Outpatient Psychotherapy With Dangerous Clients: A Model for Clinical Decision Making

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The precedent-setting 1976 judicial decision of Tarasoff v. Regents of the University of California established a duty to protect whereby psychotherapists are expected to exercise reasonable care to protect the potential victims of their clients' violent behavior. However, no standard of care for dangerous clients has been established. In this article, the authors present a model for clinical decision making to determine the best interventions for dealing with dangerous outpatient clients. The model takes into account the degree of violence risk and the strength of the therapeutic alliance. Four cases are presented to illustrate the application of the model.

Outpatient psychotherapy with a dangerous client poses a conflict for therapists between therapeutic, ethical, and legal duties to the client and a legal duty to protect any potential victims of the client's violent behavior. If a threat of violence is made known to others, either for the purpose of warning a potential victim or alerting law enforcement officials to prevent the violent act, it violates the client's confidence and could result in the client feeling intense embarrassment or anger; being charged, arrested, and possibly convicted of a criminal offense; or being denied or refusing further treatment. The therapist could also face disciplinary or civil charges for breaching confidentiality. If, on the other hand, the threat is kept confidential, any subsequent violence might have been prevented and the therapist may feel guilt, anxiety, lowered confidence, and a reluctance to treat similar clients; also, the therapist may face a lawsuit.

Before the 1976 California Supreme Court decision of Tarasoff v. Regents of the University of California, psychotherapists tended not to be concerned about legal liability for their clients' behavior outside the therapy. The Tarasoff court ruled, however, that psychotherapists in California have a duty to exercise reasonable care to protect the potential victims of their clients' violent behavior. Although the ruling was relevant only in California, almost every other jurisdiction in the United States (Fulero, 1988; Kamenar, 1984) as well as Canada (Truscott & Crook, 1993) has applied analogous legal reasoning. Although some jurisdictions differ, the duty to protect generally exists when a client has been (or reasonably should have been) assessed to pose a serious threat of physical violence to a reasonably identifiable victim or victims and when the chain of causation that results in harm is clear (Truscott & Crook, 1993). Of note also is the fact that Tarasoff did not establish a duty to warn, as is often incorrectly asserted (Truscott, 1993). An earlier, and much publicized (Gurevitz, 1977), 1974 decision (Tarasoff v. Regents of the University of California, 1974) did rule that California psychotherapists had a duty to warn, but that ruling was reheard by the California Supreme Court and superseded by the 1976 duty-to-protect decision.

Although the duty to protect does not appear to have necessitated a radical change in therapeutic practice (Givelber, Bowers, & Blitch, 1984), it has resulted in an increased fear of liability on the part of some therapists and an avoidance by some of probing into matters of dangerousness (Wise, 1978). It has also forced clinicians to consider more seriously risk for violence and to integrate that consideration into their clinical decision making. The difficulty, however, is that no standard of care for dangerous clients has been established.

In an attempt to establish just such a standard of care, Botkin and Nietzel (1987) surveyed psychologists about their use of therapeutic interventions with dangerous outpatients. Hospitalizing, building rapport, managing the client's environment so that the client would be less likely to attack others, and breaking confidentiality were rated as the interventions psychologists were most likely to employ. Therapists more experienced in the treatment of dangerous clients were more likely than those less experienced to involve significant others in treatment, to manage the client's environment, and to use behaviorally based

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1 Clinicians are advised to be aware of the existing position in their jurisdiction.
treatments. Similarly, Monahan (1993) identified three categories of interventions for clients who pose a high risk of physical violence to others: incapacitation (hospitalization), target hardening (warning potential victims), and intensified treatment. The purpose of our article is to present a model for clinical decision making to aid clinicians in selecting interventions for dealing with dangerous clients in the outpatient setting. It is, of course, tentative and exploratory at this point, and we eagerly await its evaluation beyond this paper.

