Counselling and Clinical Psychologists' Experience of Client Violence in the Workplace

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Abstract

Violence and abuse from clients within the healthcare system is a growing problem which can affect the personal and professional identity, and psychological wellbeing of healthcare professionals. Previous research and literature has focused on the risk of violence from particular client groups and understanding the aetiology of aggressive and violent behaviour towards healthcare professionals. There is a lack of research which explores psychologists' experiences of client violence, and professional organisations have provided scant or no guidelines that could support psychologists who have experienced violence at work.

To address the gaps in the present literature, this research qualitatively explored how psychologists make sense of their lived experiences of client violence in the workplace. Three counselling psychologists and four clinical psychologists who had previously experienced client violence were interviewed to take part in this research. Data was analysed using interpretative phenomenological analysis (IPA). IPA was selected for its idiographic nature, as it was hoped that the findings would provide a deeper understanding of psychologists' experience of client violence from their personal account. IPA can also assist in developing guidelines for a specific purpose to support professionals in their work, which was a secondary aim of the research.

The findings revealed that psychologists can undergo different types of experiences after being attacked by a client, and experiencing and responding to client violence has a significant effect upon their professional identity. Three superordinate themes emerged from the IPA, which relate to the different phases after an experience of client violence. The first theme - 'the moment to moment experience of client violence' - relates to the exact instant the incident took place and how the client's aggression had taken the psychologist by surprise. The second theme - 'post incident experience' -describes how participants tried to make sense of their experience of client violence,

such as by creating a formulation. The final theme - 'issues concerning professional identity' - refers to the participants' need to show that they can cope with client violence due their professional self-image of being a psychologist. More broadly, the findings revealed how the professional self-image of psychologists affects their beliefs about how they 'should' be able to work therapeutically with violent clients and be able to manage and understand it.

It is recommended that further research explores the prevalence of psychologists who experience client violence, and the type of work settings in which this is most likely. Moreover, both neophyte and qualified psychologists would benefit from specific training in how to respond safely to violent client behaviour, and from the publication of professional guidelines to help them understand the possible risks of violence, decision-making when confronted with violent clients, and how to recognise and process the potential psychological repercussions of violence incidents.

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List of Abbreviations

APA _____ American Psychological Association

BPS _____ British Psychological Society

BSA _____ Business Service Authority

DCP _____ Division of Clinical Psychology

DoCP _____ Division of Counselling Psychology

IPA _____ Interpretative Phenomenological Analysis

NAO _____ National Audit Office

NHS _____ National Health Service

PCT _____ Primary Care Trust

PTSD _____ Post Traumatic Stress Disorder

RCN _____ Royal College of Nursing

SHO _____ Senior House Officer

UEL _____ University of East London

UK _____ United Kingdom

USA _____ United States of America

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Chapter 1: Literature Review

1.1   Introduction

The threat of client violence in the workplace of health professionals has become progressively problematic in the last few decades. In the United Kingdom (UK) client violence is a recognised problem. The National Health Service (NHS) Business Service Authority (2011) found an estimated 56,718 cases of physical violence against healthcare professionals reported in 2009/10, suggesting that the direct cost of violence to the NHS is approximately £60.5 million per annum, a sum that includes costs of litigation and damages, conflict resolution training, staff turnover, anti-violence policing and staff absences and sicknesses. Consequently, addressing client violence in the healthcare service has been firmly placed on the political agenda since 1998, and the NHS has been required to establish targets to reduce staff experiences of client violence. One result of this was the NHS Zero Tolerance Zone Campaign launched in 1999 with the support of the Home Secretary, the Lord Chancellor and the Attorney General. The then Minister of Health, John Denham, stated that "aggression, violence and threatening behaviour will not be tolerated anymore" (National Audit Office, 2002-2003. p.2). The aim of this campaign was to raise awareness to staff in reporting client violence, to assure staff that violence would be dealt with appropriately by the criminal justice system, and to educate the public that violence towards healthcare staff is considered to be unacceptable behaviour.

Psychologists, particularly those working with mental and emotional disorders, can be at as much risk of client violence as other healthcare professionals. Whilst psychologists' training and experience might help them formulate explanations for violent behaviour, and to attempt to find ways to contain the situation therapeutically, this will not always prevent them from such experiences. There is currently little information about how psychologists in the UK experience client violence. Whilst this

is perhaps due in part to underreporting of violence, or a belief that violence is part of the job, client violence is nevertheless a complicated issue and the impact it has upon psychological staff within the healthcare services can be devastating.

Given a lack of information about how client violence affects psychologists, the aim of the present research is to gain a deeper understanding of the experience of client violence upon counselling and clinical psychologists. The present chapter will describe the wider context of the phenomenon of client violence, including definitions and types of violence experienced by healthcare staff from clients. This is followed by a review of the current literature on healthcare professionals' experiences of client violence at the moment it occurs and the impact it has had upon them. Literature which has provided information about the coping strategies used by healthcare staff after an experience of client violence is discussed, and finally, the aims of the present research are described.

1.2   Defining Client Violence

The Division of Clinical Psychology (DCP) of the British Psychological Society (BPS), considers that it is not "sufficient simply to regard violence in terms of physical attack" (Hilton, Perkins & Pillay, 1992. p.2), and suggest that racial and sexual harassment are included when defining "violence". Several studies have shown that the effect of verbal abuse can have the same emotional impact as physical aggression and violence (Budd, 1999; Bowie, 2000; Hatch-Maillette & Scalora, 2002; Perone, 1999) and that the risk factors for threats of violence and actual physical violence are virtually identical (Arnetz, Arnetz & Petterson, 1996; Arnetz Arnetz, & Soderman, 1998; Flannery, Hanson, Penk, Flannery, & Gallagher. 1995).

Arnetz, Bengt and Arnetz (2001) defined violence as encompassing threatening behaviour, verbal aggression, as well as physical assault. The authors found that healthcare staff who had reported being physically attacked and those who reported threats of violence showed no substantial difference in the effect it had upon their

psychological wellbeing, professional competence or personal relationships. Research has also identified that violent behaviour against staff members within the social care field has been shown to have long-term psychological effects, such as post-traumatic stress disorder (PTSD) even when no physical injury is involved (Cladwell, 1992; Graydon, Kasta, & Khan, 1994; Wykes & Whittington, 1994). Findings such as this demonstrate how different types of aggression can have an impact upon healthcare staff, even in the absence of an actual physical attack. Moreover, there seems to be evidence to suggest that individuals who had experienced threats of violence were more emotionally affected then those who had been physically assaulted (Bowie, 2000; Budd 1999).

It seems clear that merely defining client violence as specific to physical injury can be problematic as it is likely to reflect a smaller minority of people than is affected by other forms of violent behaviour (Slora, Joy, & Terris, 1991) and would exclude the vast majority of healthcare professionals' experiences of client violence. Consequently, to allow a deeper insight into the experiences of psychologists exposed to client violence, the present study adopted a broader definition of workplace violence, to include not only physical assault but also verbal abuse, aggressive behaviour, threats, fear of attack and racial and sexual harassment. Specifically, the definition of violence published by the NHS was used: "any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well-being or health" (Department of Health, 1999). It was also hoped that using a broader definition of client violence would honour individual experiences, as well as the evidence, of the impact of both verbal and physical violence.

1.3 Prevalence of Workplace Violence in the Healthcare Professions

Work related abuse from the public is considered to be one of the most serious occupational hazards facing staff working in the healthcare sector and people working

in the healthcare sector are at a greater risk of verbal abuse and threats at work than any other industry apart from police and security workers (Health Advisory Committee, 2005). This abuse can take the form of a physical attack, or verbal abuse oriented in terms of gender, race or any other characteristics and research suggests that similar levels of workplace violence are likely to be experienced by all healthcare professionals (D'Urso & Hobbs; 1989 Ryan & Poster, 1993; Stark & Patterson, 1994).

In response to this growing concern, the NHS in the UK has introduced a 'zero tolerance' campaign to tackle violence towards its staff, and created NHS Protect, an organisation that specifically identifies and tackles crime across the healthcare service. Analysing workplace violence data, NHS Protect reported that between 2009-2010, there were 56,718 reported assaults, of which 38,959 were upon mental health staff and those working with learning disabilities. The most frequent types of incidents reported were verbal abuse and threats usually involving members of staff who were in contact with individuals with extreme psychological distress, chronic mental illness, drug and alcohol impairment, and brain damage (Jorgensen & Hartman, 1997). This finding resonates with the work of other authors, who suggest that there are some clinical settings in which staff are more likely to witness or be victims of client violence, such as those working in psychiatric hospitals, prisons, and accident and emergency departments (Star, 1984; Wright, Gray, Parkes & Gournay, 2002). This is often a result of working with disturbed or vulnerable people who may have multiple issues, such as addictions, psychiatric problems, and a history of violence (Star, 1984).

Swanson (1994) has also indicated an increased risk factor for violence when working with individuals suffering with mental illness. Psychology as a profession deals with mental and emotional disorders where there is a risk of violence. In psychotic disorders particularly the symptoms of paranoid delusions, threatening behaviour, and having hallucinations can increase the risk of violence. Pope and Tabachnick (1993)

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reported that 18% of psychologists in clinical practice had been physically assaulted by patients with a mental illness, and the American Psychological Association (APA) found that 35-40% of psychologists in clinical practice were at risk of being attacked from a patient during their professional career (APA, 2002). Examining which type of client group placed psychologists in clinical practice in the USA at most risk of violence, Guy, Brown and Poelstra (1990) found that the highest level of attacks was caused by individuals with schizophrenia, followed by those with organic mental disorders, mood disorders, and finally with anxiety and adjustment disorders.

As well as working with people with specific mental illnesses, other factors can place staff at risk of being attacked. For instance, Feldmann and Johnson (1994) suggest that healthcare professionals can be at risk of violence when working with individuals with low intelligence, neuropsychological impairment and low social economic status. The risk of violence can also be exacerbated by individuals who are not adhering to their medication regimen, or are abusing drugs and alcohol.

Nevertheless, the relationship between mental illness and violence is a complex issue and is dependent upon a number of variables, including the type of disorder, the nature and severity of the illness, the influence of co-morbidity with drugs and alcohol misuse, history of previous violence and the effectiveness of treatment and management (Beech & Leather, 2006). Typically, counselling and clinical psychologists are in regular contact with a variety of client groups including those suffering extreme psychological distress, chronic mental illness, drug and alcohol abuse, and neurological and cognitive damage or problems.

Research examining the experience of violence by healthcare staff paints a similar picture: that violence has become an occupational hazard in many, if not most, healthcare professions and one of the largest occupational groups at risk of client violence are those who interact with members of the public, such as healthcare

professionals (Health Service Advisory Committee, 1997). According to Budd (1999) there are a number of reasons for this. Firstly, people who are interacting with members of the public are likely to be working with patients who are in physical or emotional pain, and are therefore more likely to exhibit violent outbursts. Secondly, healthcare professionals are often required to give bad news and confirm patients' worst fears, thus leaving them vulnerable to being attacked. Thirdly, healthcare professionals often work with people who have poor impulses and unable to control their anger. Finally they often work with patients who are held against their wishes such as those detained under the mental health act. All these factors can contribute to a much greater risk of the healthcare professional being verbally or physically abused, intimated, threatened and assaulted.

In 2009 the research company Ipsos MORI (NHS, Business Service Authority, 2009) found that those at risk of violence were healthcare professionals working in healthcare sector, which included counselling and clinical psychologists who provided psychological support to patients and staff. The survey also found that professionals working in the fields of mental health and learning disabilities were significantly more likely to have experienced client violence due to the patients' personal history, mental health issues, and the use of substances. The Health Care Commission Report (2005) also found that violence was most likely to occur in the field of substance misuse, due to the clients' vulnerabilities, underlying psychological issues and problems with drugs and alcohol.

Another Ipsos MORI survey (NHS, Business Service Authority, 2009) was conducted on behalf of the NHS, who wanted to understand their employees' perception of workplace safety and incidents of violence. The original baseline survey in 2004 was followed up in 2009 to examine the progress the service had made over the five year period in establishing a pro-security culture. A sample of over two thousand NHS

frontline staff was used, which included counselling and clinical psychologists. Data collected included information about verbal abuse and verbal threats towards staff as well as incidents of physical abuse. The 2009 survey found that in the preceding 12 months (2008-2009) one in three (32%) NHS employees interviewed had experienced verbal abuse or were verbally threatened by a patient and 5% had been physically assaulted by a patient. NHS staff had also experienced violence from members of the public, with approximately one in five (18%) reporting that they had been verbally abused or verbally threatened by a member of the public, and 1% having been assaulted by a member of the public. In the 2009 survey, of those who had experienced abuse, 22% said they had been verbally abused or threatened on one or more occasion in the last 12 months, and 42% had experienced verbal abuse and threats on between two to five occasions. Thus, rather than isolated incidents, it would appear that healthcare staff are likely to experience violence on more than one occasion. The findings of the 2009 Ipsos MORI study also revealed that whilst the frequency of physical assaults reported had increased since the benchmark survey in 2004, overall the number of staff affected by a physical attack had declined. Unfortunately this survey provided no specific breakdown of data by the various occupational groups included in the survey, meaning that data for psychology as a profession is not available.

In a survey of mental health nurses' experience of client violence in hospital and community services, Adams and Whittington (1995) found that 29% of nurses reported being verbally abused over a 10-week period. This left the nurses feeling traumatised and anxious about being at work and with their patients. Mental health nurses are not the only victims of violence, and surveys of general nursing staff, doctors, psychiatrists and social workers show that similar levels of violence at work are experienced (Stark & Paterson, 1994). Kidd and Stark (1992) surveyed a sample of psychiatric senior house officers and registrars about their experience of patient violence. They found that

35% reported being assaulted at least once in their time at work, and 90% reported

feeling in imminent danger by patients when visiting the ward. Client violence

experienced by social workers is a serious issue in the UK. According to Littlechild

(2002), in the past three decades there have been eight reported deaths of social workers

due to client violence. Moreover there have been a number of attacks causing serious

and permanent injury. This was confirmed by the British Crime Survey conducted

between 1992 to 1998 in which social work was one of the occupational groups at most

risk of client violence.

In an early study, Whitman, Armao & Dent, (1976) found that psychiatrists,

psychologists and social workers experienced a high level of incidents of client

aggression and abuse in the USA. The researchers surveyed 101 participants, reporting

that 43% felt personally threatened, and 24% were actually physically assaulted. A total

of 7% of the psychologists in the study experienced client violence, which included

those who worked in inpatient and outpatient clinics. In a later study conducted by

Bernstein (1981) a larger sample of over 400 participants was used, and a wider range

of occupational groups (psychiatrists, psychologists, social workers and counsellors).

This study found that 14% of participants reported having been physically assaulted,

35% had been threatened and 61% reported feeling physically afraid of one or more

their patients. Whilst these two studies are over three decades old, what they do show is

that violence against health care professionals has continued to be problematic for a

significant amount of time.

Psychologists might be assumed to be a professional group who would be least

likely to experience client violence as they are not always at the forefront of the

healthcare sector in the way that nurses are (Royal College of Nursing, 1994). However

Spiegal (1980) argues that client violence can be directed towards therapists as their

work often involves working at an intense personal attachment level in therapy. This can

at times produce hostile transferences within the therapeutic relationship and, if not contained appropriately, might cause the client to become violent or abusive. Transference feelings of the client can be based upon a fear of closeness, paranoia, or erotic transference, each of which can make the client feel unsettled and act out aggressively (Spiegal, 1980). Moreover, having difficult and emotionally-charged conversations with vulnerable clients such as those with a psychiatric disorder or substance misuse, might also lead to aggressive behaviour (Star, 1984). These behaviours can be seen by the therapist as defensive mechanisms to protect the client from pain and avoid talking about their thoughts and feelings but even so, client violence can be ignored and not reported as the therapist may feel that the client is being defensive and therefore formulate the aggression towards them. This can be problematic as therapists may focus more on the psychological theories and formulation whilst failing to acknowledge the impact that the violence may have upon them (Star, 1984).

Guy, Brown and Poelstra (1990) proposed that it is unclear how often psychologists are exposed to violence by their clients because they tend to underreport such incidents, and attempted to provide a more comprehensive data of incidences, severity and clinical factors associated with patient physical attacks in the USA. A sample of 340 participants was surveyed and the findings showed that 40% of the sample had been attacked one or more times by a client. Verbal threats were experienced by over half those interviewed (including being threatened with physical violence), and 58 participants had been physically injured. Psychologists described being attacked in a variety of ways including feet, fists and weapons such as guns, knives and ropes. There was no significant statistical difference between the experiences of men and women, although professional experience was a significant factor on the experience of violence: trainees were more likely to be attacked than those who had graduated and those with more professional experience. Whilst this research suggests

that psychologists do experience client violence in their place of work, it was, like many other studies, conducted in the USA. It is still unknown how many psychologists in the UK experience client violence. Moreover, this quantitative study is unable to provide a deeper level of understanding of the experiences, thoughts, feelings, and responses of those psychologists affected by violence.

Following the violent attack of a clinical psychologist by a patient, the BPS Division of Clinical Psychology (DCP) administered a survey of its members to collect information about the extent of violence encountered by psychologists in their workplace. The findings revealed that high numbers of psychologists had experienced violence in the work place (Hilton et al., 1992). The American Psychological Association (APA) has also discussed their concern of the risk of violence upon psychologists after investigating violent encounters in the different settings psychologists work in. They found high rates of violence experienced by psychologists in schools, hospitals, mental health services and social services (APA, 2002). According to Guy, Brown & Poelstra (1990) the greatest risk of violence was in psychiatric units followed by those in private practice, those working in outpatient or counselling services, and lastly by those working in forensic settings, such as the prison services. This latter group may be unique in their preparation and training to deal with client violence than other healthcare professionals and other types of psychologists. Moreover, in criminal justice settings, all staff are perhaps more vigilant for violence, and more clients are likely to be restrained or otherwise prevented from lashing out violently.

Although, violence is usually associated with those working in psychiatric units (Whittington, Shuttleworth & Hill, 1996) all health care professionals are exposed to the possibility of a violent incident in all types of settings (Littrell & Littrell, 1998; Schinden Marren-Bell, 1995). Overall, research and official reports are indicating that nursing staff, doctors, psychiatrists and social workers are similarly exposed to, and

likely to experience, client violence. This leads to a growing concern about the wellbeing of healthcare professionals across all fields, but particularly for those working in the mental health sector (Rippon, 2000).

Whilst it is evident that there is a problem with client violence, and there is a large body of prevalence data supporting this, what is less clear is how this affects individuals working in the system, and therefore how they can be helped when they encounter it. Client violence is a complicated phenomenon and no one person will respond to client violence in the same way (Barling, 1995).

1.4   Underreporting Client Violence in the Workplace

A significant issue that has been encountered by both the Health Service Advisory Committee and across published research is that the rate of reporting of workplace violence continues to be problematic with consistent evidence of underreporting (Lanza, 1987; McDonald & Sirotich, 2001; Norris, 1990). For instance, Arneetz (1998) reported that not all incidences of violence are reported by healthcare workers and that psychological abuse was particularly underreported.

Whilst verbal abuse is less likely to be reported as is often not considered serious enough, according to McDonald and Sirotich (2001) even physical violence is often underreported due to practitioners' fear of the perception their colleagues and managers would have of their performance, and the perceived damage they believed it would have on their professional image (Star, 1984). It has also been suggested that underreporting can be due to healthcare professionals feeling unsupported by their senior managers and the belief that nothing would be done about the violent behaviour, or there would be no outcome from it (Jansen, Dassen & Moorer, 1997). Other factors include the belief held by some healthcare professionals that violence is part of the job when working with patients who are likely to be violent, and particularly among mental health practitioners that they should be able to look after themselves (McDonald &

Sirotich, 2001). Shulman (1993) also found from his investigation of underreporting that those who had experienced client violence often wanted to avoid the topic. This avoidance was a result of not wanting any attention and not admitting to or acknowledging vulnerability. However, keeping silent about their experiences of violence may lead some healthcare professionals to feeling isolated and vulnerable, and not seeking appropriate support for the psychological, professional, and personal effects of the incident. A final factor that has been highlighted as contributing to a culture of underreporting of client violence is the administrative burden of paperwork within the healthcare system, with some workers viewing the forms used to report violence as being too time-consuming and complicated to do (McDonald & Sirotich, 2001).

Research consistently finds similar explanations for a lack of reporting of violence by healthcare professionals, suggesting that more needs to be done to tackle this phenomenon and increase the motivation to report and reduce stigma. Whilst Viitasara (2000) argues that violence by patients in the healthcare system is not being recognised as an occupational risk and patient violence is becoming acceptable, a multitude of factors leading to underreporting of client violence makes it difficult to assess the actual prevalence of violence experienced by healthcare professionals, and thus to address the problem where it is needed and to support victims. If a culture of underreporting continues it is going to be difficult for employers to create a safe environment for healthcare professionals to work in, and for professional organisations, such as the BPS, to support their members.

1.5   The Inner Dialogue During a Violent Encounter

Investigating 12 mental health professionals' experiences of client violence, Carlsson and colleagues (2004) were particularly interested in the victim's response at the exact moment of the violent encounter. The authors employed a phenomenological

approach to gain insight and to make sense of their participants' responses, and described both a positive and a negative response to the encounter of client violence.

A positive encounter was characterised as a successful outcome in which the patient was calmed down and the situation was brought under control. To facilitate this process, mental health professionals reported using an "inner dialogue" to find a way of containing their client. This inner dialogue involved listening to oneself and trusting one's intuition on what feels right to do in that particular situation, and enabled the practitioner to stay with the client in a respectful and benevolent way. In staying with the client's aggression, participants described a battle between a wish to stay with the situation and wanting to escape the encounter. Initially there is fear regarding the need to escape from a threatening situation, but the inner dialogue is also part of a genuine need to resolve the situation. It is during this time that the client's suffering is acknowledged, and the client is met openly with a genuine desire to understand what has made them angry and therefore a will to help. The inner dialogue not only keeps healthcare professionals with the client's aggression but also helps them to consider the advantages and disadvantages of either leaving or staying. Carlsson, Dahlberg, Lutzen, and Nystrom, (2004) reported that the practitioner's intuition guides and determines how they will manage a situation. The inner dialogue helps them manage the fear and belief in their ability to bring about a positive ending to a possible violent encounter. It seems that this inner dialogue or the conversation with oneself has multiple uses: it allows staff to decide what to next, reduces feelings of fear and anxiety, facilitates the sharing of feelings of suffering and pain with the client, and makes it more likely to bring about a positive outcome from the situation.

Conversely, a negative encounter was described where the member of staff was unable to calm the client down and violence escalated. Often the staff member left the situation and moved away from the aggressive client. In doing so, the client became

more aggressive and violent due to feeling uncared for and ignored by staff. This negative outcome was described as a product of the uncontrollable fear of the member of staff. Those participants who discussed being unable to manage their fear during the violent encounter stated being so overwhelmed that they were unable to make sense of the situation, and felt small, helpless and had a sense loss of control. This had a further effect upon their cognition, which became hesitant and uneasy, exacerbating the situation and often resulting in the practitioner becoming angry and saying or doing the "wrong things". The uncontrollable fear caused staff to feel so vulnerable and anxious that they would either find an escape route or would feel "paralysed" during the encounter.

The phenomenological analysis of the experiences of mental health workers in this study highlights how the inner dialogue can be used to enable mental health staff to respond in three ways: fight, flight or freeze, responses which are typical behaviours from people who feel threatened (Cannon, 1929).

1.6 Impact of Client Violence

Literature examining the effect of client violence has identified that individuals who have been threatened or assaulted are left feeling violated, suggesting that the victims' core assumptions are affected as they are confronted with a world that feels unsafe and unpredictable (Janoff-Bulman, 1985). Moreover, after these experiences the individual no longer sees him or herself as a confident and worthy person but rather as vulnerable and weak. Research also indicates that workplace violence can be severely traumatising and disabling psychologically and emotionally for the victims of the crime, who can also experience a sense of injustice due to a lack of successful prosecution of perpetrators within the healthcare service (Shepard, 1994). Service users within the healthcare system, including clients or patients of the victim (including the perpetrator) can also be affected by workplace violence, in that they receive poorer quality of care.

This section will describe in more detail the impact of client violence upon healthcare professionals' psychological well-being, personal and professional identity, and the quality of care provided to patients.

1.6.1 Impact of client violence upon the psychological wellbeing of healthcare professionals

The most common psychological responses to client violence include feeling depressed, anxious, self-doubt, apprehension and fear, and most victims of client violence agree that that the emotional impact of the experience outweighs the impact of the physical injury (Whittington & Wykes, 1994). Once these feelings have taken hold it can damage the professional career as well as the personal wellbeing of healthcare workers (Barling & MacEwen, 1992; Kelloway & Barling, 1991).

According to Whittington & Wykes (1992), anger was the most common emotion evoked in nurses after being assaulted by patients. A continuing threat of physical or verbal aggression in the workplace can also affect the confidence and morale of staff (Carter, Kenkre, & Hobbs, 1997; Rogers & Kelloway, 1997). Practitioners who must live with the possibility of violence occurring in their workplace often feel constant levels of fear and stress. This in turn can lead to burnout (Jorgensen & Hartman, 1997) which can also be exacerbated by feeling devalued and unappreciated by patients and employers (Freudabergar, 1974).

Killias (1990) describes how victims of workplace violence are left feeling vulnerable in three ways. Firstly the individual identifies that his or her place of work is no longer safe, as it was once believed to be. Secondly, the individual feels that he or she has a loss of control in their place of work. Thirdly, there is an anticipation of a serious consequence at work. This anticipation of serious consequences is associated with a sense of fear due to the loss of control. Given that workers in most professions hold a certain belief about their basic security and safety at work, the effect of client

violence can result in the victim leaving their job if appropriate support is not provided (Barling, MacEwen, Kelloway, & Higginbottom, 1994).

Besides burnout, a key psychological impact upon any victim of a violent attack is post-traumatic stress disorder (PTSD). PTSD is a recognised mental health disorder and can be extremely disabling for the victim, with symptoms falling into three main categories: reliving the trauma, avoidance, and arousal (Ehlers & Clark, 1999). In reliving the trauma the victim of violence may experience flashbacks of the event and feel as though the event is reoccurring. They may also experience more intense flashbacks of particular upsetting memories of the event. Other symptoms of reliving of the trauma include having nightmares of the event and uncomfortable reactions to situations that remind the victim of the event. The victim can also display several avoidance mechanisms such as feeling detached, avoiding places and people that can remind the victim of the trauma, and feelings of hopelessness of the future. The arousal symptoms include difficulty concentrating, feeling startled and having an exaggerated reaction, being hyper-vigilant, feeling irritable or having outbursts of anger, and having difficulty in sleeping (Ehlers & Clark, 1999).

