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When patients attack: The experience of inpatient mental health counselors after a physical attack from a patient

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To the Graduate Council:

I am submitting herewith a dissertation written by Evan Montgomery Burns entitled "When patients attack: The experience of inpatient mental health counselors after a physical attack from a patient." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

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When patients attack: The experience of inpatient mental health counselors after a physical attack from a patient

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Dedication

To my wife Stephanie and my son Charlie. Without you both, none of this would be possible.

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Abstract

Mental health professionals who work at inpatient facilities are at an increased risk of physical attacks from patients (Beech & Leather, 2006; Campbell et al., 2011; GAO, 2016; Gillespie et al., 2010). Research on physical attacks in the human services field has focused on other mental health professionals, such as psychiatric nurses and social workers; research looking specifically at mental health counselors is lacking. The purpose of this qualitative study, through Interpretative Phenomenological Analysis, was to understand the lived experiences of mental health counselors after a physical attack from a patient. The research interviewed four mental health counselors who experienced a physical attack from one of their patients. Through analysis of the interviews, five main themes emerged: negative patient factors, strong facility reaction, positivity from experience, psychological damage, and assigning blame. Implications for policy and practice were considered and suggestions and recommendations for future research were provided.

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Chapter 1 Introduction

Mental health counselors experience considerable amounts of physiological and psychological trauma from their clients (Arthur, Brende, & Quiroz, 2003; Bride, Choi, Olin, & Roman, 2015). The National Institute for Mental Health reported that 68.2 to 80 of 1,000 mental health professionals experience client-initiated violence (Anderson & West, 2011; Arthur et al., 2003). Violent attacks occur in many forms and can include verbal abuse, sexual abuse, and physical abuse. Clients often display different reactions when trying to deal with challenging life issues and concerns. Because mental health professionals help individuals work through their interpersonal struggles, some individuals may be aggressive in their behavior towards those from whom they are seeking help (Anderson & West, 2011; Beech & Leather, 2006).

Unwarranted attacks and victimization can occur in any mental health setting (Bride et al., 2015); however, the highest rates of victimization occur in inpatient facilities due to the patients and the acuity of their concerns (Flannery, 2001). These violent incidents are the result of multiple patient stressors that often occur simultaneously in an inpatient mental health setting (Beech & Leather, 2006). The accumulation of stressors over time can be detrimental to patients; often times, mental health workers serve as outlets for those frustrations.

Although most patients have a positive response to help, others may view help as a threat. For example, patients may experience change in their reality or struggle with substance abuse problems; these types of concerns build and lead to an increased likelihood that a patient will be violent (Anderson & West, 2011; Beech & Leather, 2006; Bernaldo-De-Quiros, Piccini, Gomez, & Cerdeira, 2015). From a patient perspective, these types of violent outbursts are an escape from perceived harm (Arthur et al., 2003; Bride et al., 2015; Shields & Kiser, 2003). Because these feelings and responses are not uncommon, many mental health professionals are not

surprised when they are victimized by their patients (Baby, Glue, & Carlyle, 2014; McAdams & Foster, 1999). Though professionals have good intentions, patients are often in such a vulnerable state that they will attack others to protect themselves from the perceived threat. In order to gain a better understanding of these attacks, Flannery, Hanson, and Penk, (1994) looked at the effect of the victims throughout the mental health profession. As interest began to increase in the mental health profession, research began focusing on different settings within the mental health profession.

Most of the research has focused on psychiatric nurses and social workers in understanding how this type of violence affects them, while mental health counselors receive little attention (Arthur et al., 2003). Understanding how mental health counselors react is critical because of the strong reaction that these other mental health professions have experienced. When exposed to violence in the field, nurses and social workers experience a wide range of reactions on a physiological and psychological level. After the victimization of a patient, these professionals will end up with cuts, bruises, and sometimes scars. While the physiological damage is typically minor, the psychological harm found in both professions can be significant. During these times, professionals experience a wide range of emotions such as anger, depression, anxiety, and fear. Many begin to question their job and it affects how they work with patients in the future. Because of these experiences span across fields, mental health counselors will likely have similar reactions towards these attacks. However, due to the current lack of research, it creates a concern about how mental health counselors will react. The lack of research amongst mental health counselors creates a concern because mental health counselors work in the same environments as social workers and psychiatric nurses. Hart (2000) noted that the relevant research for mental health counselors focuses on clients who victimize counselors outside of the

session and not during the session. As such, there is limited information about what mental health counselors in inpatient settings experience when confronted with aggressive patients.

Areas Where a Physical Attack Can Occur

An attack can take place in any workplace setting. Individuals who work in closer proximity with clients, such as treatment centers, are at a higher risk of assault. Those clients who are more acute often times require more treatment, which will require more involvement of mental health professionals (Privitera, Weisman, Cerulli, Tu, & Groman, 2005). It is important to recognize the different threats that mental health counselors face as well as the different types of settings in which these attacks can occur.

An outpatient setting is the most common setting in the counseling profession. Though outpatient counseling are not as intensive as other settings, the issues clients bring to the sessions are not necessarily different. Arthur et al. (2003) note that very little research has been conducted on the prevalence of violent in outpatient settings. However, Harris (2001) noted that 72% of outpatient practitioners are victims of an attack by a client while 41.6% of practitioners in a private practice setting experience the same victimization.

Arthur et al. (1999) found that 44% of family therapists who primarily worked in an outpatient setting experienced some form of physical violence at the hands of a client. Similarly, Arthur et al. (2003) found 61% of psychotherapists experienced some form of violence at the hands of a client at one point in their career. In an outpatient setting, additional support may not always be present and can make a counselor more vulnerable if these incidences do occur. Though counselors are taught to identify and execute a duty to warn, the focus is on protecting other people from being harmed from the client. Unfortunately, counselors themselves are still at

risk of being attacked, especially if the client is informed that additional treatment is needed such as inpatient treatment (Newhill, 2003; Schoener, 2009).

In-home services are another area that counselors have the possibility of working at in the field. During these scenarios, counselors go out into the community, such as client homes, in order to provide services to their clients for either crisis or ongoing care. Due to the vulnerability that counselors have being in an unfamiliar environment, especially during a crisis, client homes are one of the most frequent areas of violence to occur (Bernaldo-De-Quiros et al., 2015). Shin (2011) noted that 34% of professionals who provide in-home counseling services had experienced violence at the hands of their clients. When working in these situations, there is no guarantee of safety. Because the counselor is arriving into a brand new situation, clients can become aggressive towards the counselor because they were simply there at that time(Zeh, 1988). In addition to clients, family members of the client can also pose a potential risk for the counselor (Barling, Rogers, & Kelloway, 2001). When these attacks happen to counselors in the field it has the potential to influence their thoughts about work. These thoughts can how they think about their work and their expectations when entering a house (Barling et al., 2001).

Substance abuse treatment facilities are a type of intensive treatment where acute clients get the help they need. Most of the clients are struggling with some type of addiction (Bride et al., 2015; Lipscomb et al., 2012). Researchers have linked active substance abuse to higher rates of physical aggression (Anderson & West, 2011; Flannery, 2004; Gillespie et al., 2010; Harris, 2001; Shields & Kiser, 2003), with most of these attacks happening when clients are resistant to treatment protocols (Lipscomb et al., 2012). Bride et al., (2015) further noted that 3% of the staff at a substance abuse facility were physically attacked by a patient within the past the past year; however, 27% knew of a colleague who had been physically attacked by a patient. Because staff

are in charge of maintaining a safe environment many, of them become the victims of physical violence.

Residential facilities are long-term facilities for children and adolescents who deal with severe behavioral and emotional problems. Clients in residential treatment facilities tend to display aggressive, impulsive, and destructive behaviors (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004). McAdams and Foster (1999) noted that professional counselors in these settings are trained to challenge these behavioral problems in order to create a change in their clients' behavior. As a result, violent outbursts towards counselors and other staff members are more likely to happen during this change. Even though the counselors are trained to protect themselves in these situations (Residential Child Care Project, 2016), counselors can still experience the negative effects of violence and fear associated with the attack.

Inpatient facilities are typically seen as sort of last resort for patients experiencing mental health problems. Many of these individuals have severe acute symptoms and are dealing with some sort of crisis that poses a risk towards safety (Flannery et al., 1994). Due to the severity of cases and the amount of professionals involved in treatment, inpatient facilities have the greatest amount of physical violence among other mental health facilities (Privitera et al., 2005). Gournay (2002) found that physical attacks in an inpatient facility were a common occurrence, with an attack happening every 3.5 days.

In an effort in order to decrease the frequency of these attacks, many inpatient facilities implement interventions for de-escalation and physical interventions. While these interventions can be helpful in decreasing violence in the moment (Flannery, 2005; Flannery et al., 1994; Bronfenbrenner Center for Translational Research, 2016), the rate of violence within inpatient facilities continues to be high (GAO, 2016; Hartley, Doman, Hendricks, & Jenkins, 2012;

OSHA, 2002). One reason for this is because staff members do not properly implement these interventions (Dickens, Rogers, Rooney, McGuinness, & Doyle, 2009). Even though these interventions are used to reduce violence, there is a lack of focus on how to respond after the violence has happened which results in professionals having a general lack of support from their employers (Moylan, McManus, Cullinan, & Persico, 2016).

Workplace violence is an ongoing problem within the mental health field and can be found in every environment that a counselor works in. Though it is critical to ensure that clients are being treated and cared for, counselors need to be aware of their own safety and recognize the inherent risks involved in working with clients. Privitera et al. (2005) note that counselors face the most risk when they are working with more acute clients who require additional care. These clients are mostly found within an inpatient hospital setting.

Though violence does occur in other areas, there is a greater concentration of violence due to the nature of the facility and the level of care required for individuals who reside in those facilities. Counselors need to recognize their professional surroundings and understand that these surroundings will influence their work and the responsiveness of their patients (Anderson & West, 2011; P. Criss, 2010; Mueller & Tschan, 2011). From these perspectives, counselors need to recognize that their own safety is their prime responsibility so that they can continue helping other patients.

Effects of Physical Violence

Mental health professionals who experience physical violence often suffer from both physiological and psychological problems (Alden, Regambal, & Laposa, 2008; Anderson & West, 2011; Arthur et al., 1999, 2003; Faria, 2016; Freeman et al., 2013; Fuller, 2015). These physiological and psychological problems assist in changing the perspective of these

professionals and how they interact with their patients. Professionals have reported an increase in PTSD symptoms, (Alden et al., 2008; Jacobowitz, 2013; MacDonald, Colotla, Flamer, & Karlinsky, 2003), a refusal to work in the same environment, a decrease in attention to detail, and a desire to leave the field entirely (Alden et al., 2008) after a physical attack.

The physiological effects of physical violence on mental health counselors range from minor to severe. Although many physiological injuries are manageable, some professionals experience ongoing problems as a result of these injuries (Fuller, 2015). Some professionals needing increased time off as a result of these injuries; others have difficulty returning to their work environment (Anderson & West, 2011; Baby et al., 2014). If the injuries were more severe, this can physically limit what the professional is able to do and will put more pressure on coworkers (Anderson & West, 2011; Baby et al., 2014; Chen, Hwu, Kung, Chiu, & Wang, 2008). Additionally, physical impairment can decrease the quality of care for patients (Fuller, 2015). These physiological effects can create psychological issues that have the potential to continue to negatively affect the mental health professional, even after the physiological wounds are healed.

The psychological challenges these professionals face after a patient attack are often more difficult to address than the physical challenges (Alden et al., 2008; Bernaldo-De-Quiros et al., 2015; Lanctôt & Guay, 2014). Alden et. al. noted that individuals who experience these types of traumatic events reported being fearful for their own lives. Mueller & Tschan (2011) expanded on this idea and also noted an increase in anger and irritability amongst victims. In addition to these experiences, a decrease in the ability to concentrate and a loss of self-esteem often occurred (Arthur et al., 1999; Baby et al., 2014; Hart, 2000; Jacobowitz, 2013; Lanctôt & Guay, 2014). Others have noted changes in their work habits and an inability to sleep at night

(Arthur et al., 2003; Flannery, Levitre, Rego, & Walker, 2011; Gillespie, Gates, Miller, & Howard, 2010; Jacobowitz, 2013; Moylan, McManus, Cullinan, & Persico, 2016). With these incidents, professionals are at an increase in the risk of developing Posttraumatic Stress Disorder (Alden et al., 2008; Freeman et al., 2013; Jacobowitz, 2013; H. MacDonald et al., 2003; Richter & Berger, 2006).

Professionals find that decreases in motivation and effectiveness are commonly present after an attack (Baby et al., 2014; Faria, 2016; Fuller, 2015). These symptoms and incidents not only affect individuals the individual who are victimized by the attack, but it also influences how other professionals in the work environment perform. Therefore, it is necessary to understand how these physiological and psychological effects will influence an individual. In addition to looking at the individual's responses, the effects on the work environment are also critical to understand. Coworkers are expected to fill in for the work that the victim is no longer able to do while also increasing the thought a similar incident may happen to them (Alden et al., 2008). When considering these factors, the physiological and psychological effects negatively influences the work environment because it creates a less cohesive environment for these professionals to continue working as effectively as they have in the past.

Statement of the Problem

Mental health counselors working in inpatient facilities are at an increased risk of victimization (Arthur et al., 2003; R. Flannery et al., 1994). Researchers have identified the risk factors for these types of attacks as well as the types of clients who are more likely to engage in these aggressive behaviors (Flannery et al., 1999; Iozzino et al., 2015; Nijman, 2002; Renwick et al., 2016). In an effort to reduce these attacks, facilities have implemented prevention and

intervention methods; however, violence is still prevalent in the workplace (Dickens et al., 2009).

The highest rates of victimization occur in inpatient settings (Iozzino et al., 2015) As mental health counselors continue to work in these setting, their risk of victimization increases (Bureau of Labor Statistics, 2016). According to OSHA (2014), incidences of victimization are steadily increasing in mental health fields due to the increasing number of mental health counselors working in inpatient settings. Inpatient facilities serve as a haven for patients to work on these critical issues and to work towards new goals (Campbell et al., 2011; Chen et al., 2008; Criss, 2010; Flannery et al., 1994; Gillespie et al., 2010; Iozzino et al., 2015; Kelly, Subica, Fulginiti, Brekke, & Novaco, 2015). Counselors who work in these environments work with patients who are often experiencing a severe crisis. These patients often are experiencing thoughts and plans of actively harming themselves or harming others. Unfortunately, some of these patients do not respond to treatment and can display an increased risk for violent behavior (Iozzino et al., 2015; Nijman, 2002).

There are many factors that can lead to violence in inpatient settings. In addition to patient factors, hospital factors and staff factors put additional stress on the patients (Nijman, 2002). These factors help to maintain a safe environment and influence the quality of care that patients receive. When left unaddressed, the risk of violence increases. When considering these factors, it is understandable that the risk of violence would be greater. Mental health counselors are a part of this system and are at an increased risk of attack from these patients. Research has focused on the lived experiences of other human service professions (Baby et al., 2014; Bimenyimana, Poggenpoel, Myburgh, & van Niekerk, 2009; Chapman, Styles, Perry, & Combs, 2010; Koritsas, Coles, & Boyle, 2008; G. MacDonald & Sirotich, 2005); the lived experiences

for mental health counselors have not been researched. Without knowing what mental health counselor's experiences are, it makes it more difficult to understand what they are going through when faced with an attack.

Mental health counselors are legally and ethically bound to protect client welfare, which includes an increased awareness of a potential violent incident and a commitment to preventing it from occurring (American Counseling Association, 2014). Though counselors are trained to protect other individuals from harm, many counselors are left unprepared about what may happen if they become the victims of violence. As such, there is a limited awareness of how this issue affects mental health counselors.

The purpose of this study is to gain a better understanding of the lived experiences of mental health counselors who have been physically attacked by a client in an inpatient setting. Understanding this phenomenon is critical because mental health counselors need to be aware of the risks associate with working within an inpatient setting and also need to be aware of the professional and personal challenges these attacks create. The results of this study can help mental health counselors better understand what to expect if they experience an attack and can provide additional research relevant for counselor trainees and Counselor Educators as well.

Significance of the Study

Workplace violence is prevalent in the human services field (Criss, 2009; Faria, 2016; LeBlanc & Kelloway, 2002; Moylan et al., 2016). 45.5 per 100 professionals in psychiatric units experience physical violence and are nine times more likely to experience physical violence than any other department (Campbell et al., 2011). Arthur et al. (2003) notes that human service workers feel violated and angry when these incidents occur in the workplace; other researchers highlight the increasing sense of fear and anxiety experienced by victims of workplace violence

(Alden et al., 2008; Anderson & West, 2011; Arthur et al., 1999, 2003; Bride et al., 2015; Jacobowitz, 2013; H. MacDonald et al., 2003; Moylan et al., 2016; Richter & Berger, 2006). Client victimization is a salient concern for professionals in the mental health field. While few researchers have included mental health counselors in their study, no studies assess the lived experiences of mental health counselors related to victimization (Arthur et al., 2003; Bride et al., 2015; Lipscomb et al., 2012; Shields & Kiser, 2003; Versola-russo, 2006). Most of the literature focused on the lived experiences of social workers and psychiatric nurses (Baby et al., 2014; Criss, 2009; Jacobowitz, 2013; Moylan et al., 2016; Newhill, 2003; Ringstad, 2005; Sarkisian & Portwood, 2004; Spencer & Munch, 2003).

Given the prevalence of assaultive behaviors in the mental health counseling field (Anderson & West, 2011; Arthur et al., 2003), it is critical to understand their lived experiences. This study is designed to help us better understand how mental health counselors interpret and make sense of an attack from their patients. By researching their experiences, we can better understand the relevance of long term consequences on their development. This study can help clinical supervisors better understand the challenges their supervisees may face after experiencing an assault by a client. Additionally, it will provide relevant information useful for professors who discuss these types of concerns with their students during their clinical training.

In order to address these issues, I will employ a qualitative approach using an Interpretative Phenomenological Approach. Though other researchers have explored this issue from a quantitative perspective, I believe that the use of a qualitative perspective will help gain a greater understanding of the experience itself and of what this means to mental health counselors. The findings from this study will help create a new perspective on this ongoing issue

in order to inform best practices for mental health counselors, supervisors, and Counselor Educators.

Definitions

Mental Health Counselor- Mental Health Counselors are individuals are skilled professionals that provided consumer-oriented counseling. They are able to work in a variety of settings ranging from outpatient to inpatient services (AMHCA, 2016).

Workplace Violence- Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide (OSHA, 2002).

Physical Violence- Physical violence is physical force with the potential to cause harm. Physical violence includes but is not limited to: hitting, scratching, biting, pushing, grabbing, and throwing objects (Arthur et al., 2003).

Client- A client is identified as the individual who is receiving mental health services in an outpatient setting (Newhill, 2003).

Patient- A patient is an individual receiving mental health services in an inpatient setting (Joint Commission, 2016).

Inpatient facility- An inpatient facility is a psychiatric facility that provides continued day to day care to psychiatric patients. These facilities are either part of a hospital or are a standalone facility with patients are admitted either voluntarily or involuntarily (Joint Commission, 2016).

Chapter Summary

The rate of victimization for mental health professionals continues to be an ongoing problem in the United States (Bernaldo-De-Quiros et al., 2015; Chen et al., 2008; Fuller, 2015; Hegney, Eley, Plank, Buikstra, & Parker, 2006; Jacobowitz, 2013; Kelly et al., 2015; LeBlanc &

Kelloway, 2002; Luck, Jackson, & Usher, 2007; Renwick et al., 2016). Most qualitative research has focused on the lived experiences of nurses and social workers, which found distinct psychological and physiological problems after an attack (Arthur et al., 2003). Jacobowitz (2013) highlighted the fact that other human service providers, such as mental health counselors, have experienced some form of workplace violence during their careers. Though there are several studies that focus on client violence, there is a significant lack of research that focuses on the lived experiences of mental health counselors.

Patients who receive treatment in inpatient facilities experience severe and acute problems are therefore more likely to cause physical harm to mental health professionals (Criss, 2010; Flannery et al., 1994; Flannery, Irvin, & Penk, 1999; Flannery, Fisher, & Walker, 2000; Gillespie et al., 2010; Hartley et al., 2012; Iozzino, Ferrari, Large, Nielssen, & de Girolamo, 2015; Jacobowitz, 2013; Kelly, Fenwick, Brekke, & Novaco, 2016; Kelly et al., 2015; Nijman, 2002; Privitera et al., 2005; Renwick et al., 2016; Secker et al., 2004; Tishler, Reiss, & Dundas, 2013; Versola-russo, 2006). As mental health counselors continue to work in inpatient settings, they need to be aware of the risks associated with these populations and the affects that attacks can have on their lives.

The next chapter includes a literature review of the prevalence of patient violence in human service settings, with an emphasis on mental health counselors. The purpose of Chapter 2 is to identify the gap in the literature where this study has the potential to contribute. Chapter 3 includes a thorough description of the research design and methodology that comprises this study, including participants, data collection methods, and data analysis. A thorough description of the results of the emerging themes per each research question comprises Chapter 4. Finally, Chapter 5 concludes with a discussion about the implications of this study for counseling and

counselor education, an expansion of the limitations of this study, suggestions for future research on this topic, and final thoughts.

Chapter 2 Review of Literature

The purpose of this section is to gain a better understanding and highlight the current literature available about health care professionals and violence among patients. This chapter reviews prominent concepts that will help build and understand the framework for the study. The beginning of this chapter identifies the ideology and identity of counselors. This will lead to a greater understand of the profession of mental health counseling and how it differs from other mental health professions. I will then explore the different mental health professions that have had research about attacks from patients. These professions include nurses, social workers, and psychologists. After exploring the commonality of these attacks, the next section discusses the physiological and psychological effects on an individual. Finally, the last section encompasses the theoretical framework of Person-Environment fit. By looking at all the literature in several different aspects, it helps to create a greater sense of understanding as to why the issue needs to be explored with mental health counselors.

Counseling Identity

Counseling is one of the fastest growing professions in the human services field (Bureau of Labor Statistics, 2015). Since its foundation, the profession has undergone several changes. The early work of Frank Parsons, considered by many to be the father of the counseling movement due to his work in the vocational field (Erford, 2013), provided the foundation for the development of a strong identity and thus solidified its place in the human services field. Since that time, counseling branched into several different specialties designed to meet the needs of the public (Erford, 2013). Given the evolution of counseling, the need for enhanced and specific training methods and defined protocols has become central to its development. The distinctiveness of the profession is noted in how it defines itself and in how it articulates a

philosophical point of view (Puglia, 2008). With these dissimilarities noted, it will help to better distinguish the differences between counselors and other mental health professions and how they view their relationship with their patients and their patients as a whole.

Definition of Counseling

The general counseling profession has been difficult to define and has undergone several changes. Part of the problem was that several different counseling organizations had diverse perspectives and views designed to highlight the core principles of counseling (Kaplan, Tarvydas, & Gladding, 2014). Unfortunately, these organizations did not collaborate and this lack of connectedness negatively affected the profession's ability to define itself. Mellin, Hunt, and Nichols (2011) note that counseling needed a clearer definition to gain a place among the human services field.

As a result of these challenges, the 20/20 Initiative was created to foster the development of a definition for counseling. This initiative, which started in 2006, brought together 32 different counseling organizations with the sole purpose of developing a consensus definition of counseling (American Counseling Association, 2017). Kaplan et al., (2014) and colleagues performed a multi-organization analysis of the work completed by this committee. The researchers used an objective Delphi method approach so that one organization would not be favored over another. (Kaplan et al., 2014). As a result of the process, the American Counseling Association (ACA, 2017) developed and adopted a definition of counseling: "counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals". The definition modernized the profession because it articulated the it's philosophical underpinnings (Kaplan et al., 2014).

