

**DANGEROUS – DECEPTIVE
CLIENTS
Firearm Concerns
Assessments**

**GREEN SLIDES FROM
PRESENTATION**

DECEPTIVE CLIENTS *can be Dangerous Clients*

AT TIMES, COUNSELORS AND PSYCHOTHERAPISTS

ENCOUNTER CLIENTS whose participation in treatment includes the goal, often hidden, of enhancing their position in some type of legal case, such as acquiring disability benefits, obtaining custody of their children, winning a personal injury lawsuit or avoiding incarceration for a criminal conviction.

TWO IMPORTANT ETHICAL ISSUES ARE RAISED BY THESE TYPES OF SITUATIONS.

1. The therapist is ethically required to do his/her best to avoid being manipulated by the client into making untrue statements on the client's behalf.
2. Possibly even more important is the ethical obligation of the therapist to do her/his best to avoid being used by the client to harm other persons.

DECEPTIVE CLIENTS

Therapists are also likely to work with clients who have been "forced" into treatment by a spouse, employer, professional organization or court official.

- In these situations, it is not unreasonable to expect that such clients may attempt to obtain written statements or even in some cases, court testimony, from the counselor/therapist. The client may request, for example, statements from their counselor/therapist that the client has made more progress in treatment and/or exhibits less of the problem behavior than the counselor or therapists believes to be the case.

THREE INTERCONNECTED GOALS.

1. The first goal consists of describing the situations in which the generalist counselor or therapist is most likely to encounter client deception.
2. The second goal involves providing an overview of theory and research regarding the nature of deception and the psychological techniques for detecting it. Here, the generalist is provided with an easily-digestible summary of the most recent and relevant research from forensic psychology pertaining to this topic.
3. The third goal discusses ethically-based strategies for dealing with client

deception, including an analysis of when, where, why and how to confront clients if deception is suspected.

Some facts about deception in psychotherapy:

Clients who obtain treatment with a hidden legal agenda can in some cases be expected to ask their counselor or therapist to make untrue statements regarding the nature of their problem and/or treatment progress.

There are many situations in which counselors/therapists need to be alert to the possibility of client deception/manipulation.

Many techniques, including both physiologically and psychologically based, exist for detecting deception.

- Verbal content analysis, based on evaluating the words people use, has achieved significant reliability in differentiating between true and deceptive statements. Confronting client deception can be difficult for both the client and therapist.
- There are times when direct client confrontation may represent the most ethically-appropriate and clinically-effective strategy for dealing with this problem.

FIREARMS and MANDATORY REPORTING

IN DETERMINING WHETHER THE RISK IS SERIOUS, ACCESS TO FIREARMS SHOULD BE TAKEN INTO ACCOUNT, as guns are an important risk factor for both violence and suicide.

1. One study showed that having a firearm in the home was associated with a nearly fivefold increase in risk of suicide, and another showed that having a firearm in the home was associated with a nearly threefold increase of risk of homicide, after controlling for other factors.
2. Firearms are a particularly important factor in domestic violence, as roughly forty percent of female homicide victims are killed by an intimate partner (i.e., spouse, ex-spouse, lover), and roughly 60 percent of those homicides involve guns.

Mandatory Reporting Patient Violent

<https://journalofethics.ama-assn.org/article/how-should-physicians-make-decisions-about-mandatory-reporting-when-patient-might-become-violent/2018-01>

Practitioners might be faced with difficult legal and ethical decisions in cases in which patients appear at risk of violence or suicide, particularly when firearms are involved.

Discussions about the risks of firearms should be approached collaboratively so as not to diminish patient rapport.

Additionally, physicians should be cognizant of when they are required to report concerns for violence or suicide and when they are permitted to do so.

In situations in which such reporting is permitted, they should balance patient autonomy and beneficence with patient and public safety.

Check with your own healthcare organization to see what tools they have in place.

THE FOLLOWING ARE ASSESSMENT TOOLS THAT HAVE BEEN DEVELOPED FOR THIS PURPOSE.

1. Triage Tool: to assess a patient's potential danger from others or to him/herself, which may spill over to become an issue in the healthcare setting.
2. Indicator for Violent Behavior: a quick list of five observable behaviors that indicate danger to others.
3. Danger Assessment Tool: to assess the risk to nurses and other healthcare personnel of an individual who is exhibiting signs of potentially dangerous behavior.

