A Qualitative Study on the Experiences of Therapists who Have Been Threatened with Harm or Attacked by a Client or a Relative of a Client During the Course of Treatment in a Non-Residential Setting

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Abstract

This qualitative study used a phenomenological approach to understand the experience of six therapists who had been threatened with harm or attacked by a client or a relative of a client in an outpatient setting. Semi-structured interviews were employed to collect data which were then analyzed using thematic coding. While some of the results of this study are consistent with existing literature on attacks on clinicians in acute inpatient settings, many of the study findings suggest that the experiences of therapists working in an outpatient setting who are threatened by a client or a relative of client are unique to that setting. Clinical implications are discussed.

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CHAPTER I: INTRODUCTION

The Problem and its setting

Brems and Johnson (2009) assert that at some point in a therapist's career he or she will experience a threat of harm from a client. While the definition of violence perpetrated against mental health professionals has been inconsistent (Arthur, Brende, and Quiroz, 2003), various definitions have emerged in the literature. Schultz (1987) defined violence against mental health professionals in terms of physical violence, verbal threats, and property violence, while Whittington, Shuttleworth, and Hill (1996) expressed it as different forms of assault, such as aggressive physical contact with aggressive intent. Meanwhile, VanSoest and Bryant (1995) consider any "act or situation in which there is severe and intense exercise of force and power in a direct attack resulting in physical injury or loss of psychological integrity" (p. 549) as violence against a mental health professional.

Some threats against mental health professionals also turn deadly. For example, in September 2006, psychiatrist Dr. Wayne S. Fenton, an eminent schizophrenia specialist, was found dead in his office in Bethesda, Maryland. A 19-year-old client suffering from schizophrenia and bipolar disorder beat Fenton to death with his fists after becoming agitated when the psychiatrist tried to persuade him to take his medication (Barr, Londoño, & Morse, 2006). In another well-publicized case, in March 2008 an individual diagnosed with paranoid schizophrenia attacked his former psychiatrist, Dr. Kent Shinbach, with a meat cleaver after stabbing to death the psychologist with whom he shared an office in Manhattan (McKinley, 2014). And in 2011, a client who had begun blaming all of her problems on her psychiatrist, Mark Lawrence, shot and killed him in his home in McLean, Virginia, before fatally shooting herself (Wu & Ruben, 2011).

After being attacked by a teenage girl with a hunting bow and arrow designed for killing bear and deer, psychotherapist Dr. Howard Bernstein was so affected by the assault that he set out to ascertain how frequently attacks against mental health clinicians occur (Nelson, 1983). He found that 60.9 percent of licensed psychiatrists, psychologists, clinical social workers, and marriage, family, and child counselors in a San Diego County reported being physically afraid of a client, while 14.2% had actually been threatened or assaulted during their careers (Bernstein, 1981). Yet, it is difficult to secure accurate statistics on the number of assaults by clients on mental health clinicians due to the lack of consistent definitions of violence, widespread underreporting (Arthur et al., 2003; Guy, Brown, & Poelstra, 1990), and the absence of a uniform reporting system (Berg, Bell, & Tupin, 2000). Still, experts suggest that both the rise in the incidence of violence in the United States (FBI, 2012) and the increase in the number of professionals in the mental health field contributes to an increased prospect of harm or danger to therapists (Arthur et al., 2003). Accordingly, Guy et al. (1990) caution that all clinicians should be aware of the risk of violence. Indeed, several other professional surveys underscore that the threat of harm or violence is a salient issue for mental health clinicians, as illustrated in the following findings:

- Pabian, Welfel, and Beebe (2009) found that participants in their survey of randomly selected licensed psychologists practicing in Ohio, New York, and Texas saw an average of 3.2 potentially violent outpatient clients during a two-year time frame.
- Arthur et al. (2003) conducted a survey of licensed mental health providers in the state of Georgia, including clinical social workers, marriage and family therapists, masters of social work, licensed professional counselors, psychiatrists, and psychologists, and found that 29%

had feared for their lives because of threats or perceived threats from clients; 61% were actual victims of a psychological or physical violent client action.

- Pope and Tabachnick (1993) reported that 82.8 percent of psychologists surveyed from certain divisions of the American Psychology Association feared a physical attack by a client on at least one occasion; 18.9 percent reported an actual attack. They also found that over 50 percent of clinicians felt so afraid of a client that it affected their eating, sleeping, or concentration, and 80 percent felt angry with verbally abusive clients.
- A national survey of 339 psychologists found that nearly 40 percent had suffered a physical attack and 49 percent were verbally threatened. Many of the psychologists took protective measures as a result, such as opting not to treat certain clients, avoiding disclosure of personal information, and specifying unacceptable behavior (Guy et al., 1992).
- Other studies highlight that 6 to 12% of clinicians report having been stalked by a current or former client (Brems & Johnson, 2009; Galeazzi, Elkins, & Cuici, 2005; Gentile, Asamen, Haimell, & Weatheis, 2002; Romans, Hays, & White, 1996).

While there have been a handful of surveys attempting to quantify threats of violence to clinicians, there has been limited data examining the experience of licensed psychotherapists or counselors in outpatient settings who have had to navigate and cope with this difficult situation (Arthur et al., 2003). Indeed, most of the current literature regarding dangerous clients has primarily centered on clinicians who work with clients in acute inpatient psychiatric settings (Daffern et al., 2010). In these settings, the victims of violence generally include psychiatrists (Dubin & Lion, 1993; Madden et al., 1976; Ruben, Wolkon, & Yamamoto, 1980), social workers (Ellwood & Rey, 1996; Horejsi et al., 1994; Newhill, 1995; Schultz, 1987), and nursing

personnel (Appelbaum & Appelbaum, 1991; Helmuth, 1994; Lanza, 1983, 1988; Lanza, Kayne, Hicks, & Milner, 1991).

Despite a growing body of literature on threats of violence targeting clinicians in outpatient settings, limited attention has been given to the experiences of clinicians that may be unique to treating clients who threaten harm to the clinician in an outpatient setting. Yet, Guy et al. (1990) found that attacks occur in all work settings, underscoring the need to be aware of the risk of violence for clinicians who work in outpatient settings, too. Thus, this study will add to the current literature by examining the practical experiences and perceptions of clinicians who have been physically or verbally threatened with harm by a client in an outpatient setting. It may also provide some insight on the extent to which clinicians are impacted by the threat of harm. The aim of the study is to examine the experience of clinicians who have faced a threat of harm or danger from a client with the intent of informing clinical training and practice on how to cope with and address this phenomenon. Without an exploration of the experience of clinicians in out-patient settings, the effectiveness of suggested practices and trainings cannot be truly assessed.

Significance

Much of the focus of the research on threats to clinicians in inpatient settings has explored how environmental factors (Gadon, Cooke, & Johnstone, 2006) specific to inpatient settings impact patient aggression. Additionally, others have examined interactional qualities between patients and staff in inpatient settings (Daffern, 2010; Daffern, Howells, & Ogloff, 2007; Whittington & Richter, 2005). Indeed, Jacob and Holmes (2011) detail the constant struggle that inpatient mental health nurses face to avoid becoming a victim of violence while still maintaining an ability to retain empathy for patients and provide effective quality patient care. Other research on threats in inpatient settings focuses on the aftereffects of being

victimized. For example, research suggests that traumatized nurses experience both short- and long-term effects following an assault in a hospital setting, including emotional, cognitive, social, and biophysiological reactions (Lanza, 1983).

While existing literature indicates that clinicians are impacted in a variety of ways by working with clients who threaten harm or violence in inpatient settings, little attention has been given to exploring the experiences of clinicians who are threatened with harm by a client in an outpatient setting. A more extensive exploration of these clinicians' reactions and their coping mechanisms may provide valuable insights on how clinicians are affected that may be unique to the outpatient setting, including the extent to which they are impacted, as well as how they dealt with this difficult situation. Indeed, Berg et al. (2000) extol the need for clinicians to understand violence and develop appropriate perspectives regarding client violence. They recommend exploring and addressing clinicians' attitudes and effects related to violence, such as fear, permissiveness, overconfidence, aggressiveness, and detachedness because of the possible impact on their clinical judgment, as well as their patient's response to them as a mental health professional. The authors invoke warnings from experts who warn that clinicians should not deny that hate exists because it can lead to therapy that is "adapted to the needs of the therapist rather than to the needs of the patient" (Winnicott, 1949, p. 14). Conversely, they also underscore that clinicians' experiences and attitudes could also be a strength in appropriately assessing and treating violent individuals.

Similarly, Berg (1997) warns that feelings of denial can cause clinicians to miss danger signs or overestimate their ability to cope with potential violence. He asserts that denial may stem from personal experiences with violence or a lack of exposure to violence. Relatedly, Berg et al. (2000) point out that clinicians, who typically view their role as nurturing and supportive,

are often surprised by patient aggression. They go on to speculate that clinicians may view violence as part of their jobs or experience feelings of guilt related to incidents of violence. Clinicians who are frequently exposed to clients who threaten harm and other verbally or physically abusive behaviors may also be impacted in terms of their well-being and may be at risk of personal feelings of failure, as well as physical and mental health problems (Bayne, 1997; Brems, & Johnson, 2009). Likewise, a survey of psychologists who had clients who threatened harm conducted by Rupert and Morgan (2005) found emotional exhaustion to be prevalent with 44 percent expressing "high burnout."

Accordingly, a qualitative study exploring the in-depth experiences of clinicians who have been threatened by a client in an outpatient setting could expand understanding of clinicians' reactions and experiences of being threatened by a client in an outpatient setting, as well as provide contextual understanding of the impact on clinicians. The findings of a qualitative study may help inform clinical practice and training programs related to this situation. Past studies suggest that graduate training in this area has been lacking. For example, Gately and Stabb (2005) reported that the clinical psychology students they surveyed found their training in managing potentially violent clients to be deficient, which contributed to a lack of confidence in working with this population. Also, Pope, Sonne, and Holroyd (1993) reported that a sizable percentage of therapists rated their graduate training as inadequate in terms of dealing with their own feelings of anger (41%) and fear (50%).

Rationale

The purpose of this study is to explore the experience of clinicians who have been threatened with harm by a client or someone associated with a client with the intent of informing clinical training and practice on how to cope with and address this phenomenon. Thus, a

qualitative methodology seems fitting for this study in order to capture a rich description of clinicians' experiences. Indeed, this methodology will provide study participants with the opportunity to describe their personal experiences related to working with clients who threatened harm or violence along with the meaning that they ascribed to those experiences. In-depth interviews with licensed clinicians will provide the opportunity to garner rich descriptions of the lived experiences of clinicians involved in this phenomenon.

Theoretical Framework

Creswell (2007) posits that the focus of a phenomenological study is to describe the "universal essence" of a phenomenon experienced by a group of participants. He asserts that phenomenologists describe what all participants have in common as they experience a phenomenon. "What" is experienced and "how" it is experienced is addressed (Moustakas, 1994). Stewart and Mickunas (1990) propose four philosophical perspectives associated with phenomenology: 1) phenomenological studies represent a "search for wisdom"; 2) phenomenology requires a "suspension" of judgment, otherwise referred to as bracketing; 3) the reality of an object is linked to consciousness of that object; and 4) the reality of an object occurs within the context of the meaning of an individual's experience.

This study aims to explore the experience of clinicians who have been threatened with harm or danger by a client in an effort to gain insight into the impact of this phenomenon on clinicians and with the intent of informing clinical training and practice. Phenomenology will guide the basic development of this study, including the employment of a qualitative methodology and the use of in-depth, semi-structured interviews with study participants. Indeed, this research topic intrinsically requires the examination of experiences of clinicians who have been threatened with physical harm or experienced a verbal threat of harm by a client.

