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CHAPTER 6

Harassment of Clinical Psychologists by Clients

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SUMMARY

In this survey conducted in 1997 and 1998 it was found that over two thirds of 137 clinical psychologists working in Irish Health Boards and Voluntary Bodies had experienced at least one sexual, physical and verbal potentially negative interaction with a client. Twenty six percent considered that they had been sexually harassed by clients; 36% that they had been physically harassed and 64% that they had been verbally harassed. A significant minority had experienced extremely negative interactions with clients, 2% had been sexually assaulted, 18% physically assaulted, and 85% subjected to verbal abuse or suicide threats. The most harassing sexual interactions were requests for intimate physical contact, being brushed up against, touched or grabbed and being asked for a date. The most harassing physical interactions were being cornered by a client, having clients describe fantasies of physical violence involving the clinician, and being stalked. The most harassing verbal interactions were receiving suicide threats, having complaints made to senior clinicians and being phoned at home or at work without permission to do so. The frequency with which particular negative interactions occurred differed across specialties. In terms of negative sexual interactions, requests for hugs, being brushed up against, grabbed or touched in a grossly inappropriate way were more commonly

reported by psychologists working with people with intellectual and physical disabilities compared with those working within the adult or child mental health specialties. With respect to negative physical interactions, reports of clients making intimidating gestures, throwing objects, denying access or exit from rooms, pushing, kicking and physically assaulting clinicians were more commonly made by psychologists working in the areas of intellectual and physical disability and adult mental health. With respect to negative verbal interactions, more psychologists working in the area of adult mental health reported inappropriate phone calls to the home or office and also threats of suicide compared to clinicians working in child mental health or disability services. For sexual, physical and verbal negative interactions, problem solving and reappraisal based coping strategies were more commonly used than strategies that aimed to regulate distressing emotional states or facilitate avoidance of the threatening situation. Seeking support from colleagues, addressing the issues raised by the negative interaction with the client, and taking self-protective measures were the most commonly used problem-solving coping strategies. Reframing negative interactions as therapeutic issues rather than sexual, physical or verbal aggression was the most common reappraisal strategy. Problem-solving based coping strategies were perceived to be the most effective. Negative interactions with clients and harassment by clients were unrelated to clinical psychologists stress levels as assessed by the GHQ-28.

INTRODUCTION

A primary aim of this study was to ascertain the extent to which clinical psychologists were exposed to negative or harassing sexualised, physical and verbal interactions with their clients and to explore the way in which they coped with these stressful interactions.

Over the past twenty years, the issue of harassment in workplace has received an increasing amount of attention. A substantial body of research has focused on the characteristics of harassment and the long and short term consequences for victims and perpetrators (e.g. Shrier, 1996, Koss et al, 1994). However, while sexual, physical and verbal harassment have all been acknowledged as problematic issues in the workplace, it is the area of sexual harassment which has received the most attention from the media, the general public and researchers. Sexual harassment has cost millions to businesses world-wide, in terms of loss of productivity, staff replacement, sick leave and insurance claims. For example, the US Federal Government reported in 1980 that the sexual harassment of women cost one hundred and two million dollars over a two year period (Li Ping Tang & McCollum, 1996).

Before considering substantive findings on harassment, some of the methodological difficulties which have plagued research in this area deserve mention. Research into harassment has been predominantly based on retrospective, self-report surveys. Such surveys are useful because they avoid the difficulties of interviewer bias and are typically a relatively quick procedure (Shaughnessy & Zechmeister, 1994). However, they may involve the problems of response bias and low response rates. In the harassment research field there have been two additional methodological difficulties. The first has been the use of convenience rather than random sampling which limits the generalizability of results and the second has concerned the operational definition and assessment of harassment as a construct (Arvey & Cavanaugh, 1995). Behaviours are not intrinsically harassing, but rather in certain contexts particular people may

construe specific interaction as harassing insofar as they constitute an inappropriate threat posed by another person. For example, a request for a date from an adult with a moderate learning difficulty may be perceived as non-threatening but a similar request from an adult sexual offender with a history of rape may be viewed as extremely sexually harassing. Arvey and Cavanaugh (1995) propose that many survey items which researchers consider to constitute sexually harassing behaviour may not be perceived as such by respondents and so prevalence results of sexual harassment based on such surveys may be misleading.

Sexual Harassment

Sexual harassment refers to exposure to unwanted conduct of a sexual nature, or other conduct based on sex affecting the dignity of women and men at work. This can include unwelcome physical, verbal or non-verbal conduct (Commission of the European Communities, 1993). Sexual harassment can range in intensity from sexual innuendo, ambiguous touching and flirtatious remarks at one end of the spectrum to clear cut sexual assault and rape at the other (Shrier, 1996). The motivation to sexually harass is a wish for domination rather than sexual lust or desire (Gruber & Bjorn, 1982). Female workers have experienced sexual harassment by male employers since they were first represented in the work force, but sexual harassment has only been commonly accepted as a societal problem since 1976 with the publication of the Redbrook survey (Benson & Thompson, 1982). Prevalence rates of sexual harassment vary across different populations. For example, sexual harassment is experienced by as many as 64% of women in the US military (Pryor, 1995), 36% of women autoworkers (Gruber & Bjorn, 1982) and 30% of female students at Berkeley University (Benson & Thompson, 1982).

More women than men are sexually harassed and these women have unique demographic profiles (Li Ping Tang & McCollum, 1996). A woman is

more likely to experience harassment if she is younger than 34 years of age, is well educated, is single or divorced and is employed in a work environment in which there is limited amount of communication with her superiors. However, a low income female is somewhat more likely to be sexually harassed than women in higher income bracket and most victims of harassment are dependent on their jobs.

The severity and type of psychological, physical and economic consequences of sexual harassment have been shown to depend on a number of factors including how the harassment was perceived by the harassed employee, the severity and chronicity of the harassment and the work organisation's response to the harassment (Shrier, 1996). While both men and women appear to agree, for the most part, on the type of behaviours which constitute sexual harassment, men tend to report few, if any, negative short or long term effects of such behaviours (Shrier, 1996, Li-Ping Tang & McCollum, 1996). Surveys of women who have been sexually harassed indicate that harassed employees frequently experience negative outcomes related to work performance, psychological health and physical health (Pryor, 1995; Shrier, 1996).

The two principal coping strategies reported in the literature for coping with sexual harassment are ignoring it or assertively confronting the aggressor (Gruber & Bjorn, 1995; Pryor, 1995). These reflect avoidant and approach based coping styles (Ferguson & Cox, 1997). Ignoring is the most commonly reported coping strategy for low intensity harassment experiences and assertive confrontation is more commonly reported for more severe and intrusive forms of harassment.

In recent years, the issue of sexual harassment in health services has been highlighted (deMayo, 1997). According to Dan et al (1995), sexual harassment is an occupational hazard in nursing. They reported that 89% of surveyed nurses had experienced one or more incidents of sexual harassment by physicians; 83% of nurses reported being sexually harassed by co-workers; 75% reported being sexually harassed by patients; and 73% reported being harassed by visitors.

Grieco (1987) found that 76% of nurses (N=462) experienced sexual harassment in the workplace and that patients were the perpetrators of harassment in 87% of the incidents while physicians were the alleged perpetrators in 67% of the incidents.

There has been little research conducted into the prevalence and effects of sexual harassment by clients on clinical psychologists. deMayo (1997) in a survey of 750 licensed female clinical psychologists asked participants to indicate if any of their clients had engaged in any of a list of fifteen sexualised behaviours. Participant's then rated the degree to which they perceived behaviours their clients had engaged in as sexual harassment. The survey showed that 53% of psychologists reported having experienced at least one incident of sexual harassment by a client. The more severe incidents of sexual harassment involved male clients and sexual harassment in general was found to be more likely during the first ten years of licensure. A significant relationship was found between age and reports of sexual harassment with younger clinicians being more likely to state they had experienced such behaviour.

Qualitative analysis of participant's responses indicated that clinicians typically distinguished between sexualised behaviour and sexual harassment. Sexualised behaviour was judged to be benign in cases when it was perceived as transference and when it was judged contextually appropriate. However where sexualised behaviours were deemed to contain an intent to control or dominate a therapist, or where professionals' boundaries were repeatedly violated, behaviours were judged more negatively as sexual harassment. The clients' psychological status was considered important by psychologists in making judgements about the how harassing the behaviours were. For example sexualised behaviour from a psychotic client was typically viewed as a manifestation of psychopathology rather than as sexual harassment. Despite the high proportion of clinicians who had experienced sexual harassment, relatively few psychologists reported profound negative effects. deMayo proposed that the role of the psychologist and the experience of supervision and peer support may

act as protective factors against negative consequences of sexual harassment.

Physical and Verbal Harassment

Less research has been conducted on the areas of physical and verbal harassment than on the area of sexual harassment. Nevertheless, verbal and physical harassment or abuse have been reported in a number of health care areas, including psychiatry, nursing, social work and psychology (Shick-Tryon, 1986). Bernstein (1981) surveyed 453 health professionals from the disciplines of psychiatry, psychology, social work and family and marital and family counselling and found that 14% had experienced some degree of assault while 36% had been threatened with assault by patients. In only 9% of the 180 patient confrontations were therapists able to predict the impending assault.

Mezey and Shepherd (1994) report that assaults on health care professionals are on the increase, particularly for those professionals working in primary care settings. According to these authors, several risk factors for assault have been identified. These include lack of staff training, working in isolation, low staffing levels, inadequate security and situations where there is little active therapeutic activity involving patients. Furthermore the authors report that ambulance staff, family practitioners working in socially disadvantaged areas, casualty staff and health care professionals working with clients with psychiatric or intellectual disabilities are particularly at risk of assault by patients.

Everitt et al (1991) interviewed nurses about the frequency and effect of abuse by geriatric patients living in a residential setting. The authors report that both physical and verbal abuse were perceived as distressing 90% of the time and that verbal abuse was considered most distressing when the patient was considered to have reasonable cognitive functioning.

The short and long term consequences of physical and verbal abuse in heath care professionals has received limited attention by researchers. In the short term victims may react with denial or may become overwhelmed by fear to

the extent that they may become incapable of responding (Koss et al, 1994). Physical and verbal harassment may have long term negative effects on physical and psychological well-being (Burge, 1989). Van Dierendonck et al (1994) found that 25% of 576 Dutch family physicians had experienced physical harassment by patients in the year preceding the study and that this led to high levels of burnout. In this study, physicians had higher rates of burnout than nurses. Burnout was characterized by emotional exhaustion, depersonalisation and disillusionment with personal accomplishments.

Shick Tryon (1986) in a survey of 300 US psychologists in clinical practice found that verbal harassment was reported by 66% and physical attacks by 12% of respondents. There was no sex difference observed when physical assaults were examined. However women in private practice were less likely to be verbally abused than men. Interestingly, when Shick Tryon investigated therapists response to physical or verbal harassment, almost one third of the therapists reported that they continued to work with the client who harassed them. However the more frightened therapists were by violent incidents, the more likely they were to change their client selection criteria. As in the case of deMayo's (1997) survey of sexual harassment, psychologists who experienced harassment frequently sought support from colleagues.

Stress and Coping

Stress and coping offers a theoretical framework within which to consider the impact of harassment on clinical psychologists. Stress is most usefully conceptualised as a transactional process in which individuals mobilise their coping resources when confronted with perceived environmental threats (Folkman et al, 1986). Coping may serve a variety of different functions including modifying the threatening event (approach strategies), modifying the negative emotions arising from the perceived threat (emotional regulation),

altering the meaning of a potentially threatening situation (reappraisal) or facilitating avoidance of the threat (avoidance) (Ferguson and Cox, 1997). The extent to which brief daily stressors such as harassment, contribute to overall health and well being, and the effectiveness of coping strategies may be affected by the overall build-up of major stressful life events and the availability of social support from friends, family and colleagues (Billings and Moos, 1984; McCrae, 1984; Cohen and Wills, 1985).

