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Chapter 7

Approaching and Engaging the Violent Client

This chapter addresses the various approaches that are effective in engaging and interviewing clients who have problems with violent behavior. First, I discuss how to prepare to intervene with an aggressive client, including anticipating your role in the relationship and the kinds of countertransference reactions that may occur. Next, I discuss how to choose a safe interviewing environment and how to verbally connect with an aggressive client, including clients who may be psychotic or involuntarily hospitalized, using empathy, communication skills, and the strengths approach. These engagement skills can be used both in the office and during home visits. More detail regarding special considerations for home visits is provided in Chapter 9.

PREPARING FOR THE INTERVENTION

The Role of the Social Worker

Violence is a relationship between the person who perpetrates the violence and the person who is the target of the violence. A social worker who is the target of a client's violent behavior often plays a critical role in the precipitation and escalation of the violence. This is not to imply that the social worker should be blamed; rather, the point is that the victim is always part of the relationship in some way. In 26% of 588 homicides reported by Wolfgang (1958), the victim was the first to show or use a lethal weapon or to use physical violence. Also, words, looks, and attitude can be as provocative as physical blows. A sarcastic remark, an

angry look, a belittling statement can be very powerful in provoking a threat or in serving to move a threat toward violent action. Clinicians' countertransference reactions, for example, projecting rage onto or rejecting a client, may also provoke violence, and these feelings may not be fully conscious. As previously mentioned, it is important to bear in mind when analyzing client violence that such violence does not occur in a vacuum. To make a threat, one needs someone else to threaten. The dynamics of the relationship between the one who makes the threat and the one who is threatened can provide clues to motive and, subsequently, to the focus and goals of preventive action, as the following composite case from the CV Study illustrates:

> "I was seeing a very clingy, demanding client that I had known for about 6 months. I didn't want to see him that day, and I guess I wasn't as empathic as I usually tried to be with him. It was late on Friday afternoon, and I wanted to finish up and go home. Suddenly he accused me of not caring about him and then threatened to smash my head against the wall. I immediately confronted the threat, apologized for not being supportive, told him I wasn't feeling well, and asked him to not take my mood personally. Eventually I managed to get the client to calm down. I know now that the next time I feel angry toward a client, I need to get a grip or talk to a colleague or even reschedule the client rather than risk setting the client off because of how I'm feeling."

In this case, the social worker did not deliberately provoke the client, but his attitude toward the client was one of resentment and lack of empathy. The client immediately picked up on the worker's mood, felt rejected, and then became enraged. Fortunately, the worker was able to engage in immediate self-reflection and recognize his role in provoking the client—including an understanding of how perceived rejection can lead to rage—and was then able to neutralize the rage by providing empathic support. Because the worker's action was immediate, the threat was reduced, and physical violence was avoided.

Which Social Workers Are Most at Risk?

When I conduct workshops on risk assessment and intervention with violent clients, I am invariably asked the following question: "Which social workers are most at risk of being victimized?" We know that some worker characteristics do seem to elevate risk in practice. The CV Study found that male social workers were significantly more likely to be targets of client violence than female social workers and that they experi-

enced higher rates of violence than female workers (Newhill, 1996). Explanations for this finding may lie in gender differences related to practice setting and the greater willingness of male social workers to work with violent clients. Paradoxically, male workers *perceived* themselves to be *less* at risk than females did. One could speculate that this factor may play a role in male workers being more willing to place themselves, or in being asked by others to place themselves, in high-risk situations, thus leading to a higher probability of experiencing violent incidents. Anecdotally, many male respondents in the CV Study stated that they were frequently called in to intervene with violent clients, particularly when the client's worker was female; thus case assignment practices by supervisors may play a role in male workers' elevated risk (Newhill, 1996).

These findings on gender raise some important questions. Is it more culturally acceptable to express violence toward males than toward females? Is it more acceptable to place males in risky situations than to place females in risky situations? Do males self-select high-risk positions, or are cultural forces in operation? Do some male workers incite violence somehow by their practice approaches? For example, some investigators have reported that clinicians who are more authoritarian are more likely to experience client violence (Kronberg, 1983; Ray & Subich, 1998). If we want to ensure safety for all workers, males and females, we need to look for answers to these questions.

