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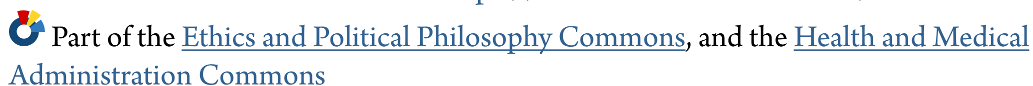
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Walden University

College of Counselor Education & Supervision

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Cynthia S. Ellison

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Walden University
2019

Abstract

Understanding the Lived Experiences of Counselors Assaulted by Clients

by

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MA, Hampton University, 2008

BS, Norfolk State University 1985

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

May 2019

Abstract

Assault of community-based mental health professionals is a worldwide phenomenon, and current extant literature examines the prevalence of client assault on counselors, social workers, and psychiatric personnel. While there is significant quantitative scholarship on the incidence of this phenomenon on social workers and psychiatric personnel, there are limited statistical data on client-perpetrated violence against community-based counselors and no qualitative studies found that examined how these professionals experience this occupation risk. Therefore, the purpose of this study was to explore how counselors who work in community-based settings make sense of these experiences. Through semi structured interviews, 6 community-based counselors living in the Southeastern region of the U.S. shared their lived experience of client assault. Hermeneutic was used as a methodological and theoretical framework to analyze the data. The following themes emerged from the data study: training as a management strategy, ambivalence as a new way of being, and connections for well-being. The results of this study have training, practice, supervision, and social change implications. Through adding counselors' voices to the discourse on client assault, the findings of this study can be used to identify experiences and training that will assist counselors in caring for themselves in the aftermath of an assault. Furthermore, understanding these experiences may inform the development of protocols for keeping this vulnerable population safe.

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Dedication

In the beginning was Simone Lynette Williams. This dissertation was birthed out of her experience of being assaulted. As I observed how this experience affected her, I realized that I was also being affected. I also began to wonder how other community-based counselors responded to this occupational risk. Simone, your lived experience provided me an opportunity to contribute to the knowledge base for client assault of community-based counselors. On behalf of the counseling profession and the stories of those written on these pages, thank you for being the impetus from which new knowledge was birthed.

Acknowledgments

Where there is no vision the people perish (Proverbs 29:18). There are two people who carried the vision of me completing a terminal degree before it was conceived in me. First, I want to thank Raymond Ellison. He first called me doctor in 1989. This milestone is bittersweet because he went to his heavenly reward before it was birthed. Secondly, I want to thank my spiritual father, Reverend Sidney Foster, Jr., who has also transcended this earthly realm. He helped me understand that I am an ambassador of the light and that my light is an outward reflection of the divine connection that I have with my eternal source. Hence, my connection to my research design and theoretical framework, hermeneutic phenomenology.

Next, I would like to acknowledge my dissertation village. I am eternally grateful to my mother, Evelyn Mahone, who boosted my confidence; my husband, Dwight Powell, for his love, support, and patience; and my son, Christopher; my sisters, Sheila, Candace, and Kimberly; and my brother, Michael, I love you all. To Aunt Dorothy, thank you for your prayers, support, and encouragement. To my proofreaders, Patricia Johnson-Lewis and Fred Jackson, thank you for your time and talents. Thomasina, thank you for your unwavering presence, patience, and prayers. Dr. Spencer Baker, thank you for believing in me.

I would also like to acknowledge my dissertation committee members. Dr. Katarzyna Peoples, Chair and Methodologist; Dr. Wynn Dupkoski, Content Specialist; and Dr. Adrian Warren, University Research Reviewer. Each of you have greatly assisted me in finding my scholarly voice.

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Table of Contents

List of Tables vii

List of Figures viii

Chapter 1: Introduction to the Study 1

Client Assault as an Occupational Dilemma 1

Problem Statement 2

Purpose 4

Significance 4

Definitions 6

Background 7

Theoretical Framework 9

Research Questions 11

Nature of the Study 12

Possible Types and Sources of Data 13

Possible Analytic Strategies 14

Assumptions, Scope, and Limitations 15

Limitations 15

Delimitations 15

Assumptions 16

Summary 17

Chapter 2: Literature Review 18

Introduction 18

Gaps in the Literature 19

Literature Search Strategy 20

A Conceptual Roadmap 21

The Philosophical Perspectives of Heidegger and Gadamer 21

The Hermeneutic Circle 22

A Critical Review of the Literature 23

The Emergence of Workplace Violence 25

Workplace Violence: A National Dilemma 25

Barriers to Understanding the Prevalence of These Events 27

Conceptualization of Assault 27

Shaming and Blaming 29

No Tracking System 30

The Prevalence of Assault 32

Acceptance of the Risk 33

Counselors 33

Social Workers 37

Psychiatric Personnel 41

Precipitants of Assault 44

Gender 45

Experience 49

Symptom Presentation 50

The Therapeutic Alliance 54

Setting. 55
Costs Associated with Assault 59
Psychological Costs 60
Client-Related Costs 62
Preventative Measures 63
Chapter Summary 66
Chapter 3: Research Method 68
Overview 68
Research Design and Rationale 68
Research Questions 69
A Phenomenological Approach 70
What is Phenomenology 70
Heidegger's View of Phenomenology 70
A Fusion of Philosophical Perspectives 72
Participants 72
Data Collection 74
Data Collection Assumptions 75
Preliminary Meeting 76
The Interview Protocol 76
Data Analysis 77
Illustrated Steps 78
Trustworthiness 83

The Role of the Researcher 83
The Ethics of Research 86
Conclusion 87
Chapter 4: Results 88
Introduction 88
Setting 90
Participant Demographics 91
Overview of Themes 92
Methodology 92
Situated Narratives 94
Analysis of Experience 96
Illustrated Summary 99
Training as a Management Strategy 99
Family of Origin 100
Perceptions about Training 101
Perceptions of Previous Work Experience 102
Theme 2: Ambivalence as a new way of Being 104
Client Ambivalence 104
Self-Ambivalence 107
Ambivalence Towards the Profession 110
Theme 3: Connections for Well-Being 112
Faith-based Connections 114

Supervisors and Peers 115
A Synopsis of the Results 116
Reflexivity..119
Parts to Whole.. 119
Whole to Parts.. 121
Trustworthiness..122
Summary 123
Chapter 5: Discussion, Conclusions, and Recommendations 125
Interpretation of the Findings...125
Theoretical Implications 127
Aligning Outcomes with Other Scholarship 128
Theme 1: Training as a Management Strategy 129
Theme 2: Ambivalence as a new way of Being... 133
Theme 3: Connections for Well-Being 136
Limitations 139
Implications..141
Training Implications.. 141
Practice Implications... 142
Supervision Implications 143
Recommendations for Future Scholarship...144
Social Change Implications 146
Conclusion 148

References...150

Appendix...1504

List of Tables

Table 1. Participants' Demographic Data 92

Table 2. Initial Meaning Units 92

Table 3. Subquestions and Thematic Categories 92

List of Figures

Figure 1. The hermeneutic circle 10

Chapter 1: Introduction to the Study

Client Assault as an Occupational Dilemma

Mental health professionals who provide mental health services to the public are at an increased risk of being assaulted (Occupational Safety & Health Administration [OSHA], 2016; Piquero, Piquero, Craig, & Clipper, 2013; Storey, 2016). Workplace violence (WPV) has been broadly defined as acts or threats meant to intimidate, harass, or cause physical or psychological harm to employees while in the workplace (OSHA, 2016). It exists on a continuum ranging from threats and assaults to homicide (OSHA, 2016). Assault, which is threatening the physical and psychological well-being of providers of mental health services, such as social workers, psychiatric personnel, and counselors, represents the largest category of these events (OSHA, 2016). In 2015, more than 2.9 million WPV incidents occurred, and approximately 562,000 of those were in the health and social service industry (OSHA, 2016). Approximately 50% of these events resulted in transfers, missed days from work, and restrictions (OSHA, 2016).

WPV is not a new phenomenon. In 1996, OSHA (2016) established voluntary guidelines to assist employers in implementing training protocols designed to minimize the risk of these events and manage them events once they occurred. These guidelines were established in recognition of the impact WPV have on community-based professionals (OSHA, 2004). Understanding the prevalence and effects of WPV on mental health professionals is critical since ethical codes of practice reinforce protection of clients (American Counseling Association [ACA], 2014; American Psychological Association [APA], 2010; National Association of Social Workers [NASW], 2008).

Problem Statement

In 2015, healthcare and social assistance professionals missed more than 158,000 workdays as a result of experiencing different forms of WPV (OSHA, 2016). Since an exhaustive review of the literature only identified a few studies on WPV experiences of counselors (Storey, 2016), statistics on how this phenomenon has affected community-based counselors are limited. According to OSHA, in 2015, the median number of days away from work to recuperate following experiencing an act of WPV was 6 (Bureau of Labor Statistics, 2016). Unscheduled absences may erode the clients trust in the therapeutic alliance; Research on the effects of the therapeutic alliance indicated that it is correlated with outcomes in therapy and premature termination of services (Swift & Greenberg, 2015). To mitigate the possible threat to client care that absences pose, the ACA (2014) has recommended that counselors providing services to clients have a clinical plan of care in place for managing absences and crisis events. Despite having a plan in place, the therapeutic alliance may be weakened and leave clients feeling abandoned when counselors are unavailable to provide care.

When counselors are victims of assault, regardless of the circumstances, counselors, their supervisees, and coworkers may question their clinical abilities (Storey, 2016). An investigation on stalking of counselors in British Columbia confirmed that counselors' sense that the assault came as a result of clinical deficits may reinforce underreporting of WPV events (Storey, 2016). Several researchers and a governmental agency have identified underreporting as a barrier to understanding the prevalence of these events (OSHA, 2016; Piquero et al., 2013; Storey, 2016). Likewise, counselors'

silence, which results from shaming and/or blaming by colleagues or supervisors, may exacerbate the risk of developing post-traumatic stress disorder (American Academic of Experts in Traumatic Stress, 2014).

Ethics also reinforce understanding the experiences of counselors assaulted by clients. Professionals working in these occupations are all required to protect clients as a demonstration of ethical conduct (ACA, 2014; APA, 2010; NASW, 2008). Although the scholarship has not focused on community-based counselors per se, the findings about the extent and nature of client assault of social workers, psychiatric personnel, and nurses extend to counselors because OSHA (2016) identified them as a segment of the mental health professionals' continuum of care.

Since experiencing violence and aggression has been linked with occupational impairment (Lopez, 2011), understanding counselors' experiences of assault may provide information that will illuminate the kinds of ethical dilemmas faced by those who have been assaulted by clients, such as practicing while impaired or accepting clients based upon their diagnosis. Understanding these issues may also provide information for improving the quality of services for clients and supervisees because outcomes in therapy (Swift & Greenberg, 2015) and supervision (Malina, Wan, & Azzahrah, 2018) have been linked with the counselor's well-being. In this study, I addressed the gap in the literature by adding the experiences of community-based counselors assaulted by clients to the knowledge base and assisting with identifying their needs following these exchanges. Understanding these experiences may assist with developing better theoretical frameworks for challenging and extending what is known and unknown about the client

assault of community-based counselors. The results of this study may also provide insight into what prior experiences or training can be used to aid the counselor in the aftermath of an assault.

Purpose

The purpose of this qualitative phenomenological investigation was to understand the lived experiences of community-based counselors assaulted by clients. While aggression in the workplace is not a new phenomenon (Flannery, Straffieri, Hildum, & Walker, 2011; OSHA, 2016; Piquero et al.,2013; Storey, 2016), little is specifically known about the client assault of community-based counselors. The results of this study will add counselors' voices to the discourse on client assault and possibly identify experiences or training that may assist the counselor in caring for themselves in the aftermath of a client assault. The goals of this study were to recognize assault as a serious occupational risk faced by community-based counselors and to add their stories to the knowledge base for establishing training and response protocols. The primary research question of this phenomenological investigation was: "What are the lived experiences of counselors assaulted by clients?"

Significance

Understanding the effect of client assault on community-based counselors is consistent with ethical standards because counselors' sense of well-being has been linked with client (Swift & Greenberg, 2015) and supervisee (Mazlina, Wan, & Azzahrah, 2018) outcomes. The findings of this study may assist with understanding the physical, emotional, and psychological experiences of this serious occupational risk on

community-based counselors. Since establishing an effective therapeutic alliance has been correlated with improved client and supervisee outcomes (Leibert & Dunne-Bryant, 2017; Wharne, 2017), understanding the experiences of community-based counselors assaulted by clients may be a protective strategy for keeping future clients and supervisees safe.

The results of this study may also provide information that describes how counselors experience the physical and psychological effects of assault. The data from this study can be used for conducting subsequent investigations to examine the relationship between client assault and its effect on client, supervisee, and counselor well-being. The knowledge generated from this study can be triangulated with data from Flannery, Straffieri, et al.'s (2011) longitudinal study on client assault of psychiatric personnel and Storey's (2016) investigation on stalking of counselors in British Columbia to generate theories to explain or predict how mental health professionals react to client assault. These theories could provide the foundation for the selection of interventions to reduce the likelihood of assault occurring or for managing it when it does occur. Counselors sharing how they make sense of these events may also provide valuable information to assist with formulating a response protocol and assessing whether additional training is warranted by adding to the knowledge base as identified in other research on client assault of mental health professionals (Flannery, LeVitre, Rego, & Walker, 2011; OSHA, 2016; Piquero et al., 2013; Storey, 2016). The findings from this study may also be beneficial for assisting counselors and counselor supervisors in

identifying strategies to mitigate symptoms resulting from the assault as well as provide insight into the handling of professional responsibilities following the assault experience.

Another benefit of understanding the lived experience of community-based counselors assaulted by clients is the potential effect that assault has on the training and development of novice counselors because the health and wellness of supervisors also affects supervisee professional identity development (Moldovan & David, 2013). Missed days from work and early retirement are two of the consequences of experiencing violence in the workplace (Myburgh, Poggenpoel, & Breetzke, 2011). Counselor impairment and its effect on future clients and supervisees are also issues to be considered since the counselor's wellbeing has been correlated with client and supervisee outcomes (Newman, 2010; Rogers, 1967; Shaffer & Friedlander, 2017).

Definitions

In this section, I will provide operational definitions for key constructs that are used throughout this study. The definition for key terms emerged based on academic criteria and from a review of the literature published on WPV.

Assault: Straus, Hamby, Boney-McCoy, and Sugarman (1996) defined assault as acts meant to cause physical and/or psychological harm Physical assault included hitting, kicking, punching, slapping, and spitting (Straus et al., 1996). Psychological violence has been being operationalized as the intentional use of power to cause physical, social, spiritual, morale, or social development harm (Straus et al., 1996). Also termed

emotional abuse, psychological violence includes verbal abuse, bullying, harassment, and threat of harm (Straus et al., 1996).

Community-based: Counselors that work in noninstitutional (i.e., long-term care) treatment/service environments, including outpatient therapy offices and clinics, community-based residential facilities and group homes, and home-based services, being included in the community-based continuum of care.

Counselors: Individuals who have completed the academic requirements culminating in awarding of a master's degree in counseling from a regionally accredited university (National Board of Certified Counselors, 2015).

Background

Professionals that work in the social service assistance and healthcare sector are at increased risk of experiencing WPV, including assaults, then individuals working in other private sector professions (OSHA, 2016). Other research on WPV reinforces these findings. Storey (2016) conducted a survey study of 2,033 members of the British Columbia Association of Clinical Counselors to determine the prevalence of stalking and stalking-related behavior, a subset of events classified as WPV, faced by this group. Based on the results of the survey, counselors in British Columbia treating clients for forensic substance abuse and sexuality issues; as well as sexual abuse" were at a greater risk of experiencing staking as a form of WPV (see Storey, 2016, p. 261).

There has been a paucity of information published on the client assault of mental health professionals in the United States in the past 5 years, and what has been published is mostly quantitative (Piquero, 2013; Storey, 2016). Because OSHA (2016) identified

social workers, psychiatric personnel, and nurses as part of the employment sector that is at increased risk of harm from client assault, data about WPV in these allied professions are relevant to this study. Itzhak (2015), seeking to understand the prevalence of WPV experienced by psychiatric nurses in a mental health center in Israel, concluded that 88.1% experienced verbal violence and 58.4% experienced physical violence within a 12-month period. Another study seeking to quantify the number of client assaults experienced by inpatient psychiatric personnel concluded that approximately 62% had experienced verbal and physical assault and that staff working with children and juveniles were more likely to be targeted by clients (Cunningham et al., 2003). Piquero et al. (2013) conducted a meta-analysis on WPV from 2000 through 2012 and concluded that additional research was warranted to understand the nature and extent of these acts by occupation.

Systematic investigation into assault has been deterred by the lack of having a standardized definition of assault (Flannery, LeVitre, et al., 2011; Piquero et al., 2013), the shaming and blaming of victims (Johnson, 2012, Piquero et al., 2013; Storey, 2016), the lack of having a national database for tracking these events (Piquero et al., 2013), and underreporting (Piquero et al., 2013; Storey, 2016). Despite these barriers to understanding the intensity and frequency of assault occurring, the extant literature is mixed regarding what type of assault is most likely to occur. Research conducted by Jayaratne, Vinokur-Kaplan, Nagda, and Chess (1996) and Ringstad (2005) identified verbal abuse as the most frequently occurring type of assault experienced by social workers. Findings from research conducted by Flannery, LeVitre et al's (2011)

longitudinal investigation into assault of psychiatric personnel identified physical assault as the most frequently occurring form of assault experienced by psychiatric personnel. The prevalence of these incidents with other helping professionals and the potential risk that it poses to counselors, clients, and supervisees reinforce understanding how community-based counselors interpret and make sense of these incidents.

Theoretical Framework

Developed by Husserl, phenomenology is both a theory and a method of examining the phenomenon of interest, with a goal of describing how participants make meaning of their experiences (Heidegger, 1962). Researchers using Husserl's phenomenological framework, transcendental phenomenology, use a process known as reduction to describe participants' lived experiences with the phenomenon of inquiry (Oxley, 2016). Researchers conducting a transcendental phenomenological investigation are expected to suspend their assumptions regarding the object of inquiry, which is a process known as bracketing (Oxley, 2016).

Hermeneutic inquiry honors the researcher's worldview and their intense personal knowledge of the subject matter (Oxley, 2016). Heidegger developed this stance in opposition to Husserl's work and believed that peoples' interpretations of the world are inextricably intertwined in how they interpret phenomena and that they are by nature unable to set aside their worldviews (Oxley, 2016). In this study, I used Heidegger's interpretative hermeneutic framework to interpret the meaning counselors assign to client assault.

Heidegger's approach to phenomenology resonated with me because I believe that a researcher's epistemological and ontological worldviews are inextricably intertwined in whatever methodology they select to understand and interpret the phenomenon they are investigating. Heidegger's view of phenomenology espoused that when attempting to understand a phenomenon, each part of the object is relative to the whole and that the whole cannot be understood without examining its parts, a relationship known as the hermeneutic circle (Jones, Rodger, Boyd, & Ziviani, 2012). Heidegger asserted that interpretation of a phenomenon is in part premised a priori on judgment and perception as well as contextual experiences, including cultural factors, time in history, and meaningful relationships (Jones et al., 2012). Heidegger agreed with his mentor, Husserl, that intentionality in examining objects includes an acceptance of preexisting knowledge resulting in ways of being (Jones et al., 2012). Heidegger coined preexisting knowledge as dasein, which literally means being-there, and contrasted it with unintentional openness to experience or ways of being (Zuckerman, 2015). Though this argument appears circular, it facilitates the interpretation of human experience (see Figure 1).

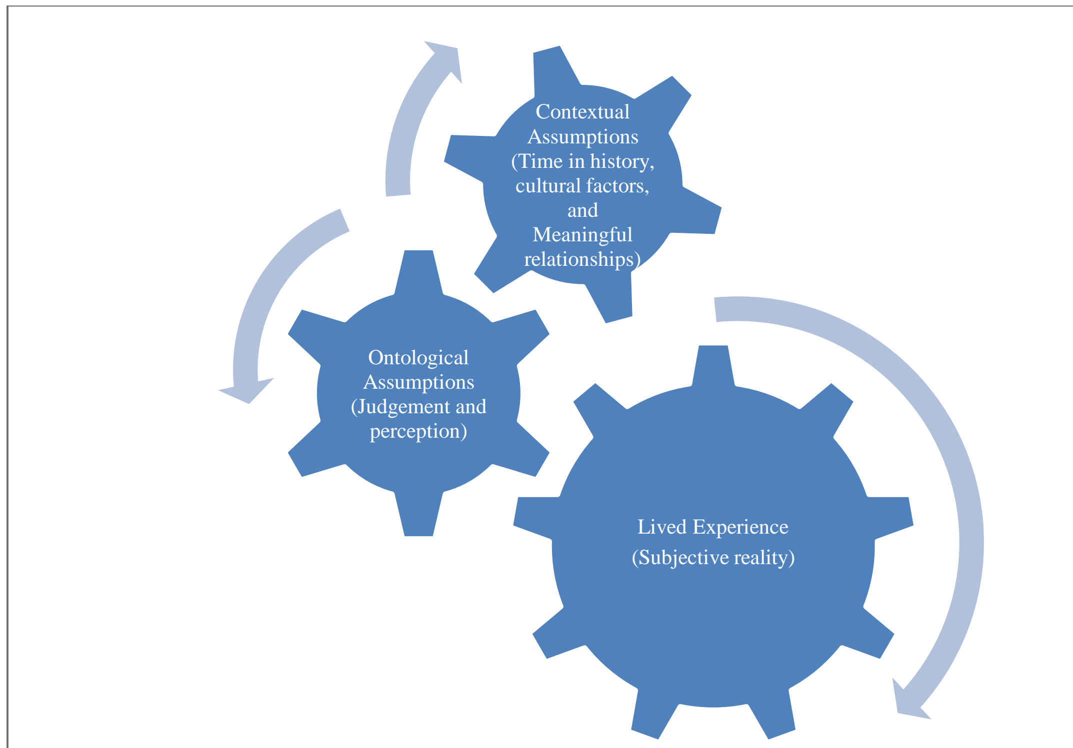

Figure 1. The hermeneutic circle.

Research Questions

The central research question of this study was: "What are the lived experiences of community-based counselors who have been assaulted by clients?" I also developed the following sub questions to guide this study:

1. What experiences do community-based counselors have that helped them manage being assaulted?
2. How do community-based counselors experience their professional responsibilities in the aftermath of a client assault?
3. How does the lived experience of community-based counselors assaulted by clients affect their self-care practices?

Nature of the Study

Famed for its thick, rich descriptions, I used hermeneutic phenomenological analysis to explain how community-based counselors understood and interpreted client assault. Grounded in philosophy and psychology, phenomenological inquiry is useful for studying the lived experience of participants (Oxley, 2016). A more detailed analysis of phenomenology will be discussed in Chapter 2. In this study, I used open-ended questions to gather descriptions of the essence of client assault as experienced by counselors as a cultural sharing group (see Casey, Eime, Payne, & Harvey, 2009). The deficiencies in the extant literature on client assault of counselors reinforced the need to conduct this qualitative phenomenological investigation. Though both phenomenological and narrative approaches are appropriate for conducting studies with a single focus (Creswell, 2013; Patton, 2015), phenomenological inquiry was used in this study because it focuses on a shared experience of individuals considered to be subject matter experts, whereas narrative inquiry may chronicle the experience of only one or more individuals (Oxley, 2016).

Endorsed for examining the health sciences (Eatough & Smith, 2017), a hermeneutical analysis was used as the framework to capture the essence of client assault through the experiences of counselors who lived through it. Specifically, I used Heidegger's approach to hermeneutical analysis to interpret and describe the nature and meaning that community-based counselors assign to client assault. The interpretation of a phenomenon (in the case of this study, counselors' experience of client assault) through

the ontological lens of the researcher is a major tenant of the hermeneutical approach (Heidegger, 1962).

My analysis of the phenomenon relied on naturalist methods of research, such as direct quotes, metaphors, and observations from face-to-face participant interviews, to generate themes and descriptions that focused on convergence and divergence in community-based counselors' lived experience of client assault. I used this idiographic approach to generate thick, vivid descriptions of participants' linguistic, cognitive, and affective experiences of assault. Participants were selected based on having experiences that would yield in-depth insight into the phenomenon of the client assault of community-based counselors. I carried out semi-structured, face-to-face interviews using open-ended questions to elicit responses that described the essence of client assault as experienced by community-based counselors (see Casey et al., 2009). Follow-up interviews were conducted to clarify the participants' thoughts, feelings, and perceptions regarding client assault and to assist in identifying commonalities and differences in experiences between the parts and the whole.

