Workplace Violence In Social Care Settings: Traumatic Stress And Burnout In Staff.

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Submitted in partial fulfilment of the requirements of the Higher Diploma in Psychology at Dublin Business School, School of Arts, Dublin.

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Declaration

I declare that this thesis that I have submitted to Dublin Business School for the award of HDip Psychology is the result of my own investigations, except where otherwise stated, where it is clearly acknowledged by references. Furthermore, this work has not been submitted for any other degree.

Signed: Daniel Dowling

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I would like to sincerely thank all participants for taking part in this research study and for sharing their experiences of workplace aggression and violence in the Social Care profession. I would like to thank Dr Sonam Prakashini Banka for all her advice and guidance during the completion of this thesis. Last but definitely not least, I would like to thank Bernie for all her amazing support, encouragement and expertise.

Abstract

The aim of this study was to examine the relationship between frequency of exposure to physical violence/aggression and traumatic stress and burnout in social care workers (SCWs). One hundred SCWs were surveyed using non-experimental, cross-sectional, quantitative design with three questionnaires: Demographic questionnaire, revised Impact of Events Scale and Maslach Burnout Inventory. Responses were analysed using SPSS quantitative software and utilised descriptive statistics, non-parametric correlational and comparative statistical tests. Results indicated statistically significant positive relationships between the frequency of exposure to physical aggression/violence and traumatic stress and burnout measures. Results also indicated significant positive correlations between traumatic stress and burnout. Furthermore, exposure to workplace violence/aggression, traumatic stress, and burnout also positively correlated with SCWs desire to leave the profession in the next five years. Finally, results indicated the presence of a significant protective role of self-care in moderating the perceived effects of workplace violence/aggression on traumatic stress and burnout in SCWs.

Chapter 1: Introduction

1.1 The Current Landscape of Social Care Work in Ireland

Social care workers (SCWs) and Assistant Support Workers (ASW) plan and provide front line care to vulnerable adults and children who experience disability, disadvantage, and marginalisation in a variety of settings. The role of SCWs and ASWs involves advocating, caring for, and supporting individuals to achieve their full potential (Lalor & Share, 2013). However, there are many physical and psychological challenges which SCW's often encounter on a daily basis which may have a profound impact on the quality of life of these primary care givers. The extent of these challenges is only coming to light in recent years.

Social Care Ireland published the Crisis, Concern and Complacency report in 2016 (Keogh & Byrne, 2016), which found that 90% of SCW's in Ireland have experienced regular abuse, threats, and physical violence in the workplace. While 100% of SCWs working in children's residential services experienced workplace violence (Keogh & Byrne, 2016). The authors also suggest that there appears to exist a culture of complacency and normality or desensitization to workplace violence at present. This culture was found to extend up to management and agency level (Keogh & Byrne, 2016). Many other studies have highlighted the risk of workplace violence that SCWs are exposed to and that this risk is increasing (Alinke, Euser, Bakermans-Kranenburg, & Van IJzendoorn, 2014; Colton & Roberts, 2006; Franz, Zeh, Schablon, Kuhnert, & Nienhaus, 2010; Harris & Leather, 2011; Mc Adams, 2002). The Health and Safety Authority defines workplace violence and aggression as *'any incident where staff are abused, threatened or assaulted in circumstances related to their work'* (Health & Safety Authority, 2018).

SCW is a profession which is as diverse as the service users supported. The Joint committee on social care professionals defined social care as:

> The professional provision of care, protection, support, welfare and advocacy for vulnerable or dependent clients, individually or in groups. This is achieved through the planning and evaluation of individualised and group programmes of care, which are based on needs, identified in consultation with the client and delivered through day-to-day shared life experiences. All interventions are based on established best practice and in-depth knowledge of life-span development. (Joint Committee on Social Care Professionals, 2002, p. 2).

SCWs operate within a person-centred and community-based framework whereby individuals being supported are treated with dignity and respect, and each of whom have unique life experiences and personalities which should be valued (Brooker & Latham, 2015; Kornbeck, 2002). In addition to empathy, patience, integrity, and understanding, another central guiding principal for SCWs is building and maintaining meaningful relationships with service users. The ultimate goal of supporting each service user is to enable individuals to live a fulfilling life and to allow them to achieve their full potential (Kornbeck, 2002).

However, the need to provide these services to some of the most vulnerable individuals in society may be impacted by global developments. The World Health Organisation (WHO) and United Nations predicts that changing global demographics will place additional demands on several areas of society, including health and social care. The global population is currently 7.6 billion and is expected to reach 8.6 billion in 2030, 9.8 billion in 2050 and 11.2 billion in 2100 (United Nations Department of Economic and Social Affairs/Population Division, 2017). This increase in population is combined with an aging population. The WHO predicts that there will soon be more older people than children and more people at extreme old age than ever before (World Health Organization, 2011). With general population increases, extended lifespan and higher proportion of elderly individuals, societies can expect demands for health and social care to increase consistently (World

Health Organization, 2015). The Economic and Social Research Institute (ESRI) found that demand for public and private health and social care services in Ireland will increase exponentially by 2030 (Wren et al., 2017). These changes will have significant and profound impacts on the health and social care sector which is already characterized by challenges of staff retention (Keogh & Byrne, 2016; Mor Barak, Nissly & Levin, 2001).

In addition to these changing demographics, the Health Service Executive of Ireland published a report in 2011 calling for the deinstitutionalisation of congregated settings in Ireland and the transition to a more local strategy of community inclusion for people living with disabilities (Health Service Executive, 2011; Inclusion Ireland, 2018). While this is welcome news and will have many beneficial effects for those living in care settings, it nevertheless places additional demands on community residential settings. For example, SCWs can be exposed to an increased risk due to lone work in community residential settings and new relief staff are often brought in temporarily to fill gaps in staffing levels. This may be seen as a symptom of an understaffed and underfunded sector (Keogh & Byrne, 2016). Where previously, congregated settings would mean there was always support from other staff, lone working often means SCWs are alone without support. The type of care setting is also important in terms of workplace violence, for example, SCWs in the disability services have been found to be exposed to high levels of workplace violence (Hensel, Lunsky & Dewa, 2012), while those working in settings such as family support and community services may be at a lower risk of workplace violence. Staff retention rates seem to differ depending on the care setting and this may possibly suggest that exposure to workplace violence may have a direct link to SCW retention rates (Keogh & Byrne, 2016).

Residential care in particular can be a complex and unpredictable environment characterised by the spectrum of diagnoses and unique personal circumstances of each service user combined with the difficulties associated with communal living, all of which can

have a considerable effect on service user's behaviour (Clough, Bullock & Ward, 2006). Furthermore, young people in residential care may have experienced disproportionately high levels of social disadvantage and trauma prior to entering residential social care which may also influence their behaviour towards care givers (Brodie, 2005). Howard (2014) stresses that residential care can be chaotic, ambivalent, turbulent, unpredictable, and often dangerous for staff and young people (Howard, 2014). SCWs in residential settings frequently experience manifest behaviour that can be chaotic and challenging. The very nature of SCW involves direct contact with vulnerable children, young people and adults who present with complex needs, and at times display aggressive or violent behaviours. This working environment places SCWs at significant risk of experiencing workplace violence (Keogh & Byrne, 2016).

1.2 The Impact of Workplace Violence

Routine exposure to workplace violence can have significant deleterious effects on quality of life for SCWs/ASWs and indeed the service users they care for. Studies have found that incidents of aggression/violence can result in primary, secondary and tertiary victims including service users who may experience traumatic stress and anxiety (Hastings & Brown, 2002; Rippon, 2000). Another study found that SCWs may experience feelings of despair, sadness, annoyance, anger and anxiety when faced with violent incidents (Emerson & Hatton, 2000). There is a growing body of evidence highlighting the extent to which SCWs/ASWs are exposed to work place violence and the potential consequences, e.g., stress, anxiety, fear. However, the full ramifications of this working environment are still lacking. Furthermore, the Crisis, Concern and Complacency report highlighted the fact that very little attention has been paid to this situation by policy makers since the first report in 2001 (Keogh & Byrne, 2016; Keogh et al., 2001).

Work-related violence and aggression can threaten the safety and well-being of service-users and employees and can cause both immediate and long-term effects. An individual who directly experiences a perceived violent or aggressive incident can suffer physical and/or psychological harm or injury (Health & Safety Authority, 2018). The impact of violence and aggression towards SCWs can be extensive and traumatic for them as victims, but also their colleagues, service users, friends, family, and the organisation (Rippon, 2000).

The personal cost of experiencing violence include the immediate physical injuries, some of which may be significant, but may also cause various psychological effects and a complex range of emotions (Lovell & Skellern, 2013). Fear, stress, frustration, guilt, anger, annoyance, and anxiety have been identified as common impacts on SCWs and social workers who experience violence (Keogh, & Byrne, 2016; Littlechild, 2000; Smith, & Nursten, 1998). Fear responses that are linked to direct and vicarious exposure to violence were found to be related to subsequent depression, anxiety and had a negative impact on the well-being of SCWs (Schat & Kelloway, 2000). These emotional states may cause distress to SCWs and may lead to feelings of being unsafe, sleeplessness, anger, and irritability (Keogh & Byrne, 2016). The multifactorial nature of SCW can also place emotional demands on staff, and staff may benefit from regular support groups and supportive supervision (Taylor, 2011). These emotional and psychological effects are not only felt after a violent incident but may also be felt prior to a violent incident which SCWs may experience as anticipatory anxiety by predicting or anticipating in advance of the incident itself. Some SCWs reported feeling relieved that a behavioural outburst had occurred which may remove the tension and fear of anticipated violence (Keogh & Byrne, 2016). Other sentiments that SCWs reported feeling after a violent incident included feelings of failure, disillusionment, disappointment, powerlessness, and embarrassment (Keogh & Byrne, 2016). More harrowing are statistics

disclosed by the Office for National Statistics (2017) in its report 'Suicide by Occupation, England: 2011 to 2015'. Analysis found that care workers of both genders were at risk of suicide that was almost twice the national average (Office for National Statistics, 2017).

While emotional and psychological issues may arise for many SCWs in response to exposure to violence and aggression, others may become desensitized to these incidents and view them as a 'normal' part of their working life (Lundström, Åström, & Graneheim, 2007) and while not acceptable, violence may be considered by some SCWs as tolerable in some care settings (Lovell & Skellern, 2013). The WHO identified social and cultural norms that are seen as rules or expectations of behaviour within certain groups and can become the standard of acceptable or unacceptable behaviour. These expectations of behavioural norms within certain groups can even encourage violence and aggression (Keogh & Byrne, 2016; World Health Organization, 2009). As many SCWs perceived violence as part of the job (Keogh et al., 2001), incidents of workplace violence have been significantly underreported (McKenna, 2004). This may be due to a belief that nothing would be done if they reported it, potentially as a result of previous reports not being acted on. Staff may also be fearful that they may be perceived as unskilled or not up to the job or could be experiencing the strain of the role and may not have time to fill out incident reports (Keogh et al., 2001).