Cushway and Tyler (1994, 1996) in a UK survey found that psychologists experience a wide variety of organizational stressors including pressure of workload, lack of resources, conflicts in relationships with other professionals, poor organisational communication and management difficulties. However, they also found that client distress, suicidal behaviour and aggressive or violent behaviours were significant stressors for clinical psychologists. The availability of social support and the use of active coping methods, which included problem-solving and planning were reported as being particularly effective and were associated with low stress levels. Avoidant coping strategies were associated with psychological distress. Talking to a friend or colleague at work was the most effective coping strategy identified in this study. Other helpful strategies included engaging in leisure or sporting activities. Sampson (1990) in a Scottish study of clinical psychologists obtained similar results.

Questions Addressed in this Study

From this review of the international literature it is clear that in other countries clinical psychologists are exposed to harassment (sexual, physical and verbal) from clients in the workplace. Harassment is a stressful experience and is coped with in a variety of ways. Probably the most effective coping strategies involve approaching the problem and seeking social support rather than avoiding the problem. To date this whole area of harassment of clinical psychologists by clients has not been investigated within an Irish context. The present study aimed

to address this gap in our knowledge by seeking answers to the following specific questions:

1. To what sexualised client behaviours have clinical psychologists been exposed in the 5 years preceding the study; with what frequency; and how harassing were these experiences?

2. To what negative physical interactions with clients have clinical psychologists been exposed in the 5 years preceding the study; with what frequency; and how harassing were these experiences?

3. To what negative verbal interactions with clients have clinical psychologists been exposed in the 5 years preceding the study; with what frequency; and how harassing were these experiences?

4. What coping strategies were used in managing sexual, physical and verbal negative interactions and what functions did these strategies serve?

5. What coping strategies were most effective in managing sexual, physical and verbal negative interactions with clients?

6. What are the profiles (in terms of sexual, physical and verbal negative interactions, coping strategies, demographic characteristics, overall life stress, and availability of social support) of groups of psychologists who report high and low levels of stress responses?

METHOD

Participants

A total of 324 clinical psychologists representing all known psychologists practicing in a clinical area in the Republic of Ireland were surveyed. One hundred and fifty three questionnaires were returned, of which one hundred and thirty seven were considered appropriate for inclusion into the study. Of the 16 unusable questionnaires, five were excluded as participants did not fulfil selection criteria outlined below. The remaining eleven questionnaires were returned incomplete and so could not be included in data analysis. Therefore the study achieved an acceptable response rate of over forty percent (42%). Participants were considered appropriate for inclusion if they met three criteria. First, all psychologists who had completed formal postgraduate clinical training, accredited by either the Psychological Society of Ireland or the British Psychological Society, were considered appropriate for inclusion in data analysis (60%). Second, psychologists in clinical posts who were eligible for application for permanent clinical posts under the Local Appointment Commission's (LAC) criteria were also considered appropriate for inclusion in data analysis (34%).

Table 6.1. Demographic characteristics

Variable	Category	N	%
Age	20-29 yr	32	23
	30-39 yr	49	36
	40-49 yr	36	26
	50-59 yr	15	11
	60-69 yr	5	4
Gender	Male	41	30
	Female	96	70
Marital Status	Single	49	36
	Married	72	53
	Other	15	11
Highest Educational Degree	BA/ BSc	9	7
	Higher Diploma in Psychology	6	4
	MA Applied/ MA Clinical	26	19
	PSI/ BPS Diploma	10	7
	M. Psych. Sc. or equivalent	61	45
	D. Psych. Sc or equivalent	6	4
	PhD	8	6
	Other	11	8
Employer	Health Board Community Care	51	37
	Health Board Special Hospital Programme	23	17
	Voluntary Organisation	46	34
	Department of Health Hospital	1	0.7
	Health Board Community Care and Special Hospital Programme	2	2
	Health Board Special Hospital Programme and other	5	4
	Voluntary Organisation and other	6	4
	Other	3	2
Health Board where employed	Eastern Health Board	16	21
	South Eastern Health Board	12	16
	Southern Health Board	5	7
	Mid Western Health Board	7	9
	Western Health Board	11	14
	North Western Health Board	11	14
	North Eastern Health Board	10	13
	Midland Health Board	5	7
Employment Status	Permanent (full and part time)	99	73
	Temporary (full and part time)	24	25
	Full time unspecified	2	3
	Part time unspecified	1	1

Table 6.1. (Continued) Demographic characteristics

Variable	Category	N	%
Grade	Basic grade	70	51
	Senior grade	50	37
	Acting Senior grade	2	2
	Principal grade	7	5
	Director/ Consultant	3	2
	Head of Service	3	2
	Other	2	2
Focus of Employment	Child and Family	59	43
	Adult	26	19
	Disability (Learning and Physical)	34	25
	Generic work with two or more client groups	17	13
	15-19 yr	24	18
	20-24 yr	13	10
	25-29 yr	6	4
	30-34 yr	4	3
Years with Employer	0-1 yr	25	18
	2-4 yr	41	30
	5-9 yr	27	20
	10-14 yr	16	12
	15-19 yr	18	13
	20-24 yr	5	4
	25-29 yr	4	3
Years in clinical practice	0-1 yr	13	10
	2-4 yr	29	21
	5-9 yr	30	22
	10-14 yr	17	13
	15-19 yr	24	18
	20-24 yr	13	10
	25-29 yr	6	4
	30-34 yr	4	3
Theoretical Orientation	Gestalt	1	1
	Eclectic	64	47
	Systems	12	9
	Humanistic/ Existential	3	2
	Integrative Psychoanalytic	4	3
	Behavioural	2	2
	Cognitive Behavioural	32	23
	Cognitive Behavioural and other	8	6
	Psychodynamic	10	7
	Psychodynamic and other	1	1
Years in Personal Psychotherapy	0-1 yr	40	30
	2-4 yr	43	32
	5-9 yr	5	4
	10-14 yr	3	2
	Other	6	4
	No personal work	38	28

Note: N=137. Missing data does not exceed 5 cases for any variable.

The final category for participation in the study included psychologists currently employed in clinical posts in either a Health Board or Voluntary Body but who neither had professional qualifications nor fulfilled the criteria for application to the LAC but who were practising under a grandfather clause. This was the smallest group of the three and comprised only 9 psychologists (7%).

Demographic characteristics of participants are outlined in Table 6.1. Respondents were predominantly married females, over four fifths of whom were aged between twenty and forty nine years of age. The majority of respondents had completed a Psychological Society of Ireland or British Psychological Society recognised post-graduate training in clinical psychology and were permanent employees of a health board in the position of a basic grade clinical psychologist, working in the area of community care. The group was almost equally divided between those who had more or less than 9 years experience. The group was also almost equally divided between those who had been with their current employer for more or less than 4 years. Nearly half of the sample reported that they were eclectic practitioners, although almost one quarter reported that their orientation was cognitive behavioural in nature. Just over thirty percent of participants had engaged in some form of personal growth work for a period of time between two and four years and 30% had engaged in personal growth work for less than a year.

On the GHQ-28 (Goldberg, 1978) the mean for the entire sample was 2.8 (SD=4.3). Thirty one psychologists (23%) scored at or above the cut off score of 5, indicating that just over one fifth of the psychologists were experiencing clinically significant levels of psychological distress and symptomatology. When psychologists' experiences of life events, as measured by the Social Readjustment Rating Scale (Holmes & Rahe, 1967), was examined, the mean life change score for the entire sample was found to be 109 (SD=81.7). In addition when psychologists' perception of social support, as measured by the Multidimensional Scale of Perceived Social Support (Dahlem et al, 1988), was

investigated, it was found that the mean score for the whole sample was 5.8 (SD=.9).

Instruments

Demographic Characteristics. A three page questionnaire covering all of the demographic characteristics listed in Table 6.1 was used to elicit relevant demographic information.

Sexual, Physical and Verbal Negative Interactions and Perceived Harassment Questionnaire. This questionnaire contained a list of 16 sexualized behaviours; a list of 16 negative physical interactions, and a list of 12 negative verbal interactions. The list of sexualised behaviours was that used by deMayo's (1997) in his survey of US female psychologists experiences of sexual harassment. The lists of physical behaviours and verbal interactions were developed for this study. For each list, respondents were asked to tick those behaviours or interactions they had experienced with their clients; the number of times they had been exposed to such behaviours or interactions with clients in the preceding 5 years; and the degree to which they experienced these behaviours or interactions as harassing. Harassment ratings were made on 7 point Likert scales.

Functional Dimension of Coping scale (Ferguson & Cox, 1997). Three copies of this scale were completed by respondents to indicate their coping responses to sexual, physical and verbal negative interactions. The copy of the Functional Dimensions of Coping Scale on which respondents indicated how they coped with clients' sexualized behaviours was completed immediately after they had completed their responses to the 16 item list of sexual behaviours mentioned in the previous section. A similar ordering of instruments was used in administering Functional Dimensions of Coping Scales to indicate how respondents responded

to negative physical and verbal interactions.

Completion of the Functional Dimension of Coping Scale was a three stage process. The first two stages of the process required participants to describe their worst incident of harassment and to specify the behaviours and cognition's they used to allow them cope with this particular stressor. To complete the third stage of the process, participants were asked to indicate the perceived function of their coping behaviours or cognitions by responding to a series of sixteen statements which covered four coping functions: approach, avoidance, reappraisal; and emotional regulation. Participants were also requested to rate the effectiveness of the coping strategies they used to deal with their most harassing incident on a seven point Likert scale.

The Functional Dimension of Coping Scale has been shown to demonstrate good factorial and criterion validity. The four factor structure has been replicated in a number of studies; the scale factors have been shown not to be associated with social desirability; and the scale factors also covary in predicted ways with a number of health anxieties (Ferguson & Cox, 1997). In this present study, alpha internal consistency reliability coefficients of above .8 were obtained for all four subscales when scales were used to assess coping responses to sexualised, physical and verbal negative interactions to clients. The only exception to this was the alpha coefficient calculated for the approach subscale used in the measurement of coping with sexualised behaviours. In this case, the alpha internal consistency coefficient was .74, which is well within the acceptable range.

The General Health Questionnaire (Goldberg, 1978). This 28 item questionnaire yields an overall score in addition to four subscale scores, which indicate the respondents status with respect to somatic symptoms, anxiety, social dysfunction and depression. Four-point response formats were used for each item. The 0,0,1,1 scoring method was used to obtain total and subscale scores. Scores are based on item totals. The reliability and validity of the GHQ-28 has

been consistently demonstrated in a substantial number of research studies. In the present study, an alpha internal consistency coefficient of .9 was obtained.

Multidimensional Scale of Perceived Social Support (Dahlem et al, 1991). This twelve item scale measures perceived social support from family, friends and a significant other. Responses to items are given on seven point Likert scales with high scores indicating greater perceived social support. Studies have indicated that the coefficient alpha for both the total scale and for the three subscales was above 0.9. This was found to be the case in the present study also. Studies have also provided little evidence to indicate that responses on the MSPSS are influenced by social desirability.

Social Readjustment Rating Scale (Holmes & Rahe, 1967). This is a forty three item questionnaire which examines stress associated with life events. The instrument yields one total score with high scores reflecting a high level of life-event related stress. All items on the scale are weighted in terms of life change units from one hundred points for death of a spouse to eleven for minor violations of the law. Scores on this scale correlate with a variety of stress responses and stress related illness (Sarafino, 1994).

Procedure

In the later months of 1997 and the early months of 1998 participants were identified by contacting psychologists of at least senior grade in each health care organisation in the 26 counties of the Republic of Ireland that employed psychologists. All senior or higher grade clinicians were sent a number of copies of questionnaires for distribution to the psychologists on their team. Each senior or higher grade psychologist received a comprehensive letter outlining the nature and aims of the study. Each basic grade psychologist also received a brief

explanatory letter. Three weeks following the initial posting, a reminder letter was sent to all senior or higher grade and basic grade psychologists.

