# Assaults by Patients on Psychiatric Residents: A Survey and Training Recommendations

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***Objective:*** **A survey was conducted to determine the frequency and severity of assaults on psychiatric residents and the level of training they receive in the management of violent patients.** ***Methods:*** **In early 1997 a survey was randomly distributed to 2,553 psychiatric residents, who represented half of all psychiatric residents in the United States. The survey asked about experiences of assaults and training received in management of violent patients.** ***Results:*** **Completed surveys were received from 517 residents, for a 20 percent response rate. Seventy-three percent reported being threatened, and 36 percent had been physically assaulted. A third received no training in managing violent patients, and a third described their training as inadequate.** ***Conclusions:*** **Two-thirds of psychiatric residents are either undertrained or feel undertrained in dealing with violent patients. The authors propose a training curriculum based on recommendations of an American Psychiatric Association task force report on clinician safety. (*Psychiatric Services* 50:381–383, 1999)**

Psychiatry is both a very rewarding and a very dangerous occupation. Studies of board-certified psychiatrists have shown that psychiatrists have a 5 to 48 percent chance of being physically assaulted by a patient during their careers (1–9). But few studies have evaluated patient violence during residency training.

One study surveyed residents in all fields, not just psychiatry, and found that 24 percent of the 200 residents who responded had been physically assaulted by a patient (10). Milstein (11) found that the frequency of assault was approximately twice as high among psychiatric residents as among medical residents. Thus, although it appears that all medical residents are at significant risk of being assaulted by patients, psychiatrists in training may be at greatest risk.

Research focusing on psychiatric residents supports this idea. Ruben and colleagues (12) found that 48 percent of 33 residents in psychiatry had been assaulted. Gray (13) found a similar high rate of assault, 54 percent, among 73 psychiatric residents. The assault rate among 136 Canadian psychiatric residents in a study by Chaimowitz and Moscovitch (14) was 40 percent, similar to that found by Fink and coworkers (15) in a larger sample of 155 psychiatric residents in Pennsylvania.

Together these studies suggest that from 40 to 50 percent of psychiatric residents will be attacked physically during a typical four-year training program (15). Unfortunately, the samples in most of the studies were of limited size and included only a small cross-section of residents. For example, Chaimowitz and Moscovitch (14) surveyed only Canadian residents, and Fink and colleagues (15) only Pennsylvania residents. Rubin and associates (12) and Gray (13) evaluated residents in one specific training program or hospital. Black and coworkers (16) surveyed three training sites at a single university.

Surveys have revealed that psychiatric residents feel their training in violence management is inadequate, with residents reporting an average of only three hours of such training (14–16). Hatti and associates (6) emphasized interpersonal dynamics in such training and suggested that clinicians may best be served when trainers direct their attention to the anxiety and fears aroused when confronting a violent patient. This approach would allow for more efficient use of verbal skills and would help diffuse the violent situation.

A task force report of the American Psychiatric Association (APA) provides a didactic outline for residency training in managing patient violence (17). Training topics should include the antecedents of violence; evaluation of violent patients; use of verbal, mechanical, and pharmacological interventions; and the psychodynamics of aggression. Black and coworkers (16) suggested that training in the use of safety measures, such as panic buttons and metal detectors, would be beneficial. They also felt that room layout, staffing patterns, and hospital policies should be evaluated to promote better staff safety. Together, these training interventions may reduce assaults on residents and provide a safer working environment (14).

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Because of psychiatric residents' perceptions of being inadequately trained to deal with patient violence, this study addressed training issues related to patient violence. Specifically, it examined residents' perceived reasons for being assaulted and threatened, their responses to violence, the amount of training they received, and their assessment of its adequacy. The study also sought information on rates of assaults and threats and environmental safety factors.

Based on the findings of this study and previous studies, a comprehensive yet brief program in violence management for psychiatric residency training is outlined. It is hoped that this effort will highlight the current status of residents' training experiences in managing violent patients, and that the training recommendations may prove valuable to residents and training directors alike.

## Methods

A short survey was mailed to 2,553 psychiatric residents in accredited programs, who represented half of all psychiatric residents in the U.S. Residents in fellowship years were not surveyed. The survey focused on the frequency and severity of assault and the training experiences offered residents in their programs. The survey packets were mailed between January and April 1997 to training residency directors with a letter requesting a random distribution to half of the active residents. All subjects received a brief cover letter, a survey, and a return envelope.

Survey responses were tabulated and assessed using the Statistical Package for the Social Sciences. Descriptive statistics were used to examine demographic characteristics, prevalence of assaults and threats, and the training variables.

