"I just can't, I am frightened for my safety, I don't know how to work with her"

Practitioners' experiences of client violence and recommendations for future practice

Abstract

To what extent is the therapist-client relationship damaged following client perpetuated violence and what steps can we take to diminish its impact? Much of the information we have on client violence comes from multiple mental health disciplines in the US and the UK over the last 20-30 years and has formed a useful, though sometimes dated and sporadic, quantitative baseline to delineate a range of issues. However, there is limited systematic research on how practitioner psychologists process the violence in the course of their everyday practice and how this impacts the therapist-client dynamic. Using Interpretative Phenomenological Analysis (IPA), we explored seven therapists' experiences of client violence across a range of work sites – acute psychiatric hospital wards, forensic hospital wards and community mental health teams. Three main themes were documented: processing the moment-to-moment experience of client violence; professional vulnerabilities and needs as a result of client violence; and the ruptured therapeutic relationship.   Strategies for supporting practicing psychologists and providing continuing professional care for clients include challenging self-doubt and re-energizing professional competencies as well as repairing ourselves and repairing the therapeutic relationship. Recommendations for credentialing and regulatory bodies in relation to client violence are also highlighted.

Introduction

Client violence in the workplace has been on the healthcare agenda over the last few decades but diminishing economic resources in healthcare settings has had an impact on institutions and organizations responding to increasing occurrences of client violence (Privitera, Weisman, Cerulli, Tu & Groman, 2005). In parallel, the research body on client violence has become more sporadic and less cohesive over the last ten year period, partly due to the fact that the topic of 'client violence' spans multiple health care disciplinary and professional areas. Contemporary publications concentrate on managing reactions to the client violence and trying to keep the health care professional safe (for example, see Bourne, 2013) while public health bodies collect incident rates of the violence itself, mainly for its impact on costing, the production of policy guidelines, and the effectiveness of those policies (for example, see National Audit Office, 2003).

Physical violence against healthcare professionals in the United Kingdom between 2009 and 2010 cost the UK National Health Service (NHS) £60.5 ($99) million per annum (National Health Service Business Service Authority, 2011). This includes costs for litigation and damages, conflict resolution training, anti-violence policing, staff exit, and staff absence and sickness. While there is a concern about the wellbeing of healthcare professionals across all fields, Wright, Gray, Parkes and Gournay (2002) suggest that there are some clinical settings in which staff are more likely to witness or be victims of client violence - staff working in psychiatric hospitals, prisons, and emergency departments. There is also particular concern for staff working with individuals suffering with mental illness (Rippon, 2000; Swanson, 1994).

The American Psychological Association (APA) reported that 35-40% of psychologists in clinical practice were at risk of being attacked from a patient at some point during their professional career (APA, 2002). Guy, Brown and Poelstra (1990) found that nearly 40% of their 340 participant sample had been attacked one or more times by a client. Psychologists suffered both physical and verbal attacks with the physical attacks involving blows from feet and fists and clients using weapons such as guns, knives and ropes. Trainees and graduate students were most likely to be attacked compared to those with more professional experience. More recent figures suggest that over a four year training period, between 40-50% of psychiatry residents will be attacked by patients and even post-qualification, health care professionals state that they have little knowledge of standard reporting procedures for client violence attacks (Rueve & Welton, 2008).

There is often no rationale for client violence (Reid, 2008) and no standard accepted definition of the violence itself (James, Fineberg, Shah & Priest, 1990) although a small scale study (N=19) in the late 1990s did acknowledge that limit setting and communication issues predicated 90% of aggressive incidents[1] (Bjøkly, 1999). While Anderson & West (2011) outline static and dynamic factors that may be useful in understanding risk factors for client violence, we do know that clients suffering from extreme psychological distress, chronic mental illness, drug and alcohol impairment, and brain damage tend to place health care professionals at particular risk for physical and verbal attacks (Jorgensen & Hartman, 1997).

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[1] 4 inpatients were responsible for 80% of the 2,021 aggressive encounters over a 10 year period

The psychological impact of client violence on healthcare professionals

Client violence is often viewed as an occupational hazard despite research evidence that its psychological impact evokes a stress response in the individual and is similar to that of trauma associated with street crime or natural disasters (Erdos & Hughes, 2001; Hogh & Mikkelsen, 2005). Several studies have shown that verbal abuse can have the same emotional impact as physical aggression (Budd, 1999; Bowie, 2000; Hatch-Maillette & Scalora, 2002) and psychological responses to client violence range from depression, anxiety, self-doubt, to anger and fear (see Pope & Tabachnick, 1993). Notably, the emotional impact of the experience often outweighs the impact of the physical injury (Whittington & Wykes, 1992, 1994).

Continuing threat of physical or verbal aggression in the workplace can also affect the confidence and morale of staff as well as staff members experiencing 'burnout' and Post-Traumatic Stress Disorder (Carter, Kenkre, & Hobbs, 1997; Ehlers & Clark, 1999; Rogers & Kelloway, 1997). Taking extended sick leave, asking for a transfer or leaving the job entirely is also a response to the violent incident as individuals avoid the client and the workplace where the attack happened (Kessler, 2000).

Client violence also negatively impacts on work performance. Whittington and Wykes (1989) found that many healthcare professionals reported experiencing a loss of concentration after being assaulted and rumination over the event caused stress, role conflict and feelings of demoralization (Arnetz & Arnetz, 2001). Individuals who have been assaulted at work often feel responsible for the attack leading them to feel angry and guilty and this is exacerbated with unsupportive colleagues and managers (Lanza, 1987).

