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SHORT REPORT

Psychiatrists and homicidal threats: a cross-sectional study

Musaab Elzain[1,*], Ahmed Bashir[1], Noreen Moloney[1], Colum P. Dunne[2], Brendan D. Kelly[3] and Gautam Gulati[1,2]

[1] *Department of Psychiatry, Mid-West Mental Health Service, University Hospital Limerick, Limerick, Ireland*
[2] *School of Medicine, University of Limerick, Limerick, Ireland*
[3] *Department of Psychiatry, Trinity College Dublin, Dublin, Ireland*

Objectives: To investigate the frequency, characteristics and impact of death threats by patients towards psychiatrists.

Methods: A cross-sectional survey of psychiatrists ($n = 60$) was undertaken to investigate the frequency, characteristics and impact of death threats by patients in one Irish healthcare region serving a mixed urban–rural population of 470,000.

Results: Forty-nine responses (82%) were received. Thirty-one per cent of respondents experienced death threats by patients during their careers. Victims were more likely to be male and in a consultant role. Patients making the threats were more likely to be males aged 30–60 with a history of violence and diagnosis of personality disorder and/or substance misuse. A majority of threats occurred in outpatient settings and identified a specific method of killing, usually by stabbing. Prosecution of the perpetrator was uncommon. Of the victimised psychiatrists, 53% reported that such threats affected their personal lives, and 67% believed their professional lives were impacted. In half of the incidents, there were adverse incidents subsequent to the threats, involving either the patient or the clinician.

Conclusions: Death threats by patients have significant psychological and professional impacts on psychiatrists. Early liaison with employers and police and transferring the care of the patient to another clinician may be useful measures.

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Key words: Death threat, doctors, psychiatrists, violence.

Background

Threats made by patients to harm or kill their psychiatrists can be a source of concern to the doctor, their family and potentially their clinical colleagues (Owen, 1992). Such threats are not uncommon; one survey of psychiatrists in the UK revealed that 34% of the respondent psychiatrists had received at least one death threat in their careers (Owen, 1992). Psychiatrists have been reported to be particularly vulnerable to such incidents, as with emergency medicine physicians and family doctors (Chicago, Ill; American Medical Association, 1995). This is most likely attributable to a combination of clinical and environmental factors in those settings, including relative prevalence of aggression and violence related to intoxication, acute psychosis and drug-seeking behaviour (Morrison *et al.* 1998).

Patients' death threats towards clinicians can be classified into two categories, situational and transferential (Brown *et al.* 1996). A situational threat usually occurs in circumstances where there may be a difference in opinion; such as when a clinician refuses to admit a patient to the hospital or a clinician declines to prescribe medications with risk of dependence (e.g. benzodiazepines). In a situational threat, the precipitant is easily identifiable. Transferential threats by comparison arise during the ongoing doctor–patient therapeutic relationship and evolve over time. A transferential threat can remain unresolved and is more likely to result in disruption to the clinician's personal and professional life (Brown *et al.* 1996).

Concerns around personal safety, paucity of relevant training and reticence to escalate threats to higher authorities are reported by doctors who have been threatened, verbally abused or physically assaulted by patients or their families while at work (Hobbs, 1994). While threats are more often made than fulfilled (Macdonald, 1967; Frelier & Holwerda, 2018), this is also true of the threat of suicide (Macdonald, 1967).

Although research on the perpetrators of death threats towards clinicians is limited, even less information is available on the experiences of physicians who were victims of these threats. Nevertheless, the available literature suggests that the impact of such threats on the physician is often substantial (Owen, 1992; Gulati, 2020). According to one survey on the impact of death threats towards psychiatrists, 45% of the victims reported an effect on their personal or professional lives (Owen, 1992).

*Address for correspondence: M. Elzain, Department of Psychiatry, University Hospital Limerick, Limerick, Ireland. (Email: musaabezain@gmail.com)

Against this background, the current study sets out to evaluate the frequency, nature, circumstances and impacts of death threats made by patients against psychiatrists, and to explore victims' perception of useful coping strategies through a cross-sectional survey in one Irish healthcare region.