Colton and Roberts (2007) identified the need for organisations to clearly convey to all individuals participating in a care setting that workplace violence is unacceptable by ensuring there are sound, research informed strategies to prevent, manage and support staff after a violent incident (Colton & Roberts, 2007). As many organisations do not currently have adequate support structures in place for staff, this can lead to high levels of stress and may ultimately be a significant contributory factor in staff burnout and also SCWs perceiving their profession as a stepping stone to other employment areas (Colton & Roberts, 2007).

1.3 Traumatic Stress

The most reported personal impact of workplace violence in SCWs was stress with 98% of SCWs surveyed reporting this effect (Keogh & Byrne, 2016). Stress is any uncomfortable emotional experience accompanied by predictable biochemical, physiological and behavioural changes (Baum, 1990). Stress can often be beneficial over an acute timeframe, for example, escaping an imminent threat or meeting high pressure work demands. However, chronic levels of stress over prolonged periods of time can have significant deleterious health consequences and may negatively affect the immune, cardiovascular, neuroendocrine and central nervous systems (Anderson, 1998) and may play a role in disease onset and progression (Cohen, Janicki-Deverts & Miller, 2007; Vedhara, Irwin & Irwin, 2005). Psychological stress occurs when an individual perceives that environmental demands tax or exceed their adaptive capacity (Cohen, Kessler & Gordon, 1995).

In social care settings, regular verbal and physical threats of violence and aggression can have an impact on SCWs stress levels and may even result in post-traumatic stress disorder in some individuals and this may impact on staff retention (Balloch, Pahl & McLean, 1998; Colton & Roberts, 2006; Colton & Roberts, 2007; Hastings & Brown, 2002; Keogh & Byrne, 2016; Santos, Leather, Dunn & Zarola, 2009; Whitaker, Archer & Hicks, 1998).

1.4 Burnout

Chronic stress can bring SCWs to the point of burnout and this impacts not only the individual SCW but the entire care team, and wider social networks (Keogh & Byrne, 2016). Burnout is a type of psychological stress, sometimes referred to as occupational burnout (Ruotsalainen, Verbeek, Mariné & Serra, 2016). Burnout is a syndrome characterized by three types of feelings; emotional exhaustion, depersonalization, and low personal accomplishment (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016). Five categories of

burnout symptoms were previously identified by Kahill (1988). These include: Physical symptoms, such as fatigue, sleep difficulties, somatic problems, gastrointestinal disturbances, colds and flu; Emotional symptoms, such as irritability, anxiety, depression, guilt; Behavioural symptoms, such as aggression, callousness, pessimism, substance abuse; Work-related symptoms, such as resigning from work, poor work performance, absenteeism, tardiness, misuse of work breaks; and Interpersonal symptoms, such as the inability to concentrate/focus on communication, withdrawal from clients/co-workers, followed by dehumanized, intellectualized interactions (Collins & Long, 2003; Kahill,1988).

Burnout may be considered a gradual process whereby staff can feel progressively worn down, overwhelmed and incapable of facilitating positive change (Figley, 1995). Burnout can have a negative impact on an individual's quality of life and can be personally distressing (Freudenberger, 1975). Burnout can also have numerous consequences for an individual's health. For example, a study by Honkonen (2006) which studied 3,368 employees in Finland found that all three aspects of burnout (emotional exhaustion, depersonalization, and low personal accomplishment) were associated with increased prevalence of musculoskeletal disorders among women and cardiovascular diseases among men (Honkonen et al., 2006). The authors also found that elevated rates of general physical illness appeared to be more common in people experiencing higher degrees of burnout compared to people with lower degrees of burnout (Honkonen et al., 2006; Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016).

Burnout may also be an important risk factor or precursor to compassion fatigue/secondary traumatic stress (Collins & Long, 2003). Compassion fatigue, like burnout, can challenge SCWs ability to provide adequate care and maintain personal and professional therapeutic relationships. While burnout is a gradual process, compassion fatigue can be sudden and acute (Collins & Long, 2003; Figley 1995). Lloyd, King & Chenoweth (2002)

found that social workers may experience higher levels of stress and resulting burnout than comparable occupational groups (Lloyd, King & Chenoweth, 2002). Maslach (2016) predicted that burnout would be related to the desire to leave one's job (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016). Gibson et al. (1989) found that 73% of social workers surveyed thought of leaving social work at some point, with half of the respondents having considered leaving in the past year. Gibson et al. (1989) carried out a study of occupational stress in Northern Ireland and analysed 176 front line social workers using the Maslach Burnout Inventory (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016). Gibson et al. (1989) found that 47% of social workers were in the moderate intensity burnout category in terms of frequency and intensity of the emotional exhaustion subscale and 42% were high intensity on the depersonalisation subscale. On the subscale that measures burnout due to feelings of lack of personal accomplishment, social workers exhibited high levels. All the respondents fell into the high burnout category for frequency (100%) and almost all for intensity (98%). The authors found that the main manifestation of burnout among the social workers was in feelings of personal accomplishment (Gibson, McGrath & Reid, 1989). Healy et al. (2007) highlighted high levels of staff turnover and retention challenges in the care profession as a result of stress and burnout (Healy, Meagher, & Cullin, 2007).

The relationship between exposure to aggression/violence and burnout, has been highlighted in previous studies investigating this link in various professions including; Nurses (Galián-Muñoz, Ruiz-Hernández, Llor-Esteban, & López-García, 2016), nursing home caregivers (Isaksson, Graneheim, Richter, Eisemann, & Åström, 2008), police officers (Kop, Euwema, & Schaufeli, 1999), Psychiatrists (Kumar, 2007), and social workers (Beaver, 1999).

1.5 Rationale For The Present Study

The current proposed research study aims to investigate whether SCWs/ASWs who have been exposed to workplace violence report a significant level of traumatic stress and potential burnout symptomology. Furthermore, does the frequency of workplace violence have an impact on the levels of traumatic stress and burnout in SCWs. This may help inform management and agencies of the challenges facing SCWs/ASWs and may contribute to our understanding of the relationship between workplace violence and well-being. Furthermore, if staff exposed to physical violence report symptoms of traumatic stress and burnout, this may have an impact on staff turnover. Studies have also found that high levels of staff turnover may affect service users in multiple ways including; lack of stability and loss of trusting relationships (Strolin-Goltzman, Kollar, & Trinkle, 2010). By losing continuity of staff and stable relationships between experienced SCWs and service users, this may lower the quality of care received by the service user (Brandt, Bielitz, & Georgi, 2016). This study also aims to examine the potential protective role of self-care in moderating the perceived effects of workplace violence/aggression on traumatic stress and burnout in SCWs.

1.6 Hypotheses

Hypothesis 1: There will be a significant positive relationship between the frequency of exposure to workplace aggression/violence and levels of traumatic stress.

Hypothesis 2: There will be a significant positive relationship between the frequency of exposure to workplace aggression/violence and burnout symptomology.

Hypothesis 3: There will be a significant positive correlation between traumatic stress and burnout.

Hypothesis 4: There will be a significant positive correlation between the frequency of exposure to workplace aggression/violence and desire to leave the SCW profession.

Hypothesis 5: There will be a significant positive correlation between traumatic stress scores and desire to leave the SCW profession.

Hypothesis 6: There will be a significant correlation between Maslach burnout subscales and desire to leave the SCW profession.

Hypothesis 7: There will be a significant negative correlation between self-care and traumatic stress and burnout.

Chapter 2: Methodology

2.1 Participants

The present study was carried out specifically on SCWs and ASWs currently working in a front-line care position across varying settings within Ireland. Participants (n = 100) were invited to complete an in-person paper-based survey which took approximately 5-10 minutes to complete.

The SCWs and ASWs were from several locations around the midland region of Ireland and worked in the private sector. Inclusion criteria for participation required participants to be over 18 years old and have current or previous experience of workplace violence in social care settings. Participation of this research study was voluntary as per section 1.3.7 of the PSI code of professional ethics and was anonymous; respondents were made aware of this prior to completing the survey. No monetary incentives were provided, and participants were informed how their responses would be used and presented. To gain access to participants, prior consent (Appendix E), was given by the person in charge of the residential units. Information and consent forms can be found in appendix A.

Participants ranged in age from 21 to 54, with mean age of 32 (SD=7.56). Of the participants, 56 were female (56%) and 44 were male (44%). The mean time in years participants had been employed as SCWs/ASWs was 5 years (SD=4.55). Seventy-nine percent worked full time and 21% worked part time. Eighty-six percent described their role as front line staff while 14% described their role as management.

2.2 Design

This study was questionnaire-based. A non-experimental, cross-sectional, quantitative design was employed to investigate relationships between variables. Each participant, recruited through non-probability purposive sampling, completed the same paper-based survey. The survey was comprised of a demographic questionnaire and established and valid measures which included the revised Impact of Events Scale (IES-r) and the Maslach Burnout Inventory – Human Services Survey (MBI-HSS). Predictor variables were; Frequency of exposure to physical aggression/violence, length of service, self-care. Criterion variables were; Burnout and traumatic stress, measured using the MBI-HSS (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016) and the IES-r (Weiss & Marmar, 1997) respectively.

2.3 Materials

The questionnaire was comprised of two booklets. The first included a fully comprehensive information form with contact details for the researcher and supervisor. The second booklet was comprised of three sections; The demographic questionnaire (16 questions), the IES-r (22 questions) and the MBI-HSS (22 questions). The estimated time for completion of the survey was approximately 5-10 minutes which ensured participants would not lose patience/interest during the survey and that they would give each question sufficient attention and thought.

2.3.1 Demographic Questionnaire

A demographic questionnaire composed of 16 questions was administered to gather role specific information for the purpose of using as predictor descriptives. See Appendix B.

2.3.2 Impact of Events Scale – Revised Edition

The IES-R is a self-administered, 22-item questionnaire based on three types of symptoms identified in the Diagnostic and Statistical Manual of Mental Disorders, third edition, as indicators of posttraumatic stress disorder (PTSD) (Spitzer & Williams, 1980). The three types being: Intrusion (INT), Avoidance (AVD) and Hyperarousal (HYP). The IES-R is not a diagnostic or screening tool for PTSD, rather, it relies on self-reporting of symptoms after a traumatic event. Participants are asked to indicate the degree of distress for 22 symptoms according to a five-point scale: 0 indicates the symptom occurs "not at all"; 1, "a little bit"; 2, "moderately"; 3, "quite a bit"; and 4, "extremely" (Weiss & Marmar, 1997). A score of 24 or more may be meaningful and may represent a clinical concern for PTSD. Individuals may have partial PTSD or at least some symptoms of PTSD (Asukai et al., 2002). A score of 33 or more represents the best cut off for a probable diagnosis of PTSD (Creamer, Bell & Failla, 2003). A score of 37 or more is high enough to potentially suppress the immune system function for as much as ten years after the traumatic event (Kawamura, Kim & Asukai, 2001). The max mean score in each subscale is 4 representing a feeling of “Extremely” for the relevant subscale. See appendix C for questionnaire.