### Intervention Selection

When a client's potential for violence becomes an issue in outpatient psychotherapy, the therapist rarely has the time to ponder the finer points of ethics, legal duty, diagnosis, and other issues. We propose that the client be thought of as occupying one of four cells in a 2 x 2 table. Interventions are then selected to strengthen the therapeutic alliance and reduce the risk of violence as identified by Botkin and Nietzel (1987) and Monahan (1993), thereby “moving” the client to the lower right cell of low violence risk, strong therapeutic alliance. This formulation is presented in Figure 1.

We assert that attending to the degree of violence risk and the strength of the therapeutic alliance is central both to the effective treatment of these clients and to the protection of their potential victims. The therapeutic alliance should be strengthened as much as possible because it is the foundation on which all treatment interventions are built (Whiston & Sexton, 1993); furthermore, if one acts only to prevent a current violent episode without attending to the therapeutic alliance, it may enrage a client and actually increase the risk of violence while simultaneously deterring the client from seeking further psychotherapeutic services for dealing with any future violent impulses (Weinstock, 1988). If the risk of violence is low, the therapist should attempt to strengthen the alliance and to shift the focus of therapy to deal more specifically with the violent behavior (as one would with any therapeutic issue).

### Assessing Violence Risk

The low degree of certitude in predicting violence on the part of psychotherapists is well documented in the research literature (Wettstein, 1984), but this does not, in and of itself, make all acts of violence unforeseeable on the part of a psychotherapist. The legal test is one of “reasonable foreseeability,” not “certainty.” That is, would a prudent psychotherapist have predicted violence on the part of the client (Barefoot v. Estelle, 1983)? Our ability to make accurate long-term predictions of any human behavior, particularly a relatively rare behavior such as violence, is poor. This difficulty is because complex human behaviors are rarely, if ever, the result of stable individual traits. Rather, they result from an interaction between characteristics of the individual and his or her environment. Virtually anyone is capable of violent behavior despite being usually nonviolent, whereas even the most violent predisposed individual is not always behaving violently. Stated differently, individual characteristics are neither necessary nor sufficient causes of violent behavior, whereas in most cases situational characteristics can be (c.f. Felson & Steadman, 1983). It is for these reasons that psychometric assessment has little to add to the prediction of imminent violence (Monahan, 1981).

Individual characteristics can serve to alter the threshold at which situational characteristics precipitate violence. An individual who possesses many characteristics typical of violence-prone persons would be considered at high risk for violence given relatively fewer situational precipitants. When one is working with a violence-prone individual, therefore, close attention should be paid to situational variables.

Thorough records are critical to document that appropriate procedures were followed and reasonable steps were taken in light of the facts. Liability is usually imposed for failing to follow appropriate procedures (especially in gathering or communicating information), not for errors in judgment in light of the known facts (Monahan, 1993). The degree to which relevant information can be obtained will depend on the circumstances of the case. If a client presents with problems related to angry or violent behavior, a thorough assessment of violence-related factors should be undertaken at intake. If concerns arise unexpectedly in the course of therapy, every reasonable effort should be made to obtain the information needed without unduly disrupting the therapeutic alliance. The following variables to be considered are adapted from Meloy (1987) and Monahan (1981).

### Individual Characteristics

**Demographic variables.** Violent behavior is most often perpetrated by non-White males in their late teens or early 20s who have a history of opiate or alcohol abuse, have a low IQ and education, and have an unstable residential and employment history. The more closely an individual resembles this fictional modal violent person, the lower the threshold for current risk.

**Violence history.** This is the single most powerful predictor of violent behavior. The more recent, severe, and frequent was...
the past violence, the lower the threshold for current risk. Such indexes as juvenile or adult court involvement for violent acts, hospitalizations for dangerous behavior, and self-reported violence are relevant.

**Situational Characteristics**

*Availability of potential victim(s).* The majority of violent crimes occur between people who know each other. Also, does the client have a history of aggressing against a particular type of person (e.g., women or coworkers) or in a particular setting? If the current situation involves the same or similar type of person or setting, the risk for violence is high.