Methods

Survey design

Following a literature review, a structured questionnaire was designed incorporating factors relevant to death threats made by patients against their psychiatrists (Owen, 1992; Brown *et al.* 1996; Sandberg *et al.* 2002). The survey questionnaire (attached as supplementary material) consisted of 23 items. These included baseline demographic data about the participant's speciality, gender and years of experience.

Participants were asked whether they had been subject to a death threat by a patient in their career in psychiatry, and the frequency of such threats, if any. Those who were victimised more than once were asked to give details on the most serious experience. Further questions probed into the frequency, nature, circumstance, impact and resolution of the event.

Participants

Eligible participants for this survey were all doctors working in the Department of Psychiatry in the Irish Mid-West; including consultant psychiatrists, and Non-Consultant Hospital Doctors (NCHDs). The region serves a mixed urban and rural population of approximately 470 000 people, residing in three counties. Following ethical approval, an online survey was sent to all eligible participants ($n = 60$) in November 2019 with a 30-day response window. Data were anonymised at the point of collection.

Analysis

Quantitative data were exported to Microsoft Excel 2016 (v.16.0) for descriptive analysis. The last three questions in the survey included open-ended 'free text' responses, and were therefore qualitative in nature. For these texts, analyses were used to assess for common themes, agreed with consensus from three independent researchers (M.Z., A.B. and N.M.).

Results

Forty-nine ($n = 49$) completed questionnaires were received, reflecting a response rate of 82%.

Table 1. *Demographic profile of victims*

Psychiatrists who were victims of threats	*n*	%
Male	9	60%
Female	6	40%
Mean (S.D.) years of experience	10.6 (9.8)	
Consultant psychiatrist	9	60%
Registrar	4	27%
Senior registrar	2	13%
Senior house officer	0	0%

Characteristics of respondents

Forty-nine psychiatrists participated in the study of whom 21 (43%) were female (Table 1). Of the 49 psychiatrists, 33 (68%) were working in adult psychiatry, 5 (10%) in the psychiatry of older adults, 5 (10%) in child and adolescent psychiatry, 2 (4%) in liaison psychiatry, 2 (4%) in psychiatry of intellectual disability and 1 (2%) each in forensic and perinatal psychiatry.

Eighteen respondents (37%) were consultants (i.e. fully qualified specialists), 15 (31%) senior registrars, 10 (20%) registrars and 6 (12%) senior house officers. The mean number of years of experience in psychiatry was 10.6 years [standard deviation (S.D.) 9.8]. The range for psychiatry experience was between 0.2 and 37 years. The median psychiatry experience was 6 years.

Psychiatrists who received death threats

Fifteen (31%) participants had received a total of 42 death threats. Nine of the 15 clinicians (60%) were males and 6 (40%) were females. Nine (60%) were consultant psychiatrists, four (27%) were registrars and two (13%) were senior registrars.

All of the nine consultant psychiatrists who received death threats from patients had received such threats on more than one occasion; two consultants received four death threats, one consultant received five death threats and two consultants received six death threats. Those who were victimised more than once were asked to provide detail on only the most serious incident.

Patients who issued death threats

The 15 patients (who issued the most serious death threats) were males and a majority ($n = 10$; 64%) were between the ages of 30 and 60 years (Table 2). Almost half ($n = 7$; 43%) had a diagnosis of personality disorder; 22% ($n = 3$) had a substance use disorder, and 79% ($n = 12$) had a history of violence.

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Table 2. *Demographic profiles of patients who made threats*

Patients issuing threats	*n*	%
Male	15	100%
Female	0	0%
Age profile		
30–60	10	64%
19–30	4	29%
13–18	1	7%
Diagnosis of patients who made threats		
Personality disorder	7	43%
Substance misuse	3	22%
Schizophrenia	1	7%
Bipolar disorder	1	7%
ADHD	1	7%
Acquired brain injury	1	7%
Conduct disorder	1	7%
Previous history of violence in patients who made threats		
Yes	12	79%
No	3	22%

Table 3. *Characteristics of the most serious death threat reported by each psychiatrist (n = 15)*

