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Death threats to psychiatrists

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Threats made by patients to harm, or even kill, their psychiatrists, may cause great stress to both the doctor and his or her family. This potential source of anxiety is seldom discussed by the profession and is a neglected area in the literature, perhaps indicating that denial is a common mechanism used to cope with any fear engendered by such threats.

Research from the USA suggests that between 3% (Reid & Kang, 1986) and 42% (Madden *et al*, 1976) of psychiatrists have actually been assaulted during their careers. The variation in these figures seems largely due to the lack of agreement as to what constitutes an assault. Similar problems exist in determining whether a 'threat' has been issued or not. In America, however, Faulkner *et al* (1990) have suggested that more than half of psychiatrists have been threatened in some way by their patients. The threat to kill a psychiatrist is, perhaps, a more narrowly defined entity and might be expected to cause greatest concern. It is a virtually unresearched area, however. MacDonald (1963) collected 100 patients in Colorado who had been admitted to hospital over a 15 month period because they had threatened to kill a person (on four occasions their doctor). Six months later two patients had killed someone (although, interestingly, not the original people who had been threatened). This compares with no deaths in a control group. The scanty literature suggests therefore that the risks are fairly small, but real and worthy of further inspection.

The study

A questionnaire was forwarded to 100 psychiatrists throughout the South Western Regional Health Authority on a random basis. Of the 100, 71 were consultants (with a main interest in general adult psychiatry or psychiatry of old age, plus 4 forensic consultants), 18 senior registrars and 11 registrars. Of the doctors, 72% were male and 28% female. The aim of the survey was to gauge how frequently death threats are made to psychiatrists, to gain information about the circumstances and characteristics of such threats and to judge the effects they have on the psychiatrists involved.

Findings

The response rate to the questionnaire was 76%. The profile of the responders was the same as the total population, in terms of sex and level of experience. Twenty-six psychiatrists had received a total of 38 death threats. This equates to 26% of the total population or 34% of the responders having suffered such a threat. In addition to this, one consultant recalled an experience when a patient threatened to blow up the whole hospital.

The profile of psychiatrists being issued death threat

The psychiatrists were asked how many years they had been working in psychiatry. On average, of those responding, a death threat was experienced once every 28 years; which is equivalent to just over once in a life-time career in psychiatry.

Of the 38 death threats, only two were made to female doctors. In two cases, the gender of the doctor was unclear. Less experienced doctors reported more death threats per years in psychiatry than more experienced doctors.

The profile of patient issuing death threat

Of the 38 death threats, 29 (76%) were issued by male patients, eight (21%) were from females and on one occasion the gender was unclear. In terms of age, 22 (58%) of the threats were issued by patients between the ages of 21–30 years old. The frequency of threats declined with age and no threats were reported from patients over 60 years old. The diagnosis of patients involved was varied. Seventeen (45%) had a personality disorder, of which seven were combined with a psychiatric disorder or drug abuse. Of the other threats, five were issued by patients with schizophrenia, five were hypomanic, two depressed, one had alcoholic hallucinosis and one had a frontal lobe tumour. On seven occasions diagnosis was unclear.

Twenty-eight (74%) of the 38 patients had a previous history of violence and with a further two cases this information was not known by the psychiatrist. In exactly half of the episodes, the threat was issued while the patient was an in-patient. A further third had out-patient status. The rest were either day patients, discharged from psychiatric care

or threats were issued when a patient was being assessed in a domiciliary visit or in an accident or emergency department.

Characteristics of the death threat

Of the death threats, 32 (84%) were made face to face. Two were issued through a third person, two were made by letter, one by telephone and one was made on an audio cassette sent to the psychiatrist. Three of the threats were made anonymously. In seven episodes a specific method of killing was mentioned. Four of these were shooting, two stabbing and one strangling.

The questionnaire also asked whether a reason was given for the threat. On 12 occasions this was not made clear. The rest were divided between a variety of causes. Six episodes occurred because the patient was unhappy about being in hospital, whereas five arose because patients were refused admission. Eleven further threats occurred because of patients' dissatisfaction with their treatment and, of these, four of the differences were focused on medication. Only three of the threats were issued as a result of a delusional belief. The final reason given was that the patient hated all psychiatry and that the particular psychiatrist involved represented his whole profession.

Aftermath of the death threat

The police were involved following the death threat on only seven of the 38 occasions. Eleven of the threats were acted on in either a violent or aggressive way. On three occasions the psychiatrist was subsequently assaulted and on three further occasions other health care workers were assaulted. Two patients set fire to the hospital ward.

Psychiatrists' response to the death threat

Of the 38 psychiatrists threatened, 18 indicated that the death threat had affected their clinical approach to the particular patient involved. Most commonly the psychiatrist either refused to see the patient again or referred the patient on to forensic services. Nine of the death threats resulted in a change of clinical approach to patients in general, usually by way of taking more precautions. One psychiatrist has taken the decision that any further threat should always lead to positive action either by using the Mental Health Act or by involving the police. Of the 38 threats, 17 affected the doctor outside work. Phrases such as 'anxious', 'on edge', 'frightened' and 'lost confidence' recurred. One doctor reported ensuring that his curtains were always closed at night so that strangers could not see in, many years after the original threat. Thirty of the 38 threats led to changes in at least one of the above categories.