One of the major difficulties for healthcare professionals who have experienced client violence is that they are unable to avoid the environment of the attack. This is because their place of work is within healthcare services and the perpetrator has nowhere else to go. One way that the healthcare professional may deal with this aspect of the difficulty is to avoid the perpetrator and their place of work by taking extended sick leave, asking for a transfer or leaving the job entirely (Kessler, 2000). The majority of the research in this area has investigated the psychological impact of client violence of other healthcare workers such as nurses. Little is known of the psychological impact upon psychologists after experiencing client violence. Psychologists work primarily to promote individuals' psychological wellbeing and therefore it would be of value to

understand how they attend to their own psychological wellbeing after experiencing client violence.

Psychological formulation is a core competency and skill in the role of clinical psychologists (Johnstone, Whomsley, Cole & Oliver, 2011) and psychologists may try to understand the client's violent behaviour through psychological theory. In order to make sense of the unwanted or unhealthy behaviours of their clients, psychologists might employ formulations to gain an understanding of maladaptive behaviours, including client violence. This is captured in Butler's (1998) description of psychologists' professional identity: "The influence of our core professional identity as scientist-practitioners can be seen in the emphasis, on applying psychological principles and theory in order to develop hypothesis about service users' difficulties. The assumption is that this process will render even the most unusual or disturbing behaviour and experience understandable... at some level it all makes sense" (p. 2).

Formulation is the lynchpin for psychologists to gain a holistic view of their clients' presenting problems, can serve as road-map for their work with the client, and enables them to understand client behaviours in the context of psychological theory. Nevertheless, although formulation can be seen as a potential tool for psychologists to attempt to understand why their client becomes violent, there is at present little knowledge about how or if psychologists do use formulations as a mechanism in dealing with client violence.

In understanding what are the most adaptive and helpful strategies used by psychologists could also provide other healthcare professionals with useful information for dealing with their own experiences of client violence.

1.6.2 Impact of client violence upon personal and professional identity of health care professionals

In 1995, Littlechild conducted a review of mental health practitioners' experiences of client violence. He concluded that the frequent effect of client assault upon practitioners had a negative impact upon their professional and personal identity. Specifically, practitioners reported loss of confidence in their ability to perform their work role effectively, self-blame, feeling guilty and angry about the episode, having concerns about their future safety at work, fear of a repeating episode and concerns about the perceptions that their colleagues and managers may have of them. Snow (1994) and a later study by Littlechild (2002) also found that practitioners who had been assaulted by clients reported feeling disempowered, anxious, depressed, and fearful.

According to Shepard (1994) healthcare professionals who have been attacked often lose trust in their ability to perform well at work. Holding a belief that one is not doing a 'good job' can lead to thoughts of not being good enough and feeling unworthy. The consequence of such beliefs can lead to the practitioner experiencing depression and anxiety, which can then reinforce their belief of not doing a good job. Victims of violence often continue to ruminate about the traumatic incident and rumination can have an impact upon the personal and professional life of the healthcare worker (Flannery, 1999). For instance, Whittington and Wykes (1989) found that many healthcare professionals described experiencing a loss of concentration after being assaulted. They would continuously replay the incident in their mind, thinking "why me?", or "what could I have done differently?" Whilst this type of rumination is an act of making sense of the experience, continuing to ruminate can also lead to little sense-making and often more confusion (Flannery, 1999). Research which has examined the experiences of nurses who were victims of client violence found that nurses reported having cognitive difficulties and being unable to concentrate on their work. This constant rumination caused stress, role conflict ("did I do the right thing?", "am I in the

right job?"), feeling demoralised and eventually feeling burnt out (Arnetz & Arnetz, 2001).

The effect of burnout from an experience of client violence can itself have a significant consequence for healthcare professionals. Burnout has been defined as an "emotional exhaustion, a sense of depersonalisation towards clients and a reduced sense of accomplishments" (Maslach, 1982, cited in Brown & Pranger, 1992, p.5). The impact of burnout from the prospect of client violence can be devastating upon a staff physical, emotional and behavioural wellbeing. According to Edelwich and Brudsky (1980) the side-effects of burnout include physical exhaustion, increased vulnerability to sickness, low self-esteem and self-worth, emotional exhaustion and, rarely, suicidal ideations. These factors can ultimately cause an individual to remain on long-term sick leave and to eventually leave their job. Other signs of burnout are low morale, increased absenteeism and presenteeism, decreased quality of work, high employee turnover and increased stress levels (Barling MacEwen, Kelloway, & Higginbottom, 1994; Kristensen, 1992; Pines & Kafry, 1978). Absenteeism is one way to avoid stress, and Mantell and Albrecht (1994) found that staff who had experienced violence at work would deliberately disengage in order to avoid the environment where the attack took place. As well as avoidance behaviour, workplace violence may also impact the psychological attachment an employee has to their organisation, such as feeling insecure at their place of work. Therefore, victims of client violence may feel less committed to their organisation and their performance at work may begin to deteriorate as a result (Barling et al, 1994).

Many individuals who enter the healthcare profession do not expect to become a victim themselves and this would seem to conflict with their role as carers. However, the fact is that many will experience client violence (Stark & Patterson, 1994; Ryan & Postner, 1993). This can leave practitioners feeling undermined and humiliated.

Research has found that those who have been assaulted at work often feel responsible for the attack, resulting in feelings of anger and guilt, and believing that they are a failure and were to blame for the attack (Lanza, 1987). This response can be exacerbated by unsupportive, critical and non-sympathetic colleagues and managers. Lanza (1987) investigated the attitudes of employees who had not been assaulted towards their colleagues who had been assaulted, finding that the assaulted employees held an extreme negative attitude towards their no-assaulted colleagues. For example they may question in their mind why they were assaulted and not their colleague and question their own skills. Therefore this might cause those who have been assaulted to not report their experience due to the fear of being scapegoat in not being able to contain the client violence.

Healthcare professionals may believe that being in the helping profession does not warrant any form of abuse especially from clients. The reality is that many people in the helping profession are in a conflicting role of helping vulnerable people who don't want their help but need their help, and sometimes patients and clients can respond or behave violently towards those who are caring for them. Nevertheless, when a healthcare professional experiences client violence, this can have a significant consequences and impact on their personal and professional identity.

1.6.3 Impact upon the quality of patient care after a violent experience

One of the major consequences of client violence upon the victim is a sense that injustice has occurred. This is particularly evident when there has been no criminal prosecution after the assault (Shepard, 1994), and can create resentment against the client because they avoided punishment. Mental health patients are often not prosecuted because their diagnosis can be used by their defence as a way of establishing their being "impaired (by) their ability to make rational decisions about their actions" (Behr, Ruddock, Benn & Crawford, 2005, p.7). Shepherd (2002) has similarly reported how

mental health patients are rarely prosecuted due to police reluctance when the perpetrator is known to suffer a mental health disorder or is receiving psychiatric treatment. However, a study by Hoge and Gutheil (1987) found that staff within a psychiatric setting that had been assaulted by a mental health patient held the opinion that the patient was aware of what they were doing. Furthermore they believed that the patient was in control of their behaviour and mental state at the time of the attack. This type of belief, coupled with a relatively low likelihood that prosecution will be pursued, or successful if it is, can create tension between patients and caregivers as the victims are left feeling angry with the injustice they believe has occurred. If these feeling persist, they might be directed either towards oneself in feels of guilty and self-blame, or directed to others such as mangers, colleagues, the institution for failing to protect them, of even the perpetrator of the violence (Barling & Kryl, 1990).

"Performance" in the healthcare sector can be defined in several ways, including patient satisfaction, the psychological health of patients, and interpersonal relationships between staff and patients. Each of these performance indicators might suffer after a traumatic experience of violence in the workplace and of particular concern is that client violence affects not only the healthcare professional involved but also the patient involved, as well as other patients in the care of that professional. This can be due to several factors, including an increasing negative attitude from the affected professional, that professional being less responsive to their patient or avoiding contact with them entirely. Consequently, the quality of care provided can quickly deteriorate due to the individuals' reaction from the assault by the client (Wallis, 1987).

Examining reports from both patients and staff, Arnetz and Arnetz (2001) reported that hospital based healthcare professionals who had experienced client violence were likely to provide lower quality care to patients, measured by patient ratings of the quality of care. This finding seems to support the literature previously

discussed relating to the personal and professional impact of client violence, particularly in terms of stress and its impact upon job satisfaction, and thus on performance (Arnetz & Arnetz, 2001).

1.7   Coping Mechanisms for Client Violence

Different people cope with traumatic incidents in different ways, and some of the coping strategies used can be harmful to the victim and impact them personally as well as professionally. As previously discussed, the most common reported symptoms of client violence are depression and anxiety (McManus, 1992). Once a member of staff is experiencing depression or anxiety, they often seek unhealthy or unhelpful methods of coping with their psychological state. Whittington and Wykes (1992) reported that the most common mechanism for coping with client violence used by healthcare professionals was an increased consumption of alcohol, tobacco and in some cases illegal substances. Whilst these coping mechanisms are initially used to manage hyper-arousal, anxiety, depression and stress following a violent attack, eventually they become problematic in themselves, leading to further deterioration of the psychological wellbeing of the victim.

Denial is often observed in victims of workplace violence, and, whilst it is typically considered a negative coping mechanism, may also have positive effects. For instance, denial was significantly related to a decrease in psychological difficulties in a study which examined the coping mechanisms used by nurses (Wykes & Whittington, 1991). One potential explanation for this is that health professionals often have to continue working with the perpetrator, and with others who have similar behavioural, physical or emotional problems to the perpetrator, so avoiding or removing themselves from the source of the original trauma is not possible. In such situations, denial can allow the healthcare professional to continue to cope with their work setting.

Adams and Whittington (1995) discuss how healthcare professionals may cope with client violence by using a particular strategy of depersonalisation. They found that staff who had been attacked would not personalise the patient's violence but rather consider it to be part of the patient's mental health issues. Furthermore, when patient violence is a daily occurrence healthcare professionals may become habituated to it.

1.8   Rationale for the Research

Verbal and physical violence is becoming an increasingly problematic issue for healthcare professionals and clinical staff (NHS, Business Service Authority, 2011) and is often underreported by victims and overlooked by educational institutions and professional bodies (APA, 2002; Kaplan & Wheeler 1983). Research and prevalence data demonstrate that anyone can be attacked regardless of their skills or abilities, and that this can have a profound effect upon the individual both as a practitioner and personally. It is evident that client violence towards healthcare professionals affects their personal and professional identity and their psychological wellbeing, yet the problem is also likely to affect the recipients of healthcare and service users, in terms of quality of care. Consequently, understanding how psychologists can protect themselves from the negative consequences to themselves and others of client violence is of value. This can be achieved by gaining a richer understanding of the experiences of psychologists who have encountered client violence in their workplace.

The present study seeks to build upon previous literature that has focused upon the risk of client violence and sought to understand the aetiology of aggressive and violent behaviour towards healthcare professionals. Previous research on violence towards mental health professionals has reported that victims of violence are often left feeling vulnerable and experience negative emotions (Rees & Lehane, 1996; Wykes & Whittington, 1994). To date, the majority of the research which has examined client violence in healthcare has employed quantitative methodologies (Adam & Whittington,

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1995; Carlsson et al, 2004; Gately & Stabb, 2005; Muller & Tschan, 2011). These methods have several advantages, such as using a large sample size in order to understand a particular phenomenon, it is flexible in investigating different phenomenon and is generally faster to collect and analyse data than qualitative methods. Quantitative research, supported by the positivist or scientific paradigm, "leads us to regard the world as made up of observable, measurable facts" (Glesne & Peshkin, 1992. p.6). For this reason, the use of surveys and questionnaires in investigating client violence towards professionals can only provide a limited understanding of how people experience client violence.

The BPS DCP (1992) and the APA (2002) have both used in-depth surveys to help aid local policies and procedures of organisations to reduce the risk of violence in the workplaces of clinical psychologists. However, neither of these surveys captured psychologists' lived experience of client violence. It is important to understand lived experiences in order find out how psychologists mange and respond to client violence, especially given that the BPS and the DCoP currently provide no information or professional guidance to their members on how to respond to violence or aggression at work. Overall it would appear that, in the UK, psychologists are following local policies and guidelines at their workplace, or must manage their experiences of violence themselves, particularly if they are in private practice.

Given the lack of professional guidelines for psychologists regarding client violence, and addressing the relative limitations of quantitative designs in exploring this complex issue, the present study adopts a qualitative design in order to gain a richer understanding of the meaning counselling and clinical psychologists make of their experiences of client violence. Because the phenomenon of interest is lived experiences of violence, the present study is firmly set in the real world where the research design and methods do not control the phenomenon of interest (Patton, 2002). Polkinghorne

describes the function of qualitative research as being "to describe and clarify experience as it is lived and constituted in awareness" (2005, p.138). The present study will use interpretative phenomenological analysis (IPA: Smith, Flowers & Larkin 2010) to uncover the meaning of counselling and clinical psychologists' experience of client violence. A more detailed overview of IPA, and the reasons for the selection of this approach will be discussed in the next chapter.

By exploring psychologists' understanding of their personal experiences of client violence in the workplace, the present research seeks to be of service to the profession of counselling psychology by providing a detailed account of the implications of violence upon psychologist's personal and professional identity and psychological well-being, as well as further insights into how counselling psychologists define client violence. Self-care is an important aspect of remaining competent as a practitioner of counselling psychology. Consequently, given that there is currently an absence of a comprehensive guideline document for practitioners from the BPS DCoP on client violence in their clinical practice, the data from the present research might help facilitate the design of a specific policy or guidelines for counselling psychologists to help them remain safe in their place of work, whether in private or NHS settings.

1.9   Research Question

The primary research question being asked is: How do psychologists understand their experiences of client violence in the workplace? Through a qualitative process of interpretative phenomenological analysis, the aim is to develop a detailed interpretation of the participants' account and lived experience, in an effort to understand how psychologists define client violence, and how experiencing it affects their professional and personal identity and psychological wellbeing.

Chapter 2: Methodology

2.1   Rationale for the Selected Research Paradigm

Social science research originates from "a loose collection of logically held together assumptions, concepts, and propositions that orientates thinking and research" (Bogdan & Biklan, 1982, p.30). The underlying choice of methodology is underpinned by a specific paradigm which is defined as the "basic belief system or world view that guides the investigation" (Guba & Lincoln, 1994, p. 105). Traditionally, quantitative research has dominated psychology. This is based upon the positivist epistemology which attempts to explain and predict what happens in the social world by "searching for regularities and causal relationships between its constituent elements" (Burrell & Morgan, cited in Krauss, 2005, p.761). Positivism takes the stance that it is possible for an objective reality to be measured independently of human perception. This standpoint makes the assumption that the researcher is capable of studying a phenomenon without influencing or being influenced by the process.

Whilst this approach can be appropriate for certain areas of research in psychology, other paradigms are considered to be more in keeping with research which seeks to explore and understand human experiences. Punch (1998) has argued that positivism's emphasis upon quantitative measurements to test a hypothesis does not capture the meaning of social behaviour. This view is also supported by Ponterotto (2005) who suggested that research exploring the social world can be too complex to lend itself to theorising by definite laws due to the presence of multiple subjective realities as opposed to a single objective reality. Consequently, some authors have highlighted the value of utilising a variety of research methodologies within different areas of investigation (e.g., Dilthey, 1976).

A number of strengths and limitations have been identified in relation to the positivist paradigm. A key strength of the utilisation of this approach is the employment

of standardised instruments to produce concise measurements and quantification in relation to how the social world operates. This potentially enables the generalisation of findings to similar target populations. These strengths might also be viewed as weaknesses, given the limited range of predetermined responses (Carey, 1993). The positivist approach can also be considered to be somewhat contradictory to the underlying philosophy of counselling psychology due to the emphasis placed upon the importance of use of the self and understanding of the interplay between subjective and inter-subjective factors within the therapeutic relationship (Morrow, 2007). As a result of these criticisms, it is important for due consideration to be given to qualitative research methodologies which place the emphasis upon the quality and nature of human experiences.

Qualitative research can be seen as an interpretative and naturalistic approach to understanding human beliefs and behaviours within the contexts in which they occur. It does not "represent a unified set of techniques or philosophy and has grown out of a wide range of intellectual and disciplinary traditions" (Mason, 1996, p3). Ontologically speaking, this paradigm recognises that there can be multiple perspectives and truths which are grounded in the individual's interpretation of reality. Qualitative research differs from quantitative approaches due to its focus upon "the quality and texture of experience" rather than "the identification of cause-effect relationships" (Willig, 2008, p.9). Consequently, this form of research considers subjective reality to be shaped by the meanings an individual attributes to their social, physical and cultural environment.

The role of language is viewed differently within specific qualitative research methodologies. Certain approaches view language as a central tenet in the exploration of meaning. In doing so, they seek to examine how language is constructed, shapes experiences and changes over generations and within cultures (Willig, 2008). These

approaches are contrasted by other forms of qualitative research which make the assumption that language is central to the description and exploration of experience.

An further key difference between qualitative and quantitative research is the role of the researcher within the research process. Whilst quantitative researchers are viewed as independent from the research process, qualitative research considers the researcher and the object of study to be strongly interlinked and co-created within the context of the process of enquiry (Guba & Lincoln, 1994). This approach is congruent with the underpinnings of counselling psychology by providing the potential to explore the meaning of an individual's subjective experience. The utilisation of a qualitative approach can therefore be considered to be in keeping with the underlying values of counselling psychology by providing an opportunity to explore the complexity and depth of participants lived experience (Morrow, 2007).

2.2   Epistemological Position

Epistemology is "concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate" (Maynard, 1994, p.10). Prior to conducting psychological research, it is crucial for the epistemological positioning to be identified and justified in order to provide insight into the researcher's theoretical lens (Smith, 1983). When conducting any form of psychological research, a variety of different epistemological standpoints can be considered in relation to the subject under investigation. This is supported by Dobson (2002) who explored the link between epistemology and methodology. In doing so, he described how ultimately "the researcher's theoretical lens plays an important role in the choice of methods because the underlying belief system of the researcher (ontological assumptions) largely defines the choice of method (methodology)" (p.2).

In seeking a deeper understanding of psychologists' experiences of client violence in the present research, the limitations of a positivist approach were apparent as this does not allow the researcher to gain a deeper understanding between the differences in thoughts, feelings, behaviours and practices of the individual. After due consideration of research paradigms within qualitative research, the phenomenon and questions of interest in present study were considered to be best positioned within interpretivist-constructivist epistemology and a post-positivist paradigm.

2.3 Methodological Position

Interpretative Phenomenological Analysis (IPA: Smith, Larking & Flowers, 2010) was considered appropriate for the present study for a variety of reasons. Firstly, the researcher holds the belief that reality is constructed in the minds of the individual, and that there is consequently potential for "multiple, apprehendable, and equally valid realities" (Ponterotto, 2005, p.129). Secondly, there is a hermeneutic element and it could be considered that only through deep reflection can one gain meaning and bring this to the surface (Ponterotto, 2005). The role of hermeneutics, in particular the double hermeneutic, is key to the present research topic, as it acknowledges that the lived experience is outside of an individual's immediate awareness but can be brought into consciousness through the researcher's interpretation of the participant's subjective experience. Thirdly, the interpretivist-constructivist paradigm takes into consideration of the lived experience within the historical social reality (Ponterotto, 2005). Finally, IPA has the quality of allowing the researcher to understand the participant's experience from their point of view but also "analysing, illuminating and making sense of something" (Smith, Larking & Flowers, 2010 p.36). This in-depth analysis allows researchers to identify novel themes in areas of research that have not been previously investigated.

2.3.1 Philosophical underpinnings of IPA

Phenomenology is a key component of IPA. This originated from the work of Husserl (1952) who considered experience and one's understanding of this experience as an essential aspect of epistemology. Heidegger, Merleau-Ponty and Sartre expanded upon the work of Husserl by emphasising that individuals do not live in isolation, and that engagement with the world influences perspectives upon life and their experiences. Phenomenologists consider the need to include their own subjectivity and perception when trying to make sense of objects within the world. Therefore, a phenomenological approach to psychological research involves a focus based upon subjective experience. It is also interested in meaning and the way in which this occurs as a result of experience. It has a more of a descriptive element as opposed to a focus upon interpretation and causality. Finally, there is an acknowledgement of the role of the researcher within the construction of meaning of the experience under investigation (Langdridge, 2007, p.9).

The second theoretical underpinning of IPA is hermeneutics - the theory of interpretation. Heidegger (1962) and Gadamer's (1998) development of hermeneutic phenomenology is concerned with the individual's subjective experience and how they make sense of their experience. Thus, the individual and the world are interlinked through social, cultural and historical contexts. Munhall (1989) attempts to simplify this process by describing it as a transaction between the individual and the world as they create and are created by one another. Heidegger considers that this process can be created by a hermeneutic circle. This involves a move between parts of experience to the experience as a whole in an attempt to provide an exploration of the process or experience under investigation.

Gadamar extended Heidegger's work, stating that "hermeneutics must start from the position that a person seeking to understand something has a bond to the subject

matter that comes into language through the traditionary text and has, or acquires, a connection with the tradition from which it speaks" (Gadamer, 1998 p. 295). In doing so, Gadamer viewed 'language' and 'understanding' as co-existing structures which are part of 'being-in-the-world' in which interpretation occurs. Gadamer's philosophy challenged Husserl's notion of the researcher's ability to 'bracket' their own experiences from the research process. Therefore, what distinguished Husserl from Heidegger and Gadamer was his focus upon the distinction between the knower and the object of study. This differs from Heidegger's philosophy, who considered the individual and experience as co-existing. Furthermore there is a double hermeneutic process which is an attempt to make sense of the participants' lived experience. This double hermeneutic process involves the researcher attempting to gain an understanding of the participant experience, while the participant is trying to gain an understanding of their lived experience (Smith et al., 2009). Therefore the role of the researcher is to make sense of the world from his or her participants' views, whilst at the same time looking at the participants' experience as a researcher.

Finally, IPA is characterised by its use of purposive homogeneous sampling. Smith, Jarman and Osborne (1999) consider a sample of ten participants to be close to the upper end of sample size within an IPA study, although some IPA research has been conducted with larger samples. IPA is idiographic due to the initial focus on an in-depth analysis of each individual participant's experience. Smith (2004) considers that only when an in-depth analysis of each case has been made does a gradual and tentative shift towards a cross-case comparison occur. In doing so, IPA attempts to consider the similarities and differences which appear within and across cases. This approach is in keeping with the aim of the present study to provide an exploration of psychologists' lived experience of client violence, as opposed to making generalisations to a broader population (Smith & Osborne, 2008). An idiographic approach also supports the

underpinnings of counselling psychology, with the focus on a client-centred approach which values the importance of individual's experience in their own right.

In this context, IPA is considered appropriate for the present research as it is phenomenological in seeking an insider's perspective on the participants' lived experience (of violence) and it considers the researcher's personal beliefs and viewpoint are necessary to make interpretations of this lived experience. The methodological framework also considers the researcher's personal beliefs and viewpoint which are an essential component of the reflexive process. The participant's experience, perceptions and views are all aspects of self-reflection and the assumption that participants seek to interpret their experience into some form that is understandable to them (Reid, Flowers & Larkin, 2005). Moreover, the participant account is a dynamic process in which the researcher attempts to access the participant's social world through a process of interpretative activity (Smith, 2003).

Given that another qualitative methodology, grounded theory, has some overlap with IPA, it is considered of value to reflect on why IPA was selected for the present study. There are several versions of grounded theory and it is beyond the scope of this thesis to discuss and critique these. However a key distinguishing feature is the interpretative element of the IPA approach. IPA provides the potential for an in-depth analysis of the lived experience of small number of participants "with an emphasis on the convergence and divergence between participants" (Smith et al., 2009, p.202). In contrast, grounded theory focuses upon identifying categories of individuals' accounts to existing theoretical constructs with a focus on the construction of theory and exploration of social processes. Moreover, whereas IPA focuses on individual transcripts as a unique entity, grounded theorists keep in mind the previous participant's data and analysis when examining the next transcript.

2.4   Research Design

Qualitative data can be collected by several different methods, broadly categorised as either interviews or observations (Draper, 2004). The present study adopted a semi-structured interview design to collect data from participants. This is in keeping with Smith, Flowers and Larkin's (2010) stance that semi-structured interviews allow the researcher to have the flexibility of focusing on particular points of interests and a deeper exploration of them. For instance if the researcher felt that a particular comment a participant had made was of interest, they have the flexibility to probe further with additional questions. Semi-structured interviews are also considered to be the most appropriate form of data collection for research using IPA as a methodology (Reid, Flowers & Larkin, 2005). The format of a semi-structured interview provides participants with opportunities to talk to the researcher about their thoughts, feelings and interpretation of the phenomenon under investigation. The relationship between the researcher and participant is an important part of the IPA process and allows rapport to develop so that participants feels more able to speak about their experiences with openness and honesty (Smith et al., 2010).

2.5   Assessment of Reliability and Validity

It is important to acknowledge criticisms that have been levelled at the use of qualitative research within social science. Positivists would contest that qualitative researchers have the potential to inappropriately fix meanings and interpretations to the data, and that qualitative research can thus generate data which lacks reliability and validity. Morgan (1998) has questioned whether qualitative methods are acceptable as scientific contributions within academia due the potential for an absence of quality and rigour. Pidgeon and Henwood (1997, p.268) have contested this viewpoint by advocating that the application of traditional quantitative criteria to assess reliability and validity within qualitative research "risks undermining the very benefit this approach

brings" (p268). Qualitative researchers consider that different means of assessing the quality of a piece of research can be utilised to assess quality and validity (Banister, 1994; Henwood & Pidgeon, 1992; Stiles, 1993).

Lincoln and Guba (1985) emphasise that it is good practice for qualitative researchers to make the reader aware of their rationale for conducting research in a specific area. Therefore, an exploration of both personal and epistemological reflexivity will be key components within the process of the present research (Chapter IV). Lincoln and Guba (1985) also consider that the provision of a detailed account of the thought processes behind research analysis, such as concerns, thoughts and feelings about the data and the research process, will enable the reader to follow the steps which lead to the development of theories or interpretations. This will be evident by the provision of a clear explanation of the research process, due consideration around personal reflexivity and a clear 'paper trail' which will enable the reader to make sense of how conclusions were reached based upon the interview data. Smith Flowers and Larkin, (2010) discuss the importance of the researcher being aware of his or her preconceptions in advance and therefore either bracketing or acknowledging their preconceptions. Later in this chapter a reflexive statement is presented where the researcher considers how they will manage the potential impact of their own personal and professional experience in the research process.

2.6   Ethical Considerations

Ethical approval for the research was obtained from the ethics committees of the University of East London (Appendix A) and NHS South West London (Appendix B). The NHS ethics application was a lengthy process, taking took four months and including a discussion with the committee on whether the research was safe to conduct.

2.6.1 Recruitment

Participants were initially recruited from an NHS Trust in London but there were difficulties recruiting participants through this route. A recruitment advertisement was subsequently posted to the website of the Division of Counselling Psychology (DoCP) (Appendix C). The UEL ethics board also granted approval for the poster (Appendix D).