2.3.3 Maslach Burnout Inventory – Human Services Survey (MBI-HSS)

MBI is recognized as the leading measure of burnout and has been developed and modified to fit different work settings. The MBI-HSS is the original and most widely used version of the MBI. It was designed to capture feelings of burnout among people working in human services, where professionals such as SCWs spend considerable time interacting intensely with clients (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016).

The MBI-HSS analyses three central aspects of burnout: emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA). The frequency by which participants experience feelings related to each scale is assessed using a seven-point scale

(Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016). When interpreting results, it is important to note that there is no definitive score that proves a participant is burned out. The mean scores can be considered where they fall on the 7-point scale from 0 (Never) to 6 (Daily). For example, an EE mean score of 5.5 would indicate the participant felt emotionally exhausted several times a week on average, but not every day. The three MBI-HSS scores should be calculated and interpreted separately and should not be combined to form a single "burnout" score. For ease of interpretation, it is useful to calculate the mean response for items in each scale. See appendix D for questionnaire.

2.4 Procedure

This research was carried out between December 2018 and February 2019. The researcher attended several residential and day service units within a Healthcare service provider in the midland region of Ireland. The aim of the research was explained to staff at a time that was suitable for them and then information and consent forms in addition to the survey was provided to staff to complete. Written instructions were in the survey booklet. Any questions participants had were answered at the time. After completion, staff were checked to ensure they were okay. Support services were then outlined and signposted verbally and in the debrief form (Appendix F), in case staff needed any support.

2.5 Ethical Considerations

Throughout this study the PSI code of ethics (Psychological Society of Ireland, 2010) were always adhered to. Participants were informed on the information sheet provided prior to taking part in the study that their identity would be protected, as the study was anonymous and confidential. Accordingly, withdrawal from the study after completion was not possible. Participants were informed of their right to withdraw from the study at any stage. Participation was voluntary, and no monetary incentive was offered. Data collected was

safely stored with the researcher at a secure off-site location. Participants were informed of psychological supports available (Appendix F).

2.6 Proposed Data Analysis

Descriptive and inferential statistics will be employed during analysis. Mean scores and standard deviation results will be given for demographic variables where possible which will highlight raw data. If the data are normally distributed, inferential statistics will include a series of Pearson's correlations to test for relationships between the predictor and criterion variables in addition to One-Way ANOVA's to determine any statistically significant differences between groups. If the data is not normally distributed, inferential statistics will include a series of Spearman correlations to test for relationships between the predictor and criterion variables and Kruskal-Wallis analysis to determine whether there are any statistically significant differences between groups.

Chapter 3: Results

3.1 Descriptive Statistics

3.1.1 Demographic Questionnaire Descriptives

Participants ranged in age from 21 to 54, with a mean age of 32 (SD=7.56), with 56 females (56%), and 44 males (44%). The mean time (in years) they have been employed as a SCW/ASW was 5 years (SD=4.55), with the shortest serving 6 months and the longest serving 25 years. Seventy-nine percent worked full time, 21% worked part time and 86% of the sample described their role as front line staff while 14% described their role as management. Participants worked in day service (10%), residential service (87%, and outreach/community service (3%).

3.1.2 Predictor Variable Descriptives

Participant scores for the predictor variable of frequency of exposure to workplace physical aggression/violence is outlined in Table 1. Groups represented the frequency of exposure to physical aggression/violence, that being; Daily, weekly, monthly, yearly. In order to compensate for lower participant numbers in the daily and yearly exposure groups, data from daily and weekly groups were combined to form one group (Daily-Weekly) and data from monthly and yearly groups were combined to form a second group (Monthly-Yearly). Both combined groups were analysed to ascertain if individual (Daily, weekly, monthly, yearly) group results were also found in the larger combined groups.

3.1.2.1 Age

The mean age (Years) of participants in the daily (30.25), weekly (30.77), monthly (32.49), and yearly (36) exposure groups was ascertained. The mean age in the combined Daily-Weekly group and Monthly-Yearly group was 30.63 years and 33.6 years respectively.

3.1.2.2 Length of service

The mean length of service (Years) in the daily (3.25), weekly (4.07), monthly (5.08), and yearly (7.83) exposure groups was ascertained. The mean length of service in the combined Daily-Weekly group and Monthly-Yearly group was 3.84 years and 5.95 years respectively and is outlined in figure 1.

Figure 1: *Mean length of service (years) in each frequency of exposure to physical aggression and violence groups. Error bars denote the standard deviation around the means.*

3.1.2.3 Frequency of exposure to physical aggression or violence

Twelve percent of SCWs/ASWs described being exposed to physical aggression and violence on a daily basis, 31% on a weekly basis, 39% on a monthly basis and 18% on a yearly basis. The number of SCWs exposed to physical aggression and violence on a daily or weekly basis comprised 43% of the sample and those on a monthly or yearly basis comprised 57% of the sample. Interestingly, the mean length of service in each of these categories followed a pattern of decreasing length of service with higher levels of exposure to physical aggression and violence, as outlined in figure 1.

3.1.2.4 Culture of Normality

When participants were asked if they thought there was a culture of normality towards being exposed to physical violence or aggression in the workplace, 92% indicated that there was. This opinion was shared among all exposure groups, front-line staff and management.

3.1.2.5 Employer Expectation

When participants were asked if they felt that being exposed to physical violence or aggression is expected of them from their employer, 81% indicated they did feel this expectation was present. This opinion was shared among front-line staff and management and the majority of each exposure group agreed.

3.1.2.6 Available supports

When participants were asked if they felt that the current supports available to them as SCWs/ASWs were adequate to maintain their physical and mental well-being, 33% indicated that they did feel the available supports were adequate, while 67% did not feel that the available supports were adequate. The majority of the daily, weekly, and monthly exposure groups did not feel that adequate supports were available, while the majority of those in the

yearly exposure group felt that there were adequate supports available. Full details of each exposure group can be seen in table 1.

3.1.2.7 Self-care

Participants were asked how frequently they engaged in self-care activities, such as exercising, mindfulness, making time for themselves. Participants engaging in daily (36%), weekly (41%), monthly (18%), and never (5%) categories were ascertained.

3.1.2.8 Future career outlook

In response to the question "Do you see yourself or wish to see yourself in the social care profession in 2-3 years' time", 68% of participants indicated that they would, while 32% indicated that they would not. When broken down into the different frequencies of exposure to aggression groups, we can see differing future career outlooks for each; Daily exposure (Yes: 50%, No: 50%), weekly (Yes: 58%, No: 42%), monthly (Yes: 72%, No: 28%), yearly (Yes: 89%, No: 11%). When looking at the combined groups we see the Daily-Weekly group (Yes:56%, No: 44%) and the Monthly-Yearly group (Yes: 77%, No: 23%). These results can be seen in figure 2.

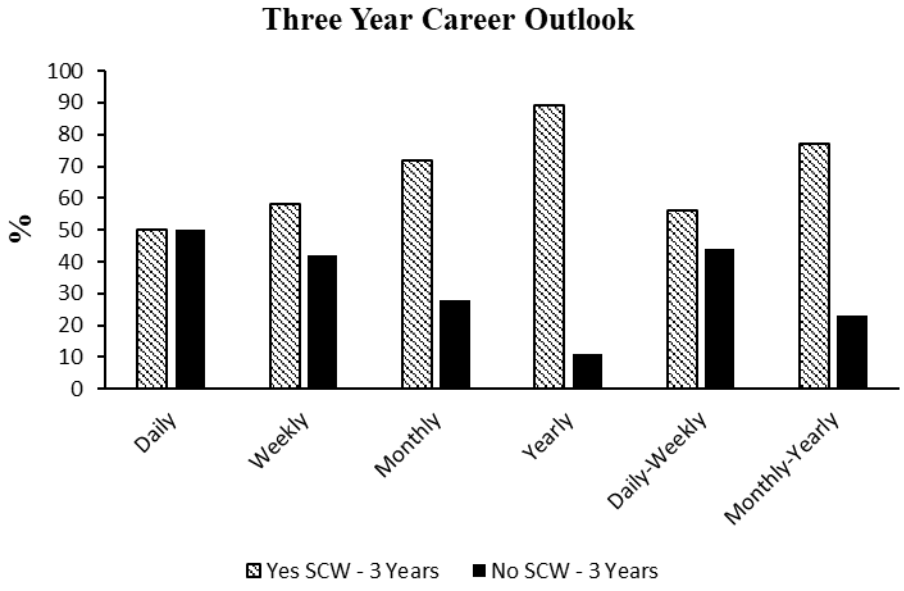

Figure 2: *Three-year career outlook for SCWs. 'Yes SCW' indicates percentage who wish to continue in SCW in three years and 'No SCW' indicates percentage who do not wish to continue in SCW in three years. Exposure groups illustrated as Daily, Weekly, Monthly, Yearly and combined groups Daily-Weekly and Monthly-Yearly.*

When asked the same question for their 5-year outlook, 57% indicated that they did, while 43% indicated that they would not like to be in the social care profession in 5 years. When broken down into the different frequencies of exposure to aggression groups, we can see differing future career outlooks for each; Daily (Yes: 42%, No: 58%), weekly (Yes: 32%, No: 68%), monthly (Yes: 67%, No: 33%), yearly (Yes: 89%, No: 11%). When looking at the combined groups we see the Daily-Weekly group (Yes: 35%, No: 65%) and the Monthly-Yearly group (Yes: 74%, No: 26%). These results can be seen in figure 3.

