I was sitting outside on a balmy Sunday reading the newspaper and enjoying a late morning breakfast, when the telephone rang. It was my office answering machine forwarding a message from a new patient: “I’m leaving! Leaving everything! If it matters to you, you can telephone me!” I had seen this patient for the first time the previous Friday. He was a small man in his early fifties, benign in appearance. When he had called to make the appointment, he professed having misplaced the name of the person who had referred him. He said he was under a lot of stress and terribly anxious. Talking about it on the telephone was too difficult and he wanted to wait and talk to me in person. He sounded troubled but coherent. During the consultation on that previous Friday, it was apparent that he was extremely paranoid. Despite my varied efforts to obtain concrete information about simple facts such as where he lived, his family, his work, and his occupation, I was blocked at every turn. “I’ll tell you when I know you better” was his stock answer. I scheduled a return visit hoping that in time I would be able to gain his trust and learn more about him, his family, or any other connections that I could enlist for support in dealing with his illness.

That was the extent of my knowledge prior to receiving his message. I quickly shifted from lazy Sunday mode to alert physician mind-set and returned his telephone call. Now he was much more disorganized. He said he going to have to leave town immediately “because there are dangerous forces out there and I may have to kill someone, I may have to kill the President.” “Why the President?” I asked, hoping to find some way to insert a bit of reality. “Because he has the power,” was the reply. With his agitation escalating by the minute, I said something to the effect of “Since the world seems such a frightening place to you, why don’t we think about finding some place where you will feel safe, such as a hospital?” That blew the lid off. He hurled a mass of expletives at me, one of which included an attack on a colleague of mine who had once forced him into the hospital. Then he hung up.

There I was on a Sunday morning with an explosive, paranoid patient who had threatened to kill the President and who had no known friends or family members. I didn’t even know his address. While I was collecting my thoughts and trying to remember whom you alert when someone threatens to kill the President (FBI?, police? secret service?), I put in a call to the colleague whose name he had mentioned, and to others I knew to be expert in dealing with police problems and hospitalizing patients. I also called a psychiatrist I knew who was a consultant for the FBI. I had quickly remembered that, when someone threatens the President’s life, you must notify the FBI. The FBI agent responded immediately and courteously. She assured me they could find out the patient’s address from the telephone number and would move to talk with him without delay.

As the day wore on, I received helpful, informative return calls from my colleagues.

The psychiatrist who had hospitalized my patient didn’t initially recognize who I was talking about. However, when I gave a more complete description, he realized it was someone he had seen under a different name. Since the patient presented a serious Tarasoff-type situation and appeared dangerous, he had placed him on an involuntary hold, further stirring up his rage. In the hospital, the patient quickly reconstituted and was soon discharged since the hospital was barred by law from detaining him for more than 72 hours and there were inadequate grounds for a probate court hearing. I also learned from this psychiatrist that the patient had an extensive gun collection.

A second colleague asked if I had a peephole in the door to my waiting room. When I said “no,” his sharp response was “Well get one, and get a gun too!”

Another colleague who returned my call was calm and reassuring. She talked about successfully treating a number of paranoid patients, including some who refused to take medication. She was ready to accept the referral to hospitalize him if that opportunity arrived.

My colleague who had done some consulting for the FBI wanted to make certain I understood the serious danger this situation posed. He said that it was important that I

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convey to the FBI how bland and benign this man appeared on the surface. His demeanor would make it much more likely that he could slip past the usual protective barriers, if, in truth, he was intent on trying to kill the President.

Despite not having the correct name or address, the FBI was able to locate the patient's home. However, when the patient didn't answer the doorbell, they were unable to go further without a court order. All the agency could do was to keep him under surveillance. Although the patient subsequently sent me hostile and paranoid letters, he did not return to my office. Fortunately he was hospitalized a few weeks later by a family member.

This alarming event and my colleagues' varied responses caused me to think anew about the issues of anticipating and dealing with patients' violent or assaultive behavior. Several studies have confirmed the unsurprising fact that there is a higher prevalence of violence in the psychiatric patient population than in the population at large.1-4 Experts in this area of research also express concern about psychiatrists' reactions of denial and avoidance. In studying assaultive behavior in psychiatric patients, Dubin et al.5 learned that, of the 56% of psychiatrists who continued to see the patient after having been attacked, 21% never discussed the incident with the patient in any subsequent session! Madden et al.6 also found that, faced with a patient making threatening statements, psychiatrists often avoided following up with specific questions that would help to clarify the risk. They surveyed psychiatrists who had been physically attacked and found that 55% of them, looking back on the sessions prior to an assault, could see that the patient had reported feelings that indicated a potential for violence against them. This was material the therapists had failed to follow up on or to clarify. An aversion to pursuing these leads puts clinicians at much greater risk.

Encounters with patients take place in a variety of settings: brief consultations in emergency rooms, longer contacts on an inpatient service, or evaluations and treatment in an outpatient setting. It is usually easier to recognize signs of decompensation and the escalating potential for violence in patients who are seen longitudinally. This is only true, of course, if one is open to the clues. The clinician's major enemy is to hear threats. This "deafness" may spring from unresolved conflicts about aggression, concerns about not being in control, fantasies of therapeutic omnipotence, or simply being afraid. Whatever the source, it needs to be made conscious and understood in order to reduce the danger to both the patient and therapist.

Those whose psychiatric practice is primarily devoted to psychotherapy are not immune from these dangers. There is always the first visit. Unless the patient has been referred by a colleague who is familiar with him or her, the psychiatrist is facing a complete unknown. It is important to take the time during the initial telephone contact to make a rough assessment of the patient's mental state while you still have the protection of distance. You should also obtain an address and telephone number that you can call back to confirm the appointment and the accuracy of the information. In the case described above, I had not done any of these things. The patient had sounded so distressed that my denial and fantasized therapeutic omnipotence conspired with my wish to help and led me to make an appointment quickly in spite of the patient's evasive answers. In this instance, the situation ended safely but that might not always be the case.

A number of strategies can help mental health professionals minimize the risk of violence:

- Appreciate the potential for violence.
- Be aware of your own reactions to expressions of violence so that you are less likely to deny realistic dangers.
- Avoid false bravado that can cause you to behave in a foolhardy manner.
- Take proper precautions: Be sure you can see who is in the waiting room. If it is possible, install a panic system that signals a colleague, answering service, or security system.
- Take a history that includes clues about possible aggressive behavior (e.g., a history of getting into fights, encounters with police, and explosive outbursts).
- Also be certain to take a history of substance abuse.
- If a patient hints at having been assaultive, or alludes to that potential, be certain to explore the exact details in an empathic and carefully considered manner.
- Never be reluctant to ask for a consultation or supervision.

References