2.6.2 Informed consent

Before interviews were conducted, participants were provided with an information sheet (Appendix E) that indicated the purpose of the study and contact information. Because it was felt that the area of research could potentially cause participants to feel distressed as they re-lived a prior violent incident, the potential risks of the study and where additional support could be sought was also provided on the information sheet. This included the contact information of Oasis, an organisation who counsel and support NHS staff, and the researcher's details for those who did not work within the NHS. The participants were informed of their right to withdraw from the study at any time. A consent form (Appendix F) was also provided to participants, which indicated their agreement to the interview being recorded and transcribed under a pseudonym, protecting their identity. Participants were also made aware that verbatim extracts may be published in academic journals, presentations and conferences.

2.2.3 Ethical issues

Certain ethical dilemmas were addressed in supervision which could have potentially affected the present study. Firstly, participants were informed that although all attempts would be made to maintain their confidentiality, this may need to be mitigated if they disclosed a danger of harm coming to themselves or others, or if they revealed details of practice which might be considered ethically questionable according to the BPS Code of Conduct (2006) (Appendix E). Secondly, the researcher considered

whether asking participants to recall a distressing situation would be ethical, as the potential impact this might have upon them was unknown. It was suggested in supervision with Dr Helen Murphy that as trainee counselling psychologist I would provide the initial support and also the participants would be provided information of a supporting agency they could use. After the interviews, participants were offered a follow-up telephone call to discuss their experience of the interview and to see they required if any support. All participants declined this offer.

2.3   Participants

2.3.1   Determining sample size

IPA is characterised for its selective homogeneous sampling and using small numbers of participants in order to illuminate specific research questions (Smith & Osborn, 2003). Small samples enable a more detailed understanding of an individual's lived experience, with a focus on quality, rather than quantity. Moreover, IPA explores upon how a particular phenomenon is subjectively lived and understood by particular people (Smith et al., 2010). Smith et al., (2010) have recommended that students on professional doctorates use between four to ten participants in order to do justice to the individual cases for analysis. Consequently, a sample of seven participants was considered appropriate in the present study. This enabled the researcher to compare participants' experiences without being confused by the amount of information being generated from the data (Smith & Osborn, 2003).

2.3.2   Inclusion and exclusion criteria

The inclusion criterion for the research was any counselling and clinical psychologists who had experienced client violence at their place of work and who were willing to explore their experiences. Violence was defined as "any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving an

explicit or implicit challenge to their safety, well-being or health" (Department of Health, 1999). Participants who had witnessed violence as opposed to experiencing it first-hand were excluded from the research.

2.3.3   The final sample

Of the seven participants recruited, two were male and five were female. Four were selected through the NHS and three responded to the advertisement on the DoCP website. Information about ethnicity, workplace and age of the participants is presented in Table 1, which includes a summary of their lived experience of client violence in the workplace, to provide a context for each participant's accounts.

2.4   Procedure

2.4.1   Recruitment process

Participants were recruited from the NHS through a link person provided by the NHS research ethics board, Dr Alison Beck a clinical psychologist and associate director for psychology and psychotherapies. Dr Beck acted on my behalf in sending out the invitation letters (Appendix G) of my research to the lead psychologists in the departments around the NHS Trust. The lead psychologists of the departments then emailed their staff with the invitation letter. Four psychologists came forward to take part in the research. From the advert placed on the DoCP website three participants emailed the researcher expressing their interest in taking part in the study.

Table 1
Title of Table Here in Italics

Name*	Gender	Age	Qualification	Work area	Source of contact	Ethnicity	Details of client violence in the workplace
Rebecca	Female	30-40	Clinical Psychologist	Acute ward	NHS	White British	Whilst working with a male patient in doing psychometric tests, the client according to Rebecca was struggling with the tests and became agitated. Sophie described how the client started shouting in her face and then was throwing parts of the equipment around.
Sophie	Female	30-40	Clinical Psychologist	Forensic ward	NHS	White British	Sophie described two experiences of violence with the same patient: the first experience was walking into the ward in which the client 'grabbed' hold of her wrist whilst holding a clenched fist with her other hand and shouting at her. The second incident was during a therapy session in which the client stood over Sophie and started shouting while raising her fist towards her.
John	Male	30-40	Counselling Psychologist	CMHT	Advert	White British	During a therapy session with a male client, the client became threatening and intimidating towards John whilst talking about his abusive father. John described how the client had lost perspective during his therapy session and transferred his feelings of anger towards his father onto John in which his behaviour had become intimidating and threatening.
Rose	Female	20-30	Counselling Psychologist	CMHT	Advert	British Asian	A client had become verbally abusive during an assessment session with Rose. In which Rose stated

Name*	Gender	Age	Qualification	Work area	Source of contact	Ethnicity	Details of client violence in the workplace
							feeling that her personal space was being invaded. She stated feeling "barricaded" in the room and described the 'attacks' to be personal.
Mary	Female	30-40	Counselling Psychologist	Forensic ward	Advert	White other	A female patient became verbally abusive in a group session and began calling Mary names and was also being intimidating by challenging her in front of others.
Martin	Male	40-50	Clinical Psychologist	Acute ward	NHS	White other	Martin was attacked by a female patient during a ward round in which he described the patient jumping off her seat and started kicking at him on his feet.
Lauren	Female	40-50	Clinical Psychologist	Forensic ward	NHS	White Irish	A male client became threatening and intimidating by shouting in Lauren's face after completing psychometric tests.

Note. CMHT = Community Mental Health Team.

*pseudonyms have been used to preserve participant anonymity

2.4.2   Interview procedure

Participants were made aware that the research would involve a semi-structured interview which would be digitally recorded and transcribed by the researcher, and that their anonymity would be preserved in all documentation. 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 their professional and personal identity and psychological wellbeing. The interviews were carried out at the participant's place of work at a time and date that was convenient for them. Each interview took between 40 to 60 minutes. After each interview the participant was debriefed and invited to speak about their experience of the interview and how they had felt about it. They were directed to the researcher's details on the information sheet if they had any questions or concerns. Participants were asked if they would like to have a summary of the analysis of the results section, and all requested to receive a copy. A report of the findings from the present study will be sent to each participant in November 2012 with an optional space to send feedback. In order to ensure anonymity the recordings were numbered and re-named under a pseudonym in the written transcripts.

2.5   Materials

2.5.1   Design of the interview schedule

The original design of the interview schedule (Appendix H) followed the guidelines of Smith and Eatough (2007), who suggest that semi-structured interview questions should allow the researcher to follow up interesting and significant issues that arise from the interview. Thus, rather than having structured questions, broader research questions should be asked in order to elicit rich information from the participants' experiences of client violence in the workplace. Furthermore, using this approach does

not confine the researcher to a strict and rigid format but rather allows a degree of flexibility in asking questions in no chronological order. The interview schedule was constructed by exploring previous research literature which has examined client violence in the workplace. This enabled the researcher to reflect upon the type of questions to ask to elicit information from participants.

The initial interview schedule was piloted with two participants. This assisted the researcher in ensuring that interview questions were appropriate and had the potential to elicit data which was relevant to the area under investigation. Piloting the interview also ensured that the interview stayed within the approximate time frame of 60 minutes which was deemed appropriate due to the time participants could commit to the interviews. Feedback following the pilot interviews enabled additional insight to be gained in relation to the interview questions and if any changes were considered appropriate. The participants of the pilot study were two female counselling psychologists from the NHS, one of the participants had been physically attacked and the other had been verbally abused. The feedback from the participants in the pilot study was that the questions were too directive, and that there were too many questions to answer. This led to some revisions to the interview schedule in terms of questions, and length. The amended schedule included much broader research questions which allowed the participant to freely express themselves. This also facilitated a shortening of the interview schedule itself. Appendix I shows the final version of the interview schedule used for the present study. The pilot study also helped the researcher to practice and improve their interviewing techniques, particularly by listening back to the audio recordings. It became apparent that there were times when multiple questions were asked of participants, making it difficult for them to know which question to answer. It was subsequently also difficult to understand which particular question the participant

had answered. The researcher became more aware of slowing down, and giving the participants more time to answer a question before moving on.

2.6   Data analysis

The process of the IPA methodology seeks to capture the quality and texture of participants' lived experience, and the researcher acknowledges that this is not directly accessible. Consequently, the researcher "attempts to unravel the meanings contained in...accounts through a process of interpretative engagement with the texts; and transcripts" (Smith, 1997; p.189). This is achieved through a process in which the researcher identifies themes and assimilates them into meaningful clusters, first within and then across cases (Willig, 2001). IPA has an idiographic approach which allows for a detailed and intensive engagement of each individual transcript. The seven verbatim transcripts obtained in the present study were individually analysed following the guidelines provided by Smith, Flowers and Larkin (2010), which is described below.

The initial stage involved a reading and re-reading of the transcript in order to gain familiarity with the texts and an overall understanding of what had been said, as well as an insight of the ideas and feelings expressed by the participants. Notes were made within the transcript that were kept within each participant's own perspective. The aim was to produce wide ranging, non-focused notes that mirrored participants' thoughts and feelings. Here the researcher summarises, paraphrases and seeks similarities and differences as well as looking for echoes, amplifications and contradictions in what the participant is saying. An example of the first stage of analysis is presented in Appendix J.

The second stage of IPA analysis required the researcher to identify and classify initial themes from each transcript which characterise each section of the text. The theme title captured an essential quality and representation of the particular texts. At this stage a higher level of terminology was used to allow for theoretical connections within

and across cases. Whilst psychological terminology was used, the researcher took care to ensure this was grounded within the participants' accounts. Transformation of initial notes into themes was continued through the entire transcript. An example of how initial notes were clustered to create themes captured from the texts is presented in Appendix K.

In the third stage of analysis, the researcher introduced further structure by considering the list of themes identified in stage two in relation to one another. Here the aim was to make sense of the connections between the themes emerging using analytical and theoretical ordering, and to explore how themes that have shared meanings and references clustered. During this phase it was important to continue making sure that the clustering of themes is kept close as possible to the primary sources. Appendix L provides an example of all the themes identified from a particular participant's transcript, which was later clustered after looking for shared meanings. This type of clustering was done for all seven participants individually which assisted in creating a table showing themes captured from all seven participants, which enabled cross-referencing when looking for themes that had similarities and differences (Appendix M). When looking at all themes discovered from the transcripts, it was found that some themes seemed to be conceptually similar, but had been labelled differently (e.g., rumination, questioning one's ability, self-blame). In this instance, these themes were grouped under one subordinate theme and relabelled (e.g., post incident experience).

The final stage involved organising the themes and developing a structure on how they fit together by keeping the research question in mind. The themes were carefully identified as those which captured something about the quality of the participants' experience of the phenomenon being investigated. This was accomplished by a method of 'abstraction' in which similar themes identified were clustered and

labelled under a superordinate theme. For example, in Martin's extract there are a series of emergent themes around his experience of the attack: 'being caught off guard', 'inner dialogue of what to do next' and 'experiencing psychological distress'. These were grouped together under the superordinate theme 'the moment to moment experience of client violence '. Grouping the themes together helped build a higher level superordinate theme as shown in Figure 1. To find support and connections for the themes across cases, a method of numeration was employed. Numeration identifies the frequency in which a theme appears across transcripts and participants (see Table 2 in Chapter III).

The moment to moment experience of client violence
Being caught off guard
Inner dialogue of what to do next
Experiencing psychological distress
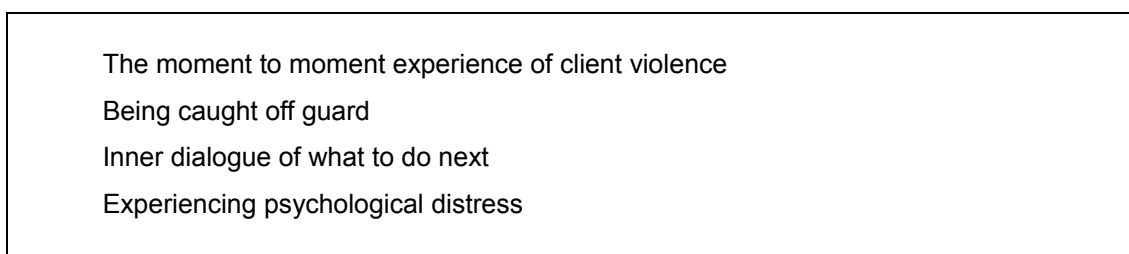
Figure 1. Abstraction leading to the development of a super-ordinate theme

In using the abstraction method it was interesting to discover contextualisation element within the analysis, which highlighted emergent themes. For instance, there was a beginning, middle and an end of the participants' experience of client violence. These stages were related to the here and now of the incident, reflecting on what had happened, and the impact it had. Identifying these stages helped build a summary table outlining the superordinate themes and the subordinate themes within them, referenced using extracts from the transcripts. An example of superordinate and subordinate themes with illustrative quotes is presented in Appendix N.

Finally, the researcher sought to construct a narrative presentation of the "interplay between interpretative activity of the researcher and the participants account of their experiences" (Smith & Eatough, 2007, p.45) using the words of the participants. The results are presented in a narrative format allowing the reader a near documentary

reading of the participants' own accounts with substantial transcript extracts. A detailed description and interpretations of the different emerging themes from the researcher's interpretation is also provided.

Overall, the utilisation of the IPA guidelines proposed by Smith et al. (2010) assisted the researcher with moving from the descriptive to the interpretative, and the narrative format of the data analysis will visibly distinguish between participants' accounts and interpretations made by the researcher. It is hoped that this will maintain the integrity of the participants' account, whilst enabling the reader to identify the analytical journey taken by the researcher.

2.6.1   Validity and quality of IPA research

The data collected from a qualitative design can be subjective as no two researchers' working with the same data are likely to come up with an exact duplication of the other's analysis. This raises the questions of validity and quality (Golsworthy & Coyle, 2001). The present study will use the guidelines for assessing validity and quality produced by Yardley (2008) which are recommended by Smith et al. (2010) given they are broad ranging criterion which can be applied to any qualitative research regardless of the theoretical orientation. Yardley (2000) highlights that good IPA research will have a significant amount of verbatim extracts from participants to allow the reader to verify for themselves any interpretations made. This 'sensitivity to context' is where the researcher uses IPA to give voice to the participants in telling their story. The present study has endeavoured to uphold this principle by keeping a considerable number of transcript quotations from participants to evidence the themes established and interpretations made. Yardley (2000) also proposes that research findings should be related back to existing literature in the discussion section. Consequently. the present research has linked the findings to existing literature upon healthcare professionals' experience of client violence. Yardley (2000) emphasises the importance of rigour and

commitment to the research topic. Rigour is "thoroughness and completeness of the data collection and analysis" (Shinebourne, 2011. p.27) whilst commitment refers to the research process as whole which includes selecting participants to data analysis. It is hoped that these conditions have been met by the researcher in the selection of participants being homogenous and meeting the inclusion criteria, and by the careful analysis of the interview data and re-telling of participants' stories to the reader. Moreover, the use of a pilot phase enabled the researcher to improving the quality of the interview schedule which facilitated the collection of a richer and hopefully better quality data. Yardley (2000) also reports that transparency of the research project improves validity and quality. In the present research, this is demonstrated by the researcher being open about participant recruitments and the construction and adaptation of the interview schedule, and in declaring the epistemological positioning in relation to the present research. Moreover, the data analysis also included ambiguities and contradictions to the themes which have also been presented. A full audit trail of the data collected from the participants is also available, to demonstrate the full process by which themes were identified and labelled.

2.7 Reflexivity

Reflexivity can affect most qualitative research. My own characteristics in the interpretations and analysis of the narrative accounts in the present research could be misleading for the reader (Brocki & Wearden, 2006). For instance, I have personally experienced client violence in a clinical placement which, it could be argued, might have lead to agenda-setting, affecting the final narrative account presented and in the process of the research itself. Having experienced client violence as trainee counselling psychologist it was important for me to be aware of my meanings of the impact it had upon my personal and professional identity as well as my psychological wellbeing. A

more detailed personal reflexive statement is provided in Chapter IV, will addresses

what the researcher brings to the research process.

Chapter 3: Results

When using an IPA approach to analyse the data, Smith (2004) recommends that the researcher stay grounded and focused on the text itself. Smith also discusses how the researcher can relate his or her interpretation "between a hermeneutic of recollection or restoration of meaning and a hermeneutic of suspicion" (2004, p.46). Thus, when making an interpretation, the researcher demonstrates empathy and meaning recollection as well as an analytical engagement with the transcripts.

In the present study, after analysing all seven transcripts and cross referencing for themes, a story emerged of the participants' experience of client violence in the workplace, described in terms of three master themes shared by all participants, and their respective subordinate themes (see Table 2: adapted from Smith, Flowers & Larkin, 2010). In this chapter, each theme and subordinate theme are discussed in more detail, using illustrative quotes. The first superordinate theme, entitled 'the moment to moment experience of client violence' regards how participants experienced the incident at the moment it occurred, and included three subordinate themes: being caught off guard, inner dialogue of what to next, and experiencing psychological distress (see figure 1). The second superordinate theme 'post incident experience' regards how participants experienced the client and their attempts to make sense of the client's behaviour. This was captured by four subordinate themes: feelings towards the client after experiencing client violence, creating a formulation in understanding the client's behaviour, being cautious of the client after the incident, and questioning whether the client was in control of his or her behaviour (see figure 2). The third superordinate theme, 'issues concerning professional identity' relates to how the experience of client violence affected participants' professional identity as psychologists and was captured by four subordinate themes; thinking on what could have been done differently, not being precious, seeking support, and being judged by others (See figure 3)

Table 2
Master List of Themes

Participant	1: The moment to moment experience of client violence		
	1.1: Being caught off guard	1.2: Inner dialogue of what to do next	1.3: Experiencing psychological distress
Rose	Yes	Yes	Yes
Martin	Yes	Yes	Yes
John	No	No	Yes
Sophie	Yes	No	Yes
Rebecca	Yes	No	Yes
Lauren	No	Yes	Yes
Mary	Yes	Yes	Yes
Present in over half the sample	Yes	Yes	Yes

	2: Post incident experience			
	2.1: : Feelings towards the client after experiencing client violence	2.2: Being cautious of the client after the incident	2.3 Creating a formulation in understanding the client's behaviour:	2.4: Questioning whether the client was in control of his or her behaviour
Rose	Yes	No	Yes	Yes
Martin	Yes	Yes	Yes	Yes
John	Yes	Yes	Yes	Yes
Sophie	Yes	Yes	Yes	Yes
Rebecca	Yes	Yes	Yes	No
Lauren	No	No	No	Yes
Mary	Yes	No	Yes	No
Present in over half the sample	Yes	Yes	Yes	yes

	3: Issues concerning professional identity			
	3.1: Thinking on what I could have done differently	3.2: Not being precious	3.3: Seeking support	3.4: Being judged by others
Rose	Yes	Yes	No	Yes
Martin	Yes	No	Yes	Yes
John	Yes	No	Yes	Yes
Sophie	Yes	No	Yes	Yes
Rebecca	No	Yes	Yes	No
Lauren	No	Yes	Yes	Yes
Mary	Yes	Yes	Yes	No
Present in over half the sample	Yes	Yes	Yes	Yes

3.1   Superordinate Theme 1: The moment to moment experience of client violence

The first superordinate theme identified was the participants' experience of the incident itself and how they lived through it. The participants' experiences are captured through three subordinate themes: being caught off guard; inner dialogue of what to do next and experiencing psychological distress which will be discussed in turn.

3.1.1   Subordinate theme 1.1: Being caught off guard

The vast majority of participants reported that the client violence was unexpected, and that they felt caught "off guard" and surprised by their client's behaviour. The suddenness of the attack had left them feeling vulnerable and confused. For example, Sophie states:

> Just really shocked, to be honest, just because I wasn't... like I say, I wasn't expecting it. I've worked with people and they've got angry and irritable before but I think it was that thing, I'd... I'd never...I'd never been in a position where you've just walked on and something's suddenly hit you in the face. She'd been fine and then suddenly started getting aroused and it was one of those things where, again, where it sort of catches you off...off guard.

For Sophie this seemed like it was her first experience of seeing a client become agitated without any trigger incident or other explanation for the their aggression. Sophie works in a forensic ward where the risk of violence is greater, and it seems that she was perhaps not vigilant for possible aggression. Consequently, Sophie perhaps felt confused how her client became so aroused so quickly. However it seems she had become more complacent with the ward environment than is usual in forensic settings, and was caught off guard. The unexpectedness of client violence for Sophie might also be related to her professional self-image that psychologists do not experience client violence.

Mary also seems to question herself about her experience of client violence, stating that:

I don't even think that I said anything...nothing that significant was even said. So it was a bit like 'where did that come from?'...I felt like, you know, well I don't...I didn't really do anything to bring it up

Mary continued to think about what could have provoked the client to challenge her in front of others and felt a sense of unfairness about the verbal abuse by the client when she had done nothing to provoke a reaction. However she later rationalises this as something which is to be expected as part of her job when she says "I would kind of say that it's part and parcel of what comes from working with this client group when you have people with personality issues". However, despite recognising that the incident is part of her job, Mary is still caught off- guard and questions why the client behaved the way she did.

Rose's experience of client violence was slightly different from the Sophie and Mary's. She speaks about how:

I was surprised because before she came into the room I... the Receptionist did tell me that... that she felt the client was a bit agitated and she'd been pacing up and down but I wasn't really expecting the twelve minutes of verbal onslaught and for it to be so personal and directed at me.

Although the client already appeared agitated before her meeting with Rose, making a potential outburst more likely, Rose still felt surprised by the extent of the client's verbal attack. Rose views the client's behaviour as unreasonable in personally attacking her without any provocation and her tone of voice when describing this incident was one of surprise and shock that she had endured such an experience. Here there seemed to perhaps be similarities with Sophie's reaction that as a psychologist she did not expect to experience client violence and for it to be so personal.

Similar to Rose's experience, Martin's client was also aroused:

She was fairly aroused, but no more than so then the other clients are, at one point she just jumped and started kicking at me... at my legs and I kinda lifted my legs up and tried to move out of the way backing my chair but she carried on

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kicking at me most of the time she hit the bottom of my shoes erm so it was quite erm a nerve wracking experience because I couldn't go anywhere.

Martin also seemed to be surprised and unprepared for his client's physical aggression. Again, whilst the client group Martin works with are often aroused whilst on the ward, it again appears that there is no professional expectation from Martin that he might be attacked without warning when working in this type of setting. Martin seemed to be trapped in the incident and was felt that he had nowhere to go to remove himself. Having no place to escape seems to have affected Martin's anxiety in the situation, particularly not knowing what might have happened to him.

Rebecca also discusses being surprise by her client's behaviour of throwing objects around and shouting in her face:

> I felt scared, really, and kind of surprised because I'd met him several times, I thought that I had a... a reasonable rapport with him, I thought that I knew kind of what was going on and yet this seemed to come, not quite out of the blue, because he was getting more agitated as the test was carrying on.

From Rebecca's interview it was clear that she had not expected anything to happen during her session with the client, even though he was becoming progressively more agitated. In her case, however, she is able to acknowledge that the client violence was not quite as unexpected as other participants described, but she feels that she could have contained the situation because of her perception of rapport with the client. However as the aggression escalated, Rebecca was taken off guard. She perhaps blames herself for her client's aggression, because she was too complacent with him and should have been more aware and vigilant of the escalating situation.

All participants have worked with clients with severe and enduring mental health issues and in some cases with a forensic history. Consequently, several participants do discuss how violence is a possibility in their work, due to the client groups they work with, and environments that they work in. Nevertheless, they mostly have not expected

to experience client violence directly, so that when it has occurred it was unexpected and they felt unprepared for responding to the situation. This reveals an interesting aspect about how psychologists view their role and abilities with challenging clients and settings. On the one hand, participants discuss their ability to pick up on early subtle warning signs and cues, such the client being agitated or aroused, yet at the same time they do not perceive the potential risk to themselves, leading to shock and surprise when events escalate. It could perhaps be inferred that psychologists do not expect to be attacked or assume that their professional skills can be used to protect them from, or at least de-escalate, potentially violent situations. Psychologists, particularly those who work in certain settings, would benefit from recognising the potential seriousness and risk of client violence upon themselves.

3.1.2 Subordinate theme 1.2: The inner dialogue of what to do next

The second subordinate theme identified from the analysis was having an inner dialogue during the incident of client violence. Participants describe how they conducted a conversation with themselves whilst considering how to respond to the incident, what do next, and how to find a safe exit without being harmed further. For instance, Rose discusses how several thoughts had gone through her mind:

> thoughts of 'Okay, do I need... will I need to press the panic button? Who... who else is in the building with me? How much can I tolerate before I may need to call for assistance? Will she get physically aggressive?' And I'm wondering whether it would escalate, whether it would stay with verbal aggression and how long I'd have to endure it really.

In sitting with the client's verbal abuse, Rose is experiencing anxiety about her own safety with the client. Rose may have tolerated the verbal abuse because, as she discussed later in the interview, she feels that verbal abuse can not be considered a violent act, and that tolerating verbal abuse feels like part of her role. This raises another

interesting point about how psychologists perceive their role, perhaps also including an expectation to tolerate and work with verbal aggression.

In Martin's interview he discusses his need to find a way out without being hurt further:

> I probably had a dialogue with myself, had to reassure myself that feeling as frightened that I felt erm was kind of okay ...as well as feeling what I do to stop this and get out of this situation. it was like what happens if this gets more worse and I have to do something like if I have to, for me to get away I think I would have had to like almost tackle patient....how to get out of there I think I would have had to kick at her to push her away so that I could get up you know...more about me just trying to getting out , not getting hit, not getting hurt

Martin's inner dialogue is finding a way to reassure himself that he is okay in which there is perhaps a fear that he may lose control of himself and not know the consequence of his actions. At the same time is also thinking about the worst case scenario of having to tackle his client if she did not stop attacking him. Martin has a fight or flight response to the attack on how to help himself out of the situation. The inner dialogue is also used to help calm him down and perhaps used as a coping mechanism.

In Mary's interview, she talks about a bad feeling that something is going to happen, she states:

> I suppose you can almost feel like adrenalin starting to pump and you kind of... you know, it's a bit of fight and flight, will I be attacked here, well, either verbally or physically and I was actually quite nervous and frightened because I kind of was thinking how I can kind of resolve the situation.

Mary seems to experience a physiological sensation and awareness before the incident. The "fight" she discusses is not attacking the client, but perhaps to find a resolution where the balance of power is restored. This concept of 'resolving' is part of her role as a psychologist and helps her to reflect on how to deal with the situation.

Lauren's inner dialogue appears to differ slightly that of other participants:

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.

Lauren seems to be contrasting the differences between her role and possible
actions she can take, with the role and actions of nurses during a violent incident with a
client. Perhaps this illustrates again how psychologists perceive their role, with Lauren
thinking that she should be able use her skills as a psychologist to work with the client
therapeutically by processing the situation, or negotiating with him, unlike the more
physical restraining 'damage limitation' approach taken by nurses. That Lauren was
unable to use her therapeutic language to de-escalate the situation left her feeling upset,
and perhaps questioning her skills. This could also be related to how psychologists
perceive their skills and training, and that they possess (or should possess) some kind of
'special' skills that should help them deal with difficult and challenging clients and
situations, that other healthcare workers do not possess. These specialist skills perhaps
help Lauren believe that as a psychologist she is immune to client violence and perhaps
has a special ability to deal with any client issues.