Data Management

Once the coding of quantitative data was complete, all data were entered into the Statistical Package of the Social Sciences for Windows 95 (SPSS Version 7.5) on an IBM compatible PC and checked for accuracy.

RESULTS

The results are presented in six sections which correspond to the six questions listed at the end of the introduction. The sections are:

- Sexualized behaviours
- Negative physical interactions
- Negative verbal interactions
- Coping strategies and functions
- Effectiveness of coping responses
- Profiles of high and low stress groups

Table 6.2. Rank ordered means of frequency of incidents of sexualised behaviours

Sexualised behaviours	No. reporting such behaviour		No. of incidents	
Client requested hug	N	63.0	M	14.0
	%	46.0	SD	25.1
Client directed a sexist remark at you	N	31.0	M	5.4
	%	22.6	SD	6.0
Client gave you a suggestive look	N	46.0	M	5.1
	%	33.6	SD	4.9
Client brushed up, touched or grabbed you	N	13.0	M	4.7
	%	9.5	SD	4.1
Client made sexually suggestive gestures	N	11.0	M	4.5
	%	8.0	SD	5.6
Client touched you in a grossly inappropriate way	N	6.0	M	4.4
	%	4.4	SD	5.6
Client made a sexual remark about you	N	29.0	M	3.0
	%	21.2	SD	4.1
Client suggestively exposed body parts	N	9.0	M	2.9
	%	6.6	SD	1.8
Client requested intimate physical contact	N	6.0	M	2.7
	%	4.4	SD	1.1
Other sexualised behaviours	N	12.0	M	2.2
	%	8.8	SD	2.0
Client described sexual fantasies about you	N	21.0	M	2.0
	%	15.3	SD	1.1
Client made physical sexual assault	N	2.0	M	1.5
	%	1.5	SD	0.7
Client asked you for a date	N	22.0	M	1.4
	%	16.1	SD	0.8
Client gave inappropriate romantic/sexually suggestive gift	N	12.0	M	1.2
	%	8.8	SD	0.4
Client threatened sexual assault	N	0.0	M	0.0
	%	0.0	SD	0.0
Client attempted to solicit sexual activity by promise of gift or reward	N	0.0	M	0.0
	%	0.0	SD	0.0
Total	N	92.0	M	16.1
	%	67.2	SD	37.6
No of Psychologists reporting experiences of sexual harassment	N	35.0		
	%	25.5		

Note: N=137

Sexualised Behaviours

Twenty six percent of clinicians reported that they had experienced sexual harassment from their clients. From Table 6.2 it may be seen that fourteen of the sixteen sexualised behaviours were experienced by at least one clinical psychologist with the more innocuous sexualized behaviours being more commonly reported. The three most commonly reported behaviours were clients requesting a hug (46%), clients giving suggestive looks (34%%) and clients making a sexist remark (23%). The least commonly reported behaviours were sexual assault (2%), clients touching psychologists in a grossly inappropriate way (4%) and clients requesting intimate contact (4%).

The distribution of three specific sexualised behaviours differed significantly across the specialties of child mental health, adult mental health and disability services. These were: *Client requested a hug* (Chi Square (df=2, N=119)=26.5, p<.01); *Client brushed up, touched or grabbed you* (Chi Square (df=2, N=119) =17.7, p<.01); *Client touched you in a grossly inappropriate way* (Chi Square (df=2, N=119) =10.3, p< .01). *Client requested a hug* was more commonly reported by those in the area of disability (79%) compared with the adult (58%) or child mental health specialties (25%). Similarly *Client brushed up, touched or grabbed you* was more commonly experienced by disability psychologists (24%) than adult psychologists (4%) or child mental health psychologists (0%). Likewise, significantly more disability psychologists (12%) experienced being touched in a grossly inappropriate way compared to adult (0%) and child mental health psychologists (0%).

The frequency with which sexualized behaviours were reported for all items is given in Table 6.2. The three most commonly occurring behaviours were a hug (M=14, SD=25.1), a sexist remark (M=5.4, SD =6) and a suggestive look (M=5.1, SD=4.9).

Table 6.3. Rank ordered means of harassment ratings of sexualised behaviours

Sexualised behaviours	No. reporting such behaviour		Harassment rating	
Client requested intimate physical contact	N	6.0	M	4.8
	%	4.4	SD	2.4
Client brushed up, touched or grabbed you	N	13.0	M	4.0
	%	9.5	SD	2.1
Client asked you for a date	N	22.0	M	3.8
	%	16.1	SD	2.0
Client made sexually suggestive gestures	N	11.0	M	3.6
	%	8.0	SD	1.2
Client gave inappropriate romantic/sexually suggestive gift	N	12.0	M	3.6
	%	8.8	SD	1.2
Client made a sexual remark about you	N	29.0	M	3.4
	%	21.2	SD	2.0
Client directed a sexist remark at you	N	31.0	M	3.3
	%	22.6	SD	1.3
Client described sexual fantasies about you	N	21.0	M	3.3
	%	15.3	SD	1.9
Client suggestively exposed body parts	N	9.0	M	3.3
	%	6.6	SD	2.0
Other sexualised behaviours	N	12.0	M	3.3
	%	8.8	SD	1.7
Client gave you a suggestive look	N	46.0	M	3.0
	%	33.6	SD	1.5
Client touched you in a grossly inappropriate way	N	6.0	M	2.3
	%	4.4	SD	1.5
Client made physical sexual assault	N	2.0	M	2.0
	%	1.5	SD	1.4
Client requested hug	N	63.0	M	1.8
	%	46	SD	1.2
Client threatened sexual assault	N	0.0	M	0.0
	%	0.0	SD	0.0
Client attempted to solicit sexual activity by promise of gift or reward	N	0.0	M	0.0
	%	0.0	SD	0.0
Total	N	92.0	M	0.6
	%	67.2	SD	0.5
No of psychologists reporting experiences of sexual harassment	N	35.0		
	%	25.5		

Note: N=137

The three behaviours which had occurred most frequently over the preceding five years for child psychologists were a hug (M=12.5, SD=27.7), a suggestive look (M=4.1, SD=4.8), and sexually suggestive gestures (M=4, SD=0). In the case of psychologists working in adult mental health, the three most commonly occurring behaviours were *Client brushed up, touched or grabbed you* (M=7.0, SD=0), *Client gave you a suggestive look* (M=5.6, SD=4.6) and *Client requested hug* (M=4.2, SD=3.8). Finally the three most commonly occurring behaviours for psychologists in the area of disability were *Client requested intimate physical contact* (M=200, SD=0), *Client requested hug* (M=26.8, SD=32.3) and *Client made sexually suggestive gestures* (M=8.0, SD=10.4).

Harassment ratings of sexualised behaviours were elicited by means of seven point likert scales where one equalled *not at all harassing* and seven equalled *severely harassing* and these are summarized in Table 6.3. Overall the most harassing behaviour was considered to be a client requesting intimate physical contact (M=4.8, SD=2.4). The second most harassing behaviour was a client brushing up, touching or grabbing the clinician (M=4.0, SD=2.1), while a client asking a clinician on a date was perceived to be the third most harassing behaviour (M=3.8, SD=2.0). Interestingly, in the two cases where sexual assault was reported, the harassment rating was quite low (M=2.0, SD=1.4). As might be anticipated, a hug was perceived to be the least harassing of all sexualised behaviours (M=1.8, SD=1.2).

Mean harrassment ratings in the three specialties of adult mental health, child mental health and disability differed significantly for three sexualised behaviours. These were: *Client requested hug* ($F(2, 116)=16$, $p<.01$), *Client brushed up, touched or grabbed you,* ($F(2,114)=4.3$, $p<.05$) and *Client touched you in a grossly inappropriate way,* ($F(2,116)=4.4$, $p<.05$). Post hoc comparisons showed that disability psychologists perceived *Client requesting hug* to be more harassing than did psychologists in the areas of adult or child mental health. Similar comparisons revealed that disability psychologists also perceived *Client brushed up, touched or grabbed you* and *Client touched you in a*

grossly inappropriate way as more harassing than did psychologists in child or adult mental health services.

Negative Physical Interactions

Thirty six percent of psychologists reported that they had been physically harassed by clients. Fifteen percent of psychologists reported that they had been threatened with physical violence by their clients while 7% of psychologists reported that they had actually been physically assaulted by clients.

Over one hundred psychologists (73%) reported that they had experienced at least one of the sixteen negative physical interactions with clients outlined in Table 6.4 with the more innocuous interactions being more commonly reported. The three most commonly reported interactions were clients scowling (56%), clients staring in an intimidating way (50%), and clients making intimidating gestures, such as thumping the palm of their hand with their fist (50%). The least commonly reported interactions were clients describing a violent fantasy involving the psychologist (3%), clients spitting at the psychologist (5%), cornering the psychologist (5%) or stalking the psychologist at home or work (5%).

The distribution of seven specific physical behaviours differed significantly across the three specialties. These were: *Client made intimidating gesture,* (Chi Square (df=2, N=119)=7.8, p<.05), *Client denied you access/exit from room,* (Chi Square (df=2, N=119)=7.3, p<.05), *Client threw objects at you,* (Chi Square (df=2, N=119)=8.5, p<.05), *Client kicked you* (Chi Square (df=2, N=119)=11.8, p<.01), *Client pushed you* (Chi Square (df=2, 119)=9.0, p<.05), *Client physically assaulted you* (Chi Square (df=2, N=119)=12.0, p<.01), and *Other Physical Behaviour* (Chi Square (df=2, 119)=8.6, p<.05).

Table 6.4. Rank ordered means of frequency of incidents of negative physical interactions

Negative physical interactions	**No. reporting such interactions**		**No. of incidents**	
Client scowled at you	N	77.0	M	12.9
	%	56.2	SD	17.6
Client stared at you in an intimidating way	N	67.0	M	8.6
	%	48.9	SD	15.7
Client spat at you	N	7.0	M	7.0
	%	5.1	SD	6.7
Client physically assaulted you	N	9.0	M	5.7
	%	6.6	SD	7.1
Client kicked you	N	16.0	M	5.0
	%	11.7	SD	8.0
Client pushed you	N	19.0	M	4.9
	%	13.9	SD	5.5
Client damaged property in room	N	25.0	M	4.6
	%	18.2	SD	4.7
Client threw objects at you	N	25.0	M	4.5
	%	18.2	SD	5.2
Client made intimidating gestures; e.g. thumped palm of hand with fist	N	67.0	M	4.4
	%	48.9	SD	4.3
Client slammed office door	N	58.0	M	3.6
	%	42.3	SD	2.7
Other physical behaviour	N	8.0	M	3.3
	%	5.8	SD	2.1
Client threatened you with physical violence	N	21.0	M	3.1
	%	15.3	SD	4.9
Client cornered you	N	7.0	M	2.0
	%	5.1	SD	1.5
Client described fantasy of physical violence involving you	N	4.0	M	1.7
	%	2.9	SD	0.5
Client stalked you either at home or in work	N	7.0	M	1.7
	%	5.1	SD	0.5
Client denied you access/exit from room	N	10.0	M	1.6
	%	7.3	SD	0.9
Total	N	101.0	M	19.4
	%	73.1	SD	34.6
No of Psychologists reporting experiences of physical harassment	N	49.0		
	%	35.8		

Note: N=137

Client made an intimidating gesture was more commonly reported by adult mental health psychologists (50%), than by psychologists working in the area of disability (47%) and in the area of child mental health (24%). *Client denied you access/exit from the room* was more commonly reported by disability psychologists (12%) than by child (0%) or adult mental health psychologists (12%). *Client threw objects at you* was again more commonly reported by disability psychologists (32%) than by psychologists in child (9%) or adult (19%) mental health. Similarly, *Client kicked you* and *Client pushed you* was more commonly reported by psychologists working in the disability area (kicked: 9%, pushed: 27%) than by psychologists working in the mental health field with children (kicked: 5%, pushed: 5%) or adults (kicked: 4%, pushed: 12%). Disability psychologists also most commonly reported being physically assaulted (18%) in comparison to psychologists in adult (0%) and child (2%) mental health services. Finally, *Other Physical Behaviours* were more commonly reported by psychologists in the disability area (15%) than by psychologists in the mental health services for adults (8%) and children (0%).