Counseling Philosophy

The four philosophical beliefs on which the profession is based are: empowerment, development, wellness, and prevention/early intervention (Puglia, 2008). The philosophical beliefs of the counseling profession help distinguish it from other mental health professions. The four fundamental beliefs are essential to counseling practice; each philosophical belief creates a greater sense of purpose for the counselor's work (Puglia, 2008; Remley & Herlihy, 2014; Woo, Henfield, & Choi, 2014). By adhering to these four philosophical beliefs, counselors embrace the need to help clients see progress in their lives and to help clients believe that they can heal and live optimally

Empowerment. Counselors believe that empowerment provides clients with the ability to face their challenges independently (Remley & Herlihy, 2014). Clients can feel powerless and alone; empowerment helps them learn that they can make changes on their own and that they do not have to be dependent on others (Remley & Herlihy, 2014). According to McWhirter (1998), empowerment is a combination of five components (called the five C's): collaboration, competence, context, critical consciousness, and community. By using these components, counselors explore limitations and help clients better understand themselves. Empowerment helps clients to feel more in control and independent, which contributes to increasing their belief in themselves. As such, clients increase their self-awareness and learn how to use their strengths to live optimally (Puglia, 2008). Remley and Herlihy (2014) noted that empowerment is a holistic practice designed to reduce the belief that something is wrong with the client and instead focus on what to change. As counselors help clients see that they can change their lives, they feel empowered to develop and grow from their experiences.

Development. In counseling, development is a continuous natural process of learning. Holistic change has roots in the developmental underpinnings of the counseling philosophy. The developmental lens identifies that challenges in life are expected and can be beneficial for personal growth (Woo et al., 2014). Remley and Herlihy (2014) see development as the ability of an individual to adjust to life circumstances and thus learn from them. As such, development is normal and expected (Remley & Herlihy, 2014). Taking this perspective allows for a change of focus for the client. The developmental focus emphasizes the relevance of life experiences and how those experiences shape thinking, feeling, and behaving. It is from these developmental experiences that clients can learn about themselves and grow (Remley & Herlihy, 2014). Development creates a stronger sense of well-being because it focuses on the client's strengths and thereby increases wellness within the client.

Wellness. Wellness is a holistic approach that views counseling from a strength-based perspective as opposed to a deficit perspective (Woo et al., 2014). Hettler (1976) theorized that wellness focuses in on six different aspects of an individual: occupational, physical, social, intellectual, spiritual, and emotion. Counselors understand that the wellness model focuses on achieving positive growth and development; as such, mental health is viewed on a continuum ranging from mentally healthy to mentally unhealthy. By using this strengths-based approach, counselors focus on achievement rather than on deficits. As clients learn about these strengths, they become protective factors. These factors then help protect clients from future problems and prevent more serious issues from arising.

Prevention/early intervention. Prevention and early intervention are philoshophical concepts that work in tandem. Prevention is designed to stop problems from occurring; early intervention is designed to address a problem before it reaches its crisis point. So, prevention

helps counselors work with clients to keep problems from occurring; when they do occur, early intervention helps counselors work with clients to keep the problem from escalating. For example, let's suppose you have a client who is dealing with anger. Prevention would focus on helping the client identify triggers and using techniques to prevent the anger from occurring (e.g. stopping negative thinking, deep breathing and imagery). If the client's anger escalates, early intervention can then be used to prevent the client from experiencing a crisis. Counselors can help clients understand the source and expression of their anger (e.g. tensing up) and teach them to use their coping skills to decrease their anger.

Puglia (2008) noted that prevention and early intervention need to be proactive in order to help the client. Albee and Ryan (1998) noted that prevention and early intervention are effective for both the individual and the individual's system because they help to reduce stress by providing skills the client can use in difficult situations. As such, clients can address challenging situations with confidence and learn skills they can use when problems arise in the future.

Summary. Since its inception, the counseling profession has evolved throughout the years and has developed a strong identity and philosophical base. Thus, it has cemented itself within the human services field and has distinguished itself from other mental health professions. Kaplan et al. (2014) note that the creation of a unique definition for the profession helped further delineate the philosophy on which the profession is based. The philosophical values help counselors teach clients how to live optimally and thus overcome problems and challenges that may experience (Puglia, 2008). Using a holistic approach, counselors address clients' needs in ways that clearly distinguish it from other human service providers (Woo et al., 2014). With these general underpinnings in place, these beliefs help shape and form how counseling can be used as a profession and where it is most beneficial, such as mental health counseling.

Mental Health Counselors

Mental health counseling is one of the fastest growing human services professions in the United States (Borsos, Weikel, & Palmo, 2011). The Bureau of Labor Statistics (2015) notes that the rate of mental health counselors will grow by 19% from 2014-2024; this rate is much higher than the national average for other human service organizations. As of 2014, there were 168,200 full-time mental health counselors employed in the United States. Projections show that by 2024 there will be over 200,000 full-time mental health counselors; this number does not include counselors who will be working in private practice (Bureau of Labor Statistics, 2015).

Traditionally, mental health counselors work in outpatient settings such as community organizations, family service agencies, and private practice (Bureau of Labor Statistics, 2015). In these settings, counselors typically work with clients over an extended amount of time (Borsos et al., 2011). Additionally, they have the added difficulty of maintaining their client's emotional health while ensuring that the client works towards his or her goals. Though the type of clientele counselors work with varies, these cases are typically not seen as acutely severe because the clients are not at a point where they would pose a danger to themselves or to others (Borsos et al., 2011).

When clients begin experiencing these symptoms, mental health counselors who work in inpatient settings focus on addressing these more acute and severe issues. Even though the majority of counselors work in traditional outpatient settings, 23% of mental health counselors work at inpatient facilities such as psychiatric hospitals and residential treatment centers (Bureau of Labor Statistics, 2015). Though the percentage is small, the number will continue to grow as more mental health counselors engage in the field. Even in these settings, they still maintain a strong sense of identity and bring a unique perspective to the field.

Mental health counselors expand on the definition and philosophy of counseling and thereby enhance its relevance in the human services field; their perspective is different from other professionals. Mental health counselors work with both the client and with the environment in which the client lives (Borsos et al., 2011). As such, they are able to identify systemic issues and create a better understanding of the client, which helps the mental health counselor effectively address his or her needs. In addition to meeting these needs, mental health counselors empower their clients to work on these issues on their own when they are outside of counseling sessions (Borsos et al., 2011). They incorporate a defined theoretical approach with a therapeutic, clinical connection to help the client grow and develop. Treatment goals are collaborative in nature; mental health counselors understand that clients have a role in the helping process and they encourage clients to understand and commit to their defined roles (Borsos et al., 2011). In order for this approach to be successful, mental health counselors undergo training protocols that include specific coursework in defined areas.

The training protocols that mental health counselors adhere to include the use of skills and theories to help their clients achieve their goals. Though each theory is different in nature and focus, it is designed to address a variety of problems that clients may face (American Mental Health Counselors Association, 2016). In addition to using theories, mental health counselors assess and further educate their clients to help them better understand their concerns. Apart from working with clients, some mental health counselors also often interact with other human service providers, such as case managers, social workers, psychiatrists, nurses, and psychologists (Borsos et al., 2011). Here, mental health counselors use their perspective to give a different outlook and incorporate the unique individual and systemic issues that help identify why the client may be struggling. As such, mental health counselors provide a unique assessment

approach that helps expand the focus and understanding of other professionals on the team. With this method, mental health counselors help further address clinical concerns that others may overlook.

Mental health counselors embrace the counseling philosophy in their scope of practice to fit their unique role within the human services field (American Mental Health Counselors Association, 2016). Mental health counselors differ from other professional human service providers, such as social workers and psychologists, due to the clientele that they work with and due to the standards of practice that guide them (American Mental Health Counselors Association, 2016). These differences allow mental health counselors to expand into a variety of settings and collaborate with other human service professionals, using their unique counseling philosophical differences for working with clients as a tool (e.g.., using the wellness model with treatment). The acceptance of the field and the increasing presence of mental health counselors is a result of more clearly defined training standards and requirements.

Training

Mental health counselors learn how to effectively treat and work with clients by completing a master's level graduate trainning program. These programs undergo strenuous standardization so that universities can produce skilled mental health professionals. In order to identify and streamline these standards, counselors and counselor educators created The Council for Accreditation of Counseling and Related Educational Programs (CACREP). CACREP's role is to create standards that support counselor training, development, and accountability. Accreditation with CACREP means that programs have achieved the gold standard in education and training (CACREP, 2016).

CACREP requires mental health counseling students to complete at least eight core areas, in addition to a detailed clinical experience. These clinical interactions include a 100-hour practicum experience and at least a 600-hour internship experience; in both situations, students work with clients under the direct supervision of a licensed professional (American Mental Health Counselors Association, 2016). After graduation with their respected master's level degree, mental health counselors seek licensure through their respective states. Although each state has their own process and requirements, CACREP standards have been adopted by many state licensure boards to help facilitate mental health counselors' pursuit of state licensure. Despite the differences amongst the states, the common elements are the fact that the counselor must pass a national comprehension exam and a state ethics exam, must complete a defined amount of clinical hours, and must get supervision from an experienced licensed professional.

These requirements and practices helped make mental health counselors' identity unique and distinctive from other types of counseling. It is clear that mental health counseling has a unique place in the human services field. This uniqueness is evident in the different roles that mental health counselors take on when working with clients in the community.

Mental Health Counselor Roles

Mental health counselors use their skills in a variety of ways and in different types of settings. When mental health counselors work in the community, they fulfill different roles in order to provide the proper care and support for their clients. Though the main role of a mental health counselor is to provide counseling services to clients in need, the additional roles counselors perform are critical to community engagement and contingent on client needs.

Mental health counselors perform assessments to create diagnoses, develop treatment plans, interact with insurance companies, and provide psychoeducation for their clients

(American Mental Health Counselors Association, 2016). All of these roles help supplement therapeutic services and provide a more thorough and accurate form of treatment. Sometimes, mental health counselors receive advanced training and take on additional responsibilities to further help clients (Mellin et al., 2011). One example of advanced training includes, specialized trauma training in Eye Movement Desensitization and Reprocessing (EMDR). This type of training is designed to treat trauma victims and help them process unresolved traumatic events. With this type of training, a certified instructor teaches new counselors how to use EMDR techniques (EMDR Institute, 2017). Counselors can be certified to engage in this type of clinical interaction with clients only after rigorous training the counselors become certified to perform this type of counseling. EMDR has been in use since 1989; since its introduction, it has been scrutinized and evaluated as an effective treatment for trauma. Davidson and Parker (2001) note that EMDR is an evidence-based treatment for clients who have experienced traumatic events. No matter the population and work setting, mental health counselors rely on their foundational counseling beliefs to help facilitate the needs of the client (Mellin et al., 2011). Counselors have maintained a sense of flexibility to achieve this role. The flexibility allows them to work from several different perspectives and interact with various mental health professionals to create a detailed treatment plan for the client. As such, the work setting often dictates the type of client population with whom the mental health counselor will work.

Client Population and Work Setting

Counselors work in a wide variety of settings and with different types of clients. These settings include but not limited to private practice, community organizations, intensive outpatient, in-home visits, employee assistance programs, and inpatient hospitals (Bureau of Labor Statistics, 2015). Though mental health counselors primarily practice in

outpatient settings, an increasing number of counselors work in more diverse treatment settings and with severe cases (Bureau of Labor Statistics, 2015). However, counselors in all settings will likely treat clients experiencing depression, anxiety, trauma, substance abuse, and behavioral problems (American Mental Health Counselors Association, 2016). In order to help treat these issues, mental health counselors work with clients and help them identify goals and changes they would like to make to live optimally. Mental health counselors tailor these goals to their work setting and expertise.

Mental health counselors who work in outpatient settings address long-term goals and discuss issues in depth (Borsos et al., 2011). In these settings, counselors typically meet with clients once a week for a one-hour session to address their clinical concerns. During this time, they typically deal with issues that can take an extended amount of time to work through. When mental health counselors work with clients in a short-term setting, the focus is more on immediate changes, such as ensuring safety and creating a foundation for further long-term treatment (Borsos et al., 2011). Sometimes, mental health counselors recognize that the services they provide are not appropriate for what the client needs. When this situation occurs, mental health counselors refer clients to counselors better suited to deal with the problem (American Mental Health Counselors Association, 2016). These referrals are designed to increase or decrease the level of care and to provide specialized treatment for a specific issue.

Mental health counselors typically do not know the extent of a client's issues until after the initial session. During this initial session, mental health counselors are trained to assess the appropriate level of needed services. Clients experiencing less severe symptoms generally seek outpatient services because they are able to function within the community; they typically do not pose a risk to themselves or others. However, risk levels change when situations become

more acute. When these situations occur, mental health professionals are trained to understand that the level of care needs to change in order to better support the client's changing needs. In these situations, counselors send clients to inpatient care because their symptoms are too severe for outpatient treatment. When clients are unable to function in society, counselors understand the need for additional mental health treatment and thus embrace the importance of inpatient services.

This change in treatment protocol is necessary, given the fact that a counselor's primary obligation is to protect the welfare of his or her client (American Counseling Association, 2014; American Mental Health Counselors Association, 2016). In order to protect the welfare of the client, the focus of treatment also changes. While in an inpatient setting the more immediate crisis is addressed as well as establishing short-term goals (Borsos et al., 2011). These short-term goals help clients establish a foundation of treatment that is then followed up in outpatient services.

Mental Health Counseling in Inpatient Settings

Mental health counselors who work in inpatient settings have unique clinical experiences and challenges not found in other work environments. First, they treat severe crises, such as suicidal ideation, homicidal ideation, and psychosis. Second, their clients do not have the luxury of scheduling sessions at their own convenience. Finally, mental health counselors do not provide exclusive treatment as they do in other settings. Their clients undergo a variety of clinical procedures, including physical examinations by nurses and assessment for medication by psychiatrists. In these instances, mental health counselors address the client's therapeutic needs in conjunction with other human service providers (Joint Commission, 2016). This collaborative approach is necessary and essential for clients in inpatient settings.

Mental health counselors who work in inpatient settings address client concerns and teach coping mechanisms that will allow them to return to their own environment. During the stay, clients become patients. Iozzino et al. (2015) note that patients within an inpatient facility experience more severe symptoms and require more intensive treatment from multiple professionals to help them in their daily functioning. This presents a major challenge for mental health counselors, who often work directly with these clients on a daily basis. For example, it is not uncommon for a mental health counselor to conduct a one-hour individual counseling session with a client and then also have a 2-hour group counseling session with multiple clients. Given the intensity of the interactions, some patients' responses to treatment can be violent (Flannery et al., 1994; Iozzino et al., 2015; Renwick et al., 2016).

Violent incidences in inpatient settings affect all of those involved (Alden et al., 2008). Even though inpatient facilities train mental health counselors to help protect themselves, situations can escalate quickly; these types of escalations require additional assistance from other paraprofessionals (Dickens et al., 2009). Unfortunately, these escalations also can lead to injury to mental health counselors (Nijman, 2002). Therefore, violence in inpatient facilities is an ongoing risk for mental health counselors due to the fluctuating emotions and more acute symptoms along with the unpredictable nature patients exhibit while in those settings.

Summary

Mental health counseling continues to be a growing profession. The Bureau of Labor Statistics (2015) projects that the number of mental health counselors will continue to grow at a higher rate than the national average. With these increasing numbers, mental health counselors have been able to create their own unique identity (Kaplan et al., 2014). Through this identity, counselors use different perspectives and approaches that focus on the well-being and strengths

of their clients. Despite the differences in approaches and perspectives, counselors still work in the same environment as other mental health professionals. Even though mental health counselors use a different approach, they fulfill additional roles that were previously seen with other mental health professions. These roles expand on what mental health counselors are capable of doing in the field and how they work in different environments. As more mental health counselors are working in inpatient settings, their exposure to severe cases and violence increases (Bureau of Labor Statistics, 2015). When violence occurs to mental health counselors, it puts them at risk of developing ongoing physiological and psychological problems.

Workplace Violence

Workplace violence is any type of violence that happens in the work environment. The United States and the Occupational Safety and Health Administration (OSHA) estimates that around two million workers are the victims of workplace violence each year (OSHA, 2002). In addition, homicide is the second most common cause of death in the workplace (LeBlanc & Kelloway, 2002). Hartley et al. (2012) note that there are three different areas where violence is more likely to occur: healthcare, education, and protective services; among these sectors, the majority of attacks are precipitated by the clients or patients who are receiving services. Workplace violence is common in the healthcare setting; LeBlanc and Kelloway (2002) stated that when a new employee accepts a position in this setting, they do so with the understanding that violence is likely to occur.

OSHA notes that anyone in these types of environments has the potential to be a victim of workplace violence (OSHA, 2002). In the United States, 3 out of every 100 workers experience a nonfatal workplace injury; there were 2.9 million such incidences in 2015 (Bureau

of Labor Statistics, 2016). The motive for these attacks will vary depending on the attacker and the victim.

Workplace violence can take several different forms, with each having their own motivations associated with them. OSHA has identified three different types of perpetrators of violence towards workers: a perpetrator who is not connected with a worker but incites violence onto the worker; a perpetrator who is receiving services from the worker; and fellow coworkers inciting violence on each other (LeBlanc & Kelloway, 2002). Though all of these types of violence occur, the most common occurrence is when a client perpetrates violence on a worker. This type of violence is predominately seen in helping professions where healthcare or social services provide care to clients in need (LeBlanc & Kelloway, 2002). Among the healthcare and social services area, hospitals and nurses in a hospital setting experience a large amount of physical violence and personal attacks. Campbell et al., (2011) note that violent incidents happen throughout the entire hospital, with some areas experiencing a greater increase in risk than others.

Hospital Workplace Violence

Hospitals have one of the highest rates of workplace violence among medical employment locations (Beech & Leather, 2006; Campbell et al., 2011; GAO, 2016; Gillespie et al., 2010). Campbell et al. (2011) found that violence happens in every department and occurs in all types of hospitals, ranging from small, rural hospitals to large, inner-city hospitals. These attacks led to 3,350 workers to take at least one day off work to recover from their injuries. In addition, violent incidents have been increasing with 24,880 reported cases in 2013 (GAO, 2016). Though these incidents happen in all areas of the hospital, there are higher concentrations

of attacks in emergency departments and psychiatric units (Campbell et al., 2011; Chen et al., 2008; Gournay, 2002).

The researchers concluded 46.8 per 100 professionals in emergency departments experienced physical violence, as compared to 45.5 per 100 professionals in psychiatric units. Professionals who worked in these two settings were nine times more likely to experience physical violence than any other department. These numbers were similar to previous studies of workplace violence within hospitals. For example, Beech and Leather, (2006) found that nurses had the second highest percentage of attacks in comparison to other occupations and were four times as likely to be a victim as compared to the national average. Forty percent of all of the health and safety incidents reported to the National Audit Office were due to violence and aggression towards staff members (Beech & Leather, 2006).

The Government Accountability Office further confirmed these numbers. In their 2015 report, they found that up to 30% of staff members within a general hospital reported physical attacks within the past year (GAO, 2016); patients were the primary perpetrator of these violent incidents. At best, these rates of violence have remained constant, but there have been growing reports that patient attacks are increasing (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014). Since 2011, physical attacks alone have increased by 12% (GAO, 2016). Even with this increase, most workers are hesitant to formally report the attacks. Due to this reluctance, it is difficult to understand the true extent of violence within hospitals.

One of the problems in measuring workplace violence is that a considerable number of professionals do not file a report. Researchers have often noted the difficulty in trusting the reporting of violent incidents due to the lack of formal information (Hegney et al., 2006; Littlechild, 2005; Moylan et al., 2016; Phillips, 2016). For those that do share their experiences,

they are more likely to engage in informal discussions with supervisors or coworkers. Arnetz et al., (2015) highlighted this disparity and noted that unreported violent incidents were a common occurrence. They conducted a survey to determine the frequency of healthcare workers formally reporting a violent incident with a patient. They found that 88% of healthcare workers attacked by a patient did not follow through with a formal report. In fact, those that discussed the incident primarily did so through talking to someone such as a coworker or supervisor (79%) but never followed through with any formal report. They concluded that the true extent of workplace violence was unknown because most professionals rarely filed a formal report (Arnetz et al., 2015). It is clear that there are some areas in a hospital where violence is more likely to occur.

Highly Susceptible Areas of Violence

As previously noted, the two most common areas of violence are within the emergency department and on psychiatric units (Campbell et al., 2011). Though psychiatric units and emergency departments have two different purposes, many of them will see similar patients. Before admittance into an inpatient facility, patients receive an initial evaluation in an emergency department. This is especially necessary if they are under an involuntary admission. Some patients admitted to the emergency department are in crisis (Alden et al., 2008). Sometimes, patients can become hostile because of a involuntary admission or because there is confusion about their current situation (Bimenyimana, Poggenpoel, Myburgh, & van Niekerk, 2009; Flannery, 2001; Iozzino et al., 2015; Tishler, Reiss, & Dundas, 2013). Thus, emergency departments become a regular place of patient violence towards hospital staff and mental health professionals.

Emergency departments. Hospital workers experience a wide range of crises in the emergency department. Alden et al. (2008) noted that crisis situations put multiple healthcare workers at risk due to the unpredictable nature of the patient's behavior. Healthcare workers in the emergency department in particular experience one of the highest rates of violence as compared to other areas in the hospital. Violence within emergency departments is an ongoing problem (Alden et al., 2008; Pich, Hazelton, Sundin, & Kable, 2010); however, these issues are not limited to the United States. For example, Luck et al. (2007) emphasized that emergency department attacks are a global concern and that the rates of violence were steady despite efforts to decrease them. In fact, attacks in the emergency department are so common that healthcare workers expect the violence to happen and accept it as part of their job (Pich et al., 2010).

Pich et al. (2010) identified factors that provide context for why attacks in emergency departments occur more frequently. One of the main factors was a previous history of violence towards others. When there was a previous history of violence, it indicated a greater likelihood that an attack was likely to occur again (Pich et al., 2010). In addition, those actively using substances posed an increased risk to staff. The risk was present because active substance abuse can lead to a change in perception and a decrease in tolerance (Anderson & West, 2011). Emergency departments were also more likely to experience violence when patients waited for extended periods of time. Amid these times, patients reported not feeling adequately treated by the hospital and demanded better care (Crilly, Chaboyer, & Creedy, 2004).

The issues related to violence in emergency departments are compounded by another prominent risk factor, mental health problems. Pich et al., (2010) noted that when patients were sent to emergency departments and had to wait an extended amount of time, it increased their risk of violence toward healthcare worker due to their altered mental state. For mental health

professionals working in these areas, they are at an increased risk of attacks because of the acuity of these patients (Alden et al., 2008). In order to address this issue, patients are sometimes isolated and forced to wait in a small room until a bed at a psychiatric facility became available. Then, they could receive further care and more intensive treatment.

Psychiatric units and facilities. Psychiatric facilities have a high degree of patient violence towards staff members (Iozzino et al., 2015). Psychiatric facilities have persistent high rates of patient initiated workplace violence (Chen et al., 2008; Iozzino et al., 2015). Iozzino et al., (2015) found that 1 out of every 5 patients initiate violent physical attacks towards mental health workers. Furthermore, Gournay, (2002) concluded that physical attacks in psychiatric facilities occur at a rate of one attack every three days. Though the amount of violence involved varies per incident, the most common form of attack is verbal. However, physical aggression continues to be an ongoing concern (Anderson & West, 2011; Baby et al., 2014; Chen et al., 2008; R. B. Flannery et al., 2000; Iozzino et al., 2015; Jacobowitz, 2013; Kelly et al., 2015; Lantta, Anttila, Kontio, Adams, & Välimäki, 2016; Moylan et al., 2016). The reasons behind why these incidents happen vary, but three primary factors that often influence when violence occurs are the patient, the facility, and the staff member (Nijman, 2002).