Possible Types and Sources of Data

In qualitative analysis, participants are chosen based upon their experiences, values, beliefs, and understandings of the phenomenon under investigation (Oxley, 2016). Though there are no established guidelines for selecting the number of participants required to yield thick-rich descriptions, the research community has established best practices for justifying the sample size. One strategy is for researchers to conduct interviews with participants until data are repetitive, which is known as data saturation

(Oxley, 2016). Originally developed for grounded theory, saturation is synonymous with rigor in qualitative analysis (Oxley, 2016).

I developed open-ended questions to elicit a description of the assault and the context in which the assault occurred. These questions were used to encourage participants to describe their feelings and perceptions about experiencing the phenomenon. Observations, interviews, and records were used to describe counselors' perceptions of assault. I also asked participants to provide demographic data about themselves, such as their age, years of experience in the profession, and type of agency in which they worked when the incident occurred. Unlike quantitative data collection procedures, phenomenological inquiry focuses on the context in which assault was experienced (Englander, 2012). Direct observation during semi-structured interviews assisted me with seeing, hearing, understanding, and describing how counselors viewed these events. While observing, I focused on the participants' body language and the words they used to describe assault during 60-minute individual interviews. An additional 30-minute interview was scheduled to clarify data acquired during the initial interview. An interview protocol was used to assist with organization. Finally, I also reviewed field notes and agency artifacts to assist with telling the story of counselors assaulted by clients.

Possible Analytic Strategies

Researchers conducting a phenomenological design are concerned with meaning, not measurement (Oxley, 2016). I read and hand-coded the resulting data before organizing them into themes. Hand-coding of the data assisted me with interpreting them

and making abstractions to illuminate how counselors understood their experience of assault. Patterns that emerge during the analysis were combined to generate themes that described counselors' experience of assault (see Oxley, 2016).

Assumptions, Scope, and Limitations

Regardless of methodology, all research paradigms are inherently flawed. Ethics demand that researchers delineate the flaws inherent in their research designs. These weaknesses are detailed in the limitations, delimitations, and assumptions sections of the study. In the following section, I will briefly outline the flaws in this study of client-perpetrated violence against community-based counselors.

Limitations

There were several limitations imposed by the design of this study. Participants in this study worked in community-based settings. One limitation was that these counselors may have differed on an unknown variable from those that worked in other settings, such as hospitals or residential facilities. Another limitation pertaining to the population being investigated was that only counselors who had received a master's degree were eligible to share their experiences of client assault. Finally, researcher bias may be difficult to detect in phenomenological inquiry.

Delimitations

Best practice in research includes the researcher establishing boundaries to guide the creation of new knowledge. In qualitative analysis, site selection informs understanding of the phenomenon under investigation (Bowen, 2008). Qualitative researchers assert that truth is relative and contextual (Creswell, 2009). Since truth is

informed by context, only counselors that worked in community-based settings were eligible to participate in this study. Counselors working in other settings, like hospitals and jails, were excluded because their experiences of assault may have differed from those working in community-based settings due to the bio-psychosocial history of clients and the context in which counseling was being provided. Inclusion of only counselors that worked in private and state community agencies also assisted with managing the volume of data generated in qualitative analysis. I did not employ a quantitative approach in this study because the purpose of the study was to understand the meaning that community-based counselors assigned to client assault, rather than the frequency of this phenomenon occurring.

Assumptions

I made several assumptions that reinforced conducting a phenomenological investigation. First, I believe that perception informs reality. In part, this assisted me in choosing to conduct a hermeneutical investigation. I believe that understanding regarding an experience is a by-product of personal history and the environment in which the phenomenon occurs. This belief is consistent with Heidegger's (1967) view on *being* and the circular relationship between the being (i.e., part) and being in the world (i.e., whole). Heidegger depicted the interconnectivity between individual experience and the environment in the hermeneutic circle. In this study, the participants and I constructed the essence of client assault. Another assumption was that the participants were truthful and open regarding their experience of assault. Lastly, a methodological

assumption surrounding phenomenological inquiry is that the researcher will understand the meaning that individuals assign to the assault experience (Creswell, 2009).

Summary

In this chapter, I provided an introduction and a rationale for conducting a phenomenological investigation into the client assault of community-based counselors. In 2017, OSHA (2016) accepted comments to assist with determining whether mandatory, rather than voluntary, standards were warranted to keep community-based healthcare providers, including counselors, safe. In this study, it was my intent to examine the lived experience of community-based counselors that had been assaulted by clients who they were ethically bound to keep safe. In Chapter 2, relevant literature that provided a foundation for this study will be summarized and evaluated.

Chapter 2: Literature Review

Introduction

The OSHA (2017) declared that WPV represents a significant occupational risk to the physical, mental, emotional, and behavioral well-being of employees in the healthcare sector. In 2016, there were more than 2 million incidences of WPV (OSHA, 2017). The highest incidence rate of nonfatal events by industry occurred in the healthcare and social assistance employment sector, with 13.7 injuries per 100 workers in nursing and residential facilities (OSHA, 2017). In recognition of the increased risk of experiencing WPV for this population, OSHA (2017) solicited comments to assist with evaluating whether to mandate employer-based guidelines for keeping this vulnerable population safe.

While aggression in the workplace is not a new phenomenon (Flannery, LeVitre, et al., 2011; OSHA, 2016; Piquero et al., 2013), the lack of having a national database for tracking these events has impacted being able to track the nature and extent of these events (OSHA, 2016). Workplace aggression has been defined as the intent to cause physical and psychological harm to workers by individuals from within or outside of the organization (Schat & Kelloway, 2005). Piquero et al. (2013), in reviewing research on WPV from 2000 to 2009, concluded that additional research is warranted to examine "whether and how victimization experiences vary by profession" (p. 384). Protecting the public also reinforces conducting research on the client assault of healthcare sector employees. Mohamed (2014) recognized the assault of healthcare professionals as a

crime against humanity because they are charged to provide care to everyone, regardless of the client's physical or mental health, in order to keep the general public safe.

In this chapter, I conduct a summary and analysis of the themes surrounding the client assault of healthcare and social assistance workers. In preparation for this study, I located significant scholarship on client-perpetrated violence against social workers (Ringstad, 2005, 2009) and psychiatric personnel (Flannery & Flannery, 2014; Flannery, LeVitre, et al., 2011). I identified relatively few studies analyzing the client assault of mental health professionals that were published in the past 5 years, and most of those located were quantitative in nature. A significant amount of the extant literature on the topic was conducted between 1996 and 2010. Several of these historical texts were used to provide a foundation for understanding the prevalence, extent, nature, and trends associated with the client assault of mental health professionals, as a subset of the healthcare population.

Gaps in the Literature

Despite the breadth of research that I located on the client assault of social workers and psychiatric personnel prior to 2010, gaps and deficiencies existed in the literature. Only two studies were located on the client assault of counselors, as a culture-sharing group (Bride, Choi, Olin, & Roman, 2015; Storey, 2016). I found no studies that were expressly focused on client-perpetrated violence against community-based counselors. Flannery, who has conducted more than 20 years of research with various colleagues on assault in psychiatric settings, called for additional scholarship on the assault of helping professionals that work in community-based settings (Flannery &

Flannery, 2014). My hope was that the current study may refocus attention on the effect this occupational risk has on mental health providers, specifically counselors that work in 3 of the 5 different contexts identified by OSHA (2004): nonresidential treatment; community care; and field work settings, such as residential facilities, group homes, private homes and agencies, and mental health centers. For the purpose of this study, these settings were collectively referred to as community-based settings. The purpose of this hermeneutic phenomenological study was to understand the experiences of community-based counselors assaulted by clients. Understanding these experiences will add community-based counselors' voices to the knowledge base and may assist in establishing protocols for keeping them, the public, clients, and supervisees safe.

Literature Search Strategy

Several themes emerged based on my critical review of the literature. Previous researchers have identified various barriers that negate understanding the seriousness of this occupational risk, including how assault is conceptualized (Beech & Leather, 2006; Finfgeld-Connett, 2009; Flannery, 1996; Lovell & Skellern, 2013; OSHA, 2016; Piquero et al., 2013, Ringstad, 2005; Shields & Kiser, 2003), the lack of a system for tracking these events (OSHA, 2016, Piquero et al., 2013), and shaming and blaming of victims (Gates & Berry, 2013; OSHA, 2016; Piquero et al., 2013; Ringstad, 2005; Storey, 2016). I used these themes to review, organize, and analyze the existing scholarship as a framework for understanding the lived experiences of community-based counselors assaulted by clients. To facilitate this review of the literature, the Walden University Library and the following databases were used: Academic Search Complete, EBSCOhost,

ProQuest, PsycINFO, PubMED, and the Nursing and Allied Health Database. The keywords and concepts used to search the electronic databases were *workplace violence, assault, assault of counselors, assault of social workers, assault of psychiatric personnel, assault in psychiatric settings,* and *experiences of assault*.

A Conceptual Roadmap

The purpose of this hermeneutic phenomenological investigation was to understand client assault from the perspective of community-based counselors. Hermeneutic phenomenology has been endorsed for understanding lived experiences and capturing knowledge that is unquantifiable (Laverty, 2000). Phenomenology is both a theory and a conceptual framework for interpreting phenomenon (Kafle, 2011). In this study, I interpreted assault through the epistemological experiences of the research participants. A phenomenological method was used because it enabled me to interpret the meaning and understand the individual and shared experiences common to community-based counselors assaulted by clients. One of the assumptions embedded in a phenomenological framework is that there are many realities and understanding is ever evolving (Kafle, 2011).

The Philosophical Perspectives of Heidegger and Gadamer

In this study, I used both Heidegger's (1927/1962) and Gadamer's (1976) philosophical views of hermeneutical phenomenology for interpreting the verbal and nonverbal meaning that community-based counselors assigned to assault. Heidegger utilized interpretive phenomenology to explicate the lived experience of research participants. I used the philosopher's focus on dasein to dissect how community-based

counselors' epistemological and ontological worldviews informed their understanding of client assault. Translated, dasein is what it means to be human (Heidegger, 1962). Gadamer extended Heidegger's views on being by acknowledging that all understanding is influenced by foreknowledge, which is inclusive of prejudices shaped by the individual's social, cultural, and historical identities. Gadamer embraced prejudice as a prerequisite to understanding and the claim to truth.

The Hermeneutic Circle

Heidegger's (1927/1962) hermeneutic circle is a visual expression that demonstrates how individual experiences are intricately woven into the totality of experience in a repetitious cycle of part to whole and whole to part. This continuous loop enables individuals to question and accept that in reality, there are no absolutes and that understanding is dynamic, not static (Laverty, 2000). Heidegger and Gadamer espoused that lived experience, also classified as understanding, is facilitated via an uninterrupted transactional process that occurs between the individual and the phenomena being studied (Laverty, 2000).

Hermeneutic phenomenology resonated with my everyday experience of supervising two community-based counselors in a private-practice setting. During this experience, I realized that the linguistic meaning that I assigned to client assault was both fixed and infinite. The presuppositions embedded in my historical and social contexts evolved as the meaning of assault was created with the two professionals directly affected by client-perpetrated violence. I embraced Heidegger's (1962) stance on being independent and dependent of *zoe*, defined as the source from which everything evolves.

The fusion of separate and distinct, yet comingling, experiences is embodied in the hermeneutic circle. Heidegger's (1927/1962) and Gadamer's (1976) philosophical views on hermeneutic phenomenology are the beginning and ending for coconstructing a textual expression of the ways in which community-based counselors experience assault and the meaning they assign to these exchanges (see Laverty, 2000). The interpretive process uncovered how societal norms and values affected participants' personal and professional identities, resulting in independent and contextual understanding of client assault.

A Critical Review of the Literature

The prevalence of the assault of community-based healthcare and social assistance personnel by clients has been well-researched; however, the number of researchers seeking to understand the experiences of mental health professionals assaulted by clients has been limited (Centers for Disease Control and Prevention [CDC], 2016; Flannery & Flannery, 2014; Piquero et al., 2013). Prior research into the assault of community-based healthcare and social assistance workers has focused on the prevalence of these incidents and descriptive analysis of socio-demographic characteristics, client presentation, settings in which assault occurs, and response protocols (Flannery, LeVitre, et al., 2011; Flannery, Farley, Rego, & Walker, 2007; Piquero et al., 2013; Ringstad, 2005, 2009; Shields & Kiser, 2003; Storey, 2016). While these investigations are beneficial for identifying patterns and trends surrounding the client assault of community-based healthcare and social assistance workers, they do not describe the experiences of mental health professionals coping with the consequences of being assaulted by a client.

Nearly 22 years after OSHA first issued voluntary guidelines for keeping community-based healthcare and social assistance workers safe in the workplace, there is still no best practice for responding to WPV (OSHA, 2016; Piquero et al., 2013). According to OSHA (2016), community-based healthcare and social assistance employees, such as counselors, social workers, and psychiatric personnel, are at increased risk of experiencing violence because of their chosen profession. OSHA has expressly identified counselors as a subpopulation of the healthcare and social assistance continuum of care. Kaplan, Tarvydas, and Gladding (2014) defined counseling "as an activity that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 366). Based on this definition, counselors, as a culture sharing group, represent a segment of the continuum of care.

WPV has been classified into four different types based on the perpetrator's relationship with the service provider or business (CDC, 2016). In Type I WPV events, the perpetrator has no relationship with the provider or the business (CDC, 2016). Examples of Type I WPV events include acts of violence such as robbery, shoplifting, and trespassing. Type II WPV events occur most often in healthcare settings and include violent acts perpetrated by clients, family members, and friends of clients (CDC, 2016). I focused on these types of WPV events in this study into the lived experiences of community-based counselors assaulted by clients. Acts of violence classified as Type III are perpetrated by a current or past employee of the business (CDC, 2016). Finally, violence classified as Type IV events include acts perpetrated by individuals that have

external relationships with employees or the business (CDC, 2016). Domestic violence falls into this category of WPV.

The Emergence of Workplace Violence

Recognition of WPV first garnered national attention in the 1980s. In 1986, a part-time letter carrier in Edmond, Oklahoma fatally shot 14 U.S. Postal employees (Pauff, 2016). The term *going-postal* was coined as a result of this mass shooting (Pauff, 2016). While these types of acts attract media attention, most acts of WPV are nonfatal (OSHA, 2016). In 2015, there were approximately 2.9 million nonfatal illnesses and injuries in the workplace, which accounted for 1,153,490 days away from work (OSHA, 2016). In this, I focused on nonfatal acts of WPV.

Investigation into the assault of helping professionals' dates back to the early 1990s when OSHA (1996) first recognized healthcare workers as a vulnerable population (Lipscomb & Love, 1992). Emerging from the Occupational Safety and Health Act of 1970, OSHA (2016) initially issued voluntary guidelines in 1996 that provided employers guidance for keeping healthcare professionals safe.

Workplace Violence: A National Dilemma

A review of the National Crime Victimization Survey from 1993 to 1999 indicated that the rate of nonviolent forms of WPV was 12.6 per 1,000 for the workforce as an aggregate and 68.2 per 1,000 for healthcare and social assistance workers (Anderson & West, 2011). Today the rate of assault of healthcare and social assistance workers continues to exceed that of all other occupations combined (OSHA, 2016). The incidence rate for nonfatal injuries of counselors in 2014 requiring days away from work

was 26.0 cases per 10,000 full-time employees, compared to 104.0 cases per 10,000 full-time employees for the aggregate of all other occupations (OSHA, 2016). Approximately 62% of the nonfatal acts of WPV perpetrated against counselors were identified as intentional injuries (OSHA, 2016). Regardless of this risk, community-based counselors are mandated to provide care to clients which may pose a threat to their physical and psychological health. Failure to provide services may result in consequences imposed by licensing boards and agencies which protect the rights of clients receiving mental health services. Consequences for failing to provide service is consistent with ethical codes of conduct for mental health professionals (ACA, 2014, APA, 2010). The inability to refuse care leaves community-based counselors vulnerable to assaultive client exchanges. In the current study data were collected to understand how community-based counselors experience client assault and may provide knowledge that can be used to create strategies for helping them heal following experiences with client related violence.

In recognition of this risk, in December 2016, OSHA issued a request for information to gather data on the nature and extent of WPV to determine whether mandatory standards for keeping this vulnerable population safe should be established (OSHA, 2016). The request was prompted in response to the increase in violent acts against healthcare workers and OSHAs acknowledgement of these professionals as vulnerable to acts of WPV (OSHA, 2016). From 2016 to 2017, the Bureau of Labor Statistics (BLS) found that workplace fatalities increased by 7% (BLS, 2016).

Healthcare professionals have been recognized as a marginalized group by social justice advocates (Beech & Leather, 2006; Wronka, 2008). Accepting healthcare workers

as a marginalized group has met some controversy since the provider is regarded as an advocate for the client and thereby the power broker in the client-provider relationship (OSHA, 2016). For this investigation, nonfatal acts are being classified as assaults. The focus of the current study is on assault of that work in outpatient or short-term care facilities like alcohol treatment centers and residential care facilities, rather than long-term institutional settings.

Based upon a review of the literature, there have been several barriers that have negating understanding how client assault effects healthcare and social assistance employees (OSHA, 2016; Piquero et al., 2013, Ringstad, 2005). In the next section of this literature review, I examine the barriers to understanding client assault of social workers, psychiatric personnel, and other human service workers. The section concludes with recommendations for overcoming these barriers.

Barriers to Understanding the Prevalence of These Events

Since the inception of WPV there have been several barriers that have negated understanding the experiences of helping professionals assaulted by clients. Based upon a review of the literature, conceptualization of assault, shaming and blaming, and the lack of having a system for tracing these events are major deterrents resulting in under-reporting of WPV events. In the following section these barriers are discussed.

Conceptualization of Assault

Understanding mental health professionals' experiences of assault have been hindered by having a standardized definition of assault across occupations (OSHA, 2016; Piquero et al., 2013). One of the early studies investigating client assault of psychiatric

personnel divided assault into four types: (a) physical, (b) sexual, (c) nonverbal, and (d) verbal (Flannery, 1996). Physical assault included hitting, kicking, pushing, and other forms of physical contact (Flannery, 1996). Sexual assault was defined as unwanted sexualized behavior (Flannery, 1996). Nonverbal assault included staring and intimidation tactics, while verbal assault was defined as swearing and threats of harm (Flannery, 1996). While this classification of the types of assault may be exhaustive, it complicates understanding the experiences and prevalence of client assault as forms of WPV. Research seeking to identify how each occupation conceptualizes assault is warranted (Piquero et al., 2013).

The way assault is conceptualized may be occupationally driven. An investigation that sought to examine the rate at which social workers are both victims and perpetrators of client assault dichotomized assault into two types, physical and psychological (Ringstad, 2005). The Revised Conflict Tactics Scale (Straus et al., 1996) was used to conceptualize assault into these two types (Ringstad, 2005). Despite the plethora of definitions of assault, there has been some agreement in how psychiatric personnel and social workers define assault. Both groups recognized physical forms of unwanted contact, such as hitting, kicking, and spitting as assaultive behavior (Flannery et al., 2007; Ringstad, 2005). However, the concept of psychological forms of aggression, like threats, has been challenged. An investigation conducted to identify the predictors of WPV and aggression exclusively defined assault as behavior that causes physical harm (Barling, Dupree, & Kelloway, 2009).

Over the past 20 years, the definition of assault has continued to evolve. The definition has been expanded and threat of harm, bullying, and harassment have been identified as assaultive behaviors (McKenna et al., 2003; Ringstad, 2005). The controversy over how to define WPV continues. Recent literature has emerged that has identified stalking as another form of WPV (Storey, 2016). OSHA (2016) defined WPV as violence or the threat of violence towards someone at work. One of the objectives of the current investigation is to determine how community-based counselors define assault. I plan to conduct a follow-up study to evaluate whether counselors are assaulted at a similar rate as social workers and psychiatric personnel. Simplifying how assault is defined may increase reporting. Increased frequency in reporting will assist with normalizing assault as a risk of being a healthcare professional. Acknowledgement of the fact that assault is a risk that comes with providing services to the public (OSHA, 2016), may reduce the shaming and blaming of those who experience and witness client assault which are also barriers to understanding this occupational risk (Lovell & Skellern, 2013).

Shaming and Blaming

Multiple perceptions regarding being a victim of client assault are impacting reporting of these experiences. Research has demonstrated that shaming and blaming of professionals assaulted by clients is a factor in reporting these events (Johnson, 2012; Lovell & Skellern, 2013; Phillips, 2016; Storey, 2016). Negative self-appraisal and that of coworkers and managers have been identified as deterrents to reporting of WPV (Johnson, 2012; Phillips, 2016; Storey, 2016). Storey (2016) conducted a survey on the factors that reinforce stalking of registered Canadian counselors indicated that those

assaulted by clients view themselves as less skilled. The coworkers of these counselors also hold negative opinions of the skills of colleagues that have experienced stalking (Storey, 2016).

These valuations reinforce counselors and other mental health professionals as seeing themselves as less skilled. This potential fallacy in thinking is also reinforced by managerial figures who assert that the risk comes with the job and is therefore to be tolerated (Piquero et al, 2013; Storey, 2016). The inadequate response of peers and authority figures effect the self-esteem and dignity of mental health professionals coping with the aftermath of client-related violence and reinforces feelings of inadequacy and guilt (Bride et al., 2015; Johnson, 2008; Sto et al., 2015; Storey, 2016). Research which seeks to determine if there is a relationship between being assaulted and clinical skills is needed to test these assumptions. Feelings of inadequacy and the harsh appraisal of colleagues and supervisors may serve as valid reasons for under-reporting of these events, which negates understanding the magnitude of client assault on community-based mental health professionals. Under-reporting of assaultive exchanges between healthcare professionals is also being affected by the lack of having a centralized database for tracking these events (Blando, Ridenour, Hartley, & Casteel, 2015; Piquero, et al., 2013).

No Tracking System

There has also been some controversy surrounding the measures used to track assault of community-based mental health professionals. Researchers investigating this phenomenon have also identified the lack of standardized reporting procedures as a barrier for understanding and quantifying these events (Flannery, Staffieri, et al., 2011;

OSHA, 2016, Piquero et al., 2013, Storey, 2016). Statistics on WPV are currently archived by the BLS which publishes annual data on WPV events. The BLS, an arm of the U.S. Department of Labor, is the only national organization that tracks these events (OSHA, 2016). However, there are several surveys which are used to collect data on WPV including the National Crime Victimization Survey and the Center for Fatal Occupational Injuries (OSHA, 2016). Differences in survey construction, how assault is conceptualized, and survey response are factors that make it difficult to understand the experiences of those effected by WPV and the prevalence of these events (Piquero et al., 2013). Standardization in reporting and warehousing of these events may facilitate understanding the experiences of community-based counselors and other helping professionals; as well as provide the knowledge required to establish a best practice for responding. A standardized reporting system and protocols will assist with understanding the magnitude of WPV on helping professionals, clients, employers, and the economy. Although there is not a centralized reporting system for tracking client assault of healthcare professionals (Piquero et al., 2013), several investigations have been conducted to understand the prevalence.

Removal of the barriers surrounding client assault of healthcare and social assistance workers is essential to keeping clients and supervisees safe, which is mandated by ethical and legal codes. Failure to minimize the effect of these barriers will camouflage the magnitude of client assault on professionals who provide services to the public and the trends surrounding this occupational risk (Blando et al., 2015). Identification of the trends surrounding client assault of allied health professionals is a

pre-cursor to establishing an effective prevention protocol for responding and creating legislation which protects the human rights of all mental and allied healthcare professionals, including community-based counselors.