From Table 6.4 it may be seen that the three physical behaviours which had been most frequently encountered by psychologists over the preceding five years were *Client scowled at you* (M=12.9, SD=17.6), *Client stared at you in an intimidating way* (M=8.6, SD=15.7), and *Client spat at you* (M=7.0, SD=6.7). Although, the incidence of behaviours such as stalking and cornering were quite low (M=1.7, SD=.5, M=2.0, SD=1.5 respectively), the frequency of physical assaults was higher (M=5.7, SD=7.1). However, this result is influenced by one clinician working in the area of child, who had been physically assaulted 20 times over 5 years.

As a result of this response, the most commonly occurring behaviour experienced by psychologists working in the area of child mental health was physical assault (M=20, SD=0).

Table 6.5. Rank ordered means of harassment ratings of negative physical interactions

Negative physical interactions	No. reporting such interactions		Harassment rating	
Client cornered you	N	7.0	M	6.3
	%	5.1	SD	1.1
Client described fantasy of physical violence involving you	N	4.0	M	6.0
	%	2.9	SD	1.0
Client stalked you either at home or in work	N	7.0	M	5.7
	%	5.1	SD	1.4
Client physically assaulted you	N	9.0	M	5.5
	%	6.6	SD	1.8
Client threatened you with physical violence	N	21.0	M	5.2
	%	15.3	SD	1.8
Client denied you access/exit from room	N	10.0	M	4.9
	%	7.3	SD	2.1
Client damaged property in room	N	25.0	M	4.0
	%	18.2	SD	2.0
Client made intimidating gestures; e.g. thumped palm of hand with fist	N	67.0	M	3.8
	%	48.9	SD	1.6
Client threw objects at you	N	25.0	M	3.8
	%	18.2	SD	2.2
Client stared at you in an intimidating way	N	67.0		3.7
	%	48.9	SD	1.5
Other physical behaviour	N	8.0	M	3.7
	%	5.8	SD	2.9
Client spat at you	N	7.0	M	3.6
	%	5.1	SD	1.7
Client pushed you	N	19.0	M	3.6
	%	13.9	SD	2.2
Client kicked you	N	16.0	M	3.4
	%	11.7	SD	1.8
Client slammed office door	N	58.0	M	3.1
	%	42.3	SD	1.6
Client scowled at you	N	77.0	M	2.6
	%	56.2	SD	1.4
Total	N	101.0	M	0.9
	%	73.7	SD	0.8
No of psychologists reporting experiences of physical harassment	N	49.0		
	%	35.8		

Note: N=137

The second and third most commonly occurring behaviours for this speciality were *Client threatening you with physical violence* (M=10.5, SD=13.4) and *Client spat at you* (M=10, SD=0). The two most frequent behaviours experienced by clinicians working in the area of adult mental health and disability were *Client scowled at you* (M=11.4, SD=15.6, M=17.3, SD=24.5 respectively) and *Client made intimidating gesture* (M=4.6, SD=5.6, M=16.2, SD=27.2 respectively). The third most frequently occurring behaviour for psychologists in adult mental health was *Client stared at you in an intimidating way* (M=4.2, SD=3.0), while the third most frequently occurring behaviour for disability psychologists was *Client spat at you* (M=8.5, SD=9.2)

Harassment ratings of negative physical interaction were elicited by means of seven point likert scales where one equalled *not at all harassing* and seven equalled *severely harassing* and these are summarized in Table 6.5. From Table 6.5 it may be seen that the three physical behaviours considered to be the most harassing for clinicians were *Client cornered you* (M=6.3, SD=1.1), *Client described fantasy of physical violence involving you* (M=6, SD=1), and *Client stalked you either at home or at work* (M=5.7, SD=1.4). Clinicians considered actual physical assault to be less harassing than these three behaviours. However, assault was still ranked quite high on the seven point likert scale (M=5.5, SD=1.8).

The three specialties differed significantly in their harassment ratings of five physical behaviours. These were: *Client slammed office door,* ($F(2, 111)=3.7$, $p<.05$), *Client made intimidating gestures,* ($F(2, 112)=4.6$, $p<.05$(, *Client damaged property in the room,* ($F(2,114)=3.2$, $p<.05$), *Client kicked you,* ($F(2,113)=4.4$, $p<.05$) and *Client physically assaulted you,* ($F(2,115)=4.6$, $p<.05$). Post hoc comparisons showed that in adult mental health psychologists perceived *Client slammed office door* to be more harassing than did child psychologists while disability psychologists perceived *Client made intimidating gestures* to be more harassing than did child psychologists. Psychologists in adult mental health perceived *Client damaged property in the room* as more harassing than did

child psychologists. Finally, disability psychologists perceived *Client kicked you* and *Client physically assaulted you* as more harassing than did psychologists from both child and adult mental health specialties.

Negative Verbal Interactions

Sixty four percent of clinical psychologists in this survey reported that they had been verbally harassed by clients. Eighty five percent of respondents had been either shouted or cursed at by clients.

All twelve verbal interactions listed in Table 6.6 and outlined on the questionnaire had been experienced by at least one clinical psychologist. In total, 69% of psychologists reported experiencing at least one of these negative verbal interactions with the more innocuous interactions being more commonly reported. The three most commonly reported negative verbal interactions were clients shouting (41%), clients repeatedly violating boundaries by asking intrusive personal questions (27%), and repeated suicide threats (23%). The three least commonly reported negative verbal interactions were clients alleging incompetence of the psychologist to other colleagues or clients (12%), clients repeatedly questioning psychologists qualifications (15%), and clients threatening litigation (15%).

The distribution of two verbal interactions differed significantly across the specialties of child mental health, adult mental health and disability services. These were: *Client repeatedly phoned you at home or in work,* (Chi Square (df=2, N=119)=9.3, $p<.01$) and *Client repeatedly threatened you with suicide,* (Chi Square (df=2, N=119)=8.2, $p<.05$).

Table 6.6. Rank ordered means of frequency of incidents of negative verbal interactions

Negative verbal interactions	**No. reporting such interactions**		**No. of incidents**	
Client frequently flooded you with information	N	30.0	M	9.7
	%	21.9	SD	13.0
Client repeatedly phoned you at home and/or work	N	29.0	M	9.1
	%	21.2	SD	19.6
Client repeatedly violated boundaries by asking intrusive personal questions	N	37.0	M	5.1
	%	27.0	SD	3.7
Client shouted at you	N	56.0	M	4.5
	%	40.9	SD	4.3
Client repeatedly threatened you with suicide	N	31.0	M	4.3
	%	22.6	SD	3.6
Client cursed at you	N	30.0	M	4.1
	%	21.9	SD	3.5
Client made derogatory comments about you	N	24.0	M	3.6
	%	17.5	SD	2.6
Client repeatedly misconstrued information	N	30.0	M	3.6
	%	21.9	SD	3.2
Client questioned qualifications repeatedly	N	20.0	M	3.0
	%	14.6	SD	2.5
Client threatened litigation when challenged	N	21.0	M	2.0
	%	15.3	SD	1.4
Other verbal interactions	N	5.0	M	1.7
	%	3.6	SD	1.1
Client alleged your incompetence to other professionals/clients	N	17.0	M	1.4
	%	12.4	SD	0.5
Total	N	94.0	M	12.5
	%	68.8	SD	18.6
Total no of psychologists reporting experiences of verbal harassment	N	88.0		
	%	64.2		

Note: N=137

In both of these cases, psychologists in adult mental health services experienced a higher percentage of these behaviours than did psychologists in the child mental health or disability specialties. Thirty nine percent of psychologists in adult mental health reported that clients phoned them inappropriately either at home or in work in comparison to 10% of those in child mental health and 24% of those in the disability services. Forty two percent of adult mental health psychologists experienced clients threatening suicide in comparison to 15% of those working with children and 18% of those in disability services

From Table 6.6 it may be seen that the three most frequently occurring behaviours experienced by psychologists over the preceding five years were *Client frequently flooded you with information* (M=9.7, SD=13), *Client repeatedly phoned you at home and/ or in work* (M=9.1, SD=19.6), and *Client repeatedly violated boundaries by asking intrusive personal questions* (M=5.1, SD=3.7). The least commonly occurring behaviour was *Client alleged your incompetence to other professionals/clients* (M=1.4, SD=.5).

The most commonly occurring behaviours for child psychologists were *Client repeatedly phoned you at home and/or at work* (M=30.7, SD=46.3), *Client frequently flooded you with information* (M=7.1, SD=6.3) and *Client shouted at you* (M=3.3, SD=2.1). Adult psychologists most frequently encountered *Client frequently flooded you with information* (M=7.2, SD=3.2), *Client repeatedly threatened you with suicide* (M=6.6, SD=3.5), and *Client repeatedly violated boundaries by asking intrusive personal questions* (M=6, SD=3). The three most frequently presenting behaviours reported by disability psychologists were *Client cursed at you* (M=6.2, SD=3.6), *Client repeatedly misconstrued information* (M=6.2, SD=3.6), and *Client frequently flooded you with information* (M=5.8, SD=3.3).

Harassment ratings of negative verbal interactions were elicited by means of seven point likert scales where one equalled *not at all harassing* and seven equalled *severely harassing* and these are summarized in Table 6.7.

Table 6.7. Rank ordered means of harassment ratings of negative verbal interactions

Negative verbal interactions	**No. reporting such interactions**		**Harassment rating**	
Client repeatedly threatened you with suicide	N	31.0	M	4.7
	%	22.6	SD	1.7
Other verbal interactions	N	5.0	M	4.7
	%	3.6	SD	1.0
Client repeatedly phoned you at home and/or work	N	29.0	M	4.0
	%	21.2	SD	1.5
Client threatened litigation when challenged	N	21.0	M	3.9
	%	15.3	SD	1.6
Client shouted at you	N	56.0	M	3.9
	%	40.9	SD	1.5
Client alleged your incompetence to other professionals/clients	N	17.0	M	3.8
	%	12.4	SD	2.0
Client repeatedly misconstrued information	N	30.0	M	3.4
	%	21.9	SD	2.0
Client frequently flooded you with information	N	30.0	M	3.3
	%	21.9	SD	1.9
Client questioned qualifications repeatedly	N	20.0	M	3.3
	%	14.6	SD	1.6
Client made derogatory comments about you	N	24.0	M	3.2
	%	17.5	SD	1.7
Client repeatedly violated boundaries by asking intrusive personal questions	N	37.0	M	3.2
	%	27.0	SD	1.8
Client cursed at you	N	30.0	M	2.8
	%	21.9	SD	1.5
Total	N	94.0	M	1.0
	%	68.8	SD	0.7
Total no of psychologists reporting experiences of verbal harassment	N	88.0		
	%	64.2		

Note: N=137

From Table 6.7 it may be seen that the three interactions perceived to be the most harassing by psychologists were *Client repeatedly threatened you with suicide* (M=4.7, SD=1.7), *Other verbal interactions* which included analysing the psychologist, threatening him or her and complaining to a manger (M=4.7, SD=1.7), and *Client repeatedly phoned you at home and/or in work* (M=4, SD=1.5). Psychologists perceived *Client cursed at you* to be the least harassing of all verbal interactions (M=2.8, SD=1.5).

Subgroups in the three specialties of child mental health, adult mental health and disability differed significantly in their harassment ratings of only one negative verbal interaction. This was *Client repeatedly phoned you at home and/or in work* ($F(2, 115)=3.7$, $p<.05$). Post hoc comparisons revealed that adult psychologists perceived such phone calls to be more harassing than did psychologists working in the area of child mental health.