Patient factors. Nijman (2002) stated that several different factors take place before an attack happens. Flannery, Irvin, and Penk, (1999) noted that as the needs of patients have changed, three consistent factors continue to be strong indicators of violence. They found that being misunderstood, having a diagnosis of a psychotic disorder, and having a history of violence are consistently seen as the most prominent risk factors; other researchers have noted the same factors (Campbell et al., 2011; Flannery et al., 1999; Flannery, Hanson, & Penk, 1994; Iozzino et al., 2015; Renwick et al., 2016). These pronounced risk factors appear across cultures,

socioeconomic status, and even across countries (Chen et al., 2008; Flannery et al., 1994; Gillespie et al., 2010; Gournay, 2002; Hegney et al., 2006; Koritsas, Coles, & Boyle, 2008; MacDonald & Sirotich, 2005; Renwick et al., 2016). Given these prominent factors, the mental health of the patient can easily serve as a conduit for increased violent behavior.

When a patient attacked a staff member in an inpatient facility, they were more than likely to have some sort of psychotic disorder diagnosis (Arthur et al., 2003; Chen et al., 2008; Flannery et al., 1999; Iozzino et al., 2015; Nijman, 2002; Renwick et al., 2016). Renwick et al. (2016) found that 44.3% of the patients that attacked staff members had a psychotic disorder. Similarly, Flannery, Fisher, and Walker (2000) found rates as high as 88%. These rates increased when patients reported having strong feelings of paranoia and believed that people were trying to poison them or to harm them (Nijman, 2002).

Because the staff members are in a position of authority, patients can feel a great deal of distrust within the facility. These feelings of distrust can lead to the patient defensiveness due to a perceived threat of harm; this in turn could trigger a violent response (Nijman, 2002). Though the presence of psychotic symptoms is common amongst patients who commit violent acts, it is not the only factor that contributes to these problems. Another factor associated with physical aggression is a history of violence.

Patients who attacked mental health professionals often had a history of violence and previous admissions into other inpatient facilities (Iozzino et al., 2015; Jussab & Murphy, 2015; Lipscomb et al., 2012; Pich et al., 2010; Tryon, 1986). The history of violence was not just geared towards staff members but found throughout the patient's life. Flannery, Hanson, & Penk, (1994) found that a history of violence was one of the highest risk factors associated with attacks towards mental health professionals. They found that even after multiple follow-ups, a history of

violence continued to be one of the main predictive risk factors associated with future attacks; other researchers have confirmed these findings (Flannery, 2005; Flannery et al., 2000; Flannery, 1999). McAdams and Foster (1999) further noted that this was one of the more reliable predictors of violence within an inpatient setting. Similarly, Renwick et al. (2016) concluded that of those patients who did end up attacking others, 72% of them had a history of violence. Additionally, they found that previous incidents of violence were the highest predictor in determining whether a patient would attack someone.

When violence occurred in these settings, many patients exhibited feelings of anger and frustration while others displayed fear and confusion. Lantta, Anttila, Kontio, Adams, and Välimäki (2016) found that patients who believed that staff would not listen to them had a higher likelihood of becoming violent towards others. They noted that there were several different areas in which this lack of belief was prominent, including not being allowed to leave the facility, being admitted involuntarily, and being fearful that other patients or staff members were trying to hurt them. Researchers also noted that some patients were mad or angry at another individual and took out their frustration and irritation on the staff (Bimenyimana et al., 2009; Nijman, 2002). When these feelings combined with other patient risk factors, it led to an increase in the likeliness that violence would happen. While patient factors are a strong indicator for violence, there are additional influences that can increase the likeliness of these attacks. Factors created by the facility further increased the likeliness of an attack, especially when a patient believed they were not receiving adequate services or felt threatened by the environment.

Facility factors. Many psychiatric inpatient facilities have specific protocols that prevent patients from leaving when they want (Nijman, 2002). These protocols are in place to ensure the safety of the patient and others and to prevent future harm from happening. Patients require

approval from the psychiatrist before they can be discharged from the facility. Iozzino et al. (2015) noted that when patients are in this position, they often feel trapped and believe they have lost all of their freedom. Patients are forced to experience a distinct set of rules and structure that are foreign to them. In an effort to test these boundaries and maintain a sense of control, some patients will lash out at others to restore their freedom (Iozzino et al., 2015; Renwick et al., 2016). Other patients sometimes make unreasonable demands, knowing that the facility is incapable of meeting those demands (Chapman et al., 2010; Kelly et al., 2015; Ringstad, 2005; Roberts, Grusky, & Swanson, 2008; Tishler et al., 2013). Some examples of these demands include insisting on seeing doctors when they want, asking for a particular type of medication, and requesting a discharge. When patients have unfulfilled needs, this can increase the likelihood that violence may occur.

One of the reasons these demands are unfulfilled is because of the continuous lack of staff. Violence is more likely to happen when there is overcrowding in these facilities, and there are not enough staff in place to be able to maintain a sense of decorum (Beech & Leather, 2006; Flannery, 2004; Tishler et al., 2013). When staff members are outnumbered, patients are more likely to get aggressive when their demands are not met and this decreases the feelings of safety for professionals working in the environment (Anton, Braga, & Cormier, 2015). For example, Anton et al. (2015) noted that several Florida hospitals had decreases in funding and thus decreases in available staff. Since these changes occurred, the hospitals noted a drastic increase in violence towards mental health professionals.

The Tampa Bay Times conducted an investigation regarding mental health facilities within the state of Florida (Anton et al., 2015). In their report, they found that over $100 million in budget cuts were performed to mental health facilities (Anton et al., 2015). Because of these

cuts, a significant amount of neglect occurred, both to the staff who worked at these hospitals and to the patients who were seeking care. Staff members were forced to work alone and oversaw a large number of patients without any support (Anton et al., 2015). Staff members reported feeling helpless if a fight broke out or if a situation needed de-escalation. Also, staff members discussed being so overworked that they were not able to properly take care of the patients that they were treating.

The lack of adequate staff made it more difficult for the facility to maintain control and to de-escalate emergencies. These situations led to an increasingly unsafe environment for all mental health professionals and a continued fear of what the patients would do (Anton et al., 2015). The investigation further noted unsanitary conditions and an environment of neglect. Patients were regularly unsupervised and would often attack each other with no one able to stop them. In addition, staff members were often victims of attacks, especially when left alone, which was common (Anton et al., 2015). Though every inpatient facility is not representative to those in Florida, these cases demonstrated that the setting and environment can help to increase patient violence. However, even when the environment is positive, staff behaviors can affect patient stability and set the stage for violent, aggressive acts.

Staff factors. The third main factor that can lead to violence towards mental health professionals are the reactions of the staff members themselves. The way staff members communicate and respond to situations dictates how patients will react to them (Nijman, 2002). As such, understanding how staff members view patients and de-escalate situations is critical in helping to curtail violent incidences.

De-escalation techniques and programs help protect staff members as well as patients from further harm. Programs such as Therapeutic Crisis Intervention (TCI) and the Assaulted

Staff Action Program (ASAP) help prevent problems from arising before physical violence occurs (Flannery, Levitre, Rego, & Walker, 2011; Residential Child Care Project, 2016). These types of programs are effective in decreasing the likeliness of an attack and in maintaining the safety of all of those involved. However, the main stipulation for these programs to be effective is that staff members need to use the techniques correctly and need to have enough support to ensure a safe environment.

Dickens, Rogers, Rooney, McGuinness, and Doyle, (2009) found that staff members do not use these programs as they are intended. When they performed an audit on the effectiveness of staff members using these techniques, they found only 17% could break away from a physical attack within 10 seconds, using the appropriate techniques. All other participants were either able to escape using an unapproved technique or were unable to break away at all. Furthermore, Dickens et al., (2009) noted that inadequately trained staff did not know how to break away from a violent patient. The inability of staff members to use these techniques properly puts these professionals at a greater risk of harm.

Untrained mental health professionals are not only vulnerable to physical harm but also are unable to effectively communicate with their patients. Bimenyimana et al. (2009) noted that these problems often start as early as orientation, where mental health professionals do not receive adequate training on how to properly work with patients struggling with severe mental health problems. Additionally, Bimenyimana et al. (2009) stated that the lack of training made psychiatric nurses ill-equipped on how to deal with certain situations, the most common of which was violence from patients. Furthermore, Baby, Glue, and Carlyle (2014) found that inadequate training significantly inhibited effective communication because mental health professionals believed that a threat was always present.

Given the poor communication and the tension within the facility as a result, additional barriers between the patient and mental health professionals often manifest themselves. Kelly et al. (2015) found that mental health professionals heavily influence the therapeutic environment due to the unique relationship they establish with their patients. Within the clinical setting, mental health professionals are very comfortable and are able to effectively communicate with their clients. However, this changed dramatically when they connect with their clients in the hospital setting. In this type of environment, effective communication is severely limited (Privitera et al., 2005). These circumstances can lead to more hostile situations and contributed to patient aggression, which further decrease effective communication (Kelly et al., 2015). Also, it decreases the level of care that they could give patients because they are fearful of how the patient may react.

Even when mental health professionals were trying to create a therapeutic environment, one main problem that they ran into was a lack of time and the inability to provide adequate services to all their patients (Sarkisian & Portwood, 2004). Flannery (2004) noted that continued hostile environments and lack of managerial support resulted in a high turnover rate for employees. As a result, the remaining mental health professionals treat more patients than they are capable of handling. Kelly, Fenwick, and Novaco (2015) noted a significant decrease in the quality of care due to patient demands and the inability of mental health professionals to meet those demands (Kelly et al. 2015). As these added pressures increase, it can lead to burnout and negatively alter how these professionals approach their job. Given these circumstances, it would be difficult to maintain a long-term therapeutic environment that was therapeutic in the long-term.

Summary

Violence within the medical field continues to be an ongoing problem and has been a global issue for several years. Researchers have learned a great deal about the violence and the prevalence of its occurrence (Arnetz & Arnetz, 2001; Arnetz et al., 2015; Beech & Leather, 2006; Chen et al., 2008; Flannery et al., 2000, 1994; Guy, Brown, & Poelstra, 1990; Iozzino et al., 2015; Kelly et al., 2015; Moylan et al., 2016; Tryon, 1986). Though violence can happen in any part of a hospital, the two most common areas are emergency departments and psychiatric facilities (Baby et al., 2014; Campbell et al., 2011; Hartley et al., 2012; Iozzino et al., 2015; Jacobowitz, 2013; Luck et al., 2007; Renwick et al., 2016). Several different factors influence the prominence of patient attacks in emergency departments and psychiatric facilities.

One of the main factors that influences patient attacks is the patients themselves. When patients are voluntary or involuntary committed for inpatient treatment, they often experience acute symptoms or severe behavioral issues that can lead to violent behavior (Campbell et al., 2011; Chen et al., 2008; P. Criss, 2010; R. Flannery et al., 1994; Gillespie et al., 2010; Iozzino et al., 2015; Kelly et al., 2015). Additionally, the environment can also lead to violence. Hospital and inpatient facilities have their own systemic problems which can prevent effective care and delay the needs of certain patients (Nijman, 2002). From budget cuts to lack of staff, the facility environment can create an atmosphere that is not safe and breeds more violence. A third factor to consider are the professionals themselves and how they interact with their patients (Nijman, 2002). Throughout these interactions, breakdowns in communication and overworked staff members can decrease patient care (Baby et al., 2014; Bimenyimana et al., 2009; Dickens et al., 2009; Kelly et al., 2016). As patients continue to feel uncared for, their anger and aggravation increase.

The factors leading to violence in inpatient facilities are complex, and there are several issues to consider. While one risk factor alone will not necessarily mean that violence will occur, when more are present, the likeliness of violence increases (Nijman, 2002). Because these incidents are frequently happening, it is important to understand how these attacks influence the work of human service providers, particularly mental health counselors.

Violence against Human Service Providers

Arthur et al. (2003) note that workplace violence is an ongoing problem in the human services professions. This section examines the frequency of the attacks as well as the challenges faced by professionals who experience these attacks. An examination of the frequency of workplace violence in the human services fields will help identify the extent of the problem and will help us better understand how other less researched practitioners, such as mental health counselors, will react in these situations.

Violence against Nurses

Workplace violence in the nursing field is one of the most common and researched phenomenon (Baby et al., 2014; Beech & Leather, 2006; Chen et al., 2008; Jacobowitz, 2013; Kelly et al., 2015; Lantta et al., 2016; Moylan et al., 2016; Phillips, 2016). In a review of literature, Beech and Leather (2006) found that nurses were one of the highest groups to experience workplace violence, second only to police officers. Additionally, researchers completed longitudinal analyses and noted that violence amongst nurses has been an ongoing, consistent global problem; interventions designed to address this problem have not reduced the rates of violence (Baby et al., 2014; Beech & Leather, 2006; Bernaldo-De-Quiros et al., 2015; Campbell et al., 2011; Chapman et al., 2010; Chen et al., 2008; Dickens et al., 2009; Kelly et al., 2015; Lantta et al., 2016; Mueller & Tschan, 2011; Richter & Berger, 2006). Nurses who work in

mental health settings are four times more likely to be victims of an attack than the national average, with one in four nurses experiencing a minor injury at some point in their career (Beech & Leather, 2006; Hegney et al., 2006). Campbell et al. (2011) and Phillips (2016) concluded that violence from a patient could happen at any place within the hospital; they noted that nurses were at the highest risk working in an emergency and psychiatric department.

Frequency of violence. The rate of these violent incidents among nurses has been an ongoing problem within hospitals. Phillips, (2016) noted that 90.5% of these attacks are at the hands of their patients. Additionally, Jacobowitz (2013) noted that psychiatric nurses experienced violence at a rate of 14%-64%, every six months. The researcher also noted that 88% of all nurses experienced violence from their patients in their lifetime. The rate of fatal attacks on nurses has not changed much since 1988. Jacobowitz (2013) also found that psychiatric nurses experienced a significant amount of violence and that the violence has continued to be an ongoing problem within psychiatric facilities.

Kelly et al. (2015) examined the frequency of attacks that took place in a given year while also looking at how these incidents influenced nurses' ability to work effectively. They found that 70% of the staff experienced a physical attack from a patient. Additionally, 99% of these attacks involved an interaction between a patient and a nurse. Of the nurses attacked, 42% considered the physical attacks as serious and involved being punched, thrown to the ground, or kicked by the patient (Kelly et al., 2015). These high ratings correlated with the continuous care that they provided and the increased patient interactions. Kelly et al., (2015) further noted that the more interactions these nurses had with their patients, the increase in probability that a future conflict would occur. They attributed this to how the way in which the interactions took place. When these exchanges became more strained and ineffective, communication broke down; this

breakdown increased the likelihood of an attack. Similarly, other parts of the world experience these challenges in the workplace.

Chen, Hwu, Kung, Chiu, and Wang, (2008) found that 35% of nurses working in a psychiatric facility in Taiwan experienced physical violence within the past year. Approximately 46% of these attacks resulted in physical injury, with 30% of those victims requiring medical treatment. Richter and Berger (2006) found that 15% of their participants experienced severe physical attacks, which resulted in broken bones and a loss of consciousness. Another 60% experienced minor injuries such as bruising or scratches. All of these physical attacks led to a change in their work due to requested time off and medical treatment for injuries.

Chen et al. (2008) noted that while these incidents could happen in any hospital, psychiatric facilities experienced a higher rate of violence. These attacks put nurses at a greater risk of experiencing ongoing problems such as PTSD. Though Chen et al. (2008) found that less than 20% experienced PTSD as a result of the attack, Richter and Berger (2006) highlighted that the severity is a strong indicator of these nurses developing PTSD. Even though PTSD does not always happen with every nurse that experiences physical assaults, nurses had strong negative reactions to their attacks.

Experiences of attacks with nurses. When nurses experience violence at such a high rate, it significantly impairs their ability to work effectively. Furthermore, these nurses have more difficulty deescalating future attacks due to the amount of stress these situations create (Kelly et al., 2015). Two of the main reasons this difficulty occurs are an increase in nurses' fear of future attacks and a decrease in feelings of competency (Baby et al., 2014; Bimenyimana et al., 2009; Jacobowitz, 2013; Moylan et al., 2016). Because of these high rates of violence, nurses take more time off work and experience increased levels of anxiety. Baby et al. (2014) noted that

nurses typically do not reach out for support when they take time off. As a result, they have decreased levels of self-esteem and confidence; this is a recipe for burnout.

Bimenyimana et al. (2009) note that nurses experience a change in their ability to work and function after an attack. Some nurses expect the violence to due to patient acuity; some even accept it as part of their job (Baby et al., 2014). Nevertheless, these attacks significantly influence nurses and their work environment. For example, Moylan et al. (2016) noted that 87% of nurses report feelings of fear of their patients and 71% report anger towards their patients. As these feelings increase, helplessness increases; this results in an ongoing rumination about the event (Moylan et al., 2016). These negative feelings influence how nurses interact with other coworkers and how they treat their patients. Furthermore, these attacks put an enormous strain on these nurses and their ability to work effectively.

Summary. Workplace violence at the hands of patients leave nurses susceptible to significant changes in their ability to provide effective care. One area of concern is the continued feelings of fear and helplessness that these nurses experienced as a result of patient violence (Moylan et al., 2016). Though nurses attempt to adapt to these situations, many accept the violence for what it is and believe that it will not change (Baby et al., 2014) or blame themselves for the violence (Chapman et al., 2010). The feelings of inadequacy and anger as a result of violent interactions with patients is not limited to the nursing profession; social workers experience similar feelings when faced with these challenges.

Violence against Social Workers

Social workers experience a high level of violence from those they are trying to serve. Newhill (2003) noted that violence against social workers at the hands of their patients has been an ongoing problem for several decades. The researcher concluded that though physical attacks

among social workers were not as common as verbal aggression, 24% of social workers experienced physical violence. Also, social workers reported that at any given point they could identify ten coworkers who experienced physical attacks at the hands of one of their clients. Respass and Payne (2008) noted that 43% of the social workers in their study reported significant difficulty in their lives aftera physical attack.

Frequency. Respass and Payne (2008) examined the trend of workplace violence among social workers. They reviewed the Bureau of Labor Statistics to identify the rate of nonfatal injuries of social workers. They found that 18.3 of 10,000 social workers missed at least one day of work due to workplace violence. They further noted that while other professions experienced a decline in workplace violence throughout the years, social workers' rates have not decreased. This provides an explanation as to why violence occurred at a much higher rate than it does for other professionals (Respass & Payne, 2008). They speculated that it was due to an acceptance of the fact that violence was part of the job. Similarly, Newhill (1996) examined 1,129 social workers about the extent, severity, forms, and impact of violence that they experienced across different work settings. She found that 71% reported that client violence was an ongoing problem that needed addressing. Also, 52% indicated that they sometimes worried about their safety while at work (Newhill, 1996).

Ringstad (2005) studied the frequency of attacks as they relate to a specific mental health setting. She investigated 1,029 social workers to examine their experiences regarding workplace violence. Of these social workers, 30.2% experienced physical aggression from clients at some point in their career (Ringstad, 2005). Additionally, 14.7% experienced the attack within the past year. Some participants stated that patients pushed or shoved them while others reported having things thrown at them; less than one percent experienced a severe injury. For those that did

experience physical violence, the highest reports were in inpatient (36.2%) and residential facilities (42.1%).

Koritsas, Coles, and Boyle, (2008) examined client and patient violence among Australian social workers. For this study, they surveyed 216 social workers in several work settings. Of these social workers, 9% experienced physical violence. Among those that experienced physical violence, they found that these attacks were more likely to happen to those who worked more hours and had a greater rate of direct client contact hours. The researchers concluded that social workers who work increased hours and interact more with clients were at a greater risk of violence. Social workers who followed these trends tended to be younger and have less work experience.

MacDonald and Sirotich (2005) evaluated social workers working in Canada. From their study, they found that 26.4% of the social workers experienced physical violence during their career while 6.6% experienced violence within the past two years (MacDonald & Sirotich, 2005). This study examined social workers from several different levels and found that those that had the highest client interaction, such as front-line staff were more likely to feel unsafe and were at a greater risk of an attack (MacDonald & Sirotich, 2005). Furthermore, they mentioned how social workers that did encounter this type of violence experienced higher levels of emotional and psychological problems such as irritability, depression, and burnout (MacDonald & Sirotich, 2005).

The frequency of these incidents has continued to be an ongoing problem for several decades. Additionally, the rates of these attacks have not decreased much over the last several decades (Criss, 2010; Jayaratne et al., 1999; Newhill, 2003; Respass & Payne, 2008). They believe that the lack of progress creates a negative atmosphere and can create a strongly negative

experience for social workers (Criss, 2010; Jayaratne et al., 1999; Koritsas et al., 2008; Newhill, 1996; Respass & Payne, 2008; Ringstad, 2005).

Summary. The experiences that social workers will have varies between the attack and the social worker. However, these social workers tend to experience feelings of fear and can even develop symptoms of PTSD (Robson, Cossar, & Quayle, 2014; Spencer & Munch, 2003). Also, social workers have a greater tendency to blame themselves for these types of attacks due to the understanding of their role in their clients' lives and due to the belief that they did something wrong to trigger the attack (MacDonald & Sirotich, 2005; Newhill, 2003; Sarkisian & Portwood, 2004). Newhill (2003) further emphasized the need for social workers to understand their role in a situation as well as the capabilities of those that they are treating. In addition, this understand is essential to effective work and collaboration with other human service providers, such as psychologists.

Violence against Psychologists

Arthur et al. (2003) noted that there is a dearth of research that focuses on the prevalence of violence against psychologists. Though psychologists have been part of sample sizes during research on patient violence, researchers combine psychologists with other mental health professionals and the results do not provide adequate information about their individual work experiences (Arthur et al., 2003; Dickens et al., 2009; Harris, 2001; Kelly, Subica, et al., 2015). Therefore, it is difficult to assess their level of risk and to assess the degree to which these physical attacks affect them. The American Psychological Association (APA) stated that 35% to 40% of psychologists experience an attack by a patient at some point in their career (American Psychological Association, 2002). Tishler, Reiss, and Dundas (2013) further validated these

numbers by stating that a client will physically attack one out of every five psychologists at some point in their career.

Jussab and Murphy (2015) note that research highlighting attacks on psychologists has been sporadic and that most of the research is not recent. However, results from these previous studies noted higher levels of violence than anticipated. For example, Tryon (1986) found that 81% of psychologists experienced some physical or verbal abuse from one of their clients; 35% experiencing physical violence. Of those who reported physical violence, psychologists in hospital settings were twice as likely to be physically attacked by a patient as opposed to a private practice or outpatient setting (Tryon, 1986). Also, the researchers found that psychologists who did not have as much experience and were not well-versed in violent patients were at a greater risk of physical attacks (Guy et al., 1990; Jussab & Murphy, 2015; Tishler et al., 2013).

Guy, Brown, and Poelstra, (1990) had similar results; in a nationwide survey, they found that 22.9% of attacked psychologists experienced physical violence at the hands of a client or patient. Furthermore, they noted that 40.5% of attacks happened in an inpatient facility. Tryon (1986) found that psychologists who were not able to choose their clients were at a greater threat of violence due to not being able to screen for any potential risk factors. For psychologists who work in an outpatient setting, they had greater freedom in being able to select their clients. However, those psychologists who worked in an inpatient setting did not have that luxury and would only work with those admitted to the hospital. As a result, due to the lack of a comprehensive vetting process, psychologists who worked in these settings were at a greater risk of an attack by a patient.

Jussab and Murphy (2015) noted that because Psychologists do not receive adequate training to help de-escalate or deal with violent patients, these challenges can often lead to an acceptance of violence. The researchers further noted that psychologists had an increase in fear and a diminished sense of well-being and professional competency (Jussab & Murphy, 2015). Furthermore, they noted that there was an even greater risk when the psychologist did not know the patient.

