LEARNING OBJECTIVES

- Understand the different forms of client resistance.
- Describe techniques for dealing with resistance.
- Explain the use of confrontation.
- Identify key variables for violence risk assessment.
- Identify and describe strategies for preventing violence.
- Describe strategies for intervening at each phase of violence.
- Understand the importance of debriefing critical incidents.
- Describe counselling interventions for dealing with angry and potentially violent situations.

RESISTANCE

Resistance, a term first introduced by Freud, refers to a normal defensive reaction that comes from the natural drive to preserve the status quo. Change challenges people to alter existing and familiar patterns of communicating or coping. Significantly, these resistance: A defensive reaction by clients that interferes with or delays the process of counselling.
patterns, however painful, are at least familiar, and so the prospect of change represents some risk as well as potential gain. Thus, resistance protects clients from the stress and threat of change.

Thus, resistance may be the client’s reaction to being pushed (by the counsellor) to do or accept something the client does not want. In fact, the psychological need to stay connected to the familiar may cause clients to resist the very changes they are seeking. For example, a client may verbalize a strong desire to curb drinking, but fail to engage with agreed-upon goals or action plans to work towards that goal. Clients may be ambivalent about change and the risks and fears of change may outweigh any momentum to action.

Active listening, particularly empathy, reduces or prevents resistance. Other counsellor responses may increase it. These include:

■ arguing for change
■ assuming the expert role
■ criticizing, shaming, or blaming
■ labelling
■ being in a hurry
■ claiming pre-eminence (“I know what is best for you”) (Miller & Rollnick, 2002:50).

By paying attention to client resistance, counsellors can examine how their own responses might contaminate the interview, and what they might do differently to prevent, neutralize, or reduce resistance.

SUCCESS TIP

Newton’s third law of motion states that for every action there is an equal and opposite reaction. Resistance is the equal and opposite reaction that happens when clients feel pressured or coerced. Counsellors need to monitor and reduce their responses that are accelerating resistance while increasing responses that reduce it.

Signs of Resistance

Resistance may reveal itself in a variety of ways, ranging from overt hostility to passivity that impedes the work. Here are some client behaviours and signs that may suggest resistance (Gladding & Alderson, 2012; Miller & Rollnick, 2002, 2013; Cormier & Hackney, 2008; Shulman, 2009):

1. Failure to comply with the basic procedures of counselling, including keeping appointments, being on time, and paying fees
2. Hostile or argumentative statements (e.g., “This is a waste of time,” “You can’t make me cooperate,” “That’s none of your business,” and “I don’t want to be here”)
3. Passivity (e.g., silence, withholding information, persistent short responses such as “I don’t know,” extreme self-censorship of ideas and feelings)—such passivity may indicate that the client does not want to be there, or it may mean that the feelings, content, and challenges of the interview are more than the client is willing or able to face
4. Diversion as a way of avoiding difficult, threatening, or incriminating content (e.g., changing the subject, using excessive humour, making small talk, introducing irrelevant material, being overly talkative, intellectualizing, and restricting the conversation to particular topics)
5. Uncooperative behaviour (e.g., failure to follow through with plans or homework, false promises)
6. Subtle undermining (e.g., acting seductively, attempting to redefine the counselling relationship as a friendship, excessive praising, being sarcastic)
7. Creating the illusion of work, described by Shulman (2009) as engaging in conversations that appear important but that in reality are empty and have no real meaning because they do not empower clients to change
8. Nonverbal cues suggesting a passive–aggressive response, such as not making eye contact, folding arms, sitting on the edge of the seat, using an angry tone of voice, clenching fists, raising eyebrows, frowning, and sighing
9. Blaming, making excuses, expressing unwillingness to change

Understanding and Responding to Resistance

Some Resistance Is Normal and Desirable  Counsellors do not have to view all resistance as problematic. Skilled counsellors recognize resistance, but they are not threatened by it. They see resistance as a signal that clients’ defences are engaged, and this insight opens a pathway to greater understanding of their clients. For example, in the beginning phase of counselling, before trust and a working contract are negotiated, many clients tend to hold back. At this stage, their counsellors are strangers, and it would be unwise for clients to open up too quickly without knowing how precious personal information might be treated.

Sheafor and Horejsi (2008) note that it is common for clients to be somewhat defensive, particularly in the beginning phase when a person’s natural resistance to change can be triggered by fear of what lies ahead: “Even a small amount of change can create a discomfort or fear for clients, especially if they hold rigid beliefs, are inflexible in their thought processes and behaviors, or are fearful about risking change in their relationships with others” (p. 205). Some clients resist because they do not understand the expectations or the process of counselling, so they wisely remain cautious and guarded. Until relationship contracting establishes the goals and purpose of the work, clients may hold back from fully participating. Counsellors also need to be explicit regarding their expectations. Resistance and the Stages of Change

The stage of change model (Prochaska & Norcross, 2001) was introduced in Chapter 7 as a model for understanding the developmental nature of change. Different skills and strategies are used to engage clients during different stages. For example, clients who are at the precontemplative stage of change do not accept that they have a problem and are not thinking about making changes, even though their behaviour is problematic for them and others. At this stage, strategies such as confrontation to push a client toward change are likely to be met with resistance, but other strategies (e.g., open questions, empathy) will help to neutralize the resistance. Some clients who are precontemplative hold to their current mode of thinking, feeling, and acting because they lack the energy necessary for change, or because they are pessimistic about the possibility of change. Whatever the reason, these clients resist counselling because it is easier and safer than embracing change. Counsellors might deal with this resistance by communicating optimism and by helping clients set small but achievable goals. By supporting and reinforcing small successes, counsellors contribute to the empowerment of their clients. However, during this process counsellors should express empathy regarding the challenges and fears associated with any change. Clients need to understand that they will not be humiliated or overwhelmed by the demands of counselling. Counselling can be presented as a way for them to find the resources, support, and motivation for change.
At the contemplative stage, clients are ambivalent about the change process and may simultaneously desire and resist efforts and opportunities for change, “even when such action is counterproductive and dysfunctional” (Gladding & Alderson, 2012, p. 141). The messages from clients seem to say, “I want to change, but I don’t want to change.” This ambivalence can freeze clients in a state of indecision; and the resolution of ambivalence is the key to change (Miller & Rollnick, 2013). Even for those clients who are highly motivated to change, the prospect of changing involves risk; risk creates anxiety, and the simplest way to reduce anxiety is avoidance. From this perspective, resistance is viewed as self-protective. To resolve ambivalence in favour of change, the benefits of change must outweigh the risks and anxiety associated with change, or anxiety regarding change must be reduced.

SUCCESS TIP
Openly expressed resistance from a client can be a great opportunity for relationship building and goal setting if it leads to frank discussion of roles, expectations, barriers, and fears.

**Relationship Issues**

Sometimes clients become increasingly resistant as counseling progresses. This may signal that the process is moving too quickly or that there is unresolved conflict in the counsellor–client relationship. Clients may be resistant because of transference reactions or simply because they do not feel a good connection with their counsellors.

Resistance may emerge when counsellors challenge long-established behaviours or attempt to encourage discussion or goal setting in areas that clients would like to avoid. Miller and Rollnick (2002) developed the theory of psychological reactance to describe how painful consequences (e.g., personal suffering from drug addiction, nagging from concerned family members) may actually increase the undesired behaviour. This theory predicts “an increase in the rate and attractiveness of a ‘problem’ behaviour if a person perceives that his or her personal freedom is being infringed or changed” (p. 18). Some clients have had bad experiences with helping professionals or other persons in authority and they fear the same outcome again. For example, if they experienced other counsellors as rude or untrustworthy, they may be guarded with new workers. This defense protects them from further rudeness, inconsistency, or breach of trust. Armed against the counsellor before they even meet, these clients may view caring as manipulative and empathy as intrusive. Asking about prior experiences helps to bring feelings and issues into the open, including any preconceptions or fears about the current relationship. When counsellors do this, they should provide a brief explanation to let their clients know they are not prying for gossip:

**Counsellor:** Have you had any other experiences with counselling in the past?

**Client:** Yes, my husband and I went for marital counselling about two years ago.

**Counsellor:** What did you like and dislike about that experience? I’m asking because I think it will help me to understand a bit about your expectations. I’d like to learn what worked for you and what didn’t.

Resistance may also develop because of conflict in the current relationship. Counseling relationships, like all relationships, are subject to periodic stress and conflict. Counsellors can make mistakes and say the wrong thing, and they can offend their clients. Vulnerable clients may be overly sensitive, or they might misinterpret messages and feel angered. This is an inevitable reality of the chemistry of human encounters. What sets effective counsellors apart is their ability to be sensitive to clues such as verbal and nonverbal shifts in the tone of the interview that signal that there is friction in the relationship.
Effective counsellors are further distinguished by their willingness and capacity to address these issues in a caring and nondefensive manner. By doing so they not only prevent further resistance, but they also build trust and understanding with their clients.

Immediacy was introduced in Chapter 3 of this book as a process for exploring, deepening, and evaluating counselling relationships. When resistance blocks the work of counselling, immediacy provides a way to deal directly with client concerns regarding the counselling process or the relationship itself. As a rule, if resistance is increasing, it is wise to deal directly with it; otherwise, the client may never return. The following questions and statements illustrate the potential variety of responses that can be used to move the interview toward a discussion of resistance:

- How do you feel about being here?
- I’m wondering what’s happening between us. Are you feeling angry toward me?
- Let’s see if we can agree on what we want to accomplish.
- If I’m not mistaken, every time I mention your father you change the subject. Would you rather avoid that topic?
- How committed are you to making changes?
- Do you believe it is possible for you to change?
- What does it mean to you to be seeing a counsellor?
- Are you worried that I will try to force you to do something you don’t want to do?

When nonverbal cues suggest resistance (e.g., lack of eye contact, single word answers, crossed arms, abrupt tone), counsellors might try “breaking the ice” with statements such as, “If I felt forced to come to counselling, I think I’d feel quite resentful.”

Shulman (2009) comments on the fact that communication is frequently indirect in that feelings and concerns are expressed in ways that might not be immediately clear. Such indirect communication challenges counsellors to understand what clients might be trying to say behind the words expressed. For example, a client who asks whether a worker has children may be communicating her fear that a childless worker might not understand her struggles. By picking up on the question behind the question, workers create an opportunity to explore these fears. Similar indirect communication might be embedded in clients’ questions such as these:

- Have you ever been in jail?
- Do you know what it is like to be on welfare?
- Have you used street drugs?

Table 8.1 presents alternative ways of responding to personal questions such as those above.