The Prevalence of Assault

A review of the landscape on client assault of healthcare professionals demonstrates that it is global and pervasive across healthcare and social assistance professions (Gillespie, Gates, & Berry, 2013; Lovell & Skellern, 2013; OSHA, 2016; Piquero et al., 2013; Ringstad, 2005; Shields & Kiser, 2003; Storey, 2016). From 1993 to 1999, the healthcare workforce experienced the highest incidence of nonfatal workplace assaults (Dunhart, 2001). The National Crime Victimization Survey recorded 1.7 million episodes of nonfatal assaults that occurred in the workplace during this timeframe (OSHA, 2002). Though qualitative inquiry into client assault of helping professionals appears sparse, an investigation into the lived experiences of varying healthcare professionals assaulted by individuals with a learning disorder concluded that experiences of violence and understanding of it is consistent across professions (Lovell & Skellern, 2013). Study participants included learning disability nurses, social workers, clinical psychologists, speech, and occupational therapists (Lovell & Skellern, 2013). Based upon the results from the semistructured interviews, experiences of assault may be similar, but nurses are more accepting of the risk than other healthcare professionals (Lovell & Skellern, 2013).

Acceptance of the Risk

Philosophies that frame different professions might provide some insight into why one professional may be more accepting of the risk than others. Since nurses' work side-by-side with medical professionals, their views on patients/clients may be in alignment with the medical model, which sees patients as diseased (Khushf, 2007; Lo Mauro & Profita, 2017). In the following section, the literature on the prevalence of assault of counselors, social workers, and psychiatric personnel will be analyzed. Since scholarship published on assault of these professionals in the past 5 years appears limited, I decided to utilize data from the mid-1990s to the present, including international investigations, to provide a foundation for the current study. All the occupations presented in this review have been identified as a sub-set of the allied healthcare profession identified by OSHA as at increased risk of harm due to providing services to the public.

Counselors

While there appears to be limited research specifically on assault of counselors, studies conducted indicated that assault represents a serious occupational risk for counselors as a culture sharing group (Arthur, Brende, & McBride, 1999; Bride et al., 2015; Davis, 2008; Storey, 2016). An investigation conducted by Bride et al. (2015) confirmed that client-initiated violence is an occupational risk experienced by substance use disorder counselors. Approximately 53% of those surveyed had personally been physically or psychologically assaulted by their client, and 15% of those affected admitted that the experience impacted their ability to care for clients (Bride et al., 2015).

The results of the Bride et al., (2015) study are consistent with the only investigation located that examined client-initiated violence against marriage and family therapists (MFT) who provided therapy to clients. Data extracted from a pilot study on violence perpetrated against mental health professionals in the state of Georgia indicated that 44% of the 67 MFT who responded to the survey had either been physically or verbally assaulted and 30% feared being fatally harmed because of being a direct care provider of mental health services (Arthur et al., 1999). Caution is warranted in interpreting these results as these results were extracted from a larger study on assault of psychotherapy providers.

In recognition of the seriousness of client perpetrated violence against MFT, healthcare, and social assistance workers, there have been calls for training programs to provide education that focuses on assessing and managing client perpetrated assault (Arthur, 1999; Bride et al., 2015; OSHA, 2016; Storey, 2016). The call for training programs to prepare healthcare professionals to manage this occupational risk is consistent with recommendations from the Council for the Accreditation of Counseling & Related Educational Programs (2016) for counselor preparation programs to implement crisis training into the curriculum. The fact that client outcomes in therapy have been correlated with the wellbeing of counselors reinforces the importance of training programs implementing this recommendation and understanding the experiences of community-based counselors assaulted by clients (Swift & Greenberg, 2015).

Research has confirmed that Type II forms of WPV negatively affects the health of the victim (Flannery, Farley, Rego, & Walker, 2007; Gillespie et al., 2010). One of

the benefits of teaching emerging mental health professionals to manage client perpetrated violence may be to protect their physical and psychological wellbeing. An added benefit to training programs teaching prevention, coping, and debriefing strategies to assist emerging professionals manage this occupational risk, may be a reduction in the number of days missed from work (Arthur et al., 1999; Bride et al., 2015).

Recent scholarship on assault of counselors has identified client assault as a global problem. An investigation on stalking of counselors in the British Columbia revealed that 94% of those surveyed had been stalked at some point during their career (Storey, 2016). The results of this inquiry are like an investigation examining the incidence of direct and indirect experiences of WPV amongst substance abuse counselors in 393 different community-based programs. Of the 1,592 counselors that participated in the study, 84% had experienced workplace violence (Bride et al., 2015). The results of Bride et al.'s investigation are consistent with research which suggests that client assault is linked to certain client presentations (Flannery, 1996; Flannery, Staffieri, et al., 2011; Flannery & Flannery, 2014, OSHA, 2016; Piquero et al., 2011; Ringstad, 2005).

Client presentation. Client presentation may foretell of an impending assault. An investigation seeking to identify the prevalence, predictors, and responses of substance abuse counselors to client assault revealed that substance abuse counselors are 2.5 times more likely to be verbally than physically assaulted (Bride et al., 2015). The results of the Bride et al., (2015) investigation are consistent with OSHA's assertion that most forms of WPV are nonfatal (OSHA, 2016). Since substance abuse has been identified as a factor in WPV this statistic, though significant, is not surprising (Flannery,

Stsffieri, et al., 2011; OSHA, 2016; Piquero et al., 2011). Being able to identity symptoms that foretell an assault occurring may be a first-line defense in preventing and reducing the likelihood of these acts occurring. However, caution is warranted in making assumptions regarding which clients are likely to perpetrate these acts. Using diagnoses and symptoms as predictors of assault may reduce healthcare providers willingness to provide care to these populations, which is prohibited by ethical codes of conduct (ACA, 2014; APA, 2010).

There has been some debate in the scientific community regarding the prevalence and type of assault experienced by counselors. A mixed methods investigation on assault of rehabilitation counselors in Montana highlighted the discrepancy in the prevalence and type of assault experienced by counselors (Davis, 2008). Of the 56 rehabilitation counselors surveyed, 80% reported experiencing various forms of nonverbal assault (Davis, 2008). For example, 40% were threatened with a lawsuit, 40% with being fired, 30% with physical violence, and 20% with destruction of property. Nearly 25% of those survey admitted to considering a change of professions due to the threat of violence (Davis, 2008). Caution is warranted in interpreting these results as they may not generalize to rehabilitation counselors in other states and due to the small sample size. These results also may not generalize to counselors as a unified body of professionals.

Defining assault. A review of the literature on client assault of counselors underscored the importance of understanding how different occupations define and experience assault. Davis's (2008) asserted that eye contact, posture, invading body space, and pounding of fist are forms of nonfatal assaults. While it is important to

understand how different mental health professionals conceptualize assault, it may be equally as important to identify trends in client presentation which foretell these events occurring so that theoretical frameworks can be identified to explain and predict the occurrence of this phenomenon. Additional research is warranted to understand how the experiences of Type II violence effect counselors' ability to extend positive regard to clients and supervisees. Given that rehabilitation counselors found it difficult to accept and respect client's following assaultive exchanges (Davis, 2008), identifying a best practice for responding may be a strategy in protecting the well-being of all stakeholders in the counseling process. Similarly, as with counselors, social workers have also found it difficult to extend positive regard following being assaulted by a client (Ringstad, 2005; Winstanley & Hales, 2015).

Social Workers

Client assault of social workers is a worldwide phenomenon. Research on client perpetrated violence against social workers has been conducted in Israel (Enosh & Tzafrir, 2015), Australia (Koritsas, Coles, & Boyle, 2010), the United Kingdom (Harris & Leather, 2012; Winstanley & Hales, 2015), and the United States (Jayaratne, Croxton, & Mattison, 2004; Ringstad, 2005; Shields & Kiser, 2003). A commonality amongst these studies is that client assault is pervasive. A study examining the prevalence of client assault of social workers in Israel indicated that 80% had experience some form of assault in the 3 months prior to the survey being conducted (Enosh & Tzafrir, 2015). Verbal assault (71%) and threats (69%) were the most pervasive form of client violence experienced (Enosh & Tzafrir, 2015), which is consistent with OSHAs’ (2016) assertion

that most assaults are nonfatal. A strength of this investigation is that the sample was comprised exclusively of community-based social workers from 34 different agencies. There is some concern regarding whether social desirability bias affected the outcome of the surveys as the data was collected during a regional meeting on workplace safety. Despite these concerns, another survey examining the rate of burnout experienced by social workers in a children's residential setting the same year confirmed that assault of social workers is pervasive. Of the 87 surveyed, 81% had been assaulted by a client within the previous 12 months (Winstanley & Hales, 2015).

The results of Enosh and Tzafrir's (2015) and Winstanley and Hales (2015) surveys are consistent with a study that examined assault of social workers in Australia. Of the 1,000 members of the Australian Association of Social Workers randomly surveyed, 67% had been assaulted within the previous 12 months (Koritsas et al., 2010). Caution is warranted in interpreting these results as assault perpetrated by colleagues is also included (Koritsas, et al., 2010).

Trends on assault of social workers from other countries is consistent with data collected in the United States from the late 90s to the mid 2000s (Beaver, 1999; Jayaratne, Vinokur-Kaplan, Nagda, & Chess, 1996; Newhill, 1996, Ringstad, 2005). One of the initial investigations on client assault of social workers is a random survey conducted on NASW members from Pennsylvania and California. The findings revealed that 57% of those surveyed had been assaulted by a client, and 48% had been assaulted more than once (Newhill, 1996). A limitation of these findings is that Newhill (1996) did not expressly identify the settings in which these professionals worked. Newhill's study

was included to demonstrate that Type II violence perpetrated against healthcare workers has been an occupational hazard since it was first recognized by OSHA in 1996. Despite the longstanding recognition of WPV as a consequence of being a healthcare provider, there is still not a best practice in responding, agreement on what constitutes assault, or standardization in laws which protect social assistance employees (Enosh & Tzafrir's, 2015).

An examination of the trends on assault on social service workers between 1995 and 2008 revealed that community-based social service workers who have contact with the public and travel to dangerous places are six times more likely to experience assault than those working in nursing homes, private homes, and hospital settings (Repass & Payne, 2008). A limitation of these results is that occupations that may be more closely aligned to social service workers, such as counselors, psychologists, and psychiatrists were not surveyed. The findings of Repass and Payne (2008) are consistent with Ringstad's (2005) examination of aggressive and assaultive exchanges between social workers and clients. Approximately 62% of the 1,029 members of the National Association of Social Workers (NASW) randomly surveyed had experienced a physical or psychological form of violence perpetrated by a client (Ringstad, 2005). Eight out of 10 participants surveyed reported practicing in community-based settings such as private practice offices, outpatient mental health settings, and child welfare settings (Ringstad, 2005). This investigation may have implications for the current study since it seeks to understand the experiences of counselors that work in the same settings.

Ringstad's (2005) investigation draws attention to the threat of harm to clients created by this dilemma. Approximately 14% of those surveyed admitted to assaulting a client (Ringstad, 2005). Though Ringstad did not provide a rationale for what prompted social workers to assault clients, the results of earlier investigations might provide some insight. A logical explanation may be concern for their own well-being (Newhill, 1996) and/or an attempt to regain control of the situation (Black, 1983). While Stand Your Ground laws affirm victim's rights to protect themselves from imminent danger (Ward, 2015), ethical codes of conduct are contradictory to these statutes as professionals are expected to protect clients (ACA, 2014; APA, 2010; NASW, 2011). Healthcare and social assistance professional's natural inclination to protect themselves places them at risk of disciplinary action from licensing boards and legal consequences. This paradox affirms the importance of understanding the experiences of community-based healthcare and social assistance employees assaulted by clients and creating a best practice in responding which protects the rights, physical, and psychological wellbeing of clients and their healthcare providers. The knowledge generated from the current investigation may be beneficial for establishing protocols for keeping clients and community-based counselors safe.

Recent scholarship on client assault of social workers continues to demonstrate that client assault of social workers is pervasive. Data published by the Bureau of Labor Statistics (2014) confirmed that employees in the healthcare and social assistance sector, in which social workers fall, were four times more likely to experience WPV than employees in all other occupations combined. This estimate may be conservative.

According to OSHA (2016), community-based healthcare and social assistance workers are six times more likely to be assaulted than other mental health professionals. Counselors are inclusive in OSHA's conceptualization of community-based healthcare and social assistance workers.

Research is needed to determine whether the prevalence and experiences of client perpetrated assault against counselors is like that experienced by social workers. While there are slight inconsistencies regarding the prevalence of client assault of social workers, based upon a review of the landscape, it is pervasive. Findings from scholarship conducted across the past 17 years demonstrate the magnitude of the problem that client perpetrated violence presents to social workers as a culture sharing group. The results from these national investigations demonstrate that Type II forms of WPV are pervasive among social workers in the United States and abroad. They may also have implications for counselors since the training and the environments in which they work are similar. In the next section of this study assault of psychiatric personnel will be examined.

Psychiatric Personnel

Client assault is also pervasive among psychiatric professionals (Flannery, 1996, Flannery, LeVitre, et al., 2011; Flannery, Fisher, Walker, Littlewood, & Spillane, 2001; Flannery & Flannery, 2014; Hatch-Maillette, Sclora, Bader, & Bornstein, 2007). Deinstitutionalization of clients with a serious mental illness is hypothesized to have influenced the rate at which clients perpetrate violence against psychiatric professionals (Flannery et al., 2001; Flannery & Flannery, 2014; Hatch-Maillette et al., 2007; OSHA, 2016). Much of the research that exist on client assault of psychiatric personnel has been

conducted in inpatient psychiatric settings. Flannery, with the Massachusetts Department of Mental Health and an Associate Clinical Professor of Psychology for Harvard Medical School, with the assistance of various other researchers, conducted approximately 20 years of research on client assault of psychiatric personnel in hospitals and community-based settings.

Almost from the beginning of his tenure investigating client assault of psychiatric personnel, Flannery defined assault as undesired contact with the intent to harm (Flannery et al., 2001). Assaultive behavior included "punching, kicking, slapping, biting, spitting, and throwing objects at staff" (Flannery et al., 2001, p. 21). Results from several investigations conducted by Flannery and his colleagues confirmed that protocols for addressing client assault were warranted to mitigate the post-traumatic type symptoms experienced by personnel in the aftermath of an assault (Flannery, 1996; Flannery et al., 2001; Flannery, LeVitre, et al., 2011; Flannery & Flannery, 2014; Flannery, Marks, Laudani, & Walker, 2007).

One of the initial investigations on assault of psychiatric personnel was a retrospective study that examined the relationship between deinstitutionalization and assault (Flannery et al., 2001). The year-long study chronicled the behavior of 32 participants discharged from a Massachusetts state hospital (Flannery et al., 2001). During the 12 months postdischarge, 42 assaults were committed and 43% of these were committed against psychiatric personnel (Flannery et al., 2001). This was the only study located that documented assault of psychiatric personnel in a community-based setting.

Flannery's et al's (2007) 15-year longitudinal investigation into the Assaulted Staff Action Program (ASAP) revealed that of 76% of psychiatric healthcare providers surveyed had been physically assaulted by psychiatric clients. Participants from inpatient and community-based settings were included in this analysis. Of the 2,152 assaults that happened during the observation period, approximately 25% occurred in community-based settings (Flannery et al., 2007). The sample was comprised of licensed clinicians, nurses, mental health workers, lab technicians, and administrators (Flannery et al., 2007).

An investigation examining international precipitants of psychiatric assault concluded that there were 2,401 assaults in community-based psychiatric settings from 2000 to 2012 (Flannery & Flannery, 2014). Based upon Flannery, Le Vitre, et al., (2011)-year analysis of the ASAP program, though assault is more prevalent in in-patient settings, it is an occupational hazard for community-based psychiatric personnel (Flannery, Le Vitre, et al.Rego, & Walker, 2011). There were 2,327 assaults to inpatient personnel, versus 564 assaults in the community setting. A rationale for this disparity may be because of the severity of symptoms in clients that are admitted to in-patient settings.

In summary, client assault is pervasive amongst counselors, social workers, and psychiatric personnel. Though Type II forms of WPV have been acknowledged as a serious occupational risk (OSHA, 2016), policies and procedures to mitigate the risk are still not regulated (McPhaul & Lipscomb, 2004; OSHA, 2016). During the first quarter of 2017, OSHA accepted comments to assist in determining whether to mandate standards to keep healthcare and social assistance employees safe. Based upon the

literature reviewed, establishing mandatory standards for keeping this vulnerable population safe is warranted as a safety precaution for clients and professionals. Another strategy for keeping healthcare and social assistance employees safe may be providing psychoeducation on the precipitants of these events.

Investigation on assault of healthcare professionals has also sought to identify the precipitants of WPV. Multiple precipitants have been identified. Factors frequently cited in the literature include socio-demographic characteristics of the provider, client pathology, the therapeutic relationship, and the setting in which these incidents occur. A brief review of these factors follows.

Precipitants of Assault

Research on client assault of community-based helping professionals has also focused on the precipitants of these events. Identifying exactly what causes a client to assault their healthcare or social assistance worker is a complex matter. Several precipitants have been identified as factors in the risk of assault of community-based mental health professionals, including gender (Flannery et al., 2001; Repass & Payne, 2008; Ringstad, 2005, Wassell, 2009), experience (Ringstad, 2005) , client symptomology (Flannery et al., 2007; Flanney & Flannery 2014), the strength of the therapeutic alliance (Bride et al., 2015; Flannery et al., 2000; Frankel, Rachlin, & Yip-Bannicq, 2012; Richards, 2011), and the setting (Flannery & Flannery, 2014; Ringstad, 2005).

Gender

To date, researchers have not agreed on the relationship between gender and client assault of community-based healthcare and social assistance workers. Several researchers have asserted that males are more likely to be assaulted than females Investigations into client assault of psychotherapists (Bernstein, 1981), psychiatrists (Carmel & Hunter, 1991), and nursing staff (Levy & Hartocollis, 1976; Rippon, 2000) have also confirmed that male helping professionals are more likely to be assaulted than females. Ringstad (2005), who examined assaultive interchanges between social workers and their clients, concluded that men are three times more like to be assaulted than females. Males also are more likely to perpetrate and report acts of violence (Ringstad, 2005).

There has been some debate about whether males are more likely to be assaulted than females. The setting in which assaults occurs may be the deciding factor on whether males or females are more likely to be assaulted (Ringstad, 2005; Shields & Kiser, 2003). Two different investigations on assault of psychiatric personnel have challenged research findings that males are more likely to be assaulted (Fisher & Gunnison, 2001; Hatch, Maillette, Scalora, Bader, & Bornstein, 2007). Flannery, LeVitre, et al. (2011) concluded that males are more likely to be physically assaulted in inpatient settings, while females are more likely to experience verbal and psychological forms of assault. The same investigation concluded that there was no statistical significance in the rate of assault between males and females in community-based settings (Flannery, LeVitre., et al., 2011). Flannery, LeVitre et al.'s observations are contrary to the results of an earlier

investigation conducted by Hatch et al. (2007) examining the type and frequencies of assaults experienced by gender. The study was conducted in two psychiatric facilities in a midwestern state. The findings demonstrated that women are more likely to be threatened than males, after controlling for years of experience and role responsibilities (Maillette et al., 2007). Since no recent research studies were located on assault of psychiatric personnel, studies examining assault of other allied healthcare professionals were examined.

The rate at which males experience assault have also been examined internationally. Findings from a retrospective study on assault of nurses that work in 10 different children's hospitals in China indicated that males are 1.9 times more likely to be assaulted than females (Li et al., 2017). In examining the relationship between violence and socio-demographic characteristics, Llor-Estebanm, Sanchez-Munoz, Ruizu-Hernandez, and Jimenez-Barbero (2017) found that male nurses were more likely to be assaulted than females. Llor-Estebanm et al. also found that the younger the provider the more likely they were to experience nonphysical forms of violence such as threats (Llor-Estebanm et al., 2017). Single professionals were also deemed at increased risk of experiencing nonphysical violence (Llor-Estebanm et al., 2017). An explanation for these observations may be that as experience accrues, the rate of assault declines.

Societal influences and gender. Gender role-norm socialization may provide some insight into why men are more likely to report being both a victim and perpetrator of client assault. The influence and power that males are perceived to have may reinforce clients assaulting them. Research on client assault has suggested that behavior

demonstrated towards clients is predictive of assault (Artkoski & Saarnio, 2013; Newbill et al., 2010). Artkoski and Saarnio (2013) investigated on the attitudes that Finnish substance abuse therapist demonstrated towards clients. Based upon the results, female therapist demonstrated more positive regard towards clients than their male counterparts (Artkoski & Saarnio, 2013).

Another reason that males may be more likely to be assaulted is that clients may be being pre-emptive in challenging someone that they perceive has power and control over them. Newbill et al. (2010) identified limit setting, activity demand, and denial of request as aversive staff behavior that appears correlated with these incidences of assault in psychiatric settings. Male acceptance of this stereo-type may inadvertent reinforce them being perpetrators, as well as victims, of client assault, especially when it involves limit setting, activity demand, or denial of requests. Likewise, male healthcare and social assistance workers may worry less about how colleagues and managers perceived them and as a result demonstrate lesser levels of empathy toward clients. Males may also feel compelled to respond to being assaulted in order to conform to the expectations of a male dominated society. All of these factors may be precipitants that fuel assault of males.

The correlation between gender and type of assault. There has also been some controversy on the relationship between gender and the type of assault experienced (Fisher & Gunnison, 2001; Flannery et al., 2007; Hatch-Maillette et al., 2007). An investigation examining the types of assaults that transpire between social workers and clients indicated that males are more likely than females to be victims of psychological forms of client assault such as threatening, swearing, and stomping away (Ringstad,

2005). More than half of the participants practiced in private practice and outpatient mental health offices (Ringstad, 2005). Previous literature contradicts the findings of Ringstad's (2005) investigation. Cunningham et al. (2003) conducted a survey in 15 inpatient child and adult psychiatric units and found no difference in the type of assault experienced based upon gender.

Gender has also been correlated with which patients are likely to exhibit aggressive behavior. Approximately eight out of 10 clients that assaulted their rehabilitation counselor working in community-based agencies were male (Davis, 2008). This statistic is surprising given that most clients seeking counseling services are female (U.S. Department of Health & Human Services, 2013). Caution is also reinforced by the fact that in 2016 there were 139,820 mental health counselors in the United States (BLS, 2017). Approximately 73% of these were female (BLS, 2017). Overall, these factors reinforce conducting additional scholarship to examine if there is a relationship between assault and gender of the perpetrator.

Other investigations into WPV have correlated the risk of assault with specific types of employment (Fisher & Gunnison, 2001; Ringstad, 2005; Storey, 2016) and client presentation (Shield & Kiser, 2003; Storey, 2016). For example, professionals working with children and adolescents (Ringstad, 2005), substance abusers (Flannery et al., 2007; Flannery, Staffieri et al., 2011), and clients with histories that include violence and being victimized are at increased risk of being assaulted (Cunningham et al., 2003; Flannery, Staffieri et al., 2011; Gillespie, 2013).

Experience

Years of experience have also been examined as a precipitant of assault (Bride et al., 2015; Jayaratne et al.,2004; Lawoko et al., 2004; Storey, 2016). While counselors with less experience are more likely to experience workplace violence, older workers have a higher lifetime incidence due to experiencing more acts of violence as years of service in the profession advance (Bride et al., 2015). Consistent with previous research (Bride et al., 2015), an investigation on stalking of counselors in the British Columbia revealed that older workers are less likely to experience workplace violence when it is defined as occurring during the previous 12 months (Storey, 2016). These results are consistent with the results of earlier investigations which confirmed that years of professional experience decrease the likelihood of being a victim of client assault (Jayaratne et al., 2004; Ringstad, 2005).

Recently there has been some debate about clinical experience being correlated with assault (Lovell & Skellern, 2013; Storey 2016). A survey on the perceptions of mental health professionals stalked by clients indicated that 50% of the licensed counselors surveyed in the British Columbia correlated clinical ability with being assaulted (Storey, 2016). Despite the fact that nearly 40% of the 133 surveyed knew about a coworker being stalked, most believed they would never be a victim of stalking due to their level of clinical skill (Storey, 2016). This perception may not only reinforce underreporting but may inadvertently increase the risk of being assaulted due to what may be a counselor's irrational belief about their clinical abilities. Additional research is

warranted to determine whether there is a correlation between experience and being victimized by clients.

Symptom Presentation

Much of the current literature on client assault seeks to identify the relationship between client psychopathology and assault of healthcare workers. There has been consensus among social scientists about which clients are likely to demonstrate violence toward providers. The results from several investigations from 2005 to the present confirmed that clients with co-occurring disorders are more likely to perpetrate verbal and physical aggression against healthcare and social assistance workers (Bride et al., 2015; Flannery, Staffieri, et al., 2011; OSHA, 2016; Ringstad, 2005). Understanding the relationship between presenting symptoms and client assault may provide knowledge that reduces the incidence of client assault of these professionals.