Though there is limited literature on the incidence of physical assaults on psychologists by patients, Tishler et al. (2013) noted that psychologists are at risk of physical attacks by clients and/or patients. This can significantly impact their well-being and their ability to effectively perform their work duties. As psychologists continue to work in these settings, they are at the same risk of experiencing similar feelings to social workers and nurses. Similarly, there is a paucity of research on physical attacks against mental health counselors.

Violence against Mental Health Counselors

One of the few studies focusing on mental health counselors and violence from patients comes from a survey carried out by Bride et al., (2015). In this study, they examined the patient violence toward counselors who worked in substance abuse facilities. They concluded that there was a significant difference for the mental health workers between verbal aggression and physical attacks; they noted that verbal aggression was much more common. Three percent of counselors experienced physical violence from their clients, 7.5% witnessed a physical attack on a counselor, and 30.2% of counselors knew a fellow counselor who experienced a physical attack. Of those who experienced a physical attack, 12% reported difficulty in being able to focus in on their work while 29% expressed personal concerns about safety while at work. Bride et al. (2015) concluded that these concerns influenced how counselors would interact with their

clients and as a result enhanced the fear associated with their work. They expressed concern that when a counselor would not feel comfortable with their client, it prevented a more authentic therapeutic relationship which, negatively affected treatment.

The research that examines the direct adverse effects to counselors after an attack remains rare. To gain a better understanding of some of the negative repercussions that can occur to mental health counselors, Storey (2016) examined the commonality of stalking and what can happen as a result of the stalking. His assumption for this study was that some counselors experienced physical attacks as a consequence of stalking behavior. Storey (2016) found that the issues of stalking have been an ongoing problem for many counselors. Though her study was conducted in Canada, she found that 94% of the mental health counselors in her study had a previous experience of stalking by a client and that clients physically attacked 6% of the counselors they stalked. Storey, (2016) further emphasized that the counselors surveyed were treating less severe cases than those that would work in a community mental health setting or an inpatient facility. Furthermore, her results echoed that mental health professionals including counselors who had a client stalk them in the past would experience a greater sense of fear, stress, and helplessness (McIvor & Petch, 2006).

As previously stated, there is a dearth of research related to violence against mental health counselors. However, the noted researcher does highlight the issue that violence among counselors does happen. Both studies emphasized yielded fewer incidences and neither study was completed in an inpatient facility, where the majority of violent incidences take place. Also, the treated clients had less severe issues than the problems that are present in inpatient facilities (Storey, 2016). Despite these concerns, it is alarming that counselors are still experiencing these

difficulties with their clients. Also, counselors exhibit similar feelings and behaviors found with other mental health professionals after they have been victims of an attack from the clients.

Summary

The human services profession is multifaceted, and each human service provider plays a unique role in helping patients and clients achieve their goals to help them feel better. Unfortunately, patients and clients are not always wanting help or are not in a state of mind to comprehend what is happening to them. As a result, the professionals that are trying to take care of them can become victims of these attacks. Nurses, social workers, psychologists, and counselors experience violence at the hands of their clients/patients, and this violence has a profound effect on their professional development and work attitudes.

Often times, patient and client violence is something human service providers expect and is viewed as a negative part of the job (Arthur et al., 2003; Baby et al., 2014; Jussab & Murphy, 2015; Moylan et al., 2016; Storey, 2016). Sometimes, the provider does not have a place to address the incident after it occurs. Despite the different professions, all exhibited high rates of violence and emphasized that it was a problem. In addition, all of the professions discussed the negative repercussions associated with it (Arthur et al., 2003; Baby et al., 2014; Bride et al., 2015; Guy et al., 1990).

Apart from the rates of violence, all professions exhibited similar feelings about themselves and their work environment. Feelings of fear, hopeless, anger, anxiety, and depression were commonly dispersed throughout the professions (Arnetz & Arnetz, 2001; Baby et al., 2014; Bimenyimana et al., 2009; P. Criss, 2010; Iozzino et al., 2015; Jacobowitz, 2013; Jussab & Murphy, 2015; Lanctôt & Guay, 2014; Moylan et al., 2016; Mueller & Tschan, 2011; Phillips, 2016; Respass & Payne, 2008; Sarkisian & Portwood, 2004; Spencer & Munch, 2003;

Storey, 2016). These incidents and feelings highlight the notion that an attack will have an adverse affect on the victimized professional and on their ability to work competently and comfortably.

Effects of Physical Violence on Mental Health Counselors

Violence within the mental health field continues to be an ongoing problem. Professionals accept violence as part of their work with clients. Though extensive efforts are made to protect professionals and curtail patient violence, these attacks continue to occur and negatively affect the victims. Often times these attacks affect individuals in two different ways: physiologically and psychologically (Arthur et al., 2003; Baby et al., 2014; Fuller, 2015; Jacobowitz, 2013; Jussab & Murphy, 2015; Lanctôt & Guay, 2014; LeBlanc & Kelloway, 2002; Neuman & Baron, 1998; Richter & Berger, 2006). As such, professional counselors need to be aware of and understand these aspects of physical violence.

Victims of physical attacks experience several different consequences. Physiologically, victims frequently complain of concussions and loss of consciousness (GAO, 2016). Also, many victims reported having a scar which served as a reminder of the assault. These reminders included memory loss, change in mobility, and decrease in eyesight. Fuller (2015) noted that there are lasting psychological effects that need to be taken into consideration.

Fuller (2015) noted that depression, anxiety, fear and even anger were the most common reactions to the attack. Victims also experienced an alteration in their perception of themselves, which led to behavioral changes. Also, victims of physical assaults were more likely to experience PTSD. Through the study, Fuller, (2015) found that there were several lasting consequences from those who experienced physical violence.

Though Fuller (2015) examined physical violence among the general population, mental health professionals also have similar experiences when attacked (Alden et al., 2008; Mueller & Tschan, 2011); the physiological and psychological consequences are similar in nature. Mental health counselors have the added burden of maintaining their professionalism in order to provide the proper service for their clients. Maintaining this level of professionalism is difficult because often times the mental health counselor provides services to the individual who perpetrated the violence (Jussab & Murphy, 2015). As a result, the violence and subsequent emotions they deal with differ from individuals in the general population who experience violence.

Physiological Effects

When mental health professionals experience physical attacks, their injuries can vary from minimal to fatal. Though a majority of assaults that take place do not have serious long-term effects, those who experience these incidences often deal with severe consequences (Baby et al., 2014; Lanctôt & Guay, 2014; Richter & Berger, 2006).

Though they are rare, mental health professionals have experienced fatal attacks. One notable case occurred in 2006 when Vitali Davydov, a 19-year-old client, killed his psychiatrist, Dr. Wayne Fenton (Carey, 2006). Dr. Fenton saw Vitali due to an unknown noncompliance with his medication. During their last meeting, Dr. Fenton was trying to convince Vitali to continue taking his medication. Unfortunately, during this conversation, Vitali beat Dr. Fenton to death in his office (Carey, 2006). As previously stated, these types of attacks are rare; however, it does illustrate that these violent attacks occur in the mental health counseling field. Typically, these attacks are fatal when they are not properly managed by the agency or individual.

Lanctôt and Guay (2014) noted that the three most common places of injury are the head, back, and arm. Many mental health professionals sustain nonfatal injuries during these attacks

but require extensive medical treatment. Even after treatment, the scars sustained during the attack force professionals to take additional time off from work. Mueller and Tschan, (2011) further stated that these professionals are at a higher risk of experiencing ongoing problems such as headaches and stomach pains due to their injuries.

Baby et al. (2014) noted, through a systemic analysis, that physiological injuries make it more difficult for these victims to perform their daily tasks. For example, professionals who sustained head injuries experienced further memory loss, which negatively affected their job performance. Also, the memory loss made them susceptible to make more mistakes than before. Fuller, (2015) expanded on this concept and noted that when a concussion occurss, it could lead to an increase in disorientation and to an inability to continue functioning normally for an extended amount of time. It depends on the severity of the brain injury as to whether or not the counselor faces lifelong effects.

Baby et al. (2014) found that concussions were one of the most debilitating injuries due to the potential change in motor functions and memory. For some of the more severe effects, lasting physiological issues required continuous treatment. As a result, these ongoing problems had financial repercussions as well due to additional time off from work and increased medical bills. Baby et al. (2014) noted that the mental health facilities were forced to find creative ways to make up for this loss of staff. Symptoms of these physiological attacks include strong headaches, seizures, and loss of consciousness. The attack created a shortage of professionals available to work and put the remaining staff at a greater risk for a future attack. Finally, when the injured professional returned to work, many were not be able to function as well as they previously could (Baby et al. 2014). Due to this decrease in effectiveness, it created a greater risk

of future victimization because it reduced the ability to give efficient and quality care to all patients.

Fortunately, not all of the attacks caused lasting physiological damage. Victims experiencing physiological damage ranged from no visible injuries to superficial bruises or scratches (Arthur et al., 2003; Baby et al., 2014; Hartley et al., 2012; Jacobowitz, 2013; Mueller & Tschan, 2011). Richter and Berger (2006) found that these types of injuries were the most common amongst the participants they interviewed and did not require any serious medical intervention. These results were similar to what Jacobowitz (2013) noted when he completed his literature review of professional victimization. According to Jacobowitz (2013), around 2.4% of attacks were life-threatening while the rest were non-fatal.

The physiological repercussions of patient attacks can be very painful and sometimes even fatal. Mental health counselors face struggles that included the inability to work effectively; however, most of the physiological damage is short-term. After the wounds heal and these professionals are physically better, they still have to adjust to the psychological changes. These changes tend to be more detrimental because they are longer lasting and influence future interactions with patients. Subsequently, it affects how competent they are in their ability to work efficiently with patients.

Psychological Effects

Arthur et al. (2003) noted that mental health professionals display psychological symptoms after physical violence occurs, regardless of the severity of the attack. These psychological changes can last well after the injury has healed and influence the thought process and actions of mental health professionals (Arthur et al., 2003; Jacobowitz, 2013; Jussab & Murphy, 2015; Richter & Berger, 2006). For some of these professionals, the psychological

effects will begin immediately, while others experience these feelings after they have calmed down and processed the event further (Arthur et al., 2003). Psychological symptoms can be debilitating and can change the way these professionals view themselves and interact with others.

Arthur et al. (2003) surveyed 1,131 mental health professionals about how they felt immediately after a physical attack. They noted that, on average, each mental health professional experienced 1.67 physical attacks at some point in their career. They found that common responses immediately after an attack include anger, irritability, loss of self-esteem, and inability to sleep. Additionally, they noted that 29% of these professionals feared for their lives while at work (Arthur et al., 2003). Furthermore, the physical attacks were more severe than psychological assaults. Finally, 16% of the professionals had a change in their profession after the attack in order to better deal with their feelings (Arthur et al., 2003). Sadly, these findings are not unique and many researchers have found similar experiences.

For example, Arnetz and Arnetz (2001) and Alden et al. (2008) found that healthcare workers who were victims of physical attacks commonly experienced feelings of fear, anger, anxiety, and even sadness. In addition, it changed the way they were able to work with their patients and even how they viewed them. Alden et al. (2008) noted that these feelings were unique to those who only experienced the violence; the feelings were not present with those who witnessed it. In addition to actually experiencing the event, the frequency and reactivity to the attacks strongly influenced the commonality of these feelings; however, the severity of the attack only minimally affected the acuteness of the symptoms with the only exception being severe trauma (Kelly et al., 2016; Richter & Berger, 2006). Unfortunately, Kelly et al. (2016) found these factors increased the likeliness that these professionals would experience depression and

anger. With these initial feelings in place, some professionals experience more debilitating long-term psychological issues.

Baby et al. (2014) and Moylan et al. (2016) found that initial feelings of fear, anxiety, anger, vulnerability, and distress led to long-term effects. Baby et al. (2014) concluded that these issues could lead to long-term problems such as loss of self-esteem, confidence, and even burnout. Moylan et al. (2016) added that, 71% of physically attacked nurses experienced a lack of control after the incident, while others experienced a sense of guilt and shame. Additionally, 65% experienced recurring thoughts of the incidents while 31% also experienced flashbacks. As these feelings continued to take place, some professionals would experience symptoms of PTSD and had the potential to develop it if not properly treated.

After these traumatic experiences happen to these professionals, PTSD is a possibility. When workplace violence takes place a majority experience problems falling asleep and frequently re-experience the event (MacDonald et al., 2003). In addition, a majority avoid similar scenarios at work or refuse to go in, in order to prevent those types of feelings from recurring. MacDonald et al. (2003) found that 89% of their participants had strong feelings of fear, anger, and anxiety as a result of the situation. Due to these intense feelings Richter and Berger (2006) found that 17% of their participants met most of the criteria needed for PTSD shortly after the event took place, but the rate dropped down to 9% after a three-month follow-up. The participants who did not have all of the criteria for PTSD still had PTSD symptoms; during the 3-month follow-up, the symptoms were still there but were less severe (Richter & Berger, 2006).

Chen et al. (2008) also examined the PTSD symptom rates for mental health professionals in Taiwan. From their findings, they discovered that a third to a half of the professionals experienced symptoms of PTSD while around 10% would meet criteria for PTSD.

Because of the work environment associated with the profession, healthcare workers remain at a higher risk of developing PTSD or symptoms similar to the diagnosis. The ongoing psychological problems they experience affect their ability to function in the clinical environment.

Key changes in work capabilities include a shift in effectiveness, a decrease in quality of care, and a reduction in enjoyment at work. (Arnetz & Arnetz, 2001). For some, these feelings eventually disappeared, but about 13% of victims live with perpetual fear about what happened and if it would occur again (Arnetz & Arnetz, 2001). These behaviors can be observed immediately or can develop after an extended period of time. Lanctôt and Guay (2014) noted, in a literature review, that mental health professionals who experienced physical attacks adopted hypervigilance and were overly cautious when they were working. Also, they were more irritable and had difficulty concentrating, while others displayed depressive symptoms. In addition, upwards of 65% experienced feelings of anxiety (Lanctôt & Guay, 2014). They also found that up to 85% of the people experienced anger after the incident happened; the more they were exposed to violence, the angrier they became.

Jussab and Murphy (2015) concluded that much of the anxiety experienced by mental health professionals manifested itself as a result of feelings of blame and distress. Psychologists reported feeling vulnerable and that these attacks negatively impacted their therapeutic relationship with their clients. The attack caused them to question their professional capabilities; specifically, it made them question their competency in being an effective psychologist. While most professionals experienced these feelings immediately after the incident, for some, these emotions would continue well after the incident took place.

Summary

Victims of physical attacks experience both physiological and psychological changes to themselves. Typically, physiological injuries are minor and do not have lasting repercussions (Moylan et al., 2016). However, when serious physiological injuries occur, they can leave lasting repercussions. Baby et al. (2014) note that incidents such as concussions are seen as severe and can significantly affect continued work progress. Fortunately, the vast majority of these incidences are non-fatal. Carey (2006) noted that though mental health professionals have been killed working with their clients or patients, they represent a small percentage of attacks. Even though the physiological attacks do not often have lasting effects, the psychological damage that these attacks cause can be long lasting.

For those wo experience physical attacks, feelings of anxiety, depression, fear, and anger are very common (MacDonald et al., 2003). These feelings influence the mental health provider's work and can change their view of the profession. Though symptoms tend to decrease with time, some professionals will meet the criteria for PTSD (Chen et al., 2008; MacDonald et al., 2003; Richter & Berger, 2006). These professionals will often have reoccurring nightmares, constant rumination about the incident, and intense feelings of fear about going to work (MacDonald et al., 2003). Though these experiences are similar to the general public (Fuller, 2015), mental health professionals have the added issue of potentially interact with the same patient who perpetrated the violent attack. In order to provide a framework for understanding how violence affects mental health counselors, a person-environment fit (PE fit) theoretical approach provides a comprehensive point of view.

Theoretical Framework: Person-Environment Fit

The Person-Environment (PE) fit can help identify interactions between workplace violence and the victim and can provide a better understanding for the impetus of these interactions. Both the environment and person combined create a more in-depth concept that is unachievable when only looking at the individual alone. Kelly et al. (2015) note that an evaluation of both the environment and the person helps to provide us with information on how the victim may respond when a violent incident occurs. PE fit helps to examine how the two impact each other and can contribute to determining the extent to which the individual reacts to the incident. The PE fit is an appropriate framework for this study because it helps us better understand the relationship between the victims' intrapersonal effects and work environment; this in turn influences how the individual copes with the stress of workplace violence.

The PE fit is a multidimensional theoretical approach that examines the relationship between the person and their work environment (Jansen & Kristof-Brown, 2006). With this theoretical approach, the work environment and the person are working together. What influences one, will also affect the other. As such, it is important for a proper match to have appropriate cohesion and the support necessary to allow for effective and efficient work.

Origins

Kurt Lewin was one of the first individuals to focus the relationship between the person and the environment. He posited that $B = f(P, E)$. In the equation, a behavior (B) becomes the function (*f*) of a person (P) within their own environment (E). Lewin (1939) stated that the equation quantifies the idea that behaviors are dictated by the person and the environment. This equation helped him create the idea of field theory, which looked at how unique changes in the environment affected the individual and vice versa. Lewin noted that the person served as the

individual and included his or her unique characteristics. The environment focused more in on the space that was around the person. The environment did not need to incorporate anything specific but was more focused on what was around the person. When these two factors interacted with each other, they created a specific behavior depending upon the interaction itself and the changes that were made (Lewin, 1939). Even though this theory was in place it was not specific to vocational work. However, this theory did provide a strong basis on how to relate it to a career.

This theory has developed over time and includes a popular interpretation designed to identify how work stress develops. Edwards and Cooper (1990) note that researchers in the 1960's postulated that a mismatch between the person and the environment occurs when work stress forms. Though several factors are responsible for this mismatch, stress, viewed from an objective or subjective lens, is a strong contributing factor.

In 1968, Lawrence Pervin helped to bring a new perspective to vocational matching by looking at the interaction between the environment and the person (Su, Murdock, & Rounds, 2015). Previously, vocational matching focused on ideas (such as trait-factor) which incorporated a more static approach to how individuals fit into a certain career. In order to change this perspective into something more fluid, Pervin began integrating counseling into choosing a career (Su et al., 2015). Thus, this theory considers not only the person alone but also the work environment as they relate to career choice. Therefore, a proper fit occurs when the person matches with the distinct factors associated with the workplace (i.e., supervisors, culture, and work groups; Su et al., 2015).

Components

The three main elements associated with PE Fit theory are: the person, the environment, and the interaction between them. The person alone consists of several different characteristics and traits that make the individual unique (Edwards, Caplan, & Harrison, 1998). These traits combine personality, training, education, and applicable skills. The person part of this framework incorporates the actual working individual. From this perspective, the person encompasses the individual's experiences and the specific point of view (Caplan, 1987). Doing so allows for the individual to decide what is important and how they will dictate what they believe is an important fit for them.

When the person is the primary focus, the personal needs and values become a core tenet in how they react to certain situations. As such, the person evaluates the importance of the environment, the physical makeup of the environment, and the function of the environment (Su et al., 2015). These characteristics help to determine what they think would create a perfect fit in the work environment and will attract them to certain positions. As a person looks for a career, they strive to find the right environment that will support their beliefs.

As the person works to create a fit, the environment reciprocates by enticing candidates who fit workplace needs and characteristics (Edwards, Cable, Williamson, Lambert, & Shipp, 2006). The environment encompasses several different perspectives and can be viewed broadly or specifically to a type of work environment. These characteristics include the various demands of the environment, the culture of the workplace, and the risks associated with the work (Jansen & Kristof-Brown, 2016). While an employer is deciding on the right fit for the position, the environment is evaluating the qualities its believes are essential for a productive employee.

The environment can encompass several different aspects in addition to the job itself. For example, in an inpatient setting, the environment will comprise of the culture of the facility, the fellow employees, the people receiving treatment, and even the perception of the provided treatment (Kelly et al., 2015). All of these have a critical role in determining a proper fit. With these expectations in place, the environment looks at what people would fit into this role. This helps create a mutual fit that appeases both the person and the environment. Because both of these roles are so important, looking at how they interact will continue to determine how well each side works with each other.

The last critical component is looking at how the two interact with each other. PE Fit Theory believes that the relationship between the two is crucial to maintaining job satisfaction and strong support while working (Su et al., 2015). If one of these components change, then it can unbalance the way the person can function or even alter the workplace into a negative work environment for others (Erickson, 2016). Several different factors can affect these changes; one area, in particular, that can cause a strong misfit is experiencing violence.

Relation to Stress and Violence

Apart from the objective actions that affect an individual, the subjective experience focuses on the interpretation of the individual interacting with the environment (Jansen & Kristof-Brown, 2006). Stress and burnout occur when the needs of the environment exceed what the person is capable of handling (Sonnentag, 2015). Researchers further note that it is not necessarily the event itself that causes the mismatch but how the person interprets the event, which then affects the correct fit (Edwards et al., 2006, 1998; Edwards & Cooper, 1990; Sonnentag, 2015; Su et al., 2015). When the person and the environment no longer have a proper fit , stress will continue to build to the point where the person is incapable of working

effectively. During these times, the person will then sustain further problems from the mismatch, such as psychological trauma, until finding a better fit within the same environment or in a new one (Erickson, 2016).

Violence is an example of a source of stress that can influence the person and the environment. Because violence is a subsidiary of the inpatient environment, the individual's subjective experience of the attack and the role of the environment will affect the impact of the attack (Edwards et al., 2006). Mismatches further increase when the person does not feel proper support from the work environment and can lead to further psychological harm due to continued fear of the workplace which will decrease efficiency and effectiveness (Tong, Wang, & Peng, 2015). As the mismatch increases, it will challenge the person's view of their position and how they feel about the environment. Further issues will also occur if the person feels that they cannot leave the environment, especially for financial reasons (Criss, 2009). Therefore, as the person continues to remain in the same environment and a change in either the individual or the environment does not happen, further problems will continue to develop.

The benefit of this theory is that it incorporates both a counseling perspective and career exploration perspective (Su et al., 2015). The counseling perspective helps us understand how both the person and environment can work together to achieve greater satisfaction in life. However, when there is not a proper match between these two, it can cause difficulty for both the person and the environment (Sonnentag, 2015). These difficulties can lead to harm of the person, which can subsequently cause additional damage to those who are receiving services. When there is an improper fit, increased levels of stress, burnout, and even trauma are more likely to occur (Kulkarni, Bell, Hartman, & Herman-smith, 2013). Given the risk factor of violence, it is during these incidences that more people are likely to become injured (Harris, 2001).

PE Fit has become the lens through whichthe focus of examining the reasons for burnout and misfit between employees and their work environment. When a misfit continues to build, then both the person and the environment will suffer until something changes. For those individuals working in a therapeutic setting, having a person working in stressful situations requires certain characteristics and expectations from the employees. Kulkarni et al. (2013) examined this concept when looking at burnout and secondary trauma for individuals working with victims of domestic violence. From their results, they identified that when employees did not feel supported by their environment, such as not receiving proper supervision or counseling services for their experiences, then it increased the likeliness that burnout would occur (Kulkarni et al., 2013). In addition, those that experienced secondary trauma struggled to separate themselves from their work environment and ended up taking more time off in order to deal with the stress of the job. Because of these situations, Kulkarni et al. (2013) found that those employees who were in a supportive and well fit environment were more effective in their work and continued at the same position longer.

