsible for multiple violent incidents. Although this confirms the findings of other studies, the reason for this age difference is not clear. In 1979, Tardiff[9] suggested that differences in the incidence of disorders between age groups may be a particularly important factor in schizophrenia, personality disorders, and drug abuse, in which acute symptoms are more commonly experienced by the young.[6]

While multiple studies examine various aspects of violent behavior, there are a few commonalities appearing throughout these articles, namely being young and also having a psychotic disorder, that increase the likelihood of violence.

RISK FACTORS FOR VIOLENCE

Risk factors for violence are divided into the following two categories: 1) static and 2) dynamic (Table 1). A static risk factor is defined as a patient characteristic that cannot be changed with clinical intervention. This includes demographic information, psychiatric diagnoses, and prior history. The most consistently affirmed static variable associated with the prediction of future violence is a history of past violence. The risk of future violence increases linearly with the number of past violent events.[3] A history of impulsivity is also related to the potential for violence. Other specific static risk factors include male gender, young adulthood, lower intelligence, history of head trauma or neurological impairment, dissociative states, history of military service, weapons training, and diagnoses of major mental illness.[3] Major mental illnesses are a static risk factor, but active symptoms may be more exact predictors of violence risk and are considered dynamic variables.[3]

Dynamic risk factors are variables in a patient's presentation that can potentially be improved with clinical intervention. The most frequently reported dynamic risk factor is substance abuse or dependence. Other important dynamic risk factors include persecutory delusions, command hallucinations, treatment nonadherence, impulsivity, low Global Assessment of Functioning (GAF) score, homicidality, depression, hopelessness, suicidality, feasibility of homicidal plan, access to weapons, and recent movement of weapons from storage.[3] When assessing risk it is important to address the following issues: the patient's insight into his or her illness, whether violence is egodystonic or related to the presence of psychosis, medication adherence, access to weapons, and whether the patient has a structured environment in his or her home life that includes a strong support system.

Some of the greatest risks to clinicians lie in situations where potential danger goes unrecognized or is not clinically intuitive. The reasons for attacks by psychiatric patients vary, but there is often no logical rationale. An article by Reid[13] further supports that violent acts could be a result of psychosis, such as paranoid delusions or hallucinations. He also concluded that substance abuse is a common correlate of assault.[13]

VIOLENCE AND MENTAL HEALTH STAFF

After an assault occurs on a mental health professional, the question is often raised whether the attack could have been prevented. In the following sections, we address the frequency of attacks, those most likely to encounter violence in the work place, treatment for victims attacked by their mentally ill patients, and prevention techniques to limit violence in hospitals and clinics. In addition, the importance of proper risk assessment by clinicians at risk is discussed.

Occurrence and outcomes. There have been several studies that examine mental health staff at the highest risk of experiencing violence at the hands of the patient. In a study by Erdos and Hughes,[2] it was found that the staff members who spend the most time with patients are at greatest risk of experiencing an assault, and those at the highest

risk were the nursing personnel. They also examined the repercussions of violent episodes affecting mental health staff. In some instances, there were minor injuries sustained by staff that resulted in missed days of work or assignments to limited duty. However, there was a small percentage of staff who sustained multiple or life-endangering injuries including fractures, lacerations, bruises, or a loss of consciousness. Forty-five percent of staff took time off of work as a result of the assault, and 65 percent of that group required one year to fully recover. Some victims reported symptoms suggestive of posttraumatic stress disorder (PTSD), such as increased startle response, changes in sleep patterns, increased body tension, and generalized body soreness.[2] Sheridan et al[14] also found nursing staff to be at greatest risk of an assault by a patient. Their frequent contact and close proximity to patients as well as their role of setting limits increased their vulnerability. Mental health staff can be viewed by patients as authority figures or even adversaries.[14]

In a study by Privitera et al[4] that examined the rates of violence toward mental health staff, they found that nurses, physicians, and advanced practice nurses reported the highest prevalence of violence against them among the clinical staff. This study also examined the prevalence in nonclinical staff, such as secretaries, and found that front desk staff and receptionists had the highest incidence of endangerment of these groups. The incident of all violent events that occurred in the 12 months preceding the survey was examined in relation to the length of staff experience in the mental health field. The authors found that experience does help protect from violent episodes, yet it does not preclude the perpetration of violence.[4]

The article by Brasic and Fogelman[15] supports this finding. They found that assaults by patients and families are likely to be directed towards young physicians who are early in their medical careers.