Impact upon the quality of client care

Quality of care provided can quickly deteriorate due to the individual's reaction to the assault by the client (Wallis, 1987). Shepherd (2001) noted that mental health patients who attack caregiving staff are rarely prosecuted when the individual is known to suffer a mental health disorder and/or is receiving psychiatric treatment. In contrast, Hoge & Gutheil (1987) found that staff that had been assaulted thought that psychiatric ward patients were conscious of, and in control of their behavior at the time of the attack. Coupled with a relatively low likelihood that prosecution will be pursued and/or be successful creates tensions in the caring didactic and anger and frustration may be directed at managers, colleagues or the organization for failing to protect them (Barling & Kryl, 1990). Health care professionals who experience client violence may feel less committed to their organization and performance at work may begin to fall (Barling, MacEwan, Kelloway & Higginbottom, 1994). Using patient ratings of the quality of care, Arnetz and Arnetz (2001) reported that hospital based healthcare professionals who had experienced client violence were likely to provide lower quality care to patients.

Processing client violence

Spiegal (1980) argues that therapists are susceptible to client violence as their professional practices often involve working at an intense personal attachment level in therapy. This can at times produce hostile counter transferences within the therapeutic relationship and may cause the client to become violent or abusive. Having difficult and emotionally charged conversations with vulnerable clients might also increase the likelihood of aggressive behavior (Star, 1984). While psychological formulation is a core competency for psychologists and serves as road map for work with the client (Johnstone, Whomsley, Cole & Oliver, 2011), tendencies to 'formulate' client aggression may become problematic as therapists focus more on psychologizing the

behavior while failing to acknowledge the impact the incident may have had upon them. Indeed, Adams & Whittington (1995) discuss how healthcare professionals use a particular strategy of depersonalization. They found that staff that had been attacked would not personalize the patient's violence but rather consider it to be part of the patient's mental health issues. In particular, there is little knowledge about how, or if, psychologists use formulation as a mechanism in dealing with client violence.

Being unable to remove oneself from the source of the original trauma site and having to continue to work with clients who have attacked them, the mental health professional may be predisposed to engage in strategies of denial (Wykes & Whittington, 1998). However, using a phenomenological approach, Carlsson, Dahlberg, Lutzen and Nystrom, (2004) identified the usefulness of an inner dialogue used by mental health professionals when they were being attacked by a client. Using an inner dialogue, participants established shared feelings of suffering and pain with the client, reduced feelings of fear and anxiety and brought about a positive resolution to the violent incident. Less successful encounters highlighted an overwhelming reaction to the event where participants were unable to cognitively process the behavior unfolding in front of them.

A culture of under-reporting?

Viitasara (2000) argues that there are factors that contribute to under-reporting client violence. Physical violence is often under-reported due to a practitioner's fear of the perception their colleagues and managers would have of their performance and the perceived damage they believe it would have on their professional image (McDonald & Sirotich, 2001). Some healthcare professionals believe that there would be no outcome from reporting the incident, dislike the administrative burden of reporting, believe that violence is part of the job

and believe that mental health practitioners should be able to look after themselves (Jansen, Dassen & Moorer, 1997). Shulman (1993) noted that those who had experienced client violence sometimes wished to avoid talking about the incident in an effort to avoid acknowledging vulnerability. Lack of follow-up and supportive counseling from management add to the culture of under-reporting (Antonius et al., 2010).

Rationale for Research

Social research, audit trails and evaluation reports have used quantitative techniques to collect incident rates and types of client violence across health professionals – for example, the APA (2002) and Hilton, Perkins & Pillay (1992), on behalf of the British Psychological Society (BPS), have both used surveys to aid in the creation of local policies and procedures to reduce the risk of violence in the workplaces of clinical and counseling psychologists. Less emphasis has been placed on documenting the subjective reality of client violence for practitioners and there is currently little information about how psychologists experience client violence. There is also limited understanding of how psychologists process the violent incident *as therapists* and how this impacts the therapeutic alliance. However, working within a qualitative paradigm and adopting a phenomenological approach, we can explore the complexity and depth of practitioners' accounts of client violence. We used Interpretative Phenomenological Analysis (IPA) as a research methodology as IPA focuses on how a 'particular' phenomenon is understood by 'particular' people (Smith, Flowers & Larkin, 2010). IPA engages us as researchers with a detailed exploration of our participants' lived experience and locates the phenomenological account within a constructed reality (Ponterotto, 2005; Smith, 2011). We also wanted to document and develop any adaptive or helpful strategies used by psychologists

as a response to client violence that could be used to help health professionals in the therapeutic professions to deal with this issue.

The Study

The Psychologists

Seven participants were recruited, four participants through the UK National Health Service (NHS) and three participants who responded to the advertisement placed on the British Psychological Society Division of Counselling Psychology website. Ethical approval for the research was obtained from both the University of East London's ethics committee and the National Health Service Research Ethics committee, South West London. All participants were Chartered[2] Counselling or Clinical Psychologists who had experienced client violence at their place of work and were willing to explore their experiences.

Client violence was pre-defined by the Department of Health's Zero Tolerance Zone Campaign (1999) – specifically, "any incident where staff are abused, threatened or assaulted in circumstances relating to their work" (see also the International Labour Office, 2013). Participant recruitment literature used the definition of client violence as encompassing "both physical and verbal abuse which includes discrimination, racism, threatening behavior, and intimidation". Participants who had witnessed violence as opposed to experiencing violence first-hand were excluded from the research.

Two of the seven participants worked on a Community Mental Health Team, two participants worked in an acute psychiatric ward and three participants worked in a forensic ward. There

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[2] Chartered status refers to the UK benchmark for competencies and expertise as a professional psychologist, is required for therapeutic practice, holds legal status, and is awarded by the British Psychological Society (BPS) under Royal Charter.

were two men participants and five women participants and their ages ranged from mid-twenties to early fifties. Three participants described their ethnicity as being White British, two participants described themselves as White Other, one participant described herself as White Irish and one described herself as British Asian.

Of the seven individuals[3] who participated in the study, five participants reported verbal abuse from their client in two community mental health settings (John and Rose), two forensic ward settings (Mary and Lauren) and one acute psychiatric ward setting (Rebecca). Two participants experienced physical abuse from their clients – Sophie in a forensic ward and Martin in an acute psychiatric ward setting. Table 1 provides participant information, including a short description of their experience of client violence in the workplace.