3.1.3   Subordinate theme 1.3: Experiencing psychological distress

All seven participants discussed how the violent incident impacted upon their
psychological wellbeing, and they experienced several emotional reactions during and
after the incident. Martin discusses his feelings after the client had attacked him:

I was obviously sacred and nervous of being hit...a mixture of feeling of fear and
arousal and that kind of what do I do to defend myself or get away...she was a
quite a big lady actually and I'm sitting in the chair stuck in the chair so it was
she was very intimidating so there was all of that issue of being frightened of

being hit and hurt...you kind of dismiss the fact that you felt really frightened, that you didn't know what the outcome was going to be at the time actually it was a big deal at the time but afterwards you sought of ask yourself all these questions...I don't want to be made to feel so frightened , to be so disrespected.

Martin's feelings of fright perhaps created the thought of a violent response of his own, hitting out at the client, in order to defend himself and find safety, or perhaps this could have been a more unconscious reaction to his feelings of being intimidated and disrespected. Being a psychologist, Martin also held the idea that he needed to remain professional and was unable to act out, yet his client's intimidating behaviour and Martin's distress seems to have contributed to a physiological response of freezing. The feelings Martin described at the time of the attack seemed to be related to both physiological and psychological manifestations of the 'fight or flight' response. Martin discussed feeling afraid, frightened and intimidated not only by the client but also of not knowing what could have happened next. Martin also felt disrespected by the client for the attack and perhaps this was related to his identity as a psychologist. Perhaps Martin was experiencing a conflict regarding how to respond to aggressive client behaviours depending upon what drives that behaviour: Do aggressive client behaviours that can be explained by conventional clinical diagnoses (i.e., 'psychotic break') warrant a more patient and therapeutic response, to those that are planned and under the self-regulation of the client? A final point Martin made was about dismissing his feelings, which could be interpreted as his not wanting to show fear in front of his colleagues and appearing to be in control, despite how frightened he was in reality.

John's psychological distress seemed to occur prior to seeing the client because of his awareness that the client was prone to losing perspective during the therapy session. According to John, the client would transfer his feeling of anger towards his father onto John:

I could feel my anxiety building and I think, especially the first two or three times it happened I...you know...I used to feel a bit anxious about it and a bit worried about it...I certainly, towards the end of it, you know, those six, seven weeks that it was building up, I found myself feeling quite anxious before the sessions as well, yeah. A bit...a bit anxious, a bit worried, a bit kind of exhausted by it.

John discussed feeling anxious and this is perhaps related to being unsure of how the client may behave in the session, or in anticipation of the potential anger his client to direct towards him. I wondered if John consciously or unconsciously had registered the risk of being physically attacked by the client, leading to a build-up of anxiety regarding the potential for the client's verbal abuse to escalate to physical violence. The continuous worry of the possibility of being attacked left John ruminating and holding onto the psychological distress each week. John uses the words "a bit" frequently when describing his feelings as if to minimise his anxieties and worries: perhaps this is due to his identity as a psychologist, such that he believes he should be prepared to deal with violence or be seen to be less affected by it. It could also be seen as a coping mechanism for dealing with his distress, and to reassure himself that it is not that bad and that he can cope?

Sophie's experience with the unexpectedness of her first incident with a violent client had left her feeling frightened of the client:

So, yeah, so initially shocked and quite... quite upset actually by it. Yeah, so I was frightened of her, so it made me sort of very wary of her every time I came into the ward… Yeah, I think it was that kind of thing when you've been completely shaken up you feel a bit sort of, 'well, this is my reaction to things like that, a bit panicky and a bit tearful'…

Sophie's psychological distress is perhaps related to her own behaviour or "reaction to things" rather than from the client's actual behaviour. The feelings that Sophie experienced from the client violence had been so powerful that she became

hyper vigilant of the clients presence in the ward. There was a second incident with the same client in a therapy session in which the client stood and shouted "I'm fucking Jesus Christ". Sophie described to me how she was feeling:

> I was on a much lower level and we didn't have personal alarms there and the only thing I could think to do was to sort of adopt a sort of submissive dog pose rather than being confrontational...I was... I was terrified, I really thought she was going to thump me and I thought because I'm sort of low down on a chair it's going to be hard to...even though I was closer to the door you kind of think... I remember feeling very frightened, very helpless. Again, it's almost... I think because the nurses deal with more aggression day to day, they're much quicker to hit the alarms whereas, you know, part of me thinks as soon as she started getting angry should I have gone and, you know, whacked the wall alarm that was, you know, sort of over there.

Sophie may have questioned herself, regarding why she did not respond to the client's aggression faster, as the nurses would have. Her distress might also be related to her response of freezing, and her unpreparedness of the possibility of being attacked, leading to feelings of helplessness. The submissive dog pose is an interesting metaphorical reference of a power shift between her and the client. The client's aggression towards Sophie instantly takes her control away leaving her experiencing psychological distress. The shock of the clients aggression had caught her off guard and left her frozen on the spot. By comparing her role to that of nurses Sophie recognises they are more prepared for dealing with client violence than psychologists are. This perhaps indicates that psychologists as a profession may be slower to respond to their clients' aggression then other healthcare professions, maybe because they believe their skills and training enable them to de-escalate situations and calm clients in ways that other practitioners are unable to, or perhaps simply because they do not receive enough training and awareness about how to react in these situations, meaning there is no automaticity of behaviour.

Rebecca discusses her feelings towards the client when he became aggressive:

I felt scared, really and kind of surprised because I'd met him several times, I thought that I had a... a reasonable rapport with him, I thought that I knew kind of what was going on and yet this seemed to come, not quite out of the blue because he was getting more agitated as the test was carrying on, but I'd said to him several times, you know, "do you want to stop or" and he... he had... he continued. So I think, yeah, I mean, 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 kind of stood over me and shouting. That was probably the most frightening bit…just kind of anxiety and feeling quite uncertain about how to do... what to do, how to handle it. So a bit kind of confused maybe… But it was more fear than anything else.

Like Sophie, Rebecca also stated that the most frightening part of the aggression was the client standing over her, leaving her feeling uncertain about what was going to happen to her next. This uncertainty about how the client's behaviour may escalate might perhaps causes the most distress, as the victim she is not able to plan for what happens next. Rebecca's feelings of anxiety and fear seem to be related to how she should handle the situation whilst it also seems to be getting out of her control. She is perhaps also questioning her ability to contain the client and the situation and find a way of de-escalating it. This seems to be a reminder of how much pressure there is upon psychologists and other healthcare professionals to 'know what to do' in an unexpected intimidating situation such as this. Having experienced verbal abuse with a client, who she felt that she had fairly reasonable rapport with, caused Rebecca to question her skills as a psychologist in dealing with the aggression. This perhaps raises the concern that psychologists are often ill-equipped and unprepared to respond to client violence, and thus could be more affected by it when it happens to them in comparison to the other healthcare professions.

Mary also discusses the feelings that arose, especially not knowing what was going to happen:

> I had a very uncomfortable feeling in my heart, is the kind of a... I have that feeling with the patients here as a fear which is more like a knot in your stomach …it was because I had the feeling like, you know, the fear I get in my... fear in my stomach but, you know, the hostility I sometimes feel in the kind of my heart which is, I don't know how to describe it but I know the feeling, and it's not a pleasant one because I think it kind of... it kind of stops you from thinking and it does put in the kind of a... in touch with your emotions..

The client's aggression was uncomfortable for Mary, and their hostility particularly induced fear into her. The feeling of fear from the client was becoming challenging and she felt that it stopped her from thinking. This may have contributed more to her distress as the more immediate physical sensations meant that she was unable to use cognitive abilities to concentrate or process the situation, and therefore think of a response to it.

Many practicing psychologists perhaps remain ill-informed regarding the potential risk of client violence occurring to them directly, rather than something that only affects other healthcare professionals. This can mean psychologists are unprepared when encountering violence, and often are unable to react in practical ways to de-escalate the situation. One consequence of this might be that client violence is much more devastating for a psychologist due to the unexpectedness, and associated feelings of shock and fear.

3.2   Superordinate Theme 2: Post Incident Experience

The second superordinate theme identified from the analysis was the participants' interaction with the client. This was represented by four subordinate themes: feelings towards the client after being attacked (which was different from the emotions aroused during the attack); creating a formulation in understanding the client's

behaviour, to gain an understanding of the client's aggression towards them; being cautious of the client after the incident; and questioning the client's behaviour.

3.2.1 Subordinate theme 2.1: Participants' feelings towards the client after experiencing client violence

Participants talked about how they felt about the client after being attacked by them. It seemed that the process of the qualitative interview provided a space to reflect and take into account what had happened, and mixed feelings of sympathy, anger, anxiety and being frightened of the client were raised. Some participants discussed how their relationship with their client had changed and that they could no longer trust them, feelings which led some participants to not want to work with the client again. For example Martin discusses how he felt angry with the client and how that had impacted upon him working with her in the future:

> Afterwards I was pissed off with her, I did not really want to talk to her. I have a clear recognition that of feeling cross of that wasn't right you know… and not wanting to do anything with her or offer help, not wanting to kind of contribute to her care erm in a way, before I would have wanted to…I have been cross at her quite a while afterwards and remember wanting to peruse things with the police My reasons for not asking another question and sitting quietly, one of them would have been maybe get a grumpy sulkiness because of what she did and that sulky of that's it I'm not going to get involved in your treatment so there may well have been some of that...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.

Martin's focus was on the injustices of the client's behaviour towards him which caused him to feel angry towards the client. These feelings had an impact upon the care he was able to provide, as he felt that he did not want to contribute to it, especially as the client broke "the rules" by attacking staff. Martin's feelings towards his client seem to include wanting to punish her for breaking this rule. He also acknowledges that his unwillingness to continue to contribute to her care is perhaps due to his personal feelings, such as his "grumpy sulkiness". One possible interpretation of this is that the

client's attack had a personal impact upon Martin, leaving him feeling disrespected, leading to a kind of passive-aggression being exhibited by Martin, perhaps the only way he felt he could react given his position. The post incident feelings after reflecting allowed him to step out of his professional self image and be himself by expressing his anger and wanting nothing more to do with his client.

John' feelings were different to that of Martin's and were more attached to his role as a psychologist rather than on a personal level:

> I always had a certain level of sympathy or, I think it was bit of sympathy, a bit of empathy for him, I always had a certain level of that because his life situation was very difficult…I could see where my client was coming from and I could understand his anger. So, from that point of view, I'd... you know, I did hold a certain level of kind of empathy towards him.

John used both the words sympathy and empathy to describe how he related to his client, and recognised and understood the anger in his client. This perhaps illustrates a conflict between John's personal and professional feelings towards the client, or that his professional identity seems intertwined with his personal identity. John's sympathy may have had an impact upon the risk of violence for him as he perhaps allowed his personal feelings to get in the way of therapy. Therefore John may allowed the client to get away with some behaviours then he would gave done other wise. On the other hand, his "certain level of empathy" describes a degree of recognition that the client had some responsibility for his aggression towards John.

Sophie discusses how her feelings towards the client affected her work with the client after the incident:

> I was frightened of her after that because it was so unexpected...I'm not sure how I'm going to work with this client because how can you work with someone if you're frightened of them.... this woman was just too unpredictable it made it very difficult to know how you work therapeutically with someone...So I think,

you know, that initial shock, feeling upset but then feeling quite annoyed and angry with the client.

Here, the client's unpredictability made them frightening to work with. These feelings of fear towards the client, seemed to be one factor that led to a rupture in the therapeutic relationship, to the extent that it seemed no longer feasible to continue working with the client. As a psychologist, Sophie tries to analyse what the client violence is about, but finds that her personal feelings of injustice are more overwhelming. Perhaps Sophie's anger is caused by a conflict between trying to do her job, but being put in that position of fear. She may also have felt guilty for feeling angry with the client as there is a sense that as a psychologist she should be more understanding of her clients' behaviours, regardless of how they are manifested. Her post incident emotions could also be a reflection of her own feelings towards herself in being complaisant with the client.

Mary's experience leads her to feeling frustrated to the point where she can no longer see the point of helping the client:

> I think, you know, at the time I was actually quite nervous and frightened because I kind of was thinking how can I kind of resolve the situation but after the group and I went to the office and actually said to my co facilitator that I want to strangle her. That's what I said and I kind of... I was at the height of that emotion that I was actually physically feeling that I would go and strangle her. I wasn't kind of thinking "oh my god, I can't face it", I was thinking more like how I can't be bothered if she's going to be like that... you know, this is one thing when you know that somebody has a personality issue, that sometimes they're really getting to you.

Mary describes the stages of the emotions aroused from being assaulted to reflecting about the incident. Her anxiety seemed to be more than about resolving the "awkward" dynamics in the group situation, and how she is being perceived in front of others, particularly her co-facilitator. Mary may feel as though she is being judged by

others due to the client's behaviour and this leads her to feeling angry and it seemed that there was also a sense of hopelessness in how the client changed her behaviour towards her. Mary, too, uses her skills as a psychologist to attempt to understand her feelings towards the client and rationalises her client's behaviour as part of her mental health difficulties, and as the client had a personality disorder diagnoses, there may have been less of a hope of the client changing. Although Mary states that her anxiety was not that she could not face the client, I wondered if she really could not face the client anymore, due to the anxiety of being challenged repeatedly and feeling hopeless about the situation ever changing. It was interesting to note the stages of how Mary's feelings changed from being anxious to anger and finally hopelessness.

Rose describes how she felt towards the client after the client had walked out of the therapy room:

> I have to say, I wasn't too empathic towards her. But a lot of that empathy came afterwards once she'd left the building actually and I didn't feel so invaded by her, I was able to think about it and... and rationalise it, I guess, rationalise her anger.

By having time to process the client's violence, it was interesting to see how Rose went from having a negative feeling towards the client to being more able to understand and empathise. This ability to reflect upon the processes and the role of both client and therapist, and to find empathy, could be due to Rose's professional training as a psychologist. Having learnt how to remain ethical and professional, she is able to contain her own personal feelings towards the experience of client violence and become more reflective, and, in some sense, still honour the client. It might also be argued that in doing so, Rose's own personal feelings are not heard or are displaced elsewhere.

Rebecca discusses how she felt about the client after the incident and stated that she was:

Very nervous at seeing him again. And... and a bit unsure, a bit kind of knocked off my feet maybe more generally. He... with him just kind of quite unsure, I think. I think particularly having felt that I had a bit of a measure of him beforehand then thinking no, I don't and... and I guess I... I thought he was more unpredictable and less known than I had before.

In being "knocked off" her feet it seems that Rebecca is questioning her skill as a psychologist and considering how well she actually really knew the client. She did not reveal holding any negative feelings towards the client for his shouting and threatening behaviour towards her, but listening also to what she was *not* saying led me to wonder whether Rebecca found it difficult to acknowledge negative feelings towards a client with mental illness. Perhaps psychologists find it difficult to discuss negative feelings towards mentally unwell (or in fact any) patients, as it might feel unethical and be seen as a failure to demonstrate the core condition of unconditional positive regard.

3.2.2 Subordinate Theme 2.2: Creating a formulation in understanding the client's behaviour

The second subordinate theme relates to how participants used formulation to understand why their client had attacked them. Formulation is a core aspect of the professions identity of psychologists. It seemed that in creating a formulation, participants were able to put the client violence into some perspective. Formulation is used by the participants to develop a hypothesis about their clients' difficulties. Furthermore, this process it is a way of putting the pieces of a jigsaw together that can help psychologists gain an understanding of the client and why they behave the way they do. Here, Rose discusses her reasons for using a formulation:

I remember thinking I want to understand this lady and I want to understand why she's angry and possibly come up with some formulation that linked her anger to her... her personal history why I was trying to understand it from a psychological perspective, trying to find a formulation to help me with my empathy…I think it was important to formulate to understand her and her difficulties and understand the aggression in order to help her.

For Rose, the formulation helped her to understand why the client became angry towards her, and was a process to link the client's anger to the client's personal history. Rose uses formulation as an intervention in understanding or making sense of the development of the clients' aggression. Formulation may also perhaps been Rose's way of remaining professional and therefore avoids acknowledging the effect this experience had on her. Rose acknowledges that psychological theory can be used as a protection, such that one can be removed from the effects of client violence. As a psychologist, Rose is using her formulation skills and knowledge of human behaviour, cognitions and emotions to understand and cope with events that happened to her. Here her self-talk ("I remember thinking") is attempting to rationalise an attack and formulation to understand it.

John discusses how he used formulation to understand his client's verbal threats and aggression through a transference interpretation:

> He'd switch it into the first person towards me and 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 in those... at those times when it was really starting to get out of control. I sort of coped with it to start off with. 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 was a process for John to understand his client's disturbing behaviour, and therefore making sense of the verbal aggression. John formulated that the client's aggression was not about him but a projection of his feelings about his father onto him. Using formulation in this way helped John to understand and therefore be able to cope with his client's aggression, because the client's threats were not personal. Holding the client's formulation in his mind that "this isn't really about me" and was something that "we can work with", seemed to help John to continue working with the

client collaboratively ("we"), and in this sense, using a formulation perhaps helped John avoid failing his client in therapy. Whilst this use of a formulation can help the client in therapy, it might also put John at risk of being hurt because he failed to recognise the very real risk of physical violence, whoever it was really directed at (the father) from the formulation. Formulation is a valid and useful psychological approach to help both client and therapist, but in this instance John's use of formulation also perhaps enabled him to hide behind psychological theories that avoided facing up to the reality of violence, and to continue to feel safe.

During Sophie's interview she discussed the uses of psychological theory in understanding the client's aggression:

> I couldn't see how to work with that [client's aggression]. When I thought about it more in a sort of schema focussed way and the idea of schema modes and flipping into different modes from something, I could see how we could help this woman later on. We were identifying the different modes that she flips very suddenly into and trying to strengthen a different mode to keep the other mode, this very aggressive impulsive one, in check and once we'd got that model it made it easy to work with because I could understand it better.

Sophie discussed the benefits of using a different approach to gain an understanding of her client's aggressive impulses, which helped her to find a possible way of working with the client. Creating a formulation was Sophie's way of identifying why the client became aggressive so quickly. Similar to John's use of a formulation, Sophie also wants to make sense of the client's aggression therefore understanding the clients disturbing behaviour. Sophie also perhaps does not want to fail the client in therapy and therefore uses formulation to try and understand the quick aggressive impulses as well as helping to make her feel safer when working with her client. Formulation is part and parcel of her professional role and is used genuinely used to support the client. Sophie seems to rely more heavily on her professional skills than she

does on her personal judgement, and this perhaps increases the risk of violence to herself.

Rebecca uses formulation to empathise with her client's aggression:

I think he'd been in that situation that he felt evaluated, that he was aware that he wasn't doing very well, probably felt frustrated, upset and that... with those kind of tests [psychometric tests] you don't get much interpersonal feedback so there's supposed to be run in a fairly standardised manner. So whilst you can be kind of pleasant, you're not saying 'oh, don't worry about it, never mind that you didn't do so well', you have to kind of keep going in a fairly routine manner. So I think that probably feels quite alienating sometimes for people, particularly if they're not doing very well. So I think it was probably frustration, a bit of shame from... from his point of view that... that triggered it off.

It seems that for Rebecca, formulation helped her to understand what had triggered the client's aggressive behaviour. She also discusses her role whilst conducting the psychometric testing in a fairly routine manner with little interpersonal feedback. Here it could be interpreted that Rebecca perceived a conflict with her role in this setting: as a psychologist, she would typically be developing a therapeutic alliance through demonstrating empathy, yet doing psychometric testing she felt that she was less empathic and perhaps this was a factor in the client being aggressive. Rebecca is possibly blaming herself for this conflict in her role, such that had she been demonstrating more empathy, perhaps her client would not have got aggressive. She might also be directing the responsibility of the client violence on the 'form-filling' psychometric task for firstly, not creating enough space for empathy to be demonstrated, and secondly for being a task that the client found frustrating and ashamed of their performance, which led to the aggressive behaviour. I wonder if this interpretation from Rebecca is superficial in terms of finding it difficult to be angry with the client's behaviour and that blame lies upon psychometric testing and lack of empathy in doing it.

Mary also uses psychological theory to gain an understanding of the client's verbal abuse towards her:

I suppose you're always managing yourself because you're in a therapeutic role here and you kind of think about, as a psychologist I think you think about what does this say about the person and what does this mean but as psychologist I think, you know, there are various ways you might be trained because I think if you are a psychoanalytic psychotherapist and your client in analysis you've seen for five years says to you that you're such a bastard, you wanker, I don't think they will go on somewhere and report verbal abuse. I think they will interpret that and, you know, I don't think they would necessarily see it as a negative thing.

Mary discusses how she knows as a therapist that the aggression is a projection of the client's own self onto the therapist. Formulation is a part of her "therapeutic role" in which Mary creates an understanding of the specific meaning of their aggression. Formulating to understand the client's aggression towards her helps Mary to detach herself from the client violence and not take it personally. This is similar to how John and Rose used psychological theories to understand, then cope with, the abuse. Using formulations seems to act as a protective barrier and coping mechanism between the client's abuse and the impact it can have upon one's feelings. Mary also discussed how formulation is part of being a psychologist and that these experiences are used to understand the client violence.

Martin discusses his hypothesis of why the client behaved the way she did:

Maybe she didn't like me because the question I asked her in such a public setting. So she behaved in a public setting that would be very awkward for me without doing any physical damage [to Martin] you know that's my hypothesis She behaved in a really thuggish way rather them erm so I felt that she had control over that behaviour she did not had to do that I think. I thought she was in kind of control the whole way through that she was in a sense kicking but trying not to damage me that sought of thing was going on in my mind so erm I have a hypothesis she could actually have done none of that at all.

Martin formulates that the client had attacked him due to the question he had asked her that humiliated the client in front of others, and she therefore wanted to also humiliate Martin in a public setting in front of his colleagues. Martin discusses how he felt that the attack from the client was controlled and therefore he felt angrier towards her as she behaved in a "thuggish" manner. Martin uses formulation to understand why the client had attacked him, however unlike the other participants he is less empathic, and more angry, for her "controlled" attack. In creating a formulation of the attack it perhaps helps to bring some sense to the event and answers the question of why she was violent.

From the data analysis it was clear that most of the participants used formulation and psychological theory to understand the client violence. Indeed, formulation is part of the participants' professional role, and can be beneficial in making sense of their clients' behaviour and their overall experience of it. This subordinate theme also brought to light that, although formulations are part of the psychologists' role, they might also be used as way of not acknowledging the effect that client violence can have upon them personally and professionally. Whilst the formulations do help in understanding violence, in continuing to work with and help the client, and helping psychologists demonstrate empathy, they may also be a concept that is used to hide behind or as a mechanism that psychologists use to cope with difficult client encounters. Using formulations perhaps prevents psychologists from appreciating to reality of the risks that they are facing with certain clients, and might also be used to mask the fact that they are, in fact, often unable to cope in more practical ways when client violence is exhibited. The idea of making interpretations of every aspect of the client's verbal and non-verbal behaviours emphasises how the profession minimises the risk of violence to the practitioner, as client violence becomes simply something else to be interpreted. Therefore the effect it has on psychologists is perhaps lost or not acknowledged as it is

not taken serious enough particularly in failing to report it, whilst formulation can be used to hide behind the effect it has upon one personally. Overall it can be seen that formulation perhaps brings comfort and closure to the participants as it helps to make sense of the client's aggression.

3.2.3   Subordinate theme 2.3: Being cautious of the client after the incident

The third subordinate theme identified was how participants were cautious of the client after the incident. Various feelings are described, particularly anxiety and uncertainty about the possibility of being attacked again. For example, Martin discusses how his relationship with the client changed after her physical attack:

> My relationship certainly changed after the incident before I didn't have any reason to be erm cautious around her or to be nervous of her or to be not just be myself in the ward round... but I was also nervous [in the ward round] and did not want a repeat of that so I was just not going to say anything in order not to risk provoking her, I need to be a bit wary and know how to pitch my questions as she may attack me.

After being attacked Martin not only reassesses his relationship with the client but also his role as a psychologist. He discusses how he did not initially have any reason to be cautious of the client, yet after being attacked he questions himself about how to re-approach the client without provoking her again. The incident led Martin to question his skill in asking questions and whether it was the way he asked her, rather than question itself, that had provoked the client to attack him. Martin seemed to be experiencing a dilemma and caution about whether to ask a question in the future ward rounds or find a more tactful way of asking the question and thus not being attacked. The fear that the client had induced into Martin stops him being himself. This impacts upon patient care as Martin felt unable to provide further support so as to not risk further violence.

Sophie discusses how she was frightened of meeting the client after the incident:

I was frightened of her, so it made me sort of very wary of her every time I came onto the ward. It's like sort of being slightly hyper vigilant, you know, "God, where is she?", "is that going to happen again?" I remember partly being a little bit nervous thinking, you know, we're in an open space, there's nothing, there's no alarms, there's no staff, there's no whatever and I know what this woman's like.

Sophie's immediate and constant thoughts after being attacked are about keeping herself safe, and avoiding the client. She did, however, encounter the client again outside the hospital and became very self conscious of her personal and professional identity as she worried about provoking another attack. For Sophie it seems that there was an element of self blame that she had in some way provoked the client and therefore she was much more cautious of the client when meeting her again unexpectedly as she tried to maintain her composure and not show anxiety or fear. Sophie also discussed how the attack left her feeling hyper-vigilant, and that she would ruminate whether the client would attack her again. This description seems to demonstrate at least some symptoms of post-traumatic stress disorder.

Participants discussed how it was important for them to be cautious or wary of the client after the incident as it seemed to be unexpected. Some felt that the client may attack again and that it might escalate in severity. Some participants remained aware of the possibility of being attacked again by their clients, and would be more vigilant and careful about how they behaved around the client, whilst others would find ways of avoiding the client altogether. Client violence also seemed to have an impact upon their professional identity as psychologists, in terms of doubting their skills for approaching the client again, without risking another unprovoked attack.

3.2.4 Subordinate theme 2.4: Questioning whether the client was in control of their behaviour

The final subordinate theme identified was how participants questioned the client's behaviour during the attack. Specifically, whether the violence was part of their

mental health issues at the time of the attack, or whether the client was in control of their behaviour and taking advantage of the diagnostic label. This interpretation of the cause or motive led to different types of reaction to the attacks. Martin had the most to say about this issue and discussed how he considered that his client's attack upon him was more to do with posturing than her mental illness:

> There was something else that she was doing in a way, she would never, I have a sense she would never have done it in the streets there is something about you can kind of get away from this kind of behaviour in psychiatric wards. It did make me think that there was a bit of posturing going on or bit of kind of erm that she had not completely lost it and you know in some way she was cross with me or angry with me not in a control way, because she didn't she was getting the most protective part of my body in a way which was my feet...she hadn't completely lost it..