Accordingly, phenomenological studies involve the collection of individual experiences, which are in turn reduced to discern the "essence" of the experiences (Creswell, 2007; White & Klein, 2002). This study was designed to describe the "essence" of clinicians' experiences of working with clients who are dangerous or threaten harm to the therapist. Indeed, a phenomenological study may help gain a deeper understanding of the phenomenon by understanding several individuals' common experiences of it. A quantitative study employing a standardized measure would have limited the ability to capture study participants' rich experiences.

Self as Researcher

My impetus for this research is partially personal. As a graduate student working as a therapist intern in Virginia Tech's onsite-clinic, I worked with a client who had homicidal ideations and threatened violence towards third parties. The experience caused me to worry about my safety, along with the safety of my loved ones. At the time, I was grateful to have the solid support and guidance of my supervisor and faculty. However, the experience made me wonder about how my experience would have been different had I not been working in the graduate student clinic, or if I didn't have the unyielding support of seasoned supervisors and faculty. Additionally, I wondered how my experience compared to clinicians who had been directly threatened by a client.

Purpose of the Study

The purpose of this study is to explore the experience of clinicians who have been threatened with harm or danger by a client or a person associated with a client in an outpatient setting in an effort to gain insight into the impact of this phenomenon on clinicians. Examining clinicians' experiences will help gain a better understanding of how clinicians are impacted by

threatening clients, as well as the extent to which they are impacted. In-depth interviews will also provide an opportunity to shed light on the context surrounding the threatening experience.

It is the intent of the researcher to add to the body of literature that examines research on dangerous clients who threaten harm to their clinicians. The current literature regarding dangerous clients or clients who threaten harm has primarily focused on clinicians who work with clients in inpatient settings versus outpatient settings, particularly mental health nurses working in forensic psychiatric settings. This study will shed light on the experience of several clinicians who have been threatened physically or verbally by a client they see on an outpatient basis. Graduate programs, clinicians in training, or seasoned clinicians experiencing this phenomenon themselves will have the opportunity to examine the collective experience of the participants in this study and consider how those experiences may inform their own actions in terms of self-care, supervision, assessment, and treatment.

CHAPTER II: LITERATURE REVIEW

A *New York Times* article entitled, "Acts of Violence Against Therapists Pose a Lurking Threat," (Nelson, 1983) describes how psychiatrist Bruce L. Danto, a private practitioner in Detroit and special deputy for the Wayne County Sheriff's Department, had armed himself when a violent former policewoman, carrying a handgun in her purse, verbally threatened him in a session. Ultimately, Dr. Danto de-escalated the client verbally, but the case illustrates how frightening client threats can be for clinicians. Indeed, the same article quotes a New York psychiatrist who asks the reporter not to print the therapist's name in the article because of an "absolutely terrifying" threat from a violent patient many years ago. The article quotes the therapist as saying, "These people stay crazy. They don't forget and they stay out there."

Despite the impact of threatening clients on clinicians in outpatient settings, little attention has been paid in the academic literature to the experiences of clinicians who have been threatened in these settings. The majority of the literature has been focused on the experiences of mental health clinicians working in inpatient settings. The following literature review outlines the existing literature focused on clinicians' experience and the aftermath of being threatened by a client in an outpatient setting. The literature review was conducted in the spirit of identifying research that may help inform areas worthy of further exploration in situations when a therapist is threatened by a client in an outpatient setting. It also highlights the unique factors inherent to inpatient settings which points to the need for separate and distinct research exploring clinicians' experiences in the entirely different outpatient setting.

Much of the academic literature on clinician responses to exposure to client violence is quantitative in nature and focuses on psychiatric nurses, probably owing to the fact that the prevalence of assault is among the highest in inpatient psychiatric units compared to other

settings (Hartley & Ridenour, 2011). Furthermore, Hatch-Maillette et al. (2007) assert that psychiatric nurses are assaulted more frequently than other staff due to the amount of direct client contact and the job security functions that they perform. Thus, client assaults have been a notable topic of scholarly interest for psychiatric nurses.

Non-somatic experiences and effects:

In seminal research conducted by Lanza (1992), she suggested that psychiatric nurses threatened by clients experience a range of non-somatic effects as a result of the threatening incident. In fact, she found evidence suggesting that psychiatric nurses were impacted bio-physiologically, emotionally, cognitively, and socially. In 2006, Needham conducted a meta-analysis of studies examining patient aggression towards nurses in accordance with the range of non-somatic effects originally put forth by Lanza (1992): biophysical, emotional, cognitive, and social. Following is a summary of Needham's meta-analysis:

Biophysical:

Fear or anxiety appeared as the most reported biophysical impact in the meta-anlysis. Fear or anxiety can manifest in a generalized form (Lanza, 1983, Whittington & Wykes 1992); may be associated with the perpetrator or other clients (Hauck 1993, Lanza, 1983, Whittington & Wykes 1992); may be related to fear of permanent side effects stemming from the assault or becoming dependent on others (Lanza, 1983); may encompass fear of retaliation towards the violent client (Lanza, 1983); or may be characterized as fear of the future (Hauck, 1993).

Emotional effects:

Hauck (1993) reports that anger is an emotional reaction to client assaults on psychiatric nurses and it can be directed at the nurses themselves, superiors, or the institution where they

work. Feelings of guilt, self-blame, and shame were also reported in a majority of the studies (Needham et al., 2006). In fact, some nurses express guilt for the way they handled patient aggression (Hauck,1993). Moreover, feelings of guilt and self-blame can be reinforced when superiors blame the victims for the assaults (Hauck, 1993). Additionally, feelings of guilt and shame may lead to a decline in self-confidence (Hauck, 1993). Needham et al. (2006) speculates that feelings of guilt, self-blame, and shame may be associated with the required dual responsibilities of nurses when dealing with aggressive clients — protecting one's own rights while also providing the best quality of care. Indeed, Murray and Snyder (1991) report on the high expectations that psychiatric staff have for themselves which could contribute to conflicting feelings over living up to professional moral standards while safeguarding their own rights (Needham et al., 2006). Interestingly, Needham et al. (2006) also underscore that feelings of guilt and shame may also represent barriers to reporting client assaults. Indeed, Hauck (1993) asserts that the myth perpetuating that a "good" caregiver would be exempted from client assault may be a factor in underreporting.

Cognitive Effects:

Cognitive effects are often related to feelings of threatened personal integrity or pride (Needham et al., 2006). For example, some psychiatric nurses reported feeling humiliated (Hauck 1993, Lanza et al., 1991). Others express disbelief that the client aggression occurred (Adams & Whittington, 1995). Similarly, denial or rationalization of the assault is also reported (Lanza, 1983). Additionally, client aggression also leads some psychiatric nurses to change their view of the world with some stating that nothing will be the same again (Hauck, 1993, Lanza 1983). Some perceive the world as less predictable and more threatening.

Social effects:

Flannery et al. (1995) asserts that assaults can undermine the clinician-client relationship as evidenced by feeling less eager to spend time with clients or avoiding them altogether. Likewise, some nurses' work and workplace satisfaction is affected (Needham et al., 2006). For example, psychiatric nurses who were assaulted consider changing jobs because they questioned the acceptableness of being attacked at work or because they feel less in control and more vulnerable (Hauck, 1993, Lanza, 1983). Also, patient aggression and assault led some nurses to question the competency of their work (Whittington & Wykes, 1992). Accordingly, a study of a pediatric psychiatric hospital's nurses reported that nurses who had been assaulted were more likely to consider leaving their jobs compared to non-assaulted staff. The assaulted nurses also reported higher levels of difficulty performing their work (Ryan et al., 2008).

Post-traumatic stress disorder:

More recent literature has explored post-traumatic stress disorder in psychiatric nursing staffs. The American Psychiatric Association (2000) delineates that PTSD is characterized by the following symptoms: exposure to a traumatic event; (2) persistent re-experiencing of the event; (3) avoidance of stimuli associated with the event; and (4) symptoms for more than 30 days. A recent review of the literature by Jacobowitz (2013), indicated that the rate of PTSD in the psychiatric nursing population is between 9 and 10 percent. While the author points out that there is a lack of longitudinal studies, one study by Richter and Berger (2006) reported that 17 percent of participants met all of the symptom-related criteria for PTSD immediately following the assault, and six months later 9 percent of participants met the criteria. This study also found that study participants who reported no physical injuries showed evidence of higher levels of stress than those with minor physical injuries, prompting the authors to assert that subjective experiences of trauma play a role regarding the development of stress symptoms.

Likewise, Nachreiner et al. (2007) suggested that there is a relationship between verbal abuse and stress, after finding that nurses reported that the following symptoms manifest more frequently after a verbally threatening episode: "frustration, anger, fear/anxiety/stress, irritability, fatigue, sadness, difficulty concentrating, shame/low self-esteem, depression, headache, and difficulty sleeping." Similarly, Walsh and Clarke (2003) reported that verbal abuse had a notably greater effect on stress symptoms versus physical assault. Thus, Jacobowitz (2013) underscores that the fear associated with abuse, whether it is verbal or physical abuse, may impact development of PTSD more than the extent of physical injury.

Long-term effects:

Lanza (1983) also highlights that some non-somatic effects can endure long-term. For example, some nurses re-experience earlier cognitive reactions, maintain denial/rationalization, continue to blame themselves, and have an increased sense of vulnerability. Indeed, research suggests that psychological and emotional wounds may persist and disrupt normal work and lifestyle activities for months or years after the incident (Rippon, 2000). For example, in a study by Baxter, Hafner, and Holme (1992), 49 percent of nurses assaulted by psychiatric patients conveyed that emotional recovery from an assault can take several months.

Relatedly, the stages in the "response cycle" to client violence has been described by Wykes and Whittington (1994). The "impact" stage encompasses the response immediately following the assault which is largely physiological. It is characterized by the following types of symptoms: heightened arousal, shock, numbness, confusion, disorientation, heightened feelings of fear, vulnerability, helplessness, dependency, anger, appetite change, sleep loss, fatigue, and avoidance of the reminders of the incident. It is worth noting that this response may occur several hours after the incident. The next stage, the "recoil" stage is defined by a loss of a sense

of security, along with focus on making sense of the assault and searching for reasons for why the person was victimized. Finally, the "reorganization" stage is the period during which the victim regains emotional control.

Coping:

Despite the undeniable non-somatic effects of client assaults, scant research has been done regarding how clinicians cope with this phenomenon. One small-scale study describes the types of coping mechanisms adopted by 24 psychiatric staff (23 nurses and 1 doctor) whose assaultive incidents were characterized as low in terms of severity level (e.g., no detectable injury or minor bruising or swelling) (Wykes & Whittington, 1991). Coping mechanisms included "talking to others about the incident, thinking about the incident, wanting/taking time away from the job, avoiding thinking about the incident, just getting on with the job, planning for next time, filling in an incident form, planning to leave the job" (p.42). The study authors note that most staff turned to emotion-focused palliative strategies, rather than problem-solving strategies. They also delineate that varying coping strategies were reported at different stages of the study. For example, in an initial study interview, victims expressed that they relied more on talking about and thinking about the incident, while in later interviews there was an increase in the use of avoiding thoughts about the incident. Furthermore, the number of strategies employed by victims decreased over time, but the strategies that decreased most were those characterized as "re-experiencing" the event (e.g., talking and thinking about the event).

