Client-perpetrated violence against student clinicians: A survey of directors of clinical training at APA accredited clinical, counseling, and school psychology doctoral programs

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Abstract
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The purpose of this study was to survey Directors of Clinical Training (DCTs) from APA accredited clinical, counseling, and school psychology doctoral programs regarding their level of awareness about client-perpetrated violence against psychologists in mental health settings, their perceptions of students’ level of awareness concerning this issue, and to obtain information about training provided by their institutions in the areas of prevention, violence risk assessment, and management of potentially violent or violent clients prior to students’ first practicum placements. Results found that participants’ level of awareness and their perceptions of students’ level of awareness regarding client-perpetrated violence against psychologists in mental health settings were higher than expected. The majority of participants did not believe that client-perpetrated violence against practicing psychologists or student clinicians is a major area of concern at training institutions, but endorsed mandatory training at their institutions in prevention, violence risk assessment, and management of potentially violent/violent client prior to students’ first practicum placements. However, the majority participants indicated that students received less than four hours of training in these three areas combined, calling into question the breadth and quality of the training provided.

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Keywords: client violence, violence against clinicians, clinician training, clinician safety
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INTRODUCTION

The tragic and brutal death of New York psychologist Dr. Kathryn Faughey on February 12, 2008 shocked the mental health community in New York and stunned mental health professionals throughout the country (Kleespies, 2008). Dr. Faughey was stabbed to death at her Upper East Side private practice office in New York City, which she shared with psychiatrist Dr. Kent Shinbach. The assailant had a prior history of violence and suffered from a severe mental disorder. According to her assailant, his intended victim was Dr. Shinbach, whom he blamed for his involuntary commitment to a mental hospital 17 years prior. Attempting to help Dr. Faughey when he heard her screams, Dr. Shinbach sustained serious injuries and was robbed at knifepoint. Although fatal or severe attacks on clinicians are rare (Gately & Stabb, 2005; Reid, 2008) and most incidents of client-perpetrated violence against clinicians do not culminate in serious physical injury (Bernstein, 1981; Guy, Brown, & Poelstra, 1990; Kleespies, 2008; Tryon, 1986), the potential for threats of violence and actual assaults on therapists by their clients is an uncomfortable professional reality that constitutes an occupational hazard (Arthur, Brende, & Quiroz, 2003; Breakwell, 1989; Kleespies, 2008; Kleespies & Dettmer, 2000; Snow, 1984; Tryon, 1986; Woody, 1996). In actuality, many mental health professionals are unaware or ignore the reality that they are at risk for being victims of client-perpetrated violence, despite the fact that their risk for being assaulted is significant (Berg, Bell, & Tupin, 2000; Dubin & Ning, 2008).

For many mental health professionals, the notion that a client might attempt or actually succeed in harming them physically and/or emotionally can be unsettling at best. Confronting the topic of client-perpetrated violence against mental health clinicians is both an unpopular and an uncomfortable topic for those who have dedicated themselves to a career defined by the desire to
ease others’ emotional distress (Guy & Brady, 1998; Leadbetter, 1993; Star, 1984). In fact, most
mental health professionals neither expect, anticipate, nor consider the possibility that they could
potentially become the victims of client-perpetrated violence (Barbrack, 2000; Berg et al., 2000),
and many see it as just part of the job (Breakwell, 1989; MacDonald & Sirotich, 2001; Snow,
1994). Tryon (1986) argues that therapists are much more eager to discuss their successful cases,
rather than those in which the client made threats to harass or attack them. She stresses that fear
of being criticized by other professionals for such incidents not only hinders the
acknowledgment of the existence of client-perpetrated violence against clinicians, but also
prevents the formation of constructive dialogue among therapists concerning how to deal with
such incidents. Therefore, given these factors, it is not surprising that this important subject is
often ignored or minimized during the training years (Gately & Stabb, 2005; Guy & Brady,
1998; Kleespies, 2008; Madden, Lion, & Penna, 1976; Whitman, Armao, & Dent, 1976; Tishler,

Unfortunately, no clinician is immune from the potential of being harmed due to the
potential for client-perpetrated violence against him or her (Arthur et al., 2003; Brems &
Johnson, 2009; Guy & Brady, 1998; Snow, 1994). All clinicians, whether students in training or
highly experienced professionals, need to be prepared to face the likelihood that at some time in
their careers, they may be exposed to some form of physical and/or emotional threat from their
clients (Brems & Johnson, 2009). In addition, a clinician’s own denial can function as a potent
psychological defense, which can obscure his or her willingness to acknowledge the importance
of personal safety, the awareness of impending client violence, and minimize the resulting
emotional impact of an act of client-perpetrated violence in its aftermath (Berg et al., 2000; Guy
& Brady, 1998; Maier, 1996; Snow, 1994).
Client-perpetrated violence against mental health professionals can, and does, occur in all types of mental health settings, though it is more frequent in high-risk settings, such as inpatient psychiatric facilities or emergency rooms (Dubin & Ning, 2008; Flannery & Walker, 2008; Lion, 1995; Reid, 2008; Tardiff, 1995; Star, 1984). Guy and Brady (1998) point out that no specific demographic variable has been identified that reliably reduces a clinician’s chance for becoming a victim of client-perpetrated violence. Several researchers contend that client-perpetrated violence against mental health professionals is highly prevalent and is increasing (Breakwell 1989; Dubin & Ning, 2008; Kaplan & Wheeler, 1983; McAdams & Foster, 1999; Privitera, Weisman, Cerulli, Tu, & Groman, 2005). The literature suggests that many incidents of client-perpetrated violence against clinicians are presumed to be underreported or unreported for numerous reasons, making it difficult to obtain accurate data of the true prevalence of such incidents (Guy et al., 1990; Littlechild, 1995; Lion, Snyder, & Merrill, 1981; Needham, 2006; Star, 1984).

Client-perpetrated violence against the clinician, including fatal assaults, can occur in virtually any mental health setting including, but not limited to, private outpatient offices, hospitals, community mental health centers, academic centers, and also military installations (Dubin & Ning, 2008). It is not unusual to associate settings such as hospital emergency rooms and psychiatric units that provide acute care with an increased risk for client-perpetrated violence against clinicians. These clinical settings are usually open to the public, the patients are frequently unscreened, more patients present with drug abuse, and law enforcement bring these potentially violent patients into such settings on a daily basis (Dubin & Ning, 2008; Lion, 1995; Tardiff, 1995; Star, 1984). While it is true that these settings pose a greater risk for client-perpetrated violence against mental health clinicians, Reid (2008) points out that in such
facilities, the clinicians and staff often possess increased awareness regarding the potential for client violence, which can greatly attenuate their risks for becoming victims of client-perpetrated violence. In addition, staff who work on units with patients who are extremely violent and/or have histories of severe assault are often very knowledgeable regarding safety procedures. The physical settings of these units are also often specially designed to prevent client violence directed at staff (Reid, 2008). Referring to the current standard of care in inpatient psychiatric facilities, Reid goes on to state that inpatient psychiatric care has seen progress in successful implementation of “safe, effective, and humane physical management of on-unit agitation” (p. 179). Inpatient psychiatric staff, in both the United States and Canada, are now being routinely trained in proper decision-making and action. Nevertheless, the unfortunate fact remains that all mental health providers, regardless of employment setting, are at risk for becoming victims of client-perpetrated violence at some point in their careers (Arthur et al., 2003; Dubin & Ning, 2008; Guy et al., 1990; Guy & Brady, 1998; Reid, 2008; Snow, 1994; Tishler et al., 2000). Star (1984) states that traditionally, mental health professionals working in outpatient settings have felt less vulnerable to the potential for client-perpetrated attacks due to their assumptions that such clientele are generally less threatening. However, she notes that client populations are changing, with community-based agencies now treating increasingly larger numbers of severely mentally ill and potentially violent client populations.

The Department of Justice’s National Crime Victimization Survey for 1993-1999 (Durhart, 2001) focused on nonfatal violence in the workplace, specifically, rape and sexual assault, robbery, aggravated assault, and simple assault. Data from the survey show that the average annual rate of violent victimization in the workplace for all occupations was 12.6 per 1,000 workers. The rate for physicians was 16.2, and for nurses it was 21.9. In the mental health
occupations, the rate for professionals (psychiatrists/social workers) was 68.2, for custodial staff it was 69.0, and for other mental health workers the rate was 40.7.

In their publication, *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers* (U.S. Department of Labor Occupational Safety and Health Administration, 2004), the U.S. Department of Labor Occupational Safety and Health Administration (OSHA), cites Bureau of Labor Statistics data that show “48% of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services” (p. 3). The publication also underscores that job-related violence in these sectors is not a new phenomenon; workers in these sectors have been at significant risk for job-related violence for years, with risk of assaults being a serious safety hazard.

Incidents of violence perpetrated against workers in these sectors often goes underreported as well, due to what is speculated as a “persistent perception within the health care industry that assaults are just part of the job” (OSHA, 2004, p. 3). Several reasons employees may not report such incidents are put forth in the OSHA guidelines. First, the organization or institution may lack formal reporting policies. Second, employees may believe that reporting will be of no benefit, and third, employees may fear they will be perceived as being at fault due to negligence or inadequate job performance.

**LITERATURE REVIEW**

*Client-perpetrated violence against mental health clinicians*

Formal research regarding client-perpetrated violence against mental health professionals, particularly patient assaults, is a relatively new topic in this country (Star, 1984). She contends interest in the topic surfaced around 1960 and is based on information generated from two predominant sources: (a) research of patient violence in inpatient settings, and (b)
surveys generated from mental health professionals. Tryon (1986) points out that the existing literature regarding patient violence perpetrated against mental health clinicians began to materialize in the early 1970’s, and up until that time had been scarce, focusing primarily on patient-perpetrated violence toward psychiatrists. She cites Ekblom’s literature review (p. 357; also cited in Madden et al., 1976, p. 422), which examined acts of violence committed by psychiatric patients from 1889-1970 and spanned only 2 ½ pages.

Kalogerakis (1971) was the first researcher in the United States to collect statistical data on patient violence among psychiatric inpatients (Bernstein 1981; Tryon, 1986). He conducted an investigation of the frequency of patient assaults perpetrated against nursing staff at Bellevue Psychiatric Hospital from 1964-1969 by examining Accident and Incident reports collected by the hospital’s Nursing Service. At that juncture in time, only the nursing staff kept records of such incidents because of their frequent contact with patients. In addition, Kalogerakis compared the frequency of patient assaults recorded at Bellevue with those of five other State Hospitals in the New York City vicinity and one private psychiatric facility. Based on his research, he concluded that patient violence directed at staff was “most uncommon” (p. 374) and very few patients admitted to psychiatric hospitals actually pose a danger.

However, in their survey of 115 psychiatrists from the University of Maryland School of Medicine, Madden et al. (1976) found that 42% had been victims of patient assault. Survey participants came from a variety of clinical and administrative settings and held either full or part-time positions at the university. The researchers investigated whether psychiatrists either overtly or covertly provoked violent behavior in their patients. Participants in the survey were asked if they had been the victim of an assault by a patient or patients during the course of their career. The researchers examined specific aspects of the assault(s), the diagnostic characteristics
of assaultive patients, and the degree of therapeutic involvement between the participant and the assaultive patient.

Several of the psychiatrists in their survey reported multiple assaults by patients, especially those who worked in settings that carried a greater risk for being assaulted such as prisons, forensic units of state hospitals, and emergency rooms. While they found that high-risk settings may place psychiatrists at greater risk for assault, especially when they must make decisions to incarcerate, continue incarceration, or commit a patient, they also discovered that assaults against practitioners occurred in less high-risk settings as well, including private practice (Madden et al., 1976).

Whitman et al. (1976) surveyed 101 therapists in the Cincinnati, OH area. Fifty-two percent of the participants were psychiatrists, 27% were psychologists, and 21% were social workers. Of the 101 participants, 80 worked primarily in outpatient settings and 21 worked in inpatient settings. Forty-three percent of the therapists surveyed reported at least one incident in which he or she had felt personally threatened by a patient, and 24% of the participants reported an actual assault during the past year by one or more patients.

Bernstein (1981) surveyed 422 mental health professionals in order to examine the frequency of threatening and assaultive behavior toward clinicians. Survey data was collected from four groups of mental health professionals: (a) Psychiatrists, (b) psychologists, (c) clinical social workers, and (d) marriage, family, and child counselors (MFC’s). Of all the mental health disciplines surveyed, Bernstein’s data revealed that as a group, psychiatrists were the most threatened, assaulted, and fearful, with 61 out of 100 being threatened and 42 suffering actual assaults. Among the other disciplines, he found that 32 of 100 therapists will actually be threatened, and the chances of an assault were less than one in 10. Of the total respondents,
14.22% reported they had been assaulted on 116 occasions; 35.55% reported being threatened on 536 occasions, and 60.9% reported being physically afraid of clients. Bernstein found that 76% of the therapists had been threatened or assaulted by a client-perpetrator who had a prior history of violence. He also found that in terms of clinical setting, there was little relationship between inpatient and outpatient settings, with 33% of all incidents taking place in inpatient settings, 26% in outpatient settings, and 21% in private practice.

Hatti et al. (1982) sought to gain greater understanding of the interpersonal dynamics that possibly trigger patient assaults. They surveyed experienced clinical psychiatrists who had been victims of patient assault. They examined the factors that provoke patient assault, ways in which the clinician managed the assault, and patient-associated factors that may indicate he or she may be at higher risk for perpetrating violence against the clinician. Several participants reported they had been assaulted more than once. Forty-nine percent of the assaults occurred in inpatient settings and 51% occurred in outpatient settings. Participants were unable to identify any known precipitant to the assault(s) in 40% of the cases. The researchers also suggested that precipitants to patient assault might be the result of clinicians’ inattentiveness to “clues of impending violence” (p. 661). Twenty-four percent of the respondents identified conflict in therapy as a precipitant, 22% identified paranoid ideation of the patient as a precipitant, and 10% attributed the assaults to transference problems.

Tryon (1986) surveyed 300 psychologists who were independent practitioners. Ninety percent of those in her sample were Ph.D.s. Seventy-one percent of the sample rented their offices (53% urban and 32% suburban locations). The aim of her research was to expose the occurrence of assaultive behaviors and to determine the frequency of other negative behaviors directed at therapists by their clients. Of the 300 therapists who completed the survey, 81%
reported at least one occurrence of physical assault, verbal abuse, or another type of harassment in private practice, at another job, or both. Verbal abuse was reported most frequently. Physical attacks were twice as likely to occur at other jobs, such as hospitals and clinics, than in private practice. She found that the most common types of harassments perpetrated against clinicians by their clients were annoying phone calls, threats to sue, and threats to harm or kill, and occurred in over one third of the independent practices, which was almost twice as often as at other jobs. Interestingly, of the 158 participants who responded to questions regarding their most memorable attack, only 39% changed their process for selecting clients and 31% continued services with the client. Tryon found that therapists who had been victims of client-perpetrated violence were more likely to tell a colleague about the incident (74%), followed by a supervisor (39%), followed by “other” (29%), and lastly, the patient’s relatives (23%).

Guy et al. (1990) directed their research toward examining the incidence, severity, and clinical factors associated with client-perpetrated physical attacks directed toward psychologists. In their nationwide anonymous survey of 340 psychologists, 39% of the participants reported actual physical attacks by a client on one or more occasions. Almost half of their sample (49%) reported they had been verbally threatened with a physical attack. The total number of attacks per clinician ranged from one to 20 (M = 2.4). They found a significant relationship between type of clinical setting and the frequency of attack, with 40.5% of the attacks occurring in public psychiatric units or hospitals, 21.9% occurring in private psychiatric units or hospitals, 13.6% occurring in outpatient or counseling centers, 4.3% occurring in forensic settings, and 4.3% occurring in another type of setting. They also found that a clinician’s level of professional experience was correlated with the likelihood of being the victim of a client-perpetrated physical attack, with the greatest number of attacks occurring during the training years. Formal training
received by the participants in managing patient harassment and violence ranged from zero to 56 hours (M = 3.3 hours). Participants reported an average of zero to 3.5 hours of training prior to graduation from their training programs (M = one hour) to 0-56 hours post graduation (M = 2.3 hours). Participants who reported the greatest number of verbal threats also reported being physically attacked more often, with 52% who reported verbal threats also reporting a physical attack at some point. Twenty-nine percent of the participants who were attacked at least once sustained physical injuries, and of the entire sample, 9% suffered physical injuries. Ninety percent of the physical injuries incurred by the participants were reported as “minor”, 10% were reported as “moderately severe”, and 0% were reported as “serious” (Guy et al., 1990, p. 494).

In a much later study, Arthur et al. (2003) surveyed 1,131 mental health providers in the state of Georgia. Their research examined the frequency and type of assaults mental health professionals are most likely to experience, which types of clinical settings place clinicians at higher risk for becoming victims of client-perpetrated violence, and the effects of client-perpetrated violence against clinicians. Participants consisted of licensed practicing counselors (28%), licensed clinical social workers (24%), psychologists (23%), masters in social work (10%), psychiatrists (8%), and marriage and family therapists (6%). Over the course of their careers, participants identified working in outpatient settings (45%) and private practice settings (25%) most often.

Participants were given a list of 19 types of physical assaults and six types of psychological assaults. They were also asked to respond to a series of questions about the violent events they experienced and were given a survey to assess for the presence and severity of posttraumatic stress symptoms. Over the course of their careers, 61% percent of the participants endorsed being victims of client-perpetrated violence including physical and/or psychological
acts of violence. Twenty-nine percent of those participants reported that they had feared for their lives at some point when working with a client(s). The most prevalent violent physical acts perpetrated against clinicians were (from most to least): pushing, grabbing, kicking, holding, and property damage. Although perpetrated much less frequently against clinicians, the most stressful violent acts committed against clinicians by their clients (ranked in order by level of severity) were rape, attempted rape, knifing, and shooting. The most common incidents of psychological violence reported by participants were intimidation, harassing telephone calls, and verbal threats to harm the clinician.