Flannery has conducted more than 20 years of research on the relationship between presenting symptoms and client assault of psychiatric personnel in inpatient and outpatient settings. Flannery, Staffieri et al., (2011) 16-year analysis of ASAP identified the common single and multiple precipitants of assault. Single precipitants correlated with assault included denial of services, acute psychosis, and excess sensory stimulation (Flannery et al., 2011). Being victimized, victimization of others, and substance abuse, collectively identified as the violence trio, have been significantly correlated with assaultive exchanges between clients and psychiatric personnel (Flannery, Staffieri et al., 2011). Though these results may not generalize to other environments due to a convenience sample being used (Flannery, Staffieri et al., 2011), they may have

implications for clients and community-based counselors. Ascertaining client symptomology during intake could negate a client receiving services, placing the agency and its staff at risk of allegations pertaining to discrimination and violation of rights.

Recent scholarship confirmed Flannery, Staffieri et al.'s (2011) findings. Adams et al., (2017) confirmed that a history of violence towards others and substance abuse, when combined, increased the risk of being assaulted (Adams et al., 2017). Adams et al. asserted that the risk of being assaulted was further intensified if the patient was also diagnosed with cognitive deficits. These results have been echoed in international investigations seeking to identify the precipitants of assault. Based on the results of these investigations substance abuse and psychosis are precipitants of client related violence and client assault is a worldwide problem (Adams et al., 2017; Alexander, 2004; Enosh & Tzafrir, 2015; Flannery et al., 2007; Flannery, LeVitre et al., 2011; McEwan, Mullen, & MacKenzie, 2009).

Correlating a client's psychological and behavioral symptoms with the risk of committing an assault may be a form of profiling. Profiling clients likely to demonstrate violence toward their mental health provider is a violation of ethical conduct as their presenting symptoms and social history may be used to deny or grant access to healthcare services (ACA, 2014). Identifying which diagnoses are correlated with an increased risk of assault may marginalize clients as they may experience indifference and less regard from providers. This behavior may cause harm and as such is expressly prohibited by Standard 3.04 of the APA (2010) *Code of Ethics* and Standard A.4.a of the ACA (2014) ethics code. Screening for predetermined precipitants may inadvertently violate the

Health Insurance Portability and Accountability Act (HIPAA) regulations and confidentiality since administrative staff will be knowledgeable of protected health information.

The population being served has also been linked with increased risk of being assaulted. Psychiatric personnel working with children and adolescents with a mental health diagnosis in inpatient units and residential schools are more likely to be assaulted than those working with adults (Cunningham, Connor, Miller, & Melloni, 2003). Cunningham et al. (2003) did not specify what constituted an inpatient setting. An explanation for the increased rate of assaults in inpatient settings may be due to the seriousness of symptomology required for admission to these facilities.

Extensive investigation to identify the precipitants of client assault have been conducted (Flannery, Fisher, Walker, 2000; Flannery, Fisher, Walker, Littewood, & Spillane, 2001; Flannery, Hanson, & Rego, 2003; Flannery, Staffieri, et al., 2011; Flannery, Hanson, & Corrigan, 2006; McEwan, Mullen & MacKenzie, 2009; Wootton, Buchanan, & Leese, 2008). The results of a 16-year retrospective study of the Assaulted Staff Action program were used to assess the precipitants of assault of psychiatric personnel (Flannery, Staffieri, et al., 2011). Flannery, Staffieri, et al. found that multiple precipitants were more indicative of the risk of assault than single precipitants. Specifically, they found that history of being victimized, victimizing others, and substance use disorders were more frequently associated with assault when combined, than were denial of services, acute psychosis, and excess sensory stimulation as single precipitants (Flannery, Staffieri, et al., 2011). History of being victimized, victimization

of others, and substance use disorders, commonly catalogued as the violence triad, were implicated in 90% of the 2,566 incidents that were analyzed between January 1, 1994 through March 31, 2010 (Flannery, Staffieri et al., 2011). Community-based assaults accounted for approximately 22% of these incidents (Flannery, Staffieri et al., 2011). Understanding which clients have the propensity for violence has implications for employees and organizations that employ them. Specialized training can be provided to staff caring for these clients. Conversely, it also has potential implications for clients and could negatively impact access to services as providers may be hesitant to treat clients that present with the violence triad.

There is some debate about the precipitants of assault of mental health professionals. Newbill et al., (2010) conducted direct observation to identify the precipitants of assault of psychiatric aides. The 26,000 hours of direct observational coding revealed that aversive staff behavior preceded assault (Newbill et al., 2010). Limit setting, activity demand, and denial of requests were also significantly correlated with assault. These results are inconsistent with the report of staff in the same investigation that identified various forms of psychosis as the primary precipitant of assault (Newbill et al., 2010). A major strength of the Newbill et al. investigation is that the observers were trained for this analysis. The results from investigations that seek to identify the precipitants of assault can be used to inform training protocols. Identifying which client presentations are correlated with an increased risk of assault may help mental health professionals become more skilled in managing these types of interactions

with clients. A couple of research studies have correlated the strength of the therapeutic alliance with the risk of being assaulted.

The Therapeutic Alliance

The strength of the therapeutic alliance has been touted as the panacea for client change and supervisee development (Bernard, 2005; Kress, Barrio, & Minton, 2015; Richards, 2011; Swift & Greenberg, 2015). The quality of the working relationship may also be a buffer against Type II forms of WPV (Bride et al., 2015; Flannery LeVitre, et al., 2000; Frankel et al., 2012). Demonstrating unconditional positive regard and empathy towards clients has been deemed essential to the curative process (Bride et al., 2015; Frankel et al., 2012). The results of research on patient violence demonstrated toward substance abuse counselors concluded that counselors who were providing services for clients in the recovery phase of a substance use disorder were less likely to be physically or verbally assaulted by clients (Bride et al., 2015). According to Bride et al. (2015), acceptance and empathy, tenets of unconditional positive regard, may reduce the likelihood of being assaulted (Bride et al., 2015). An earlier investigation that examined the characteristics of staff victims of psychiatric assault laid the foundation for these results (Flannery, LeVitre, et al., 2011). Attachment theory may also provide some insight on how the connection between the client and therapist reduce the likelihood of an assault occurring. Clients who have an avoidant attachment style or feel misunderstood may become fearful of disclosing (Richards, 2011). In response, they may lash out at the counselor. Therapist that are adept in using self-disclosure and empathy may be able to mitigate potential ruptures in the therapeutic relationship, thereby reducing the risk of

being assaulted by clients. Additional scholarship examining the relationship between the therapeutic alliance and the risk of assault of healthcare and social assistance employees is warranted.

Setting

The risk of being assaulted has also been correlated with the environments in which these acts occur. A survey conducted in the Midwest on 171 social workers, indicated that those working in rural areas were more likely to experience threats of violence than those working in urban areas (Shields & Kiser, 2003). The same study revealed that working for non-profit agencies in the community had a higher risk of assault than those working for other organizations (Shields & Kiser, 2003). An explanation for this phenomenon may be that nonprofit agencies, like community service boards and behavioral health authorities, serve clients that rely on public entitlements to meet their basic needs (Counseling Today, 2015). The inability to meet basic needs result in increased anxiety and depressive symptoms, which has been correlated with aggression and violence (Neumann, Veenema, & Beiderbeck, 2010). Research conducted by Koritsas et al. (2010) contradict these results. Social workers working in metropolitan areas are twice as likely to be assaulted by clients than those working in rural areas (Koritsas et al., 2011).

There has been some debate about whether assault is more likely to occur in inpatient versus community-based settings. Ringstad (2005) concluded that social workers working in inpatient, correctional, and school settings are at increased risk of experiencing psychological forms of assault but did not provide data on frequency per

environment. Similarly, an investigation that sought to identify the precipitants of assault of psychiatric personnel concluded that of the 2,002 incidents of assault that occurred from January 1, 1994 to March 10, 2010, 22% of these incidents occurred in community-based settings (Flannery, Staffieri, et al., 2011). Flannery and Flannery (2014) conducted a review of scholarship examining the precipitants of assault internationally in community settings. Similar as in inpatient settings (Flannery, Staffieri, et al., 2011), acute psychosis and substance abuse were correlated with increased risk of assault in community-based settings (Flannery & Flannery, 2014). Only nine studies were located that had examined client assault in community-based settings between 2000 and 2011 (Flannery & Flannery, 2014).

Based upon a review of the literature, healthcare and social assistance workers are more likely to be assaulted by a client than the aggregate of other occupations combined (BLS, 2016). In summary, there are several factors that have negated understanding the precipitants of client assault of healthcare and social assistance workers. First, the literature appears to be outdated. Research on client assault of this population appears to have waxed following OSHA's acknowledgement of client assault as a hazard to this population (OSHA, 1994). Given that serious incidents of WPV (incidents requiring days away from work) are on the rise (OSHA, 2016), mandatory standards for keeping these workers safe are warranted. OSHA's request for information to assist it in evaluating whether mandatory standards are warranted to keep this population safe appears justified. The Clark Doll Study is a poignant demonstration of the importance of

scholarship in advancing change. Stigmatization of professionals assaulted by clients may also be a barrier to the identification of factors that reinforce these acts occurring.

Assault of other professionals who work with the public reinforce understanding how this occupational risk effects the psychological and physical well-being of community-based counselors. Police officers experience the most assaults of any occupational group (Federal Bureau of Investigation [FBI], 2016). In 2016, 66 police officers were killed and 57,180 were assaulted while protecting and serving the public (FBI). Correctional officers and jailers rank second in experiences of assault in the execution of their professional obligations. In 2015, there were 16,080 incidents of assault of this population (BLS, 2016). Regardless of the profession, being assaulted by those one serves in the execution of their occupational obligations violates the intrinsic rights and safety of the professional and the public they are called to serve.

As a point of departure, there are several factors that reinforce understanding the precipitants of assault. Firstly, identifying the precipitants of assault of counselors may avert a crisis for clients and supervisees since outcomes in therapy (Swift & Greenberg, 2015) and supervision (Mazlina et al., 2018) have been linked with counselor wellbeing. While previous scholarship has sought to identify factors correlated with client assault of professionals that provide services to the public, community-based counselors have not been the focus of those investigations. Several researchers have called for occupational specific data to understand the experiences of professionals coping with the aftermath of these incidents (Flannery & Flannery, 2014; OSHA, 2016; Piquero et al., 2012). The current investigation may be a response to those calls.

Secondly, identifying factors correlated with client assault may also re-ignite interest in developing theoretical frameworks which explain how this phenomenon affects community-based mental health professionals. Up-to-date scholarship is a prerequisite for developing systemic interventions that raise awareness necessary for the protection of their rights (Arthur & Collins, 2014; Singh, Urbano, Haston, & McMahon, 2010). As endorsed by Singh et al. (2010), understanding how community-based counselors interpret these experiences may provide knowledge that mitigates the shame and blame that accompany client assault. De-constructing others and self-deprecating thoughts and beliefs may inadvertently reinforce self-advocacy skills, which may result in increased reporting of these incidents. Self-advocacy may posit change in individuals and systems which advance social justice through practice, training, and research (Arthur & Collins, 2014).

In recent years serious incidents of WPV (requiring days off from work) have increased, though research on the risk of healthcare professionals being assaulted appears to have waxed and waned. Further research is warranted to understand client assault of healthcare professionals in community-based settings (Flannery, 2014). Understanding the relationship, if one exists between precipitants and client perpetrated violence of community-based counselors, may provide data to inform the establishment of context specific safety protocols and help with identifying costs associated with this risk. In the next section of this literature review, costs associated with this risk will be examined.

Costs Associated with Assault

There are several direct and indirect costs associated with client assault of community-based healthcare and social assistance employees. Direct costs are those occurring in the immediate aftermath of the event such as loss days from work, medical care, and legal expenses which effect the victim and perpetrator (National Academies Press, 2011; OSHA, 2016). Indirect costs are those not directly caused by the assault such as the effect on co-workers and society at large, in addition to the cost of training of personnel to prevent these events from occurring (National Academies Press, 2011; OSHA, 2016).

Though the research community has come to a census on the two types of costs associated with client assault, there is debate about whether these costs can be quantified (OSHA, 2016). Several factors reinforce being unable to calculate the exact cost of this serious occupational risk. First, differences in how agencies, insurance companies, and governmental agencies record statistics related to these events negate being able to track the actual dollar amount of client assault (Beech & Leather, 2006; Piquero et al., 2013). Another deterrent to calculating the cost of client assault is the diversity in responses that victims have to client precipitated violence (Hartley, 2012; OSHA, 2016; Piquero et al., 2013). Some victims of client assault may miss time from work, while others may report to work and have low productivity (National Research Council, 2011; OSHA, 2016).

Estimates vary on the actual dollar amount of client assault of community-based mental health professionals. Type II WPV is reported to have cost a hospital that employs psychiatric personnel and nurses $94,156, with approximately $15,000 of the

total being for lost wages (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Data gathered from the 2014/2015 British Crime Survey indicated that workplace assault cost victims and their families approximately $7 million and the government and taxpayers $21 million (Health and Safety Executive, n.d.). OSHA (2016) estimated the annual cost of WPV to be $55,000,000 in lost wages.

There are several costs associated with experiences of workplace violence that are unquantifiable. Factors that make it difficult to estimate the financial cost of these events include early retirement, absenteeism, training, and administrative costs such as recruitment, retention of new staff, and deterioration of the physical health of direct and indirect victims (Beech & Leather, 2006; OSHA, 2016; Piquero et al., 2013; Ringstad, 2005). Variations in the number of days lost from work due to client assault range from 1,154,000 to 1,175,000 (BLS, 2016; OSHA, 2016). Differences in reporting, how assault is defined, and the instruments used to measure this occupational risk are impeding calculating the actual cost of client assault.

Psychological Costs

Psychological costs associated with client assault of mental health professionals are also difficult to calculate. Among them are an increase in psychosomatic symptoms, poor concentration, impaired judgment and problem solving, reduced self-confidence, anxiety, depression, hypervigilance, and lowered occupational performance (Lovell & Skellern, 2013; OSHA, 2016; Piquero, 2013; Storey, 2016). A phenomenological investigation seeking to understand how managers in South Africa experience WPV concluded that experiencing aggression in the workplace is correlated with a decreased

sense of wellness and an increase in somatic symptoms such as migraines, increased tension, gastrointestinal problems, diminished sleep, and decreased libido (Myburgh et al., 2011). Psychological fright has been identified as one of the most pervasive symptoms experienced by victims (Flannery, Farley, & Walker, 2006). These symptoms are linked with a deterioration in functioning and can impact an individual's personal and professional resiliency (Lopez, 2011). Resilience has been correlated with occupational perseverance (Lopez, 2011). Moreover, both direct and indirect exposure to aggressive acts have been shown to cause impairment in an individual's ability to attend to activities of daily living (Lopez, 2011). Mitigating impairment in community-based counselors providing services to clients and supervision to junior members of the counseling profession are valid reasons for understanding how client assault effects this vulnerable population.

Since the cost of responding to assault after one has occurred is 100 times more costly than preventative measures (Papa & Vanella, 2013), additional research is warranted to understand how counselors experience these events and what resources are necessary to prevent and mitigate them. Identifying culturally appropriate coping strategies can assist with mitigating costs associated with assault and enhancing resiliency in individuals coping with being a victim of client precipitated violence (Lopez, 2011).

Understanding community-based counselors’ experiences of client assault may assist with more accurately identifying costs associated with this occupational risk. The earlier interventions are provided following a traumatic event the less likely an individual

is to demonstrate impairment in occupational functioning (Flannery, LeVitre et al., 2011; Lopez, 2011). A support system that includes family members, peers, and external supports enhance resiliency (Lopez, 2011). Intrinsic, as well as extrinsic factors such as the environmental context, are strong predictors of how and whether an individual recover from violence perpetrated by clients (Lopez, 2011). The current investigation on client assault of community-based counselors may help with identifying whether intrinsic factors like support networks consisting of family, peers, and coworkers buffer Post Traumatic Stress Disorder type symptoms associated with client assault (Lopez, 2011). In addition to the personal costs to healthcare professionals and their families, there are costs to clients associated with client assault.

Client-Related Costs

Community-based healthcare and social assistance workers lack of positive regard for clients may be a serious cost associated with client assault. Social workers and psychiatric personnel that have been assaulted by clients reported being discontent with clients and demonstrating less empathy in the aftermath of being assaulted (Ringstad, 2005; Flannery, LeVitre et al., 2011). These feelings are inconsistent with the positive regard that community-based counselors are expected to afford clients and supervisees (Sommers-Flannagan, 2015). Despite the fact that aggressive behavior expressed towards clients by helping professionals is expressly prohibited by codes of conduct (ACA, 2014; APA, 2010; NASW, 2008), they may retaliate against their client as a self-defense mechanism. Research on assault of social workers (Ringstad, 2005) and psychiatric personnel (Flannery, LeVitre et al., 2011) have validated this concern.

Another study described the individual consequences of assault experienced by 22 helping professionals, which included learning disability nurses, clinical psychologist, occupational therapist, speech and language therapist, a physiotherapy, social workers, and a physician (Lovell & Skellern, 2013). Results were coded, and data was reduced to three themes: the reality of violence, change over time, and tolerance. Though participants did not described consequences in terms of physical or psychological terms, most described the event as being the "worst experience" they have ever had (Lovell & Skellern, 2013, p. 2267). Further clarifying their cognitions, participants indicated the assault "would not be forgotten" (Lovell & Skellern, 2013, p. 2267). Results from these studies seem to suggest that assault affects helping professional's self-efficacy and result in feelings of helplessness, which may have a negative effect on clinical outcomes with clients and supervisees. Understanding the experiences of community-based counselors and other helping professionals assaulted by clients is warranted, in order to identify preventative measures that protect clients, supervisees, and the public.

Preventative Measures

Protecting the wellbeing of clients and supervisees reinforce identifying protective factors (Gillespie, Gates, Miller, & Howard, 2010; Mazlina et al., 2018; Swift & Greenberg, 2015). Research seeking to identify the factors that protect healthcare workers after experiencing a client assault indicated that providing support to healthcare workers was correlated with a reduction in the physical and psychological symptoms associated with WPV (Gillespie et al., 2010). The results of a 20-year longitudinal study of ASAP confirmed the importance of providing services to direct victims of client

assault (Flannery, LeVitre, et al., 2011). The results of these investigations give credence to uncovering what factors assisted community-based counselors cope in the aftermath of a client assault. Services shown effective in mitigating impairment include Critical Stress Debriefing, individual and group counseling, and family victim counseling (Flannery, 1996; Flannery, LeVitre, et al., 2011). Providing direct victims and their colleagues crisis intervention services after experiencing a client assault mitigates the intrusive thoughts, avoidant behavior, and somatic symptoms such as startle response and hypervigilance which follow these events (Flannery, 1996; Flannery et al., 2006).

Mental health workers that received support in the aftermath of a client assault had a more positive attitude about work and did less ruminating about the event (Gillespie et al., 2010). Though providing support mitigated the physical and psychological sequeale following being assaulted by a client, the most effective strategy for mitigating the effects of WPV may be having a plan in place prior to these events occurring (see Flannery, LeVitre, et al., 2011). In response to the increase in fatal forms of WPV, from December 2016 to March 2017, OSHA accepted comments regarding whether employers should be mandated to establish guidelines for keeping community-based healthcare and social assistance employees safe (OSHA, 2016).

Several researchers have examined whether training reduces the risk of being assaulted (Adams, Roddy, Knowles, Ashworth, & Irons, 2017; Beech & Leather, 2006; Wassell, 2009). A before and after quantitative investigation was conducted to examine the effectiveness of clinical education on teaching participants how to identify clients likely to commit violent acts and reducing the incident of these events (Adams et al.,

2017). Based upon the results of Adams et al. (2017) investigation providing employees in healthcare settings additional training on de-escalation may be beneficial in reducing the incidence of violent behavior. Adams et al., (2017) conducted a 6-month pre and post assessment to evaluate the efficacy of training on reducing assaultive exchanges. A 45% reduction in aggressive and violent incidents was detected during the post education analysis (Adams et al., 2017). Identification of the precipitants to aggression and providing training are strategies that should be further investigated. Moreover, the results of this investigation reinforce the importance of effective assessment as a preventative strategy.

There has been some question regarding the efficacy of training in mitigating WPV (Beech & Leather, 2006; Brewer, 1999; Wassell, 2009). Beech and Leather (2006) conducted a review of training protocols meant to mitigate harm to healthcare workers. While training has been identified as a first level defense in a comprehensive plan for keeping healthcare employees safe, the one-size fits all approach to training has reduced its efficacy (Beech & Leather, 2006; Wassell, 2009). Providing training which focuses on mitigating provider characteristics and environmental factors may enhance the safety of community-based healthcare professionals (Flannery, LeVitre, et al., 2011). For example, teaching professionals how their behavioral presentation can either escalate or de-escalate client aggression and conducting regular reviews of protective measures like break away and restraint.

Burnout, vicarious trauma, and compassion fatigue are well-established costs of being a helping professional (Lawson & Myers, 2011; Maslach, 2003). Client assault

warrants consideration as an additional cost. In recognition of the costs associated with caring, in 2003 the ACA launched a taskforce whose goal was to identify and develop strategies to mitigate impairment (ACA, 2015). Mitigating impairment is consistent with the ethics of protecting clients (ACA, 2014). Once experiences are understood, training and safety protocols can be tailored to meet the needs of different healthcare and social assistance professionals. Illuminating thoughts, feelings, and responses that community-based counselors have in response to client assault is also a form of advocacy for the profession, which all counselors are admonished to do (ACA, 2014). Conducting research to understand the lived experiences of community-based counselors assaulted by clients may be a next step in reducing and managing client assault and mitigating impairment.

Chapter Summary

There are several benefits and consequences of providing service to the public. Social status and enhanced psychological wellbeing are amongst the benefits (Liker, 2003), while assault from clients may be one of the most serious occupational risks (Barling et al., 2009; Piquero et al., 2013). Understanding the lived experiences of community-based counselors coping with the physical and psychological costs associated with this occupational risk may increase awareness of deficits in educational and workplace training models. Adding community-based counselors voices to the literature on client assault may add additional knowledge on how assault effects occupational performance and client-supervisee safety. The literature on the prevalence of assault of social workers and psychiatric personnel adds credence to OSHA moving from voluntary

to mandatory guidelines for keeping community-based healthcare and social assistance workers, including counselors, safe. Once experiences are understood training and safety protocols can be tailored to meet the needs of different healthcare and social assistance professionals. The current investigation may provide valuable information by answering this question, “What are the lived experiences of community-based counselors assaulted by clients”? In Chapter 3, the methods for understanding community-based counselors personal and professional experiences of assault will be outlined.

Chapter 3: Research Method

Overview

In Chapter 2, I detailed the barriers to understanding the client assault of healthcare and social assistance employees and the prevalence, predictors, costs, and strategies for mitigating this occupational hazard. Most of what is known about the client assault of counselors, social workers, and psychiatric personnel is quantitative in nature (Flannery & Flannery, 2014). While there have been a few studies that have focused on the meaning these professionals assign to client assault (Koritsas et al., 2010; Lovell & Skellern, 2013; Storey, 2016), studies focusing on the meaning that community-based counselors assign to violence perpetrated towards them by clients appear limited. The purpose of this study was to explore the lived experience of community-based counselors who had been assaulted by clients they were legally and ethically bound to protect. In this chapter, I will provide a description of Heidegger's approach to phenomenology and the data collection and analysis methods used to conduct the current investigation. The chapter will also include a discussion of the protocols implemented to minimize the risk of harm to the participants.

Research Design and Rationale

Qualitative research was the most appropriate method for exploring the lived experiences of community-based counselors who had been assaulted by clients. Specifically, qualitative analysis has been endorsed as appropriate for conducting interviews to collect data in healthcare research (Gill, Stewart, Treasure, & Chadwick, 2008). As in counseling, I placed an emphasis on establishing rapport with participants

to solicit their thoughts, feelings, and perceptions about client assault. Phenomenological inquiry, which is appropriate for describing the shared meaning a group of individuals assigns to an event or situation (Laverty, 2000), was the approach best suited to answering the central research question.