Flannery, Hanson, and Penk, (1994) initially looked at the risk factors associated with violence in inpatient facilities. From their perspective, they believed that it was important to identify how the person and the environment interacted with each other when physically attacked (Flannery et al., 1994). In their study, they believed that it was important to consider the environment that those employees were working in and how these patients would react to different staff members. By focusing in on the risk factors such as a history of violence, sensory overload, and inadequate staffing, they were able to further highlight the connection between the person and the environment by identifying why these incidences happened (Flannery et al.,

1994). They also looked at how these attacks affect the relationship between the person and the environment (Flannery et al., 1994).

Kelly et al. (2015) looked at how PE fit works specifically within inpatient hospitals after an assault took place. They found that this framework highlighted the demands of the job and the capabilities in addition to the expectations of the individual. Due to the amount of stress that these individuals experience when confronted with this type of event, they found that the person's ability to deal with this kind of conflict and the support from the environment would dictate how they reacted to the assault. From their study, they found that those participants who had lower stress reactivity were more likely to become victims of assault and have a more difficult time processing the attack (Kelly et al., 2015). Due to the diverse nature that assaults take place, they identified that only certain people with specific reactions to stress and stressful situations could cope and deal with the assaults that they experience.

The PE Fit is a theoretical framework used to help gain perspective on the relationship between a person and their work environment. The theory helps to show the connection between how the individual and the environment react to different stressful situations. Due to the frequency of workplace violence among inpatient facilities, having a thorough comprehension of both the individual and the environment helps create an in-depth understanding of the experience.

Chapter Summary

In this chapter, I provided information about the development of the counseling profession with an emphasis on mental health counseling identity development. I highlighted the importance of understanding the relevance of patient/client violence as it relates to individuals who work within the human services field. I emphasized the challenges mental health counselors

face and noted the effects client violence has on their development. I theorized that the person-fit theory could be a useful framework for helping us better conceptualize client violence as it relates to mental health counselors.

In Chapter three, I will provide a rationale for the study and highlight the salient aspects help us better understand the necessity of this research. I will provide a specific method for data collection and analysis as well as detail the relevant research questions related to the study. I will provide a rationale for the chosen methodology and evaluate its effectiveness by highlighting other research studies where this methodology has been effective. Finally, I will consider any threats to validity of my study and address areas of concern related to trustworthiness.

Chapter 3 Methodology

Method

This Interpretative Phenomenological Analysis (IPA) study was designed to gain a better understanding of what happened to mental health counselors who worked in inpatient settings after they experienced a physical attack by a patient. The study approached IPA through a Person-Environment Fit framework. The combination of these two perspectives allowed for a more homogenous perspective that helped create a clearer understanding of what mental health counselors described. In order to understand their perspective, one-on-one interviews, in a semi-structured format, were used to gain a stronger understanding of the reflections of these mental health counselors after experiencing this trauma.

Research Questions

This dissertation used these research questions to guide the study:

1. How do mental health counselors attacked from a patient interpret their experience?
2. How do mental health counselors perceive their work environment after an attack from a patient?
3. How does an attack from a patient impact mental health counselors' sense of self?

This chapter described the design of the study, including procedures and methods necessary to address these research questions.

Rationale for an Interpretative Phenomenological Analysis Study

For this study, I looked to explore the experiences of mental health counselors after a physical attack by a patient. IPA helped gain a deeper understanding of what these counselors experienced through how they made sense and drew meaning from their experience.

IPA is a form of phenomenology that looks at the "comprehensive unit" of an experience (Smith et al, 2009). This means that researchers examine the experience of a specific event and how that event leads to different changes in a person's life. IPA focuses more on how the experience has a larger significance on the individual. Within IPA, it is important to recognize that different times will yield different experiences; also, it is important to note how the experiences provide more meaning to the individual. The focus of IPA is on how these individuals reflect upon these changes and how that influences their own lives. IPA is most suitable when there has been limited discussed about the topic and when there is complexity and multiple factors associated with it.

Due to the complexity of many of these issues, researchers are highly limited by what their participants share with them. Because of this limitation, IPA focuses on the researcher's own interpretation of what the participants share with them. IPA uses hermeneutics, which is a theory of interpretation, in order to inform and conceptualize these interpretations. Though hermeneutics are used within phenomenology, IPA looks specifically at how the participants interpret their situation and how the researcher believes the participants interpret their experience. Therefore, the researcher and the participant go through a parallel process as the information is discussed.

Due to IPA utilizing strongly about the interpretation of the researcher, IPA has multiple influences depending upon what the researcher is trying to discover and interpret. For this research, I utilized Heidegger's philosophy on phenomenology in order to inform this IPA study. Heidegger examined more of a worldly experience by focusing more closely on the relationships and how the environment plays into the experience. Because Heidegger focuses more on the intersubjectivity of the environment and the interactions, these beliefs match up well

with the theoretical lens of Person-Environment Fit. Because Heidegger focuses in on relationships and the relation to other objects and actions, using this philosophical background helps to gain a more comprehensive understanding of not just how the participant perceives the experience but also how the environment influences these beliefs. Researchers have not yet explored how mental health counselors experience and make sense of these attacks from a patient. Though researchers have examined experiences of other professionals such as nurses and social workers, the experiences of mental health counselors remain untouched in the current literature. This study helped identify the unique interpretations of mental health counselors to gain a better understanding of how they made sense on the issue as whole. Not only did this approach help gain a better understanding of the event itself, but it also contributed to how an attack affects their lives as a whole.

Background and Personal Experiences

My perspectives on dealing with physical attacks of inpatient mental health counselors from their patients come from a personal and professional experience. I have worked as a mental health counselor in an inpatient setting where I have treated a wide range of patients ranging from individuals with severe and persistently mental illness to those who are going through a single traumatic event; each patient has experienced some sort of trauma that led them to require additional help and services. During this time, I have personally experienced several different reactions from patients receiving treatment. Though a vast majority are willing to receive help, there have been some patients who either do not understand the circumstances or are upset that they are even at the facility.

Although none of my experiences have been physical, I have received verbal abuse from patients. Patients have told me that I should kill myself and that they will kill me; I have been

belittled for simply offering to help. These experiences shaped the way I processed the work I was doing and affected how I interacted with my patients. During these times, I experienced negative emotions which led to feelings of fear and anxiety about what will happen the next time I work with a patient or how I will respond if I interact with that patient again. Although I have processed through these experiences intrapersonally and in supervision, the memories of them still resonate with me. I have experienced how words alone from patients influence me on a personal and professional level.

I have also witnessed verbal and physical attacks on staff members while working at an inpatient facility. I have witnessed staff members getting bitten, punched, kicked, hair pulled, and objects thrown at them. In addition, I have known staff members who sustained serious injuries while attempting to give care; I spoke with one staff member who was hospitalized as a result of an attack. Those victims noted how the experience of assault changed their behavior and ability to function. From these interactions, I learned that the feelings of fear, anxiety, and anger are common and can be persistent if not appropriately addressed. For example, one individual talked about how she did not feel supported and felt isolated after dealing with the attack. Given these discussions and personal experiences, I am aware of my bias and understand its influence on this research study.

These experiences will be valuable in building trustworthiness with participants because it demonstrates how my own personal views influence my own interpretation which will allow for more authentic interviews. My personal view of this issue is a major impetus for completing this study; I believe other mental health providers need to be aware of the challenges related to working in inpatient settings. In addition, it is important to note that these experiences are mine alone and are dependent on how I have interpreted them. Therefore, during my interviews with

other inpatient mental health counselors, it was important that I did not allow my views to distort the experiences of my participants through not revealing about my own experiences associated with the attack. However, I should not ignore my personal experiences. Given my biases, I used additional trustworthiness strategies to ensure that I captured my participants' experiences in their fullest.

Research Design

I used IPA (Smith, Flowers, & Larkin, 2009) to perform this research study. IPA is a type of phenomenological study used to gain a better understanding of participants' experiences, perceptions of a specific event or phenomenon, and meaning-making following an event. There are three central components that are associated with the effective creation of an IPA study: phenomenology, hermeneutics, and idiography. The first central component, phenomenology, focuses in on the lived experience of the individual. These experiences are what the participants have experienced in the moment and the meaning that they make from them. The experience looks at the relationships the participant has with the environment and the interactions between others.

The second central component, hermeneutics, is critical for separating IPA from other forms of phenomenology. IPA examines not just how the participants interpret their own experience but also how the researcher interprets the participants' interpretation of their experience (double hermeneutics). Hermeneutics is a detailed analysis of what the researcher believes is important; as such, the researcher is keenly aware of the shared information.

The third aspect of IPA is idiography, which details the need to focus on a smaller sample to help bring out more specific details. When smaller sample sizes are used, it creates stronger and more robust interpretations and thus helps to bring meaning to participants' words and

experiences. These three tenets serve as the central components of IPA and allow for its distinction from other qualitative research methodologies.

IPA studies are often conducted through the use of interviews, most commonly semi-structured interviews. These interviews lead to a greater understanding of participants' experiences and provides clearer details of those experiences. The interviews are analyzed through three different types of coding processes: descriptive, linguistic, and contextual. Descriptive coding focuses on the participant's words and experiences through the use of direct quotes.by at quotes and sharing their direct experience. Linguistic coding focuses on voice fluctuations and highlights words and phrases emphasized by the participant. Contextual coding focuses on the researcher's interpretation of the participant's works. This type of coding effectively addresses the concept of double hermeneutics and thus plays a vital role in generating themes from the interviews. The coding process allows for the generation of individual participant themes, which then are merged together by the researcher. As such, IPA creates a unique perspective that addresses not only the participants' experiences but also the interpretation of those experiences.

Several researchers have utilized IPA to better understand experiences following assaults by patients. Jussab and Murphy (2015) used IPA to explore experiences of attacked nurses by their patients. By using the same design, IPA helped to further distinguish what these experiences were like for mental health counselors and brought their unique perspective to the forefront. Their experiences allowed for a more in-depth perspective about how they perceived the attack and how they were able to make sense of it. The use of an IPA qualitative design allowed me to identify new insights and understanding of how these physical attacks affected mental health counselors. Though researchers have studied mental health professionals in terms

of dealing with physical violence in general, the lack of focus on mental health counselors is disconcerting. Therefore, it was imperative to gain a better understanding of the experiences of mental health counselors. In order to gain better insight into the phenomenon, IPA focused on expanding the knowledge of this topic (Merriam & Tisdell, 2016). With the increase in knowledge it may inform mental health counselors, supervisors, and counselor educators of ways to respond to these situations (Flick, 2014).

Sample Selection and Participants

After receiving approval from the University of Tennessee Institutional Review Board (IRB), I used two different forms of sampling to gain appropriate participants. The first was purposive sampling based on the characteristics of degree earned and the location of the physical attack (Flick, 2014). Purposive sampling is a common approach in IPA qualitative studies due to the specific requirements that participants need to fulfill (Merriam & Tisdell, 2016). In addition, homogeneity is a critical aspect of purposive sampling. The researcher needs to be able to highlight the individual participant's experiences When this occurs, the results lend greater credence to individual differences and thus provide the framework for the generation of meaningful themes. So the homogeneous sampling approach helps to further validate the study by attending to the unique interactions amongst the population of interest (Smith et. al., 2009).

Furthermore, snowball sampling provides an appropriate extension to purposive sampling. Flick (2014) noted that snowball sampling is a viable option for securing participation from hard-to-reach populations. In this instance, after a participant agreed to be part of the study, the investigator would ask for additional mental health counselors who would be able to contribute to the study. To do this, I gave out a card containing contact information such as an email and phone number. It is the intent that those that hear about the study from the participant

would be interested and reach out to me in order to gain additional information about it. Snowball sampling would also be appropriate due to the number of mental health professionals who know of physically attacked coworkers (Arthur et al., 2003; Bride et al., 2015; Criss, 2010).

In order to participate in the purposive sampling, mental health counselors would have to fulfill two requirements for an invitation to participate in the study. The first qualification was that the mental health counselor must have graduated from a master's program in either community counseling, mental health counseling, or clinical mental health counseling. This would ensure that participants have the same educational background and theoretical understanding of clinical work with clients. Because counselors' training and focus are different from other mental health professions such as social workers, nurses, and psychologists, they have a unique perspective on the issue that merits further investigation. The second qualification needed was that the physical attack must have happened while working at an inpatient mental health facility. One of the core tenets of IPA is to gain perspective on a specific phenomenon that was happening (Smith et al., 2009). Due to the specific perspective that was investigated, creating a homogenous sample was imperative to formulating a more consistent viewpoint. The structure of these facilities created a unique environment for the patients and the staff that was exclusive from other treatment settings. By maintaining the setting, it allowed for more consistency throughout the study and decreased the likeliness that other variables from different settings would influence their reaction.

Recruitment

Initial recruitment of participants happened in person and electronically. I reached out via email to counselors who were coworkers and former supervisors to encourage their participation in my study. Then, I sought out additional participants by connecting with supervisors and

directors of inpatient facilities. I visited the facilities and spoke with the clinical supervisors about the study; I left information about my study to give to their employees. I asked them to identify any employees who would fulfill these requirements. Because this study was not state or region restricted, mental health counselors were also reached through electronic means. Counseling websites such as Listservs and counseling organizations helped gain additional potential participants that fulfilled the study's criteria.

I had hoped to have between 4 and 7 participants. These numbers are comparable to other IPA studies and recommendations from researchers. Smith et. al. (2009) recommend that beginning researchers have no more than 5 participants so that they can detail the specifics of the participants' experiences. The authors believe that additional numbers would yield the same results, so it is permissible to have 5 as the maximum amount.

Data Collection

When an individual accepted my invitation to participate in the study, I gave them a copy of the informed consent to review and sign and a demographic questionnaire to complete; once these documents were completed and returned to me, I scheduled an interview based on their availability. All of the one-on-one interviews took place at a mutually agreed upon private location. In addition, participants were given pseudonyms to maintain their confidentiality. Three of the interviews were conducted in person and one was conducted via real time video. In order to maintain confidentiality of the participants, several checks helped secure their identity. First, I secured all identifying information including the records in a password-protected folder that was on a password protected computer. Secondly, I then locked all paper documents in a secure location. Finally, upon completion of the research, all information will then be deleted and destroyed.

Interview Protocol

During the interviews, data collection followed a semi-structured interview protocol. The semi-structured interview allowed for a more in-depth understanding of the topic (Ritchie & Lewis, 2014). The interview was projected to take around 45 minutes in time. The actual interview lengths varied, with the shortest being 35 minutes in length and the longest being 48 minutes in length. In the interview protocol, participants were given a brief background about the study as well as what to expect in the interview. In these studies, I asked all participants the same core questions from the protocol provided; however, the semi-structured interview allowed me to ask additional questions to gain a better understanding and clarity of the phenomenon under investigation (Ritchie & Lewis, 2014).

For the interview, two introduction questions provided a better basis for the incident, followed by ten targeted questions that helped identify the personal and professional experiences of these mental health counselors. I further asked questions that were not on the list based on participant responses. In order to further protect the participants' confidentiality, I did not ask for any identifying information. When identifying information occurred during the interview, I removed it from the transcripts. Following the interview, all of the participants were given information that included a national crisis prevention line in case they felt that they needed to process the incident further. They were provided with my contact information and a description of the study as well; I asked them to consider anyone who fit the criteria and would be an appropriate participant for the study. Participants were further instructed that they would be contacted after the transcripts and theming was completed in order to give their own feedback.

Below is a list of the interview questions for all the participants. Table 1 is provided to demonstrate the purpose of the interview questions to the research questions.

Table 1

Semi-Structured Interview Questions

Interview Questions	**Research Questions**		
	RQ1: How do mental health counselors attacked from a patient interpret their experience?	RQ2: How do mental health counselors perceive their work environment after an attack from a patient?	RQ3: How does an attack from a patient impact a mental health counselors sense of self?
1. What preceded that led you to being attacked by a patient?	X		
2. How did your supervisors and coworkers react to your attack?		X	
3. How did you feel after the attack had happened?	X		X
4. How have these feelings changed or not changed since the attack?	X		X
5. How has your work been influenced by the attack?	X	X	
6. Who did you talk to about the incident?	X		X
7. What, if any, were the lasting effects after the incident?	X		X
8. How has the incident changed or not changed you?	X		X
9. What have you learned about yourself from the attack?			X
10. What would you want others to know about these attacks?	X	X	X

Analysis of Data

All one-on-one interviews were audio recorded and transcribed verbatim. Before analyzing the data, I removed any identifying information to maintain confidentiality of the participants.

With IPA, identifying themes became the essence of understanding the meaning of what was said during the interviews. These themes were identified per the individual interview and then further combined with the other interviews to help identify overarching themes associated with the topic. These themes were examined individually and then combined in order to identify overarching similarities between each participant. This process allowed for a more homogenous understanding of the participants understanding of their experiences'. After analyzing data from an IPA perspective, there was a significant amount of fluidity in how the data was analyzed. The fluidity was due to my own interpretations and what I found important. Therefore, analysis followed a specific flow in order to capture each of the participants meaning before combining them together. Smith, Flowers, and Larkin (2009) laid out a specific plan in order to help streamline the analysis into a way that created a clear understanding of each participant and bridge the participant's themes together.

In order to create these overarching themes, Smith et al. (2009) highlighted the importance of reading and rereading the transcripts. By becoming more familiar with the text, it helped me create a more thorough and authentic understanding of where the participant was coming from and understand their meaning of the experience. After becoming more familiar with what was written, the next step was the initial noting. This process allowed for me to begin to identify the richer aspects of the interview and created a more descriptive understanding of what the participants were saying. The initial noting process looked at three distinct aspects of the

interview: descriptive, linguistic, and conceptual. The descriptive aspect focused on how the participant describes certain events or focused in on their experiences. The linguistic then looked at what the participant emphasized and how it was being stated. Here the analysis looked more at the tone and the metaphors behind what was said. The conceptual aspect then looked at more of the ideas and abstractions of what was stated and inferred by the participant. Smith et al. (2009) emphasized that this would lead to writing out questions which led to further rereading of the text. The conceptual process allowed for me to examine the participants overall understanding of the process and how it affected them and how they perceived the environment responded. After these processes were completed, the next step was to create the emerging themes from these notes.

As the notes were separated onto themselves, the themes began to emerge. In this step, identifying the themes created a more interpretative process to gain a better understanding of the participants experience and understanding. With the new themes, the data became something different that was then interpreted and put into a more phenomenological lens. In order to follow through with this step, the notes were combined and categorized into statements or phrases that help capture the essence of what was said in a conceptual way. Therefore, the themes became a combination of the researcher's own interpretation and participants' original statements in order to create a more interpretative phenomenological understanding. Once the themes were discovered, finding the connections between them became the next step.

The connections between the themes helped to gain a greater understanding of how these themes related to each other. These themes were organized and categorized in order to identify the most critical and important aspects of the participants interpretation. Categorizing these themes became dependent upon what I believed was the most important aspects to consider and

what I believed the participant was trying convey. As the categorized themes were completed for each individual participant the next step was to identify the similarities and differences between each case.

Identifying the patterns found between cases was the last step of the analysis process. Each case presented its own unique themes. Much like categorizing the themes within a case, converging the themes between cases underwent a similar process. In this part of the analysis, the categories and themes were examined to help identify what areas built off of each other, had stark similarities, and illuminated the differences between the cases. These themes were cross-examined through the interpretation of what I believed highlights not only each participant's personal sense of meaning making but also the collectives' perspective on how they interpreted their experience.

After these steps were completed, I ensured rigor by having others check my work. The use of a third party and the participants themselves helps to solidify a more concrete interpretation that captured the true concept of what the participants shared to help instill greater rigor and trustworthiness into the study.

Trustworthiness

The concept of trustworthiness is a qualitative term that helps to instill rigor into a qualitative study. The use of trustworthiness is to help ensure that the study can capture the participants' true essence and help demonstrate meaning within this specific context (Merriam, 1995). For this study, credibility, dependability, and confirmability were all examined to provide trustworthy data applicable to an inpatient setting (Creswell & Miller, 2000). In order to ensure credibility, a statement of the researcher's experience highlighted any personal bias and

perspective of the issue, in addition to member checking, peer examination helped ensure credibility and dependability.

Statement of Researcher Experience

Creating a statement of the researcher's experience helped show readers the researchers' own personal biases and perspective when approaching this study. The statement, conducted at the beginning of the research, explained data interpretation and how the study influences the researcher.

Member Checking

In order to ensure the validity of the interviews, the use of member-checking helped to ensure the true essence of the interview (Merriam, 1995). With member-checking, the participants received a completed transcription of the interview and the interpreted results from their interviews. During this time the participants were asked to take a look at their transcripts and to determine if I captured everything the participant mentioned in the interview (Creswell & Miller, 2000). The information was sent through secure e-mail and participants were given one week in order to look over all of the information. The participants were instructed to read the transcript and identify any incorrect aspects from the transcripts. They were then told about what the codes were and the different types of coding that was displayed. If the participants note that I incorrectly captured something, the participant informed the researcher of the errors and help to change them. Doing so helped to ensure that I did not initiate personal bias into what was being stated (Creswell & Miller, 2000).

Because IPA displayed codes and themes within each interview, the participants looked over the different themes that were present during their interview. These participants then shared with me the accuracy of the themes and if they capture the true essence of what they shared. All

of the participants responded within the time frame and responded with comments. The changes that were made by the participants were minor, with some changes happening in the transcript. None of the participants indicated any changes to the codes or themes. Allowing this process to happen, further increased the accuracy of what the participant said in order to capture their intended meaning and interpretation of the event.

Peer Examination

The use of a peer examination was another form of ensuring the validity of this study. With peer examination, the data and themes were examined by a peer or colleague in order to see the plausibility of the results (Merriam, 1995). The peer examination process happened following the completion of the participant member check. These steps happened with an audit trail. During an audit trail, another peer, chosen by the researcher, helped to confirm the findings found within the research. This individual explored the data and inform the audit process in six different categories: Raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, materials related to intentions and dispositions, and preliminary development information (Carcary, 2009).

By conducting the audit, it allowed for that peer to challenge what was found and helped to reexamine the primary researcher's assumptions (Creswell & Miller, 2000). The peer auditor received the information through secure email and the discussion of the findings were convered through email. The auditor was given specific instructions that identified what needed to be examined and was also given information about IPA and the research process. The auditor discussed his agreeance with the themes and made recommendations on wording of some codes. However, he agreed with the themes and felt that they captured what was being said by the

individual participants and the overarching themes present. After examining all of the aspects the research the audit helped to confirm or the overall themes (Carcary, 2009).

The study utilized Interpretative Phenomenological Analysis to interview four participants about their own experiences with a physical attack. The interviews were analyzed using descriptive, linguistic, and conceptual coding designed to assess the meaning of each participant's story. With all of the codes identified, the research questions provided a guide to categorize them. The codes were then categorized per the research questions and then themed for each participant. Each participant's themes were then merged to generate five themes and eight sub-themes. These themes helped gain a better understanding of the lived experiences of physically attacked mental health counselors from their patients. Through these experiences, the participants provided their own interpretation of the experience and processed its affect both during and after the attack. The participants talked about the environment's influence on the phenomenon and its impact on the perception of the attack.

Sample and Demographics

Four individuals participated in this study. Of the participants, Rebecca and Rose were licensed while Kelsey and Dennis were still working on theirs. Participants' experience working as a mental health counselor varied. The longest that someone practiced was 20 years and the shortest was 3 years. Three of the participants were female and one was male. In addition, three of the participants identified as white/Caucasian and one was biracial. The age of the participants ranged from the 20-30 range to 50-60. All of the participants worked at an inpatient facility for under ten years and their experience ranged from two years to seven years. Further, all of the incidents happened within the past five years, the oldest happened in 2015 and the most recent in 2018. See Table 2 below for more specific demographics.