Definitions of client-perpetrated violence

There is currently no operational definition of client violence that is applied consistently in the literature and definitions of client-perpetrated violence vary even among the scientific community (Needham, 2006). Needham points out in his review of the literature that the term “violence” is often used to describe a broad range of adverse client behaviors, which can have both physical and emotional consequences for the clinician-victim. In the literature, client-perpetrated violence toward the clinician is sometimes defined as a broad spectrum of client behaviors (e.g., physical violence, verbal abuse, verbal threats [implicit or explicit], harassment, property destruction, or stalking). Other proposed definitions of client-perpetrated violence against the clinicians may focus more narrowly on only one specific type of violence (e.g., physical assault). However, there is a great amount of subjectivity when it comes to determining what qualifies as an incident of patient violence (Guy & Brady, 1998; Leadbetter, 1993; Snow, 1994). In essence, one could say that whether an incident is violent is incumbent upon the perception(s) of the clinician.
Petit (2005) defines violence as behaviors used by individuals “that intentionally threaten or attempt to or actually inflict harm on others” (p. 702). Schultz (1997), in his study of 150 randomly selected social service workers from a variety of settings, including those serving child/adolescent, handicapped, and elderly populations, as well as health/mental health, corrections, and emergency services settings, defined three types of violence: (a) physical violence, (b) verbal threats, and (c) property damage. Privitera et al., (2005) classify violence as both “a subjective and objective experience” (p. 481). They define a threat as “an expression to inflict pain, injury, or other harm” (p. 481), which can be either verbal or non-verbal. They define assault as “physical contact that results in injury” (p. 481), which can be major or minor.

Flannery, Hanson, and Penk (1995) point out that most studies that have examined patient assaults against staff have restricted the definition of violence to incidents of “unwanted physical or sexual contact” (p. 451). For the purposes of their research, they expanded the definition to include “threats that included specific statements of intent to harm specific staff, and specific nonverbal, noninterpersonal acts meant to frighten specific staff” (p. 451). Arthur et al., (2003), in their survey of 1,131 licensed mental health providers in the state of Georgia, provided respondents with a list of 19 possible types of physical assaults as well as specifying six types of psychological assaults (intimidation, intent to harm helper, harassing telephone calls, intent to harm property, stalking, and intent to harm family) and allowed participants to include additional experiences of violence that they had experienced.

The words assertive and/or aggressive are sometimes used interchangeably in the literature with the term violence. Breakwell (1989) contends that terms such as “assertive”, “aggression”, and “violence” refer to three specific and distinct types of behavior; however, she argues that the distinction between these terms often gets confused. She defines violence as “acts
in which there is a deliberate attempt to inflict physical harm” (p. 8), whereas aggression is “typically defined by psychologists as any form of behaviour intended to harm or injure someone else against his or her wishes” (p. 8). This definition of aggression includes both psychological and physical injury. Assertiveness, according to Breakwell, entails “insisting on your rights or opinions; it involves claiming recognition from others that, within the constraints of the law, you have the right to decide how you will think, feel and act” (Breakwell, 1989, p. 8).

Maier (1996) discusses threatening client behavior in terms of verbal threats of violence, which he classifies into two categories: (a) threats that are part of an escalation process, and (b) threats that are part of a controlling process. The first type of threat is classified explicit (hot), wherein the client reflects intense emotion. He contends that such threats, if acted upon, will lead to imminent aggression. The second type of threat is implicit (cold) and is delivered by the client to the clinician in an unemotional manner with the intent of exercising control over the person threatened by causing the generation of a fantasy within the intended target. Though expressed differently, both types of threats are intended to intimidate.

Flannery and Walker (2008), in a 15-year retrospective study, defined four standard categories to examine patient assaults: (a) physical assaults, which include “unwanted contact with another person with intent to harm” (p. 178), (b) sexual assaults, consisting of unwanted sexual contacts including “rape, attempted rape, fondling, forced kissing, and exposing” (p. 178), (c) nonverbal intimidation, which they define as actions meant to threaten and/or frighten staff, and (d) verbal threats, which include threats against life and property, racial slurs, and other “derogatory comments” (p. 178). Therefore, from their perspective, client-perpetrated violence can incur both negative physical and emotional consequences for the clinician-victim and encompass a broad spectrum of aversive client behaviors. For the purposes of this study, the
definition of client-perpetrated violence will include any explicit or implicit behavior by a
client/patient that is intended to threaten or harm the physical and/or emotional integrity of the
clinician. Such behaviors include, but are not limited to actual or threatened physical attack,
sexual assault, verbal abuse, verbal threats, repeated harassment based on one’s gender, race, or
ethnicity, intimidation, stalking, property destruction, or threats to harm others associated with
the clinician (e.g., family, friends, pets, spouse, etc.). In addition, the terms client and patient will
be used interchangeably, as some mental health professions are more apt to use the term patient
as opposed to client.

The impact of client-perpetrated violence on the clinician

Client-perpetrated violence against the clinician may bring up uncomfortable, powerful,
and conflicting emotions for clinicians, such as concurrent anger and empathy (Bernstein, 1981).
Rodolfa, Kraft, & Reilley (1988) in their questionnaire survey of 135 respondents from VA
centers and 144 from counseling centers, found that all groups in each sample, including
professionals, interns, and practicum students, rated the most stressful perceived client behavior
as physical attack against the therapist. The clinician, especially one who has experienced a
severe assault, may have feelings of guilt regarding his or her professional competence and the
future welfare of the patient, professional difficulties, and the need to adapt to injuries or
disability resulting from the incident, as well as emotional and behavioral confusion following
such an incident (Reid, 2008). Because client-perpetrated violence against the clinician has the
potential to inflict not only physical but also emotional duress upon the practitioner, many
clinicians may choose to deny the seriousness of such events (Berg et al., 2000; Bernstein, 1981;
Dubin & Ning, 2008; Madden et al., 1976; Snow, 1994; Star, 1984) or assume personal
responsibility or self-blame for such occurrences (Bernstein, 1981; Hatti et al., 1982; Madden et
al., 1976; Guy, Brown, & Poelstra, 1991; Schwartz & Park, 1999; Snow, 1994). Some clinicians may believe they should have been able to prevent and/or predict an attack (Guy et al., 1991), despite research that shows the ability of clinical judgment alone to predict which clients will actually engage in violent behavior is unreliable (Bernstein, 1981; Otto, 2000; Reid, 2008; Swanson, 2008; Tishler et al., 2000).

Also perplexing is that client violence perpetrated against the clinician often defies rational explanation. Clinical experience is not sufficient alone to always guarantee an accurate assessment of such risk, and relying simply on one’s experience may even jeopardize one’s safety (Reid, 2008). Reid emphasizes that “being alert to the risk and mitigating it is the point” (Reid, 2008, p. 180). He warns clinicians against relying upon what often amounts to an overestimation of their safety and their ability to recognize danger.

In his work studying the effects of violence upon social workers in England and Wales, Littlechild (1995) asserted that clinicians who experience violence perpetrated against them suffer a decrease in their confidence in performing their work role effectively. In addition, they are prone to experience self-blame, guilt, and anger related to the incidents, which can lead to future concerns about their safety at work and even at home.

Violence-perpetrated against the clinician can create stressful work conditions, which may also lead to professional impairment. Sherman and Thelan (1998) surveyed 522 practicing psychologists and found working with difficult clients to be a frequent work factor associated with professional impairment. Their research found that stressful work factors are associated with decreased professional satisfaction. In addition, competence related to basic job functions was compromised.
Guy et al. (1991), in their survey of 340 psychologists practicing psychotherapy, sought to examine the emotional and physical health consequences of client-perpetrated physical attacks upon clinicians and their families. They found that few demographic and professional factors were related to the consequences experienced by psychologists who were physically attacked by their clients. They considered theoretical orientation, personal injury, attribution of personal responsibility, and the frequency of occurrence as factors that influenced the way psychologists handled the aftermath of such attacks. The most prevalent and negative consequence of a client-perpetrated attack on the clinician was an increase in the psychologist’s personal sense of vulnerability, which was reported by 40% of participants.

Psychologists who were physically injured by a client-perpetrated attack were most likely to experience an increased sense of vulnerability. Not surprisingly, psychologists who received the most serious physical injuries reported the greatest increases in their sense of personal vulnerability. Several other negative consequences were reported as well, including decreases in emotional well-being (16.2%), an increase in loved ones’ concern for their safety (16.2%), and decreases in feelings of competence (13.8%). In addition, 5.4% of those physically attacked by a client reported an increase in family/marital tensions, 3.8% reported a decrease in motivation, 3.1% reported a decrease in physical health, and 3.1% reported an increase in nightmares (Guy et al., 1991).

In terms of personal responsibility, 39% of the participants believed retrospectively that the attacks could have been predicted, 33% of the participants believed retrospectively that the attacks could have been prevented, and 31% of the participants believed retrospectively that the attacks could have been managed in a more “helpful manner” (p. 39). Psychologists in the sample who believed their attacks could have been predicted and prevented were more likely to
employ greater selectivity when accepting future patients. Guy et al. (1991) note that it is not unusual for practitioners to take on the burden of feeling responsible for anticipating and preventing “an array of self-destructive patient behaviors” (p. 41), which results in blaming oneself for the client’s violent behavior, as well as attributing it to “personal incompetence or error” (p. 41). In addition, many therapists feel guilt due to their belief that they should have been able to predict and/or prevent a client-perpetrated attack, which adds even more to their emotional distress following such an event. Despite these adverse emotional consequences, the researchers point out that three-quarters of the participants who experienced a client-perpetrated physical attack did not become more selective of the clients they were willing to treat.

Caldwell (1992) assessed the incidence of trauma and PTSD among staff at two mental health facilities. The two sites were selected based on their representation of a broad range of treatment settings. Survey questionnaires were distributed to staff at a private psychiatric facility with an outpatient community mental health center in a middle-class urban area (Site A) and at a state hospital, which was located in a lower middle-class inner-city area (Site B).

At Site A, 102 clinical staff and 76 nonclinical staff members received the questionnaire. At Site B, the questionnaire was distributed to 122 clinical staff members. The questionnaire asked the employee if any “traumatically stressful events” (p. 838) had occurred while he or she was on the job and how recently the event(s) had taken place. The questionnaire also included a checklist of PTSD symptoms adapted from DSM-III-R diagnostic criteria. The questionnaire served three purposes: (a) to determine how many staff had experienced traumatically stressful events while on the job, (b) to determine how many staff members developed PTSD or symptoms of PTSD because of experiencing a traumatically stressful event(s) at work, and (c) to gather data about the availability and effectiveness of posttraumatic debriefing sessions. Analysis
of the data revealed that 62% of the clinical staff who responded to the survey (n = 224) reported experiencing a serious threat to life or physical safety or witnessing serious injury or death while on the job. Twenty-eight percent reported their experiences had occurred within six months prior to completing the questionnaire, with 61% reporting symptoms of PTSD. Data analysis further indicated that of those reporting symptoms, 10% qualified for a DSM-III-R diagnosis of PTSD given the number of symptoms they reported. Furthermore, results of the survey indicated that only 15% of clinicians who reported experiencing traumatic incidents reported a later internal review of the incident.

Based on the data gathered from his survey, Caldwell asserts that more than one staff member in 20 suffers from PTSD at these two facilities. Clinical staff at both sites were more symptomatic than nonclinical staff. Despite the fact that traumatic events occurred frequently at the two sites, Caldwell found that the level of organizational support for traumatized staff at both sites was either “minimal or nonexistent” (p. 839).

Snow (1994) studied the psychological impact of clients’ aggressive behavior on clinicians who worked with children and youth. She hypothesized that child and youth workers commonly experience assault, that these workers experience psychological distress because of the assaults, and that assaulted workers are given few supports. Her sample consisted of 20 child and youth workers who were self-selected. Child and youth workers were defined in this study as those who had a minimum of four years post-graduate experience in order to ensure they were career child and youth workers, not just temporary workers in the field. She used a semi-structured interview to gather data on characteristics of the subjects, the frequency of assault and intimidation, the degree of psychological distress experienced by participants, and their
comments on the topic. She defined assault in her study as “any time you [sic] were physically harmed as a result of intentional client action” (p. 14).

Snow points out that many of the participants were “reluctant to describe patient action as assault” (p. 14). In general, participants were of the opinion that being kicked, bitten, and scratched by their clients was just part of the job. Ninety percent of the participants reported fear of imminent personal danger at work and 85% of the participants reported being fearful of the potential for physical danger at work. The majority of participants experienced PTSD symptoms. Following incidents of assault by clients, 60% of participants reported an increase in alcohol use and 25% reported an increase in drug use.

Similar to findings in previous studies (Bernstein, 1981; Guy et al., 1991; Hatti et al., 1982; Madden et al., 1976), many participants were prone to assuming self-blame and responsibility for the client-perpetrated violence against them. Seventy percent of the participants believed they were at fault for being injured and assaulted. Fifty-five percent of the participants reported those with whom they worked blamed them for being assaulted or injured including supervisors/employers (53.33%), those in other disciplines (20%), coworkers (20%) and the clients’ parents (6.67%).

Arthur et al. (2003) surveyed 1,131 mental health providers in the state of Georgia including clinical social workers, marriage and family therapists, professional counselors, psychologists, psychiatrists, and social workers. They examined the psychological effects of client-perpetrated violence against the participants. The majority of providers in their sample had 11-30 years of experience in their specific discipline. They developed a list of 21 possible psychological effects regarding participants’ postassault symptoms and behaviors. Of the 690 participants who reported suffering assaults or being victimized by a client, 39% reported feeling
violated, 37% reported anger, 21% reported irritability, 18% reported no effect, 12% reported an
impaired sense of professional identity, 12% reported emotional detachment, 11% reported loss
of esteem, and 9% reported they were unable to sleep. Of those participants who had been
assaulted, only 20% reported taking proactive measures to improve their training in safety
techniques.

The problem of clinician denial

Even the earliest literature on the topic of patient-clinician violence recognizes clinician
denial in the acknowledgement of patient-clinician violence (Madden et al., 1976). Denial of the
problem of client-perpetrated violence against the clinician continues to remain the predominant
reason for the paucity institutional concern that is fueled by ignoring the need for safety training
(Berg et al., 2000). Denial, by definition, operates as a psychological defense, allowing the
clinician to alleviate his or her anxiety by “disavowing thoughts, feelings, or external reality
factors that are consciously intolerable” (Dubin & Ning, 2008, p. 466). The clinician’s denial
may also stem from his or her resistance to acknowledge the dangers in clinical work, the
limitations of his or her professional competence, his or her lack of control over the patient’s
behavior(s), and the simple fact that one’s personal safety cannot be guaranteed (Berg et al.

Dubin and Ning (2008) assert that clinician denial plays a major part in the obstruction of
effectively managing and treating the violent client for several reasons. Denial can cause
clinicians to: (a) ignore critical clinical data and/or behavioral information that can indicate
impending patient violence, (b) project a “sense of false machismo, fearlessness, or confidence”
(p. 466) rather than recognizing their feelings of anxiety or fear, (c) fail to obtain data about a
patient’s prior history of violence, and (d) neglect to inquire about the patient’s present levels of
aggressive behavior(s). The dynamics of patient violence, especially physical attacks, are unique, and as pointed out previously, physical attacks, which involve serious injuries or result in the clinician’s death, are very rare. Lion (1995) asserts that denial is the “principal defense” (p. 43) utilized by clinicians to cope with violent threats. However, clinicians need not “assume a position of paranoia or fear” (Guy & Brady, 1998, p. 409). Because both emotional and physical distress can result from acts of client-perpetrated violence against clinicians, they should strive to cultivate a “healthy respect” (p. 409) for the possible occurrence of patient violence in their clinical work in order to generate “informed decisions” (p. 409) regarding effective prevention, management, and coping in response to patient-perpetrated physical aggression (Guy & Brady, 1998).

Gender and ethnicity in client-perpetrated violence

The variables of gender, race, and ethnicity and their relationship to client-perpetrated violence against mental health clinicians are mentioned infrequently, or entirely excluded in much of the literature on this topic. In the literature reviewed for this proposal, consideration of the variables of clinician race and ethnicity and their relationship to client-perpetrated violence was mentioned in only one article (Littlechild, 1995). In almost all of the studies that did consider gender in their analyses, this variable did not emerge as significant, regardless of the type of mental health setting or the clinician’s professional discipline (i.e., psychiatrist, psychologist, or social worker). Similar findings were reported in many of the studies concerning gender as a risk for client-perpetrated violence.

Dubin, Wilson, and Mercer (1988) examined the characteristics of psychiatrists who reported having been assaulted in outpatient settings. Questionnaires were mailed to 3800 psychiatrists. Eighty-one percent of the respondents were male and 19% were female. Their
statistical analyses yielded no significant relationship between the severity or type of assault with respect to the gender of the psychiatrist. Carmel and Hunter (1991) compared the characteristics of staff psychiatrists injured by patient-perpetrated violence to those who did not experience patient-perpetrated violence against them over a period of five years (January 1984 through December 1988) at Atascadero State Hospital in CA. Over the five-year study period, male staff psychiatrists were injured by patients at a rate of almost 50% more than their female counterparts (14.3% vs. 8.3%). However, based on their analyses, the researchers concluded the difference did not reach significance. A later study by Schwartz and Park (1999) surveyed psychiatry residents (N = 517) to examine the frequency and severity of patient-perpetrated assaults they experienced. More than half the respondents were male (52%). One hundred and eighty-six (36%) residents who responded reported 636 physical assaults perpetrated by their patients against them. Thirty-seven percent of male residents reported being assaulted compared to 34% of the female residents. In terms of threats, 379 residents reported 1,884 incidents. Again, more male residents experienced incidents (79%) in comparison to female residents (69%).