Research Questions

To generate descriptive themes that described community-based counselors experiences of client assault, I developed research questions to elicit the thoughts, feelings, perceptions that community-based counselors assigned to client assault. The participants' individual experiences of client-perpetrated violence were compared to each other to generate a thick, vivid description of the phenomenon. I conducted a semistructured interview with each participant to decipher how their epistemological and ontological experiences shaped how they managed client, professional, and self-care in the aftermath of being assaulted. Questions were loosely framed to reduce social desirability bias, since I was a member of the group being studied. The central research question was: What are the lived experiences of community-based counselors who have been assaulted by clients? I also developed three subquestions to guide the study:

1. What experiences do community-based counselors have that helped them manage being assaulted?
2. How do community-based counselors experience their professional responsibilities in the aftermath of a client assault?
3. How does the lived experiences of community-based counselors assaulted by clients affect their self-care practices?

A Phenomenological Approach

Phenomenological inquiry is the most suitable method for collecting information from people who share a common experience, such as client assault (see Laverty, 2000). My use of phenomenology assisted in clarifying how community-based counselors conceptualized assault. Understanding how community-based counselors defined assault was essential to identifying frameworks for explaining this phenomenon, clarifying how counselors respond to this occupational risk as a culture sharing group, and understanding how it affected the execution of their professional responsibilities.

What is Phenomenology

Phenomenology is a philosophy and a theoretical lens. As a research method, it is beneficial for making the invisible visible. Husserl, the German philosopher who founded phenomenology, endorsed it for the intentionality of studying what it means to be human (Kafle, 2011; Laverty, 2000). The research community has embraced it for discovering, describing, and understanding phenomena from the human perspective (Laverty, 2000). Since I sought to understand how community-based counselors attended, perceived, recalled, and thought about client assault, phenomenology was appropriate for uncovering multiple realities in the quest to generate knowledge that is unquantifiable (see Laverty, 2000).

Heidegger's View of Phenomenology

Heidegger’s views on phenomenology are contrary to Husserl. Husserl’s philosophical stance on examining structures of consciousness demands researchers to set aside their epistemological and ontological views, referred to as bracketing in the

scientific community (Kafle, 2011). Heidegger rejected this philosophical stance (Kafle, 2011). Heidegger asserted that the investigators prejudices and biases are innately embedded from the beginning to the end of the research process because the individual is both separate and apart of the whole, just as the whole is both separate and a part of the individual (Kafle, 2011).

I selected Heidegger's approach to phenomenology, hermeneutics, for use in this study because it was appropriate for self-reflection on the phenomenon a priori and in relation to the context in which it occurs (Kafle, 2011). One of the assumptions embedded in this research method is that all experiences are a compilation of culture and the individual's interaction with the phenomena (Laverty, 2000). Heidegger depicted this assumption in a construct identified as the hermeneutic circle (Laverty, 2000). The hermeneutic circle is premised on the belief that individual experiences are intricately woven into the totality of experience in a repetitious cycle of part to whole and whole to part (Laverty, 2000). This continuous loop enables individuals to question and accept that in reality there are no absolutes and that understanding is dynamic, not static (Laverty, 2000). Heidegger espoused that lived experience (i.e., understanding) is facilitated via a continuous transactional process that occurs between the individual and the phenomena being studied (Laverty, 2003).

Gadamer (1975) expanded Heidegger's view of the researcher's preconceptions as the embryo to new understanding and knowledge. Gadamer espoused that knowledge is the by-product of interpretation gleaned from the dialectical exchange between being in and being with the world (Moustakas, 2010). This construct, which Gadamer referred to

as a fusion of horizons, is a metaphor for the hermeneutic circle and the symbiosis between the researcher and the phenomenon (Oxley, 2016). As horizons merge, a new way of being rather than knowing emerges (Oxley, 2016).

A Fusion of Philosophical Perspectives

Heidegger's philosophical stance on hermeneutic, or interpretive, phenomenology is consistent with my ontological and epistemological worldview. As a cognitive behavioral therapist, I believe that it is not what happens to an individual that causes shifts in functioning but the perception of an event. Instead of describing the reality of assault, I focused on participants' experiences of being assaulted and the way they interpreted these events. As endorsed by Gadamer (1975), my historical, social, and political identities effect my *being in the world* and were intertwined in participants' accounts of assault. Instead of bracketing out my preconceptions regarding the phenomenon, participants' recollections of assault elucidated my assumptions on the phenomenon.

Participants

In qualitative analysis, intentionality and not statistics guides the selection of participants (Creswell, 2009). I chose participants for this study based on their experiences, values, beliefs, and understandings of the phenomenon under investigation (see Laverty, 2003). The scientific community has defined this process as purposeful sampling (Devers & Frankel, 2000). Due to the nature of this study, a homogeneous, purposive sampling strategy was used to explore the perceptions and meanings that community-based counselors assigned to being assaulted by clients.

In addition to homogeneous purposive sampling, I used criterion sampling to ensure that participants with knowledge of the phenomenon were selected for the study. Snowball sampling was used with participants being encouraged to refer other colleagues whom they knew fit the inclusion criteria. The following criteria guided my selection of participants:

- Had earned a master's degree in counseling from a regionally accredited university (National Board of Certified Counselors, 2015) and had experienced physical (i.e., hitting, kicking, punching, slapping, and spitting) and/or psychological harm (i.e., verbal abuse, bullying, harassment, and threat of harm) perpetrated by a client (see Straus et al., 1996),
- Had worked in a nonresidential setting as defined by OSHA (2016). These settings include clinics, outpatient therapy offices, mental health centers, and home-based care.

In qualitative analysis, participants are chosen who have first-hand knowledge of the phenomenon being investigated (Moustakas, 1994). First-hand experience yields in-depth, information-rich stories which allows the research questions to be answered (Oxley, 2016). Potential research participants were recruited from the ACA Connect Call for Study Participants Community and the CESNET-L listserv community. ACA Connect, is a community forum comprised of professional counselors hosted by the flagship organization the ACA (2017). CESNET-L is a counselor education and supervision community. I also recruited participants from Black Therapists Rock, which is a social media community on Facebook. To honor the netiquette of these communities,

I posted an announcement on each site calling for research participants. Perspective research participants were instructed to send me an e-mail to the e-mail address I provided if they were interested in participating in the survey.

I sent participants that expressed interest in participating in the study an e-mail response with a hyperlink to the Informed Consent and Disclosure Statement. Participants reviewed the Informed Consent and Disclosure Statement and were asked to send an e-mail to me if they were interested in participating in the study. Instructions on how to contact me was provided so that any questions participants had could be addressed. The benefits of using a listserv included saving time involved with personalizing and composing e-mails. Additionally, when responding to questions from potential participants, I directed the response to everyone on the list giving all perspective participants the same information. Snowball sampling was also used with participants being encouraged to invite their colleagues who met the inclusion criteria to participate in the study.

Data Collection

Hermeneutic inquiry demands a descriptive methodology be employed (Heidegger, 1962). I used multiple methods of data collection to conduct a scholarly inquiry into the client assault of community-based counselors. For a phenomenological study to be considered as rigorous, it must "be methodologically articulated in such a manner that data collection and data analysis are both seen as part of a single, unified process with the same underlying theory of science" (Englander, 2012, p. 15). In this study, I collected data through the personal experiences of assault captured in one-on-one

interviews with the participants, observations, and the words and phrases that community-based counselors used to generate a rich description of the experience. In the following subsections, the methods used to explore what categories evolve when considering client assault are discussed.

Data Collection Assumptions

Heidegger (1962) asserted that understanding is grounded in historical life experience and the context in which understanding occurs. The hermeneutic circle is a diagram that depicts the relationship between historical life experiences and the environment (Dreyfus & Wrathall, 2005). There were several phenomenological assumptions employed to uncover the participants' preconceptions and experiences of client assault. Use of a phenomenon interview protocol was one of the assumptions embedded in this phenomenological data collection procedure (see Englander, 2012). This premise provided a frame of reference for conducting interviews to ensure that all data were collected in a systematic and focused manner. Acting as participant observer, I presented as someone who had intense personal knowledge of the lived experience of client assault.

Another data collection assumption was that research questions would generate descriptive data about the assault and the context in which it occurred that would explicate the meaning participants assigned to assault (Englander, 2012). Open-ended questions were utilized to encourage participants to describe their feelings and perceptions about the phenomenon, as well as how the experience effected their professional behavior during and after the assault. Understanding how community-based

counselors think and feel about being assaulted by a client may be a prerequisite to developing and identifying theories that explain and provide a framework for responding to client assault of healthcare and social assistance employees.

Preliminary Meeting

A premeeting was held with each participant via an end-to-end Advanced Encryption Standard -based cryptography HIPAA compliant Internet platform, GoTo Meeting to assist with establishing trust, reviewing the informed consent procedures, and educating participants of their rights and risks as they pertain to this study. Demographic information was collected to document identifying data including gender, age, years of experience, and setting in which the clinician worked during the assault experience. An interview protocol was established to structure the interview, ensuring that the same topics were covered with each participant. Interviews were conducted online using GoTo Meeting. Though participants were afforded the option of interviewing in a confidential site of their choosing, all of the interviews were conducted in their private homes.

The Interview Protocol

Participants were notified by e-mail of their inclusion in the study. I scheduled the interview and provided participants with a date, time, and link for attending the Internet facilitated audio-recorded interview. I listened and recorded the affective responses of participants in a journal listening for silence and emphasis on certain words and phrases, which were used for formulating themes (Gibbs & Taylor, 2010). Affective coding has been endorsed for understanding the values, attitudes, and beliefs of internal

and external experiences like client perpetrated violence against community-based counselors (Miles Huberman, & Saldaña, 2014).

Data collected were transcribed into a Word document verbatim after the interview was conducted for each participant. Transcriptions were saved in two password protected locations: my laptop and in Dropbox. Both storage sites were password protected to ensure confidentiality. The online storage site was utilized as a back-up to reduce the possibility of data being lost due to computer technical problems.

Data Analysis

Researchers conducting a phenomenological design, utilizing hermeneutical inquiry are concerned with meaning, not measurement. Following in the tenets of hermeneutical analysis, I read, coded and organized the data into themes. Gibbs and Taylor (2010) endorsed the use of a content analysis approach for organizing thoughts, feelings, and behaviors into meaningful segments. As endorsed by Gibbs and Taylor repetitive words were coded. Codes were linked to create larger meaningful segments of data which formed the themes.

The thick rich descriptions characteristic of qualitative inquiry generates volumes of data to be structured and organized. Hand-coding was utilized for organizing data into categories and themes. Descriptive and reflective notes taken during the study were cleaned and coded as they provided valuable insight into the primary researcher's preconceptions and the essence of the lived experiences of counselors assaulted by clients. The data was presumed to be valid.

There are several strategies that qualitative researchers use for uncovering and understanding data collected. Despite which strategies are used, the conceptual framework and the questions to be answered reinforce what data matters most (Gale, Heath, Cameron, Rashid, & Redwood, 2013). As espoused by Heidegger, my ontological and epistemological worldview affected how data collected was used to interpret the meanings assigned to assault by community-based counselors (Kafle, 2011). The following steps were used to analyze data:

1. Read entire transcript. Omit extraneous words.
2. Conduct member-checking.
3. Identify preliminary meaning units.
4. Conduct follow-up interviews and insert missing data into transcript.
5. Finalize meaning units for each interview.
6. Generate situated narratives for each interview.
7. Synthesize situated narrative into recurring themes across experiences.
8. Summarize experience of population into one narrative.

Illustrated Steps

The first step was to read the entire transcript of the individual interview to get a sense of the entire description, deleting irrelative information such as “um” and “let me see.” Transcribing interviews enabled me to study the participant's experience of the phenomenon in question. Transcription has been described as an interpretive process which transforms verbal and nonverbal data into written form (Bailey, 2008). Observation of participants body language, including facial expressions and voice tone,

assisted me in formulating follow-up questions which described community-based counselors lived experience of client assault (Meho, 2006).

Member-checking was conducted to ensure the accuracy and resonance of each participant's experience. Each participant was e-mailed a copy of their transcript. In qualitative analysis member-checking is synonymous with trustworthiness (Chang, 2014). This process is an essential step in the fusion of multiple realities that shape experience. One of the drawbacks of member-checking is that it may lead to confusion as participants may change their accounts of the event due to fear of being negatively appraised (Harvey, 2015).

Next, I broke down the elements into preliminary "meaning units," which described a characteristic of client assault. Ryan and Bernard (2003) endorsed several different techniques for identifying preliminary "meaning units". Word count, key-words, line-by-line scrutiny, and comparing accounts of the phenomenon were utilized to develop descriptions that generated vivid recollections of client perpetrated violence against community-based counselors (Ryan & Bernard, 2003). An example of two preliminary units is illustrated from Becky's description of the phenomenon under investigation. In the first meaning unit she describes how her childhood helped her manage client perpetrated violence while the second meaning unit describes her thoughts on how her master's training did little to prepare her for this occupational risk. Becky stated, "Teachable moments from my childhood helped me realized that I have a natural talent for this". She added, "my classroom and internship training really failed me when it came to being prepared to run into personality characteristics and resistant clients".

The fourth step in data analysis, is conducting follow-up interviews and cleaning the data. I identified gaps in the data, such as missing information or unclear statements, based upon the original transcripts. Follow-up questions were formulated for each participant. Missing information was inserted into the original analysis of meaning units, which resulted in an edited synthesis of each participant's assault experience. Once omitted text had been inserted, a complete transcript of each interview was generated. In the following example of an edited synthesis, I sought to clarify what Sheila meant when she stated that she "experienced the assault mentally." The information obtained in the follow-up interview is highlighted in bold text. Sheila added, **"I experienced the assault mentally. In my mind, I began to second guess myself and question my capabilities. I needed to regroup on how I would move forward as a counselor".**

Then, I broke down the data into final meaning units for each participant which deepened my sense of the entire description through the identification of shared meaning in and across participant's recollections of assault. Previous themes like "shaming and blaming" (Johnson, 2012, Piquero et al., 2013; Storey, 2016) and "premature departure from the profession" (OSHA, 2004) were utilized as precoding structures for deciphering final meaning units. Each participant's experience was compared with these themes. For example, all the participants experienced some level of shame and doubted their professional ability. Candace, Theresa, and Becky asked, "what did I do wrong." However, Theresa is the only participant that did not consider leaving direct care. She is also the only participant that provided supervision leading to licensure to junior members of the profession at the time of this investigation.

A situated narrative was created for each participant. Narrative learning theory is premised on the assumption that humans utilize data from events and happenings to tell stories which assist them in understanding their experiences (Polkinghorne, 2015). A story was created which described how each participant constructed meaning from their experience and how this experience has been integrated into their cognitive structure, as well as their personal and professional identity. For example, in my narrative of client assault it is being used as a catalyst for protecting the helper from those they are obligated to protect. Instead of seeing myself as a victim, I see myself as an advocate for community-based counselors. Theresa, one of the licensed professional counselors in this investigation, framed her experience of assault as a part of her situated professional identity. Unlike, the other participants, she did not accept client assault as a risk that comes with the job as it is the anthesis to self-care, which is mandated in Section C of the ACA (2014) *Code of Ethics.*

Experiences were synthesized to create a situated narrative across experiences, transforming the language used to describe assault from an individualized subjective experience to a global textual experience of the population being studied. Ryan and Bernard (2003) endorsed comparing of experiences for development of themes by novice researchers. Individualized language focuses on phenomenon based upon the attitudes, values, and beliefs of a specific participant, while global language is a composite of the definitions and values that a culture or a population uses to describe a phenomenon. An example of global language that permeated across situated narratives is ambivalence about clients following experiencing assault. For example, Becky said, “the opportunity

for me to be therapeutic with somebody who's seeking to exert power over me neutralizes that therapeutic opportunity," while Sheila explained that it is difficult "to continue working because it can get very intimidating once the relationship has deteriorated. It's really hard to move forward." Another global experience is that assault is a risk that comes with the job, which is consistent with the experiences of social workers and psychiatric personnel assaulted by clients (OSHA, 2004). These shifts were necessary to move from a personal to a more global understanding of the phenomenon in question. Similarities in situated narratives were combined into three themes that characterize client assault of community-based counselors: training for managing these events, ambivalence regarding professional responsibilities in the aftermath of client-perpetrated violence, and the use of connections as self-care practices. These shifts are depicted in the hermeneutic circle and demonstrate the connectivity of the counselor to the population and population to the counselor.

Finally, one narrative that described how community-based counselors experience assault was created and organized based upon the identified themes surrounding this phenomenon. The narrative contained data which describes how this population experienced client assault. This data may be utilized to assist with developing protocols for responding and mitigating this risk. For example, based upon the data extrapolated from participant interviews multiple types of training are beneficial for the management of client assault. Specifically training from family of origin, counselor preparation programs, and previous work experiences.

Trustworthiness

Qualitative researchers utilize multiple strategies for evaluating the validity of phenomenological studies. Participants were asked to validate that their story of client assault to ensure that it had been transcribed correctly. Member-checking was utilized to determine whether the essence of each participants experience had been captured, as members were e-mailed a copy of their transcript and asked to read it to ensure that it accurately reflected their experience of assault. A best practice for establishing trustworthiness in qualitative research is to collect data until it becomes repetitive (Walker, 2012). The research community has termed the process of collecting data until no new data or themes emerge as saturation (Walker, 2012). While there has been some debate about when saturation is reached, it has been endorsed as the gold standard in purposive sampling (Walker, 2012). No new data emerged following the fourth interview. There is some question in the research community regarding how many interviews are required to reach saturation. However, to conform with the recommendation of Creswell (2009) two additional interviews were conducted.

The Role of the Researcher

In qualitative analysis, the researcher is the instrument (Pyett, 2003). This assumption is consistent with Gadamer's philosophical stance that in hermeneutical analysis the researcher's worldview affects how they interpret the meaning that participants assigned to the phenomenon (Converse, 2012). Gadamer (1975) believed that truth and understanding are relative, and that the researcher's biases and preconceptions are essential elements in meaning making about the phenomenon.

However, the scientific community has not adequately defined or delineated how the researcher's worldview and experiences are to be incorporated into the interpretation process (Converse, 2012).

One of the biggest challenges for researcher's conducting a hermeneutic study is to be transparent in disclosing their preconceptions regarding the phenomenon being studied (Converse, 2012). To mitigate this potential drawback the researcher's preconceptions are being made transparent so that readers of this text may judge to what extent it influenced the generation and analysis of the findings. My knowledge of client assault emerged as a result of supervising two counselors in a private community-based agency that were assaulted by a client. Following this intense event, I began to examine the literature surrounding client assault to provide guidance to management on developing a response to these critical incidents.

The preconceptions I had regarding client assault of community-based counselors were inconsistent with the literature. Prior to conducting a miniliterature review to identify strategies for responding to community-based counselors being assaulted, I was not consciously aware of assault as a risk that comes with being a mental health provider (Lovell & Skellern, 2014; OSHA, 2016; Piquero et al., 2013; Ringstad, 2005). The process of examining the literature facilitated a shift in my being.

Another assumption I held was that the agency's response to the counselors assaulted would affect how they would provide care to clients post assault experience. Based upon the data gathered during this study, the therapeutic alliance may be disrupted post-assault experience regardless of how the counselor's employer responds. Following

the assault experience, participants experienced ambivalence regarding clients. Fight or flight theory may provide a plausible rationale for the mixed feelings participants had regarding clients. Candace’s experience demonstrated that employer response may not be correlated with community-based counselors lack of regard post-assault experience. Talking about this issue, Candace said,

> My supervisor was the one who suggested that I go press charges. The police were called when it happened, and she was the one that suggested I press charges. She wanted to make sure that I was ok. That's not the norm in this business.

Despite the response of her employer, she still reported being distrustful of clients and openly admitted to reconsidering providing direct client care. “I do not have to be at the forefront and actually working with people.”

In response to the assumption that the researcher’s subjective experience is always present in the research, I kept field notes and journaled throughout the research process. Journaling of thoughts and feelings regarding client assault of community-based counselors began once the topic was approved for dissertation. Field notes and observations were utilized to develop initial meaning units and themes which explain the experiences of community-based counselors assaulted by clients. They were also used to elucidate my assumptions regarding the phenomenon of interest, which is an essential step in achieving rigor and demonstrating congruence between method and philosophy in phenomenological research (Lowes & Prowse, 2001).

The Ethics of Research

Researchers are bound to conform to ethical standards when conducting research involving human subjects (National Institutes of Health, 2016). Throughout the research process several strategies were utilized to protect the identity of coresearchers. An advertisement announcing the study was electronically sent to subscribers of the ACA Connect and CESNET-L listservs. Subscribers to these groups are counseling professionals committed to educating and supervising novice counselors. Once participants agreed to participate in the study, they were e-mailed a copy of the Informed Consent Procedures and provided an opportunity to ask questions about the risks, benefits, and purpose of the study. Since participation in the study was voluntary, they were informed in writing and verbally, during the premeeting that participation was voluntary and that they could withdraw from the study at any time. To further protect the confidentiality of participants, their contact information was stored on my password protected laptop and, in a password, protected on-line site, Dropbox, which is HIPAA compliant. I will be the only individual with access to these locations.

Individual interviews were audio-taped. Conducting interviews individually assisted with ensuring confidentiality. Participants were provided an opportunity to review their transcribed interview to add information they felt was pertinent to understanding their experience. Allowing participants to review transcribed data has also been endorsed as being affirming and cathartic (Forbat & Henderson, 2005). Review of transcripts assisted with ensuring that my knowledge and experience of client assault did not overshadow the coresearchers and that the knowledge generated was coconstructed.

This process is commonly referred to by the research community as member-checking. Birt et al. (2016) endorsed member checking when one of the goals of the research study is to change practice. Finally, each participant was provided the option of receiving a final copy of the study. Though none of the participants expressed wanting a copy of the final study, if they later request a copy it will be mailed via the U.S. Postal Service.

Conclusion

The objective of Chapter 3 was to describe the procedures that were used for eliciting the meaning that community-based counselors ascribe to client assault. In this section the questions, participants, procedures, data collection and analysis, and ethical considerations necessary to replicate this study were delineated. A phenomenology design was chosen because it is appropriate for describing, how community-based counselors think, feel, and act in response to assault as an occupational risk. A purposive sample was utilized to collect the thick-rich descriptions of client assault. Data collection continued until it was repetitive, and no new data emerged. This process is known as data saturation (Fusch & Ness, 2015). Originally developed for grounded theory, saturation is synonymous with rigor in qualitative analysis. The methodology served as the map for conducting the research. The results of the data collected are presented and analyzed in Chapter 4. In Chapter 5, I will discuss the implications from this study and offer recommendations for follow-up investigations.

Chapter 4: Results

Introduction

The purpose of this hermeneutic phenomenological investigation was to explore the lived experiences of community-based counselors who had experienced being assaulted by a client for whom they were providing care. In this chapter, I present a demographic representation of the research participants and an analysis of the interviews I conducted with them to address the following central research question: What are the lived experiences of community-based counselors that have experienced a client assault? The interviews were 60-minute, semistructured tele-video conferences that generated a descriptive landscape of the phenomena under investigation. I also developed the following subquestions to explore how participants made meaning of their experiences:

1. What experiences do community-based counselors have that helped them manage being assaulted?
2. How do community-based counselors experience their professional responsibilities in the aftermath of a client assault?
3. How does the lived experience of community-based counselors assaulted by clients affect their self-care practices?

In this study, I examined participants' responses to generate an individual narrative and a shared culture of how master's-trained counselors working in private and state-funded agencies in the community experienced and made meaning of this serious occupational risk. I transcribed each interview before conducting the next one to ensure that each participant's story reflected their experience. As endorsed by Miles et al.

(2014), a transcript of the interview was sent to each participant to ensure accuracy and reduce researcher bias.

Starting with the end in mind, I used a precoding structure to collect and analyze data simultaneously to answer the main research question. Based on a review of the literature and a coding structure beneficial to the examination of the phenomenon (see Gibbs & Taylor, 2010), data were precoded based on the findings of previous researchers on the topic of the client assault of helping professionals. Preestablished codes served as a focal point from which to start to collect and analyze data (see Miles et al., 2014).

Since it is a social constructivist process, researchers using hermeneutic inquiry construct meaning using individual and collective responses to understand experience (Oxley, 2016). As endorsed by Miles et al. (2014), I read and reread participant transcripts to explore the lived experiences of community-based counselors assaulted by clients whom they were providing therapy. During in-depth reading of the transcripts, key descriptive phrases from each participant's experience were hand-coded in a color that correlated with a preestablished code. Consistent with social constructivism, which hermeneutic inquiry is a relative of, I outlined key descriptive phases of each participant's story to generate the shared experience of community-based counselors assaulted by clients.