**Resistance and Fear of Change**

For most people it is difficult to change from established routines and ways of coping. They communicate fears regarding the imagined consequences of change through resistance. Some clients have trouble with intimacy, and counselling may be seen as an unwanted intrusion that threatens their need to maintain personal distance and privacy. A variety of counsellor responses might be considered:

- Candid discussion with clients about their fears and the real risks of change.
- Target small but achievable goals.
- Empathize with the clients’ fears.
- Reassure clients that they will not be pushed beyond their capacity and that they are in control of the pace of change.
- Limited counsellor self-disclosure to normalize fears about change.
Chapter 8

Resistance and Personal Beliefs

Some clients are resistant because they believe that taking help is a sign of weakness. They may believe that counselling will undermine their personal autonomy. For others, cultural or familial values promote privacy about one’s personal struggles and the belief that they should not be shared with strangers. One way for counsellors to address this resistance is to look for appropriate opportunities to reframe counselling as a sign of strength rather than feebleness. Counsellors can also deal with fears about loss of independence by making sure that clients are active and informed partners in the work of counselling.

Involuntary Clients and Resistance

Sometimes resistance stems from clients’ resentment at being forced to come for counselling and an inability to see a need for change. These clients may see themselves as fighting “the system,” and the counsellor who represents it. Involuntary clients typically receive services from large bureaucratic organizations, but the structure and procedures of these agencies can make it difficult for counsellors to support their clients. Systems designed to help clients may overwhelm them with rules and regulations, and counsellors often have to make troubling decisions on how to use their scarce resources and time. It is important that counsellors understand how clients may perceive them.

Johnson and Yanka (2004) remind us that clients may overestimate the extent of a worker’s power. When clients assume counsellors have more power than they actually have, they might withhold information, avoid meetings, or otherwise resist counselling. Therefore, frank discussion of roles, responsibilities, and the limits of power may assist in clients’ fears.

With involuntary clients, it is important to restore their sense of control and right to self-determination. These clients need to be able to answer the question “What can counselling do for me?” They need to see goals and outcomes that they desire as opposed to those imposed on them. Counsellors need to be patient with unwilling clients by remaining nonjudgmental and caring. Moreover, they can decrease resistance by demonstrating their ability to talk calmly with their clients about their reasons for not wanting to be there. Counsellors should be especially diligent about informing

---

**TABLE 8.1** Five Choices for Responding to Personal Questions

<table>
<thead>
<tr>
<th>Client: Do you have children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Answer the question: “I do not have any children.”</td>
</tr>
<tr>
<td>2. Explore the meaning of the question: “I’m curious about your reasons for asking.”</td>
</tr>
<tr>
<td>3. Explore the implication of different answers: “What would it mean to you if you heard that I don’t have any children?” or “... if you heard that I have children.”</td>
</tr>
<tr>
<td>4. Empathy: “Are you perhaps worried that I might not understand what it’s like for you, a single mom with two kids?”</td>
</tr>
<tr>
<td>5. Silence: Provides an opportunity for the client to elaborate and perhaps share concerns and feelings associated with the question.</td>
</tr>
</tbody>
</table>

---

**BRAIN BYTE** Resistance

The brain is wired to keep us safe. Neural pathways over time result in “hard wired” ways of thinking or doing. Emotional reactions to risk taking, changing behaviour, or feeling pressured by others may be experienced as threats to the comfort of the status quo. This creates anxiety about change, even when the changes are seen by clients as good and desirable. The brain reduces this anxiety by avoiding the change or creating pressure to revert to familiar patterns, thus sabotaging the change. Significantly, some of this anxiety may be displaced as resistance or anger toward counsellors, even when clients are willing partners in the objective to change. Counsellors can help by assisting clients to anticipate and plan for the natural anxiety associated with modifying established patterns.
unwilling clients about their rights, including the limits of confidentiality. Clear, succinct statements about these issues will help to reduce their suspicions. Sometimes counsellors can modify expectations through reframing. The following interview excerpt provides a brief illustration:

**Counsellor:** What do you hope to achieve?

**Client:** Nothing.

**Counsellor:** What’s behind that answer?

**Client:** I just think that counselling is a waste of time. What good does it do to talk about problems anyway?

**Counsellor:** You also seem to be saying that if counselling could in some way help you with your problems, you would be more satisfied.

**Client:** I guess so.

In Chapter 7, “rolling with resistance” was introduced as a way to avoid any direct challenges that might precipitate a power struggle. This strategy identifies but accepts the resistance. This approach is illustrated below:

**Client:** I just think that counselling is a waste of time. What good does it do to talk about problems anyway?

**Counsellor:** Given your pessimism, it seems to me that you’re wise to be cautious about what we might accomplish here.

The following story provides another example:

A holy man and an atheist met one day. The atheist challenged the holy man to debate, exclaiming, “I don’t believe in God!” The holy man replied, “Tell me about the God you don’t believe in.” The atheist talked at length about the absurd wars that had been fought in the name of God. He attacked the “hypocrites” who espoused their religious values and beliefs but behaved in quite the opposite fashion. The holy man listened patiently until the atheist had said his piece. Only then did he respond: “You and I have a lot in common. I don’t believe in that God either.”

Figure 8.1 outlines some counsellor responses that both increase resistance and decrease resistance.

![Figure 8.1 Resistance](image-url)
CONVERSATION 8.1  Working with “Involuntary” Clients

COUNSELLOR: You work with street-involved youth. What have you learned about working with involuntary clients?

YOUTH COUNSELLOR: I learned the hard way doesn’t work. There’s no point in lecturing, moralizing, or preaching about the dangers of drugs. What seems to work best is to focus on the relationship.

COUNSELLOR: How do you do that?

YOUTH COUNSELLOR: Sometimes it’s just little things, like bringing a cup of coffee to a sex-trade worker, or checking to see if they are all right or need anything. I try to be ready for the “teachable moment.” That can happen anytime, such as after a “bad date” or when they’re feeling down. Then, empathy and listening skills are best, especially empathy. Spending time with clients without having an “agenda” goes a long way towards establishing trust. When the time is right, you’ll be the “go to” person.

COUNSELLOR: That’s right. As you know, involuntary clients can be rebellious, and being forced into counselling arouses their defences. For example, I recently met with one who was referred by his employer because he could not get along with his co-workers. He claimed that others in his work team simply had difficulty dealing with his assertive manner and his high standards. He came in to see me, but it was evident that his main motivation was to preserve his job. With him I found that it worked best to encourage him to express his anger about being told what to do. This diffused his resistance to the point where he no longer saw me as the enemy.

YOUTH COUNSELLOR: It’s like that with our clients as well. With youth on probation I like to look for ways to give them power and involve them in decision making. Here again, empathic listening can help them arrive at a plan that suits them, one that doesn’t feel imposed.

COUNSELLOR: So involuntary clients are not necessarily pre-contemplative. Many are well aware of their problems and the need to change. They just don’t like being told what to do, and that’s the key to working successfully with them. When I worked in corrections, I found that many of my clients were initially resistant and overtly hostile to authority. Clients with such anti-authoritarian values are not going to respond to directive, rigid attempts to control them. Such strategies will only serve to increase resistance. As always, paying attention to the relationship is crucial. For example, with clients coming out of prison, relationship credibility can be developed by helping them with basic needs, such as housing, clothes, food, and a job.

INTERVIEW 8.1  Dealing with Resistance

The following interview excerpt shows some ways for dealing with client resistance. The client is a young male, age 19, who has been referred to an addiction counsellor as a condition of his probation. This excerpt is from the first interview, and it begins about 15 minutes into the interview. It is clear from the client’s nonverbal behaviour that he doesn’t want to be there (e.g., he has not removed his coat, he gives single-word or short answers to questions, and his voice tone is hostile).

Client: How long is this going to take? I’m really not in the mood to be cross-examined.

Counsellor: Of course, you are free to leave at any point. But before you do, why don’t we take a moment to talk straight. I know that you were forced to come here by your probation officer. I’m wondering how you feel about that.

Client (sarcastically): I think this is all crap. It makes no sense. What’s the point?

Counsellor: I appreciate your honesty. We do agree on one thing. You don’t want to be cross-examined, and I don’t intend to try. You don’t have to tell me about anything you don’t want to talk about.

Client: Let’s get one thing clear. I do not need your permission to do anything.

Analysis: The client’s opening comment clearly communicates his resistance in a way that should not be ignored. At this point the counsellor needs to control her own emotional response to ensure that she does not become defensive, a response that would almost certainly increase resistance. Instead, the counsellor encourages the client to say more about his feelings. The counsellor reminds the client that he does have a choice about whether to stay or go, which gives him back some of the power he feels he has lost.

Analysis: Use of “radical acceptance” (see Chapter 7). The counsellor tries to find a point of agreement, but her response is greeted by more anger. At this point it is important that the counsellor not give up. Even though the client’s response is less than ideal, he has heard what the counsellor said. The counsellor needs to remain calm, patient, and empathic. This will give the client an opportunity to spill out some of his anger, which often helps to soften it.
INTERVIEW 8.1  Dealing with Resistance (continue)

Counsellor: Agreed. But since you have decided to stay, let’s talk. If you’re feeling angry because your probation officer thinks you need counselling, I can understand. I sure do not like it when I’m forced to do something against my will. **Analysis:** The counsellor continues to “roll with resistance.” The counsellor tries to ally herself with the client by using self-disclosure to encourage him to talk about his resistance. She emphasizes that the client has made choices. Sometimes it is less threatening for clients when counsellors avoid questions (see Chapter 5). The client’s earlier statement that he “doesn’t want to be cross-examined” is a good indication that questions would be inappropriate in this interview.

Client: It’s not you. I just don’t see the point. There’s nothing wrong with me. I don’t understand why I have to come here. **Analysis:** The counsellor’s persistence works, as the client begins to open up. At this point, it is important for the counsellor to avoid becoming defensive. If she starts to “sell” her client on the merits of counselling, she may lose him.

Counsellor: Sounds as if you really want to stand up and say, “This is my life. Butt out.” **Analysis:** An inferred empathic response acknowledges the client’s feelings.

Client: Yeah. What gives them the right to say I’m crazy? **Analysis:** Cautiously, the client begins to share his feelings, including his reservations about what will happen in the relationship.

Counsellor: And now that you’re here, you might be worried that I’ll do the same thing. That I will try to get into your head, tell you what to do. **Analysis:** The counsellor uses immediacy to verbalize the client’s central concern, which the client has expressed implicitly.

Client: Of course. Isn’t that how it works? I have been to counselling before. (laughs.) You guys aren’t happy unless you’re mucking someone up. **Analysis:** Despite his initial resolve to keep his distance from the counsellor, the client is beginning to connect. He is seeing the counsellor as less of a threat.

Counsellor: (laughs.) Well, we have to shrink our quota of heads. Client: (laughs.) My head is staying just where it is. **Analysis:** A little humour from the counsellor helps build rapport while showing empathy with the client’s feelings. The counsellor’s humour affirms her ability to talk about the issues without becoming defensive. However, when using humour timing is critical. What works very well in one situation might result in disaster in another.

Counsellor: I am impressed that you’re able to say what you want. Client: I do not believe in playing games. **Analysis:** The counsellor does not attempt to break down her client’s defences, which are helping this client cope with a threatening situation. Instead, she reframes his stance as a strength.