A survey by Bernstein (1981) of mental health professionals in a San Diego County, which included data on psychologists and marriage and family clinicians who were assaulted in an outpatient setting, indicates that, as with psychiatric nurses who work in inpatient settings, an overwhelming reaction to an assault is fear. Thus, some of the research that has emerged on

assaults on clinicians in inpatient settings may be indicative of clinicians' experiences and reactions to assaults that occur in an outpatient setting. However, data on threats to clinicians working in an outpatient setting remains extremely limited, giving little sense of whether factors unique to an outpatient setting may have an impact on these assaulted clinicians' experiences. Indeed, a body of research has emerged detailing how situational variables, or factors unique to the inpatient setting environment may impact clinicians working in that setting (e.g., high-traffic areas in inpatient hospitals, temporal factors, management strategies, staff features). Thus, a qualitative study on clinicians who have been threatened in an outpatient setting may reveal how factors unique to the outpatient setting impact these clinicians' experiences of a threat or assault. Indeed, a qualitative study may provide valuable data on the context of threats to clinicians in an outpatient setting, as well as the extent to which they are impacted.

Inpatient versus outpatient

While research on threats to clinicians in inpatient settings may be indicative of possible findings regarding threats to clinicians in an outpatient setting, there are certainly significant differences between the two settings which may lead to distinguishing experiences between the two settings. Indeed, a systematic review of the literature on situational variables and violence in inpatient psychiatric settings conducted by Gadon (2006), underscores the contrast between outpatient and inpatient settings. Gadon's literature review includes research on the following situational variables:

Location:

Research suggests that there is a higher risk for violence in high-traffic areas in psychiatric hospitals (Harris and Varney, 1986). In fact, Hodgkinson et al. (1985) reported that most patient–staff assaults occurred in the dining room, day rooms, and sleeping areas.

Timing:

Temporal aspects unique to inpatient hospital settings also seem to be a factor into patient-client assaults. Research suggests that assaults commonly occurred during vulnerable times of high patient–staff interactions such as shift changes, breakfast, and medication times **(**Daffern, Mayer, & Martin, 2003; Grainger & Whiteford, 1993; Hamadeh et al., 2003; Hodgkinson et al.,1985; Weizmann-Henelius & Suutala, 2000).

Patient population and diagnosis:

In terms of patient population size, research indicates that more assaults occur when there are more patients present in the psychiatric unit (Flannery, 1997, Palmstierna et al.,1991). In addition, Palmstierna (1991) asserted that patient diagnosis is also a factor. The researcher found violent incidents were more common when the patient mix in the psychiatric unit included more patients who suffer from a schizophrenic illness.

Management:

Research that management strategies may play a role in violent incidents in psychiatric inpatient hospitals. Indeed, a study conducted by Morrison et al. (2002) reported a decrease in physical, verbal, and sexual patient–staff violence after new managerial strategies addressing violence were implemented. The strategies included engaging a nurse consultant as an advocate for staff, an aggression management plan for high-risk patients, and the formation of a special management team dedicated to restraining at-risk patients when necessary. Yassi et al. (1998) also found that staff training regarding how to enforce rules, how to respond to patient requests, and how to protect themselves during interactions with patients had an impact on levels of patient–staff violence.

Physical changes:

Studies also suggest that the physical environment can have an effect on client-staff assaults. For instance, when furniture in a communal area in a psychiatric hospital was rearranged to facilitate social interaction among patients, Baldwin (1985) reported a significant decrease in physical patient-staff assaults, as well as patient–patient violence. Another environmental control was examined by Zaslove et al., 1991, who reported that there was a decline in patient–staff assaults and patient-patient incidents when the sale of caffeinated drinks was banned.

Staff features:

Several studies investigated the impact of staff features on violence in inpatient psychiatric hospitals. For example, research suggests that violence is associated with higher rates of staff-patient interaction (Lanza et al., 1991, Whittington and Wykes (1994b). Gadon (2006) notes that this finding may indicate that high levels of interaction serves to increase the possibility of patient–staff assault. However, Druxbury (2002) also reported that aggressive patients attributed their violent behavior to poor communication and controlling approaches by staff. Furthermore Sheridan et al. (1990) suggested that precipitators to violence include the staff's enforcement of rules, patient discharges and transfers, and denials of patient requests.

In studies that investigated the relationship between staff position and violence, most studies found that staff nurses and student nurses were more likely to be assaulted compared to other staff positions (Grainger & Whiteford, 1993, Weizmann-Henelius & Suutala, 2000). Similarly, Hodgkinson et al. (1985) reported that training grades were found to be assaulted more than experienced staff members. Additionally, a few studies examined the relationship between staff age and gender and violent assaults. Whittington and Wykes (1994a) found that younger

staff were more likely to be assaulted which they posited could be explained by a lack of confidence (i.e., increased confidence comes with increased experience). As for gender, the majority of studies found that there was no relationship between gender and physical assault (Grainger & Whiteford, 1993; Hodgkinson et al., 1985; Lanza et al., 1991; Whittington & Wykes, 1994a).

Staff Support:

A significant decrease in patient-staff assaults has been reported after implementation of a voluntary program that offers support to staffs who are victims of patient assaults, called the Assaulted Staff Action Program (ASAP). The program involves debriefings and assessments with assaulted victims (Flannery et al., 1998). The program's administrators ascribe the decline in assaults to an increased awareness of violence policies, as well as increased confidence and morale resulting from the provided support. Furthermore, Peek-Asa et al. (2007) reports that many psychiatric hospitals are working to address workplace violence, primarily focusing on external or environmental issues, such as using rating scales to better predict assaults, training in de-escalation techniques, as well as self-defense, and utilizing physical restraints and alarm systems. Research suggests that training is linked to greater confidence in managing patient aggression (Beech & Leather, 2003, Hills, 2008; Martin & Daffern, 2006; Nau et al., 2009; Thackrey, 1987). However, Jacobowitz (2013) points out that it is unclear whether the acquired skills gained through training or the psychological factors related to the training experience have the greatest effect. Moreover, he highlights that the targeted staff for trainings may be the least likely to attend such sessions out of a desire to avoid recalling the traumatic circumstances and possibly re-experiencing the stress.

The collective research on situational variables or environmental factors unique to the inpatient setting underscores the limitations of applying research on threats to clinicians working in this setting to those working in an outpatient setting and the need to determine the distinct experiences of clinicians working in an outpatient and how the context of their situations may impact their experiences. Indeed, a strong argument could be made that working in an outpatient setting leaves a clinician much more vulnerable than inpatient settings that have institutionalized policies and procedures and dedicated staff to respond to violent incidents. In fact, many experts warn that certain precautions should be taken in private offices where clinicians are responsible for their own safety, such as installing an emergency call button or a spring-locked door that can be closed quickly on potentially dangerous visitors (Colling, 1996; Lion, Dubin, and Futrell, 1996). Likewise, experts assert that it is important that clinicians responsible for their own safety in private homes or offices refrain from seeing clients with a history of violence or are diagnosable as borderline with a lack of impulse control (Pynoos & Nader, 1988).

In addition to situational variables unique to inpatient settings, additional research has focused on interactional qualities between patients and staff that may be unique to inpatient settings (Daffern, 2010; Daffern, Howells, & Ogloff, 2007**;** Whittington & Richter, 2005). For example, research suggests that clinicians in inpatient settings often become conditioned to view patients as being potentially dangerous. Moreover, Foster, Bowers, and Nijman (2007) posited that fear of patient aggression in inpatient psychiatric settings may compel staff to manage patient aggression with seclusion and physical restraint. A qualitative study on the experience of clinicians that have been threatened by a client in an outpatient setting may shed light on interactional context of the incident that may be unique to that setting.

Chapter III: Methods

Qualitative study

This study employed in-depth, semi-structured qualitative interviews to gain an understanding of the experiences of licensed clinicians who have been threatened with physical harm or verbally threatened with assault by a client or a relative of a client, as well as the meaning they ascribed to those experiences. Conducting qualitative interviews with licensed clinicians who have experienced such threats provided details, context, and subtleties that defined their experiences. This qualitative study included rich descriptions about these clinicians' experiences that is not currently found in the existing quantitatively laden literature. Indeed, Creswell (2007) asserts that qualitative research provides a "complex, detailed understanding" of an issue.

Participants

Specific inclusion criteria for participants in the study is as follows: Licensed clinicians who hold a LMFT, LPC, LCSW, PsyD, PsychD, or licensed psychiatrists or licensed psychiatric nurses who have felt threatened physically or verbally by a client or someone associated with a client (i.e., a relative) with harm at some point in their careers while working in an outpatient setting. For the purposes of this study, the threat of harm encompassed physical violence (e.g., hitting, kicking, pushing, scratching, stabbing, shooting) and verbal threats of assault.

Participants in this study were selected through criterion, purposive and snowball sampling. Specifically, I recruited participants for the study by word of mouth, as well as through more aggressive recruitment techniques, such as posting notices on professional listservs. I recruited and interviewed participants until I reached "saturation." In other words, until no new themes seem to arise. I interviewed six licensed clinicians.

Procedures

After obtaining IRB approval, I worked to identify potential participants by word of mouth and through the use of relevant listserv postings. After identifying potential participants, I contacted individuals by phone to verify eligibility requirements and to set up the interview. Interviews were held at a mutually agreed upon location or were conducted via telephone. Prior to beginning each interview, I informed participants of the confidential and voluntary nature of the study and obtain participants' signatures indicating informed consent and agreement to participate in the study. Participants were also informed of the purpose of the study and of potentially sensitive and explicit interview questions. Interviews lasted between one hour and one-and-a-half hours. Participants were not offered any incentive or payment for participating in the study.

To ensure confidentiality of participants, all personal data (e.g., names, addresses, phone numbers) collected was safeguarded and kept secured in a password-protected file stored in a safe location in the researcher's home.

Instrument

Interviews were semi-structured, with questions focused on unearthing each therapist's experience of working with a client who threatened physical harm or communicated a verbal threat of assault against them. General interview questions include the following:

Demographical questions:

- What is your specialty area?
- How long have you been practicing?
- Generally describe the client population that you see.

Description of the threatening incident:

1. Describe the incident that made you feel threatened.
2. Describe the environment where the incident took place.
    - What type of practice was it? (e.g., individual practice, community health center, group practice)
    - What was the spatial environment like?
    - What security measures were in place?
    - What type of support was available?
3. Did you anticipate the threat? Why or why not?
4. Did you feel prepared to deal with the threat? Why or why not?
5. Was there a specific action or something that the client said that especially impacted you?
6. What other factors impacted the way you felt about the threatening incident?
    - Environmental factors or situational variables?
    - Degree of threat?
    - Form of threat?
    - Past traumatic experience?
    - Had you ever been a victim of verbal and/or physical acts of violence prior to being threatened by your client? How do you think that experience impacted your reaction to the threat of harm by your client?
    - Training experiences/lack of training?

Description of what happened following the event

1. Who did you discuss the threat with? How did you feel after discussing it?

2. What happened to your relationship with the client? Did you continue working with the client? If so, what interventions did you employ? How did the threatening incident change how you felt about your client?
3. How did the threat make you feel about your skills as therapist?

Short-term effects (e.g., immediately following the event, including the first several months following the incident):

10. Describe how you were effected by the threat of harm by your client in the short-term Biophysically? Emotionally? Cognitively? Socially? Professionally? Changes in your personal life? Changes in your practice?

1. Did it change the way you felt about your skills as a therapist?
2. Changes in the way you felt about clients other than the client that threatened you?
3. How did you feel about your safety in practicing prior to the incident? How did you feel about your safety after the incident?

Long-term consequences (e.g., more than 6 months following the incident):

14. How have your feelings about the threatening incident changed over time?
15. Describe how the effects of the threatening incident that you experienced changed over time, if there were any changes?
16. Changes in how you feel about the profession?

Coping:

17. What sort of strategies did you adopt to deal with the stress of being threatened/assaulted?
    - Psychological support? Participation in therapy?
    - Supervision?
    - Peer support?

- Self-care practices?