CHOOSING A SAFE INTERVIEWING ENVIRONMENT

Facing an agitated, angry, verbally threatening, and abusive client is very intimidating, particularly if the client is unfamiliar to the clinician. Violent clients are often brought involuntarily to the agency. They are not asking for a social worker's help and may be forced to see you against their will by other interested parties, such as family, friends, the police, or the court system. Under such therapeutically adverse circumstances, how do you successfully engage the client? Here you must balance two considerations: (1) safety and (2) choosing the approach that will best serve to empathically connect with the client and provide compassionate care.

Safety is important not only because you want to protect yourself but also because any feelings of nervousness, apprehension, or fear will interfere with the effectiveness of any interventions you apply and may result in escalation of the violence and increase the risk of subsequent physical injury. Thus, when you decide how and where to interview the client, you must be sure that your decision supports feeling safe and being safe with the client.

There are a range of choices in terms of interviewing environments, from most restrictive to least restrictive. Most social workers believe strongly in the importance of employing the least restrictive alternative when working with clients. This is an ideal, however; and although one might value it, reality may dictate a more restrictive alternative in order to fulfill the goal of safety. Because the level of restrictiveness can change as your work with the client progresses, your initial choice of a more conservative approach to restrictiveness can be changed if you judge such change to be prudent and therapeutic. Tardiff (1996) identifies five interview options, graded from least to most restrictive, as follows:

- Interviewing the client alone in the office with the door closed.
- Interviewing the client alone in the office with the door open.
- Interviewing the client alone in the office with the door open and staff members present outside the door.
- Interviewing the client with staff members present inside the office.
- Interviewing the client while the client is in physical restraints.

The least restrictive and most private option is to be alone with the client in the interview room with the door closed. Being alone with the client means that you do not have immediate visible access to other people who may be a source of protection, but there is still much that you can do to promote your personal safety. For example, the usual recommendation is that the clinician should sit between the client and the office door. If the client becomes violent, you will be the closest to the door and can easily escape. Some have made the argument that allowing the client to sit by the door decreases the risk that the client will feel trapped, which serves to reduce the potential for violence. The problem with this argument is that such a seating arrangement traps *you*, and you will have more difficulty escaping. The best design for an interview office is to have two doors so that both you and the client can sit by an exit. Many clients will choose escape before they choose violence. For example:

> "I was interviewing a client who had been brought in by the police because he was trying to direct traffic in a busy intersection downtown and had almost been hit by a car. I had seen this client twice before, so we at least had an acquaintance. As I began to inquire about what had happened to cause the police to bring him in, the client became very agitated and then threatened to punch me. Fortunately, the interview room had two exits—I was sitting by one and the client was sitting by the other. The client stood up and

> balled up his fist as if to try to hit me but then he saw the door next to him, opened it, and ran out of the room and out of the clinic. The police caught him and brought him back, this time keeping handcuffs on, along with sitting unobtrusively in the interview room with me" (Newhill, 1995b).

In the CV Study, 8% of the clients who engaged in attempted or actual physical attacks were trying to escape from some kind of confining situation, usually a locked inpatient unit, and attacked the social worker simply because he or she was in the way or because the worker was perceived as the main obstacle between the client and escape.

To recap, the most private option, albeit the least protective of safety, is to be alone with the client in the office with the door closed. If you do not feel safe with the client under these circumstances, the next option is to interview the client alone in the office with the door open. If you do not know the client, or the immediate history is one of violence and unpredictability, or the client appears agitated and threatening, this option is preferable to the first. This option preserves some privacy and enhances safety, because the open door increases the probability that staff members will hear any calls for help. Safety is further enhanced if staff members stand by right outside the open office door. In this case, however, privacy is further decreased because the staff members can hear clearly what is going on in the interview.

What do you do if the client asks you to close the door? Remember, safety is one of the main priorities, and you must respect your assessment and gut feelings and not feel obligated to abide by the client's request. However, it is important to be sensitive to the issue of privacy, and the client is entitled to an explanation as to why you prefer the door to remain open. For example, you could say the following: "I understand that you would prefer that I close the door, however, I am more comfortable with the door open for now until we've had a chance to talk some more. Could you tell me more about what was happening when your mother called the police?" If the client still insists that he or she wants complete privacy, you can then say: "I understand that you want privacy, but I'm concerned about what your family has told me about what happened today, and you still seem pretty upset. For everyone's safety, I would prefer that the door remain open until we've sorted out what is going on and how we can help you." In this statement, the clinician is frank about the safety issue but is not blaming the client. Furthermore, the safety issue is combined with the message that the clinician wants to learn the facts of the situation objectively and, most important, wants to help the client.