Counsellor: Me neither. So let’s talk about what you’d like to see happen here. I will need some help from you. And if it’s okay with you, I’ll share some of my ideas. Client: I guess so. It is not like I have a choice. **Analysis:** There is much work to be done to establish a solid working relationship with this client. The counsellor’s responses allow the process to move forward, but her manner gives the client some much needed control and power. Asking for the client’s help about process and direction is very empowering. An important beginning has been established.

Resistance and Counsellor Self-Awareness

Counsellors should monitor and manage their own emotional reactions to resistance. Client resistance can be unsettling and demoralizing, and it can test almost any counsellor’s ability to be nonjudgmental. Common counsellor reactions include fear, anxiety, avoidance, defensiveness, anger, pessimism, and a sense of rejection. Counsellors may turn against their clients, blame them for their problems, and look for ways to refer them to another counsellor.
CONVERSATION 8.2 | Saying No

STUDENT: What are some ways to say no to clients? I really hate it when I have to deny them what they want or need.

TEACHER: That is my reaction too. None of us in the helping professions wants to be seen as harsh or uncaring. Saying no may evoke feelings of guilt in us, as well as strong negative reactions from our clients. We really need to be able to address our own emotions as well as those of the client.

STUDENT: I suppose it’s a reality of the business. Sometimes we have to make tough decisions, such as who gets the training money and who qualifies for assistance. In the residential part of the program where I work, we often have to say no when the kids want exceptions to the rules. No problem when you’re able to give them what they want. But what about when you have to turn down requests?

TEACHER: Even when you’re saying no, it’s important that clients know you care. You need to listen and be available to respond with empathy and compassion. Find a way to show you understand, even if you are not able to give your clients what they want. Or see if there is a way to compromise to help your client save face. What do you think?

STUDENT: I have learned a couple of things. Be direct, clear, and brief. Don’t waffle, hint, or avoid the “bottom line.” With kids, I’ve found that, even when they test the limits, they may need limits and even welcome them when imposed. It increases their sense of safety and control when they learn the boundaries of acceptable behaviour.

TEACHER: I agree. I think it is important that you don’t make a hasty retreat. Expect that anger, defensiveness, and counter-attack are the ways that some clients respond to frustration. In extreme situations, you need to protect yourself. Anticipate potentially violent situations and take defensive action. Also, be sure to debrief with a colleague or supervisor after difficult encounters. And if necessary, take a break to ensure that your reactions do not contaminate your ability to deal with your next client objectively. Finally, remind yourself that no matter how your client reacts, you must stay in a professional role.

STUDENT: When someone says no to me, I find it a lot easier to accept it if I know why. So I try to explain my rationale or the policy. Then I invite questions while remaining clear when the policy is nonnegotiable.

TEACHER: If you can, help your clients identify other ways to meet their needs.

In response, clients may view their counsellors’ defensive reactions as proof that the situation is hopeless. Thus, it is important that counsellors find ways to depersonalize the situation. Otherwise, they run the risk of further worsening the situation by rejecting the client or retaliating in subtle ways.

Counsellors need to be able to objectively evaluate their own conduct and take their fair share of responsibility for resistance. When counsellors have high self-awareness of their actions, they are able to monitor themselves and change their behaviour to be more effective. Hill (2004) echoes sentiments from many sources with the simple yet profound advice to counsellors to “respond to client anger as they would to any other emotion” (p. 417).

Counsellors can use colleagues and supervisors for support when dealing with highly resistant clients, who can tax the patience of even the most dedicated counsellor. Collegial support can help counsellors unwind from tough sessions. They can help counsellors to be more objective, or they can be a source of fresh ideas for reaching difficult clients.

CONFRONTATION

Many people associate confrontation with conflict and hostility, and perhaps this association arises from the fact that confrontation often comes from frustration or anger. For counsellors, effective confrontation is not considered a hostile act. Confrontation is simply a way of directing clients’ attention to aspects of their personality or behaviour that they might otherwise overlook. It is a tool to move clients to a higher level of understanding of themselves and others. Moreover, caring confrontation can deepen the level of trust in the counselling relationship. It is also a major skill for helping clients develop fresh perspectives on themselves and their behaviour.
Types of Confrontation

The two main types of confrontation are feedback confrontation and confrontation of incongruities. Feedback confrontation provides new information to clients about who they are, including how they are perceived by others and the effects of their behaviour on others. Feedback confrontation can be used to help clients become aware of the consequences of their decisions and actions. It is not reserved for negative or critical feedback; it can also be used to identify strengths.

In some cases, clients do not recognize the harmful effects of their behaviour on themselves and others. They continue to behave in ways that are hurtful, yet they lack insight into how they are affecting others. Because they are unaware and fail to see their behaviour as problematic, they have no motivation to change. Feedback confrontation can help these clients examine the consequences of their actions. The following are examples of client blind spots:

- Jerry thinks of himself as humorous, but he is unaware that his jokes are offensive and sexist.
- Nathan has bad breath and body odour.
- Parvinder is unaware of how his aggressive behaviour pushes others away.
- Estelle has been in a series of relationships in which she has been battered. She does not understand how this has affected her children.

Despite its potential power as a helping tool, feedback confrontation is often misused. Some counsellors avoid it, perhaps because they fear that they might alienate their clients or arouse their anger. Other counsellors feel the need to keep the helping relationship pleasant, so they distort or lie to clients to sustain their approval. However, effective counsellors need to be willing and able to confront clients when necessary. Thus, counsellors must remain aware of their beliefs, fears, and expectations regarding confrontation to use this skill appropriately.

Sometimes beginning counsellors (and some experienced ones too) are reluctant to confront. They may hold beliefs such as the following, which potentially limit their effectiveness:

- “I was brought up to believe that if you don’t have something good to say, then don’t say anything at all.”
- “If I confront, I might damage the relationship. I don’t want to upset my clients.”
- “I don’t want to hurt my clients.”
- “My clients might retaliate.”

Yet most of the above beliefs arise from an erroneous understanding of confrontation as a “no holds barred” assault on clients. Assault-type confrontation strategies should, of course, be avoided. At the other extreme, refraining from confronting clients under any circumstance is an evasion of responsibility that cuts clients off from the potential benefits of new information and feedback. Competent counsellors should not withhold potentially useful feedback.

The second type of confrontation, confrontation of incongruities (Ivey, Ivey, & Zalaquett, 2010), is directed at inconsistencies and mixed messages:

- Discrepancy between a client’s verbal and nonverbal messages
  
  Client: (Crying) It’s really nothing. I’m not bothered.

- Discrepancy between a client’s values or beliefs and behaviour
  
  Client: There’s nothing more important to me than my kids. I know I haven’t spent much time with them. It’s just so hard to say no to my buddies when they ask me to help.
Discrepancy between what a client says and what he or she does

Client: I’m committed to looking for work. Yesterday something came up before I could get to the employment office.

In confronting discrepancies, counsellors need to remain calm and nonjudgmental while presenting clients with facts. Ivey, Ivey, and Zalaquett (2010) look at confrontation as a way to support clients in a gentle and respectful manner rather than a harsh challenge. Its purpose is to aid clients to have a more complete understanding by offering additional information or perspective. It opens up new possibilities for changes in thinking and behaving.

The Misuse of Confrontation

Although confrontation has potential for motivating clients to change and can assist clients in developing insight, misuse of confrontation can be destructive. As a rule, counsellors should use it sparingly and should be prepared to offer support and caring to ensure that confrontation does not overwhelm or devastate their clients.

There are risks to confrontation, and some clients do react poorly. They may respond with hostility and attempt to question the integrity or credibility of the counsellor. Such a hostile reaction may be a type of denial, indicating that the client is simply not ready to acknowledge the validity of the confrontation. Hostile reactions are more likely to occur when feedback or confrontation is unsolicited, but they may occur even when clients appear to be seeking information or feedback. Counsellors also need to consider that harsh client reactions may arise for legitimate reasons. Sometimes feedback is confusing or the manner and tone of the counsellor are abrupt. Secure counsellors have to be open to the possibility that they may have erred.

Confrontation is not an outlet for a counsellor’s anger or frustration. When counsellors are not in control of their own feelings, clients are more likely to view them as aggressive and to feel their confrontation is unsupportive. The counselling relationship is formed to meet the needs of clients, and responsible counsellors forgo their own needs to this end. In addition, counsellors should be self-aware enough to know their reasons for wanting to confront.

Overly confrontational styles have been found to result in a high client dropout rate and poor outcomes. “Counsel in a directive, confrontational manner and client resistance goes up. Counsel in a reflective, supportive manner, and resistance goes down while change talk increases” (Miller & Rollnick, 2002, p. 9). Ultimately, “the manner in which we present confrontations affects the way they are heard and accepted or rejected by the client” (Sperry, Carlson, & Kjos, 2003, p. 120).

SUCCESS TIP

“Do not confront another person if you do not wish to increase your involvement with that individual” (Hamachek, 1982, p. 230).

Principles for Effective Confrontation

Principle Number 1  Unsolicited confrontation tends to result in resistance, hostility, and defensiveness, but solicited (invited) feedback is more likely to be accepted. The skill of anticipatory contracting can be used to engage clients in accepting feedback:

Counsellor: One of the ways I might be able to help is by sharing some of my impressions about what you are doing, or even about our relationship. What do you think?
Client: Sure. I would appreciate that.

Counsellor: Well, let’s look ahead. Suppose I wanted to give you some feedback about something I thought you were doing wrong that you were not aware of. What would be the best way for me to approach you?

Client: I do not like to be overwhelmed. And I like the good mixed with the bad.

This example shows how contracting can be used to help the counsellor “customize” feedback to meet the needs and expectations of the client. Some clients like blunt feedback; others prefer it “sandwiched” between positive statements. Anticipatory contracting empowers clients and communicates respect for their rights to make choices. When confrontation is invited, it is much less likely to meet with resistance.

**Principle Number 2** Confrontation should be used sparingly and in combination with other skills, particularly sensitivity and empathic listening.

Confrontation may involve feedback that is unsettling for clients, and empathy reminds counsellors to remain sensitive to the impact of confrontation. In addition, counsellors should not confront clients without assisting them to develop new alternatives. Confrontation should also be measured to avoid overwhelming clients with more information than they can handle. Ideally, confrontation should not undermine the self-esteem of clients. At first, clients may respond defensively to feedback, but after reflection, they may be more accepting. Alternatively, they may appear to be accepting but later become resentful. Thus, it is important to check with clients how they feel about the feedback or confrontation. Counsellors should monitor immediate reactions. As well, checking back with the client during the next session is a useful tool for identifying delayed reactions and for noticing any feelings that might impair the relationship. The example below illustrates the process:

Counsellor: I’m wondering how you felt about our last meeting. Remember, I shared with you some of my opinions about the things you are doing that seem to distance you from your family.

Client: I almost did not come today. (Silence.)

Counsellor: Because?

Client: I was embarrassed by what you thought of me.

Counsellor: You thought that I might think less of you?

Client: Yes.

Counsellor: Would you like to find out for sure what I think?

Client: Okay.

This counsellor’s strategy sets the stage to help the client correct any distortions, and it is crucial for dealing with the aftermath of confrontation. It also reinforces the understanding that any feelings about what happens in the counselling relationship can be dealt with openly.