The degree of distress resulting from a death threat seems to be variable. A number of factors appear to increase the distress, although the relatively small numbers in this survey do not allow these to reach statistical significance:

(a) long period of significant risk
(b) anonymous threat
(c) threat not issued face to face
(d) threat made to doctor's family
(e) specific method of killing mentioned.

Comments

Death threats made by psychiatric patients to their doctors are relatively rare events, but many psychiatrists will experience at least one during a career, and usually there will be significant psychological and behavioural effects.

Male psychiatrists and those with less experience appear more likely to receive death threats. These data are not explainable in terms of a responder bias to the questionnaire, but may have a number of underlying causes. In terms of gender, it is generally less socially acceptable to threaten women. Females may be less confrontational and more sensitive to patients' emotions and therefore better equipped to pre-empt dangerous clashes. Furthermore there may be some selection bias resulting in different gender psychiatrists dealing with different patients. For example, females may treat forensic patients less often than males. As for the experience factor, it is possible that this difference is produced by selective memory, such that events distant in time are recalled less readily. It is also plausible that more experienced psychiatrists handle patients more effectively or that junior doctors have a tendency to be exposed to more acutely ill patients. A further possibility is that these episodes have become more frequent over recent years.

The profile of patients issuing death threats is largely in line with that expected of violent patients. Patients with personality disorders are frequently involved and a previous history of violence is common. The fact that a good proportion of patients acted on the threat in some way is perhaps worrying and should act as a reminder that the risks following such threats are real.

The issue of threats made to psychiatrists, and in particular death threats, deserves greater awareness and warrants further research. Of the 38 death threats in the survey, 22 were made as a result of disagreements about the patients' management. This suggests that improved training in interview skills and communication may be of benefit. It is clear from the questionnaire replies that, after their death threat, many psychiatrists felt unsupported and unclear about the best course of action. Formalised guidelines or a code of practice, together with a

more adequate system of support, could reduce these feelings of uncertainty.

I am keen to hear of other psychiatrists' experiences and comments.

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Violence and junior doctors working in psychiatry

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Aggression directed towards health care workers has been widely discussed (Health Services Advisory Committee, 1987), but information relating to British psychiatry has been anecdotal. The Collegiate Trainees' Committee (CTC) has recently expressed concern about the apparent dearth of training opportunities in the recognition and management of aggression, and the difficulty in obtaining post-incident counselling (1991).

There is evidence that verbal aggression forms part of a continuum with physical assault (McNiel & Binder, 1989), yet studies in this area often give little attention to the monitoring and management of such incidents. We have attempted to quantify the frequency of both verbal and physical aggression encountered by junior doctors working in psychiatry, focusing on the issues of education, reporting of incidents and post-incident counselling.

The study

Lists of junior psychiatric staff were obtained for 13 hospitals in six Health Board areas in West and Central Scotland. Questionnaires were sent to all those working as senior house officers and registrars in January 1991. Those who did not reply were sent a reminder three weeks later. Two other hospitals with junior psychiatrists were excluded from the study because we were unable to obtain staffing lists.

Findings

Of 83 questionnaires distributed, 61 were returned (73.5% response rate). The differential response rate was 92% for psychiatric trainees, and 40% for general practice trainees. Of respondents, 64% were female and 36% male; this reflected the sex distribution in the sample as a whole. Respondents had spent a median of 30 months in psychiatry, with a range of 4–79 months.

The doctors were asked from what sources they had obtained advice on the recognition and management of aggressive behaviour. Some respondents had received advice from more than one source. Of doctors, 32.8% had received advice from consultants; 60.7% from peers; 50.8% from nursing staff and 6.6% from formal postgraduate training; 3.3% had received advice from other sources. No doctor recalled any undergraduate training. Thirteen (21.3%) indicated that they had never received advice from any source.

Doctors were asked whether they had been physically assaulted while working in psychiatry. Thirty-nine respondents (65%) had never been assaulted; 15 (25%) had been assaulted once; 5 (8.3%) had been assaulted twice and one doctor (1.7%) had been assaulted three times. Five assaults (17.8%) were reported, while 23 (82.2%) were not. (Completion of an accident form or the reporting of an incident to a consultant were classified as a reported incident, while mentioning the incident to peers or nursing staff was not.) Doctors were asked to indicate whether support or counselling had been offered after each incident. In six incidents (22.2%) it was said to be unnecessary. Support had been offered after one incident (3.7%) and following 20 incidents (74.1%), no support was offered. No details were given for one incident.

Doctors were asked if, while working in psychiatry, they had felt in imminent danger without