Martin was feeling angry which was reflected in the tone of his voice when describing how he felt that the attack upon him was in the client's control. The client's posturing behaviour together with her being a mental health patient led Martin to feel that his client felt she had the right to attack him, and was in control of her behaviour. Martin also talked about how this kind of behaviour is seen as more acceptable in psychiatric wards and his feelings that the NHS has some responsibility for allowing staff to be attacked. Martin's anger is thus also directed towards the NHS for not doing enough to protect healthcare staff from client violence and for placing no responsibility upon service users. He discussed how he feels that service users in the mental health system should be made aware that they can be prosecuted for controlled attacks. Because Martin believed the client was in control and had no respect for him, and that it was like being attacked by a stranger, he wanted to seek justice. This was interesting to observe as it seemed that psychologist's role was only to treat the 'diagnosed' client when they are exhibiting their 'diagnosed' mental illness. Once they act out in other ways that are not features of their illness, do psychologists suddenly lose empathy.

For Sophie there was a conflict between her personal and professional feelings regarding the client's behaviour:

> I know there's an overlap but a part of you is going "you're not even floridly psychotic", do you know what I mean? So it's not rational and it goes against my clinical knowledge and my clinical thoughts, it just doesn't mean that someone's not easily aroused but it just... you're kind of like... part of you is thinking about the client, 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 for putting me in that position, if I'm being honest.

Sophie seems to be experiencing a conflict between her professional knowledge and her personal feelings. Personally, she felt that the client was in control of his behaviour as he was not psychotic at the time. Like Martin, this seemed to make her feel angry with the client because the behaviour could not be explained by his illness, implying that violence during a psychotic episode is more easily justified. Professionally, Sophie is aware of how clients can become easily aroused and lash out although still feels angry at being attacked. Here, the reason for an attack seems to lead to potentially different emotional reactions: if a psychologist feels that the attack is part of the client's illness perhaps they are able to deal with it better, than if they feel it is a personal or controllable attack.

In contrast, John discusses how he felt that the client was not in control of his behaviour and that they could not help being abusive:

> I understand that losing... like merging the third person and the first person that's part... that is part of psychosis and... and he was... he's... he's one of those service users with a kind of psychotic presentation that's never really become full blown so I understand it as part of his... part of his psychological difficulty.

John attributed the client's verbal abuse towards him as a manifestation of the client's psychosis and his personal early history, which allowed John to gain an understanding of his client's behaviour and perhaps experience less personal negative

feelings as a result. It seemed that John could only make sense of the client's verbal abuse through his role as a psychologist, which might act as barrier to facing the aggression on a personal level. In doing so, John has taken the client's responsibility for the violence away from him and puts the responsibility upon the client's history and mental health issues. John views the client's aggression as normal and something which is to be expected as he is "one of those service users", which perhaps helps him to avoid the reality of client violence.

Lauren also attributes the client's behaviour to him being unwell:

Well I…I just feel…I kind of put it down to him being really unwell actually and ...and there had been signs of him becoming unwell before he went on the ward.

I didn't feel antagonistic or upset with him in any way. So I wasn't angry or... I kind of... I was just able to see it as part of his mental health problem rather than a personal attack on me. I think if... if it had felt a bit more like a real personal attack then I would have felt more angry with him perhaps or annoyed but I don't remember feeling that.

I suppose I might have taken it as a bit more of a personal attack if it was somebody who wasn't so obviously unwell.

By explaining and justifying the client's behaviour as part of his mental illness, Lauren is able to avoid feeling that it was a personal attack. It seems that if Lauren had considered the verbal abuse to be a personal attack then she may have felt "antagonistic or upset" with the client. Therefore for Lauren the client violence was clearly out of his control and this helps her to deal with his aggression and to not take it personally. Attributing violence to the client's mental health problems can be a coping mechanism to protect her from dwelling on the impact client violence might have upon her.

Rose describes some possible explanations for her client's violence:

She was very angry with the Mental Health Services and having waited for... for months really to be assessed and then she was also angry about it being an assessment as opposed to psychological therapy because she came in with the assumption that we'd be starting therapy. And she was also very angry that she

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had to tell me about her difficulties when she'd felt she'd... she'd told the psychiatrist and other professionals previously. So, yeah, and I think she'd been butted around from one service to another and hadn't really received the treatment that she wanted to and she just saw... saw the assessment as another barrier really to getting what she wanted.

Rose discusses how the client did not receive the treatment she wanted, which suggests an element of control by the client in her verbal abuse towards her. However there is also some empathy for the client who had been "butted around". In this way Rose seems to be finding reasons to legitimise the client's aggression, and feeling that she understood why the client became violent possibly helped her to rationalise that she was not to blame for the outburst, but rather it reflected problems within the wider mental health services.

Overall, there seemed to be a split between psychologists' personal feelings and professional roles. Professionally, client violence was seen as an acceptable, understandable and part of the job, whilst personally there was often a sense of injustice and anger and being violated. This was also influenced by perceptions of whether the client violence could be explained by the perpetrator's current mental health or diagnosis. Placing sole responsibility for an outburst upon the client's illness, rather than the client or the therapist's own role, might serves as a way of personally managing the attack, and by removing responsibility from the perpetrator the psychologist does not feel the attack is personal, and it is easier to continue to work with the client or remain in that workplace. The point highlighted by Martin, that clients are violent in the mental health system "because they can", identifies a major issue that needs attention. If this is the case there is a problem in that healthcare staff will not feel that the issue of client violence is being taken seriously enough.

3.3   Superordinate Theme 3: Professional Identity

The final superordinate theme identified was the participants' sense of professional identity following a violent experience with a client. This theme is represented by four subordinate themes: thinking on what could have been done differently, not being precious, seeking support, and being judged by others.

3.3.1   Subordinate theme 3.1: Thinking on what could have been done differently

After the incident, all participants described how they thought about their experience of client violence, such as questioning their role in the event, and what they could have done differently to prevent or minimise the event. Here, Sophie discusses her own thinking process:

> I think it's partly maybe thinking 'should I have seen this?' you know, 'Should I have seen this coming?' Since she's already grabbed me, should I know that she's someone who'll escalate incredibly quickly and not be able to contain it.

Due to Sophie's previous experience of being assaulted by the client she is looking back upon the risk of violence to herself. This may have led to some self-blame, such as her own role in the attack due to her negligence of not keeping the client's risk in mind. It seemed that Sophie is questioning her ability for failing to identify the trigger that led to the violence, or for becoming complacent. However,, Sophie may have therapeutically trusted her client as she was trying to help her. This perhaps shows how holding such expectations, whilst failing to also recognise how the client might become aggressive, can be problematic.

Rebecca speaks about thinking whether she had made the right decision to take the client off the ward:

> The things that I wondered if I'd messed up on Yeah, probably right through, 'did I do the right thing there' because I'd seen that he was getting agitated and I'd said to him did he want to stop and he'd said no, he wanted to continue. But I could have probably stopped it. But I guess in looking back, I mean, you don't

know, do you, with 20/20 hindsight you can see now that it got worse but actually at the time I couldn't have predicted that. So, yeah, there were... there were some of those maybe I shouldn't have taken him off the Ward, maybe I shouldn't have kept asking him, maybe I should have handled it differently when he started shouting.

Rebecca seemed to be evaluating her approach with the client and what she could have done differently. She discusses her decision to continue with the psychometric testing as she stated that she could not have predicted that the client would become aggressive. Rebecca questions whether her role as a psychologist means that she should have known how to reduce the risk of client violence, or could have stopped her client becoming threatening. However, whilst talking about being unable to predict the client's aggression, Rebecca realises how limited she was in knowing how far the incident would escalate. This perhaps brings some comfort to Rebecca to help her acknowledge that she was not to blame. Moreover Rebecca's 'should' statements can also be viewed as being rules for the future in dealing with client aggression differently.

Both Rose and John had a similar content to their thought processes about their skill, and both thought about what they could have done differently or better to contain the client and the situation. For example Rose states that:

I guess I questioned whether I'd responded in the most appropriate way, whether I could have done anything to maybe calm her anger down so that she would say for fifteen minutes, or for the entirety of the assessment. I guess I felt a bit bad really that I could not do that in the session and if I'd been able to do that in the session, maybe she would have stayed, maybe she would have engaged in the assessment, maybe she'd be placed on a waiting list for therapy. Yeah, those were my thoughts on it.

Rose questions her professional skills as a psychologist, both her ability to contain the client in staying for the duration of the assessment, and keeping her longer in therapy. Rose spoke as if she had somehow failed the client. This is perhaps related to being in a profession where there is an expectation that one can help all clients,

regardless of what they bring into therapy. There seems to be a belief that as a psychologist she should have been able to contain the client. Therefore this expectation of her role as a psychologist can lead her to feel like a failure. In looking back at her intervention with the client, Rose could also be using it as an opportunity to learn from the experience and reflect upon what she would have done differently.

John states that:

I guess towards the end of that I also started questioning, I guess, maybe not that intensely but there were doubts in my mind about my ability to handle the situation as well...I found my mind going back over what had happened and thinking could I have done that a bit differently, you know, and... and was I actually at risk of getting hit then...some of the questions I had in my mind at the time about him...was obviously around perhaps the way I was working with him and was I…did I do enough of the kind of anger management work first before moving into the exploratory work.

Here, John seems to be thinking about his skill as a psychologist and whether he did enough to manage and contain the client's anger before moving on. Like Rose, John's thoughts also seems to be about failing the client due to his own personal skill and believing he had not handled the situation as well as he felt he could have done. These doubts about his ability possibly reflect his confidence as a psychologist working with high risk clients. Moreover, John also analyses on how things may have been different if he had used a different approach. He seems to consider risk issues and his ability to handle the client if the situation had become physical. Similar to Rose, John is perhaps also looking back and reflecting on this incident as a learning opportunity for what could have been done differently.

Mary discusses how she would also analyse about her own role in the incident:

I suppose maybe... maybe there's kind of a... a little bit of something in us that, you know, maybe questions what is it about me. I mean, it did make me scrutinise in kind of like what was I saying during the group and how was I saying it and I suppose I started questioning was there something that I did to

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brought this about which I found quite annoying because it's a bit like... I suppose that where the frustration came from because it was a bit like 'well, how do really really know, do you really think I'm a victim here'. But then I suppose, no it's the whole kind of victim mentality.

There was a very de-personalised tone in what Mary was saying. She makes a very general claim about her experience of client violence as a personal attack. This caused her to question whether something about her as a person and not as a psychologist had prompted the episode. She then scrutinises about her in-session process, whether it was the question she had asked or if it was the way she had asked the question that provoked the client. In both cases, Mary was considering her own role in the abuse. She then quite quickly dismisses these thoughts as being "victim mentality". This pseudo-psychological description is perhaps Mary's way of seeing herself as a victim of violence because as a psychologist working in a forensic unit "violence was part and parcel of the job". Mary rationalises her thoughts of being a victim in order to remove the personal and professional impact the client violence had upon her. This seems to be a coping mechanism of Mary's when dealing with client violence. However, it is important to keep in mind that by asking questions about the process (what I said or did, *and* what the client said or did) is an important part of the professional role, and not necessarily 'victim' mentality. Perhaps it is worth asking questions such as whether the working alliance was strong enough, or whether something that was said or done acted as a trigger.

Martin discusses how he thought about whether he had made the wrong choice of question, and how, as a psychologist he should have reacted better:

> I remember being or well thinking oh shit have I asked a bad question that kind of thing...I do remember having such thoughts as a clinical psychologist I should know better than to ask a provocative question, I remember these kind of thoughts…

Similar to the other participants, Martin also has many "should" statements which suggest that he is questioning his skills and has expectations about how infallible psychologists should be. There seems to be an element of self-blame, and Martin puts an unrealistic pressure about what it means to be a psychologist in these situations where he is expected to know what do to - for example, that he should have had more perspective and awareness of risk issues. This unrealistic expectation is an important issue to highlight as it describes beliefs that might be held by many psychologists about how they should cope with particular issues such as client violence. In Martin's case there is an element of what it means to be a psychologist and therefore he has thoughts about there being no room for error: consequently, when something does go wrong it can have an effect on his professional identity. Perhaps he believes that his insight in clients behaviour is unique and this adds pressure of being perfect at the job.

Unlike the other participants, Lauren found a different way of dealing with the client's abuse:

> I suppose I had felt well, there wasn't much point on dwelling on it and kind of going over and over in my head could I have done something differently and what do other people think of me. But it wasn't going to get me anywhere thinking like that so.

Lauren did not dwell upon her experience of client violence. Instead, she deals with the experience in a far more matter-of-fact way. Her tone of voice was unemotional which may also be a coping strategy similar to Mary's. By not dwelling about her experience of client violence (or at least, in not admitting to doing so), Lauren is perhaps also not wanting to be seen as a victim of client violence and instead as someone who can cope.

Like most people following a traumatic incident, these participants had many statements illustrating that they thought about what they could have done differently. It also seemed that having the role of psychologist seems to result in their placing pressure

and high expectations on themselves to always know how to react to challenging situations, such as client violence. There was also a sense of self-blame, and a scrutiny of whether they had said or done something as a therapist or as a person which caused the client to be violent towards them. However, besides thinking what they could have done differently, it seemed the participants were also looking to understand their clients' behaviour. This is probably due to their professional identity as psychologists and that it is a core skill to understand certain experiences. This was an interesting theme as it highlighted the different thought processes the participants were describing. After the incident most participants described what seemed to be either or both a rumination or reflection. Rumination is characterised by wondering about one's role in the event and what could have done differently to prevent or minimise the incident. Reflection is characterised by an active process in which participants try to understand all the factors that had contributed to the violence. These concepts are further covered in the discussion section.

3.3.2   Subordinate theme 3.2: Not being precious

The second subordinate theme was that participants felt that they did not want to make a big issue about the incident they had experienced. This theme particularly seemed to reflect expectations or beliefs about what psychologists should be able to cope with professionally, and what they should expect in certain work environments. For instance, Rebecca speaks of a comparison between nurses who face violence regularly, and psychologists within the same workplace:

> You're aware that the nurses have to deal with a lot of that stuff all the time so you don't want to make a fuss because you kind of think am I being really precious because I'm a psychologist, you know, about this whereas, of course, on these kind of places people do get aggressive and you know the nurses get the brunt of it. So in a way you kind of don't want to be a baby or precious about

it...don't want to make a fuss because you kind of think am I being really precious because I'm a psychologist, you know, about this.

Rebecca is making a comparison between the two professions, psychologists and nurses, and considers that the latter receive the brunt of client violence. Rebecca also questions whether she is "being really precious because I am a psychologist" about the violent incident, thus reducing the legitimacy of discussing the impact of client violence. She also seemed to convey a tone of not having the right to talk about her experience of client violence. It seems that Rebecca is suggesting that if nurses can deal with violence without being precious then as a psychologist she should do the same. In addition it seems she is stating the client violence is part of the job and therefore there is no justification for being precious about it. There was a subtle tone that client violence does affect her but due to the environment she possibly feels unsafe to make a fuss about it.

Rose discussed her discomfort in drawing too much attention to the aggression:

This might sound a bit silly but I didn't want to... I didn't want to make a big deal out of it and if I'd labelled it as an act of aggression against me it might... it sounds like I'm making a big deal out of the incident, which I didn't want to do. Perhaps it would show that I couldn't cope, perhaps it would show that I couldn't cope with verbal abuse or people being angry and a lot of our clients in complex care do get very angry and that's... it's kind of a given…I feel a bit silly saying that now but I didn't want to make a big deal out of it and that's why I didn't report it…But, obviously, if I was supervising someone I would say the complete opposite. So, yeah.

From Rose's interview she seemed to feel embarrassed about speaking of her experience of client violence. She felt that by labelling her experience as aggression she would be seen as someone who is unable to cope with her job and possibly has a fear that she may lose her job. Again, there is perhaps an assumption that as psychologist she should be able to cope with difficult clients, including aggressive ones. The complexity

of the role of a psychologist is in being reflective of the effect of client violence, looking for and understanding the underlying processes behind the violence, but and to personally cope with violence. Moreover as Rose is working with a demanding client group where aggression and anger are expected, she did not want to be judged for being in the wrong profession. This belief led Rose to consider not reporting violence, as it perhaps shows a sign of professional weakness. It was interesting to note the contradiction in Rose's interview, as she stated that she would want her own supervisee to report client violence. This indicates the profession's own incongruence of wanting to be supportive 'as a whole' but at the same time individual psychologists remain fearful of the consequences of reporting it.

Similar to both Rose and Rebecca, Mary also discusses how she does not want to over-react to client violence, especially as she feels that it is part of the job:

> I'm starting to feel like, you know, I'm kind of making a meal out of it and then at the same time I'm thinking that I'm... I'm... I'm talking about it because I'm being asked about this and, you know, in some ways it's important and, you know, am I just being defensive if I'm just kind of saying it doesn't impact me because, you know, clearly it looks like I can talk about it for a good hour or whatever. But then I could say fine, this is something that happens at work.

For Mary this has been her only opportunity to openly discuss the issue of client violence. Thus, it possibly felt unusual for her to talk about it in detail and the effect it has upon her. The work environment that she is in seems to indicate that client violence is part of the job and that she needs to get on with it. Thus in talking about client violence with me, she may worry that she is perhaps not dealing with it as well as she thought she was. There is a conflict of being a psychologist who believes in talking about issues that effect people, and the forensic environment which often does not allow her to make a deal out it. Mary discussed how she felt that she was making a "meal" of the client's aggression, whilst also acknowledging that it is an important topic to

discuss. At one point in the interview Mary stated that she could talk about the topic for over an hour, and therefore perhaps that it did affect her after all. She questioned whether she was being defensive in believing that her experience of client violence did not affect her. This suggests that in being a psychologist she needs to cope with this experience and not "make a meal out of it". The interview was an opportunity to reflect upon this experience and the effect it had upon her.

Lauren discusses that psychologists in comparison to other ward staff rarely experience client violence, however it can still happen to them:

> I suppose what it does it makes you a bit more aware that these things happen...I think sometimes as Psychologists we can be in a little bit of a bubble and these things don't happen to us. We hear it happening to ward staff and we support ward staff through it but actually it rarely happens to us. So I think it's made me more aware of safety and perhaps to... sometimes it's better to leave things rather than do more engaging and reflecting and that it's okay to leave things and go with your gut feeling in a way I think it kind of helps them realise that we're not in a bubble and these things can happen to us and just to be a bit more aware of our... our own personal safety and that it's okay to walk away from something, you don't obviously have to stay and try and sort it out, yeah.

Lauren's case highlights the lack of awareness that psychologists have of being attacked by a client. She discusses how the profession is in a "bubble" which indicates the reality of the environment psychologists are working in. She also highlights an important issue of support for coping with the effect of client violence. On the one hand there is an expectation of being reflective and discussing how something has affected psychologists as practitioners. On the other hand there is a need to show resilience that psychologists can cope with such incidents, and are strong enough to support others.

The vast majority of the participants felt the client violence was part of their job, particularly when working with clients with mental illnesses, in a forensic setting, where all staff will experience violence. There was a also a comparison to other

professions, specifically the nurses who get the brunt of client violence, which led participants to feel uneasy making an issue out of the far less frequent incidences of violence they experience. There was also an idea that being a psychologist perhaps client violence is more of an issue due to their professional identity, and that when other professions experience the same phenomenon, it is not seen as important. Therefore in order to fit in with the other health care professions, perhaps psychologists feel they should not make an issue out of it and not be seen as being precious.

3.3.3   Subordinate theme 3.3: Seeking support

The third subordinate theme was the type of support participants received or had looked for after their experience of client violence. From the interviews it seemed that participants experienced both positive and negative encounters with several different types formal and informal support. For instance, John discusses how he used formal and informal support for dealing with different aspects of the experience:

> 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" I think we do separate out that kind of more informal support and our more formal supervision. 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 kind of 'yeah, that sounds really tough' which is generally what I got from them. I had a kind of very solid and kind of trusting relationship with that supervisor. So...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.

John splits both formal and informal support, each of which has its own function. Through informal support John was seeking empathy and confirmation of how difficult his session was with the client whilst in a formal session he uses supervision to put theory into practice. This might illustrate a lack of personal support available for John in supervision to sufficiently explore his personal thoughts and feelings of his

experience of client violence. It might also say something about how John chooses to use his supervision and what he feels he needs to demonstrate as a practitioner within supervision. Thus, keeping supervision professional and theoretical could perhaps be John's way of showing his competency at coping with client violence. John's use of the word "objective" when describing supervision depersonalises the supervisory relationship and process, and instead places a greater emphasis on it more as a theoretical or abstract process. Again, this seems to be a professional identity issue in trying to appear to be a 'good' or 'competent' practitioner, rather then seeking support after being in a dangerous situation and looking at ways to respond to similar situations in future.

Sophie discusses how after the incident with the client she also looked for informal support:

> There was a woman in their [nursing staff in staff room] who I got on well quite well and she was very nice and she could see I was obviously a bit shaken, kind of sat me down. We just went through what happened, recorded it all in the notes, did incident report...it was...I mean, it wasn't a formal sort of debrief so it... it was very useful... I think that's about sort of 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, that didn't feel very nice, thought I was going to get hit, didn't know what I was doing'... but yeah I found it useful, helpful.

From Sophie's interview it seemed that informal support was useful to verbalise her thoughts and feelings of what had happened. Having support in completing the incident form was helpful for Sophie. This indicates the support after experiencing violence can be beneficial in having time to mentally process the event for herself and to get some perspective. Similar to John's account, it was a place to find the right person who would just listen and say the right things. Her use of informal support suggests that Sophie is perhaps not getting personal support from supervision, or is perhaps not

willing to use it. In either case this is suggesting that there is an issue for her receiving the appropriate type of support. Furthermore this might also reveal something about the profession not recognising the affect of client violence upon its members.

Lauren discusses how talking to her trainee and supervisor about the incident was a learning process:

> My trainee had actually been in the room with me so it was quite nice to talk to her about...about it so that helped the feelings kind of dissipate, but it also was good to talk to her about how I felt, that helped the feelings reduce, I think, yeah. So it was kind of supportive as well as a learning thing for her about how I was feeling so that you know its kind of training... kind of learning experience for her actually that you can have a reaction to something like that and its okay...its okay talk about it.

Similarly to other participants, Lauren also used informal support to dissipate her feelings and thoughts about her experience of client violence. It seemed Lauren used her trainee psychologist as a way of normalising her experience of client violence, but also to show the trainee an acceptable way to respond to it. This might indicate that personal support is not provided in a formal forum, such as supervision, or that psychologists feel uncomfortable in using it. Lauren found it helpful to talk with her trainee about the incident with the client by describing it in terms of a good learning process. Perhaps Lauren finds it difficult to put her professional role to one side and instead talk about how the experience personally affected her. The fact that Lauren used her experience as a learning process for both her trainee and in her own supervision, indicates that for her, the experience is perhaps more do with processing, reflecting and learning from. This in turn might be Lauren's way of compartmentalising the violence, by keeping her personal and professional identity separate. I felt that this was also reflected in her interview, during which she remained very formal and I felt that there was barrier between us.

Mary's idea of support was different from both Sophie and John's. She discussed how working in stressful environment where client violence is a common occurrence leads staff to deal with client violence differently:

> And, you know, it's a question of opinion, I don't know how much we actually talk about the impact of the work on us and... but, you know, it's kind of a ... it gets laughed about and joked about and... and I'm thinking we kind of support each other in some kind of a mutual understanding of our difficult role.

For Mary, client violence is "part and parcel" of the job and that staff express and minimise their feelings about it through joking and laughter, which seems to be the only support available and a coping mechanism for such intense and stressful work. It was interesting to note that Mary used the word "we" and not "I" which might suggest that there is a more general lack of support for healthcare staff when dealing with the personal impact of client violence. It is unclear whether talking about client violence is distressing for Mary, although if it was it could possibly make her feel too vulnerable and helpless and therefore it is not really discussed openly.

Martin discusses seeking support as a way of telling his story and seeking justice for his attack:

> The police are not interested and that is often supported by the police as they would often respond to a psychiatric ward because they will say there's nothing we can do because the patient is mad , so nothing is going to be, there is going to be no prosecution or whatever I remember when the process didn't go the way I was hoping it would go and was frustrated with that then working towards letting go and not feeling cross towards her and letting go of perhaps some sense of hope the organisation would be more supportive…You know these posters up saying 'zero tolerance and you will be prosecuted if you attack our staff' erm it's one thing to say that and to put the actual systems in place to support that is another thing actually erm yeah I came away thinking that the systems are not really able to facilitate and being somewhat disillusioned and irritated that too.

The unhelpfulness from Martin's organisation and the police might lead him to feel uncared for, let down, and a sense of injustice. Martin seems to feel that his organisation does not take client violence seriously enough, and describes his indignation at what he had experienced and how his search for justice was put to an abrupt end. That the doctors also simply forgot about the incident may have increased or maintained his sense of indignation at being forgotten about by the very people who had witnessed the event. It seemed that Martin has lost faith in the very systems and structures that are meant to support him in client violence and therefore the posters and advice on support for victims are meaningless to him.

Rebecca discusses her surprise at her supervisor's response to her distress of working with the client:

> I was quite surprised actually because part of me thought... you know you get all the posters about staff won't tolerate violence and you got trained if you ever felt frightened about going in a room just don't, do you know what I mean, if you're in doubt about a session and your safety just don't do it, 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, like I say, was quite firm and said but, you know, therapeutically that's really difficult, it's another sort of experience of abandonment for this client and this, that and the other.

Rebecca discussed how her supervisor used psychological theory to think about what it would mean if she stopped the sessions rather than continued to provide support. Rebecca was surprised by her supervisor discussing abandonment issues while she was feeling frightened of working with the client. Here it seemed that there was a conflict between the NHS campaign of zero tolerance to violence, and her supervisor being firm about her seeing the client again. One interpretation of this is that Rebecca perhaps felt unsupported by her supervisor in what she was experiencing with the client, yet she also felt that she could no longer work with the client while she was feeling threatened. This contradiction between an organisational stance, and the supervisory view that a failure

to work with the client would be abandonment, posed a moral dilemma for Rebecca. This portrays the idea that part of the role of psychologist is to remain in unsafe situations, purely because they understand the impact of psychological processes, such as abandonment. Rebecca's supervisor's support demonstrates how client violence may still not be taken seriously enough by the profession, or that psychologists need to have a broader type of supervision where psychological theories and formulations are considered and the client is honoured, yet balanced with an attention to the to important function of practitioner's own self-care and ability to read and respond to dangerous situations in the workplace.

It seemed that participants discriminated between formal and informal support. Formal support was more about understanding, being objective, and drawing upon psychological theories. Informal support was about finding the right person who would know the right things to say after the experience. However participants often seemed to feel unsupported or let down by their formal support options, as they seemed to ignore the victim's own thoughts and feelings.

3.3.4   Subordinate theme 3.4: Being judged by others

The final subordinate theme contains participants' views on how they were perceived by their colleagues following the violent attack. Participants discussed their thoughts of what their colleagues were thinking about their skills and ability to handle client violence. Rose states that:

> I felt quite safe telling him [colleague] what I'd done because I felt like he wouldn't judge me as a clinician just based on those ten, fifteen minutes that I was describing to him. So... so it was easier to tell him and it was easier to be reassured by him whereas, if someone else, such as maybe a manager who didn't know as much about the way I practice, I think that would have been a lot harder because I felt like maybe they would have possibly critiqued my practice or the interventions I made.