**Principle Number 3** Confrontation should serve the goals of counselling by leading the client to improved ways of behaving, thinking, and feeling.

Relevant confrontation always meets the needs of the client. Thus, it is inappropriate for a counsellor to use confrontation as a means to vent frustration, anger, or to punish clients.

Counsellors can best deal with feelings related to the relationship or the work by using I-statements rather than trying to mask their feelings as helpful feedback. I-statements are assertions about personal feelings or reactions that do not blame or
Chapter 8

judge others. Instead of saying “You don’t care,” an I-message would be “I feel confused when you don’t answer my questions.” I-statements are much less likely to cause resistance.

**Principle Number 4**  Confrontation must be timed appropriately at a point when clients are ready and willing to take advantage of feedback and when there is a reasonable possibility that feedback can motivate them to change.

Counsellors need to pay attention to timing and ensure that there is a well-developed counselling relationship to support confrontation. As a rule, it is preferable to avoid strong confrontation in the beginning phase of counselling. Clients are more receptive and likely to accept feedback as credible when there is a relationship and climate of trust, when they do not feel insulted and misunderstood. Otherwise, they may never return.

Confrontation should be done as close as possible to the relevant behaviour, events, or circumstances that are being addressed. In some cases, such as when strong emotions are clouding communication, it may be best to wait. A client’s ability to handle confrontation is a crucial variable. If clients are already overwhelmed with feelings, confrontation may add to their stress but contribute little to their ability to cope. Moreover, clients who are highly defensive and guarded may respond poorly to confrontation. In such situations, counsellors may find it wise to delay or avoid confrontation entirely.

Effective confrontation is an investment in the relationship. After confronting, counsellors need to be able and willing to invest time to help their clients understand any feedback. As well, counsellors must be available to help clients deal with any feelings that may result from the confrontation. Consequently, the end of a counselling interview is generally a poor time to confront.

**Principle Number 5**  Effective confrontation needs to be specific without attacking the personality of the client.

*Counsellor (Choice 1—ineffective confrontation)*: You don’t seem at all interested in what’s happening here. If you’re too lazy to care about our work, why don’t you just quit? *(Counsellor is attacking and judging the client without offering any concrete feedback.)*

*Counsellor (Choice 2—more effective confrontation)*: When you don’t show up for appointments, I wonder whether you’re as committed to your goals as you say you are. *(Counsellor’s comments are linked to specific client behavior.)*

*Counsellor (Choice 3—most effective confrontation)*: I think your best work has happened on those days when you came on time and when you took the effort to focus. My sense is that if you could make every appointment, you’d get a lot more out of our time together. *(Counsellor focuses on strengths and what the client can do that will be more effective—people are motivated more by positive feedback than negative feedback.)*

**AGGRESSION AND VIOLENCE**

Counsellors and other social service professionals are increasingly vulnerable to violence (Newhill, 2003, 1995; MacDonald & Sirotich, 2001, 2005). For example, a counsellor’s denial of a client’s request for financial assistance may evoke retaliation. Hospitals, especially emergency rooms, can be a particularly dangerous place. A survey of over 9000 registered nurses in Canada revealed that almost 40 percent had experienced some form of workplace violence and about 20 percent had been physically assaulted (spit on, bitten, hit, or pushed) (Canadian Institute for Health Information, 2012). A study at one private psychiatric hospital found that the frequency of violence by male patients was 50 percent higher than a decade before, and that
violence by female patients was 150 percent higher than a decade before (Tardiff, Marzuk, Leon, Portera, & Weiner, 1997). Situations that may increase counsellors’ risk for violence include:

- Dealing with people who are using street drugs
- Dealing with mentally ill people who are not taking their medication or mixing prescribed medication with street drugs
- Investigating situations of child abuse and neglect
- Institutional work in prisons, group homes, and hospitals
- Work that includes some elements of social control (e.g., probation, involuntary clients, establishing eligibility for income assistance)
- Assisting police intervention in domestic abuse
- Hospital emergency work

Canadian studies by MacDonald & Sirotich (2001, 2005) and de Léséleuc (2004) found the following:

- Almost 90 percent of social workers have experienced verbal harassment.
- About 65 percent have been threatened with physical harm.
- About 30 percent have been sexually harassed.
- Close to 8 percent have been physically assaulted and injured.
- One-third of all workplace violence incidents took place in social service or health care settings, with about 71 percent involving physical assault.
- About 50 percent of incidents were linked to substance abuse.
- Males were accused in 93 percent of the assaults, and 54 percent of them were under 35 years of age.

Sometimes clients cause fear because their behaviour is threatening, or they have a history of violent behaviour. At other times, counsellors’ fears are based on intuition or hunches, the internal response to subtle signals that not all is well. In fact, some clients provide abundant reasons for fear, because of either intimidating behaviour or overtly violent acts.

**Intimidating behaviour** includes name calling, obscene or sexually harassing language and gestures, shouting, threatening displays of power such as fist shaking, invasion of personal space, stalking, and verbal threats. Clients also behave in an intimidating manner when they will not take no for an answer or when they refuse to leave the office. As well, clients may attack workers with personal insults, or they may intimidate them with threats to call the newspaper or civil rights groups. In general, intimidating behaviour should be controlled or managed to prevent escalation to violence. The following case examples of threatening behaviour are all based on real incidents:

- new client in a welfare office says, “If I don’t get some help, you’ll be sorry.”
- man in his late twenties stares obstinately at an intake worker.
- angry parent tells child protection workers that if his child is not returned, the worker will know what it’s like to lose someone you love.
- teenager in a group home refuses to comply with house rules. He tells his child care counsellor, “I’ve had enough. Things are going to change around here.”
- parole officer meets a new parolee for the first time. He is pleasant and cooperative, but the parole officer knows the man has a short fuse and a long history of assault charges.
mental health counsellor deals with her client, a young male with a history of self-destructive behaviour. It is obvious that he is not taking his medication, and he seems unusually agitated.

10-year-old child who witnessed abuse at home grabs a pair of scissors and lunges toward the counsellor.

Violent behaviour means hitting, pushing, biting, slapping, kicking, throwing objects, and using weapons such as guns, knives, or syringes. It also refers to kidnapping and stalking.

social worker in a hospital emergency ward is threatened with a syringe by an angry HIV-positive patient.

angry client picks up a chair and hurls it at the counsellor.

client, disgruntled with the counsellor’s refusal to provide him with money, spits in the counsellor’s face.

Nonetheless, it is important that counsellors do not become hypervigilant and conduct their work in constant fear. Such a stance makes it difficult for them to separate actual hazards from situations that present no real risk. Moreover, unwarranted fear of clients leads to uninformed responses. Though very real dangers exist in the workplace, by and large it is a place of safety. The challenge is to be able to answer some basic questions:

Which clients are likely to become violent? What are the indicators of potential violence?

Under what conditions should a client’s anger be cause for concern?

What are the skills and behaviours that can be used to de-escalate dangerous situations?

SUCCESS TIP

Anger, when expressed assertively, is a normal and potentially useful part of relationship communication. Assertive anger respects the rights, obligations, and feelings of self and others. Aggressive anger involves intimidation, misuse of power, and disrespect for others.

Risk Assessment for Violence

Violence arises from a complex array of psychological, social, biological, and physiological factors. Although certain variables are more likely risk factors, risk assessment is difficult and violence cannot be predicted with precision (Miller, 2000). There is simply no foolproof way to predict with certainty who is likely to become violent.

Violence may be perceived as a desperate act by an angry client to regain control and power. Multiple stressors, such as poverty, the loss or absence of supportive relationships, and substance abuse, may magnify a client’s vulnerability and stress to the breaking point. Moreover, counsellors may be in positions of authority with the right to deny clients access to goods or services. Clients may perceive such denials as further threats to their fragile power and self-esteem, and the risk of violence may escalate. Attacking others works as a psychological defense against feelings of shame and humiliation.

Based on his review of the academic literature, Ross (1995) identifies five primary causes of violent crime in Canada: “interpersonal conflict situation (over status, resources, power, control, and reputation), presence of weapons, influence of drugs
and/or alcohol, media facilitation, and cultural or subcultural reinforcement” (p. 348). The key variables that have been found to have some validity for predicting violence include (1) past and current behaviour, (2) substance abuse, (3) age and gender, and (4) personality (see Figure 8.2). The more risk factors present, the greater the risk, but the presence of a risk factor does not mean that a given person will become violent in a given situation.

**Past and Current Behaviour** The best predictor of future violence is a history of violence (Miller, 2000), and the more recent and severe the violent behaviour, the greater the risk. Kelleher’s (1997) conclusion that a history of violent behaviour should always be given serious consideration is echoed consistently in the research on violence: “Although the argument can be made that historical evidence of violence is not a guarantee of future violent behavior, an understanding of any form of violent criminal activity clearly supports the contention that a history of violence is often a predictor of future violence” (p. 13).

Counsellors should be particularly interested in noting how a client has handled difficulties and frustrations in the past. Some clients who were victims of abuse as children have grown up without a capacity for warmth and empathy for others, which can make them oblivious to the suffering of others (Miller, 2000). In extreme cases, violence may even bring these clients pleasure or sexual gratification. Counsellors should also be interested in the level of remorse that clients show for past acts of violence, particularly for those who show no regret. On the other hand, clients who have learned other ways of managing their anger now have more choices and are less likely to act out physically. In this respect, it might be revealing for counsellors to explore how their clients are managing stress outside the counselling relationship. For example, do they show evidence of a lack of concern for the safety of others? Are there indicators of inappropriate or uncontrolled anger? Are they typically extremely defensive, irritable, or self-centred? To what extent are they prone to impulsive behaviour? Impulsive clients might assure counsellors that they have no intent to harm anyone and then attack another client in the waiting room 10 minutes later.

Furthermore, clients who have a specific plan of violent action and the means to carry it out represent an immediate risk of violent behaviour. Counsellors need...
to consider their professional obligations and legal requirements to warn any intended victim by examining their codes of ethics as well as relevant legislation or legal precedent.

**Substance Abuse**  
Violence from substance abuse is associated with:

- the effect of drugs
- violence to get drugs
- violence in the drug culture

Common sense and empirical research suggest that intoxicated and agitated clients should be approached cautiously. Substance abuse, particularly in combination with other risk factors, compounds the risk of violence (Miller, 2000). Reviewing the role of drugs in violence, Roth (1987, pp. 13–14) concludes the following:

- Hallucinogens such as LSD and PCP, glue sniffing, amphetamines, and barbiturates have been associated with aggressive and homicidal behaviour.
- Narcotics tend to suppress violence, but individuals might become violent in order to get these drugs.
- Alcohol reduces inhibitions and it is implicated as the most frequent drug linked to violence.