*Access to a weapon.* Weapons are both situationally disinhibiting and lethal. An individual with combat or martial arts training, or an individual who possesses great strength, is capable of inflicting greater harm.

*Alcohol use.* Alcohol (or other disinhibitors) increase the risk of impulsive behavior.

*Stressors.* Stress related to family, relationships, peer group, finances, and employment can erode an individual's frustration tolerance as well as provide the motivation for violence.

### Assessing the Therapeutic Alliance

The interpersonal interactions between therapist and client form the basis on which therapeutic interventions are built. There is considerable agreement among both practitioners and researchers that the quality of the relationship is important to the outcome of therapy (Highlen & Hill, 1984; Horvath & Symonds, 1991; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Orlinsky & Howard, 1986; Whiston & Sexton, 1993).

Gelso and Carter (1985) developed a three-component model of the therapeutic relationship and later elaborated the interactions among these components (Gelso & Carter, 1994). Their model was based on an earlier three-component model proposed by Greenson (1967) and includes the working alliance, the transference relationship, and the real relationship. Gelso and Carter argued that all components are present in all therapeutic relationships, but emphasis given to the components of the relationship varies according to the therapist's theoretical perspective.

The therapeutic alliance refers to the development of an emotionally warm relationship and an alignment of client and therapist that creates the sense of working together toward common therapy goals. The transference, or unreal, relationship refers to the client's repetition of past feelings, behaviors, and attitudes connected with earlier relationships in his or her interaction with the therapist. This unreal, or distorted, component also includes countertransference: the therapist's responses to the client that are prompted by events in the therapist's own life and past significant relationships. The real relationship refers to the humanistic concepts of therapist genuineness, warmth, authenticity, and congruence and also includes the interchange between client and therapist. It is the therapeutic alliance that is most important to client compliance with treatment and to successful therapy outcome (Horvath & Greenberg, 1994).

Bordin (1994) developed a formulation of the therapeutic alliance that incorporates a mutual understanding and agreement between therapist and client about the goals of therapy, the necessary tasks to move toward these goals, and the establishment of an emotional bond to maintain the work of this partnership. The active collaboration of the therapist with the client in determining goals and tasks and the forming of bonds are central to the development of a strong alliance and promote client compliance to treatment. The development of this therapeutic alliance early in the relationship is crucial and is predictive of a significant proportion of final outcome variance (Henry & Strupp, 1994; Horvath & Symonds, 1991).

### Formal Assessment of the Therapeutic Alliance

A number of measures have been developed to assess the therapeutic alliance. They include the Working Alliance Inventory (Horvath & Greenberg, 1989), the Penn Helping Alliance Scale (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982), the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983), and the California Psychotherapy Alliance Scale (Gaston & Ring, 1992). The interested reader may refer to several sources for a more comprehensive discussion of issues, research, and associated measures of the therapeutic alliance (Horvath & Greenberg, 1994; Sexton & Whiston, 1994; Tichenor & Hill, 1989). These measures are primarily research instruments that continue to undergo validation studies, however, and are not suited for use by practicing therapists to assess the status of the therapeutic relationship.

### Informal Assessment of the Therapeutic Alliance

To determine what the client perceives as helpful or engaging in therapy, the initial client assessment should include an active inquiry into the client's history of other constructive interpersonal relationships (Whiston & Sexton, 1993). Also it will be relevant to determine the client's expectations of the therapy relationship (Whiston & Sexton, 1993). Because the therapeutic alliance is interactive, it is important to periodically review the alliance and to maintain a record of indicators through careful and detailed case notes. Careful documentation can help address any biases associated with retrospective interpretation of the alliance by enabling a comparison of current experience with previous notes. Consultation may also be helpful in assessing the therapeutic alliance. In addition, the therapist's personal reactions to clients may provide additional insights into how the therapy is progressing and may suggest various interventions that can help a struggling alliance.