## Results

Completed surveys were received from 517 residents, for a 20 percent response rate. Fifty-two percent of the respondents were male. Respondents' ages ranged from 25 to 61 years. The average program size was 38 residents. Thirteen percent of respondents were in the first year of training, 31 percent in the second year, 28 percent in the third year, and 25 percent in the fourth year. Fifty-two percent of responses were received from the East Coast, 26 percent from eastern noncoastal states, 5 percent from the Midwest, and 16 percent from the West.

A total of 636 physical assaults by patients were reported by 186 residents (36 percent). Thirty-seven percent of men and 34 percent of women respondents had been assaulted.

A total of 1,884 threats were reported by 379 residents. Seventy-nine percent of male respondents and 69 percent of female respondents reported having been threatened by patients.

Of the 186 residents assaulted, 69 percent reported an assault to a supervisor, 24 percent contacted a medical or residency training director, 17 percent contacted law enforcement, and 12 percent contacted other sources. Of the residents reporting assaults, 43 percent had a debriefing with or made a factual accounting of the incident to a supervisor, and 33 percent received supportive counseling from a supervisor or colleague. Sixteen percent felt they were to blame for the altercation.

Among the 517 respondents, 19 percent reported that no clear policy existed for reporting assaults, and 12 percent felt that being assaulted by patients was an inherent part of the profession. When asked about their reasons for not reporting assaults, small percentages of residents who had been assaulted cited poor staff support (5 percent), shame and guilt over the incident (4 percent), a feeling that seeking to change the situation would be futile (3 percent), other staff members' denial that the assault occurred (1 percent), and fear of scrutiny (.6 percent). Residents were asked about their perceived reasons for being assaulted; 19 percent attributed the assault to their refusal to satisfy a patient's request, and 17 percent to setting limits on the patient.

Reporting on environmental safety factors, 27 percent of residents said that metal detectors were present in at least one training site at their program. Fifty-four percent reported that most doors to facility workspaces opened inward—a safety risk.

A total of 372 of the 517 residents (72 percent) reported receiving any training during their residency careers on management of violent patients. Training averaged 4.8 hours over their residency careers (median, four hours; mode, two hours; range, 0 to 27 hours). Seventy percent reported training in the evaluation of potential violence, 67 percent received lectures on dealing with violent patients, and 47 percent received instruction on restraint procedures. Twelve percent were told about safety procedures such as room searches and metal detectors.

Thirty-three percent of the residents described their training as adequate and 37 percent as inadequate. Ten percent received training outside of the residency program to help manage aggressive patients, and 8 percent reported seeking self-defense training to increase their preparedness to deal with violent patients. Seventy-one percent of all respondents felt that a well-organized course or seminar especially designed for residents on managing violent patients would be very beneficial.

## Discussion

Results of this study and previous studies clearly portray psychiatric residency as a high-risk time for assault. The assault rate during the four years of residency appears similar to the rate among board-certified psychiatrists over the course of a one- to 40-year career—about 30 to 40 percent. Based on these findings and using the APA's task force report on clinician safety (17) as a guide, we present the following outline of essential components of a residency training program in violence management. The basic ten-hour course should be given in the first training year.

Didactic lectures should be developed to provide a basic understanding of violence so that more advanced techniques may be applied to decrease the risk of assault. A concise reading list should be developed. The readings should cover APA's suggested topics of causes of violence, psychodynamics of aggression, initial encounter with and evaluation and diagnosis of violent patients, pharmacology, seclusion and restraint, environmental safety, and forensic issues.

Three brief works would provide this information quickly and easily: the second edition of Tardiff's *Concise Guide to Assessment and Management of Violent Patients* (18), Bernstein and associates' *On Call Psychiatry* (19), and APA's task force report (17). Much of these texts are printed in outline format. Reading time could be reduced to as little as two hours if specific selections are used. These texts would form the core reading for a lecture series.

Three of the suggested topics—causes of violence, psychodynamics of aggression, and initial encounter with and evaluation and diagnosis of violent patients—could be taught in a one-hour lecture-discussion that would reinforce the reading material. Introduction of case material might increase interest in and salience of each topic. The other four topics—pharmacology, seclusion and restraint, environmental safety, and forensic issues—could be taught in a second one-hour session tailored directly to the residents' work sites using site-specific safety protocols.

Behavioral restraint techniques should be taught to ensure safety not only for residents but also for patients. Initially, residents should have didactic lectures on administering medications, implementing physical restraint manually or by leather assisted-restraint devices, and implementing seclusion. Ideally, didactic lectures would be followed by a practical session in which these techniques could be applied in simulated situations. The lectures and practical section could be completed in a two- to three-hour seminar.