Table 2

Demographics of Participants

	Rebecca	Rose	Dennis	Kelsey
Practicing counselor	7 years	20 years	4 years	3 years
Licensed	Yes	Yes	No	No
Year of attack	2015/2016	2018	2015	2016
Race/ethnicity	White	Biracial	White	White
Gender	Female	Female	Male	Female
Age	32	57	52	28
Years working in inpatient	5	7	3	2

Rebecca

Rebecca was a 32-year-old white female and at the time of the interview had been practicing as a counselor for seven years. Over the last five years she worked as an inpatient counselor; during that time, she had two different physical attacks. She was attacked once while working on an adolescent unit and once while working as an intake counselor. The first patient attacked her was an adolescent who punched her in the arm several times. The second patient was an adult who kicked, punched, and scratched her multiple times. She spoke in detail about the attacks, including her perceptions of the attacks and her thoughts about the hospital's reaction.

Though the physical damage was minimal, there was still a volley of attacks:

> she tried attacking me and the tech several times by punching us and kicking us and trying to bite me several times she scratched my arms up and down and we were able to basically wrestle her to get her on her bed and cover her up since she

> was nude and put her in a four-point restraint because that was the only way we're going to be able to stop her.

She had to restrain the patient to prevent any further aggressive acts. She stated that this incident changed her perspective on life; she redefined what she considered to be important and decided to continue her clinical growth and development.

After the attack, Rebecca noted that there were longer lasting psychological effects associated with the attack. Rebecca described the psychological effects as being the most prevalent shortly after the attack first happened. Rebecca discussed increased in feeling "skittish" at times. These feelings were strongest when she returned to the site of the attack. She discussed how ever since she always felt more uncomfortable on that unit because of the population which involved more severely psychologically ill patients, "I don't want to walk on unit 5 half the time because we have patients that are completely psychotic they will just flip out with no triggers whatsoever so it has made me a lot more aware of my surroundings." The feelings of skittishness led to more cautious behaviors. Rebecca ensured that everyone knew where she was going, and she changed her behavior to determine if she needed additional support or where she met the patient.

Despite these negative behaviors, Rebecca still found positivity in the attack that happened to her. She found that now she has been able to increase her own empathy from and is more apt to validate the feelings of others, especially other attacked coworkers:

> I guess I gain perspective on how they deal with things and then think about how I dealt with things and how we can kind of make sure that stuff doesn't happen again how can we make things better most just letting them vent when they come to me and say I just had this happen to me and I say that sucks that shouldn't happen to you what you think we can do differently going forward.

These feelings led to a desire to advocate for counselors and for patients. She expressed to "advocate for yourself, advocate for your patients, how can you keep yourself safe, how can

you keep your patience safe, how can you mentally and emotionally be able to process everything that you see in and hear here." Rebecca chose to be an advocate because of management's response to her dilemma and because of her treatment at the hospital.

Although Rebecca discussed how management was initially supportive, they then began to blame her for the attack:

> At the time things were really bad back then and it was kind of like it was go for the course here honestly umm it was kind of just like you shouldn't have gone on unit four, well I had to do the assessment on the patient so I had to or we should have never admitted this patient in the first place because they are so medically needy and mentally needy and I was like yeah but I'm not the doctor I didn't admit the patient. So honestly it was just kind of par for the course for that time.

Rebecca disdained the response and the hospitals perspective, that it was part of the job. Rebecca accepted the idea that physical attacks were part of the job: "I mean I feel like it's part of the job here someone as I was the only therapist on the unit at the time." Rebecca accepted the fact that these attacks happen and while they are not okay, it was part of being in such an unpredictable work setting.

Despite the negative experience, Rebecca shared that that she accepted the attack and identified that it did not have much of an effect on her, Rebecca did however go to a different position within the hospital and was no longer in the same area as she was before "I don't really have one-on-one interactions with the patients anymore now that I am in UR." With her new position she continued to work on advocating for increase in safety of patients as well as staff. Rebecca highly focused on these two areas because of her own past experiences and strived for more quality care in these facilities.

Kelsey

Kelsey was a 28-year-old white female who worked as a counselor for three years while being in inpatient for two years. She experienced two separate attacks from two adolescents

when she worked in an inpatient facility. One attacked her with a pen while the other threw things at her in her office. Kelsey shared that the incidents happened after she gave her patients negative news. Kelsey described her experience to be full of "fear, hurt, confusion and …frustration too." Although there was no lasting physical damage done to Kelsey, she expressed that she wished she would have handled the situation differently "I'm sure I could've found a different way to maybe inform the kid maybe before the session and say 'hey your family is going to come in and when they leave it can be hard, how do you want to handle this?' and talk with maybe how they will cope with it."

Kelsey discussed how these patients were not properly prepared for such drastic news and that the presentation for it increased the susceptibility for these kids to act out in a more aggressive manner. Due to this thought process, Kelsey blamed herself because of the result. Kelsey believed that she could have been more therapeutic and empathic in her approach and that there needed to be a different way to present the information than how she did in session. While she was doubtful of herself, part of her learned to accept these attacks due to the severity of the clientele that she was working with and the position that she was in:

> I had to get it done if they were going to residential the next day and they didn't know until the day of so I definitely felt some pressure to kind of push things along, especially if they were not ready yet and most of the times they were not really ready for a change and they just adjusted to inpatient so sometimes it was a lot for them and I think that that would definitely made for a difficult therapeutic relationship with them.

Kelsey discussed the idea that attacks were bound to happen and there was only so much that anyone can do about it. Despite accepting this as her own reality, she still experienced some negative effects as a result.

Kelsey discussed the extent of her psychological effects that she admitted still affected her today. Kelsey emphasized the strong emotional response that was initially present, and while

it was still there, it decreased over time. Despite the decrease in severity Kelsey discussed multiple primary feelings about the attack. One of the most prominent feelings was fear:

> definitely the fear because initially I did not think it would ever happen, you feel like every relationship is safe and when that happens it shocks you and it scares you, it's not something that you would expect happen so when it does you're not really sure how to react to it.

Kelsey discussed how she was afraid of those patients and feared that it would happen again. Due to these feelings of fear, she avoided those that attacked her until they discharged. She also found herself much more distant with her patients in general than she was previously, "I was very avoidant just in general whether it was hanging around in the group room around that person or if it was talking about things that they know can make her upset again." While Kelsey initially questioned herself, she found positivity in the attack itself, after much processing.

Kelsey emphasized that the change was primarily due to her being able to process through the event itself. Kelsey no longer works where the events took place. After she left, she discussed the marked difference in her own attitude, due to the change of her environment. When looking at her environment after the attack, she described a distinct difference between how her superiors and her coworkers treated her. Kelsey identified that her coworkers were supportive of her, especially those that witnessed the violence happen. While her coworkers were supportive, she did not find much support from her supervisor "yeah I mean the conversations were pretty quick when it came to me meeting with the coworkers or to meet with the supervisors saying, 'hey what happened' or asking how I could have made the approach it differently." Although her supervisor checked on her initially, there was never any follow through to continue to check in on her. Kelsey blamed the culture of the hospital itself for the behavior:

> I definitely felt like there wasn't a really choice ummm and I had to get it done if they were going to residential the next day and they didn't know until the day of so I definitely felt some pressure to kind of push things along, especially if they were not ready yet and

> most of the times they were not really ready for a change and they just adjusted to inpatient so sometimes I was a lot for them and I think that that would definitely made for a difficult therapeutic relationship with them.

She talked a lot about how the hospital pushed people out before they were ready and how many patients were not able to adjust to the changes because they were only there for a short amount of time. These frustrations then had the potential to be physical because the counselors were the ones who were communicating more with the patient. The high-pressured environment put additional stress on herself because of the demanding expectation. She was required to address difficult issues in such a short amount of time without having the ability to gain much rapport while at the same time expecting more results "it may not be at the pace that [the facility] wanted it to which leads to more resistance and therefore difficult sessions yet I felt kind of pressure being in an inpatient setting to have things completed." When the environment was combined with poor managerial communication about handling violent situations, Kelsey described how it created a highly stressful environment because it became much more unpredictable. It was during this time that Kelsey considered leaving the field altogether.

The stress from the position and the attacks led Kelsey to leave the position and find another counseling position. It was during that time she was able to better process what happened to her and find more positivity in the attack. Kelsey focused much more on mindfulness and described increased self-awareness. In addition, she looked to take extra steps to ensure the comfort of her patients. Kelsey attributed a lot of positive change towards her current supervisor "I feel like I really support system which is my coworkers, my supervisor, I check in with her frequently just check in and say you know this is what's about to happen and she's good at coming out and asking me questions like how am I feeling going into this?" She helped Kelsey explore more about her own situation and how it her affected before and currently. Kelsey

emphasized the importance of effective supervision and the benefits associated with it. During her more recent supervision, Kelsey expressed that she was able to learn from the attack and be more proactive in her approach. While Kelsey consistently identified that these attacks never go away, she stated that she can learn from them and continue to be supportive of others who experienced a similar fate.

Dennis

Dennis was a 52-year-old white male who has been working as a counselor for four years and in inpatient for three years. He experienced an attack from an adolescent female, "She got frustrated she came up and kicked me very hard in the private area. This is the first time she'd ever been aggressive towards me and I didn't see it coming." Dennis discussed how his patient kicked him in the groin for not letting her leave the unit due to being aggressive towards other peers. He described the attack as being completely unexpected and never thought that he would have been the victim of an attack. He believed that his role as a counselor would have deterred her away from attacking him. Dennis felt that he was unprepared for the incident. He shared that he never received any proper training or guidance on how to deal with this sort of situation. While Dennis did state that he received training on how to de-escalate situations, it did not really address how to process through the aftermath of an attack. As a result, Dennis began to put some blame on himself for the incident:

> And I understand the gravity of where we work and how we're doing with populations that have people under severe stress and duress. And so maybe I did all I could that that maybe there wasn't anything profound therapeutic relationship available, maybe was never gonna happen. That's the part that I kinda blame myself that maybe if this young lady felt safer around me and around others and I'm talking about not just me but the hospital staff, maybe she would not of been so inclined to to be aggressive and I think a lot of that would be a protective sort of thing that she did. So yeah in that instance yeah I blame myself.

He discussed how he should have reacted differently or approached the situation in a more therapeutic way. Due to these feelings of ongoing blame, it played a significant role in him feeling burned out. During the interview Dennis expressed strong feelings of burnout, even though he was in a different position within the same workplace environment:

> I've given this three years and I feel I'm rather burned out. Every day is very stressful and I mean come on this is an emergency room for psychiatry, of course a stressful. I don't know what I would do if I was present will the clinical director maybe consider rotating the clinicians to different units because I happen to be in a very difficult unit right now and I am burning out rapidly because every day there is a risk of getting hurt. Every day there is a risk of patients attacking one another and it's really too stressful. Again one of the solutions, may be more adequate staffing or maybe additional training for the staff members as of the nacelle train that well even if I hadn't gotten hurt to be in this position after three years so I guess that is my long-winded answer okay

The rest of the burnout was attributed to the work environment and how upper management handled the situation. Dennis expressed how initially they and his coworkers were supportive of him after the attack happened. They wanted to make sure he was okay and encouraged him to talk about the incident. However, after the initial shock of the attack wore off, Dennis reported that others blamed him, especially upper management:

> 'why didn't you gather more technicians, why didn't you do that, why didn't you see this coming' and that kind of thing so yeah. Initially the sport was there and was maintained with my colleagues you know but people you know with the that mental health and social work piece that never changed. But when the incident began to be digested by the risk manager and all that they were they were looking for that it was kind of on you and if there weren't enough technicians in the room then why were you going to have group. Because that's when we have group and that kind of thing and I was made to blame for some of that was our policy while the earth without be my responsibility. I'm having a hard time trying to provide therapy for 14 patients and surely it's not my responsibility for scheduling because of the hospitals responsibility scheduling.

They stated that he should have not tried to have group without enough staff present and that he should have known where the rest of the staff were when the attack happened. Because of their response Dennis has a strong response to the facility:

> it was disgusting. Like to me it seemed like the bar was being lowered once again as well and this was the nature of an inpatient psychiatric facility. We're dealing with a lot of

> unknowns and it was really up for you to anticipate those unknowns and should have known ahead of time to look and make sure you have enough technicians and you know I don't know who's going to go on break or what anyone's schedule is like so for anyone to put that on me to me instead of raising the bar as of okay what can we do better next time to okay who can we assign blame to the flat. Instead of having management really looking at it, they are looking at putting it back on the the frontline staff such as myself.

Dennis felt the general sense of blame from the facility and believed that they put too many expectations on him that were outside of his scope of practice.

As the facility blamed him, Dennis blamed the facility primarily for the attack. He reported that there was a significant lack of staff and that the management did not ensure his safety "I just keep in patient safety and keeping employees safe and again the fact that there was just not adequate staff did not make me feel safe then and I wasn't safe and there are still moments where I feel like I have my head on a swivel." Dennis felt that the facility was more concerned about bringing in more patients than they were about the staff ratio. Dennis further described how the facility portrayed this as "part of the job" and that due to the population, these types of things happen:

> I don't accept that will and so I'm more soured from that experience and because it hasn't this happened to me but it's happened to other technicians, the counselors, and I continue to hear that well is to be expected and that has soured my view on this, on this facility. I don't know the grass greener on the rails and maybe this is the nature of inpatient have them will research on inpatient but I just don't accept that. I don't think we are doing everything we can to consider everyone safety. Patients and staff.

Dennis strongly rejected this idea and believed that it was the facilities responsibility to keep him safe:

> yes [blaming the facility], for not being adequately staffed. That's a big one. The facility is also responsible for not vetting those particular patients. This patiently new before she ever arrived, yes everyone is entitled to treatment but in the setting and you have to have the right sort of environment therapy to take place and this lady was very resistant from the moment she walked in the door. She was determined to establish herself at the top of the pecking order and exert her dominance and so you and I don't think we gave that consideration, we had into bed and we need to fill it okay.

Because of this, Dennis felt that the work environment was not safe, and anyone present at the facility was at an increased risk of an attack.

These beliefs led to a basic fear of being in the facility. Dennis described that when he was specifically at work he had an increase in tension and fear because of the worry that another attack would happen:

> When I hear a commotion, I get nervous. Before that incident and I had been working this hospital for a year, before that incident that was that was I mean I would be curious but I would not be like oh my goodness fight or flight kind of thing and I feel that and I feel that every time I hear voices raised and every time I hear something like let's say a chart is slammed to the floor or dropped you know that noise that set a very loud noise it gets me in that scared instantly. I noticed that I tend to have my head on a swivel if I walk onto a different unit and there are a lot of patients gathered and maybe it's just smart to scan the room anyway but I notice I am doing that more than ever. So I am on a kind of heightened alert. May be more aware of the potential threats so yeah.

These fears became so strong that any loud noises would set him off. He stated that this was unique to the facility and that when he was anywhere else, he did not have these worries. Due to the consistent worry and fear these feelings led to burnout. In order to better deal with the stress, Dennis changed units within the facility. However, he expressed that just being at the facility continued to increase his stress made it difficult for him to work effectively at times.

Despite these negative beliefs, Dennis still managed to find some positivity from the attack. He expressed that he was more diligent in his work and found a greater sense of purpose:

> just how important it is for me to be mindful and present in the moment. Not just to be there for the patient or the clients but also to attend to my own safety for example. And also as you get instead of the coming callous from that experience. I see that they can give an opportunity for more self-evaluation and reflection and all that.

Dennis further discussed how he was working to be an agent of change to make sure that proper rules were enforceable and hoped to alter the viewpoint that these attacks were acceptable. From a personal standpoint, Dennis talked about how he learned to be more mindful with his work. He

believed that he was better able to take the time to express more empathy and be more present focused on himself, his patients, and his safety the more he practiced.

Rose

Rose was a 57-year-old biracial female who has been working as a counselor for 20 years and in inpatient for seven years. She experienced a physical attack at the hands of her patient when she hit was with a shoe. Rose gave the patient negative news and was restricting her to the unit due to her behavior. The patient got upset at Rose, took off her shoe, and hit Rose with it. Rose reaction to the attack was more minimal and she did not perceive the issue as some significant to her. She described it as a "hiccup." Rose was adamant to discuss how the incident did not have a strong effect on her and identified that these types of incidents were more likely to occur when working with acute adolescents "I know that a lot of times when people say things when they act out they are doing it because they are angry or because they are hurt about something, so, hmmmm… for the most part the I don't take things seriously you know from this population."

As a result, Rose put the blame of the incident solely on the patient. Unlike the other participants, Rose believed that the patient was at fault for the incident because "this patient literally took an object and threw it at me." She did not assign any blame to anyone else nor to herself after the incident. She did state, however, that after the incident she did become more alert because of the uncertainty that something may happen again, however it only lasted about 24 hours because "then the threat goes away."

Rose primarily attributed this to the staff that she was working with and feeling comfortable being where she was. Rose expressed how her coworkers were protective of her and ensured that she was okay. Rose expressed that she did not even alert her supervisors about the

incident because she did not feel that it warranted their interference. Even though Rose expressed that she did not believe that the incident was something to worry about, she did discuss the continued concern that she has about the lack of enough present staff throughout the day:

> I mean you know we are always short staffed, there's not enough staff you know we're always out of ratio so if there was any real immediate danger you know what would that look like, I don't know. Like when the call the code purples you know they have staff from other units, coming to aid and assist but when you are taken away from other units then that leaves that unit vulnerable, absolutely. So I guess I would have to say no in that sense, you know because of the staffing problem.

Rose reported that one of the reasons why she could maintain herself was because there were other staff around to help and support her. She expressed that when there was not as much staff present, then she would begin to worry about what may happen on the unit. Those feelings further tied into the idea of attacks being part of the job "I know that we are talking about children okay, so I know they are going to act in a particular manner when they don't get what they want or they do not like what they're hearing you know so yes that is expected." Rose also rejected the idea that an attack was part of the job, "Do I have in my mind that when I come into work every day that I'm going to be assaulted in some way? Absolutely not. I would hate for someone to tell me that it's part of the job because it's not part of the job, no one deserves to be assaulted period." While Rose was more forgiving with the population that she was working with, she had a clear distinction between having the patients express themselves freely and openly versus becoming violent towards her or staff. She expressed how she believed that the threat of safety and attacks was an ongoing problem within psychiatric hospitals and that she knew other people who were victims of an attack.

From the situation and the attack, Rose still found positive aspects about herself that she was able to learn from. One of the key aspects was her resilience when faced with an attack. Rose expressed how she had no concerns about the attack after it happened and that she felt she

handled the situation well. Rose prided herself on how she handled the difficult situation in a calm and effective manner. She further believed that her resilience helped to ensure that she did not take the incident personally, “that is something I have been all my life and I don’t know where a developer from but I have learned at a very very young age not to let people get to me or bother me you know.”

She also attributed this to being previously prepared for an attack. Rose knew going into the position about these kinds of attacks and the impact they could have on her “Some people are really good at dealing with people you know certain populations and in some way or somehow I feel like I’ve become one of those people. I am good with people I know that.” She believed that being prepared helped deal with the situation and not let it significantly affect her. Furthermore, she attributed mindfulness as a positive aspect she learned about herself. Rose emphasized the need to be more mindful of herself and the situation around her. Her increased mindfulness helped ensure that what she was doing was effective.

Chapter Summary

For this chapter, the proposed methodology for the research study was discussed. This chapter focused on the purpose of the study, the rationale for the study, the participants, the method, and the proposed analysis for this study. Interview questions were put into a table format in order to show the purpose of each question in addition to which research question they help to answer. The final section of this chapter demonstrated how this research would maintain trustworthiness throughout the study.

Chapter 4 Findings

The purpose of this study was to gain a better understanding of the lived experiences of mental health counselors who have been physically attacked by a client in an inpatient setting.

Merged Themes

Based on the results of the interviews, I noted five merged themes and eight subthemes (see Table 3). These themes were developed using the previously discussed IPA process of merging individual themes. I broke three of the themes down into subthemes to create a better sense of clarity; one theme had three subthemes, another theme had one subtheme, and the final theme had four subthemes. These final themes formed through the merging of those individually present for each participant. Combining them through processes such as contextualization and numeration helped bring to the forefront what the participants focused in on with the attack and how it affected their own interpretation and sense of self after the attack happened.

Table 3

Merged Main Themes and Sub-themes of Participants

Main Theme	Sub-theme
Negative Patient Factors	
Strong Facility Reaction	Supportive coworkers
	Negative hospital environment
	Part of the job
Positivity from Experience	Mindfulness
Psychologically Damaging	
Assigning Blame	Blame the facility
	Blamed for the attack
	Blame the patient
	Blame self

Each combined theme and sub theme helps to identify what mental health counselors experience when these attacks happen.

Negative Patient Factors

There were consistencies amongst the participants in terms of the types of patients that attacked them. The participants reported that before the incident happened, the patients received negative news. For the participants, it did not matter who delivered the negative news to the patients but the proximity of the counselor when the patient heard the information. All but one of the attacked participants were working with patients who had cognitive delays and had a history of aggressive behaviors. While half of the patients used weapons to attack the participants, the overall physiological damage was more minor, and no one experienced any lasting physiological damage. The most severe damage found included scratch marks and some bruising after a kick in the groin but there was no permanent damage from these injuries. Only one participant ended up going to a Med Check for examination, but he rationalized that it was primarily to make sure that there was a paper trail present of the incident.

While no one anticipated that the attack, Dennis described how the patient's aggressive behavior was unexpected; he was caught off guard:

> She got frustrated she came up and kicked me very hard in the private area. This is the first time she'd ever been aggressive towards me and I didn't see it coming. Honestly it really surprised me, I thought she was to come up and yell at me and is perfectly prepared to de-escalate that situation and explain again that you know we have these policies in place instead I guess it considerable frustration certainly directed towards me as she saw me at as a position to override that but I was unwilling and that was the last straw for her so she kicked me and it hurt.

From this incident the counselor never expected the attack to happen and was anticipating a different result from the patient. While all experienced verbal threats from patients before the act of a physical attack was completely unexpected. Rose described the incident further

discussed how the incident caught her off guard and that the negative interaction spiraled into something she was not prepared for:

> Because of what's being said, and you don't know if they're going to fall through or not and it's never happened you know. The incident with the shoe was unexpected, you know, but it happened. So, I don't know, I guess that's the difference, with the threats your on alert and hear you're not expecting anything in it just came out of the blue.

These negative interactions left the participants caught off guard and unprepared for the attack. While there was a better expectation of receiving verbal threats, the incidences escalated to the point where physical violence happened, although the damage was minor there was a psychological impact associated with it.

Psychologically Damaging

Despite the lack of physiological damage from the attacks, the participants experienced a wide range of psychological effects that lasted an extended amount of time; for some, the incidence continues to negatively impact their development. The most commonly found psychological effects were fear, avoidance, and caution. As a result of these feelings, burnout became more prevalent. These attacks led to a questioning of how the participants viewed not only their patients but also themselves and their environment.

Fear, and the belief that it would happen again, was the most commonly discussed feeling that was present from these participants. These feelings of fear led to the desire to avoid certain situations and Kelsey discussed how it initially affected her ability to counsel effectively, "the fear because initially I did not think it would ever happen, you feel like every relationship is safe and when that happens it shocks you and it scares you, it's not something that you would expect happen so when it does you're not really sure how to react to it" She was further worried that saying something to a patient would upset them and she did not want to get another patient upset and potentially attack her. As a result, she noted that it impacted her ability to provide effective

counsel for her clients. Dennis experienced these feelings as well: “I am feeling too much anxiety, too much fear, sometimes I don’t feel as effective as I need to be because one night go into a group there’s always a little bit of fear and there wasn’t too much fear before”. He described the feeling of fear as being something more persistent for him which led to continued problems for himself.