The client's view of the therapeutic alliance is regarded as especially predictive of therapy outcome (Luborsky, 1994; Whiston & Sexton, 1993). The following client perceptions to be considered are adapted from Bordin (1994), Gelso and Carter (1985), and Whiston and Sexton (1993).

*Trust.* The working alliance is based on the client trusting the therapist to place the client's best interest first and help the client face his or her problems no matter what those interests and problems may be. It is also dependent on the client perceiving the therapist as genuine and as an expert. The degree to which the client is able to trust people in general (especially any paranoid tendencies) and any previous experience with trust.
issues in therapy (e.g., perceived abandonment) are also relevant.

Understanding and acceptance. Has the client expressed, explicitly or implicitly, positive interpersonal feelings toward the therapist? Does the client perceive the therapist as warm, supportive, concerned, empathic, compassionate, and respectful? Is there an emotional bond with the therapist?

Working toward shared goals. How has the client formulated his or her reason for seeking help? What are the client’s change goals and are they consistent and congruent with the therapist’s?

Helpfulness of therapy. Has the client expressed any opinions about the helpfulness of therapy so far? Any missed appointments and reasons for same may be relevant.

Values of treatment process. Does the client agree with the therapist as to what tasks and behaviors will be helpful in attaining their shared goals? In particular, to what degree is the client committed to discussing problems in therapy rather than acting on them outside of the therapy?

Case Illustrations

The following cases illustrate the application of the model to clients at high risk for violent behavior. All occurred in the context of the delivery of psychological services through the Workers’ Compensation Board of Alberta.

High Risk, Strong Alliance → Low Risk, Strong Alliance

If the risk of violence is high and the therapeutic alliance is strong, therapy should be intensified and the therapeutic alliance should be used to help the client make his or her environment less lethal, thereby assisting the client to control his or her violent behavior (Roth & Meisel, 1977; Wulsin, Burzstajn, & Guthel, 1983). Sessions can be scheduled more frequently, medication initiated or increased, weapons removed, or joint sessions held with the client and others who are significant to the occurrence of violence (Monahan, 1993).

Case 1. Mr. B., a 29-year-old welder, was seen following a closed-head injury. In the initial interview, he reported instances of involuntary aggression against a variety of people, including strangers and a playmate of his child, and he requested assistance in dealing with them. Neuropsychological and intelligence test results were within normal limits, as were a computed tomography scan and an electroencephalogram. He complained of blackouts in connection with his violent behavior, but these had never been observed and they appeared to be a dissociative reaction to extreme emotion. At the time, he was taking antiseizure medication with limited effect.

As a child, Mr. B. witnessed his father inflict extreme violence on his mother. As Mr. B. grew older, he became increasingly enraged with his father to the point of threatening to kill him. As an adult, he continued to have nightmares in which he assaulted his father in order to protect his mother. Mr. B.’s wife left him a year after the accident because of his violent behavior toward her.

During therapy, Mr. B. reported being very frightened by his episodes of uncontrolled violence. Anger management training was initiated that focused on his being able to calm himself in interpersonal situations. Shortly after therapy was initiated his mother died and his fiancée miscarried their pregnancy. He reported being increasingly frightened by the feeling that he was likely to harm someone. He and his therapist decided that he should stay in his home, enlist his brother to take away a gun and the knives in his house, and avoid contact with others until he was able to attend a neuropsychiatric consultation. This consultation was arranged on an emergency basis, and a trial of antidepressant medication was initiated, which substantially decreased his violent impulses. Anger management training continued to good effect.