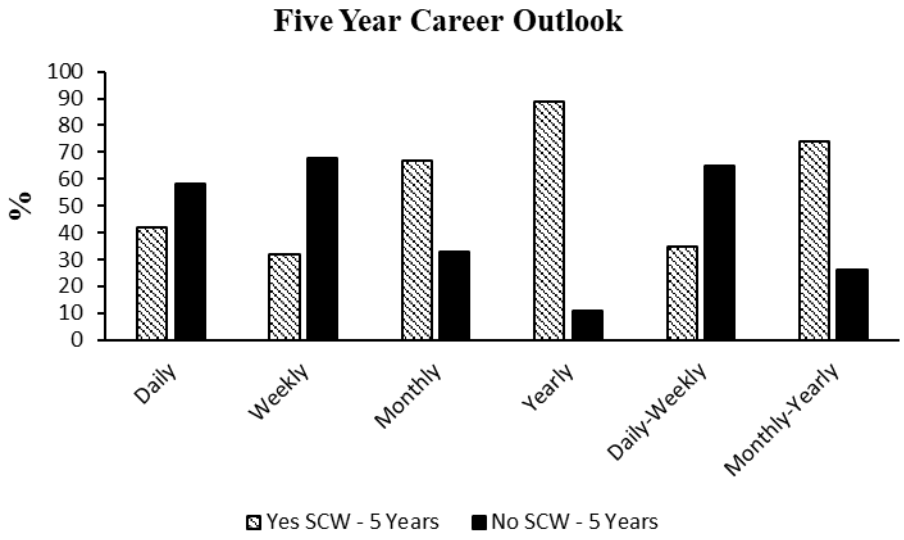

Figure 3: *Five-year career outlook for SCWs. 'Yes SCW' indicates percentage who wish to continue in SCW in five years and 'No SCW' indicates percentage who do not wish to continue in SCW in five years. Exposure groups illustrated as Daily, Weekly, Monthly, Yearly and combined groups Daily-Weekly and Monthly-Yearly.*

Table 1:

Demographic variable descriptives with Predictor Variable: Frequency of exposure to physical aggression or violence. Frequency of exposure groups illustrated as Daily, Weekly, Monthly, Yearly and combined groups Daily-Weekly and Monthly-Yearly.

	Total	Daily	Weekly	Monthly	Yearly	Daily-Weekly	Monthly-Yearly
Count	100	12	31	39	18	43	57
Gender							
Male	44	6	16	16	6	22	22
Female	56	6	15	23	12	21	35
Mean Age	32.32	30.25	30.77	32.49	36	30.63	33.6
Years Employed	5.04	3.25	4.07	5.08	7.83	3.84	5.95
Work Schedule							
Full Time	79	9	30	26	14	39	40
Part Time	21	3	1	13	4	4	17
Job Role							
Front Line Staff	86	11	27	32	16	38	48
Management	14	1	4	7	2	5	9
Area of Work							
Day Service	10	1	0	3	6	1	9
Residential	87	11	30	34	12	41	46
Community Outreach	3	0	1	2	0	1	2
Culture of Normality							
Yes	92	10	31	37	14	41	51
No	8	2	0	2	4	2	6
Employer Expectation							
Yes	81	11	28	29	13	39	42
No	19	1	3	10	5	4	15
Supports Available							
Yes	33	2	10	9	12	12	21

No	67	10	21	30	6	31	36
Self-care							
Daily	36	3	9	16	8	12	24
Weekly	41	4	13	16	8	17	24
Monthly	18	2	9	5	2	11	7
Never	5	3	0	2	0	3	2
SCW 2-3 years?							
Yes	68	6	18	28	16	24	44
No	32	6	13	11	2	19	13
SCW 5 years?							
Yes	57	5	10	26	16	15	42
No	43	7	21	13	2	28	15

3.1.3 Criterion Variable Descriptives

Participant scores for the Criterion variables of post-traumatic stress and burnout in relation to the frequency of exposure to workplace physical aggression/violence is outlined in table 2.

3.1.3.1 Post-Traumatic Stress

The average total IES-r score for all participants was 22.56, with a mean score of 1.02. To ensure meaningful reporting of results which highlights the relationships between workplace violence and stress/burnout in individuals exposed to different frequencies of physical aggression and violence, each exposure group and combined Daily-Weekly and Monthly-Yearly groups were analysed. Total and mean scores for individual subscales within the IES-r were calculated for all participants and each exposure group. *Daily Exposure* (n = 12)*:* Total IES-r (43.25) and total mean (1.96). Mean subscale scores: Intrusive thoughts (2.02), Avoidance (1.85), Hyperarousal (2.03). *Weekly Exposure* (n = 31): Total IES-r (24.61) and total mean (1.12). Mean subscale scores: Intrusive thoughts (1.23), Avoidance (.9), Hyperarousal (1.23). *Monthly Exposure* (n = 39)*:* Total IES-r (19.21) and total mean (.87). Mean subscale scores: Intrusive thoughts (.88), Avoidance (.91), Hyperarousal (.8). *Yearly Exposure* (n = 18)*:* Total IES-r (12.5) and total mean (.57). Mean subscale scores: Intrusive thoughts (.54), Avoidance (.6), Hyperarousal (.56). *Daily-Weekly Exposure Combined* (n = 43)*:* Total IES-r (29.81) and total mean (1.35). Mean subscale scores: Intrusive thoughts (1.45), Avoidance (1.16), Hyperarousal (1.45). *Monthly-Yearly Exposure Combined* (n = 57)*:* Total IES-r (17.09) and total mean (.78). Mean subscale scores: Intrusive thoughts (.77), Avoidance (.81), Hyperarousal (.72).

3.1.3.2 Burnout

Mean scores for individual subscales within the MBI-HSS were calculated for all participants and each exposure group. *Total scores* (n = 100) were: Emotional Exhaustion (2.74), Depersonalization (1.57), Personal Accomplishment (4.14). *Daily Exposure* (n = 12)*:* Emotional Exhaustion (3.86), Depersonalization (2.77), Personal Accomplishment (3.6). *Weekly Exposure* (n = 31)*:* Emotional Exhaustion (3.27), Depersonalization (2.1), Personal Accomplishment (3.56). *Monthly Exposure* (n = 39)*:* Emotional Exhaustion (2.42), Depersonalization (1.08), Personal Accomplishment (4.43). *Yearly Exposure* (n = 18)*:* Emotional Exhaustion (1.76), Depersonalization (.94), Personal Accomplishment (4.89). *Daily-Weekly Exposure* (n = 43)*:* Emotional Exhaustion (3.43), Depersonalization (2.29), Personal Accomplishment (3.57). *Monthly-Yearly Exposure* (n = 57)*:* Emotional Exhaustion (2.21), Depersonalization (1.04), Personal Accomplishment (4.58).

Table 2:

Descriptive Statistics for Criterion Variables: IES-r subscales [Intrusion (INT), Avoidance (AVD), Hyperarousal (HYP)] and MBI-HSS [Emotional Exhaustion (EE), Depersonalization (DP), Personal Achievement (PA)]. Frequency of exposure to physical aggression/violence groups illustrated as Daily, Weekly, Monthly, Yearly and combined groups Daily-Weekly and Monthly-Yearly.

	Total	Daily	Weekly	Monthly	Yearly	Daily & Weekly	Monthly & Yearly
Impact of Events Scale							
Total	22.56	43.25	24.61	19.21	12.5	29.81	17.09
Total Mean	1.02	1.96	1.12	0.87	0.57	1.35	0.78
INT Mean	1.07	2.02	1.23	0.88	0.54	1.45	0.77
AVD Mean	0.96	1.85	0.9	0.91	0.6	1.16	0.81
HYP Mean	1.04	2.03	1.23	0.8	0.56	1.45	0.72
Maslach Burnout Inventory							
EE Mean	2.74	3.86	3.27	2.42	1.76	3.43	2.21
DP Mean	1.57	2.77	2.1	1.08	0.94	2.29	1.04
PA Mean	4.14	3.6	3.56	4.43	4.89	3.57	4.58

3.2 Inferential Statistics

Preliminary statistical analysis found that some data was non-normally distributed. Accordingly, non-parametric tests were used to analyse all variables. Analysis was carried out on each exposure group (Daily, weekly, monthly, yearly). 'Daily' and 'Weekly' were combined and 'Monthly' and 'Yearly' groups were combined to create larger sample size for more reliable analysis.

3.2.1 Traumatic Stress

Spearman's Rho correlation coefficients indicated a large significant positive relationship between frequency of exposure to physical aggression/violence and levels of traumatic stress in all measures of the IES-r except the Avoidance subscale, which had a medium significant positive relationship. IES-Total/mean score (r_s = .527, p < .001). Mean IES-Intrusion (r_s = .538, p < .001). Mean IES-Avoidance (r_s = .354, p < .001). Mean IES-Hyperarousal (r_s = .517, p < .001). Combined Daily-Weekly and Monthly-Yearly groups also found a medium significant positive relationship between frequency of exposure to physical aggression/violence and higher levels of traumatic stress in all measures of the IES-r except the Avoidance subscale which had a small significant positive relationship. IES-Total/mean score (r_s = .429, p < .001). Mean IES-Intrusion (r_s = .461, p < .001). Mean IES-Avoidance (r_s = .240, p = .016). Mean IES-Hyperarousal (r_s = .453, p < .001). Therefore, the null hypothesis was rejected; higher frequency of exposure to physical aggression/violence was related to higher levels of traumatic stress.

Kruskal-Wallis H test indicated that there was a statistically significant difference between the daily, weekly, monthly, and yearly frequency of exposure to physical aggression/violence groups and levels of traumatic stress. *Total IES-r mean:* $\chi 2(3) = 31.81$, p < .001, with mean rank of 87.79 for daily exposure, 55.85 for weekly exposure, 44.29 for monthly exposure and 29.86 for yearly exposure. *IES-r mean Intrusion:* $\chi 2(3) = 30.12$, p <

.001, with mean rank of 83.04 for daily exposure, 59.11 for weekly exposure, 43.62 for monthly exposure and 28.89 for yearly exposure. *IES-r mean Avoidance:* $\chi 2(3) = 20.33$, $p <$ .001, with mean rank of 83.33 for daily exposure, 48.84 for weekly exposure, 48.44 for monthly exposure and 35.94 for yearly exposure. *IES-r mean Hyperarousal:* $\chi 2(3) = 28.79$, $p < .001$, with mean rank of 83.88 for daily exposure, 58.40 for weekly exposure, 42.60 for monthly exposure and 31.75 for yearly exposure.

Kruskal-Wallis H test indicated a statistically significant difference between the combined Daily-Weekly and Monthly-Yearly frequency of exposure to physical aggression/violence groups and levels of traumatic stress. *Total IES-r mean:* $\chi 2(3) = 18.26$, $p < .001$, with mean rank of 64.77 for Daily-Weekly exposure and 39.74 for Weekly-Monthly exposure. *IES-r mean Intrusion:* $\chi 2(3) = 21.03$, $p < .001$, with mean rank of 65.79 for Daily-Weekly exposure and 38.96 for Weekly-Monthly exposure. *IES-r mean Avoidance:* $\chi 2(3) = 5.72$, $p = .017$, with mean rank of 58.47 for Daily-Weekly exposure and 44.49 for Monthly-Yearly exposure. *IES-r mean Hyperarousal:* $\chi 2(3) = 20.34$, $p < .001$, with mean rank of 65.51 for Daily-Weekly exposure and 39.18 for Monthly-Yearly exposure.