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

Here, Rose seems to feel more comfortable talking to a close colleague who would not judge her. Rose's anxiety was about appearing incompetent or weak in front of her manager and she seems to be looking towards her colleague, who knew how she worked, for confirmation and acceptance of her experience of client violence. Rose also saw client violence as part of her job and consequently that she must be seen to be able to cope with it. This may have to do with her role as a psychologist, in which if she is seen as weak and unable to cope then perhaps she believed she would be criticised for it. Perhaps too, Rose had a fear that she would be seen as someone who is unable to do the job well in that particular work environment. It would seem that client violence is in her place work is perhaps not a recognisable occupational hazard when working with severe and enduring mental health services.

Martin feels that he needs to appear professional and find a dignified exit to the situation:

It was in a very public place you know my colleagues were sitting next to me on either side so I might have had my team on one side and my assistant psychologist perhaps on the other, there was a doctor, SHO, the consultant, SHO…There's this self-consciousness around how do I deal with this how do I...how do I stop it in a way that's professional but yeah so that anxiety around behaving professionally behaving responsibly behaving erm and not panicking…

Also questioning my skills in front of the observers, are the thinking, well that was a clumsily asked question or that was a provocative question.

Martin's main anxiety was a result of his thoughts about his own reaction to the attack, and how he was judged by others. There is expectation of how to behave in front of his colleagues to appear professional. This is perhaps related to his role as a psychologist and needing to be seen as having control over the situation and appearing

professional. Martin also discussed feeling frightened, but to avoid being judged by others he tries to find a way of containing his emotions. He states that "a part of me thought 'well I can't be too frightened'", perhaps his way of showing that he was in control of the attack. As well as feeling self-conscious about behaving appropriately, Martin also feels that his skills as a psychologist are being judged, and discusses having thoughts of others thinking that he has asked a "clumsy" question for a psychologist. The attack by the client may have brought about feelings of shame and rumination regarding how he is being perceived by others.

Lauren also discusses her anxieties about how she is being perceived by others:

I suppose one of the thoughts I had was maybe they thought that I hadn't just let it go quick enough. I mean, I didn't discuss it with them actually about it but I suppose I did think "oh, I wonder whether they 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 oh, maybe she doesn't know what she's talking about.

It seems that Lauren was thinking that the nursing staff might be judging her skills as a psychologist since she herself had experienced client violence. In feeling that she is being judged by others, Lauren's main anxiety seems to be about appearing incompetent to other staff in the workplace.

Participants discussed various thoughts and feelings, especially anxieties, about being judged in front of others, with the main concern being judged for their professional competence (or incompetence) in handling client violence by a manager or by colleagues. Being attacked seemed to leave participants with a sense of helplessness and vulnerability, and of being more self consciousness when interacting with clients.

3.4   Summary

Overall, the interview data presented a narrative account of psychologists' experience of client violence in the workplace. This narrative was related to the different stages of the phenomenon being experienced. The first theme 'the moment to moment experience of client violence' is a focus upon the here and now of the situation. The participants described the precise moment of experiencing client violence which included being caught off guard, thinking about what to next and finally describing their emotional state at that particular moment. The next stage, the second superordinate theme, was related to reflecting upon the client's behaviour after the attack. This included reflecting on their feelings towards the perpetrator after the attack, making sense of why the client became violent, being cautious of another attack, and finally considering if the violence was under the client's control. The final part of the narrative, and third superordinate theme, was the impact the experience of violence had upon the participants' professional identity as psychologists. This included ruminating on one's skills and feeling judged by colleagues.

These three stages relate to how the participants understood their experience of client violence and the effect it had upon them. Although the phenomenon experienced by each individual is particular and unique to themselves, it is lived with a shared context. Through looking beyond the immediate claims made by the participants, this research identified some unique insights into psychologists' experience of client violence - such as creating a formulation to make sense of it - as well as some themes that have been identified in previous literature - such as being judged by others.

Chapter 4: Discussion

This chapter begins by a discussion of the findings from the analysis, which are related back to the existing literature on healthcare professionals' experience of client violence. The discussion of the findings will also focus upon how knowledge of psychologists' experiences of client violence can help in designing professional guidelines for keeping psychologists safe, receiving the appropriate type of support, and normalising the pressures of being a psychologist in face of client violence. This is followed by a discussion of the validity, trustworthiness and rigour of the present study. Next, the researcher's personal reflexivity is described with respect to the analytical journey of interpreting themes within the participants' accounts. This is followed by the applied implications of the finding for the profession of counselling psychology, and the chapter concludes with some of the limitations of the present study and recommendations for future research.

4.1   Discussion of the Findings

The present study investigated the experiences of seven psychologists who had encountered violence from clients in their workplace. The study used a qualitative research design, interpretive phenomenological analysis (IPA) to gain in-depth understanding of participants' lived experience. The analysis showed that client violence is an issue that affects psychologists in several different ways and that there are three main areas of impact. These were identified under three superordinate themes that captured the meaning of the participants' experience of client violence: moment to moment experience of client violence; post incident experience; and issues concerning professional identity. Each of these themes will be discussed with reference to the wider contexts of the present study.

4.1.2 Analysis from the first superordinate theme: Moment to moment experience of client violence

A key aspect of the first subordinate theme was how participants described being caught "off guard", and this surprise or unexpectedness of client violence was labelled as one of the subordinate themes. Participants also described client violence as seeming senseless and unprovoked. This theme of being caught off guard is not documented within the research literature on healthcare professionals' experience of client violence, and perhaps is unique to psychologists for whom, it might be argued, violence is a poorly acknowledged occupational hazard, unlike many of the other healthcare professions, particularly mental health nursing. The participants all seemed to acknowledge that the client became agitated or aroused, and so there may have been some evidence to suggest that the client might become violent in time. A closer analysis of this theme could also lead to the interpretation that psychologists do not view themselves as potential victims of violence in their workplace, or as being in a profession where this is a real risk. As one participant noted, psychologists are living in denial of the reality of client violence. If this is the case then more needs to be done to firstly help psychologists recognise the risks they may face at work, and to receive safety training for responding to client violence if it occurs to them or their colleagues. This topic can be introduced during an initial training period, such as professional doctorates in counselling psychology, and the institutions that assess placements for trainees could also review the processes those placement organisations have in place for supporting trainees with client violence (Munsey, 2008).

Participants also described having an 'inner dialogue of what to do next' during their experiences of client violence, a dialogue which was processing how to contain the client or how to escape from them. This inner dialogue can be defined as a conversation with oneself on how best to deal with a situation without coming to harm, and was

labelled as the second subordinate theme. The inner dialogue has been discussed by Carlsson et al. (2004) as a way of managing fear by nurses who were under attack. The present study found that the inner dialogue discussed by the participants was more about reflecting. Participants were contemplating how they might intervene in the situation, and what to do next. This ability to reflect could be due in part to the participants' profession as psychologists, for whom reflection is an integral part of their professional development, as is attending to events, emotions and cognitions in the 'here and now'. This theme is similar to the finding by Carlsson et al. (2004) who reported that healthcare professionals used their inner dialogue to either contain or find a safe exit away from a violent client. However, this finding would appear to contradict Molander (1996) who argued that a reflection is seen as a "consciously used instrument" (Molander. 1996, cited in Carlsson et al. 2004, p.209) in which the individual takes a step back and thinks about the situation calmly and peacefully. However, according to Molander, there is not time to reflect when being attacked by a client.

Participants also discussed the psychological distress they had endured from their experience of client violence, which was labelled as the final subordinate theme. The overwhelming feelings experienced by the participants demonstrated the full range of anxiety symptoms. This has also been discussed in a great detail in other research which has investigated the impact of client violence on other healthcare professionals (Arnetz et al., 2008; Whittington & Wykes, 1992; Wykes & Whittington, 1994). Mueller and Tschan (2011) discuss how the feeling of fear is related to future attacks by clients, and a fear of future attacks can lead employees to have less job satisfaction, symptoms of depression and consider leaving the job altogether. This finding was not reflected in the analysis of the present study, where participants discussed how their feeling of fear was more in the here and now of the incident, and was reduced after making sense of it. Participants in the present study were also aware that they were experiencing a normal

reaction following a traumatic event. This might also be indicative of their professional self-image as psychologists, who should be, or are, able to describe and understand their own feelings and reactions, even during traumatic events they are themselves experiencing. As Muller and Tschan (2011) discuss, negative outcomes from experiences of client violence can lead to the victimisation experience: perhaps psychologists are more likely to consciously avoid being a 'victim' of violence in order to show that they can cope with it. Moreover, therapists are trained to sit with their anxiety in order to process their feelings through the counter-transference of what is happening for the client (Cox, 1974). This particular subordinate theme suggests that for psychologists, the impact of client violence is continuously about 'making sense'. In doing so, they can be helped to feel safe and secure by understanding why the client behaved the way they did.

4.1.3   Analysis from the second superordinate theme: Post incident experience

The second superordinate theme covered participants' discussion of their feelings for the client after being attacked, which was also identified as a subordinate theme. In particular, participants felt that their experience of client violence had led to a breakdown in the therapeutic alliance, brought about by a variety of emotions such as fear, shock, upset, annoyance, nervousness and feeling anger towards their client. The therapeutic alliance is one of the most important factors in the relationship between client and psychologist (Cox, 1974) and the strength of it is implicated in patient outcomes. Therefore ruptures or a breakdown of the alliance can have an impact upon the working relationship and success of the client's treatment. Feeling angry combined with a level of uncertainty about how to work with an unpredictable client led psychologists to describe, at least to some degree, a feeling of not wanting to be part of the client's care in future. Wright and colleagues (2002) have discussed how the

combination of the break down in the therapeutic relationship and patient care can lead
the likelihood of further violence.

Moreover, there was a sense of injustice experienced by the participants, who
felt that their client had broken the rules of being cared for. This illustrates a belief that
being in the helping profession one should be immune to being attacked and when this
does happen it feels unwarranted and unfair. This can also leave the healthcare
professional feeling ashamed, taken advantage off and their professional identity under
attack. Arnetz and Arnetz (2001) discuss how the interpersonal relationship between
staff and patient can be affected after workplace violence and consequently impact upon
patient care. The feelings expressed by the participants can be signs that staff would
avoid the patient as a means of coping, which can obviously impact upon the quality of
care provided (Watts & Morgan, 1994). Nevertheless, as discussed previously,
psychologists can use formulation to make sense of their clients' behaviour, and process
their own thoughts and feelings, and this might have little effect upon patient care.

The participants also discussed the need to make sense of the client's behaviour
following the violent incident. From the analysis, a phenomenon was identified in
which the participants created a formulation that would enable them to understand their
client's behaviour. The theme of creating a formulation appears to be unique to the
present study and has not been identified in previous literature investigating similar
phenomena. This demonstrates a clear advantage of using a qualitative methodology, in
that it can provide unique insights that might be missed by quantitative approaches.
According to Johnstone and colleagues, formulation "is a core skill for clinical
psychologists at all levels and in all specialities" (2011 p.2). They further assert that it is
also part of other psychologists' core skills. It was therefore perhaps not surprising to
identify this theme of creating a formulation to understand the client's behaviour.
Formulation in psychology is rooted in understanding behaviour from a theoretical

framework and creating a hypothesis about a person's difficulty which links theory to practice and guides interventions. Formulation has also been identified as an intervention to help find the best way forward in the client's interest. In response to client violence in the present study, this coping mechanism seems to have both helpful and unhelpful purposes. For instance, participants described three reasons for creating a formulation for why the client had become violent. Firstly, to gain a psychological and theoretical understanding of what had triggered the client in becoming violent. Secondly, to help with their empathy in order to continue working with the client and not abandon them. Thirdly, the formulation was used as a barrier so that the psychologists could remove themselves from the violence, and not take it personally. In this case, formulation was used as a way of coping with, and managing the effects of, client violence. Once again, this may be due to the professional training and self-image held by psychologists, particularly psychologists who frequently make formulations in their applied work. This is supported by the work of Lanza (1998) who states that coping is a protective measure used to make the situation better, help the person deal with stress and not damage his or her morale and social functioning. It has been argued that the ability to cope with violence can help build confidence and reduce fear of being attacked again (Semmer, McGrath & Beehr, 2005). Thus, creating a formulation can be seen as a function which helps psychologists cope with client violence and to have a better sense of the clients' issues. This coping device might also help other mental health practitioners with their experience of client violence, as it can help them to make sense of the client's behaviour and help clinicians rationalise their experience. Another advantage of creating a formulation is that it can be used to specifically think about patient care and how best to help the client.

There are also two potential disadvantages of creating a formulation as a reaction to a violent encounter. First, it might be used as an avoidance mechanism:

psychologists using a formulation could fail to also acknowledge the personal impact of client violence upon them, which in turn can prevent the emotional processing that is an important part of the recovery process needed to alleviate the distress caused by the incident (Cox, 1974). Secondly, by building a formulation, the psychologist may fail to recognise or accurately assess the actual risk of the situation they are currently in, which may prevent them from removing themselves at an appropriate time.

This study supports Killias' identification of the three factors that underpin the fear of crime: "exposure to non-negligible risk; loss of control, that is, lack of effective defence, protective measures and/or possibility of escape; anticipation of serious consequence" (1991, p.619). The participants discussed how they became cautious of the client in future encounters. Despite creating a formulation, the dynamics between the psychologists and their violent clients changed, particularly characterised by a lack of trust of the client. Participants also discussed how they were concerned of a repeat unprovoked attack, making them feel more nervous of the client due to the unpredictable nature of their aggression. It seemed that after experiencing client violence participants had to face the reality that violence was an occupational risk for themselves, not just for other health care professionals, and that they needed to think about keeping safe. Participants also questioned their skills as a practitioner as they discussed their apprehension of provoking another attack, not knowing what had triggered it in the first instance.

Another unique theme identified from the analysis was how participants questioned whether their client was in control of his or her behaviour. For instance, participants reflected on whether the client violence was psychotically driven (i.e., perceived perceptions of being outside of the client's control) or if it was a personal attack upon them (i.e., perceived perceptions of being within the client's control). Some participants discussed how they felt that the client was in control of their behaviour and

therefore the aggression was a controlled attack. In this case participants discussed feeling enraged towards the client and feeling violated of their personal safety. Of the participants who believed the client was in control of the attack, Martin was the only psychologist who discussed wanting justice and reporting it to the police. He also made an important argument for how client violence appears to be dismissed within mental health institutions and the police because the client is seen as unwell, and that a prosecution would be unlikely. This is supported by a House of Commons survey, conducted in 2003, which found that staff were unlikely to report client violence due lack of support and no action taken by their organisation. This lack of support can impact upon the morale of healthcare professionals in reporting, and lead to them feeling an on-going resentment that the patient 'got away with it'. Another participant stated the dilemma of working with clients who are unwell yet also have a degree of control over their behaviour, and how when one is attacked by such a client there is little support provided by one's employer. This is a significant finding, and demonstrates how healthcare professionals will eventually see client violence as part of the job, leading to them failing to report many instances of violence. This may contribute to the significant underreporting within the NHS (National Audit Office, 2003).

Not all participants viewed client violence as a controlled attack. Two discussed their experience of client violence as being part of their client's psychosis. This is a controversial issue as Behr, Ruddock and Crawford (2005) argue that "most people who experience a mental illness retain capacity and to regard them otherwise (by default) is stigmatising" (p.7). It could be argued that these participants find it difficult to give the client the responsibility of his or her behaviour due to the label of mental illness that client has within the healthcare system. Behr et al. (2005) continue to argue that people with mental illness should be treated same as the rest of society and take the consequence of their actions. However, prosecuting clients can feel awkward for

healthcare professionals due to conflict with their ethos of duty of care and their professional responsibility to the client. Moreover, Hoge and Gutheil (1987) report how mentally ill individuals are unlikely to be charged under the current system, due to the reluctance of police to press charges against patients suffering a mental disorder and especially those who are in care.

4.1.4 Analysis from the third superordinate theme: Issues concerning professional identity

The final superordinate theme identified from the analysis was how participants questioned their own professional identity following an experience of client violence. Issues with professional identity were related to the impact the experience had upon them as psychologists. Here, a subordinate theme described how participants thought about what they could have done differently in the situation. Whilst thinking about the violence, participants were often self-blaming and had self-doubt about their ability as a psychologist. They would question their skills, particularly in believing they should have been more able to predict when their client would become violent and what they could have done differently. Experiencing client violence unexpectedly left them feeling professionally incompetent and experiencing negative affect. Participants discussed how they thought about ways on containing the situation and the client better, to prevent an escalation of the violence, or even the occurrence of violence in the first place. This again suggests how psychologists might hold beliefs about their role and abilities to use their therapeutic skills in any client situation. This seems to be an important aspect of the training and supervision of psychologists – specifically that as a trainee, and even as a practising psychologist, one will not always know how to react to a situation, or work with it therapeutically, and that this includes client violence. Therefore psychologists have to keep in mind that sometimes it is better to leave things rather the do more engaging. McAdams and Foster (1999) found that practitioners who believed it was

their failure to prevent an attack often had professional self-doubt and felt they had personally failed, and that one long-term consequence of this belief of this nature can lead to professional burnout. Participants in the present study also used many "should" statements when discussing the various alternative measures and reactions they could have taken to the violence encountered. This is a common theme within research literature when thinking about a traumatic event (Carlsson et al., 2004).

This theme of participants 'thinking' can be linked to be either a reflection or rumination upon their experience of client violence. Both reflection and rumination are thought processes of looking back at particular events in ones life but there are crucial differences. Reflections are healthy behaviours that can positively encourage a person to learn from the event (Moon, 1999) - as shown by participants who discussed learning what they might have done differently in the future. Rumination is understood as an unhealthy process in which a person repeatedly focuses their attention on negative affect and which can lead to depressive episodes (Nolen-Hoeksema, 1991). This can be seen in participants' accounts of continued 'should' statements, which can lead to self blaming and eventually feeling inadequate for the profession (McAdams & Foster, 1999). There is controversial research in the area of the role and processes of self rumination and reflection. Pennebaker and Chung (2007) argue that reflection can help facilitate resolving mental distress by giving it meaning, coherence and structure. On the other hand, research by Nolen-Hoeksema, Wisco and Lyubomirsky (2008) argues that self reflection can be maladaptive and eventually turn into rumination. This in turn can lead to ruminating upon the negative thoughts and emotions and can be a risk factor in clinical disorders.

The present study was limited in enquiring further about the differences of self rumination and reflection for psychologists as a profession after an experience of client violence. Several important questions have arisen from this present work, including:

How do psychologist differentiate between the two concepts of self-reflection and rumination? Do psychologists consciously try not to ruminate and rather reflect upon their experiences due to their professional identity? Further investigation is warranted in this area, particularly on psychologists' construction of self reflection and rumination.

The second subordinate theme reflected how the majority of participants discussed not wanting to make a fuss about their experience of client violence. Psychologists described feeling anxious that by making a fuss about their experience they would be seen as being special due to their professional self image. Moreover, participants were also worried that they would be judged and other colleagues would feel that they were not coping with it. This in turn had an impact upon their professional identity as a psychologist specifically looking strong and capable in front of others. This may affect how or whether psychologists seek and receive appropriate support after their experience, as it can be seen by managers and supervisors that psychologists are able to deal with client violence on their own, and psychologists may themselves also strive to maintain this view. Thus, psychologists may leave themselves vulnerable to receiving either social or professional support. An additional issue that arose from the analysis was that after experiencing client violence, participants felt it was as an expectation of the job and therefore they did not make a big deal out of it. Similarly McDoanald and Sirotich (2001) found underreporting of violence by healthcare professionals was due to fear of being perceived negatively.

A further aspect to the professional identity theme was how participants described a hierarchal issue between themselves and nurses within their workplace. Being in the more senior position, psychologists may feel more obliged to show that they can cope. This might also be due to psychologists' own identity as 'experts' on human behaviour, and of needing to be seen to rise above the client violence and behave logically when confronted with difficult situations. Lauren made an interesting and

insightful comment about psychologists' egos, stating that psychologists believe that using their core skills of engaging and reflecting will somehow prevent them from client violence. This is not a unique theme to this research of minimising the severity of the impact of client violence, and is perhaps psychologists' way of showing they are psychologically adjusted (Lanza, 1984).

Participants discussed seeking both formal and informal support. Informal support was sought from a trusted colleague whose role was to be empathic, say the right things, listen, be understanding, acknowledge the distressing situation, and allow the participant to off load. Mezey and Shapherd (1994) similarly discuss how healthcare professionals look towards their colleagues and managers for some care and concern and an acknowledgement that it was a difficult event. Formal support included supervision, which was objective, theoretical and reflective. This highlights a possible serious concern for the profession to address in that psychologists who have experienced client violence may see supervision as being less personally supportive. If this is the case it would need to be addressed in appropriate guidelines on how to supervise psychologists who have experienced client violence in order for them have a more formal setting to normalise their distress. One participant discussed her shock of being told by her supervisor that not wanting to see the client again due to her fear of him could be seen as abandonment by the client. This highlights an important point that using supervision for theoretical purposes only can be damaging when the supervisee has a trauma that they wish to discuss. It also reflects poorly upon the NHS zero tolerance campaign to violence, if psychologists are not included in it. Placing the client's needs above the psychologist's even in cases of violence, can be seen as being uncaring and failing to recognise their distress.

Semmer et al. (2005) discuss the importance of having supportive peers and supervisors as this can significantly improve a victim's sense of coping and lessen their

fear of further attacks. This is why supportive supervision is vital for helping psychologists who have experienced client violence with their coping skills and self-efficacy. Clinical supervisors have the scope within their role to provide the appropriate personal and emotional processing support after a trauma. However, the analysis also identified how supervisees may not want to use supervision to discuss certain reactions or feelings about events in their professional life. This might also be related to a need to protect their professional self-image, by showing that they can cope and are strong and can talk about issues from a detached academic or theoretical perspective. There is an element of not wanting to show signs of apparent weakness to their supervisors, as one participant discussed not feeling like they had failed.

Finally, one of the concerns brought up by a few of the psychologists was having thoughts of being judged by others. Participants discussed their anxieties regarding appearing incompetent in front of others and this was specifically related to their own practice and how they believed they were being judged on their skills as a psychologist. This theme was not unique to the psychologists in the present study, and many other authors have observed that this is a shared belief amongst other healthcare professionals (Brasic & Fogelman, 1999; Flannery, Naderson, Marks & Uzoma, 2000; McDonald & Sirotich, 2001; Spencer & Munch, 2003). For instance, according to Beale and colleagues (1998), healthcare professionals who have been attacked may not report client violence due to psychological pressure and may feel self-consciousness about how they might be judged by supervisors, colleagues and managers. As a consequence this can lead to a gradual acceptance of low-level violence within their job, such as aggression and verbal threats. Moreover, continuing to work in an environment where there is a threat of violence can eventually lead to low staff morale, feeling burnt out, and low job satisfaction (Carter et al., 1997).

4.1.5 Summary of Findings

It is clear that psychologists can be affected in several ways by client violence, some of which are similar to the experiences of other healthcare professionals. There also appear to be some specific or unique factors for psychologists, which relate to their professional self-image and beliefs about how psychologists should be equipped to deal with various situations. The findings also highlight how client violence on psychologists is often not appropriately managed, which suggests that specific guidelines are required. Most of the guidelines about client violence focus on healthcare staff training in the prevention and management of client violence (Beech & Leather, 2005). This mostly covers de-escalation techniques, break-away training, control and restraining, and risk assessment to reduce the risk of violence. It also includes post-incident action of reporting, investigation and counselling. These are all important and vital training packages to have as it can help reduce or contain client violence. The present research supports the need to develop additional profession-specific guidelines for psychologists which contain appropriate content regarding the support of the impact of client violence has upon their professional identity and self-image of the profession. Overall, the findings suggest that participants may have found the role of being cared for, as opposed to being the carer, a difficult transition to make, and one which may threaten their professional identity. Being part of the helping professions might make it difficult for them to be seen needing support after being attacked (Janoff & Bulman, 1998; Eykes & Whittington, 1998).

4.2   Provisional guidelines for supporting psychologists after an experience of client violence

Previous research and literature which has examined healthcare professionals' experience of client violence has focused upon identifying and reducing the risk of being attacked (Beech & Leather, 2006; Carter et al., 1997; Gately & Stabb, 2005;

Hilton et al., 1992). In contrast, the present study has explored how psychologists experience client violence, with an aim of understanding how they might best be supported following a workplace violent attack by a client. Providing guidelines for this support may be beneficial for individual psychologists in private practice, trainee psychologists, those who supervise and manage psychologists, training institutions, and the British Psychological Society.

After analysing the data of the lived experience of psychologists following client violence, it became apparent that the professional self-image of a psychologist might affect both their help-seeking behaviours, and the adequate provision of appropriate support from their institutions or employers. For instance, psychologists might lack the confidence to talk about their experience of violence in order to avoid being viewed as a failure and seen as not coping, and because they believe they need to demonstrate their professional skills and knowledge by being seen to cope with client violence.

These findings have been used to produce some preliminary suggestions for a *Client Violence* guidelines document that could be communicated to all stakeholders who are concerned with the training, development, professional practice, and support of psychologists. The key messages for this document include:

- **Defining client violence:** "Violence" describes more than simply physical attacks. Violence includes threatening or aggressive behaviour, verbal aggression and abuse, racial and sexual harassment, threats and a fear of being attacked. Experiencing any of these types of violence might create an emotional disturbance and affect practice.

- **Having awareness:** Violence in the workplace is a reality and that no healthcare profession is immune to it. It is therefore important for psychologists to recognise and acknowledge this occupational hazard, especially when working with people with mental and emotional disorders.

- **Expecting the unexpected:** 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.

- **Psychological distress:** A number of emotional reactions can be experienced during and after client violence and can continue over a period of time, including fear, guilt, shame, and sadness. These feelings are a normal part of the experience of a traumatic incident but will usually decrease over a period of time.

- **Making sense:** Part of the role of being a psychologist is to make sense of our clients. This can include making sense of their aggression towards the psychologist, and is usually done by creating a formulation. Whilst this can be a useful tool after experiencing client violence and can help in the recovery process, it might also prevent a psychologist from taking adequate self-care because they will fail to emotionally process the effect of the incident.

- **It is okay to walk away**: Given their training and knowledge, 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. Nevertheless, sometimes it is simply safer to walk away or to find an escape route, rather than remaining in a potentially dangerous situation.

- **Taking 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, client violence can be unpredictable, and potentially dangerous, and it is important to place your own safety first, and to consider it before engaging with a violent client.

- **Violence is not part of the job**: Psychologists who working in particular environments may believe that client violence is part of the job. This belief should

be challenged and questioned, because it can not only cause psychologists to place themselves, or remain, in dangerous situations with clients, but it can also lead to burnout if a victim of violence believes that it is part of their job.

- **Outlook towards the client:** Several feelings and thoughts can arise towards the client following a violent incident, including feeling nervous and afraid of seeing the client again, anger towards the client, and a breakdown in trust. This can create a breakdown in the therapeutic alliance and therefore likely to impact on the goals and tasks of therapy and therefore the outcomes for the client. It should be standard practice where possible that the perpetrator of the violence is removed from the caseload of the psychologist who was attacked.

