

## JAMA Network Insights

## Guidance for Working With a Patient Who Elicits Fear in the Psychiatrist

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**While it is clear** that most societal violence is not due to mental illness, there is conflicting evidence regarding whether mental illness itself increases violence risk.<sup>1</sup> Nonetheless, variables associated with mental illness, particularly substance abuse, have been shown to be predictors of violence.<sup>1</sup> As such, psychiatrists do treat individuals at risk of violence and are at times themselves at risk. The rate of nonfatal violent crime against mental health professionals is more than 5 times that for all occupations.<sup>2</sup> While underreporting of assaults seems prevalent, more than one-third of psychiatrists report having been physically assaulted at least once, and psychiatrists in training seem particularly vulnerable.<sup>2</sup>

This article provides guidance to psychiatrists and other mental health clinicians regarding working with a patient who evokes anxiety and fear in the clinician regarding their own physical safety or the safety of others. This may involve overt aggression or violent behavior, explicit or implicit threats of violence, or stalking behaviors. The encounter with a patient who elicits fear can be immediate, such as an extremely agitated patient in an inpatient unit, or fear can emerge over time, such as when a psychiatrist is treating an individual as an outpatient who they fear could harm them despite the absence of evidence of imminent risk. This guidance provided in this article applies to both types of encounters.

While psychiatrists experience anxiety and fear when treating patients with suicidal ideation, the quality of the anxiety and fear is different and more personally disturbing when clinicians fear for their own safety or that of their loved ones. Clinicians may also feel anger at the patient or feel helpless to effectively intervene. Defenses such as denial, reaction formation, or withdrawal may interfere with the clinician's recognition and management of risk. A clinician's emotional reactions and clinical judgment can be distorted when interacting with a patient whom they fear.

The approach to working with a patient who elicits fear begins with conducting a violence risk assessment, assessing both static (eg, violence history, psychopathy, head trauma, male sex) and modifiable dynamic risk factors (eg, substance use, impulsivity, access to a weapon, psychosis, treatment nonadherence) initially and over time, ideally using a structured assessment tool that incorporates professional judgment.<sup>3</sup> Structured assessment tools help to guide the systematic assessment of risk factors but to date have only low to moderate positive predictive value, limiting their clinical utility in identifying those at increased risk.<sup>4</sup> The modest success associated with such tools presumably contributes to the anxiety and fear that clinicians may experience.

Identification of interpersonal risk factors "associated with the relationship between the clinician and the patient, particularly when the relationship is... emotionally intense... or has particular psychological meaning to the patient"<sup>5</sup> may be particularly relevant. Violence may occur as a reaction to feelings of passivity and helplessness.<sup>6</sup> Recognition of the psychiatrist's own emotional reactions to the patient may provide important clues regarding the assessment, eg, fear may be warranted and may need to be acted on.

Psychiatrists may also underreact to risk. The input of other treatment team members can help to identify risk where it may have been missed, minimized, or overestimated. Notwithstanding the importance of risk assessment, it is important to acknowledge the limited ability of psychiatrists to predict violence and to be aware of risk associated with situations and/or patients who may be unpredictable, unstable, or unfamiliar.<sup>5</sup>

The risk assessment informs treatment planning, taking into account the treatment setting, including emergency or inpatient settings for acute imminent risk, consideration of the appropriate outpatient setting (eg, private practice, clinic care, partial hospitalization, assertive community treatment), and consideration for mandated outpatient treatment if indicated and applicable in that jurisdiction. Treatment plans should explicitly address violence risk, including dynamic risk factors and safety planning to address violent impulses. For those with psychosis, use of antipsychotic medication and a focus on treatment adherence are critical; there is particular evidence that long-acting injectable antipsychotics and clozapine may decrease aggressive behavior.<sup>7</sup> Where possible, treatment should include teaching the patient skills in communicating feelings verbally, meeting needs through assertive rather than aggressive behavior, recognizing their own escalating anger, and removing themselves from volatile situations.<sup>2</sup>

A critical component of assessment and treatment planning is the identification of measures supporting the psychiatrist's own safety in the treatment setting: sitting closer to an exit, maintaining physical distance, avoiding being isolated, considering a chaperone or third party in the room, informing an on-site colleague or security of a meeting, not providing personal information to a patient, contacting law enforcement when needed, and seeking help from a supervisor or consultant. While involving law enforcement when needed has the potential to be lifesaving, it also may put individuals at risk of violence. This risk is heightened for Black individuals.<sup>8</sup> Consultation and supervision can be crucial in helping psychiatrists identify how their reactions may be affecting their ability to assess and treat the patient.

Psychiatrists should receive training in violence risk assessment, conflict management, and de-escalation skills. Novitsky and colleagues<sup>6</sup> describe the importance of talk-down strategies during the period of escalation, including affect management, active listening, and validation to avert violent behavior. Training in conflict management and de-escalation skills may be helpful. Guay and colleagues<sup>9</sup> describe the Omega program, developed to prevent workplace aggression toward health care workers by enhancing the knowledge, attitudes, and skills of clinicians when facing aggression by patients. An evaluation of the program found improvements in scores of psychological distress, confidence in coping, and in levels of exposure to violence.<sup>9</sup>

It is important to consider and try to mitigate the influence of bias in predicting and responding to violence risk. Whaley<sup>10</sup> reports that Black youth with violent behavior have been more likely to be sent to correctional facilities, whereas their White counter-

parts with similar levels of psychopathology and violent behavior were sent to a psychiatric hospital and that non-White (mainly Black) youth were more like than White individuals to be physically restrained for similar acts of aggression.<sup>10</sup> Interventions targeting implicit bias among clinicians may help to reduce disparities in risk identification and response to violence, although this warrants further study. Similarly, as indicated earlier, bias on the part of law enforcement can result in more aggressive behavior toward Black individuals, particularly male Black children, adolescents, and men. This may be particularly relevant when police are summoned to help manage an individual who is threatening violent behavior.

When treating a patient who elicits fear, it becomes apparent that what might be best for the patient, the clinical and ethical imperative of care, may conflict with what the psychiatrist believes is needed to protect themselves. However, avoiding aggression toward the clinician is ultimately in both parties' interests, and psychiatrists can align with patients by ensuring that treatment goals include those that the patient identifies, as well as by doing their best to prevent violence and pursue the safety of all parties. When risk becomes imminent, it is imperative that the clinician act to mitigate risk through use of emergency services, and if needed, law enforcement. This protects both the patient and the clinician.

#### ARTICLE INFORMATION

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