High Risk, Weak Alliance → Low Risk, Strong Alliance

When a client is at high risk for violence and the therapeutic alliance is weak, the therapist should attempt to strengthen the alliance. If an alliance has not yet been established, the therapist should endeavor to behave in an affiliative, autonomy-granting manner and should refrain from responding in a hostile or controlling manner (Henry & Strupp, 1994). If the therapeutic alliance has already been established and is strained by the current situation, the therapist should openly identify and discuss the client’s perception of the alliance, listen nonjudgmentally, identify any misperceptions, and make any necessary adjustments to the therapeutic relationship (Safran, Muran, & Samstag, 1994). The strong reactions that the therapist is likely to feel should be used to help understand the client and to help the client understand the reactions that they arouse in others (Gelso & Carter, 1985). Simultaneously, or in sequence, the therapist should work with the client to alter those aspects of the client’s physical and interpersonal environment that are promoting or maintaining violence.

Case 2. Mr. V., a 30-year-old laborer, received psychotherapy for the following reasons: to assist him in dealing with seeking a new line of work, despite his being functionally illiterate and physically handicapped; to help him learn how to deal with his constant pain without using medications; and to help him with marital difficulties. His presentation was marked in its extremity; he was very jovial and laughed almost continuously throughout the first interview. He agreed to meet weekly, although he stated that he did not think it necessary.

After missing numerous sessions, Mr. V. asked for an extra session. He presented at this time as very upset. He explained that attempts to improve his relationship with his wife (from whom he was recently separated) had not gone well and that he had been diagnosed as having cancer. He reported feeling very alone with no one to confide in. Additional sessions were scheduled and marital sessions were arranged. Over the next few days, he calmed down, but his marital situation continued to deteriorate, and he cancelled the marital sessions. One and a half weeks (and four sessions) after asking for an extra session, Mr. V. presented on a Friday afternoon as extremely upset. He was very angry and paced around the office.

He reported that his wife had taken all of the belongings from their home, including his clothing and every article of furniture. Mr. V. reported that he had felt suicidal the night before but that he now wanted to kill his wife.

The therapist focused on strengthening the therapeutic alliance by clearing his schedule to spend more than 2 hours with Mr. V. and allowing him adequate time to emotionally vent in a nonjudgmental atmosphere. The risk of violence was addressed and the relationship was further strengthened by discussing the rationality of his plan, alternate plans, and ways of reducing other stressors. In the interests of strengthening the alliance further still, and to pro-
vide an opportunity to reduce any increase in violence risk, the therapist gave Mr. V. his after-hours telephone number and made an appointment for the following Monday.

On Monday, Mr. V. reported feeling settled and had decided to sever all ties with his wife. He attended two more sessions over the next two months and reported that he did not desire any further therapy. A year and a half later, he reported that he was doing well and no harm had come to his (now ex-) wife.

High Risk, Weak Alliance → Low Risk, Weak Alliance

If the alliance cannot be strengthened, the factors promoting violence should be eliminated or significantly reduced so that risk is lessened. This risk reduction will often involve including significant others, such as the client’s family members or possibly the police in preventative measures; however, a warning to potential victims should not be issued at this stage. A warning may result in needless emotional distress in the potential victim if the violence is prevented, and this psychic injury could even form the basis for a lawsuit against the therapist (Lewis, 1986). The client should be informed of the limits of confidentiality and the steps that will be taken. Civil commitment proceedings should also be considered—even if there is some doubt as to whether or not the client meets the appropriate criteria—ideally by the client on a voluntary basis. Under this circumstance, the therapist would be responsible for following up to ensure that the client had indeed been committed.

Case 3. Mr. K. was never seen in person. He telephoned a receptionist and began a long diatribe about how he had been mistreated by the Compensation Board, the government, and a variety of other institutions. He was intoxicated and, after about 20 min of nonstop talking that grew more and more abusive, threatened to “drive up there and shoot the whole lot of you.” The receptionist contacted the Psychology Department for assistance.