18. Which coping strategies seem to be related to reductions in psychological distress as a result of the incident?

Preventing future threats:

19. Do you think anything could have been done to prevent the threat before it occurred?
20. What steps have you taken to protect yourself from patient-initiated harm since the incident(s) when you felt threatened?
21. How do you think your training prepared you to deal with the threat of harm by your client?
22. How do you think your training didn't prepare you?
23. What would have helped you better deal with the attack?
24. What advice would you give to clinicians who are threatened by a client?

Design and Analysis

Every interview was audio-recorded with a digital recorder and a back-up recorder. The recordings were transcribed immediately and reviewed at least twice to ensure that there were no transcription errors. Data analysis followed the process outlined by Moustakas (1994) for phenomenological studies. Accordingly, data collection and analysis was closely connected. I also wrote memos and journaled to record any thoughts or questions that may have aided in identifying themes or assisted in making links to the phenomenological and bioecological theoretical frameworks guiding the study. I also worked to bracket my personal experience with a threatening client in order to maintain a fresh perspective toward this phenomenon and the study participants' experiences.

After immersing myself completely in the data, reading through the transcripts multiple times, I began open coding, and eventually combined open codes into categories or "parent

codes," working to identify themes. Once open coding for all transcripts was completed, I reviewed the transcripts again to ensure that I hadn't missed any codes, paying special attention to earlier interviews that later transcripts may have been able to inform. Moreover, I continually reviewed my memos and journals. The open coding process continued until all developed themes had been identified. I also identified quotes that illustrated the themes. The developed themes and corresponding significant supporting statements were used to write descriptions of the clinicians' experiences of being threatened with physical or verbal threat of harm by a client or a relative of a client (textural descriptions) and descriptions of the context that may have influenced how the participants experienced this phenomenon (structural descriptions).

To help ensure reliability and validity of my interpretations of the data, I worked with a mentor to cross-code data to help ensure codes weren't missed and to confirm the accuracy of codes identified. In addition, my analysis included thick descriptions of the clinicians' experiences and insights.

Finally, I worked to maintain theoretical sensitivity throughout the data collection and analysis process by regularly "stepping back" and reflecting about what I was seeing, thinking, and feeling while also preserving an appropriate level of skepticism.

CHAPTER IV: RESULTS

Description of Participants

Six participants were recruited. They represented a variety of mental health professions working in a wide range of outpatient settings (e.g, child welfare agency, community health services board, community health center, therapeutic school, partial hospitalization unit, private group practice). Additional background on the participants and the threats or attacks they experienced is included in the following table.

	License	Total Yrs. in Practice	#of Yrs. in Practice at time of threatening incident or attack	Description of threatening incident or attack	Setting	Profile of Threatener/ Attacker
Participant 1 (female)	LPC (2002)	~17	5 or 6 years	Client moved aggressively towards therapist	In client's home during home visit for community services board program	Severely mentally ill female suffering from delusions
Participant 2 (female)	LCSW	~12	Not reported	Therapist was pushed up against a wall	Level 5 therapeutic school	Male adolescent with autistic tendencies suffering from delusions
Participant 3 (male)	LCSW	~3	2	Verbally and physically attacked while in a moving vehicle	In a car (Therapist was transporting client as part of his responsibilities working at a state child welfare agency.)	Teenage male client with intellectual disability, moderate mental retardation and paranoid schizophrenia suffering from both visual and auditory command hallucinations

	License	Total Yrs. in Practice	#of Yrs. in Practice at time of threatening incident or attack	Description of threatening incident or attack	Setting	Profile of Threatener/ Attacker
Participant 4 (female)	LMFT	~34	8	Attacked and held at gunpoint.	Therapist's office in a group practice	Father of a child client
Participant 5 (female)	LCSW	~41	6	Hit with blunt force	Partial hospitalization unit of community mental health center	Female client with paranoid schizophrenia
Participant 6 (female)	Psy.D.	~10	9	Verbally threatened with harm — participant felt like she was in danger of being physically attacked or even killed	Therapist works in a group practice	Father of a child client

Table 1: Participant Demographics

While the threats or attacks experienced by the study participants occurred in a variety of settings (e.g., client's home, vehicle, therapeutic school, partial hospitalization unit, private group practice), the study findings suggest that some experiences of therapists who are threatened by a client or a relative of client in an outpatient setting may be unique to being in a non-residential setting. Following are the six common themes that emerged from the therapists' experiences of being threatened by a client or a relative of a client after thorough thematic analysis: surprised and unprepared, fear and panic, response, continued distress, recovery, and addressing future threats of harm and advice for other therapists:

Surprised and unprepared

All six therapists expressed surprise or shock at being threatened or attacked by a client or a relative of a client, even though many of them had maintained no illusions about the risk of a client attack. Indeed, all of the participants worked with high-risk, seriously mentally ill clients or on cases involving volatile issues such as sexual abuse, past histories of violence, and custody battles. Some other participants had also had past personal or professional experiences related to violence that led them to be on heightened alert for an attack. Still, there seemed to be an overwhelming sense of surprise and feeling of unpreparedness when the participants encountered an actual threat or attack from a client or a relative of a client. Participant 5 described her surprise at being attacked:

> At the moment it happened, I was shocked, I was stunned. And, I had a couple seconds where I was disconnected from my body and my brain. I was shocked out of my system. So, I had a little dissociative moment and then I came back in my body and I could feel immediately the pain...So, the immediate effects were just shock and disbelief and, 'What the hell!'

Participant 1 discussed her surprise even though she and the colleague she was with anticipated the potential for danger: "We knew enough to know that she was starting to slide...So, but, we still didn't think THAT was going to happen...It was still, like, a surprise. But, not a good surprise."

Participant 3, who had suffered previous attacks, distinguished each experience of being threatened or attacked:

> The only similarity is that you're under threat. I don't want to say that you become numb to it, but you kind of become more...you kind of...you kind of like get shell-

shocked...It was a different beast. So you're prepared sort of. Let me take that back, you are never prepared.

Additionally, participant 2, who shared that she "always assume(s) that there's going to be a threat," also still expressed a sense of surprise. She recalled, "I was just very numb right after the physical attack. Like, wow, that really happened."

Factors that led to feelings of being unprepared for the threat

In addition to the overarching theme of surprise and unpreparedness found in the study, participants also discussed factors that contributed to their feelings of being unprepared for the threat or attack. Two participants, for instance, didn't anticipate danger from the relative of a client. Another factor that led to feelings of surprise and unpreparedness was the tendency to minimize safety issues. Additionally, a couple of therapists expressed how their own sense of overconfidence in their skills contributed to their feelings of unpreparedness when they encountered actual attacks. In addition to describing personal factors that led to feelings of unpreparedness, many of the participants also discussed problems at an institutional or systemic level that they felt contributed to their feelings of being unprepared or ill-equipped to deal with the threatening situation they encountered, ranging from inadequate training to lack of support from agency supervisors.

Accordingly, the factors that contributed to feelings of being unprepared for the threat or attack fell into six categories: unanticipated threat from a relative of a client, minimizing safety concerns, false sense of confidence, lack of security protocols or measures, inadequate training, and inadequate support and resources.

Unanticipated threat from a relative of a client

Both participants 4 and 6 were threatened with harm or attacked by the father of child clients who they didn't initially view as dangerous — and in the case of participant 6, she didn't think that she was going to have any interaction with the father whatsoever. She said,

> No, I would say at that point it was similar to many cases that we get. A lot of mothers come in and say, 'Look, something's happened to my kid and I'm really scared. The abuser is going to be mad...' Whatever that is. So, there's nothing unusual about that presentation. The other thing is that the threat is this father, I was going to have no contact with...

Minimized safety concerns or naive about self-protection

A number of the participants discussed how being threatened made them realize how much they had either minimized safety concerns in the past or had been naive about protecting themselves. Participant 1 stated, "I think what it did was made me realize that I was lucky that nothing had happened to me before. That I was pretty naive about how I went about things."

Participant 2 talked about how her history of minimizing safety concerns may have played a role in the attack she experienced: "I laugh about it because it's like, 'What the hell was I thinking...that I was safe because I was helping these people!' And maybe that's my false sense of security with the day to day that I dealt with at <name of therapeutic school>."

Participant 4 acknowledged the propensity to minimize safety and provided commentary on why it happens. She stated "...you know the tendency is, that we all have, because of the work that we do, is to make it less than it is because, otherwise if you really sat there and just worried about it you could eventually talk yourself into being really worried."

False sense of confidence

A couple of participants discussed how they had developed a false sense of confidence in terms of working with violence or high-risk clients, which led them to feel unprepared for the attacks that they experienced. Participant 4 stated,

> And, to be honest with you, I think I had become unrealistically emboldened somehow about working with violence because I had worked in groups with parents who were violent, I had worked in domestic violence situations...But, I think I got myself over-inflated about my ability to handle any situation that came in front of me...So, I ended up feeling like I could set very firm limits with people and that I could protect myself. This was my mentality.

Participant 5 said this of her overconfidence:

> I think I was overly confident that I could handle the group by myself. I think that I had gotten used to the other clinician who was supposed to be with me. I got used to him not being interested and leaving...So, I just got overly confident that I could just handle everything all by myself. And I think that was an interference in my being properly prepared.

Lack of security protocols or measures

Relatedly, all six participants also conveyed a sense that safety concerns were minimized at a systemic level, as evidenced by the lack of safety measures in place prior to their attacks or threatening experiences, which led to feelings of being unprepared. Participant 1 speculated on why safety protocols weren't implemented at the community services board program where she worked: "I think it was just assumed that people knew what to do. But, we never went through a protocol of what we should do."

Participant 5 compared the security measures at the community mental health center where she was attacked by a client to her previous experience at a residential treatment hospital:

> When I was a trainee at <name of residential treatment hospital> every group I ran had two staff members from the ward — eyes on the ground, feet on the ground...Yeah, I always I had that backup. No matter where I was on <name of hospitals's> grounds. And I should have had that [at the community mental health center where she was attacked].

Similarly, participant 6 compared the lack of security measures in the private group practice where she works to a public agency with security measures:

> We are a private, we are a group practice. We don't have security. We don't even have a receptionist...It's one thing, if you work for the <name of an agency> or an agency where they have security measures...No group practice can financially do that...We had [at the public agency] a panic button, we had a receptionist, there's security codes, there's those kind of things.

Inadequate training

Almost all of the participants, five of the six, cited inadequate training in their graduate programs and/or through the agencies or institutions where they worked as a reason for why they felt unprepared to address the attacks they experienced. Participant 4 captured this common sentiment: "I would say that in retrospect, I was completely unprepared. I had never visualized this, I had never role played a situation like that, I had never really had this addressed anywhere in my training."

Participant 1 described her training this way: "Well, we were trained to work with people who were really sick, but we never had the actual discussion of, if you feel like you're being threatened, or they are threatening you, here's what you should do."

Another participant expressed that she favored the general self-defense technique she had learned in college versus the clinical training addressing threats or attacks that she received. She stated:

> And a lot of the things that they taught us in self-defense are things that they don't want us to do trained in restraint [restraint training that the participant took at the therapeutic school where she works]...Like we don't do that if they have a choke hold, we have to move to the weakest point. They don't want us to touch anybody unless we absolutely have to, which is counterintuitive to me...For getting out of holds, if kids grab your hair, if someone grabbed my hand or had me like in a choke hold, my first reaction would be to hit him in the gut, kick him, and go run...But, that's not the way they [the therapeutic school] want you to do it. I think it's a load of shit.

Inadequate support and resources

Three participants revealed that a lack of adequate resources contributed to not feeling fully equipped to deal with threatening incidents. Participant 2 summed up the situation at the therapeutic school where she worked this way:

> We needed to accept students in order to keep our numbers up...and look like we were doing something <chuckle>, I guess...It just wasn't a good model for him...And what I saw as a trend after that is that we started getting a lot more kids that were kind of pushing the limits of what our skill sets were to work with these kids.