INSERT TABLE 1 HERE

The Research Interviews

The interview questions focused upon Counselling and Clinical Psychologists' experience of client violence in the workplace, specifically looking at the effect it may have had upon professional and personal identity and psychological wellbeing (see Appendix A). The semi-structured research interviews lasted between 40-60 minutes and were carried out in the participant's workplace. During the debrief, participants were provided with information of a NHS based organization that specialized in providing free and confidential support to NHS staff. Participants were also offered a follow up telephone call from the researcher to discuss their

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[3] Pseudonyms were used and references to locations or specific National Health Service settings were removed during transcription

experience of the research interview but all participants declined this offer. The research interviews were transcribed by the first author.

Data Analysis

Analyzing participants' accounts is a dynamic process in which the researcher attempts to access the phenomenological experience through a process of interpretative activity (Smith, 2003). Smith et al. (2010) also discuss the importance of the researcher being aware of his or her preconceptions in advance and brackets or acknowledges his or her preconceptions. In response to this, the first author produced a reflexive log and referred back to this during each stage of analysis. IPA allows for a detailed and intensive engagement of each individual transcript and the guidelines provided by Smith et al. (2010) were followed for the purposes of this analysis.

The initial stage involved reading and re-reading the transcripts to gain familiarity with the texts and an overall understanding of what had been said, as well as an insight into the ideas and feelings expressed by the participants. The second stage of IPA analysis required the first author to identify and classify initial themes from each transcript that characterized each section of the text. During the third stage of analysis, the first author reviewed the emerging themes and, with the second author, explored how themes that have shared meanings clustered. The final stage involved developing a framework for the themes, considering how they fit together both within and across transcripts.

Using interpretive phenomenological analysis (IPA), we found three main themes, each with two sub-themes (see Table 2). *Processing the moment-to-moment experience of client violence* had sub-themes of "feeling afraid" and "listening to an inner dialogue"; *professional vulnerabilities and needs as a result of client violence* had sub-themes of "questioning professional competencies" and "getting the right support"; and *the ruptured therapeutic relationship* had sub-themes of "rejecting the client" and "accepting the client through formulation".

INSERT TABLE 2 HERE

Processing the moment-to-moment experience of client violence

This theme has two sub-themes – the first with a basic, predictable and understandable feeling of panic and fear in response to the client violence. The second sub-theme, listening to the inner dialogue documents the passing of the fearful response, prominent emergence of self-talk and real time processing of the incident through active decision making.

"Being afraid"

Therapists reported fear when the client became aggressive and while this is expected, we note how it impacts the power dynamics of the therapeutic relationship, revealing a loss of control and an increasing sense of vulnerability for the therapist. Rebecca discusses her feelings towards the client when he became aggressive:

> *I thought I had a reasonable rapport with him… as he was shouting I felt quite scared, I was thinking what was going to happen, very aware of where the exits were….He stood up at one point, I was still sitting down, and he was a fairly big chap so he was stood*

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over me and shouting. That was probably the most frightening bit... feeling quite uncertain about what to do, how to handle it.

Here we find that the givens of the therapeutic relationship have been overturned and Rebecca froze in fear of the client's physicality. Rebecca became unsure of how to deal with the situation she faced and in some ways, she was locked in by the script of the therapeutic relationship. Rebecca does not have an appropriate alternative script to process the client's behavior. While dimensions of the therapeutic relationship have locked Rebecca in, this does not seem to be the case for the client.

Sophie described how the therapist led interaction was overturned:

We didn't have personal alarms there and the only thing to do was to adopt a submissive dog pose rather than being confrontational... I was terrified, I really thought she was going to thump me... I remember feeling very frightened, very helpless.

Sophie found herself in a position where she used her body language to clearly display her powerlessness and vulnerability as she feared for her personal safety. The client took control of the immediate environment and the psychologist is helpless in trying to garner support for herself. Even the organizational structure, with the absence of personal alarms, has let Sophie down. The therapeutic relationship fades into the background as personal safety takes prominence and for this moment, fear pushed the therapeutic alliance into a lost space.

"Listening to the inner dialogue"

Martin moved through the fear response and considered direct physical action against the client:

I probably had to reassure myself that feeling frightened was kind of okay ...as well as what [do] I do to stop this and get out of this situation? I would have had to kick at her to push her away so that I could get up.. just trying to get out, not getting hit, not getting hurt

Martin experienced unfamiliar feelings in the therapeutic setting, attempting to defend himself and aggress against the client. He sought a route away from the client – the antithesis of the therapeutic intimacy usually found in the therapist-client dyad. The inner dialogue is used to escape from the pressing threat posed by the client's behavior in an attempt to pull through the fight-flight response. Lauren used the inner dialogue to access core therapeutic competencies in an effort to restore equilibrium:

> *I suppose my immediate thought was 'I wonder if I can actually help him calm down? I was trying to think I'd try and do something different to what a nurse would do, which is to grab him and take him away, I thought that actually maybe I could do more talking, sit him down and get him to calm down by talking and it didn't work and I suppose I felt upset that it hadn't worked really. That I hadn't kind of managed to carry on engaging him.*

Relying on therapeutic skills to deal with the violent incident brought a sense of foolishness and the inner dialogue highlighted frustrated failure as she registers her disappointment with the usefulness of her clinical engagement skills in the midst of the incident.

Professional vulnerabilities and needs following the violent incident

This second major theme is revealing for counseling and clinical psychologists who took part in the study as it uncovers the professional positioning that these health professionals find themselves in following an incident of client violence. The first sub-theme, questioning professional competencies, highlights a deep sense of professional failure experienced as a result of the client violence. Getting the right support, the second sub-theme, noted the struggles participants have with talking through the clients' needs in a supervisory relationship and points towards a need for therapists to be listened to, and to validate their experience of the violent incident.