Self-defense techniques should be taught, with emphasis on anticipating and escaping assaults by patients. Again, a lecture followed by a practical review is recommended; two to three hours would be adequate.

Simulated training exercises should be implemented in each training program. The APA task force highlighted this recommendation as most important (17). Practice in using these techniques will provide fluency in an emergency. The exercises could be presented in a two- to three-hour seminar.

Finally, a centralized and clear-cut reporting process for residents should be made available. The APA task force recommended that residents should have access to and be informed of all statistics related to violence in their department. Residents should be aware of reporting policies, particularly whom to contact after a threat or an assault. Besides providing psychological support, immediate supervision may help residents assess their feelings related to assault and denial, transference, and countertransference. More important, better reporting practices should decrease beliefs that being assaulted is part of the job or that the resident is to blame for assaults. Evidence suggests that many residents who are assaulted once tend to be assaulted again (12). By requiring immediate reporting, programs may help residents work through factors related to assault, thereby preventing subsequent attacks.

## Conclusions

Psychiatric residency can be a dangerous as well as a rewarding time. We have written this paper in hopes of tipping the scale toward the rewarding side and away from the dangerous side. We believe that if the above training suggestions are widely implemented, assault rates among residents would decrease in frequency and severity.

The suggestions for training comply with recommendations on clinician safety by an APA task force. We believe that the ten hours of training outlined in this paper should be given in the first training year, followed by two-hour simulation seminars during each following year of residency. Over four years of residency, approximately 15 hours of training would be given. This minimal amount of dedicated time by residents and faculty may prove to be very helpful in reducing the frequency and severity of assaults by patients not only during residency but also in practice after residency. ♦

### *References*


1. Bernstein HA: Survey of threats and assaults directed towards psychotherapists. American Journal of Psychotherapy 35: 542–549, 1981
2. Carmel H, Hunter M: Psychiatrists injured by patient attack. Bulletin of the American Academy of Psychiatry and Law 19:309–316, 1991
3. Carmel H, Hunter M: Staff injuries from patient attack: five years of data. Bulletin of the American Academy of Psychiatry and Law 21:485–492, 1993
4. Faulkner LR, Grimm NR, McFarland BH, et al: Threats and assaults against psychiatrists. Bulletin of the American Academy of Psychiatry and Law 18:37–46, 1990
5. Haffke EA, Reid WH: Violence against mental health personnel in Nebraska, in Assaults Within Psychiatric Facilities. Edited by Lion JR, Reid WH. Orlando, Fla, Grune & Stratton, 1983
6. Hatti S, Dubin WR, Weiss KJ: A study of circumstances surrounding patient assaults on psychiatrists. Hospital and Community Psychiatry 333:660–661, 1982
7. Madden DJ, Lion JR, Penna MW: Assaults on psychiatrists by patients. American Journal of Psychiatry 133:422–425, 1976
8. Reid WH, Kang JS: Serious assaults by outpatients or former patients. American Journal of Psychotherapy 40:549–600, 1986
9. Whitman RM, Armao BB, Dent OB: Assault on the therapist. American Journal of Psychiatry 133:426–429, 1976
10. Fink D: Violence and psychiatric residency, in Patient Violence and the Clinician. Edited by Eichelman BS, Hartwig AC. Washington, DC, American Psychiatric Press, 1995
11. Milstein V: Patient assaults on residents. Indiana Medicine 80:753–755, 1987
12. Ruben I, Wolkon G, Yamamoto J: Physical attacks on psychiatric residents by patients. Journal of Nervous and Mental Disease 168:243–245, 1980
13. Gray GE: Assaults by patients against psychiatric residents at a public psychiatric hospital. Academic Psychiatry 13:81–85, 1969
14. Chaimowitz GA, Moscovitch A: Patient assaults against psychiatric residents: the Canadian experience. Canadian Journal of Psychiatry 36:107–111, 1991
15. Fink D, Shoyer B, Dubin WR: Study of assaults against psychiatric residents. Academic Psychiatry 15:94–99, 1991
16. Black KJ, Compton WM, Wetzel M, et al: Assaults by patients on psychiatric residents at three training sites. Hospital and Community Psychiatry 45:706–710, 1994
17. Dubin WR, Lion JR (eds): Clinician Safety: Report of the American Psychiatric Association Task Force on Clinician Safety. Washington, DC, American Psychiatric Press, 1993
18. Tardiff K: Concise Guide to Assessment and Management of Violent Patients. Washington, DC, American Psychiatric Press, 1996
19. Bernstein C, Ladds B, Maloney A, et al: On Call Psychiatry. Philadelphia, Saunders, 1997