- **Questioning the client's motive:** One potential response to client violence is for the psychologist to question whether the client was in control of the attack at the time, given their psychological issues and diagnoses to understand whether the attack can be explained by the client's mental illness, or whether it was a personal attack. These are legitimate questions to reflect upon and can lead to different feelings depending upon the answer. Believing that the client was in control of their actions at the time, and that it was a personal attack, can lead to the victim feeling enraged and violated of their personal space. In this instance, there may also be a desire to pursue action via the criminal justice system. A psychologist may also feel conflicted about taking action against the client, because it contradicts their ethos of caring. Victims of client violence should be supported by their organisation and managers if they wish to involve the police after being attacked.

- **Thinking about the incident:** A common effect after experiencing a traumatic event can be either rumination or reflecting. Rumination is a negative thought process characterised through self-blame and self-doubt which can be a normal part of the process. Psychologists found to be ruminating may need additional attention

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as they, more than other healthcare professionals, are likely to believe that their training and experience should have taught them to predict such incidents and respond to them better. Any support that is provided, including supervision, should encourage psychologists to question the reality of these beliefs and to move away from self-blame.

- **Feeling Judged** Psychologists who experience client violence can worry about how their skills are being judged by others in the workplace, their training institutions, and supervisors. This might lead them to intellectualise and theorise about the incident, rather than exposing their true feelings about it. Therefore it is important for supervisors and managers to allow the psychologist to freely discuss their experience of violence. Particular attention should be paid to ensuring the victim feels supported and not judged for their initial behaviours during, or reactions to, the event, or how they are coping. Acknowledge with the victim that support is available and that their feelings and reactions are understandable.

- **Support Sessions**: Clinical supervision should be clearly separated from support sessions for psychologists who have experienced client violence. Support sessions should be provided with the aim of: (i) exploring their distress and trauma; (ii) acknowledging their distress, vulnerability and impact upon their professional identity; and (iii) providing a space to emotionally process their experience with limited use of theoretical or psychological formulations.

4.3   Assessment of Validity

When assessing for validity and quality the present research followed the guidelines provided by Yardley (2000) and recommended by Smith and colleagues (2010). These guidelines are: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance.

4.3.1 Sensitivity to context

Yardley (2000) emphasises the importance of discussing literature relevant to the phenomenon under study in relation to the participants. The present study synthesised a considerable body of research on the topic of workplace violence and the impact it has upon healthcare professionals. This literature review also revealed a relative paucity of literature in the UK which specifically explores psychologists' experience of client violence, hence providing a rationale for the research.

The present research has also defended its epistemological position and the selection of a qualitative research methodology, IPA. This selection was guided by the research question in which an interpretivist-constructivist and a post-positivist paradigm were adopted. Consequently, IPA was used to analyse the data, being considered the most suitable approach for an idiographic focus in interpreting participants' lived experience of client violence (Chapter II). The present research grounded its interpretation to the participants' data as closely as possible in order to support the discovery of themes. It is hoped that the context and relevance of major and subordinate themes is well evidenced by providing a considerable number of verbatim extracts from participants' interview transcripts.

4.3.2 Commitment and rigour

The present study was committed to the IPA research process and endeavoured to follow it rigorously, specifically "the quality of the interview and the completeness of the analysis" (Smith et al., 2009 p.181) as well as the selection of an idiographic sample of psychologists who had experienced client violence. This was achieved through recognising that a phenomenon is experienced by an individual in a particular and unique way and yet it is experienced within shared contexts. Furthermore as the researcher I tried to understand and sympathise with each participant's experience of client violence by looking at what was said and how it was said.

4.3.3 Transparency and coherence

The transparency of the process was achieved by providing a thorough and comprehensive review of the stages of the research and analysis (Chapter II), including participant selection, the development of the interview schedule, how interviews were conducted, and how the data was analysed. Furthermore, in Chapter II the researcher has discussed what he brings to the research process, such as direct experience of client violence. The researcher also discusses in the present chapter (Section 4.4) what he brings to the process of analysis, as a trainee counselling psychologist, and his bracketing of these processes. Coherence for this study was understanding participants' lived experience of client violence. Within each of the themes identified in Chapter III, ambiguities were also included, such as a participant who it was felt fitted into the theme whilst expressing a different point of view from the other participants (e.g., whilst the majority of participants discussed their rumination/reflection about the incident, Lauren talked about the unhelpfulness of rumination).

4.3.4 Impact and importance

According to Smith et al., "the real validity (of a piece of research) lies in whether it tells the reader something interesting, important or useful" (2009, p.183). This view is also supported by Yardley, who states that impact and importance is "the decisive criterion by which any piece of research must be judged" (2000, p.223). There is a rationale for conducting this study for the psychological community in order to understand how psychologists can protect themselves from the negative consequences of client violence. As well as to developing specific professional guidelines for psychologists in keeping safe and finding support after experiencing client violence. Additionally in order to make sure the study was relevant to the profession the research has been put through a rigorous process of examination and scrutiny. This included an initial proposal, an upgrade proposal and presentation of the development of the

research to the professional doctorate counselling team. There was also a strict and stringent NHS ethics process followed by a consultation from the various professions that made up the NHS ethics committee who considered the study to be safe and worthy of investigation.

4.4   Personal Reflections on the Research Process

This was an exciting yet challenging piece of research to conduct due to the different roles that can impact upon the research process. These roles included: my particular experience of client violence and the influence this may have had in the interviews with the participants; my role as an IPA researcher; and my role as a trainee counselling psychologist. All three roles can have an impact upon the research process, particularly in being placed in an expert position (Smith et al, 2010).

Having experienced violence from a client during a work placement as trainee counselling psychologist, I was aware of the consequences and affect the experience had upon my cognition, emotions, physiological reactions and behaviour. Whilst I would not have shared my experience of client violence with the participants, my non-verbal communication might still have influenced what aspects of their story participants chose to share or discuss in more detail, particularly as, being psychologists themselves, they may be more finely attuned to non-verbal communication. To limit my own influence upon the research process, it was important for me to acknowledge my own experience and process my emotions before interviewing each participant. My personal experience was processed in personal therapy and I also kept a journal of the impact upon me of my experience of violence (Appendix O), which enabled me to bracket (Smith et al., 2010) my own feelings before meeting participants.

The role of the researcher in IPA is to stay with the participants' experience and not the philosophical account of the lived experience. As an IPA researcher who had experienced client violence, I attempted to bracket my own experience and gave my full

concentration to the participants' experience of client violence. I endeavoured to remain focused upon discovering their meanings to their stories, and attempted to understand what it meant to them and how they made sense of that particular experience. Thus the data was analysed by me trying to make sense of the participant making sense of their experience. This was achieved by trying to be in the participant's position, understanding and empathising with their lived experience, whilst at the same time standing alongside the participant in suspicion and asking questions (Ricoeur, 1970). It was hoped that this enabled me to make an interpretation that was close to what my participant had stated but also far enough to show my own interpretations of the data.

As a trainee counselling psychologist, I had received training in several therapeutic modalities, including the cognitive behavioural and psychodynamic approaches. Towards the end of my training, my personal philosophy of how the process of change happens was closely aligned with the psychodynamic approach, and I predominantly worked within this framework with clients. Consequently, it was essential that I remain aware of not attaching psychodynamic interpretations to my analysis of the participants' lived experiences of client violence. This was a challenging process for me and my supervisor noticed in my research supervision meetings that I would often interchangeably call participants "clients", reflecting perhaps an unconscious process of my attempting to understand and describe their experiences from a psychodynamic, or at least therapeutic, perspective. I was aware that this was affecting the research process and I used supervision to contain my psychodynamic interpretations of the data and focus on being an IPA researcher, which is part of the supervision process.

I was surprised not to find any information from the participants about the personal impact violence had upon them, for example, whether there was any affect upon their personal relationships. I wondered if the reason they did not talk about

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personal impact is perhaps because I was a psychologist too and they wanted to protect their self-image in front me, or perhaps they felt that I was more interested in their professional experiences (for my study) than their personal ones. In this instance perhaps I did influence their choice of topics to discuss. It might also have could have been the case that my research questions had not provided them the opportunity to discuss the personal effect it had upon them.

4.5   Implications for the Practice of Counselling Psychology

There is currently no extant research that has qualitatively examined how counselling psychologists understand and account for their personal experiences of client violence, and the present research presents an original contribution to knowledge in counselling psychology. There is evidence to suggest that psychologists as profession are not usually trained to deal with or expect client violence, in comparison to other mental health practitioners and the present study supports the assertion of Kleepies (2002) that psychologists are currently not giving client violence the appropriate consideration or concern. This study also emphasises how psychologists need to be aware of the risk of client violence when dealing with vulnerable clients who can become violent, and has identified how psychologists might be less concerned about their own emotional and psychological wellbeing than they are about making sense of the client's behaviour. Consequently, it would appear that specific professional guidelines that provide support to psychologists who experience client violence would be of benefit.

The Division of Counselling Psychology (DCoP) of the British Psychological Society (BPS) seems to have largely ignored the issue of violence experienced by its members. The professional practice guidelines of the DCoP do not include information upon violence or aggression. With a lack of guidance from their professional body, counselling psychologists must manage their experience of violence using local policies

and guidelines at their workplace, or find their own methods of responding and coping if they are self-employed. A new set of guidelines might specifically address psychologists' attitudes towards client violence, and would raise awareness of client violence upon the profession, advice about strategies for coping with the aftermath of traumatic incident, normalising thoughts and feelings about personal and professional identity, and supervisors' role after an incident. Other divisions within the BPS, particularly those with members who also face the risk of violence from vulnerable clients, such as the Divisions of Health and Forensic Psychology, should be encouraged to also develop similar guidelines.

In having explored the experience of client violence this research may help counselling and clinical psychologists to be more aware of the risks they may be putting themselves in as well as realising their limitations as a clinician. For example the research uncovered how psychologists' professional self-image influences how they 'should' be able to work therapeutically with violent clients and be able to cope and understand client violence. It is essential to raise the awareness that as a profession psychologists are leaving themselves vulnerable to the risk of being attacked due to their professional self-image. This can lead to potential personal, professional and psychological damage to themselves. For example whilst ruminating the participants stated how they had self-doubt and blame themselves for the violence which can lead to eventually feeling burnt out (Barling MacEwen, Kelloway, & Higginbottom, 1994; Edelwich, & Brodsky. 1980; Kristensen, 1992). This research also highlighted that the participants were worried that they were making a 'big deal' out of it and therefore felt the need to cope independently after experiencing client violence.

The present study provides a unique insight into clinical and counselling psychologists' lived experience of client violence, demonstrating not only how client violence is a real problem for psychologists, but also how client violence can affect

psychologists' professional and personal lives. It is hoped that this research will encourage psychologists, their educational institutions, and their professional bodies to have more awareness of the realities of client violence. Further research is required to fully understand the risk factors, and the impact and effect of client violence upon psychologists in the settings in which they work, but it seems important that adequate training is provided, and guidelines produced, for psychologists working with client violence, whatever their therapeutic modality. Support for psychologists who have experienced client violence should be provided by their workplace or employer, but also by their professional bodies.

4.6   Limitations and Recommendations for Future Research

Although the present study provided a unique insight into the experience of counselling and clinical psychologists' experience of client violence, several methodological limitations have also been identified. One limitation identified is that the interview schedule used (see Appendix I) perhaps did not go far and deep enough in understanding the personal meanings of how psychologists understand and cope with a phenomenon like client violence. The interview questions were perhaps too closed and not open to the individual's experience of client violence. In considering the interview schedule used the questions can perhaps be viewed as being too positivist and pre-defined. This raises the question of whether this undermines our understanding of the impact of client violence upon psychologists. However this study followed the recommendations by Smith et al. (2009) in which the interview schedule was informed by the main research question and facilitated the discussion of relevant topics. In researching the wider literature on client violence in healthcare, this study designed an interview schedule that focused upon impact of client violence on an individual's personal and professional identity and psychological well being. After all the aim of a qualitative research interview is a conversation with a purpose (Smith et al., 2009).

Nonetheless future research in this area can perhaps be less formulaic with the interview schedule and ask participants to define client violence themselves. This may enhance our knowledge in the personal meanings of the experience of client violence in the workplace.

Another limitation is that time constraints meant that member checks could not be performed to examine whether the participants validated the themes identified by the researcher. This type of respondent validation is recommended in qualitative research as it can ensure the participants views are not misrepresented and have been understood by the researcher (Yardley, 2008).

A further limitation was that the qualitative data collected relied upon participants' memory and recall of their experiences of client violence. It is likely that certain thoughts and feelings that were salient at the time of the incident may have been lost during the interview process as they were not available to the participants. This is by no means an issue that is unique to the present study, and much qualitative and quantitative research that relies upon participants' recall of events, feelings, behaviours or cognitions it likely to experience similar issues. When asking participants to recall upsetting or traumatic experiences, a technique used with people suffering from post-traumatic stress disorder (PTSD) might be one way of enabling more detail and accuracy in their accounts (Ehers & Clark, 2000). However, the researcher's status as a trainee and lack of experience working with victims of trauma, combined with the fact that in using this technique with participants who do not have a PTSD diagnosis, meant that this was not an option in the present study.

That the researcher was a novice IPA researcher (and indeed, qualitative interviewer) might have affected the quality or content of the data that was collected. This could have influenced how the interviews were conducted, such as issues over the depth of questioning and analysis by the researcher. Another issue identified was the

power dynamics between the researcher and the participant. The researcher is a trainee counselling psychologist interviewing qualified and experienced psychologists and perhaps this may have had an influence upon the participants not sharing as much of their experience of client violence as they might have done with a more experienced practitioner. This could be due to the participants not feeling comfortable in talking about their experience too intimately.

The themes captured in the present research represent a starting point for further research into the phenomenon of interest – how psychologists experience and cope with client violence in the workplace. It would be of benefit if qualitative data were gathered from victims of client violence soon after the trauma has occurred, to capture more salient features of the experience, greater accuracy of recall, and avoid less retrospective intellectualising about the event, which is likely if data is collected at a later point in time. This type of research could highlight new themes or challenge some of the themes identified by the present study. Future research might also employ longitudinal designs, to explore the long- and short-term effects of client violence. This might provide more information about the emotional, cognitive, social and bio-physiological responses after being assaulted by a client, and the process of both spontaneous and assisted recovery from the event.

This research also recommends a extensive and comprehensive questionnaire to be used for qualitative research, that would be suitable for reaching a wider audience and a larger sample. In doing so, the data could provide more information on the number of psychologists experiencing client violence and thus providing more accurate information about the current scale of the problem. This research could also investigate how factors such as theoretical orientation and amount of clinical experience relate to experiences of client violence. As psychologists are working in different clinical and non-clinical settings it is unknown where violence is more problematic. The participants

of this research were from a forensic or CMHT setting and thus further research is warranted of the different settings that psychologists work in e.g. PCT or private practice to understand the scale of the problem. Finally, investigating gender differences in the type of violence endured could also help professional bodies to understand whether there are specific risk factors for men and women working as psychologists (e.g., sexual harassment, racism and discrimination) which could help bring more awareness to practitioners as well as support.

Many of these recommendations are perhaps more suited to a quantitative research design as they would require large samples which could demand statistical analysis to observe trends in the data. The advantages of quantitative methodologies are that they can help provide a generalisation to a target population. They also use standardised instruments to produce concise measurements and quantification in relation to how the social world operates.

Overall, the present research has provided a unique account of counselling and clinical psychologists' experience of client violence and has also presented recommendations on a specific professional guideline. It is hoped that this could provide a framework suitable to support psychologists who have been victims of client violence. It is hoped that this research will serve as a useful starting point for future research in developing it further.

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Appendix A: UEL ethics confirmation

UEL
University of
East London

Dr Helen Murphy
School of Psychology, Stratford

ETH/10/91
02 September 2009

Dear Helen,

Application to the Research Ethics Committee: An Interpretative Phenomenological Analysis of psychologists experience of client violence (F Jussab).

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Simiso Jubane
Admission and Ethics Officer
s.jubane@uel.ac.uk
02082232976

Research Ethics Committee: ETH/10/91

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:...Date: ....

Please Print Name:

Appendix B: NHS ethics confirmation

South West London REC
Room 4W/12   4 Floor We
Charing Cross Hospit
Fulham Palace Ro:
London W6 8F

Telephon
Facsimil

19 December 2010

Mr Fardin Jussab
Counselling Psychologist in Training
7 Waterfall Terrace
Tooting
London
SW17 9LT

Dear Mr Jussab

Study Title:	**Counselling and Clinical Psychologists' Lived Experience of Client Violence.**
REC reference number:	10/H0803/120
Protocol number:	n/a

Thank you for your letter of 03 December 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by a sub-committee of the REC at a meeting held on 24 November. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Investigator CV		03 August 2010
Protocol	1	03 September 2010
cv for supervisor	Dr H Murphy	
Confirmation of enrolment & attendance for Professional Doctorate in counselling psychology UEL	signed by Melanie Spragg	28 November 2007
Confirmation from Debbie Dada regarding insurance policy cover for UEL	ETH/10/91	03 September 2010
Email from Towergate confirming Research work is covered by insurance	JUFX02	03 September 2010
REC application	27615/14881 9/1/809	10 September 2010
Interview Schedules/Topic Guides	1	03 August 2010
Letter of invitation to participant	1	03 August 2010
Participant Information Sheet: Reviewed PIS	2	03 August 2010
Response to Request for Further Information	2	03 December 2010
Participant Consent Form	1	03 August 2010
Evidence of insurance or indemnity	JUFX021N0 1	19 November 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0803/120	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Christine Heron
Chair

Email: kristy.randall@imperial.nhs.uk

Enclosures:	List of names and professions of members who were present at the meeting
Copy to:	Helen Murphy, University of East London

Appendix C: Advert for the DoCP Website

Counselling and Clinical Psychologists' Experience of Client Violence in the Workplace.

I am currently looking for participants for my research project on Psychologists' experience of client violence in the workplace. I am a Counselling Psychologist in training at the University of East London. The main research question is "how do psychologists understand their experience of client violence in the work place?" The aim is to develop a detailed understanding of the participants' account on how client violence affects psychologists' professional and personal identity and psychological wellbeing.

The definition of violence encompasses both physical and verbal abuse which includes discrimination, racism, threatening behaviour and intimidation.

To take part in the study you must be a Counselling or Clinical Psychologist who has experienced client violence.

If you are interested in participating and would like further information, please contact me at 0003581@uel.ac.uk. This research is supervised by Dr Helen Murphy at the University of East London.

Appendix D: Amendment of Ethics from UEL to advertise in the DCOP

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa

Quality Assurance and Enhancement

MR FARDIN JUSSAB
7 WATERFALL TERRACE
TOOTING
LONDON
WANDSWORTH
SW17 9LT

Date: 15 July 2011

Dear Fardin,

Project Title:	Counselling and Clinical Psychologists' Experience of Client Violence in the Workplace
Researcher(s):	Fardin Jussab
Supervisor(s):	Dr Helen Murphy

I am writing to confirm that the proposed amendments to your application have now been granted ethical approval by University Research Ethics Committee (UREC).

Should any significant adverse events or further considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approval is given on the understanding that the 'UEL Code of Good Practice in Research' (www.uel.ac.uk/qa/manual/documents/codeofgoodpracticeinresearch.doc) is adhered to.

Yours sincerely,

Merlin Harries
Research Degrees Subcommittee (RDS)
Quality Assurance and Enhancement
Telephone: 0208-223-2009
Email: m.harries@uel.ac.uk

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 3322   Fax: +44 (0)20 8223 3394   MINICOM 020 8223 2853
Email: r.carter@uel.ac.uk

Appendix E: Participant information sheet

Participant information sheet

Counselling and Clinical Psychologists' lived experience of client violence in the work place

Please take time to read the following information carefully.

You are being invited to participate in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Talk to others about the study if you wish.

This study is being conducted by Mr Fardin Jussab, a student under the supervision of Dr Helen Murphy in the School of Psychology at the University of East London. The researcher will go through the information sheet with you and answer any question you have.

Volunteer status and Confidentiality

Your participation in this study is completely voluntary and confidentiality is assured in all published and written data resulting from the study. You have the right to refuse to answer particular questions. You may elect to withdraw from this study at any time and the information we have collected from you will be destroyed. If you decide to participate the information you provide will be used only for the completion of this study.

Furthermore, I am required to follow the BPS code of ethics which is to be "aware of the scientific and professional activities of others..." (BPS, Ethical Principles of Responsibility pg.18). Therefore as a Counselling Psychologist in training should I come across what I consider to be unsafe practice I am duty bound in line with the BPS code of ethics August 2009 Pg. 17:

"Encourage colleagues whose health-related or other personal problems may reflect impairment to seek professional consultation or assistance, and consider informing other potential sources of intervention, including, for example, the Health Professions Council, when such colleagues appear   unable to recognise that a problem exists. Psychologists must inform potential sources of intervention where necessary for the protection of the public."(BPS Code of Conduct, August 2009)"

Purpose

The aim of this research is to gain a detailed understanding of your experience of client violence in the work place. The objective of this study is to find out the effect of client violence upon your personal and professional identity and psychological well being. Moreover the research is interested on how you interpret the term violence. Overall I am interested in your account and experience of client violence.

Procedure

The research will take place at your place of work at a suitable and convenient time for you.

At the first instance you will be fully briefed regarding the aims of the research after which your consent will be sought.

If you agree to take part in the research, you will meet with the researcher for a meeting.

The meeting will begin with the researcher asking you about your experience of client violence and what that was like for you.

The meeting will take approximately one hour, which will be audio recorded and later transcribed.

All of the materials used will be kept anonymously and will be identifiable only by a number, not by your name. For confidentiality reasons, a pseudonym will be used throughout the transcript and in any published research.

Furthermore, you will be given the transcription before any work is handed in to the University of East London, to check that your confidentiality is maintained at all times. If you feel that your confidentiality has been breached, changes will be made to the transcript.

Additionally, the recording of the tape will be either destroyed or handed back to you once it is no longer required.

Risks

It is not expected that participation in the study has any risks; however you are being asked to recall a distressing situation. If you require further support and work for the NHS below there are details of an independent organisation that provides advice, guidance and counselling free of charge to you.

However if you do not work for the NHS and you find any of the questions asked upsetting, and would like to talk about this, please contact the researcher at Fardin.Jussab@gmail.com for further support.

The researcher is insured by Towergate Professional Risks, 5 old Bond Street, London, EL2N 1AD.

Oasis is an NHS based organisation that specialises in providing free and confidential support to NHS staff. OASIS has a highly experienced advice, careers guidance and counselling team who will help with various work and personal difficulties

To make an appointment call: 020 7380 9800.

Benefits

There is likely no direct benefit to you for participating in this study. However, it will help to gain an in-depth understanding of your experience of violence by a client particularly upon your professional and personal identity and psychological well being. Furthermore, your information may help to facilitate in producing guidelines on how to deal with client violence in the Professional Practice Guidelines of the Division of Counselling Psychology of the British Psychological Society.

Payment

Unfortunately you will not be paid for participating in this study.

Ethical clearance

Ethical Clearance for this research has been approved by The School of Psychology at The University of East London. Furthermore all Research in the NHS is reviewed by independent group of people called the Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by South West London Research Ethics Committee 3.

Furthermore the research and verbatim extracts may be published in academic journals, presentations and conferences and these extracts will be read by internal and external examiners for submission.

For Further Information please contact: Fardin.Jussab@gmail.com

If you have any concern about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions. If you still remain unhappy and wish to complain formally, you can do this through the Graduate School University of East London, 4-6 University Campus Way, London, E16 2RD. Tel: 0208 223 2976 Fax: 0208 223 2826.

1 copy for the participant.

1 copy for research site.

1 copy for researcher.

Appendix F: Consent Form

Participant Identification number:

Centre No:

Consent Form

Title of the project: Counselling and Clinical Psychologists' lived Experience of Client Violence in the work place

Name of researcher: Fardin Jussab

Please initial boxes:

1. I confirm that I have read the information sheet dated 27th October 2010 for the above study. I have had the opportunity to consider the information and ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I am willing for my meetings with the researcher to be audio recorded.

4. I am aware that the research and that verbatim extracts may be published in academic journals, presentations and conferences and these extracts will be read by internal and external examiners for submission.

5. I agree to take part in the above study.

-------------------------------   -------------------   ----------------------------

Name of participant   date   signature

I have explained the study to this participant and answered their questions honestly and fully.

_____   _____   _____

Name of researcher   Date   signature

Appendix G: letter of invitation

Dear Participant,

My name is Fardin Jussab. I am a Trainee Counselling Psychologist at the School of Psychology in the University of East London. I am conducting a research study as part of the requirements of my Doctorate in Counselling Psychology and I would like to invite you to participate.

I am studying Counselling and Clinical Psychologists' experience of client violence in the work place. If you decide to participate, you will be asked to meet with me for an interview about one hour. In particular, you will be asked questions about the effect of client violence upon your personal and professional identity and psychological well being. The meeting will take place at a mutually agreed upon time and place, and should last about sixty minutes. The interview will be audio recorded so that I can accurately reflect on what is discussed. The tapes will only be reviewed by members of the research team who will transcribe and analyse them. They will then be destroyed. You may feel uncomfortable answering some of the questions. You do not have to answer any questions that you do not wish to.

Although you probably won't benefit directly from participating in this study, however your information may help to facilitate in producing guidelines on how to deal with client violence in the Professional Practice Guidelines of the Division of Counselling and Clinical psychology of the British Psychological Society.

Participation is confidential. The results of the study may be published or presented at professional meetings, but your identity will not be revealed. Participation is anonymous, which means that no one (not even the research team) will know what your answers are. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering.

 I will be happy to answer any questions you have about the study. You may contact me on 07968918755 or Fardin.Jussab@gmail.com or my Clinical Supervisor, Helen Murphy at Helen.Murphy@uel.ac.uk . If you have any questions about your rights as a research participant, you may contact The Graduate School,

University of East London
Docklands Campus, 4-6 University Way, London E16 2RD
Tel: 0208 223 2976   Fax: 0208 223 2826.
Thank you for your consideration. If you would like to participate, please open the attached participant information sheet and consent form. When you are done, please contact me at the number listed below to discuss participating. I will call you within the next week to see whether you are willing to participate.

With Kind Regards,
Fardin Jussab
Counselling Psychologist in Training
07968918755

Appendix H: Original Interview Questions

Interview Schedule

1. What are the perceived influences upon their professional identity and role after the incident?

Prompt: any thoughts of incompetence, how did they feel talking to their peers about it?

2. After the incident, did they construct a story in their mind of the possible consequences?

Prompt: will I lose my job or what are people going to say?

3. After the incident, did it have any effect upon their relationship with their colleagues and supervisors?

Prompt: did you feel humiliated of what others will think or any thoughts that it may damage my professional image.

4. Are there any affects upon their personal life, after the incident?

5. How did they feel about reporting the incident?

Prompt: who was it reported it to? When they did report what was going through their mind?

6. How did they perceive their job after their incident?

Prompt: did you feel safe?