3.2.2 Burnout

Spearman's Rho correlation coefficients indicted a large significant positive relationship between higher frequencies of exposure to physical aggression/violence and higher levels of burnout in two of Maslach's burnout inventory subscale; Emotional Exhaustion ($r_s = .534$, $p < .001$), Depersonalization ($r_s = .500$, $p < .001$), and a medium negative relationship with the Personal Accomplishment subscale ($r_s = -.476$, $p < .001$). Combined Daily-Weekly and Monthly-Yearly groups also found a medium significant positive relationship between higher frequencies of exposure to physical aggression/violence

and higher levels of burnout in two of Maslach's burnout inventory subscale; Emotional Exhaustion (r_s = .481, p < .001), Depersonalization (r_s = .498, p < .001), and a medium negative relationship with the Personal Accomplishment subscale (r_s = -.469, p < .001). Therefore, the null hypothesis was rejected; higher frequency of exposure to physical aggression/violence was related to higher levels of staff burnout scores in the emotional exhaustion and depersonalization subscales and lower levels of personal accomplishment scores.

Kruskal-Wallis H test indicated that there was a statistically significant difference between the daily, weekly, monthly and yearly frequency of exposure to physical aggression/violence groups and levels of burnout. *Mean Emotional Exhaustion:* $\chi 2(3)$ = 28.22, p < .001, with mean rank of 75.21 for daily exposure, 63.08 for weekly exposure, 43.56 for monthly exposure and 27.39 for yearly exposure. *Mean Depersonalization:* $\chi 2(3)$ = 26.38, p < .001, with mean rank of 75.71 for daily exposure, 63.63 for weekly exposure, 39.64 for monthly exposure and 34.61 for yearly exposure. *Mean Personal Accomplishment:* $\chi 2(3)$ = 24.34, p < .001, with mean rank of 36.58 for daily exposure, 34.29 for weekly exposure, 58.12 for monthly exposure and 71.19 for yearly exposure.

Kruskal-Wallis H test indicated a statistically significant difference between the combined Daily-Weekly and Monthly-Yearly frequency of exposure to physical aggression/violence groups and levels of burnout. *Mean Emotional Exhaustion:* $\chi 2(3)$ = 22.87, p < .001, with mean rank of 66.47 for Daily-Weekly exposure and 38.46 for Monthly-Yearly exposure. *Mean Depersonalization:* $\chi 2(3)$ = 24.50, p < .001, with mean rank of 67.00 for Daily-Weekly exposure and 38.05 for Monthly-Yearly exposure. *Mean Personal Accomplishment:* $\chi 2(3)$ = 21.77, p < .001, with mean rank of 34.93 for Daily-Weekly exposure and 62.25 for Monthly-Yearly exposure.

3.2.3 Correlation between traumatic stress and burnout

Spearman's Rho correlation coefficients indicated a medium significant positive relationship between total mean IES-r (traumatic-stress) and burnout in two of Maslach's burnout inventory subscales; Emotional Exhaustion (r_s = .497, p < .001), Depersonalization (r_s = .484, p < .001), and a medium negative relationship with the Personal Accomplishment subscale (r_s = -.419, p < .001). Scatter plots were produced as both variables were scale data and can be seen in figure 4.

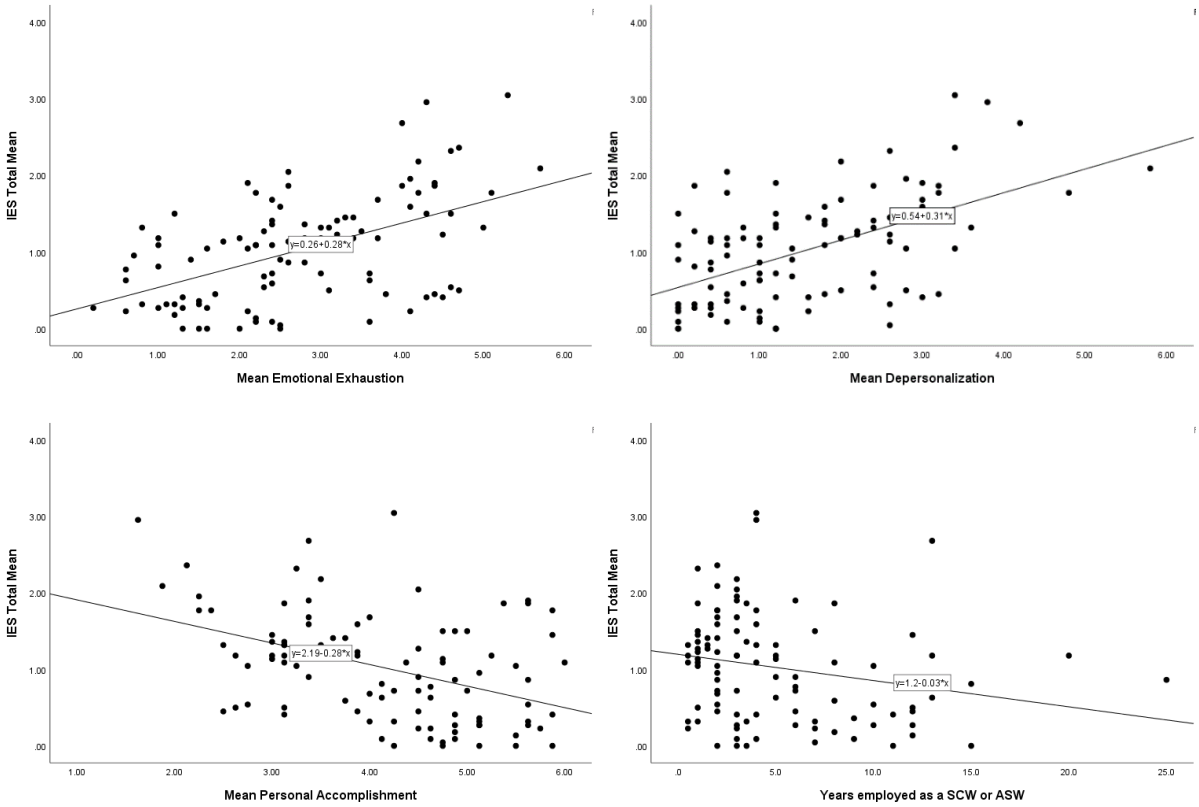

Figure 4: *Spearman's Rho correlation between traumatic stress and burnout. Total Mean IES-r was correlated with 'Years employed as a SCW and Maslach Burnout subscales; Emotional Exhaustion, Depersonalization, Personal Accomplishment.*

3.2.4 Impact of workplace violence/aggression, traumatic stress, and burnout on desire to leave SCW

3.2.4.1 Exposure to workplace violence/aggression and desire to leave SCW

Spearman's Rho correlation coefficients (n = 100) indicated a small positive relationship and a medium positive relationship between frequency of exposure to workplace violence/aggression and desire to leave SCW in the next two-to-three years (r_s = .263, p = .008) and in the next five years respectively (r_s = .395, p < .001).

Kruskal-Wallis H test showed no significant difference between the frequency of exposure to physical aggression/violence groups and desire to leave SCW in two-to-three years*:* $\chi 2(3) = 6.99$, p = .072, but did find a significant difference for the desire to leave SCW in five years*:* $\chi 2(3) = 17.67$, p = .001.

3.2.4.2 Traumatic stress and desire to leave SCW

Spearman's Rho correlation coefficients indicated a small positive relationship and a medium positive relationship between total IES-r traumatic stress scores and desire to leave SCW in the next two-to-three years (r_s = .266, p = .007) and five years respectively (r_s = .305, p = .002).

3.2.4.3 Burnout and desire to leave SCW

Spearman's Rho correlation coefficients indicated a large positive relationship between Emotional Exhaustion scores and desire to leave SCW in the next two-to-three years (r_s = .516, p < .001) and five years (r_s = .602, p < .001).

Spearman's Rho correlation coefficients indicated a medium positive relationship between Depersonalization scores and desire to leave SCW in the next two-to-three years (r_s = .366, p < .001) and five years (r_s = .453, p < .001).

Spearman's Rho correlation coefficients indicated a medium negative relationship between Personal Accomplishment scores and desire to leave SCW in the next two-to-three years (r_s = -.355, p < .001) and five years (r_s = -.482, p < .001).

3.2.5 Self-Care

Self-reported frequencies of self-care engagement highlighted individuals who engage in daily (n = 36), weekly (n = 41), monthly (n = 18) self-care and those who never engage in self-care (n = 5).

3.2.5.1 Self-Care and Traumatic Stress

Spearman's Rho correlation coefficients indicated a small significant negative relationship between frequency of self-care and total levels of traumatic stress in all measures of the IES-r except the Avoidance subscale, which had a small non-significant negative relationship. *IES-Total/mean* (r_s = -.249, p = .012). *Mean IES-Intrusion* (r_s = -.225, p = .025). *Mean IES-Avoidance* (r_s = -.166, p = .099). *Mean IES-Hyperarousal* (r_s = -.297, p = .003).

Kruskal-Wallis H test indicated that there were non-significant differences between daily, weekly, monthly, and yearly frequency of self-care and levels of traumatic stress. *Total IES-r mean:* $\chi 2(3) = 7.29$, p = .063, with mean rank of 41.85 for daily self-care, 53.05 for weekly self-care, 55.53 for monthly self-care and 73.80 for never. *IES-r mean Intrusion:* $\chi 2(3) = 5.44$, p < .001, with mean rank of 42.28 for daily self-care, 53.40 for weekly elf-care, 55.94 for monthly self-care and 66.30 for never. *IES-r mean Avoidance:* $\chi 2(3) = 5.34$, p < .001, with mean rank of 44.58 for daily self-care, 52.96 for weekly self-care, 49.97 for monthly self-care and 74.80 for never. *IES-r mean Hyperarousal:* $\chi 2(3) = 8.96$, p < .001, with mean rank of 40.68 for daily self-care, 52.21 for weekly self-care, 60.61 for monthly self-care and 70.80 for never.

3.2.5.2 Self-Care and Burnout

Spearman's Rho correlation coefficients indicated a small significant negative relationship between self-care and burnout in two of Maslach's burnout inventory subscales; Emotional Exhaustion (r_s = -.293, p = .003), Depersonalization (r_s = -.260, p = .009), and a medium positive relationship with Personal Accomplishment subscale (r_s = .392, p < .001).

Kruskal-Wallis H test indicated that there was a statistically significant difference between different frequencies of self-care and levels of burnout. *Mean Emotional Exhaustion:* $\chi 2(3) = 11.39$, p = .01, with mean rank of 43.43 for daily self-care, 47.18 for weekly self-care, 64.58 for monthly self-care and 77.90 for never. *Mean Depersonalization:* $\chi 2(3) = 12.01$, p = .007, with mean rank of 45.56 for daily self-care, 45.22 for weekly self-care, 63.72 for monthly self-care and 81.80 for never. *Mean Personal Accomplishment:* $\chi 2(3) = 19.40$, p < .001, with mean rank of 60.35 for daily self-care, 54.23 for weekly self-care, 31.97 for monthly self-care and 15.70 for never.