Jayaratne, Vinokur-Kaplan, Nagda, and Chess (1996) surveyed a random sample of 633 social workers drawn from a national sample in the United States. With respect to gender and vulnerability to client-perpetrated violence against the clinician, they hypothesized that the number of threats and incidents reported by male and female social workers would be similar. They note that data at the time of their study concerning gender differences and client-perpetrated violence had been “mixed” (p. 2), excluding incidents of sexual harassment, which plagues female social workers at a higher rate than male social workers. Although their study sample was predominantly female (79.1%), they found gender to be a “significant predictor of threats and assault” (p. 8) among male social workers; however, female social workers were
more likely to be subjected to sexual harassment. They point out that male social workers were also more likely to report being victims of client-perpetrated violence. Jayaratne et al. (1996) suggest that these differences may be reflective of “gender interaction biases prevalent in today’s society” (p. 12). Given this assumption, they point out that it may be perceived as more socially acceptable to threaten or hit a man than a woman; however, an assailant may view threatening or assaulting a woman sexually as more “damaging” (Jayaratne et al., 1996, p. 12).

Littlechild (1995) examined client-perpetrated violence against social workers and staff in England and Wales. He points out that the published literature on this topic is sparse in terms addressing specific agency policies that could be supportive of social work staff who have been victims of client-perpetrated violence. He also considers the issue of underreporting such incidents and discusses the variables of gender and race as they potentially relate to this trend. He states, “in terms of ethnic or racial background, there is no clear evidence on whether there are any significant differences in worker victimization” (p. 125). He cites a text by Norris (1990), which included a large number of social service agencies, noting that the issues of race and gender, especially race, was ignored by most agencies. He also cites a study by Smith (1988), noting that Black staff may be hesitant to report incidents of client-perpetrated violence against them for fear of possibly being judged more harshly than their White counterparts by managers, as well as by their White colleagues. Regarding gender, Littlechild asserts that women workers may also be hesitant to report client-perpetrated violence against them due to concerns that male managers, in particular, “will not look sympathetically either at the woman’s experience of the incident or at her attempt to stop the violence” (p. 126). Because the literature has not always been specific about the gender ratio of victimization, Littlechild asserts it is “impossible to draw any firm conclusions” (p. 126) in this area.
Whitman et al. (1976) surveyed 101 therapists including psychiatrists, psychologists, and social workers, which examined three threat categories: (a) How many patients posed a threat to others, (b) how many patients posed a threat to the therapist, and (c) how many patients actually assaulted the therapist. Respondents were asked to recall either an incident within the last year or from anytime during his or her professional career. Findings from their research yielded no significant differences based on gender in any of the three threat categories they analyzed.

In another study utilizing a multidisciplinary sample (N = 422), which consisted of psychiatrists, psychologists, clinical social workers, and marriage, family and child counselors (MFC’s), Bernstein (1981) explored the frequency of threatening and assaultive behaviors directed toward clinicians. One hundred and eighty-seven incidents were reported by respondents, which included both client-perpetrated threats and assaults toward the clinicians. Male respondents reported 77.2% of the incidents, while female respondents reported 22.8%. Bernstein concluded that female clinicians were threatened or assaulted “slightly less than would be expected” (p. 545). He found no gender differences between psychiatrists and psychologists in terms of threats and assaults and concluded from his research that female social workers and MFC’s are threatened or assaulted less than their male counterparts.

Harris (2001) also surveyed a multidisciplinary group of practitioners consisting of licensed marriage and family therapists, psychologists, and clinical social workers in the state of Alaska (N = 151). Twenty-eight percent of the respondents reported they had been physically attacked at least once by a client. Harris found that being male was predictive of a “higher mean number of attacks per provider” (p. 394).

Tryon (1986) surveyed 300 psychologists who were independent practitioners. Eighty-one percent of the respondents reported at least one occurrence of client-perpetrated physical
attack, verbal abuse, or other type of harassment as a private practitioner. In the survey, female clinicians were less likely to report being victims of verbal abuse from their clients; however, she found that they were equally as likely as male clinicians to be victims of physical attack and other types of harassment, both in the private practice setting as well as other work settings. In terms of being at risk for physical attack, Guy et al., (1990), in their nationwide survey of 340 psychologists, found that male clinicians were more likely to be physically attacked than female clinicians. However, they noted that the relationship of gender and the risk of physical attack did not reach significance in their study.

*Student clinicians at risk for client-perpetrated violence*

Training beginning clinicians to effectively respond to various forms of client-perpetrated violence, whether potential, imminent, or emergent, should be a necessary focus of training programs within the mental health professions. However, such training has and continues to be neglected in training programs, which places beginning clinicians in physical, as well as emotional peril (Gately & Stabb, 2005; Kleespies, 2008; Tryon, 1986; Whitman et al., 1976). Tishler et al. (2000) point out that many psychologists, as well as other staff often “have little or no training regarding the management of potentially violent clients” (p. 34). Often, graduate students are not informed about the potential for client-perpetrated violence against them and such behaviors are rarely discussed (Tryon, 1986), and aside from looking at years of clinical experience in relation to incidents of client-perpetrated violence against clinicians, the existing literature on the topic does not support any specific profile which can reliably identify therapists who are most likely to become victims of client-perpetrated violence (Guy & Brady, 1998). McAdams and Foster (1999) assert that the attention of training programs to the “reality of aggressive clients may vary within formal education programs as well as within the training
curriculum of different treatment programs” (p. 308). Such variability, they argue, may result in practitioners being inadequately informed regarding the nature of violent behavior, as well as being ill prepared to manage and cope with the potential effects of client-perpetrated violence.

Several studies have pointed out that clinicians in training are at greater risk for being victims of client-perpetrated violence. Madden et al. (1976) sought to examine what role, if any, psychiatrists might have in provoking violent behavior in their patients. They surveyed 115 psychiatrists affiliated with the University of Maryland School of Medicine. Their sample included participants who held positions in administrative, academic, inpatient, outpatient, forensic, and private practice settings. The researchers found that the majority of assaults directed at participants occurred during the early phase of their training. Whitman et al. (1976) found that while there was no difference between staff and students for personal assaults, staff psychologists and psychiatrists “reported a significantly smaller percent of patients who presented threats to others than student psychologists and psychiatrists” (p. 428).

Bernstein (1981) surveyed a group of 422 mental health professionals consisting of psychiatrists, psychologists, clinical social workers, and marriage, family and child counselors (MFC’s) in the San Diego area. Similar to the findings of Madden et al. (1976), Bernstein found that less-experienced therapists are threatened or assaulted with greater frequency than more experienced therapists. Bernstein’s research indicates that therapists with eleven or more years of experience were less likely to be assaulted than those with less than eleven years of experience by a ratio of 1:4, leading him to conclude that level of experience is “an important factor in the incidents of threats and assaults” (p. 546). Guy et al. (1990), in their nationwide survey of 340 psychologists, also found support for the finding that a psychologist’s level of professional experience is correlated to the likelihood of being attacked by a client. Of the attacks reported by
psychologists in their sample, 45.9% occurred during the participants’ training years. Participants reported they had received only 0 to 3.5 hours of training (M = 1 hour) prior to graduation in the management of violent and aggressive client behaviors. Guy et al. (1990) assert that because of lack of training in this critical area, and in some cases no training in this area, many psychologists are often unprepared to manage patient attacks.

Guy and Brady (1998) propose several hypotheses why the training years may pose the greatest risk for client-perpetrated violence against the clinician. First, they assert that student clinicians may be more apt to tolerate client behavior that experienced clinicians would deem unacceptable. For instance, student clinicians may impose fewer limits on clients and may tolerate more acting-out behaviors. This may have the potential to lead to client aggression, which may result in client-perpetrated violence against the student clinician. Second, student clinicians may lack the requisite expertise to “predict, anticipate, and control patient behavior” (p. 400). Third, they contend that it is more likely that student clinicians receive their training in inpatient settings where they are often assigned the most difficult and dangerous clients, which increases their risk for becoming a victim of client-perpetrated violence. They argue that it is reasonable to assume that clinicians with greater experience have found strategies to avoid clients who pose a greater risk for violence, which reduces their potential for being victimized. Indeed, the most frequently utilized safety precaution used by clinicians who have been prior victims of client-perpetrated violence, particularly physical attack, is refusal to accept clients who pose a high risk for potential violence (Tryon, 1986; Guy et al., 1991).

While enhanced client screening procedures may be a luxury for some practitioners and may reduce the risk of becoming a victim of client-perpetrated violence, not all clinicians are able to choose their clients. Brems and Johnson (2009) assert that even enhanced screening
procedures are no guarantee that clinicians will be able to avoid clients who will eventually threaten or harm them. They point out that therapists, who work in some clinical settings, may have no choice in the clients they see because intake staff or receptionists assign clients. This is certainly truer for student clinicians, who may be reluctant to voice their concerns about seeing a potentially violent client due to fear of negative repercussions from supervisors at their practica sites and/or their home training programs. In addition, student clinicians have the added pressure of the need to accumulate direct client contact hours to qualify for desired internship slots, which may make them less likely to turn away a client, even if they pose a threat to their physical and emotional integrity.

_Inadequate training in programs_

It could be argued that the issue of training students to manage potentially violent client behavior is not of concern due to the presumed infrequency of such incidents. Because serious physical injuries or fatalities resulting from client perpetrated-clinician violence are rare, the provision of formal training to assess and manage the potentially violent client may be uncommon (Gately & Stabb, 2005). However, clinician safety should be considered a training issue of significance, which has been inadequately broached in training clinicians (Fink, 1995). However, as discussed previously, there is a wide range of aversive client behaviors that can be considered violent, or at the very least, stressful for clinicians, which have the propensity to negatively affect a beginning student clinician, as well as more experienced student clinicians. Gately and Stabb (2005) in their exploratory study that surveyed 202 clinical and counseling psychology students found that 10% of the participants had been actual victims of client violence, 26% reported they had witnessed client violence, and 26% reported being verbally assaulted by a client. Imbuing student clinicians, especially those in the first year of their clinical
training, with awareness of this issue and arming them with the appropriate clinical skills to both assess and manage potentially violent as well as violent clients, would appear to be a logical and integral component of basic clinical training. Training is a critical time for students as they are in the process of developing their professional identity, which may be especially vulnerable during the beginning years of training. Tishler et al. (2000) pointed out that mental health professionals rarely receive verbal or written materials pertaining to personal safety.

The fact remains that findings from the literature (Gately & Stabb, 2005; Guy & Brady, 1998; Guy et al., 1990; McAdams & Foster, 1999; Madden et. al, 1976; Tardiff, 1995; Tishler et al., 2000; Tryon, 1986) indicate that inadequate or lack of training in the management of potentially violent clients may contribute to placing student clinicians at greater risk for becoming victims of client-perpetrated violence. The finding that the potential for becoming a victim of client-perpetrated violence appears to attenuate as one accumulates years of professional experience does not excuse training programs from adequately preparing their students, at a minimum, to be aware of the risks when working with clients, especially those who are most likely to inflict violent behavior on the clinician.

Kleespies (2008) recently stated, “the profession of psychology appears to have done little to systematically educate practitioners in evaluating and managing the potentially violent patient” (p. 9). Guy et al. (1990) found that psychologists in their study reported a mean of one hour of clinical training on the management of patient violence during their predoctoral training years. Breakwell (1989) points out that it is confounding that those in the mental health professions are bound to encounter the expression of strong emotions from their clients, but few are trained directly to manage powerful emotions, with many practitioners being forced to develop an understanding of “the extremes of emotional expression through on-the-job training”
Gately and Stabb (2005) also refer to this as the “trial by fire training method” (p. 684). They argue that while this training model is commonly practiced and accepted in training programs, it is an unsuitable choice when the issue is client violence. Although their study found a “positive relationship between students’ exposure to client violence and higher levels of confidence” (p. 684), they emphasize that exposing students to client violence should not be the training tool of choice for increasing students’ confidence in this area. When the issue is client violence, they argue that “clear and specific training” (p. 684) is crucial.

Corder and Whiteside (1995) interviewed 60 psychologists primarily by phone using a structured questionnaire. Only 23% of their sample reported receiving any training at all in safety, and 95% of the participants interviewed felt that “their training was inadequate for dealing with their present concerns or interest in professional safety issues” (p. 66). In addition, prevention training, which covers such issues as agency safety policies and plans, personal safety, and workplace safety, is often minimized by supervisors (Gately & Stabb, 2005). While not all violence is preventable, proper instruction, precaution, and training can successfully attenuate the risk of client-perpetrated violence against the clinician (Tishler et al., 2000) and educational and training programs should focus on both global and personal security concerns (Tishler et al., 2000).

Client-perpetrated violence against clinicians can be stressful even for the most experienced professionals, but for the beginning student clinician, the aftereffects may be even more detrimental. Student clinicians are frequently more vulnerable to self-doubt and self-criticism and may have greater difficulties coping with feelings of failure and incompetence that can ensue after exposure to client violence (Guy and Brady, 1998). Student clinicians may view their inability to effectively manage or prevent client violence as a personal failure that may lead
to debilitating self-doubt (McAdams & Foster, 1999). In addition, student clinicians also face an array of psychosocial stressors as they struggle to maintain equilibrium in the academic, clinical, and interpersonal areas of their lives. Many student clinicians are dealing with the burdens of financial hardship, academic pressures, and perhaps, because of relocating geographically to attend a specific training program, may have lost physical access to their prior support networks (Guy & Brady, 1998).

The importance of training

Given the potentially devastating emotional and physical effects that client-perpetrated violence can have upon the clinician, especially the student clinician, it seems reasonable that all training programs should provide their students with mandatory education about the potential for client-perpetrated violence against clinicians, the types of client-perpetrated violence they are likely to encounter, and the basic skills and knowledge to work as competently as possible in such circumstances. Educational training deficits regarding the assessment and management of potentially violent clients for psychologists, as well as other mental health professionals can not only lead to deleterious physical and emotional outcomes for the clinician, but also the client. Inadequate training in these areas not only places the clinician at risk, but also deprives violence-prone clients of appropriate treatment interventions and can diminish the efficacy of treatment outcomes for the client (Tishler et al., 2000). Indeed, the negative emotional impact of client-perpetrated violence toward the clinician can introduce anxiety and attributions, which may affect both the quality of care provided and increase the potential for future aversive incidents (Cottle, Kuipers, Murphy, & Oakes, 1995). Major areas of focus should include training in prevention strategies, skills for managing the violent client, and appropriate assessment
techniques to better identify clients who may be more likely to engage in aggressive behavior toward the clinician.

When appropriate training is combined with experience, the clinician has a greater capacity to comprehend the client’s inner conflicts and feelings that arouse threat, which allows the clinician to maintain objectivity, protect the client’s self-esteem, and thereby reduce the likelihood of violent acting-out behavior (Guy & Brady, 1998). Rodolfa et al., (1988) note that therapists-in-training more “readily assume responsibility for ‘fixing the client’ and as expected, experience cognitions of incompetency and inadequacy when their treatment interventions do not succeed.” (p. 47). When clinicians have insight into their own feelings and reactions towards threatening clients, it can greatly enhance their ability to intervene with violent clients in a more effective manner (Hatti et al., 1982). In addition, possessing solid clinical skills can allow one to better recognize the cues that can signal impending violence and can allow the clinician to intervene appropriately (Tryon, 1986), thereby reducing the risk of client-perpetrated violence against the clinician (Arthur et al., 2003).

Kleespies and Dettmer (2000) assert that failure of training programs to instill the requisite instruction and experience to equip student clinicians to anticipate and cope with “life-threatening patient behavior” (p. 1361), will ultimately leave them unprepared to manage the impact of such behavior, should it transpire, later in their careers. They argue that basic education in the management of behavioral emergencies such as client-perpetrated violence against the clinician can assist clinicians in training to “make adjustments in their assumptions and beliefs about the occurrence of behavioral emergencies and their ability to prevent them” (p. 1363). Mental health providers in training need to be informed of the potential for client-
perpetrated violence directed against them and educated about the need for effective coping skills in order to reduce the risk of such incidents (Arthur et al., 2003).

**Recommended areas of training for clinicians**

Throughout the literature on client-perpetrated violence against mental health clinicians, three specific training areas consistently emerge as critical for providing clinicians with the crucial knowledge and effective clinical skills to prepare them for the possibility of client-perpetrated violence against them. First, and perhaps the most basic training area, is prevention. Knowledge of basic prevention strategies can, at most, avert the risk of client-perpetrated violence against the clinician altogether, or at least, greatly minimize the clinician’s risk for becoming a victim of client-perpetrated violence. Second, clinicians can attenuate their risks for becoming victims of client-perpetrated violence by attaining knowledge of relevant violence risk assessment skills combined with appropriate and thorough application. Third, recommendations are made for managing the potentially violent or violent client competently with specific clinical skills and interventions.

While these three training areas can be viewed as discrete entities, overlap often exists. For instance, knowledge and application of violence risk assessment skills and specific interventions for the management of the potentially violent client or violent client could be considered prevention strategies as well. However, application of knowledge and skills in violence risk assessment and management of the potentially violent or violent client appear to be incumbent on a firm foundational knowledge of basic prevention strategies. Likewise, when clinicians are capable of obtaining an in-depth, thorough, and accurate violence risk assessment of clients, they will be in a more advantageous position to determine which clinical management
skills and specific interventions may be most effective in deterring an episode of client-perpetrated violence, and in turn, which interventions will be most therapeutic for the client.