Similarly, participant 3 described the lack of support he felt in addressing the threatening client situation he encountered while working for a state child welfare agency: "The state made no supports whatsoever for the staff, no supervision. It was child welfare and it is based on

numbers, getting the kids to their appointments, making sure that the job get's done. And that the kid is off the streets."

Participant 5 discussed this issue on a broad scale:

> I think what has changed over time is that I realize that the measures that we take to help people who are really in severe trouble are soooo inadequate. We are so unfunded. We are so ridiculously blind to how much effort it really takes to help someone who is in dire straights. And the six month program, it was great and it was structured in a wonderful way. We had hard working and good clinicians — it probably wasn't enough.

Fear and panic

"...I was genuinely, I was terrified of this child...Yes. And just like, also fear for other people and for himself," said participant 3 about the client who attacked him.

He was not alone in his fear — all six participants expressed fear and panic as a result of the threat of harm or attacks that they suffered from clients. Participant 1 revealed she was most scared of being physically hurt when she was threatened. She stated, "But, when she came after me, I mean, that was really scary. That's when I backed out and left...Yes, that's the scary moment here because she could hurt me."

Yet, fear and panic arose for participants regardless of whether the threat involved an actual physical act of aggression or was verbal in nature. Indeed, several participants shared that the verbal threats made by their assailants engendered just as much, if not more, fear than the threat of being physically hurt. For instance, participant 4, who was held at gunpoint, stated this about a verbal threat her attacker made towards her:

> At one point we were talking and he said, 'You don't know me, you don't know what I'm capable of.' That really hit me hard. I was like, 'You're right about that.' When he

said, ‘You don’t know what I’m capable of,’ it felt like much more of a threat...And just the reality that he was absolutely right. I had no idea of what he was capable of right now.

Participant 2, who suffered a physical attack, but who endures more frequent verbal threats of harm and verbal abuse, compared the two types of threats when she stated:

> The verbal impacts me more because it’s ongoing. With the physical attack, I knew there was an end to it. I didn’t have to say goodbye to this kid. There was an end and he was never coming back. And so I think that’s the biggest difference. These verbal attacks, threats, abuse, that you get daily, I think that wears you down.

Factors contributing to the fear and panic

As the participants discussed their fear and panic, factors contributing to their fears quickly emerged as a sub-theme. For instance, participants’ fear appeared to be influenced by characteristics known or learned about the threatener, such as past history of violence. Also, two environmental factors unique to working in an outpatient setting — being alone and locale — were consistently cited by participants as contributing to their fear and panic. And for two participants, the limitations of police or legal protection factored into their feelings of fear and panic. Thus, the factors contributing to the participants’ fear and panic fell into the following categories: characteristics of the threatener, environmental factors, and limitations of police or legal protection.

Characteristics of the threatener. Participant 6 talked of her increased fear because of what she learned about the threatening father of her child client:

> But, then the data that started to work with this child supported this [the father] is a dangerous individual. And then when the mother told me that the father was looking into

where I practiced and...had the means and the resources to find me. And, then I knew he had a house full of fire arms...And I knew enough about him that everything was at stake...So, knowing that my voice could cause somebody who is unstable to lose everything...That's why I feel like my fear was very real.

Environmental factors. The most oft-cited environmental factor that contributed to feelings of fear and panic was "being alone," which was mentioned by five of the six participants — all of whom worked in a variety of settings (e.g., private practice, child welfere agency, therapeutic school, community mental health center). For example, participant 2 stated, "The only thing that frightened me was that nobody is in this building. And maybe he's stronger than I think he is. But, he's not going to get me without a fight. <Laughs>"

Participant 4 explained that her fear was compounded by the fact that she was alone and it was late at night. She stated, "I was there alone and also it was late at night. And it was dark, there wasn't a lot of noises outside. Just everything got accentuated very quickly."

Locale was another environmental factor identified by a couple of participants as a factor that contributed to their feelings of fear and panic. As an example, participant 1 spoke of her uneasiness of being in her client's apartment during a home-visit. She said, "Um, I think the fact that we were in her apartment didn't make things any better because...It wasn't a bad neighborhood, but it wasn't the greatest neighborhood. And it was her space...So, I don't think that helped either."

Limitations of legal and police protection. Additionally, participants 4 and 6 spoke of their fears that flowed from limitations of legal and police protection. For participant 4, her fear about the limitations of legal and police protection manifested even after her attacker was incarcerated. She said, "And, you know, I didn't trust the system that well at that point either. I

thought, you know, yeah, they are saying but there could be technicalities or maybe he'll get off on probation."

Participant 6 talked more broadly of the limitations of police protection:

> Well, you're subject to the same, which I think the system is, it's not supportive of just citizens in this. You have some information where you feel like you're the target of someone, but unless you have an incident where the harm is imminent, there is nothing you can do. So, you're really largely unprotected until the harm has started. And psychologists, we're even less protected... And what you're told to do is wait until the harm gets closer.

Response

In addition to discussing their response to the threat of harm or attack by a client or a relative of a client in terms of immediate physiological effects ("flight, fight, or freeze"), most of the participants also discussed the uncertainty they felt in terms of determining the course of action they should take in responding to the threat or attack. They also described how the threatening incident or attack made them feel about their clinical skills and about their client. In fact, many of them felt positive about their clinical skills and empathy for their clients. However, several also described conflicting feelings over client care versus taking care of their own needs. Thus, the sub-themes that emerged as participants discussed their response to the threat of harm by a client or someone related to the client including the following: "fight, flight, or freeze," unsure about course of action, impact on feelings about clinical skills, empathy for the client, and conflicting feelings of client care versus therapist care.

"*Fight, flight, or freeze"*

Participant 1 summed up the fight, flight, or freeze theme that emerged when she stated, "I think in the short-term, you know that whole fight, flight, or freeze situation is happening. I know I was rattled."

Participant 3 described it this way: "But at the moment almost, you go into cave man mode. You can't think so much about the external environment right there, you're thinking about yourself."

Unsure about course of action

Five out of six of the participants expressed uncertainty or self-doubt about the course of action that they should take in response to the threat of harm by a client or someone related to the client. For example, participant 4 stated:

> I was just uncertain what to do. And, as I said, at one point I tried to get up. I also tried to sort of reason with him a little bit about...You know, 'You need to put the gun away. This isn't really helping your cause.' That kind of thing, but he pretty much kept the gun pointed the whole time...I remember that at some point, geez, I just went to a workshop dealing with violent people or dealing with threatening clients...So, I was sitting there thinking, what the hell did he <the workshop trainer> say?..It was so funny cause I was trying to really engage my brain and I couldn't, I couldn't think of what he said. And then I remember that at one point he had said to say to people, Don't say vague things to people, like 'give it to me,' meaning giving the gun. Because they could hear that as 'give it to me,' meaning shoot me. And you had to say, 'put the gun in my hand.' And I remember when I did talk to <the assailant> about the gun, at one point I put my hand out and I said, 'I think you need to put the gun in my hand.' And that was because of what I

> remembered about <name of trainer>. And, then, of course, he <the assailant> said, 'Oh, screw you, who do you think you're talking to,' something like that. And I remember sitting there thinking, 'What did <name of trainer> say to do if they say, 'no?' <laughs>... Because in his example, apparently, the guy just handed in the gun. So, it was kind of surreal, thinking and not thinking. I was trying to force my brain to help me and there were times when I could do a little bit of thinking and then I would just go blank again...

Related to other participants' sentiments about feeling unprepared because of a lack of adequate training, participant 4 also expressed that inadequate training played a role in her feelings of uncertainty about how to respond to the threat she encountered, even though she had recently attended a workshop on dealing with threatening clients. She explained that the workshop she had attended was conducted by a conflict negotiator who often consulted with federal officials on terrorist situations and she didn't feel his work was aligned closely enough to her situation.

A couple of participants also discussed an unsureness or a lack of confidence in their decision-making following the attacks they experienced. Participant 2 talked of her regret of not calling and confronting the hospital that she believed owed her a "duty to warn" call because the client who attacked her had made threatening comments about her while previously in the hospital's care:

> I think I did everything I could do in that situation, except maybe call the hospital. And like, thinking back on it, I should have felt more confident to call. I think I needed a little more assurance from my direct supervisor that it was ok to call...Yeah, and I'm like a new clinician. I never thought this would happen within the first few years. I always

thought that I would be the one making the call to "duty to warn." I wasn't thinking that somebody else would be calling ME as a duty to warn.

Participant 5 grappled with whether or not to press charges against the client who attacked her. Here, she spoke of her decision not to press charges as she had wanted, but to follow her supervisor's wish for her not to press charges:

> Well, I think over time, I've certainly come to terms with the fact that I made my choice about what to do with her — not pressing the charges based on what I now understand were other issues that I had with my supervisor, that I was trying to please him and appease him. [supervisor]

Impact on feelings about clinical skills

While many of the participants expressed feelings of uncertainty about the course of action they should take in response to the threat or attack by a client or a relative of a client, most of the participants, four of the six, shared that they felt confident in their clinical skills, even after the incident, as encapsulated by participant 1:

> Oh, it didn't affect that. It made me feel better that I think some people might not have handled it that way and made it worse. So, I felt like, well, she must feel close to me on some level because I became part of this kind of unpleasant delusion. I always feel like that shows you're connected to someone. But, I didn't make it worse. And we were fine after. My skills didn't really...they helped actually in this situation.

Similarly, participant 2 stated: "So, I felt relatively good. I did my checking. I felt like I still worked with the kids and the staff felt confident that I knew what to do. And that I stayed even. Sometimes, I think people leave after that."

By contrast, participant 5 divulged the self-doubt that she experienced as a result of the attack she experienced. She stated,

> I felt embarrassed. I felt like I had been singled out. I felt like I must have done something wrong to bring this on. What did I miss? What did I not pay attention to...lulled into that false security. I was being very harsh in my own judgment...I had to think long and hard and it went on for weeks and weeks. Every time I went into group, I would think, 'Am I going to be ok? Am I going to have whatever I need to assess what's going on here? I didn't assess correctly.' Yeah, so painful moments of doubt. And just wondering, 'Is this right? Is this right for me?'

Empathy for the client

Several of the participants discussed having empathy for their clients despite having been attacked or threatened by them. In fact, participant 3 discussed how empathy for his client and other clients in the child welfare system were a primary motivator for him to participate in this study:

> And for what the kids experience. What they have to deal with. They are coming from such a dark place where they are having to resort to that level and compelled by whatever is going on inside that they aren't getting the care that they need and the help they need. And, they're being let down. Really, that's the big motivating thing behind me to also shed some light onto that.

Conflicting feelings of client care versus therapist care

Half of the participants related struggles that they felt in terms of balancing client care versus safety or care for themselves. As an example, participant 5 discussed how she felt care for the client overrode concern for her safety when the client's previous threatening behavior wasn't

shared with her by her supervisor: “And so I felt like what was happening, was there was an attempt to protect her from her own demons, but not to protect me from her demons.”

Participant 3 chalked up the reason for the imbalance between care for the patient and therapists taking care of themselves this way: **“**And there’s also this sort of, I don’t know how to say it, but there’s these tough feelings because there’s this imbalance of the social worker being trained to advocate for others, but not for themselves.”

Participant 3 also discussed feeling constrained in protecting himself from harm from his client because of restrictive legal and professional rules and regulations. He stated, “...and you’re not allowed to defend yourself, according to <state> law. If marks come on the child and it is observed that the child says the worker is the one who made the marks, then the worker can be, basically, put on trial, kicked out of the job, lose your licenses, and, basically, even go to court for child abuse.”