The fourth option is to interview the client with staff members pres-

ent inside the interview room. This option is the best alternative if the client is not in restraints but is highly agitated, unpredictable, or threatening. Intoxicated clients usually fall within this category. It is also a good alternative in cases in which, although the client may appear in control when you see him or her, a reliable witness has reported serious threats or violent behavior just prior to the evaluation. Even with staff members present in the room, violence can still occur. For example, Newhill (1995a) reports the case of a social worker who was interviewing a psychotic client who had been brought to the hospital by two sheriff's deputies after he was found walking naked down the middle of a highway. Although the social worker interviewed the client with the deputies present in the room during the interview, the client was still able to leap across the room and try to strangle the social worker. However, because the deputies were present and were able to act quickly, the social worker suffered only minor injuries.

The final, and most restrictive, interviewing option is to interview the client while the client is in physical restraints. Other clinicians and researchers have written extensively about the proper use of restraint and seclusion (see, e.g., Bernay & Elverson, 2000; Tardiff, 1996), addressing indications and contraindications, proper procedures, methods of containment, and proper documentation; thus these issues are not addressed here beyond briefly noting the primary indications. Restraint and seclusion are two different interventions with different purposes. Restraint is indicated under three conditions (Tardiff, 1996): (1) to prevent imminent harm to the client or others when less restrictive means are not effective; (2) to prevent significant disruption of the treatment program or serious damage to the physical environment; (3) as an appropriate consequence in a behavioral treatment program. In contrast, the purpose of seclusion is to reduce the stimulation a client is exposed to, either by recommendation of staff or at the client's request. Psychotic and manic clients, for example, are often highly sensitive to any kind of sensory stimulation, and seclusion can help reduce stimulation, which can have a beneficial effect on the client's symptoms and the client's response to medication.

Attempting to physically control a client can be a high-risk activity for staff members, and many studies report that a significant proportion of staff injuries occur during containment procedures (see, e.g., Fisher, 1994). To be physically restrained by someone else can be a dehumanizing and humiliating experience for the client (Bernay & Elverson, 2000), and thus it is usually viewed as a treatment of last resort. To ease the client's fear and humiliation, it is extremely important to explain to the client clearly why he or she is being restrained or secluded and what will happen to him or her in the immediate future, even if the client is grossly

psychotic or manic and may not appear to follow what you are saying. On some level, he or she will hear you, and such understanding will be a significant comfort for the client. As a former client once commented to me: "I know I was really out of it and you probably didn't think I heard you but I did, and knowing why the cuffs were on and that they'd be taken off once I felt better helped me feel less scared in the hospital" (personal communication, 1983).

When making a decision about restrictiveness, rely on your clinical judgment, based on your gut feelings related to safety combined with a thorough risk assessment of the client. In addition, you should pay self-reflective attention to any negative countertransference reactions, such as anger or denial, on your part that might interfere with effective intervention with the client. If you realize, for example, that you are feeling resentful about seeing the client, give yourself a time-out before you begin the interview or make any decisions about restrictiveness. Talk it over with a trusted colleague, take a few minutes by yourself to sort out your feelings, or consider the possibility that perhaps you should refer the client to a coworker if you are too angry, upset, or resentful to provide effective intervention. Even in high-pressure settings such as emergency rooms, you can always take a few minutes to reflect and collect your wits. In addition to countertransference reactions, we all have bad days, and things can happen in our personal lives that can temporarily affect our clinical abilities. You must be able to recognize when this happens and be willing to make decisions accordingly, with the client's best interest in mind.

ENGAGING AND TALKING WITH THE VIOLENT CLIENT

Once you have decided where you will interview the client, the next question is: How do you approach the client? First, you should speak in a normal tone of voice, not loudly or too softly, in a nonprovocative, nonjudgmental manner and begin by commenting in a neutral, concrete way about an overt aspect of how the client appears and behaves (Tardiff, 1996). For example, you could say to an angry client, "You look angry," or to a visibly anxious client, "You seem to be very anxious." This opens the conversation with an clear concrete message that you are attempting to understand what the client is experiencing. You want to avoid any negative or belittling comments, because such comments are provocative and may result in goading the client into aggression. You want to appear both in control and nonthreatening.