Furthermore, many studies link substance abuse to violent behaviour (Swanson et al., 1997; Tardiff et al., 1997). Newhill (1992) reviewed the available research and recorded that certain drugs subdue aggression, whereas others escalate it: “Anticholinergics, antipsychotics, antidepressants, sedative hypnotics, and analgesics tend to suppress aggression. Amphetamines and withdrawal from drugs such as morphine or alcohol induce aggression” (p. 70). Moreover, people who abuse drugs are at an increased risk of victimization. The link between drug abuse and violent behaviour may arise, at least in part, from the fact that alcohol and other drugs are more likely to be abused in a dangerous place.

**Age and Gender**  
The vast majority of people who are violent and who have been arrested for violent behaviour are male. The highest risk for violence is found in people from 15 to 39 years of age. The rate of violent acts for this age group is three times that of the general population (Newhill, 2003). Violence declines with age, but dementia and other cognitive problems can result in an increase in violence by those over 65.

**Personality**  
Some clients deal with their sense of personal fragility by lashing out at others, and they are hypervigilant about protecting themselves from perceived threats from others. Miller (2000) notes:

Tendencies toward low frustration tolerance, impulsive behavior, vulnerability to criticism, feeling humiliated and powerless, superficial relationships, lack of empathy, a pattern of externalizing problems, and failing to accept responsibility for one’s own actions are all associated with more-violent behavior. (p. 300)

De Becker (1997) cautions that some people assume the worst possible motives and character and that they write their own scripts: “The Scriptwriter is the type of person who asks you a question, answers it himself, then walks away angry at what you said... The things that go wrong are the work of others who will try to blame him. People are out to get him, period” (pp. 148–149). These clients believe that you are uncaring and bent on harming them. Whatever counsellors do and however caring their actions, these clients will react based on their expectations. They may try to control the relationship through manipulation and intimidation. However, this behaviour should be interpreted as a warning signal only. These clients may not escalate to violence.
Violence and Mental Illness

The question whether people with mental illnesses are more dangerous than the general public continues to be the subject of research, debate, and controversy. Not surprisingly, many people believe that there is a strong link between mental illness and violence. But advocacy groups argue that the media, through selective and exaggerated reporting, have stimulated the development of false assumptions about the dangers posed by people with mental illnesses. Sensationalized headlines such as “Schizophrenic Man Kills Wife, Then Turns Gun on Himself” and “Voices Told Me to Kill My Child” create the impression that mental illness is associated with violence. However, objective research evidence supports different conclusions.

One comprehensive Canadian study of the literature on the link between mental illness and violence concluded that there is no scientific evidence that mental illness causes violence (Arboleda-Florez, Holley, & Crisanti, 1996). Echoing many other research findings, they also implicated substance abuse as the most significant risk factor, noting that studies suggest that “individuals are at greater risk of being assaulted by someone who abuses substances rather than someone who is suffering from major mental illness such as affective disorder, anxiety disorder, or schizophrenia.” Another study (Swanson et al., 1997) confirms the link between violent behaviour and substance abuse, particularly when there has been absence of recent contact with mental health service providers. A different study concluded that predictions of violence based on a history of violence were more accurate than clinical predictions based on diagnosis (Gardner, Lidz, Mulvey, & Shaw, 1996). Overall, persons with mental illness are over 2.5 times more likely to be victims rather than perpetrators of violence, particularly when other factors such as poverty and substance abuse are present (Canadian Mental Health Association, 2005). The vast majority of violence comes from people who are not mentally ill, yet the widespread belief that persons with mental illness pose a threat contributes to the stigmatization of this group (University of Washington, School of Social Work, 2015).

Although “major mental disorder and psychiatric disturbance are poor predictors of violence” (Harris & Rice, 1997), Miller (2000) found that certain mental disorders, such as schizophrenia with paranoia and command hallucinations, mania, substance use disorders, antisocial personality disorders, and borderline personality disorders, are more likely to be associated with violence. Moreover, in recent decades deinstitutionalization of psychiatric patients has resulted in unprecedented numbers of people with mental illnesses in the community. Clients with a history of severe mental illness and violence who stop taking their medications can be very dangerous, particularly if they have command hallucinations (voices and images directing them to be violent).

A comprehensive follow-up study of patients discharged from psychiatric hospitals concluded that former patients who do not abuse drugs are no more violent than a random population sample (Bower, 1998). Pastor (1995) concluded that unrealistic and delusional thinking tends to increase the likelihood that violence will result. He also noted, “Manic symptoms, such as irritability, increased energy or activity, psychomotor agitation and grandiosity, also increase the risk of violent behavior. A belief that ‘others’ are responsible for the person’s misfortune increases the likelihood of striking out against those persons” (p. 1173).

BRAIN BYTE  Head Trauma and Violence

Organic brain disease and head trauma may reduce clients’ impulse control and lead to an increase in aggression and violence, as well as changes in memory and ability to reason. A study of prisoners links a history of brain trauma with an increased likelihood for violence (McCook, 2011).
Violence Risk Assessment: Key Questions

Although long-term prediction of violence is difficult, counsellors should be able to make reasonable short-term forecasts based on consideration and assessment of the following questions and issues:

1. Does the client have a history of violent behaviour or an arrest record for violent crime? The counsellor should review agency file records and other anecdotal evidence for information.

2. To what extent does the client appear dangerous, as evidenced by marked or escalating agitation or threatening behaviour? The counsellor should consider verbal threats as well as nonverbal expressions of aggression.

3. If the client is threatening violence, are the threats concrete and specific? Does the client have a plan? Does the client have the means to carry out the stated plan? Does the client have a weapon or access to one, especially a gun?

4. Is the client under stress (e.g., recent death, poverty, unemployment, or loss of social support)? Has there been a recent event that represents the last straw for the client? Noticeable changes in baseline behaviour (the client’s usual personality and manner) should be noted, such as the following examples:
   - Haydon, usually quite demanding and argumentative, becomes quiet.
   - Jeff, a 16-year-old group home resident, who is typically very social, withdraws to his room.

5. What systemic factors might be exacerbating the situation (e.g., missed or delayed appointments, denial of benefits)?

6. What counsellor variables might be heightening the client’s anger? Is the counsellor acting in ways that the client might see as provocative? For example, is the counsellor defensive or judgmental toward the client?

7. What high-risk symptoms are present? For example, is the client experiencing command hallucinations? Is the client impulsive? Is the client near panic? Is the client narcissistic or self-centred and prone to blaming others for his or her misfortune? Is the client hypersensitive to any criticism or hint of rejection?

8. Is there evidence of substance abuse?

9. Has the client failed to take psychiatric medications? Has the client cut off or failed to keep scheduled contact with a psychiatric caregiver?

10. Does the client believe that he or she is able to control his or her behaviour? Is the client socially isolated?

11. Is there a history of brain injury or organic brain disease?

These questions are references for the purpose of assessment only. The presence of any of the factors does not mean that the client will necessarily become violent. However, when there are numerous strong clues that suggest violence, counsellors should proceed cautiously and look for ways to reduce risk factors to establish safety.

**BRAIN BYTE**

**Aggression**

Society for Neuroscience (2007) reported findings on the neurobiology of aggression. It found evidence of brain damage in neural circuits related to moral decision making in violent individuals. Damage to the prefrontal cortex, and the angular gyrus can also increase violent behaviour. Hyperactive responses in the amygdala (responsible for managing threats and fear) and decreased activity in the frontal lobe are also implicated. As well, low levels of the neurotransmitter serotonin may help predict violence.
Managing Angry and Potentially Violent Behaviour

**Preventing Violence**  Effective intervention begins with prevention. Organizations need to be open to the fact that there may be elements of their service system that act as triggers for clients who are stressed or have short fuses. Additionally, workers need high self-awareness to recognize their own triggers, as well as how their responses and behaviour might escalate frustrated and angry clients to violent responses.

**Systemic Factors**  Many clients come to counselling in a state of crisis, with low tolerance for added stress. Consequently, it is important that agency policies and routines do not compound the risk by exacerbating client frustration. Parada, Barnoff, Morratt, and Homan (2011) comment on this Canadian reality:

> Community members who use social services often have to wait too long for an appointment, wait too long to be seen on the day of their appointment, and have too little time with you or other professionals when they are finally seen. The forms they must complete are often lengthy and confusing. Some agency staff can be insensitive, unhelpful, or downright rude. Then together, these practices reinforce the idea that community members who have to use these services are unworthy and lack dignity (p. 6).

Organizations need to understand that for many clients, systemic change is what is needed. Part of this ought to include review of the structure and service delivery systems of the agencies whose mandate is to help.

**Agency Safety Precautions**  In settings where there is significant risk for violence, procedures should be developed for dealing with potentially violent clients. In fact, employers usually have a legal responsibility to provide a safe working environment. Minimum safety precautions might include the following:

**Policy**  Agencies should develop and regularly review policies and procedures for dealing with potentially violent situations. Policies should address issues such as the procedures for visiting homes, giving clients home phone numbers, using last names, and interviewing after hours. Generally, counsellors should not make home visits alone if there is a possibility for violence. Many counsellors who work with potentially dangerous clients use unlisted phone numbers as a way to ensure privacy and safety. In extreme situations, such as dangerous child abuse investigations, counsellors may need to be protected by police. Generally, counsellors should avoid making unescorted visits to high-crime areas. And only those counsellors with legal authority should investigate allegations of child abuse or neglect.

**Staff Training**  Training should address tactics for dealing with difficult clients, including those who are involuntary, angry, or acting out. Front office and reception staff should also be trained so that they can relate to clients in ways that do not escalate.

---

**BRAIN BYTE**  **Flight or Flight**

When counsellors or clients feel fear or threat from the other, the classic "flight or fight" response may result for either or both. Stored memories of similar threatening events have an enormous influence on how individuals respond. Five major areas of the brain, amygdala, hippocampus, hypothalamus, thalamus, and sensory cortex all play a part in the decision to run (flight) or fight, (although some may respond by freezing). When the threat is perceived as real, hormones such as epinephrine (adrenaline) and norepinephrine (noradrenaline) are released which cause an increase in heart rate and blood pressure. Muscles tense, breathing rate increases, digestion slow or stops and blood glucose levels increase. Because attention is fully directed at the threatening situation, individuals may be unaware of other things such as how their responses are affecting others. (Layton, 2015, Sherrard, 2015). Thus, some angry and aggressive clients may be quite unaware how frightening their behaviour is to other people.
the clients’ frustration or anger. Periodic team simulations will ensure that everyone is familiar with their roles and responsibilities. This prevents members of the team from becoming confused during a critical incident. Simulations also help staff build confidence in themselves and trust in their colleagues as backups.

**Interviewing Procedures and Office Design** Counsellors who are interviewing difficult or dangerous clients should work in offices where access to immediate help can be provided. A silent system for alerting others that a dangerous situation is developing should be implemented (e.g., panic button, encrypted phone message). Leaving the door open during the interview can allow other staff to monitor any increasing danger, but this practice may violate the client’s confidentiality.

**SUCCESS TIP**
An ideal office seating arrangement gives both the counsellor and the client a clear, unobstructed path to the doorway.