Treatment. There are a variety of treatment options available to staff members who have been the victims of an assault by a patient.[2] Erdos and Hughes[2] discussed utilizing Critical Incident Stress Debriefing (CISD). There are six phases of CISD that are typically implemented over a three-hour period. The phases include the following: 1) introduction, 2) fact, 3) feeling, 4) symptom, 5) teaching, and 6) re-entry. During the introduction phase, the group facilitator explains the purpose of debriefing. In the fact phase, the participants describe their roles in the incident. The feeling phase gives the participants the opportunity to discuss their thoughts about the incident. The symptom phase allows the participants to describe their physical and psychological symptoms, and their stress responses are analyzed. The teaching phase allows the instructor to describe symptoms the participants should look for in themselves and others. Finally, during the re-entry phase, the instructor provides reassurance and follow up planning for the participants. Evidence suggests that this type of intervention may reduce the detrimental effects of traumatic events. The goals of debriefing are to help victims cope with the event by decreasing their feeling of helplessness and fear and by providing a supportive emotional atmosphere.[2]

Mental health professionals should also be aware of institutional procedures related to reporting acts of violence. Many residents state that they have no knowledge of a clear policy or protocol for handling and reporting violent attacks.[16] One study[16] that examined physically assaulted residents found that only a small percentage reported the incident; and an even smaller percentage followed up after the assault or received any sort of supportive counseling.[16] These findings suggest a tendency to underreport assaultive incidents, which is concerning given the physical and psychological impact of a violent assault. Surveys of practicing psychiatrists suggest that the tendency not to report assaultive behavior continues after residency training.[16]

A variety of factors contribute to workers' underreporting violent incidents, including the perceptions that violent incidents are an inevitable part of their work and that mental health professionals should be able to care for themselves. In addition, many agencies lack reporting requirements or subtly discourage reporting because it leads to additional time-consuming paperwork. Finally, people may not report such incidents because they believe management is not supportive or fear being criticized by supervisors.[17]

Prevention. Sheridan et al[14] suggested that nursing staff may place too much emphasis on the control of violence through restraint, medication, and seclusion at the cost of examining means of prevention. While the aforementioned methods may be effective in the short term, they state that it may be more beneficial in the long term to attempt to intervene through changing behavioral patterns. The study suggests that patients who are repeatedly chemically or physically restrained likely perceive violence as an effective means to express their feelings of fear, anger, or frustration. Alternate approaches taught to patients could include communicating feelings verbally, meeting needs through assertive rather than aggressive behavior, recognizing their own escalating anger, and removing themselves from the situation. In addition, patients can learn how negative thoughts perpetuate aggressive behavior and learn how to improve their conflict resolution skills.[14]

In a time of restricted healthcare budgets, a structured risk assessment is a low-cost intervention that has been proven to be effective in diminishing violence. Abderhalden et al[18] conducted a study analyzing violence risk assessment on an

inpatient psychiatric ward. The risk assessment was conducted twice daily for the first three days of hospitalization in patients with acute psychiatric symptoms. The risk assessment scores were followed by action tailored to the patients risk level.[18] Risk assessments to evaluate violence potential may be a crucial first step in predicting and preventing aggressive and assaultive behavior in patients. It should also be an important element of treatment and management considerations.[16]

Researchers in Norway developed the V-RISK-10, a structured risk assessment to be used in short-term psychiatric facilities. The V-RISK-10 has the ability to briefly and effectively screen patients for risk of violence at admission and discharge from an acute psychiatric unit. Most other risk assessments are developed for use in the forensic setting following long-term treatment. The V-RISK-10 can be utilized at both admission and discharge, is equally applicable to both genders, and has good predictive accuracy up to one year after discharge from acute psychiatric facilities.[19]

Currently, little formal risk-assessment training occurs in psychiatric settings. A study in Oregon found that only 40 percent of surveyed psychiatrists had received some form of violence-management training.[16] Another large study found that one-third of psychiatric residents did not receive adequate education in dealing with violent patients and assessing potential violence during their training.[16] These statistics are particularly concerning given that clinicians with less experience are more likely to be victimized.[16] Additionally, lack of training may negatively affect staff attitudes toward the management and treatment of violent psychiatric patients, thereby creating a less than optimal therapeutic environment for these individuals. Thus, proper training in dealing with violent patients in order to effectively assess, treat, and cope with this population should be implemented in training programs for mental health professionals.[16]

Finally, an increase in patient violence has been associated with a decrease in permanent nursing staff. There are many reasons as to why this may occur. One theory suggests that patients prone to violence are often psychotic and in need of stability and continuity around them.[6] James et al[6] speculated that staff may interact less with more severely disturbed patients, and extreme behavior, such as violence, may be the most immediate way for the patient to gain attention. It is essential that staff are able to set reasonable limits for behavior and are trained in techniques of aggression control.[6]

Swanson[20] suggested performing a structured risk assessment only on those patients who have committed violent acts in the past or report thoughts of hurting someone in the future. Swanson also suggested that more accurate and efficient prediction tools are needed to asses this patient population.[20]