Second, you want to be sure that there is adequate space between you and the client. You should both be on the same level, either both

sitting or both standing, preferably sitting. You want to avoid being physically above or below the client, because such differences symbolize differences in power and control. You don't want to be literally "looking down on" or "looking up to" the client. If the client is on a gurney in physical restraints, rather than standing by the gurney, sit down so that, although the client is lying down, you can still be at eye level with him or her. You don't want to present yourself in an intimidating way, because you want to avoid putting the client in the position of feeling powerless and having to defend him- or herself. Respect for the client must be consistently conveyed, both in your verbal and nonverbal messages.

Third, you should try to avoid continued direct eye contact with the client, because it may be interpreted as a challenge that could provoke violence. Communicating a challenge via direct eye contact is an aggressive behavior demonstrated by most animals, including humans. Two wolves, for example, who are preparing to fight over territory will circle each other and stare at each other's eyes until one of them makes the first aggressive move. You also don't want to appear to be avoiding eye contact. A good way to handle this is to look at the client at a point between his or her eyes. This way you are looking at the client and communicating interest and involvement, but you are also avoiding direct eye contact.

What do you do when the client begins to talk? When the client begins to talk, you should listen and appear empathic, concerned, and uncritical, which should be natural for most social workers. It is important that you do not interrupt the client and that you let him or her have his or her say. Often clients who are violent or threatening have difficulty in expressing themselves verbally, and so your role at this stage is to support and encourage their verbal expression without interrupting them with premature advice. If you do not do this, you may provoke the client:

> "I was interviewing a client who had been brought in by the police after threatening to kill himself and his child. The client had great difficulty in expressing himself, and I was feeling really anxious about the situation and wanted to get it resolved. As he was slowly telling me about how his life was unraveling, I stupidly jumped in and finished a sentence for him. He became very angry and then wouldn't talk to me anymore. I had to call in a colleague to finish the interview. The best thing I learned from that experience was the importance of being quiet" (Newhill, 1995b).

The goal is to try to obtain the client's view of the situation and what led up to the violent incident. Once this information has been elicited, then you can gently begin to state your perception of the situation and work on correcting any misunderstandings or misperceptions held by the client. Finally, as you proceed with the interview, avoid making any premature promises (Tardiff, 1996), for example, promising not to admit the client to the hospital before your evaluation is complete or promising a resource that may not be available. The reason for this precaution is straightforward: You may not be able to keep that promise, and not keeping a promise can rupture the fragile trust built between you and the client. Say to the client honestly, "I don't know yet if you will be hospitalized or not. I need to complete my evaluation first, and a decision will be made."

Engaging Violent Clients Who Have Delusions and Hallucinations

As noted in Chapter 5, violence in psychotic individuals usually occurs when the psychotic symptoms, such as paranoid delusions or command hallucinations, make the individual feel personally threatened (Link & Stueve, 1994). You should not try to argue the client out of a delusion, nor should you collaborate in the delusion. The job of the clinician, when intervening with such an individual, is to understand the nature of the symptoms and then take whatever action is needed to help the client feel safe. Helping the client feel safe is the best antidote to preventing violence in such cases.

Taylor and colleagues (1994) also suggest that certain qualities of the delusional beliefs carry a greater risk of violence. For example, the strength of the individual's delusional belief and the nature of the content of the belief—for example, the extent to which the individual believes that an outside agency has spiritual or physical control of him or her—has a significant association with subsequent violent behavior. Thus clinicians should do more than simply note whether a delusion is present or not. Rather, adequate evaluation of the potential of the delusional belief itself to influence violence is critical. Such an evaluation involves assessing the content and fixity of the delusion, along with exploring the client's perception of the impact of the delusion. Does the client feel safe? If not, what does the client believe needs to be done to achieve safety, and does such action involve violence? Some clients are very guarded about revealing the content of their delusions, and others are not. However, if the client believes that the clinician's motive in gathering information about his or her delusion is to ensure his or her safety

and welfare, and if the clinician empathizes with the client's fear and anxiety, then enough trust may be achieved for the client to reveal the information needed. At that point, the clinician can engage in problem solving with the client, with the goal of identifying alternatives that avoid violence. The following composite case provides an example of how this approach works:

> The client was a young woman who had been diagnosed with paranoid schizophrenia. She was compliant with her medication but still had an unshakable delusion that workers at a certain fast-food restaurant were controlling her mind. In the town where she lived, there were several restaurants in this chain, and she had to pass by one of them to get to the day treatment program at the mental health center. She was becoming very anxious and revealed that she was thinking of doing something violent to the personnel of that particular restaurant to force them to close. I discussed with her the risks of doing this and asked if we could talk about some alternatives that would help her to feel safe. She agreed to work on this, and we identified an alternate route to the mental health center that would allow her to avoid passing by the restaurant. The plan included identifying alternative public bus stops so she could easily make the trip, whether she walked or rode the bus. She tried this and it worked well for her. The delusion remained, but she felt safe and didn't have any more thoughts of violence (Newhill, 1995b).

Clients who experience command hallucinations telling them to harm others are more than twice as likely to be violent as those who do not have such hallucinations (McNeil et al., 2000). Thus, when evaluating violent or threatening clients who are psychotic, it is important to investigate whether the client is experiencing command hallucinations and, if so, what the content of the hallucinations is and whether the client thinks he or she can ignore the hallucinations or whether he or she must comply with them. The individual's actual and perceived ability to cope nonviolently with hallucinations is a critical variable when assessing violence risk and determining the most appropriate treatment. The following composite case example illustrates this:

> The client was a 23-year-old man with paranoid schizophrenia who came to the hospital emergency room asking for admission. He had been seen at the psychiatric emergency clinic every other day in an effort to get treatment to control his severe auditory hallucinations but hadn't had much relief. Up until that day, the voices had been loud but benign. At this point, he said he was hearing command

hallucinations telling him to kill other people, particularly family members. With an impending holiday, his family was having various gatherings. The anticipation of having so many people around was making the client more anxious and fearful about losing control. He stated he could not ignore the voices any longer and was afraid he would get a gun or knife and kill someone that night if he was not admitted. He was very agitated, preoccupied, appeared to be responding to internal stimuli, and was irritable. In spite of close outpatient follow-up and compliance with his medication, he had not stabilized, and, therefore, it was decided to admit him to the hospital. When he was told of the admission decision, the client said he felt relieved and began to cry (Newhill, 1995b).

Although evidence from numerous studies over the past decade have shown a positive relationship between command hallucinations and violence, this association may be related to a number of moderating variables (McNeil, 1994). For example, the nature and course of the disorder causing the hallucinations is relevant (Monahan, 1988). During acute episodes of psychosis, there is a stronger relationship between command hallucinations and violence than there is during periods in which the individual is stabilized with treatment, even if he or she is still experiencing hallucinations. Medication seems to help not only in controlling the hallucinations but also in enabling the individual to better handle the hallucinations that remain. As a client once commented to me: "When I had to go to the hospital I couldn't handle the voices—they were too loud and I just lost it [meaning that he had became violent]. Now after being in the hospital and taking my medicine, I still hear voices, but I can ignore them" (personal communication, 1985).

The individual's environment is another critical variable that affects whether or not the hallucinations will lead to violence. Studies have shown that individuals with paranoid schizophrenia are more likely to be violent outside the hospital, in the community, than they are when stabilized within a structured hospital setting (Krakowski, Volavka, & Brizer, 1986). McNeil (1994) suggests that the reason for this may relate to a variety of factors, including differences in how a client responds to medication in the community versus in the hospital, different responses related to the structure provided by an inpatient unit versus the openness of the community setting, greater compliance with treatment on inpatient settings, and the greater likelihood that the client will encounter individuals in the community about whom he or she has delusions. In sum, the best treatment for psychotic symptoms to prevent violence is

medication and positive, structured social support. If that fails, hospitalization should be considered.