"Questioning professional competencies"

Rose brought into question her basic competencies given that it would be usual that this particular client group experiences issues such as anger management and would have difficulties sustaining inter-personal relationships:

> *Perhaps it would show that I couldn't cope with verbal abuse or people being angry. A lot of our clients in complex care do get very angry.. it's a given.*

Yet here it is not only Rose becoming conscious of a perceived lack of skills but how that could be perceived by others who are significant in her professional sphere. This becomes evident in Lauren's response:

> *I did think "oh, I wonder whether they [other colleagues] thought I'd provoked him?" Because I suppose one of the things that we do as psychologists on the ward, we often support ward staff after incidents and debriefings and maybe they thought "Maybe she doesn't know what she's talking about?"*

Lauren brings into play the more complex professional relationship of the psychologist working in an environment where psychologists are used in a consultant role for other health professionals. The hierarchal nature of workplace dynamics between health care professionals is perceptible here and so the participants not only self-judge their competencies following the violent incident but also consciously process the potential judgments coming from team peers. More specifically, Martin comments:

> *The incident was in a very public place. My colleagues were sitting next to me, my team on one side and my assistant psychologist on the other - there was a doctor, SHO [Senior House Officer], the consultant. There's this self-consciousness around how do I deal with this anxiety around behaving professionally, behaving responsibly and not panicking… Are they thinking, "well, that was a clumsily asked question" or "that was a provocative question"?*

Martin's professional skills were brought into question not only by the client's violent behavior but also by the perceived professional judgments of his peers and senior colleagues. Martin felt his therapeutic skills were under scrutiny and the intensity of that scrutiny is magnified with his self-doubt.

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"Getting the right kind of support"

Participants were clear in how they thought the client violence could be dealt with in the workplace and moved away from talking about the incident when in supervision as this returned them to the therapeutic relationship where the needs of the client were paramount. Rebecca initially establishes the occupational parameters and local agreements relating to client violence in her workplace:

> *I was quite surprised actually - you get all the posters about staff won't tolerate violence and you got trained if you're in doubt about a session and your safety, just don't have the session. And I remember saying to her "I just can't, I am frightened for my safety, I don't know how to work with her". And my supervisor was quite firm and said "but therapeutically that's really difficult, it's another sort of experience of abandonment for this client".. and this, that and the other.*

During supervision, Rebecca feels unheard as the supervisor places the client's needs above those of Rebecca and Rebecca feels pushed to continue to deliver therapy to the client. Rebecca's phenomenological experience of the client violence dissipates into a therapeutic modality that leaves Rebecca cold and detached from the supervisory process. John contrasts the different preferred reactions between peer support and supervision:

> *I can remember just feeling like I needed to offload about it a little bit and all I really wanted from my colleagues was "God that sounds difficult" . So when I shout like that I don't particularly want my colleagues to say 'have you thought about doing A, B and C', I just want a bit more of 'yeah, that sounds really tough'. I had a kind of very solid and kind of trusting relationship with that supervisor. So I had no doubts about bringing it to him and I kind of knew that he'd deal with it in a very sort of objective way. I could bring a dilemma like that and not feel like I'd failed somehow. So I didn't feel nervous about bringing it to supervision.*

Whereas Rebecca's blocks in the supervision relationship concerned her supervisor not appreciating fears of personal safety, John considered whether his supervisor would doubt his therapeutic skills. John decided that his supervisor would be supportive (and not critical) before actually taking the incident to supervision. John defines the specific conditions that

made him able to speak about client violence in a comfortable manner in supervision – these center around the assessment and predicted judgment of his supervisor.

Both John and Rebecca bring to light the tensions of dealing with client violence in supervision where they find the supervision response lacking or judgmental. In contrast, Sophie comments on an initial, almost informal post-incident debriefing:

> *There was a woman [a nursing staff member] who I got on quite well with and she was very nice and she could see I was obviously a bit shaken.. [she] sat me down. We just went through what happened, recorded it all in the notes, did the incident report.. It's about speaking to somebody that I knew and who could say the right sort of things to me. So it wasn't a case of having to have a debrief, it was just a kind of 'rah, rah, that didn't feel very nice, thought I was going to get hit, didn't know what I was doing'... I found it useful, helpful.*

Sophie experiences a suitably compassionate, sensible and comforting support from a trusted colleague. It is adequate for the level of client violence that she experienced and Sophie feels listened to and not judged.   The offered support was non-threatening yet acknowledged Sophie's vulnerability during the incident. Sophie's account links to the leveling response that John and Rebecca speak of - where they feel (or want to feel) heard by colleagues and want some acknowledgement about the impact of the client violence against them.

The Ruptured Therapeutic Relationship

The third theme, The Ruptured Therapeutic Relationship, points out a set of dialectical tensions following client violence. Therapists found it difficult to sustain a balanced therapeutically based relationship with their aggressor and reactions to the client violence ranged from outright rejection of the client and thoughts of physically harming them to attempting to repair the relationship by 'formulating' the client violence away.