A therapist contacted Mr. K. by telephone and assessed the situation as follows: Mr. K. appeared to intend to carry out his threat, he reported having been violent in the past, he had a contentious claim with the Compensation Board, but he stated that he had no further avenues for appeal regarding his claim for compensation. The only positive factor in this assessment was that he had no further avenues for appeal regarding his claim for compensation. Once confidence is broken, the client’s trust in the therapist, and probably in psychotherapy in general, will be lost along with the opportunity for any further therapeutic work. Ideally, permission will be obtained from the client to warn the intended victim(s) or notify the police, thereby circumventing any violation of confidentiality (Fulero, 1988) and loss of trust (Slovenko, 1975). When third parties are involved, only that information necessary to prevent the foreseen violent act should be divulged.

Case 4. Mr. M. telephoned a receptionist and asked to speak with a therapist. After the call was transferred, he proceeded to explain that he had sent his wife and children to a shelter for battered women, that his house had been robbed, and that he was very angry about how he had been treated by the case worker who was handling his Workers’ Compensation Board claim. He then issued an ultimatum that he get the money he needed “or else,” and he then terminated the telephone call.

Mr. M. telephoned again later that day, and the therapist informed him that he had made enquires into who would be best able to help him. Mr. M. stated that he would talk to no one else but the therapist and requested a face-to-face meeting. This meeting was arranged and the call was ended. He called again an hour later and asked how things were proceeding. He was much more angry and emotionally upset and spent little time engaged in rational planning. He then issued a veiled threat toward his case worker and hung up. Fifteen minutes later, he called once again and was even more emotional; he stated that he would shoot his case worker and then hang up.

Mr. M’s threat was judged to be serious, his history of violence was unknown apart from the implication that he had been violent toward his family, he knew where his intended victim worked, his access to a weapon was unknown, he appeared to be very agitated, he perceived his case worker as the source of his problems, and efforts to dissuade him appeared to be ineffectual in the context of a weak therapeutic alliance.

The therapist informed the police and warned the case worker. Mr. M. was apprehended, and, after two court appearances, he eventually pleaded guilty to criminal charges of uttering a threat to cause death or bodily harm.

Conclusion

The purpose of this article has been to present a model for clinical decision making that can be used quickly when selecting interventions for dealing with dangerous clients in the outpatient setting. Through the model and four case studies pre-
sented, we have attempted to demonstrate that the conflict between our therapeutic duty to dangerous clients and our duty to protect their potential victims can best be resolved by reducing the degree of violence risk while building or maintaining a strong therapeutic alliance. Although these situations will always be difficult, it is hoped that having this model in mind will help clinicians make the best decisions during times when, most likely, they will be struggling clinically, emotionally, and personally, and often may not have the time to reflect and consult with colleagues before making their decision.

Another purpose of this article has been to help therapists in solo practice. Very often, in situations such as the ones presented, solo practitioners may not have the opportunity to consult with colleagues before having to make a decision. Having a model to help them in their decision making may be very much appreciated indeed. We feel fortunate in our work setting that there are a number of psychologists, working in somewhat different situations, with whom we can consult when we feel the need for another opinion. In regard to the cases presented in this article, the opportunity to consult with other psychologists in formal and informal settings, where we were able to receive feedback about the decisions made and actions taken, was invaluable.

In regard to the model, a number of questions remain. Does it apply to all clinical settings? Does it apply to crisis settings, short-term care settings, and long-term treatment settings? Would it be the same when the threat arose 6 months into psychotherapy as compared to being what caused the clinical contact to begin? What is common and what is unique to our specific setting and with our particular clients? Also, what might generalize to other settings and situations, and what might not? These are questions that have yet to be answered, and we hope that they will be explored further. Presently, we are thinking of our model as generalizable to many settings and possibly to other high-risk situations such as suicidal behavior. Basically, we think of psychotherapy as an art (Storr, 1990) where art is defined as the skilled use of knowledge to achieve goals (Fox, 1972). This knowledge can be based on intuition, logic, personal observations, research data, or consultation with colleagues (Evans, 1988). We believe that when dealing with dangerous clients, all of these sources of knowledge should be used to make the difficult and important clinical decisions that are called for.

References


