



STRATEGIES FOR **reducing** THE RISK OF **patient** **violence** TOWARD CLINICIANS

Few challenges facing psychology practitioners are more distressing than the possibility of patient violence toward the clinician. National surveys have indicated that 15–25% of psychologists may be at risk of being assaulted by a patient at some point in their careers. While there have been instances in which patient assault has resulted in serious injury, most patient violence results in minor injury or no injury at all. The emotional distress is usually far more disturbing than any physical injury. Education and training in the evaluation and management of potentially violent patients is often minimal. Because of the complexity of such patients and the high intensity of the context in which they can present, it is helpful to be prepared with knowledge and some plans for dealing with this situation. This pamphlet provides helpful information. It does not offer all the answers, but can offer structure for doing more evidence-based assessment and management.

Tips for Reducing Risks of Violence by Patients Toward Clinicians—Being Prepared for Possible Patient Violence

Make Your Office Safer

1. In furnishing an office, consider that items such as small, heavy objects, letter openers, pictures, scissors, etc., can be used by patients as weapons.
2. Arrange seating so that you have access to an exit if necessary.
3. Have a method of communicating with others if you need help (e.g., panic button, emergency code or signal).
4. If patient is known to be at high risk, consider meeting where other staff would hear or see a disturbance.
5. Patients at very high risk often can be served better by integrated systems of care (e.g., clinics, medical centers) than solo practitioners.

Evaluate for Risk of Violence

An evaluation for risk of violence is needed at the first contact with the patient, when violent thoughts are reported, and when there are pertinent clinical or behavioral changes. Here are some important domains to consider when evaluating for risk.

1. Identify the patient's past risk factors, including history of

- a. violent behavior
- b. child/adolescent behavior problems, particularly aggression
- c. arrests
- d. having been a victim of violence
- e. substance abuse
- f. personality disorder (e.g., antisocial, borderline)
- g. serious mental illness
- h. cognitive impairment/brain damage
- i. unstable relationships

2. Identify present risk factors

- a. behavior marked by anger, agitation, hostility, tension, suspiciousness, excitement, stress
- b. command hallucinations to harm others, paranoid delusions
- c. intoxication (slurred speech, unsteady gait, flushed face, dilated pupils, etc.)
- d. acute symptoms of mania, schizophrenia, psychosis, delirium

- e. thoughts/threats of violence
- f. poor therapeutic alliance
- g. Poor response to treatment
- h. access/possession of firearms/other weapons
- i. impulsive behavior

3. Identify future risk factors

- a. poor compliance with treatment (e.g., discontinuing medication)
- b. lack of social support
- c. peers who support criminal/aggressive behavior
- d. unrealistic plans
- e. impending losses (e.g., likely loss of home, job, friend, family member)

Develop a Plan Based on Analysis of Risk Factors

1. High risk—If the patient is tense or on edge, attempt to de-escalate by using calming statements, calling upon the patient's ability to cope and tolerate distress, taking a break, or having a colleague join you. If the patient is at imminent risk for loss of control, be prepared to use your options for safety (e.g., panic button, emergency code, exit room for assistance). Consider psychiatric hospitalization, civil commitment, police involvement.

2. Moderate risk—Consider a higher level of care with increased structure and/or observation. Based on patient needs, consider medication consultation, substance abuse treatment, anger management, improving the working alliance, referral to another clinician, etc.

3. Low risk—No special resource allocation is required.

Document the risk assessment and risk management plans (including rationale for decisions that were made).

Suggested Dos and Don'ts

Do

1. **Be alert** to signs of tension in the patient's behavior; e.g., motoric restlessness, pacing, clenching fists
2. **See** if patient can receive feedback that he/she seems tense and can calm hi/herself
3. **Pay attention** to "gut" feelings of threat or danger
4. **See** if patient can receive feedback that his or her behavior seems frightening
5. **Inform** colleagues or other staff if you plan to see a high-risk patient
6. **Participate** in continuing education activities to develop skills in managing potentially violent interactions with patients
7. **Keep up to date** with literature on risk assessment for violence, including the availability of decision-support tools relevant to your setting
8. **Consult** with a colleague or someone with expertise in managing violent patients when you have a higher-risk patient

Don't

6. **Get isolated** with a patient who seems at risk for loss of control
7. **See "edgy" patients late** in the day when few others are around
8. **Try to take a weapon** from a patient (unless there is no alternative); ask the patient to put it down

If you have been threatened or assaulted by a patient, consider seeking assistance through your state Psychology Association Colleague Assistance Program or APA's ACCA.

References for Evaluating, Managing, and Coping With the Aftermath of Patient Violence

General Reference

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Borum, R. (2009). Children and adolescents at risk of violence. In P. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization* (pp. 147–163). Washington, DC: APA Books.

McNiel, D. (2009). Assessment and management of acute risk of violence in adult patients. In P. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization* (pp. 125–145). Washington, DC: APA Books.

Coping With Risk to the Clinician

Kleespies, P., and Ponce, A. (2009). The stress and emotional impact of clinical work with the patient at risk. In P. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization* (pp. 431–448). Washington, DC: APA Books.

Sandberg, D. A., McNiel, D. E., and Binder, R. L. (2002). Stalking, threatening, and harassing behavior by psychiatric patients toward clinicians. *Journal of the American Academy of Psychiatry and the Law*, 30, 221–229.

Web Site

Kenneth Pope: <http://kspope.com/index.php>. Resources for therapists who are stalked, threatened or attacked by patients.



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