As discussed previously and according to the literature, less experienced clinicians, especially those in training are often the most likely victims of client-perpetrated violence (Bernstein, 1981; Guy & Brady, 1998; Guy et al., 1990; Madden et al., 1976; Tardiff, 1995; Tishler et al., 2000; Whitman et al., 1976). Given this unsettling data, it is unimaginable that educators of future psychologists and other mental health professionals would neglect their responsibility to educate and prepare students for the possibility of client-perpetrated violence against them. Hopefully, educators will continue to gain awareness of both the physical and psychological perils of client-perpetrated violence against psychologists, especially student clinicians, and proactively integrate basic components of recommended safety training into their curricula to help students prepare for the potential of client-perpetrated violence against them as students, and as future practicing psychologists with confidence and competence. The following discussion highlights the most frequently mentioned and recommended components of training for mental health clinicians found in the literature in the areas of prevention, violence risk assessment, and management of the potentially violent or violent client.

**Prevention**

At best, student clinicians can eliminate the risk and/or occurrence of client-perpetrated violence against them, or at least, mitigate such risk, with knowledge and application of basic prevention strategies. Star (1984) asserts that prevention is “the first line of defense” (p. 227) against client-perpetrated violence against the clinician. Similarly, Dubin and Ning (2008) assert that prevention is the “most effective intervention” (p. 64) when clinicians are confronted with potentially violent or violent patients. The most basic, yet most critical prevention strategy is
stimulating awareness of the problem. Educators have a responsibility to inform students without alarming them, early in their training, of the realities, risks, and types of client-perpetrated violence against clinicians that are prevalent in all types of mental health settings. This responsibility also extends to clinical supervisors who oversee student training experiences. It is up to mental health leadership to “place the issue of personal safety in the consciousness of clinicians” (Berg et al. 2000, p. 11). Guy and Brady (1998) argue that at the very least, supervisors must “be cognizant of the possibility of patient attack” (p. 411) so they can “anticipate” students’ limitations in areas of assessing, indentifying, and managing patients who present with a high likelihood of being physically violent. Thus, if educators and clinical supervisors of student trainees do not possess awareness of the risks regarding client-perpetrated violence against mental health clinicians, how can students be expected to have such awareness, pertinent knowledge, and realistic expectations of their abilities to effectively manage client-perpetrated violence against them in clinical settings? Clinicians should cultivate a heightened awareness concerning the risk of client-perpetrated violence against them, which ultimately enables them to function more effectively in their ability to assess the potential for violence prior to its occurrence (Guy and Brady, 1998). In sum, clinician safety is incumbent upon awareness of the potential for violence in clinical situations and settings (Berg et al., 2000).

Student clinicians should also be taught to value their personal safety when working with clients in clinical environments, regardless of the type of setting, since it has been established in the literature that client-perpetrated violence against clinicians can occur in any type of mental health setting (Arthur et al., 2003; Bernstein, 1981; Dubin & Ning, 2008; Flannery & Walker, 2008; Guy & Brady, 1998; Guy et al., 1990; Reid, 2008; Star, 1984; Tishler et al., 2000). Brems and Johnson (2009) point out that all therapists need to be prepared for the “inevitability” during
their careers that they will be subjected to “some degree of physical or emotional threat from their clients” (p. 21). In addition, they assert that the “most basic level of self-care is self-protection from clients’ threats of harm to the clinician” (p. 216). Indeed, such self-protection is guaranteed by the American Psychological Association’s “Ethical Principles of Psychologists and Code of Conduct” (APA, 2002). Standard 10.10(b) states, “Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.”

Clinicians should not only be encouraged to acknowledge the importance of their personal safety, but also to examine their personal attitudes about violence (Berg et al., 2000). Because beginning student clinicians often lack experience working with clients and have not been directly or indirectly exposed to client-perpetrated violence, it is recommended that they “explore and address those experiences with trauma and violence that might influence their judgment” (Berg et al., 2000, p. 11). Clinicians’ degrees of experience and their attitudes about violence could enhance their ability to assess and treat violent clients (Berg et al., 2000). However, clinicians’ perceptions of what acts constitute client-perpetrated violence against the clinician are highly subjective and apt to be based on personal interpretation and/or personal experience (Guy & Brady, 1998; Leadbetter, 1993; Snow, 1994).

Clinician safety could also be enhanced by teaching students to recognize the most common verbal, behavioral, and physiological signs of impending violence that might exhibited by a client. For example, Tardiff (1996, 2008) urges clinicians to pay attention to specific aspects of a patient’s appearance and behavior, which can alert them to the possibility for potential violence. He identifies patients who are loud, agitated, angry, impatient, and refuse to comply with standard intake procedures as problematic. He also urges clinicians to listen carefully to
patients who present as quiet and guarded, as they may harbor “subtle violent ideation” (p. 6). In addition, he identifies such physiological phenomena as dysarthia (difficulty in speaking or forming words), unsteady gait, dilated pupils, and tremors as possible indicators of drug and/or alcohol intoxication, which places a client at a greater risk for acting out violently.

Petit (2005) identifies behaviors such as pacing, psychomotor agitation, and/or assuming a “combative posture and stance” (p. 704) as warning signs of impending client violence. In addition, he identifies other behaviors such as threatening remarks, acting out, guardedness, suspiciousness, the presence of paranoid ideation and/or delusions, carrying or access to weapons, poor impulse control, low frustration tolerance, and irritability and/or impulsivity as possible behavioral precursors to violent client behavior. Being able to recognize potentially violent clients by their behavioral, physical, emotional, and/or physiological presentation rapidly can elevate the clinician’s level of alertness to the potential for client violence and can decrease the chances a client will act out violently (Petit, 2005).

As another basic preventative strategy, student clinicians should also be educated about the dynamics of violence. Successful management of client violence requires an understanding of its dynamics (Dubin and Ning, 2008). Dubin and Ning contend that violence “is a reaction to feelings of passivity and helplessness” (p. 467). They go on to explain that a client’s threatening behavior is “commonly an overreaction to feelings of impotence, helplessness, and perceived or actual feelings of humiliation” (p. 467). Kaplan and Wheeler (1983) assert that violence can be perceived as “disequilibrium of power” (p. 339), which places one at risk for feelings anger and acting out destructively in an attempt to “reclaim that power”. Petit (2005) states, “agitation, aggression, impulsivity, and violence are behaviors that may arise from innate drives or as a response to frustration, and they may be manifested by destructive and attacking behaviors or
covert attitudes of hostility and obstruction” (p. 702). He goes on to say, “Such behaviors can be triggered by a trivial event or may be unprovoked and find an external expression; they can also fluctuate and overlap with many other conditions” (Petit, 2005, p. 702).

Several researchers have commented on the utility of providing clinicians with conceptual frameworks to facilitate their understanding of the dynamics of violence and aid them in choosing the most appropriate interventions (Berg et al., 2000; Gately & Stabb, 2005; Kaplan & Wheeler, 1983). Berg et al. (2000) propose the “Hierarchy of Aggression” (p. 12) as a framework for helping clinicians understand different levels of aggression. This framework presents five different levels of aggression and each level’s related manifestation: a) lowest level of aggression, b) self-assertion, c) dominance, d) hostility, and e) hatred. They assert that clinicians who have an understanding of the various levels of aggression can “structure their responses to the various levels of aggression appropriately” (p. 12).

Kaplan & Wheeler (1983) propose eight client and environmental variables, when considered in conjunction with knowledge of the phases of an assault, can help clinicians avert potentially assaultive episodes of client-perpetrated violence against them and/or staff in mental health settings. First, the clinician is encouraged to consider the environmental and emotional constraints of the client’s environment. What degree of control does the client have regarding decisions that personally affect him or her? Is passivity imposed upon the client by his or her environment? Second, to what degree is aggressive behavior tolerated in the environment? Third, are the boundaries of acceptable behavior clearly understood by the client and are these parameters consistently enforced in the environment? Fourth, clinicians are encouraged to consider the client’s past history of managing his or her frustration. Fifth, clinicians should consider the client’s primary relational style (e.g., passive, aggressive, or assertive, etc.). Sixth,
clinicians should be aware of any recent changes in the client’s environment or normal routine. Seventh, clinicians should be aware that inclement weather might increase clients’ impulsive behavior in residential settings. The eighth variable is consideration of any social, political, and/or economic factors that may exacerbate a client’s feelings of “insecurity and powerlessness” (Kaplan & Wheeler, 1983, p. 340).

Paul Smith, (as cited in Kaplan & Wheeler, 1983), outlines the phases of an assaultive episode, which Kaplan & Wheeler (1983) refer to as a “psychoenviromental model” (p. 340) to facilitate identification of the specific phases of an assault. “The Assault Cycle” consists of five interrelated phases that are typically present in most assaultive and/or violent episodes: a) the triggering phase, b) the escalation phase, c) the crisis phase, d) the recovery phase, and e) the post-crisis phase.

The first phase or “triggering phase” occurs when the client’s behaviors begin to deviate from his or her baseline level of behavior. This deviation is usually the first indication that the client may be experiencing some type of internal distress. In the second phase or “escalation phase”, the client enters into the realm of assaultive behavior, which begins to escalate. In this phase, the client’s ability to respond to interventions decreases, as does his or her ability to respond in a rational manner to clinical strategies intended to divert him or her away from the assaultive behavior(s). In the third phase or “crisis phase,” the client’s level of physiological, psychological, and emotional arousal has greatly increased, while his or her ability to control aggressive impulses has reached its limit. Now, the client begins to actively engage in assaultive behavior(s). The primary objective at this point becomes the safety of the clinician, client, staff, or others who may be present.
The fourth phase or “recovery phase” occurs after the client’s engagement in assaultive behavior(s) and the client begins to transition back to his or her baseline level of behavior. It is during this phase that most “intervention errors are enacted” (p. 341). Often, clinicians or staff attempt to hasten this phase in order to alleviate their own personal anxiety about the situation. Kaplan & Wheeler (1983) point out that clients’ adrenalin levels can remain elevated and active for up to 90 minutes following their engagement in assaultive behavior. Therefore, they urge clinicians to provide optimal support for clients during this phase and to be mindful of the pace of interventions they initiate, in order to prevent a client from regressing back to the “crisis phase” (p. 341).

The final phase is the “post-crisis depression phase”. In this phase, the client’s behavior recedes below his or her baseline level of behavior and he or she is usually exhausted, both physically and mentally. During this phase, the client often displays a willingness to engage in interventions due to his or her desire to “make reparations to the victims, relieve guilt, and be able to return to the environment as a functional member” (Kaplan & Wheeler, 1983, p. 341).

In addition to understanding the dynamics of violence and conceptualizing it as a series of phases or levels, clinicians are also encouraged to develop a personal safety plan prior to finding themselves in a potentially threatening or violent situation with a client. When formulating a personal safety plan, it should be flexible enough to conform to the uniqueness of different situations, but specific enough to facilitate rapid implementation for all involved parties (Guy & Brady, 1998). Some suggested elements for a personal safety plan include strategies to summon help from others in the environment (Dubin and Ning, 2008; Eichelman, 1995; Guy and Brady, 1998; Tishler et al. 2000), using code words to alert others in the office of threatening situations (Dubin and Ning, 2008), and organizing one’s office layout to ensure rapid egress
should exiting the therapy room become necessary due to personal safety concerns (Petit, 2005). In addition, a clinician may want to pre-prepare a speech intended to calm a potentially violent or violent patient (Guy & Brady, 1998). Clinicians are also urged to be mindful of their clothing choices with respect to their clientele, as certain clothing and accessories could be used by the assaultive client to harm them. Such items include, but are not limited to, neckties, scarves, dangling jewelry (e.g., earrings, necklaces, etc.), and eyeglasses (McNeil, 2009; Tishler et al., 2000).

Clinicians should be encouraged to evaluate the physical safety of their office environments as well, and choose office décor that is “consistent with the type of patient the clinician is treating” (Dubin & Ning, 2008, p. 477). The use of heavy furniture that cannot be lifted is also recommended and small decorative objects that could be thrown or used as weapons should not be accessible to the client (Dubin and Ning, 2008). Clinicians should be encouraged to familiarize themselves with all organizational safety policies and procedures at their places of employment. As Guy & Brady (1998) point out, it is crucial to have a premeditated plan in the event of encountering a violent patient, as few clinicians “have the ability to think clearly and act effectively” (p. 411) when confronted with a client-perpetrated attack if no prior consideration has been given to such a scenario.

Supervision and/or consultation is another prevention strategy that can be used by clinicians to diminish the potential for client-perpetrated violence against the them, to provide support and enhanced training when working with violence-prone clients, and support following the aftermath of client-perpetrated violence. Training programs should encourage students from the start to seek out supervision and/or appropriate consultation for guidance and support when feeling unsafe or threatened by a client, or following a client-perpetrated attack. Supervision and
consultation can be a source of ongoing support especially when clinicians are in the midst of treating clients who threaten their safety.

Student-clinicians are often the most vulnerable victims of client-perpetrated violence, especially in terms of the emotional consequences they may suffer. Student victims of client-perpetrated violence may experience greater shame and feelings of incompetence (Guy & Brady, 1998). Therefore, it is imperative that clinical supervisors of student clinicians have an awareness of the consequences of client-perpetrated violence against students and can provide students who are at risk or have been victims of client-perpetrated violence with a an emotionally safe environment, free from judgment or blame to discuss such experience(s) and concerns. Appropriate supervision and/or consultation not only provides support for students who feel threatened by their clients or who have been victimized by their clients, but can assist them with establishing diagnostic clarity, formulating pertinent treatment plans to reduce the potential for client violence, and can promote “the most efficacious and least restrictive intervention possible” (Guy & Brady, 1998, p. 410), all of which ultimately provide a safer working environment for the clinician and the most therapeutic care for the violence-prone client.

**Violence Risk Assessment**

When working with any client, initial and ongoing risk assessment is necessary. However, when treating a potentially violent or violence-prone client, a thorough violence risk assessment is critical and could avert or mitigate the clinician’s risk for becoming a victim of client-perpetrated violence. While there is no specific combination of variables that can predict which clients will be violent with complete accuracy, clinicians can become more astute by arming themselves with knowledge of the most common predictors and correlates of client violence. Learning to recognize the most common risk factors of impending client violence, as
well as the most common behavioral, physiological, clinical, demographic, and historical variables of violence, can alert the clinician to potential client violence. Knowledge and recognition of the major risk factors and key variables of violence prior to the occurrence of client violence against the clinician also allows the clinician the chance to formulate targeted treatment planning strategies to attenuate the potential for violence and enhances clinician safety (Dubin and Ning, 2008).

Berg et al. (2000) point out that several studies have shown that clients with certain mental disorders are more likely to be violent. Freedman et al., (2007) contend that no discernable clinical picture has been correlated with violent behavior; however, they warn clinicians that an escalation of paranoid fear in a client should merit serious concern about the patient’s propensity for violence. Despite the evidence that violent patients comprise a heterogeneous group, similar characteristic and risk factors are often evident (Petit, 2005; Star, 1984). Petit (2005) has identified the most common psychiatric disorders associated with violence: (a) personality disorders (particularly antisocial and borderline), (b) conduct disorder, (c) delirium, (d) dementia, (e) dissociative disorders, (f) intermittent explosive disorders, (g) mental retardation, (h) oppositional defiant disorder, (i) personality change caused by a general medical condition, aggressive type, (j) posttraumatic stress disorder, (k) schizophrenia, paranoid type, (l) sexual sadism, (m) premenstrual dysphoric disorder, and (n) substance related disorders.

Tardiff (1996, 2008) proposed a model that details ten crucial factors that should be evaluated to determine if a client presents a short-term risk of violence. He underscores the importance of focusing not only clinical variables, but also on demographic, historical, and environmental factors that may be associated with an increased risk of client violence. This basic model could be introduced to students early in their training to supplement basic intake
assessment skills, especially if the student has an awareness of the basic behavioral (both verbal and non-verbal), physiological, and physical appearance indicators that may signal a client has the capacity to escalate toward violence.

First, Tardiff emphasizes that attention should be paid to the physical appearance of the client/patient. As previously discussed, this entails noticing specific behavioral and physiological signs exhibited by the client that may signal potential violence. Clinicians should observe if the client is cooperative, overly guarded, or suspicious. Although a client may not overtly verbalize intent to be violent, common signs of agitation and specific physical behaviors exhibited by the client can be early warning signals for the clinician that the potential for violence may exist.

Second, clinicians should carefully assess the presence of violent ideation, as well as the degree of planning and formulation reported by the client. The clinician should inquire about any thoughts the client may have about perpetrating violence toward others and how organized the ideation and/or threat is. Third, the clinician should assess the client’s intent to be violent. In this step, the clinician must distinguish if the client is having thoughts of harming another or if the client’s thoughts of harming another are purposeful and directed toward imminently harming another. Fourth, the clinician should always inquire about available means (i.e., weapons). It should be kept in mind that available means not only applies to the client’s access to lethal weapons, but to the accessibility of the potential victim(s) as well.

Fifth, it is essential that the clinician inquire about the client’s past history of violence, since it is well established that a prior history of violent behavior is often a predictor of future violent behavior. Clients should be questioned about injuries sustained by other persons due to the client’s behavior, property destruction, criminal offenses, reckless driving, suicide attempts, sexual acting out, and other relevant impulsive behaviors. Tardiff (2008) suggests that episodes
of violence, when reported by the client be “dissected in a detailed and concrete manner by the clinician” (p. 7). When the client presents with a history of violence, Tardiff also recommends that the clinician note the date(s), frequency, place(s) of occurrence, and the severity of the violence. Sixth, it is crucial to evaluate the history, extent, and frequency of the client’s alcohol and/or drug use. Because alcohol and/or drug use can exacerbate psychopathology in existing psychiatric disorders, intoxication and/or withdrawal from alcohol and/or drugs can portend an increased risk for client violence.