Coping Strategies and Functions

In this section both qualitative and quantitative data relating to the coping strategies used by clinical psychologists and the coping functions these strategies fulfilled in dealing with sexual, physical and verbal interactions will be described. A content analysis was conducted on the qualitative responses of psychologists to the following question which was asked in relation to sexual, physical and verbal negative interactions with clients: "*There are many different ways of dealing with the type of stress that these behaviours can cause. If you experienced any of the above behaviours when working with clients, please indicate which behaviour you perceived to be the MOST HARASSING and then briefly describe the activities and/or thoughts you used to help you deal with such behaviour"* Respondents qualitative descriptions of the coping strategies they used were classified into four categories which were defined by the four coping functions outlined in the Functional Dimension of Coping Scale (Ferguson and

Cox, 1997). These four coping functions are as follows:

- Approach: The strategy involves approaching the threatening event and attempting to modify it
- Emotion regulation: The strategy involves modifying the negative emotions arising from the perceived threat
- Reappraisal: The strategy involves altering the meaning of the threatening situation
- Avoidance: The strategy involves physically avoiding or avoiding thinking about the threatening situation

A description of the actual coping strategies used by respondents, the way in which they were classified into these four categories, and the frequency with which they were reported for sexual, physical and verbal negative interactions are presented in Tables 6.8, 6.9 and 6.10 respectively.

From Tables 6.8, 6.9 and 6.10 it may be seen that across the three classes of negative interactions (sexual, physical and verbal) far more coping strategies which fulfilled the function of helping psychologists approach the problem and modify it or reappraise the situation were used than strategies which were classified as fulfilling the functions of emotional regulation or avoidance. Seeking support from colleagues, addressing the issues raised by the negative interaction with the client, and taking self-protective measures were the most commonly used strategies which fulfilled the function of helping psychologists approach the problem and modify it. Reframing negative interactions as therapeutic issues rather than sexual, physical or verbal aggression was the most common strategy used to reappraise the meaning of the potentially threatening situation.

Table 6.8. Content analysis of coping strategies used by psychologists to deal with sexualized interactions

Coping Functions	Coping Strategies	F
Approach	1. Discussed incident with colleagues/ team/supervisor	37
	2. Address issues/ set clear boundaries with client , e.g. discussed the incident with the client	26
	3. Redirected client to more appropriate behaviours, e.g. Gently asked client to redress and discuss/get check up with GP	11
	4. Concentrated on aspects of personal safety, e.g. used co- therapist when in 1:1 situations, or altered physical surroundings for next 1:1 session	9
	5. Re-referral, e.g. I decided no therapeutic work could happen from herein and he was transferred to another psychologist	4
	6. Assessed clients motivation to stop such behaviour	1
	7. Reported the client who was then readmitted to psychiatric unit	1
	8. Added assault up as a useful piece of information to know about this disabled client which we didn't know and would want to watch out for	1
	9. Used self talk strategies	1
	10. Used stress management techniques to cope with parents sexist comments	1
Emotion regulation	1. Used humour	2
	2. Reassurance , e.g. knew that I didn't have to keep seeing the client if I didn't feel comfortable	1
Reappraisal	1. Reframed difficulties as therapeutic issue, e.g. recognised that clients behaviour was part of his/her problem/ transference and so didn't personalise it	21
	2. Assessed own personal resources to prevent future occurrences	1
Avoidance	1. Ignored behaviour, e.g. ignored child's arousal	5
	2. Avoid client contact, e.g. avoided interaction with client who was giving me suggestive looks	1

Note: Content analysis based on 137 protocols. F=frequency

Table 6.9. Content analysis of coping strategies used by psychologists to deal with negative physical interactions

Coping Functions		Coping Strategies	F
Approach	1.	Discussed incident with colleagues/ team/ supervisor/ family member	21
	2.	Concentrated on aspects of personal safety, e.g. used backup staff/ ensured that another member of staff could be available if necessary, made sure I had the phone number of the local Garda station	20
	3.	Addressed the issue with the client	15
	4.	Attempted to diffuse the situation, e.g. tried to talk down the situation calmly/ drawing attention to body language etc., did not try to engage the client at a personal level until they had backed off.	8
	5.	Informed other relevant professionals, e.g. reported the client who was then readmitted to psychiatric unit	2
	6.	Investigated more appropriate means of communicating & teaching it	1
	7.	Objectified behaviour	1
	8.	When threatened with firearm, I thought let someone else deal with this and called the police	1
	9.	When stared at by client, did not show fear	1
	10.	Physically overpowered client in such a way that the client wasn't hurt	1
	11.	Cleared up the room after client was gone	1
	12.	Tried to have empathy with clients distress in the broader situation	1
Emotion regulation	1.	Reassurance, e.g. the secretary said that the client had also been rude and abrupt with her before session and this helped	1
	2.	Decided that it wasn't the clients fault and it wasn't anything I did	1
Reappraisal	1.	Reframed difficulties as therapeutic issue, e.g. drew on psychological formulation for an understanding how best to respond	22
	2.	Recognised that threats were from specific client group and that majority of client groups are okay. Realised that threats were made to other colleagues as well	1
Avoidance	1.	Ignored behaviour in session, e.g. ignore behaviour and focus on something else while taking on board the fact that it is not really personal harassment coming from people with severe/ profound learning disability	5
	2.	Distraction, e.g. had a cup of coffee	1

Note: Content analysis based on 137 protocols. F=frequency

Table 6.10. Content analysis of coping strategies used by psychologists to deal with negative verbal interactions

Coping Function		Coping Strategies	F
Approach	1.	Used supervision to address the issues/ discussed incident with colleague	35
	2.	Addressed the issue with the client(s)	15
	3.	Concentrated on aspects of personal safety	5
	4.	Defined boundaries of therapeutic relationship	4
	5.	Sought objective legal advice re threats of litigation and incompetence	4
	6.	Tried to diffuse the situation	3
	7.	Spent time going over misconstrued information with client without backing down. Checked their understanding of what was said	3
	8.	Informed other relevant professionals	3
	9.	Conducted a through suicide assessment, followed procedures involving safety measures, i.e. contacting and consulting other professionals, family etc.	2
	10.	Bought answering machine to deal with phone calls from clients	1
	11.	Client repeatedly phoned me at work. I stopped taking phone calls unless prearranged and took messages only. Kept contact within session time only	1
	12.	Improved communication with client	1
	13.	When client suggested that I had touched her in an inappropriate manner, I invited external investigation and evaluation	1
Emotion regulation	1.	Reassurance, e.g. reminded myself that I have done what I could do in order to minimise risk and must not accept the burden of responsibility for others actions	5
	2.	Expectations of difficult behaviours, e.g. Challenging behaviours are a constant and ever present feature of some clients with whom I work and as a result I do not take such assaults personally, even though they are unpleasant	4
	3.	Took comfort in the protection of Professional Indemnity Insurance	1
Reappraisal	1.	Reframed difficulties as therapeutic issue, e.g. verbal behaviours… occurred within the context of challenging group therapy with sex offenders. My understanding of the need for confrontation and how individuals use defence mechanisms help in dealing with behaviours	15
	2.	Reassurance, e.g. (re complaints made to Med Director, PSI etc) What helped was being able to prove that the information on which the allegations was founded was false	2
	3.	Challenge content of derogatory comments and alleged incompetence and ask myself do the important people support me and how do they value me as a professional	1
Avoidance	1.	Ignored behaviour in session e.g. decided not to engage or feed into the suicide threats as I had a strong sense that the threats wouldn't be followed through	7

Note: Content analysis based on 137 protocols. F=frequency

When participants had indicated the strategies they used to deal with their most harassing sexual, physical and verbal negative interactions with clients, they rated the degree to which the strategies fulfilled coping functions on 7 point likert scales using the 16 item Functional Dimension of Coping Scale. These mean ratings of the degree to which coping strategies fulfilled particular functions in coping with sexual, physical and verbal negative interactions are given in Tables 6.11, 6.12 and 6.13 respectively. In the rank ordering of the total coping function scores, a similar pattern is evident in all three tables. Mean ratings for the total approach coping function scores are higher than those for emotional regulation, and these are higher than those for reappraisal. Ratings for the avoidance function are the lowest of all. Results of dependent t tests on adjacent pairs of rank ordered means in each of the three tables showed that all of these differences are statistically significant ($p<.05$). Thus, it may be concluded that the coping strategies used to deal with sexual, physical and verbal negative interactions fulfilled some coping functions more than others. In rank order these functions were, first approaching the threatening event and attempting to modify it; second, modifying the negative emotions arising from the perceived threat; third reappraising the meaning of the threatening situation; and fourth physically avoiding or avoiding thinking about the threatening situation.

Effectiveness of Coping

When participants had described coping strategies that they used to cope with their most harassing sexual, physical and verbal interactions with clients and rated the coping functions of this strategy on the Functional Dimensions of Coping Scale, they then gave a rating on a 7 point likert scale of the perceived effectiveness of their coping strategy.

Table 6.11. Functions of coping responses to sexualised behaviours

Approach		
1. Allow you to deal directly with the problem	*M*	5.6
	SD	1.7
2. Provide you with information useful in solving the problem	*M*	5.1
	SD	1.9
3. Allow you to understand something about the nature of the problem from which you could attempt to deal directly with it.	*M*	5.2
	SD	1.9
4. Help you to think about the problem in a new and useful way	*M*	4.5
	SD	2.0
Total for Approach	*M*	5.1
	SD	1.4
Emotional regulation		
1. Allow you to manage the distress and upset caused by the event.	*M*	4.8
	SD	2.0
2. Allow you to handle the anxiety caused by the event.	*M*	5.0
	SD	1.9
3. Enable you to deal with the emotional upset caused by the situation	*M*	4.8
	SD	2.1
Total for Emotional regulation	*M*	4.9
	SD	1.9
Reappraisal		
1. Help you to find meaning and understanding from the situation.	*M*	4.6
	SD	2.1
2. Allow you to grow and develop as a person.	*M*	3.6
	SD	2.1
3. Allow you to learn more about yourself and others.	*M*	4.0
	SD	2.1
4. Allow you a more optimistic outlook to the future.	*M*	3.0
	SD	1.9
5. Allow you to step back and look at the problem, in a different way, so that it seemed better.	*M*	4.2
	SD	2.1
Total for Reappraisal	*M*	3.9
	SD	1.7
Avoidance		
1. Help you to divert your attention away from the problem	*M*	3.0
	SD	1.9
2. Allow you to deny that anything was wrong	*M*	1.9
	SD	1.6
3. Allow you to avoid having to deal directly with the situation	*M*	2.0
	SD	1.5
4. Distract you from thinking about the problem	*M*	2.1
	SD	1.5
Total for Avoidance	*M*	2.2
	SD	1.4
Perceived effectiveness in coping with behaviours/interactions	*M*	5.6
	SD	1.2

Note: N=137

Table 6.12. Functions of coping responses to negative physical interactions

Approach		
1. Allow you to deal directly with the problem	*M*	5.5
	SD	1.6
2. Provide you with information useful in solving the problem	*M*	4.9
	SD	1.9
3. Allow you to understand something about the nature of the problem from which you could attempt to deal directly with it.	*M*	5.2
	SD	1.6
4. Help you to think about the problem in a new and useful way	*M*	4.5
	SD	1.9
Total for Approach	*M*	5.0
	SD	1.4
Emotional regulation		
1. Allow you to manage the distress and upset caused by the event.	*M*	4.6
	SD	1.9
2. Allow you to handle the anxiety caused by the event.	*M*	4.6
	SD	1.9
3. Enable you to deal with the emotional upset caused by the situation	*M*	4.3
	SD	2.1
Total for Emotional regulation	*M*	4.5
	SD	1.8
Reappraisal		
1. Help you to find meaning and understanding from the situation.	*M*	4.4
	SD	2.0
2. Allow you to grow and develop as a person.	*M*	3.4
	SD	2.0
3. Allow you to learn more about yourself and others.	*M*	3.8
	SD	1.9
4. Allow you a more optimistic outlook to the future.	*M*	3.2
	SD	1.9
5. Allow you to step back and look at the problem, in a different way, so that it seemed better.	*M*	4.0
	SD	2.1
Total for Reappraisal	*M*	3.7
	SD	1.6
Avoidance		
1. Help you to divert your attention away from the problem	*M*	2.5
	SD	1.8
2. Allow you to deny that anything was wrong	*M*	1.7
	SD	1.2
3. Allow you to avoid having to deal directly with the situation	*M*	1.9
	SD	1.4
4. Distract you from thinking about the problem	*M*	1.9
	SD	1.4
Total for Avoidance	*M*	2.0
	SD	1.3
Perceived effectiveness in coping with behaviours/interactions	*M*	5.4
	SD	1.1