"Rejecting the client"

Sophie's first response to the incident is to look to acute psychological causes but her anger and frustration grow as she struggles to use more logical format as she sees this in not the case:

> *It goes against my clinical knowledge and my clinical thoughts… part of you is thinking you should have control, how dare you, it's not like you're so 'floridly unwell' that you're all over the place. So again, that anger with the client.*

The quotation reveals the parameters around the therapeutic relationship where Sophie believes that the client has moved out of the expected (and controllable) therapeutic relationship. Essentially Sophie is angry with and rejected the client because they have broken the psychological contract and Sophie is unable to use the client's psychological state to explain the aggressive outburst. Martin became so angry with the client that the therapeutic relationship was severely undermined:

> *Afterwards I was pissed off with her, I did not really want to talk to her. I have a clear recognition of not wanting to contribute to her care… [I] remember wanting to pursue things with the police. I was cross with her - that combination of grumpy and 'you tried to hurt me last time' so I'm not going to help you, not get involved in your treatment.*

Martin distances the client through making the incident a legal matter but essentially Martin begins to withdraw from the therapeutic relationship itself. Clear boundaries are drawn in terms of what Martin has now found unacceptable from his subjective experience of the incident. It was an attack on the self and Martin is clear that the withdrawal of his therapeutic 'help' is a consequence for the client. Mary publically admits feelings of annihilation towards the client:

> *After the group and I went to the office and actually said to my co-facilitator that I want to strangle her. I was at the height of that emotion that I was actually physically feeling that I would go and strangle her.*

This acknowledges the extremely fractious relationship that has developed between Mary and her client and the inter-personal destruction that the incident created. It has become a critical event in the delivery of the therapy and we record elements of distrust, distaste, anger and visceral hatred from the therapist to the client.

"Accepting the client through formulation"

Rose's empathy with her client was challenged as a result of the violence and Rose reaches to clinical competencies to restore a balanced, steady and neutral alliance:

> *I remember thinking, 'I want to understand why she's angry' and possibly come up with some formulation that linked her anger to her personal history… I was trying to understand it from a psychological perspective, trying to find a formulation to help me with my empathy.*

For Rose, the risk of losing empathy is abated through the use of formulation and John discusses how he used formulation to understand his client's verbal threats and aggression through a transference process:

> *He'd refer to me as if I was his dad. So he'd start saying "I'm going to kick your head in". I don't think he was actually threatening me as a therapist but he was at risk of forgetting who I was. I kept it in my mind the this isn't about me, you know, he's feeling that way and he's talking to me in the first person but actually he is still thinking about his dad and this isn't really about me and we can work with it.*

Formulation helps to distance the violent behavior and makes it more accepting and acceptable to the psychologist. Formulating the aggressive outburst from the client allows the therapist to regain control and reject negative behavior emanating from the client. Formulation is used again as Sophie considers how a <u>future</u> therapeutic relationship can be re-established (i.e. not in the here-and-now):

> When I thought about it [the client's aggression] in a schema focused way.. the idea of schema modes and flipping into different modes from something, I could see how we could help this woman later on.

Sophie adopted a more sustaining perspective through the use of formulation – where the meaning of the aggressive behavior is suspended for a more appropriate space in the therapeutic process for consideration. Ultimately, this [re-]accepts the client back into a therapeutic relationship by reversing the power imbalance as a result of the violence and placed the therapist back in a dominant position compared to the client. Formulation brings clarity but also the re-establishment of basic roles between therapist and client.

Challenging self-doubt and re-energizing competencies

Client violence is a poorly acknowledged occupational hazard for professional psychologists delivering therapy in public (and private) healthcare sites. Our participants experienced tangible fear and displayed reactions similar to other healthcare professionals who had found themselves at the end of client violence (for example, the presence of an inner dialogue) (Carlsson et al. 2004). Reflecting on the causes of client violence was not appropriate during the incident (see Molander, 1996) and participants relied on an inner dialogue to help keep them safe within the environmental and organizational boundaries they found themselves in. Most organizations have specific protocols to deal with clients who have a history of dangerous and violent behavior and psychologists should be familiar with and adequately trained to implement such procedures on site. While institutional assessments should continually review the processes they have in place in order to support psychologists delivering therapy, what can the practicing psychologist do in response to overt client violence? In the sections below, we set out recommendations for practitioners using the current research literature available and the main findings from this research study. We also include recommendations for credentialing and regulatory bodies to help support practitioners tackle the issue of client perpetuated violence.

Recommendations for Practicing Psychologists

Mueller & Tschan (2011) point out that residual feelings of psychological distress stay with healthcare professionals following the violent incident and leave employees with less job satisfaction, depression and fear of future attacks. To a degree, participants ruminated over their professional practices with the client in question and became conscious of and began to doubt their competencies, especially in front of peer groups and senior colleagues. Similar

reactions amongst other healthcare professional groups have been recorded in the literature (Brasic & Fogelman, 1999; Flannery, Naderson, Marks & Uzoma, 2000; Spencer & Munch, 2003).

Our research participants actively looked towards their colleagues and managers for support and acknowledgement following client violence in the workplace and, indeed having supportive peers and supervisors can significantly improve a victim's sense of coping and lessen their fear of further attacks (Mezey & Shepherd, 1994). Despite this, participants noted that client violence was part of the job and were reticent to take complaints against clients further.

Worryingly, Beale, Fletcher, Leather and Cox (1998) comment that healthcare professionals who have been attacked may not report further client violence due to adverse judgments from peers and managers, leading to passivity from the victim's perspective and under-reporting from an organizational perspective (see McDonald & Sirotich, 2001). Consequently, low-level violence within their job, such as aggression and verbal threats becomes 'tolerable'. Continuing to work in an environment where there are threats of continuous violence will lead to low staff morale, professional burn-out and, again, low job satisfaction (McAdams & Foster, 1999).

Recommendations to challenge self-doubt and re-energize competencies

Client violence is usually an isolated incident: one incident of client violence is superseded by many other successful psychological interventions over a professional career

Giving permission to take care of oneself: Psychologists might sometimes feel that their specialism means that they "should" be able to respond to a broad range of difficult and challenging clients and situations in the workplace. However, keeping yourself safe in the face of client violence allows us to continue to deliver care in the longer term.

Acknowledging psychological distress: A number of emotional reactions are experienced during and after client violence and can continue over a period of time, including fear, guilt, shame, depression, and sadness. These feelings are a normal part of the experience of a traumatic incident and it is important to talk these feelings through with a trusted colleague.

Our responsibilities as colleagues: Listening, being aware and being mindful of colleagues' experiences are integral to our fidelity and integrity as psychologists, especially with trainee or novice practitioners. Discussing the option of re-assigning the client to another practitioner may be an avenue of support for the therapist-victim.