CONCLUSIONS

Threats and assaults on mental health staff are prevalent and increasing in the psychiatric population.[4] Several authors have stated that violent patients are not a homogenous group, and their violence reflects various biological, psychodynamic, and social factors. Most researchers and clinicians agree that a combination of factors plays a role in precipitating violence and aggression, although there are differing opinions regarding the importance of individual factors.[3] Friedman states, "The challenge for medical practitioners is to remain aware that some of their psychiatric patients do, in fact, pose a small risk of violence, while not losing sight of the larger prospective—that most people who are violent are not mentally ill and most people who are mentally ill are not violent."[1]

It is paramount to patient care to sufficiently train staff to identify precipitants of violence as well as effective techniques to manage violent patients so that the incidence of violent attacks against mental health professionals decreases. While it is impossible to prevent every violent situation, it has been shown that proper training in de-escalation techniques can help substantially. As stated previously, most violent attacks occur early in a clinician's career; therefore, it would be beneficial for psychiatric residency programs to implement proper management of violent patients into their training curriculum. This training should extend beyond the scope of the use of medications for behavioral control and include simple verbal de-escalation techniques and methods of self protection. It is also essential to outline the correct way to report a violent incident, should it occur, so that mental health staff can receive the proper treatment in the aftermath of the incident. While the job of mental health professionals is to put the patient first and provide them with the best care, it is also important not to neglect one's own mental and physical health so that the provider is able to perform his or her job effectively.

REFERENCES

1. Friedman RA. Violence and mental illness: how strong is the link? *N Engl J Med*. 2006;355:2064–2066.
2. Erdos B, Hughes D. Emergency psychiatry: a review of assaults by patients against staff at psychiatric emergency centers. *Psychiatric Serv*. 2001;52:1175–1177.
3. Rueve M, Welton R. Violence and mental illness. *Psychiatry* (Edgmont). 2008;5(5):34–48.
4. Privitera M, Weisman R, Cerulli C, et al. Violence toward mental health staff and safety in the work environment. *Occup Med (Lond)*. 2005;55:480–486.
5. Raja M, Azzoni A. Hostility and violence of acute psychiatric inpatients. *Clin Pract Epidemiol Ment Health*. 2005;1:1–11.
6. James D, Fineberg N, Shah A, Priest R. An Increase in violence on an acute psychiatric ward: a

study of associated factors. *Br J Psychiatry*. 1990;156:846–852.
7. United States Deptartment of Health and Human Services, National Institute of Mental Health. Epidemiologic Catchment Area Study, 1980–1985. http://www.icpsr.umich.edu/icpsrweb/NACDA/studies/6153/detail. Access date March 1, 2011.
8. Swanson JW, Swartz MS, Essock SM, et al. The social-environmental context of violent behavior in persons treated for severe mental illness. *Am J Public Health*. 2002; 92(9):1523–1531.
9. Tardiff K, Marzuk P, Leon A, et al. Violence by patients admitted to a private psychiatric hospital. *Am J Psychiatry*. 1997;154:88–93.
10. Faulkner LR, Grimm NR, McFarland BH, Bloom JD. Threats and assaults against psychiatrists. *Bull Am Acad Psychiatry Law*. 1990;18:37–46.
11. Krakowski M, Czobor P. Gender differences in violent behaviors: relationship to clinical symptoms and psychosocial factors. *Am J Psychiatry*. 2004;161:459–465.
12. deMause, L. Why males are more violent. The Origins of War in Child Abuse. 2010; http://www.psychohistory.com/originsofwar/02_whymalesaremoreviolent.html. Accessed March 25, 2011.
13. Reid, W. Assaults against psychiatrists and other mental health professionals. *J Psychiatr Pract*. 2008;14:179–181.
14. Sheridan M, Henrion R, Robinson L, Baxter V. Precipitants of Violence in a psychiatric inpatient setting. *Hosp Community Psychiatry*. 1990;41:776–780.
15. Brasic J, Fogelman, D. Clinician safety. *Psychiatr Clin North Am*. 1999;22:924–935.
16. Antonius D, Fuchs L, Herbert F, et al. Psychiatric assessment of aggressive patients: a violent attack on a resident. *Am J Psychiatry*. 2010;167:253–259.
17. Spencer P, Munch S. Client violence toward social workers: The role of management in community mental health programs. *Soc Work*. 2003;48:532–544.
18. Abderhalden C, Needham I, Dassen T, et al. Structured risk assessment and violence in acute psychiatric wards: randomized controlled trial. *Br J Psychiatry*. 2008;193:44–50.
19. Bjorkly S, Hartvig P, Heggen F, et al. Development of a brief screen for violence risk (V-RISK-10) in acute and general psychiatry: An introduction with emphasis on findings from a naturalistic test of interrater reliability. *Eur Psychiatry*. 2009;24:388–394.
20. Swanson J. Preventing the unpredicted: Managing violence risk in mental health care. *Psychiatr Serv*. 2008;59:191–193.