Note: N=137

Table 6.13. Functions of coping responses to negative verbal interactions

Approach		
1. Allow you to deal directly with the problem	*M*	5.4
	SD	1.6
2. Provide you with information useful in solving the problem	*M*	5.0
	SD	1.8
3. Allow you to understand something about the nature of the problem from which you could attempt to deal directly with it.	*M*	5.1
	SD	1.8
4. Help you to think about the problem in a new and useful way	*M*	4.7
	SD	2.0
Total for Approach	*M*	5.1
	SD	1.6
Emotional regulation		
1. Allow you to manage the distress and upset caused by the event.	*M*	4.8
	SD	1.8
2. Allow you to handle the anxiety caused by the event.	*M*	4.8
	SD	1.8
3. Enable you to deal with the emotional upset caused by the situation	*M*	4.7
	SD	1.9
Total for Emotional regulation	*M*	4.8
	SD	1.7
Reappraisal		
1. Help you to find meaning and understanding from the situation.	*M*	4.6
	SD	2.0
2. Allow you to grow and develop as a person.	*M*	3.6
	SD	2.0
3. Allow you to learn more about yourself and others.	*M*	3.9
	SD	2.0
4. Allow you a more optimistic outlook to the future.	*M*	3.2
	SD	1.9
5. Allow you to step back and look at the problem, in a different way, so that it seemed better.	*M*	4.4
	SD	2.0
Total for Reappraisal	*M*	4.0
	SD	1.6
Avoidance		
1. Help you to divert your attention away from the problem	*M*	2.5
	SD	1.7
2. Allow you to deny that anything was wrong	*M*	1.8
	SD	1.2
3. Allow you to avoid having to deal directly with the situation	*M*	1.9
	SD	1.4
4. Distract you from thinking about the problem	*M*	1.9
	SD	1.4
Total for Avoidance	*M*	2.0
	SD	1.1
Perceived effectiveness in coping with behaviours/interactions	*M*	5.2
	SD	1.1

Note: N=137

Mean effectiveness ratings for coping with sexual, physical and verbal harassment incidents are given in the final rows of Table 6.11, 6.12 and 6.13 respectively. All three means fell between 5 and 6 on a 7 point scale, where 7 indicates that the respondent believes that he or she coped extremely effectively with the harassment.

Table 6.14. Coping styles predictive of perceived effectiveness in dealing with negative sexualised, physical and verbal interactions, identified in multiple regression analyses.

Outcome Variable (perceived effectiveness in coping)	No. of steps	Predictive Factors	% Variance accounted for by predictive factors	F
Perceived effectiveness in coping with sexualised behaviour	1	Approach strategy	28%	25.4***
Perceived effectiveness in coping with physical behaviour	1	Approach strategy	14%	11.4***
Perceived effectiveness in coping with verbal behaviour	1	Approach strategy	24%	18.8***

Note. ***p<.001. Percentage of variance accounted for is based on adjusted R^2.

To establish the relative effectiveness of the four coping functions, i.e. approach, emotional regulation, reappraisal and avoidance, in dealing with sexualised, physical and verbal interactions, a series of three stepwise multiple regressions were conducted. In each of the multiple regressions, perceived coping effectiveness was entered as the dependent variable and total coping function scores for each of the four functional dimension of coping scales were entered as the independent or predictor variables.

Results from these three analyses, which are presented in Table 6.14, showed that the approach function was the only predictor of perceived coping effectiveness for all three types of negative interactions and accounted for between 14 and 28% of the variance in perceived coping effectiveness.

Profiles of High and Low Stress Sub-groups

The entire group of respondents was divided into high and low stress sub-groups on the basis of the cut-off score(i.e. 5) for clinical caseness on the GHQ-28. Twenty three percent (N=31) fulfilled the criteria for caseness and were therefore assigned to the high stress sub-group. Seventy four percent (N=102) scored below the cut off point and were assigned to the low stress sub-group. There were missing data for the remaining cases who were excluded from this analysis.

Using Chi Square statistics and independent t-tests, the high and low stress sub-groups were compared on all demographic variables and also on their life event scores and social support scores, as indexed by the Social Readjustment Rating Scale and Multidimensional Scale of Perceived Social Support respectively. In addition, the two groups were compared on variables indexing their experiences of sexualised, physical and verbal negative interactions and coping function scores from the Functional Dimensions of Coping Scale.

Overall, the two groups showed significant differences on only two variables, that is, employer and Social Readjustment Rating Scale total scores. A significant difference was found between the numbers from high and low stress groups working in Health Board Community Care programmes, Health Board Special Hospital programmes, and voluntary organisations (Chi Square (df=3, N=133)=15.7, $p<.001$). Significantly more highly stressed psychologists were found to be working in the Health Boards Special Hospital programmes. The high stress group also had experienced significantly more life events in the six month preceding the study as measured by the Social Readjustment Rating Scale than the low stress group ($t=3.8$, $p<.001$).

In an attempt to estimate the best predictor of overall adjustment, again as indexed by the GHQ-28, an exploratory stepwise multiple regression analysis was conducted. In this analysis, the dependent variable was the total GHQ-28 score. The total score for the Social Readjustment Rating Scale, the total score for the Multidimensional Scale of Perceived Social Support, the total sexualised

behaviour score, the total physical behaviour score, the total verbal interaction score, the total approach coping score, the total emotional regulation coping score, the total reappraisal coping score and the total avoidance coping score were all entered as independent or predictor variables.

The results of this stepwise multiple regression analysis showed that only the build up of stressful life events, as measured by the Social Readjustment Rating Scale, was found to be a significant predictor of psychological well being, as indexed by the GHQ-28. In all, Social Readjustment Rating Scale total scores were found to account for nearly twelve percent of the variance in GHQ-28 total scores ($F(1, 96)=13.8$, $p<.001$, Adjusted $R^2=.118$). This result of the multiple regression analysis was consistent with the results of the comparison profiles of high and low stress groups reported above.

Negative interactions with clients were not associated with psychological well-being or stress responses as assessed by the GHQ-28.

DISCUSSION

A central conclusion of this study was that negative interactions with clients of a sexual, physical or verbal nature are a relatively common phenomenon for clinical psychologists in Ireland. However, our results clearly indicate that psychologists are a highly resilient group and use problem-solving coping strategies to cope effectively with these potential threats to their well-being. A summary of key findings from the study in given in Table 6.15. These will be discussed below with reference to the six questions this study was designed to address and which are listed at the end of the introduction.

Sexualized Behaviours

The first question concerned psychologists exposure to negative interactions with clients involving inappropriate sexualized behaviour. Sixty seven percent of psychologists surveyed reported that they had at least one negative interaction with a client involving sexualized behaviour. Twenty six percent of respondents considered that they had been sexually harassed by clients and 2% had been sexually assaulted. The most harassing sexual interactions were requests for intimate physical contact, being brushed up against, touched or grabbed and being asked for a date. The frequency with which particular negative sexualized interactions occurred differed across specialties. Requests for hugs, being brushed up against, grabbed or touched in a grossly inappropriate way were more commonly reported by psychologists working with people with intellectual and physical disabilities compared with those working within the adult or child mental health specialties. Compared with psychologists in the child and adult mental health specialties, harassment ratings given by clinical psychologists working within the disability speciality were higher for these three categories of sexualized behaviour.

Negative Physical Interactions

The second question concerned psychologists exposure to negative interactions with clients involving physically aggressive behaviour. Seventy three percent of psychologists surveyed reported that they had at least one negative physical interaction with a client involving aggressive or potentially behaviour. Thirty six percent reported that they had been physically harassed and 18% physically assaulted or kicked. The most harassing physical interactions were being cornered by a client, having clients describe fantasies of physical violence involving the clinician, and being stalked.

The frequency with which particular negative physical interactions occurred differed across specialties. Reports of clients making intimidating gestures, throwing objects, denying access or exit from rooms, pushing, kicking and physically assaulting clinicians were more commonly made by psychologists working in the areas of intellectual and physical disability and adult mental health. Compared with psychologists in the child and adult mental health specialties, harassment ratings given by clinical psychologists working within the disability specialty were higher for incidents involving intimidating gestures, being kicked and being assaulted. Psychologists in the adult mental health specialty rated door slamming and property damage incidents as more harassing than their colleagues in child mental health and disability services.

Negative Verbal Interactions

The third question concerned psychologists exposure to negative interactions with clients involving verbally aggressive behaviour. Sixty nine percent of psychologists surveyed reported that they had at least one negative verbal interaction with a client. Sixty four percent reported that they had been verbally harassed and 85% had been subjected to verbal abuse or suicide threats. The most harassing verbal interactions were receiving suicide threats, having complaints made to senior clinicians and being phoned at home or at work without permission to do so. The frequency with which particular negative verbal interactions occurred differed across specialties. More psychologists working in the area of adult mental health reported inappropriate phone calls to the homes or their office and threats of suicide compared with clinicians working in child mental health or disability services. Psychologists in the adult mental health specialty rated being phoned at home or work without permission by clients as more harassing than their colleagues in child mental health services.

Coping Strategies and Functions

The fourth question concerned the strategies used by clinical psychologists to cope with negative interactions with clients and the functions these strategies fulfilled. For sexual, physical and verbal negative interactions, problem solving and reappraisal based coping strategies were more commonly used than strategies that aimed to regulate distressing emotional states or facilitate avoidance of the threatening situation. Seeking support from colleagues, addressing the issues raised by the negative interaction with the client, and taking self-protective measures were the most commonly used problem-solving coping strategies. Reframing negative interactions as therapeutic issues rather than sexual, physical or verbal aggression was the most common reappraisal strategy.

When considered collectively, coping strategies used by clinical psychologists to deal with sexual, physical and verbal negative interactions fulfilled some coping functions more than others. In rank order these functions were, first approaching the threatening event and attempting to modify it; second, modifying the negative emotions arising from the perceived threat; third reappraising the meaning of the threatening situation; and fourth physically avoiding or avoiding thinking about the threatening situation.

Effectiveness of Coping Responses

The fifth question addressed in this study concerned the effectiveness of coping strategies used by clinical psychologists to cope with negative interactions with clients. Clinical psychologists in this study rated their coping strategies as very effective for dealing with negative sexualized, physical and verbal interactions with clients. Their mean ratings were between 5 and 6 on a 7 point scale, where 7 indicates extremely effective coping. Problem solving based coping strategies

were perceived to be the most effective, rather than those that entailed emotional regulation, reappraisal or avoidance.

Profiles of High and Low Stress Sub-groups

The sixth and final question concerned the profile of high and low stress sub-groups. Such subgroups differed in only two respects. First, more highly stressed psychologists were found to be working in Health Board Based special hospital programmes working with adults who have mental health problems. Second, the high stress group had also experienced significantly more life events in the six month preceding the study than the low stress group.

Comparisons with other Studies

In some domains the rates for negative interactions with clients and harassment which we found were comparable to those found in other studies, whereas in others there were noteworthy differences. However, such differences may reflect both methodological differences between studies as well as substantive differences between populations.