Low level client violence is unacceptable: Workplaces to move beyond tolerating low level violence and organizations and private practices continually review the processes they have in place, paying heed to local conditions and variations, putting in place effective safeguards

Repairing us and repairing the therapeutic relationship

Participants experienced dialectical tensions in terms of accepting and rejecting their clients following the violent incident. They were left in an impasse where it became difficult to move forward with their clients in an authentic fashion, but producing a formulation allowed the participants to begin to think about re-constructing a working alliance. Client violence is a therapy interfering behavior and some therapeutic modalities advocate that this client violence could become the focus of therapy (see The Linehan Institute, 2014). For the purposes of this paper, formulating the client's behavior in such a way may function to reduce the fears of being attacked again for the psychologist (Semmer, McGrath & Beehr, 2005). 'Presenting a formulation' of the violent behavior, especially to senior colleagues, demonstrates continued competencies and avoids the fear of losing clients and future referrals. However, there may be a risk that using formulation in this manner may prevent the psychologist from emotionally processing the incident. Psychologists might be less concerned of their own emotional and psychological wellbeing than they are concerned about making sense of the client's behavior.

As we have seen, psychologists are not immune to vocational hazards and feelings of diminished professional competencies negatively impact our psychological wellbeing (Mahoney, 1997; Smith & Moss, 2009). Some psychologists may be reticent to receive help, support and compassion from others. Barnett (2008) notes that we have 'professional blind spots' as we perceive ourselves predominantly as helpers rather than those who need to be helped. This may prevent us from seeking further consultation and taking corrective action over violent incidents. Indeed, Kleepies (2002) asserts that psychologists are currently not giving client violence appropriate consideration or concern. We have professional obligations for self-care and this includes making effective decisions about continuing to see clients while ensuring our own safety (see also Johnson & Barnett, 2011).

Putting perspective on the therapeutic relationship following client violence

Raising awareness about client violence: Violence in the workplace is a reality and psychologists can recognize and acknowledge this occupational hazard, especially when in contact with specific client groups. Violence can occur *without warning* and can often seem unprovoked and senseless. There are not always obvious triggers or signs that indicate the client will become violent or aggressive.

Giving yourself permission to walk away: Psychologists can find it difficult to resist the desire to help, to seek a therapeutic way of responding to a challenging moment with a client, or to consider ways in the situation can be de-escalated using psychological methods. Sometimes it is safer to walk away from the incident, rather than attempting to continue care.

Continuing therapy? Fear and anger towards the client creates a breakdown in trust and the fissure in the therapeutic alliance is likely to impact on the goals and tasks of therapy and, therefore, the outcomes for the client. The psychologist may discuss the option not to continue to deliver therapy for the client with colleagues; and/or to terminate therapy when threatened or put into danger by the client.

Targeted Support Sessions following a violent incident with a client: Support sessions may firstly, explore the distress and trauma associated with the violent incident; secondly, acknowledge impact upon professional identity and competencies; and thirdly, provide a space to emotionally process their experience with limited use of client formulations. Clinical supervision *should be clearly separated* from targeted support sessions for psychologists who

have experienced client violence. Targeted support sessions allow the psychologist to take adequate self-care to emotionally process the impact of the incident.

Recommendations for Credentialing and Regulatory Bodies

Most guidelines for client violence focus on its prevention and management to include de-escalation, break-away, control and restraint, and risk assessment to calm the offender and further reduce the risk of violence (Beech & Leather, 2006). Although this includes post-incident actions of reporting, investigation and counseling, simply focusing upon identifying and reducing the risk of being attacked may not be adequate (Gately & Stabb, 2005). Findings suggested that participants find their professional role undermined as a result of client violence targeted towards them and while support for psychologists who have experienced client violence is usually provided by their employers, professional regulatory bodies have a part to play in bringing forward the realities of client violence and raising its profile as a pertinent issue for the profession.

Professional members can be supported by professional bodies to:

- Maintain optimum standards of safety and self-care at the point of delivery, both in private and public settings
- Receive an immediate debriefing from a peer or manager
- Have access to legal support
- Receive continuing support from peers and managers
- Share information about client violence to other staff members
- Share and discuss diverse population perceptions and expectations clients have of professional helpers
- Actively contribute to staff training in this area through organizational invitation
- Be _exceptionally_ supportive of trainee or novice practitioners by working to enhance training programs to effectively deal with the impact of client violence
- Actively promote the provision of safe and effective environments for the delivery of therapy

Limitations and future directions

Although our small and purposive sample size allowed us to demonstrate the intricacies of the impact of client violence on therapist and the therapeutic alliance, it would be useful to capture more salient features of client violence closer to the incident itself. In contrast to our qualitative approach, large-scale empirical research could use longitudinal designs employing comprehensive questionnaires and inventories that are able to capture psychological sequelae linked with the traumatizing event. Such research may collect more accurate and contemporaneous data on the numbers of psychologists experiencing client violence which would allow for the isolation of factors such as client violence setting (public/private, community/acute); theoretical orientation of the therapist; length of therapeutic relationship and years of practice. This may help with prediction, control and prevention of client violence for practitioners.

While some incidents of client violence reported in this study stated that clients became aggressive when being asked to complete psychological assessments by the practitioner, the study sample size is too small to make any assertion that psychological testing aggravated the clients to attack the practitioner. Indeed, there is room here to consider a quantitative study, documenting the particular context of client violence and perhaps re-visiting the limit setting and communication issues noted by Bjøkly (1999).   It may also be timely to invite clients to provide accounts of the attacks on clinicians, as this research may be suited to an ideographic approach at the outset.