Engaging Involuntarily Admitted Violent Clients

Many violent individuals come to clinical attention involuntarily, and thus it is important to know the strategies that can be effective in engaging and intervening with such clients. The *legally involuntary* client is under some kind of judicial mandate that requires social work intervention, whereas the *socially involuntary* client is not under legal mandate but is under strong social pressure to participate in treatment—for example, the husband whose wife tells him to get counseling or she will file for divorce. Being involuntary means that the client has lost some valued freedoms, and this loss can precipitate a range of responses, including hostility and aggression, obstinacy, and refusal to cooperate or participate in treatment. To reduce these responses and increase the probability of engaging the client, the clinician can use a number of useful strategies, including the following (Murdach, 1980; Rooney, 1992):

- Approach the client with respect and present yourself in an authentic and genuine manner.
- Support client self-determination by increasing the client's choice of alternatives as much as possible.
- When using confrontation, combine it with empathy. You can empathize with the client's feelings, such as anger and resentment, but remain firm about mandates and behavior limits.
- Explore two or more sides to questions and decisions.
- Avoid overemphasizing suggestions for behavior change.
- When identifying areas in which the client must change, be highly specific, identify areas in which the client doesn't have to change, and emphasize that the clinician–client contract will focus on the eventual restoration of freedom.
- Use bargaining and negotiating as a strategy for treatment contracting and goal setting and set feasible goals that support clients's strengths.

As you can see, these strategies emphasize the use of empathy and drawing on client strengths. These are two very critical areas when working with violent clients.

THE ROLE OF EMPATHY AND COMMUNICATION SKILLS IN WORKING WITH VIOLENT CLIENTS

Along with presenting yourself in an authentic and genuine way, empathy and good communication skills play crucial roles in working with violent clients. Empathy involves communicating an understanding of the other person's feelings without taking that person's position, thus retaining one's separateness and objectivity. There are several ways in which empathy can be used to connect with violent aggressive clients (Hepworth et al., 1997).

First, empathy helps to establish initial rapport with the client. Violent clients are often clients who have not experienced much empathy from others. In spite of the fact that the client may be experiencing painful feelings, the violence he or she has engaged in has usually served to elicit angry punitive responses from others rather than support and understanding. Connecting with someone who is willing to empathize with whatever feelings are behind the violence can be very beneficial. This does not mean that you condone the violent behavior; rather, you attempt to understand what the client is experiencing and feeling.

Second, empathy enables you to stay in touch with the client as you are interviewing him or her so that you can sense any subtle shifts in mood and behavior that may be precursors to violence. This can serve to promote safety because you will detect minute changes indicating escalation of anxiety, agitation, or aggression. Third, empathy assists in gathering data from the client. Many violent clients are guarded about answering questions and providing information, but empathy can serve to build trust. Fourth, empathy can help in correcting clients' misunderstandings, confusion, fears, or anxiety and can help in managing anger and aggression. Violent clients often report feeling angry, hurt, and frustrated about their conflicts with other people and their inability to resolve such conflicts without violence. Empathic responding can help clients work through such feelings by ventilating, by encouraging them to think through their conflicts, and by clarifying and relinquishing painful feelings until they feel more in control and can begin to make some rational decisions about their situation and develop nonviolent alternatives to solving their problems.

Fifth, and finally, empathy is helpful in maintaining your safety if the client becomes angry with you, because it can help you to avoid a defensive reaction and will support efforts to understand the client and tune in to his or her frustration and feelings of helplessness. For example, clients may expect you to make the police disappear or the criminal charges go away, or they may have other unrealistic expectations of what you can do to help them. When faced with the reality of their situation, they may lash out at you. Being clear about limits but at the same time empathizing with their feelings of frustration can help de-escalate the client's anger and prevent any violent action.

Client violence and aggression, however, come in all forms, and sometimes clients have committed behaviors that you find repellent and difficult to understand—for example, the husband who is brought to the clinic on charges of domestic violence and then indignantly complains to you that his wife won't obey him even when he beats her. Or the mother who is referred to you from jail on charges that she shook her 2-week-old baby, causing brain hemorrhaging, because the baby wouldn't stop crying. Conflicts can occur between your personal and professional values and your client's expressed values or behavior that can negatively affect your ability to empathize. How can one empathize with someone who has committed a heinous act? How can we as social workers remain helpful and nonjudgmental toward someone whose behavior upsets or even disgusts us?