Files on clients with a history of violence should clearly document details of any past violent behaviour or threats. For clients with a high propensity toward violence, a team approach may be desirable, with two or more persons being present during the interview. In such cases, it is usually preferable if only one person does the interviewing. This can lessen any feelings the client might have of being ganged up on. Too many people may heighten the client’s anxiety. Backup help can be stationed out of sight, but on quick standby for dangerous situations.

Office furnishings should be carefully chosen to minimize risk. For example, shatterproof glass can be used, and items that are potential weapons, such as scissors, should be removed. Also, soft lighting and calming colours may have some modest effect on mood. In addition, the agency itself should have good external lighting. Finally, during high-risk hours, such as late at night or early in the morning, access doors should be locked, and workers should not have to walk alone into dark parking lots.

Table 8.2 on the next page provides some tips on how to prevent and manage anger and violent behaviour. The table is organized according to the phases of violence, which are discussed in the next section.

**SUCCESS TIP**
A written script for staff calls to police or emergency backup intervention ensures that relevant information is presented quickly and clearly. In a panic situation, people may forget basic information, such as emergency phone numbers.

**The Phases of Violence**

The National Crisis Prevention Institute (2012) has developed a model for nonviolent crisis intervention that is widely used in Canada. It is based on four phases of violence: (1) anxiety, (2) defensiveness, (3) acting out, and (4) tension reduction (see Figure 8.3 on page XX). Each phase is characterized by particular indicators and demands specific responses.

**Phase 1: Anxiety** In the anxiety phase there are often early warnings that are marked changes in the client’s behaviour. The client’s agitation and anxiety may include verbal challenges, such as the refusal to follow directions or questioning of authority. Statements such as “You can’t tell me what to do” accompanied by finger pointing may suggest escalating anger. Signs of escalation, such as pacing, intense...
### TABLE 8.2 Preventing and Managing Anger and Violent Behaviour

**Preventive Phase**
- Recognize risk factors
- Identify and minimize systemic factors that might be triggers for clients
- Structure the agency to reduce client stress and danger to personnel
- Set up emergency response protocols
- Practise crisis responses with simulations
- Take steps to protect identified intended victims
- Self-awareness

**Early Warning Phase (Anxiety)**
- Pay attention to changes in client behaviour such as increased anxiety
- Attempt to identify and rectify client “triggers”
- Promote client involvement in decision making to give them a sense of empowerment and control
- Take “gut instincts” and threats seriously
- Use empathy and reassurance to acknowledge and attend to client needs

**Late Warning Phase (Defensive)**
- Pay attention to changes in client behaviour such as increased defensiveness, challenges, and verbal threats
- Set clear, reasonable, and enforceable limits
- Respect client need for increased space
- Remain calm and avoid sudden movements
- Avoid using an authoritarian tone; respond assertively
- Use basic counselling skills
- Search for compromises and “win–win” solutions

**Uncontrolled Anger and Violence (Acting Out)**
- Call the police (do not try to disarm clients who have weapons and do not risk personal safety unless unavoidable)
- Try to ensure the safety of everyone, including bystanders, other staff, and the client
- Use a team approach, including, if necessary and appropriate, physical restraint, but extreme caution is required as untrained persons can inflict injury or death
- Refer or arrange to transport clients to hospital for assessment or medication
- Try to re-establish verbal communication

**Tension Reduction**
- Support the client’s return to a state of calm
- Re-establish communication
- Elicit available family support

**Post-Event Follow Up**
- Involve clients in long-term counselling
- Help clients learn nonviolent solutions to problems
- Implement consequences, if any
- Conduct individual and team debriefing
- When clients have plans to harm a specific victim, warn the victim and notify the police
- Review procedures for handling disruptive clients
staring, and refusing to sit down, should be noted (Shea, 1998). Other indicators may include excessive euphoria, angry facial expressions, increased voice volume, and prolonged staring. Counsellors should watch for changes in client baseline behaviour or personality patterns.

During the anxiety phase, the client may respond to gentle directives and invitations, such as “Let’s talk and see if we can work things out” and “I’m willing to listen.” This phase offers counsellors the best opportunity to intervene early to prevent anger from intensifying into acting-out behaviour.

Usually, clients enter the anxiety phase because of stress, which can come from multiple sources, including jobs, relationships, health, and finances. Clients define stressful events; thus, counsellors cannot measure stress just by knowing the facts about a situation. What one client might see as an opportunity, another might experience as a threat. Kelleher (1997) describes the triggering event as an incident that pushes the potentially violent person toward violence: “It is the proverbial ‘straw that broke the camel’s back,’ and, like the straw, may often be perceived by others with far less significance than it’s perceived by the perpetrator” (p. 11). Before clients see counsellors, they may already be feeling helpless and abandoned. Any counsellor or agency behaviour that the client views as provocative or rejecting may further propel the client toward violence. Counsellors may have to deny assistance, and clients may believe that they are denying them access to goods or services. These clients may perceive themselves as “losers” and look for ways to save face, including resistance, with statements such as “I don’t have to put up with this treatment.”

Individuals who are predisposed to violence respond to stress with increasing anger and anxiety. A person’s emotional reaction can also influence whether he or she might become violent. Labig (1995) suggests that people who are prone to anger, hatred, and those who tend to blame others are at higher risk of becoming violent, while those who are more empathic are less likely.

**Dealing with Threats** Counsellors need to take action when clients exhibit changes in their normal behaviour. This action could include referral for psychiatric assessment and re-evaluation of medication. Immediate crisis intervention might result in moving the client out of the environment where others might be injured, for example, a crowded waiting room. As well, long-term counselling might focus on anger management or relaxation training. The immediate goal is crisis management, but the long-term goal is crisis prevention. This interesting conclusion reached by Quinsey, Harris, Rick, and Cormier (1998) challenges one common misbelief: “encouraging angry individuals to relieve anger through catharsis (e.g., boxing, using a punching bag) is contraindicated because it may lead to increased hostility and aggression” (p. 204).
SUCCESS TIP

“When any type of threat [from a client] includes indirect or veiled references to things they might do, such as ‘You’ll be sorry’ or ‘Don’t mess with me,’ it is best to ask directly, ‘What do you mean by that?’ Ask exactly what the person is threatening to do. His elaboration will almost always be weaker than his implied threat. If, on the other hand, his explanation of the comment is actually an explicit threat, better to learn it now than to be uncertain later” (de Becker, 1997, p. 117).

Counsellors need to be attuned to their own fears and anxieties. Appropriate anxiety is a clue that the situation is escalating and that remedial action is necessary. De Becker (1997) argues that people have a basic intuition that tells them when all is not well, but that they often disregard the red flags of danger. It is only in the aftermath that they reflect and realize that they had sufficient information to make better choices but that they ignored it.

Phase 2: Defensive This is a late warning phase with clear indicators that the person is about to lose control. The client may become more challenging and belligerent by making direct threats and provocations. The client has become irrational and clear warning indicators may be present, including clenching or raising of fists, rapid breathing, grasping objects to use as weapons, and showing signs of movement toward attack (e.g., grasping the arms of the chair, denoting that the client is about to rise and advance) (Shea, 1998; Sheafor & Horejsi, 2008).

At this point, it is crucial that counsellors refrain from reciprocating with the same aggressive behaviour that the client is using. This requires some self-discipline, as the counsellor’s natural reaction might be to respond in kind, which only serves to escalate or precipitate violence. Decreased eye contact might be appropriate with some clients. As well, counsellors are wise to increase the physical distance between themselves and their clients since potentially violent persons may have an increased need for space. Note that physical contact, however well intentioned, should be avoided. Sometimes counsellors try to calm clients by touching their shoulders, but this is ill-advised as clients may interpret it as aggression.

During this phase counsellors need to be self-disciplined and to model calmness. When counsellors stay calm, clients are more likely to emulate their composure. This calmness should be reflected in their voice and manner with slow, non-jargonistic language. Counsellors who speak calmly and avoid any loud or authoritarian tone have a greater chance of calming their anxious clients. On the other hand, counsellors who match their clients’ defensiveness and anger exacerbate the situation and increase the possibility of violent retaliation. Rigid and authoritarian counsellor reactions may leave clients feeling pressured or trapped.

It is essential that counsellors maintain their own equilibrium and remain in control. They need to develop their capacity to monitor their own feelings and behaviour, including their ability to ask for help or to withdraw when they are not in control. Counsellors also need to resist any tendency to be baited by clients into angry confrontation or retaliation, which only escalating the crisis. If clients perceive that their counsellors are anxious and not in control, they may become more irrational.

Labig (1995) reminds us of the importance of emotional tone. He notes that a loud or aggressive voice can quickly precipitate retaliation, while a voice tone that is calm and supportive inhibits violence. Simply put, a threatening environment increases the risk of violence.

Basic communication and counselling skills are excellent tools both for preventing violence and for dealing with clients who are on the verge of losing control. In particular,
active listening skills communicate that counsellors are willing to listen to and learn about clients’ wants and needs. Counsellors should try to speak calmly and avoid any mannerisms that clients might interpret as threatening (e.g., touching a client, making a sudden movement, or invading a client’s personal space). Encourage the client to sit and to be comfortable. Listen, empathize, paraphrase, and summarize while avoiding defensiveness. As a rule, respond to clients in the anxiety and defensive phases with supportive and empathic statements.

However, some clients may misinterpret empathy as an unwanted intrusion on personal privacy and react defensively. Counsellors should be alert to clients’ reactions to certain topics or questions. This will help counsellors make intelligent decisions about when it is appropriate to challenge or confront, and when they should back off because the subject is agitating the client to a dangerous level.

The Power of Compromise  Violent clients often feel disempowered and disadvantaged. When counsellors promote compromise, they restore some balance of power in the relationship and show their willingness to reach a solution. Conversely, when counsellors argue with, threaten, or ignore the needs of their clients, the clients may become increasingly belligerent.

Compromise helps clients find a way to save face and retain their dignity. While counsellors have the responsibility to set appropriate limits, they must not argue with, ridicule, challenge, threaten, or unfairly criticize clients. The language used by the counsellor can help establish an atmosphere of compromise and mutual problem solving—for example, “Let’s work together to find a solution we can both live with” and “I really do want to find a solution.”

Client: (Yelling loudly.) I am sick and tired of getting the runaround.

Counsellor: (Calmly.) Your anger makes it clear to me how strongly you feel about this. I can see that this is an important issue for you, but I will be able to work better with you if you stay calm and don’t threaten me. Let’s see if there’s another way to approach it.

Client: (Pacing and yelling.) Are you going to help me or not?

Counsellor: (Calmly.) I’m willing to work at this problem to solve it.

Client: (Sits and stares intently.)

Counsellor: I understand that you think that this is the best solution. I also appreciate your reasoning, but there are two of us here. We need to find a solution that both of us can live with.

Client: (Loudly, but not yelling.) I am trying to be reasonable!

Counsellor: Okay, I’m listening. I’d like to hear your ideas on how to . . .