Seventh, the clinician should carefully assess the patient for the presence of psychosis. Although psychosis can be a symptom of several psychiatric disorders, its presence is frequently correlated with an increased risk for client violence, regardless of a patient’s presenting psychiatric diagnosis. Tardiff (2008) warns the clinician that psychotic paranoid patients can be particularly problematic because their delusions may not exhibited explicitly and they may attempt to conceal them. Eighth, Tardiff urges clinicians to be familiar with the risk for violence posed by patients who suffer from antisocial or borderline personality disorder. Ninth, clinicians should inquire about patients’ compliance with previous treatment, given that those presenting with a history of noncompliance with treatment may be at an increased risk for violence. Tenth, he identifies specific demographic factors that have been correlated with violent behavior that should be heeded by the clinician. In particular, he identifies patients who are younger and male as posing an increased risk for violence, as well as those from impoverished environments, those who have experienced disruptions in family, and those with “decreased social control in which violence is considered an acceptable means of obtaining a goal in the absence of other legitimate means or education” (Tardiff, 2008, p. 12).
McNeil (2009) also emphasizes the importance of obtaining a detailed history of violence from patients. He urges clinicians to assess for recent episodes of aggressive behavior, which can alert the clinician of the possibility that the patient is experiencing “an ongoing crisis in which violence is a manifestation.” (p. 126). McNeil also encourages clinicians to be aware of any patterns of escalation that may signal a patient is repeating a violent cycle. He also emphasizes the importance of considering the patient’s symptoms in relation to prior violence, as well as the context(s) in which the prior violence occurred. The clinician should inquire if the violence was planned or impulsive in nature and identify any specific precipitating or immediate triggers to the patient’s past violence. It is also important to question patients about their attitudes concerning prior violence, as well as their attitudes related to any recent episodes of violence or provocation (McNeil, 2009).

McNeil (2009) also details demographic and personal history factors that are correlated with an increased risk for client violence. However, he points out that violence is not exclusive to younger people, noting, “associations between diagnosis and risk of violence appear to vary depending on age (p. 127). In terms of gender, he maintains that research suggests the risk for increased violence is “less pronounced among persons with mental disorders” (p. 127). If available, clinicians are urged to obtain and review pertinent prior client records as soon as possible (e.g., records from former therapists, medical records, law enforcement records, etc.) and to collect information from collateral sources (e.g., family, friends, police, etc.) when treating a client who may pose a risk for violence or has a known history of violence (McNeil, 2009; Newhill, 2003; Star, 1984; Tardiff, 2008; Tishler et al., 2000).
Management of the potentially violent/violent client

Management of the potentially violent client or the violent client is predicated on the clinician’s knowledge and application of prevention strategies, as well as his or her skill and ability to conduct an accurate and detailed violence risk assessment of such clients. When working with clients who present an increased risk for violence, basic safety considerations should be of paramount importance to the clinician, as well as having a “clear management approach” (Petit, 2005, p. 702). Petit (2005) makes several recommendations for competent management of the potentially violent or violent patient. He suggests clinicians utilize a “stepwise approach” (p. 707) that employs the least restrictive but most effective means of controlling the patient. He urges clinicians to make safety their first priority and to assess emergent patient violence in order to prevent or decrease future escalation (Petit, 2005). When confronted with the agitated patient, Petit (2005) recommends that clinicians first utilize verbal and nonverbal de-escalation techniques (i.e., defusing or talking down) to minimize the likelihood of potentially violent situations with clients. The use de-escalation techniques to manage the agitated or threatening client is a basic skill, which all clinicians should be familiar (Berg et al., 2000).

Berg et al. (2000) outline and describe the three components of de-escalation: a) verbal, b) space, and c) body language. The main goal of de-escalation is to persuade the client to model the positive behaviors of the clinician to promote a calmer interaction between the client and clinician. The objective of de-escalation is to attenuate a client’s “feelings of fear, inadequacy, and hopelessness” (Berg et al., 2000, p. 21).

Limit setting is a verbal de-escalation technique often recommended for use with agitated or potentially violent patients (see Green, Goldberg, Goldstein, & Leibenluft, 1988). When used
appropriately, limit setting can be both therapeutic and decrease the potential for violent behavior (Dubin and Ning, 2008). In their book, Green et al. (1988) discuss limit setting, which functions to suppress and thwart maladaptive and unacceptable client behaviors that hinder therapy and threaten the clinician’s safety. Effective limit setting involves clear identification by the clinician of the client’s maladaptive behaviors followed by the clinician’s clear articulation of the specific consequence(s) that will occur if the client’s unacceptable behavior continues. Thus, successful limit setting follows three steps: a) the clinician tells the client the behavior(s) are unacceptable, b) the client is told specifically why the behavior is unacceptable, and c) the client is offered a choice of treatment interventions to remedy the behavior.

Star (1984) asserts that many patients who are violent fear losing control and often find limit setting helpful because it allows them to regain “a sense of mastery over impending violent urges” (p. 229). However, should a clinician choose limit setting as an intervention, he or she must be able to ascertain if the patient is capable of responding to and comprehending the intervention, since factors such as cognitive impairment and/or high levels of threat may preclude the use of limit setting as an intervention (Dubin and Ning, 2008). In addition, when choosing to use verbal limit setting with the client, clinicians must be cautious not to be perceived as authoritative or threatening.

In some instances, the clinician may be able to lessen the patient’s fear and threatening manner by expressing that he or she is frightened by the patient’s behavior. In addition, the clinician should make efforts to assure the patient that he or she is understood through active listening, paraphrasing, and empathy (Berg et al., 2000). Problem solving with the patient can be utilized to address the patient’s source(s) of agitation and may decrease the intensity of his or her angry feelings. Clinicians should allow patients to verbalize their “angry or resentful feelings”
(Star, 1984, p. 229) as this “both defuses the intensity of the emotion and demonstrates the therapist’s ability to deal with anger in a nonfearful way” (Star, 1984, p. 229). Clinicians should also be very mindful of the volume, rate, and tone of their speech, which has the potential to either calm or increase the patient’s agitation. It is suggested that clinicians speak at a slightly lower volume than the patient; however, if the clinician’s speech volume is too low, the patient may perceive it as threatening (Berg et. al., 2000). The goal of the clinician should be to model calm behavior (verbal and body language), which can encourage the patient to model such behavior as well in order to decrease his or her agitation or escalating behavior (Berg et al. 2000).

The second component of de-escalation involves being mindful of the agitated or escalating patient’s personal space. Clinicians should keep a safe distance from a patient who is agitated or escalating and maintain respect for the patient’s personal space (McNiel, 2009; Petit, 2005). Patients who feel threatened, agitated, or display assaultive tendencies require larger circumferences of personal space (Tishler et al., 2000) and are also more fearful that their personal space will be violated (Berg et. al, 2000; Tishler et al., 2000). It is recommended that clinicians keep at least 4-6 feet of space between themselves and an agitated or escalating patient, as intrusion into the patient’s personal space increases the chance of the clinician being assaulted (Berg et al., 2000). In addition, clinicians should never turn their back on an agitated or escalating patient, and always approach the patient either from the front or the side rather than from behind, which is “extremely threatening” to the patient (Berg et al., 2000, p. 21).

The third component of de-escalation involves the appropriate use of body language by the clinician. Because the agitated or escalating patient is very sensitive to body language, Berg et al. (2000) recommend that the clinician assume a non-aggressive stance and posture, which is
perceived as less threatening by patients and communicates and models the clinician’s calmer attitude. They recommend that clinicians place their hands at waist level, keep their palms up and open, or assume the “thinker” stance in which the clinician places one forearm across his or her chest with the opposite elbow resting on it and the index finger of that hand on his or her chin. They suggest that the clinician keep his or her body at a 45˚ angle to the patient outside of the patient’s personal space, which allows for a “larger reactionary gap” (p. 22) should the patient, escalate to a sudden assault.

It is also suggested that clinicians mirror the body language of patients, which communicates empathy with patients’ “current state and control of the situation” (Tishler et al., 2000, p. 35). Petit (2005) cautions the clinician against intense or prolonged direct eye contact with the patient, which can be perceived by the patient as “menacing” (p. 707) as well as crossing one’s arms and placing one’s hands behind the back. Berg et al. (2000) recommend that that the clinician assume a position that makes him or her appear smaller and less threatening in relation to the patient, as well as to avoid engaging in any sudden movements that may startle the patient. They also stress that clinicians must be aware of the appropriate uses of and the risks and benefits of utilizing de-escalation skills with the potentially violent client. They caution that competent use of these techniques requires practice in training situations. Similarly, they assert clinicians also require practice in order to present a calm demeanor when confronted with intensely charged verbal tirades from agitated or escalating patients.

This section has presented a brief overview of some of the most frequently mentioned training areas on the topic of client-perpetrated violence against psychologists, student clinicians, and mental health clinicians of various disciplines in the literature. The training recommendations presented in the areas of prevention, violence risk assessment, and
management of the potentially violent or violent client in each of these areas are intended to be suggested recommendations and do not constitute an exhaustive list of all possible interventions that may facilitate clinician safety or the management of the potentially violent or violent client. The training recommendations presented here, are for the most part, basic, and could easily be incorporated as didactic components that compliment and enhance current training provisions for students in basic clinical and counseling skills prior to their first practicum placements.

At the most basic level of prevention, training programs have a responsibility to make students of aware of the potential for client-perpetrated violence against them in mental health settings and of their right to personal safety. Training students in enhanced skills in violence risk assessment that go beyond basic intake questions about harm to self and others, as well as educating them about the warning signals of impending violence, can increase clinician safety and decrease the potential for client-perpetrated violence against them. When students are knowledgeable about the most common correlates and predictors of violent behavior (e.g., historical, demographic, clinical, environmental, and diagnostic), as well as possess a basic understanding of the dynamics of violence, increased student competence and confidence in the assessment and management of the potentially violent or violent client is more likely. Competent clinical management of the potentially violent or violent client is founded on the ability of the clinician to apply relevant prevention strategies and obtain a thorough violence risk assessment to defuse potential, emergent, or imminent client violence before it becomes detrimental to the physical and psychological well-being of the clinician, client, and if applicable, others present in the clinical setting.

In their Task Force Report on Clinician Safety (APA, 1993), the American Psychiatric Association recommends that clinicians engage in “several hours of role-playing encounters” (p.
in which they are confronted with managing different types of aggressive patients. The task force recommends that the simulations be critiqued by peers. This is an exercise that could be easily incorporated into basic clinical and counseling skills training for students, and could enhance their awareness about the potential for client-perpetrated violence against clinicians, as well as provide opportunities for them to begin to formulate personal strategies and safety plans for possible encounters with potentially violent or violent clients in the future. Similarly, Guy and Brady (1998) suggest the use of role-play and dramatic reenactment supplemented by discussion to help student clinicians safely and effectively manage situations involving patient violence.

Summary

The literature on the topic of client-perpetrated violence against mental health clinicians is scant. This topic appears to generate only meager interest among practicing professionals and educators in the mental health disciplines. This is surprising given the research indicates that client-perpetrated violence against mental health clinicians is not a recent or even rare phenomenon. The literature has shown that client-perpetrated violence is highly prevalent and appears to be increasing within the mental health professions (Breakwell, 1989; Dubin & Ning, 2008; Kaplan & Wheeler, 1983; McAdams & Foster, 1999; Privitera et al., 2005). Research indicates that most, if not all, mental health clinicians, will be subjected to some form of client-perpetrated violence against them during their careers, regardless of the clinical setting(s) in which they practice (Arthur et al., 2003; Brems & Johnson, 2009; Dubin & Ning, 2008; Guy & Brady, 1998; Reid, 2008; Star, 1984). The evidence suggests that client-perpetrated violence against clinicians is a professional reality (Arthur et al., 2003; Breakwell, 1989; Brems & Johnson, 2009; Dubin & Ning, 2008; Kleespies, 2008; Kleespies & Dettmer, 2000; Snow, 1984;

There have been concerted efforts by professional organizations such as the American Psychological Association (see the Division 12, section VII report on education and training in behavioral emergencies, APA, 2000) and the American Psychiatric Association (see the Task Force Report on Clinician Safety, APA, 1993), as well as government agencies (OSHA, 2004; Bureau of Justice Statistics Special Report, as cited in Durhart, 2001) to address the issue of client-perpetrated violence against mental health clinicians. However, the issue continues to receive negligible attention from practitioners and educators and remains an unpopular topic (Guy & Brady, 1998; Leadbetter, 1993; Star, 1984). The issue of client-perpetrated violence against mental health clinicians is also frequently minimized or ignored during the training years (Gately & Stabb, 2005; Guy & Brady, 1998; Kleespies, 2008; Madden et al.1976; Tishler et al., 2000; Tryon, 1986; Whitman et al., 1976). Therefore, it is not surprising that many psychologists and other mental health providers receive inadequate education during their training years in how to manage the violent or violence-prone client.

This is particularly concerning given that the literature indicates that client violence against clinicians is correlated with level of clinician experience, and student clinicians are often the most likely to be victims of client-perpetrated violence (Bernstein, 1981; Guy & Brady, 1998; Guy et al., 1990; Madden et al., 1976; Tardiff, 1995; Tishler et al., 2000; Whitman et al., 1976). Students, especially those in the beginning phases of their clinical training, may lack an awareness of even the possibility of client-perpetrated violence against them. Education in prevention, violence risk assessment, and management of the potentially violent or violent client are frequently mentioned in the literature, as areas of crucial training, which can assist mental
health clinicians in developing a practical framework for understand client-perpetrated violence and for developing the specific clinical skills to intervene competently with the potentially violent or violent client in clinical settings. Attainment of these clinical skills protects the emotional and physical well-being of the clinician as well as the client.

The majority of research in this area has focused on the experiences of practicing mental health clinicians of various disciplines who have been victims of client-perpetrated violence (e.g., psychiatrists, psychologists, social workers, licensed practicing counselors). To this investigator’s knowledge, only one study (Gately & Stabb, 2005) has surveyed students regarding their exposure to client-perpetrated violence and their perceptions of the training they received to prepare them for the management of potentially violent or violent clients. This investigator was unable to locate any research exploring the perceptions of educators concerning client-perpetrated violence against clinicians and the educational provisions currently in place in training institutions to prepare students for encounters with potentially violent or violent clients in clinical settings.

The purpose of this study is to survey current Directors of Clinical Training (DCTs) at APA accredited clinical, counseling, and school psychology doctoral programs to gather information about their level of awareness and concern regarding client-perpetrated violence against psychologists and student clinicians in mental health settings. In addition, information will be gathered about current training opportunities offered at their institutions that specifically prepare student clinicians, particularly prior to their first practicum placement, to recognize and mitigate the possible risks of potential or actual client-perpetrated violence against them in clinical settings.
DCTs will be asked to provide information in five areas: (a) their overall level of awareness and concern regarding the risk of client-perpetrated violence against psychologists in mental health settings and beginning student clinicians, (b) their perceptions of students’ level of awareness of this issue at their training institutions, (c) current training opportunities offered by their institutions to educate beginning clinicians in prevention strategies, violence risk assessment, and management of potentially violent or violent clients, (d) their personal experience (if applicable) with students who have been victims of client-perpetrated violence, and (e) their views regarding the responsibility of training institutions to educate and prepare students for the possibility of encountering client-perpetrated violence against them.

The following hypotheses have been proposed for this study:

1. Level of awareness pertaining to the issue of client-perpetrated violence against practicing psychologists and student clinicians will not be reported as a major area of concern by the majority of DCTs.

2. The majority of DCTs will perceive their students’ level of awareness concerning the potential for client-perpetrated violence against psychologists in mental health settings as “Low”.

3. The majority of DCTs will report that potential or actual client perpetrated violence against student clinicians will not be a major area of concern at training institutions.

4. The majority of DCTs will report that education for students in the three recommended training areas (prevention strategies, violence risk assessment, and management of the potentially violent or violent client) will not be mandatory prior to a student’s first practicum placement.
5. The majority of DCTs will report that the training their institution provides in the areas of prevention, violence risk assessment, and management of the potentially violent or violent client adequately prepares its students to manage encounters with potentially violent or violent clients prior to their first practicum placement.

6. The majority of DCTs will report that students at their institution receive less than four hours of training in the combined areas of prevention, violence risk assessment, and management of the potentially violent client or violent client prior to their first practicum placement.
METHOD

Participants

Three hundred and forty Directors of Clinical Training from APA accredited clinical, counseling, and school psychology doctoral programs were recruited and invited to participate in this study by the principal investigator. In cases where contact information could not be obtained for a person holding the exact title “Director of Clinical Training,” person(s) holding a similar position were invited to participate in the study (e.g., Training Director, Co-Training Director, Director of Doctoral Training, Program Clinical Coordinator, Program Director, Field Placement Coordinator, Director of Professional/Professional Field Training, Department Chair/Head, Director of Practicum Training, Clinical Program Director, etc.).

Survey Instrument

Each participant completed a survey instrument entitled, “Student Clinicians and Client-Perpetrated Violence” (See Appendix A). The survey was a non-standardized, unpublished instrument developed by the principal investigator to examine current levels of awareness and concern among Directors of Clinical Training about client-perpetrated violence against psychologists, and more specifically, client-perpetrated violence against beginning student clinicians in mental health settings. The survey was also intended to elicit information regarding current training provisions at institutions, which specifically assist student clinicians to recognize, prevent, and mitigate their risks for exposure to client-perpetrated violence against them in clinical settings (i.e., prevention strategies, violence risk assessment, and management of the potentially violent or violent client). Content for survey questions were drawn from the principal investigator’s review of the literature. The survey consisted of 40 questions and
included five parts: (a) Demographic information, (b) awareness, (c) training, (d) experience with student victims of client-perpetrated violence, and (e) education.

**Procedure**

For the purpose of recruiting participants, the principal investigator obtained the most recent lists of doctoral programs in clinical, counseling, and school psychology that were accredited by the American Psychological Association. Each program’s website was accessed by the principal investigator in order to identify its Director of Clinical Training and gather email contact information. If no individual with the title “Director of Clinical Training” could be identified on a program’s website, contact information for the person with the most similar title/responsibilities was obtained, and that individual was invited to participate in the study.