Chapter 4: Discussion

4.1 Interpretations

As previously highlighted, the demand for all types of public and private health and social care services in Ireland will increase exponentially by 2030 (World Health Organization, 2015; Wren et al., 2017). Physical violence and aggression have been described as a characteristic aspect of SCW (Keogh & Byrne, 2016), and this has been linked to increased levels of stress and burnout in staff (Lloyd, King & Chenoweth, 2002). Maslach (2016), also predicted that burnout would be related to the desire to leave one's job (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016). Furthermore, the Crisis, Concern and Complacency report (2016), highlighted the fact that very little attention has been paid to this situation by policy makers since the first report in 2001 (Keogh & Byrne, 2016; Keogh et al., 2001). As a result of this information, it was important to investigate this area further to better understand the relationship between workplace violence/aggression and well-being in SCWs.

The aim of the current research was primarily to examine the relationship between the frequency of exposure to physical violence/aggression and traumatic stress and burnout in SCWs. Secondary analysis included whether there was a correlation between traumatic stress and burnout and also whether any of the predictor variables were found to have a statistically significant relationship with the criterion variables of traumatic stress and burnout as measured by the revised Impact of Events Scale (IES-r) and the Maslach Burnout Inventory – Human Services Survey (MBI – HSS). This research also aimed to elucidate whether the frequency of self-care may have a protective mechanism against traumatic stress and burnout symptomology.

In summary, the findings of this research indicate a statistically significant positive relationship between the frequency of exposure to physical aggression/violence and traumatic stress and burnout measures. Current findings also indicate a significant positive correlation between traumatic stress and burnout. When the frequency of exposure to workplace violence/aggression, traumatic stress, and burnout scores were examined in relation to SCWs desire to leave the profession in two-to-three years and/or five years, the findings indicate the presence of a significant positive relationship between the variables. Finally, the findings of this study indicate the presence of a significant negative correlation between self-care and traumatic stress and burnout. Detailed interpretations of each research hypothesis will now be discussed and followed by a critical evaluation of the present research.

Hypothesis 1: This research hypothesis was accepted; Inferential analysis indicated a significant positive relationship between the frequency of exposure to workplace aggression/violence and levels of traumatic stress. Analysis also indicated that there was a significant difference between the daily, weekly, monthly, and yearly exposure to violence/aggression groups. As shown in table 2, total average IES-r scores for the daily and weekly exposure groups were above the threshold for indicating potential clinical concern for PTSD and individuals may experience partial PTSD (Asukai et al., 2002). The daily exposure group had scores high enough to potentially suppress the immune system function for as much as ten years after the traumatic event (Kawamura, Kim & Asukai, 2001). This finding is supported by the Crisis, Concern and Complacency report (2016) which found that 98% of SCWs exposed to workplace violence experienced stress (Keogh & Byrne, 2016). Stress was also found to be of significant concern in social workers exposed to workplace violence/aggression (Littlechild, 2000; Smith, & Nursten, 1998). Rippon (2000) also highlighted how violence is becoming a significant concern for healthcare professionals and that primary, secondary and tertiary victims of violence may experience symptoms of PTSD

(Rippon, 2000). The current findings indicate that traumatic stress resulting from workplace violence exposure may be dependent on the frequency of exposure, with higher frequencies resulting in higher levels of traumatic stress.

Hypothesis 2: This research hypothesis was accepted; Inferential analysis indicated a significant positive relationship between the frequency of exposure to workplace aggression/violence and burnout subscales of emotional exhaustion (EE) and depersonalization (DP). Analysis also indicated a significant negative relationship between workplace aggression/violence and personal accomplishment (PA). There were significant differences between the exposure groups, with daily exposure indicating the highest levels of EE and DP while having the lowest PA. This trend was also found in the combined exposure groups. This finding is supported by previous studies examining the role of exposure to violence and burnout in various professions including; Nurses (Galián-Muñoz, Ruiz-Hernández, Llor-Esteban, & López-García, 2016), nursing home caregivers (Isaksson, Graneheim, Richter, Eisemann, & Åström, 2008), police officers (Kop, Euwema, & Schaufeli, 1999), Psychiatrists (Kumar, 2007), and social workers (Beaver, 1999).

Hypothesis 3: This research hypothesis was accepted; Inferential analysis indicated a significant positive correlation between traumatic-stress and burnout subscales EE and DP, and a significant negative correlation with the PA subscale. Burnout is a type of psychological stress (Ruotsalainen, Verbeek, Mariné & Serra, 2016), and characterized by emotional exhaustion, depersonalization, and low personal accomplishment (Maslach, Jackson, Leiter, Schaufeli & Schwab, 2016). This result highlights the risk of burnout when SCWs experience elevated levels of stress and this may predict SCWs desire to leave the job (Maslach, 2016). A longitudinal study found stress and burnout subscales showed reciprocal causation and a study of clinical psychologists found a relationship between perfectionism, stress, and burnout (D'Souza, Egan, & Rees, 2011; McManus, Winder, & Gordon, 2002).

Hypothesis 4, 5, and 6: This research hypothesis was accepted; Inferential analysis indicated a significant positive relationship between; frequency of exposure to workplace aggression/violence, traumatic stress, burnout subscales (EE, DP) and desire to leave SCW. Analysis also identified a significant negative relationship between burnout subscale (PA) and desire to leave. The strength of correlation was strongest when SCWs considered their five-year career outlook. Descriptive analysis found that 43% of SCWs did not wish to be in the profession in five years with the highest proportion of SCWs with a desire to leave experiencing daily (58%) and weekly (68%) exposure to violence/aggression. Interestingly, the mean length of service in the daily, weekly, monthly, yearly exposure to violence groups followed a pattern of decreasing length of service with higher levels of exposure to physical aggression/violence, as outlined in figure 1.

Hypothesis 7: This research hypothesis was accepted; Inferential analysis indicated a significant negative relationship between frequency of self-care and traumatic stress and burnout subscales EE and DP. Analysis also found a significant positive relationship between frequency of self-care and personal accomplishment. The current research indicated that 67% of SCWs did not feel that the available supports were adequate to maintain their physical and mental well-being. As the frequency of self-care during SCWs personal time has been indicated in the current research to have an ameliorative effect on SCW stress and burnout, it is important for employers to consider policy changes to allow self-care activities during work to reduce stress and burnout in staff. SCW is often characterized by a lack of dedicated lunchbreaks and shifts can often be twelve hours in length with consecutive shifts. One policy change employers could make may be to provide additional support staff to allow SCWs to have guaranteed lunchbreaks.

4.2 Critical Evaluation

4.2.1 Limitations

The current research has some potential limitations. Firstly, a small sample size of 100 participants may not allow for adequate statistical strength and confidence. Results may be more significantly impacted by outliers. The crisis, concern and complacency report by Social Care Ireland (2016), which has informed this current study had 402 participants. Furthermore, the field of SCW is very diverse and the majority of participants in this study worked in residential services (n = 87) which have been characterized as being complex and unpredictable environments (Clough, Bullock & Ward, 2006). Howard (2014) stresses that residential care can be chaotic, ambivalent, turbulent, unpredictable, and often dangerous for staff and young people (Howard, 2014). This may have resulted in the survey population being primarily composed of SCWs exposed to higher frequencies of physical aggression/violence. In addition to sample size, the method of investigation involved the use of self-reported questionnaires which have some flaws. Participants may not always have the necessary self-reflection skills to provide unbiased and accurate self-reporting. Participants may also be fearful that they may be perceived as unskilled or not up to the job (Keogh et al., 2001). As the survey was completed during working hours, time constraints may have resulted in participants not taking adequate time to fully consider each question and response.

4.2.2 Strengths

The current research has several attributes which may qualify as strengths. There was a gender balance (56% female, 44% male) and wide age range (21-54). Participants also had a wide range of experience in SCW (6 months – 25 years). Both full and part time staff and front line and management participated in the study. The questionnaire was completely anonymous which may have given participants more confidence to give honest responses. The questionnaire length was relatively short (5-10 minutes) which ensured participants

didn't lose patience or interest during the survey and that they would give each question sufficient attention and thought. This helped to give a 100% survey completion rate across all participants. This research may also be unique in that it examined the potential protective role of self-care in moderating the perceived effects of workplace violence/aggression on traumatic stress and burnout in SCWs

The revised Impact of Events Scale and Maslach Burnout Inventory (MBI) are well researched and validated. The reliability of the MBI-HSS exceeds the recommended levels for research instruments and the validity has been demonstrated by numerous studies and meta-analytic reviews confirming hypotheses regarding relationships between job characteristics and burnout (Maslach, 2016). The revised Impact of Event Scale is one of the most widely used self-report measures for traumatic stress and has high reliability and validity scores (Beck et al., 2008).

4.2.3 Future Research

Future research would benefit from addressing some of the limitations of this current research. For example, a larger sample size incorporating a wider and more diverse sample of SCWs in different settings may give a more accurate representation of the full spectrum of SCW experiences. Future research would also benefit from attempting to mirror/incorporate the strengths in this study.

4.2.4 Implications and Applications

The current research has implications and applications for social care policy and guide support for SCWs to ensure optimal well-being is maintained by encouraging self-care activities and by providing additional staff supports to allow rest periods and support during/after incidents of physical violence/aggression. Social care employers may introduce

training and awareness of the important benefits of self-care in ameliorating the detrimental impact of stressful events, and in doing so may reduce the potential for staff burnout.

4.2.5 Conclusion

This study examined the relationship between frequency of exposure to physical violence/aggression and several variables. The results of this research indicate a statistically significant positive relationship between the frequency of exposure to physical aggression/violence and traumatic stress and burnout measures. Current findings also indicate a significant positive correlation between traumatic stress and burnout. Exposure to workplace violence/aggression, traumatic stress, and burnout also positively correlated with SCWs desire to leave the profession in the next five years. Results also highlighted several interesting points, such as 92% of SCWs indicating that they believed there is a culture of normality towards exposure to physical violence/aggression as part of their daily work. Eighty-one percent of participants also indicated that they believed their employer expected them to be exposed to workplace violence. The results also indicated that the average length of time SCWs stay in the profession is five years, and this decreases to three years and four years for SCWs who are exposed to physical aggression/violence on a daily and weekly basis respectively. Finally, these initial findings indicate the presence of a significant protective role of self-care activities in moderating the perceived effects of workplace violence/aggression on traumatic stress and burnout in SCWs. This protective role of self-care may help ameliorate current rates of traumatic stress and burnout in SCWs.

References

Alink, L. R., Euser, S., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2014, April). A challenging job: Physical and sexual violence towards group workers in youth residential care. In *Child & Youth Care Forum* (Vol. *43*, No. 2, pp. 243-250). Springer US.