Hocker and Wilmot (1995) identify five principles for establishing effective collaboration: (1) join with the other, (2) control the process, not the people, (3) use productive communication, (4) be firm in your goals, flexible in your means, and (5) remain optimistic about finding solutions to your conflict (p. 212). They suggest a variety of means for operationalizing the principles, such as using “we” language to affirm common interests, actively listening even when you disagree, and persuading rather than coercing. As well, they emphasize the importance of separating the issues from the relationship and dealing with the important items one at a time. Such a collaborative approach requires that counsellors remain positive, creative, and constructiive. The general goal must be “We, working together, can solve this problem that is confronting us” (Hocker & Wilmot, 1995, p. 205). Dubovsky and Weissberg (1986) underscore the importance of promoting collaboration. They contend that the client “protects himself from feeling
powerless, inadequate and frightened by attempting to demonstrate how powerful and frightening he can be. His threatening behavior increases if he feels he is not being taken seriously” (p. 262).

SUCCESS TIP
If aggressive behaviour is escalating, the safety of others must be a priority. This might include evacuating the waiting room, removing objects that might be used as weapons, and seeking backup from other available staff.

Setting Limits Setting and enforcing reasonable limits makes it possible for counsellors and clients to continue working together. Failure to set limits reinforces acting-out behaviour, which if unchecked could lead to more violent and destructive consequences. In the defensive phase, clients may still respond to appropriate limits. Limits let clients know what will and will not be tolerated, but counsellors need to apply certain principles in setting limits. Counsellors should be specific and tell clients which behaviour is inappropriate since they may not be aware what is acceptable. Moreover, they may not know how their behaviour is affecting others. Limits should include enforceable consequences, and counsellors should state the consequences of noncompliance.

SUCCESS TIP
Limit setting is more effective when it is stated in a positive tone with a payoff for compliance, as in this example: “If you stop yelling at me, then I will sit with you to see if we can find a solution.”

Phase 3: Acting Out At this stage the client has lost control and has become assaultive. Protection of self and others is the primary goal. Ideally, agency procedures are operative, and counsellors who are dealing with such situations will receive immediate assistance from the staff team. Police intervention and restraint of the acting-out client may also be required. When dealing with acting-out clients, a team approach with a well-organized and trained staff is the preferred way to address the crisis. A team approach provides increased safety for everyone, including the client. A well-trained team may subdue violent clients before they injure themselves or others, but staff should be trained in techniques for physical restraint and control. The team members provide support and can act as witnesses if litigation should arise because of the incident.

Police Intervention Counsellors should not hesitate to call the police if a client becomes too threatening or aggressive. No counsellor is expected to risk his or her life or endure physical assault as part of the job. Moreover, sometimes clients are unwilling or unable to constrain their hostility, and police or psychiatric restraint is essential for managing the crisis. Police intervention is particularly crucial when dealing with clients who have weapons. In addition, counsellors should not try to prevent a client who is determined to leave by blocking the exit. In general, counsellors who are assaulted by clients should consider laying criminal charges. This establishes the importance of clients’ taking responsibility for their actions.

SUCCESS TIP
Never block angry clients from leaving your office; allow a clear path for them to exit. Never run after clients who storm out.

Never interview when you are alone in the office. Never enter a client’s home when you know the client is talking about hurting someone.
Phase 4: Tension Reduction  The tension reduction phase is characterized by a gradual reduction in aggressive behaviour and a return to more rational behaviour. The client may still be driven by adrenaline, so it is important that counsellors proceed cautiously to avoid reactivating aggressive acting out.

Follow-up Counselling Interventions  Clients can be counselled to become alert to their own warning signs, such as “tenseness, sweating palms, a tightening of the stomach, pressure in the chest and a surge to the head” (Morrissey, 1998, p. 6). Once clients are aware of their own triggers, they can be counselled on appropriate diversionary tactics, such as employing relaxation techniques, taking time out, and using assertiveness and other behavioural response alternatives. Morrissey (1998) describes a technique that a counsellor used with a client who was on the verge of violence. The counsellor reassured the client “that he was there to help him and commended the client for coming to see him rather than acting on his feelings of rage. He also asked the client what was keeping him in control thus far and used that as proof to reinforce the fact that he could indeed control himself” (p. 6).

At the end of the tension reduction phase and after the client has returned to normal, the client may be mentally and physically exhausted and show signs of remorse and shame. Consequently, counselling can be directed toward helping the client use the experience as a learning opportunity—for example, to develop alternative responses for future similar stresses. Interview 8.2 provides an example.

Counsellors are well-prepared to teach their clients techniques for resolving conflict and crises nonviolently. The skills of counselling are also, to some extent, the skills of effective everyday communication. Communication skill training equips clients with more choices for asserting their rights and respecting others. Assertiveness training can help clients express feelings in a nonaggressive manner. When clients are able to respond assertively, they establish an atmosphere of cooperation and conflict can be peacefully resolved. Often conflict is difficult for clients to settle because they are unable to see the perspectives or feelings of others in the conflict. Clients who learn empathy and other active listening skills are better able to compromise because they are less likely to judge their own behaviour as absolutely right and that of others as absolutely wrong.

Sometimes, long before violence erupts, counsellors intuitively feel that the situation is worsening. This feeling may be based on unconscious reactions to subtle cues and indicators. Counsellors and clients might find it useful to try to concretely identify these clues. Doing so will assist clients in becoming sensitive to those initial psychological responses that signal the imminent onset of the anxiety phase. Clients who become adept at recognizing early warning indicators are in a much better position to take early warning action, such as withdrawing from an explosive situation or switching to healthier problem-solving strategies.

Critical Incident Debriefing

An organization needs to have a mechanism in place for debriefing after a violent or hostile act. This enables the counsellor to restore a sense of equilibrium. It is important to remember that a critical or violent incident may also affect and traumatize staff who were not directly involved, including clerical, janitorial, and kitchen personnel. Therefore, they should be involved in the debriefing.

Counsellors who have been assaulted or threatened with assault may be traumatized. They may experience symptoms such as recurrent images or thoughts of the event, distressing dreams, flashbacks, and intense stress when returning to the scene.
INTERVIEW 8.2  Follow-up to a Violent Incident

In the following example the counsellor, a group home worker, is reviewing an incident with her client. The incident occurred two hours ago and was precipitated when the counsellor denied the client, a 16-year-old male, permission to meet with some of his friends later that night. The client threw his chair across the room and stormed out of the office while screaming obscenities.

Counsellor: I'd like it if we could talk about what happened.

Analysis: Whenever possible, it’s important that clients be invited to review prior incidents. By telling the client how she felt, the counsellor may be giving the client new information that will increase the client’s capacity for empathy. Often, violent or acting-out clients are so preoccupied with their own needs and fears that they don’t realize the impact they have on others.

Client: I guess I got a bit carried away.

Analysis: This helps the client to retain some dignity. Notice that the counsellor’s acceptance of her client’s apology does not condone his behaviour, as would a statement such as “It’s okay. Don’t worry about it. No real harm was done.”

Counsellor: I was scared.

Analysis: One goal of counselling is to help clients recognize their own early warning indicators that they are in danger of losing control.

Client: I’m sorry. I won’t let it happen again.

Analysis: Empathy confirms that feelings have been heard and understood.

Counsellor: I accept your apology.

Analysis: The client rationalizes his behaviour, putting the responsibility on others. Without directly challenging the rationalization, the counsellor shifts the focus back to a client strength.

Client: I was still upset from seeing my mother. When you said no, it was just too much.

Counsellor: It’s never been easy for you to talk to your mom. You always seem to come back really wound up.

Analysis: Feedback confrontation challenges the client to consider some new alternatives. The counsellor takes advantage of an opportunity to reframe the client’s problem statement into a goal.

Client: Yeah, those are the days that people should stay out of my face.

Counsellor: Good point. Sounds like you know that you need some time alone when you’re stressed.

Analysis: Acknowledgment of the client’s restraint, however late, provides a base for further development. By doing so, the counsellor reinforces nonaggressive behavioural alternatives.

Client: You got it.

Counsellor: As we talk, I’m wondering what prevented you from taking that time. If you’d taken the time to cool off before approaching me, things would have been a lot different.

Client: Sure, I know I have to learn to control my temper, but once I get going I just can’t seem to stop myself.

Counsellor: Put another way, your hope is to find a way to deal with your feelings so that you don’t get angry and hurt someone.

Analysis: Of the incident. There may be a marked decline in their ability to handle routine work tasks, and they may feel detached and isolated from colleagues. They may develop sleep difficulties and have difficulty concentrating. Frequently, they return to work in a state of hypervigilance, constantly expecting further trauma. Often they describe themselves as “numb” and unable to enjoy activities that usually give them pleasure.
MacDonald and Sirotich (2005) reviewed studies and reported that victims of client violence might experience the following:

- troubled relationships (with colleagues and family)
- reduced ability to function in the workplace
- more absenteeism
- higher levels of burnout, depression, anxiety, and general irritability stemming from threats or abuse

When symptoms such as these are present, counsellors should consider obtaining medical assessment or professional counselling.

Even when counsellors are not injured, the threat of violence can be just as traumatic. Typical responses may include helplessness and thoughts of leaving the profession. These feelings may develop immediately or emerge after a delay of months or even years. Consequently, it is important to debrief critical incidents to lessen shock, reduce isolation, and restore personal control. Team debriefing should take place as soon as possible after the incident. Debriefing should be conducted by an objective third party in a safe setting. It should be held as soon as possible after the critical incident, usually within 24 to 72 hours, to minimize the effects of any trauma that victims or witnesses may be experiencing. This is important in promoting a return to the normal routine of the agency. A typical debriefing session is like a counselling interview. The debriefing should reinforce team interdependence. Sometimes counsellors are reluctant to ask colleagues for assistance, believing that asking for help is a sign of incompetence. One goal of a debriefing is to develop a staff culture in which asking for help is understood as a sign of strength rather than a weakness. A critical incident debriefing generally has the following elements:

1. All team members are invited to share feelings and reactions about the current or prior incidents. Active listening can be used to promote this process. This helps individuals who were threatened or assaulted to “normalize” their own reactions. Counsellors should require little persuasion about the benefits of talking about their feelings. They might be reminded that sharing feelings is something they routinely ask of their clients. Helping team members manage feelings is the major objective of the debriefing. At this time it is important to identify the potential physical and emotional reactions that staff may experience. As well, information regarding services, such as employee assistance programs (EAPs) that are available to staff who need additional help to manage their emotions, should be detailed.

2. The team conducts a post-mortem on the violent event. A thorough analysis of what transpired is used to review and reinforce procedures for dealing with violent clients. An important question for the team to consider is “What, if anything, could we have done to prevent this incident?” For example, the team can explore whether any early warning indicators of pending violence were overlooked. They can investigate whether there were things that individuals or the agency did or did not do that contributed to the client’s behaviour.

3. The team debriefing is an important “teachable moment” when staff are highly motivated to develop their skills. It is a chance to explore alternative responses that might have been used at all stages of the critical incident. Role-play and simulations can be used to practise alternative responses. This step helps empower individuals and the team by moving them away from any tendency to feel helpless.
COUNSELLING ANGRY AND VIOLENT CLIENTS

The obvious counselling goal is to assist these clients to develop skills and responses that do not harm others. Safety is the top priority. While there is no single best strategy, the following intervention choices can be tailored to meet the needs of individual clients.