A recruitment letter entitled, “Invitation to Participate in Dissertation Research about Student Clinicians and Client-Perpetrated Violence” (see Appendix B) was sent to three hundred and forty potential participants via contact information obtained from their program’s website. Each invitation was personally addressed and sent electronically via the web link collector in SurveyMonkey from the principal investigator’s school email address. The recruitment invitation informed potential participants how their contact information had been acquired, the reason they had been invited to participate in the study, introduced the survey instrument, and explained the purposes of the research. The recruitment invitation also provided information regarding the estimated length of time required to participate in the study, as well as explaining the potential risks associated with participation in the study. Potential participants were made aware that the data collected from the survey would be completely anonymous, that their participation was voluntary and could be withdrawn at anytime during their participation without penalty, and that completion of the survey would constitute their informed consent. A link to the survey was
included in the invitation, which routed the participant directly to the survey. In addition, contact information for the principal investigator, her faculty advisor, and the Pacific University Institutional Review Board was provided in the recruitment invitation.

After clicking the link provided in the recruitment invitation, participants could then complete the survey. Prior to beginning the survey, participants were presented with a page with the survey’s title and the page title: “Pacific University Informed Consent to Act as a Research Participant” (see Appendix C). This page presented the purpose of the study, eligibility requirements to participate in the study, specified the duration of the data collection period, estimated time commitment to participate, outlined what type of information/questions would be included in the survey, stated that participation was voluntary and could be withdrawn at any time during participation without penalty, that data collected from the survey would be completely anonymous, and that completion of the survey would constitute the participant’s informed consent. In addition, participants were informed of the potential risks associated with completing the study. Contact information was provided for the principal investigator, her faculty advisor, and the Pacific University Institutional Review Board. Participants were informed that their participation in the study constituted their informed consent.

After the “Pacific University Informed Consent to Act as a Research Participant” page, participants were provided with the definition of client-perpetrated violence for the purposes of this study. After this definition, participants could then begin taking the study by clicking on the “next” button. The survey was considered complete if the participant clicked on the “done” button at the end of the survey. This was followed by a screen thanking participants for completing the survey.
Two weeks following the initial distribution of the recruitment invitations, a reminder invitation (See Appendix D) was emailed to all potential participants, with the exception of those who had contacted the principal investigator indicating they had either taken the survey, or that they were not the appropriate contact. The initial email recruitment invitation yielded 21 participants and the reminder invitation yielded an additional 12 participants. The data collected from the survey was stored in the principal investigator’s password protected SurveyMonkey account until the completion of the study. Participation in the survey was completely anonymous; the investigator collected no personally identifiable information and the web-based program did not store any identifiable information, which could personally identify participants.

Data Analysis

Due to the small sample size (33 participants out of 340 potential participants), only basic descriptive data collected from the web-based program is presented. This data includes sample sizes and percentages to report results that pertained to the proposed hypotheses of this study. Data reported was obtained from a summary report generated by the web-based program.
RESULTS

Thirty-three participants took the survey. The sample population consisted of current Directors of Clinical Training, or in some cases, possibly persons holding similar positions. The majority of the participants (20) were affiliated with clinical psychology programs, followed by participants from counseling psychology programs (seven participants), and school psychology programs (six participants). The highest terminal degrees offered by the majority of participants’ academic institutions were the PhD (26 of 32 participants, 81.3%) and the Psy.D (six of 32 participants, 18.8%). Programs located in the South had the highest number and percentage of participants (12 of 30, 40%), followed by participants from programs located in the Northeast (nine of 30, 30%). The majority of participants had held the position of Director of Clinical Training at their institution for 1-5 years (15 of 32, 46.9%). Table 1 presents all participant demographics in detail.

Table 1

<table>
<thead>
<tr>
<th>Participant Demographics</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>20</td>
<td>60.6</td>
</tr>
<tr>
<td>Counseling</td>
<td>7</td>
<td>21.2</td>
</tr>
<tr>
<td>School</td>
<td>6</td>
<td>18.2</td>
</tr>
<tr>
<td><strong>Highest terminal degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD</td>
<td>26</td>
<td>81.3</td>
</tr>
<tr>
<td>Psy.D</td>
<td>6</td>
<td>18.8</td>
</tr>
<tr>
<td><strong>Program location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast (CT, ME, NH, NY, MA, NJ, PA)</td>
<td>9</td>
<td>30.0</td>
</tr>
<tr>
<td>Midwest (IN, IL, MI, OH, WI, IA, KS, MN, MO, NE, ND, SD)</td>
<td>8</td>
<td>26.7</td>
</tr>
</tbody>
</table>
Table 1

**Participant Demographics (continued)**

<table>
<thead>
<tr>
<th>Program location</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South (DE, DC, FL, GA, MD, NC, SC, VA, WV, AL, KY, MS, TN, AR, LA, OK, TX)</td>
<td>12</td>
<td>40.0</td>
</tr>
<tr>
<td>West (AZ, CO, ID, NM, MT, UT, NV, WY, AK, CA, HI, OR, WA)</td>
<td>1</td>
<td>3.3</td>
</tr>
</tbody>
</table>

**Years as DCT**

<table>
<thead>
<tr>
<th>Years as DCT</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a year</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td>1-5 years</td>
<td>15</td>
<td>46.9</td>
</tr>
<tr>
<td>6-10 years</td>
<td>10</td>
<td>31.3</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>5</td>
<td>15.6</td>
</tr>
</tbody>
</table>

Several hypotheses were proposed for this study. The first hypothesis proposed that levels of awareness of client-perpetrated violence against practicing psychologists in mental health settings would not be reported as a major concern among Directors of Clinical Training. Participants were asked to rate their level of awareness regarding the potential for client-perpetrated violence against psychologists in mental health settings on a six item scale ranging from “Not a relevant concern for me” to “Very high”. Thirty-two of the total 33 participants answered this question.

The majority of the participants (13 of 32, 40.6%) did not report a level of awareness exceeding “Medium” as shown in Table 2. However, participants’ level of awareness was clearly in the higher range of the item scale versus the lower range, with fourteen of the participants (43.8%) rating their level of awareness in the range of “Somewhat high” to “Very high”. Therefore, in contrast to the proposed hypothesis, the results appear to favor an overall elevated
level of awareness among the majority of the participants concerning the risk for client-perpetrated violence against psychologists in mental health settings.

Table 2

**Participants’ Awareness Levels**

<table>
<thead>
<tr>
<th>Awareness level</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>18.8</td>
</tr>
<tr>
<td>Somewhat high</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>Medium</td>
<td>13</td>
<td>40.6</td>
</tr>
<tr>
<td>Low</td>
<td>3</td>
<td>9.4</td>
</tr>
<tr>
<td>Not a relevant concern</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td></td>
</tr>
</tbody>
</table>

The second hypothesis proposed that participants would perceive the level of awareness among students at their training institutions concerning the potential for client-perpetrated violence against psychologists in mental health settings as “Low”. Participants were asked to rate how they perceived their students’ level of awareness regarding this issue on a six item scale ranging from “Not a relevant concern for most students” to “Very high”. Findings from the data are summarized in Table 3.

Table 3

**Perceived Student Awareness Level**

<table>
<thead>
<tr>
<th>Awareness level</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>High</td>
<td>3</td>
<td>9.4</td>
</tr>
<tr>
<td>Somewhat high</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>Medium</td>
<td>15</td>
<td>46.9</td>
</tr>
<tr>
<td>Low</td>
<td>6</td>
<td>18.8</td>
</tr>
<tr>
<td>Not a relevant concern for most students</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td></td>
</tr>
</tbody>
</table>
Similarly, the results indicate that almost half of participants (15 of 32, 46.9%) perceived students at their institutions as possessing a “Medium” level of awareness regarding the issue of client-perpetrated violence against psychologists in mental health settings. Unlike the participants’ ratings of their level of awareness, ratings of their students’ perceived level of awareness was almost evenly divided between the higher three levels and the lower two levels of awareness. Nine participants (28.1%) perceived their students’ levels of awareness in the “Somewhat high” to “Very high” range in comparison to eight participants (25.1%) who perceived their students’ levels of awareness in the range of “Low” to “Not a relevant concern for most students”. Interestingly, the data indicates that overall, the participants rated their students’ level of awareness as slightly higher than their own (40.6% vs. 46.9%).

The third hypothesis proposed that participants would indicate that potential or actual client-perpetrated violence against student clinicians would not be a major area of concern at training institutions. Data from the survey appears to confirm this hypothesis as presented in Table 4. Only six participants (19.4%) indicated that they felt this was a major area of concern at training institutions, while 25 of the participants (80.8%) indicated it was not a major concern. However, it should be noted that 25 participants (83.3%) responded that they believed it should be an area of concern at training institutions versus five participants (16.7%) who did not believe it should be an area of concern.

Table 4

<table>
<thead>
<tr>
<th>Area of concern</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>19.4</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>80.8</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td></td>
</tr>
</tbody>
</table>
The fourth hypothesis proposed that the majority of the participants would indicate that mandatory training is not implemented at their institution in the three training areas that were assessed in the survey prior to a student’s first practicum placement: (a) Prevention, (b) violence risk assessment, and (c) management of the potentially violent or violent client. Contrary to this hypothesis, as shown in Table 5, the majority of the participants that answered these questions endorsed that training in all three areas was mandatory prior to students’ first practicum placements. However, when rating the training in each of the three areas as either mandatory or not mandatory, a number of participants chose to skip this question. Of the 33 participants, nine skipped both the question asking if training was mandatory in the area of prevention strategies and violence risk assessment. Even more striking, 14 participants chose not to answer the question inquiring whether training was mandatory in the area of management of the potentially violent or violent client. This may suggest that this particular training area is the least likely of the three areas to be addressed in training programs or that participants may be unaware that this type of training is offered at their institution.

Table 5
*Training Provisions Prior to First Practicum*

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Mandatory</th>
<th></th>
<th>Not mandatory</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants</td>
<td>Percentage</td>
<td>Participants</td>
<td>Percentage</td>
</tr>
<tr>
<td>Prevention strategies</td>
<td>18 (24)</td>
<td>75.0</td>
<td>6 (30)</td>
<td>25.0</td>
</tr>
<tr>
<td>Violence risk assessment</td>
<td>19 (24)</td>
<td>79.2</td>
<td>5 (24)</td>
<td>20.8</td>
</tr>
<tr>
<td>Management of the potentially violent/violent client</td>
<td>16 (19)</td>
<td>84.2</td>
<td>3 (19)</td>
<td>15.8</td>
</tr>
</tbody>
</table>

Note. ( ) denotes number of participants who responded to the question.

The fifth hypothesis proposed that the majority of participants would feel that the training provided by their institution prior to students’ first practicum placements in the areas of
prevention, violence risk assessment, and management of the potentially violent or violent client, adequately prepares them to respond to clients posing a threat of potential or actual violence in some form against the student. As presented in Table 6, twenty-seven of the participants answered the question pertaining to their institutions training provisions as providing adequate preparation in all three training areas (prevention, violence risk assessment, and management of the potentially violent or violent client) to prepare students to respond adequately to a client who is either potentially violent or who is actually violent. However, the results were almost evenly split with 14 participants (51.9%) endorsing that their program’s training provisions provide students with adequate preparation versus 13 participants (48.1%) who disagreed. It is interesting that the majority of the participants chose to answer this question, given that many participants stated that their training institutions required mandatory training in all three training areas. Although mandatory training in these three areas may be required at some of the participants’ institutions, it appears that almost half of the participants do not feel that the training provided by their institution is adequately preparing students to deal with encounters with potentially violent or violent clients.

Table 6

<table>
<thead>
<tr>
<th>Adequate training</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14</td>
<td>51.9</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>48.1</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td></td>
</tr>
</tbody>
</table>

The sixth hypothesis proposed that the majority of participants would report that students at their institution receive less than four hours of training in the combined areas of prevention, violence risk assessment, and management of the potentially violent or violent clients prior to
their first practicum placements. As seen in Table 7, twenty-six of the 33 participants responded to this survey item, with over half of the participants (15, 57.7%) indicating that students indeed received less than four hours of training in these three areas combined prior to their first practicum placements. If these results are representative of the majority of training institutions, it would appear that this result is consistent with the literature, with professional psychologists retrospectively reporting receiving only 0-3.5 hours of training in the management of violent and aggressive client behaviors during their predoctoral training (Guy et. al, 1990).

Table 7

*Estimated Training Time Prior to First Practicum*

<table>
<thead>
<tr>
<th>Training hours</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 hours</td>
<td>15</td>
<td>57.7</td>
</tr>
<tr>
<td>4-6 hours</td>
<td>7</td>
<td>26.9</td>
</tr>
<tr>
<td>More than 6 hours</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

Although a hypothesis was not proposed that students would have continued opportunities for training in prevention, violence risk assessment, and management of the potentially violent or violent client throughout their graduate training, results from the current study indicated that such opportunities became less available at their academic institutions after their first year of training. When participants were asked if there were training opportunities in the areas of prevention, violence risk assessment, and management of the potentially violent or violent client provided by their institution throughout students' training, 62.1% (18 of 29) of the participants answered “No” to the question and 37.9% (11 of 29) answered “Yes” to the question. It could be inferred from this data that training programs’ interest and/or concern in
preparing their students to competently manage the potentially violent or violent client wanes and fewer training opportunities are offered after students begin their first practicum placement.

Perhaps as training programs begin to perceive students as more experienced in working with clients, they may believe that continued need for such training is diminished or is no longer warranted. This may also suggest that training programs assume that students will accumulate such knowledge through interaction with supervisors and training at their practica or fieldwork sites in the future, absolving training programs from future investment or interest in such training. More concerning is the possibility that students without the adequate preparation will gain experience through actual exposure to client violence and learn from their experience, even though they may not be equipped with the requisite clinical skills to manage such unfortunate occurrences competently.

Though not hypothesized, this investigator wondered if participants who had experience with student victims of client-perpetrated violence would exhibit heightened levels of awareness and concern regarding the risks for exposure to client-perpetrated violence among psychologists and student clinicians. Of the 33 participants that completed the survey, nine participants (30%) endorsed having had experience with a student or students who had been a victim(s) of client-perpetrated violence and of those, one participant (11.1%) indicated that he or she was aware of an incident at his or her training institution within the past five years which resulted in a student sustaining physical injury/injuries while working at a practicum and/or fieldwork site. Table 8 summarizes the most common types of client-perpetrated violence reported to participants by their students.
Heightened levels of awareness about client-perpetrated violence against psychologists in mental health settings were exhibited by participants who indicated they had experience with student victims of client-perpetrated violence. As shown in Table 9, when compared to their counterparts who had no experience with student victims of client-perpetrated violence, 77% (seven participants) rated their level of awareness in the range of “Somewhat high” to “Very high” in comparison to participants with no experience dealing with student victims of client-perpetrated violence who rated their level of awareness in the range of “Somewhat high” to “Very high” (five participants, 23.9%).

Table 8

*Types of Client-Perpetrated Violence Reported by Students*

<table>
<thead>
<tr>
<th>Type of violence</th>
<th>Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal abuse/threats</td>
<td>7</td>
<td>77.8</td>
</tr>
<tr>
<td>Physical attack</td>
<td>5</td>
<td>55.6</td>
</tr>
<tr>
<td>Intimidation</td>
<td>4</td>
<td>44.4</td>
</tr>
<tr>
<td>Stalking</td>
<td>4</td>
<td>44.4</td>
</tr>
<tr>
<td>Repeated harassment based on gender, race or ethnicity</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td>Property destruction</td>
<td>1</td>
<td>11.1</td>
</tr>
</tbody>
</table>
Table 9

Comparison of Participants’ Awareness Levels

<table>
<thead>
<tr>
<th>Awareness level</th>
<th>Experience</th>
<th>No Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants</td>
<td>Percentage</td>
</tr>
<tr>
<td>Very high</td>
<td>3</td>
<td>33.3</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td>Somewhat high</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td>Medium</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Low</td>
<td>1</td>
<td>11.1</td>
</tr>
<tr>
<td>Not a relevant concern</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

Participants who had experience working with student victims of client-perpetrated violence also perceived the level of awareness among students at their training institutions concerning the potential for client-perpetrated violence against psychologists in mental health settings as higher than participants who had no experience with student victims of client-perpetrated violence. Four participants (44.4%) who endorsed experience with student victims of client-perpetrated violence rated their students’ level of awareness in the range of “Somewhat high” to “Very high” in comparison to three participants (14.3%) who did not endorse experience with student victims of client-perpetrated violence and rated their students’ level of awareness in the range between “Somewhat high” to “Very high”. Table 10 presents a breakdown of awareness by each level and type of participant experience.
Table 10

Comparison of Perceived Student Awareness Levels

<table>
<thead>
<tr>
<th>Awareness level</th>
<th>Experience</th>
<th></th>
<th>No Experience</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants</td>
<td>Percentage</td>
<td>Participants</td>
<td>Percentage</td>
</tr>
<tr>
<td>Very high</td>
<td>1</td>
<td>11.1</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>High</td>
<td>1</td>
<td>11.1</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Somewhat high</td>
<td>2</td>
<td>22.2</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
<td>33.3</td>
<td>12</td>
<td>57.1</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>22.2</td>
<td>4</td>
<td>19.0</td>
</tr>
<tr>
<td>Not a relevant concern</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td></td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Several other findings are also interesting to compare when looking at differences between these two groups. For example, the data indicate that participants who had experience with student victims of client-perpetrated violence have stronger opinions, as would be expected, that the risk of client-perpetrated violence against student clinicians and practicing psychologists should be an area of concern, in contrast to those with no experience with student victims of client-perpetrated violence (100% vs. 76.2%). Also, participants who indicated they had experience with student victims of client-perpetrated violence, as opposed to those who did not, indicated that they believed more strongly that potential or actual client-perpetrated violence directed at student clinicians is major concern at training institutions in clinical, counseling, and school psychology programs (44.4% vs. 9.5%). Participants who had experience with student victims of client-perpetrated violence were also more likely to believe that their training institutions were providing their students with the clinical skills to competently manage potentially violent or violent clients in mental health settings prior to their first practicum placements compared to those participants lacking experience with student victims of client-
perpetrated violence (77.8% vs. 42.9%). It may be that those who have had experience working with student victims of client-perpetrated violence have more confidence in their training programs and perhaps have a more realistic view of the potential for client-perpetrated violence against psychologists and student clinicians.