Anderson, N. B. (1998). Levels of analysis in health science: A framework for integrating sociobehavioral and biomedical research. *Annals of the New York Academy of Sciences*, *840*(1), 563-576.

Asukai, N., Kato, H., Kawamura, N., Kim, Y., Yamamoto, K., Kishimoto, J., & Nishizono -Maher, A. (2002). Reliability and validity of the Japanese-language version of the impact of event scale-revised (IES-R-J): four studies of different traumatic events. *The Journal of nervous and mental disease*, *190*(3), 175-182.

Balloch, S., Pahl, J., & McLean, J. (1998). Working in the social services: Job satisfaction, stress and violence. *The British Journal of Social Work*, *28*(3), 329-350.

Baum, A. (1990). Stress, intrusive imagery, and chronic distress. *Health psychology*, *9*(6), 653.

Beaver, H. W. (1999). *Client violence against professional social workers: Frequency, worker characteristics, and impact on worker job satisfaction, burnout, and health* (Doctoral dissertation, ProQuest Information & Learning).

Beck, J. G., Grant, D. M., Read, J. P., Clapp, J. D., Coffey, S. F., Miller, L. M., & Palyo, S. A. (2008). The Impact of Event Scale-Revised: Psychometric properties in a sample of motor vehicle accident survivors. *Journal of anxiety disorders*, *22*(2), 187-198.

Brandt, W. A., Bielitz, C. J., & Georgi, A. (2016). The impact of staff turnover and staff density on treatment quality in a Psychiatric Clinic. *Frontiers in psychology*, *7*, 457.

Brodie, I. (2005). Education and residential child care in England: A research perspective. *Facing forward: Residential care in the 21st century*, 163-171.

Brooker, D., & Latham, I. (2015). *Person-centred dementia care: Making services better with the VIPS framework*. Jessica Kingsley Publishers.

Clarke, S., & Cooper, C. (2004). *Managing the risk of workplace stress: Health and safety hazards*. Routledge.

Clough, R., Bullock, R., & Ward, A. (2006). *What Works in Residential Child Care: A review of research evidence and the practical considerations*. London: National Children's Bureau.

Cohen, S., Kessler, R. C., & Gordon, L. U. (1995). Strategies for measuring stress in studies of psychiatric and physical disorders. *Measuring stress: A guide for health and social scientists*, 3-26.

Cohen, S., Janicki-Deverts, D., & Miller, G. E. (2007). Psychological stress and disease. *Jama*, *298*(14), 1685-1687.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health- care workers–a literature review. *Journal of psychiatric and mental health nursing*, *10*(4), 417-424.

Colton, M., & Roberts, S. (2006). The retention of residential group care workers. *International Journal of Child and Family Welfare*, *9*(3), 160.

Colton, M., & Roberts, S. (2007). Factors that contribute to high turnover among residential child care staff. *Child & Family Social Work*, *12*(2), 133-142.

Creamer, M., Bell, R., & Failla, S. (2003). Psychometric properties of the impact of event scale—revised. *Behaviour research and therapy*, *41*(12), 1489-1496.

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*(1), 17-28.

Emerson, E., & Hatton, C. (2000). *Violence against social care workers supporting people with learning difficulties: a review.* University of Lancaster.

Figley C.R. (1995). *Compassion fatigue as secondary traumatic stress disorder: an overview. In: Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (ed Figley, C.R.), pp. 1–20. Brunnar/Mazel, New York.

Franz, S., Zeh, A., Schablon, A., Kuhnert, S., & Nienhaus, A. (2010). Aggression and violence against health care workers in Germany-a cross sectional retrospective survey. *BMC health services research*, *10*(1), 51.

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy: Theory, Research & Practice*, *12*(1), 73.

Galián-Muñoz, I., Ruiz-Hernández, J. A., Llor-Esteban, B., & López-García, C. (2016). User violence and nursing staff burnout: The modulating role of job satisfaction. *Journal of Interpersonal Violence*, *31*(2), 302-315.

Gibson, F., McGrath, A., & Reid, N. (1989). Occupational stress in social work. *The British Journal of Social Work*, *19*(1), 1-18.

Harris, B., & Leather, P. (2011). Levels and consequences of exposure to service user violence: Evidence from a sample of UK social care staff. *British Journal of Social Work*, *42*(5), 851-869.

Hastings, R. P., & Brown, T. (2002). Behavior problems of children with autism, parental self -efficacy, and mental health. *American journal on mental retardation, 107*(3), 222-232.

Health Service Executive. (2011). Time to Move on from Congregated Settings: A Strategy for Community Inclusion. *Report of the Working Group on Congregated Settings.*

Health & Safety Authority (2018). *Managing the Risk of Work-related Violence and Aggression in Healthcare. Information Sheet*. *Hsa.ie*. Retrieved 25 December 2018, from:https://www.hsa.ie/eng/Publications_and_Forms/Publications/Information Sheets /Violence_in_Healthcare_Information_Sheet.pdf

Healy, K., Meagher, G., & Cullin, J. (2007). Retaining novices to become expert child protection practitioners: Creating career pathways in direct practice. *British Journal of Social Work, 39*(2), 299-317.

Hensel, J. M., Lunsky, Y., & Dewa, C. S. (2012). Exposure to client aggression and burnout among community staff who support adults with intellectual disabilities in Ontario, Canada. *Journal of Intellectual Disability Research, 56*(9), 910-915.

Honkonen, T., Ahola, K., Pertovaara, M., Isometsä, E., Kalimo, R., Nykyri, E., ... & Lönnqvist, J. (2006). The association between burnout and physical illness in the general population—results from the Finnish Health 2000 Study. *Journal of psychosomatic research, 61*(1), 59-66.

Howard, N. (2014). The Irish association of social care workers. *Social care: Learning from practice*, 12-23.

Inclusion Ireland (2018). Deinstitutionalisation in Ireland; a failure to act. *Inclusionireland.ie*. Retrieved 25 December 2018, from

https://www.inclusionireland.ie/sites/default/files/attach/basic-page/1655/deinstitutionalisation-ireland-failure-act.pdf

Isaksson, U., Graneheim, U. H., Richter, J., Eisemann, M., & Åström, S. (2008). Exposure to violence in relation to personality traits, coping abilities, and burnout among caregivers in nursing homes: a case–control study. *Scandinavian journal of caring sciences*, *22*(4), 551-559.

Joint Committee on Social Care Professionals (2002). *Final report of Joint Committee on social care professionals*. *Lenus.ie*. Retrieved 23 December 2018, from https://www.lenus.ie/handle/10147/46110

Kahill, S. (1988). Interventions for burnout in the helping professions: A review of the empirical evidence. *Canadian Journal of Counselling*.

Kawamura, N., Kim, Y., & Asukai, N. (2001). Suppression of cellular immunity in men with a past history of posttraumatic stress disorder. *American Journal of psychiatry*, *158*(3), 484-486.

Keogh, P., & Byrne, C. (2016). *Crisis, concern and complacency: A study on the extent, impact and management of workplace violence and assault on social care workers*. Social Care Ireland.

Keogh, P., Fitzpatrick, A., Hopkins, G., Greene, S., Andrews, N., Ryan, R., & Bailey, P. (2001). *The Nature and Extent of Workplace Violence Experienced by Social Care Workers: An Irish Report*. Irish Association of Care Workers.

Kop, N., Euwema, M., & Schaufeli, W. (1999). Burnout, job stress and violent behaviour among Dutch police officers. *Work & Stress*, *13*(4), 326-340.

Kornbeck, J. (2002). Reflections on the exportability of social pedagogy and its possible limits. *Social work in Europe*, *9*(2), 37-49.

Kumar, S. (2007). Burnout in psychiatrists. *World Psychiatry*, *6*(3), 186.

Lalor, K. & Share, P. (2013). *Understanding social care. Applied social care: An introduction for students in Ireland* (3rd edition, pp. 3-18). Dublin: Gill and Macmillan.

Littlechild, B. (2000). I know where you live': How child protection social workers are affected by threats and aggression. *A study into the stresses faced by child protection workers in Hertfordshire. Department of Health and Social Care. Hatfield: University of Hertfordshire*.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of mental health*, *11*(3), 255-265.

Lovell, A., & Skellern, J. (2013). 'Tolerating violence': a qualitative study into the experience of professionals working within one UK learning disability service. *Journal of clinical nursing*, *22*(15-16), 2264-2272.

Lundström, M., Åström, S., & Graneheim, U. H. (2007). Caregivers' experiences of exposure to violence in services for people with learning disabilities. *Journal of psychiatric and mental health nursing*, *14*(4), 338-345.

Mansell, J., & Beadle- Brown, J. (2004). Person- centred planning or person- centred action? Policy and practice in intellectual disability services. *Journal of Applied Research in Intellectual Disabilities*, *17*(1), 1-9.

Maslach, C., Jackson, S. E., Leiter, M. P., Schaufeli, W. B., & Schwab, R. L. (2016). Maslach burnout inventory manual, fourth edition. Published by *Mind Garden, Inc.* Received from mindgarden.com on October 19, 2018

McAdams, C. R. (2002, April). Trends in the occurrence of reactive and proactive aggression among children and adolescents: Implications for preparation and practice in child and youth care. In *Child and Youth Care Forum* (Vol. 31, No. 2, pp. 89-109). Kluwer Academic Publishers-Plenum Publishers.

McKenna, K. (2004). Study of work-related violence. *Committee on Workplace Violence. North Eastern Health Board, Ireland*, 1-121.

McManus, I. C., Winder, B. C., & Gordon, D. (2002). The causal links between stress and burnout in a longitudinal study of UK doctors. *The Lancet*, *359*(9323), 2089-2090.

Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social service review*, *75*(4), 625-661.

Office for National Statistics (2017). Suicide by Occupation, England: 2011 to 2015. *Office for National Statistics*. *Ons.gov.uk*. Retrieved 25 December 2018, from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015

Rippon, T. J. (2000). Aggression and violence in health care professions. *Journal of advanced nursing*, *31*(2), 452-460.

Ruotsalainen, J. H., Verbeek, J. H., Mariné, A., & Serra, C. (2016). Preventing occupational stress in healthcare workers. *Sao Paulo Medical Journal*, *134*(1), 92-92.

Santos, A., Leather, P., Dunn, J., & Zarola, A. (2009). Gender differences in exposure to co-worker and public-initiated violence: Assessing the impact of work-related violence and aggression in police work. *Work & stress*, *23*(2), 137-154.

Schat, A. C., & Kelloway, E. K. (2000). Effects of perceived control on the outcomes of workplace aggression and violence. *Journal of occupational health psychology*, *5*(3), 386.

Smith, M., & Nursten, J. (1998). Social Workers' Experience of Distress—Moving Towards Change?. *The British Journal of Social Work*, *28*(3), 351-368.