DOCUMENTS are on WEB PAGE

Triage Tool

The Triage Questions below originated from research with abused women and interviews with Emergency Department staff at a major city hospital and emergency workers in community mental health. (Hoff & Rosenbaum, 1994)

TRIAGE QUESTIONS

1) Have you been troubled or injured by any kind of abuse or violence? (e.g., hit by partner, forced sex)
 Yes No Refused
 If yes: By someone in your family? By an acquaintance or stranger? Describe.

2) If yes: Has something like this ever happened before?
 Yes No
 If yes, when? Describe.

3) Do you have anyone you can turn to or rely on now to protect you from possible further injury?
 Yes No
 If yes, who?

4) Do you feel so badly now that you have thought of hurting yourself/suicide?
 Yes No
 If yes, what have you thought about doing?

5) Are you so angry about what's happened that you have considered hurting someone else?
 Yes No
 If yes, have you ever threatened or hurt someone in the past?

These five basic questions will help ascertain the needs of an individual patient, but to be meaningful an interviewer needs to follow up beyond simple 'yes/no' responses. This can be an opportunity to talk someone down.

The intent of the triage questions is to reveal:

- A history of victimization, suicide attempts, and assault increases current risk. Past violence is a major indicator of potential violence.
- If a victimized person is isolated without available social support, suicide risk is increased.
- If a person with violent fantasies or plans of assault also considers suicide, the risk of assault and homicide increases.
- Level of support or conflict with significant other.

A triage tool is essential for patient safety as well as for nursing personnel. Spillover from domestic violence, for example, can lead to violence in the workplace.

Indicator for Violent Behavior

Danger assessment tools may vary by healthcare organization and even by department (such as emergency or psychiatric departments). Check with your organization to see what tools they may use.

As an example, Luck et al* describe a general tool, with the acronym **STAMP**. They identify five distinctive elements of observable behavior that indicate the potential for violence in patients and those who accompany them.

These five interconnected components are:

- Staring and eye contact
- Tone and volume of voice
- Anxiety
- Mumbling
- Pacing

As the potential for violence escalated, study participants reported that the number of STAMP components and cues increased. It should be noted that although these may represent a preliminary framework on which to build a useful nursing violence assessment tool, this study took place in a single ED, so the findings may not be generalizable.

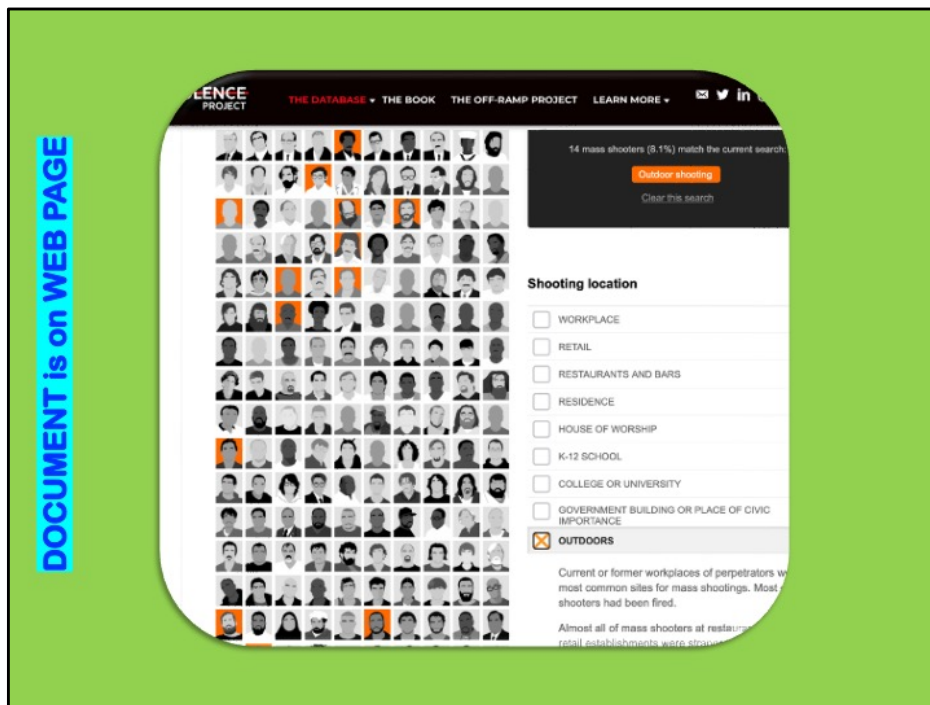
TRIAGE TOOL: Questions to ask the client

- The use of such a scale is important because it established a standard and consistent framework for evaluation.
- Without it, we are left to rely on best guesses and gut reactions.