In our study it was found that 67% of clinical psychologists reported at least one negative sexualized incident with a client in the preceding 5 years. This is lower than rates of similar incidents found in US surveys of nurses (75%, Dan et al, 1995) but not female psychologists (53%, deMayo, 1997). In our study we found that 36% of respondents had been physically harassed. A similar level of physical harassment (36%) was found by Bernstein (1981) in a study of 453 US health professionals from the disciplines of psychiatry, psychology, social work and family and marital and family counselling. We also found that 18% of respondents had been physically assaulted. This is higher than the rate of assault

(12%) found by Shick Tryon (1986) in a survey of 300 US psychologists in clinical practice. We found a rate of 64% for verbal harassment in our study and this is similar to the rate of 66% found by Shick Tryon (1986) in a survey of 300 US psychologists.

The coping styles most commonly used psychologists in our study were similar to those reported in both Cushway and Tyler's (1994) UK study and Sampson's (1990) Scottish study. In both of these studies seeking support from colleagues was considered to be the most effective strategy for dealing with work related stress.

In our study 23% of clinical psychologists met the criterion for clinical caseness on the GHQ. This level of caseness is considerably lower than that found in other studies of psychologists and professionals in general population surveys. Sampson (1990) found that 33% of Scottish psychologists scored in the clinical range on the GHQ while Cushway and Tyler (1994) in a UK survey reported that 29% scored above the cut-off point for caseness on the GHQ. Cox, Blaxter, Buckle, et al. (1987) in a UK national survey of a sample of over 6000 members of the general population found that 32% of cases scored above a cut-off of 5 on the GHQ 30 and 27% of those who were classified as professionals between 18 and 64 years scored in the clinical range. From these comparisons it may be concluded that the clinical psychologists surveyed in this study contained a lower proportion of cases in the clinical range than in these other three studies (23% vs 33%, 29% and 27%).

In our study negative interactions with clients were not found to be predictors of psychological stress as indexed by the GHQ. It is possible that negative interactions with clients is only one of many occupational stressors which contribute to the overall stress of clinicians. According to Cushway and Tyler (1994) occupational stressors include pressure of workload, lack of resources, conflicts in relationships with other professionals, poor organisational communication and management as well as negative behaviours from clients. These other stressors were not examined in the present study.

Methodological Issues and Future Research

The response rate of 40% obtained in this study was reasonably good. The typical response rate for a mail survey is around 30% (Shaughnessy & Zechmeister, 1994). However without comparative data on the profile and practice of non-respondents, it is difficult to make more than moderate claims for the generalisability of the results.

The present study was based on self-report data. Future research on negative interaction with between psychologists and clients should gather data from multiple perspectives including researcher based observational measures; reports of managers and professionals from other disciplines; and client reports. Of course studies such as these would be time intensive, complex to conduct from a pragmatic perspective, and fraught with ethical problems.

This study only investigated the nature and characteristics of negative interactions which psychologists have with their clients. According to Dan et al (1995) eighty nine percent of nurses in their US survey reported that they had experienced incidents of sexual harassment with other professionals. It is possible therefore that psychologist's experiences of negative interactions in the workplace is higher than that reported here, particularly when negative interactions with co-workers, supervisors and others are taken into account. A study which focused on such experiences may be helpful in discovering the full extent to which clinical psychologists are exposed to negative interactions during their time at work.

Implications for Policy, Practice and Training

According to deMayo (1997) studies which report on the harassment of clinicians

can help to overcome the notion that psychologists are protected from such interactions by the nature of the therapeutic relationship in which the power balance tends to rest with the clinician. In addition, he suggests that the idea that well trained clinicians do not get harassed is to promote the idea that professionals who are harassed are at least in part responsible for their harassment. It is obviously important that clinicians understand that such interactions do occur and that open discussion of these may be helpful in making the workplace safer for clinical psychologists.

In terms of promoting professional development in this area, it seems likely that information on recognising and managing negative interactions effectively should be introduced into training courses.

According to deMayo (1997), as more women enter the profession and men more readily seek psychotherapy, the potential for sexual harassment of female psychologists is greater than when most psychologists were men and most patients were female. By implication also, the increasing number of female psychologists may also be at more risk of physical and verbal harassment than is currently recognised by health service organisations in Ireland. It seems likely therefore that institutions which employ psychologists may need to develop appropriate guidelines and policies to help protect their employees from unwanted negative interactions with clients. Indeed, it may be helpful for psychologists to have silent panic buttons installed in their offices which can alert others in the building to potentially risky situations.

It seems likely too that training courses in managing difficult situations both inside and outside the therapy rooms may be warranted. In this study, only one quarter (26%) of clinicians reported that they had attended some form of training in managing harassment. Given that over sixty percent of clinical psychologists had experienced at least one physical, sexual or verbal interaction, it seems that more training is necessary and that the organisations which employ psychologists should insure that their staff routinely receive such training.

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APPENDIX TO CHAPTER 6
SURVEY OF NEGATIVE INTERACTIONS WITH CLIENTS

Please answer the demographic questions listed below by placing an ¸ in the relevant box.

1. Age in years:	20 - 29	[]
	30 - 39	[]
	40 - 49	[]
	50 - 59	[]
	60 - 69	[]
2. Gender:	Male	[]
	Female	[]
3. Marital Status	Single	[]
	Married	[]
	Other	[]
4. Employer:	Health Board (Community Care)	[]
(Part 1)	Health Board (Special Hospital)	[]
	Voluntary Organisation	[]
	Private Practice	[]
	Other	[]
	Please specify:_____	

If not employed by health board please go straight to question 6. If employed by a health board, please tick the relevant box below:

5. Employer	Eastern Health Board	[]
(Part 2)	South Eastern Health Board	[]
	North Eastern Health Board	[]
	Southern Health Board	[]
	Midwestern Health Board	[]
	Western Health Board	[]
	North Western Health Board	[]
	Midland Health Board	[]
6. Job Status	Permanent	[]
	Temporary	[]
	Part time	[]
	Full time	[]
7. Job Title:	Basic Grade Clinical Psychologist	[]
	Senior Grade Clinical Psychologist	[]
	Principal Grade Clinical Psychologist	[]
	Director/ Consultant Clinical Psychologist	[]
	Other	[]
	Please specify:_____	

8. Please indicate the one area which is the main focus of your current job

Child and Adolescent	[]
Intellectual Disability	[]
Adult Mental Health	[]
Physical Disability	[]
Older Adults	[]
Validation Team	[]
Health Psychology	[]
Neuropsychology	[]
Psychotherapy	[]
Family Therapy	[]
Other [Please specify]_____	

9. Years in Practice:0 - 1 []
2 - 4 []
5 - 9 []
10 - 14 []
15 - 19 []
20 - 24 []
25 - 29 []
30 - 34 []
35 - 39 []
40 - 44 []
45 - 49 []

10. Years with Current Employer:
0 - 1 []
2 - 4 []
5 - 9 []
10 - 14 []
15 - 19 []
20 - 24 []
25 - 29 []
30 - 34 []
35 - 39 []
40 - 44 []
45 - 49 []

11. Highest Educational Degree:
BA/ BSc Hon Psychology []
DipPsych []
MA Applied/ MA Clinical []
M.Psych.Sc (or equivalent) []
D.Psych.Sc (or equivalent) []
PhD []
BPS/ PSI Dip in Clinical Psychology []
Other []
Please specify: _____

12. Theoretical Orientation: Please indicate which is your main theoretical orientation
Gestalt []
Eclectic []
Psychodynamic []
Cognitive Behavioural []
Systems []
Humanistic-existential []
Other [Please specify]_____

13. How many years have you been involved in personal psychotherapy, personal growth work, process work etc. in an attempt to examine your own issues?
No []
0 - 1 y []
2 - 4 y []
5 - 9 y []
10 - 14 y []
Other [Please specify]_____

This section of the questionnaire is concerned with three main areas. Firstly, it aims to examine the extent to which clinical psychologists are exposed to particular types of verbal, physical and sexual behaviours when working with clients. Secondly, the questionnaire aims to investigate whether or not clinicians construe such behaviour as harassment. Thirdly, the study aims to examine the methods by which clinicians deal with such behaviours. You are encouraged to answer all the questions as honestly and fully as possible.

1. Have you ever attended a workshop or seminar about the effects and management of emotional, physical or sexual harassment ?

No	[]
Conference	[]
In-house training	[]
Self defence classes	[]
As part of clinical training	[]
Other [Please specify]_____	

2. Have you ever experienced an incident of emotional, physical or sexual harassment while working with clients ? If so, please state the number and circumstances of such incidents

Verbal Harassment (i.e. .inappropriate verbal interactions that caused you to feel uncomfortable, threatened or intimidated)_____
_____
_____

Physical Harassment (i.e. inappropriate physical threats/ actions that caused you to feel uncomfortable, threatened or intimidated)_____
_____
_____

Sexual Harassment (i.e. inappropriate sexual references/ gestures or actions that caused you to feel uncomfortable, threatened or intimidated) _____
_____
_____

3. If you answered yes to any part of question number 2 on the previous page, please describe the most severe incident in detail and include information pertaining to the client, such as gender, age, diagnosis or presenting problem

Verbal Harassment _____
_____
_____

Physical Harassment _____
_____
_____

Sexual Harassment _____
_____
_____

Please turn now to the next page

SEXUALIZED BEHAVIOURS

Below is a list of potentially sexualised behaviours. Please complete the following three steps:

1. **If you have been exposed to any of these behaviours from clients over the *PAST 5 YEARS*, please tick the type of behaviours experienced.**
2. **Secondly, state the frequency of such incidents within the *PAST 5 YEARS***
3. **On the 7 point scale, where 1 equals *not at all harassing* and 7 equals *severely harassing*, please indicate the extent to which you perceived each behaviour ticked to be harassing.**
   REMEMBER, THINK ABOUT EXPERIENCES YOU HAVE HAD OVER THE PAST FIVE YEARS.

Sexualised Behaviour	Behaviour	No of times it happened	How harassing was it?
Client requested hug	[]	__	1 2 3 4 5 6 7
Client gave you a suggestive look	[]	__	1 2 3 4 5 6 7
Client directed a sexist remark at you	[]	__	1 2 3 4 5 6 7
Client made a sexual remark about you	[]	__	1 2 3 4 5 6 7
Client described sexual fantasies involving you	[]	__	1 2 3 4 5 6 7
Client asked you for a date	[]	__	1 2 3 4 5 6 7
Client brushed up, touched or grabbed you	[]	__	1 2 3 4 5 6 7
Client made sexually suggestive gestures	[]	__	1 2 3 4 5 6 7
Client gave an inappropriate romantic/ sexual suggestive gift	[]	__	1 2 3 4 5 6 7
Client suggestively exposed body parts	[]	__	1 2 3 4 5 6 7
Client requested intimate physical contact	[]	__	1 2 3 4 5 6 7
Client touched you in a grossly inappropriate way	[]	__	1 2 3 4 5 6 7
Client threatened sexual assault	[]	__	1 2 3 4 5 6 7
Client attempted to solicit sexual activity by promise of gift/ reward	[]	__	1 2 3 4 5 6 7
Client made physical sexual assault	[]	__	1 2 3 4 5 6 7
Other sexualised behaviour	[]	__	1 2 3 4 5 6 7

If other, please specify: _____

There are many different ways of dealing with the type of stress that these behaviours can cause. If you experienced any of the above behaviours when working with clients, please indicate which behaviour you perceived to be the MOST HARASSING and then briefly describe the activities and/ or thoughts you used to help you deal with such behaviour. Please turn then to the next page.

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COPING WITH SEXUALIZED INTERACTIONS

In relation to your methods of dealing with the sexualised behaviours you previously ticked, please complete the following set of questions using the seven point scale where 1 equals *not at all* and 7 equals *very much so*.

To what extent did the activities or thoughts used to help you deal with sexualised behaviours …..