One approach that can be useful is to try to separate the *person* from the *behavior*. In this way, you can affirm the client's worth and dignity *without* condoning behavior that may be destructive or harmful to the client and other people. It is important to realize that in order for the client to be willing to look at alternative ways of handling his or her life, he or she must feel understood and respected by you.

Although it may be tempting, you should avoid moralizing with clients, particularly with clients who have problems with aggressive behavior. Moralizing can induce shame and humiliation, and these are individuals who often already harbor such feelings. You should give the client an opportunity to save face, and moralizing will only reinforce the shame that the client is already experiencing (Gilligan, 1996). Avoiding this, however, requires that you are clear about where you stand in terms of values so that you can separate your values from the values and needs of the client. Then you will be better equipped to approach clients who are behaving in ways you would never personally condone in an empathic and nonjudgmental manner. This will give you a better chance to help the client change his or her destructive behavior into positive behavior.

ROLE OF THE STRENGTHS PERSPECTIVE

Another important component in working effectively with violent clients is using a strengths perspective. The strengths perspective is an important ingredient when working with violent clients because, rather than immediately focusing on what may be wrong with the client, it capitalizes on the client's strong points, positive qualities, current coping abilities, and overall potential for resolving his or her problems and controlling his or her behavior. In contrast, the violent client is usually focused

on his or her own weaknesses, limitations, or past mistakes and often feels powerless and ashamed. The strengths perspective can be helpful for clients who have problems with violence because it engenders hope and encouragement and enhances motivation rather than simply punishing them for their behavior. The following is an example of a dialogue between a social worker and a client that illustrates both the use of empathy and the strengths perspective.

Case Example

The client was a 26-year-old single African American man who was brought to the emergency room by the police. The client had been drinking and got into an argument with his father. When the father took his bottle of whiskey away, the client assaulted him with a broom. The client came willingly into the social worker's office but kept his head down and wouldn't make eye contact.

SOCIAL WORKER: My name is John Smith and I'm a social worker here in the emergency room. The doctor asked me to see you because he thought I might be able to help you with what is going on tonight. Could you tell me why the police brought you in to see us?

CLIENT: I don't know. What difference does it make?

SOCIAL WORKER: Well, the police usually don't bring someone in unless something happened. Who called them out?

CLIENT: My mom.

SOCIAL WORKER: Do you know why your mom called them?

CLIENT: I'm just a piece of crap . . . (*begins crying and doesn't say anything else for a couple of minutes*) . . . oh man, I was just drunk. Look, just get out of my face. I don't need some social worker poking into my life.

SOCIAL WORKER: Sounds like things aren't going so well and you're feeling pretty upset. I really want to help you, but I'd like to hear your side of things. I don't want to just go on what the police have told me. Or what your mom says. Could you tell me a little about yourself? Are you living with your parents?

CLIENT: Yeah.

SOCIAL WORKER: Are you working?

CLIENT: Yeah, I work. I have a good job. Look, I know I have a drinking problem, you know. And I went to rehab and got sober—I've been sober for six months and I'm just living with my folks 'til I can save

up enough money to get an apartment. But my girlfriend left me and I bombed out—starting drinking again—my dad tried to take the bottle away and so I hit him and I feel like crap about it . . . (*sobs*) . . . my folks have been good to me. Are they going to put me in jail?

SOCIAL WORKER: I don't think you're going to jail—my understanding is that your folks aren't pressing charges—they just want you to get some help. From what you're telling me, you've been doing great until today. You've been sober for several months—that's a tough thing to do—and you've got a job and plans for the future. Part of recovery is realizing that everyone can relapse, and most folks do, particularly when there's a crisis, but the key is to get back into recovery and you can do that—you did it before. You haven't lost all you've accomplished.

CLIENT: Yeah, I guess . . . I have an AA sponsor and he's an okay guy.

SOCIAL WORKER: Good. You can give him a call from here if you want after we finish talking. I can understand that you're feeling really bad right now, but you've got a lot going for you and I think your folks know that. Tell me a little more about what happened with your girlfriend. . . .