Setting		
Outpatient	9	60%
Inpatient	4	28%
Emergency department	1	7%
Forensic settings	1	7%
Precipitating events (87%, *n* = 13)		
Disagreement over prescriptions	7	53%
Patient mental status	3	23%
Clinician refused to admit patient	1	8%
Clinician involuntary admitted patient	1	8%
Clinician part of patient's delusion system	1	8%
Aftermath of the death threat		
No event followed	6	40%
Patient damaged property	3	20%
Patient assaulted the clinician	3	20%
Patient harmed themselves	1	10%
Patient apologised	1	10%
Impact on clinicians' professional life	10	67%
Impact on clinicians' personal life	8	53%

Characteristics of death threats

The analysis presented reports 15 of the most serious threats, and therefore relates to 15 incidents involving 15 victims and 15 perpetrators. Sixty per cent of the most serious death threats ($n = 9$) occurred in outpatient psychiatric settings and 28% ($n = 4$) in acute inpatient units (Table 3). Thirteen (87%) threats were made face to face and two (13%) were communicated through a third party. Fourteen (93%) of the perpetrators were known to the clinician and one (7%) was anonymous.

In nine (60%) cases, a specific method of killing was mentioned. Of those, 66% ($n = 6$) threatened stabbing with a knife. In one case, the perpetrator was armed with a knife, and in another, the perpetrator mentioned to the clinician that he was going to 'Kill [them] with a knife and cannibalise [their] heart'. Other threats included shooting, throwing acid on the clinician and stabbing using the clinician's pen.

A precipitating event was identified by the clinician in 13 (87%) cases. Of those 13 threats, 7 (53%) occurred because of disagreement over prescriptions, 3 (23%) were primarily due to patients' mental states, 1 (8%) was due to clinician's refusal of admission, 1 (8%) occurred after the clinician recommended involuntarily admission, and in one case (8%), the clinician formed part of the patient's delusional system (Table 3).

Aftermath of the death threat

In six (40%) cases, no adverse event followed the death threat. On three (20%) occasions, the patient damaged property and in another three occasions (20%), the patient physically assaulted the psychiatrist. In one incident, the patient harmed themselves and on another, the patient apologised and retracted the threat.

The police were informed following the threat in seven cases (46%). In two cases (25%), the matter proceeded to prosecution. A health service incident form was completed on one occasion only.

Regarding the psychiatrist's treatment plan for the patient who issued the threat, the doctor declined to see the patient again in seven cases (47%) and continued seeing the patient in four cases (27%). One patient (7%) was referred to forensic psychiatry services.

Effects on the clinicians' personal life and professional practice

The majority ($n = 10$; 67%) of psychiatrists who had experienced threats believed that the incident impacted on their professional attitude or behaviour. Reported changes included being more careful and cautious with similar cases, being fearful of patient's reactions and of possible attack, being extra vigilant about disclosing any personal details, taking every threat seriously, being more aware of the dangers of seeing patients alone, taking extra precautions and consideration of Tarasoff disclosures.

Eight of the doctors who received death threats (53%) believed that the threats affected them personally. They reported changes to their personal lives

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including increased anxiety and stress in the short term, anxiety every time they think about the incident, psychological harm and distress, stress and worry, and increased awareness of security at home and when coming and going from their place of work. In one case, the clinician changed their family GP as the patient was attending the same practice. In another case, the clinician reported that they had to be accompanied by security to and from their car for several months after the threat. Another clinician had avoided certain places and events, as they feared another encounter.

Factors that modulated the effects on clinicians' lives

Seven of the threatened psychiatrists (47%) mentioned that they found the support of their supervisors, colleagues or their teams very helpful. Three (20%) described their previous life experiences and own resilience skills as helpful. One psychiatrist described the support from the hospital security staff as helpful.

Discussion

This study investigated psychiatrists' experience of death threats by patients in one Irish healthcare region. A total of 31% of those who responded had experienced death threats from patients. This was comparable to Owen's (Owen, 1992) survey of 100 British psychiatrists, which found that 34% of respondents had experienced death threats by patients.