Spitzer, R. L., Md, K. K., & Williams, J. B. (1980). Diagnostic and statistical manual of mental disorders. Third Edition. In *American psychiatric association*.

Strolin-Goltzman, J., Kollar, S., & Trinkle, J. (2010). Listening to the voices of children in foster care: Youths speak out about child welfare workforce turnover and selection. *Social Work*, *55*(1), 47-53.

Taylor, M. (2011). Understanding and responding to the emotional challenge of working in residential child care settings: the case for staff support groups. *European Journal of Social Education*.

United Nations Department of Economic and Social Affairs/Population Division (2017). *World Population Prospects: The 2017 Revision, Key Findings and Advance Tables.* ESA/P/WP/248. Retrieved 24 December 2018, from https://population.un.org/wpp/Publications/

Vedhara, K., Irwin, M. R., & Irwin, M. (Eds.). (2005). *Human psychoneuroimmunology*. Oxford University Press on Demand.

Weiss, D. S., & Marmar, C. R. (1997). The Impact of Event Scale-Revised. In JP Wilson, & TM Keane (Eds.), 399–411. *Assessing Psychological Trauma and PTSD: A Practitioner's Handbook*.

Whitaker, D., Archer, A., & Hicks, L. (1998). *Working in children's homes: Challenges and complexities*. Wiley.

World Health Organization. (2009). *Reducing violence through victim identification, care and support programmes.*

World Health Organization. (2011). Global health and aging. *Geneva: World Health Organization*, 1-32.

World Health Organization. (2015). World report on ageing and health. *World Health Organization.*

Wren, M. A., Keegan, C., Walsh, B. M., Bergin, A., Eighan, J., Brick, A., ... & Banks, J. (2017). *Projections of demand for healthcare in Ireland, 2015-2030: First report from the Hippocrates Model*. Economic and Social Research Institute.

Zelnick, J. R., Slayter, E., Flanzbaum, B., Butler, N. G., Domingo, B., Perlstein, J., & Trust, C. (2013). Part of the job? Workplace violence in Massachusetts social service agencies. *Health & social work*, *38*(2), 75-85.

Appendices

Appendix A: Information and Consent Form

Workplace violence in social care settings: Traumatic stress and burnout in staff.

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Take time to decide whether or not you would like to take part.

Who I am and what this study is about?

I am a final year student in the H.Dip Psychology at Dublin Business School. As part of the H.Dip I am undertaking research on traumatic stress and burn-out in social care/care assistant staff who experience workplace violence.

What will taking part involve?

Participation in this study will require you to complete three written questionnaires. We expect that this whole process will take approximately 20-30 minutes. These questionnaires will explore stress and burnout. We will also gather some demographic information. All questionnaires will be anonymised, and as such you can withdraw during the process of completing the survey, however once submitted it will not be possible to withdraw your

questionnaire. Your participation in this research is completely confidential and as such participation will have no adverse consequences on your employment.

Why have you been invited to take part?

I am asking you to take part in this research because your experience as a social care worker/assistant support worker is important in informing knowledge in this area.

Do you have to take part?

Participation in this study is completely voluntary and refusal to participate will not result in any negative consequence whatsoever. All answers will be anonymised, and as such you can withdraw during the process of completing the survey, however once submitted it will not be possible to withdraw your questionnaire.

What are the possible risks and benefits of taking part?

There is a possibility that participation in this research may bring up uncomfortable or distressing emotions or memories. A debrief form will be provided to each participant at the end of participation, including information about the employee access program. This form will outline appropriate support services that people can access if they feel they have been impacted by participating in the research. The benefits of taking part are that you get to share your experience as a care worker which may help advise future opinions and policy relating to social care employment.

Will taking part be confidential?

All information gathered will be anonymised. Questionnaire results will be collated, so no one individual will be identified. Only the lead researcher will be able to identify individual surveys. Your participation in this study is completely confidential. Only the research supervisor and I will have access to the information that you have provided. No information will be given to any employer regarding participation of any employee. However, there are limits to confidentiality. If the researcher has a strong belief that there is a serious risk of harm or danger to either you or another individual (e.g. physical, emotional or sexual abuse, concerns for child protection, rape, self-harm, suicidal intent or criminal activity) or if a serious crime has been committed this information will have to be passed on to the relevant services/professionals.

How will information you provide be recorded, stored and protected?

Data gathered will be stored securely. Only my research supervisor and I will have access to the data. Data from this study will be retained for 1 year, after which point it will be destroyed. Under freedom of information legalisation, you are entitled to access the information you have provided at any time.

What will happen to the results of the study?

Results from this study may be used in presentations or publications of the work. A research report concerning the results will also be submitted to Dublin Business School in part fulfilment of my H. Dip in Psychology.

Who should you contact for further information?

If you would like to ask any further information prior to agreeing to participate in this study, please contact me at xxxxxx@mydbs.ie or my research supervisor, Dr. Sonam Prakashini Banka xxxxxxx@dbs.ie

Thank you very much for your time and participation.

Kind regards,

Daniel Dowling

Consent to Participate

- I voluntarily agree to participate in this research study.
- I understand that even if I agree to participate now, I can withdraw at any time during the survey or refuse to answer any question without any consequences of any kind. However once submitted, it will not be possible to withdraw your responses as they are anonymized.
- I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.
- I understand that participation involves completing three written questionnaires.
- I understand that I will not benefit directly from participating in this research.
- I understand that all information I provide for this study will be treated confidentially.
- I understand that in any report on the results of this research my identity will remain anonymous. This will be done by anonymising and collating the data.
- I understand that if I inform the researcher that myself or someone else is at risk of harm, they may have to report this to the relevant authorities.
- I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Please tick as appropriate:

I agree: ☐	Date: _____
I do not agree: ☐	Date: _____

Appendix B: Demographic Questionnaire

Have you experience physical violence in the workplace	Yes ☐ No ☐
Gender you identify with	Female ☐ Male ☐
Age	
Work Schedule	Full Time ☐ Part Time ☐
Years of employment as Social Care Worker or Assistant Support Worker	_____ Years
Current role	Front line staff ☐ Management ☐
Main area of work	Day service ☐ Residential service ☐ Outreach/Community service ☐ Other ☐
Main population of service users in area of work (Tick all that are applicable).	Intellectual / Developmental Disability, e.g. Autism ☐ Physical Disability ☐ Mental Health Disorder ☐ Acquired Brain Injury ☐ Elderly care ☐ Children's services ☐ Adult services ☐ Other ☐
How often do you personally experience physical aggression/violence?	Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

	Never ☐
How often do you witness physical aggression/violence against colleagues	Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Never ☐
Do you feel like there is a culture of normality towards being exposed to physical violence?	Yes ☐ No ☐
Do you feel like being exposed to physical violence is expected of you from your employer?	Yes ☐ No ☐
Do you feel like the current supports available to you as a social care professional are adequate to maintain your physical and mental wellbeing?	Yes ☐ No ☐
Do you engage in self-care activities, e.g. exercise, mindfulness, making time for yourself etc.	Daily ☐ Weekly ☐ Monthly ☐ Never ☐
Do you see yourself or wish to see yourself in the social care profession in 2-3 years' time?	Yes ☐ No ☐
Do you see yourself or wish to see yourself in the social care profession in 5 years' time?	Yes ☐ No ☐

Appendix C: Impact of Events Scale - Revised

Instructions: The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate (by circling) how distressing each difficulty has been for you *during the past 7 days* with respect to the challenging event. How much were you distressed or bothered by these difficulties?

		Not at all	A little bit	Mod erate -ly	Quite a bit	Ex- treme -ly
1	Any reminder brought back feelings about it.	0	1	2	3	4
2	I had trouble staying asleep.	0	1	2	3	4
3	Other things kept making me think about it.	0	1	2	3	4
4	I felt irritable and angry.	0	1	2	3	4
5	I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6	I thought about it when I didn't mean to.	0	1	2	3	4
7	I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8	I stayed away from reminders about it.	0	1	2	3	4
9	Pictures about it popped into my mind.	0	1	2	3	4
10	I was jumpy and easily startled.	0	1	2	3	4
11	I tried not to think about it.	0	1	2	3	4
12	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13	My feelings about it were kind of numb.	0	1	2	3	4
14	I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15	I had trouble falling asleep.	0	1	2	3	4

16	I had waves of strong feelings about it.	0	1	2	3	4
17	I tried to remove it from my memory.	0	1	2	3	4
18	I had trouble concentrating.	0	1	2	3	4
19	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20	I had dreams about it.	0	1	2	3	4
21	I felt watchful and on guard.	0	1	2	3	4
22	I tried not to talk about it.	0	1	2	3	4

Scoring:

The total score for each subscale should be calculated using the mean of the scored responses. Scores will range from 0 to 4. The maximum 'total mean' IES-R score is 12. Lower scores are better. A total IES-R score of 33 or over from a theoretical maximum of 88 signifies the likely presence of PTSD. The Intrusion subscale is the MEAN item response of items 1, 2, 3, 6, 9, 14, 16, 20. The Avoidance subscale is the MEAN item response of items 5, 7, 8, 11, 12, 13, 17, 22. The Hyperarousal subscale is the MEAN item response of items 4, 10, 15, 18, 19, 21.

Appendix D: Maslach's Burnout Inventory – Human Services Survey

Scoring:

The three MBI-HSS subscale scores should be calculated and interpreted separately and should not be combined to form a single "burnout" score. For ease of interpretation, it is useful to calculate the mean response for items in each scale. For all scales, the mean scores can range from 0 (Never) to 6 (Daily). Calculate the scale Sum and then divide by the number of items in the scale.

:

Appendix E: Letter of Access

Re: Letter of access for research survey.

To whom it may concern;

Daniel Dowling currently works at Nua Healthcare as an Assistant Support Worker. Daniel has requested a letter of access to distribute a survey within the service to investigate the effects of violence in the workplace on staff as part of his Higher Diploma in Psychology research thesis. I am writing this letter to confirm that I am allowing Daniel to distribute this survey among staff. If you have any further questions, please do not hesitate to contact me.

Kind regards,

Deirdre Corrigan

Person in Charge, Nua Healthcare

Appendix F: Survey Completion Debriefing Information Sheet

Thank you for your answers and for your participation, it is greatly appreciated. Your response has been recorded. If you feel that answering this survey has raised some issues for you, please consider contacting some of the support services listed below, or speak to a friend, family member or professional. Some available supports that you may find helpful include:

Aware:

The Aware Support Line 1800 80 48 48

Available Monday – Sunday, 10am to 10pm.

Email for support at: supportmail@aware.ie

Samaritans:

Call on: 116 123

Available 24hours a day, 365 days a year. Free to call.

Email: jo@samaritans.org

Employee Assistance Program

Call 1800 911 909

Available 24 hours a day, 365 days a year

www.layaeap.ie