This excerpt illustrates how the strengths perspective can be interwoven into the clinical interview. Here we have a client who has been doing well with his substance abuse problem, but a crisis sent him into a relapse and an incident of violence. What the social worker does is to validate and empathize with his painful feelings and also give him positive feedback about the areas in which he has significant strengths. These strengths represent resources that can be tapped to help the client resolve the current problem. If you view your clients positively, with a sincere belief that they can work out their problems, they will usually adopt the same attitude eventually, if not immediately. They will leave your conversation feeling realistically hopeful that they have the capacity to solve their problems.

CONCLUSION

Approaching and successfully engaging a violent client is a challenging task, particularly if the client comes involuntarily and has not sought help on his or her own. This challenge is compounded if the client is suffering from serious psychiatric symptoms, such as psychosis, that can impede his or her ability to trust and connect with the clinician. This

chapter has addressed how to prepare for interviewing the violent client, both clinically and in terms of the interviewing environment, and how to use empathy, communication skills, and the strengths approach to do this successfully. One must always remember that violence is a relationship, and thus establishing an empathic, trusting relationship with the client is one of the best strategies to prevent violence toward you, the clinician. Chapter 8 focuses on reviewing a range of suggested treatments for work with violent clients, with emphasis on the indications and contraindications for each type of intervention.

SKILL DEVELOPMENT EXERCISES

Engaging Violent Clients Role-Play Exercise

Following are five client situations in which the clients are violent and either legally involuntary, socially involuntary, resistant, or a combination thereof. Role-play participants should be divided into pairs—one plays the role of the client, the other plays the role of the social worker. A third participant may be added in the role of observer to give feedback to the role-play participants. In the role play, the social worker should interview and engage the client and try to accomplish the following goals:

- Directly address the violence expressed by the client
- Establish initial contact and rapport
- Express appropriate empathy
- Identify, communicate, and draw on the client's strengths
- Monitor his or her own feelings throughout the role play
- Provide appropriate confrontation
- Establish the beginning of an intervention plan

Client Situation 1

The client is a white male, age 18, on probation for motor vehicle theft and reckless driving. His probation officer has sent him for counseling because she is concerned about the client's inability to control his temper; thus counseling has been made a condition of probation. Failure to comply will result in jail time. The client has been given a dual diagnosis of personality disorder and chemical dependence. Before he can even be called into the social worker's office, he barges in and kicks over a chair.

CLIENT: Look, man, I don't need no social worker. I've got to find me a

job and a place to crash—the courts have messed me over enough already. I don't have nothing to talk about.

Client Situation 2

The client is a Hispanic male, age 36, who had been ordered to counseling by the court because he was convicted of a second driving under the influence (DUI) charge. When arrested, he got into a fight with the police officer and punched him. Failure to comply with treatment will result in jail time. He looks angry, slouches in his chair, and glares at the social worker:

CLIENT: I don't know why I have to talk to you. So I had a couple of beers one night? So what? I don't have a drinking problem—I can stop any time I want to. My only problem is having to see you. Get out of my face or I'll fix you like I did that cop.

Client Situation 3

The client is a 28-year-old African American female who has been accused of neglecting her baby. The child protection social worker makes a home visit. When she introduces herself, the client slaps the social worker across the face and tells her to leave. The client's family then restrains the client and asks the social worker to please stay and talk with them. According to the family, the patient suffered a head injury six months ago after a car accident and has been unpredictable since then. They say that they have tried to help her care for the baby but she refuses their help.

CLIENT: (*Doesn't say anything and just cries*)

Client Situation 4

The client is a white female, age 21, ordered to counseling by the court and child protection services after she left her two children, ages 5 months and 6 years, home alone for 2 days. The court claims she was out copping dope with her boyfriend; she also has a history of bipolar disorder. To get her children back, she must comply with treatment. She sits sullenly in the chair and digs out a crumpled yellow paper from her purse and throws it at the social worker.

CLIENT: Here's the damn court paper. Do what you have to do and let me get out of here.

Client Situation 5

The client is a Japanese American male, age 21, seen in the jail infirmary after trying to hang himself in his cell. The jail has requested that you evaluate him for a possible psychiatric commitment. He was jailed on a charge of assault with a deadly weapon and has been diagnosed with antisocial personality. As the social worker enters the room, the client throws a wastebasket toward him, although it doesn't end up hitting him.

CLIENT: You don't give a shit about me—it's just your job. You think I should live? Well, just give me one good reason. Don't have one, huh? Get out of here and leave me alone.

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