For participant 6, professional and ethical obligations left her feeling stuck in a situation where she felt threatened by the father of a child client, but still needed to continue to work on the case. She stated, “But, now this I have to continue because it’s most ethical and I have to continue even if my fear grows..So, this is a child in constant fear. So, the ethical dilemma is, well, I can’t tell him, “I’m afraid too, so good luck, go see someone else.’”

Her feelings of professional obligation also came into play during the initial stages of the case when she revealed how patient and continuity of care impacted her decision to continue with the case even after learning of the father’s history of aggression:

> So, he’s got this history. Not towards me, but he has it. So, at that point, I could have said, I’m going to transfer this child. I’m not comfortable working with a family that puts me at harm. And that would have been my right. I just chose not to...I think for me, it

went through what would then happen. Where would I transfer him to? And I couldn't think of a place that would continue the work that I knew needed to be done with this little boy that was in his area. And that maybe was in a protected agency.

Continued distress

As participants discussed their experiences of being attacked or threatened, it became clear that many of them suffered ongoing distress from their encounters lasting months, or even a year, after the initial threat or attack. Accordingly, several sub-themes of continued distress emerged: ongoing fear, trauma/post-traumatic stress disorder/symptoms of post-traumatic stress disorder, anger towards their attacker, and contemplated or made significant professional changes.

Ongoing fear

Most of the participants talked about the ongoing fear that they experienced as a result of an attack or threat of harm by a client or a relative of a client that they suffered. Participant 3, who was attacked only about a year ago, had this to say about his ongoing fear:

> ...I have not found catharsis yet. I've been able to separate out from it and view it from a different lens to a degree, but I still have very visceral, in terms of feeling like scared, feeling like upset. At this point, I was not upset for me. I was upset for him. So, that was a really big growth step. But, also just upset for my wife, my family, and everything...That does not leave.

Participant 4 also talked about how her fear escalated and continued. She stated, "I think I felt so much afraid after the attack than while I was in that room...Later the reality just hit me like a ton of bricks."

Trauma/post-traumatic stress disorder (PTSD)/PTSD symptoms

Many of the participants referred to their experience of being attacked by a client or a relative of a client as traumatizing. Participant 4 captured common sentiments about suffering from PTSD:

> ...I think I had a lot of the signs and the symptoms of PTSD and they were for a good six months. That trip that we took was great and I felt like a lot of a relief while I was away...But, soon as I got back to work, I could feel it creeping up again. So, it lasted for quite awhile. Even talking about it now is uncomfortable.

Participant 4 also noted the vicarious trauma that her colleagues experienced when she shared her experience of being attacked by the father of a child client with her colleagues in the group practice where she worked. She stated, "I told them the whole situation and then it was really — talk about vicarious trauma...People were like really shook up and worried."

In terms of suffering from symptoms of PTSD, all of the study participants discussed experiencing increased vigilance or hyper-vigilance as a result of being the victim of an attack or threatened with harm by a client or a relative of a client. Participant 6 talked of her hyper-vigilance: "It's really, and if you talk to my family and friends too, there's now, and I think there's the threat of harm in just the work that we do, but now there's a hyper-vigilant state that becomes kind of the norm...So, I think it's more of a long-term impact."

Anger

Two of the participants professed the anger that they felt as a result of being attacked by a client. For example, participant 3 stated,

> Yeah, the fear, the anger, the intense dislike. You know, basically, all of the transference. Basically, getting to the point of bordering on getting to like hate of the agency, hate of the system, hate for the kid. I couldn't stand it. I couldn't separate it.

Participant 5 also had this to say:

> And I was angry at her [attacker]. I was very angry at her...I felt that it was just so unjust. All she had to do was say, 'I hate you.' Even though intellectually she knew she wasn't in touch with reality. So, on that level I knew not to blame her, but on the physical level I'm killing her. And, she's the implement of my pain.

Contemplated or made significant professional changes

Many of the participants, four of the six, discussed how their distressing threatening experiences served as a catalyst for contemplating or making "big picture" professional changes, whether it was finding a new job working with a less high-risk population, considering a location change, or contemplating leaving the therapeutic role altogether. Participant 1 described how the threat of harm she experienced by a client contributed to her decision to switch jobs:

> I think also that it might have had something to do with, because I only stayed at that job for about a year and half before I switched to a different position in the county...And I was a single mom and I felt like, 'Wow, this probably is not the safest. What if something could happen?' So I think that is probably what started me working with a less acute population.

Furthermore, participant 6 spoke of her thoughts of leaving the profession altogether:

> So, really doubting that I wanted to do this work at all. It's kind of like I would have these moments of, 'What am I doing?'...I didn't doubt what I needed to do for this case, but the question that came up was, 'But do I take any more?'...Or, do I just start saying,

> ‘I’m not going to do anything with these kinds of referrals.’...I love my work, but I don’t want to check the parking lot every night.

Recovery

In terms of recovering from an assault or threat by a client or a relative of a client, all of the participants discussed a variety of coping mechanisms, ranging from talking with peers or a supervisor to going fishing and painting. Several participants also discussed the relief that they felt because the relationship with the client who threatened or attacked them ended. Ultimately, all of the participants, except for one who was still in the midst of a threatening experience, discussed the incident as a growth experience in terms of what they learned about themselves, as well as how to deal with threatening or dangerous situations with a client or a relative of a client. Thus, the participants’ discussions of their recovery fell into three sub-themes: coping mechanisms, relief when the client relationship ended, and growth experience.

Coping mechanisms

Some of the most oft-cited coping mechanisms were talking about the threatening incident or assault with peers or a supervisor, seeing a therapist, and spending time with friends and family. However, participants discussed a wide variety of coping measures that they employed. All of the coping measures that the participants referenced are described below.

Talking with colleagues/supervisor. All six of the participants referenced employing this coping mechanism. Participant 6 spoke about how talking to peers helped her:

> Well, when I called and spoke with the police, I felt prepared emotionally because I work in a really good group practice who are emotionally supportive of each other. And <name> is a friend and I can just call her and say, ‘Look, I’m really bothered by this...’

A couple of participants also specified that what they found most helpful when they talked to peers or supervisors is the reassurance that they were not at fault. Participant 5 summed up this sentiment:

> And she [supervisor] reassured me that this girl was crazy. Whatever happened, the meds not right, whatever, we don't know. She lost touch with her reality and she was only in touch with her own anger and she needed a place to put it and I was convenient...Much better. She helped tremendously.

Participant 1 also stated: "I felt better after having talking about it because we staffed twice a day. So, we talked about it in group. People were kind about it. Nobody felt like it was my fault."

Participant 4, discussed how it helped her to talk to someone outside of the group practice where she was attacked:

> I think I called a good friend of mine who is a therapist and just talked about it with her. And that one felt a little bit better than talking to people at my office. I felt like with the people at my office because they work there they almost needed taking care of. With my other friend, there weren't so many questions related to why I had to stay late and stuff like that...It was much more of a processing with her.

By contrast, participant 2 talked about how important it is to talk to an immediate supervisor:

> I think they need to seek their supervisor immediately, and if their supervisor doesn't listen, to go to the next person up and to go to the next person up, and the next person up until somebody does choose to listen because I think that's where my downfall was...I think the supervisor should say: 'Are you ok? What do you think we need to do about

this? Do you have any ideas? Do you need me to talk to anybody? Do you feel safe now?‘ Actually, I would ask that question before I would ask any of the others I just said because I think the safety piece is huge and if a clinician doesn’t feel safe or doesn’t feel like someone has their back, it’s not going to be a good therapeutic relationship with any client that comes in that they see.

Therapy. Most of the participants, five of the six, sought therapy at some point following being attacked or threatened by a client or a client’s relative. Participant 5 captured the essence of this coping mechanism: “It was tough. It was tough at the time, it was very tough. But, therapy, working on myself, and time passing, really did help me tremendously.” She went on to recommend that other therapists who have been threatened or attacked by a client also get therapy. She advised, “Get some therapy. It’s trauma. It’s been induced. Do some hard work removing trauma from your system.”

Friends and family. Several participants mentioned seeking support from friends and family members as a coping mechanism. As an example, participant 2 said, “Well, I have a good social community. I have my parents, most of this time I was single or dating my husband. So, I feel like I could escape this and still be myself.”

Internal resources: Participant 5 spoke of relying on “internal” resources to cope with the situation. She explained, “I basically just powered through...I came back to work the next day. I reestablished my position in the clinicians’ group and the greater treatment group...I had internal conversations with myself a lot.”

Not being scared away. This coping mechanism was mentioned specifically by participant 3 who stated, “Just because, you know, I tell myself that I’m not scared away. Not that I have to prove that I’m tough or anything, but that being able to distinguish that this one

individual of this whole group, and that it's not such a boogie man closet. I don't need to make it out to live in fear."

Other coping mechanisms mentioned by participants included taking a vacation, eating, and personal activities such as fishing, being outdoors, and painting.

Relief when client relationship ended

For two participants, the relationship with the client was terminated immediately following the attack. Two others continued to work with the clients who threatened or attacked them until they consciously switched jobs. And two other participants continued to work with the child clients despite being threatened by the child's father. Of the participants who terminated the relationship with the client who threatened them immediately, or soon after the attack, all of them discussed how it was a relief when the client relationship ended, which helped with the recovery process. Participant 5 summed up her experience this way: "She was immediately let go...I did feel a sense of relief. I wasn't going to be subjected to having to go through this process with her because she was clearly out of touch with reality."

Growth experience

In contrast to all of the negative effects that the study participants described as a result of the attacks or threats of harm that they experienced by clients or relatives of clients, every participant, except the participant who was still experiencing a threat, expressed that they had gained some positives out of their experiences. Participant 5 captured this common theme when she stated:

> And I know that I'll never totally forget that incident, but I can see that it's something that just adds to the information in my universe, my personal universe and my professional universe about being aware, taking care, making sure, 'Don't be lulled into a

> false sense of security, be on top of your game.' And that's what I've done. I've been on top of my game...I know I've made it through and, if God forbid, something bad happens again, I'm pretty sure I'd make it through that too now because I'm feeling stronger and more resilient.

Participant 4 also shared how she has made a conscious effort to limit the impact that being threatened has had on her life:

> The thing that I'm really conscious of is not letting it take over as much as it did at one time and not feeling like, you know...You know the victim role to me, although that was definitely an episode of being victimized, being in the victim role, always by definition is that sense of helplessness and hopelessness and I try to do the opposite. I try to look at how am I not helpless about this and how can I feel hopeful.

Addressing future threats of harm and advice for other therapists

All six participants discussed a range of safety measures that they implemented themselves to feel less vulnerable and to prevent future threats of harm or attacks, from steering clear of working alone late at night with clients to being vigilant about working out to be physically strong enough to fend of an attack. Moreover, all of the study participants offered advice to other therapists on addressing threats of harm or attacks by a client or a relative of a client. Their advice was very much aligned with their own experiences and lessons learned in terms of efforts to prevent future attacks. Participants' prevention efforts and their advice for other therapists who could also face threatening client incidents fell into three categories: implementing safety measures, training and prevention, and clinical skills.

Implemented safety measures

A quote by participant 4 captured the essence of this sub-theme:

> We implemented so many changes afterwards...The one thing that I felt really strongly about afterwards was the late night hours that somebody had to be there. And we also made a security contract with the security guards around the building. And that had been posed to us before, but we didn't want to pay the extra money. A lot of things we took a look at differently after this [incident], than before.

While participant 4 specifically mentioned the move to avoid practicing alone late at night and employing a security guard , following are comments from participants that illustrate a variety of other safety measures they implemented.

Staying strong enough to fend of a physical attack. Participant 1 discussed the importance of staying physically strong: "So, I know that I'm physically very strong. Not that I want to engage in combat with someone, but I know that I would have the wherewithal to run to protect myself, so that's helped."