INDICATORS OF VIOLENT BEHAVIOR: Things to pay attention to and note in clinical records based on your clinical judgement

Acronym: **S.T.A.M.P.**

→ See slide



([The Violence Project: How to Stop A Mass Shooting Epidemic](#), Abrams Press, 2021).

Search The Database

Explore the shooters, their backgrounds, guns and motivations.

<https://www.theviolenceproject.org/mass-shooter-database/>

WHY ASK ABOUT Internet use and MULTIPLAYER Video Gaming?

All mass shooters since 2000 have/had been active players on the more violent multiplayer video games (Like Call of Duty)...

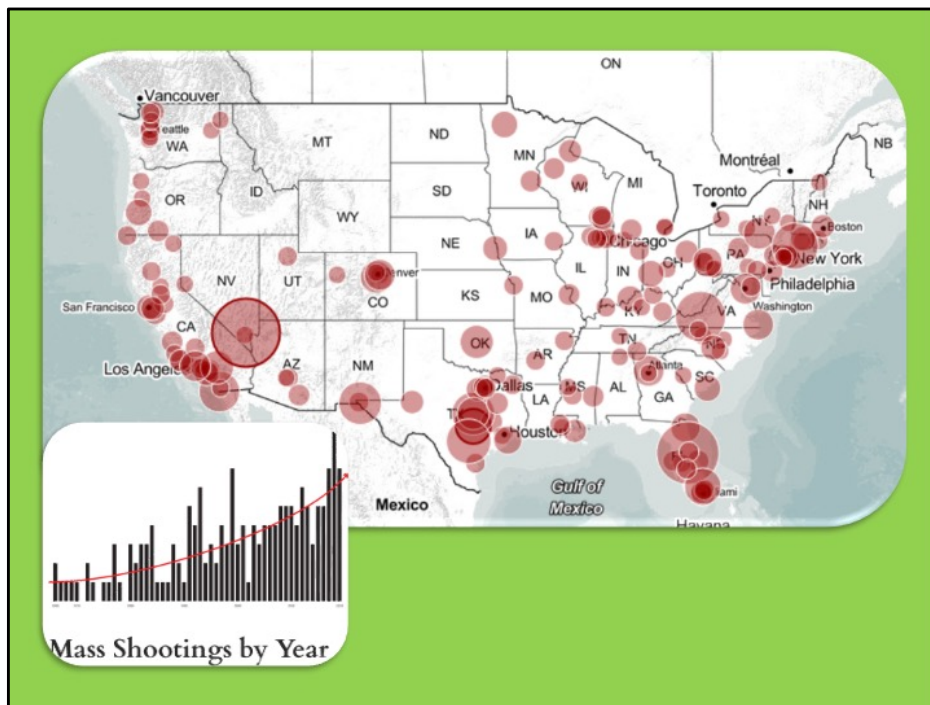
BUT keep in mind *MANY individuals play these* and **MASS SHOOTERS** only make up **0.00000197%** of all video game players

- **2000: Multi-player games** → Halo: Combat Evolved & World of Warcraft
- **2017: Most violent multi-player video games** → Bullstorm, Conan Exiles, Dark Souls, Dead by Daylight, Outlast, Resident Evil
- **2020: Rated the most violent video games ever** → Manhunt 2, The Punisher, Hatred, and Agony. **Most Played Games in 2020: Ranked by Peak Concurrent Players** → Crossfire – 8 Million

Gaming Disorder: New ICD-11 Diagnosis

The Implications of Gaming Disorder being classified in the ICD-11:

- **According to the World Health Organization (WHO)**, Gaming Disorder is defined in a draft of the 11th Revision of the International Classification of Diseases (ICD-11) as a pattern of gaming behavior (“digital-gaming” or “video-gaming”) characterized by impaired control over gaming, increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities, and continuation or escalation of gaming despite the occurrence of negative consequences.



(*The Violence Project: How to Stop A Mass Shooting Epidemic*, Abrams Press, 2021).

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