These feelings of avoidance further led to more cautiousness when entering the unit or even conducting group. Dennis stated how he would even avoid conducting group sessions if there was not enough staff present with him at all times “Are there enough staff in the room and if there are not enough staff in the room under the group these days I cancel it. I won’t do it. I will tell my supervisor to find enough people to do it”. Rebecca talked about how even going on the unit where she was attacked makes her more cautious “ I am just a lot more aware of my surroundings so like I know when I walk on unit six, I’m not going to have many issues versus five that’s a whole different story you know that’s that’s where I’m a lot more aware, I’m a lot more cautious about going unit 5 especially if I feel like something is going to happen.” Even Rose discussed how she was more alert and cautious “if I’m going to be on alert, then it is probably no longer than 24 hours. It just depends on what the patient is doing, what they are saying, they eventually calmed down.”

All these feelings led to a general sense of burnout. While none of the participants discussed how they wanted to leave the field, none of the participants were still working in the same position that they were when attacked. While Kelsey and Rebecca reported that they were happy to leave because of their experiences, Dennis addressed directly the idea of burnout: “maybe I have hit that level of burnout at least in this kind of environment because I feel like that way so often because this place is loud and there are unexpected things that come up and worse

there is a point time where I handle that but I'm not handling very well anymore so no I am feeling too much anxiety, too much fear". Three of the participants changed to working with adults primarily and one ended up working in utilization review. While none of the participants identified that the attack itself led to the change in position, it did impact their decision regarding staying on what they were doing. Kelsey discussed how it was not until she was in a new position that she felt more confident in what she was doing.

All the participants had a wide range of effects of psychological impact with Dennis experiencing the most intense symptoms. He described them as:

> not necessarily outside of this building but certainly in this building the minute I hear raised voices sometimes this is the staff having a good time I get nervous. When I hear a commotion, I get nervous. Before that incident and I had been working this hospital for a year, before that incident that was that was I mean I would be curious but I would not be like oh my goodness fight or flight kind of thing and I feel that and I feel that every time I hear voices raised and every time I hear something like let's say a chart is slammed to the floor or dropped you know that noise that set a very loud noise it gets me in that scared instantly. I noticed that I tend to have my head on a swivel if I walk onto a different unit and there are a lot of patients gathered and maybe it's just smart to scan the room anyway but I notice I am doing that more than ever. So I am on a kind of heightened alert. May be more aware of the potential threats so yeah.

Dennis described how feeling like this has been "exhausting" and realizing that this position has not been for him.

Rose described her impact as minimal and that while she became more alert for a short amount of time she did not pay much attention to it:

> nothing, I don't even bring it up. I don't bring up the incident. Shortly after there was a threat or the shoes being thrown, that patient is always coming back moments later, maybe an hour later, saying I'm sorry I didn't mean to and I'm just like I know you didn't mean to and we go from there.

While each participant was attacked, it becomes evident that how they interpreted the event led to a change in the imposed psychological damage. In addition to the fact of their interpretations, the attack also influenced their view of their work environment.

Strong Facility Reaction

The facility played an influential role in how the effect of the attack and how the participants interpreted their experience. The participants made distinctions between upper management and coworkers when discussing their work environment. In addition, they further addressed the facility's perception of the attacks. This led to three distinct subthemes associated with this theme. The participants had two different perceptions towards their coworkers and upper management. This then leads into the third subtheme associated with upper management.

Supportive coworkers. All the participants found that their coworkers were highly supportive of them and were wanting and willing to talk with them about the incident. Collectively, the most supportive group of individuals who were supportive were the front-line staff working with the patients. The participants reported that many of them disclosed previous attacks and that they were willing to make sure that they were okay and talk with them about that incident. Those that the participants felt the closest were further willing to make sure that they were okay and not needing anything else. For example, Dennis discussed the support of one coworker in particular "There is one colleague who I was closely working with she she dropped everything she did and said work in the process this together"

One important note to make however, was that the help and support was primarily found when the incident immediately happened and for just a short amount of time afterwards. As the incident became less pressing, coworkers tended not to follow up with the counselors about how they were doing, and the participants believed that it was their expectation to further follow-up as needed. Kelsey discussed this issue: "I know when they saw that it happened some of them came up to me and talked with me and some of them didn't and I wonder if that was just they just did not know how to react to me and my reaction to the event or maybe they just didn't think it was a

big deal, I have no idea.". However, only Kelsey continued to work with her supervisor about what she was experiencing. Unfortunately, the experience with upper management was completely different.

Negative hospital environment. The participants' experience with upper management was two-fold. They found that while upper management was supportive like their coworkers initially, the environment slowly began to change. The supervisors and administration tended to blame the participants for the attack and that it was their fault for the attack happening. Only Rose did not have this experience because she did not inform her supervisors of the incident and did not want to get them involved. Dennis described how management blamed him for the incident:

> But when the incident began to be digested by the risk manager and all that they were they were looking for that it was kind of on you and if there weren't enough technicians in the room then why were you going to have group. Because that's when we have group and that kind of thing and I was made to blame for something that was our policy, why on earth would that be my responsibility. I'm having a hard time trying to provide therapy for 14 patients and surely it's not my responsibility for scheduling because of the hospitals responsibility scheduling.

The participants further noted that these incidents did not lead to any changes, and upper management quickly looked past them. The experiences led to further negative feelings and found to be associated with burnout and negative psychological effects.

Kelsey highlighted part of the issue further pressed on by the hospital environment. She discussed the idea that the hospital puts a lot of pressure on the counselor as well as the patient. "I definitely felt some pressure to kind of push things along, especially if they were not ready yet and most of the times they were not really ready for a change and they just adjusted to inpatient so sometimes I was a lot for them and I think that that would definitely made for a difficult therapeutic relationship with them".

Rebecca and Dennis further emphasized that their environment was only focused in on getting more patients despite what they were going through and there was little to no vetting process. Rebecca stated that "we should have never admitted this patient in the first place because they are so medically needy and mentally needy and I was like yeah but I'm not the doctor I didn't admit the patient. So honestly it was just kind of par for the course for that time." Dennis expanded on how this also created a problem with the environment "We still face that on a nearly daily basis where we don't have adequate staffing but that doesn't mean we don't continue to pick up the phone to get people in empty beds so yeah" The participants experienced the attacks as being "part of the job" and attributed this mentality to the lack of support from management.

Part of the job. All the participants discussed the concept that these incidences were "part of the job." Participants held different opinions regarding whether these types of attacks were part of the job or not. Rebecca was told to believe that violence was part of the job "I told my superiors and at the time there just wasn't anything that was done about it it was like well that's that's part of dealing with psychotic patients. So I said okay so that was it." This experience was very different from Dennis who continues to refuse to accept that notion:

> You just have to assume they are going to get hurt, you got to assume that people really yell and scream and cuss which of course you have to assume that I can get hurt at some point in time, and I don't accept that. I don't accept that will and so I'm more soured from that experience and because it hasn't this happened to me but it's happened to other technicians, the counselors, and I continue to hear that well is to be expected and that has soured my view on this, on this facility.

While this notion had separate beliefs, all of the participants discussed whether or not it was part of the job. While every participant discussed the notion of attacks being part of the job, deciding whether it was or not, was quite polarizing. Dennis and Rose were adamantly against the idea

that this should be part of the job. Kelsey identified the notion but was more undecided. Only Rebecca accepted the idea that physical attacks were part of the job.

Assigning Blame

The participants all assigned a certain blame after the incident had happened. In order to help process the experience of the incident, the participants projected blame onto who they felt was responsible for the attack to happen. While some participants assigned blame on multiple fronts, there was always at least one person to blame. The subthemes associated with this theme explores who the participants blamed for the incident and their reasoning behind it.

Blames the facility. The facility became the primary source of blame by all of the participants. The primary reason as to why they blamed the facility was due to lack of staffing and allowing for the attack to happen. They believed that if there was enough staffing then the incident would never have happened. Dennis and Rebecca further discussed the lack of a vetting process that needs to be in place to ensure that the facility admits the proper patients. In addition, the participants also blamed the hospitals due to their stronger desire to fill beds and not worry about the staff ratio. Dennis highlighted this issue "We still face that on a nearly daily basis where we don't have adequate staffing but that doesn't mean we don't continue to pick up the phone to get people in empty beds so yeah. And I don't feel like I'm jaded, I feel like I'm fairly sobering understanding of just how a facility like this works."

One important factor to note was that none of the participants shared that they went through any form of debriefing. Kelsey mentioned a debriefing experience after her attack: "I did feel that ha maybe they could have debriefed the patient with me or debriefed in a different way because it was… I mean it was a lot for the patient too and a lot for me…I mean the conversations were pretty quick when it came to me meeting with the coworkers or to meet with

the supervisors saying, “hey what happened” or asking how I could have made the approach it differently”. All of the others stated that they talked to a supervisor or coworker but that they did not participate in any formal debriefing process.

Blamed for the attack. In addition to the participants blaming the facility, the facility further blamed the participants for the attack. Apart from Rose, who did not discuss the issue with her superiors, the other participants noted that they were blamed for the attack. Rebecca talked about how she was blamed for the attack: “it was kind of just like you shouldn’t have gone on unit four, well I had to do the assessment on the patient so I had to or we should have never admitted this patient in the first place because they are so medically needy and mentally needy and I was like yeah but I’m not the doctor I didn’t admit the patient.” Dennis also received blame because he should have known the schedules of the other staff before trying to have group.

Blame the patient. Rose was the only counselor to assign blame to the patient. Because of this polarizing view she had no other blame on any other factors apart from the patient. All of the participants were directly asked about who they felt was at fault for the attack. Only Rose was blunt with her discussion of who to blame by simply stating “the patient” and “because this patient literally took an object and threw it at me.” When asked directly who they blamed, all other participants were careful not to assign blame to the patient except for Rose, who put the blame solely on the patient. In addition to putting the blame solely on the patient, she did not express any self-blame.

The other participants did not discuss their own thoughts on the patient. Instead, they were quick to put the blame somewhere else. Dennis and Rebecca immediately focused on the facility. Kelsey was the only participant to mention anything about blaming the patient; however,

she did express it in a different manner: "…because I can see where the kid was coming from and the second time when they just wanted to ummm be with their parents".

Blames self. Self-blame was another common trait that found amongst the participants. Only Rose expressed no self-blame for the incident. The rest of the participants gave some of the blame either directly or indirectly to themselves because they believe that they should have read the situation better or would have taken a different approach than what they did. Dennis addressed this issue directly:

> I understand the gravity of where we work and how we're doing with populations that have people under severe stress and duress. And so maybe I did all I could that that maybe there wasn't anything profound therapeutic relationship available, maybe was never gonna happen. That's the part that I kinda blame myself that maybe if this young lady felt safer around me and around others and I'm talking about not just me but the hospital staff, maybe she would not of been so inclined to to be aggressive and I think a lot of that would be a protective sort of thing that she did. So yeah in that instance yeah I blame myself.

The idea that they could have done something differently however does lead into the last theme present, that while there was still significant self-blame, all the participants were able to take away something positive from the attack.

Finding Positivity

All of the participants expressed that while the attack was detrimental to them, they were able to draw a positive meaning from it and learn more about themselves in the process. All of them discussed how they have either changed their perspective on how they counsel or have reinforced the more positive aspects of what they are doing. Kelsey discussed how now she takes extra time to gain rapport with patients, and Dennis explained how it helped motivate him how to express himself better when feeling upset about something and is learning how to speak up. Rebecca also discussed how she has learned how to better advocate for herself and her patients because of the attack and approaches these situations in a more meaningful way. Even Rose

found that physical attacks do not let her question her own ability to counsel and that she is able to work well under stressful situations.

In addition, from these self-learned abilities, all the participants found that as they were able to find a sense of meaning and purpose from the attack, the negative impact of the attack seemed to diminish as well. While all the participants still vividly remember the attack, they have been able to draw a positive outlook from and feel that it has not decreased their own ability to counsel and do not feel that they are less of a counselor as result.

Mindfulness. One of the ways that counselors found positivity was through a sense of mindfulness. All of the participants specifically discussed about mindfulness and attributed that they were more aware now as a result of the attack and that the attack helped them develop a higher level of awareness. As the participants' mindfulness increased, they found that they were able to truly learn about themselves and begin to let go some of their negative experiences and turn them into something positive. Kelsey discussed how mindfulness further shaped her perspective on herself and how she works moving forward with her patients:

> I really ummm believe that there is always opportunity for growth and that after that happened you know you realize that this inpatient setting is something that really impacted me and the pressure to you know make sure that they had a place and they had somewhere to go, I felt like just giving me mindfulness and realizing how the environment affected my relationship with the kids ummm mindfulness how I need to perceive the future and a lot of things affected me and with mindfulness being one, cautiousness being another, and I had to come back later when they were ready and coming back when people are not ready in order not to force them to.

Chapter Summary

Chapter four provided information about how mental health counselors in inpatient facilities experience a physical attack at the hands of a patient. All these themes played an integral role in how the participants were able to achieve a sense of self, interpret the experience, and reconnect to the work environment. The main themes found were: negative patient

interaction, psychologically damaging, strong facility reaction, assigning blame, and finding positivity. These themes help to clarify the overarching experience that the participants faced when working in inpatient facilities. They further exemplified the difficult struggles that not only occurred with the patient but also the work environment.

All of the participants were physically attacked but only received minor physical injury that did not leave any long-term effects. In addition, these attacks enacted a psychological response that lasted for the counselors. The main determinant of the impact was the role that the environment played on them. Those that had stronger psychological responses tended to blame the environment for not keeping them safe and improperly handling the situation. This is in contrast to blaming the patient and holding the patient accountable. When the patient was blamed, it elicited a more resilient perspective. In addition, patient accountability created less self-blame about the incident. Chapter four further explored that despite the negative act, they were still able to identify positive aspects about themselves.

Chapter 5 Discussion

In this chapter, I will summarize the results and discuss the findings from chapter four. I will apply the research questions and connect them to the theme of the study. The implications, recommendations for future research, and limitations will be discussed.

The purpose of this study was to gain a better understanding of the lived experiences of mental health counselors who were physically attacked by a client in an inpatient setting. Using an interpretative phenomenological approach, inpatient mental health counselors helped explore three research questions:

1. How do mental health counselors attacked from a patient interpret their experience?
2. How do mental health counselors perceive their work environment after an attack from a patient?
3. How does an attack from a patient impact a mental health counselor's sense of self?

Themes and Research Questions

The themes that emerged from the participants address the essence of the research questions posed at the beginning of the research. Table 3 provides a list of the themes and subthemes developed as a result of the interviews. The research results highlight the sampling procedures and their relevance to capturing the participants' experiences. The purpose of IPA studies are to examine in great detail the experiences of the participants. It is important to note that these results reflect their own experiences as well as my own interpretations of how they experienced these traumatic events.

How do Mental Health Counselors Attacked from a Patient Interpret their Experience

The overall experience for mental health counselors in this study was that they encountered an unexpected adverse attack perpetuated by negative patient factors that put them

at risk for physical harm. The participants talked about their interaction with the patients and the characteristics they believe led to the attack. They further discussed what they thought of the experience as whole and what they thought about the idea of being attacked.

A common element among the patients who attacked their counselors was a history of violence and aggressive behavior. Pich et al. (2010) noted that a history of violence is one of the leading predictors of aggressive behavior in patients. The findings here reflect previous research on patient behavior and their interactions with counselors. One of the other findings associated with their experience was that an adolescent attacked all of the counselors, while one counselor was attacked by an adult she was cognitively the age of a child. Though an adult attacked Rebecca, she categorized the patient as more of a child because she had the intellect of a four-year-old.

The attacks themselves proved to be minor in regard to physiological harm, with none of the counselors requiring major medical interventions. The minor physiological damage to the counselors was congruent with other studies involving social workers who experienced physical attacks (Arthur et al., 2003; Newhill, 2003). Given the mental health work both these professionals human service providers take on in inpatient settings, the similarity in experiences makes sense.

It is important to note that mental health counselors have a different role than that of nurses and typically tend not to be as physically active with patients. However, Rebecca demonstrated that physical harm can be more prevalent when forced into that role such as having to restrain a patient. Even Kelsey experienced more physical attacks when she restrained a patient. The lack of role definition and clarity in these settings could serve as a mitigating factor

for mental health counselors and could be the impetus for increased risk when working with these patients.

In addition to the actual attack, all of the participants noted that the attack itself was unexpected. No one truly anticipated the attack and never really thought it would happen to them. In addition to it being unexpected, most participants felt that they were unprepared for these things to happen. Rose felt that she was prepared for an attack due to her previous professional experiences. These feelings left them being vulnerable and not ready to properly address the incident.

How do Mental Health Counselors Perceive their Work Environment after an Attack from a Patient

The role of the environment was paramount to how the counselors viewed the incident. Environmental supports influenced the participants' reaction to the physical attack. Participants who had a negative experience with their environment exhibited more negative behaviors towards themselves. Furthermore, the psychological impact of the attacks was mediated by the level of support they received from the administration. The theme of having a supportive environment was common among the participants. Though there was a mixture of positive and negative reactions, the comprehensive aspects of the facility environment influenced how the participants viewed themselves and also affected whether or not working in this setting was the right for them.

One of the largest factors that resonated with the counselors was the notion that attacks were "part of the job." The participants believed that personal attacks were considered to be an expectation; there were differing views about this notion amongst the participants. Some supported the notion because they worked with a higher risk population with significant

problems, while others stated that violence is never acceptable in these situations. Research supports the idea that mental health professionals are divided on whether or not these experiences are part of the job (Arnetz et al., 2015; Arthur et al., 2003; Baby et al., 2014; Beech & Leather, 2006; Carrilio, Packard, & Clapp, 2004; Criss, 2010; Gillespie et al., 2010; Jacobowitz, 2013; Jayaratne et al., 2004; Jussab & Murphy, 2015; LeBlanc & Kelloway, 2002; G. MacDonald & Sirotich, 2005; Moylan et al., 2016; Mueller & Tschan, 2011; Neuman & Baron, 1998; Phillips, 2016; Pich et al., 2010; Respass & Payne, 2008; Robson et al., 2014; Sarkisian & Portwood, 2004; Shields & Kiser, 2003; Shin, 2011; Versola-russo, 2006). The participants in this study were more mixed in regards to these feelings. As such, the findings further demonstrate the lack of clarity in the field regarding this issue. Moylan et. al. (2016) note that this dichotomy continues to exist in the human services field and is an accepted component of the culture of inpatient facilities.

However, in spite of what the participants thought, when the facility identified that physical attacks were "part of the job" it increased the participants' likelihood of viewing the environment in a negative fashion. When participants accepted the idea, participants noted that the facility maintained the current operating procedures and did not offer long-term support to the counselors. For example, one of the participants noted that there was a lack of frontline staff when the incident happened; this made the participant feel more vulnerable. The increased feelings of vulnerability and the fear associated with it made combined to make the work environment almost unbearable.

Along with the lack of staff, the expectations of the hospital also played an effect on the counselor's experience. Because inpatient facilities have a fast turnaround with new patients coming in and leaving after a few days, counselors had to address specific issues even when they

or their patients were not ready to address them. These constant expectations played a direct role with the participants after the attack. While there was an initial change in the perception of the environment with the participants, the original idea to continue addressing these specific issues resumed shortly after the incidents. Lantta et. al. (2016) noted that counselors who work in inpatient settings are expected to continue to fulfill their professional duties despite the trauma related to experiencing an attack by a patient. Even though the participants feared another attack from a patient, they still expressed the need to continue exploring difficult topics that could have brought the patient to the hospital in the first place. Because of the expectations of the hospital needing counselors to maintain their work, the concept of these attacks being "part of the job" tended to be more prevalent and hospital management would not focus in on it, despite it creating a negative effect. Sarkisian and Portwood (2004) noted that this is due to the belief that management cannot do anything about the violence

Participants noted a positive atmosphere in the environment after the physical attack, which is different from previously discussed environmental concerns related to productivity. Participants noted that coworkers tended to be the most supportive of them during the attack and right after the attack happened. Baby et. al. (2014) note that peer support is the most common form of support and is very helpful after an attack. Staff demonstrated their support and communicated empathy towards the participants to help them better deal with the shock and surprise of the attack. The coworkers helped support the participants and emphasized the unity of those who worked in that environment. Those who tended to be the most supportive were those who had gone through it before. They were aware of the implications of such an event.

Additionally, supervisors and other upper management personnel were more helpful when the incident first occurred. The initial support is a marked improvement; Baby et al. (2014)

acknowledge that management around these issues has improved due to the increased awareness of administrators. In this study, management encouraged the participants to get help and to seek medical attention as needed. They offered support and some even asked what they could do to help the participant get through the initial experience of the attack. The participants perceived that this led them to believing that the environment was helpful for them and would assist them in getting through the struggles of an attack.

Though the participants noted that the initial response was very positive, the responses from others after the shock of the encounter wore off stayed with the participants and left a stronger impact. The participants shared that as time went on their behaviors were scrutinized upper management tended to blame the participant for the attack. Sarkisian et al. (2004) emphasized that when this occurs, it creates more negative results and does not address the complexity of the problem. Participants noted that upper management's need to blame them for the attack left them feeling as if they had done something wrong, even when they expressed that what happened was out of their control. Participants noted that supervisors and some co-workers stated that they expected more from them; they were surprised by this notion. As a result, participants noted an increase in anger and frustration. They expressed their frustration with the inability to work in a safe environment blamed the lack of appropriate staffing as a major contributor to the physical attack. One participant noted that the facility was more focused filling beds than ensuring that the person was appropriate for the hospital. As a result of the back-and-forth commentary regarding blame, participants noted that they did not feel safe in environment and that it no longer served as a good fit for their professional development. Participants noted an increase in feelings of burnout and a decrease in feelings of security and comfort.

Participants noted an increase in feelings of burnout and a decrease in feelings of security and comfort. The insecurity and discomfort generated by these feelings often lead to high turnover rates in inpatient facilities (Hyde, 2013). Mental health workers lose their desire to work in the facility and do not feel supported by their supervisors. Also, their ability to do efficient and productive work is severely hampered. The conditions counselors are exposed to and their lack of support are major contributing factors to turnover and burnout in inpatient facilities (Hyde, 2013).

How does an Attack from a Patient Impact a Mental Health Counselor's Sense of Self

Ultimately, because of the strong influence that the environment had on these participants, they did begin to doubt themselves and some blamed themselves for the attack. They began questioning what they were doing and their own competency. One participant even questioned whether she should still be a counselor. While the blame either came directly or indirectly, the environment perpetuated the idea that the counselors did something wrong. One interesting point to notice was that all of the participants at the time of the interview either moved to a different unit or a different position overall with the majority of them noting that the incident played a role in leading to their change because they felt they could not deal with the continued pressure anymore. Lanctôt and Guay (2014) emphasized that the exhaustion of dealing with these attacks often had a role in counselors experiencing burnout.

Participants stated that they learned positive and negative things about themselves as a result of these attacks. They reflected on how these attacks influenced their professional development and growth. The participants demonstrated that the increase in time had a positive effect on how the incident impacted what they could learn about themselves after the attack has happened.

The negative effects of these attacks were most prominent shortly after the incident happened. Participants noted an initial response of shock and disillusionment; psychological problems became more prevalent after some time had passed. These negative effects include a decreased perception in therapeutic confidence and capabilities combined with a sense of worry about their future in the mental health counseling profession. Participants noted that the attack created a sense of worry; they questioned their abilities to maintain therapeutic relationships with clients. Three of participants stated that there were some longer lasting effects that made it difficult for them to work as effectively, in some ways, as they could before the attack.

The attack was psychologically damaging because of the change in perspective and thoughts of themselves. Even Rose, who displayed the least amount psychological change, noted some adjustment in her own behavior, even though it was for a short amount of time. For the other participants, they identified changes to their thoughts and feelings which affected how they reacted towards different situations. Among these three participants, one of the most frequently recurrent identified feelings were fear. Fear was highly present because the participants noted a continued worry that something would happen to them again. Fear tends to be one of the more commonly expressed emotions after an attack (Arthur et al., 2003; Criss, 2010; Mueller & Tschan, 2011). They described that the fear created a negative environment and they began to question themselves and what it meant to be on the unit. Even though the participants discussed limited interactions with those patients after the attack, the fear of another patient attacking them and having to experience the same if not worse thing again became more present in their thinking. The increase in fear led to an increase in feeling cautious.