The coding process assisted me with understanding the relationship between individual and collective experiences of the phenomenon under investigation. This process is also consistent with making meaning of participant's subjective experience as situated in the contextual environment in which the act occurred, which depicts the parts

to whole and whole to parts intersectionality of the hermeneutic circle. I kept a journal that chronicled the transitions and shifts in my thoughts and subjective interpretation of the phenomena being investigated during the data analysis phase of this study, which helped ensure that a thick, rich landscape of this social phenomena was being created (see Miles et al., 2014).

Setting

Each of the interviews were Internet-mediated via the online video conferencing platform, GoTo Meeting. All of the participants attended the online interviews from a secluded room of their home. I conducted the face-to-face meetings for three of the participants on the weekend and three during the week. A benefit of conducting online interviews is that it mimics the back and forth of an in-person, face-to-face interview, which adds depth to the understanding through observation of the participants' verbal and nonverbal communication. Each participant consented verbally before their interview was scheduled. They were also provided with an opportunity to ask questions at the start and conclusion of the interview. I reminded each participant that they could redraw from the study at any time. Four of the interviews occurred seamlessly. One interview was abruptly terminated due to the participant's Internet connection being dropped during a storm (i.e., Kimberly). Though the baby of the final participant was not in the room for the interview (i.e., Candace), he could be heard at times crying and playing with his dad. She was occasionally distracted, attempting to hear what they were doing in the other room. I used an interview guide to facilitate flow and solicit each respondent's account of their experience of client assault.

Participant Demographics

All the participants in this study had an earned master's degree in counseling and had experienced one or more assaults while providing client care in a school, private home, residential facility, and/or an outpatient therapy office. Three of the participants experienced assault in a school setting, three in their client's home, one in a short-term residential setting, one in an outpatient therapy setting, and three of them in multiple combinations of these settings. Participants ranged in age from 29 to 52 years old. Four of the participants were African-American and two were White. Two licensed professional counselors and one resident were among the participants. The average years of experience was 7. Two were single, two divorced, and two were married. I recruited participants by placing an announcement in two listservs, CESNET and ACA Connect, as well as placing an announcement in Black Therapists Rock, which is a closed-community on Facebook. The descriptive statistics of study participants are provided in Table 1.

Table 1

Participant's Demographic Data

	Age	Gender	Marital status	Years of experience	Assault environment
Kimberly	52	Female	Married	10	Elementary school
Katie	52	Female	Divorced	3.5	School and home
Candace	32	Female	Divorced	10	School and home
Teresa	50	Female	Single	8	Residential facility
Sheila	29	Female	Single	3	Home
Becky	48	Female	Married	8	Residential facility and home

Overview of Themes

Three themes and eight subthemes emerged to describe participants' experiences of client assault. In Theme 1, community-based counselors described how they used training gleaned from their family of origin, master's program, and previous work experience to manage Type II assault. Theme 2 was focused on the multiple forms of ambivalence these healthcare professionals experienced in the execution of their professional obligations to clients, themselves, and the counseling profession. Finally, Theme 3 was focused on how their faith-based practices and relationships with peers and supervisors functioned as self-care strategies.

Methodology

As explained in Chapter 3, I received approval from Walden's Institutional Review Board (Approval No. 08-15-18-0302261) to conduct this scholarship on client assault. Following the approved recruitment method, eight subjects expressed interest in

participating in the study; however, two were screened out due to not meeting the established criteria to participate. Following completion of the informed consent procedure, I conducted an audio-recorded interview with each participant via the GoTo Meeting Internet platform. Though interviews were anticipated to be approximately 60 minutes, one lasted 54 minutes and one 67 minutes. All the interviews conducted were analyzed and synthesized into the population narrative.

I used a semistructured interview process to solicit participants' unedited responses. Open-ended questions were used to engage participants to share their experiences, thoughts, feelings, and beliefs about their experience (see Appendix A). I used clarifying questions to ensure that a meaningful description of their experience within the context in which the assault occurred could be recreated. Each audio tape and transcribed interview was reviewed at least three times. I read and reread each participant's transcript to develop key words and phrases to describe each experience. After several iterations of the meaningful segments of each experience, I was able to develop a coding and thematic schema to generate a contextual analysis of the client assault of community-based counselors that aligned with the themes found in the literature. I used hand-coding to assign colors to interview questions, meaningful segments of data, and categories to simplify understanding the transcription and formulation of themes. A field journal, in which I recorded my foreknowledge and observations about the phenomenon to make meaning of participant's experience, was also employed.

Situated Narratives

Kimberly's motivation to become a counselor emanated from watching her mother, who was a nurse, "take care of" her patients. She was assaulted while working in an urban school environment. Kimberly was 52 years old and had worked 10 years as a community-based counselor at the time of this interview. She had worked with consumers in their homes and in the community teaching them independent living skills. She had been married 31 years and has three daughters.

Katie "felt a spiritual call" to become a counselor while working in a middle school as a special aide assistant. The divorced, 52-year-old, White female had worked with adults diagnosed with developmental delays in their homes in a rural community. She had 3.5 years of counseling experience and was currently taking additional courses so she could become a licensed professional counselor. Katie had also worked with children with mental, emotional, and behavioral disabilities in a rural school setting. She experienced client assault in both settings.

Candace had a 1-year-old and was currently engaged to be married. An African-American female, at the time of the interview, she was 32 years old and had 10 years of mental health experience, 8 of them post-master's. She had worked with adults diagnosed with serious mental illnesses and children with behavioral disorders. Candace provided counseling services in schools and in client homes. She reported being assaulted in both of these environments. At the time of the interview, she was receiving supervision to become a licensed professional counselor. Her motivation to become a counselor was birthed while observing her mother take of children placed in foster care.

In this study, she discussed being assaulted in a school and a private home, both in urban settings.

Theresa became a counselor after serving as a human resource professional with a major transportation company. She was single at the time of the interviews and reported not having any biological children, though she has been instrumental in raising her niece's two daughters. A 50-year-old, African-American female, she had worked in multiple outpatient settings, including a short-term residential care facility for youth, in private practice settings, and supervised home-based care. Theresa reported having 8 years of post-master's experience. She had provided clinical oversight for a program that provides Employee Assistance Program counseling to members of the Armed Forces. Her assault experiences occurred in an urban outpatient therapy setting and in a short-term residential treatment environment.

Sheila reported that she loves children and originally wanted to be a school teacher. However, she realized that she had "no desire to be directly in a classroom," which is what "pushed" her towards becoming a counselor. Her passion for working with children first emerged while volunteering out in the community with youth. After recognizing how trauma affects children, she enrolled in school to become a counselor. A 29-year-old, African-American female, she had provided community-based care by working as an intensive in-home services and therapeutic day treatment counselor with children in their homes and schools, respectively. The assault experience she referenced in this study occurred in the client's home, located in an urban neighborhood. At the time of this study, she had 3 years of mental health experience.

Becky was employed as a full-time counselor educator at a historically Black institution at the time of this interview. She was married to a math professor and had a 3-year-old son. The 38-year-old, White female is a licensed professional counselor with 8 years of mental health experience. She described herself as "being a good counselor" who had provided care for clients from 15 to 98 years old. In her role as a community-based counselor, she reported that she had worked in urban and rural, short-term alcohol treatment and residential facilities where she "routinely" experienced assault. Prior to receiving her master's in counseling, she worked in student services in higher education. In her spare-time, she reported pampering herself by getting manicures and pedicures.

Analysis of Experience

Community-based counselor's lived experiences were interpreted using a hermeneutic phenomenology lens. Heidegger, the creator of hermeneutic phenomenology, argued that understanding of experience is mediated and deposited through language, personal bias, and the context in which it occurs. The interdependence of these variables is depicted in the hermeneutic circle, which recognizes that understanding and interpretation are a by-product of the relationship between the unit and its independent components and vice-versa. Multiple experiences were examined to glean the essence of how counselors that work in private and state agencies, as well as short-term group home and residential settings, make meaning of client assault.

In phenomenological analysis the researcher must read, code, and organize volumes of data, creating codes to recognize the commonalities of experience. To analyze the story that participants shared about the phenomena being investigated and to

identify themes, I color-coded key words and descriptive phases as recommended by Gibbs and Taylor (2010) and Creswell (2014). A line-by-line analysis was conducted to identify key words and phrases, initial meaning units, which were grouped to generate themes (See Table 4.2) to answer the primary research question, "What are the lived experiences of community-based counselors that have been assaulted by clients?").

Table 2

Initial Meaning Units

	Kimberly	Katie	Candace	Theresa	Sheila	Becky	Theme
Family of origin	X	X	X	X	X		1
Hypervigilance	X	X	X	X	X	X	3
Master's training	X	X		X		X	1
Work experience	X	X	X	X		X	1
Shame & blame	X	X	X	X	X	X	2
Self-Care		X	X	X	X	X	3
Supervision	X	X	X	X		X	3
Self-doubt	X	X	X	X	X	X	2
Premature termination		X		X		X	2
Faith practices	X	X	X		X	X	3
Training deficits	X	X	X	X	X	X	1
Ambivalence	X	X	X		X	X	2
Risk comes with the job	X	X	X	X	X	X	3

After reviewing transcript data and my field journal the following themes emerged to answer the question what are the lived experiences of community-based counselors that have been assaulted by clients: training, ambivalence, and connections. Hand-coding facilitated the development of these themes. I conducted line-by-line analysis to identify key words and phrases. To facilitate the process, I reflected on the

concept the key words and phrases were conveying, which was then color-coded. Next, I cut and pasted statements together by focusing on the subject matter. Similarity in answers and repetitious words guided the formation of the themes that emerge.

Four initial meaning units – family of origin, master's training, work experience, and training deficits were combined to create theme 1, training as a management strategy. The commonality of experience across participants, space, and time, indicated that various types of training were beneficial for managing an assault once it occurred. Once an assault occurred, all the participants acknowledged having ambivalence regarding clients, themselves and the profession. The following initial meaning units were combined to form theme 2, ambivalence as a new way of being, shame and blame, self-doubt, hypervigilance, premature termination, and ambivalence. Finally, each of the participants identified their faith practices, colleagues, and peers as buffers that reinforced self-care in the aftermath of an assault. To formulate theme 3, connections for well-being, I combined the following initial meaning units- hypervigilance, self-care, supervision, faith practices, and the risk comes with the job.

The identified themes are summarized in the table below. It is important to note that these themes are not exclusive to the question being asked as there is some overlap in participant responses. Below is an illustrated summary of the alignment of the sub-questions, themes, and initial meaning units: (see Table 3)

Table 3

Subquestions, Theme, and Initial Meaning Alignment

Subquestions	Theme	Initial Meaning Units
What experiences do community-based counselor have that helped them manage being assaulted?	Theme 1	Family of origin Master's raining Work experience Training deficits
How do community-based counselors experience their professional responsibilities in the aftermath of a client assault?	Theme 2	Shame and blame Self-doubt Premature termination Ambivalence
How does the lived experience of community-based counselors assaulted by clients affect their self-care practices?	Theme 3	Hypervigilance Selfcare, supervision Faith practices Risk comes with the job

Illustrated Summary

Following the data analysis, the following themes emerged: training as a management strategy, ambivalence as a new way of being, and connections for well-being. What follows is a more fully developed detailed analysis of these themes. I have correlated these themes in alignment with the primary research question and the literature contained in Chapter 2.

Training as a Management Strategy

Based upon the data extrapolated from participant interviews multiple types of training are beneficial for the management of client assault. Specifically training from family of origin, counselor preparation, and previous work experiences. After multiple reviews of the transcripts I discovered that 4 of the 6 participants utilized the following key phrases: "*taking care of and being concerned," "instilled in me," "my previous experience," "each office where we trained," "my background," "training helped me*

normalize," "on-the-job-training," "employer training," "know your limits," and *"going back to the books"* to describe what experiences assisted them with managing client assault. Moustakas (1994) endorsed using key words and phrases for revealing the implicit structure and essence of a phenomenon.

Family of Origin

Most of the participants identified that values from their family of origin helped them manage the assault experience. Five of the 6 participants explained that the work they do is connected to enhancing the quality of life for society, which is the mission of the ACA (2014). Kimberly succinctly stated, "I was taught to take care of and be concerned for people. It instilled in me a desire to help others, especially those that really need help". Another participant reported that observing her mother in her role as a therapeutic foster care parent helped her normalize how she managed this experience. She stated, "My mother was patient and spent more and more time with them". Candace credited the compassion she observed provided to special needs kids as a key factor in "remaining committed to the counseling profession in the aftermath of being assaulted". Other participant statements that indicated how family of origin values helped them manage assault included: "Teachable moments from my childhood helped me realized that I have a natural talent for this" (Becky), "Values instilled by my family inspired me to help others" (Katie)," "My family told me there is not a lot of money and the hours are long, but I'd like being an asset, to plant that seed of change", (Sheila), "I think that's where the seed started and it's what helps me deal with clients" (Kimberly) and "My upbringing taught me to value others and myself" (Theresa). Alignment of professional

values with family of origin values appears to reinforce community-based counselor's acceptance of this occupational risk, "because it's not if it happens, but when it happens" (Sheila).

Perceptions about Training

As discussed in Chapter 2, participants agreed that training is an essential element in managing and preventing this occupational risk. However, perceptions about what type of training has been received and whether it is beneficial were mixed. Based on the experiences of the participants in this study, additional training is warranted.

Participants called for counselor education programs to offer additional training that emphasizes how to manage client assault. To assist with mitigating the risk, Sheila recommended "additional courses and training in masters' programs and in the field, role-playing real scenarios of how to respond to different threat levels especially since a threat to me, is a threat to the client." Another recommendation is for healthcare providers assaulted by clients to create the protocols for responding, instead of managers who are often removed from the risk (Kimberly). She also encouraged community-based counselors to "know your limits" (Kimberly).

Most of the participants felt that their masters training was not beneficial. Specifically, Katie, Theresa, Sheila, and Becky noted the fact that their masters training program did not prepare them for managing assault. Becky indicated,

> Most of my training in a classroom, even in the internship roles, prepared me for basic circumstances. You know basic counseling skills in reflecting feelings, nodding, and being encouraging. Most of that training tends to assume that I'm

> working with a compliant person or somebody who is voluntarily participating in counseling. There are a lot of folks that are highly resistant. There were a lot of personality disorders that we covered in the Diagnostic Statistical Manual and the program did not prepare me for what it means clinically to have to work with personality disorders. We weren't educated on the severity of impact these diagnoses could have on me or the individuals diagnosed with them. My classroom and internship training really failed me when it came to being prepared to run into personality characteristics and resistant clients.

Theresa agreed and added, “I didn’t get training in any environment to prepare me for assault”. In the absence of experiential training, Sheila acknowledged pulling from her own personal experiences and disclosed, “Sometimes you have to use what you learned on the street. You have to use your abilities that aren’t in the textbook as a means of survival.” All the participants called for additional training to assist them in managing this experience. Katie summarized the overall feelings of her peers, “No matter how prepared you are, it is still not enough”. She called for “more than just an academic course. We need some physical classes and some crisis training” (Katie).

Perceptions of Previous Work Experience

Previous work experience provided participants an opportunity to develop skills and abilities that could not be learned in the classroom to manage this risk. Four of the participants expressed that their on-the-job training help them acquire the “knowledge, skills, and abilities” to survive the experience. Katie stated,

> They touched on it in my on-the-job training. It helped, but I think it should be more in-depth. Some of the moves taught in my training for the job weren't helpful. We need something more. The knowledge that I acquired from my master's program also helped somewhat. I believe that additional training is required to keep us and the client safe, cause not being properly trained can cause you to not want to work in this field anymore. I just need to be equipped to deal with it physically, cognitively, and emotionally. Unfortunately, a lot of the training and knowledge you get through experience. Because no matter what environment you're in they're all different and you're going to have different clients with different behaviors based on the environment. You can't put it all in one box and say we're going to give you this training and this should make you better equipped to handle all types of violent aggressive situations.

Candace echoed her sentiments and stated, "My training was good, but it wasn't specific enough. Everything was vague." She called for individuals with first-person experience of client assault to create context specific protocols to manage the risk noting, "Training could be a whole lot better if they shared their life experience" (Candace). Her experience is consistent with that of Kimberly and Katie who both called for "more specialized training, rather than universal precautions" for dealing with assault (Katie). These experiences are inconsistent with one participant's experience. Theresa acknowledged that her internship and residency employer never dealt with safety matters. In fact, she stated that "It was (safety) never dealt with in any environment" even though there were times when she worked alone. She stated, "I would ask well what happens if a

patient becomes homicidal? What mechanisms do we have in place for me to get help"? Theresa reported that she "never received answers to these questions".

Theme 2: Ambivalence as a new way of Being

Each of the participants in the current investigation acknowledged a commitment to ethical conduct. However, once a community-based counselor is assaulted by a client they experience ambivalence about fulfilling their professional responsibilities. They experience anger regarding having to care for clients instead of themselves. Concern about how their peers and supervisors view them post assault result in them questioning their professional abilities. Finally, lack of support in the aftermath of an assault reinforce community-based counselors examining their motivation to remain in the field. Their experience of ambivalence is consistent with that of other healthcare professionals (OSHA, 2016; Piquero et al., 2013; Ringstad, 2005).

Client Ambivalence

Community-based counselors experience internal conflict with their beliefs, values, and behavior following an assault, which makes it difficult to fulfill their obligation to protect clients and the well-being of the public. The Code of Ethics (2014) reinforces protection of clients and self-care. Tension created by these two intersecting roles reinforce what "feels like" competing responsibilities (Theresa). All the participants expressed some level of ambivalence about client's after the disruption in the therapeutic alliance. For instance, Becky conveyed,

> There is a hesitancy. I don't know. I think it depends on the client. I think some folks in some instances have been able to come back and say I am so sorry. I was

> completely out of line and I say you know what, Thank you for apologizing. I appreciate that, and you know, let's talk about what happened. In that situation we can continue to work, and I can chalk it up to some part of the therapeutic process. But when that's not the case, then my continued work with them tends to stall. I kind of start recognizing that behavior as different and as a different kind of diagnosis that I recognize as relatively unchangeable. And you know the opportunity for me to be therapeutic with somebody who's seeking to exert power over me neutralizes that therapeutic opportunity.

Sheila shared that her commitment to providing care was challenged by her fear of being able to move forward with the client. She asked, "Was I going to be able to come back? Were we going to be able to continue working because it can get very intimidating once the relationship has deteriorated. It's really hard to move forward". She also noted that the expectations of the client's family increased the tension experienced following the assault. The family expected her to transport the client to the hospital, following an incident in which her safety was threatened with a knife. Sheila asserted, "I did not take him because it was too dangerous". Theresa discussed that it is challenging to continue providing care to clients following assaultive interactions and she informs them how breaches in the therapeutic alliance, resulting from assaultive behavior, will be handled at the initiation of the relationship. Theresa reported telling her clients,

> Once you come across my space, I am going to defend myself and then I will discharge you. I let them all know that when I first meet them. It's a part of my

> disclosure statement to them which explains the way we're going to conduct business.

The ambivalence which ensues following an assaultive interaction appears to affect client care and the discharge transition process. Four of the six participants indicated that they lose their ability to be person-centered when their safety is compromised, and discharge becomes imminent. Katie asserted that "I tried to move forward, but that whole session was a mistake. It was not productive". Becky echoed her sentiments. She explained,

> I started having a policy that if people were disrespectful to me I wasn't going to work with them because I do not have to and in my private practice I have a little more liberty to do that. I started engaging in referral behavior or termination behavior because the therapeutic alliance just seemed to be damaged and you know, I was not sure what to do from that point.

Theresa also engaged in immediate discharge of clients explaining that the rupture in the therapeutic alliance "had broken the trust and it cannot be repaired. I do not have a control alt delete button." Client assault may be a risk that comes with the job, but Becky suggested that it is "above my pay grade", which results in them "being moved along". Ambivalence about professional responsibilities may result due to participants not realizing that the risk of being assaulted may be a consequence of providing counseling services. None of the participants anticipated this consequence prior to experiencing assault.

Based upon participant's physiological response to the assault, it appears that they feel compelled to protect themselves rather than their client. Fight or flight, which is an automatic response of the sympathetic nervous system, may shed some light on why community-based counselors find it challenging to continue working with clients in the aftermath of being assaulted. Theresa explained that once she has been assaulted it becomes "me versus you. I will use protective measures to restrain clients and any other means necessary to ensure client safety, my safety, and the safety of all the other staff and patients present".

Self-Ambivalence

A subtheme of ambivalence that emerged following the assault experience is that community-based counselors question their fit for the profession. In the aftermath of a client assault study participants "second-guessed" (Kimberly) themselves and "questioned their capabilities" (Sheila). Candace echoed the sentiments of Kimberly and Sheila and shared that,

> Professionally, these experiences have worked two-fold. On the one hand, the experiences have scarred me, I often second guess my ability and repeatedly replay interactions in my head. On the other hand, I am growing a thicker skin, learning how to not take these experiences personally.

These feelings of inadequacy and second-guessing of self are also familiar to Katie, Theresa, and Becky. Following the assault all of them ask themselves, "What did I do wrong?" Katie explained, "I was feeling inadequate, like I didn't know what I was doing. But I had done everything I was supposed to do. I had taken all the right steps in the

right order". Their collective experience was consistent with the self-doubt experienced by other healthcare professionals assaulted by clients (Piquero, et al., 2013; Ringstad, 2005; Storey, 2016). For victims of client assault, the constant self-doubt and belief that they "let this happen" (Kimberly) may result in increased hypervigilance and being less person-centered. Sheila recalled that she experienced increased anxiety and nervousness following the incident: She explained,

> For a while I was nervous all the time, then I realized that I can't be nervous all the time. But you just never know what, when, or where it can spiral out of control. So, from that that point I made sure that I learned the protocol.

However, after being assaulted several times in multiple environments, Becky reported that she doesn't question herself anymore,

> I've realized that skill sets only go so far. I always do want to say that I did what I could do to have influenced this situation, but the truth is that the assumption that I did something to make that happen in every situation is extraordinarily arrogant.

Theresa indicated that it's not just about competency, but how community-based counselors are cared for and care for themselves as a culture-sharing group. "Who comes around and says, 'How are you?' Who comes and says, 'What can I do for you?" Sheila agreed, "I am supposed to take care of me. It's a natural instinct. Instead we ask ourselves what could I have done differently?" She also noted that community-based counselors are not only concerned about their skill-set, but "there are concerns about income, which is connected to our self-efficacy and survival".

Community-based counselors also have some concerns about their peers and supervisor's perception of them. Except for Theresa, all the co-researchers expressed that the incident affected their thought process, how they felt about themselves, and their skills. The perception that "I put myself in that situation forced me to look at the cost of helping" (Sheila). All the participants expressed some level of concern regarding lack of confidence in themselves and deficits in their training.

Another consensus among participants is that they are solely responsible for their safety. Katie summarized the beliefs of her colleagues about whose job it is to keep them safe and admitted that,

> I think about it on a daily basis since the assault. I am always thinking about what I can do to make it safer for me. I ask myself am I trained enough to keep them from escalating to that point.

Theresa expanded her colleagues' views and added, "We expect to sometimes take our jobs home, to care too much. We expect compassion fatigue. I was prepared for these consequences, but I wasn't prepared to be harmed by those I am supporting". Four of the participants reported that they "missed" the step where the police should have gotten involved (Kimberly, Katie, Candace, and Sheila). These self-identified missteps have resulted in participants having a lack of self-confidence in their knowledge, skills, and abilities and second-guessing whether they are prepared for client work. Theresa agrees with OSHA's (2004) assertion that deficits in training, codes, and laws are reinforcers of this serious occupational risk occurring. She acknowledged that, "the support is not there for us" (Theresa).