In terms of the importance placed on educating students in prevention, violence risk assessment, and management of the potentially violent or violent client in order to ensure their preparedness to encounter situations with potentially violent or violent clients as students as well as future professionals, there were sharp contrasts between those who had had experience with student victims of client perpetrated violence and those who did not. Fifty-five percent (five participants) who had experience with student victims of client-perpetrated violence rated training in these areas as “Very important” compared to 19% (four participants) that had no experience with student victims of client-perpetrated violence. When asked if participants thought that institutions had an ethical obligation to prepare, educate, and equip their students with the necessary clinical skills to competently handle potential or actual client violence directed toward them, 100% of participants who had experience with student victims of client-perpetrated violence answered “Yes” to the question in contrast to 84.2% of participants with no experience with student victims of client-perpetrated violence. In terms of the overall sample, 89.3% answered “Yes” to this question (28 participants). However, it is disconcerting to think that even a small percentage of some educators in these programs do not feel training students to be safe is an ethical obligation.

Participants who indicated they had experience with student victims of client-perpetrated violence were also asked to indicate which types of client-perpetrated violence against students they had found to be the most commonly reported at their institutions. Consistent with the
literature, 77.8% (seven participants) reported that verbal abuse and threats were the most prevalent form of client-perpetrated violence reported by student victims, followed by physical attack reported by 55.6% (five) of the participants. Both stalking and intimidation were reported by 44.4% (four) of the participants. Results are summarized in Table 8.

Participants were also asked if their training program encouraged students to seek support to enhance effective coping with the possible negative emotional and/or physical sequelae following an incident of client-perpetrated violence against them. The majority of the participants 69% (20) answered “Yes” to this question in contrast to 31% (nine) of the participants who answered “No”. Of those participants who had experience with student victims of client-perpetrated violence, 88.9% (eight) of the participants answered “Yes” versus 11.1% (one) of the participants who answered “No”. This may suggest that Directors of Clinical Training who have had experience with student victims of client-perpetrated violence may perceive their institutions as supportive of student victims, or because of being exposed to student victims of client-perpetrated violence, they may recognize the need for training programs to be supportive of students who have experienced client-perpetrated violence.
DISCUSSION

Summary

The purpose of this study was to survey Directors of Clinical Training (DCTs) from clinical, counseling, and school psychology doctoral programs currently accredited by the American Psychological Association (APA) to assess their level of awareness and concern regarding client-perpetrated violence against psychologists in mental health settings, as well as their perceptions of their students’ level of awareness regarding this issue. In addition, the study sought to elicit information from DCTs about the specific types of training provisions currently in place at their institutions that educate and prepare students to prevent, assess, and competently manage encounters with potentially violent or violent clients in clinical settings prior to students’ first practicum placements. The survey also gathered information regarding the availability of ongoing opportunities in these training areas provided by institutions following students’ first year of training, as well as the estimated amount of time allotted to such training in the three areas combined prior to students’ first practicum placements.

The three training areas assessed by the survey were: (a) prevention, (b) violence risk assessment, and (c) management of the potentially violent or violent client. Knowledge and specific skills from these areas have been identified in the literature on client-perpetrated violence against clinicians as essential for facilitating clinician safety, equipping clinicians with the requisite clinical skills to avert or mitigate the physical and/or emotional risks posed by encounters with violence-prone or violent clients, and in promoting appropriate and effective treatment interventions with such clients. DCTs were also asked to assess the adequacy of their institutions’ training provisions in the three recommended training areas, and about their experience (if applicable), with student victims of client-perpetrated violence.
DCTs from three different program affiliations were surveyed. The total number of participants was 33. The majority of the participants endorsed affiliation with clinical psychology programs (60.6%) that offer the PhD as the highest terminal degree (81.3%), followed by counseling psychology programs (21.2%) that offer the PhD as the highest terminal degree, and school psychology programs (18.2%). The Psy.D degree was offered by 18.8% of clinical and school psychology programs surveyed. Twenty of the participants were affiliated with clinical psychology programs, seven with counseling psychology programs, and six with school psychology programs. This breakdown is proportionally consistent with programs accredited by the APA, with programs in clinical psychology being the most numerous, followed by counseling psychology programs, and then school psychology programs.

Results of the survey show that the majority of participants (40.6%) endorsed a “Medium” level of awareness about the potential for client-perpetrated violence against psychologists in mental health settings. When participants were asked to rate their perceptions of students’ level of awareness regarding this issue, the majority (46.9%) rated their students’ level of awareness as “Medium” as well. Interestingly, participants rated their students’ level of awareness as slightly higher than their own. Results of the survey also indicate that the majority of the participants (80.6% vs. 19.4%) do not believe that potential or actual client-perpetrated violence against student clinicians is a major area of concern in clinical, counseling, and school psychology programs.

In terms of training provisions, the majority of participants indicated that training was mandatory at their institutions in each of the three recommended training areas (prevention, violence risk assessment, and management of the potentially violent or violent client) prior to students’ first practicum placements. In the area of prevention, 75% of participants endorsed
mandatory training (18 of 24 participants), 79.2% endorsed mandatory training in violence risk assessment (19 of 24 participants), and 84.2% endorsed mandatory training in management of the potentially violent or violent client (16 of 19 participants). However, caution is suggested when interpreting these numbers, as numerous participants skipped this question in each training category. The majority of the participants (51.9% vs. 48.1%) felt the training provided by their institution prior to students’ first practicum placements in prevention, violence risk assessment, and management of the potentially violent or violent client adequately prepared them to respond to such clients. Of the 27 participants who answered this question, 14 endorsed a response of “Yes” and 13 a response of “No”, indicating that participants were almost evenly split on this issue.

The majority of participants (57.7%, 26 of 33 participants) estimated that less than four hours of time is allotted to training students in the combined areas of prevention, violence risk assessment, and management of the potentially violent or violent client prior to students’ first practicum placements. When asked if training opportunities in these areas were provided by their institution throughout students’ training, 62.1% (11 of 29 participants) answered “No” and 37.9% answered “Yes”, which appears to indicate that the importance placed on these types of training may decrease substantially after the student begins working directly with clients.

Thirty percent of the participants (nine) endorsed that they had experience with at least one student who had been the victim of client-perpetrated violence. One participant indicated knowledge of an incident within the last five years in which a student sustained physical injury due to client-perpetrated violence while working at a practicum or fieldwork site. When examined as a separate group, participants who endorsed experience with student victims of client-perpetrated violence exhibited higher levels of awareness regarding the potential for
client-perpetrated violence against psychologists in mental health settings with 33.3% rating their level of awareness as “Very high” contrasted with participants with no experience with student victims of client-perpetrated violence, with only 4.8% rating their level of awareness as “Very high”.

Participants who endorsed experience with student victims of client-perpetrated violence felt more strongly that client-perpetrated violence against student clinicians and practicing psychologists in the field should be of greater concern than their counterparts who had no experience with student victims of client-perpetrated violence (100% vs. 76.2%). In addition, participants who had experience with student victims of client-perpetrated violence were more inclined to believe that the concern for client-perpetrated violence against student clinicians was of greater concern at training institutions as opposed to their counterparts with no experience with student victims (44.4% vs. 9.5%). Similarly, those having experience with student victims of client perpetrated violence were more likely to believe that their training institutions provided students with the clinical skills necessary to competently manage potentially violent or violent clients prior to their first practicum placements (77.8% vs. 42.9%). Not surprising, participants who had experience with student victims of client-perpetrated violence placed greater importance on educating and training students in prevention, violence risk assessment, and management of the potentially violent or violent client in order to prepare them for the possibility of encountering potentially violent or violent clients, both as students and as future professionals in psychology, with 55.6% rating this as “Very important” vs. 19%.

Last, the majority of all participants (28 of 33) surveyed felt that training institutions have an ethical obligation to prepare, educate, and equip students with the necessary clinical skills to competently handle potential or actual client violence against them (89.3% vs. 10.7%). However,
among those participants who had endorsed experience with student victims of client-perpetrated violence, 100% responded “Yes” to this question.

Conclusions

It is encouraging that levels of awareness among participants regarding client-perpetrated violence against psychologists in mental health settings were greater than hypothesized. Cumulatively, the level of awareness reported by participants was in the higher levels ("Somewhat high" to High”) with participants appearing to demonstrate healthy levels of awareness concerning the potential and actual risk of client-perpetrated violence against psychologists in mental health settings. While this issue is serious to say the least, clinicians are cautioned about becoming overly concerned or paranoid about client-perpetrated violence and to maintain a “healthy respect” (Guy and Brady, 1998, p. 409) about the risks of becoming a victim. A healthy level of awareness related to the possibility of client-perpetrated violence ultimately helps the clinician make informed decisions that generate the most effective prevention, management, and coping strategies for dealing with client aggression in one’s daily work (Guy & Brady, 1998). Berg et al (2000) also caution clinicians against assuming an attitude of paranoia about client-perpetrated violence. They suggest clinicians cultivate a “sustained level of alertness” (p. 16) in terms of recognizing the potential for client-perpetrated violence against them, which ultimately enhances safety and prevention. They compare this level of alertness to “driving a car defensively” (p. 16).

An interesting finding was that the majority of participants rated their students’ level of awareness regarding the risks for client-perpetrated violence against psychologists in mental health settings as slightly higher than their own. It is likely that participants may have limited contact with their institution’s students given their job responsibilities. The proximity ratings in
this area may be due to convenience or lack of information. However, cumulative levels of participants’ perceived level of student awareness was almost evenly split between the higher and lower ratings of the item scale (28.1% vs. 25.1%) It could be that participants who rated their students’ level of awareness in the higher ranges (“Somewhat high” to “Very high”) may possess higher levels of awareness themselves, or may have had experience with student victims of client-perpetrated violence. Similarly, participants who rated their students’ level of awareness in the lower range (“Low” to “Not a relevant concern for most students”) may also possess lower levels of awareness themselves, or may have inexperience with student victims of client-perpetrated violence.

Based on findings in the literature, it is not surprising that an overwhelming number of participants (80.6%) did not believe that potential or actual client violence against student clinicians was a major area of concern in clinical, counseling, and school psychology programs. On the other hand, when asked if they believed client-perpetrated violence against practicing psychologists and student clinicians should be an area of concern, the vast majority of participants (83.3%) responded affirmatively. This may suggest that those who chose to participate in this study have a much greater interest in this issue, and perhaps have had experience with client-perpetrated violence against students, or possibly have been victims themselves.

Also encouraging were results showing the majority of participants endorsed mandatory training at their institutions in the recommended training areas of prevention, violence risk assessment, and management of the potentially violent or violent client prior to students’ first practicum placements. However, when taken with the findings that the majority of participants estimated that less than four hours were spent educating students in all three training areas
combined, and that opportunities for such training were often limited or non existent past students’ first year of training, questions arise about the comprehensiveness and quality of the training being provided. One recent study surveyed 202 clinical and counseling psychology students (Gately & Stabb, 2005). One part of the study asked students to rate their perceptions of their training experiences in management of the potentially violent client in the areas of violence assessment, workplace safety, verbal strategies, and restraint techniques. Results showed that students rated their training in all of these areas as inadequate. Research has emphasized the importance of simulated training experiences (APA, 1993; Berg et al., 2000; Guy & Brady, 1998) as well as ongoing safety training for clinicians throughout their careers. Tishler et al. (2000) emphasize that training clinicians in appropriate management of violence should be “proactive” (p. 40) and should occur prior to experiencing a violent episode with a patient. Berg et al. (2000) assert that safety training for clinicians “should be as routine as fire drills” (p. 10) and that ongoing and mandatory education in violence safety should be required of clinicians throughout their careers, including the training years.

Thirty percent of the participants endorsed experience with student victims of client-perpetrated violence. Gately & Stabb (2005) in their study, which surveyed 202 clinical and counseling students, found that 10% of the participants reported being victims of client violence. Though the overall sample of participants in this study was very small and DCTs were surveyed as opposed to students, the rate of student victimization due to client-perpetrated violence was twice as high as that reported by Gately and Stabb (2005). However, due to the small sample size of this study, it is not clear whether such results are representative of the experiences of the entire population of DCTs from APA accredited clinical, counseling, and school psychology programs. Nevertheless, this data is still concerning, given that participants who had experience with
student-victims of client-perpetrated violence in this study reported physical attack as the second most common form of client-perpetrated violence reported by students at their institutions.

The majority of the participants (89.3%) were affirmative in their belief that training institutions have an ethical obligation to prepare, educate, and equip students with the necessary clinical skills to competently manage potential or actual client violence against them. Standard 7.01 of the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002) states, “Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program.” The reason(s) that 10.7% of the participants from this study do not feel this is an ethical obligation required by training institutions is not clear; however, as educators they should be familiar with the standards in the ethics code that pertain to education and training, especially when the safety of their students is concerned. In sum, educators cannot be responsible for the safety of their students, but they are responsible for educating them about the risks inherent in the profession and providing them with the appropriate training to mitigate such risks. In this sense, “appropriate knowledge and proper experiences” could also be seen as consistent with standard 3.04 of the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002) which states, “Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.”
Ramifications

Previous research indicates that student clinicians and clinicians with less experience are the most vulnerable to client-perpetrated violence. Guy and Brady (1998) point out that students are the “least capable of adequate assessment, identification, and containment of physically aggressive patients” (p. 411). In addition, they contend that students are “often assigned the most disturbed patients who are inherently more likely to be dangerous” (p. 411). Recent research by Gately & Stabb (2005), which surveyed 202 clinical and counseling psychology students, found that 10% of the participants reported being victims of client violence and 26% reported witnessing client violence. The bulk of the research on the topic of client-perpetrated violence against mental health clinicians over the past four decades has been retrospective in nature and has limited the scope of participants to practicing clinicians in varied mental health disciplines. To this investigator’s knowledge, no study has sought to directly gather data from current DCTs about their level of awareness and concern regarding client-perpetrated violence as it pertains to practicing psychologists and student clinicians, or to obtain information about current training provisions in the areas of prevention, violence risk assessment, and management of potentially violent or violent clients that assist students in reducing their risks for becoming victims of client-perpetrated violence in mental health settings.

The low response rate of this study may suggest that DCTs are not an accessible population for this type of research. However, they are likely the most knowledgeable about training provisions in place at their institutions that help students learn to manage the clinical, personal, and professional challenges of the potential for client-perpetrated violence against them. Should future research on this topic be attempted with this population, it may be prudent to use a survey instrument that is more focused and less broad than the one developed for this
study. In addition, given the target population’s challenging time constraints, use of a survey instrument that is more brief may facilitate participation. For example, targeting questions in one specific area such as training provisions, or experience with student victims of client-perpetrated violence might be more appropriate than trying to cover several areas pertaining to client-perpetrated violence in one survey instrument. In addition, narrowing the definition of client-perpetrated violence may be beneficial as well. For instance, one might focus only on the most common types of client-perpetrated violence against clinicians found in the literature.

The input of educators regarding training provisions for students in this area is crucial in order to achieve an accurate assessment of the types of training students are receiving regarding client-perpetrated violence against clinicians as well as the efficacy of such training. Since it appears that DCTs are reluctant, for what could be numerous reasons, to participate in research on this topic, it may be useful to continue to gather information about training provisions and client-perpetrated violence from students who may be more accessible and willing participants.

Limitations

Several limitations existed in this study. First, only DCTs of APA accredited clinical, counseling, and school psychology programs were invited to participate, making the proposed target population of the study approximately 364 participants. Efforts were made to contact DCTs from all accredited programs; however, contact information could not be found for all programs, yielding a potential sample size of 340 DCTs. Response rate was less than ten percent, with only 33 DCTs participating in the study. Since very little data was obtained, meaningful generalizability of results to the target population is simply not possible. Therefore, only speculative conclusions based on descriptive data from a small group of participants can be proposed.
Since participation in this research was voluntary, and given the small number of participants, it may be likely that participants had greater interest in the topic of the study than non-participants. Aside from simply lacking interest in the study topic, lack of time may have been a significant factor that deterred potential participants. The fact that client-perpetrated violence against clinicians is identified as an unpopular topic in the literature and one that most clinicians find aversive should not be overlooked. Research on this topic continually identifies clinician denial as a major obstacle that prevents them from recognizing and/or acknowledging this issue as a relevant occupational danger. For this reason, some potential participants may have elected not to complete the survey. In addition, because lack of reporting or underreporting of client-perpetrated violence against mental health clinicians is common, potential participants may not have knowledge of the true prevalence of such incidents at their institution, resulting in little or no experience in dealing with students who have been victims of client-perpetrated violence, making the issue much less salient for them.

It is also possible that some potential participants may have been victims of client-perpetrated violence at some point in their training or career, and completing the survey may have been deemed too psychologically distressing for them. In addition, recent research (Gately & Stabb, 2005) continues to support previous findings in the literature that training programs are not equipping students with the appropriate awareness or clinical skills to work competently with potentially violent or violent clients. Some potential participants may have been reluctant or defensive about taking the survey, especially if they perceived their institution’s training provisions for students as inadequate.