1. Allow you to directly deal with the problem 1 2 3 4 5 6 7
2. Provide you with information useful in solving the problem 1 2 3 4 5 6 7
3. Allow you to understand something about the nature of the problem from which you could attempt to deal directly with it 1 2 3 4 5 6 7
4. Help you to think about the problem in a new and useful way 1 2 3 4 5 6 7
5. Allow you to manage the distress and upset caused by the new event 1 2 3 4 5 6 7
6. Allow you to handle the anxiety caused by the event 1 2 3 4 5 6 7
7. Enable you to deal with the emotional upset caused by the event 1 2 3 4 5 6 7
8. Help you to find meaning and understanding from the situation 1 2 3 4 5 6 7
9. Allow you to grow and develop as a person 1 2 3 4 5 6 7
10. Allow you to learn more about yourself and others 1 2 3 4 5 6 7
11. Allow you a more optimistic outlook on the future 1 2 3 4 5 6 7
12. Allow you to step back and look at the problem, in a different way, such that it seemed better 1 2 3 4 5 6 7
13. Help you to divert your attention away from the problem 1 2 3 4 5 6 7
14. Allow you to deny that anything was wrong 1 2 3 4 5 6 7
15. Allow you to avoid having to deal directly with the situation 1 2 3 4 5 6 7
16. Distract you from thinking about the problem 1 2 3 4 5 6 7

Finally overall how effective do you think your method of dealing with what you perceived to be the MOST HARASSING sexualised behaviour was in helping you, as a psychologist, to manage such potentially negative interactions? Please rate your response on the 7 point scale outlined below where 1 = not effective at all and 7 = extremely effective.

1 2 3 4 5 6 7

NEGATIVE PHYSICAL INTERACTIONS

Below is a list of physical behaviours you may have encountered when working with clients. Please complete the following three steps:

1. **If you have been exposed to any of these behaviours from clients over the *PAST 5 YEARS*, please tick the type of behaviours experienced.**
2. **Secondly, state the frequency of such incidents within the *PAST 5 YEARS***
3. **On the 7 point scale, where 1 equals *not at all harassing* and 7 equals *severely harassing*, please indicate the extent to which you perceived each behaviour ticked to be harassing.**

REMEMBER, THINK ABOUT EXPERIENCES YOU HAVE HAD OVER THE PAST FIVE YEARS.

Physical Behaviour	Behaviour	No of times it happened	How harassing was it?
Client scowled at you	[]	__	1 2 3 4 5 6 7
Client stared at you in an intimidating way	[]	__	1 2 3 4 5 6 7
Client slammed office doors	[]	__	1 2 3 4 5 6 7
Client made intimidating gestures, e.g. thumped palm of hand with fist	[]	__	1 2 3 4 5 6 7
Client described fantasy of physical violence involving you	[]	__	1 2 3 4 5 6 7
Client denied you access/ exit from room	[]	__	1 2 3 4 5 6
Client cornered you	[]	__	1 2 3 4 5 6 7
Client damaged property in room	[]	__	1 2 3 4 5 6 7
Client threw objects at you	[]	__	1 2 3 4 5 6 7
Client spat at you	[]	__	1 2 3 4 5 6 7
Client kicked you	[]	__	1 2 3 4 5 6 7
Client pushed you	[]	__	1 2 3 4 5 6 7
Client threatened you with physical violence	[]	__	1 2 3 4 5 6 7
Client stalked you either at home or in work	[]	__	1 2 3 4 5 6 7
Client physically assaulted you	[]	__	1 2 3 4 5 6 7
Other physical behaviour	[]	__	1 2 3 4 5 6 7

If other, please specify: _____

There are many different ways of dealing with the type of stress that these behaviours can cause. If you experienced any of the above behaviours when working with clients, please indicate which behaviour you perceived to be the MOST HARASSING and then briefly describe the activities and/ or thoughts you used to help you deal with such behaviour. Please turn then to the next page._____

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COPING WITH NEGATIVE PHYSICAL INTERACTIONS

In relation to your methods of dealing with the physical behaviours you previously ticked, please complete the following set of questions using the seven point scale where 1 equals *not at all* and 7 equals *very much so*.

To what extent did the activities or thoughts used to help you deal with physical behaviours …..

1. Allow you to directly deal with the problem 1 2 3 4 5 6 7
2. Provide you with information useful in solving the problem 1 2 3 4 5 6 7
3. Allow you to understand something about the nature of the problem from which you could attempt to deal directly with it 1 2 3 4 5 6 7
4. Help you to think about the problem in a new and useful way 1 2 3 4 5 6 7
5. Allow you to manage the distress and upset caused by the new event 1 2 3 4 5 6 7
6. Allow you to handle the anxiety caused by the event 1 2 3 4 5 6 7
7. Enable you to deal with the emotional upset caused by the event 1 2 3 4 5 6 7
8. Help you to find meaning and understanding from the situation 1 2 3 4 5 6 7
9. Allow you to grow and develop as a person 1 2 3 4 5 6 7
10. Allow you to learn more about yourself and others 1 2 3 4 5 6 7
11. Allow you a more optimistic outlook on the future 1 2 3 4 5 6 7
12. Allow you to step back and look at the problem, in a different way, such that it seemed better 1 2 3 4 5 6 7
13. Help you to divert your attention away from the problem 1 2 3 4 5 6 7
14. Allow you to deny that anything was wrong 1 2 3 4 5 6 7
15. Allow you to avoid having to deal directly with the situation 1 2 3 4 5 6 7
16. Distract you from thinking about the problem 1 2 3 4 5 6 7

Finally overall how effective do you think your method of dealing with what you perceived to be the MOST HARASSING physical behaviour was in helping you, as a psychologist, to manage such potentially negative interactions? Please rate your response on the 7 point scale outlined below where 1 = not effective at all and 7 = extremely effective.

1 2 3 4 5 6 7

NEGATIVE VERBAL INTERACTIONS

Below is a list of verbal interactions you may have encountered when working with clients. Please complete the following three steps:

1. **If you have been exposed to any of these behaviours from clients over the *PAST 5 YEARS*, please tick the type of behaviours experienced.**
2. **Secondly, state the frequency of such incidents within the *PAST 5 YEARS***
3. **On the 7 point scale, where 1 equals *not at all harassing* and 7 equals *severely harassing*, please indicate the extent to which you perceived each behaviour ticked to be harassing.**

REMEMBER, THINK ABOUT EXPERIENCES YOU HAVE HAD OVER THE PAST FIVE YEARS.

Verbal Interactions	Behaviour	No of times it happened	How harassing was it?
Client questioned qualifications repeatedly	[]	__	1 2 3 4 5 6 7
Client threatened litigation when challenged	[]	__	1 2 3 4 5 6 7
Client cursed at you	[]	__	1 2 3 4 5 6 7
Client made derogatory comments about you	[]	__	1 2 3 4 5 6 7
Client shouted at you	[]	__	1 2 3 4 5 6 7
Client repeatedly violated boundaries by asking intrusive personal questions	[]	__	1 2 3 4 5 6 7
Client frequently flooded you with information	[]	__	1 2 3 4 5 6 7
Client repeatedly phoned you at home and/or work	[]	__	1 2 3 4 5 6 7
Client alleged your incompetence to other professionals/ clients	[]	__	1 2 3 4 5 6 7
Client repeatedly threatened you with suicide	[]	__	1 2 3 4 5 6
Client repeatedly misconstrued information	[]	__	1 2 3 4 5 6 7
Other	[]	__	1 2 3 4 5 6 7

If other, please specify _____

There are many different ways of dealing with the type of stress that these behaviours can cause. If you experienced any of the above behaviours when working with clients, please indicate which behaviour you perceived to be the MOST HARASSING and then briefly describe the activities and/ or thoughts you used to help you deal with such behaviour. Please turn then to the next page._____

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COPING WITH NEGATIVE VERBAL INTERACTIONS

In relation to your methods of dealing with the verbal interactions you previously ticked, please complete the following set of questions using the seven point scale where 1 equals *not at all* and 7 equals *very much so*.

To what extent did the activities or thoughts used to help you deal with verbal interactions …..

1. Allow you to directly deal with the problem 1 2 3 4 5 6 7
2. Provide you with information useful in solving the problem 1 2 3 4 5 6 7
3. Allow you to understand something about the nature of the problem from which you could attempt to deal directly with it 1 2 3 4 5 6 7
4. Help you to think about the problem in a new and useful way 1 2 3 4 5 6 7
5. Allow you to manage the distress and upset caused by the new event 1 2 3 4 5 6 7
6. Allow you to handle the anxiety caused by the event 1 2 3 4 5 6 7
7. Enable you to deal with the emotional upset caused by the event 1 2 3 4 5 6 7
8. Help you to find meaning and understanding from the situation 1 2 3 4 5 6 7
9. Allow you to grow and develop as a person 1 2 3 4 5 6 7
10. Allow you to learn more about yourself and others 1 2 3 4 5 6 7
11. Allow you a more optimistic outlook on the future 1 2 3 4 5 6 7
12. Allow you to step back and look at the problem, in a different way, such that it seemed better 1 2 3 4 5 6 7
13. Help you to divert your attention away from the problem 1 2 3 4 5 6 7
14. Allow you to deny that anything was wrong 1 2 3 4 5 6 7
15. Allow you to avoid having to deal directly with the situation 1 2 3 4 5 6 7
16. Distract you from thinking about the problem 1 2 3 4 5 6 7

Finally overall how effective do you think your method of dealing with what you perceived to be the MOST HARASSING verbal interchange was in helping you, as a psychologist, to manage such potentially negative interactions? Please rate your response on the 7 point scale outlined below where 1 = not effective at all and 7 = extremely effective.

1 2 3 4 5 6 7

Thank you for your co-operation

Table 6.15. Summary of psychologists experiences of sexual, physical and verbal negative interactions with clients

Domain	Sexualised behaviour		Negative physical interaction		Negative verbal interaction	
Negative interaction	At least one from list	67%	At least one from list	73%	At least one from list	69%
Harassment	Sexual harassment	26%	Physical harassment	36%	Verbal harassment	64%
Severe Event	Sexual assault	2%	Physical assault (incl kick)	18%	Shouting, cursing or suicide threats	85%
3 most common interactions	Requested hug Suggestive look Sexist remark	46% 34% 23%	Scowled Intimidating stare Intim. gestures	56% 49% 49%	Shouted Intrusive quest. Threat. suicide	41% 27% 23%
3 most harassing interactions	Req. intimacy Touched/grab Requested date	4.8 on 7 point scale 4.0 on 7 point scale 3.8 on 7 point scale	Cornered you Aggr fantasy Stalked you	6.3 on 7 point scale 6.0 on 7 point scale 5.7 on 7 point scale	Threat. suicide Other verbal Phone home	4.7 on 7 point scale 4.7 on 7 point scale 4.0 on 7 point scale
Differences between specialties in no. reporting negative interactions	Hug Touched/grab Gross inapprop touching	D (79%) >A (58%) >C(25%) D (24%) >A(4%) > C (0%) D (12%) >A (0%) >C (0%)	Intim. gestures Denied ac or ex Threw objects Kicked Pushed Assaulted Other phy	A (50%) >D (47%) >C(24%) D (12%) > A (12%) > C(0%) D (32%) > A (19%) >C (8%) D (9%) > C (5%) > A (4%) D (27%) > A (12%) > C(5%) D (18%) > C (2%) > A (0%) D (15%) > A (8%) > C (0%)	Phoned home Threat. suicide	A (39%) > D (24%) > C (10%) A (42%) > D (18%) > C (15%)
Differences between specialties in harassment ratings	Hug Touched/grab Gross inapprop touching	D > A, C D > A, C D > A, C	Slammed door Intim. gestures Damaged prop Kicked Assaulted	A > D, C D > A, C A > C D > A, C D > A, C	Phoned home	A > C

Note: D= Psychologists working in disability speciality. A= Psychologists working in adult mental health speciality. C= Psychologists working in child and adolescent speciality