Lack of self-regard and legislative support were also identified as reinforces for this population not feeling valued or supported. The lack of regard results in mixed feelings and contradictory ideas about their chosen occupation. Theresa, who migrated to the profession from a human resources background, stated that in prior work environments staff was “the most valuable resource, but the human service industry doesn’t seem to value us that way.” Her frustration about the lack of regard afforded human service workers was echoed by two other participants. Candace in an elevated voice stated, “For real nobody cares about the counselor. Everything is geared towards client safety and I feel irritated by that fact.” Her experience of less than positive regard aligns with the reality of other healthcare professionals that work in the community (OSHA, 2004; Piquero et al., 2013). Candace explained, the risk comes with the job, so supervisors minimize you and coworkers ostracize you when it occurs.” Then you feel bad about yourself, which is “the worst part of the job.” Negative self-appraisal may result in feeling guilty, especially when clinicians advocate for themselves in the aftermath of an assault. Katie acknowledge her guilt by saying, “I thought gosh I really shouldn’t have said what I was feeling, but I shouldn’t have to choose between taking care of myself or my clients.” Based on study participant’s experience, assault may be a daily reality. Kimberly referenced assault as a “normal” part of the job that she must be “prepared to face. It’s a part of what comes with my job” (Kimberly).

Ambivalence Towards the Profession

Ambivalence also manifest in the way that community-based counselors feel about the profession. Like social workers (Ringstad, 2005) and psychiatric personnel

(Flannery, LeVitre, et al., 2011), 5 of the 6 participants at one time in their career have contemplated leaving the profession because of being assaulted by those they are mandated to protect. Five of the 6 participants admitted they were naïve' about this occupational risk. Katie said,

> We're kind of like police officers in a sense in that we respond to a home that we know nothing about and that to me comes with a certain amount of risk. I didn't think about this in the beginning.

Her insight is consistent with data collected by OSHA (2016), which indicated that community-based healthcare professions are at increased risk of assault second only to police officers.

Concerns regarding safety have also called into question continued commitment to the counseling profession. Kimberly expressed her ambivalence about continuing to work with clients and explained, "It has in some sense made me question if working with children is really what I want to continue to do. But I go back the next day because I want to be responsible for helping" (Kimberly). Candace shared these sentiments and explained that she routinely contemplates whether she wants to remain in direct care. She expressed her ambivalence about the profession and explained, "I don't necessarily have to see people every day. I don't have to be at the forefront." The fact that client assault comes with the job (OSHA, 2004) has also resulted in Katie questioning her commitment to the profession. She acknowledged her unconscious acceptance of the risk and asserted, "I guess I always knew in my mind that this was a risky job and I would be putting myself in harm's way. I do not want to do mobile crisis forever, but I do want to

stay in the field." Her concern regarding her safety was reflected by Sheila who expressed,

> I worried whether I was going to be able to come back. Was I going to be able to continue working. It's an uneasy feeling to be assaulted at work, especially in this field because my goal is to help others and not be harmed by the agency or the client.

Though Sheila continues to be committed to the profession, she acknowledged that "for some people it may be too much. It depends on where they are in their personal journey" (Sheila). Becky described her contemplation of whether to remain in the field as a crisis. She declared, "I definitely had an existential crisis. I asked God am I really cut out for this or not?" Only Theresa, who also provides supervision to those seeking professional licensure, did not contemplate leaving the profession though she expressed feeling "invaded by the client and betrayed by my employer." However, she is also the only one that recognized that the "departure of senior clinicians from the field will affect the perpetuation of the profession, since we are responsible for training emerging counselors."

Theme 3: Connections for Well-Being

Community-based counselors identified connections to their faith practices, supervisors and peers, and training protocols as protective factors reinforce self-care in the aftermath of an assault. Though self-care is a facet of ethical conduct (ACA, 2014), 3 participants reported that expectations of caring for clients and fear of sanctions from licensing boards make it difficult to engage in practices to ensure well-being (Candace,

Theresa, & Becky). These difficulties mirror those experienced by other healthcare professionals that have experienced client assault (Piquero et al., 2013; Ringstad, 2005; Storey, 2016). Each of the participants in this study admitted to a deterioration in their functioning, "due to increased stress and living on edge" (Sheila), following an assault. Theresa described being hypervigilant by stating,

> I would say I experienced the emotion of fear and it's a lingering fear. It's nervousness about having to keep showing up in that environment and having to encounter those individuals. I fear having to go out to my car, you know at the end of the shift. Or you know, depending on the intensity of somebody's perceived offense with my services, you know, I might be afraid at home. You know, it's like I don't want somebody following me home. I don't feel comfortable being by myself at the grocery store or taking a walk because I don't know where that confrontation will end. You know, I feel like if they're going to harass me in a place that's highly structured and supervised, what will they do in an environment where there isn't that kind of structure?

The hypervigilance experienced by Theresa is consistent with Kristen's assault experience and described it by stating, "I always check my surroundings, no matter where I am because prior to being assaulted I was simply a casual observer of behavior." In the next section, I will discuss how participants utilized their connections to their purpose and their peers to manage self-care following an incident.

Faith-based Connections

There was a global perspective amongst participants that their connection to a higher power and faith practices assists them maintain balance to stay mentally and physically grounded following an assault. For example, all of them found strength and support in the fact that their occupation was connected to a higher purpose. This observation is consistent with the reciprocal connectivity between the parts and whole of a phenomenon depicted in the hermeneutic circle. Katie reflected on what she does immediately following an assault by explaining, "I come home, and I think what in the world did I do Lord. What did I get myself into?" Concurrently, Theresa shared that to cope with being "invaded and betrayed" by clients that she "prays and meditates" as self-care measures. She recommended that other community-based counselors do whatever they need to do to ensure they return home to their families "whole" (Theresa). Becky in the ensuing days that follow a client related incident acknowledged talking to God. The fact that this occupational hazard can happen anytime has resulted in one participant "constantly checking my surroundings and praying" as preventative methods of self-care (Sheila). Sheila acknowledged that her connection to her faith has strengthened since she moved from being an "observer to a victim of client assault. So, I stay prayed up, which has kept me in this field." Kimberly also acknowledged, "staying prayed up." Five of the 6 participants in this study confirmed that their faith was a mitigating factor that reinforced their strength and ability to "move forward in their purpose" (Sheila).

Supervisors and Peers

Another protective factor that emerged from the participant perspectives is that connections with supervisors and peers mitigate the shame and blame associated with this occupational risk (Johnson, 2012; Lovell & Skellern, 2013; Phillips, 2016; Storey, 2016), as well as the development of trauma symptoms (Flannery, 1996; Flannery et al., 2001; Flannery et al., 2007; Flannery & Flannery, 2014). Four of the six participants identified these connections as beneficial. Supervision with someone trained in the use of theoretical models of supervision assisted Becky in processing the assault experience. In explaining the benefit of supervision, she stated, “You feel really isolated and you want to protect yourself from social consequences in the work environment.” With the assistance of a trained supervisor, assaultive exchanges can become “teachable moments, especially if the supervisor is outside of the environment” (Becky). Engaging in supervision after an assault assisted Becky in refining her perspective of counseling.

> My help is really kind of a cog in a larger machine, you know. I can help a person to a point and that might maintain them for a certain amount of time or it might not. It might resolve things well enough that they can continue doing their own thing. But the idea that I was going to make them better has faded. You know my egos changed. I guess the idea that I was going to be somebody that could reach everybody has faded.

Kimberly, Katie, and Candace agree with this observation and added that supervision can also mitigate the hypervigilance that occurs. One participant specifically identified the value of peer-to peer consultation. “It keeps you from putting yourself on

auto-pilot and taking that foolishness home to your family" (Theresa). Sheila expressed that having peers that have been in the profession longer than her to normalize the experience "was comforting." Concurrently, Katie stated that the comradery among her peers "before, during, and after an assault" assisted her in feeling better about the risk she assumes "each day." Supervision has also assisted Theresa in caring for novice counselors. She stated,

> It made me more compassionate as a supervisor. It made me more aware. I probably harass my supervisees in a good way about self-care. I probably overdo it because I had a very good clinician train me. I had a very good supervisor. When it happened to me she made me realize that somebody does care. Somebody gets it, that the strong need help. We need support.

Unlike the other participants, Sheila reported that her "supervisor neither heard nor understood" what she was experiencing.

A Synopsis of the Results

In this section, I will summarize findings that answer the research question: what is the lived experience of community-based counselors that have been assaulted by clients? The recollections of the real-life experiences of this population were created to give voice to these encounters. They may also provide knowledge to assist legislators and policy makers in evaluating whether changes in legislation and codes are warranted to protect these healthcare providers, who in turn protect clients and the public.

From the outset of this investigation, I held several deeply rooted beliefs about how this experience affects counselors as a culture sharing group. First, as I anticipated

community-based counselors experience ambivalence about clients, themselves, and the profession in the aftermath of an assault. Mixed feelings about clients result in premature terminations, which has the potential to cause harm to the client as it may derail progress and the counselor due to potential sanctions from licensing board resulting from abandonment. Clients terminated must begin the therapeutic process all over, which could also negatively affect clinical outcomes. Counselors may experience feelings of doubt regarding their competency to perform care. Additionally, this experience results in counselors questioning whether they want to continue providing direct care to clients. Counselors that do not continue providing care jeopardize being sanctioned by state licensing boards for client abandonment. All the participants also reported that they felt unsupported when an incident of assault occurred and 5 of the 6 have questioned whether they wanted to continue providing direct client care. Participants in this investigation believe that there are no codes and laws that protect counselor's rights as they pertain to client assault. To the contrary, codes admonish professionals to do no harm to clients and reinforce the notion that the professional is the power broker in the helping relationship. When an assault occurs, professionals are often reluctant to press charges or report these events due to fear of being negatively appraised by their colleagues (Candace; Johnson, 2012; Theresa). Furthermore, the unlikelihood that clients will be held legally liable for their actions reinforce non-reporting, which is consistent with literature in Chapter 2 (OSHA, 2004; Piquero et al., 2013).

Another shared counselor experience is the fact that connections to faith practices and with supervisors and peers are types of self-care practices, which mitigate the risk

associated with client assault. As a culture sharing group, community-based counselors reported that a sense of purpose and the motivation to assist others have meaning and significance results in them having meaning and significance. This sense of duty may reinforce continued commitment to providing client care and act as a buffer to premature termination from the profession. Similarly, positive connections with supervisors and peers appear to reinforce counselor self-efficacy. Debriefing with supervisors, provide community-based counselors immediate support that may mitigate the trauma-type symptoms that accompany client perpetrated violence. Furthermore, supervision following an assault may be a form of on-the-job-training that is essential to improve safety awareness and prevent injuries. Finally, engaging in supervision and consultation with individuals formally trained in supervision and discussing the incident with peers may be first-line interventions in deconstructing the shame and blame experienced by community-based counselors in the aftermath of client assault.

Since client progress is contingent on the quality of the therapeutic alliance, the development of systemic interventions that reinforce counselor's well-being when an assault occurs is warranted (Singh et al., 2010). Failure to hold client's accountable for assaulting those legally and ethically bound to protect them, marginalizes counselors and may have a negative effect on client outcomes and the personal and professional well-being of counselors as it does social workers (see Ringstad, 2005), and psychiatric personnel (Furthermore, not having an evidenced based protocol for responding may undermine client safety (OSHA, 2004), deteriorate the mental and emotional health of counselors (Accenture, 2004), and increase the physical, emotional, psychological, and

financial costs associated with management of this occupational risk. Development of a best practice in responding to these events and establishment of policies and procedures for reporting client assault may reinforce safety, protect the rights of community-based counselors, and demonstrate positive regard for this population.

Reflexivity

Heidegger, the father of hermeneutic phenomenology, asserted that understanding is gleaned from repeated circular movement of parts to whole and whole to parts. The relationship between the parts and whole are characterized in a framework known as the hermeneutic circle. The circle provides a rationale for understanding the connection between preexisting knowledge, which Heidegger referred to as *dasein* (translated being), and ways of being (Zuckerman, 2015). In the following section, I conduct an exegesis of the essence of client assault through my ontological lens and then I reverse the process by conducting a global analysis of client assault from participant's perspectives.

Parts to Whole

Having vicariously experienced client assault through the stories of the participants in the current study and the two community-based counselors that I supervised, there have been shifts in my positionality on client assault. These shifts are hallmarks of hermeneutic phenomenology. I have developed a more intimate and intense sense of self and the phenomenon under investigation. These shifts are distinguishable in my role as a student, researcher, practitioner, and change agent.

First, as a student of client assault I have increased my desire to know and be known. When I first began this exploration into client assault it was in response to

having to provide guidance to two master's trained professionals that had been assaulted by a client. I was only looking for academic answers to mitigate my own risk in the event there was a lawsuit, though I did feel a deep sense of obligation in restoring these professionals to their pre-assault level of functioning. Like the participants in the current investigation, my family of origin values instilled in me that assisting these professionals was the right thing to do. Having immersed myself in the literature, I have developed a genuine desire to *know*, to do the hard-intellectual work of understanding client assault from community-based counselor's perspectives.

The longing to know transitioned me from being a student to wanting to know and create knowledge as a researcher. To demonstrate my understanding, I shifted from being a consumer of research to a producer of research. Delving into research resulted in a deepened understanding of the phenomenon and its implications to practice. I now recognize that assault is a risk that comes with this job. Initially, I resisted this premise.

In response to my deepened understanding of client assault, my professional identity as a practitioner also shifted. Personal values and passion reinforce what social change initiatives professionals adopt. Caught between ethical, legal, and political forces, I adopted client assault as my scholar-practitioner platform. As a Counselor Educator, my first job is to care for clients (ACA, 2014). However, Section F of the *Code of Ethics* also admonishes me to train, develop, nurture, and protect counselors under my tutelage (ACA, 2014).

As I conclude this journey, a new identity has evolved - change agent. Another byproduct of experiencing client assault in multiple ways is that I have developed the

ability and the confidence to advocate for counselors against this serious occupational risk. Dedicated and focused effort on this phenomenon has resulted in me developing a desire to contribute to the knowledge base through creation of this manuscript and by presenting these findings at research conferences and symposiums. When I began my terminal degree, there was little to no interest in conducting research. Now I recognize that one of the ways I advance change for community-based counselors and the profession is by producing and presenting research findings.

Whole to Parts

Individual experiences were then interwoven to create a thick-rick textural description of client assault for community-based counselors as a population sharing group (whole) which served as the premise for understanding individual experiences of assault (parts). Each participant in this investigation appeared to appreciate that someone was interested in validating their experience. Based upon participant's responses, this is the first time they have been encouraged to "tell my story" (Katie). They acknowledged being unaware of the potential for being assaulted while practicing in their chosen profession. Their conscious decision to become a counselor, came with a potential unconscious choice – client assault. One participant summarized how experiencing client assault changed her outlook about her skill-set and herself:

> I've realized that skill sets only go so far. I always do want to say that I did what I could do to have influenced this situation, but the truth is that the assumption that I did something to make that happen in every situation is extraordinarily arrogant. (Becky)

Four of the other participants shared her view (Kimberly, Katie, Candace, & Sheila).

Despite feeling abandoned and the potential of physical and legal harm to themselves, community-based counselors are accepting of client assault as an occupational risk. Values instilled by their family of origin may reinforce this acceptance. Despite this acceptance, each participant has shifted their regard of clients, themselves, and the profession. Instead of extending unconditional positive regard, they are guarded in their acceptance of clients, themselves, and the profession following assaultive exchanges with clients. They also reported increased anxiety and hypervigilance when providing direct client care. Polarity between their ideal self and their real self has resulted in participants reconceptualizing their role as a counselor. Several participants reported considering an administrative role rather than providing direct client care. This shift in professional identity may result in there being less practitioners to provide care to clients and potentially threatens the viability of the counseling profession. Employers, the counseling profession, and legislators may need to examine how their response to client assault is affecting community-based counselors, which in turn will affect the profession and the safety of the public.

Trustworthiness

To ensure procedural integrity characteristic of hermeneutic qualitative analysis, I followed the four-step process outlined by Miles et al. (2014) which consisted of interviewing each participant, collecting, coding, and analyzing data. Participants account of client assault was triangulated with the findings of other community-based healthcare professionals to ensure the findings are credible and transferable to other

contexts. Caution is warranted in transferring these findings to other settings and community-based healthcare professionals. These results may offer insight into how other community-based healthcare professionals, including counselors in other settings, experience client assault. Following the same procedures that I used to conduct the current investigation on client assault should yield comparable findings with similar populations.

In Chapter 3 I provided a detailed blueprint on how to replicate this study. To increase the rigor of this investigation, I utilized member-checking to ensure that each participant's account of client assault reflected their experience. All the participants confirmed the accuracy of their interview transcript. This process is one-way to reduce researcher bias. Finally, I kept a field journal throughout the research process to document my foreknowledge of client assault and shifts in my experience of the phenomenon as I immersed myself in the literature and participant's lived experience.

Summary

In this chapter I generated a situated narrative across experiences to describe how community-based counselors experience client assault. Based upon participants' experience, client assault is a risk that comes with being a community-based counselor. Collectively, the community-based counselors interviewed have embraced this risk though it compromises their safety and their economic rights. The lived experiences of community-based counselors that have been assaulted revealed that there are deficits in training and protocols which reinforce assault occurring. The counselors in this study have in part utilized their training and connections to mitigate the ambivalence that

comes from having to manage this occupational risk. However, the participants in this investigation shared that their counselor-education and employer-based training did not sufficiently prepare them for responding to or managing client assault. Additionally, three participants acknowledged engaging in premature discharge of clients following assaultive exchanges. To mitigate client assault, community-based counselors endorsed changes in employer-based policies and procedures, legislation, laws, and counselor education training curriculum as protocols for keeping them safe. In Chapter 5 of this investigation, I summarize the findings from this study and outline additional steps for understanding this occupational risk

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In the final chapter, I examine the findings of the study, delineate the limitations, and review the implications for social change. As a point of departure, I offer recommendations for additional inquiry into the client assault of community-based counselors. In this phenomenological hermeneutic study, I interviewed six community-based counselors who had experienced client assault in outpatient, school-based, or home-based settings. Healthcare professionals that provide service to clients in these settings have been identified by OSHA (2004) as being at increased risk of assault by those for whom they provide care. All of the participants in this study resided in the eastern United States. The goal of this study was to add community-based counselors' voices to literature on this phenomenon. Data were collected using a semi-structured interview protocol (see Appendix B) and which I audio recorded, hand-coded, and transcribed. In addition to the semi-structured interviews, a field journal and direct observation were used as data sources for this investigation. The research question for this study was: What are the lived experiences of community-based counselors who have been assaulted by clients?

Interpretation of the Findings

Based on participant responses, three major themes and eight subthemes emerged that describe the essence of client assault as experienced by the participants. Theme 1 was training as a management strategy, with the subthemes of family of origin, master's preparation, and work experiences. Theme 2 was ambivalence as a new way of being,

with the subthemes of clients, self, and profession regard). Theme 3 was connections for well-being, with the subthemes of faith practices and colleagues and peers). I interpreted the data from this study based on the peer-reviewed literature discussed in Chapter 2. In this, I offer my interpretation of the findings and emergent themes.

As an occupational risk faced by community-based healthcare professionals, assault has been a significant subject in the literature; however, research on counselor experiences of this occupational risk were limited. As identified by OSHA (2016), all the community-based counselors in this investigation have embraced client assault as a risk that comes with providing community-based direct client care. Their experiences of this phenomenon are consistent with research that indicated that the client assault of healthcare professionals presents a serious threat to their physical and emotional well-being (Lovell & Skellern, 2013; OSHA, 2016; Piquero et al., 2013; Storey, 2016).

To mitigate the potential threat of harm that this risk poses to community-based healthcare providers, including counselors, OSHA (2004) issued voluntary protocols that employers could use as guidelines for keeping this vulnerable population safe. Participants' calls for additional training are supported by the literature in the field (Adams et al., 2017; Beech & Leather, 2006; Flannery 1996; Flannery, LeVitre, et al., 2011; Ringstad, 2005; Shields & Kiser, 2003), as are their feelings of ambivalence regarding clients (Flannery et al., 2013; Ringstad, 2005), themselves (Gates & Berry, 2013; Ringstad 2005; Storey, 2016), and the profession. In 2017, OSHA (2016) accepted comments to evaluate whether standards of care should be mandated for employers of community-based healthcare professionals. The results of their request for information

have not been made public at this time. Based on the responses of the participants in this study, mandating safety standards is warranted. Following is my interpretation of the themes based upon those identified in peer-reviewed scholarship.

Theoretical Implications

Each of the six community-based counselors in this study descriptively shared how they experienced client assault. Like social workers (Ringstad, 2005) and psychiatric healthcare providers (Lovell & Skellern, 2011), the findings of this study suggested that community-based counselors have consciously embraced client-perpetrated violence as a risk that comes with their obligation to protect clients and the public. Though they were not initially aware that client assault would be a consequence of their occupational reality, each of the participants remained committed to the profession. However, there appear to be limits to their commitment to working with clients.

Based on the results of this study, these professionals were not motivated to continue working with the client that perpetrated the assault due to concerns for their own safety. Their diminished willingness to work with the assaultive client in the aftermath of the event may pose harm to the client due to services being terminated prior to the client resolving the issue for which they initially sought treatment (Swift, Greenberg, Tompkins, & Parkin, 2017). However, harm resulting from premature termination may be mitigated if the counselor has established a plan for continuation of treatment a priori to the assault occurring as reinforced by Section A.11 of the ethics code (ACA, 2014). Establishing a plan of care for "interruptions such as vacations, illness, and following

termination," may also protect community-based counselors from sanctions by licensing boards resulting from improper termination and abandonment of clients (ACA 2014, p. 6).

The fight or flight response may provide some insight into community-based counselors' motivation for discharge and may play a critical role in assisting these healthcare professionals cope with the threat. Three of the participants admitted being intentional in discharging clients following assaultive exchanges. Becky admitted to engaging in "referral behavior." Theresa commented, "Once you come across my space, I am going to defend myself and then I will discharge you." Consistent with ethical codes of conduct, she informed clients there *will be* a forced discharge if they violate her personal space. Katie explained that it is hard to be person-centered when your safety is being threatened.

Protection of clients and themselves from licensing board sanctions reinforces community-based counselors' call for additional training, which is consistent with findings from Adams et al.'s (2017) investigation on the effectiveness of clinical training on WPV. Five of the six participants (i.e., all except for Becky) in the current study also called for counselor education programs to offer additional training on the management of client assault. Additionally, Katie called for counselor preparation programs to offer some physical classes and more intense crisis training.

Aligning Outcomes with Other Scholarship

Previous studies into this occupational risk have concluded that client assault is a risk that comes with the job (OSHA, 2004; Piquero et al., 2017; Ringstad, 2005; Storey,

2016). All of the participants in this study participated in a semistructured interview, which provided them with an opportunity to respond to the same questions as well as answer additional questions specific to their experience. The three major themes that emerged from their descriptions of their experiences as community-based counselors that were assaulted by clients were (a) training as a management strategy, (b) ambivalence as a new way of being, and (c) connections for well-being. The rich data gleaned from the interviews provided insight into their experience of Type II WPV. As stated in Chapter 2, scholarship on how client assault affects community-based counselors is limited; however, the findings of this study are consistent with scholarship on the client assault of nurses (Khushf, 2007; Lo Mauro & Profita, 2017), social workers (Enosh & Tzafrir, 2015; Harris & Leather, 2012; Jayaratne et al., 2004; Koritsas et al., 2010; Ringstad, 2005; Shields & Kiser, 2003; Winstanley & Hales, 2015), and psychiatric personnel (Flannery, 1996; Flannery et al., 2001; Flannery & Flannery, 2014; Hatch-Maillette et al., 2007).

Theme 1: Training as a Management Strategy

As cited in the extant literature, training is essential to managing client assault before and after it occurs (Arthur, 1999; Bride et al., 2015; OSHA, 2016; Storey, 2016). The community-based counselors in this study credited the beliefs and ideas imparted by their family of origin as a prerequisite for coping with being assaulted by a client. All the participants reported having unconditional positive regard for clients before being assaulted. Their regard of participants appeared to stem from their personal values and beliefs. Statements that demonstrated their regard stemming from their upbringing

included, “instilled in me,” “teachable moments from my childhood,” “taught to take of and be concerned for,” and “values instilled by my family.” Acceptance of assault as a risk was congruent with their subjective experience and is an evolutionary process of becoming and changing. Becoming and changing because of experience is congruent with the interconnectivity between the being and the whole and the whole and the being (Kafle, 2011; Laverty, 2000).