More particular about working with certain clients. This category was mentioned by several participants. Participant 3 provided his thoughts on this safety measure: "I know what I can and can't handle, you know professionally...but it's like I can't work with individuals who have psychiatric, psychotic disorders, or sexual offenders, like personality disorders, severe personality disorders, sociopathic. I can't, I've purposely focused my skills and my training away from that, so that I don't have to, you know...I really like having that personal, being able to have that personal advocacy."

Attentive about attire. Participant 2 discussed ways she's careful about her attire. She stated, "So, I won't wear skirts to school anymore. So, I'd make those kind of changes." She also talked about wearing shoes that she can run in so that it would be easier to escape if necessary.

Restricted social media use. Participant 2 described how she refrains from using social media with her clients: "I don't do any social media with any former student at all, which is unusual for my colleagues. They accept anybody and I'm like 'What are you doing? Crazy!'" Participant 6 also described taking her picture off of her group practice's website immediately following threats of harm by a child client's father. Here, she explained her reasoning for not wanting her picture online: "But, I do feel like we're a specialized place that has some really volatile situations. And if somebody gets mad and they show up on the website, and they want to confront someone, well they have a picture right there to go to them."

Avoidance of known upsetting triggers. Participant 4 revealed that the father of a child client who assaulted her became triggered when she shared some upsetting recommendations with him that she was planning to make in court. She described telling him in advance so that he wouldn't hear upsetting news for the first time in court, but she talked about changing that practice after being attacked: "In retrospect, it was not a good decision to give these recommendations face to face...I don't do that anymore. If [there is] something that I think is going to upset everybody, I submit the report to the court and let them deal with it there..."

Engaged other staff to be "lookouts." Participant 4 talked of a system her group practice used to help alert staff of possible danger: "I remember when we got a receptionist, we had this system that if any of us had a parent that we thought was erratic or volatile or threatening, then we would put a picture with the receptionist." Participant 6 didn't have a receptionist at her group practice, so she put a picture of the threatening father of a child client in the staff work room.

Connect with legal authorities. Participant 6 was not eligible for police protection because there wasn't an "imminent threat" but she still talked of staying connected with legal

authorities: “I contacted the detectives. I got a number of who I would call if anything happened.” She also talked of documenting, for legal reasons, every time the threatening father tried to contact her.

Cautious when coming and going from the office. Participant 6 stated: “I’m much more careful about where I park my car. Under a light. Just aware of my surroundings as I leave the building.” She also described that they don’t put names on the office doors at their group practice, so that if someone threatening came in, her office wouldn’t be readily apparent.

Strategic sitting position in the therapy room. Participant 2 and participant 5 both described that they have always been aware of where they sit in the therapy room — participant 2 sits near the door in order to be able to escape more easily and participant 5 sits away from the door and explained why: “Yes, and quite frankly, because I never sat at the doorway, that’s a given, I don’t even sit at the doorway in my own private office, as you can see. And sometimes, I will joke with people, ‘It’s so that you can run screaming from the room and you don’t have to get involved with me if you don’t like what’s happening.’”

Training and prevention

Several of the participants focused explicitly on advice for improving training. Participant 4 talked of needing specific training on working with dangerous individuals:

> So, that’s the kind of thing that we need to get better about in the training programs...I think very specific things about how they interact with those people and decreasing the level of contact that they have, making sure that if they are going to be with them and they are concerned, they have another colleague sitting with them.

Three of the participants mentioned the need for more realistic training, as captured by this statement by participant 3:

> And what I was looking for, not trying to be a downer, but I'm looking for something a little more realistic. I know you're trying to teach the skills, but at the same time, but what happens when that doesn't work? The videos are like, you know, not real life. Like it works there, but what happens when it doesn't?

Participants also offered recommendations on the importance of taking precautionary safety measures. As an example, participant 5 suggested being cautious with items that could be used as weapons: " I mean I could say, and I will say, that perhaps dangerous materials — knives, X-acto knives, the tongs of wood — other things, maybe they should have been kept under lock and key." Participant 5 also advised: "If you're in a group setting, just talk to your fellow clinicians and everybody should be on the same page. There should be some sort of procedures in place about how to deal with an immediate physical threat. Make sure that your group has that."

Clinical skills

Participants offered several thoughts on clinical skills for addressing threats of harm by a client, including paying attention to feelings of discomfort, the need to be observant and knowledgeable, maintaining a non-threatening stance, the importance of knowing how to de-escalate an escalated client — and when to "cut and run" if they don't de-escalate or if countertransference issues become overwhelming. Each of these categories is described below.

Paying attention to feelings of discomfort. Participant 4 provided thoughts on not working with clients who make the therapist feel uncomfortable:

> Not taking cases where you're feeling like you feel like less than comfortable. All those sorts of things...You know, if you're feeling threatened, it will decrease your ability to be

helpful to that person and there's lots of people who specialize in working with violent people who you should refer to.

Be observant and knowledgeable of your clients. Participant 3 described this advice when he stated: "Know your client. Know who you're working with." Later in his study interview, he added, "I guess I can't stress enough, know when to back out of the situation. Learn the triggers of your clients. Don't learn by provocation, but get as much information as you can. Talking to them, talking to family, talking to friends, talking to other people who are involved professionally with them. It can't help but to learn."

Therapeutic stance. Participant 3 described the therapeutic stance he advised: "At the end of the day, you know, the biggest thing is be polite, be mindful, be aware, be calm, be composed, even with everything."

De-escalate, but know when to "get out": While both participants 3 and 5 stressed the importance of knowing how to de-escalate a threatening situation, they also underscored that it's critical to know when to "get out." Participant 5 summed up this sentiment in the following statement: "Make sure that if you're alone, you have some understanding of how to defuse the situation and/or allow the person to leave. You can always call the police. But, do not attempt on your own to take care of a dangerous person...That's stupid. And it's not helpful for them either because they're freaked out."

Know when to "cut and run": Along the same lines of knowing when to "get out" of an escalating threatening situation, participant 3 specifically discussed also knowing when to end a client relationship: **"**That's when you know that you have to cut and run, when you can't separate your feelings."

Chapter V: Discussion

Prior to this study, little was known about the experiences of therapists who had been threatened or attacked in an outpatient setting by a client or a relative of a client. Much of the existing literature has focused on threats or attacks on therapists working in acute inpatient settings. While some of the results of this study are consistent with existing literature on acute inpatient settings, many of the study findings suggest that the experiences of therapists working in an outpatient setting who are threatened by a client or a relative of client differ in meaningful ways from those clinicians threatened in acute inpatient settings. Understanding the unique experiences of clinicians' who have been threatened in an outpatient setting by a client or a relative of a client opens the door to identifying effective ways to address this phenomenon in an outpatient setting in terms of prevention, responding to and coping with threatening situations, as well as training and education.

Six common themes emerged from the therapists' experiences of being threatened by a client or a relative of a client after thorough thematic analysis: surprised and unprepared, fear and panic, response, continued distress, recovery, and addressing future threats of harm and advice for other therapists.

Surprised or unprepared. The common theme of feeling surprised by or unprepared for an attack by a client or a relative of a client seems to represent a departure from the existing literature on client attacks on clinicians in acute-inpatient settings. In fact, research included in Needham's (2006) meta-analysis examining patient aggression towards psychiatric nurses, shock or surprise was reported as a "less common" reaction. Perhaps, the sense of surprise and unpreparedness is a "less common" reported effect in the literature in acute inpatient settings because there is increased awareness and anticipation of the potential risk for client threats given

the seriously mentally ill population typically found in that setting. This study's findings on feelings of surprise and unpreparedness also suggest an overall lack of awareness of the risk of threats from clients or their relatives in outpatient settings.

Fear and panic. All six participants expressed fear and panic as a result of the threat of harm or attacks that they suffered from clients or a relative of a client. This finding is consistent with Needham's (2006) meta-analysis, which found fear or anxiety to be the most reported biophysical impact of aggression on psychiatric nurses. However, in describing factors that contributed to their fear, many of the therapists mentioned environmental factors unique to outpatient settings that contributed to their fear. Being alone emerged as the most oft-cited environmental factor that contributed to feelings of fear and panic, which stands in direct contrast to acute inpatient hospitals where staff and security personnel are ever-present. Interestingly, this theme held up for therapists working in a variety of outpatient venues: during transport of a client, at a therapeutic school, a community mental health center, and group practices. These findings suggest that institutions or agencies should work to ensure that their staff aren't working by themselves in risky situations and those with individual practices may need to take extra safety precautions. Similarly, group practices may want to consider implementing specific safety protocols to protect their therapists who may work alone in the office at various times.

Response. A notable sub-theme that emerged under the response theme was participants' uncertainty about how they should respond to the threat of harm they encountered. Similar to the surprised and unprepared theme, this theme suggests a lack of awareness and inadequate education and training on how to address threats of harm in an outpatient setting. In fact, this study's findings regarding inadequate training are consistent with existing literature by Gately

and Stabb (2005). They reported that the clinical psychology students they surveyed found their training in managing potentially violent clients to be deficient, which contributed to a lack of confidence in working with this population.

Another notable finding under the response theme was that many of the participants, four of six, expressed confidence in their clinical skills following the attacks or threats that they suffered by a client. By contrast, feelings of guilt, self-blame, and shame were reported in a majority of the studies in Needham's (2006) meta-analysis on aggression towards psychiatric nurses. Perhaps the notable difference in confidence levels found in the present study with therapists working in an outpatient setting compared to the clinicians' working in an acute inpatient setting can be attributed to differences in responses from supervisors. Indeed, Huack (1993), purports that feelings of guilt and self-blame can be reinforced when superiors blame the victims for the assaults. In the present study, three of the four participants who reported feeling confident about their clinical skills also reported feeling reassured or supported by peers or supervisors.

Another possible theory on the difference between confidence levels between therapists in this study and Needham's meta-analysis is perhaps associated with the context of the attack. In the cases of three of the participants in the present study who reported feeling good about their clinical skills, the therapists were threatened or violently attacked and were either alone or in the threatening client's space without any security measures in place. The context of these attacks contrasts distinctly with acute inpatient hospital settings where there are typically safety protocols and security staff. Thus, perhaps when a therapist working with little or even no support in an outpatient setting survives such a terrifying experience, survival in and of itself becomes the definition of "success" clinically.

Ongoing distress. The results that emerged under this theme underscore the serious impact of being threatened by a client or relative of a client and are consistent with findings examining threats of harm in acute inpatient settings. For instance, a recent review of the literature by Jacobowitz (2013) indicated that the rate of PTSD in the psychiatric nursing population is between 9 and 10 percent. Still, it is reasonable to consider whether some symptoms of PTSD, like hyper-vigilance, may be even more heightened for therapists working in outpatient settings due to the fact that they may continue to work in settings without as many safety measures as those institutionalized at inpatient acute care hospitals, leaving them still feeling vulnerable to threats.

Recovery. In contrast to Needham's (2006) meta-analysis on aggression towards psychiatric nurses, which reported only negative effects in response to threatening incidents, this study found that all the participants, except for one who was still in the midst of a threatening experience, ultimately described being threatened attacked by a client or a relative of a client as a growth experience. Many of the present study's other findings may help explain this "positive" effect finding. For example, all of the participants described successfully employing a variety of coping mechanisms, including talking to peers and supervisors. Moreover, several of the participants expressed that they felt reassured by peers or supervisors that they weren't at fault for the threat or attack by the client. Thus, similar to the discussion related to the findings on confidence in clinical skills, perhaps the reassurance from supervisors contributed to participants' ability to ultimately view the threat or attack they encountered as a growth experience.

Addressing future threats of harm and advice for other therapists. Results from this section represent "lessons learned" and offer some initial insights into addressing threats of harm

unique to an outpatient setting. Many of the participants' thoughts were consistent with the best practices for maximizing safety put forth by Berg et al. (2000), including the following: be on alert for potentially violent situations and settings, be aware of potentially dangerous persons unknown to the clinician, create a protective environment, know how to de-escalate a violent situation, know when to get help, and be prepared to use self-defense.