7. How did they feel about the support they received?

8. What would they do differently in the future?

9. Did the incident have an effect upon their work with other clients?

10. What advice would they give to others in dealing with violence?

Prompt: what would you advice newly qualified psychologists or trainee psychologists on the issues of violence?

11. What they would not have done differently and why?

12. What was helpful after the event and why it was helpful or what made it helpful?

13. What would have been helpful before?

Prompt: having some detail of the individual history, keeping a panic alarm etc.

14. What was not helpful before or after the event?

Prompt: writing a report, what colleagues or a manager may have said.

15. How have they been dealing with the emotions and thoughts after the event?

16. How long did it take them to overcome the event?

17. How did you overcome the event, what helped with the process?

Prompt: would there be a shorter period to overcome this event if things where done differently?

18. How did you deal with your feelings of fear?

Appendix I: Final Interview Questions

Section 1- Establish the nature of the incident.

Can you describe to me what happened?

Setting

How long ago

Their relationship with the person

Section 2- Thoughts and feelings about the incident

What were your thoughts about the event at the time?

What are your thoughts about it now?

Did you think anything was going to happen to you?

How did you feel about the incident at the time?

Now looking back how do you feel about it now?

How have you been dealing with your emotions and thoughts after the incident?

Section 3 - Perspectives about the incident (personal impact and professional impact)

Did the incident have any effect upon you as a clinician?

What effect did it have upon you as a person?

What kind of support did you receive, if any?

What was helpful or not helpful of the support?

After the incident, what was your relationship like with other people e.g. colleagues/ supervisors?

Did the incident have any effect upon your work with others? e.g. clients.

Was the incident reported?

How long did it take them to overcome the event?

How did you overcome the event, what helped with the process?

Prompt: would there be a shorter period to overcome this event if things where done differently?

Appendix J: Initial comments

Transcript	Notes
she was sitting over there and I was sitting here , just jumped up and started kicking at my legs and I kinda lifted my legs up and tried to move out of the way backing my chair but she carried on kicking at me most of the time she hit the bottom of my shoes erm so it was quite erm a nerve racking experience because I couldn't go anywhere feeling what I do to stop this and get out of this situation	The unexpectedness of being attacked Trying to defend himself? Escape? Nowhere to move Emotional response of incident but not of client Feeling stuck/trapped Reflecting/ I need to get out/ reflecting on what skill to use.
It was very public in a ward round and could remember having concerns about what other people would be thinking about how I was responding being attacked. trying not to behave in a way that will be assessed that I was going to imagine my colleagues assessing it in a very inappropriate way of behaving under these circumstances	Happened in a public setting 'having concerns' perhaps feeling judged on his skill ass psychologist or personal identity? Have to look professional in front of my colleagues What is he worried about? Questioning himself after the incident of did I behave professionally or did I let my personal feelings get in the way??
I guess because there I am the psychologist on the ward perhaps yeah so I have much greater degree of self-consciousness around being attacked.	Psychologists shouldn't be attacked
My relationship certainly changed after the incident before I didn't have any reason to be erm cautious around her or to be nervous of her or to be not just be myself in the ward round	Therapeutic relationship broken down after being attacked. Feelings become more intense towards her: nervous/cautious
I remember being or well thinking oh shit have I asked a bad question that kind of thing	Self-blame.
it did make me think that there was a bit of posturing going on or bit of kind of erm that she had not completely lost it and you know in some way she was cross with me or angry with me not not in a control way, because she didn't she was	Client not taking personal responsibility.

Transcript	Notes
getting the most protective part of my body in a way which was my feet	
Afterwards I was pissed off, I did not really want to talk to her after that, from a combination of on the one hand I didn't want to be attacked again but that was the smaller part of it because I think I knew well, I concluded that she was erm she does it because she knew she could erm just being nasty really	Feelings towards the client – anger

Being weary of the client of another attack.

Client being nasty |
| I have a clear recognition that of feeling cross of that wasn't right you know that's just breaking the rules of that sense of being really cross with her and not wanting to do anything with her or offer help, not wanting to kind of contribute to her care erm in a way, before I would have wanted to but would not have felt to treat her any differently from anyone else on the ward. | Injustice of being attacked leading to feeling anger towards the client.

Not wanting to be part of the patients care anymore. |
| Maybe she didn't like me because the question I asked her in such a public setting. So she behaved in a public setting that would be very awkward for me without doing any physical damage you know that's my hypothesis. | Questioning why I happened, then formulating the reasons.

Thinking about how the attack was controlled, in order to make him look bad as he made her look bad in front of others. |
| The more and more I think about it she jumped up and did did what she did for whatever reason she had in her mind she jumped up and attacked me and erm in my mind I have concluded that she did not really want to hit me or cause much harm er so in some sense she like did this controlled attack feels like to me now where was wanting perhaps to you know feel powerful equal in some sense | Client wants to show him that he is not immune to being attacked. Or there is a revenge attack for the question he asked. |
| mental health patients believe they can behave anyway how they like because the police are not interested and that is often supported by the police as they would often respond to a psychiatric ward because they will say there's nothing we can do because the patient is mad , so nothing is going to be, there is going to be no prosecution or whatever | Generalisation 'they' can behave however they like.
Criminal justice system not interested.

Mental illness used as excuse for client violence. |

Appendix K: Looking for themes

Transcript	Themes
she was sitting over there and I was sitting here , just jumped up and started kicking at my legs and I kinda lifted my legs up and tried to move out of the way backing my chair but she carried on kicking at me most of the time she hit the bottom of my shoes erm so it was quite erm a nerve racking experience because I couldn't go anywhere	Being caught off guard
feeling what I do to stop this and get out of this situation	Inner dialogue
It was very public in a ward round and could remember having concerns about what other people would be thinking about how I was responding being attacked.

trying not to behave in a way that will be assessed that I was going to imagine my colleagues assessing it in a very inappropriate way of behaving under these circumstances | Being judged by others |
I guess because there I am the psychologist on the ward perhaps yeah so I have much greater degree of self-consciousness around being attacked.	Being judged by others? Psychologists' shouldn't be attacked?
My relationship certainly changed after the incident before I didn't have any reason to be erm cautious around her or to be nervous of her or to be not just be myself in the ward round	Feelings towards the client
I remember being or well thinking oh shit have I asked a bad question that kind of thing	Self-blame /rumination/reflecting
it did make me think that there was a bit of posturing going on or bit of kind of erm that she had not completely lost it and you know in some way she was cross with me or angry with me not not in a control way, because she didn't she was getting the most protective part of my body in a way which was my feet	Questioning whether the client was in control of her behaviour

Transcript	Themes
Afterwards I was pissed off, I did not really want to talk to her after that, from a combination of on the one hand I didn't want to be attacked again but that was the smaller part of it because I think I knew well, I concluded that she was erm she does it because she knew she could erm just being nasty really I have a clear recognition that of feeling cross of that wasn't right you know that's just breaking the rules of that sense of being really cross with her and not wanting to do anything with her or offer help, not wanting to kind of contribute to her care erm in a way, before I would have wanted to but would not have felt to treat her any differently from anyone else on the ward.	Feelings towards the client
Maybe she didn't like me because the question I asked her in such a public setting. So she behaved in a public setting that would be very awkward for me without doing any physical damage you know that's my hypothesis. The more and more I think about it she jumped up and did did what she did for whatever reason she had in her mind she jumped up and attacked me and erm in my mind I have concluded that she did not really want to hit me or cause much harm er so in some sense she like did this controlled attack feels like to me now where was wanting perhaps to you know feel powerful equal in some sense	Creating a formulation
mental health patients believe they can behave anyway how they like because the police are not interested and that is often supported by the police as they would often respond to a psychiatric ward because they will say there's nothing we can do because the patient is mad , so nothing is going to be, there is going to be no prosecution or whatever	Lack of support / seeking support, but support not available.

Appendix L: Clustering of themes

Themes Identified	Key word quotes from Martin
Creating a formulation and not taking is personal attack	"Making sense of the attack "
Psychological well being	"Feeling scared and nervous"
Caught off guard	"I couldn't go anywhere"
Ruminating/reflecting/thinking	The more I think about it
Am I Being judged by others?	"What other people would be thinking." Indignation
Professional identity/ Questioning ones PI	"psychologist shouldn't be attacked"
Being a psychologist	"Being a psychologist I should have known better"
Self-blame	"Did I ask a bad question" "Provoking the client by asking a difficult question"
feelings towards the client	"being cautious around her" "pissed off with her"
Support	"No support from the police" "Lack of support from the NHS" "colleagues were supportive"
Being rescued	"Being rescued by nurses"
Client was in control of his/her actions	"client was aware of what she was doing" "Behaved to make it awkward for me" "Using mental illness as an excuse"
There was an expectation of being hit??	"Client already aroused"
How am I behaving / others perception	"self-conscious of one's own behaviour"
Keeping calm/keeping control	"trying not to panic"
Questioning one's ability (Rumination)	"I did the best I could have done"
Worst case scenario	"it could have been worst"
Patient care	"Not wanting to do anything with her" "Cooked your goose"
Justice	"Wanting justice" "client taking responsibility"

Appendix M: Themes captured from all seven participants

Emerging Themes	Rose	Martin	John	Sophie	Rebecca	Lauren	Mary
Making sense / Creating a Formulating in understanding the clients behaviour	*"I want to understand this lady"*	*"Making sense of the attack"*	*"Making sense of the aggression"* *"Transference relationship"*	*"Using psychological theory to understand the violence"*	*"Making sense of the attack"*		*"That's how the client feels about herself".*
Psychological wellbeing/ psychological distress		*"Feeling scared and nervous"*	*"Anxiety building up"*	*"Feeling terrified"*			
Feeling threatened and intimidated	*"Feeling threatened"*		*"Feeling threatened"*			*"He was being threatening and intimidating"*	
Being Caught off guard	*"I wasn't expecting it"* *"shocked & surprised"*	*"I couldn't go anywhere"*		*"Catches you off guard"*	*"Suddenly hit you in the face"*		*"It was a bit of surprise"*
Ruminating on what I could have done differently	*"Could I have something differently"*	*"Thinking oh shit have I asked a bad question"*	*"Going back over what happened"*	*"Is she going to hit me"*		*"Could I have done something differently"* *"No point in ruminating"*	*"I started questioning was there something that I did to brought this about"*

Emerging Themes	Rose	Martin	John	Sophie	Rebecca	Lauren	Mary
Am I Being judged by others?	*"Worried about being judged"*	*"What other people would be thinking."* *Indignation*				*"They were thinking I don't know what I am doing"*	*"Feeling embarrassed"* *"Need to look clever"*
Professional identity	*"Feeling powerless"*	*"Psychologists shouldn't be attacked"*		*"Got to be professional about this"*	*"I'm I in the right job"*	*"Professional hat on"*	
Being a psychologist	*"Not making a big deal"*	*"Being a psychologist I should have known better"*	*"I can deal with it"* *I should be protected because I am a psych"*	*"Not being precious"* *"Luxury nurses can deal with this"*	*"Self-evaluation"* *"Psychologist in a privileged position"*	*"Were psychologists this doesn't happen to us"* *"Not making a meal out of it"*	
Self-blame / Ruminating		*"Did I ask a bad question"* *"Provoking the client by asking a difficult question"*	*"Doubts in my mind about my ability"*	*"What have I done wrong"*	*"I could do more"*		
Feeling concerned for the client	*"Feeling concerned for the clients wellbeing"*		*"A certain level of sympathy"*				
Inner dialogue of what to do next	*"Thinking of reducing risk"*	*"I need to escape"* *"Had a dialogue with myself"*				*"I just need to go"*	*"How do I resolve this"*

Emerging Themes	Rose	Martin	John	Sophie	Rebecca	Lauren	Mary
Feelings towards the client	*"Not feeling empathic"*	*"being cautious around her"* *"pissed off with her"*	*"Not feeling safe"*	*"Frightened of the client"*	*"Scared of him"*		*"I want to strangle her"*
Seeking Support	*"Informal support from peers"*	*"No support from the police"* *"Lack of support from the nhs"* *"colleagues were supportive"*	*"Using supervision to reflect upon"* *"Needing to off load"*	*"Nurses were concerned"* *Supervisor not supportive*	*"Having an outlet"*	*It was nice to feel cared for*	*"Having a laugh"*
Being rescued by nurses		*"Being rescued by nurses"*			*"Nurses took over"*		
Client was in control of his/her actions		*"client was aware of what she was doing"* *"Behaved to make it awkward for me"* *Using mental illness as an excuse*	*"It was part of the clients psychological difficulty"* *"He was not ready for therapy"*		*"Client had control over their action"* *"Client was intimidated"*	*"It was his mental illness"*	
There was an expectation of being attacked	*"Client already agitated"*	*"Client already aroused"*	*"Client losing perspective"*				
Feelings towards the client	*"Not feeling empathic"*	*"being cautious*	*"Not feeling safe"*	*"Frightened of the*	*"Scared of him"*		*"I want to*

Emerging Themes	Rose	Martin	John	Sophie	Rebecca	Lauren	Mary
		around her" *"pissed off with her"*		*client"*			*strangle her"*
Seeking Support	*"Informal support from peers"*	*"No support from the police"* *"Lack of support from the nhs"* *"colleagues were supportive"*	*"Using supervision to reflect upon"* *"Needing to off load"*	*"Nurses were concerned"* *Supervisor not supportive*	*"Having an outlet"*	*It was nice to feel cared for*	*"Having a laugh"*
Being rescued by nurses		*"Being rescued by nurses"*			*"Nurses took over"*		
Client was in control of his/her actions		*"client was aware of what she was doing"* *"Behaved to make it awkward for me"* *Using mental illness as an excuse*	*"It was part of the clients psychological difficulty"* *"He was not ready for therapy"*		*"Client had control over their action"* *"Client was intimidated"*	*"It was his mental illness"*	
There was an expectation of being attacked	*"Client already agitated"*	*"Client already aroused"*	*"Client losing perspective"*				
Questioning one's ability (Rumination)	*"Could I have something differently"*	*"I did the best I could have done"*	*"Am I up to the task of managing him"* *"Loss of*				

Emerging Themes	Rose	Martin	John	Sophie	Rebecca	Lauren	Mary
			confidence" *"Knowing my limitations"*				
Patient care	*"Client butted around from one service to another"*	*"Not wanting to do anything with her"* *"Cooked your goose"*	*Ended sessions* *"Let the client down"*	*"I'm not working with this woman"*			*"I can't be bothered"*
Personal identity	*"Personal space"*		*"Intimidated by the client"*				
Camaraderie		*"Being part of the inn crowd"* *"Nursing staff get the brunt of it"*					
Being cautious after the violence		*"Could get attacked again"*	*"Relief"*	*"Hyper vigilant"* *"Don't provoke her"*	*"Being cautious"*		
Empathy for nurses		*"Nurses get attacked"*		*"Nurses have to deal with it"*	*"They get it more often"*		
Physiological response						*"My body was shaking"*	
Part and parcel of the job						*"Part and parcel of the job"*	*"Part of the job"*

Appendix N: Superordinate and subordinate themes with illustrative quotes

Superordinate Theme 1: The moment to moment experience of client violence	
Subordinate themes	**Example quotes of subordinate themes**
Being caught off guard	*"just really shocked, to be honest, just because I wasn't... like I say, I wasn't expecting it. I've worked with people and they've got angry and irritable before but I think it was that thing, I'd... I'd never... I'd never been in a position where you've just walked on and something's suddenly hit you in the face."*
Inner dialogue of what to do next	*"I probably had a dialogue with myself, had to reassure myself that feeling as frightened that I felt erm was kind of okay..."*
Experiencing psychological distress	*"I could feel my anxiety building and I think, especially the first two or three times it happened I... you know."*
Superordinate Theme 2: The Psychologist reflecting after the incident	
Subordinate themes	**Example quotes of subordinate themes**
Feelings towards the client after experiencing client violence	*"it felt close to that a couple of times and when I tried to de-escalate it, it... that didn't really work and there was two sessions that I terminated because of that, I said to him that I didn't feel safe in the room with him and stopped the sessions."*
Creating a formulation in understanding the client's behaviour	*"I think he'd been in that situation that he felt evaluated, that he was aware that he wasn't doing very well, probably felt frustrated, upset and that... with those kind of tests you don't get much interpersonal feedback so there's supposed to be run in a fairly standardised manner. So whilst you can be kind of pleasant, you're not saying 'oh, don't worry about it, never mind that you didn't do so well', you have to kind of keep going in a fairly routine manner. So I think that probably feels quite alienating sometimes for people, particularly if they're not doing very well. So I think it was probably frustration, a bit of shame from... from his point of view that... that triggered it off."*
Being cautious of the client after the incident	*"I was frightened of her, so it made me sort of very wary of her every time I came onto the Ward. It's like sort of being slightly hyper vigilant, you know, 'God, where is she', 'is that going to happen again'."*
Participants questioning whether the client was in control of his or her behaviour	*"she hadn't completely lost it. She had some sense of control and I still think that this was kind of posturing behaviour she was behaving like that because she could".*

Superordinate Theme 3: Issues concerning professional identity	
Subordinate themes	**Example quotes of subordinate themes**
thinking on what could have done differently	*"I suppose I thought maybe I... I suppose I was trying to think could I have done something different, you know, could I have said something in a different way or should I have just left it and not gone after him and then... so I was more trying to reflect on what I'd done."*
Not being precious	*"This might sound a bit silly but I didn't want to... I didn't want to make a big deal out of it and if I'd labelled it as an act of aggression against me it might... it sounds like I'm making a big deal out of the incident, which I didn't want to do."*
Seeking support	*"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". I didn't want any particular... I think we do separate out that kind of more informal support and our more formal supervision."*
Being judged by others	*"I suppose I did think 'oh, I wonder whether they thought I'd provoked him or, you know, I could have done something different."*

Appendix O – Extract of Personal reflections of experiencing client violence

Having experienced client violence in the past as a trainee counselling psychologists and conducting research in this area it seemed sensible to process my own thoughts and feelings around this issue. This was in order not to influence the interviews with my participants as I was aware that both verbal and non verbal cues may affect the research process.

My experience of client violence was during my first year placement in a drug and alcohol service for the NHS. I had been in the placement for three months and had been counselling clients with various presenting problems. This particular client had been known to the service as he was someone who was difficult to engage with. I had been asked to call the client and offer him an appointment for counselling. During my conservation with him the client, he had started to become agitated and was raising his voice. The client had then threatened me over the phone to attack me with his friend. From this incident I recall experiencing various feeling and thoughts about the threat.

Initially I recall immediately feeling fine about it as I had worked in forensic services for many years. However after time to reflect I recall feeling worried about my safety especially leaving the building on my own and constantly wondering if he and his friend were waiting for me outside the service to hurt me. During that time I remember whilst walking to the tube station I would look back to see if I was being followed by any one.

I was overwhelmed with feelings of shame and self doubt in which I was questioning my interventions with clients at every turn. I believed that I was to blame for the incident and had caused the client to become distressed and for him to threaten me. This made me feel very embarrassed in which I thought about keeping the clients aggression a secret and recall telling my self that 'no one needs to know'. I also thought I was going to lose my placement and eventually the university will also ask me to leave the professional doctorate course altogether. These thoughts had obviously caused me a lot of distress and panic.

I had questioned my skills over and over again and believed that I was a bad therapist. Furthermore I saw myself as a useless therapist and perhaps was not ready or not good enough for the profession. I found it very difficult to ask for support and recall thinking 'I wish I could make the incident go away'. However I did talk to my clinical supervisor and eventually took this process to therapy and worked upon my thoughts and feelings around the incident.

Overall this is a small extract from my personal diary from my therapy over the incident. It describes some of the thoughts and feelings that I had experienced and eventually worked through them in therapy and supervision. In re-reading my experience of violence helped me to keep separate my experience to my clients' experience and attempt not to influence the research process.

Figure 1: Flow charts of theme identification

Flow chart 1: Superordinate theme 1 with the corresponding subordinate themes
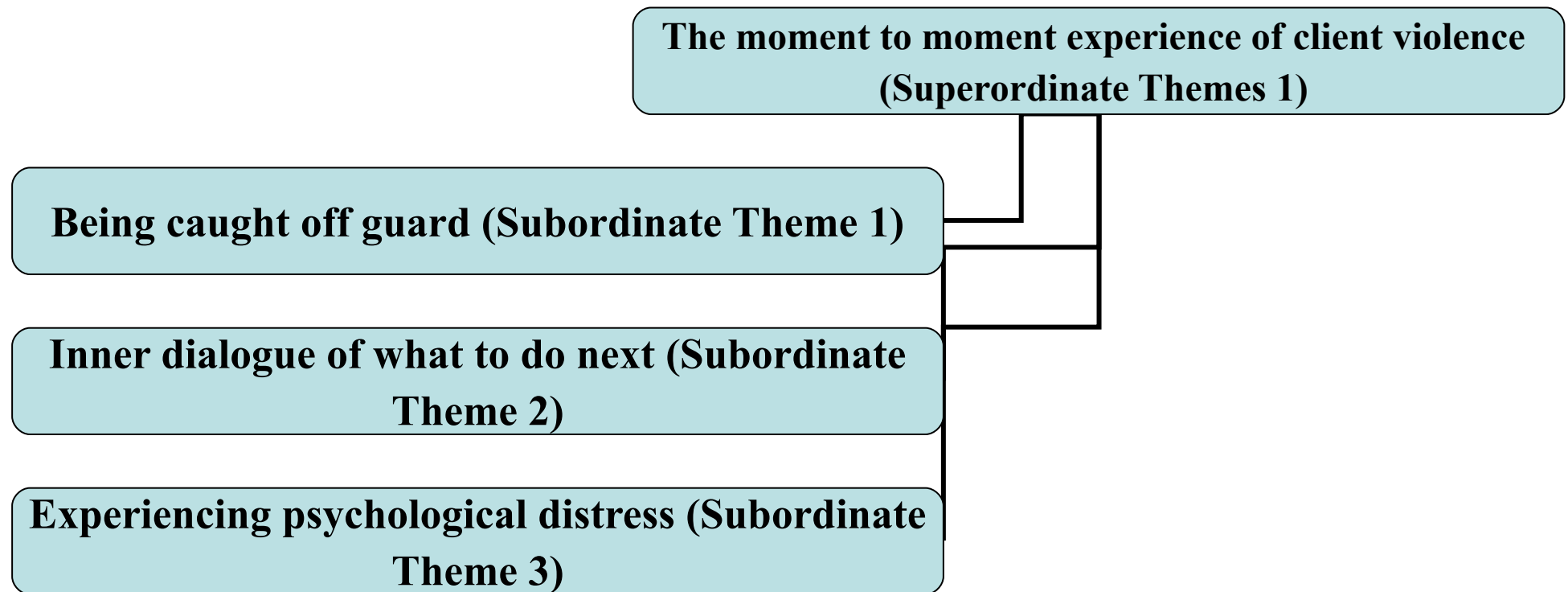
Figure 2: Superordinate theme 2 with the corresponding subordinate themes

Psychologists' reflecting after the incident (Superordinate theme 2)

Creating a formulation in understanding the clients behaviour (Subordinate Theme 1)

Being cautious of the client after the incident (Subordinate Theme 2)

Participants Feelings towards the client after experiencing client violence (Subordinate Theme 3)

Participants questioning whether the client was in control of his or her behaviour (Subordinate Theme 4)
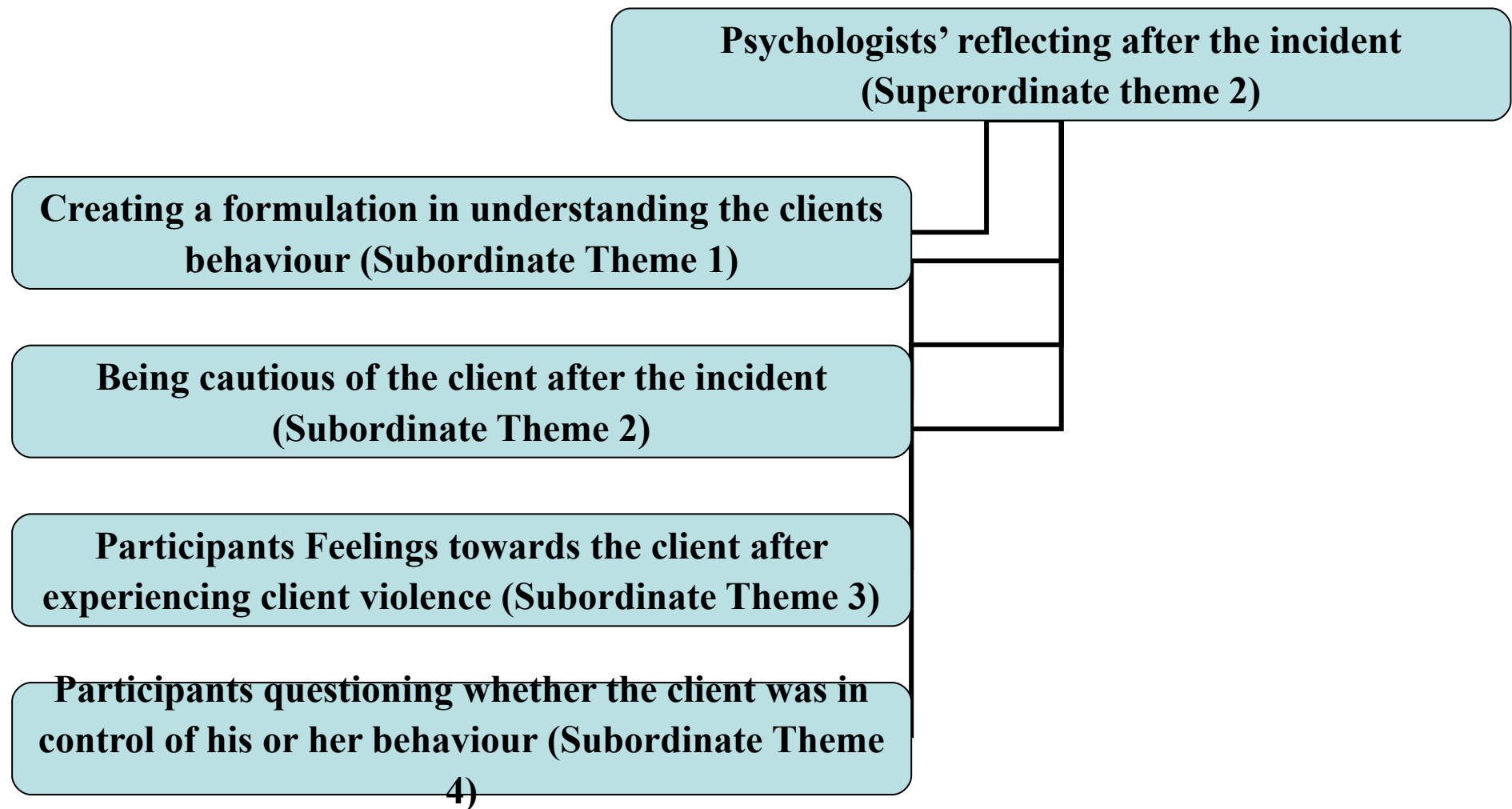
Figure 3: Superordinate theme 3 with the corresponding subordinate themes