When I first encountered client assault, it was not congruent with my expectations of being a professional helper. My acceptance of assault as an occupational risk emerged while I was immersed in finding solutions for a counselor who had experienced this phenomenon. Talking with other professionals and searching the literature enabled me to recognize that assault is an unacknowledged occupational risk for counselors (see OSHA, 2004; Piquero et al., 2013). While conducting interviews with participants, I recognized they had no preknowledge of assault as an occupational hazard when they first entered the profession. Nevertheless, there is a paradigm shift in which they moved from being unconsciously aware to consciously aware that this risk comes with the job (see OSHA, 2004; Piquero et al., 2013). Despite this fact, the community-based counselors’ commitment to the profession appeared to enable them to assimilate the experience into their existing beliefs. Through immersing myself in the literature and facilitating participants interviews, I have accepted and integrated assault into my professional identity. Research conducted by OSHA (2004), Piquero et al. (2013), Ringstad (2005), and Storey (2016) confirmed that assault is a way of life for healthcare professionals, including community-based counselors. The experiences of all of the research

participants in the current investigation corroborated previous findings (OSHA, 2004; Piquero et al., 2013; Ringstad 2005; Storey 2016). Two of the participants summarized my coresearchers' views with Katie identifying the risk as the "worst part of the job," and Candace acknowledging that unconsciously she knew "this was a risky job."

All the participants discussed how their master's training informed their management of assault. There was consensus that formal training indirectly prepared them to cope with WPV. Participants specifically accredited theories as well as diagnosis and assessment courses with providing insight on how to recognize and respond to client violence, though their programs did not directly identify assault as an occupational risk. Participants' recognition of their master's training as a potential management strategy for mitigating WPV is consistent with research that affirmed the importance of being proactive in managing assault (see Adams et al., 2017; Beech & Leather, 2006; Flannery, LeVitre, et al., 2011; Wassell, 2009). Four of the participants reported that their graduate training assisted them in recognizing clients who are likely to be assaultive. Adams et al. (2017) confirmed the importance of recognizing the precipitants of assaultive behavior.

There have also been calls for training programs to provide education that prepares trainees to directly manage client-perpetrated assault (Arthur, 1999; OSHA, 2016; Bride et al., 2015; Storey, 2016). The call for training programs to prepare emerging counselors to manage this occupational risk is consistent with recommendations from CACREP (2016) for counselor preparation programs to implement crisis training into the curriculum. The experiences of study participants also reinforced providing specialized training "rather than universal precautions" (Katie).

Prior to engaging in dialogue with research participants, my prereflective understanding was that my master's training did not provide a foundation for my experience. However, the transactional analysis that occurred between participants and me, in addition to immersion in the literature, have resulted in the constitution of a new reality that incorporates assault as a routine experience (see OSHA, 2004; Piquero et al., 2013; Ringstad, 2005; Storey, 2016). This new reality may also provide insight into the shifts in knowing that community-based counselors experience in the aftermath of an assault and provide a rationale for why they feel their training was inadequate. I will further illuminate my foreknowledge of the impact of my graduate training when I describe how the assault experience affected my perspective of my professional responsibilities. However, understanding counselors' experiences of assault may assist with identifying gaps in the preparation and training of counselors (Piquero et al, 2013).

Participants also cited on-the-job training as a factor in managing client assault. Recognition of the role of employer-based training protocols in mitigating WPV is consistent with the research conducted by Flannery et al. (2013) and Wassell (2009). Context specific training may serve as a proactive stance in reducing the prevalence of these acts occurring. Consistent with the recommendations of study participants, previous studies have noted the importance of contextual training (Bride et al., 2015; Wassell 2009). Training that focuses on mitigating provider characteristics and environmental factors may enhance the safety of community-based healthcare professionals (e.g., teaching professionals how their behavioral presentation can either escalate or de-escalate client aggression and conducting regular reviews of protective

measures like break away and restraint). WPV prevention programs routinely offers specialized training to mitigate harm to clients and healthcare providers who work in community-based mental health facilities.

Theme 2: Ambivalence as a new way of Being

Based on the results of this study the participants experienced mixed feelings and attitudes about clients after being victimized by clients. In the immediate aftermath of client assault, each of the participants acknowledged struggling with demonstrating unconditional positive regard and acceptance of the perpetrator of the assault. Their feelings are consistent with research on assault of social workers in which 14% of the respondents acknowledged retaliating against the client that assaulted them (Ringstad, 2005). These findings highlight a potential harm that clients who perpetrate violence against their healthcare professional may face. While none of the participants in the current investigation acknowledged assaulting their client, they admitted to discharging clients immediately following the experience. Most of the participants admitted to focusing on self-care in the aftermath of an assault. While their behavior is to be anticipated based on what is known about fight or flight response, it may be inconsistent with ethical codes of conduct which reinforce a systematic plan of discharge, rather than an abrupt end to services (ACA, 2014). Premature termination of services may pose a threat of harm to clients as they would be forced to enter a new therapeutic relationship or simply abandon their need for care. One of the licensed providers in the current study explained that she notified clients in the informed consent procedure at the initiation of services that assault behavior would be immediate grounds for termination of therapy.

None of the other participants acknowledged informing clients about this potential risk of treatment. Premature termination of services can also place community-based counselors at risk of harm from sanctions by licensing boards resulting from abandonment of clients. There is also some risk involved in continuing to provide care after experiencing assault. Becky admitted to "showing up for work. But I would say that my performance and my investment in the client's well-being dropped even though I was showing up." Showing up may also have negative implications for other clients on the clinician's caseload. Becky recognized that her care for other clients was "sub-par" to services provided prior to the assault. Harm to clients is inconsistent with the code of conduct for professional counselors (ACA, 2014).

Community-based counselors also experience ambivalence about themselves and their professional competency in the aftermath of assault. Participants admitted to "feeling scared," and "second-guessing" themselves and wondering "what did I do wrong." Their negative self-appraisal is consistent with findings from a research study conducted by Storey (2016), which concluded that counselors stalked by clients negatively appraise themselves and worry that their co-worker's and managers perceive them as less competent. Potential fallacies in thinking bring with it feelings of shame, blame, inadequacy, and guilt (Bride, 2015; Johnson, 2008; & Sto et al., 2015), which may reinforce under-reporting of these events (Johnson, 2012; Phillips, 2016; Storey, 2016). Five participants acknowledged feeling shame. Becky's comments may have captured the essence of community-based counselors' perception of their competencies in their recognition "that skill-sets only go so far." She also acknowledged that she is careful

about reporting these events due to not wanting to be viewed "as hysterical or less competent" than her male counterparts. Understanding the relationship between assault and self-efficacy may be a first step in removing the self and others stigma associated with this phenomenon. Moreover, this negative self-appraisal may affect the establishment of building an effective therapeutic alliance. The inability to maintain meaningful connections may also cause harm to clients since clinical outcomes have been linked to the strength of the therapeutic alliance (Richards, 2011; Swift & Greenberg, 2015). Three of the participants in the current study admitted to terminating the relationship following the assault.

Another type of ambivalence that participants experience is in their regard for the counseling profession. Research on client assault indicated that professionals assaulted by client's prematurely leave the profession (Lovell & Skellern, 2013; Myburgh et al., 2011; Ringstad, 2005). Though only one of the clinicians in this investigation has contemplated leaving the profession, several have considered assuming "administrative roles" rather than providing "direct client care."

Transitioning clients in the aftermath of assault, also forced community-based counselors in this investigation to choose which part of the Code of Ethics to follow. Standard A.11.c admonishes counselors to provide pretermination counseling though they have been harmed by clients (ACA, 2014). However, Standard C.2.g reinforces counselors abstaining from providing care when demonstrating signs and symptoms of impairment related to the acute stress they may be experiencing (ACA, 2014). Four participants immediately discharged the client.

The responsibility of providing counseling prior to an unplanned discharge may force clinicians to choose between competing professional obligations. Several statements made by participants demonstrated that thought disturbance and trauma symptoms are consequences of being assaulted and included “it was sub-par to what I know I was capable of,” “hyper-vigilance and an extension of my guardedness,” “a lot of anxiety. I felt rattled,” “very scary,” “I experienced the emotion of fear,” and “I was overwhelmed with the grossness of the behavior.”

Participants acknowledgement of the physiological and psychological symptoms of acute stress may be correlated with impairment in functioning. Participants connection and disconnection from the profession is also reinforced by the fact that they feel abandoned as codes and laws reinforce protection of clients over counselors. Each of the participants reported feeling “abandoned,” “isolated,” “unprotected,” and “alone.” The experiences of these practitioners affirmed Belle and Doucet’s (2003) call for the establishment of policies which protect community-based healthcare professionals economic and civil rights as a form of self-care and a best practice for responding. Protection of their rights may accrue goodwill and reduce them transitioning into administrative roles.

Theme 3: Connections for Well-Being

Self-care is consistent with ethical conduct (ACA, 2014). The participants in the current investigation were intentional in utilizing their connections to manage the psychological and somatic symptoms associated with client assault. Scholarship has endorsed the importance of counselors engaging in peer-to-peer consultation and

supervision as self-care strategies for managing personal and professional dilemmas (Savic-Jabrow, 2010). Peer-to-peer consultation and supervision have also been endorsed for improving practice, enhancing effectiveness and ethical conduct, and as a form of professional advocacy (Carney & Jefferson, 2014). However, there has been some resistance to these perceived benefits, among them the lack of awareness regarding the need for supervision (Carney & Jefferson, 2014).

All the participants in this investigation adopted a proactive stance regarding utilizing their connections with peers and supervisors as forms of self-care in the aftermath of an assault. Becky lauded supervision by those trained as clinical supervisors for managing thoughts and feelings related to being assaulted. She acknowledged that "Supervision helped me to understand that there are some mental health states that are beyond even the best training" (Becky). Her sentiments are consistent with that of other study participants who reported that supervision assisted them in mitigating guilt and doubt about their skill-sets. Considering that participants believe that their chosen career is a calling to fulfill a specific task in life that "holds other-oriented values and goals as primary sources of motivation," their use of faith-based practices as self-care strategies align with what they perceive to be their purpose (Dik & Duffy, 2009, p. 427). Participants acceptance of this risk as a part of their purpose is indigenous to the experiences and values instilled by their family of origin, which may act as a buffer for self-care in the aftermath of an assault. Their reliance on faith-based practices for coping with client assault is situated in their prejudices based on superficial self-knowledge and that which is familiar. The circular relationship between self-care practices and

experiences for managing these acts have ontological significance. Participants identification of what has already been interpreted as a resource may reflect what is already understood and familiar.

Participants also credited supervision with assisting them in "reframing their expectations for themselves," "managing hyper-vigilance," and "normalizing the experience." Their identification of supervisors as self-care resources may be a visible manifestation of their relationship with counseling as a helping community (part to whole). Supervisors acting as facilitators for increased coping in turn appears to have assisted participants in embracing their dichotomous role, counselor-client, and integrating it into their professional identity (whole to part).

Becky's experience of supervision following being assaulted affirmed that all forms of supervision are not equal and demonstrates that the parts to whole and the whole to parts circle has significance for community-based counselors assaulted by clients. She recommended that counselors assaulted by clients engage in supervision with clinical supervisors that have been trained to supervise based on a theoretical model rather than their clinical model. Becky's recommendation is consistent with research conducted by Fallendar (2018) which confirmed that competency-based training provides a safe environment for managing reactivity to certain client presentations and the affective-emotional responses which accompany them. Based on findings of the current investigation clinical supervision provided by individuals trained to provide oversight may negate the fight-or-flight response and keep them connected to their chosen occupation.

As identified by Adams et al. (2017), the consensus among participants in the current investigation is that additional training is warranted. Participants identified that multiple types of training have proven beneficial in helping them cope with this occupational risk. Based upon their perceptions training from their family of origin, formal training program, and work experience were valuable for managing this experience to varying degrees.

Limitations

Limitations are inherent in any research study. There are two limitations related to the selection of participants for this investigation. All the participants were residents of the Southeastern region of the U.S. at the time of this investigation. These community-based counselors may differ from those in another state on a significant factor which could affect their experiences of assault. I posted the call for research participants in several forums to invite a diverse counselor population to participate in the study. Another limitation of the current study is that all the research participants were female. Research on client assault has identified gender as a factor in these events occurring (Davis, 2008; Hatch et al., 2007; Ringstad, 2005; Tytti & Pekka,2013). Males may experience this phenomenon differently than females; therefore, the current findings may not be reflective of the experiences of males assaulted by clients.

The context in which client assault was analyzed presented as another limitation of the current study. Only counselors that work in private and state agencies and field settings such as schools, homes and short-term community-based settings participated in

this study. Peer-reviewed literature in Chapter 2 highlighted how contextual factors may reinforce this occupational risk occurring.

The population chosen for this study represents another limitation. The way counselor has been conceptualized is based upon criteria established by the National Board of Certified Counselors. Therefore, only individuals that had been awarded a master's degree in counseling from an accredited university were eligible for inclusion. To mitigate my bias and increase confidence in the findings, participants were provided an opportunity to review their account of client-assault for accuracy in describing their experience.

The interconnectivity of the researcher's and participant's experience may represent a form of transference and counter-transference between the phenomenon and the ontological and epistemological identities of the instrument and the data. This fusion of parts to whole and whole to parts is depicted in the hermeneutic circle (Heidegger, 1962). Journaling was also utilized to mitigate my bias, throughout the research process as a method for capturing contextual observations and shifts in the preconceptions that I brought to the investigation. For example, one of the assumptions that I brought into this investigation is that community-based counselors' education and training have not prepared them for this occupational risk. Based upon participant responses, this assumption is not totally accurate as several participants credited their master's training as a strategy for coping with Type II forms of workplace violence.

Finally, participants desire to be viewed as good individuals, referred to as social desirability bias, may have impacted participants recollection of their experience

(Frankfort-Nachmias & Nachmias, 2008). Since the data being recalled may be related to a traumatic experience, participants recall may be somewhat biased. Further, the fact that I am a member of the group being investigated may have further biased participants recollection of the assault (Frankfort-Nachmias & Nachmias, 2008). Two strategies endorsed by Cope (2014) were used to mitigate these limitations. First, I triangulated study findings with other investigations on client assault of healthcare professionals. As noted above, I also utilized member checking to ensure that I have properly transcribed and interpreted the meaning participants ascribed to client assault.

Implications

The findings of this investigation have implications for training, practice, and supervision. Collectively, they may mitigate harm to community-based counselors and the profession, which may in turn protect clients. Below I briefly discuss the implications for each of these areas.

Training Implications

As cited in the literature and in the current investigation (Adams et al., 2017; Beech & Leather, 2006; Wassell, 2009), training to mitigate potential impairment in functioning that may occur following these events is warranted. Educational programs that train and prepare counselors should infuse training protocols into their curriculums that assist emerging professionals in recognizing and evaluating their risk of being assaulted, including recognizing and managing personality disorders. Understanding of these disorders and strategies for effective management of them may be a priori interventions in management of assault.

Graduate training programs should also assist students with creating a personal protocol for reducing the effects of client assault. For example, programs should ensure that each student creates a personal crisis plan, including identification of personal and professional forms and sources of support, as well as personalized strategies for managing stress, and self-care. CACREP (2016) standards mandate that masters and doctoral training programs integrate crisis training into the curriculum. Assisting novice counselors understand the effects of crisis on their functioning and creating a personalized crisis plan for managing this occupational hazard could be infused into diagnosing and assessment courses, as well as the professional identity course. In doctoral programs, crisis training, and preparation can be aligned with courses which focus on leadership and advocacy training as being personally prepared for a crisis may be a form of self-advocacy.

Practice Implications

Another implication is that participants' migration from direct care to administrative roles may result in fewer providers which match the demographics of clients. For example, in the current investigation four of the clinicians were African-American. Having a shortage of African-American counselors may negatively affect client outcomes as matching client and therapist ethnicity has been positively correlated with treatment outcomes (Horst et al., 2012). While community-based counselors may not be leaving the healthcare profession, like other social assistance workers (OSHA, 2004), transitioning from direct to indirect service may indeed still be a form of

abandonment. Research is warranted to understand African-American counselors experience of client assault and its effect on that population seeking counseling.

Supervision Implications

Clinical supervision has been touted for providing emotional support which enhances client and supervisee outcomes (Fallendar, 2018; Swift & Greenberg, 2015; Vallance, 2005). The experiences of community-based counselors in this investigation confirm the benefits of supervision; especially in the aftermath of a client assault. Becky, one of the participants in the current investigation, specifically cited supervision with an individual trained in supervisory methods for enhancing her well-being, resilience post assault experience, and reducing the shame and blame which accompanies being assaulted. She explained that following the assault experience "you feel really isolated and you want to protect yourself from social consequences in the work environment." With the assistance of a trained supervisor, assaultive exchanges can become "teachable moments, especially if the supervisor is outside of the environment" (Becky).

Another participant, Theresa, explained that being a victim of client-perpetrated violence "made me more compassionate as a supervisor. It made me more aware. I probably harass my supervisees in a good way about self-care." Based upon the experiences of these two community-based counselors the profession may need to consider implementing a protocol for extending supervision post licensure.

Counselor educators and supervisors may play an instrumental role in assisting these professionals integrate client assault into their professional identity. Educators orient and prepare novice counselors to assist clients manage traumatic events. This

training may need to be expanded to include preparing students for client assault, which is a risk that comes with the job (OSHA, 2004). As supervisors, counselor educators use of theoretical models of supervision to guide assaulted clinicians into making sense of the experience, may in turn negate them leaving the profession or moving into administrative roles. The assumption of these responsibilities has benefits for all the stakeholders in the counseling relationship. Clients may not experience setbacks from having to find new providers. Counselors may reduce the likelihood of sanctions from licensing boards and the shame and blame which accompanies being assaulted (Piquero et al., 2013; Ringstad, 2005; Storey, 2016). Lastly, the profession may not experience a shortage of providers. The profession may need to advocate for a new best practice which requires community-based supervisors to be trained in developmental and theoretical methods of supervision as a strategy for providing support to counselors and mitigating harm to clients and the profession.

Recommendations for Future Scholarship

The findings from this study may underscore the importance of OSHA moving from voluntary to mandatory standards for keeping community-based counselors and other allied healthcare professionals safe. Given that the safety and well-being of clients, junior members of the profession, and the public are intricately linked to the functioning of these professionals, additional scholarship is warranted which seeks to identify a theory to explain the phenomenon and a best practice in responding once it occurs. Moreover, these findings demonstrate that community-based counselors face the same challenge as social workers (Enosh & Tzafrir, 2015; Ringstad, 2005) and psychiatric

personnel (Flannery, LeVitre, et al., 2011; Flannery & Flannery, 2014) and need support to manage the risk and the assault experience. A grounded theory study is also warranted to identify the steps and stages of integration of client assault into community-based counselors professional identify. The inclusion of counselors' voices on client-assault may be adding to the knowledge base necessary to establish theories that explain the phenomenon and the development of a best practice in responding to these incidents.

Scholarship which seeks to identify the frequency at which counselors working in community-based and inpatient settings experience assault should be conducted. Once this data has been collected, it could be compared to the prevalence at which social workers and psychiatric personnel experience this phenomenon. If differences exist, curriculum should be examined to uncover possible causes for the discrepancy. Research is also warranted to examine how counselors, as a culture-sharing group, define assault. Several participants indicated that they almost did not respond to the call for research participants because they were unsure if their experiences qualified them for inclusion in the current study. Comments of uncertainty included, “prior to now I wasn't sure if I had been assaulted,” “I called it being pushed up on,” and “I viewed client's as acting out.” Community-based counselors' confusion regarding how assault is conceptualized is consistent with other investigations into this phenomenon (OSHA, 2017; Piquero et al., 2013). Standardization of assault would assist with understanding the prevalence of these acts occurring. Since participants in the current study touted the benefits of supervision with a trained supervisor, an investigation which seeks to evaluate the efficacy of clinical supervision for managing client assault.

Social Change Implications

The current investigation has social change and advocacy implications. The counseling literature is proliferated with research studies which indicates that the counselor is the power-broker in the therapeutic alliance (Kress et al., 2015; Ringstad, 2005). However, once an assault occurs the counselor may become powerless as the laws and statues appear to be written to protect the rights of clients. Understanding the effect that client assault has on counselors is reinforced by the ACA (2014) Ethics Code. The primary responsibility of professional counselors is to protect all the stakeholders in the counseling process, including themselves, which is delineated in Standard A.4.a of the code. Moreover, Standard A.7.a reinforces counselors advocating for marginalized groups (ACA, 2014).

Gaps in laws and policies which enable counselors social and economic rights to be violated result in them being a marginalized group. Since work can enhance or detract from the quality of life, counselors may unconsciously be accepting of client assault because of being a professional helper. Further, counselors may also be willing participants in their own exploitation by the bourgeoisie to meet their basic needs. The process of meeting basic needs results in conflict between the haves and the have-nots, which may oppress the latter (McClelland, 2000a). This symbiotic circular relationship enables each party to have their needs met amid conflict and instability that results from the class struggle. In part this explains the anger that community-based counselors experience in the aftermath of an assault. To mitigate this risk and protect their rights, community-based counselors will need to be intentional in advocating for themselves.

Community-based counselors will have to report instances of client assault to have their physical, mental, and emotional needs met following an incident. Though shaming and blaming has reinforced silence (Johnson, 2012), counselors will have to go against the status quo to identify possible solutions that do not further marginalize them. Counselors speaking out about incidences of assaultive behavior and their needs following these events may assist with establishing policies and protocols for preventing and managing client assault once it occurs.

As asserted by Belle and Doucet (2003) the establishment of policies could promote the well-being of counselors. Moreover, a training program focused on preventing assault could be launched in community-based mental health offices (Belle & Doucet, 2003). The program could include psychoeducation on precipitants of assaultive behavior, which has been shown to decrease the frequency of assaultive exchanges between patients and staff in psychiatric settings (Flannery, Staffieri, et al., 2011). The training could be an add on to Crisis Protection Institute training and educate counselors on the precipitants of assault, including what diagnosis are correlated with an increased risk of assault and which staff behaviors fuel these events.

Understanding counselor's experience of assault may assist with identifying gaps in preparation and training of counselors (Piquero et al, 2013). Programs responsible for training counselors should consider incorporating the precipitants of assault behavior into the curriculum in courses that focus on diagnosing and assessing at the master's level. Additionally, doctoral programs could integrate client assault into the leadership and

advocacy domain of professional identity since this risk can affect the daily work of counselors (CACREP, 2016).

Conclusion

Community-based counselors, as healthcare professionals, are vulnerable to client assault. There is limited scholarship that explains or predicts how this occupational risk is affecting community-counselors as a culture sharing group. Findings from the current investigation into client assault of community-based counselors suggest programs that train counselors are doing an insufficient job preparing them to deal with this occupational risk. Furthermore, current legislation and codes of conduct offer minimal support to assist them with managing this risk. Based on the experiences of participants in this investigation there may be gaps in graduate and postgraduate training. Participants identified faith-based practices and clinical supervision as essential elements in coping with this occupational risk. New levels of accountability may be warranted. Master's trained counselors, regardless of licensure status, may need to engage in clinical supervision each year with an individual that is board qualified to provide clinical training. The goal of the supervision would be to monitor clinical effectiveness and practitioner well-being. This requirement may provide more immediate and effective supervision to mitigate potential harm to clients and counselors in the aftermath of an assault. Given the tangible and intangible costs of client assault, the call for additional training should be undertaken to reduce the likelihood of harm to clients, counselors, and the counseling profession.

The objective of this study was to understand the lived experiences of community-based counselors who have been assaulted by clients. Additionally, the goal was to add this population's voice to the knowledge on client assault as a serious occupational risk. The research question was, what are the lived experiences of community-based counselors that have been assaulted by clients. I used a hermeneutic phenomenology lens to solicit the thick-rich stories of these participants. Purposive and snowball sampling methods were utilized to recruit and interview masters' trained counselors affected by this phenomenon. A semistructured interview protocol was utilized to evacuate these experiences.

Based upon participant responses three themes were identified: training to mitigate the risk, ambivalence about professional responsibilities, and connections as a form of self-care. Based upon the responses of these participants, they have embraced client assault as a risk that comes with the job. Community-based counselors are acutely aware of the limits of their training in managing this occupational risk and the importance of utilizing peers and supervisors as forms of self-care in the aftermath of client perpetrated violence. Lastly, they experience mixed feelings about clients, themselves, and the counseling profession as a result of their lived experience.

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Appendix: Semistructured Interview Questions

1. Tell me about your assault experience?
2. What experiences assisted you in managing the assault?
3. What feelings are connected to the experience?
4. How did the experience affect you?
5. What assisted you in managing this experience?
6. What meaning do you assign to being assaulted?