Additionally, several of the participants' sentiments on carefully selecting clients echoes Brems and Johnson's (2009) advice on avoiding potentially dangerous situations altogether by selecting clients, when possible, that are appropriate for the clinician's experience and physical environment. Similarly, Guy et al. (1990) advised that clinicians should assess their capacity to competently provide care to threatening clients and to refer clients as needed, stressing that this process may be especially important for clinicians in a single-office setting.

In this study, all of the participants' stories begin at a point of feeling surprised and unprepared to deal with a threat or attack by a client or a relative of a client, along with scary feelings of fear and panic, but most end up at a point of recovery, and growth. (One participant was still in the midst of feeling threatened at the time she was interviewed for this study.) As they moved along their path of recovery, they gained understanding and awareness of how to address threats of harm by clients in an outpatient setting both on an individual level and on a broader systemic level. Additionally, the study findings shed light on factors unique to the experience of therapists who have been threatened by a client or a relative of a client in an outpatients setting.

Limitations

There are a number of limitations to this study. First, a larger group of participants is desirable. Because of challenges in recruiting, the author may have missed interviewing therapists who did not share the characteristics of those who volunteered. Thus, this sample may represent a unique subgroup of therapists that has different perspectives on being threatened. For instance, it is possible that the therapists who volunteered for this study were more "resilient" or somehow coped better than other therapists. Indeed, everyone except the therapist who was still in the midst of feeling threatened ultimately described their experiences as a "growth experience." Relatedly, perhaps the challenge in recruiting that the researcher encountered was a result of some therapists' not wanting to discuss their experiences because of feelings of guilt and shame connected to their experiences of being threatened by a client. As mentioned previously, feelings of guilt, self-blame, and shame were reported in a majority of the studies included in Needham's (2006) meta-analysis of aggression towards psychiatric nurses. Or, perhaps, therapists who were still experiencing severe PTSD as a result of being threatened or attacked weren't ready to share their stories and "relive" their experiences. Moreover, some therapists who were impacted more severely by an attack may have dropped out of the profession altogether. Indeed, this study did not actively work to recruit therapists who had left the field.

Additionally, only one male therapist volunteered for the study, limiting the opportunity to gain a greater perspective on whether there were distinctive differences between male and female therapists' experiences. Though, notedly, issues of gender didn't arise in the study.

Finally, only one participant suffered physical repercussions from being attacked — back pain that lasted several days and bruising that lasted a few weeks. Thus, this study was not able

to capture the experiences of therapists who were dealing with more severe physical injuries resulting from an attack.

Clinical and training implications

The themes identified in this study offer useful implications both clinically and in terms of education and training not only for therapists practicing in an outpatient setting, but for the agency or institutional supervisors and administrators with whom they work. For example, based on this study's findings that suggested a general lack of awareness of the risk of threats by a client or a relative of a client in an outpatient setting, it seems important to increase efforts to ensure that therapists in outpatient settings aren't caught off guard by potential client threats. Indeed, increasing awareness of the risk of this phenomenon should be paramount, as well as improved training on risk assessment and predictors of violence. This is particularly important given that many therapists working in outpatient settings see clients who are considered to be high-risk: clients experiencing psychotic symptoms (e.g., hallucinations, delusions) (Link, Andrews, and Cullen, 1992), clients with a past history of violence (Klassen & O'Connor, 1988), and users of drugs and alcohol (MacArthur Foundation, 2001), to name a just a few risk factors.

In addition to education and training on risk assessment and predictors of violence, the study findings make it clear that comprehensive education and training on a host of topics addressing threats of harm by clients or their relatives is warranted, such as prevention, ethical and legal considerations, recommended safety protocols and measures, de-escalation skills, identifying and addressing triggers, self-defense skills, and coping mechanisms. These trainings seem to become all the more salient given the findings in this study that indicate that there is not only a tendency to minimize safety concerns in an outpatient setting, but also a lack of certainty about the course of action that should be taken when a threat or attack is encountered.

Furthermore, it may be important to emphasize therapist self-care and professional and ethical rights related to safety in trainings due to this study's findings which revealed that therapists often feel a tension between focusing on their own care versus caring for potentially dangerous clients.

In addition to comprehensive training and education addressing the topics mentioned above, the findings of this study are an important reminder of the serious toll that threats of harm by clients or their relatives take on therapists. Therefore, it's not only important for supervisors to offer appropriate support, but therapists who see other therapists who have suffered from a threat or an attack should be prepared to treat the therapist for PTSD.

Future research

While a number of common themes emerged among participants who were threatened or attacked by a client or a relative of a client in a wide variety of non-residential mental health settings, there are likely rich insights that could be gained by exploring each varying outpatient setting independently. In other words, conducting separate and independent studies that focus specifically on each setting — community mental health clinics, therapeutic schools, home visits, and private practice.

Also, given the serious impact on therapists that threats of harm by clients or their relatives have found in this study and in other previous existing literature, preventing these incidents seems paramount. Perhaps a study exploring the experiences of therapists who have thwarted attacks in an outpatient setting would give more specific insights on what actually worked and didn't work in preventing harm from transpiring.

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APPENDICES

Appendix A: Recruitment flier

Have you ever been threatened with harm by a client? Participate in a study aimed at gaining a better understanding of this ever-present risk for mental health clinicians.

Virginia Tech

1872

Research Topic

I am conducting a study exploring the experience of mental health clinicians who have been threatened with harm by a client in an effort to gain insight into the impact of this phenomenon on clinicians. The study is part of a graduate student thesis and may be published at a future date.

What does my involvement within the study entail?

- You will be asked to complete an interview in which you reflect on your experience of being threatened with harm by a client you were treating in an outpatient setting.
- All interviews will be audio-recorded to allow the data to be reviewed, transcribed, and analyzed for the study.
- Confidentiality will be maintained throughout the study. The responses you provide regarding the research questions will not have any identifiable information linked to them

Where at?

Interviews will be held at a mutually agreed upon location, or may be conducted via telephone or Skype.

How do I know if I am eligible to participate?

To participate you need to be:

- A licensed marriage and family therapist/ social worker/counselor/psychiatrist/ psychologist/psychiatric nurse
- Have felt threatened physically or verbally with harm by a client at some point in your career while working in an outpatient setting.
  - For the purposes of this study, the threatened harm encompasses physical violence (e.g., hitting, kicking, pushing, scratching, stabbing, shooting) and verbal threats of assault.

If you would like more information or would like to participate, please contact:

Kit Wolverton
kitgwol9@vt.edu
202-557-0488

Appendix B: Consent form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY
Informed Consent for Participants
In Research Projects Involving Human Subjects

Title of Project: A Qualitative Study on Therapists' Experiences in Treating Outpatient Clients Who Threaten Harm to the Therapist

Investigator(s): **Angela Huebner, ahuebner@vt.edu**

Kit Gray Wolverton, kitgwol9@vt.edu

I. Purpose of this Research Project

The purpose of this study is to explore the experience of mental health clinicians who have been threatened with harm or danger by a client in an outpatient setting in an effort to gain insight into the impact of this phenomenon on clinicians. This study may shed light on how to address threatening incidents, including helping clinicians cope with such a stressful situation and informing related training practices. Finally, the author is simply hoping to add to the insufficient body of research on threats of harm to clinicians that currently exists.

II. Procedures

As a participant in this study:

- You agree to participate in an audio-recorded interview about the experience of being threatened with harm by a client you were treating in an outpatient setting.
- You can expect the interview to last roughly 60 to 90 minutes.
- You will have the information you provide combined with other study participants' responses into a report. The report will be about the participants' experiences of being threatened with harm by a client being treated in an outpatient setting.

III. Risks

- There is some risk of emotional distress or discomfort for study participants as you will be asked to recall a threatening situation with a client and/or continued difficulties arising from the client threat.
- Should you wish to process any difficult emotions through therapeutic treatment, any expenses accrued for seeking or receiving treatment will be your responsibility and not that of the research project, research team, or Virginia Tech.

IV. Benefits

- Retelling your experiences of being threatened by a client in an outpatient setting may prove to be empowering for you.
- You may provide insight that could help other therapists who experience a threat of harm by a client cope with this challenging situation.
- You may help inform training practices for future therapists.
- You will be helping add to the currently insufficient body of research on threats of harm by clients in an outpatient setting.

Virginia Tech Institutional Review Board Project No 14-1053
Approved October 24, 2014 to October 23, 2015

APPENDIX C: Semi-structured interview questions

Demographical questions:

- What is your specialty area?
- How long have you been practicing?
- Generally describe the client population that you see.

Description of the threatening incident:

1. Describe the incident that made you feel threatened.
2. Describe the environment where the incident took place.
    - What type of practice was it? (e.g., individual practice, community health center, group practice)
    - What was the spatial environment like?
    - What security measures were in place?
    - What type of support was available?
3. Did you anticipate the threat? Why or why not?
4. Did you feel prepared to deal with the threat? Why or why not?
5. Was there a specific action or something that the client said that especially impacted you?
6. What other factors impacted the way you felt about the threatening incident?
    - Environmental factors or situational variables?
    - Degree of threat?
    - Form of threat?
    - Past traumatic experience?
    - Had you ever been a victim of verbal and/or physical acts of violence prior to being threatened by your client? How do you think that experience impacted your reaction to the threat of harm by your client?
    - Training experiences/lack of training?

Description of what happened following the event

1. Who did you discuss the threat with? How did you feel after discussing it?
2. What happened to your relationship with the client? Did you continue working with the client? If so, what interventions did you employ? How did the threatening incident change how you felt about your client?
3. How did the threat make you feel about your skills as therapist?

Short-term effects (e.g., immediately following the event, including the first several months following the incident):

10. Describe how you were effected by the threat of harm by your client in the short-term Biophysically? Emotionally? Cognitively? Socially? Professionally? Changes in your personal life? Changes in your practice?

1. Did it change the way you felt about your skills as a therapist?
2. Changes in the way you felt about clients other than the client that threatened you?
3. How did you feel about your safety in practicing prior to the incident? How did you feel about your safety after the incident?

Long-term consequences (e.g., more than 6 months following the incident):

14. How have your feelings about the threatening incident changed over time?
15. Describe how the effects of the threatening incident that you experienced changed over time, if there were any changes?
16. Changes in how you feel about the profession?

Coping:

17. What sort of strategies did you adopt to deal with the stress of being threatened/assaulted?
    - Psychological support? Participation in therapy?

- Supervision?
- Peer support?
- Self-care practices?

18. Which coping strategies seem to be related to reductions in psychological distress as a result of the incident?

Preventing future threats:

19. Do you think anything could have been done to prevent the threat before it occurred?
20. What steps have you taken to protect yourself from patient-initiated harm since the incident(s) when you felt threatened?
21. How do you think your training prepared you to deal with the threat of harm by your client?
22. How do you think your training didn't prepare you?
23. What would have helped you better deal with the attack?
24. What advice would you give to clinicians who are threatened by a client?

Appendix D: IRB approval letter

VirginiaTech

Office of Research Compliance
Institutional Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website http://www.irb.vt.edu

MEMORANDUM

DATE: October 27, 2014

TO: Angela J Huebner, Katherine Gray Wolverton

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)

PROTOCOL TITLE: A Qualitative Study on Therapists’ Experiences in Treating Outpatient Clients Who Threaten Harm to the Therapist

IRB NUMBER: **14-1053**

Effective October 24, 2014, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 6,7**
Protocol Approval Date:	**October 24, 2014**
Protocol Expiration Date:	**October 23, 2015**
Continuing Review Due Date*:	**October 9, 2015**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.