Final thoughts

Where exactly do psychologists stand in understanding client violence and to what extent can psychologists challenge clients for their violent behavior? Behr, Ruddock and Crawford (2005, p. 7) argue that "most people who experience a mental illness retain capacity and to regard them otherwise (by default) is stigmatizing" and there were certainly elements of anger expressed by participants who believed that the clients were in control of their behavior at that particular time point. Hoge and Gutheil (1987) state that mentally ill individuals are unlikely to be charged under the current system, especially if clients are already hospitalized. This leaves us a rather interesting dilemma of client culpability. It may be helpful to establish/re-negotiate psychological contracts with the client outlining the nature of therapy delivery which highlights clients' roles and obligations to maintain constructive relationships with their therapists. Ultimately, if we continue to under-report and under-prioritize violence against practitioner psychologists, this may lead to a passive acceptance of client violence for ourselves, our colleagues, our workplaces, and our profession.

References

Adams, J., & Whittington, R. (1995). Verbal aggression to psychiatric staff: Traumatic stressor or part of the job? *Psychiatric Care, 2*, 171-174.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist. 57*, 1060-1073.

Anderson, A., & West, S. G. (2011). Violence against mental health professionals: When the treater becomes the victim. *Innovations in Clinical Neuroscience*, *8*, 34-39.

Antonius, D., Fuchs, L., Herbert, F., Kwon, J., Fried, J. L., Burton, P. R. S., Straka, T., Levin, Z., Caligor, E., & Malaspina, D. (2010). Psychiatric assessment of aggressive patients: A violent attack on a resident. *American Journal of Psychiatry*, *167*, 253-259.

Arnetz, J. E., & Arnetz, B. B. (2001). Violence towards healthcare staff and possible effects on the quality of patient care. *Social Science and Medicine*, *52*, 417-427.

Barling, J., & Kryl, I. P. (1990). Moderators of the relationship between daily work stress and mood. *Work and Stress. 4,* 319-329.

Barling, J., MacEwen, K. E., Kelloway, E. K., & Higginbottom, S. F. (1994). Predictors and outcomes of elder care based inter-role conflict. *Psychology and Aging, 9*, 391-391.

Barnett, J. E. (2008). Impaired professionals: distress, professional impairment, self-care and professional wellness. In M. Herson & A. M. Gross (Eds.), *Handbook of Clinical Psychology* (Vol 1), (pp. 857-884). New York: Wiley & Sons.

Beale, D., Fletcher, B., Leather, P., & Cox, T. (1998). *Review on Violence to NHS Staff Working in the Community.* Nottingham: University of Nottingham, Centre for Organisational Health and Development.

Beech, B., & Leather, P. (2006). Workplace violence in the healthcare sector: A review of staff training and integration of training evaluation models. *Aggression and Violent Behaviour, 11*, 27-43.

Behr, J. P., Ruddock, P., Benn, P., & Crawford, M. J. (2005). Zero tolerance of violence by users of mental health services: The need for an ethical framework. *British Medical Journal, 187*, 7-8.

Bjøkly, S. (1999). A ten-year prospective study of aggression in a special secure unit for dangerous patients. *Scandinavian Journal of Psychology*, *40*, 57– 63.

Bourne, I. (2013). *Facing Danger in the Helping Professions: A Skilled Approach*. Maidenhead: Open University Press.

Bowie, V. (2000). Current trends and emerging issues in workplace violence. *Security Journal, 13,* 7-23.

Brasic, J. R., & Fogelman, D. (1999). Clinician safety. *Psychiatric Clinics of North America 22,* 923-940.

Budd, T. (1999). *Violence at Work: Findings from the British Crime Survey*. London: Health and Safety executive.

Carlsson, G., Dahlberg, K., Lutzen, K., & Nystrom, M. (2004). Violent encounters in psychiatric care: A phenomenological study embodied caring knowledge. *Issues in Mental Health Nursing, 25,* 191-217.

Carter, Y. H., Kenkre, S., & Hobbs. F. D. R. (1997). The development of a training pack on the management of aggression and violence in primary care. *Safety Science. 35*, 223-230.

Department of Health. (1999). *NHS Zero Tolerance Zone: We Don't Have to Take This.* London: HMSO.

Ehlers, A., & Clark, D. M. (1999). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38,* 319-345

Erdos, B. & Hughes, D. (2001). Emergency Psychiatry: A review of assaults by patients against staff at psychiatric emergency centers. *Psychiatric Service*, *52*, 1175-1177.

Flannery, R. B. Jr., Anderson, E., Marks, L., & Uzoma, L. L. (2000). The assaulted staff action program (ASAP) and declines in rates of assault: Mixed replicated findings. *Psychiatric Quarterly, 71,* 165-175.

Gately, L., & Stabb, S. D. (2005). Psychology students training in the management of potentially violent clients. *Professional Psychology: Research and Practice,* 36, 681-687.

Guy, J. D., Brown, C. K. & Poelstra, P. L. (1990). Who gets attacked? A national survey of patient violence directed at psychologists in clinical practices. *Professional Psychology: Research and Practices, 21*, 493-495.

Hatch-Mailette, M. A., & Scalora, M. J. (2002). Gender sexual harassment, workplace violence, and risk assessment: Convergence around psychiatric staff's perceptions of personal safety. *Aggression and Violent Behaviour, 7*, 271-291.

Hilton, M., Perkins, R., & Pillay, H. (1992). *Guidelines for the Management of Violence at Work*. Leicester: The British Psychological Society.

Hoge, S. K., & Gutheil, T.G. (1987). The prosecution of psychiatric patients for assaults on staff: A preliminary empirical study. *Hospital and Community Psychiatry, 38*, 44-49.

Hogh, A., & Mikkelsen, E. G. (2005). Is sense of coherence a mediator or moderator of relationships between violence at work and stress reactions? *Scandinavian Journal of Psychology*, *46*, 429–437.

International Labour Office (2013). *Work Related Violence and its Integration into Existing Surveys.* Geneva: Nineteenth International Conference of Labour Statisticians.