In our study, the majority of psychiatrists who received death threats were consultants (60%), rather than junior doctors. We also found that a significant proportion of the death threats (40%) were made against female doctors; a percentage that is significantly higher than Owen's (Owen, 1992) finding of 5%.

Our data showed that most threats occurred in outpatient settings 60%, compared to 28% in inpatient settings. This finding is different from that of Owen (Owen, 1992), where half of all threats were issued in inpatient settings. This may reflect the effect of psychiatric care moving increasingly from an institutional to the community model in the last three decades.

The clinical and demographic profile of patients who issued the death threats is largely in line with known risk factors for violence and is similar to previous studies. This includes middle age, male gender, diagnosis of personality disorders or substance misuse and a previous history of violence and aggression (Owen, 1992; Brown *et al.* 1996; Sandberg *et al.* 2002). Threats by people with severe mental illness (schizophrenia and bipolar affective disorder) were less common.

More than half of the identified precipitating events were due to disagreement over prescriptions. This suggests that the majority of threats were situational. Threats were associated with consequences both for the clinicians and the patients. Serious consequences were reported following half of the death threat episodes, for example, patients damaged property, physically assaulted the psychiatrist or harmed themselves, and in one incident, the perpetrator was armed with a knife.

Approximately 70% of psychiatrists who were subjected to death threats felt that the incidents affected their professional lives, and more than half stated that their personal lives changed as a consequence of the death threat. The respondents reported significant psychological distress, and that the incident had a long-term impact on their personal and family life.

Although clinicians who provide care to those with mental illness often evaluate and manage aggressive behaviour, deciding which course of action is best in a given situation can be challenging (Sandberg *et al.* 2002). Victimised clinicians may experience chronic and pervasive emotions including anxiety, detachment and indifference (Brown *et al.* 1996). Their personal and professional lives face disruption (Brown *et al.* 1996). The perpetrators, on the other hand, have often led lives with multiple challenges (Warren *et al.* 2008; Gulati, 2020).

In our study, an incident form was completed on one occasion only. Less than half of the clinicians experiencing death threats reported these to the police, and only in a quarter of the episodes did the matter proceed to prosecution of the perpetrator. Doctors' under-reporting of death threats may be explained by multiple reasons (Gulati *et al.* 2020). Doctors may hesitate to report threats at work, because they believe this to be an isolated event without any sequelae or they feel guilty and somehow responsible for provoking the incident (Morrison *et al.* 1998). Clinicians may feel embarrassed or think coping with aggressive patients is 'part of the job' (Harris, 1989; Morrison *et al.* 1998). Brown *et al.* (Brown *et al.* 1996) highlighted clinicians' denial as a defence mechanism impeding the successful management of patients' threats against clinicians.

Patient's death threats to clinicians result in complex clinical and ethical dilemmas. These demand a thoughtful response to maintain the balance between the clinician's safety and the patient's wellbeing. Acknowledging the lack of guidance for practitioners who may be the subject of death threats, Gulati *et al.* (Gulati *et al.* 2020) recommended that healthcare organisations develop explicit policies of zero tolerance for threats. They suggested that doctors have personal and ethical duties to inform both their line managers and the police, and to transfer care of the patient in order to ensure that the patient receives the care they need.

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Strength and limitations of the present study

The strength of this study is the high response rate (82%) and the breadth of data gathered from clinicians to inform a relatively under-researched area. The study is limited in generalisability by response bias, recall bias and refers to one region in Ireland. The same study carried out in a different region in Ireland or indeed another country may yield different results.

Conclusion

Death threats made by psychiatric patients to their doctors are not uncommon and many psychiatrists will experience at least one during their career in psychiatry. Death threats have significant psychological and professional impacts on psychiatrists. Direct supervisor and peer support can reduce this impact. Early liaison with employers and the police is a useful measure, as well as transferring the care of the patient to another clinician, in order to ensure that the patient receives the care they need.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The study protocol was approved by the Ethics Committee of University Hospital Limerick. Written informed consent was obtained from all the participants.

Supplementary material

To view supplementary material for this article, please visit https://doi.org/10.1017/ipm.2021.14.

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