The noted feeling of cautiousness was closely related to fear. After these attacks happened all the participants reported a heightened sense of alertness and were cautious of their

surroundings. Arthur et al. (2003) discussed that feelings of cautiousness and being on alert are common reactions after an attack had occurred. Reports of skittishness was closely associated with being cautious because of the noted question that the participants had about whether they felt safe or not. All of the participants expressed that they were their most cautious when they felt that the environment was unsafe. Arthur et al. (2003) further noted that there is an ongoing worry that the attack will happen again. For theses participants, the leading factor of an unsafe environment was identified as a lack of staff support. When there was a lack of staff support, all of the participants expressed the need to be more on guard in order to protect themselves. However, when the support was present, they noted a greater sense of protection.

Due to these responses, there was a distinct change on how the participants discussed their view of themselves in a counseling role. While no one questioned their identity as a counselor, they all questioned themselves on if inpatient was the right setting for them. From the participants, there were two marked differences in response to the attack. Rose reported a reinforcing belief that she was in the right field due to the lack of a significant negative response after the attack. The other three participants expressed a more negative perspective which they discussed brought into question them working in inpatient again. The participants noted that burnout became one of the behaviors that stemmed from these psychologically damaging feelings.

These changes lead to the belief that burnout played a role in their decisions to go to a different area within the counseling field. Lanctôt and Guay (2014) stated that burnout is a prevalent psychological factor counselors experience after an attack. For many mental health professionals, the exhaustion of dealing with the aftermath of these attacks has a strong role in burnout. For example, participants in this study and lack of support. These experiences are

common for counselors and are linked to increased dissatisfaction with the working environment and the profession (Bimenyimana et al., 2009). Much of the burnout for these participants was due to the lack of support they received over time which left them to deal with their emotions on their own. The burnout eventually led to a change in the role that these participants had in their career to where these three participants discussed how they left their previous role that they worked on to work with a different population or changed their jobs completely within the counseling field.

As their careers continued, all of the participants discussed how they reflected on what they experienced and they all identified positivity from the experience. The participants noted that they learned more about themselves throughout this process. Chapman et al. (2010) described how as time continues to go on and self-reflection takes place, there is a greater introspection, which often leads to drawing positivity. One positive aspect that all of the participants highlighted was their increased self-awareness and how they grew to gain a better understanding of themselves when faced with negative situations. With their increased self-awareness, they discussed that they looked at their patients and the facility in a different way. Though Chapman and his colleagues focused on self-exploration, research attributed to environmental changes is lacking. The participants in this study described their desire to increase advocacy to prevent these attacks from happening again. Three of the participants discussed their new renowned sense of purpose to what they felt for themselves and for others. This purpose created a greater desire to want to make a change to prevent these issues from happening again. These participants stated that as a result they became more involved with upper management on expressing more concerns about the issue and the care for their patients.

The increase in care led all of the participants to learn more about themselves and their ability to be more empathic in their work. All of the participants showed more concern for their patients and took extra time to work with them after they were attacked. While two of the participants noted that this was originally motivated due to the fear of something negative happening again, it was reframed to ensure that their patient's needs were met.

In addition, mindfulness became an overarching theme that all of the participants discussed. Interestingly, mindfulness was a unique outcome not mentioned in previous research on psychological feelings after an attack. All of the participants in this study talked about increased mindfulness and noted that they were more willing to reflect on themselves. They stated that mindfulness helped with their processing and assisted them in coming to a greater peace about the entire issue. When mindfulness became a more central focal point with the participants' lives they were finally able to identify more of the positives associated with the attack.

Person-Environment Fit

The person-environment fit theory examines the interaction between an employee and the work-environment. The theory assumed that each component had a direct effect on each other in terms of finding an appropriate match between the two entities (Jansen & Kristof-Brown, 2006). For example, an employer looks for specific qualifications and characteristics in a prospective employee to have so that they can find a strong match for what they need. When the employer finds a candidate that matches these qualifications, it leads to a well-defined and connected relationship (Jansen & Kristof-Brown, 2006). The relationship strengthens and grows as the employee works in the position. When there is an appropriate match there is satisfaction to both the employee and the work environment. Researchers note that there are different stressors which

can affect the fit. These stressors can be acute or progressive over time. An example of a stressor is the way both sides respond to a workplace event. If one side is disappointed or upset with the other side's response, it can lead to an imbalance in the fit. This imbalance can lead to dissatisfaction and anger; sometimes an individual can be fired from their position or demoted as well.

The theory of person environment fit strongly resonates within this study. In this study both the person and the work environment were examined. Both aspects of PE were relevant for this study. The person focused on the participant and their own personal thoughts; the environment focuses on how the individual interprets the milieu in which the experience occurs. The interactions between the two (person and environment) provide the framework for understanding the participants' experiences. The participants noted the environment's influence on their physical and psychological health. The environment contributed to the participants' ability to effectively process the event. Some of the participants blamed the environment for the attacks while other participants believed that they were being blamed by the environment.

Blaming the environment was an important theme in this study. When examined through a person-environment lens, it allowed for a more thorough look into how both the participants and the environment affected each other. If both aspects would have not examined, it would have negated the strong impact that the environment had on each participant. Participants believed that they were not protected by the. Concomitantly, participants noted that individuals within the environment believed that they could have engaged in preventive measures to avoid the incidences from occurring in the first place.

As the blaming increased, it further increased the participants' view of their job and their own overall satisfaction. In Person-Environment Fit theory, when an environment puts additional

pressures on a person, it can lead to the employee not feeling comfortable at the workplace and to a decrease in job satisfaction (Sonnentag, 2015). Participants noted that the decrease in job satisfaction mediated their ability to do effective work; they began to doubt their competence. Participants who experienced higher dissatisfaction had more extreme responses and more negative effects as a result of the attack. As the participant felt more abandoned and less supported by the environment, they experienced an increase in self-doubt, self-blame, fear, and burnout.

In addition to decrease in job satisfaction, participants noted that they felt the least safe when there was not enough staff and that they felt pressured to do something they were not ready to do. As a result, there was increased dissatisfaction in their environment and in their capabilities. The Person-Environment fit that was strong before the attack significantly decreased because the participants did not feel that their needs were being met and did not feel safe in the workplace.

Person-Environment fit became prevalent because when the participants shared they were blamed for the attack by their environment, they then blamed the facility for the attack. When both sides focused on what they each did wrong, the participants reported animosity towards the environment because of not feeling supported. These feelings led to a change in how the blamed participants felt about their own environment and their effectiveness to work at that facility. Person-Environment fit demonstrated that in this scenario, the interaction between both the participants and the facilities created an additional stressor to the participants. The stress negatively affected the participants ability to work effectively and feel supported when going through a difficult experience.

Implications for Practice

The results of this study highlight the issues and future problems that face mental health counselors when working in inpatient settings. The findings stress the ongoing issues surrounding workplace violence in psychiatric hospitals and add to the ongoing problems associated with both the employees and the work environment. The results demonstrate the role that the environment and counselor have when it comes to attacks. To better address the issue, the implications for practice focus in on counselors, facilities, supervision, and education.

Counselors

As mental health counseling positions continue to grow, the risk of them working with more dangerous patients and clients will continue to grow. Counselors will need to be more vigilant and aware that these risks are a possibility and that depending on the circumstances, patients can become violent towards a counselor, especially when there is a history of violence present. As counselors become more aware, it is critical that they continue advocating for themselves and their patients to make sure that they are both safe. Because counselors sometimes deal with very difficult and triggering subjects, ensuring their safety can allow for them to feel more comfortable addressing these issues without being afraid will allow for a more therapeutic and constructive environment.

It is important to note that the participants left their previous position for another one in the counseling field. Because of this, it is possible that they felt jaded by the experience and that they resented others who they blamed for the attack. As such, counselors need to consider ways in which these attacks can influence how they look at their previous environment. In contrast, someone still employed at the agency where the attack occurred may have a different

understanding of the situation and thus may have a different set of emotional, physical, and psychological experiences.

Furthermore, counselors also need to be aware of the symptoms that can happen to them after an attack. As counselors better understand the effects that are likely to happen psychologically, it will allow for them to become more aware of their situation. Through this awareness they can be more attentive to the warning signs of a greater problem at hand. The awareness will further help prevent any problems from escalating to more severe reactions such as burnout or even PTSD. The participants in this study noted that relating to those who were empathetic to the experience helped them more effectively process it and thereby heal from it. Through continued processing with supportive co-workers and supervisors, counselors can understand and find meaning in their experiences and thus enhance their professional growth and development.

Facility

The facility has the fiduciary responsibility to its employees to ensure that they are always safe. Because of the increase in risk of patients that are present in inpatient facilities, it is critical to maintain a safe environment. When the facility maintains a safe environment, employees will feel more comfortable coming to work and will not be worried about what may happen to them. Counselors will know that if they address an issue that could be triggering, they will have support from additional staff to deescalate any situation that may come from the session. Not only do staff members need to be present at all times, but there needs to be appropriate ratios of patients to staff at all times in case there is a crisis in the facility. In addition, adequate staff needs to be a consistent for safety reasons. The concern about enough

staff was common; it is imperative to not only keep the environment safe but also to provide a therapeutic space for optimal work with patients.

Facilities further need to take responsibility for their employees' injuries to minimize the severity and frequency of these attacks. In addition, they need to stop blaming their employees for becoming injured. When facilities blames the employee, it creates a greater sense of expectation that attacks are acceptable and disdain for the facility. Instead, facilities need to work with their employees so that no one resorts to blaming. For examples, upper management can advocate for better working conditions and for more supportive environments; this helps employees stay longer and get more invested in where they work.

Additionally, facilities need to eliminate the concept that it is "part of the job" to experience an attack by a patient and to push for creating environments where no attacks occur. The idea that it is "part of the job" remains a cultural issue within inpatient facilities. Instead of accepting this, facilities need to plan on how to work together so that all employees' voices are heard. Instead of blaming employees for the attack they need to take a focus that helps to prevent these attacks from happening. One of the biggest ways to do this is to help ensure that properly trained staff are always present in a facility.

Furthermore, any mentioning of a debriefing after an attack was informal at best. Facilities need to be more intentional in debriefing procedures to show victims of attacks that they are not alone in the incident and that the agency will continue to work to ensure employee safety.

Supervision

Supervision is an important aspect for those who become victims of a physical attack. Kelsey highlighted the importance of supervision and how it helped enable her to process what

she experienced. Supervision is a critical way in order for counselors to process their experiences and learn to work past them. Not only does an attack psychologically affect a counselor but it also impacts the way they can work with a patient. When counselors are afraid to address certain things with their patients then it can lead to missed opportunities for the patient to grow and be treated fairly.

Supervisors need to be aware of the different impacts that can affect counselors and be cognizant of the work that their supervisees are doing. For example, mandatory supervision can be part of an agency's debriefing procedures. This helps the supervisor assess the impact of the attack and consider whether or not additional services are warranted. The supervision would be focused on assessing the psychological impact of the attack and evaluating the supervisee's level of fear, avoidance, and caution. Thus, it provides a foundation for assessing potential burnout and for further evaluating employees' feelings about the environment. Furthermore, when supervisors are more aware of these situations it can lead to a greater way to advocate for other counselors to ensure that the environment maintains its safety and does not set the precedent that this is something that should be expected to happen.

Education

Only one of the counselors was even aware that an incident like they experienced could have happened to them. None really addressed it when they were training to be a counselor and they never learned about it in school. Educators can use the information provided to help better prepare their students about the severity of patient's conditions and the risk that they have when working with high risk patients. While educators need to be careful about not to stigmatize those that have a mental disorder, they do need to be aware of how to properly deal with these situations and what can be helpful if they do encounter a physical attack. Educators can discuss

these critical issues with their students and highlight important information about secondary stress, compassion fatigue, and burnout. This can increase the student's awareness of potential burnout and thereby enhance their development.

Furthermore, with the increasing number of mental health counselors, a greater focus needs to be on inpatient treatment. Inpatient treatment is very different from outpatient and there are certain expectations that facilities have in place to maintain an appropriate census and make sure that patients do not stay longer than needed. Educators can help inform their students about the expectations needed and practice with them how to handle a person in a crisis when they are upset about being in a facility. The more comfortable students are dealing with these high stress environments, the more likely they will be able to succeed in deescalating and controlling their emotions when challenged. In order to increase exposure to these different settings, shadowing and diversifying internship opportunities can help students understand the way these facilities operate and compare it to what they learn in the classroom.

Recommendations for Future Research

The current findings show that these attacks can impact a mental health counselor in multiple ways, however it is currently unknown how wide spread this issue is amongst the field. Further research can determine how widespread the issue is and where most mental health counselors experience physical aggression from their patients. The use of quantitative studies can help cover the breadth of this issue with mental health counselors. The use of a quantitative studies can further help identify how is the frequency of this concern and assess the emotional components of one's experiences after they have experienced an attack.

In addition to identifying breadth of the issue, additional studies can help identify the differences, if any, that mental health counselors experience when working in non-inpatient

settings. Studying the differences will be important because it will help show the impact that the environment has on the situation. Furthermore, identifying the difference in population will be important. All the participants in this study experienced a physical attack form an adolescent. Understanding the role of the population will further help to gain a better understanding of what role age and mental capacity plays with the research.

Supervision is another area that can benefit from increased research. Through conducting research on supervisors, it will help discover how supervisors deal with these situations and how prepared they feel handling one of their supervisees after an attack. Through research, best practices can be explored to help others understand effective ways to help supervisees understand, process, and move through the negative impacts of these attacks after the initial shock wears off.

In addition to supervisors, researching educators can also help identify how much they are aware of the issue of violence towards mental health counselors and how they integrate that into their curriculum when teaching their students. Gaining a better perspective on this issue will help determine how well prepared newer counselors are for the situations and how they can best respond if an occurrence happens to them.

Finally, facilities themselves need future research, especially upper management to gauge their knowledge of these issues and the effect that it has on their counselors' ability to effectively perform counseling. The findings associated with the facilities will help to explore how seriously facilities take the issue and explore how they help to prevent the issues from continuing to happen to counselors.

Observations can also help give a different experience on what is happening in these settings. By having a researcher present in these settings will give a first-hand experience to what

the daily experience of counselors are as well as how they interact with the environment. Observations will also help to share the different perspectives to help gain clarity on where counselors, supervisors, and even the facilities are coming from when an attack happens.

Limitations of Research

The purpose of this study was to gain a better understanding of the lived experiences of mental health counselors after a physical attack by a client in an inpatient setting. When considering the findings of an Interpretative Phenomenological Analysis it is critical to understand the specific context of the study (Smith et al., 2009). Due to the small sample size of the study and looking at the specific meaning and interpretation of the participants, the findings found in this study cannot be generalized beyond these four counselors and should instead be viewed as preliminary. Because these results are preliminary, it is ill-advised to generalize these effects to all mental health counselors working in inpatient settings. However, I do argue that the experiences found within the study help to gain a better understanding of the issue associated with physical attacks on mental health counselors and shows that these attacks can have an impact on counselors.

One main limitation is in regard to the sample size of the study. IPA research is known for having small sample sizes (Smith et al., 2009). This is intentional to gain a greater depth of the participants to uncover their own interpretation of the incident and how they make meaning of the situation (Smith et al., 2009). Because of the interpretation and lack of sample size, it makes it more difficult identify if these reactions are more unique to the individuals or are part of a consistent trend among mental health counselors. However, it is important to note that these feelings mark some specific similarities to other attacked mental health professionals.

Another limitation of the study was the brevity of the interview process. Though the protocol used in this study is well within acceptable IPA guidelines, the process could have benefitted from either a second interview after all of the first interviews were complete. Also, the researcher could have engaged in a longer interview with the participants. These approaches could have solidified the themes generated by the study and could have clarified any merged themes.

A third limitation is in noting that there was not a triangulator present throughout the process. Though member checks and an auditor were used, they examined the research after it was completed as opposed to an evaluation of the research in the moment. As such, a triangulator could help give additional perspectives to what the codes, themes, and merged themes meant.

Conclusion

The experiences of these four participants were the focal point of this research. Through understanding how they made meaning and interpreted their situation, the participants shared not just what they experienced, but also how it affected them as well. Through the lens of Person-Environment Fit, the participants described that it was not just the attack itself but the environment that influenced how they responded to the situation. Much like other mental health professionals, these participants experienced similar feelings such as fear and cautiousness (Arthur et al., 2003; Mueller & Tschan, 2011). In addition, burnout was also either directly mentioned or indirectly talked about due to the change in jobs. Despite the lack of physiological damage that was present, the psychological impact presented a significant factor with these participants. As mental health counselors continue to work in more high-risk positions such as inpatient facilities, it is critical to note the impact that these attacks can have on others. In addition, if these inpatient facilities continue to act in a manner that does not lend support to their

employees after an attack, it will further perpetuate the problem that already exists in many of these facilities. As some participants mentioned, it is the duty of mental health counselors to maintain a sense of advocacy not only for their patients but also themselves, so they can give effective care in inpatient facilities.

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Appendices

Appendix A

INTERIVEW INVITATION EMAIL – MENTAL HEALTH COUNSELORS
The Experience of Mental Health Counselors after a Physical Attack from a Patient

Subject of Email:
Invitation to Participate in Doctoral Study Regarding Counselor Experience of Violence

Body of Email:
Good morning/afternoon/evening,

My name is Evan Burns. I am a doctoral candidate in Counselor Education at the University of Tennessee, Knoxville. I am currently conducting my dissertation research and I am interested in learning more about the experience of mental health counselors who work in inpatient settings after being physically attacked by a patient.

I would like to schedule an interview with you to inquire about your own personal experiences with this incident. This interview will last approximately 45 minutes. The interview will take place at a mutually established time and place.

This research has been approved by the Institutional Review Board (IRB) at the University of Tennessee, Knoxville.

Your responses to interview questions may help inform other mental health counselors, supervisors, counselor educators, and hospitals about the impact that these attacks have on mental health counselors who work in inpatient settings. If you would like to participate in this research, please provide me with a list of days and times that you are available between [start date] and [end date].

Thank you for your time and consideration.

Sincerely,

Evan M. Burns, Doctoral Candidate
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Appendix B

INFORMED CONSENT STATEMENT
Inpatient Mental Health Counselors Experience of Patient Physical Violence

INTRODUCTION
You are invited to participate in a doctoral dissertation research study about mental health counselors who work in inpatient settings and their experience after being physically attacked by a patient. We are examining how mental health counselors respond to these situations.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY
Your involvement in this study asks you to participate in a one-on-one interview for approximately 45 minutes. I will record this interview to assure accuracy of information. All audio recordings will be destroyed after they have been transcribed. After the interview is complete, it will be transcribed, coded, and themed for analysis. You will be given a copy of your transcription along with the codes and themes associated with the interview, via email. You will be asked to confirm or challenge any of the themes that you see in order to identify a clearer understanding of your experience. These changes will be made in written format and sent back to the principal investigator. If no response is given to the investigator by one week of the sending date, no changes will be made to the themes. Following the return of any corrections, your involvement will be complete.

RISKS
Though there are minimal risks to the participants of the current study, sensitive topics will be explored in this research; please note that you have the right to stop the interview at any time. Confidentiality will be protected to the extent that is allowed by law. We will make every effort to protect the confidentiality of participants data obtained during this study.

BENEFITS
This research may assist in better understanding how mental health counselors who work in inpatient settings respond to and react to patient violence. In addition, this study will support a doctoral candidate in the pursuit of a Ph.D. in Counselor Education.

CONFIDENTIALITY
The information you provide during this interview will be kept confidential. Only the researchers will have access to your information and the data will be stored on a password protected computer in a secure location. Any identifying information will be removed from the transcripts for this interview. No references will be made in any reports that could link you as a participant to the study or the data.

CONTACT INFORMATION
If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the principal investigator at the University of Tennessee, Knoxville (Evan Burns; eburns9@vols.utk.edu); or the Faculty Advisor, Dr. Shawn L. Spurgeon (sspurgeo@utk.edu). If you have any questions about your

rights as a participant, you may contact the University of Tennessee, Knoxville IRB Compliance Officer at utkirb@utk.edu or (865) 974-7697.

PARTICIPATION
Your participation in this study is completely voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed, your data will be destroyed.

CONSENT
I have read the above information. I have received a copy of this form. I agree to participate in this study.

Please indicate if the interview can be audio recorded by placing a ☑ in the appropriate box:

☐ Yes, the interview can be audio recorded

Participant's Name (printed) _____

Participant's Signature _____ Date _____

Investigator's Signature _____ Date _____

Appendix C

INTERVIEW PROTOCOL
Inpatient Mental Health Counselors experience of Patient Violence

Instructions and Introduction

My name is Evan Burns. I am here today to learn more about your experience of a physical attack from a patient as part of a doctoral dissertation study. This interview will last approximately 45 minutes.

I appreciate your honest and candid feedback. Your opinion is important and any feedback provided can help us understand better the experiences of inpatient mental health counselors and how these attacks affect them. Thank you in advance for your feedback.

Even though you have agreed to meet me today, you still have the option of declining to participate. This is purely voluntary. You can opt out at any point during this interview. Any information you choose to provide today will be kept confidential; I will not connect your responses with your identity.

I will be recording the interview today so that I can accurately summarize the information you provide. All audio recordings will be destroyed after the recording has been transcribed and sanitized of any identifying information. I will not identify any individual in the transcripts. Do you have any questions?

Is it okay that I record this interview? Please indicate whether the interview can be recorded on the informed consent by selecting the appropriate box? [If participant does not agree to have the interview recorded, take detailed notes].

----------Begin Recording----------

Before we begin, do you have any questions? Okay, let's get started.

<u>Opening Questions</u>:

- How long have you been a mental health counselor?
- When did, the incident happen?

<u>Mental health counselor experience Questions:</u>

1. What preceded that led you to being attacked by a patient?

2. How did your supervisors and coworkers react to your attack?
    a. How supportive of you were they?
    b. What, if anything, would you have wanted them to do differently?

3. How did you feel after the attack had happened?
    a. Who did you believe was at fault?

4. How have these feelings changed or not changed since the attack?

5. How has your work been influenced by the attack?
    a. What, if anything, do you differently when counseling?

6. Who did you talk to about the incident?
    a. How did they respond?

7. What, if any, were the lasting effects after the incident?

8. How has the incident changed or not changed you?
    a. How do you feel this incident has influenced you as a counselor?

9. What have you learned about yourself from the attack?
    a. Was there anything positive that you have taken away from the incident?

10. What would you want others to know about these attacks?
    a. Do you feel that this is an ongoing problem in inpatient facilities?
    b. What advice do you have for new counselors?

Conclusion:

This is the end of our time together. Thank you for taking time out of your schedule to participate in this interview. If you do not have anything else to share, that concludes this interview and I will end the recording. I appreciate your time and feedback. If you have additional information or documentation that you would like to share after today, feel free to contact me.

----------End Recording----------

Vita

Evan Montgomery Burns was born in Johnstown, PA to David and Denise Burns. He graduated from Clarence High School and attended the Indiana University. He graduated from Indiana University with a B.S. in Psychology. In 2011, Evan decided to continue pursuing his education by receiving his M.S. in Mental Health Counseling at Walden University. Through his passion of working with others he decided to pursue his doctorate at the University of Tennessee. He worked as a graduate assistant for two years at the Tennessee Dad Project. Evan graduated from the University of Tennessee December 2018. He plans to continue to apply his research in the field by working to improve conditions in inpatient facilities.