James, D., Fineberg, N., Shah, A., & Priest, R. (1990). An increase in violence on an acute psychiatric ward: A study of associated factors. *British Journal of Psychiatry*, *156*, 846 852.

Jansen, G., Dassen, T., & Moorer, P. (1997). The perception of aggression. *Scandinavian Journal of Caring Science, 11*, 51-55.

Johnson, W. B., & Barnett, J.E. (2011). Preventing problems of professional competence in the face of life-threatening illness. *Professional Psychology: Research and Practice*, *42*, 285-293.

Johnstone, L., Whomsley, S., Cole, S., & Oliver, N. (2011). *Good Practice Guidelines on the Use of Psychological Formulation*. Leicester: The British Psychological Society

Jorgensen, J. D., & Hartman, P. M (1997). *Social Work in Juvenile and Criminal Justice Settings.* Springfield IL: Charles C. Thomas.

Kessler, R. C. (2000). Post-traumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry, 34*, 44-47.

Kleespies, P. (1998). *Emergencies in Mental Health Practice: Evaluation and Management.* London: Guilford Press.

Lanza, M. L. (1987). The relationship of assault to blame placement for assault. *American Psychiatric Nursing, 35 (a)*, 269-279

Mahoney, M. J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice*, *28*, 14-16.

McAdams, C. R., & Foster, V. A. (1990). A Conceptual framework for understanding client violence in residential treatment. *Child & Youth Care Forum*, *28*, 307-328.

McDonald, G., & Sirotich, F. (2001).Reporting client violence. *Social Work, 46*, 107-114.

Mezey G., & Shepherd J. (1994). Effects of assaults on health care professionals. In J. Shepherd (Ed), *Violence in health care. A practical guide to coping with violence and caring for victims.* New York: Oxford University Press Inc.

Molander, B. (1996*). Knowledge in Action*. Goteborg: Daidalos.

Müller, S., & Tschan, F. (2011). Consequences of client-initiated workplace violence: The role of fear and perceived prevention. *Journal of Occupational Health Psychology, 16,* 217-229.

National Audit Office (2003). *A Safer Place to Work? Protecting NHS Hospital and Ambulance Staff from Violence and Aggression*. London: The Stationary Office.

National Health Service, Business Service Authority. (2011). *Criminal sanctions rise of assaults on NHS staff*. Retrieved from http://www.nhsbsa.nhs.uk/3489.aspx

Ponterotto, J. G. (2005). Qualitative research in counselling Psychology: A primer in research paradigms and philosophy of science. *Journal of Counselling Psychology, 2*, 126-137.

Pope, K. S., & Tabachnick, B. G. (1993) Therapists' anger, hate, fear, and sexual feelings: A national survey of therapists response, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice, 24*, 142-145.

Privitera, M., Weisman, R., Cerulli, C., Tu, X., & Groman, A. (2005). Violence towards mental health staff and safety in the work environment. *Occupational Medicine*, *55*, 480-486.

Reid, W. H. (2008). Assaults against psychiatrists and other mental health professionals. *Journal of Psychiatric Practice*, *14*, 179-181.

Rippon, T. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing, 31*, 452-460.

Rogers, K., & Kelloway, E.K. (1997). Violence at work: Personal and organisational outcomes. *Journal of Occupational Health Psychology, 2*, 63-71.

Rueve, M., & Welton, R. (2008). Violence and mental illness. *Psychiatry (Edgmont), 5*, 34-48.

Semmer, N. K., McGrath, J. E., & Beehr, T. A. (2005). Conceptual issues in research on stress and health. In C. L. Cooper (Ed.), *Handbook of stress and health* (pp. 1-43). New York: CRC Press.

Shepherd, J. (2001). *Violence in Health Care: Understanding, Preventing and Surviving Violence*. Oxford University Press, Oxford.

Shulman, L. (1993). *Interactional Supervision*. Washington, DC: NASW Press.

Spencer, P. C., & Munch, S. (2003). Client violence toward social workers: The role of management in community mental health programs. *Social Work, 48,* 532-544.

Spiegal, R. (1980). On psychotherapy with patients with problems of hostility. *American*

Journal of Psychotherapy, 34, 178-187.

Smith, J. A. (2003). *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2010). *Interpretive Phenomenological Analysis: Theory, Method, and Research*. London: Sage.

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented and what can be done to address it? *Clinical Psychology: Science and Practice*, *16*, 1-15.

Star, B. (1984). Patient violence/therapist safety. *Social Work 29*, 225-230.

Swanson, J. W. (1994). Mental disorders, substance misuse and community violence: an epistemological approach. In J. Monahan & H.J. Steadmann (Eds.), *Violence and mental disorder developments in risk assessment* (pp. 101-136). Chicago, IL: University of Chicago.

The Linehan Institute Behavioral Tech (2014). *What is Dialectical Behaviour Therapy?* Retrieved from http://behavioraltech.org/resources/whatisdbt.cfm

Viitasara, E. (2000). V*iolence in Caring: Risk Factors, Outcomes and Support*. London: UK Department for Work and Health.

Wallis, D. (1987). Satisfaction, stress, and performance: Issues for occupational psychology in the 'caring' professions. *Work & Stress, 1*. 113–128.

Whittington, R., & Wykes, T. (1989). Invisible injury. *Nursing Times, 42,* 30-32.

Whittington, R., & Wykes, T. (1994). An observational study of association between nurse behaviour and violence in psychiatric hospitals. *Journal of Psychiatric and Mental Health Nursing, 1,* 85-92.

Wright, S., Gray, R., Parkes, J., & Gournay, K. (2002). *The Recognition, Prevention and Therapeutic Management of Violence in Acute In-Patient Psychiatry: A Literature Review and Recommendations for Good Practice*. London:UKCC

Wykes, T., & Whittington, R. (1998). Prevalence and predictors of early traumatic stress reactions in assaulted psychiatric nurses. *Journal of Forensic Psychiatry, 9*, 643-651.