Prevention

Sometimes, long before violence erupts, counsellors intuitively feel that the situation is worsening. This feeling may be based on unconscious reactions to subtle cues and indicators. Counsellors and clients might find it useful to try to concretely identify these clues. Doing so will assist clients in becoming sensitive to those initial psychological responses that signal the imminent onset of the anxiety phase. Clients who become adept at recognizing early warning indicators are in a much better position to take early warning action, such as withdrawing from an explosive situation or switching to healthier problem-solving strategies.

Assertiveness Training

Assertiveness involves exercising personal rights, including the ability to express feelings and ideas without guilt or undue anxiety, without denying the rights of others (Shebib, 1997). It requires respect and empathy for other people. Assertiveness training helps clients express feelings in a nonaggressive manner. When clients are able to respond assertively, they establish an atmosphere of cooperation where conflict can be peacefully resolved. It is clearly distinguished from aggression, which involves the use of power, domination, and intimidation to achieve one’s goals, and passivity, which foregoes personal rights and needs. Counsellors can help clients develop assertive communication skills such as active listening, especially empathy. Some clients know how to respond assertively, but low self-esteem or fear inhibits them from making appropriate assertive choices. Cognitive behavioral counselling can be used to address these issues. Strategies such as relaxation training, deep breathing, and mindfulness can be used to assist clients to deal with anxiety.

The skills of counselling are also, to some extent, the skills of effective everyday communication. This puts counsellors in a good position to teach their clients techniques for resolving conflict and crises nonviolently. Communication skill training equips clients with more choices for asserting their rights and respecting others. Often conflict is difficult for clients to settle because they are unable to see the perspectives or feelings of others in the conflict. Clients who learn empathy and other active listening skills are better able to compromise because they are less likely to judge their own behaviour as absolutely right and that of others as absolutely wrong.

Cognitive Behavioural Counselling

As discussed in Chapter 7, CBT helps clients to identify and manage unhelpful thinking patterns such as catastrophizing or blaming others. CBT can also focus on helping clients learn alternate behavioural choices which, when practised, will lessen any tendency to default to the anger mode.

Anger Management

Anger is a normal emotion and the appropriate expression of anger can deepen relationships. Out of control anger can destroy relationships. Anger management skills
include recognizing and managing triggers (e.g., avoiding problematic situations). Counsellors can use role playing and modeling as a way to help clients develop alternate responses. They can also teach breathing and relaxation techniques.

**Substance Misuse Interventions**

The use of illicit substances is strongly linked to increased violence, so intervention targeting this important area is crucial. A wide range of choices include 12-step programs, residential treatment, CBT, harm reduction, treatment of co-occurring mental disorders, traditional healing practices, exercise, nutrition, spirituality, and many other strategies have proven effective.

**Psychiatric Intervention**

Psychiatric assessment can determine whether medication is warranted. Antidepressant or antianxiety medication may be useful as an adjunct to counselling. Medication alone is not recommended.

**Reduction of Stressors**

Resolution of issues related to unemployment, poverty, relationship dysfunction, and housing are important targets for intervention.

**Counselling Victims**

Counsellors may be called upon to deal with domestic violence where the overwhelming number of victims are women. A 2015 survey by the Canadian Women’s Foundation provides startling statistics that underscore the extent of the problem for women in Canada:

- Fifty percent of women over 16 report having experienced at least one incident of physical or sexual violence since the age of 16.
- Every six days a woman in Canada is killed by her intimate partner.
- On any given day in Canada, more than 3,300 women (along with their 3,000 children) are forced to sleep in an emergency shelter to escape domestic violence.
- Each year, over 40,000 arrests result from domestic violence—that’s about 12% of all violent crime in Canada. Since only 22% of all incidents are reported to the police, the real number is much higher.
- As of 2010, there were 582 known cases of missing or murdered Aboriginal women in Canada.
- In a 2009 Canadian national survey, women reported 460,000 incidents of sexual assault in just one year, but only about 10% of all sexual assaults are reported to police.
- More than one in ten Canadian women say they have been stalked.

When counsellors are working with victims of violence, the number one concern is to help them take steps to ensure their safety. Clients should be made aware of their rights and options including use of police (phone 911), restraining orders, and transition homes. When dealing with perpetrators of victims of spousal violence, counsellors may face the challenge of dealing with cultural or religious ideologies that favour patriarchal dominance and control. Further, cultural norms may preclude disclosure and the victim, fearful of judgment and shame, may suffer the abuse in private. Counsellors might explore whether there are culture-specific resources such as support groups or community leaders that might be of assistance.
BRAIN BYTE  Children and Abuse

The brains of children who are abused (or witness abuse) can be profoundly affected and lead to a wide range of problems, including emotional regulation (damage to the amygdala, and changes in brain chemistry including affecting neurotransmitters such as epinephrine, dopamine and serotonin increased and the stress hormone cortisol), learning deficits such as difficulty concentrating/focusing, language acquisition, organizing, loss of interest (damage to the cortex and hippocampus, sleep disturbances, relationship issues, and low self-esteem. (American Psychological Association, 2015, Kendall, 2002)

SUCCESS TIP

A common, repeating pattern (cycle), often emerges in abusive relationships. This cycle of abuse or violence develops through four stages: 1. Build-up of tension; 2. Abusive incident (verbal, emotional, physical, sexual); 3. Abuser remorse; and 4. Honeymoon period (when all is calm).

For many and varied reasons, women may choose to stay in abusive relationships. Counsellors need to remain empathic and suspend any tendency to impose judgment or to push women to leave. While counsellors can help women understand the inherent risks of remaining in the home, they need to support the decision to stay or leave as belonging to the woman, even where this choice seems to defy logic.

SUMMARY

- Resistance is a common defensive reaction that interferes with or delays the process of counselling. It may be evident in a variety of ways, such as failure to cooperate with the basic routine of counselling, subtle or direct attacks, passivity, and nonverbal cues.
- It is important for counsellors to evaluate their own feelings and behaviour as well as aspects of the agency that might be triggering resistance.
- Effective confrontation helps clients come to a different level of understanding, behaving, or feeling.
- Clients may become violent or threatening for a number of reasons. Although it is difficult to predict with certainty which clients will become violent, some risk factors can be isolated. The best predictor of violent behaviour is a history of violence; substance abuse is also a common variable. Other factors that counsellors should consider when assessing risk are age, gender, and personality characteristics.
- Effective management of potentially violent situations includes prevention and appropriate responses to the four phases of violence: anxiety, defensiveness, acting out, and tension reduction. It is important to debrief critical incidents to lessen shock, reduce isolation, and restore personal control. Team debriefing should take place as soon after the incident as possible. It should provide an opportunity for people to talk about their feelings and to review what went wrong.
- Counselling interventions include a focus on safety, assertiveness training, anger management, cognitive behavioural counselling, harm reduction, psychiatric assessment and treatment, and support for victims of spousal abuse.
EXERCISES

Self-Awareness

1. Self-evaluate your personal comfort when confronting others.
   a. What people would you have difficulty confronting?
   b. Do you avoid confronting?
   c. Think of times when it was reasonable to confront but you didn’t. What prevented you from confronting?
   d. Finish the following sentence: When I confront, I feel . . .

2. Review your experiences dealing with individuals who are angry, resistant, or potentially violent. What is your natural reaction when someone’s anger starts to escalate? Do you tend to fight back? Or do you withdraw? What aspects of your experience will help you deal effectively with difficult situations? What aspects will impede your ability?

3. Reflect on your thoughts, feelings, and behaviour when you were forced or pressured to do something against your will. How might your reactions help you to understand and work with clients who are “involuntary”?

Skill Practice

1. Work with a colleague to role-play an appropriate counselor confrontation in each of the following situations:
   a. youth who has hygiene problems
   b. colleague who has, in your opinion, behaved in an unprofessional manner
   c. client who consistently arrives late for appointments

2. Evaluate the effectiveness of each of the confrontations below; suggest improvements:
   a. Try to do better next time.
   b. You’re an idiot.
   c. You’re saying that you’re okay, yet you’re crying.
   d. Grow up and act your age.
   e. As long as you continue to act like a doormat, you’re going to get abused. If you’re serious about protecting yourself, leave him.

3. Interview counsellors from different settings regarding their experiences with violent or potentially violent clients. Discuss strategies that they have found effective.

4. Work in a small group. Assume that you are members of an inner-city needle exchange centre. Develop detailed policies and procedures for dealing with violent and potentially violent clients.

5. Suppose you review the file on your next client, a 16-year-old male, and discover that he was loud and abusive with his previous counsellor. What are some possible explanations for this client’s behaviour? Suggest some strategies for working with this client.

6. Work in a small group to explore the potential benefits and risks of each of the following:
   a. having an unlisted phone number
   b. making home visits alone
   c. making home visits only when accompanied by a colleague
   d. conducting joint interviews for potentially hostile clients
   e. using only your first name with clients
   f. knowing that a client has a history of violence
   g. interviewing a client with a police officer present
   h. refusing to see a client with a history of violence
   i. striking a client to defend yourself
   j. calling the police
   k. warning an intended victim
   l. seeing a client who has been drinking

7. The setting is a residential centre for youth. Your last interview with Peter was particularly distressing. It ended with his throwing the chair against the wall, swearing loudly at you, and then storming out of your office, slamming the door in the process and breaking one of the hinges. This incident seems to have been precipitated by his frustration at not being allowed to smoke in the centre. Develop a plan for dealing with Peter during the next interview and in the coming months. Suggest specific leads you can use in the next interview. Consider three possible scenarios:
   a. He displays remorse over what happened.
   b. He downplays the serious nature of the incident.
   c. He’s still angry.

8. Work with one or two colleagues to practise assertiveness:
   a. expressing anger
   b. saying “no” to a request
   c. sharing positive feelings such as love or affection
   d. accepting a compliment
   e. expressing disagreement
   (Suggestion: Role play aggressive and passive responses for each of the above scenarios, then discuss how assertiveness differs).

Concepts

1. Research legal and ethical codes to explore your responsibility to notify intended victims of violence. Talk to counselors and agencies for their opinions.

2. Write a short concept paper that describes what you believe are the elements of effective confrontation.

3. Hamachek (1982) says, “Do not confront another person if you do not wish to increase your involvement with that individual” (p. 230). Develop a rationale that supports this statement.

4. How can assertively expressed anger deepen relationships?
WEBLINKS

The Crisis Prevention Institute provides information about training programs and resources for nonviolent crisis information
www.crisisprevention.com/program/nci.html

Canadian Centre for Occupational Health and Safety provides information about violence and violence prevention
www.ccohs.ca/oshanswers/psychosocial/violence.html

This website provides access and links to a wide range of health and emotional issues (use the search feature to research topics)
www.mayoclinic.com

A comprehensive Canadian study on mental illness and violence