Finally, the manner in which clinicians define acts of client-perpetrated violence is often highly subjective. Some clinicians may view only extreme and explicit acts of violence such as
physical assault as client-perpetrated violence, while others may recognize more subtle acts (e.g., verbal abuse/threats, intimidation, and harassment) as acts of client-perpetrated violence against clinicians. Assisting clients with the management of intense emotions is part of the clinician’s job and is to be expected. Thus, lack of interest, lack of time, inexperience with client-perpetrated violence against themselves or their students, discomfort with the study topic, denial of the problem of client-perpetrated violence against clinicians, or possible defensiveness related to inadequate training provisions at their institution may all be factors that inhibited participation in this study. Either educators may not be concerned with the safety of their students with respect to client-perpetrated violence, or they are preparing them so well to encounter client-perpetrated violence against them that this study topic was not worthy of their attention. However, previous research on this topic appears to confirm that little has changed over the past four decades in terms of preparing student clinicians to prevent, assess, and manage the clinical demands and challenges posed by the violence-prone or violent client.
REFERENCES


Cottle, M., Kuipers, L., Murphy, G., & Oakes, P. (1995). Expressed emotion, attributions and coping in staff who have been victims of violent incidents. Mental Handicap Research, 8(3), 168-183.


APPENDIX A

Student Clinicians and Client-Perpetrated Violence
Student Clinicians and Client-Perpetrated Violence

Client-perpetrated violence for the purposes of this survey includes any explicit or implicit behavior by a client that is intended to threaten or harm the physical and/or emotional integrity of the clinician. Such behaviors include, but are not limited to actual or threatened physical attack, sexual assault, verbal abuse, verbal threats, repeated harassment based on one’s gender, race, or ethnicity, intimidation, stalking, property destruction, or threats to harm others associated with the clinician (e.g., family, friends, pets, spouse, etc.).

Part I: Demographic Information

1. With which type of psychology program are you affiliated?
   Clinical Psychology
   Counseling Psychology
   School Psychology

2. What is the highest terminal degree offered by your institution?
   PhD
   Psy.D
   Ed.D
   M.A.
   M.S.

3. In which geographical region of the United States is your program located?
   Northeast (CT, ME, VT, NH, NY, MA, RI, NJ, PA)
   Midwest (IN, IL, MI, OH, WI, IA, KS, MN, MO, NE, ND, SD)
   South (DE, DC, FL, GA, MD, NC, SC, VA, WV, AL, KY, MS, TN, AR, LA, OK, TX)
   West (AZ, CO, ID, NM, MT, UT, NV, WY, AK, CA, HI, OR, WA)

4. How many years have you been the Director of Clinical Training at your institution?
   Less than 1 year
   1-5 years
   6-10 years
   More than 10 years

Part II: Awareness

5. How do you perceive your level of awareness regarding the potential for client-perpetrated violence against psychologists in mental health settings?
   Very high
   High
   Somewhat high
   Medium
   Low
   This is not a relevant concern for me
6. How do you perceive the level of awareness among your training institution’s students regarding the potential for client-perpetrated violence against psychologists in mental health settings?
   Very high
   High
   Somewhat high
   Medium
   Low
   This is not a relevant concern for most students

7. In your opinion, do you believe that the risk of client-perpetrated violence against student clinicians and practicing psychologists in the field should be an area of concern?
   Yes
   No

8. In general, do you believe that potential or actual client-perpetrated violence directed at student clinicians is a major area of concern among training institutions in clinical, counseling, and school psychology?
   Yes
   No

Part III: Training

9. Please indicate when formal clinical training (students begin working directly with clients) begins at your institution.
   Within the first 6 months
   Within the first seven to 12 months
   In the second year
   After the second year

10. Does your training program currently provide students with education in prevention strategies to mitigate the incidence of client-perpetrated violence against them prior to their first practicum placement?
    Yes
    No

11. If your training program provides students with education in prevention strategies, which of the following are emphasized during training? Please mark all that apply.
    Stimulating awareness among students about the prevalence of client-perpetrated violence against clinicians
    Educating students about the potential for becoming a victim of client-perpetrated violence
    Educating and teaching students to recognize the various forms of client-perpetrated violence against clinicians
    Educating students about environmental and architectural safety in clinical settings
    Educating students about the psychodynamics of violence
Educating students to recognize the most common physiological, verbal, and behavioral signs of impending violence
Encouraging students to become familiar with workplace safety policies and procedures in practicum settings to maximize their physical safety
Encouraging students to obtain appropriate supervision and/or consultation when concerned for their personal safety when working with a potentially violent or violent client
Encouraging students to formulate a personal safety plan prior to becoming a victim of client-perpetrated violence
Role-play to gain competence in managing potentially violent or violent clients
Basic nonviolent self-defense training

12. If such training exists at your institution, in which type(s) of format(s) is it offered? Please check all that apply.
   Classes
   Seminars
   Reading
   In-Service training
   Grand Rounds

13. Is this training mandatory?
   Yes
   No

14. Does your training program currently provide students with education in violence risk assessment to aid them in recognizing the common factors associated with potentially violent or violent clients prior to their first practicum placement?
   Yes
   No

15. If your training program provides students with education in violence risk assessment, which of the following areas are emphasized during training? Please mark all that apply.
   Educating students to recognize the most common clinical, demographic, historical, environmental, and situational variables that are frequently associated with a client-perpetrated violence against the clinician
   Educating students regarding the most common psychiatric disorders associated with an increased risk for violence.
   Appropriate assessment of a client’s physical, behavioral, and verbal presentation, which may alert the clinician to a client’s potential for violence
   Stressing the importance of obtaining a thorough history of violence from the client
   Assessment of past violent behavior (frequency, severity, and proximity) in order to determine the client’s current level of risk for violence
   Assessment of recent episodes of violent behavior
   Assessment to aid the clinician in recognition of the client’s triggers and patterns of violent behavior
   Training students in differential diagnosis to inform appropriate treatment interventions with potentially violent or violent clients
Training in the use of actuarial aids

16. If such training exists at your institution, in which type(s) of format(s) is it offered? Please check all that apply.
   Classes
   Seminars
   Reading
   In-Service training
   Grand Rounds

17. Is this training mandatory?
   Yes
   No

18. Does your training program provide students with the clinical skills to competently manage potentially violent or violent clients in mental health settings prior to their first practicum placement?
   Yes
   No

19. If your training program provides students with education in the management of potentially violent or violent clients, which of the following areas are emphasized? Please mark all that apply.
   Selection of appropriate treatment interventions that match the client’s present level of risk for violence against the clinician
   Training students how to react and intervene when confronted with a client who has a weapon
   Use of appropriate verbal de-escalation strategies
   Use of affect management
   Use of limit setting
   Use of nonviolent self-defense techniques
   Use of appropriate nonverbal responses (e.g., body language, eye contact, speech rate and volume, respecting the client’s need for personal space and maintaining appropriate distance from the client)
   Use of problem solving with the client
   Use of active listening and paraphrasing to convey empathy, attentiveness, and to establish a sense of connectivity with the client

20. If such training exists at your institution, in which type(s) of format(s) is it offered? Please check all that apply.
   Classes
   Seminars
   Reading
   In-Service training
   Grand Rounds

21. Is this training mandatory?
22. Does your training program encourage students to seek support to enhance effective coping with the possible negative emotional and/or physical sequelae following an incident of client-perpetrated violence against them?
Yes
No

23. Which type(s) of support would you encourage students to obtain should they become a victim of client-perpetrated violence? Please mark all that apply.
- Encourage student to disclose incident to a supervisor
- Encourage more frequent supervision and/or consultation to lessen stigma of incident
- Encourage the necessity of personal and professional self-care
- Encourage the student to engage in personal therapy to manage negative emotional consequences
- Encourage prompt debriefing after an incident with student’s supervisor
- Consult the literature for more information to manage negative consequences
- Get medical attention for physical injuries

24. How much time do you estimate is allotted to training students in the previously mentioned prevention strategies, violence risk assessment, and management strategies to prepare them for working with potentially violent or violent clients and possibly being victims of client-perpetrated violence prior to their first year of practicum training at your institution?
- 1-3 hours
- 4-6 hours
- More than 6 hours

25. Do you feel the training that is provided by your institution prior to a student’s first practicum placement in prevention strategies, violence risk assessment, and management strategies adequately prepares the student to respond to a client that is potentially or actually violent?
- Yes
- No

26. If such training is not required prior to a student’s first practicum placement at your institution, is it expected that students would receive such training at their first practicum site?
- Yes
- No

27. Is the training that is provided by your institution limited to specific mental health settings and clinical populations or does the training generalize to most mental health settings and clinical populations?
- The training offered is site specific
- The training offered specific only to certain clinical populations
The training offered is site specific and population specific  
The training offered generalizes to most mental health settings

28. Are there training opportunities in the areas of prevention strategies, violence risk assessment, and management of the potentially violent or violent client provided by your institution throughout the student’s training at your institution?  
Yes  
No

29. Are these training opportunities mandatory?  
Yes  
No

Part IV: Experience with student victims of client-perpetrated violence

30. Have you had experience with a student or students who have been victims of client-perpetrated violence at your training institution? (if “No” is chosen they will automatically be sent to the next section of the survey).  
Yes  
No

Please base your answers to the following seven questions in this section on your experience with students who have been victims of client-perpetrated violence at your training institution.

31. Do you think there is a need for more opportunities during the training years to prepare students to work with potentially violent or violent clients?  
Yes  
No

32. Do you think there is a need to better prepare students during the training years for the possibility of becoming victims of client-perpetrated violence?  
Yes  
No

33. Do you think that training in prevention strategies, violence risk assessment, and management of potentially violent/violent clients should be a required component of students’ training prior to the beginning of their first practicum placement?  
Yes  
No

34. When do you believe students are most vulnerable to being victims of client-perpetrated violence?  
First year of clinical work with clients  
Second year of clinical work with clients  
Third year of clinical work with clients
Fourth year of clinical training and above
Anytime during their work with clients

35. What types of clinical settings do you think place students at the greatest risk for becoming victims of client-perpetrated violence? Please check all that apply.
- Inpatient settings
- Residential treatment settings for adults
- Residential treatment settings for juveniles
- Forensic settings (correctional facilities, state hospitals)
- Schools
- College counseling centers
- Community Mental Health Clinic
- Counseling center affiliated with and located within the student’s training institution

36. Which types of client-perpetrated violence against students have you found to be the most commonly reported at your training institution? Please check all that apply.
- Physical attack
- Sexual assault
- Verbal abuse/threats
- Property destruction
- Stalking
- Repeated harassment based on one’s gender, race, or ethnicity
- Intimidation
- Threats to harm others associated with the student clinician (e.g., spouse, children, family members, friends, and pets)

37. Are you aware of any incidents of client-perpetrated violence at your institution, within the last five years, in which a student sustained physical injury/injuries while working at a practicum and/or clinical fieldwork site?
- Yes
- No

V: Education

38. How important do you feel it is to educate students at your institution in these three training areas (prevention, assessment, and management) in order to ensure that they are prepared for the possibility of encountering potentially violent or violent clients, both as student clinicians, and as future licensed professionals in the fields of clinical and counseling psychology?
- Very Important
- Important
- Somewhat Important
- Minimally important
- Not important
39. Do you feel it is largely the student clinician’s responsibility to be aware of, educate, and equip himself or herself with effective strategies to prevent, assess, manage, and cope effectively with the potential for or actual occurrence of client-perpetrated violence against himself or herself?
Yes
No

40. Do you think that training institutions have an ethical obligation to prepare, educate, and equip their students with the necessary clinical skills to competently handle potential or actual client violence directed toward them?
Yes
No
APPENDIX B

Invitation to Participate in Dissertation Research about Student Clinicians and Client-Perpetrated Violence
Dear Dr. Doe:

My name is Misty Hoslitas and I am a doctoral candidate in clinical psychology at Pacific University’s School of Professional Psychology. Your contact information was obtained from the American Psychological Association’s listings of accredited doctoral programs in clinical, counseling, or school psychology and from your institution’s website. I am currently collecting data for my dissertation under the direction of Jay C. Thomas, PhD, ABPP and would like to invite you to participate in an online survey entitled “Student Clinicians and Client-Perpetrated Violence”.

The purpose of this research is to survey current Directors of Clinical Training at APA accredited clinical, counseling, and school psychology doctoral programs to gather information about: (1) their overall level of awareness and concern regarding the risk of client-perpetrated violence against psychologists in mental health settings and beginning student clinicians, (2) their perceptions of students’ level of awareness of this issue at their training institutions, (3) current training opportunities offered by their institutions to educate beginning clinicians in prevention strategies, violence risk assessment, and management of potentially violent or violent clients, (4) their personal experience (if applicable) with students who have been victims of client-perpetrated violence, and (5) their views regarding the responsibility of training institutions to educate and prepare students for the possibility of encountering client-perpetrated violence against them.

Completion of the survey is not expected to exceed more than 20-25 minutes; however, this time could be shorter or longer depending upon the training opportunities provided by your institution and if you have had experience with students who have been victims of client-perpetrated violence. The risk of completing this survey may cause some participants to experience minor emotional discomfort if they have been victims of client-perpetrated violence or have dealt with student victims. While the risk should be minimal, the decision to participate should be considered with this in mind.

Data collected from this survey will be completely anonymous. Individual results will not be reported. Participation in this survey is voluntary and you have the right to discontinue participation at any time without penalty. Completion of the survey will constitute your informed consent. If you would like to complete the survey, please proceed to the following link:

http://www.surveymonkey.com/s/FXQG7RZ

Thank you for taking the time to read this request. Your participation in this survey is greatly appreciated and will hopefully shed light on a topic that has often received limited attention. Should you have any questions pertaining to this research, please feel free to contact my faculty advisor or me. All correspondence will be kept confidential. You may also contact the Pacific University Institutional Review Board at (503) 352-2112 should you have further inquiries regarding this study.
Sincerely,
Misty Homlitas, MS
Doctoral Candidate
School of Professional Psychology
Pacific University
mcar1930@pacificu.edu
Principal Investigator

Jay C. Thomas, PhD, ABPP
Distinguished University Professor and Assistant Dean
School of Professional Psychology
Pacific University
thomajc@pacificu.edu
Faculty Advisor
APPENDIX C

Pacific University Informed Consent to Act as a Research Participant
Student Clinicians and Client-Perpetrated Violence

1. PACIFIC UNIVERSITY INFORMED CONSENT TO ACT AS A RESEARCH PARTICIPANT

You are invited to participate in a study that examines level of awareness and concern regarding client-perpetrated violence against psychologists and student clinicians in mental health settings as well as current training opportunities offered at APA accredited clinical, counseling, and school psychology doctoral programs that specifically assist student clinicians, particularly beginning student clinicians, with recognizing and mitigating the possible risks of potential or actual client-perpetrated violence against them in clinical settings.

You are eligible to participate in this study if you are currently a Director of Clinical Training at an APA accredited clinical, counseling, or school psychology doctoral program. This study is anticipated to begin in February of 2011 and to be completed by March 2011.

Should you agree to participate in this study, you will be asked to complete a survey entitled “Student Clinicians and Client-Perpetrated Violence”. The time required to complete the survey will vary depending upon your personal experience(s) with student victims of client-perpetrated violence and current training provisions offered at your institution; however, it is estimated that the survey should take no more than 20-25 minutes to complete.

The survey will ask you to provide basic demographic information, and to answer questions pertaining to your level of awareness and concern about client-perpetrated violence against psychologists and student clinicians in mental health settings and training programs, your perceptions regarding students’ level of awareness of this issue at your institution, and the type(s) of training currently provided by your institution to educate student clinicians in strategies to prevent, assess the potential and risks for client-perpetrated violence against them, and to competently manage violent clients in clinical settings. In addition, you will be asked to indicate the type(s) of support that are available and/or encouraged by your institution for student victims of client-perpetrated violence, to answer questions based on your personal experience (if applicable), with students who have been victims of client-perpetrated violence, and about your views regarding the responsibility of training institutions to educate and prepare students for the possibility of encountering client-perpetrated violence against them.

Participation in this study is voluntary and data collected from this survey will be completely anonymous. You may withdraw your participation at any time without penalty. Completion of this survey will constitute your informed consent.

Completing this survey may cause some participants to experience emotional discomfort if they have been victims of client-perpetrated violence and/or have had upsetting personal experience(s) with students and/or colleagues who have been victims of client-perpetrated violence. Such risk is anticipated to be minimal; however, participants should consider the costs and benefits of completing the study given such risk.
If you have any questions or concerns regarding this study, you may contact the principal investigator, Misty Homlitas, MS at mcar1930@pacificu.edu or (503) 459-3250, or the principal investigator’s faculty advisor, Jay C. Thomas, PhD, ABPP at thomajc@pacificu.edu or (503) 352-2623.
APPENDIX D

Reminder Invitation
Dear Dr. Doe:

My name is Misty Homlitas and I am a doctoral candidate in clinical psychology at Pacific University’s School of Professional Psychology. I am currently collecting data for my dissertation under the direction of Jay C. Thomas, PhD, ABPP. If you have received this correspondence, you were the recipient of an invitation, which was sent to you two weeks ago to participate in a survey entitled “Student Clinicians and Client-Perpetrated Violence”.

I understand that your time is very valuable. However, I hope you will consider completing the survey, which should take no more than 20-25 minutes. To my knowledge, no survey of Directors of Clinical Training has been done on this topic. By participating in this research, you have an opportunity to contribute information to area of psychology that has received to date, very limited attention in the literature, which could potentially inform and/or improve current clinical training provisions for beginning student clinicians in the areas of prevention strategies, violence risk assessment procedures, and management of the potentially violent or violent client in clinical settings. If you would like to participate in the survey, please connect to the following link:

http://www.surveymonkey.com/s/FXQG7RZ

Again, thank you for your consideration. Should you have questions about this study prior to participation or afterwards, please feel free to contact me or my faculty advisor. All correspondence will be kept confidential. You may also contact the Pacific University Institutional Review Board at (503) 352-2112 should you have further inquiries regarding this study.

Sincerely,

Misty Homlitas, MS  
Doctoral Candidate  
School of Professional Psychology  
Pacific University  
mcar1930@pacificu.edu  
Principal Investigator

Jay C. Thomas, PhD, ABPP  
Distinguished University Professor and Assistant Dean  
School of Professional Psychology  
Pacific University  
thomajc@pacificu.edu  
Faculty Advisor